SINGLE COMMISSIONING BOARD

Day: Tuesday
Date: 11 July 2017
Time: 2.00 pm
Place: George Hatton Hall, Dukinfield Town Hall

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker, Senior Democratic Services Officer, to whom any apologies for absence should be notified.

SOCIAL CARE TRANSFORMATION

To consider the attached report of the Assistant Executive Director (Adults).

7. URGENT ITEMS

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

8. DATE OF NEXT MEETING

To note that the next meeting of the Single Commissioning Board will take place on Tuesday 22 August 2017.

9. EXCLUSION OF THE PUBLIC AND PRESS

That under Section 100A of the Local Government Act 1972 (as amended) the public be excluded for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Schedule 12A to the Local Government Act 1972. Information relating to the financial or business affairs of the parties (including the Council) has been provided to the Council in commercial confidence and its release into the public domain could result in adverse implications for the parties involved. Disclosure would be likely to prejudice the Council's position in negotiations and this outweighs the public interest in disclosure.

10. ANY QUALIFIED PROVIDER (AQP) TO DELIVER ADULT HEARING, DIAGNOSTIC IMAGING (NON OBSTETRIC ULTRASOUND AND MAGNETIC RESONANCE IMAGING (MRI) HEAD AND NECK ONLY)

To consider a report of the Director of Commissioning. The report will be circulated at the meeting as it contains information considered to be Commercial in Confidence.

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker, Senior Democratic Services Officer, to whom any apologies for absence should be notified.

TAMESIDE AND GLOSSOP
SINGLE COMMISSIONING BOARD

22 June 2017

Commenced: 2.00 pm **Terminated: 3.00 pm**

PRESENT: Jamie Douglas (Chair) – Tameside and Glossop CCG
Steven Pleasant – Tameside Council Chief Executive and Accountable Officer for NHS Tameside and Glossop CCG
Councillor Peter Robinson – Tameside MBC
Carol Prowse – Tameside and Glossop CCG

IN ATTENDANCE: Sandra Stewart – Director of Governance
Clare Watson – Director of Commissioning
Gill Gibson – Director of Nursing and Quality
Stephanie Butterworth – Executive Director (People)
Ali Rehman – Public Health
Trevor Tench – Joint Commissioning and Performance Management

APOLOGIES: Alan Dow – Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Councillor Gerald Cooney – Tameside MBC
Christina Greenhough – Tameside and Glossop CCG
Alison Lea – Tameside and Glossop CCG

12. DECLARATIONS OF INTEREST

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

13. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 25 May 2017 were approved as a correct record.

14. PERFORMANCE REPORT

Consideration was given to a report of the Director of Public Health providing an update on quality and performance data. Assurance was provided for the NHS Constitutional Indicators. In addition, Clinical Commissioning Group information on a range of other indicators were included to capture the local health economy position. This was based on the latest published data at the end of April 2017.

The evolving report would align with the other Greater Manchester Health and Social Care Partnership and national dashboard reports. The following were highlighted as exceptions:

- A&E Standards were failed at Tameside Hospital Foundation Trust;
- Ambulance response times were not met at a local or at North West level;
- Improving Access to Psychological Therapies performance for recovery remained a challenge;
- 111 Performance against key performance indicators.

Attached for information was the draft Greater Manchester Partnership dashboard and the latest NHS England improvement and Assessment Framework dashboard.

RESOLVED
That the content of the performance and quality report be noted.

15. CARE HOMES AND CARE HOMES WITH NURSING – CONTRACTUAL MONITORING AND QUALITY ASSURANCE

Consideration was given to a report of the Director of Nursing and Quality informing the Board of planned work in relation to the contract monitoring and quality assurance processes for the Care Home and Care Home with Nursing sector. The report provided a short overview of the Care Quality Commission position for Care Homes and Care Homes with nursing in Tameside and Glossop. This included a summary of the themes identified in Tameside homes where ratings within domains had been reported as 'inadequate' or 'requires improvement'.

The report also provided an early update on planned areas of joint work in respect of contract monitoring and quality assurance for Tameside. This included the intention to develop a full action plan linked to the Greater Manchester Health and Social Care Partnership work programme and aligned to the recently approved proposal for Quality Improvement Team. Reference was made to a number of initial actions identified in the following areas detailed in Section 4 of the report:

- Contractual Performance Documentation and Quality Assurances Processes;
- Contract Performance Database and Systems;
- Governance and Intelligence; and
- Quality Improvement and Support.

RESOLVED
(i) That the content of the report be noted.
(ii) That the initial actions identified at Section 4 of the report be supported.

16. REVIEW OF CANCER DATA

The Board received a report for information from the Director of Public Health detailing local specific actions being developed to ensure the Tameside and Glossop Clinical Commissioning Group in partnership with Tameside and Glossop Integrated Care Foundation Trust contributed to the ambitions set out within the plan for the Greater Manchester Cancer Board and the cancer programme of the Greater Manchester Health and Social Care Partnership. National, Greater Manchester and local data had been used to inform areas of improvement to be incorporated into the locality specific actions to meet the level of ambition with the aim of preventing avoidable deaths, reducing variation and improving experience.

RESOLVED
(i) That the content of the report be noted.
(ii) That a further report be submitted to the next meeting together with locality specific action plan.

17. SAVINGS AND ASSURANCE CONTRACTS AND GRANTS REVIEW

The Director of Commissioning presented a report advising that as part of the savings assurance process a small project team was established to review all NHS and Local Authority investment and contracts with a view to identifying any additional opportunities to make a contribution towards the gap in 2017/18 and ensure effective investment going forward. The project team assigned financial values for 2017/18 against all contracts within the combined contracts database and scrutinised these to identify any opportunities for further savings through demand management, redesign or contract renegotiation.

The Projects Team would be working towards greater clarity of investment through aligning the total investment against both the Care Together and Life Course themes. This would enable a

strategic appraisal of investment against priorities, identification of efficiencies, support value for money analysis and priority areas for redesign / recommissioning.
The detailed analysis of the Single Commission Function contracts and grants had identified the following areas for action:

- Out of locality NHS costs and volume contracts;
- Planned care activity;
- QIPP plan;
- Direct Access Diagnostics contracts;
- Community Cross Border activity;
- Mental Health;
- Block contracts;
- Contracts held by individual GP practices;
- Other contracts

Commissioners had worked with providers to identify the opportunity for savings within Tameside MBC and Clinical Commissioning Group grants, analysing the impact of reductions in funding of 5%, 10% and 15% on service provision. This had been a challenging process and potential savings were detailed in Appendix 1 to the report grouped into the following 5 categories:

- Savings agreed;
- Grants supporting organisational infrastructure;
- Grants supporting actual hours of care;
- Direct care; and
- Contracts where savings had already been achieved through contract / grant negotiations.

RESOLVED

(i) That the savings already achieved through contract / grant negotiations be noted.

(ii) That the range of further actions identified by the project team be noted.

(iii) In recognising the challenges that any reductions would have decisions would not be made until after the Integrated Care Foundation Trust tender for Social Prescribing and Asset Based Community Development concluded to ensure no duplication and that grant funding be extended at 2016/17 level for a further quarter in the interim.

(iv) That the work to achieve greater clarity of investment through aligning the total investment against both the Care Together and Life Course themes be continued.

(v) That the value of the Voluntary and Community Sector be recognised and the Voluntary and Community Sector Compact currently being revised be developed as a whole system document to support a thriving sector providing core services.

18. CARE TOGETHER PROGRAMME MANAGEMENT SUPPORT – CONTRACT EXTENSION

The Programme Director, Care Together, submitted a report which stated that the current contract for care together programme management support awarded to Pricewaterhouse Coopers was for support with the setting up of a comprehensive programme management office for the Care Together Programme and was due to be concluded by 1 June 2017. The report requested authorisation to extend the contract for a further 3 month period.

It was explained that this was due to the initial scoping exercise of Pricewaterhouse Coopers finding that the majority of key economy saving schemes were not as detailed as originally thought and that as a result, a significant gap in the overall financial gap had been identified. Additionally, Princewaterhouse Coopers had set up the Programme Management Office and its systems but these needed to be carried forward by a substantive team. This had taken longer than planned and although recruitment processes had commenced, the team was unlikely to be in place until the

end of August 2017. Without extending the Pricewaterhouse Coopers support, there was unlikely to be sufficient mechanisms to provide assurance on transformational funding and the delivery of economy wide financial savings schemes. The value for the extension period would be a maximum of £200,000.

RESOLVED

(i) That approval be given to extend the contract for a maximum of three months for Pricewaterhouse Coopers management support to the Care Together Programme Office.

(ii) That the contract extension does not exceed £200,000.

(iii) That an update report be presented to a future meeting on the benefits realised to the Care Together programme via this contract.

19. BREASTFEEDING PEER SUPPORT PROGRAMME

Consideration was given to a report of the Director of Public Health explaining that Tameside MBC and Oldham MBC had jointly tendered the breastfeeding peer support programme running for a period of three years from 1 October 2017 with Tameside MBC as the lead commissioner.

The service would focus particularly on those women who were least likely to initiate and continue breastfeeding. Using information provided from needs assessments, a targeted approach would be taken for those areas exhibiting low rates of initiation and maintenance and high levels of deprivation. A breastfeeding peer support service would work in close partnership and help to develop accessible pathways with midwifery, health visiting and children centre services who would demonstrate best practice breastfeeding management through UNICEF baby friendly full accreditation standards.

In relation to current provision and performance, the current provider had 13 staff and 29 trained peer support volunteers delivering two breastfeeding courses per year. Over the past 2 years between 6 and 10 volunteers per course had completed the training and gone on the become volunteers. The current provider's performance was in line with the commissioners expectations and performance data for the period 2016/17 was detailed in the report. The existing contract was due to end on 30 September 2017 and was solely funded by Tameside MBC at the existing annual contract value of £116,250.

A full open joint tender exercise was undertaken by Tameside MBC as the lead commissioner and Oldham MBC using the North West Centre of Excellence electronic tendering portal. Only one tender was received. This was within the available budget and was deemed fully compliant with the tender requirements. The tender was evaluated against the stated criteria and the outcome of the exercise was detailed in Appendix 2 to the report. Given the specialist nature of the service being tendered it was likely that a significant number of the organisations that looked at the tender but did not go on to express and interest would not have had the requisite experience or expertise.

Approval was being sought from the Single Commissioning Board to accept the tender on the basis that procurement activity had resulted in the receipt of only one tender submitted.

RESOLVED

That approval be given under Procurement Standing Order D3.2 to accept the tender submission despite fewer than three tenders being received.

20. TENDER FOR THE PROVISION OF SPECIALIST MENTAL HEALTH SUPPORTED ACCOMMODATION FOR ADULTS WITH COMPLEX HEALTH NEEDS

Consideration was given to a report of the Director of Commissioning which explained that the current contract for the delivery of supported accommodation for adults with complex mental health

needs commenced on 1 June 2014. The contract was awarded for a term of three years with the option to extend for a further two years and under NHS standard contract technical guidance the contract was extended once from 1 April 2017 to 31 March 2018.

The contract currently delivered mental health recovery focused support as required 24 hours a day 365 days a year to individuals living in their own home in three properties across the borough provided by a registered social landlord working with the support provider and individuals to ensure tenancies were able to be maintained.

The overall service was delivered on an outcome model basis on the principles of recovery and rehabilitation. The service facilitated opportunities for individuals to engage in purposeful activity, develop and improve life skills, inclusion within the community and ensure a pathway to recovery that increased independence and a move on to more independent living.

Reference was made to the other alternatives considered, value for money, and the implications if the service was not re-commissioned.

Authorisation was being sought to re-tender the service and continue to commission the delivery of the outcomes above with emphasis on promoting independence pathways supporting people to remain in the community and reducing the need for hospital admission or residential placements.

RESOLVED
That authorisation be given to re-tender for the provision of specialist mental health supported accommodation for adults with complex mental health needs.

21. TENDER FOR THE PROVISON OF A SUPPORTED ACCOMMODATION SERVICE FOR YOUNG ADULTS WITH LEARNING DISABILITIES

Consideration was given to a report of the Director of Commissioning advising that the current contract for the provision of a supported accommodation service for young adults with learning disabilities commenced on 16 February 2015 for a period of three years with the option to extend for up to a further two years. The key objectives of the service had been to provide intensive assessment, support, enablement and development of life skills to five young adults with learning disabilities who had recently made the transition from Children's Services through to Adult Services.

The active engagement with families, carers and other stakeholders in a collaborative approach to supporting each person using the service to fulfil their maximum potential had also been key to successful delivery. The accommodation offered five self-contained flats and a staff flat.

Authorisation was being sought for a contract extension from 1 April 2018 to 31 March 2020 to continue to deliver these outcomes with a continued emphasis on promoting independent pathways for individuals and ensuring there was an opportunity to move on. This would be achieved through the provider delivering person-centred approaches and working in a multi-disciplinary way with key partners.

RESOLVED
That authorisation be given to extend the contract for the provision of a supported accommodation service for young adults with learning disabilities from 1 April 2018 to 31 March 2020 in line with clause 3.2.

22. TENDER FOR THE PROVISION OF A SUPPORTED ACCOMMODATION SERVICE FOR ADULTS WITH LEARNING DISABILITIES

Consideration was given to a report of the Director of Commissioning which explained that the contract for the delivery of supported accommodation for adults with a learning disability was divided into four contract lots delivering support as required 24 hours a day 365 days a year to individuals with a learning disability living in their own home in the community. The service was based on the principles of person-centred support, the promotion of independence and enablement and community engagement giving people the opportunity to make a positive contribution to the communities they live in and the potential to move away from the need for paid support.

The accommodation was provided by a number of registered social landlords working with the support providers and individuals to ensure tenancies were able to be maintained. The accommodation in each contract lot was made up of houses where a number of individuals shared facilities and extra care schemes where people had their own self-contained flat within a building specifically for that service contract.

Reference was made to other alternatives that had been considered, implications if the service was not re-commissioned, value for money and contract performance.

Authorisation was being sought from the Board to extend the contract lots from 1 April 2018 to 31 March 2020. The service extension would continue to deliver the outcomes detailed above with a continued emphasis on promoting independent pathways. This would be achieved through the provider delivering person-centred approaches and working in a multi-disciplinary way with key partners.

RESOLVED
That authorisation be granted to extend the contract lots for the provision of a supported accommodation service for adults with learning disabilities from 1 April 2018 to 31 March 2020 in line with clause 3.2.

23. DRUG AND ALCOHOL RECOVERY SERVICE: CONTRACT NOVATION AND MONITORING

At the Single Commissioning Board meeting held on 25 May 2017, the Board adopted a recommendation to transfer the contract for the local Drug and Alcohol Recovery Service from Lifeline to CGL (Change, Grow, Live) from 1 June 2017. This was prompted by a request from Lifeline and CGL based on an agreement that had been reached between them following the change in the financial circumstances of Lifeline. The terms of the novated contract were the same as that agreed with Lifeline in 2015 running to July 2025.

In view of concerns raised, the comments of the Section 151 Officer, the short notice of the change, the limited knowledge of the new provider and the absence of a tender process, the Board requested a proposal for enhanced financial and performance monitoring to support assurance and consideration of whether a re-tender was necessary.

The Board considered a report of the Director of Public Health outlining a proposed monitoring framework to build on the existing process including the following elements:

- Current contract monitoring process;
- Tameside MBC Internal Audit and Care Quality Commission reviews in July 2017;
- Additional financial monitoring and organisational intelligence;
- Enhanced monitoring measures identified by the commissioner Clinical Lead;
- Nationally published statistics.

The Single Commissioning Board Clinical Lead for substance misuse had identified alcohol community detox activity as an important indicator of service quality and performance. National data collection did not currently provide adequate monitoring data and the provider had committed to review recording. Details of the current monitoring framework would be reviewed with the

Clinical Lead and the Quality Team with a view to identifying further aspects of performance that required closer examination.

RESOLVED

(i) That the proposed monitoring framework included in the current contract and the additional elements be endorsed.

(ii) That a contract monitoring report be submitted to the October 2017 meeting of the Single Commissioning Board.

24. URGENT ITEMS

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

25. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 11 July 2017 commencing at 2.00 pm at Dukinfield Town Hall.

CHAIR

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	11 July 2017
Officer of Single Commissioning Board	Kathy Roe – Director Of Finance – Single Commission Ian Duncan - Assistant Executive Director – Tameside Metropolitan Borough Council Finance Claire Yarwood – Director Of Finance – Tameside and Glossop Integrated Care NHS Foundation Trust
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2017/18 CONSOLIDATED FINANCIAL MONITORING STATEMENT AT 31 MAY 2017 AND PROJECTED OUTTURN TO 31 MARCH 2018**
Report Summary:	This is a jointly prepared report of the Tameside & Glossop Care Together constituent organisations on the consolidated financial position of the Economy. The report provides a 2017/2018 financial year update on the month 2 financial position (at 31 May 2017) and the projected outturn (at 31 March 2018). The Tameside & Glossop Care Together Single Commissioning Board are required to manage all resources within the Integrated Commissioning Fund. The CCG and the Council are also required to comply with their constituent organisations' statutory functions. A summary of the Tameside and Glossop Integrated Care NHS Foundation Trust financial position is also included within the report. This is to ensure members have an awareness of the overall financial position of the whole Care Together economy and to highlight the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the financial gap next year and through to 2020/21.
Recommendations:	Single Commissioning Board Members are recommended : To note the 2017/2018 financial year update on the month 2 financial position (at 31 May 2017) and the projected outturn (at 31 March 2018). Acknowledge the significant level of savings required during the period 2017/18 to 2020/21 to deliver a balanced recurrent economy budget. Acknowledge the significant amount of financial risk in relation to achieving an economy balanced budget across this period.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	This report provides the consolidated financial position statement of the 2017/18 Care Together Economy for the period ending 31 May 2017 (Month 2 – 2017/18) together with a projection to 31 March 2018 for each of the three partner organisations. The report explains that there is a clear urgency to implement associated strategies to ensure the projected funding gap is addressed and closed on a recurrent basis across the whole economy.

	A risk share arrangement is in place between the Council and CCG relating to the residual balance of net expenditure compared to the budget allocation at 31 March 2018, the details of which are provided within the report. It should be noted that the Integrated Commissioning Fund for the partner Commissioner organisations will be bound by the terms within the Section 75 agreement and associated Financial Framework agreement which has been duly approved by both the Council and CCG.
Legal Implications: **(Authorised by the Borough Solicitor)**	Given the implications for each of the constituent organisations this report will be required to be presented to the decision making body of each one to ensure good governance.
How do proposals align with Health & Wellbeing Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Health and Wellbeing Strategy
How do proposals align with Locality Plan?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Locality Plan
How do proposals align with the Commissioning Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Single Commissioning Strategy
Recommendations / views of the Professional Reference Group:	A summary of this report is presented to the Professional Reference Group for reference.
Public and Patient Implications:	Service reconfiguration and transformation has the patient at the forefront of any service re-design. The overarching objective of Care Together is to improve outcomes for all of our citizens whilst creating a high quality, clinically safe and financially sustainable health and social care system. The comments and views of our public and patients are incorporated into all services provided.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	The reconfiguration and reform of services within Health and Social Care of the Tameside and Glossop economy will be delivered within the available resource allocations. Improved outcomes for the public and patients should reduce health inequalities across the economy.
What are the Equality and Diversity implications?	Equality and Diversity considerations are included in the re-design and transformation of all services
What are the safeguarding implications?	Safeguarding considerations are included in the re-design and transformation of all services

What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report and therefore a privacy impact assessment has not been carried out.
Risk Management:	Associated details are specified within the presentation
Access to Information :	Background papers relating to this report can be inspected by contacting :

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TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position

2017/2018 Revenue & Capital Monitoring Statements

Period Ending 31 May 2017 (Month 2)

11 July 2017

Kathy Roe
Claire Yarwood
Ian Duncan

NHS Tameside and Glossop Clinical Commissioning Group

NHS Tameside and Glossop Integrated Care NHS Foundation Trust

Tameside Metropolitan Borough

Section 1

Care Together Economy

Revenue Financial Position

Care Together Economy Revenue Financial Position

	Year to Date (M2)			Year End			Movement	
	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Single Commission	79,962	79,952	10	483,063	489,846	(6,783)	0	(6,783)
ICFT	(4,496)	(4,635)	(139)	(24,506)	(24,506)	0	0	0
Total Whole Economy	**75,466**	**75,317**	**(129)**	**458,557**	**465,340**	**(6,783)**	**0**	**(6,783)**

Single Commission - Risk Share	£'000	£'000	£'000
TMBC - Non Recurrent Contribution	(5,000)	0	(5,000)
TMBC	(309)	0	(309)
CCG	(1,474)	0	(1,474)
Total	**(6,783)**	**0**	**(6,783)**

The 2017/18 financial position in all 3 organisations is shown in the table above. The projected year end deficit across the economy is currently £6.783 m:

- The CCG is reporting that all financial control totals will be met. However there is meaningful risk attached to this. Against a £23.9m QIPP target there are £17m of savings which we are certain of meeting. Leaving £6.8m still to be delivered, there is significant risk attached to fully realising this residual target.

- Further analysis is required on the forecast net expenditure of Children's Services to 31 March 2018. A nil variance is currently reported, however this will be updated within the month 3 report presented to the Single Commissioning Board.

- The risk share of the projected year end single commission deficit by constituent organisation is provided. This includes a non recurrent contribution of £5 million by TMBC with a reciprocal arrangement by the CCG within a 4 year period as per the terms of the ICF Financial Framework

- ICFT are working to a £24.5m deficit position for 2017/18. This has not yet been agreed by NHSI. Delivery of £10.4m efficiencies are required to meet this control total.

Tameside & Glossop CCG

£000's	Year to Date (M2)			Year End			Movement	
Description	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
Acute	32,996	33,053	(58)	202,953	202,973	(20)	0	(20)
Mental Health	4,934	4,925	9	29,563	29,563	(0)	0	(0)
Primary Care	13,543	13,370	174	83,983	83,928	55	0	55
Continuing Care	2,278	2,297	(19)	13,668	13,599	69	0	69
Community	4,570	4,547	23	27,457	27,526	(69)	0	(69)
Other	3,489	3,722	(233)	18,712	18,747	(35)	0	(35)
QIPP	0	0	0	0	6,840	(6,840)	0	(6,840)
CCG Running Costs	835	730	105	5,155	5,155	0	0	0
CCG Expenditure	**62,644**	**62,644**	**(0)**	**381,491**	**388,331**	**(6,840)**	**0**	**(6,840)**
CCG Surplus	**4,261**	**4,261**	**0**	**7,174**	**7,174**	**0**	**0**	**0**

For 2017/18 the CCG has an allocation of £381,491k, from this baseline the CCG is expected to:

- Deliver a surplus of 1% (£3,496k),
- Achieve a £23,900k QIPP target.
- Keep 0.5% of allocation uncommitted to fund a national system risk reserve
- Demonstrate growth in Mental Health spend of 2%
- Remain within the running costs allocation

In 2016/17 the CCG had to keep 1% (£3,678k) of the allocation uncommitted in line with nation planning guidance. This was used to create a national system risk reserve which mitigated significant financial risk across the NHS as a whole, in particular within the provider sector. In March 17 a letter was received asking CCGs to release this reserve and increase surpluses.

This additional surplus has been carried forward into CCG accounts in 2017/18, Increasing the total surplus reported in the table above to £7,174k. While this carry forward is included in our financial position for reporting purposes, it is important to appreciate that the CCG is not able to access this resource.

Comprehensive post reconciliation data for 2016/17 had still not been received and verified at the point the M2 position was finalised. As such the M2 position does include the impact of any cross year benefits or pressures. However we anticipate the net impact of any movements will be small and this will be reflected in the M3 position.

As things stand the CCG still needs to find £6,840k of additional savings in order to fully address the QIPP target and meet financial control totals. A more comprehensive exploration of QIPP performance is included later in this report.

The table to the right details the financial position at M2 by directorate. Highlights include:

- **Acute**: While we have received pre reconciliation data for M1 from providers, this data is very much provisional and subject to change. Several organisations have caveated the M1 data provided, citing problems caused by the recent cyber attack.

  As such it is difficult to draw firm conclusions about performance or to assess if some of our QIPP targets are on trajectory. For this reason, we are forecasting to plan for all of our big acute providers. That said there was nothing to cause particular alarm in the data we have seen, overall activity appears to be broadly in line with plan, though we do have a small pressure caused by a high cost critical care patient at Central Manchester.

  The £20k adverse variance in the position relates to a marked increase in MSK and physio activity at CATs. Further work will be done to determine if this is a one off spike or part of an ongoing trend.

The figure quoted in the table differs from that reported to NHS England in the Non ISFE return, due to the treatment of QIPP and national profiling of the surplus. This variance is purely presentational and does not affect the underlying position. It has been agreed at Single Commissioning Board, that all financial gaps (including QIPP) should be treated as a deficit for the purposes of internal reporting until there is absolute certainly on delivery of the savings (i.e., those schemes which are reported as green or blue in QIPP/recovery plans)

Tameside & Glossop CCG

- **Mental Health:** The current mental health forecast ensures that the CCG will meet statutory duties around the Mental Health Investment Standard (MHIS). This includes an element of the forecast which is currently 'unallocated'.

  It may be that some of this can safely be released to QIPP while still meeting the MHIS. However we are also cognisant of the five year forward view and the investment requirement associated with this. There are ongoing discussions at GM level in order to understand the implications and any potential funding streams to address the five year forward review. This element of the forecast will be reviewed once the requirements are clear.

  Out of area MH placements managed by the individual commissioning teams are assumed to budget until the CHC review is concluded.

- **Primary Care**: We have a challenging QIPP target of £2.5m against prescribing in 17/18. In order to achieve this, there will need to be a concerted effort between GP practices and the CCG to maintain the progress made towards the end of 16/17. PMD data containing the prescribing position for April will not be available until mid June, therefore the M2 position reflects a breakeven position pending more detailed information.

  The favourable position on Primary Care relates to Delegated Co-Commissioning.

- **Continuing Care**: A breakeven position has been assumed for M2 reporting, however we are aware of significant financial risk against this budget. A financial recovery plan for CHC is being prepared, which will quantify the pressure and look at ways to mitigate risk. Forecasts will be updated once this plan has been completed.

- **Community:** The contract for intermediate care provision at Grange View will come to an end in 2017, with the service transferring to the ICFT. At budget setting we knew there would be a £300k pressure associated with this. However, following contract negotiations with Meridian about payments during the wind down period we have been able to reduce this pressure down to £69k.

- **Other:** At M2 there is nothing in the position relating to the additional costs of surgical activity moving to Stockport as part of Healthier Together, which we know will be a pressure in future months.

- **CCG Running Costs**: To date £390k of corporate QIPP savings have been realised and we are track to remain within control total for running costs. Staff vacancies and budget for services previously commissioned from GMSS explain the YTD underspend. This is being discussed with budget holders with view to moving to QIPP next month.

The Financial Gap

Establishing the Financial Gap

- The financial gap as outlined in the locality plan across the health and social care economy in Tameside & Glossop is estimated to be £70.2m by 2020/21.
- In 2017/18 the required savings by organisation is:

CCG	£23,900k
TMBC	£773k
ICFT	£10,349k
Total	**£35,022k**

- Against an annual CCG target of £23.9m, £8.78m (37%) of the required savings have been banked in the first 2 months of the year. This puts us slightly ahead of trajectory on a YTD basis.
- In addition to this there is a further £8.28m, which we are completely confident of realising in future months. Leaving savings of £6.84m still to find.
- After optimism bias we anticipate making further savings of £3.88m from schemes currently rated as amber or red. This leaves post optimism savings still to find of £3m.
- While this is an improvement since last month, it needs to be noted this is before application of pressures on continuing health care and for healthier together. There is still significant risk to fully achieving the QIPP target.
- As such it is important that more work is done to turn amber/red scheme green and to bring new schemes forward in order to close this residual gap.
- £12.99m (54%) of the expected savings will be delivered on a recurrent basis, contributing toward closing the recurrent £70 economy wide gap.
- A more detailed table of QIPP schemes is included as an appendix to this report.

Planned Savings (before application of optimism bias)

	Recurrent	Non Recurrent	Total	Prior Month	Movement
R	3,022,902	2,428,000	5,450,902	5,950,902	-500,000
A	6,429,067	240,000	6,669,067	6,875,268	-206,201
G	4,433,883	3,843,560	8,277,443	10,572,932	-2,295,490
B	5,041,211	3,741,820	8,783,031	5,791,820	2,991,211
	18,927,062	**10,253,380**	**29,180,442**	**29,190,922**	**-10,480**

Expected Savings (after application of optimism bias)

	Recurrent	Non Recurrent	Total	Prior Month	Movement
R	302,290	242,800	545,090	595,090	-50,000
A	3,214,534	120,000	3,334,534	3,437,634	-103,101
G	4,433,883	3,843,560	8,277,443	10,572,932	-2,295,490
B	5,041,211	3,741,820	8,783,031	5,791,820	2,991,211
	12,991,917	**7,948,180**	**20,940,097**	**20,397,476**	**542,621**

QIPP Target	**23,900,000**	**23,900,000**	**0**
Savings Still to find	**2,959,903**	**3,502,524**	**-542,621**

Value of savings about which we are certain (i.e blue & green schemes) 17,060,473

Tameside MBC

	Year to Date (M2)			Year End			Movement	
	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Adult Social Care & Early Intervention	5,480	5,470	10	49,672	49,615	57	0	57
Children's Services, Strategy & Early Intervention	5,234	5,234	0	35,192	35,192	0	0	0
Public Health	6,604	6,604	0	16,708	16,708	0	0	0
Total	**17,318**	**17,308**	**10**	**101,572**	**101,515**	**57**	**0**	**57**

Adult Social Care

- There are no material variations projected at this stage in the financial year. It should be noted however that the budget includes the additional investment announced in the spring budget on 8 March 2017, a total allocation of £ 10.296 million to the local economy over the three financial year period to 2019/2020. £ 5.365 million is allocated to 2017/2018. Investment proposals were presented to the Single Commissioning Board on 25 May 2017 which are being developed further (where appropriate) to ascertain the benefits which will be realised across the local economy.

Children's Social Care

- Further analysis is required on the forecast net expenditure of Children's Services to 31 March 2018. A nil variance is currently reported, however this will be updated within the month 3 report presented to the Single Commissioning Board.

Public Health

- There are no material variations projected at this stage in the financial year. However it should be noted that the Community Services contract value c £ 5.02 million will be wholly paid in advance of 30 June 2017 to the Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT) to support the cashflow of the organisation and reduce the value of loan finance interest payable during 2017/2018. The value of the investment interest forgone by the Council will be recovered from the ICFT during quarter four of this financial year.

Tameside and Glossop Integrated Care NHS Foundation Trust

Description	Year to Date			Forecast		
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s
Income	34,009	34,447	438	204,752	204,752	0
Expenditure	37,037	37,558	521	224,864	224,864	0
EBITDA	(3,028)	(3,111)	(83)	(20,112)	(20,112)	0
Financing	1,468	1,524	56	4,394	4,394	0
Normalised Surplus/(Deficit)	(4,496)	(4,635)	(139)	(24,506)	(24,506)	0
Exceptional Items	0	28	28	159	159	0
Net Deficit after Exceptional Costs	(4,496)	(4,664)	(168)	(24,665)	(24,665)	0

Financial Position

- For the 2 months to May 2017, the ICFT is delivering a deficit of £4.7m, which is £0.2m worse than plan
- The Trust will undertake a detailed forecast at Month 3 and is currently forecasting breakeven. Key risks include:
  - Delivery of the £10.4m, Trust Efficiency Programme.
  - Referrals from associates commissioners falling and the Trust being able to remove costs at the same rate
  - Continued reliance on Agency staffing in a number of key specialties.
  - Delivery of the Tameside and Glossop CCG block contract and activity levels staying in line with those planned.

