# SINGLE COMMISSIONING BOARD

**Day:** **Tuesday**
**Date:** **22 August 2017**
**Time:** **3.00 pm**
**Place:** **Lesser Hall 2 - Dukinfield Town Hall**

| Item No. | AGENDA | Page No |
|---|---|---|
| 1. | **WELCOME AND APOLOGIES FOR ABSENCE** | |
| 2. | **DECLARATIONS OF INTEREST**<br>To receive any declarations of interest from Members of the Single Commissioning Board. | |
| 3. | **MINUTES OF THE PREVIOUS MEETING**<br>To receive the Minutes of the previous meeting held on 11 July 2017. | 1 - 10 |
| 4. | **FINANCIAL CONTEXT** | |
| a) | **FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND**<br>To consider the attached report of the Director of Finance, Single Commission. | 11 - 30 |
| 5. | **QUALITY CONTEXT** | |
| a) | **UPDATE ON CHILDREN'S SERVICES INSPECTION**<br>To consider the attached report of the First Deputy (Performance and Finance) / Director of Children's and Adults. | 31 - 48 |
| b) | **PERFORMANCE REPORT**<br>To consider the attached report of Anna Moloney, Consultant, Public Health. | 49 - 86 |
| 6. | **COMMISSIONING FOR REFORM** | |
| a) | **INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP**<br>To consider the attached report of the Director of Commissioning. | 87 - 214 |
| 7. | **URGENT ITEMS**<br>To consider any items which the Chair is of the opinion shall be considered as matter of urgency in accordance with legal provisions as set out in the Local Government Act 1972 (as amended). | |
| 8. | **DATE OF NEXT MEETING**<br>To note that the next meeting of the Single Commissioning Board will take place on Tuesday 26 September 2017 commencing at 3.30 pm. | |

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.

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**TAMESIDE AND GLOSSOP**
**SINGLE COMMISSIONING BOARD**

**11 July 2017**

**Commenced: 2.00 pm** **Terminated: 3.20 pm**

**PRESENT:** Alan Dow (Chair) – NHS Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Councillor Gerald Cooney – Tameside MBC
Alison Lea – NHS Tameside and Glossop CCG
Jamie Douglas – NHS Tameside and Glossop CCG
Christina Greenhough – NHS Tameside and Glossop CCG
Carol Prowse – NHS Tameside and Glossop CCG

**IN ATTENDANCE:** Kathy Roe – Director of Finance
Clare Watson – Director of Commissioning
Angela Hardman – Director of Population Health
Aileen Johnson – Head of Legal Services
Tom Wilkinson – Deputy Section 151 Officer
Paul Dulson – Head of Adult Assessment and Care Management

**APOLOGIES:** Steven Pleasant – Tameside Council Chief Executive and Accountable Officer for NHS Tameside and Glossop CCG
Councillor Peter Robinson – Tameside MBC

## 26. DECLARATIONS OF INTEREST

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

## 27. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 22 June 2017 were approved as a correct record.

## 28. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

Consideration was given to a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the consolidated financial position of the economy and provided a 2017/18 financial year update on the month 2 financial position at 31 May 2017 and the projected outturn at 31 March 2018.

In summary, the Director of Finance stated that the projected year end deficit across the economy was currently £6.783m. The Clinical Commissioning Group was reporting that all financial control totals would be met, however, there was meaningful risk attached to this. Against a £23.9m QIPP target there were £17m of savings which it was certain would be met, leaving £6.8m still to be delivered and therefore significant risk attached to fully realising this residual target.

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

Reference was also made to the risk share of the projected year end single commission deficit by constituent organisations. This included a non-recurrent contribution of £5m by Tameside MBC with a reciprocal arrangement by the Clinical Commissioning Group within a 4 year period as per the terms of the Integrated Commissioning Fund Financial Framework.

The Integrated Care Foundation Trust was working to a £24.5m deficit position for 2017/18. This had not yet been agreed by NHS Improvement and delivery of £10.4m efficiencies were required to meet this control total.

**RESOLVED**

**(i) That the 2017/18 financial year update on the month 2 financial position at 31 May 2017 and the projected outturn at 31 March 2018 be noted.**

**(ii) That the significant level of savings required during the period 2017/18 to 2020/21 to deliver a balanced recurrent economy budged be acknowledged.**

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

## 29. ANNUAL REVIEW OF 2016/17 SECTION 75 AND FINANCIAL FRAMEWORK AGREEMENTS

The Director of Finance presented a report explaining that 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. The return included details of the income and expenditure within the Pooled Fund and other pertinent information by which Partners could monitor the effectiveness of the Pooled Fund and represented the annual return for 2016/17.

The Section 75 Agreement commenced 2016/17 at a value of £216.40m which include the Better Care Fund. The wider "Aligned and In Collaboration" funds had also been added to provide a total Integrated Commissioning Fund value of £435.52m.

During the course of 2016/17 values were amended to reflect changes in the Clinical Commissioning Group allocations and Tameside Council resources. A particular feature for 2016/17 was the receipt of £5.2m transformation funding to the Tameside and Glossop health economy from the Greater Manchester Health and Social Care Partnership.

The closing value of the Section 75 Agreement at 31 March 2017 was £233.03m reflecting an increase of £16.63m 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 £17.66m at 31 March 2017.

In conclusion, the Director of Finance advised that monitoring information would continue to be reported to the Single Commissioning Board in 2017/18 on a monthly basis to enable the Board to monitor the effectiveness of the Pooled Fund.

**RESOLVED**

**That the review of the Section 75 Agreement within the wider Integrated Commissioning Fund be approved in accordance with the governance outlined at Paragraph 11 of the 2016/17 financial framework for the Integrated Commissioning Fund.**

## 30. CANCER UPDATE

Dr Alison Lea presented a report informing the Board about a review of cancer data to help inform the development of specific actions to ensure the locality 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 Strategic Partnership Board.

There were 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' and the six key work streams of the National Cancer Strategy. A substantial part of the plan in 2016/17 and 2017/18 was part of the vanguard innovation programme and funded by NHS England's New Care Models Team. At Greater Manchester and local level work was ongoing to meet the level of ambition with the aim of preventing avoidable deaths, reducing variation and improving experience. The level of contribution required by Provider Trusts and Clinical Commissioning Groups was detailed in Appendix 1 and Appendix 2 to the report.

The Greater Manchester Cancer Plan had been received by the Tameside Health and Wellbeing Board at its meeting on 9 May 2017. The Tameside and Glossop Cancer Board, led by the Tameside and Glossop Integrated Care Foundation Trust, was currently developing a comprehensive implementation plan and details were outlined in the report for information.

It was explained that 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). Statistics for childhood cancers were not routinely published for Greater Manchester, the North West or Tameside. Local data would be requested from the North West Local Cancer Intelligence Network and an analysis of data would be incorporated into the developing plan.

In Tameside and Glossop Clinical Commissioning Group, all of the following were higher than the NHS England average:

- Incidence of cancer;
- Mortality rates;
- Under 75 years of age mortality;
- Number of deaths from cancers considered preventable;
- Adult smoking rates.

The Board heard that for the majority of time, Tameside and Glossop achieved the operational waiting times standards (93% within two week wait, 96% within 31 days and 85% within 62 days). Tameside and Glossop had a higher than average number of 2 week wait referrals than the NHS average for suspected cancers per 100,000 of the population. The conversion rate into diagnosed cancer was lower than the NHS England average but 2015/16 data showed that the gap was reducing.

While survival rates from cancer were increasing Tameside and Glossop Clinical Commissioning Group had a relatively high number of cancers detected late, with 20% of all cancers identified through emergency presentation and consequently reduced survival rates, compared to the England average and other Clinical Commissioning Groups across Greater Manchester.

Board members discussed the importance of focusing on prevention and early diagnosis of cancer, for example screening update, to reduce any variation across Tameside and Glossop Clinical Commissioning Group.

The development of locality-specific actions, currently being developed within the Tameside and Glossop Clinical Commissioning Group would support achievement of all the measures identified 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 needed to be considered as part on an ongoing improvement process and incorporated into the plan:

- What else could be done to detect cancer earlier and raise public awareness through national and local campaigns;
- How could emergency presentations be reduced;
- Role of Primary Care, e.g. use of e-referrals and EMIS templates;
- Improving access;
- Ensuring access to services was equitable;

- Planning, demand and capacity.

**RESOLVED**
**That the content of the report be noted and the Board be kept informed of progress with any areas of concern escalated as appropriate.**

## 31. TRANSFORMATION ENABLERS RELEASE OF FUNDING

Consideration was given to a report of the Programme Director (Care Together) outlining the proposed release of some Greater Manchester Health and Social Care Transformation funding in line with the Neighbourhood Strategy within Care Together detailed in section 2 of the report.

It was noted that the approved Greater Manchester Transformation funding bid included an allocation of £0.600m funding to support transformation projects within the locality estates and £1.000m funding to support transformation projects within organisational development. The report sought approval for the release of Transformation Funding up to the value of £0.400m for Estates and £0.150m for Organisational Development to support in delivering the transformation outcomes required by these enabling schemes.

The Estates funding would support three fixed term posts to support delivery of projects in the Estates transformation work stream and a number of outcomes were detailed in the report. The Organisational Development funding would support recruitment to a fixed term post to support delivery of projects in the Organisational Development work stream.

**RESOLVED**
**That approval be given to the release of Greater Manchester Health and Social Care Partnership funding up to the value of £0.400m for Estates and £0.150m for Organisational Development to support in delivering the transformation outcomes required by these enabling schemes in line with the Neighbourhood Strategy within Care Together.**

## 32. DISINVESTMENT AND DECOMMISSIONING POLICY

The Director of Commissioning presented a report advising that as part of the ongoing work towards achieving the 2017-18 Quality, Innovation, Productivity and Prevention target of £23.9m, and contributing to the system wide Savings Assurance programme, the decision had been taken to develop a Disinvestment and Decommissioning policy for consideration by Single Commission governance.

Reference was made to the Policy appended to the report, which had been developed by the Commissioning Directorate, and was based on best practice from policies in other localities across the country. Although based on examples from elsewhere, the Policy was inclusive of Tameside and Glossop specific plans and priorities, and was designed to align with the delivery of the Locality Plan and the Care Together programme. The Policy provided 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.

In terms of financial implications, whilst there was no direct value for money implications in the report, the adoption of the Policy could have significant implications in the future. However, it was important that an economy wide view was taken including the effect of stranded costs and future consequences, e.g. if stopping medium cost treatment today was likely to result in the need for high cost treatment in several years' time.

The Policy sought to clarify the circumstances in which services might be decommissioned or disinvested from and described the approach and processes that would be adopted to ensure decisions were fully informed and implemented effectively, following a safe, fair and transparent

process. Decommissioning and disinvestment impacted on patients and therefore required a formal process providing an evidence trail and clear governance supporting any decisions. Full Equality Impact Assessments would be carried out for any proposal developed and taken through the processes outlined in the Policy and would be kept under regular review to ensure it remained fit for purpose.

In addition, the Board discussed and agreed that full Health Impact Assessments would also be undertaken to determine the potential effects of a proposal on the health of the population or impact on other service areas.

There was a need to ensure that when approval had been given by the Single Commissioning Board to decommission or disinvest from a service, a clearly defined process was followed, with clear lines of accountability and responsibility. A process flowchart was highlighted making reference to presentation of proposals to committees and ultimately to the Single Commissioning Board.

**RESOLVED**

**(i) That the Disinvestment and Decommissioning Policy for use in supporting disinvestment and decommissioning proposals be approved.**

**(ii) That in addition to Equality Impact Assessments being undertaken, Health Impact Assessments to determine the potential effects of a proposal on the health of the population or impact on other services should be undertaken.**

**(iii) That an economy wide view is taken of any proposal put forward for disinvestment / decommissioning.**

## 33. INTEGRATED CHILDREN'S NEIGHBOURHOOD PILOT

The Director of Commissioning presented a report seeking approval for the development and implementation of a pilot Integrated Neighbourhood Children's Team aimed at delivering improved outcomes and efficiencies for children and young people and those who cared for them. The Integrated Neighbourhood Children's Team pilot would 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 and intervene early in an emerging problem;
- One team, knowing their area and each other;
- Person centred approach within the context of family and community; and
- Services delivered within the community, close to home from a flexible asset base.

The model for Children's Integrated Neighbourhoods had been developed over a number of months, building on the existing 'Neighbourhood Approach' proposals, taking into account the local progress made through the Care Together Programme. In addition, the growing evidence base being delivered by the Stockport Family Approach was highlighted as detailed in Appendix A to the report. Through consultation with stakeholders and engagement with the Ashton neighbourhood and using the principles detailed above and key objectives, a model had been developed which included a 'core offer' and local priorities which were specific to meet the needs of the neighbourhood. If the pilot was successful it was anticipated that in rolling out wider, the five Integrated Neighbourhoods would look different and would eventually be staffed according to the local needs and demands though they would share the same objectives, goals and outcomes.

The level of intervention delivered by the Integrated Neighbourhood Children's Team would be determined by the needs of the individual and the population. Needs would be met by a range of people with the appropriate skills from community health, education and social care providers, the 3rd sector, General Practice and incrementally expand to the wider public sector teams (e.g. fire service, police service, council provided support.

The proposal was that the transformation funding requested from Greater Manchester would be used to support any developments in the core offer which required additional funding. Details of existing staff and teams had been produced at a neighbourhood level to facilitate the development and redesign of the Integrated Neighbourhood Children's Team model and these were outlined in the report. Through the implementation phase, a detailed process and pathway would be developed to ensure the access to support from the Integrated Neighbourhood Children's Team was clear to all and would need to align with the reformed Children's Hub and existing neighbourhood infrastructure.

To achieve effective integrated care, fundamental systemic and institutional redesign of the organisations and resourcing of services and the children's workforce was required. The Integrated Neighbourhood Children's Team pilot provided a vehicle in which to evolve the system and deliver better outcomes for children, young people and those who cared for them.

The Board was advised that meetings had taken place at director level within the Tameside and Glossop Integrated Care Foundation Trust to ensure understanding of the proposal.

The Single Commissioning Board expressed their support for the pilot noting that the successful development and mobilisation of an Integrated Children's model would require ownership with executives, clinical and service leaders and a collaborative mind set and further development of the model was required in moving to implementation.

**RESOLVED**

**(i) That the strategy of an integrated neighbourhood children's model be agreed.**

**(ii) The 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 Services (social care and education) and Single Commission Framework.**

**(iii) That existing resources be aligned to developing and implementing the pilot including those already deployed around the existing Care Together Integrated Neighbourhood Teams agenda and social prescribing.**

**(iv) To ensure executive / director ownership, oversight and drive of the agenda / pilot.**

## 34. PROPOSED INTEGRATED MENTAL HEALTH COMMISSIONING STRATEGY 2017/19

Consideration was given to a report of the Director of Commissioning and accompanying presentation proposing an integrated commissioning strategy to meet 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 were:

- 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 Funding agreed at the Integrated Care Foundation Trust Joint Management Team on 15 June 2017.

The Five Year Forward View for Mental Health was outlined including the key themes in the strategy and recommendations for the NHS and system partners. This was the basis for the Greater Manchester Mental Health Strategy which proposed a whole system approach that included involvement from the independent and third sector, to improve the mental health and wellbeing of individuals and their families, supported by resilient communities, inclusive employers and services that maximised independence and choice. It aimed to build on existing best practice

to lift patients' experience of care and support through the development and application of national and Greater Manchester standards relating to access and care delivery. The Greater Manchester investment strategy priorities and Greater Manchester wide co-ordinated mental health programmes were detailed.

In terms of next steps, there was a commitment to continue to share pans with Greater Manchester Strategy leads to support decision and continue to work with Pennine Care Foundation Trust and footprint commissioners to agree investment in core services and development of sustainable models for people with serious mental illness. A team of commissioners from the Integrated Care Foundation Trust and the Single Commission would engage all partners to develop models further and associated integrated business cases in line with the following developments:

- Post diagnostic dementia support in the community by the end of July 2017;
- Mental health within the Neighbourhoods by end of August 2017; and
- Mental health crisis care by end of October 2017.

In welcoming the report, the Single Commissioning Board was pleased to note that there was new investment within mental health and recognised that this integrated commissioning proposal would ensure that this would build on and transform existing services.