Key Risks to the Financial Position

- Increased expenditure on agency staffing.
- Cost of Escalated beds as the Hospital continues to have a High occupancy rate.
- Savings relating to transformation schemes being delivered.
- Performance targets requiring unplanned expenditure to use the independent sector.

Key Information

- The Trusts has still not agreed its control total with NHSI.
- As the Trust is planning for a deficit, there is a requirement for a DH loan to fund it. The Trust will be subject to a higher interest rate for borrowing if a control total is not agreed.

Integrated Commissioning Fund 2017/18

£000's	Year to Date (M2)			Year End			Movement	
Description	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
Acute	32,996	33,053	(58)	202,953	202,973	(20)	0	(20)
Mental Health	4,934	4,925	9	29,563	29,563	(0)	0	(0)
Primary Care	13,543	13,370	174	83,983	83,928	55	0	55
Continuing Care	2,278	2,297	(19)	13,668	13,599	69	0	69
Community	4,570	4,547	23	27,457	27,526	(69)	0	(69)
Other	3,489	3,722	(233)	18,712	18,747	(35)	0	(35)
QIPP	0	0	0	0	6,840	(6,840)	0	(6,840)
CCG Running Costs	835	730	105	5,155	5,155	0	0	0
CCG Sub Total	**62,644**	**62,644**	**(0)**	**381,491**	**388,331**	**(6,840)**	**0**	**(6,840)**
Adult Social Care & Early Intervention	5,480	5,470	10	49,672	49,615	57	0	57
Childrens Services, Strategy & Early Intervention	5,234	5,234	0	35,192	35,192	0	0	0
Public Health	6,604	6,604	0	16,708	16,708	0	0	0
TMBC Sub Total	**17,318**	**17,308**	**10**	**101,572**	**101,515**	**57**	**0**	**57**
GRAND TOTAL	**79,962**	**79,952**	**10**	**483,063**	**489,846**	**(6,783)**	**0**	**(6,783)**

A: Section 75 Services	**45,127**	**45,212**	**(85)**	**265,029**	**268,864**	**(3,835)**
CCG	33,107	33,159	(52)	200,085	203,720	(3,635)
TMBC	12,020	12,053	(33)	64,944	65,144	(200)
B: Aligned Services	**29,441**	**29,407**	**34**	**184,678**	**187,050**	**(2,373)**
CCG	24,143	24,152	(9)	148,050	150,679	(2,630)
TMBC	5,298	5,255	43	36,628	36,371	257
C: In Collaboration Services	**5,394**	**5,333**	**61**	**33,356**	**33,932**	**(575)**
CCG	5,394	5,333	61	33,356	33,932	(575)
TMBC	0	0	0	0	0	0

Risk and Other Issues

- The main financial risks to the financial position of the the Integrated Commissioning Fund are listed below.
- Detailed registers including further information on risk and mitigating actions are regularly reviewed at Audit Committee. Copies are available on request.

Transformation Funding

- Transformation funding of £23.2m has been approved by Greater Manchester Health & Social Care Partnership. The Investment Agreement that will support the release of the funding been developed and was signed on 16 December 2016. Subject to continuing to meet performance trajectories, we anticipate that £7.97m will be received by the economy in 2017/18.

Financial risk	Probability	Impact	Risk	RAG
Not spending transformation money in a way which delivers required change	2	4	8	A
Over spend against GP prescribing budgets	3	4	12	R
Over spend against Continuing Health Care budgets	4	4	16	R
Operational risk between joint working.	1	5	5	A
Failure to meet recurrent QIPP targets	4	4	16	R
Over spend on PbR contracts	3	4	12	A
CCG Fail to maintain expenditure within the revenue resource limit and achieve a 1% surplus.	3	4	12	A
In year cuts to Council Grant Funding	2	3	6	A
Care Home placement costs are dependent on the current cohort of people in the system and can fluctuate throughout the year	4	4	16	R
Looked After Children placement costs are volatile and can fluctuate throughout the year	3	4	12	A
Unaccompanied Asylum Seekers	4	3	12	A
Care Home Provider Market Failure	3	5	15	R
Funded Nursing Care – impact of national changes to contribution rates and potential legal challenge	4	3	12	A
IR35 – the potential impact of reduced availability of 'off payroll' workers from 6 April 2017 and the increased cost impact if they are subsequently employed by the Economy.	4	4	16	A

Section 2

Appendices

Tameside MBC – Capital

Scheme	Approved Capital Total Scheme Budget	Approved 2017/2018 Allocation	Expenditure to Month 2	Projected Expenditure to 31 March 2018	2017/2018 Projected Outturn Variation	Scheme Comments
	£'000	£'000	£'000	£'000	£'000	
Children's Services - In Borough Residential Properties	912	125	32	125	0	Purchase of 2 additional in-borough properties including associated property adaptations. An Edge of Care establishment is yet to be purchased
Public Health - Leisure Estate Reconfiguration	20,268	10,174	5	10,174	0	**Active Dukinfield (ITRAIN)** - The scheme is complete and the facility fully operational. **Active Longendale (Total Adrenaline)** - The scheme is complete and the facility fully operational. **Active Hyde (Pool Extension)** - The scheme has been tendered and additional investement is required to deliver the scheme as planned. The additional investment is yet to be confirmed. **Denton Wellness Centre** – Key Decision taken in April 2017 which approved the project and associated timescale. **Medlock Roof -** Works now complete. **Wave Machine Replacement at Active Hyde -** Work to be undertaken to concide with the Pool extension scheme. **Pitch Replacement Scheme at Active Copley** - Works completed.
Adult Services - Disabled Facilities Grant - Adaptations	2,950	2,950	197	TBC	TBC	
Total	24,130	13,249	234	10,299	0	

GM Transformation Funded Schemes

Scheme Description	Progress
Home First	Underway – delivering reduced length of stay
Digital Health	Underway – pilot commenced in March 2017
Neighbourhoods	Recruitment to some posts completed. Caseload reviews commenced in April 2017
System Wide Self Care	Delivery commenced 1 April 2017 in Glossop. Tender launched 31 March 2017 for Tameside
Flexible Community Beds	Grange view has stopped taking new patients. Full service transfer from 1 July 2017
Home Care	In Development
Organisational Development	Economy OD engagement events taken place. Future sessions in neighbourhoods to be arranged
Estates	Underway

CCG QIPP Schedule

2017/18 QIPP (£)	R	A	G	B	Grand Total	Expected Saving	Opening Target
Tameside FT	0	0	3,698,883	739,777	4,438,659	4,438,659	4,438,659
Other Associate Providers	0	2,752,729	0	0	2,752,729	1,376,365	2,752,729
Other Acute	1,530,000	291,286	0	557,233	2,378,519	855,876	2,378,519
GP Prescribing	1,123,350	1,393,000	0	0	2,516,350	808,835	2,516,350
CCG Commissioned Primary Care	35,000	223,825	29,000	2,724,000	3,011,825	2,868,413	3,011,825
Delegated Primary Care	0	87,500	0	0	87,500	43,750	587,500
Community Health Services	828,000	0	0	1,310,217	2,138,217	1,393,017	2,138,217
Continuing Healthcare	934,552	0	0	0	934,552	93,455	934,552
Mental Health	0	700,000	62,000	232,000	994,000	644,000	994,000
Corporate	0	626,163	120,000	390,837	1,137,000	823,919	1,137,000
Other	1,000,000	594,564	524,000	87,147	2,205,711	1,008,429	2,205,711
Reserves	0	0	3,843,560	2,741,820	6,585,380	6,585,380	804,938
Grand Total	**5,450,902**	**6,669,067**	**8,277,443**	**8,783,031**	**29,180,442**	**20,940,097**	**23,900,000**

	R	A	G	B	Grand Total	Expected Saving
Recurrent	3,022,902	6,429,067	4,433,883	5,041,211	18,927,062	12,991,917
Non Recurrent	2,428,000	240,000	3,843,560	3,741,820	10,253,380	7,948,180
Grand Total	**5,450,902**	**6,669,067**	**8,277,443**	**8,783,031**	**29,180,442**	**20,940,097**

N.B.

It should be noted that green and blue schemes total a £17.060m against a QIPP target of £23.900m . This leaves a sum of £6.840m to be delivered (as per the month 2 CCG summary table on slide 4).

There is a significant risk to the delivery of this residual balance.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	11 July 2017
Officer of Single Commissioning Board	Kathy Roe – Director Of Finance – Single Commissioning Team Ian Duncan - Assistant Executive Director – Tameside Metropolitan Borough Council Finance
Subject:	**REVIEW OF THE 2016/17 SECTION 75 AGREEMENT**
Report Summary:	Under the terms of the Financial Framework for the Integrated Commissioning Fund and in accordance with requirements of the Section 75 Agreement and associated regulations, the Chief Financial Officer(s) designated as the Pooled Fund Manager(s) must present an annual return to the Single Commissioning Board. This return is to include details of the income and expenditure within the Pooled Fund and include other pertinent information by which the Partners can monitor the effectiveness of the Pooled Fund. This report represents the annual return for 2016/17.
Recommendations:	Single Commissioning Board Members are recommended to note the review of the Section 75 agreement within the wider Integrated Commissioning Fund and formally authorise this report in accordance with the governance outlined at Paragraph 11 of the 2016/17 Financial Framework for the Integrated Commissioning Fund.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	These are the subject of the report.
Legal Implications: **(Authorised by the Borough Solicitor)**	Given the implications for each of the constituent organisations this report will be required to be presented to the decision making body of each one to ensure good governance.
How do proposals align with Health & Wellbeing Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Health and Wellbeing Strategy
How do proposals align with Locality Plan?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Locality Plan
How do proposals align with the Commissioning Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Single Commissioning Strategy
Recommendations / views of the Professional Reference Group:	The report has not been considered by the Professional Reference Group
Public and Patient Implications:	Service reconfiguration and transformation has the patient at the forefront of any service re-design. The overarching objective of Care Together is to improve outcomes for all of our citizens whilst creating a high quality, clinically safe and financially sustainable health and social care system. The comments and views of our public and patients are incorporated into all services provided.

Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	The reconfiguration and reform of services within Health and Social Care of the Tameside and Glossop economy will be delivered within the available resource allocations. Improved outcomes for the public and patients should reduce health inequalities across the economy.
What are the Equality and Diversity implications?	Equality and Diversity considerations are included in the re-design and transformation of all services
What are the safeguarding implications?	Safeguarding considerations are included in the re-design and transformation of all services
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report and therefore a privacy impact assessment has not been carried out.
Risk Management:	Associated details are included within the Section 75 agreement
Access to Information :	Background papers relating to this report can be inspected by contacting : Stephen Wilde, Finance Business Partner, Tameside Metropolitan Borough Council  Telephone:0161 342 3726  e-mail: stephen.wilde@tameside.gov.uk Tracey Simpson, Deputy Chief Finance Officer, Tameside and Glossop Clinical Commissioning Group  Telephone:0161 342 5626  e-mail: tracey.simpson@nhs.net

1 INTRODUCTION

1.1 Under the terms of the Financial Framework for the Integrated Commissioning Fund and in accordance with requirements of the Section 75 Agreement and associated regulations, the Chief Financial Officer(s) designated as the Pooled Fund Manager(s) must present an annual return to the Single Commissioning Board. This return is to include details of the income and expenditure within the Pooled Fund and include other pertinent information by which the Partners can monitor the effectiveness of the Pooled Fund. This report represents the annual return for 2016/17.

2 SECTION 75 AGREEMENT

2.1 The Section 75 Agreement commenced 2016/17 at a value of £216.40 million which includes the Better Care Fund. The Wider Aligned and In Collaboration funds were also added to provide a total Integrated Commissioning Fund value of £435.52m. The opening balances approved for the 2016/17 financial year are provided at **Appendix 1**.

2.2 During the course of 2016/17 values were amended to reflect changes in CCG allocations and Tameside Council resources. A particular feature for 2016/17 was the receipt of £5.2 million transformation funding to the Tameside and Glossop Local Health Economy from the Greater Manchester Health and Social Care Partnership.

2.3 The closing value of the Section 75 Agreement at 31 March 2017 was £233.03 million reflecting an increase of £16.63 milion during 2016/17. Taking into consideration the changes in year to the wider Aligned Budget and In Collaboration funds, the total net increase to the Integrated Commissioning Fund was £17.66 million at 31 March 2017.

2.4 As Host Partner for the pooled fund, Tameside Council reported the following closing balances in the 2016/17 Annual Accounts:

2016/17 Integrated Commissioning Fund Closing Balances at 31 March 2017

	Section 75	Wider Aligned Budget	In Collaboration	Total
	£'000	£'000	£'000	£'000
Acute	85,924	111,784	0	197,708
Mental Health	28,757	0	0	28,757
Primary Care	6,595	43,529	31,591	81,715
Continuing Care	13,388	0	0	13,388
Community	27,101	0	429	27,530
Other	25,014	1,788	961	27,763
CCG Running Costs	4,411	0	0	4,411
CCG Sub Total	**191,191**	**157,101**	**32,981**	**381,272**
Adult Social Care	40,381	1,575	0	41,956
Childrens' Social Care	191	28,493	0	28,684
Public Health	1,264	0	0	1,264
Council Sub Total	**41,836**	**30,068**	**0**	**71,904**
Grand Total:	**233,027**	**187,169**	**32,981**	**453,176**

3. PROGRESS

3.1 Monthly consolidated economy finance reports have been submitted to the Single Commissioning Board throughout 2016/17 which detail the movements of financial flows between the different components of the Integrated Commissioning Fund month by month. The Financial Framework document and Section 75 Agreement (incorporating the Better Care Fund) has been updated for 2017/18 and includes the 2017/18 opening budgets together with a risk sharing arrangement between the Clinical Commissioning Group and Tameside Council. Monitoring information will continue to be reported to the Single Commissioning Board in 2017/18 on a monthly basis to enable the Single Commissioning Board to monitor the effectiveness of the Pooled Fund.

4 RECOMMENDATION

4.1 As stated on the report cover.

Appendix 1

SUMMARY OF SERVICES INCLUDED WITHIN THE INTEGRATED COMMISSIONING FUND 2016-17

SECTION 75 SERVICES

Service Area	Net 2016/17 Budget £'000	Net 2016/17 Forecast £'000
TMBC		
Adult Social Care	25,682	40,170
Adults Early Intervention	1,287	1,272
Childrens Social Care - Youth Offending Team	136	134
Public Health	1,571	2,342
Capital Investment - Revenue	0	1,808
2% Social Care Precept	0	-1,429
Non Recurrent Transitional Budget (16/17) - Adult Services	8,000	0
TMBC Total	**36,675**	**44,296**
TMBC - Efficiencies To Deliver Financial Balance		
Adult Social Care	0	-14,488
Non Recurrent Transitional Budget (16/17) - Adult Services	0	8,000
Adults Early Intervention	0	16
Childrens Social Care - Youth Offending Team	0	2
Public Health	0	-772
Capital Investment - Revenue	0	-1,808
2% Social Care Precept	0	1,429
TMBC Total inc Efficiencies	**36,675**	**36,675**
CCG		
Tameside FT Contract (excludes community transfer)	73,372	73,372
CCG Commissioned Primary Care	6,198	6,198
Continuing Care	13,902	13,902
Mental Health	28,150	28,150
Acute (excludes Tameside FT)	14,179	14,179
Community	27,579	27,579
Corporate	5,151	5,151
BCF - Derbyshire Only - Tameside Included Wihin Adult Social Care	2,205	2,205
Other	8,989	8,989
CCG Total	**179,725**	**179,725**
Grand Total Section 75 Services including Efficiencies/QIPP	**216,400**	**216,400**

ALIGNED SERVICES		
Service Area	**Net 2016/17 Budget £'000**	**Net 2016/17 Forecast £'000**
TMBC		
Adult Social Care	1,413	1,374
Childrens Social Care	18,435	24,184
Childrens Strategy & Early Intervention	1,828	1,929
Non Recurrent Transitional Budget (16/17) - Childrens Services	4,000	0
TMBC Total	**25,676**	**27,486**
TMBC - Efficiencies To Deliver Financial Balance		
Adult Social Care	0	40
Childrens Social Care	0	-5,749
Non Recurrent Transitional Budget (16/17) - Childrens Services	0	4,000
Childrens Strategy & Early Intervention	0	-101
TMBC Total inc CIP	**25,676**	**25,676**
CCG		
Tameside FT Contract (excludes community transfer)	59,451	60,451
CCG Commissioned Primary Care	41,933	41,933
Acute (excludes Tameside FT)	54,132	55,132
Mental Health	0	500
Other	6,333	17,333
CCG Total	**161,850**	**175,350**
CCG - QIPP To Deliver Financial Balance		
CCG QIPP	0	-13,500
CCG Total inc QIPP	**161,850**	**161,850**
Grand Total Aligned Services including Efficiencies/QIPP	**187,526**	**187,526**

IN COLLABORATION SERVICES		
Service Area	**Net 2016/17 Budget £'000**	**Net 2016/17 Forecast £'000**
CCG		
Safeguarding	1,148	1,148
Co-Commissioned Primary Care	30,445	30,445
CCG Total	**31,593**	**31,593**
Grand Total In Collaboration Services including Efficiencies/QIPP	**31,593**	**31,593**
Grand Total Integrated Commissioning Fund Efficiencies/QIPP	**435,519**	**435,519**

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	28 June 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning Angela Hardman, Director, Public Health
Subject:	**CANCER UPDATE**
Report Summary:	The purpose of this report is to inform the Board about a review of cancer data to help inform the development of locality specific actions to ensure we contribute to the ambitions set out within the plan for Greater Manchester.
Recommendations:	The Single Commissioning Board are asked to note the contents of the report

Financial Implications:

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

Budget Allocation (if Investment Decision)	No direct budget implications in paper
CCG or TMBC Budget Allocation	N/A
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	N/A
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	N/A
Additional Comments We note the data contained within this report. There are no immediate direct financial implications in the report, but over the longer term if we are able to improve outcomes for patients without significant additional investment, there would be clear alignment to the aspirations and goals of the Care Together programme.	

Legal Implications: **(Authorised by the Borough Solicitor)**	The purpose of this report is to ensure that the Board has sufficient data and performance information to ensure that it is allocating resources appropriately.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with Starting Well, Developing Well, Living Well, Working Well, Aging Well and Dying Well.
How do proposals align with Locality Plan?	The proposals are consistent with Healthy Lives (early intervention and prevention), Community development, Enabling self-care, Locality based services, Urgent Integrated Care Services and Planned care services strands of the Locality plan.

How do proposals align with the Commissioning Strategy?	The work contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	In light of the information within this report the Board are asked to endorse the approach taken in ensuring better outcomes for our patients in terms of contributing to the level of ambition set for preventing avoidable deaths, reducing variation and improving experience.
Public and Patient Implications:	The implications for Public and Patients are to aim to develop a local plan that aims to prevent avoidable deaths, reduce variation and improve experience.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	This report will help us to understand the impact we are making to reduce health inequalities to incorporate into the local plan.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristics groups within the Equality Act.
What are the safeguarding implications?	Safeguarding will be central to the review /plan.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications as part of the review. No privacy impact assessment has been conducted.
Risk Management:	No current risks identified
Access to Information :	The background papers relating to this report can be inspected by contacting Louise Roberts  Telephone: 07342056005  e-mail: Louise.roberts@nhs.net

1. BACKGROUND

1.1 NHS Tameside and Glossop Clinical Commissioning Group in partnership with Tameside and Glossop Integrated Care Foundation Trust are developing locality specific actions to ensure we contribute to the ambitions set out within the plan for the Greater Manchester Cancer Board and the cancer programme of the Greater Manchester Health and Social Care Partnership Strategic Partnership Board.

1.2 There are eight domains within the Greater Manchester plan**;** reflecting a combination of the five key areas for change set out in '**Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-2021'** (each part of the system will be expected to contribute and will be held to account) and the six key work streams of the National Cancer Strategy.

1.3 A substantial part of the plan in 2016/17 and 2017/18 is part of the vanguard innovation programme and funded by NHS England's New Care Models Team; this may be funded by Transformation funding going forward. At a Greater Manchester and local level, work is ongoing to meet the level of ambition with the aim of preventing avoidable deaths, reducing variation and improving experience. Refer to **Appendix 1** for the level of contribution required from Provider Trusts and **Appendix 2** for Clinical Commissioning Groups).

1.4 This report uses National, Greater Manchester and Local data to inform areas for improvement which can be incorporated into the locality-specific actions that are currently being developed within NHS Tameside and Glossop Clinical Commissioning Group.

1.5 The Greater Manchester Cancer Plan was received by Tameside Health and Wellbeing Board on the 09 March 2017. The Tameside and Glossop Cancer Board, which is led by T&G ICFT with membership from SCF, are currently developing a comprehensive implementation plan. The contributions of the SCF to the plan are outlined in the timeline at 5.1 below.

1.6 Reporting into Board currently includes the Better Care Measures:

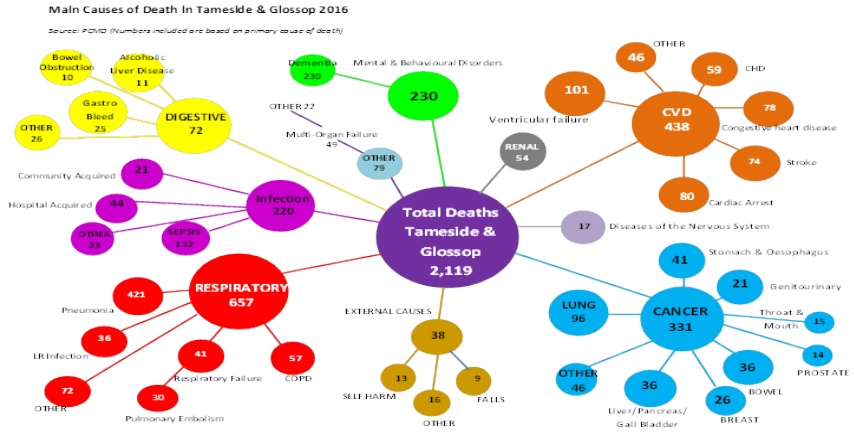
- One-year survival from all cancers;
- Proportion of people with Cancer diagnosed at an early stage;
- Cancer Patient experience;
- Cancer 2 week wait (2ww), Cancer 31 day wait and Cancer 62 day wait.

1.7 These need to be considered alongside measures that prevent incidence of cancer (e.g. reducing smoking prevalence, lifestyle and activity), cancer screening programmes and access to diagnostics along the pathway for patients.

1.8 Patients often have co-morbidities and we need to consider how we work across pathways in partnerships; for example Right Care data shows that of 187 patients admitted for Cancer, 54 patients were admitted for Gastro Intestinal conditions, 48 for Respiratory Conditions, 39 Genito Urinary, 43 Poisoning and adverse effects and 31 for circulation.

2. OVERVIEW

2.7 In 2016 Cancer was the main cause of death in 15.6% of the population in Tameside and Glossop Clinical Commissioning Group (331 out of 2,119 total deaths).



2.8 In 2012/14 1,756 children in England were newly diagnosed with Cancer (less than 1% of all cancers were in children) of these 257 died, 82% surviving five years and 91% one year. The commonest childhood cancer is leukaemia. Other than age and genetics, there is very little good evidence on risk factors that contribute to cancer in childhood. Statistics for childhood cancers are not routinely published for Greater Manchester, the North West or Tameside. Local data will be requested from the North West Local Cancer Intelligence Network and an analysis of data will be incorporated into the developing plan.

2.9 In Tameside and Glossop Clinical Commissioning Group all of the following were higher than the NHSE average:

- incidence of cancer;
- mortality rates;
- under 75 years of age mortality;
- number of deaths from cancers considered preventable;
- adult smoking rates.

2.10 The majority of the time we are achieving the operational waiting times standards (93% within 2ww, 96% within 31 days and 85% within 62 days).

Better Care

Description	Indicator	F	Level	Better is...	Threshold	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	Exceptions
Cancer 2Week Wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	M	T&G CCG	H	93%	95.3%	97.1%	94.1%	94.3%	94.6%	95.4%	94.5%	97.5%	96.3%	94.4%	91.6%	95.3%	91.9%	
	Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	M	T&G CCG	H	93%	93.3%	98.0%	91.8%	94.0%	94.7%	97.3%	100.0%	100.0%	96.8%	100.0%	91.4%	98.3%	91.6%	
Cancer 31 Day Wait	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	M	T&G CCG	H	96%	100.0%	98.9%	100.0%	100.0%	96.8%	98.9%	96.0%	98.2%	100.0%	98.9%	100.0%	97.7%	100.0%	
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	M	T&G CCG	H	94%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	M	T&G CCG	H	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Breach due to deferred treatment in Jan-16.
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	M	T&G CCG	H	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	100.0%	100.0%	100.0%	100.0%	
Cancer 62 Day Wait	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	M	T&G CCG	H	85%	89.7%	88.6%	91.3%	89.6%	91.1%	78.6%	91.7%	90.6%	88.0%	89.1%	87.7%	82.6%	91.4%	There were 10 breaches out of a total of 70 seen in Sept 16.
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	M	T&G CCG	H	90%	100.0%	100.0%	66.0%	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Maximum 62 day wait for first treatment following a consultant's decision to upgrade the priority of the patients (all cancer)	M	T&G CCG	H	85%	81.1%	85.7%	94.4%	82.4%	100.0%	56.8%	71.7%	94.6%	73.4%	75.0%	87.5%	85.2%	91.7%	For Jan 17 20 patients treated with 4 being treated over the target. For Dec 16 14 patients treated with 3 being treated over the target. For Sept 16 there were 13 patients treated with 6 being treated over the target

2.11 We have a higher than average number of 2ww referrals than the NHS average for suspected cancers per 100,000 of the population.

2.12 The conversion rate into diagnosed cancer is lower than the NHSE average but 2015/16 data shows that we are starting to reduce the gap.

2.13 While survival rates from cancer are increasing we have a relatively high number of cancers detected late, with 20% of all cancers identified through emergency presentation (slightly higher than NHSE average), and consequently reduced survival rates, compared to the England average and other CCGs across Greater Manchester.

2.14 Therefore it is important to focus on prevention and early diagnosis of cancer and offer support to reduce any variation across Tameside and Glossop CCG, for example screening uptake within Tameside is lower than High Peak for Breast and we are outliers across Greater Manchester for cancer screening for people with Learning disabilities.

3. HOW DO WE COMPARE?

3.1 NHS England Clinical Commissioning Group Improvement and Assessment Framework:

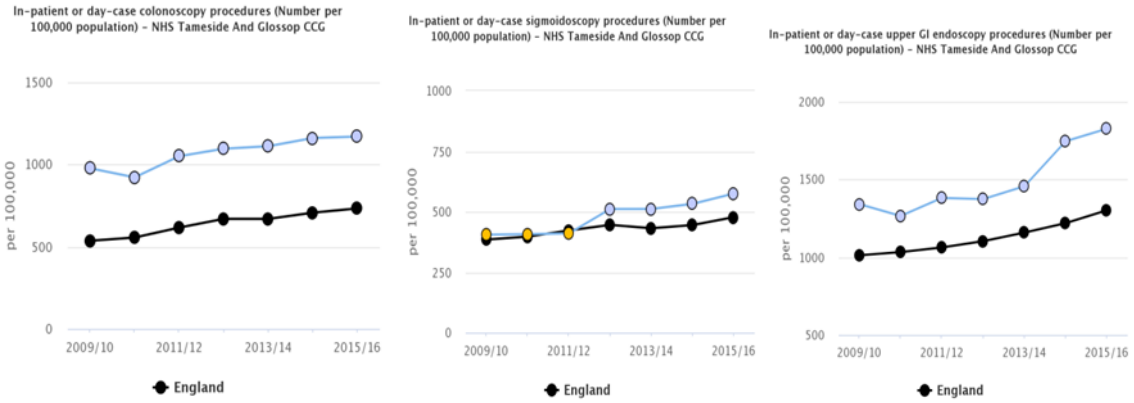
- One year survival from cancer is improving year on year but is lower that the NHSE average (70.2%) at 67.6% in 2013. When comparing to 10 similar CCGS two were lower than T&G CCG.
- Fewer cancers (45.2%) are detected at an early stage compared NHSE Average 50.7% in 2014. When comparing to 10 similar CCGS one was lower.
- Better than the NHSE average (82.2%) for GP referral to first definitive treatment within 62 days in Q1 16/17. When comparing to 10 similar CCGS all were lower.
- Cancer patient experience is slightly lower than the National average in 2015.

3.2 Public Health NHSE Dashboard and trends :

- Higher Incidence rate of cancers per 100,000 in 2014 at 647.82 compared to NHSE 608.3.
- 20.7% of Cancers are diagnosed through an emergency presentation (higher than average and a good proxy measure).
- Achieve the operational performance standards (2ww, 31 days and 62 days standard) and better than the NHSE average; however our average 2ww for breast, lower GI and lung is higher than the NHSE average.
- Worse than the NHSE Average (608.3) for Cancer Incidence and Mortality at 647.82 per 100,000, < 75 mortality, from cancers considered preventable and adult smoking rates (21.7% 2015).

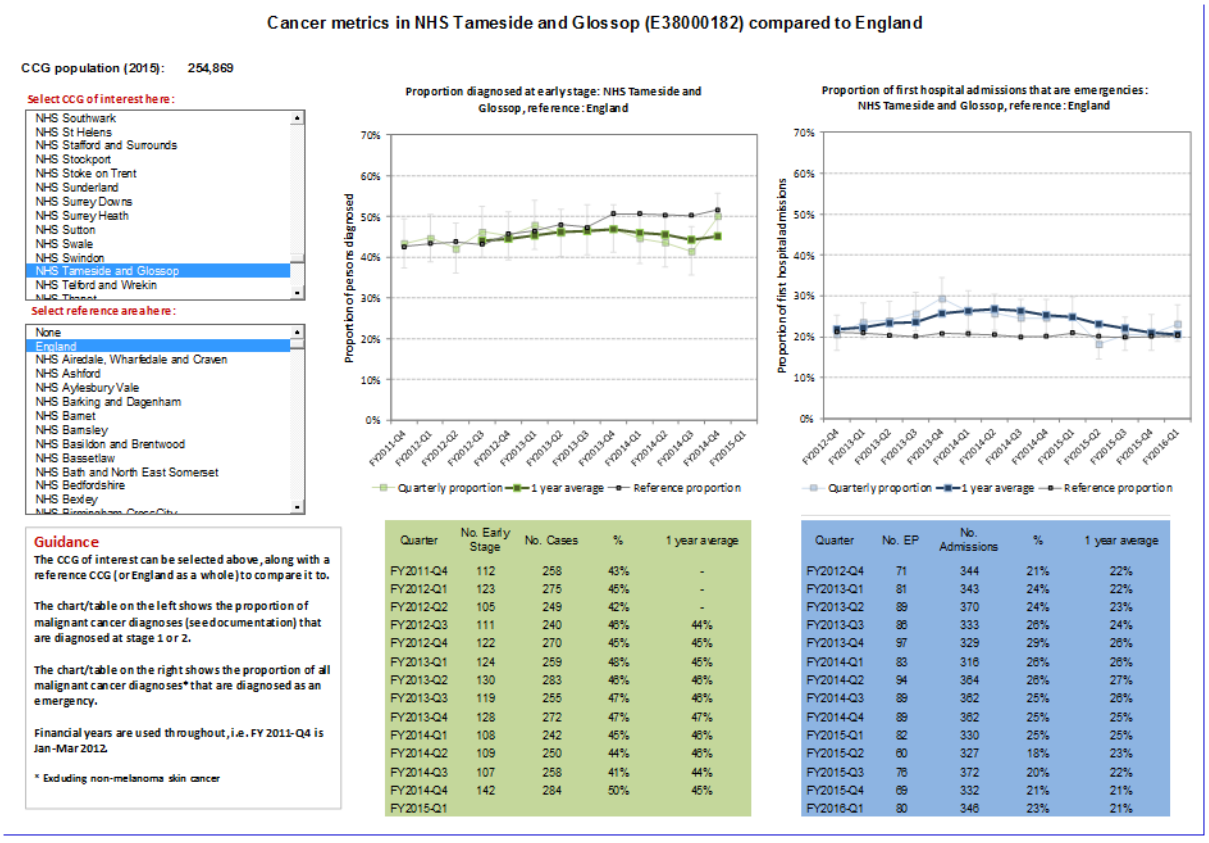
	Breast	**Bowel**	**Lung**
Incidence rate per 100,000 – 2014 (CCG)	NHSE 173.38 Tameside 148.52	NHSE 70.43 Tameside 78.43	NHSE 78.34 Tameside 121.8
Incidence rate per 100,000 – <75 Mortality, 2014 (CCG)	NHSE 21.21 Tameside 25.35	NHSE 11.9 Tameside 13.03	NHSE 33.26 Tameside 46.82
Screening uptake 2015 (LA) %	NHSE 75.4 Tameside 68.4 High Peak 77.4	NHSE 57.1 Tameside 52 High Peak 60.02	X

- Alignment to Local Authority level shows variation across tumour sites.
- Clinical Headline Data is also available by provider for Breast, Colorectal and Cervix.
- Higher than the NHS and GM average for In patient day case colonoscopy, upper GI endoscopy and sigmoidoscopy.