**RESOLVED**

**(i) That the Integrated Mental Health Commissioning Strategy 2017/19 be approved and the opportunities it provide to improve mental health outcomes through this approach be recognised.**

**(ii) That there was a need for commitment across the whole system to develop sound business cases in line with this Commissioning Strategy for approval as soon as possible.**

## 35. ENGAGEMENT OF CONSULTANTS TO UNDERTAKE COST BENEFIT ANALYSIS OF ADULT SOCIAL CARE TRANSFORMATION PROPOSALS

Consideration was given to a report of the Assistant Director (Adults), which explained that the Chancellor of the Exchequer presented his Spring Budget on March 2017 and 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 equated to a total of £10.296m through to 2019-20. Subsequently, the Single Commissioning Board had received a report at its meeting on 25 May 2017 seeking agreement for proposals for how Adult Services should invest this additional funding and the Board had been advised on a series of projects in relation to priority areas of backlog, unmet need, business as usual and transformation that this funding could be used to address.

These plans were currently undergoing a locality wide governance process applying programme management techniques to gain a better understanding of the proposals, any risk, costs and performance monitoring and were at present at varying degrees of development. Simultaneously, there was a parallel process to consider the transfer of Adult Social Care into the Integrated Care Foundation Trust, planned for delivery in April 2018. This process was also considering the transfer of services, functions and staff from the Single Commissioning Function into the Integrated Care Foundation Trust, utilising phased implementation.

To consider if this was viable and sustainable, NHS Improvement would undertake a detailed risk assessment of the proposed transfer to the Integrated Care Foundation Trust. Detailed financial and legal due diligence and a comprehensive business case process were significant aspects of the process currently being worked up across the locality.

The financial impact and risk across the system of such a significant transaction would require detailed modelling of locality costs and benefits. There was agreement that a thorough cost benefit

analysis of the Adult Social Care Transformation Programme be undertaken to ascertain the programme's contribution to ensuring outcomes were met.

The difficulty of conducting the cost benefit analysis in-house was outlined in the report and therefore the Council was looking to engage consultants to undertake the cost benefit analysis of Adult Social Care Transformation proposals on a two month contract. On this occasion, three organisations were approached directly who had the requisite track record and expertise to undertake the cost benefit analysis and who already had Tameside data to baseline and analyse, two of which had been fully engaged supporting Greater Manchester on the detailed review and modelling of Adult Social Care.

The service sought to let the contact by seeking quotations. However, due to the nature of the services and the timescales in which they were to be delivered only one of these organisations, an improvement support agency and independent charity working with adults, families and children's care across the UK, had provided a detailed, fully costed proposal. The quotation detailed in Appendix 1 to the report had been determined to meet the stated requirements and therefore permission was being sought to engage the Social Care Institute of Excellence to undertake this work without undertaking a formal procurement exercise.

**RESOLVED**
**That approval be given to accept the quotation of the Social Care Institute for Excellence, despite fewer than three quotations from suitably experienced firms being received, for the reasons explained in the report.**

## 36. URGENT ITEMS

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

## 37. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 22 August 2017 commencing at 3.00 pm at Dukinfield Town Hall.

## 38. EXCLUSION OF THE PRESS AND PUBLIC

**RESOLVED**
**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) had been provided in commercial confidence and its release into the public domain could result in adverse implications for the parties involved and this outweighed the public interest in disclosure.**

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

Consideration was given to a report, which included three procurement outcome reports compiled on behalf of the Greater Manchester Procurement Evaluation Panels for the Any Qualified Provider (AQP) contracts for the provision of Adult Hearing and Diagnostic Imaging (Non Obstetric Ultrasound) and Magnetic Resonance Imaging (head and neck only) following the completion of

the evaluation of applications received in response through Contracts Finder and OJEU published on 31 March 2017.

**RESOLVED**
**That the recommendations of the evaluation process be accepted and the approved applicants be invited to enter into a contract with the Clinical Commissioning Groups, subject to the usual pre-contractual due diligence and the evidencing of associated assurances.**

**CHAIR**

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| **Report to:** | **SINGLE COMMISSIONING BOARD** |
| **Date:** | 22 August 2017 |
| **Officer of Single Commissioning Board** | Kathy Roe – Director Of Finance – Single Commission<br>Ian Duncan - Assistant Executive Director – Tameside Metropolitan Borough Council Finance<br>Claire Yarwood – Director Of Finance – Tameside and Glossop Integrated Care NHS Foundation Trust |
| **Subject:** | **TAMESIDE AND GLOSSOP CARE TOGETHER ECONOMY – 2017/18 CONSOLIDATED FINANCIAL MONITORING STATEMENT AT 30 JUNE 2017 AND PROJECTED OUTTURN TO 31 MARCH 2018** |

**Report Summary:**

This is a jointly prepared report of the Tameside and 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 3 financial position (at 30 June 2017) and the projected outturn (at 31 March 2018).

The Tameside and Glossop Care Together Single Commissioning Board are required to manage all resources within the Integrated Commissioning Fund. The Clinical Commissioning Group 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/acknowledge:

- The 2017/2018 financial year update on the month 3 financial position (at 30 June 2017) and the projected outturn (at 31 March 2018).
- The significant level of savings required during the period 2017/18 to 2020/21 to deliver a balanced recurrent economy budget.
- 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)**

| | |
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| **Budget Allocation (if Investment Decision)** | Details contained within the report |
| **CCG or TMBC Budget Allocation** | Details contained within the report |
| **Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration** | Details contained within the report |

| | |
|---|---|
| **Decision Body – SCB, Executive Cabinet, CCG Governing Body** | Details contained within the report |
| **Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons** | Details contained within the report |

**Additional Comments**

This report provides the consolidated financial position statement of the 2017/18 Care Together Economy for the period ending 30 June 2017 (Month 3 – 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 the Clinical Commissioning Group 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 the Clinical Commissioning Group.

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| **Legal Implications:**<br><br>**(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. |

| | |
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| **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 30 June 2017 (Month 3)

22 August 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 (M3) | | | Year End | | | Movement | |
|---|---|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | Budget | Forecast | Variance | Previous Month | Movement in Month |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Single Commission | 125,057 | 125,039 | 18 | 486,227 | 497,176 | (10,949) | (6,783) | (4,166) |
| ICFT | (6,781) | (6,993) | (212) | (24,506) | (24,506) | 0 | 0 | 0 |
| **Total Whole Economy** | **118,276** | **118,046** | **(194)** | **461,721** | **472,670** | **(10,949)** | **(6,783)** | **(4,166)** |

| **Single Commission - Risk Share** | £'000 | £'000 | £'000 |
|---|---|---|---|
| TMBC - Non Recurrent Contribution | (5,000) | (5,000) | 0 |
| TMBC | (4,739) | (309) | (4,430) |
| CCG | (1,210) | (1,474) | 264 |
| **Total** | **(10,949)** | **(6,783)** | **(4,166)** |



The 2017/18 financial position across the health and social care economy is shown in the table above. The projected year end deficit across the economy is currently £10.949m:

- 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 £18m of savings, which we are certain of meeting. Leaving £5.86m still to be delivered. There is significant risk attached to fully realising this residual target.
- Children's Services – Please see appendix 4.
- 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 (M3) | | | Year End | | | Movement | |
|---|---|---|---|---|---|---|---|---|
| Description | Budget | Actual | Variance | Budget | Forecast | Variance | Previous Month | Movement in Month |
| Acute | 49,945 | 50,116 | (171) | 203,584 | 204,041 | (457) | (20) | (437) |
| Mental Health | 7,388 | 7,652 | (264) | 29,483 | 30,462 | (978) | (0) | (978) |
| Primary Care | 20,457 | 19,915 | 542 | 83,771 | 83,714 | 57 | 55 | 1 |
| Continuing Care | 3,420 | 4,703 | (1,283) | 13,671 | 16,887 | (3,217) | 69 | (3,286) |
| Community | 6,857 | 6,686 | 171 | 27,455 | 27,616 | (161) | (69) | (92) |
| Other | 8,058 | 7,252 | 805 | 21,520 | 16,764 | 4,756 | (35) | 4,792 |
| QIPP | 0 | 0 | 0 | 0 | 5,860 | (5,860) | (6,840) | 980 |
| CCG Running Costs | 1,572 | 1,372 | 200 | 5,171 | 5,171 | 0 | 0 | 0 |
| **CCG Expenditure** | **97,697** | **97,697** | **0** | **384,655** | **390,515** | **(5,860)** | **(6,840)** | **980** |
| **CCG Surplus** | **4,261** | **4,261** | **0** | **7,174** | **7,174** | **0** | **0** | **0** |



For 2017/18 the CCG has an allocation of £384.655m, from this baseline the CCG is expected to:

- Deliver a surplus of 1% against opening allocation (£3.496m), plus carry forward of £3.678m from 16/17
- Achieve a £23.900m 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

As things stand the CCG still needs to find £5.860m of additional savings in order to fully address the QIPP target and meet financial control totals. This is an improvement in the position reported last month of £0.980m. A more comprehensive exploration of QIPP performance is included later in this report.

The table to the right details the financial position at M3 by directorate. Highlights include:

- **ICFT Contract:** The ICFT is coded across more than one cost centre to allow the CCG to comply with central reporting requirements to report acute and community expenditure separately. Payment has been agreed on a block basis for 17/18 and as such there will be no variance against budget reported as a result of changes in activity. This contractual arrangement has enabled the CCG to report fully realisable QIPP savings of £4.4m in relation to the ICFT contract.

  Nevertheless, activity data is still being reported. There has been a significant increase in emergency activity at Tameside in month 2, whether this is an abnormal spike or the start of a more permanent trend will become apparent in the coming months.

  But these pressures in non-elective care are offset by reductions in outpatient and elective/day case activity; in turn these are driven by a decrease in referrals and in particular referrals from GPs. If we look at referrals in March & April of 2017, we see a total reduction in referrals to the ICFT of 11.6% when compared to the same period in 2016.

  Had we been on a PbR based cost and volume contract, the net impact of the activity changes above would be an underspend of £0.711m.

- **Acute**: We have received pre reconciliation data for M2 from providers, this data is likely to change once the final post reconciliation adjustments have been made.

  At month 2 we have transacted contract variations in relation to Specialist Identification Rules which has seen a change in the responsible commissioner for a number of procedures (mainly spinal surgery and neurology). This has seen the value of our contract with Salford Royal FT increase by £1.2m. We have subsequently received an IAT for £1.2m from NHSE, which has been recognised in the YTD and forecast positions.

  We have recognised a £0.051m YTD pressure at the Christie within elective and day cases procedures, this has been escalated to GM level as a number of CCGs are seeing similar surges in activity.

*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

We have also recognised pressures at South Manchester and Stockport in relation to high cost patients and long stay critical care admissions.

| £000's | Annual Plan | YTD Plan | YTD Actual | YTD Variance |
|---|---|---|---|---|
| Central Manchester | 22,192 | 3,573 | 3,502 | 71 |
| Salford | 4,826 | 786 | 796 | -10 |
| Stockport | 10,500 | 1,706 | 1,733 | -28 |
| South Manchester | 6,582 | 1,062 | 1,157 | -95 |
| Wrightington | 975 | 151 | 167 | -17 |
| Pennine Acute | 3,763 | 610 | 566 | 44 |
| Bolton | 81 | 14 | 14 | 0 |
| | **48,919** | **7,901** | **7,936** | **-35** |

The CATS service currently forecasts £0.140m over planned levels. This is in recognition of recent increased referrals into the MSK service and the noted significant OPFA' who are entering the service. Whilst this is good news due to the fact that the CATS cost is less, at 75% of PbR tariff, the corresponding activity reduction is noted in the ICFT block contract and therefore cannot be recognised as a financial benefit. This will continue to be closely monitored over the coming months.

- **Mental Health:** Out of area MH placements are managed by the individual commissioning teams and fall within the scope of the CHC recovery plan.

  The pressures reported in the mental health directorate are all related to this review and will contribute towards achievement of the Mental Health Investment Standard.

- **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. We have reviewed M1 data and have realised a QIPP saving of £0.850m in relation to April. We will continue to monitor PMD data and will release more money to QIPP as appropriate. There are also some emerging national concerns regarding CAT M drugs which is being investigated.

- **Continuing Care**: A detailed financial recovery plan for CHC will be presented to finance committee in July. The Individualised Commissioning Team have cleansed a significant part of the database and found significant pressure against the previously reported position.

  Although there is still ongoing work to further refine the data, it is now clear that CHC spend in 16/17 was 14% higher than 15/16 on a like for like basis. In light of the recovery plan and close scrutiny CHC is currently receiving, we do not anticipate that this trajectory will continue into 17/18, but nevertheless the forecast from the cleansed Individualised Commissioning database shows a pressure in excess of £4m against budget for 17/18 (of which around £1m links to OOA MH placements).

  Indications are that faster growth has been experienced in volume of fast track, learning disabilities and mental health patients. Early indications also suggest a significant movement of patients between different settings in the health economy being behind growth in the number of individualised commissioning patients. Further work is being undertaken to establish the impact of this movement.

- **Community:** There is an £0.088m pressure on the Wheelchair contract within Community due to the new contract value budget being set without VAT. The CCG are consulting with our VAT liaison provider to establish if this is payable or not. This has been assumed to be payable at M3 forecast to be prudent.

- **Other:** At M3 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.

- **Transformation Funding:** The first tranche of 17/18 Transformation Funding from GM Devolution has been received in M3. This is the first quarter's allocation. The funding is allocated directly to schemes so the funding will transfer to TGICFT.

- **CCG Running Costs**: To date £0.427m 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, £9.51m (40%) of the required savings have been banked in the first quarter of the year. This puts us slightly ahead of trajectory on a YTD basis.
- In addition to this there is a further £8.52m, which we are completely confident of realising in future months. This leaves savings of £5.86m still to find.
- After optimism bias we anticipate making further savings of £3.38m from schemes currently rated as amber or red. This leaves post optimism savings still to find of £2.47m.
- While this is an improvement since last month, it needs to be put into context against the £4m pressure in relation to CHC. There is still significant risk to fully achieving the QIPP target in 2017/18.
- 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.
- £13.21m (55%) of the expected savings will be delivered on a recurrent basis, contributing toward closing the recurrent £70m 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 | 3,040,926 | 2,428,000 | 5,468,926 | 5,450,902 | 18,024 |
| A | 5,434,031 | 240,000 | 5,674,031 | 6,669,067 | -995,036 |
| G | 4,681,625 | 3,843,560 | 8,525,185 | 8,277,443 | 247,743 |
| B | 5,509,760 | 4,004,733 | 9,514,493 | 8,783,031 | 731,462 |
| | **18,666,342** | **10,516,293** | **29,182,635** | **29,180,442** | **2,193** |

**Expected Savings (after application of optimism bias)**

| | Recurrent | Non Recurrent | Total | Prior Month | Movement |
|---|---|---|---|---|---|
| R | 304,093 | 242,800 | 546,893 | 545,090 | 1,802 |
| A | 2,717,016 | 120,000 | 2,837,016 | 3,334,534 | -497,518 |
| G | 4,681,625 | 3,843,560 | 8,525,185 | 8,277,443 | 247,743 |
| B | 5,509,760 | 4,004,733 | 9,514,493 | 8,783,031 | 731,462 |
| | **13,212,493** | **8,211,093** | **21,423,586** | **20,940,097** | **483,489** |

| | | | |
|---|---|---|---|
| **QIPP Target** | **23,900,000** | **23,900,000** | **0** |
| **Savings Still to find** | **2,476,414** | **2,959,903** | **-483,489** |

*Value of savings about which we are certain (i.e blue & green schemes)* 18,039,678

# Tameside MBC

| | Year to Date (M3) | | | Year End | | | Movement | |
|---|---|---|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's |
| Description | Budget | Actual | Variance | Budget | Forecast | Variance | Previous Month | Movement in Month |
| Adult Social Care & Early Intervention | 10,005 | 9,978 | 27 | 49,672 | 49,565 | 107 | 0 | 107 |
| Childrens Services, Strategy & Early Intervention | 7,240 | 8,539 | (1,299) | 35,192 | 40,388 | (5,196) | 0 | (5,196) |
| Public Health | 8,825 | 8,825 | 0 | 16,708 | 16,708 | 0 | 0 | 0 |
| **TMBC Sub Total *** | **26,070** | **27,342** | **(1,272)** | **101,572** | **106,661** | **(5,089)** | **0** | **(5,089)** |

**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**

- Please see appendix 4

**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 was 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 | 50,947 | 51,486 | 539 | 204,752 | 204,752 | 0 |
| Expenditure | 55,522 | 56,184 | 662 | 224,864 | 224,864 | 0 |
| EBITDA | (4,575) | (4,698) | (123) | (20,112) | (20,112) | 0 |
| Financing | 2,206 | 2,295 | 89 | 4,394 | 4,394 | 0 |
| Normalised Surplus/(Deficit) | (6,781) | (6,993) | (212) | (24,506) | (24,506) | 0 |
| Exceptional Items | 0 | 42 | 42 | 159 | 159 | 0 |
| Net Deficit after Exceptional Costs | (6,781) | (7,035) | (254) | (24,665) | (24,665) | 0 |

**Financial Position**

- For Quarter 1, the ICFT is delivering a deficit of £7m, which is £0.3m worse than plan
- The Trust has agreed to report a detailed forecast with its regulator at Month 6 and is therefore showing breakeven. Key risks include:
  - Delivery of the £10.4m, Trust Efficiency Programme.
  - Referrals from associate 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 and the implications of IR35
  - 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.
- Delayed Transfers of Care and consequential impact on being able to close beds.