Key: Light blue – Higher then NHSE and GM and Dark Blue – Lower than NHSE and GM

3.3 Cancer Outcomes: Stage at Diagnosis and Emergency Presentations



Quarter	No. Early Stage	No. Cases	%	1 year average
FY2011-Q4	112	258	43%	-
FY2012-Q1	123	275	45%	-
FY2012-Q2	105	249	42%	-
FY2012-Q3	111	240	46%	44%
FY2012-Q4	122	270	45%	45%
FY2013-Q1	124	259	48%	45%
FY2013-Q2	130	283	46%	46%
FY2013-Q3	119	255	47%	46%
FY2013-Q4	128	272	47%	47%
FY2014-Q1	108	242	45%	46%
FY2014-Q2	109	250	44%	46%
FY2014-Q3	107	258	41%	44%
FY2014-Q4	142	284	50%	45%
FY2015-Q1				

Quarter	No. EP	No. Admissions	%	1 year average
FY2012-Q4	71	344	21%	22%
FY2013-Q1	81	343	24%	22%
FY2013-Q2	89	370	24%	23%
FY2013-Q3	86	333	26%	24%
FY2013-Q4	97	329	29%	26%
FY2014-Q1	83	316	26%	26%
FY2014-Q2	94	364	26%	27%
FY2014-Q3	89	362	25%	26%
FY2014-Q4	89	362	25%	25%
FY2015-Q1	82	330	25%	25%
FY2015-Q2	60	327	18%	23%
FY2015-Q3	76	372	20%	22%
FY2015-Q4	69	332	21%	21%
FY2016-Q1	80	346	23%	21%

3.4 Health and care of people with learning disabilities:

- Data shows the number of eligible adults with Learning disabilities screened for cancer is poor in Tameside and Glossop CCG compared to those with no Learning Disability and we are outliers across Greater Manchester. Cervical 25%, Breast 33% and Bowel 48%.

3.5 NHS Right Care data highlights the following areas for improvement as we were worse than our average 10 CCG equivalents in the following

- Breast cancer screening, emergency presentation of breast cancer and <75 Mortality from breast cancer.
- Bowel cancer screening, < 75 mortality from colorectal cancers and cases of C.diff.

- Number of successful 16+ quitters, Non elective spend on lung cancer, detection of lung cancer at an early stage, lung detected at an early stage and <75 mortality from lung cancer.
- Spend on Primary Care Prescribing.
- Lower GI - 6 week waits for colonoscopy and rate of emergency colonoscopies.
- Upper GI - 6 week waits for Gastroscopy and number of alcohol related hospital admissions.
- Liver Disease Pathway – Alcohol specific hospital admissions, non-elective spend on liver disease, alcoholic liver disease - emergency admissions, Liver cancer incidence and <75 mortality from liver disease.
- The Right Care Focus data pack published in May 2016 suggested the additional improvements areas: Cervical screening, LOS, Detecting bowel cancers at an early stage, diagnostic and surgical procedures and Information provided following discharge.
- The Cancer focus pack was updated in April 2017 to include further possible improvement areas: spend on non-elective admissions, total spend on Cancer, detecting breast cancer at an early stage, rate of bed days and average number of days spent in hospital as a result of an emergency admission for patients in their last year of life.

3.6 Tameside and Glossop Integrated Care Foundation Trust presents a cancer performance report to the Cancer Board. The report provides assurances that standards are being met, includes exception reporting of any breaches, highlights any area of concerns and how they will mitigate these. Information is available by tumour site and directorate pathways. The December 2016 / January 2017 Board report showed 38 breaches year to date on the 62 day pathway, 24 were due to complex cases with co morbidities; 5 patient dis engagement, 4 Internal diagnostics, 2 multiple MDTs and treatment delays. The Trust will continue to review capacity and demand.

4. CONSIDERATIONS

4.1 The development of locality-specific actions, currently being developed within NHS Tameside and Glossop Clinical Commissioning Group will support achievement of all the measures identified in within 'Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-2021' and the six key work streams of the National Cancer Strategy. The following areas need to be considered as part of an ongoing improvement process and incorporated into the plan:

- What else can we do to detect Cancer earlier and raise Public awareness through National and Local Campaigns?
- How do we reduce emergency presentations (impact on non-elective admissions)?
- Role of Primary Care e.g. Use of E Referrals and EMIS templates.
- Improve access e.g. STT Colonoscopy, New Lung pathway, Bowel prep issued within Primary care etc.
- Ensure access to services are equitable.
- Planning, demand and Capacity.
    - Impact of Locum staff e.g. new rules IR35.
    - How do we reduce the number of DNAs?
    - Learning from breach analysis.
    - Support within the Community.
    - Data shows LOS in hospital is greater than comparative CCGS.
    - Care planning, data shows we only prepare 32.5% of after care plans
    - How do we improve Patient experience?

5. TIMELINE

5.1 The following Timeline details the development of the locality specific action plan.

DATE	PROGRESS OR ACTIONS REQUIRED
Early 2017	Greater Manchester (GM) Plan ratified on 24 February 2017.
March 2017	Introduction to GM plan to Health and Wellbeing Board on the 09 March 2017.
March 2017	Outcomes from local Cancer Board discussions on 29 March 2017: • Ongoing development of locality specific actions • Audit of Local working position and develop actions required to meet the Locality Specific actions • Identified membership of GM Cancer Plan local working group to further progress the plan.
March 2017	On 07 March 2017 established a GM Cancer Plan local working group that will meet on a monthly basis.
April 2017	Review of Cancer data to highlight areas for consideration for inclusion within the plan.
May 2017	GM Cancer Plan local working group: • agreed Terms of Reference and governance process agreed by Cancer Board on 19 May 2017 • assigned a Care Together Project Manager who started to develop a project plan • progressed the development of the Locality specific plan • Established Task and Finish Groups for each of the work streams identified within the plan to oversee the implementation of Locality Specific actions. • The work streams are: o Prevention and Earlier & Better Diagnosis (lead - Gideon Smith) o Living With and Beyond Cancer (lead - Carol Diver) o Improved & Standardised Care (lead – Susi Penney o Patient Experience & User Involvement (lead - David Banks) o Commissioning & Accountability (lead - Alison Lewin) o Research & Education – (lead Tameside and Glossop Cancer Board) • **Appendix 3** provides an update on the current local position and next steps required to deliver the contributions required in the Locality specific plan.
June 2017	Present update at Chairs Brief on 13 June 2017 and 28 June 2017
July 2017	Present update at Single Commissioning Board on 11 July 2017
July 2017 to March 2021	GM Cancer Plan local working group Board will be kept informed of progress with any areas of concern escalated as appropriate.

6. RECOMMENDATIONS

5.1 As set out at the front of the report.

APPENDIX 1

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Achieving world-class cancer outcomes: Taking charge in Greater Manchester

Implementation annex #1

Provider Trusts

The Greater Manchester Cancer Board's cancer plan for Greater Manchester was ratified by the GMHSC Partnership Strategic Partnership Board in February 2017. The delivery of the ambitions that it contains will require contributions from each part of the cancer system. The Greater Manchester Cancer Board will hold each part of the system to account for its role in the delivery of the plan.

This document summarises the key actions required from Greater Manchester Cancer's **hospital provider trusts**. In addition to the trust-specific actions set out in the plan, all hospital providers will be expected to make the following contributions.

	What	When

1	• Deliver a year-on-year improvement in the proportion of **cancers diagnosed at stage one and stage two** –
	  ○ Work with commissioners to agree data collection trajectories to ensure robust and timely staging data collection
	• Reduce the proportion of **cancers diagnosed following an emergency admission**
	  ○ Support primary care implementation strategies for all patients diagnosed as an emergency to have their cases looked at through a Significant Event Audit
		By June 2017
		
		By December 2017

2	Enable the delivery of the **system-wide pathways** to diagnosis and treatment set by clinical pathway boards, with a focus on streamlining the patient journey.	By December 2017
3	Support pathway board efforts to review the **pathway MDT processes** and standardise the approach to streamline the MDT discussions in routine cases and create more time for complex case discussion. Explore sector based and GM based MDT approaches.	By December 2017
4	Ensure 85% of patients continue to meet the 62-day **cancer waiting time standard**. Work towards achievement of the 28-day faster diagnosis standard. Ensure sufficient capacity for timed pathways for lung and HPB to deliver a • 50-day standard • 42-day standard	By March 2018 By March 2019 December 2017 December 2018
5	Work with commissioners, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree an **optimal Greater Manchester specification** for each tumour type.	To a timetable to be set by Greater Manchester Cancer

APPENDIX 1

6	Support the **implementation of the Recovery Package** through: • A contribution to the development of a standard Greater Manchester approach, and • Enabling all clinical teams to deliver each of its elements	To a timetable to be set by Greater Manchester Cancer
7	Ensure Greater Manchester Cancer agreed **stratified follow up pathways** of care are in place for ○ Breast cancer ○ Prostate and Colorectal cancer	 By March 2018 By March 2019
8	Work with commissioners, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree system-wide **follow-up protocols** and create a timetable for offering stratified follow up arrangements dependent on risk.	By September 2017
9	Work with commissioners, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree a co-produced cancer **patient access charter**	By June 2107
10	Ensure **access to a CNS or other key worker** for all cancer patients through identifying gaps in access by pathway and developing access improvement plans	By December 2017
11	Maintain oversight and **facilitate recruitment to the 100,000 Genome Project** in appropriate eligible pathways.	From March 2017

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester **Cancer**

Achieving world-class cancer outcomes: Taking charge in Greater Manchester

Implementation annex #2

Clinical Commissioning Groups

The Greater Manchester Cancer Board's cancer plan for Greater Manchester was ratified by the GMHSC Partnership Strategic Partnership Board in February 2017. The delivery of the ambitions that it contains will require contributions from each part of the cancer system. The Greater Manchester Cancer Board will hold each part of the system to account for its role in the delivery of the plan.

This document summarises the key actions required from Greater Manchester's **Clinical Commissioning Groups**. In addition to the locality-specific actions set out in the plan, all localities will be expected to make the following contributions.

	What	When
1	Strengthen existing tobacco controls and smoking cessation services, in line with **reducing smoking prevalence** to below 13% nationally • Implement locality requirements outlined in the Greater Manchester tobacco control plan (expected April 2017) • Ensure effective and accessible locality based smoking cessation services are in place	By March 2020
2	Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to test a GM wide **social movement focused on cancer prevention**	By March 2019
3	Oversee roll out primary care **prescribing of drugs to prevent breast cancer**, subject to GM business case agreement	By May 2017
4	Improve access to, and uptake of, three national **cancer screening programmes** (bowel, breast, and cervical) and ensure a locality contribution to the overall GM targets of: • Achieve bowel cancer screening uptake (FIT and scope) of 75% • Increase cervical screening coverage to 80% • Increase breast screening coverage by 10% to 75%	By March 2020 By March 2021

5	**Improve one-year survival rates** to achieve 75%.
	• Deliver a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two –
	  ○ Agree data collection trajectories with providers to ensure robust and timely staging data collection
	  ○ Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to raise awareness of the signs and symptoms of cancer and encourage earlier presentation and advice seeking
		By March 2020
		April 2017 onwards

	• Reduce the proportion of cancers diagnosed following an emergency admission
	  ○ Contribute towards a GM reduction in the proportion of cancers that are diagnosed as an emergency to below 18%
	  ○ Implement strategies for all patients diagnosed as an emergency to have their cases looked at through a Significant Event Audit
		By March 2020
		
		By December 2017

6	Drive earlier diagnosis by:
	• **Implementing NICE** referral guidelines
	  ○ Ensuring primary care adherence to use of updated standardised suspected cancer referral process and forms
	  ○ Support a GM approach to training and education for primary care professionals on cancer symptoms and referral processes
	• Ensuring local provision of **GP direct access** to key investigative tests for suspected cancer
		By March 2018

7	Work with providers, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree a co-produced cancer **patient access charter**	By June 2107
8	Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day **cancer waiting time standard**. Work towards achievement of the 28-day faster diagnosis standard. Ensure sufficient capacity for timed pathways for lung and HPB to deliver a • 50-day standard • 42-day standard	By March 2018 By March 2019 December 2017 December 2018
9	Work collaboratively to develop a commissioning plan for an **integrated acute oncology service** for implementation in 2018	By October 2017
10	Work collaboratively to develop and commission comprehensive **lymphoedema** services	By March 2020
11	Work with clinical pathway boards, hospital providers, people affected by cancer and other stakeholders to develop and agree an **optimal Greater Manchester specification** for each tumour type.	To a timetable to be set by Greater Manchester Cancer
12	Lead the **implementation of the Recovery Package** through: • A contribution to the development of a standard Greater Manchester approach, and • Building the delivery of each of the Recovery Packages elements into commissioning specifications	To a timetable to be set by Greater Manchester Cancer

13	Ensure patients have access to Greater Manchester Cancer agreed **stratified follow up pathways** of care for
	  ○ Breast cancer
	  ○ Prostate and Colorectal cancer
		By March 2018
		By March 2019

14	Work with providers, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree system-wide **follow-up protocols** and create a timetable for offering stratified follow up arrangements dependent on risk.	By September 2017
15	Ensure all patients have access to a **clinical nurse specialist** or other key worker	By December 2017

APPENDIX 2

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APPENDIX 3

TAMESIDE AND GLOSSOP COMMISSIONING INTENTIONS AND ACTION PAPER

The table below provides an update on the contributions required from Clinical Commissioning Groups to meet the level of ambition across Greater Manchester; these will be developed further and incorporated into the Locality specific plan.

	What do we need to do? - Update on the local position and next steps required.	When
Prevention, Earlier and better diagnosis		

1	Strengthen existing tobacco controls and smoking cessation services, in line with **reducing smoking prevalence** to below 13% nationally
	• Implement locality requirements outlined in the Greater Manchester tobacco control plan (expected April 2017).
	• Ensure effective and accessible locality based smoking cessation services are in place.
	
	Local Actions required
	• Raise awareness of lifestyle risk factors and change behaviour.
	• Help people to understand their individual risk of cancer.
	• Deliver lifestyle-based secondary prevention.
	
	Local Current Position
	• Be Well Tameside provides a person-centred, holistic service which is flexible and responsive to the needs of local people. The service operates on 3 levels.
	  ○ Support for multiple lifestyle issues (e.g. improving the quality of diet and nutrition, stopping smoking, reducing alcohol intake, increasing physical activity).
	  ○ Community Liaison, outreach and capacity building. The service works with residents, groups and organisations to promote Health and Wellbeing and encourage greater access to Be Well Tameside services.
	  ○ Training and Learning and Development. Be Well Tameside offers a health and wellbeing training programme to enhance and develop the competencies and skills of the wider public health workforce across organisations and the community. The training programme this year will include, Making Every Contact Count, Brief Advice/Intervention, Stop Smoking, Weight Management, Oral Health and other health related subjects.
	• Glossop has a newly commissioned Smoking Cessation service run by Derbyshire County Council/ Public Health.
	• Tameside are in their first year of a 3 year contract with Be Well (Pennine Care) who provides smoking cessation services for Tameside.
	
	Next Steps
	• Delivery model of lifestyle-based secondary prevention developed as part of new aftercare pathways by April 2018
	• Identify areas for Improvement.
	• Social care assessments for all age groups (lifestyle interventions that would impact positively on a family/individual) Youth and young
		By March 2020

	adults 16+ (12 years + for smoking support) • Consider innovative ideas to use Apps, software and website design for an interactive experience. • Greater Manchester population health plan produced by January 2017 • Greater Manchester tobacco control plan produced by April 2017 • Online tool for the assessment of individual risk of cancer available to people in Greater Manchester by September 2017.	
Prevention, Earlier and better diagnosis		
2	Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to test a GM wide **social movement focused on cancer prevention** **Local Actions required** • Create a citizen-led social movement **Local Current Position** • The local Cancer Early Detection Network links local stakeholders including: public health, Be Well, Bowel Cancer Screening Team, Cancer Research UK, workplace health, Macmillan GP, CCG commissioner, Tameside Macmillan Centre. • Be Well Tameside provide a training package on cancer symptom awareness for staff and volunteers in Tameside. Be Well are also recruiting and supporting volunteers, including some who are trained in cancer symptom awareness. • The Be Well service is a legacy from the Macmillan funded Community Cancer Awareness Project. **Next Steps** • Early Detection Network to oversee implementation plan.	By March 2019
Prevention, Earlier and better diagnosis		
3	Oversee roll out **primary care prescribing of drugs to prevent breast cancer**, subject to GM business case agreement **Local Actions required** • Prescribe drugs that are effective in preventing cancers. **Local Current Position** • Medicines Management Committee has had oversight of prescribing to date and this role will be picked up by the new Joint Medicines Optimisation Committee. **Next Steps** • Tameside and Glossop Clinical Commissioning Group Joint Medicines Optimisation Committee carry out Assessment of evidence of effectiveness of drugs to prevent breast cancer and business cases agreed by May 2017.	By May 2017
Prevention, Earlier and better diagnosis		
4	Improve access to, and uptake of, three national **cancer screening programmes** (bowel, breast, and cervical) and ensure a locality contribution to the overall GM targets of:	

	• Achieve bowel cancer screening uptake (FIT and scope) of 75% • Increase cervical screening coverage to 80% • Increase breast screening coverage by 10% to 75% **Local Actions required** • Enhance cancer screening • Increase public awareness of screening, and cancer signs and symptoms • Make the Manchester Cancer Improvement Programme lung health check available to all if successful • Pilot patient self-referral. **Local Current Position** • The local Cancer Early Detection Network links local stakeholders including: public health, Be Well, Bowel Cancer Screening Team, Cancer Research UK, workplace health, Macmillan GP, CCG commissioner, Tameside Macmillan Centre. • Be Well Tameside provide a training package on cancer symptom awareness for staff and volunteers in Tameside. Be Well also recruit and support volunteers, including some who are trained in cancer symptom awareness. • The Be Well service is a legacy from the Macmillan funded Community Cancer Awareness Project. • Pilot for Lung Cancer screening programme within Manchester Macmillan Cancer Improvement Partnership provided by University Hospital of South Manchester. **Next Steps** • FIT in use in bowel screening programme by April 2018 • HPV testing in cervical screening programme implemented by April 2018 • Bowel scope programme for 55 year old in place by April 2020 • Breast screening improvement trial reports findings in May 2017 • Bowel and cervical screening improvement trials report findings in October 2017 • Health equity profiles to identify areas of low screening uptake produced by July 2017 • Be Clear on Cancer branded campaign to promote bowel screening, January-March 2017 • Decision on implementation of MCIP lung health check across Greater Manchester by May 2017.	By March 2020 By March 2021
Prevention, Earlier and better diagnosis, Improved and standardised Care, Commissioning, provision and accountability and Patient experience and user involvement.		

5	**Improve one-year survival rates** to achieve 75%.
	• Deliver a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two –
	  ○ Agree data collection trajectories with providers to ensure robust and timely staging data collection
	  ○ Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to raise awareness of the signs and symptoms of cancer and encourage earlier
		By March 2020
		
		April 2017 onwards
		
		By March 2020

6	presentation and advice seeking
	
	• Reduce the proportion of cancers diagnosed following an emergency admission
	  ○ Contribute towards a GM reduction in the proportion of cancers that are diagnosed as an emergency to below 18%
	  ○ Implement strategies for all patients diagnosed as an emergency to have their cases looked at through a Significant Event Audit
	
	Drive earlier diagnosis by:
	• **Implementing NICE** referral guidelines
	  ○ Ensuring primary care adherence to use of updated standardised suspected cancer referral process and forms
	  ○ Support a GM approach to training and education for primary care professionals on cancer symptoms and referral processes
	• Ensuring local provision of **GP direct access** to key investigative tests for suspected cancer
	
	Local Actions required
	• Greater Manchester Cancer Volunteers – Raising awareness and Changing Behaviour
	• Implement the NICE suspected cancer referral guidelines
	• Improve adherence to NICE suspected cancer referral guidelines
	• Support pathway-specific efforts to deliver earlier and better diagnosis
	• Encourage Serious Event Audits (SEA)
	• Develop rapid cancer investigation units
	• Pilot patient self-referral
	• Reduce diagnostic waiting times
	• Contribute to regional improvements in diagnostic services
	• Agree data collection strategies to ensure robust and timely staging data collection.
	
	Local Current Position
	• GP TARGET sessions held in 2016 and 2017 .
	• Support available to Practices to reduce any variation
	• New GM wide referral proformas developed by ST & Macmillan GP colleagues in collaboration with MC pathway board clinical leads.
	• New e-referral templates installed on practice systems.
	• SEA of all emergency presentations to identify any key themes
	• ACE wave 2 Pilot of one-stop-diagnostic clinic for patients with non-specific symptoms at UHSM and PAHT from Jan 2017.
	
	Next Steps
	• GP use of updated standardised suspected cancer referral process and forms audited by June 2017 (Brain and sarcomas to follow)
	• Use of standardised suspected cancer referral process extended to other referrers by January 2018
	• Study into the impact of feedback on GP referral behaviour reports findings by September 2017
		By December 2017
		
		By March 2018

	• Regional haematological malignancy diagnostic service in place by January 2018 • Regional jaundice pathway for pancreatic cancer in place by January 2018 • Regional optimal lung cancer pathway implemented by January 2018 • Standardised approach to prostate cancer diagnosis agreed and implemented by January 2018 • Standardised approach to one-stop unexplained vaginal bleeding clinics by August 2018 • Pilot of straight-to-test pathway for colorectal cancer by October 2017 • Sector MDT model in colorectal cancer fully implemented by September 2017 • Pilot of streamlined oesophago-gastric cancer diagnostic pathway by January 2018 • Current provision of breast one-stop triple assessment clinics audited and plan developed by September 2017 • Non-specific but concerning symptoms clinic pilots start March 2017 • Faster pathways in Bolton for lung, colorectal and oesophago-gastric cancers by May 2017 • Share learning on faster pathways locally and nationally by December 2017 • Workshop to commence regional radiology development programme by March 2017 • Proposal for regional cellular pathology development programme produced by September 2017.	
Prevention, Earlier and better diagnosis, Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
7	Work with providers, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree a co-produced cancer **patient access charter**	By June 2107
Prevention, Earlier and better diagnosis, Improved and standardised Care, Commissioning and provision and accountability.		
8	Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day **cancer waiting time standard.** Work towards achievement of the 28-day faster diagnosis standard. Ensure sufficient capacity for timed pathways for lung and HPB to deliver a • 50-day standard • 42-day standard **Local Actions required** • Reduce diagnostic waiting times • Contribute to regional improvements in diagnostic services • Speed up pathways to treatment **Local Current Position** • Consistently achieving the 62 day standard.	By March 2018 By March 2019 December 2017 December 2018

	Next Steps • Faster pathways in Bolton for lung, colorectal and oesophago-gastric cancers by May 2017 • Share learning on faster pathways locally and nationally by December 2017 • Workshop to commence regional radiology development programme by March 2017 • Proposal for regional cellular pathology development programme produced by September 2017 • 50-day pathway in place in identified tumour types by December 2017 • 42-day pathway in place in identified tumour types by December 2018 • System in place to report average and range of waiting times for all pathways by April 2017 • Identify priority pathways by April 2017	
Improved and standardised Care and Commissioning, provision and accountability.		
9	Work collaboratively to develop a commissioning plan for an **integrated acute oncology service** for implementation in 2018 **Local Actions required** • Deliver an integrated acute oncology service • Lead oncology patient safety translational research **Next Steps** • Commissioning plan for integrated acute oncology service by October 2017 • Agreed model for integrated acute oncology service implemented by October 2018	By October 2017
Improved and standardised Care and, Commissioning, provision and accountability.		
10	Work collaboratively to develop and commission comprehensive **lymphoedema** services **Local Actions required** • Commission a comprehensive lymphoedema service **Local Current Position** • T&G ICFT lymphoedema service available **Next Steps** • Sustainable lymphoedema service by March 2020	By March 2020
Prevention, Earlier and better diagnosis, Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
11	Work with clinical pathway boards, hospital providers, people affected by cancer and other stakeholders to develop and agree an **optimal Greater Manchester specification** for each tumour type. GM Led approach.	To a timetable to be set by Greater Manchester Cancer

	Local Current Position • Living With and Beyond Cancer group and End Of Life Strategy Group progressing. • Annual Dying Matters events organised. **Local Actions required** • Ensure access to seven-day specialist palliative care advice and assessment • Deliver choice in end of life care • Ensure that shared digital palliative and end of life care records are rolled out **Next Steps** • A detailed map of specialist palliative care provision against national standards and competencies by March 2018 • An innovative economic modelling proposal for the delivery of a seven-day specialist palliative care advice and assessment by March 2018 • Qualitative and quantitative evaluation tools to measure the impact of seven-day specialist palliative care advice and assessment services agreed by March 2018 • Dying Matters Coalition events across Greater Manchester by May 2018	
Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
12	Lead the **implementation of the Recovery Package** through: A. A contribution to the development of a standard Greater Manchester approach, and B. Building the delivery of each of the Recovery Packages elements into commissioning specifications GM led approach Ensure all parts of the Recovery package are available to patients including: A. Holistic Needs Assessment and Care Plan at diagnosis and end of treatment B. Treatment Summary is sent to GP at end of treatment C. Cancer Care Review completed by GP within 6 months of cancer diagnosis **Local Actions required** • Commission the Recovery Package • Develop new aftercare pathways • Explore supported patient decision-making in progressing disease • Improve access to psychological support • Support people with long-term consequences of treatment • Earlier integration of supportive care into cancer care **Local Current Position** • Actively support Greater Manchester Recovery Package Implementation Group to agree standardised approach within	To a timetable to be set by Greater Manchester Cancer

	region by August 2017 • Facilitate a scoping exercise to understand what treatments are provided locally • Explore the introduction of an electronic holistic needs assessment. **Next Steps** • Standardised Greater Manchester approach to the Recovery Package agreed by August 2017 • Full Recovery Package available to all patients reaching completion of treatment by March 2019 • All patients receive a care plan at the point of diagnosis and treatment decision, and at the end of their treatment, based on holistic needs assessments, by December 2017 • Health and wellbeing events in place for all breast, colorectal and prostate cancer patients to support new aftercare pathways by March 2018, with models for other pathways developed by March 2019 • All patients receive a care plan at the point of diagnosis and treatment decision, and at the end of their treatment, based on holistic needs assessments, by December 2017 • Health and wellbeing events in place for all breast, colorectal and prostate cancer patients to support new aftercare pathways by March 2018, with models for other pathways developed by March 2019 • Full Recovery Package available to all patients reaching completion of treatment by March 2019 • New aftercare pathways defined and implemented for all breast, colorectal and prostate patients by March 2018 • New aftercare pathways pilots begin in further tumour types by March 2019 • Goals of Care tool tested in appropriate clinics at The Christie from March 2017 • Goals of Care tool pilot extended to other sites by March 2018 • Role of regional psychological support clinical group formalised by June 2017 • Psychological support clinical group to produce plan for improved access to psychological support by October 2017 • Potential consequences of treatment mapped by pathway by June 2017 • Assessment of current consequences of treatment expertise in Greater Manchester by June 2017 • Action plan to address any gap in support for consequences of treatment by September 2017 • Enhanced supportive care outpatient clinic piloted at the Christie centre at the Royal Oldham by April 2018.	
Prevention, Earlier and better diagnosis, Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
13	Ensure patients have access to Greater Manchester Cancer agreed **stratified follow up pathways** of care for ○ Breast cancer ○ Prostate and Colorectal cancer	By March 2018

	Next Steps • Current provision of breast one-stop triple assessment clinics audited and plan developed by September 2017 • Health and wellbeing events in place for all breast, colorectal and prostate cancer patients to support new aftercare pathways by March 2018, with models for other pathways developed by March 2019 • New aftercare pathways defined and implemented for all breast, colorectal and prostate patients by March 2018 • New aftercare pathways pilots begin in further tumour types by March 2019 • Goals of Care tool tested in appropriate clinics at The Christie from March 2017	By March 2019
Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
14	Work with providers, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree system-wide **follow-up protocols** and create a timetable for offering stratified follow up arrangements dependent on risk. Greater Manchester approach. Refer to point 12 above.	By September 2017
Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
15	Ensure all patients have access to a **clinical nurse specialist** or other key worker Local Cancer Nurse specialists working across all Tumour pathways.	By December 2017

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	11 July 2017
Officer of Single Commissioning Board	Jessica Williams, Programme Director, Care Together
Subject:	**TRANSFORMATION ENABLERS RELEASE OF FUNDING**
Report Summary:	This paper outlines the proposed release of some Greater Manchester Health and Social Care Transformation funding in line with the Neighbourhood strategy within Care Together.
Recommendations:	The Strategic Commissioning Board is recommended to approve the release of Greater Manchester Health and Social Care Transformation Funding up to the value of £0.4m for Estates and £0.15m for Organisational Development to support in delivering the Transformation outcomes required by these enabling schemes in line with the Neighbourhood strategy within Care Together as detailed in section 2 of the report.

Financial Implications:

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

Budget Allocation (if Investment Decision)	The Greater Manchester Health and Social Care Transformation fund – within the approved bid exists an allocation of £0.600 million relating to the transformation of the locality estate and £1.000 million relating to the transformation of locality organisational development.
CCG or TMBC Budget Allocation	TMBC
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	Single Commissioning Board
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	The funding for estates will support the reconfiguration of the locality estate alongside the realisation of estates related savings. The funding for operational development will support the evaluation of phase 1 and the delivery of phase 2 – which is hoped can largely be delivered internally.

	These will contribute towards addressing the financial challenge within the locality which is currently projected to be £ 70.2 million by 2020/2021.

Additional Comments

Section 2 of this report provides details of the outcomes to be delivered from this funding release.

The estimated estates £0.400 million cost will be financed via the allocation of £0.600 million relating to the transformation of the locality estate within the Greater Manchester Health and Social Care Transformation fund approved bid of £23.2 million.

The estimated organisational development £0.150 million cost will be financed via the allocation of £1.000 million relating to the transformation through organisational development within the Greater Manchester Health and Social Care Transformation fund approved bid of £23.2 million.

It is essential this funding contributes to the realisation of related savings to address the financial challenge within the locality which is currently projected to be £ 70.2 million by 2020/2021.