**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 (M3) | | | Year End | | | Movement | |
|---|---|---|---|---|---|---|---|---|
| Description | Budget | Actual | Variance | Budget | Forecast | Variance | Previous Month | Movement in Month |
| Acute | 49,945 | 50,116 | (171) | 203,584 | 204,041 | (457) | (20) | (437) |
| Mental Health | 7,388 | 7,652 | (264) | 29,483 | 30,462 | (978) | (0) | (978) |
| Primary Care | 20,457 | 19,915 | 542 | 83,771 | 83,714 | 57 | 55 | 1 |
| Continuing Care | 3,420 | 4,703 | (1,283) | 13,671 | 16,887 | (3,217) | 69 | (3,286) |
| Community | 6,857 | 6,686 | 171 | 27,455 | 27,616 | (161) | (69) | (92) |
| Other | 8,058 | 7,252 | 805 | 21,520 | 16,764 | 4,756 | (35) | 4,792 |
| QIPP | 0 | 0 | 0 | 0 | 5,860 | (5,860) | (6,840) | 980 |
| CCG Running Costs | 1,572 | 1,372 | 200 | 5,171 | 5,171 | 0 | 0 | 0 |
| **CCG Sub Total** | **97,697** | **97,697** | **0** | **384,655** | **390,515** | **(5,860)** | **(6,840)** | **980** |
| Adult Social Care & Early Intervention | 9,996 | 9,978 | 27 | 49,672 | 49,565 | 107 | 57 | 50 |
| Childrens Services, Strategy & Early Intervention | 8,539 | 8,539 | (1,299) | 35,192 | 40,388 | (5,196) | 0 | (5,196) |
| Public Health | 8,825 | 8,825 | 0 | 16,708 | 16,708 | 0 | 0 | 0 |
| **TMBC Sub Total** | **27,360** | **27,342** | **(1,272)** | **101,572** | **106,661** | **(5,089)** | **57** | **(5,146)** |
| **GRAND TOTAL** | **125,057** | **125,039** | **(1,272)** | **486,227** | **497,176** | **(10,949)** | **(6,783)** | **(4,166)** |
| | | | | | | | | |
| **A: Section 75 Services** | **70,872** | **71,513** | **(641)** | **267,185** | **271,545** | **(4,359)** | | |
| CCG | 52,155 | 52,803 | (649) | 202,241 | 206,646 | (4,404) | | |
| TMBC | 18,718 | 18,710 | 8 | 64,944 | 64,899 | 45 | | |
| **B: Aligned Services** | **45,963** | **45,537** | **425** | **185,692** | **191,919** | **(6,227)** | | |
| CCG | 37,321 | 36,905 | 415 | 149,064 | 150,157 | (1,093) | | |
| TMBC | 8,642 | 8,632 | 10 | 36,628 | 41,762 | (5,134) | | |
| **C: In Collaboration Services** | **8,221** | **7,988** | **233** | **33,349** | **33,712** | **(363)** | | |
| CCG | 8,221 | 7,988 | 233 | 33,349 | 33,712 | (363) | | |
| 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. The first £2m was received in June.

| 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 | A |
| 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 | 3 | 12 | A |

# Section 2

# Appendices

# Tameside MBC – Capital

| Scheme | Approved Capital Total Scheme Budget | Approved 2017/2018 Allocation | Expenditure to Month 3 | 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 | 51 | 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 | 21 | 10,174 | 0 | **Active Dukinfield (ITRAIN)** - The scheme is complete and the facility fully operational.<br>**Active Longendale (Total Adrenaline)** - The scheme is complete and the facility fully operational.<br>**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.<br>**Denton Wellness Centre** – Key Decision taken in April 2017 which approved the project and associated timescale.<br>**Medlock Roof -** Works now complete.<br>**Wave Machine Replacement at Active Hyde -** Work to be undertaken to concide with the Pool extension scheme.<br>**Pitch Replacement Scheme at Active Copley** - Works completed. |
| Adult Services - Disabled Facilities Grant - Adaptations | 2,950 | 2,950 | 346 | 2,200 | 750 | |
| Total | 24,130 | 13,249 | 418 | 12,499 | 750 | |

# 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.<br>Caseload reviews completed |
| System Wide Self Care | Delivery commenced 1 April 2017 in Glossop.<br>Tender launched 31 March 2017 for Tameside |
| Flexible Community Beds | Grange View contract ended 30 June. Service transferred to ICFT on 1 July. |
| Home Care | In Development |
| Organisational Development | Economy OD engagement events taken place.<br>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 | 3,328,994 | 1,109,665 | 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 | 1,141,374 | 554,443 | 735,218 | 85,315 | 2,516,350 | 1,211,892 | 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 | 0 | 296,193 | 996,193 | 646,193 | 994,000 |
| Corporate | 0 | 645,450 | 64,413 | 427,137 | 1,137,000 | 814,275 | 1,137,000 |
| Other | 1,000,000 | 418,798 | 524,000 | 262,913 | 2,205,711 | 1,096,312 | 2,205,711 |
| Reserves | 0 | 0 | 3,843,560 | 2,741,820 | 6,585,380 | 6,585,380 | 804,938 |
| **Grand Total** | **5,468,926** | **5,674,031** | **8,525,185** | **9,514,493** | **29,182,635** | **21,423,586** | **23,900,000** |

| 2017/18 QIPP (£) | R | A | G | B | Grand Total | Expected Saving |
|---|---|---|---|---|---|---|
| Non Recurrent | 2,428,000 | 240,000 | 3,843,560 | 4,004,733 | 10,516,293 | 8,211,093 |
| Recurrent | 3,040,926 | 5,434,031 | 4,681,625 | 5,509,760 | 18,666,342 | 13,212,493 |
| **Grand Total** | **5,468,926** | **5,674,031** | **8,525,185** | **9,514,493** | **29,182,635** | |

**Notes:**

Blue: Schemes where savings which have already been realised.
Green: Savings we are absolutely confident of realising in future months, 100% expected saving assumed.
Amber: Moderate risk attached to achievement of benefit. 50% realisation assumed for expected savings.
Red: Schemes with high risk of not achieving. 10% realisation assumed in expected savings calculation.

Green and blue schemes total £18.040m against a QIPP target of £23.900m . This leaves a sum of £5.860m to be delivered (as per the month 3 CCG summary table on slide 4).

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

**Children's Services – 2017/18 Qtr 1 Projected Outturn Revenue Monitoring**
**Projected Outturn Variation + £ 5.196 million**

Children's services has been subject to an unprecedented demand on service provision since the 2017/18 Council budget was approved on 28 February 2017.

Despite the inclusion of £ 9.3 million additional funding in 2017/18, there is currently a £ 5.2 million projection of net expenditure in excess of revenue budget provision by 31 March 2018.

£ 5.0 million of the projected additional net expenditure relates to placements within independent sector provision. It is currently estimated that there will be an additional 68 children in need of placements over and above the number of placements estimated when the 2017/18 budget was approved in February.

The analysis of the additional placements is per table 1 below.

**Table 1**

| Independent Sector Placement | Projected Additional Placements 2017/18 | Average Rate Per Week £ | Projected Additional Cost in 2017/18 £'000 |
|---|---|---|---|
| Fostering | 35 | 773 | 1,407 |
| Residential | 16 | 3,300 | 2,746 |
| 16 + | 11 | 975 | 558 |
| Unaccompanied Asylum Seeking Children | 6 | 773 | 241 |
| **Total** | **68** | | **4,951** |

Whilst Tameside MBC is a member of the Placements North West commissioning arrangements, which seeks to minimise the market spend, it is currently the case that the framework prices are sometimes being exceeded across all local authority areas. Providers increasingly charge additional fees for, e.g. 1-1 care of a complex child or additional therapeutic input where that is a part of the care plan. The lack of available placements also drives the market price up.

It should be noted that the weekly placement cost for children placed in external residential care can exceed £ 3,000 per week. A continual review of external placements is facilitated to ensure children are receiving the appropriate care and support which has been commissioned together with the

opportunity to reduce the fees levied for the care and support provided. This is co-ordinated by the Placement Panel which is chaired by Assistant Director, Children, and includes finance and commissioning in the membership.

The £ 9.3 million additional investment referred to earlier included investment to support the recruitment of additional Social Workers to support the increased demand in caseloads.

The initial 2017/18 budget assumed whole service caseloads of 2,050. The number of caseloads had increased to 2,632 by 30 June 2017.

It should also be noted that the number of children looked after within these caseload totals has increased from 485 at December 2016 to 530 by June 2017, an increase of 45. This increase is reflected within the analysis provided with table 1.

The projected expenditure includes provision for 54 whole time equivalent temporary Social Workers recruited via independent agencies. The Council has a strategy to reduce the number of Social Workers on independent agency contracts onto permanent contracts to improve the quality and stability of the establishment. There is also an average annual cost saving of approximately £ 6,500 per employee when comparing permanently employed Social Workers to those employed via an independent agency.

A group to review the Borough wide Early Help offer is being led by the Director of Population Health and seeks to reduce demand for service in the medium term. In the immediate, the service has and will be implementing initiatives to intervene early with families, reduce service demand together with associated ongoing expenditure.



These initiatives include :

- Edge of care service to work with families beyond standard working hours and offer direct intervention earlier in the life of the problem to avoid admission to care.

- Recruitment of in borough foster carers. Currently the service is predicting a net gain of 9 fostering households in 2017-8. As part of the regional You Can Foster collaboration which will see a major advertising campaign in the autumn along with additional capacity in the fostering team which is in place in preparation, we anticipate this figure should grow further.

- Family group conferencing service has been running since quarter 3 of 2016-7 and is demonstrating clear success and efficacy. The service has a clear expansion plan to ensure maximum usage.

- From care to success. The transitions team to support our care leavers is in place and working well to ensure that care leavers are well prepared for adulthood and minimise the risk of future involvement. The team is working well with housing providers and partner agencies.

There are stringent monitoring arrangements and procedures in place relating to the performance and the associated budget of the service. A further update on the projected 2017/18 budget position at 31 March 2018 will be reported to the Executive Cabinet during the autumn of 2017.

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| **Report to:** | **SINGLE COMMISSIONING BOARD** |
| **Date:** | 22 August 2017 |
| **Officer of Single Commissioning Board** | Councillor Jim Fitzpatrick – First Deputy (Performance and Finance)<br>Stephanie Butterworth – Director of Children's and Adults |
| **Subject:** | **UPDATE ON CHILDREN'S SERVICES INSPECTION** |
| **Report Summary:** | The report updates the Single Commissioning Board of the progress to date following the Ofsted Inspection in September 2016. |
| **Recommendations:** | The Single Commissioning Board is asked to:<br>• Note the progress update and the contents of the attached letters from Ofsted in relation to the Ofsted monitoring visits of March and June 2017.<br>• Support the delivery of the 12 week action plan. |
| **Financial Implications:**<br>**(Authorised by the statutory Section 151 Officer & Chief Finance Officer)** | The Single Commissioning Board are reminded to note that the Children's Services Improvement Plan is supported by additional investment included within the 2017/18 Council Budget Report approved by the Council on 28 February 2017. Recurrent budget provision of £6 million is within the Children's service budget from 1 April 2017 to support the additional demands on service provision together with investment previously approved by the Executive Cabinet on 14 December 2016. This investment included the family group conferencing, edge of care and care to success initiatives.<br>The Single Commissioning Board members are also reminded to note that an additional non-recurrent sum of £6 million is also included within the service budget over the medium term to facilitate service improvement initiatives. These improvements include a review of service provision pathways and the associated business processes and system infrastructure together with additional capacity to improve the development of the service workforce.<br>Investment at these levels is clearly not sustainable in the context of declining Council resources. It is therefore essential that the service identifies how expenditure can be reduced over the medium to longer term. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | Tameside Children's Service need to continue to develop and implement the improvement programme to ensure that the necessary improvements are made. Failure to do so will result in risk to children and families of poor outcomes and unsatisfactory quality of life with the subsequent reputational risk that poses to Tameside Council and partners. As set out in 'Putting Children First' all local authorities that are rated inadequate by Ofsted for their children's services go into intervention. Failure to respond effectively could lead to escalation of the intervention. |

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| **How do proposals align with Health & Wellbeing Strategy?** | This paper feeds into the ongoing links between the Tameside Safeguarding Children Board and the Health and Wellbeing Board. |
| **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. Providing the best start for children supports these objectives. |
| **Recommendations / views of the Professional Reference Group:** | This report has not been presented to the Professional Reference Group. |
| **Public and Patient Implications:** | None. |
| **Quality Implications:** | None specific although quality of work continues to be key to the improvement journey. |
| **How do the proposals help to reduce health inequalities?** | N/A |
| **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?** | As per the main report. |
| **What are the Information Governance implications? Has a privacy impact assessment been conducted?** | There are no information governance implications within this report. |
| **Risk Management:** | The Improvement plan seeks to mitigate the risks inherent. |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting the report writer Stephanie Butterworth by:<br>  Telephone: 0161 342 2163<br>  e-mail: stephanie.butterworth@tameside.gov.uk |

## 1.0 BACKGROUND

1.1 This report summarised the update on the progress, it also details the findings of the monitoring visit of June. The letter from this monitoring visit – attached at **Appendix 1** – was published on the Ofsted website on 6 July 2017.

1.2 During each monitoring visit Ofsted focus on a specific area, as clearly it is not possible for them to inspect the whole service over a period of one and half days. At this monitoring visit the inspectors reviewed the progress made, with a particular but narrow focus on assessment work in the safeguarding and duty teams.

1.3 Ofsted considered a range of evidence, including electronic case records of four children and a further sample of approximately 10 cases, some supervision files and notes, and observation and discussion with six social workers, two team managers and senior managers.

## 2.0 PROGRESS AND ACHIEVEMENTS

2.1 Whilst challenges remain in the improvement process improvement work has been continuing at pace across the service. The section below highlights some of the key achievements and progress since Ofsted's inspection report was first published in December 2016:

- Creation of Improvement Board with an Independent Chair and full membership from across the whole system, including DfE. This Board tests the progress against the Improvement Plan and the responsibilities of all partners.

- Improvements to hub acknowledged in 1st monitoring visit (letter attached at **Appendix 2**); including timely decisions, appropriate application of thresholds, and the elimination of backlogs within the hub. Further improvements include:
  - An Independent Reviewing Officer is now located in the Hub to support Child Protection processes;
  - Appointment of education link officer for the hub serve as a point of contact for schools and other educational settings.

- Joint work with schools, e.g. Droylsden Academy, to share understanding and response to children and young people in need of support.

- Ofsted acknowledge progress on the use of performance data including:
  - Improved scrutiny of performance data and a clearer understanding of service provision;
  - Improved identification of areas of concern and better understanding of many areas of performance.

- "Getting to Good" monthly development meetings – focusing on the actions that need to be undertaken to achieve a 'good' Ofsted rating.

- Governance Visits are now well established and providing crucial feedback and strengthening management oversight.

- Dedicated time for teams to work outside the office on specific tasks that support service improvement.

- Introduced the role of Consultant Social Worker alongside Head of Service for Quality. The consultant Social Worker role is focused initially on supporting and developing Newly Qualified Social Workers on Assisted and Supported Year in Employment.