Legal Implications: **(Authorised by the Borough Solicitor)**	Members will need to be satisfied that the funding represents true value for money and ensures compliance with the public sector's fiduciary duty to the public purse in producing beneficial outcomes for the community in the transformational journey.
How do proposals align with Health & Wellbeing Strategy?	The Estates and Organisational Development transformation programmes support the Care Together programme which is tasked to deliver the health and social care integration agenda as determined by the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	The Estates and Organisational Development transformation programmes support the Care Together programme which is tasked to deliver the health and social care integration agenda as described within the Locality Plan.
How do proposals align with the Commissioning Strategy?	The Commissioning Strategy is based on improving healthy life expectancy, reducing inequalities, improving health and social care outcomes and delivering financial sustainability The Estates and Organisational Development transformation programmes support projects that are working to deliver these objectives.
Recommendations / views of the Professional Reference Group:	None.
Public and Patient Implications:	None.
Quality Implications:	None.

How do the proposals help to reduce health inequalities?	None.
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	None.
Risk Management:	The aim of the Estates and Organisational Development transformation is to support truly integrated services across all our localities. The key risk to the economy would be in not delivering these programmes due to lack of resource to carry out the planning and delivery of the transformation.
Access to Information :	Further information can be obtained from Jessica Williams, Programme Director for Care Together:  Telephone: 07985 276263  e-mail: jessicawilliams1@nhs.net

1. BACKGROUND

1.1. The approved Greater Manchester Transformation funding bid included an allocation of £0.600 million funding to support transformation projects within the locality estate and £1.000 million funding to support transformation projects within organisational development.

1.2. This report recommends the approval of the release of GMHSC Transformation Funding up to the value of £0.4m for Estates and £0.15m for Organisational Development to support in delivering the Transformation outcomes required by these enabling schemes in line with the Neighbourhood strategy within Care Together.

2. OUTLINE OF REQUIRED OUTCOMES FOR ESTATES

The Estates funding will support three fixed term posts to support delivery of projects in the Estates transformation workstream with the following outcomes;

2.1. Lead, plan, design and deliver the agreed outputs of the health and social care workstream under the guidance and strategic leadership of Tameside & Glossop Strategic Estates Group (SEG).

2.2. Develop and implement the health and social care estates business model involving extensive partnership and stakeholder engagement within the context of a complex environment and our emerging priorities.

2.3. Work in partnership with identified professional leads to develop initial outline business cases for Hyde and Denton Integrated Neighbourhood hubs.

2.4. Develop the estate business cases for each neighbourhood.

2.5. Develop plans for estate rationalisation.

2.6. Facilitation of employee engagement meetings and events together with supporting the necessary decant and recant from / to all locations within the estate.

2.7. Provision of public and neighbourhood consultation support.

2.8. The provision of support to transformational ways of working across the locality e.g. agile working.

3. OUTLINE OF REQUIRED OUTCOMES FOR ORGANISATIONAL DEVELOPMENT

The Organisational Development funding will support recruitment to a fixed term post to support delivery of projects in the Organisational Development transformation workstream with the following outcomes;

3.1. Evaluating the outcome of the Organisational Development programme in the Integrated Care Foundation Trust.

3.2. Designing Phase 2 of Organisational Development transformation.

3.3. Delivering the majority of this in house.

3.4. Developing an economy wide induction programme which reinforces the social prescribing and new models of care.

3.5. Ensures newly transferred staff feel engaged and welcomed.

4. FINANCIAL IMPLICATIONS

3.1 The estimated cost to deliver the above outcomes through the recruitment to fixed term posts is £0.400 million for Estates and £0.150 million for Organisational Development.

5. RECOMMENDATIONS

4.1 As stated on the front of the report.

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Report to: **SINGLE COMMISSIONING BOARD**

Date: 11 July 2017

Officer of Single Commissioning Board Clare Watson, Director of Commissioning

Subject: **DISINVESTMENT AND DECOMMISSIONING POLICY**

Report Summary: As part of the ongoing work towards achieving the 2017-18 QIPP target of £23.9m, and contributing to the system wide Savings Assurance programme, the decision has been taken to develop a Decommissioning and Disinvestment policy for consideration by Single Commission governance.

The attached policy has been developed by the Commissioning Directorate, and is based on best practice from policies in other localities across the country.

The policy, although based on examples from elsewhere, is inclusive of Tameside and Glossop specific plans and priorities, and is designed to align with the delivery of the Locality Plan and the Care Together programme.

Recommendations: SCB are asked to accept the attached Decommissioning & Disinvestment policy for use to support disinvestment and decommissioning proposals in the Tameside and Glossop locality.

Financial Implications:

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

Budget Allocation (if Investment Decision)	N/A at this stage
CCG or TMBC Budget Allocation	Potentially both in the future
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Potentially all areas in future
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	This is a framework to support decision making around decommissioned services in the future. No direct value for money implications today but adoption of policy could have significant implications in the future.
Additional Comments One of the key considerations of any decommissioning decision has to be the financial consequences of the decision and the potential savings to be made. It is	

	important that an economy wide view if taken – including the effect of stranded costs and future consequences (e.g. if stopping medium cost treatment today is likely to result in the need for high cost treatment in several years' time). Support the idea of a scoring matrix to ensure that a fully informed decision is made, however question is there should be a weighting applied to the grid with a clear criteria about threshold from which proposals are progressed (i.e. are safety, quality and finances perhaps more important than stakeholder engagement. Should there be something about reputational risk included in the assessment).
Legal Implications: **(Authorised by the Borough Solicitor)**	It is important for any public decision maker to have agreed criteria on which to base their actions, and so the development of this policy represents good practice, and encourages consistent and robust decision making capable of withstanding legal challenge. An equality impact assessment is attached to which members are required by law to have regard before making their decision, and from which will flow individual assessments when considering each proposal. Any policy must be kept under regular review to ensure it remains fit for purpose. As Single Commissioning Board meetings are held monthly, certainly for the immediate I would suggest decisions are made by the Board. In due course should there be a need for more frequent decisions, the Board should be asked to consider agreeing to delegate the function to specific officers, after taking Borough Solicitor advice on the most appropriate governance arrangement.
How do proposals align with Health & Wellbeing Strategy?	The policy states that any proposal put forward for decommissioning / disinvestment must be presented to the Single Leadership Team, and with their approval, to PRG and SCB for debate and consideration. It also states that any proposal will therefore be required to evidence alignment with the Health & Wellbeing Strategy.
How do proposals align with Locality Plan?	The policy states that any proposal put forward for decommissioning / disinvestment must be presented to the Single Leadership Team, and with their approval, to PRG and SCB for debate and consideration. It also states that any proposal will therefore be required to evidence alignment with the Locality Plan.
How do proposals align with the Commissioning Strategy?	The policy states that any proposal put forward for decommissioning / disinvestment must be presented to the Single Leadership Team, and with their approval, to PRG and SCB for debate and consideration. It also states that any proposal will therefore be required to evidence alignment with the Commissioning Strategy.
Recommendations / views of the Professional Reference Group:	The policy was accepted by the PRG and SCB, with some amendments to emphasise the Single Commission nature of the policy. PRG proposed the acceptance by SCB of decisions being made on a virtual basis, to ensure the process of presenting proposals to committee meetings does not delay decision making where patient/public safety issues are the reasons for the disinvestment

	/ decommissioning proposal. Section 4.1 of the policy has been revised to reflect this.
Public and Patient Implications:	The policy outlines a clear expectation to include a programme of public and patient engagement and, where applicable, formal consultation, to ensure the patient and public implications are understood and taken into account in relation to any proposal taken through this process. Evidence of this is a requirement of the policy.
Quality Implications:	Quality Impact Assessments will be undertaken for any proposal taken through this process and assessed / evaluated using this policy. The policy includes statements to this affect, and includes Quality as a section in the assessment framework.
How do the proposals help to reduce health inequalities?	The assessment of any proposal put forward for decommissioning / disinvestment will include consideration of the impact on health inequalities, as stated in section 4 and appendix 1 of the policy.
What are the Equality and Diversity implications?	Equality Impact Assessments will be undertaken in line with the Single Commission 'Safe & Sound' approach to commissioning. The requirement for this is included in the policy.
What are the safeguarding implications?	The policy states that any proposal put forward for decommissioning / disinvestment must be presented to the Single Leadership Team, and with their approval, to PRG and SCB for debate and consideration. It also states that any proposal will therefore be required to evidence any safeguarding implications.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The policy states that any proposal put forward for decommissioning / disinvestment must be presented to the Single Leadership Team, and with their approval, to PRG and SCB for debate and consideration. It also states that any proposal will therefore be required to evidence any information governance implications.
Risk Management:	The policy states that any proposal put forward for decommissioning / disinvestment must be presented to the Single Leadership Team, and with their approval, to PRG and SCB for debate and consideration. It also states that any proposal will therefore be required to evidence any risk management issues.
Access to Information :	The background papers relating to this report can be inspected by contacting Alison Lewin, Deputy Director of Transformation:  Telephone: 07979 713019  e-mail: alison.lewin@nhs.net

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Tameside & Glossop Disinvestment and Decommissioning Policy

Date policy adopted by Single Commissioning Board: 11th July 2017

Date for review of policy: 31/3/2018 and annually thereafter

1 Introduction

NHS Tameside & Glossop Clinical Commissioning Group (CCG) is the local lead commissioner of NHS services, with responsibility to improve the health of local people and commission high quality services that meet their needs within the resources available.

Across the Tameside & Glossop locality there is now a single place-based commissioning body comprising NHS Tameside & Glossop Clinical Commissioning Group and Tameside Metropolitan Borough Council known as the Tameside & Glossop Care Together Single Commissioning Board to commission effectively for the transformation programmes within the locality plan as well as for gaining benefits from jointly commissioning existing services.

To support this there is now a single leadership team which has been established as a joint committee of the two organisations with delegated decision-making powers and resources. This is the Single Commissioning Board. This will create a unifying group within both the statutory and collaborative governance arrangements for the first time. The key role of this Board will be:

- To provide executive leadership for the locality plan from a commissioning perspective
- To oversee the management of any delegated commissioning functions and pooled budgets
- To lead the development of commissioning as part of statutory and Health and Wellbeing Board governance arrangements.

The Single Commissioning Board considers commissioning proposals which are funded from the Integrated Commissioning Fund. This fund is comprised of three elements as set out in the table below:

Budget Allocation Sections	Detail	Governance implications
Section 75	This relates to legislation that allows the establishment of pooled funds between NHS bodies and local authorities at a local level	The Single Commissioning Board makes decisions on this funding which are binding upon the two statutory partner organisations.
Aligned Services	Funding contributions for services that cannot be delegated for formal joint provision	The Single Commissioning Board makes recommendations on the spending of this funding. These recommendations will require ratification by the relevant statutory organisation.
In Collaboration Services	Funding for services which cannot be included within Section 75 arrangements without a change in legislation. These specialised services are jointly commissioned with NHS England.	The Single Commissioning Board makes recommendations on the spending of this funding. These recommendations will require ratification by NHS England and the relevant statutory organisation.

In the current financial climate, where funding growth allocated to all public services, including the NHS is increasingly constrained, it is important that the Single Commissioning Board demonstrates effective use of public money to commission services that deliver the

greatest health benefit for local people. To achieve this, effective contracting arrangements and strong performance management are essential, together with robust, evidence based approaches to prioritisation.

The Single Commissioning Board will ensure that commissioning decisions are fully informed, are based on health outcomes and public health data, and are benchmarked against similar health and social care systems.

To ensure that limited resources are consistently directed to the highest priority areas the Single Commission has developed this Decommissioning and Disinvestment Policy that sets out the agreed principles for decommissioning and disinvesting in services so that funding can be redirected, where necessary to higher priorities. This process is being presented in the form of a policy to ensure the process is formalised and approved by the Single Commissioning Board.

2 The Approach to Decommissioning and Disinvestment

The aim of this Decommissioning and Disinvestment Policy is to provide a framework to guide Single Commission decision making with regard to significant service changes proposed by the Single Commission in order to deliver its priorities, within the financial resources available to it.

The policy seeks to clarify the circumstances in which services may be decommissioned or disinvested from and describes the approach and processes that will be adopted to ensure decisions are fully informed and implemented effectively, following a safe, fair and transparent process. Decommissioning and disinvestment impacts on patients and therefore requires a formal process which provides an evidence trail and clear governance supporting any decisions.

There is a need to ensure that when approval has been given by the Single Commissioning Board to decommission or disinvest from a service, a clearly defined process is followed, with clear lines of accountability and responsibility.

The following definitions have been applied in the development of this Policy:

Decommissioning: This relates to the withdrawal of funding from a provider organisation with services being subsequently re-commissioned in a different way.

Disinvestment: This relates to the withdrawal of funding from a provider organisation and the subsequent stopping of the service.

In the event that decommissioning or disinvestment is proposed, the it is recognised that a number of steps will be required prior to a final decision being taken by the Tameside & Glossop Single Commissioning Board. These include engagement with the member practices, consideration as to whether a consultation exercise is required with partner organisations/patients/public, and completion of full Quality Impact Assessment and Equality Impact Assessment processes.

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This policy sets out the processes that will be followed, and the roles of individuals and committees in developing and scrutinising proposals for disinvestment/decommissioning, prior to them being brought to the Single Commissioning Board for consideration and approval. The policy ensures that patient safety is considered in the assessment of service changes proposed.

The Disinvestment and Decommissioning Policy is to be applied when making both clinical and non-clinical disinvestment and decommissioning decisions.

The aim of this document is to:

- Provide a rationale and process to allow services to be identified for review prior to any decision to decommission or disinvest.
- Deliver best value for money by ensuring that local health care resources are directed to the most effective services for the local population.
- Ensure all commissioned services are monitored in terms of performance, health outcomes, efficiency, demand management and fitness for purpose to allow for a robust decision to be made regarding the continuation of that service.
- Contribute to the delivery of the CCG's operational plans and strategies in order to ensure that resources are directed to the highest priority areas in order to achieve the best possible health outcomes for the local population within available resources.
- Ensure all decommissioning and disinvestment decisions are taken in a fully informed manner and follow a set procedure agreed by the Single Commissioning Board.
- Ensure the safety of patients remains a key consideration

3 Principles & Criteria

3.1 Principles

The process outlined in this policy is guided by the following principles:

- Initiation of a decommissioning or disinvestment proposal must be based on tangible evidence
- The user experience and local health need must be a key consideration in informing any decision. Action should be taken to minimise the impact of gaps in service provision once the services is decommissioned or disinvested
- Appropriate stakeholders must be engaged and consulted before the decommissioning or disinvestment decision is made
- Detailed consideration must be given to the broad-ranging impact of the decision – impact assessments must be undertaken in order to quantify and clarify the positive or negative impact on patient care and the wider community; the potential destabilising effect on other services and organisations of a decision to decommission/disinvest should be fully considered, so as to avoid unintended consequences arising from a decision.
- Providers must be consulted as early as possible to allow time to adjust to the proposal

3.2 Conditions for Decommissioning or Disinvestment

The Single Commission will consider decommissioning or disinvesting from services where:

- A needs assessment demonstrates existing services are not meeting the health needs of the population
- There is a clear and objective reason for the decommissioning of a service that is based on assessment of the current providers' performance, value for money, and the need for service redesign to improve services for patients
- The original decision to fund a services was made on assumptions that have not been realised or have been overtaken by events
- There are demonstrable benefits for the decommissioning of a service
- There is an inability to demonstrate delivery of agreed outcome measures or failure to deliver outcomes, despite agreed remedial action as detailed in the relevant contract

- The service does not deliver value for money, as demonstrated through financial review, utilising programme budgeting tools
- The investment in a service does not maximise the health gain that could be achieved by reinvesting the funding elsewhere
- The service fails to meet the standards of a modern NHS as defined by the NHS Constitution, professionally driven change, and nationally driven changes
- The service is unable to demonstrate clinical and cost effectiveness
- The service provided is no longer the statutory responsibility of the CCG or local authority
- The service is deemed low priority / of limited clinical value relative to other services that need to be protected or enhanced
- The service is unsafe or of poor quality

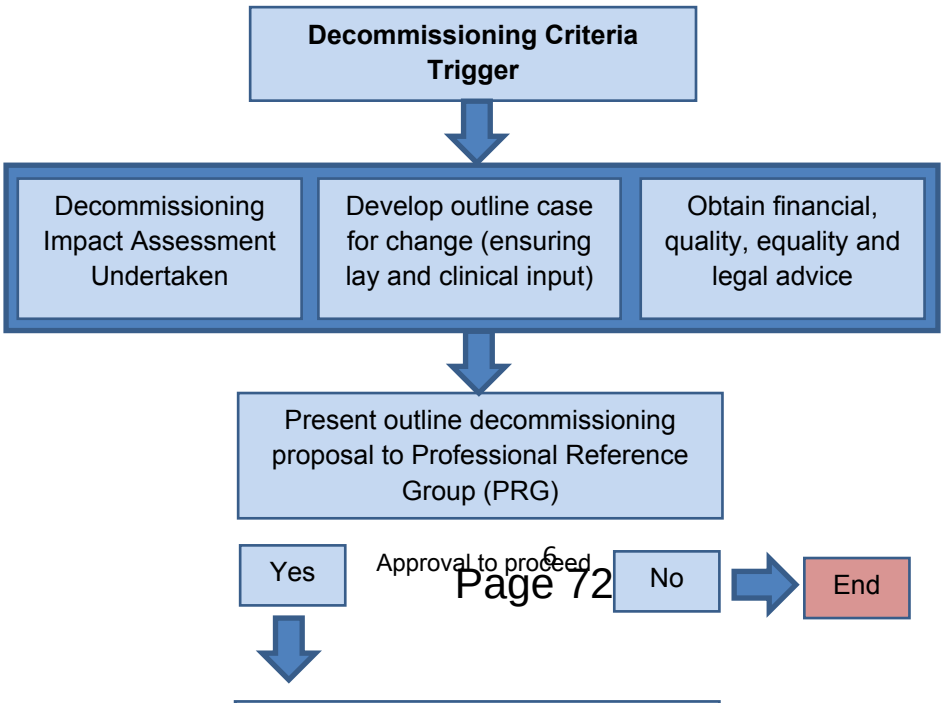
4 Decommissioning and Disinvestment Process for Commissioned Services

4.1 Process Flowchart

The Disinvestment / Decommissioning process flow chart provides at a glance the agreed process for commissioners to follow. Where a recommendation or decision relates to services funded from the 'aligned services' element of the Integrated Commissioning Fund (set out in section 1 of this policy) the outcome of any recommendation or decision will be reported to the statutory organisation responsible for the budget. The Single Commissioning Board makes recommendations on the spending of this funding. These recommendations will require ratification by the relevant statutory organisation.

The structure below makes reference to presentation of proposals to committees, and ultimately the Single Commissioning Board. Where proposals have arisen from patient safety concerns, the SCB will be asked to make decisions / give permission to proceed on a virtual basis rather than await SCB meeting dates.

In all cases, the commissioning directorate will aim to ensure the process is as slick as possible, and whilst ensuring all elements of this policy are adhered to, ensuring that delays are minimised.



4.2 Investment Criteria Assessment Framework

An assessment framework has been developed to ascertain the fit of any proposed decommissioning / disinvestment against the criteria established by the Single Commission. The proposal will be scored and will be required to meet a threshold to proceed to the next stage. The assessment framework will consider the proposal against:

Quality: Addressing health inequality or inequity; delivering wider benefits to society; Maximising voluntary sector / social value; Impact on others – people, community. Improvement in the quality of services delivered to the population / evidence of no detrimental quality impact from any disinvestment or decommissioning. Details of evidence based supporting the proposal.

Financial: Financial and performance outcomes of the proposed changes, inclusive of costs and financial benefits. Evidence of value for money and return on any investment required (including elsewhere in the system) to support the proposal. Consideration of the impact of the proposal on other parts of the system, including the potential for 'stranded costs'.

Safety: Evidence that the proposal either addresses an area where there are currently concerns regarding patient safety OR assurance that the proposal will not have a detrimental impact on patient safety

Stakeholder engagement: Evidence that the proposal has been developed with input from stakeholders, including the public/service users. Evidence where applicable that the proposal will improve the position in relation to stakeholder integration, involvement, and partnership working

Strategic Priority fit: Contribution to Single Commission commissioning intentions, Locality Plan, integration opportunities and strategic direction/statutory responsibility. Strength of local feeling and political sensitivity should be included where possible.

The assessment framework is attached at **appendix 1.**

4.3 Outline Case for Change

Step 1: The identification of an area as a potential decommissioning proposal, in line with the conditions set out in section 3.2 above, by a member of the Single Commission

Step 2: Completion of initial assessment of the proposal against the criteria for decommissioning / disinvestment in the Investment Criteria Assessment Framework using the standard template at Appendix 1

Step 3: Where the proposal meets the required threshold in the initial assessment, proceed to the production of an outline case for change for consideration by the Single Leadership Team. This case for change must include full narrative to outline the proposal, financial model to demonstrate the impact, a completed assessment framework, and the standard Single Commission governance processes outlined below.

Completion of the standardised front sheet for Single Commission governance will ensure no proposal proceeds beyond Single Leadership Team consideration if the proposal has not been considered for alignment with the Locality Plan, Commissioning Strategy and Health & Wellbeing Strategy. This process also ensures that any proposal taken through Single Commission governance outlines how the proposal addresses:

- Public & patient impact
- Quality issues – completion of a Quality Impact Assessment required for all papers
- Health inequalities
- Equality and diversity implications – completion of an Equality Impact Assessment required for all papers
- Safeguarding implications
- Information governance issues
- Risk management

All proposals will be required to include a full assessment from the Single Commission Legal Team and the system finance team, who provide detailed comments to support the discussions in Single Commission governance committees.

5 Structure and Accountabilities

5.1 Single Commission Governance Framework

Within the context of the Governance Framework the following principles for decision making regarding the decommissioning or disinvestment of services will apply:

- It is a right and role of the CCG GP membership to identify services that should be considered for decommissioning or disinvestment.

- The CCG Governing Body , as the legally accountable body for NHS resources in Tameside & Glossop, will ultimately make the decision with regard to the decommissioning of any service following the criteria and process set out in this policy. The Governing Body may choose to delegate the decision-making to the Single Commissioning Board but it cannot delegate its accountabilities.

- Consultations will be carried out with the public / partners / providers and will be informed by statutory and best practice requirements in line with the locality's 'Safe & Sound' processes.

5.2 Committee Responsibilities

A number of the Single Commission's Committees will need to be involved in preparing a 'case for change' prior to it being formally considered by the Single Commissioning Board.

An important role of these committees will be to fully understand and scrutinise any proposals.

The Single Commissioning Board (with support and assurance via the Professional Reference Group and Finance Economy Workstream), will be responsible for ensuring that the criteria and processes outlined in this policy have been applied and that the process has been followed accordingly.

The Quality and Performance Assurance Group will have a key role in ensuring that the consequences of decommissioning and disinvesting from a service have been fully quantified and the impact assessed. In addition, the committee will be able to propose any remedial action that might be required to mitigate clinical risk and/or adverse impacts.

The Professional Reference Group (PRG) will make final recommendations to the Single Commissioning Board in relation to any proposed case for change. PRG recommendations and subsequent SCB decisions regarding disinvestment and / or decommissioning will always be ratified by comments from the Single Commission legal team and the locality Finance Economy Workstream.

5.3 Single Commissioning Board Responsibilities

As part of its decision making process the Single Commissioning Board is required to fully consider the quality and equality impact assessments undertaken, results of public and statutory consultation and holds the authority to approve or reject proposals for decommissioning and disinvestment of services.

6 Officer Roles and Responsibilities

6.1 CCG Accountable Officer / Council Chief Executive

The CCG Accountable Officer / Council Chief Executive is accountable for the actions undertaken by the Officers of the Single Commission, as noted below.

6.2 Single Commission Leadership Team / Directors / Heads of Commissioning

The lead officer responsible for the commissioned service is required to undertake the following actions when considering disinvestment / decommissioning proposal:

- Secure any appropriate legal and specialist financial advice through discussions with the Chief Finance Officer and the Single Commission's legal team.
- Assess the benefits the service has realised and assess the potential for any further improvement to the services effectiveness and value for money.
- Adopt a programme management approach to manage the processes to inform the development of a 'case for change' document that will be used to consult and ultimately be presented to the Board in line with section 4 of this policy.

6.3 Quality & Safeguarding Directorate

The Quality and Safeguarding Directorate and the Quality and Performance Assurance Group are key forums to notifying commissioners when concerns are raised in terms of the quality and safety of the services provided. The team utilise information from a variety of sources to assess the safety, efficacy and service user experience of commissioned services. This information along with site visits and other intelligence is used to assess the relative quality of services commissioned or contracted by the Single Commission.

The Quality Team will work with the lead commissioner, proposing the decommissioning of service(s) to ensure that a reduction in services does not have a direct or indirect negative

impact on patient safety or the quality of any other related service. This will include evaluation of a commissioner-led Quality Impact Assessment.

6.4 Finance Directorate

The Single Commission's Finance team are key to supporting a review of expenditure against health outcomes and identifying service / programme areas to be considered for potential decommissioning or disinvestment. The Directorate, working as part of the system-wide Finance Economy Workstream, will use a variety of tools and information sources to support this work, including:

- Programme Budgeting: Using the programme budgeting benchmarking tool to identify how much is spent for each programme compared with similar CCGs / previous PCTs. These resources have the ability to analyses the relationship between spend and the health outcomes, and investigate variation.
- Benchmarking tools: These can be used to analyse the trends in activity, spend and outcomes over time in comparison to other commissioning bodies.
- Analysing service delivery by care setting e.g. Acute Care, Primary Care, 3rd sector, community services, social care, mental health etc, and comparing cost and outcomes with other areas, to identify potential to change the delivery model.
- Ensure all proposals for decommissioning and disinvestment are aligned with the locality Savings Assurance programme and wider financial planning.

6.5 Public Health Directorate

When considering service decommissioning or disinvestment the Public Health Directorate will support the assessment and evaluation of proposals and determine the contribution towards improving population health and tackling health inequalities. These teams will express the health outcomes produced from services in the context of the population's health need and contribute to the health impact assessments required in making informed decommissioning / disinvestment decisions.

The Public Health directorate will, through the interpretation of population based data, highlight areas for decommissioning, such as benchmarking tools which compare the cost and/or outcomes of services compared to other localities.

6.6 Contracting Teams, Performance Management and Business Intelligence

The Performance team has a joint responsibility with the lead commissioners to provide key performance information to commissioners to ensure that services are appropriately reviewed. The information behind a decision to decommission must be of high quality, be auditable and able to be presented as evidence which can withstand challenge should a decision based on performance be disputed. Areas that will be considered as part of the performance review of contracts will include areas of:

- Poor performance against NHS Constitutional Standards and other national or local targets
- Delivery of poor health outcomes
- Poor value for money
- Inequality of service provision
- Activity of limited clinical value being undertaken

In addition, the Business Intelligence team will provide a key role to support finance colleagues in reviewing the programme budgeting reports when considering expenditure compared to health outcomes.

Contracting and procurement advice will be sought to ensure that the rules and principles relating to any decommissioning and disinvestment activity will follow the relevant legal guidance.

Relevant guidance must be considered to ensure that no sector of the provider market is given any unfair advantage during the decommissioning process, and the Single Commission will retain an auditable documentation trail regarding all key decision. The Procurement advisors will also ensure market assessments are completed to analyse any impact on the provider market.

6.7 Human Resources Advice

Human resources expertise will be sought should the decommissioning of services be confirmed, to ensure all legal obligations and any potential workforce planning issues are appropriately managed.

6.8 Communications and Engagement

If decommissioning or disinvestment is proposed due to the introduction of a new service model, then the commissioner will seek expert advice from the communications team in relation to carrying out the appropriate level of engagement / consultation to comply with best practice and statutory requirements.

This advice will be sought at the earliest possible opportunity to ensure adequate time for the required engagement and consultation.

Appendix 1

Investment Criteria Assessment Framework: Where services are being considered for decommissioning or disinvestment the following scale will be used

Criteria	Scale			Score	Threshold
Quality impact	**-1 point** Detrimental or no contribution to improving health & quality outcomes/ patient experience	**1 point** Some evidence of contribution to improving health & quality outcomes/ patient experience	**2 points** Strong evidence of significant contribution to improving health & quality outcomes/ patient experience		**1**
	-1 point Negative impact and increases health inequalities	**1 point** Some evidence of positive impact on health inequalities	**2 points** Significant evidence of considerable positive impact on health inequalities		1
Financial impact NB: Significant savings equate to more than £500k per annum	**-1 point** Limited evidence that significant savings would be made	**1 point** Some evidence that significant savings would be made	**2 points** Good evidence that significant savings would be made		**1**
	-1 point Savings will make no significant contribution to the locality's Savings Assurance programme and will have a detrimental effect on other parts of the locality – commissioner and provider	**1 point** Savings will make a limited contribution to the locality's Savings Assurance programme	**2 points** Savings will make a significant contribution to the locality's Savings Assurance programme		**1**
Safety: Assess for impact on patient safety	**-1 point** Safety levels would be compromised	**1 point** Safety levels would be unchanged	**2 points** Safety levels would improve		
	-1 point There would be unmanageable safety risks	**1 point** There would be manageable safety risks	**2 points** There would be no safety risks		
Stakeholder engagement	**-1 point** No evidence of involvement of stakeholders in the development of the proposal, including patients / carers	**1 point** Evidence of involvement of stakeholders in the development of the proposal, including patients / carers	**2 points** Evidence of involvement of stakeholders in the development of the proposal, including patients / carers, and Maximises voluntary sector / social value		**1**
Strategic priority fit	**-1 point** Not identified in the Locality Plan, Commissioning Strategy or a statutory / GM requirement	**1 point** Identified in the Locality Plan, Commissioning Strategy or a statutory / GM requirement	**2 points** Identified in the Locality Plan, Commissioning Strategy and a statutory / GM requirement		**1**

The narrative accompanying any proposal for decommissioning / disinvestment needs to address the criteria outlined in this framework by covering the points below against each of the criteria.

Quality: Addressing health inequality or inequity; delivering wider benefits to society; Maximising voluntary sector / social value; Impact on others – people, community. Improvement in the quality of services delivered to the population / evidence of no detrimental quality impact from any disinvestment or decommissioning. Details of evidence base supporting the proposal.

Financial: Financial and performance outcomes of the proposed changes, inclusive of costs and financial benefits. Evidence of value for money and return on any investment required (including elsewhere in the system) to support the proposal.

Safety: Evidence that the proposal either addresses an area where there are currently concerns regarding patient safety OR assurance that the proposal will not have a detrimental impact on patient safety

Stakeholder engagement: Evidence that the proposal has been developed with input from stakeholders, including the public/service users. Evidence where applicable that the proposal will improve the position in relation to stakeholder integration, involvement, and partnership working

Strategic Priority fit: Contribution to CCG/Single Commission commissioning intentions, Locality Plan, integration opportunities and strategic direction/statutory responsibility. Strength of local feeling and political sensitivity should be included where possible.

Appendix 2

Report to:	**PROFESSIONAL REFERENCE GROUP / SINGLE COMMISSIONING BOARD**
Date:	
Officer of Single Commissioning Board:	
Subject:	
Report Summary:	
Recommendations:	
Financial Implications: ***(Authorised by the statutory Section 151 Officer & Chief Finance Officer)***	*Will not be accepted unless financial comments are included*
Legal Implications: ***(Authorised by the Borough Solicitor)***	*Will not be accepted unless legal comments are included*
How do proposals align with Health & Wellbeing Strategy?	
How do proposals align with Locality Plan?	
How do proposals align with the Commissioning Strategy?	
Recommendations / views of the Professional Reference Group:	*To be completed following the PRG meeting*
Public and Patient Implications:	
Quality Implications:	
How do the proposals help to reduce health	

inequalities?	
What are the Equality and Diversity implications?	
What are the safeguarding implications?	
What are the Information Governance implications? Has a privacy impact assessment been conducted?	
Risk Management:	
Access to Information :	The background papers relating to this report can be inspected by contacting ☎ Telephone:  e-mail:

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

Subject / Title	Disinvestment & Decommissioning Policy

Team	**Department**	**Directorate**
Commissioning	Commissioning	Commissioning

Start Date	**Completion Date**
28th June 2017	

Project Lead Officer	Alison Lewin
Contract / Commissioning Manager	Alison Lewin
Assistant Director/ Director	Clare Watson

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

PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	The aim of this Decommissioning and Disinvestment Policy is to provide a framework to guide Single Commission decision making with regard to significant service changes proposed by the Single Commission in order to deliver its priorities, within the financial resources available to it.

1b.	**What are the main aims of the project, proposal or service / contract change?**	The policy seeks to clarify the circumstances in which services may be decommissioned or disinvested from and describes the approach and processes that will be adopted to ensure decisions are fully informed and implemented effectively, following a safe, fair and transparent process. Decommissioning and disinvestment impacts on patients and therefore requires a formal process which provides an evidence trail and clear governance supporting any decisions. Full EIAs will be carried out for any proposal developed and taken through the processes outlined in this policy.

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics?

Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age		✓		Proposals for disinvestment / decommissioning could impact specific age groups. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.
Disability		✓		Proposals for disinvestment / decommissioning could impact people with disabilities. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.
Ethnicity		✓		Proposals for disinvestment / decommissioning could impact specific ethnic groups. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.
Sex / Gender		✓		Proposals for disinvestment / decommissioning could impact specific gender groups. The demographics of people accessing current services will

				be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.
Religion or Belief		✓		Proposals for disinvestment / decommissioning could impact people of a specific religion / belief. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.
Sexual Orientation		✓		Proposals for disinvestment / decommissioning could impact people of a specific sexual orientation. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.
Gender Reassignment		✓		Proposals for disinvestment / decommissioning could impact people who have undergone gender reassignment. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.
Pregnancy & Maternity		✓		Proposals for disinvestment / decommissioning could impact people in this category. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.
Marriage & Civil Partnership		✓		Proposals for disinvestment / decommissioning could impact people in this protected characteristic group. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected				

groups?				
Mental Health		✓		Proposals for disinvestment / decommissioning could impact people with mental health needs. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB..
Carers		✓		Proposals for disinvestment / decommissioning could impact carers. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.
Military Veterans		✓		Proposals for disinvestment / decommissioning could impact military veterans. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.
Breast Feeding		✓		Proposals for disinvestment / decommissioning could impact people breastfeeding. The demographics of people accessing current services will be analysed fully as part of any project / proposal and prior to the presentation development of any proposed model to PRG and SCB.

Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (e*.g. vulnerable residents, isolated residents, low income households)*

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

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

1d.	Does the project, proposal or service / contract change require a full EIA?	Yes	No
			✓

1e.	**What are your reasons for the decision made at 1d?**	Although there is the potential for any proposal taken through the disinvestment and decommissioning process to impact on protected characteristic groups, the reasons for not completing a full EIA at this stage are: - The detail of the EIA would be specific to the proposal to be addressed by the processes outlined in this policy - Each individual proposal presented to PRG/SCB using the Disinvestment and Decommissioning policy and process will be required to complete an EIA screening, and where appropriate a full EIA, prior to presentation to PRG and SCB. This is clearly stated in the policy

Signature of Contract / Commissioning Manager	**Date**
Alison Lewin	**28th June 2017**
Signature of Assistant Director / Director	**Date**
Clare Watson	**28th June 2017**

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Report to: **SINGLE COMMISSION BOARD**

Date: 11 July 2017

Officer of Single Commissioning Board Clare Watson, Director of Commissioning

Subject: **INTEGRATED NEIGHBOURHOOD CHILDREN'S TEAM (INCT) PILOT PROPOSITION**

Report Summary:

The report seeks the approval for developing and implementing a pilot Integrated Neighbourhood Children's Team, which seeks to deliver improved outcomes and efficiencies for children and young people and those who care for them.

The Integrated Neighbourhood Children's Team Pilot will facilitate provision of, and access to, bespoke person centred holistic solutions, working to the following principles of place based care:

- Integrated local services ensuring collaborative responses to local need;
- Services that build on assets of the community & intervene early in an emerging problem;
- One team, knowing their area and each other;
- Person centred approach within the context of family & community; and
- Services delivered within the community, close to home from a flexible asset base.

Recommendations:

1. To acknowledge the contents of this report;
2. To commit and agree to the strategy of an integrated neighbourhood children's model;
3. To seek commitment of staff time to move to further development and phased implementation from Tameside and Glossop Integrated Care Foundation Trust, Primary Care Foundation Trust, Tameside MBC Children's Service's (Social Care and Education) and Single Commission Framework;
4. To agree and support that existing resources should be aligned to developing and implement the pilot; including those already deployed around the existing Care Together Integrated Neighbourhood Teams agenda and social prescribing (e.g. forthcoming Voluntary and Community Sector tender for support); and
5. To ensure executive / director ownership, oversight and drive of the agenda/pilot.

Financial Implications:

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

Budget Allocation (if Investment Decision)	N/A at this stage
CCG or TMBC Budget Allocation	Both

Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75 & Aligned
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB, Exec Cabinet and CCG GB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Cannot comment at this stage

Additional Comments

It is acknowledged that this paper is purely to seek agreement to develop and pilot an integrated children's neighbourhood model and further work is required to develop and operationalize the model. Finance support this proposal but would highlight that GM transformation funds are limited and non-recurrent in nature. Therefore, should there be any future rollout of pilots should this prove successful, this will need to be funded from within the existing recurrent resources available within the system/economy and there will be no additional funding available.

All neighbourhood proposals requiring funding are expected to complete PID's in line with the single commissioning PMO requirements in which it is also necessary to quantify the cash releasing benefits expected to be derived from any new non-recurrent investment, along with proposals for continuation once the non-recurrent funding expires.

Legal Implications:

(Authorised by the Borough Solicitor)

Whilst all initiatives to support the Council's Children's Services are welcomed, it will be very important to (a) monitor and assess precisely how the pilot's outcomes have a direct effect on those children most in need in the Borough; (b) ensure that resources are targeted effectively; and (c) show how this in turn impacts on the Council's legal duty to protect children from significant harm, neglect and abuse. The pilot therefore needs to have direct linkages to Children's Services so that these outcomes are captured and reported on at both operational and strategic levels.

How do proposals align with Health & Wellbeing Strategy?

The proposal directly aligns with the vison of the strategy and the challenges noted. The paper directly supports 3 of the 5 key priorities (Priority 1: Starting well, Priority 2: Developing well and Priority 3: Living well).

Developing Well: there is a need to identify opportunities in relation to improving our commissioning and delivery systems to achieve better outcomes for children and young people and to mobilise the whole system from prevention, early help to specialist services to make sure we are providing better outcomes through:

- Providing clear pathways;

	• Providing a clear plan of how children and young people's health and care needs will be me; • Producing strategies that will provide targeted awareness and improve identification; • That build on the assets of the children, young and those who care for them; and own communities.
How do proposals align with Locality Plan?	The proposal is consistent with the following priority transformation programmes: • Healthy Lives (early intervention and prevention); • Community development; • Enabling self-care; • Locality based services; • Urgent integrated care services.
How do proposals align with the Commissioning Strategy?	The proposal contributes to the Commissioning Strategy by: • Patients and communities being empowered to care for themselves and to work together to support local health and wellbeing; • Technology enabled access to information, advice and care; • Locality based integrated teams of multi skilled health and social care professionals using integrated case management and care co-ordination; • Identification and support of "at risk" people; • High Quality Primary Care working through new models; • Fewer overnight stays in hospital and more community based urgent care.
Recommendations / views of the Professional Reference Group:	PRG fully support the paper noting the recommendations that include SCB to identify and nominate director level ownership and oversight to enable pilot implementation. PRG noted in addition work is needed to ensure understanding of the paper within TGICFT at director level. However this should not delay the paper going forward.
Public and Patient Implications:	The proposal has been developed through consultation and engagement – utilising the voice of the child and those who care for them existing consultation and engagement findings. The Integrated Children's Neighbourhood Team will deliver improved experiences and outcomes for those children and young people and families needing support.
Quality Implications:	A quality impact assessment has been completed and is attached.
How do the proposals help to reduce health inequalities?	The proposal seeks to reduce health inequalities, targeting the resources to where most needed and ensure services are accessible to all.

What are the Equality and Diversity implications?	It is not anticipated that the proposal will have a negative effect on any of the protected characteristic group(s) within the Equality Act. An Equality Impact assessment has been completed and is attached.
What are the safeguarding implications?	Strengthening of current provision and systems, notably providing a delivery vehicle for OFSTED Children's Improvement Response
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of the NHS. NHS providers, GP Practices and neighbourhood teams would have IG policies in place and they would be expected to adhere to these. If the pilot was agreed part of operationalisation Information Sharing Protocols (ISP) may need to be developed to minimise barriers to sharing information with consent.
Risk Management:	The paper seeks to address the potential fragmentation of care between and within Children's Health, Education and Social Care; supporting a number of Children's agenda e.g. Special Education Needs and Disability (SEND), OFSTED Children's Improvement Response and the wider Care Together agenda.
Access to Information :	The background papers relating to this report can be inspected by contacting Alan Ford, Commissioning Manager Children, Young People & Families

 Telephone: 07500 980612

 e-mail: alan.ford4@nhs.net

1. BACKGROUND

1.1. The Integrated Neighbourhood Children's model reflects the key characteristics set out in the following strategic context and seeks a collaborative approach in response to this environment.

Special Educational Needs and Disability (SEND)

1.2. The Special Educational Needs and Disability (SEND) Reforms, enshrined in Part 3 of the Children and Families Act 2014 came into force on 1 September 2014 and outlined the biggest transformation to special educational needs and disabilities support for 30 years. Local Areas now have responsibility for all children and young people with SEND aged 0 – 25. Through the Children and Families Act and the Code of Practice, responsibility for the development of SEND services lies with the Local Area.

1.3. A new framework for the inspection of local areas' effectiveness in meeting the needs of children and young people with (SEND) has been implemented. The new inspection programme began in May 2016, with potentially a Tameside assessment likely in 2017. It is important to note that this is a local area inspection, not a local authority inspection. The local area includes the Local Authority (Education and Social Care), Clinical Commissioning Groups and Public Health and the services commissioned through them e.g. Tameside and Glossop Integrated Care Foundation Trust. The new joint inspection framework for SEND will seek to hold the local area to account and ensure the area's joint planning is effective in:

- Identifying children and young people who have special educational needs and/or disabilities;
- Meeting the needs of children and young people who have special educational needs and/or Disabilities;
- Improving the outcomes of children and young people who have special educational needs and/or disabilities.

Tameside Local Authority Children's Ofsted Inspection

1.4. All local authorities in England are inspected by Ofsted within a three/four year period under the unannounced single inspection framework for children in need of help and protection; children looked after and care leavers. Her Majesty's Inspectors (HMI) carry out these inspections under section 136 (2) of the Education and Inspections Act 2006. When a local authority Children's Service is rated inadequate there is a clearly defined process that Ofsted and the Department for Education follow for action planning, ongoing monitoring and re-inspection.

1.5. Tameside was inspected by Ofsted over a four week period that concluded at the end of October 2016. Despite notable areas of good practice the Inspectors overall outcome rated Tameside as inadequate.

1.6. Tameside's response to the Ofsted inspection has already started and an improvement plan has been formulated. This plan recognises to effectively support children and help families with complex needs falls beyond the resources of single agency approach. The plan sites and draws upon Tameside as having a track record of multi-agency and working together with the local community to address needs.

1.7. The improvement plan holds the following vision for an effective multi-agency Children's Services partnership:

'"We want children and their families in Tameside to be successful. We will work to ensure that positive opportunities and effective help are available at the earliest opportunity – enabling children and their families to make the choices that mean they can thrive and achieve. Where children and families do need to access services they

will be responsive, of a high quality and focused on achieving self-reliance. We will seek to break the cycle of dependence on services, and support children and young people to grow in a stable and settled environment. Children will have better experience of their time growing up in Tameside and be supported to realise their aspirations'.

1.8. The vision is supported by a number of cross-cutting themes:

- Multi-agency partnership working based on a shared understanding of common goals and collaborative action by all agencies to achieve better outcomes for children's and families.
- The voice of the child will inform both individual care and support planning as well as being a guide for the long-term development of services so that they are relevant to children at all levels of need.
- Quality of practice will be delivered by a highly engaged motivated and skilled workforce who has sufficient time, knowledge and resources to support children in need of help and support.
- Across the partnership there will be a shared understanding of thresholds and each agency will be aware of their organisational responsibilities and accountabilities.
- All activity by agencies and individuals will be focused on building resilience and independence to ensure children and families are successful and the multi-agency partnership is sustainable in the long term.

Care Together

1.9. The Care Together programme holds the ambition to significantly raise healthy life expectancy (HLE) in Tameside and Glossop, through the adoption of a place based approach to better prosperity, health and, wellbeing. The Tameside and Glossop Locality Plan set's the bold ambition of raising healthy life expectancy to the North-west average by 2020. For both men and women, this means an increase in healthy life expectancy of 3.3 years over the next five years. Care Together vision to achieve this ambition is to move quickly to a fully person-centred and integrated model of care, with a much heavier emphasis on prevention, supporting self-care and care closer to home. The Tameside and Glossop Commissioning for Reform Strategy sets out the strategic commissioning priorities for improving population health over the next 5 years as:

- A focus on the *wider determinants* of health and wellbeing, in particular giving children the best start in life and helping people to stay in and return to work, thereby improving their own prosperity.
- Early intervention and prevention across the life course to encourage *healthy lifestyles* and promote, improve and sustain population health.
- Creating the right care model so that people with *long term conditions* are better supported and equipped with the right skills to look after themselves and manage their conditions more effectively, reducing dependency on the health and social care system by promoting independence.
- Supporting positive *mental health* in all that we do.

1.10. A key delivery agent of Care Together sits within the Early Intervention and Prevention agenda. If we are to successfully deliver and sustain the ambition then we must develop a clear offer for Children, Young People and those who care for them.

1.11. Tameside and Glossop Care Together partners are part of a wider Greater Manchester health and social care system. In February 2015, the 37 NHS organisations and local authorities in Greater Manchester (GM) signed a landmark agreement with the government to take charge of health and social care spending and decisions in the Greater Manchester area; Tameside and Glossop Clinical Commissioning Group and Tameside Council are two of the 37 organisations.

Greater Manchester Health & Social Care Devolution

1.12. Greater Manchester Health & Social Care Partnership (GMHSCP) started on 1 April 2016 bringing a new era for Greater Manchester, as the region became the first in the country to take control of its combined health and social care budgets – a sum of more than £6 billion. (GMHSCP) underpinned by four key long-term goals

- Creating a transformed health and social care system which helps many more people stay independent and well and takes better care of those who are ill.
- Aligning our health and social care system far more closely with the wider work around education, skills, work and housing.
- Creating a financially balanced and financially sustainable health and social care system.
- Making sure all the changes needed to do this are done safely so the NHS and social care continues to support the people of Greater Manchester during the next five years.

Greater Manchester Public Service Reform (PSR)

1.13. Public Sector Reform principles have been agreed, which are to promote:

- A **new relationship** between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services. Do with, not to.
- An **asset based approach** that recognises and builds on the strengths of individuals, families and our communities rather than focusing on the deficits.
- **Behaviour change** in our communities that builds independence and supports residents to be in control
- A **place-based approach that redefines services** and places individuals, families, communities at the heart
- Stronger prioritisation of **well-being, prevention and early intervention**
- An **evidence led** understanding of risk and impact to ensure the right intervention at the right time

1.14. In May 2015, Combined Authority members at a GM level agreed to the principles of adopting Place Based Integrated Working as a Public Service Reform workstream. The development of place-based integrated working is an essential feature of the GM whole-system approach to the creation of new Public Service delivery models and is central to the GM Health and Social Care reforms. It is intended that new models will maximise operational effectiveness within the context of reduced budgets and essential to the sustainability services.

Tameside & Glossop Neighbourhood Approach

1.15. The following vision statement was developed in Tameside and Glossop for the Care Together Programme:

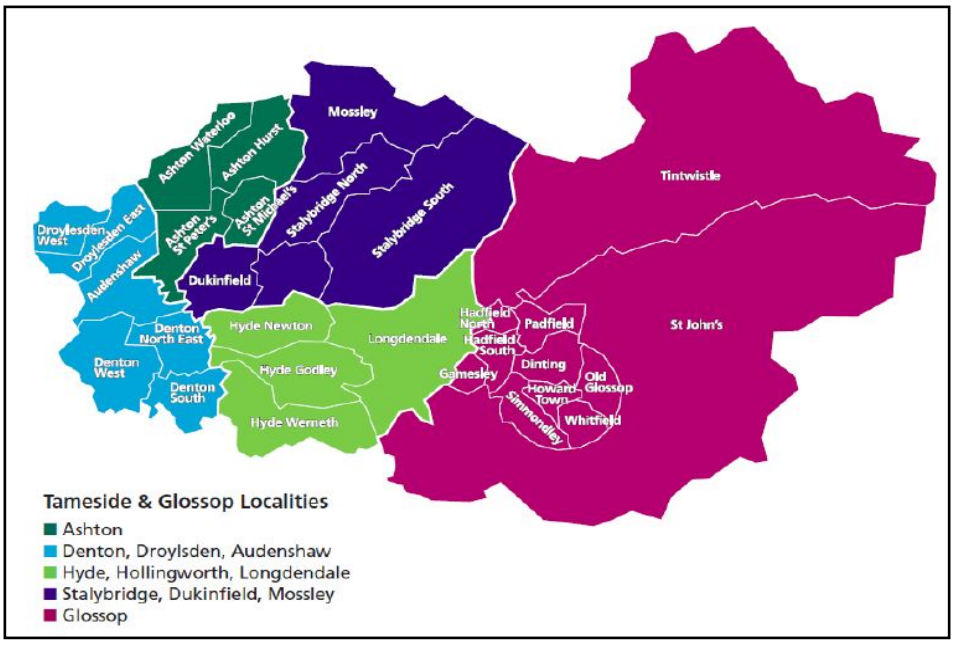
> *"Our vision is to significantly raise healthy life expectancy in Tameside and Glossop through a place-based approach to better prosperity, health and wellbeing and to deliver a clinically and financially sustainable health and social care economy within 5 years"*

1.16. A Neighbourhood Development work stream has been implemented to improve health and social care outcomes, increase healthy life expectancy, reduce duplication, improve patient/service user satisfaction and reduce dependency on the acute sector

1.17. Five Integrated Neighbourhoods across the Tameside and Glossop Single Commission footprint have been established. Four of the Neighbourhoods are co-terminus with the Tameside Metropolitan Borough Council Neighbourhoods. Glossopdale will be supported by Derbyshire County Council from a social care perspective.

1.18. As a Single Commission function we will continue to work with Derbyshire County Council on issues relating to the commissioning of services for the Glossopdale neighbourhood and maximise collaborative working with Derbyshire Children's Social Care.

1.19. Integrated Neighbourhoods will bring wider health and social care teams into these place based hubs to deliver a wide range of services that not only treat illness but promote care, wellness and behaviour change. This involves a comprehensive response from community services, social and primary care, outreach from hospital specialists, mental health and support from public health and preventative services. Input from the voluntary and community sector will be central to the success of this approach.



2. INTRODUCTION

The Integrated Neighbourhood Children's Ashton Pilot Principles and Objectives

2.1. The Integrated Neighbourhood Children's Pilot will facilitate provision of - and access to - bespoke person centred holistic solutions, working to the following principles of place based care:

- Integrated local services ensuring collaborative responses to local need
- Services that build on assets of the community & intervene early in an emerging problem
- One team, knowing their area & each other
- Person centred approach within the context of family & community
- Services delivered within the community, close to home from a flexible asset base

2.2. The key objectives are to:

- Provide Universal support within the early years to reduce escalation and improve general health and wellbeing for neighbourhoods (all seems a bit medical)
- Proactively identify children and young people at high risk of requiring access to services, through early intervention and prevention;
- Help children and young people and those who care for them live as independently as possible whilst managing one or more long term conditions;

- Co-ordinate delivery of services from all providers, with teams of multi skilled professionals based in the Neighbourhood;
- Optimise self-care and family/carers support to enable children and young people to stay safe and to stay at home for as long as possible;
- Focus on improved condition management to avoid admissions;
- Reduce Child in Need and formal safeguarding proceedings by intervening early with clear integrated holistic offer of support; and
- Support CYPF health, wellbeing, safety, educational attainment, happiness wealth.

2.3. The INs will achieve the aims and objectives outlined above as follows:

- Focus on wellbeing, wellness and preventing illness and longer term health improvement and proactive self-care.
- Provide high quality safe and sustainable services centred around the child and those who care for them.
- Provide short term interventions to maximise independence and self-management of illness/condition and/or social issues.
- Provide medium to longer range interventions where this is required.
- Work closely with partners to ensure smooth and seamless support during periods of crisis and transition.
- Use a Multi-Disciplinary case management approach to co-ordinated consistent care and support as close to home as possible.
- Provide high quality, holistic child centred care and support – promoting individual choice and control.
- Where appropriate, conduct Multi-Disciplinary Team meetings to review children and young people at high risk of admission to longer term care and/or Child in Need and safeguarding proceedings.
- Identifying children and young people who may benefit from care co-ordination by a lead professional to improve individual outcomes, reduce repetition, duplication and 'hand offs' between services.
- Ensuring children and young people receive the right level of care and support at the right time and in the right place, therefore reducing the need for crisis interventions.
- Support families and/or carers towards self-reliance and away from being dependent on services.

2.4. The fundamental principle of the Integrated Neighbourhood proactive approach to care is that individuals are assessed for the level of care they require. Delivering robust universal services giving opportunities for all to access at the earliest possible stage access to advice and guidance in order to ensure risks are minimised.

2.5. Depending on the level of risk an individual has at any given point, they would be managed / signposted within the relevant framework of the model. The model takes a proactive approach to the management of individuals across the whole risk spectrum and not just those at the higher end of need.

3. INTEGRATED NEIGHBOURHOOD CHILDREN'S TEAM OUTCOMES

3.1. During the development of the Integrated Neighbourhood Children's Team model it is proposed to produce a clear metrics/scorecard that supports a cross system Outcome Based Accountability framework.

3.2. Outcome Based Accountability (OBA), first developed in the 1990s by Mark Friedman, is now used extensively across the UK increasingly in local authority Children's Social Care and the NHS. The Integrated Neighbourhood Children's Team operational performance

measurement should seek to answer the outcome based accountability three questions. These are:

- How much did we do? (the quantity of service provided);
- How well did we do it? (the quality of the service provided); and
- Is anyone better off? (the effect of the service provided).

3.3. This third question is crucial. It assesses whether outcomes have been improved for children and young people and those who care for them. In support of this question 'I statements', similar to those in the Children's Emotional wellbeing and Mental Health Outcome framework could be developed (see **Appendix B**). The Integrated Neighbourhood Children's Team outcome framework would be presented to the Care Together Programme team to ensure they are included in the overall Care Together metrics, and are refined if required to ensure they are in line with the programme approach.

3.4. In addition to the core framework (application of outcome based accountability 3 questions) additional proxy measures from current children's indicators (see **Appendix C**) could be applied from baseline (pre-pilot) to review and evaluation e.g.

- A&E attendances (in 5 to 10 year olds, 10 to 16 year olds);
- Hospital Admission rates ((in 5 to 10 year olds, 10 to 16 year olds);
- Immunisations (Vaccination) Rates amongst children;
- Number of contacts with the Children's Hub (Children's Social Care s17, s47);
- Number of Looked After Children;
- School Readiness;
- School Attendance/Exclusions;
- 16-18 years olds Not in Education, Employment or Training (NEET);
- First time entrants to the youth Justice system;
- Number of children with an Education, Health and Care Plan (EHCP).

3.5. Finally, in addition to the proxy measure outlined above elements of Tameside MBC Children's Social Care Performance, Quality Assurance and Continuous Improvement Framework could be applied system wide e.g.

- Standard 1: All children will have an assessment which reflects a clear picture of the child's experience and wishes and feelings;
- Standard 2: All children will have a plan which explains their needs, outcomes and agreed actions;
- Standard 3: All assessments, plans and interventions will reflect an understanding of the wishes, feelings and needs of parents and carers and will be focused on enabling them to fulfil their responsibilities to their children.

4. INTEGRATED NEIGHBOURHOOD CHILDREN'S TEAM MODEL

4.1. Our model for Children's Integrated Neighbourhoods has been developed over a number of months, building on the existing 'Neighbourhood Approach' proposals, taking into account the local progress made through Care Together Programme. In addition the growing evidence base being delivered by the Stockport Family Approach (see **Appendix A**).

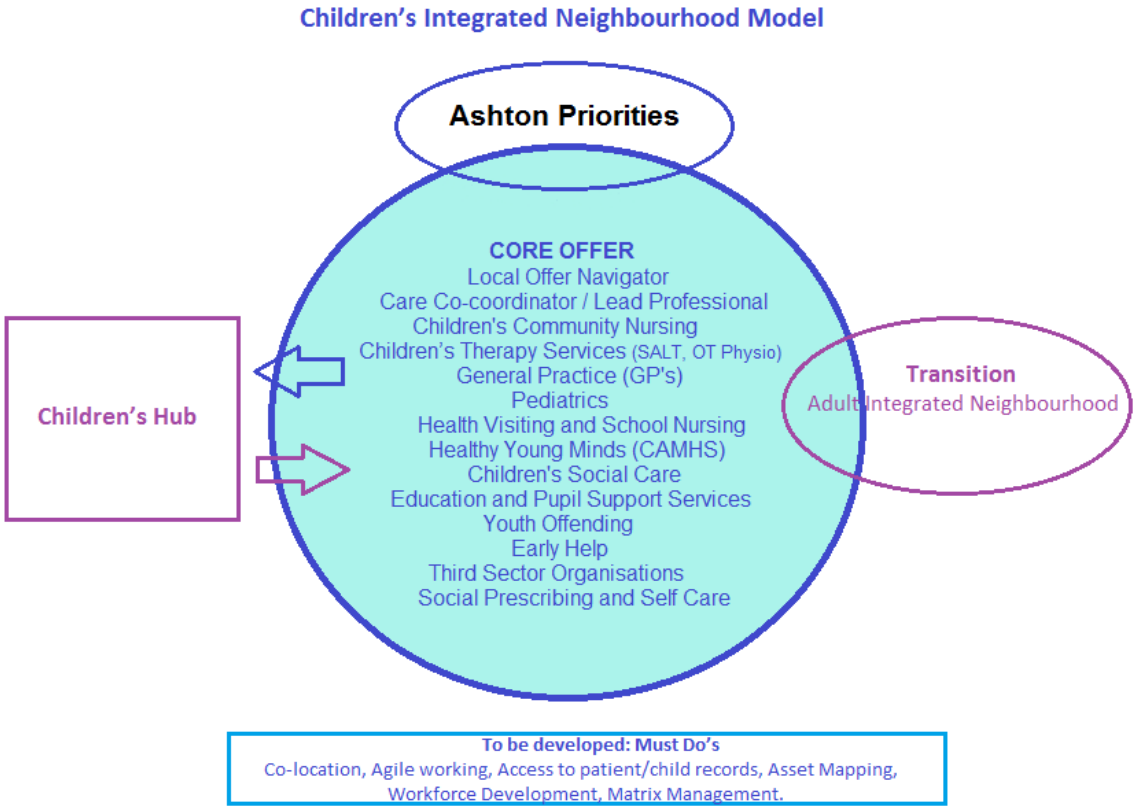
4.2. Through consultation with stakeholders and engagement with the Ashton neighbourhood, using the vision and objectives outlined above, we have developed a model which includes a 'core offer' and local priorities which are specific to meet the needs of neighbourhood. If the pilot is successful it is anticipated that in rolling out wider the five Integrated Neighbourhoods will look different and will eventually be staffed according to the local needs and demands, though they will share the same objectives, goals and outcomes.

4.3. The initial work has been focused on the population aged 0-18 years recognising the Integrated Neighbourhood adult model is already developed and operating in Ashton.

4.4. Building on the Stockport Family Approach the core principles will utilise restorative approaches when working with children, young people and those who care for them and other services. Traditionally, services and professionals have determined what families need and 'done to' and for families'.

4.5. The intend pilot will move to a system where an integrated offer and workforce works with children, young people and their families development interventions to enable building on their strengths and resources and gain appropriate support from universal and targeted services and their community.

5. CORE OFFER



5.1. The Ashton Pilot seeks to test and develop an Integrated Neighbourhood Children's Team 'core offer' – an offer which could be rolled out to all 5 neighbourhoods following evaluation – and local priorities which are specific to meet the needs of neighbourhood. The level of intervention delivered by the Integrated Neighbourhood Children's Team will be determined by the need of the individual and local population. Needs will be met by a range of people with the appropriate skills from community health, education and social care providers, 3rd sector, General Practice (and wider primary care, e.g. pharmacy), and incrementally expand to wider public sector teams (e.g. fire service, police service, council provided support). The core offer has been developed through consultation with stakeholders and members of the developing integrated neighbourhoods, and currently includes the functions outlined below.

5.2. The proposal is that the transformation funding requested from Greater Manchester will be used to support any developments in the core offer which require additional funding.

5.3. The following subsection lists of existing staff and teams have been produced at a neighbourhood level to facilitate the development and redesign of the Integrated Neighbourhood Children's Team model.

Care Co-ordinator and Navigators

5.4. The Integrated Neighbourhood Model is based upon the principle of care co-ordination and navigation. The initial proposed staffing structure includes 'care navigator' roles to support people to access the support they require, encouraging and enabling self-care and supported self-management. Key to the success of the Integrated Neighbourhood Children's Team will be the delivery of effective care co-ordination and key worker roles from within the existing multi-disciplinary teams, delivering the clarity and support required across what can at times be a complex system.

General Practice / Primary Care

5.5. The Integrated Neighbourhood model is based on the inclusion of our member practices as part of the multi-disciplinary team / offer to our residents. Primary Care is at the heart of integrated care and our GPs have a unique opportunity to contribute to and where applicable lead the development of the Integrated Neighbourhood Children's Team. The evolving agenda requires leadership and engagement to ensure that the pathways, models of care, quality and performance are designed with primary care at the centre, working as a fully integrated partner in the new delivery model.

5.6. The recently published NHS England 'General Practice Forward View' gives legitimacy and credibility to the work already underway in Tameside and Glossop to work with our practices in a new way: offering support to improve quality of care, recognising the pressures some of our practices are under and working with them to alleviate this, and working increasingly at a Neighbourhood (place) based level.

Children's Community Nursing & Therapy

5.7. Children's nursing in the community is provided by:

- Integrated Services for Children with Additional Needs (ISCAN), an integrated service made up of nurses, therapists and social care. ISCAN works with children, young people with disabilities and their families. The service will work on a neighbourhood basis with team members having responsibility for, and allocated to, one of the five neighbourhoods to ensure delivery of the core community nursing services as part of this model.

- The Community Nursing Team - based at the hospital and working with acutely ill children out in the community.

- Public Health Nursing Teams- Community Health Visiting and School Health Nursing teams based within locality settings providing universal health care provision and health support across the continuum of need. Family Nurse Partnership Nurses working with teenage parents, Specialist Looked after Children's Nurses and CSE Nurse based in one locality but working across Tameside localities,

Children's Social Care

5.8. Building on Tameside MBC and Derbyshire County Council inclusion of their Adult Social Care teams in the Care Together Integrated Care model for the 5 neighbourhoods. Children's Social Care are committed to delivering services via the Integrated Neighbourhood Children's Team.

Mental Health Support

5.9. One of the commissioning priorities included in the Tameside and Glossop Commissioning for Reform Strategy is 'Supporting positive mental health in all that we do'. The Integrated Neighbourhood Children's Team model will include support for the mental health needs of

children, young people and those who care for them. Healthy Young Minds (formerly CAMHS) provided by Pennine Care Foundation Trust offer specialist services to children and young people up to age 16, or 18 on specific pathways, who may be experiencing mental health difficulties. The multidisciplinary team consists of specialist staff including psychiatrists, nurses, social workers or psychologists. Healthy Young Minds has been transformed to align with the neighbourhood model, which means from an operational perspective each neighbourhood will know the resource available, who the people are, and how services can be accessed.