- In duty and safeguarding teams there has been an increase in the number of social workers from 82 to 117 enabling the creation of a 4th team and increased capacity to respond to demand. The rolling recruitment process is continuing to support a continued increase in numbers to meet demand, reduce reliance on agency staff and increase workforce stability. The recruitment of appropriately qualified and skilled staff will reduce the average caseloads to an acceptable level.

- Research in Practice working with Tameside to support practice development of children's social workers through the delivery of a three day practice development programme focused on three topic areas: Understanding the Child's World, Critical thinking in assessment and assessing and enabling parental capacity.

- Launch of Neglect Strategy and promotion of the Graded Care Profile – June 6 2017.

- Early Help attachment Service offering training to all social workers and surgeries with the Looked After Children psychologist on a monthly basis from July.

- Early Years Provider Development Team has seen the uptake of 2 year funding for child care provision increase from just over 50% to 97% for the spring term.

- Children's homes have had inspections by Ofsted and achieved positive results:
  - Boyd's Walk – "Outstanding with sustained effectiveness"
  - Clough Fold – "Good with improved effectiveness"

- Innovative use of social media and residential settings including: residential settings using Social Media and other tools such as Facebook and Survey Monkey to communication with Young People in a manner they are comfortable with. This includes weekly positives, house rules resources and weekly activities.

## 3.0 TWELVE WEEK ACTION PLAN

3.1 In response to the findings from the second Ofsted monitoring visit a 12 week action plan has been developed. This sets out a planned escalation to our improvement work, to build on the progress made to date and to accelerate our improvement journey. The 12 week action plan is attached at **Appendix 3.** The Single Commissioning Board will note that we are half-way through the 12 week period with significant progress having been made.

3.2 The action plan does not replace the existing improvement plan rather it draws out a number of specific actions to be delivered over the next 12 weeks (July – September 2017) that will ensure progress against, and achievement of, the most time critical elements of the improvement plan – that will have greatest immediate impact. There is a key focus on ensuring compliance, continuing recruitment of appropriately skilled staff which in turn will impact on the caseload numbers and continuing the work on improving quality to remove variance.

3.3 This set of deliverables will be actively monitored for direct impact on practice improvement on a fortnightly basis (using an agreed set of key metrics) with a view to it having a direct and measurable impact on the quality of social work practice by September 2017.

3.4 Whilst significant challenges remain monitoring show an improving trajectory in a number of areas. These include:

- Key weekly compliance indicators show that performance has begun to recover with an improving trajectory on timeliness indicators. Provisional monthly data for July 2017 shows the proportion of Child and Family Assessments completed within 46 working days at the highest level since May 2016 (77% July 17, 79% May 16).

- Looked After Children with current Personal Education Plan recovering from 28.75% at Q3 2016/17 to 60% at quarter 1 and 67% in July 17 (provisional data)
- Looked After Children with Statutory Visits up to date 86% in July 17 increased from 81% at quarter 4 16/17.
- In the context of a 105% increase in the number of referrals meeting the Threshold for social care in 16/17 compared to 15/16, overall caseload levels have reduced with the proportion of social work staff with caseloads over 25 decreasing by 8% to 28% between 6 December 16 and 2 August 17.
- Staff turnover has reduced increasing stability of the services being delivered to children and families. Recruitment activity focused on reducing reliance on agency staff is beginning to impact positively on the numbers of permanent employees in the workforce.
- Threshold guidance revised and relaunched by Tameside Safeguarding Children Boards, multi-agency training sessions have been taking place to support understand and application of thresholds across the system.
- Data and intelligence review underway with learning used to inform ongoing development of future 12 week plans.

## 4.0 NEXT STEPS

4.1 Implementation of the 12 week action plan has commenced from the beginning of July and will be monitored on a weekly basis by the Director of Children's Services (DCS). This includes significant data points which are monitored on a daily or weekly basis as necessary, for example caseload information, compliance with statutory timescales and recruitment data.

4.2 The six-monthly update meeting with Department for Education Advisors took place on 11 July 2017.

4.3 Ofsted have advised that the next monitoring visit will be on 12 and 13 September 2017.

## 5.0 RECOMMENDATIONS

5.1 As set out on the front of the report.

## 6.0 APPENDICES

6.1 The following appendices are attached.

- **Appendix 1** – second monitoring visit letter from Ofsted.
- **Appendix 2** – first monitoring visit letter from Ofsted.
- **Appendix 3** – 12 week action plan.

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6 July 2017

Stephanie Butterworth
Tameside Borough Council
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Tameside
OL6 6DL

Dear Steph

**Monitoring visit of Tameside Borough Council children's services**

This letter summarises the findings of the monitoring visit undertaken on 8 and 9 June 2017. The visit was the second monitoring visit since the local authority was judged inadequate in December 2016. The inspectors were Paula Thomson-Jones HMI and Lolly Rascagneres Ofsted inspector.

The local authority has made only limited progress in the period since the last monitoring visit.

**Areas covered by the visit**

During the course of this visit, inspectors reviewed the progress made in the area of help and protection, with a particular focus on assessment work in the safeguarding duty teams. The visit considered a range of evidence, including electronic case records, supervision files and notes, observation and discussion with social workers, team managers and senior managers. The inspection made a specific recommendation for improvements required in social work assessment. This monitoring visit focused on this, in addition to reviewing progress against the four recommendations considered at the last monitoring visit.

- Ensure that social work assessments include an effective consideration of history and parenting capacity that informs a thorough analysis of risk and ensures that assessments are updated regularly to reflect children's changing needs and circumstances.
- Ensure that all areas of service have staff with a suitable level of qualification and experience for the role that they are required to undertake, and that their workloads are manageable.

- Ensure that action taken by social workers is compliant with statutory guidance, and that the application of thresholds is appropriate in casework with children and families.
- Ensure that the quality assurance of work by senior and middle managers routinely considers the quality of managerial decision making and the application of thresholds at all stages of the child's involvement with the local authority, including contacts in the public service hub.
- Ensure that staff receive high-quality supervision and managerial oversight at a frequency that reflects their skills and levels of experience.

**Overview**

A continued increase in demand for services, compounded by the instability of the workforce and high caseloads, continues to impact on the quality of the service that children and families receive. Despite improvements in the scrutiny of data to understand performance, compliance with statutory requirements remains a challenge. There is a lack of consistent improvement in several key areas, including visits to children who are subject to child protection plans. The recent implementation of a quality assurance framework has resulted in better-quality audit work, but this is not having an impact on the quality of practice. The quality of social work assessment has not improved, resulting in ineffective decision making and planning continuing for many children.

**Evaluation of progress**

Despite securing funding to establish additional posts in the safeguarding duty teams, the actual number of social workers has not increased, and caseloads for most staff remain too high. There continues to be a significant challenge in recruiting and retaining social workers and team managers. Agency staff hold the vast majority of posts and turnover has increased, and 28 social workers have left since January 2017. This has resulted in many children and families experiencing a further change in their social worker during the period of their assessment, and this has caused a delay in service provision, for some. The local authority believes that it understands the reasons for this turnover and is continuing to take steps to improve recruitment, but teams remain vulnerable to instability because of the large numbers of agency staff. The high turnover has resulted in whole caseloads of children, who each need an assessment, being reallocated to new workers who have joined the service. The local authority acknowledges that, because of this volatility of the staffing positon, it needs to improve the systems that are currently in place to ensure that it is safely managing the transfer of work.

Improvement in the scrutiny of performance data has enabled the local authority to have a much clearer understanding of service provision. Clear reporting structures via senior managers and leaders have resulted in an improved identification of areas

of concern and, as a result, the local authority demonstrates a better understanding of many areas of performance.

Despite this scrutiny, a consistent improvement of compliance with key requirements, such as the visits to children and the multi-agency reviews taking place at the right time, has not been achieved. Although there were periods of improvement earlier in the year, the timeliness of visits to children looked after and subject to child protection plans has recently declined. The timeliness of key meetings, such as to convene initial child protection conferences, and reviews for looked after children also significantly deteriorated during April.

The local authority has implemented a revised quality assurance framework that includes senior and political leaders' involvement in governance visits to frontline services and, more recently, a programme of regular case auditing. The eight governance visits undertaken since January have increased leaders' understanding of the challenges faced by frontline staff, and some of the issues identified have resulted in action such as increased business support to teams and the provision of appropriate equipment to support mobile working.