Children's Social Prescribing, 3rd Sector and Self Care

5.10. The involvement of the 3rd sector is key to the success of integrated neighbourhoods, as is the use of 'social prescribing' and the development of a non-medical model. The alignment of our Integrated Neighbourhood model with the Healthy Lives work stream will ensure we have the pathways and services available to deliver our social prescribing and 3rd sector access effectively across all 5 neighbourhoods. The 'Healthy Lives' Greater Manchester transformation funding proposal will support this element of the Integrated Neighbourhood model.

5.11. One of the key approaches to creating a sustainable economy will be supporting the population to manage their health more effectively, adopt healthier behaviours and choose appropriately when accessing support from health and social care. We will adopt a system wide approach to self-care and supported self-management, where self-care becomes our default and something promoted by all parts of the health system, and this begins from birth.

5.12. Children's services are underpinned by a wide range of third sector support including:

- 42nd Street;
- The Anthony Seddon Fund;
- Off The Record;
- Tameside Oldham and Glossop Mind;
- Our Kids Eyes;
- Lifeline;
- Papyrus;
- Home Start;
- TASCA.

5.13. These services support children, young people and families who are under stress or need support with the challenges of daily living; they offer a range of counselling and advice from infant feeding to suicide and substance abuse. Aligned to the neighbourhood model, each neighbourhood will know what services are available and a keyworker will be allocated to one of the five neighbourhoods as a key contact.

5.14. We will focus on the development of social prescribing at scale and combine it with an asset based community development approach seeking to unlock the potential of communities and individuals. Tameside and Glossop Integrated Care NHS Foundation Trust are actively seeking to build capacity in the local voluntary, community and faith sector, working with a range of groups to support their development and growth. Their funding for social prescribing includes capacity for investment in the Voluntary and Community Sector including spot purchasing and the award of small contracts/grants to ensure:

- Signpost and support individuals to opportunities for a range of activities including arts, physical activity, advocacy, peer support, befriending etc.
- Become a fully integrated part of the health and social care system, providing a bridge between traditional health and care services and more than medicine approaches usually accessing in the voluntary, community and faith sectors;

Education

5.15. Schools work in cluster groups and will align to neighbourhoods so that they can be supported by health and social care teams as well as specialists. The schools mental health pilot is a good example of this multidisciplinary neighbourhood work and will continue to evolve making sure that children young people and their families have the right support at the right time and in the right place.

5.16. Behaviour for learning and inclusion service (BLISS) and communication language and autistic spectrum support (CLASS) are also included, and will have specialist link workers aligned to each neighbourhood.

Youth Offending Team

5.17. The youth offending team will work across the neighbourhoods, interlinking with education, third sector and social support to encourage all children young people and families to recover and rebuild their lives.

Acute Children's Support

5.18. As part of the drive to keep patients out of hospital and better integrate services across settings, Paediatrics consultants are seeking to work beyond their traditional remit and boundaries. As part of this journey the establishment of the Paediatric Triage, Advice and Guidance (TAG) model between Paediatrics and GPs has been agreed.

5.19. Each practice in a phased roll out will have a name Paediatric Consultant providing consultation, advice and guidance with case specific discussion with the aim to improving referral and patient flow and to enable Paediatric resources, held at the hospital, to outreach into the neighbourhoods. Paediatric Named Consultant TAG Model holds opportunity to develop and build, offering:

- Education / Training;
- Incident review;
- Pathway development

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Universal Health

5.20. Health Visiting and School Nursing offer universal health screening as part of the Healthy Child Programme. Support and interventions at all levels of need are provided by the services at very early intervention levels to child protection procedures.

5.21. Schools in the neighbourhood will have allocated link workers who can liaise with other members of the multidisciplinary team to ensure care and support is wrapped around the individuals, and that the GP is aware of the input to proactively manage vulnerable children, young people and families.

Early Help

5.22. The Early Help Service is aligned to neighbourhood delivery and works together parents and children providing support with parenting, debt issues, school attendance, housing and other issues which concern the focal family. They service with you other agencies and organisations to complete a family plan (CAF) that will enable the family to overcome difficulties and improve their circumstances.

6. ACCESSING THE CHILDREN INTEGRATED NEIGHBOURHOOD TEAM

6.1. Through the implementation phase a detailed process and pathway will be developed to ensure the access to support from our Integrated Neighbourhood Children's Team is clear to all – professionals and public. This will need to align with the reformed Children's Hub and existing neighbourhood infrastructure.

7. CONCLUSION

7.1. This paper seeks make reference to integrated care being an 'umbrella' term to describe initiatives that aim to address fragmentation of care between and within Children's Health, Education and Social Care. As such existing programme such as the existing Paediatric new ways of working, Early Help Strategy and the Children's Services Improvement journey should consider the Integrated Neighbourhood Children's Team as a means to delivery improved outcomes across a number of Children's agendas.

7.2. To achieve effective integrated care, fundamental systemic and institutional redesign of the organisations and resourcing of services and the children's workforce is required. Radical system change is about revolution as much as evolution for all involved. The Integrated Neighbourhood Children's Team pilot provides a vehicle in which to evolve the system and deliver better outcomes for children, young people and those who care for them.

7.3. Finally, successful development and mobilisation of an Integrated Neighbourhood Children's model will require ownership by executives, clinical and service leaders, and a collaborative mind-set. Further development of the model is required in moving to implementation. Early on, system-wide joint outcomes must be agreed that holds the voice of the child but also address the system pressures.

8. RECOMMENDATIONS

8.1 As set out on the front of the report.

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Stockport Family

Summary of Proposals to Accompany the Consultation

Paper for Health Stakeholders

The purpose of this document is to give you an overview of the Stockport Family model. The document also contains the proposed delivery structure. It is important as we continue to develop Stockport Family that we consult with and listen to stakeholders before a finalised proposal is submitted.

If you have any questions in relation to the proposal, you can email questions@stockport.gov.uk and we will attempt to respond to these during the consultation period. We hope that this will support you in submitting an informed response to the proposals.

- **Introduction**

The Stockport Family Approach is one of the 14 business cases submitted as part of the Council's Investing in Stockport Programme and the Foundation Trust's commitment to integrated children's services.

We aim to establish a single, fully integrated Stockport Family Service that provides the highest quality support to all of Stockport's children and families, with integrated responsive support for those who are most vulnerable. This proposal is for whole system change.

Our driving ambitions and priorities are:

- Our children are given the very best start in life by their parents and carers who are supported to optimise their child's development
- Our children/young people enjoy good health and receive effective services as needed in order to optimise independence and the best health outcomes
- Our children/young people are well prepared for adulthood and engage in education, employment and training; contribute to their community and rates of crime and anti-social behaviour reduce
- Our children/ young people live safely and happily within their families – and there are fewer family breakdowns

- **What is Stockport Family?**

Within the current system and practice there are many repeat assessments, thresholds to cross and delay as children move between services. This is inefficient, unpopular with families and can be ineffective. Families' strengths often get lost because of the inability of services to look at the whole family picture and a culture of referring on has developed, which fragments relationships between professionals and families. Over the past few years, as a result of the integration between Health services and Council services through the Integrated Children's Service, we have made significant progress on addressing these issues, with further work to be done building on the improvements already achieved. It focusses on

the family as a whole and will be underpinned by restorative approaches as the practice model with families, communities and other services

- **What is a Restorative Approach?**

All the Stockport Family workforce will utilise restorative approaches when working with families and other services. Traditionally, services and professionals have determined what families need and 'done to' and for families'.

We intend to move to a system where a reduced integrated workforce works with struggling families, offering coaching and development interventions to enable individuals and families to build on their strengths and resources and gain appropriate support from universal services and their community.

- **The Proposed Delivery Model**

The proposal is to have an integrated delivery model based around the four locality areas defined by the Clinical Commissioning Groups (CCG's): Heaton and Tame Valley, Stepping Hill and Victoria, Cheadle and Bramhall and Marple and Werneth. Each locality would comprise of teams including -:

- Health Visitors
- School Nurses
- Midwives
- Social Workers
- Children's Centres/Children and Family Centres
- Stockport Family Workers (proposed new role).

We would be delivering our universal Health offer across Health Visiting and School Nursing as well as continuing to provide specialist, borough wide Health services such as:

- Parenting team
- Infant Parent Service
- Specialist immunisation and continence teams
- Specialist Health visiting services
- Special school nursing teams
- Continuing care and complex LTV nursing teams
- Therapy teams
- The Vulnerable Children's team (Safeguarding children and Looked after children's teams)
- Family Nurse Partnership

Working in conjunction with the Council services will strengthen these teams, especially with the links with Public Health and Social Care providing more integrated working and co-location for our workforce.

In addition to the value added by integration and co-location, we will be developing new joint posts across the service called the "Stockport Family Worker" – this role will see the creation of a shared job description across the Band 4 workforce with the equivalent council roles. All schools within the locality would have a named Stockport Family Worker and there will be a 0-4 workforce concentrating on delivering early years interventions.

The new model would enable the 'call in' of more specialist interventions at the right time to address need as it arises in a sequenced, appropriate and effective way.

- **The Proposed Staffing Model**

The Stockport Family structure charts, inserted below are intended to illustrate how we will integrate children's health professionals with local authority early years, early help, safeguarding, child protection and specialist workers to provide a joined up offer to families in need. There are small changes to the job description and roles of our Nursery Nurses and our team and service managers will have a revised JD to reflect the changing titles and accountability within the new structure.

Throughout the integrated structure there is joint accountability to both Directors within the Council and the FT; the principles agreed in the Integrated Children's Service model remain in terms of both professional accountability and responsibility, and line management. Health staff may be line managed by a council employee but they will have a professional and employment accountability to the FT.

Stockport Family Teams and Functions Senior Management
The proposal is to delete four Heads of Service posts but retain the LA post of Head of Safeguarding and Learning, in recognition of the need for an arms-length lead on safeguarding.

The new Head of Stockport Family role will report jointly to the Service Director Safeguarding and Prevention in the council and the Director of Child and Family services in the Foundation Trust.

Four new Principal Lead Posts will drive the Stockport Family ambition. The Principal Lead role is key to facilitating the Greater Manchester Combined Authority Transformation Programme. One Principal Lead will manage fostering and adoption services. The three remaining Principal Leads will each lead a locality taking responsibility for the further integration of Stockport Family with Stockport Together. In addition each of these Principal Leads will manage a portfolio of borough wide interventions and strategic leads.

Health Teams
There is no proposed reduction in the Health Visiting, School Nursing or Midwifery workforces as a result of this consultation.
There is a proposal to integrate the role of Nursery Nurse in Health Visiting with a comparable role in the early year's council team; there are no job losses as a result of this within the health teams.

Within the borough wide teams there are no changes to line management or workforce – these teams will continue to function under their current clear line management.
There are some changes proposed to the number and roles of the practice teachers in both school nursing and health visiting – some of these proposals reflect the decrease in the number of student HV's as the Call to Action ends, and also reflects the need to provide leadership in learning and development of our teams.
The structure (attached) demonstrates that there is clear Health Leadership built into this model with an emphasis on integration at the Locality and Team Manager level to ensure that teams are working together and not continuing in silos; the principles of ICS remain and with the incorporation of social care and the integrated disability partnership plus the move to co-locate our teams from this winter, we anticipate delivering a high quality and responsive service for all of our children and families.

Social Care
The functions of the Integrated Children's Service social workers would be incorporated into locality social work teams. The functions of the Children's Disability Partnership would be maintained and delivered through the proposed locality model. It is proposed that in the next 12 months we will work towards absorbing the functions of the children's disability social work team into the wider social care teams. Each school would have a named social worker.

Services for Young People
The proposed model would continue to deliver the current Services for Young People statutory duties. Elements of the current enhanced offer would cease i.e.:-
• Information, Advice and Guidance involvement in events put on by other services or schools would be reduced or no longer available unless purchased.
• Providing Careers Information Advice and Guidance to Special Educational Needs young people educated in Stockport who are resident elsewhere. This will revert back to the resident authority.

Stockport Family Worker
The Stockport Family Service would crucially work closely with the universal services at the centre of localities and communities. Each school will have a named Stockport Family Worker. Schools, health visitors, school nurses, and social workers would be supported in the four localities by a proposed Stockport Family Worker linked both to locality teams and to schools.
We would reduce the number of staff roles that deliver 'family support' activities across a range of service areas, with the view to creating new teams of Stockport Family Workers.

We would establish, through training and supervision, a professional attitude, core competencies and a common language across services that embeds our collective ambition for children and families in Stockport. The proposed Stockport Family Workers would have skills in engagement and persistence and be trained in solution focused work, motivational interviewing and key working.

Stockport Family Workers would be deployed as follows:

Stockport Family Worker (Early Years) - The aim is to establish a common job description used across the Stockport NHS Foundation Trust and Stockport Council, these roles would support the delivery of the Healthy Child Programme 0-5 years and the targeted intervention programmes in Children's Centres.

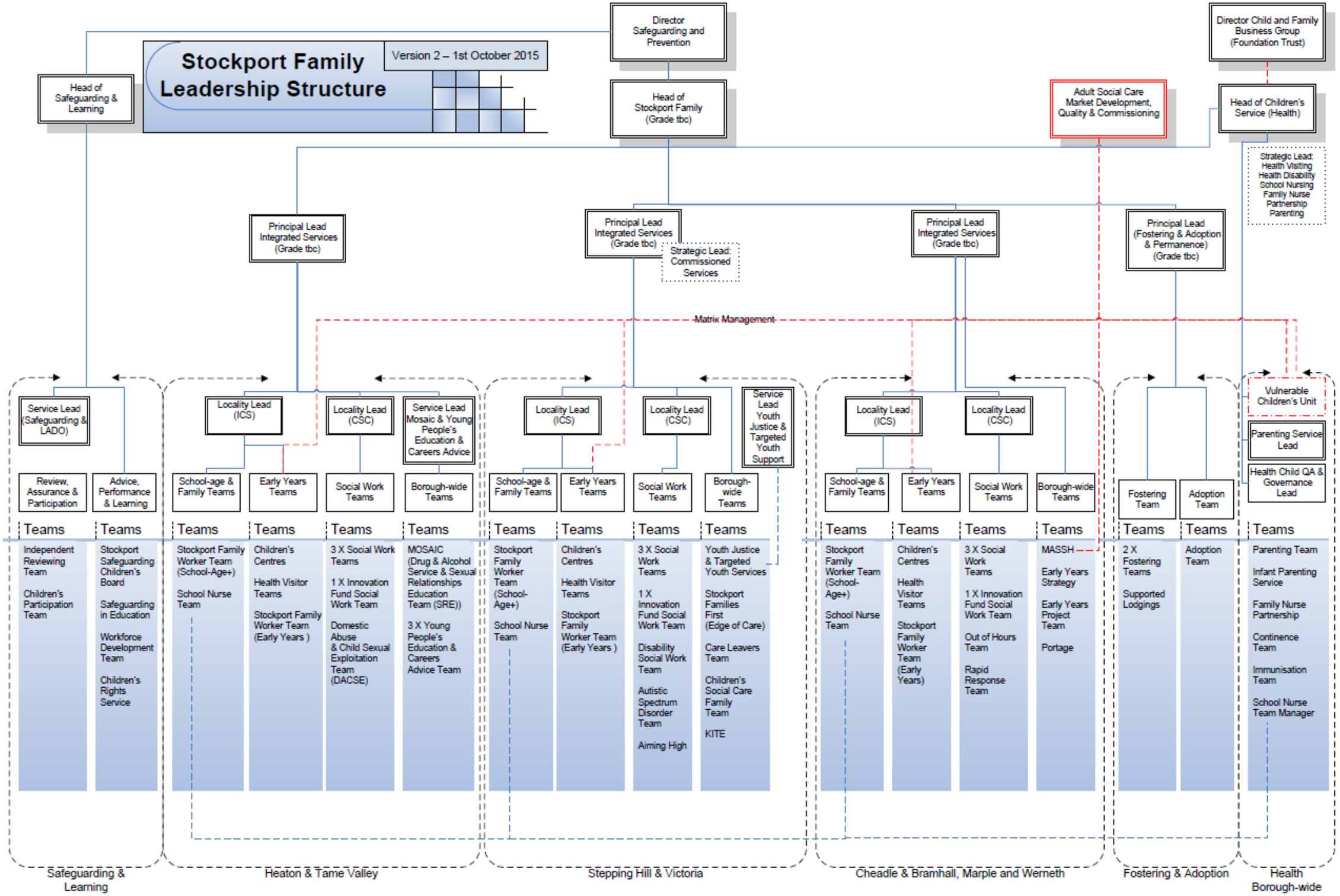
Stockport Family Worker (school age plus) - This role will have a school and higher education focus, working closely with the link social worker, school nurse, health visitors and other school based and locality services to offer and support assessment and a range of interventions underpinned by restorative approaches with children and young people (0-25 years) and families in order to improve family functioning and resilience.

Young People's Education and Careers Advice Worker - This role would ensure all of the statutory functions currently managed by Services for Young People are maintained.

APPENDICES

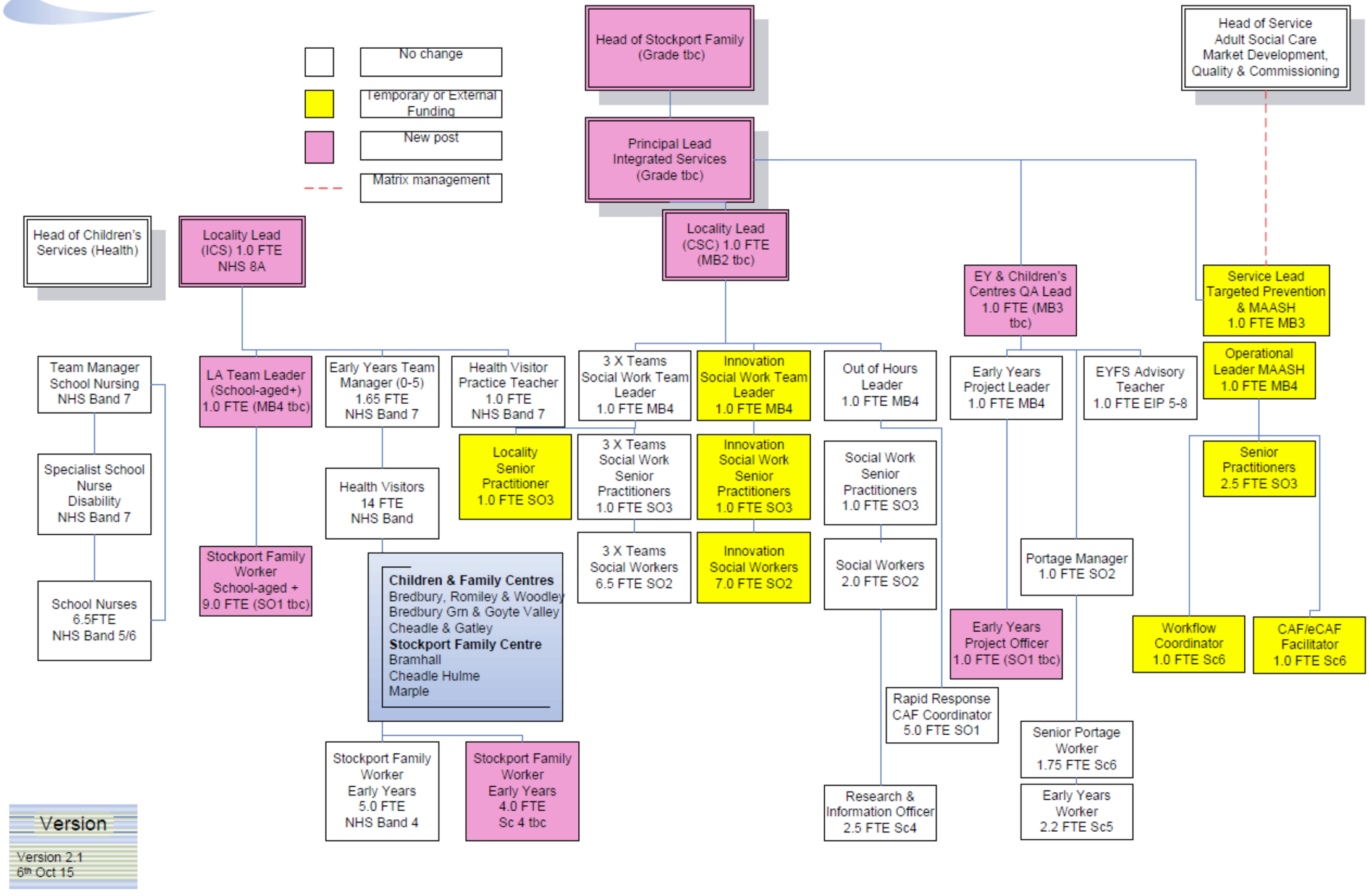
1. **LEADERSHIP STRUCTURE**
2. **HEATON AND TAME VALLY STRUCTURE**
3. **STEPPING HILL AND VICTORIA STRUCTURE**
4. **CHEADLE, BRAMHALL, MARPLE AND WERNETH STRUCTURE**
5. **FOSTERING AND ADOPTION STRUCTURE**
6. **SAFEGUARDING AND LEARNING STRUCTURE**
7. **HEALTH BOROUGH WIDE STRUCTURE**

Appendix 1 - Overall Management Structure



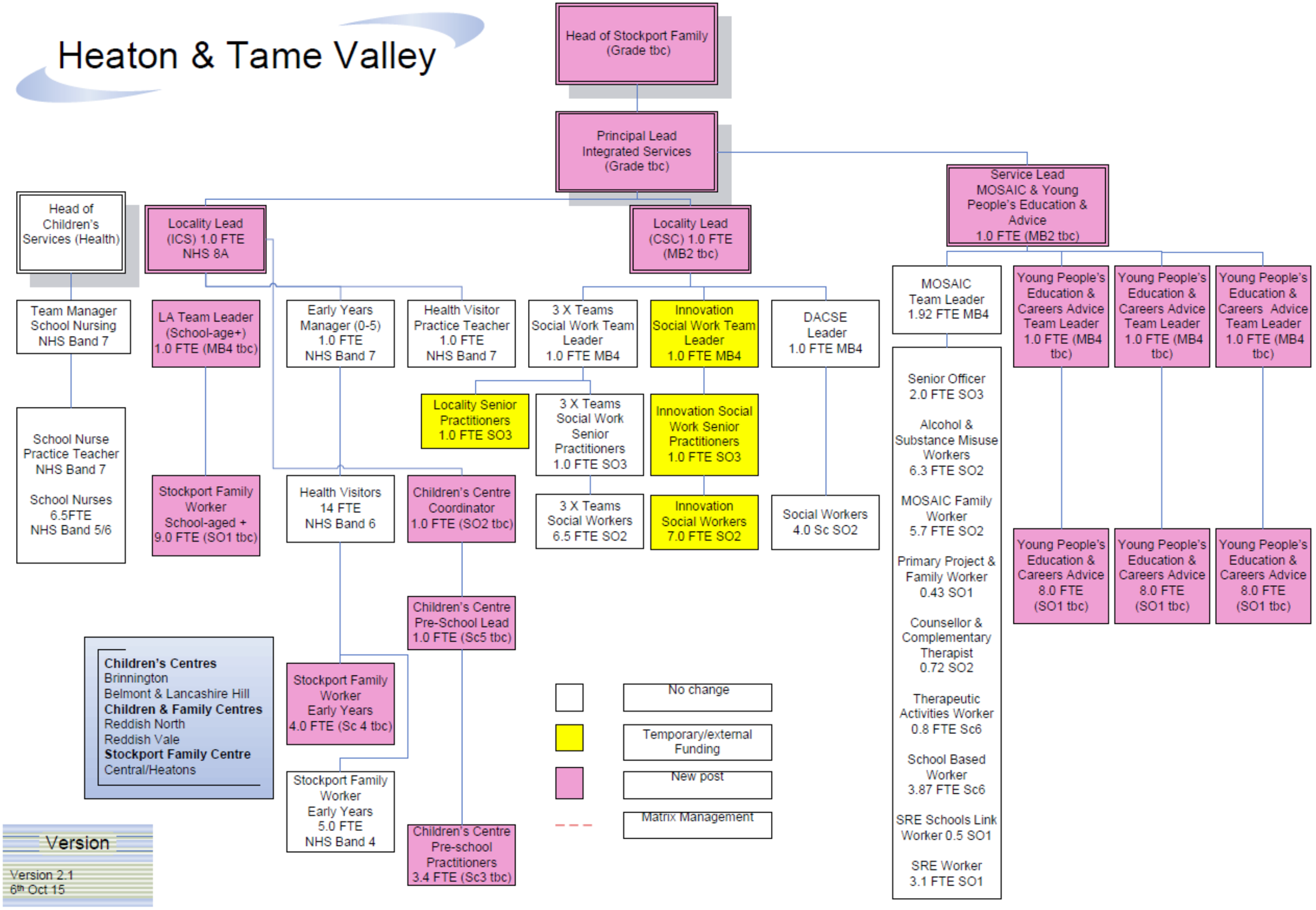
Appendix 2 - Cheadle, Bramhall, Marple & Werneth

Cheadle, Bramhall, Marple & Werneth

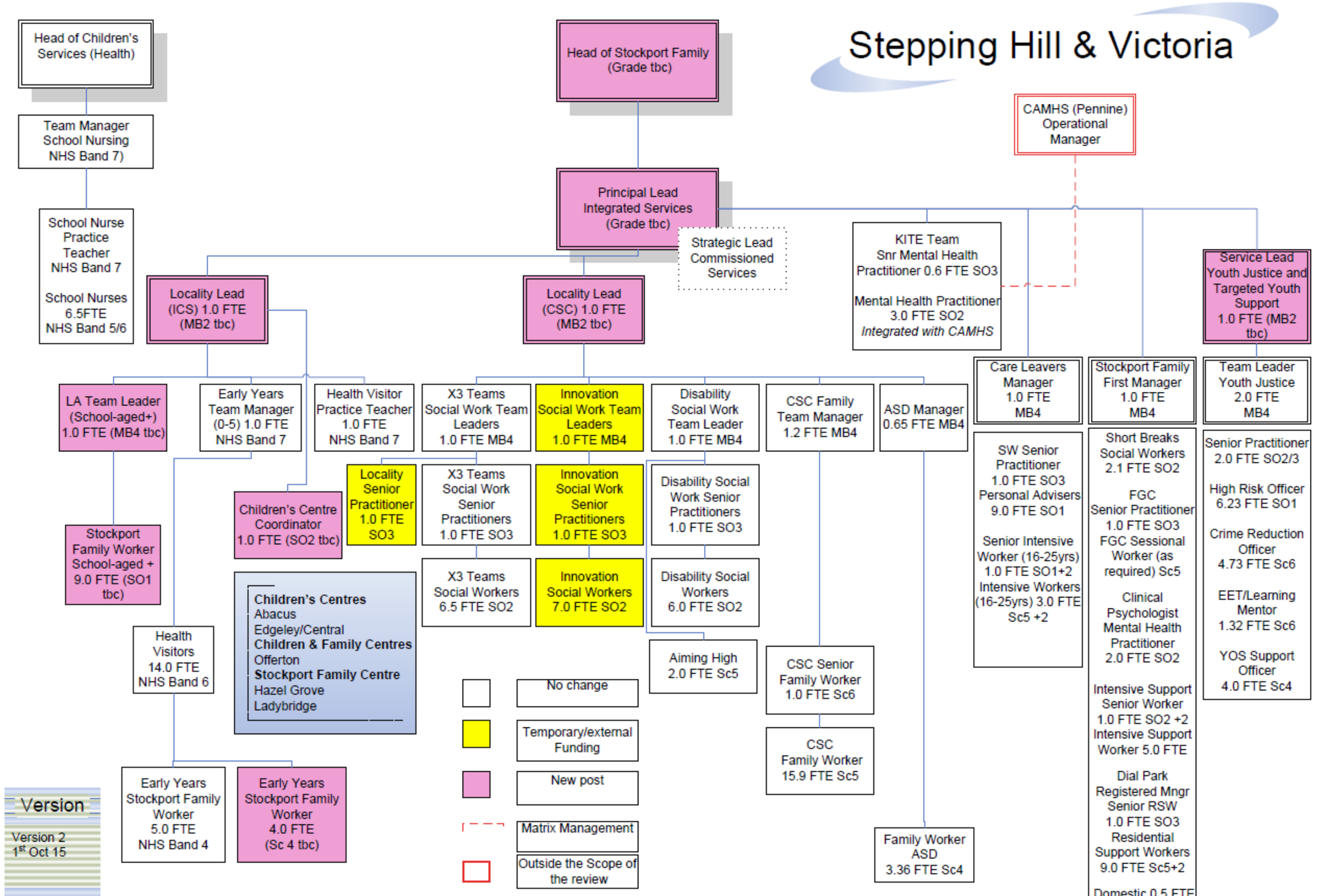


Appendix 3 - Heaton & Tame Valley

Heaton & Tame Valley

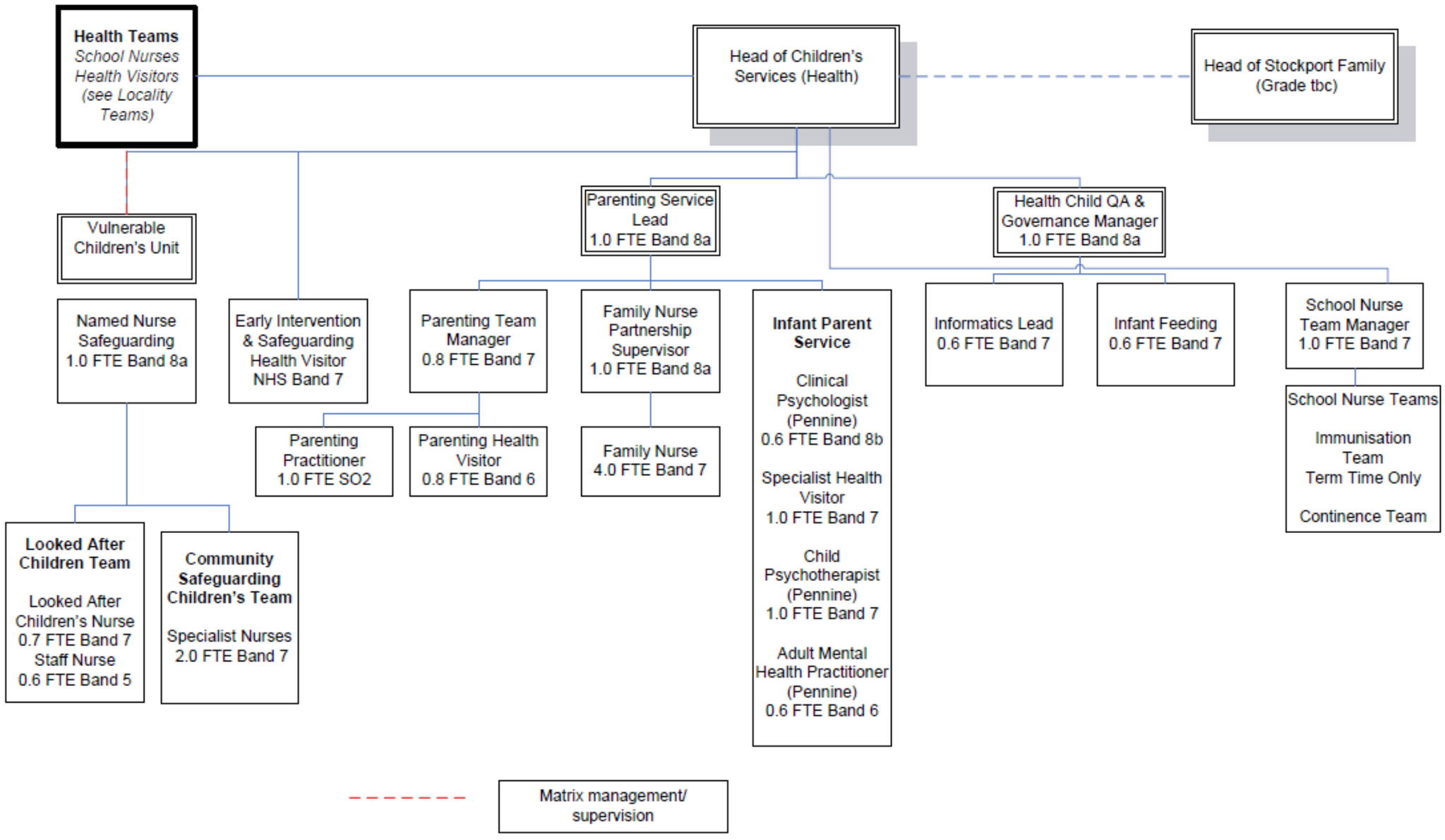


Appendix 4 - Stepping Hill & Victoria



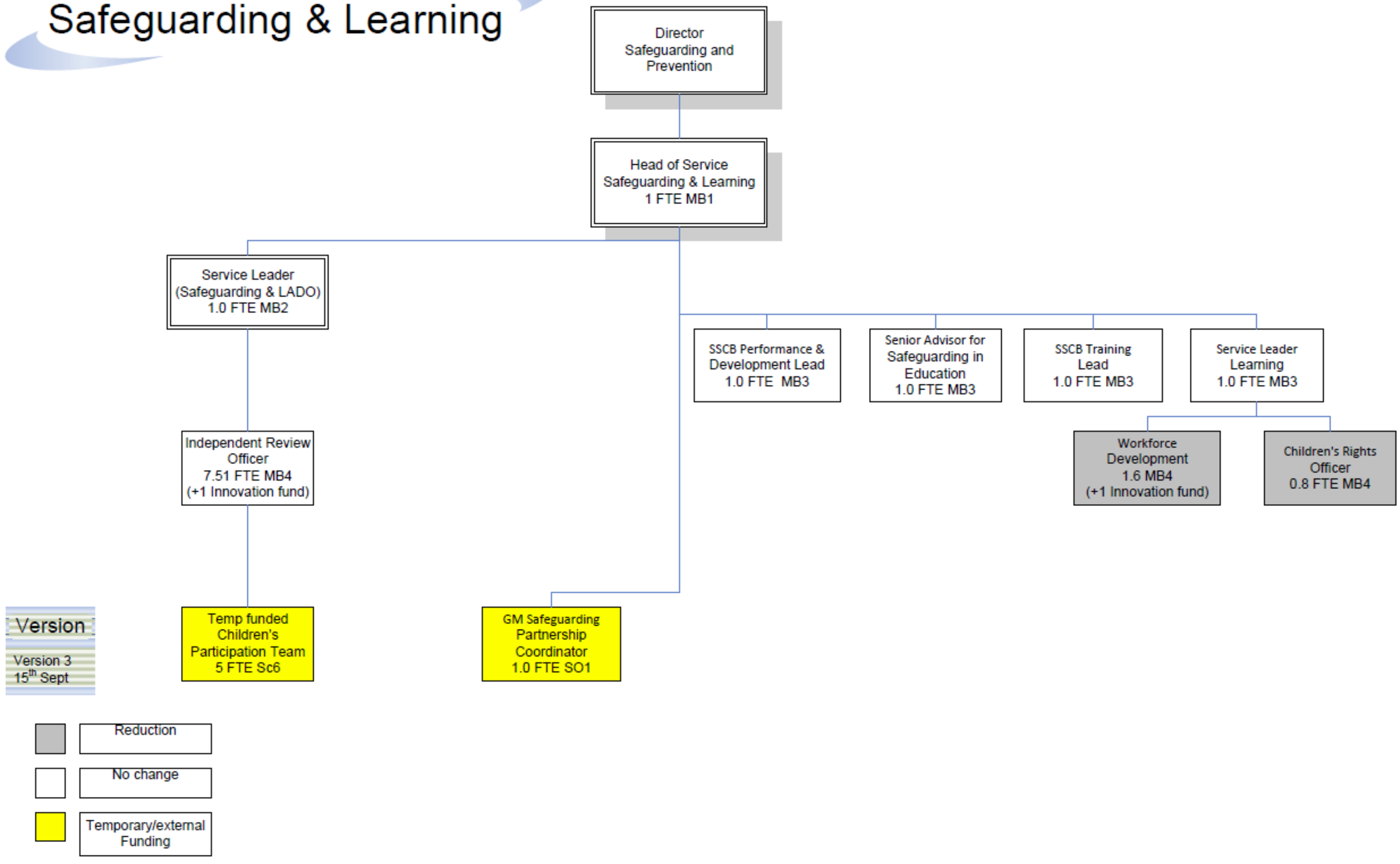
Appendix 5 - Health borough-wide services

Health Borough-wide



Appendix 6 - Safeguarding & Learning

Safeguarding & Learning



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APPENDIX B

Statements (outcome framework)

CYP EWB and MH Transformation Plan: I Statements – Voice of the Child

1. I should be listened to, given time to tell my story and feel like what I say matters.

2. I want my situation to be treated sensitively and I should be respected and not feel judged.

3. I want the professionals that I come into contact with to be kind and understanding and realise that I need to trust them if they are going to help me.

4. I should always be made to feel safe and supported so that I can express myself in a safe environment.

5. I should be treated equally and as an individual and be able to shape my own goals with my worker.

6. I want my friends, family and those close to me to understand the issues so that we can support each other.

7. I want clear and up to date detailed information about the services that I can access.

8. I want to get the right type of help, when things first start to be a problem, at the right time in the right place and without having to wait until things get worse.

9. I want to feel that services are shaped around my needs and not the other way round, but I also want to know that I am not alone in how I am feeling.

10. I want my support to feel consistent and easy to find my way around, especially if I need to see different people and services.

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APPENDIX C

Children's Score Card (outcome framework)

Indicator number	**Indicator**	Indicator number	**Indicator**
PB.1	Number of Maternities	**PS.1**	Number of troubled families with children under 5 years
PB.2	% babies born in most deprived quintile	**PS.2**	% of children who received a $2^{1/2}$ year review
PB.3	Booking appointment between 0-70 days	**PS.3**	% of children who at $2^{1/2}$ completed their ASQ3
PB.4	% women with complex social needs	**PS.4**	% of children reaching ASQ standard for Gross Motor Skills
PB.5	% of women who were obese at time of booking	**PS.5**	% of children reaching ASQ standard for Fine Motor Skills
PB.6	% of women who were overweight at time of booking	**PS.6**	% of children reaching ASQ standard for Communication Skills
PB.7	% of women smoking at time of delivery	**PS.7**	% of children reaching ASQ standard for problem solving Skills
PB.8	Births to mums under 18 years	**PS.8**	% of children reaching ASQ standard for personal-social Skills
PB.9	Flu vaccination up take in pregnant women	**PS.9**	% of children from the 20% most deprived quintile reaching ASQ standard
PB.10	Number of women who had a pre-birth antenatal visit by a health visitor	**PS.10**	Emergency admission rate for children under 5 years
PB.11	Early attachement	**PS.11**	Population vaccination coverage - MMR for two doses (5 years old)
PB.12	Mothers Perinatal mental health	**PS.12**	% of 3 year olds taking up the flu vaccination
PB.13	Fathers perinatal mental health	**PS.13**	% of 4 year olds taking up flu vaccination
EY.1	Total number of children aged 0-4 years	**PS.14**	School readiness
EY.2	Number of children provided early help	**PS.15**	School readines in children in receipt of free school meals
EY.3	Infant mortality (under 7 days)	**PS.16**	School readiness in children with SEN
EY.4	Proportion of new mums with post-natal depression	**PS.17**	Prevalence of overweight and obesity in reception aged children
EY.5	Babies born at a low birth weight (<2500g)	**PRS. 1**	Total number of children aged 5- 11 years
EY.6	% of babies eligible for newborn blood spot screening who were screened (coverage)	**PRS. 2**	Hospital admissions in children aged 4-5 years for tooth extractions
EY.7	Number of Admissions of babies under 14 days	**PRS. 3**	A&E attendances in 5 to 10 year olds

EY.8	Infant mortality (<1 year)	**PRS. 4**	Hospital admissions in children aged 6-9 years for tooth extractions
EY.9	Breast Feeding Initiation	**PRS. 5**	Number of children with Asthma (under 11 yrs)
EY.10	% of infants who received a new birth visit within 30 days	**PRS. 6**	Number of children with at least 1 long term condition
EY.11	% of babies who had a 6 to 8 week review	**PRS. 7**	Proportion of children with a risk stratifiaction score above 50% (under 11 years)
EY.12	% babies breast fed at 6 to 8 weeks	**PRS. 8**	Number of looked after children
EY.13	% of children who received a 12 month review	**PRS. 9**	Prevalence of overweight and obesity in year 6 aged children
EY.14	% 2 year olds taking up the flu vaccination	**PRS. 10**	Number of children with child protection plans 0-18 yrs)
EY.15	2 to 3 year olds taking up their free entitlement to school and settings that have a OFSTED rating as good or excellent	**PRS. 11**	Number of looked after children
YP.1	Proportion of children in secondary mainstream school with SEND	**PRS. 12**	Number of troubled families with children 5 to 16 years
YP.2	Secondary school fixed period exclusions: % of school pupils	**PRS. 13**	Number of children who are home schooled
YP.3	Children in care who gained 5 GCSEs at A*-C incl. English and Maths	**PRS. 14**	Number of adults in drug and alcohol rehab with children under 11 years
YP.4	16-18 year olds not in education employment or training	**CF.1**	Proportion of children in secondary mainstream school with SEND
YP.5	Looked after children aged 10-15	**CF.2**	Secondary school fixed period exclusions: % of school pupils
YP.6	Looked after children aged 16+	**CF.3**	Children in care who gained 5 GCSEs at A*-C incl. English and Maths
YP.7	Young people providing unpaid care (aged 16-24)	**CF.4**	16-18 year olds not in education employment or training
YP.8	Homeless young people aged 16-24	**CF.5**	Looked after children aged 10-15
YP.9	Hospital admissions as a result of self-harm (15-19 yrs)	**CF.6**	Looked after children aged 16+
YP.10	First time entrants to the youth justice system		
YP.11	Hospital admissions as a result of self-harm (20-24 yrs)		
YP.12	Annual HPV vaccine uptake - Year 8 girls		
YP.13	Chlamydia detection rate / 100,000 aged 15-24		
YP.14	Under 18s conception rate / 1,000		

Report to: **SINGLE COMMISSIONING BOARD**

Date: 11 July 2017

Officer of Single Commissioning Board Clare Watson, Director of Commissioning

Subject: **PROPOSED INTEGRATED MENTAL HEALTH COMMISSIONING STRATEGY 2017/9**

Report Summary: This presentation proposes an integrated commissioning strategy that meets the national and Greater Manchester expectations regarding mental health by aligning four additional mental health funding streams, with existing mental health investment, to transform mental health provision in Tameside and Glossop. The funding streams are:

- Care Together Transformation Investment for Mental Health;
- Clinical Commissioning Group Mental Health Standard investment;
- Adult Social Care Transformation funding; and
- Greater Manchester Mental Health Transformation funding.

The proposal was supported at Locality Executive Group on 21 June 2017 and the focus for the Care Together Transformation Funding agreed at the Integrated Care Foundation Trust Joint Management Team on 15 June 2017.

Recommendations: PRG recognises the opportunities to improve mental health outcomes through this integrated approach and recommends that this proposal is agreed by SCB.

It is also recommended that SCB recognises the need for commitment across the whole system to develop sound business cases in line with this Commissioning Strategy for approval as soon as possible.

Financial Implications:

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

Budget Allocation (if Investment Decision)	
CCG or TMBC Budget Allocation	£29.067m total planned Single Commission investment in 2017-18
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	All
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB, CCG Governing Body
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	
Additional Comments Continued investment in Mental Health Services is a key focus both locally and nationally. As a Single Commission in	

	Tameside we currently invest in excess of £29m per year in Mental Health Services (detail of which can be found in **Appendix 1**) Mental Health is one of the key priorities in the Care Together Joint Commissioning Strategy and, as a locality Tameside continues to meet the national requirements for Parity of Esteem for Mental Health investment. It is important to note that GM Transformation Funding is finite and has many competing demands. Any expenditure against the GM Transformation Fund allocation will require approval via the Care Together Programme Board and will need to be assessed for the contribution towards the agreed KPI's associated with the funding stream and to ensure there is no duplication.
Legal Implications: **(Authorised by the Borough Solicitor)**	In agreeing proposals and business cases SCB should ensure it is satisfied they are fit for purpose, and that there are systems in place to monitor compliance, and refresh when required, as demonstration of a rational, consistent and up to date approach based on best practice is highly effective in dealing with any legal challenge.
How do proposals align with Health & Wellbeing Strategy?	The proposal aligns with Living Well and Aging Well in the Health and Well-being Strategy.
How do proposals align with Locality Plan?	The proposal fills gaps regarding mental health within our locality plan.
How do proposals align with the Commissioning Strategy?	The proposal aligns to our Commissioning Strategy
Recommendations / views of the Professional Reference Group:	PRG was pleased to note that there is new investment within Mental Health and recognises that this integrated commissioning proposal will ensure that this will build on and transform existing services.
Public and Patient Implications:	Healthwatch is engaged in the development and the proposals are in line with Healthwatch findings from service users. Healthwatch are establishing focus groups to confirm and challenge the detailed proposals.
Quality Implications:	The proposals will improve access, capacity and quality of mental health provision in Tameside and Glossop.
How do the proposals help to reduce health inequalities?	People with mental health needs often experience poor physical health and vice versa. The proposal of integrating mental health into the neighbourhood and across the hospital will reduce these inequalities.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act. The service will be available to Adults with a mental health need regardless of ethnicity, gender, sexual orientation, religious belief, gender re assignment, pregnancy/maternity, marriage/ civil and partnership.

What are the safeguarding implications?	None.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	None.
Risk Management:	Risks will be identified in each business case.
Access to Information :	The background papers relating to this report can be inspected by contacting Pat McKelvey, Head of Mental Health and Learning Disabilities: Telephone: 07792 060411 e-mail: pat.mckelvey@nhs.net

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Provider name	Service Area	Lead within Single Commission	Comments (inc contract title)	2016/17 Contract value	2017/18 Contract Value (opening)
Mersey Care NHS FOUNDATION TRUST	Mental Health	CCG	Mental Health Services		£143,368
PENNINE CARE NHS FOUNDATION TRUST	Mental Health	CCG	Mental Health Services	£22,907,505	£22,444,420
PENNINE CARE NHS FOUNDATION TRUST	Mental Health	CCG	Military Veterans IAPT service	£183,005	£186,299
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	Mental Health	CCG	Community; Mental Health and Learning Disability Services	£375,602	£276,849
Age UK	Mental Health	CCG	Day centre reablement for Mental Health	£105,404	£107,301
Richmond Fellowship	Mental Health	CCG	Provision of twenty four (24) hour supported accommodation to adults	£777,164	£697,740
Tameside and Glossop Hospice Limited (Willow Wood)	Mental Health	CCG	Dementia grant - funds a dementia role at the hospice	£57,000	£57,000
42nd Street	Mental Health	CCG	Mental health practitioner in the Young People's Mental Health Team	£49,500	£49,500
LGBT Foundation	Mental Health	CCG	HIV Prevention Programme for LGBT Population	£12,732	£12,961
Home-Start Oldam, Stockport, Tameside (HOST)	Mental Health	CCG	Parent Infant Mental Health (Tameside Services)	£40,742	£40,742
Turning Point	Mental Health	TMBC	Community support service - MH network support Mental Health Recovery Service - support to people living in their own homes	£157,340	£157,432
Turning Point	Mental Health	TMBC	This service provides community-based support for people recovering from mental health issues to develop their skills to live independently in the community. The service focuses on empowering people to rediscover and develop ways of living a meaningful and fulfilling life through embedding confidence, a sense of hope and optimism. The service enables people to decide what recovery means to them and supports people to make positive choices.	£558,800	£523,625
Tameside, Oldham & Glossop Association of MIND	Mental Health	TMBC	Joint agrmt - poss lowest level - key national players from camp point of view The promotion and maintenance of mental health and wellbeing through health promotion services and preventative initiatives. The service is delivered primarily at the Topaz Well-Being Centre in Ashton through the provision of information, advice and guidance; counselling; publicity; drop-in duty; daytime activities; and the provision and co-ordination of volunteers.	£131,850	£125,258
RADAR	Mental Health	CCG	RADAR		£55,544
PICU Risk Share	Mental Health	CCG	PICU Risk Share		£273,350
Tameside, Oldham & Glossop Association of MIND	Public Health	TMBC	Mental Health and wellbeing primary schools workshop	£19,875	£19,875
Off the Record	Public Health	TMBC	Young Persons Counselling Service	£91,670	£91,670
Tameside MBC	Mental Health	TMBC	Opt In Service	£66,075	£48,640
Tameside MBC	Mental Health	TMBC	Community Mental Health Teams	£845,740	£891,710
Tameside MBC	Mental Health	TMBC	Mental Health Direct Payments	£140,000	£182,460
Tameside MBC	Mental Health	TMBC	Deprivation of Liberty Safeguarding (DoLS)	£277,410	£279,840
Various Care Home providers	Mental Health	TMBC	Alternative Accommodation S117	£120,430	£120,430
Various Care Home providers	Mental Health	TMBC	Other Mental Health Care Home Placements	£2,330,760	£2,423,990
Total Single Commission Investment				**£29,248,604**	**£29,066,637**

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Integrated Commissioning Proposal to improve Mental Health Outcomes

By pooling all available resources to meet the Five Year Forward View for Mental Health

June 2017

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Tameside
Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

Why?

1. The Five Year Forward View for Mental Health (Feb 2016) is based on economic evidence that investment in the priorities will result in **savings** within the system
2. The MH5YFV is basis for **GM MH Strategy**
3. There are **gaps** in Mental Health provision
   a. In primary care for low level MH needs
   b. between Healthy Minds and Secondary Care in both psychological therapy and mental health expertise
   c. For people with chronic and relapsing MH needs
   d. In post-diagnostic dementia support
4. As well as redesigning existing MH investment there is **new funding** from GM, the Single Commission (CCG & TMBC) and within Care Together – aligning this will ensure no duplication and no gaps

Five Year Forward View for MH

Simon Stevens: "Putting mental and physical health on an equal footing will require major improvements in 7 day mental health crisis care, a large increase in psychological treatments, and a more integrated approach to how services are delivered. That's what today's taskforce report calls for, and it's what the NHS is now committed to pursuing."

Prime Minister: "The Taskforce has set out how we can work towards putting mental and physical healthcare on an equal footing and I am committed to making sure that happens."

The Report in a Nutshell:

- 20,000+ People Engaged and Designed for and with the NHS Arms' Length Bodies
- All Ages (Building on Future in Mind)
- Key Themes in the Strategy:
  - Genuine Parity of Esteem between Physical and Mental Health
  - Prevention
  - Improved Waiting Times & New Commissioning Approaches to Transform Services
  - Integration of Physical and Mental Health Care
  - High Quality 7-day Services for People in Crisis
  - Provision Close to Home for those with Acute Intensive Needs, particularly Young People
  - Focus on Targeting Inequalities
- 58 Recommendations for the NHS and System Partners
- £1bn Additional NHS Investment by 2020/21 to Help an Extra 1 million People of All Ages

National Context – 2017/19 Must Do Priorities

- **IAPT**
  - Waiting times
  - Access – ratchet-up for up to 25%
  - Integrated (Long-term conditions / employment)
  - Recovery

- **Severe Mental Health Illness**
  - Early intervention in psychosis waiting times and NICE treatment compliant up to 53%
  - SMI IAPT
  - Individual placement and support prep
  - Physical health care – smoking / obesity

- **Dementia United**
  - Diagnosis
  - Post-diagnostic support
  - Carers

- **Armed Forces**

- **CAMHS**
  - Waiting times
  - Community Eating Disorders
  - Crisis care support & acute mental health liaison
  - Tier 4 collaborative
  - Early intervention and prevention – iThrive+
  - Perinatal – Specialist and early help
  - Transforming care

- **Crisis care**
  - A&E Psychiatric liaison – core 24 / RAID
  - All-age acute care pathway redesign (including CRHTs and Primary care MH)
  - Crisis care triage / support
  - Custody / liaison and diversion

- **Suicide prevention**

- **Secure care pathways**

GM Mental Health and Well-being Strategy Vision

Improving child and adult mental health, narrowing their gap in life expectancy, and ensuring parity of esteem with physical health is fundamental to unlocking the power and potential of GM communities.

Shifting the focus of care to prevention, early intervention and resilience and delivering a sustainable mental health system in GM requires simplified and strengthened leadership and accountability across the whole system.

Enabling resilient communities, engaging inclusive employers and working in partnership with the third sector will transform the mental health and well-being of GM residents.

GM Mental Health and Well-being Strategy – The Plan on a Page

CHARACTERISTICS TO UNDERPIN VISION	
PREVENTION	Place based and person centred life course approach improving outcomes, population health and health inequalities through initiatives such as health and work.
ACCESS	Responsive and clear access arrangements connecting people to the support they need at the right time
INTEGRATION	Parity of mental health and physical illness through collaborative and mature cross-sector working across public sector bodies & voluntary organisations
SUSTAINABILITY	Ensure the best spend of the GM funding through improving financial and clinical sustainability by changing contracts, incentives, integrating and improving IT & investing in new workforce roles

MENTAL HEALTH AND WELLBEING STRATEGY

STRATEGIC GOLDEN THREADS

- Parity of Esteem
- Research Deployed to Inform Best Practice
- Technology Providing New Innovative Forms of Support
- Leverage Successful Programmes e.g. Troubled Families
- Prepare the Workforce for Integrated Joined Up System

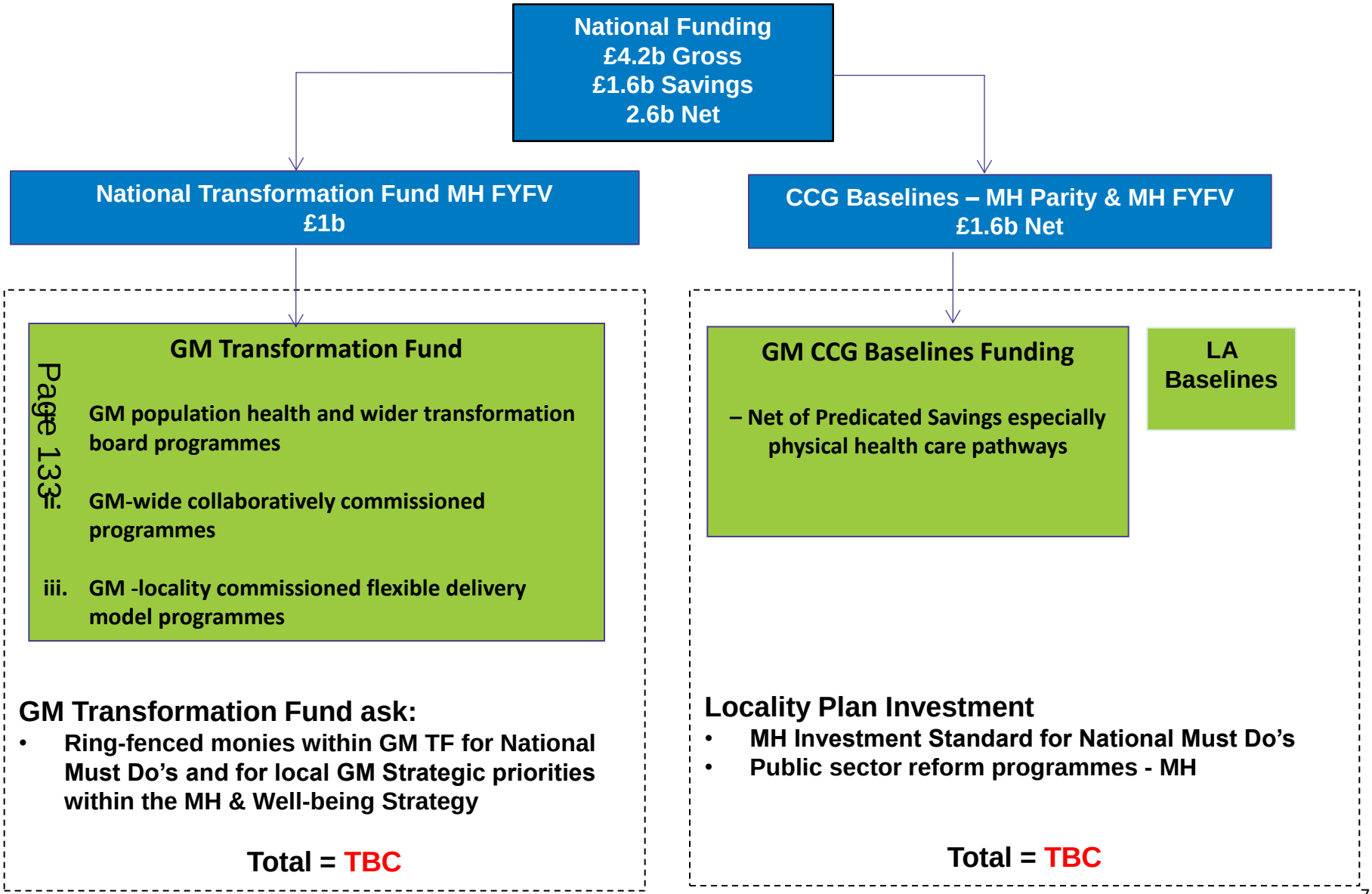
PREVENTION	ACCESS	INTEGRATION	SUSTAINABILITY
Early Years: Children & Family	Single Point of Access and Care Co-ordination	**Integrated place based commissioning & contracting aligned to place based reform**	System leadership
Improve Mental Wellbeing	IAPT Services of Consistent High Quality for GM	Vertical & horizontal integration across community, primary & acute care	Working practices
Building Capacity for Self care	Improving Support for Carers and Parents at Risk	Whole person integrated vertical care pathway across a horizontal integration of care	Programme prioritsation
Suicide Prevention	**Introduce 24/7 Mental Health and 7 Day Community Provision - CYP**	A strong partnership with the community and voluntary sector	Pooling of mental health budgets
Early intervention	**Ensure Consistent 24/7 MH and 7 Day Community Provision for Adults including Crisis Concordat**	Asset-based approach and devolution estate managed centrally	**Provider Landscape Redesign**
Targeted public health campaigns	Consistent Standards and Protocols for Step Up and Step Down	**Integrated monitoring, standards and KPIs**	Payment and incentives
Supporting vulnerable people	Self-sufficiency in GM Provision (out of area placements)	Integrated data sharing	Regulation reform
Workplace and employment support	Eating Disorders for Children and Young People		New investment streams
	Consistent ADHD all-age services ps		

Priorities Identified for Years 1 and 2

The Strategic Initiatives

CASE FOR CHANGE PRIORITY POPULATION GROUPS STRATEGIC INITIATIVES

Making Sense of the Investment Strategy – Work in progress



GM Investment Strategy Priorities

1. **GM CCG and Locality Baselines Funded Programmes (MH must do's) – mandated programmes of work set out in the 5YFVMH that Localities are committed to deliver through existing funding**
    - Treatment Access - Additional psychological therapies
    - High quality MH services - CYP IAPT
    - Expand Capacity – Psychosis treatment
    - Individual Placement Support into Secondary Care – Severe mental illness
    - Referral to Treatment - Community Eating disorder teams
    - Eliminate Out of Area Placements for non-secure for non-specialist acute care
    - Reduce suicide rates
    - Increase baseline spend on MH to deliver MH Investment standard
    - Dementia diagnosis rate/post diagnostic care & support
    - MH Access & Quality standards – 24/7 access to community, home & liaison teams

2. Transformation Funding

Areas of the 5YFVMH and GM MH Strategy have been prioritised to receive significant transformation funding in addition to what exists in locality baselines. It is proposed that programmes listed in I and II are coordinated at a GM level:

I. GM Coordinated Programmes of Work to be Delivered through the Theme 1 Population Health Work Stream of the GM 'Taking Charge' Strategy and Other Transformation Boards

- Suicide prevention, overcoming MH stigma and Supporting Communities of Identity
- Improving mental wellbeing, building capacity and resilience of communities
- Work and Health across the life-course
- Dementia United
- Health and Justice

II. GM Coordinated Programmes of Work to Deliver 5YFVMH and GM MH Strategy

- 24/7 Community-based access and Crisis Care (children and young people)
- GM iThrive Network and CYP MH Workforce development
- GM Perinatal and Parent-Infant mental health
- Liaison Mental Health – Core 24 access GM

For the programmes listed in III, it is proposed that transformation funding is awarded directly to localities to improve mental health services. This funding would be in addition to what has already been allocated in locality baselines:

III. CCG Locality Plans to Deliver 5YFVMH and GM MH Strategy

- Enhanced Adult Crisis & Urgent Care Options
- Integrated IAPT/Primary Care RAID
- Individual Placement Support
- Secure Care

GM-Wide Co-ordinated Mental Health Programmes

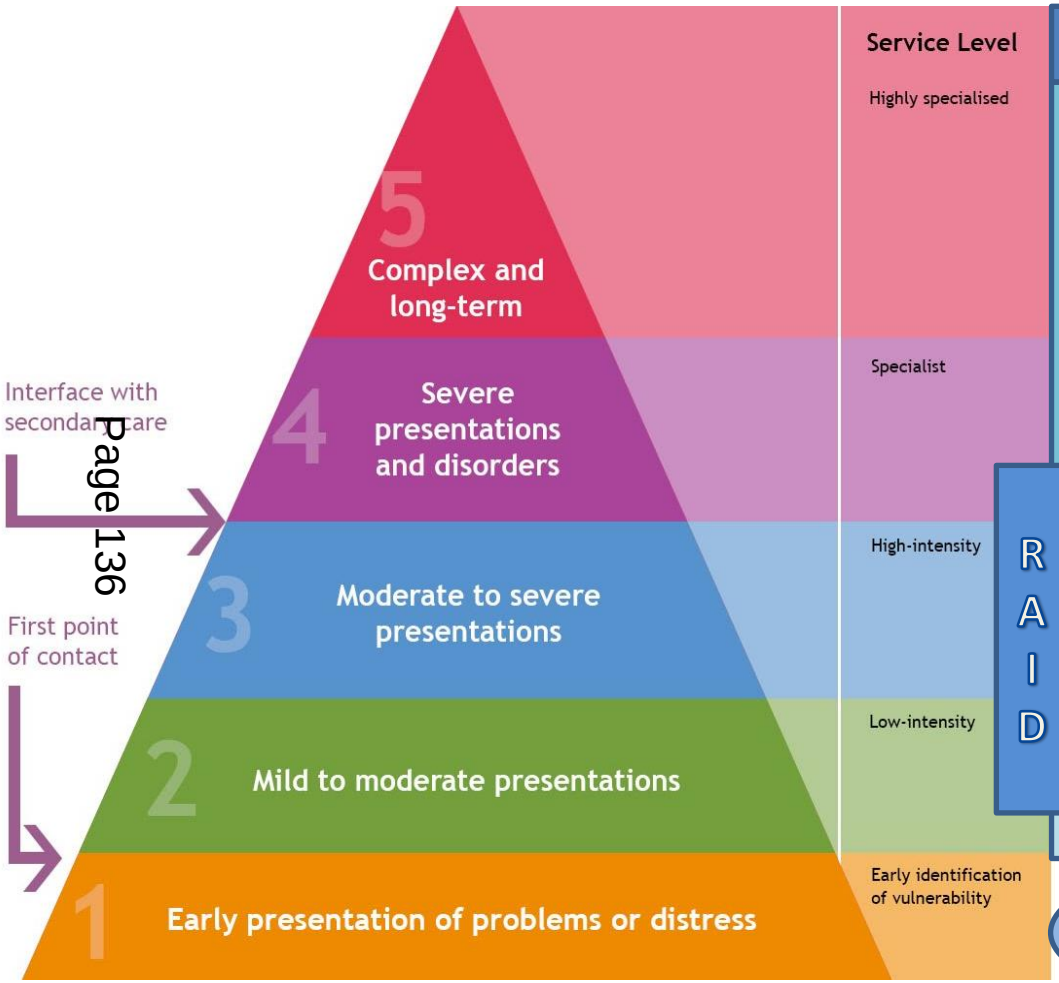
- **Perinatal and Parent / Infant Mental Health Support** – Developing and implementing GM integrated GM specialist inpatient and outreach perinatal mental health teams – linked with Mother and Baby Unit. Developing and implementing parent-infant mental health early help and attachment programmes - with extended fast-track IAPT access. Supporting perinatal mental health network leadership and engagement.

- **iThrive network and CYP MH Workforce development** – ensuring iTHRIVE model is integrated throughout GM and provides the focus for CYP services/workforce development, CYP pathway development, promotion of shared learning and system-wide effective responses to Adverse Childhood Experiences

- **24 / 7 community based access and crisis care for children & young people** – implementing CYP MH 24/7 community based access and crisis care delivering on the GM service pledges and iTHRIVE model to facilitate appropriate levels of help suited to CYP and family needs - ensuring self-help and library resources, community-based in-reach/out-reach home treatment teams, all age RAID services and CYP safe spaces/inpatient access. Intervention and support is focussed around the 4 pillars of Getting help, Getting more help, Getting risk support and Coping

- **Liaison mental health** – ensuring all-age Core-24 compliant support for acute hospitals with 24/7 A&E and Urgent Care Centres, beginning with specialist hospitals to improve early detection and treatment of mental health problems in people with existing physical health problems/medically unexplained symptoms, reduced lengths of inpatient stay and discharges to community

Existing Mental Health Commissioned Services Provision in T&G (16y +)



OOA Specialist MH – in-patient, CHC, ED, secure

Pennine Care FT Secondary Care services
- Adults 16 to 65y
- Older People 65+

Inpatient
Community MHTs
Home Treatment
Crisis /AMHP
Early Intervention in Psychosis Team
ADHD

Supported Accommodation

R A I D

GAP Complex Needs

Step Down
Opt In & Mind Allotments
Age UK OPSMI step down
DCC Peer Recovery
MVETS

PCFT Heathy Minds Service
Step 2
Step 3
Integrated psychological therapy in **LTC/Pain** services
(soon - LD MH provision in Community LD Team)

Capacity GAP

GPs
The Sanctuary
Mind & Off the Record

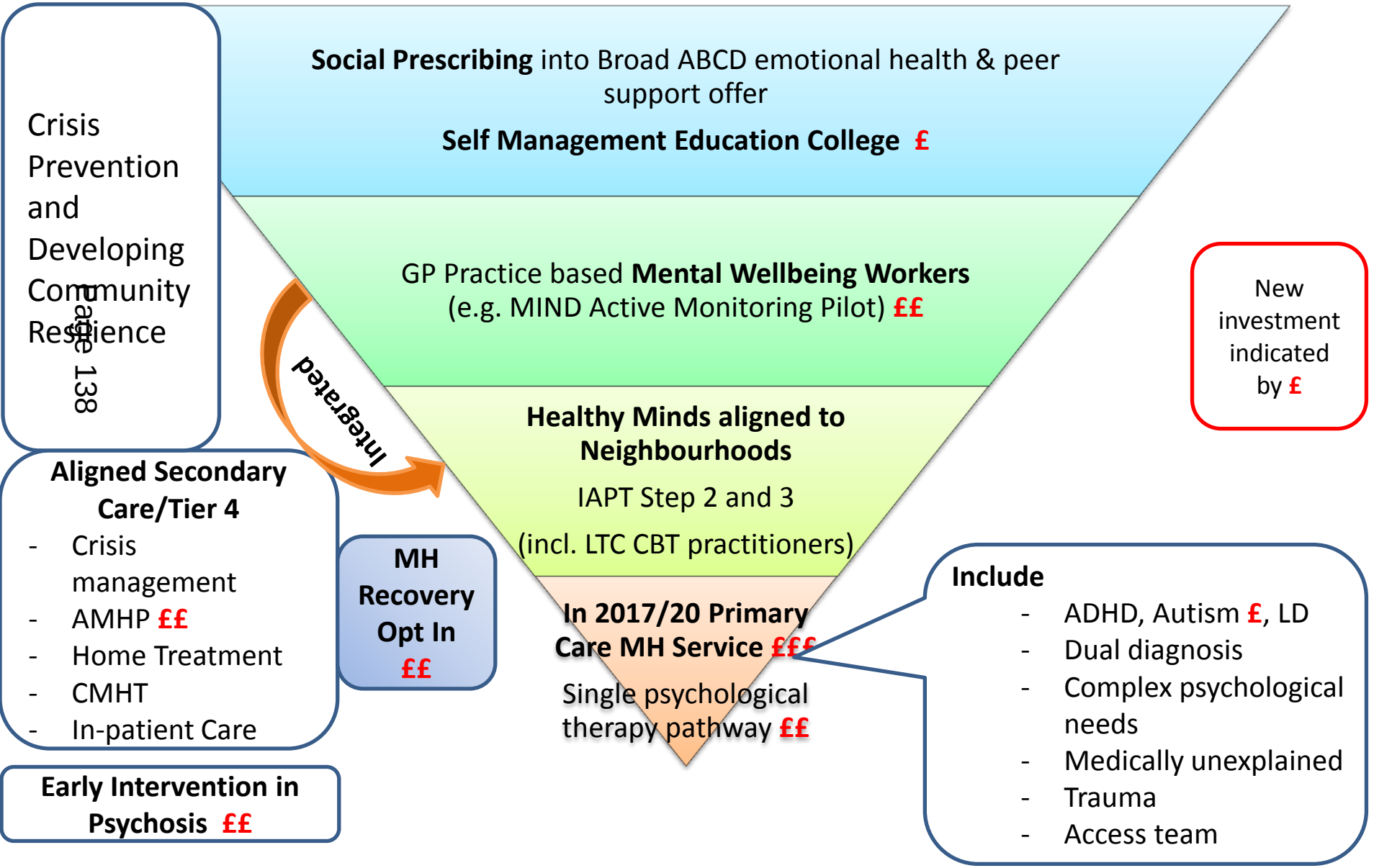
Community Support

Proposal to Align Investment

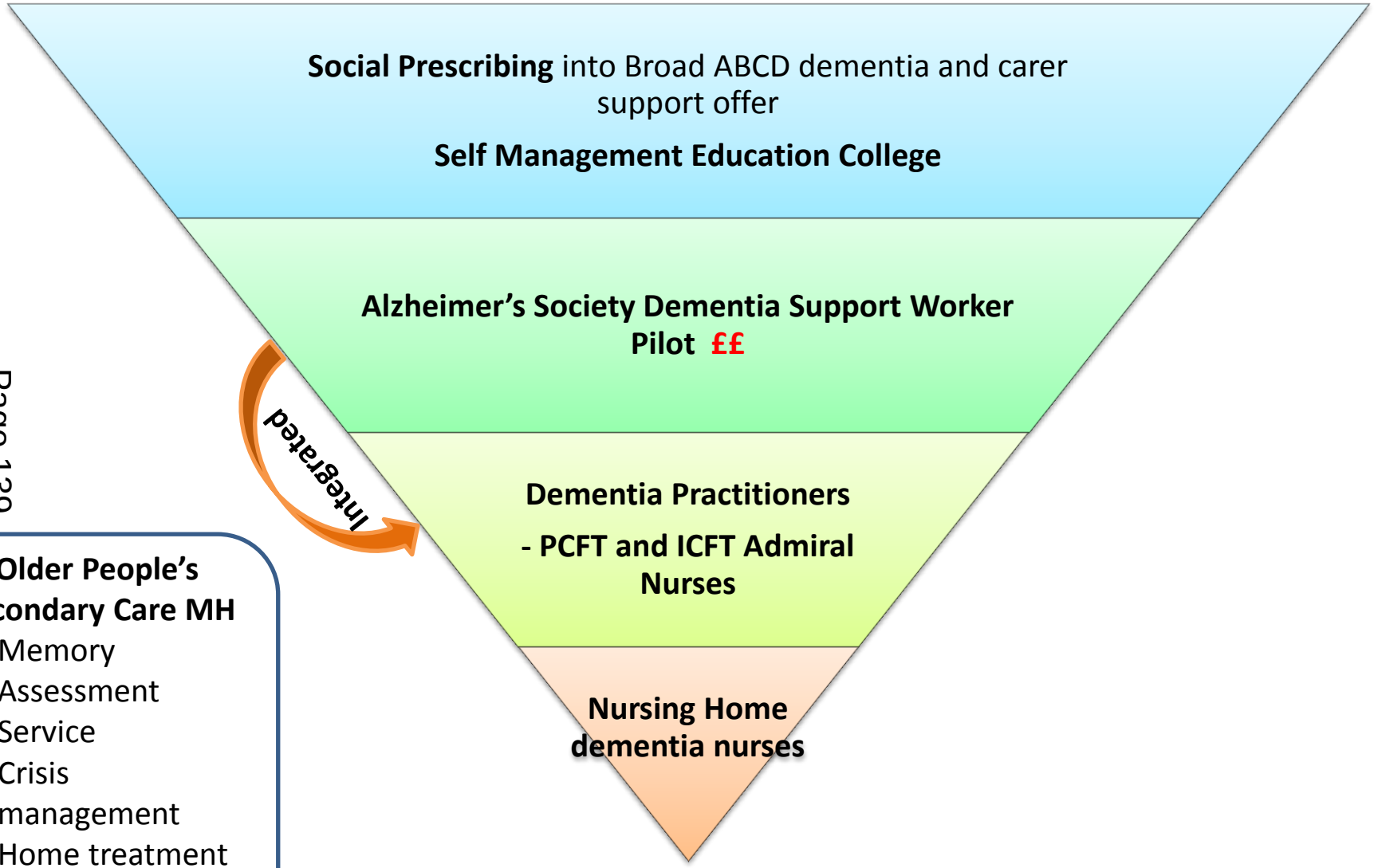
It is proposed that the new mental health funding streams are aligned, with existing MH investment, to deliver local, GM and national MH priorities as follows:-

- **Care Together Transformation Funding** £280,000 per year for 3 years
  - Establish new model of IAPT provision by pooling this funding with CCG Mind Grant and invest in integrated mental well-being service (Healthy Minds and Mind)
  - Contribution towards central Self Management Education College costs
- **CCG MH Investment Standard** – circa £400,000
  - Invest in Early Intervention in Psychosis to meet NICE compliant standards
  - Increase IAPT intermediate psychological therapy capacity to support MH standards and as a start towards a primary care mental health service for people with complex needs
- **TMBC Adult Social Care Transformation Fund** – circa £280,000 per year for three years
  - Increase Approved Mental Health Practitioner capacity by 3 posts within CMHTs
  - Commission additional Mental Health Recovery support aligned to ABCD and Opt In
  - Expand Autism provision by expanding Autism team
  - Increase post-diagnostic dementia provision in the Neighbourhoods including Alzheimer's Society Dementia Support Workers pilot
- **GM MH Transformation funding** - £tbc
  - Dependent on requirements could include Core 24 MH Liaison/ Primary Care MH workers/Community Crisis Care

Proposed Model - Mental Health in the Neighbourhoods



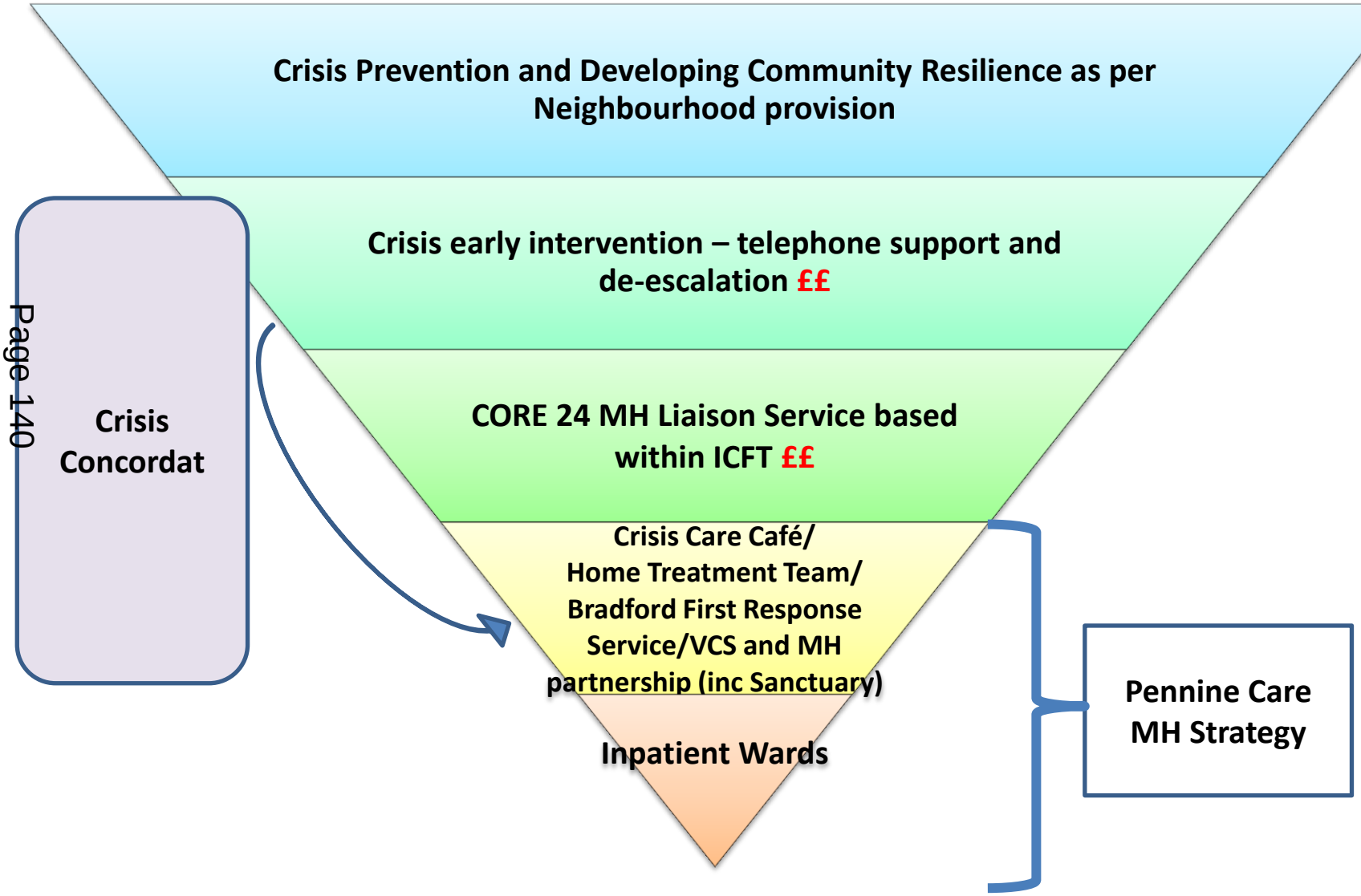
Proposed Model - Post-diagnostic Dementia Support in the Neighbourhoods



Older People's Secondary Care MH

- Memory Assessment Service
- Crisis management
- Home treatment
- CMHT
- In-patient Care

Developing Strategy – Urgent and Crisis Care Pathways



Next Steps

1. Whole system agreement in principle to integrated commissioning approach – L.E.G, PRG and SCB

2. Continue to share plans with GM Strategy leads to support decisions

3. Continue to work with PCFT and footprint commissioners to agree investment in core PCFT services and development of sustainable models for people with Serious Mental Illness

4. Bring together a team of commissioners from ICFT and Single Commission to engage all partners develop the models further and develop integrated business cases in line with the following developments:-
    - Post diagnostic dementia support in the community by end July 2017
    - Mental Health within the Neighbourhoods by end August 2017
    - Mental Health Crisis Care by end of October 2017

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	11 July 2017
Reporting Member / Officer of Single Commissioning Board	Sandra Whitehead, Assistant Executive Director (Adult Services)
Subject:	**ENGAGEMENT OF CONSULTANTS TO UNDERTAKE COST BENEFIT ANALYSIS OF ADULT SOCIAL CARE TRANSFORMATION PROPOSALS**
Report Summary:	Given the additional £10.296 million funding made available to Tameside and the potential financial impact and risk across the system of such a significant transaction, detailed modelling of locality costs and benefits will be required. There is agreement that a thorough cost benefit analysis of the Adult Social Care Transformation Programme be undertaken to ascertain the programmes' contribution to ensuring outcomes are met. This report seeks permission to engage the Social Care Institute of Excellence (SCIE) to undertake this work without undertaking a formal procurement exercise.
Recommendations:	That the Single Commissioning Board approves a waiver under Procurement Standing Order C5.3 and accepts the quotation of Social Care Institute for Excellence (SCIE) despite fewer than three quotations from suitably experienced firms being received.

Financial Implications:

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

Budget Allocation (if Investment Decision)	The non recurrent single commission Care Together transition budget. This was an initial non recurrent pooled budget sum of £6.38 million.
CCG or TMBC Budget Allocation	Pooled resource of both organisations
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	Single Commissioning Board
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	These will be reported within the outcome of the commissioned project brief.
Additional Comments It is essential the commissioned brief does not exceed the maximum sum of £39,150 (excluding VAT).	

	It is also essential that the associated cost benefits expected from the Adult Social Care Transformation Programme are realised and stringently monitored on an ongoing basis thereafter.
Legal Implications: **(Authorised by the Borough Solicitor)**	The Council is obliged to follow its own procurement standing orders where there are exceptional circumstances to justify such a course of action and it will not contravene any legal obligation. The service sought to let the contract in accordance with Procurement Standing Order C5 by seeking quotations however due to the nature of the services and the timescales in which they are to be delivered only 1 quotation has been received. The quotation has been determined to meet the stated requirements. It would not be unreasonable or unlawful to accept this quotation.
How do proposals align with Health & Wellbeing Strategy?	The proposals and strategic direction are consistent and aligned.
How do proposals align with Locality Plan?	The proposals and strategic direction are consistent and aligned.
How do proposals align with the Commissioning Strategy?	The Commissioning Strategy is based on improving healthy life expectancy, reducing inequalities, improving health and social care outcomes and delivering financial sustainability. The Care Together Programme, of which Adult Social Care is an integral part, supports all of these objectives.
Recommendations / views of the Professional Reference Group:	The report has not been presented to PRG.
Public and Patient Implications:	None caused by the CBA
Quality Implications:	None caused by the CBA
How do the proposals help to reduce health inequalities?	None caused by the CBA
What are the Equality and Diversity implications?	It is not anticipated that there are any equality and diversity issues with this proposal.
What are the safeguarding implications?	There are no anticipated safeguarding issues. Where safeguarding concerns arise as a result of the actions or inactions of the provider and their staff, or concerns are raised by staff members or other professionals or members of the public, the Safeguarding Policy will be followed.
What are the Information Governance implications?	None
Has a privacy impact assessment been conducted?	No
Risk Management:	In line with best practice and Programme Management Office standards, robust risk registers will be developed, regularly maintained and reviewed.

Access to Information :

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

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1. BACKGROUND

1.1 The Chancellor of the Exchequer presented his Spring Budget on 8 March 2017. The Budget included an additional £2bn of funding for Adult Social Care to be made available to local authorities over the period 2017-18 to 2019-20. For Tameside this equates to a total of £10.296 million through to 2019-20.

1.2 A report was presented to the Single Commissioning Board on 25 May 2017 to seek agreement for the proposals for how Adult Services proposed to invest this additional funding allocated by government to improve outcomes and quality across adult social care, looking to support the whole health and social care economy to function effectively across the programme of transformation. A series of projects were recommended, in relation of priority areas of backlog, unmet need, business as usual and transformation that this funding could be used to address.

1.3 These plans are currently undergoing a locality wide governance process applying programme management techniques to gain a better understanding of the proposals, any risks, costs and performance monitoring. The projects are at varying degrees of development at present.

1.4 Simultaneously, there is a parallel process to consider the transfer of Adult Social Care into the Integrated Care FT, which is planned to be delivered in April 2018. This process is also considering the transfer of services, functions and staff from the Single Commissioning Function into the ICFT, utilising phased implementation.

1.5 To consider if this is viable and sustainable, NHS Improvement (NHSI) will undertake a detailed risk assessment of the proposed transfer to the ICFT. Detailed financial and legal due diligence, and a comprehensive business case process are significant aspects of the process, which are currently being worked up across the locality.

2. COST BENEFIT ANALYSIS (CBA)

2.1 The financial impact and risk across the system of such a significant transaction will require detailed modelling of locality costs and benefits.

2.2 NHSI will have an enhanced focus on the financial planning of the proposed transaction in order to formulate a judgement on the decision to transfer, and are aware of the financial gap for the locality of approximately £70m if we 'do nothing'.

2.3 The key principles of the Care Together Programme are such that this gap is a locality gap as partner organisations work together to deliver the findings of the CPT report, collaborating and integrating delivery to ensure improved outcomes for local people.

2.4 It follows then that a cost benefit analysis of the Adult Social Care Transformation Programme be undertaken to ascertain the programmes' contribution to ensuring outcomes are met. It is clear, and should be noted, that the additional ASC funding has not been provided to ensure financial savings; however, this does not mean that there are not benefits to the system in doing so.

2.5 In undertaking this cost benefit analysis, it also contributes to the information required by NHSI for the transactional business case process. The timescale for the delivery of the Outline Business Case is by August 2017. Therefore, there is urgency to be able to deliver some high level CBA impacts to include as part of this process, alongside other wider CBA processes in relation to the locality financial gap of £70m.

2.6 The difficulty in conducting the cost benefit analysis in-house are as follows:

- Capacity of staff and specialist skills to model and analyse information in the required level of detail;
- Uncertainty in developing, agreeing and applying robust assumptions to new transformation plans which have not been delivered before, and therefore there is not the richness of learning from previous improvements to utilise. In addition, there is a significant amount of change in the system happening simultaneously at scale and pace, and hence it is difficult to attribute any changes to individual interventions.

2.7 The original GM CBA process concentrated efforts on acute activity, growth assumptions and potential benefits to the ICFT. However, due to tight timescales, articulating the impact of these schemes on the out of hospital / community development was not able to be conducted.

2.8 This proposed and specific CBA exercise would be a good starting point to unpick that, as the Adult Social Care projects will support the process of quality assurance, support to remain at home, and asset based approaches.

3. GREATER MANCHESTER ADULT SOCIAL CARE TRANSFORMATION PROGRAMME

3.1 Tameside's ASC Transformation Programme complements the wider Greater Manchester programme and where appropriate, for example a single set of quality standards and commissioning frameworks, and specialist commissioning for high cost care Adult Services will fully engage with the Greater Manchester programme.

3.2 As a complement to the Greater Manchester Health and Social Care Partnership transformation programme Greater Manchester Association of Directors of Adult Social Services has agreed and is developing four key priorities:

- Care at Home;
- Residential and Nursing Care;
- Learning Disabilities;
- Support for Carers.

3.3 It is important that new and additional work should not be created, and Tameside has contributed significantly already to multiple GM requests for information and continues to engage with GM for any opportunities to be more involved in any pilots or test cases.

3.4 These organisations therefore, already have Tameside data to baseline and analyse. It would be advantageous, both in time and costs to consider working with one of these to be able to ensure full alignment with the GM perspective.

4. DETAILS OF PROPOSED CONTRACTUAL ARRANGEMENTS

4.1 The Council is looking to award a two month contract. The contract is expected to commence as soon as possible following consideration of this report.

5. APPROACH USED

5.1 The Council's Procurement Standing Orders require the lead officer to use The Chest to get at least three quotations from suitably experienced firms that can meet the Council's needs.

5.2 Given the circumstances outlined in section 3 above, on this occasion three organisations were approached directly. All three organisations – Oxford Brookes, the New Economy and SCIE – have the requisite track record and expertise to undertake the cost benefit analysis, with the latter two fully engaged supporting GM on the detailed review and modelling of Adult Social Care across these priority areas.

6. RESPONSE

6.1 No response was received from Oxford Brookes.

6.2 The New Economy explained that they do not have the capacity currently to take on more work.

6.3 SCIE provided a detailed, fully costed proposal (see **Appendix 1**) the details of which SCB has been briefed on.

7. CONTRACT VALUE

7.1 Based on the specification and project brief provided to SCIE, they have quoted £39,150 (excluding VAT) to complete the project.

7.2 This would be the maximum price paid for the piece of work. Conversations will take place with SCIE if this proposal is approved to review this price based on the actual number of projects that require a CBA.

8. BACKGROUND INFORMATION ON PROVIDER

8.1 The Social Care Institute for Excellence (SCIE) are an improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK as well as related services such as health care and housing.

8.2 SCIE are currently involved in working with the GM Health and Social Care Partnership including preparing the baselining and best practice review and asset based strategy. This fits well with the requirements from this piece of work. The Director identified to lead this work, is now on the GM ASC Advisory Board so would ensure there is strong linkages where necessary with Greater Manchester plans.

9. RECOMMENDATION

9.1 As stated at the front of this report.

APPENDIX 1

Review of Tameside Adult Social Care Transformation Proposals

Introduction

We are delighted to have been asked to submit a proposal to review of draft proposals for the transformation of adult social care in Tameside.

As you are aware, SCIE has been supporting the Greater Manchester Adult Social Care (GM ASC) programme, including preparing the baselining and best practice review and asset based strategy, so is well placed to support you with this work. Ewan King, who would lead this work, is now on the GM ASC Advisory Board so would ensure there is strong read across and linkages where necessary with Greater Manchester plans.

Our understanding of your needs

Tameside has established a social care reform programme with the aim of radically transforming adult services in order to deliver more person-centred, coproduced and high quality services to individuals, carers and families.

As part of this programme, Tameside will develop a number of transformation projects in relation to different areas of care and support delivery, including:

- Shared lives
- Community response service
- Dementia
- Carers
- Alternative housing options

It is anticipated that these projects, taken together, will bring about significant benefits to adult social care, but also the wider system, including better outcomes and cost savings over the longer term.

You require external support to:

1. **Conduct a review of the draft transformation projects to assess their fitness for purpose and potential to contribute to the transformations you require.** We will review each project in relation to a set of bespoke criteria that we will develop to reflect the unique local circumstances in Tameside, the emerging GM ASC Strategy, and national good practice. Based on what we find through the review, we will provide recommendations on the projects and how they could be enhanced, including bespoke solutions where appropriate.

2. **Conduct a Cost Benefit Analysis of each project to assess the potential savings of each project and the programme as a whole.** Tameside is aware that there is significant potential for these projects to avoid costs for the whole system, but it needs external support to identify and articulate these savings. We will review available data, taking into consideration that which has been captured by Tameside

and other local or national data sets. This review will inform the depth and breadth of the cost benefit analysis.

We understand that Tameside wants to use findings from the review and the CBA to form part of an Outline Business Case to NHSI. This business case is due by the end of July 2017.

Suggested approach

Planning meeting

We would meet with the leads for the Adults Transformation Programme as soon as is feasible to discuss the project in further detail and agree a programme of work. We would expect to use this meeting to:

- Agree the scope of the work, including the number of projects involved in the review
- Identify key contacts and sources of documentation
- Identify a schedule for the two workshops and participant lists
- Agree reporting and liaison arrangements.

In addition, we understand that you are keen to understand the opportunities available at Greater Manchester level, particularly around the wider work happening with the GM ASC programme. We can use the planning meeting to discuss this landscape and explore the potential role of Tameside within it in future.

Review criteria

We would develop a set of criteria – which would be bespoke to Tameside – which would enable us to systematically assess each project. The criteria will include markers of good practice, which will differ slightly for each type of project, and local factors such as capacity and capability, investment, leadership and system alignment.

Review

The review of the projects will involve a combination of in depth interviews with project leads and practitioners, and desk research of existing plans and documents, any relevant performance, demand and service utilisation data. Alongside the work locally, we will conduct a rapid review of relevant national, and regional, good practice in relation to the key projects.

This review will enable Tameside to understand where new models of care might be relevant and create an evidence base to inform the future commissioning of services.

Cost benefit analysis (CBA)

We will design scope out and design a framework for conducting cost benefit analysis that will establish, as much as is feasible, high-level estimates of cost benefit for the different projects and for the programme as a whole. This framework will be based on a theories of change (ToC) approach (which should give them some clear indication of likely benefits), coupled with a rapid evidence review and the surfacing of likely costs/benefits; effects sizes, etc.

To do this, we will conduct interviews with a range of key staff (c.8 telephone interviews over the phone); review key documents (assuming c.10 documents); review and map their existing data; produce a draft ToC and test it with stakeholders; conduct a rapid evidence review to pull out relevant info to support the theory of change and economic analysis; produce a short output summarising the work.

Draft report

We will produce a draft report setting out the findings from the review and CBA activities. This would set out at assessment of each project in relation to the review criteria and the associated projected cost and benefits of each (where the data allows this). This report would be produced to meet the deadline for the submission to NHS Improvement by late July 2017.

Review workshops

We would propose running two workshops to test out the emerging findings from our review; the first with social care and wider health and housing leads, and the second with service users and carers.

Each workshop would run for half a day and be facilitated by a senior consultant from SCIE. At each workshop we would present the findings from our review and then conduct an option appraisal emerging project proposals against the review criteria, to ensure that each project is stress-tested in relation to a broad ranging of stakeholder views.

Final report

We will produce a final full report of our work, drawing on the findings form the review, CBA and workshops. The report will set out a small number of specific recommendations on each of the proposals and on the programme as a whole. This final report will be delivered in August 2017.

Timings

So that we can meet the deadlines set out in this proposal we suggest to the following timescales:

- 3 – 17 July – Scoping and set-up meeting, develop review criteria and review dates set for CBA and conduct review and CBA
- w/c 24 July – submit draft report to inform NHS Improvement business case
- 31 July – 14 August – complete review, CBA and host review workshops
- w/c 21 August – submit final report

Costs

Indicative costs for this project are set out below.

Activity						EXPENSES	TOTAL	COSTS (£)
Planning	£1,000	£850	£600	£450	£850		DAYS	COSTS (£)
Planning Meeting		1.00		1.00		400	2.00	£ 1,750
Project plan				1.00			1.00	£ 450
Develop review criteria	0.50	0.50	1.00	1.00			3.00	£ 2,000
Review								
Interviews with stakeholders (20)		1.00	3.00	3.00		400	7.00	£ 4,450
Desk review		1.00	2.00	3.00			6.00	£ 3,450
Draft report	0.50	1.00	2.00	2.00			5.50	£ 3,500
Cost Benefit Analysis								
Interviews					10.00		10.00	£ 8,500
Theory of chance					4.00		4.00	£ 3,400
Modelling					4.00		4.00	£ 3,400
Workshops								
Design workshops		0.50					0.50	£ 450
Facilitate workshops (x2)	0.50	1.00		2.00		1,200	3.50	£ 3,500
Final Report								
Draft report		1.00	1.00	2.00			4.00	£ 2,400
Presentation to Board		1.00	1.00			400	2.00	£ 1,900
Total Days	1.50	8.00	10.00	15.00	18.00		52.50	£ 39,150
Total Costs (Excluding VAT) Including Probon	£ 1,500	£ 6,800	£ 6,000	£ 6,750	£ 15,300	£ 2,400		£ 38,750
Total Costs (Including VAT @ 20%)	£ 1,800	£ 8,160	£ 7,200	£ 8,100	£ 18,360	£ 2,880		£ 46,980

CVs