The recent audit programme established in April demonstrates improvement in the quality of case reviews, with a greater focus on the quality of practice and learning rather than just measuring compliance. However, the audits do not always result in clear actions to improve practice, and there is currently no effective system in place to monitor the actions required or ensure that the learning is effective in improving the experiences of children. As a result, some audits identify the work required effectively, yet this does not result in an improvement in the quality of work with children.

The quality of assessment has not improved. The vast majority of assessments do not include an effective consideration of history and parenting capacity that informs a thorough analysis of risk. There has been very little effective work to improve practice, and staff are not clear about how they should use historical information to inform their analysis of adults' capacity to parent or to make change. There is no consistent or effective approach to the analysis of risk and, as a result, decision making is not robust. This means that many children seen during this visit are not receiving services at the appropriate level of need, and some children experience repeated assessments within short periods.

Management oversight is not effective in improving practice. Decisions are often unclear and lack an explanation, even when they appear to disagree with social work recommendations. There is a lack of challenge of poor practice and a lack of consistency between teams across the service. As a result, management oversight is not improving the quality of service that children receive.

Although staff reported feeling well supported, formal supervision is not taking place as regularly as it should and the quality has not improved, with brief records, a lack of follow up on actions and little opportunity for reflection.

While there has been considerable effort and activity to try to improve the service that children receive, the improvement plan has not been translated into a coherent strategy, a well-coordinated service or team planning that is understood by all staff and managers. This, exacerbated by the high staff turnover, means that a lack of understanding remains about the key priorities and practice improvement that are required.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Paula Thomson-Jones

**Her Majesty's Inspector**

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4 April 2017

Stephanie Butterworth
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OL6 6DL

Dear Steph,

**Monitoring visit of Tameside Borough Council children's services**

This letter summarises the findings of the monitoring visit undertaken on 7 and 8 March 2017. The visit was the first monitoring visit since the local authority was judged inadequate in December 2016. The inspectors were Paula Thomson-Jones HMI and Lolly Rascagneres Ofsted Inspector. The local authority has made some progress in the short period since the inspection.

**Areas covered by the visit**

During the course of this visit, inspectors reviewed the progress made in the area of help and protection, with a particular focus on arrangements in the public service hub (the hub) and safeguarding duty teams.

The visit considered a range of evidence, including electronic case records, supervision files and notes, observation and discussion with social workers and managers undertaking referral and assessment duties, and other information provided by staff and managers. In addition, a range of staff were spoken to, including senior and team managers, social workers, other practitioners and administrative staff.

The inspection made some specific recommendations for improvements in the service provided to children in need of help and protection. This monitoring visit focused on four of these:

- Ensure that all areas of service have staff with a suitable level of qualification and experience for the role that they are required to undertake and that their workloads are manageable.

- Ensure that action taken by social workers is compliant with statutory guidance and that the application of thresholds in casework with children and families is appropriate.
- Ensure that the quality assurance of work by senior and middle managers routinely considers the quality of managerial decision-making and the application of thresholds at all stages of the child's involvement with the local authority, including contacts within the public service hub.
- Ensure that staff receive high-quality supervision and managerial oversight at a frequency that reflects their skills and levels of experience.

**Overview**

An increase in staffing has ensured that children referred to the hub are now responded to in a timely way. The employment of more experienced social workers has improved the quality of risk analysis, and work seen during the visit demonstrated that appropriate thresholds are consistently applied. In addition, increased management capacity in the hub has improved the quality and timeliness of decision-making and reduced the delay in children being provided with a service. However, the resulting increase in children requiring assessment is causing caseloads of social workers in the duty teams to continue to be too high, despite an increase in social work posts. The increase in the number of social workers is not yet matched by a corresponding increase in management capacity and, at the time of this visit, management oversight of the work was not effective in the duty teams.

**Evaluation of progress**

The local authority has taken action to increase social work capacity to respond to children referred to children's social care via the hub. A dedicated member of staff now reviews and processes police notifications and, during the monitoring visit, inspectors observed children referred by the police because of incidents of domestic abuse having their needs considered in timely way. There continue to be delays of up to two weeks from when a domestic abuse incident occurs to when the police send notifications to children's social care. This means that, for some children, there can be a delay in receiving a response from social care. Senior managers in the local authority are closely monitoring the level of notifications from the police and are continuing to work with Greater Manchester Police to find a solution to address the delay.

Improvements made in the hub since the inspection mean that the timeliness and quality of the service offered to children have improved. The number of social work posts in the hub has been increased, and the local authority has ensured that these staff are suitably qualified and experienced. Information from social care records and partners is gathered and evaluated to inform timely decision-making. Appropriate application of thresholds means that children who need further assessment receive this. The recent appointment of a permanent team manager in the hub to work

alongside the existing practice manager has also resulted in improved timeliness and quality of management oversight, which is clearly recorded on children's records. These improvements are still at an early stage, and the service continues to be vulnerable to changes in demand and a reliance on a number of agency staff.

When children require further social work assessment, they are transferred quickly to social workers in the safeguarding duty teams. However, differences in the application of thresholds by the two teams result in debate between managers and inconsistent decision-making or outcomes for some children. The local authority is aware and plans to address this issue as part of the work for the planned restructure.

Although the capacity of the safeguarding duty teams has been increased, caseloads in the teams continue to be too high and, for some social workers, have increased since the inspection. Some social workers spoken to during the monitoring visit had up to 53 children on their caseload and, as a result, are under tremendous pressure and are struggling to improve the quality of their work or to record it in a timely way.

Managers ensure that children are allocated a social worker in a timely way and that social workers visit children quickly to ensure their safety and to start assessments of need. However, managers who are currently responsible for up to 13 social workers are not effective in going on to monitor the quality of social work practice. Children's records have evidence of managers having reviewed pieces of work but, in many cases, this has not resulted in appropriate action, and several examples were seen by inspectors of managers authorising inadequate assessments. The local authority is aware that their plans to further increase capacity of staff and managers need to be implemented as quickly as possible to support any further improvement and create the right conditions to enable social workers to deliver good services for children.

Social workers and team managers reported many positive changes since the inspection and that they feel that senior managers and leaders are more willing to consult with them and to listen to their concerns. Social workers reported having regular supervision, but a review of supervision files during the visit did not evidence that this is happening regularly for all staff. This lack of supervision is undermining the work to improve practice and needs significant improvement. The local authority has plans for further supervision training for managers and a renewed supervision policy for implementation in April 2017.

Although some audit work has been undertaken since the inspection, frontline managers have not had training, support or the time to enable them to complete regular audits of casework. Despite oversight by senior managers and coordination by the assistant director, the majority of the case audits reviewed during the monitoring visit were poor. Audits focused on compliance, with little comment about the quality of work and a lack of meaningful feedback for social workers, to support them to improve. In many cases, auditors have not commented on key deficits or

gaps in the service provided and have not evaluated the work done in the context of the impact and outcomes for children.

The local authority has established a head of service post to lead on the development and implementation of an effective quality assurance framework in recognition of the need for improvement. However, in order for any new framework to be effective, the entire senior management team need to ensure that they have a shared and accurate understanding of what good-quality social work practice looks like, in order that they can lead practice improvement effectively.

The local authority is in the very early stages of improving services and has a realistic view of the progress to date. The changes to arrangements at the hub have resulted in children receiving a safer and more effective response than was seen at the time of the inspection, and although the changes are still very new, this is a good first step towards improvement. The plans for reorganisation of teams and additional posts to further increase capacity need to keep pace with increasing demand in order that they address the key challenge of high caseloads and support future improvement in the quality of practice.

I am copying this letter to the Department for Education.

Yours sincerely

Paula Thomson-Jones

**Her Majesty's Inspector**

# TAMESIDE CHILDREN'S SERVICES

## 12 week action plan

This document draws together three key areas of learning and provides clarity about key actions being undertaken in the next 12 week period through July, August and September 2017.

It draws on;

- The Tameside Children's Services Improvement Plan.
- The work of the Tameside Safeguarding Children Board.
- The work of the independently chaired Tameside Children's Services Improvement Board which agreed that reviewing actions on a 12 week cycle was appropriate.
- Advice from the Department for Education advisors to focus on outcomes (direct impact on children) and outputs (data reports which evidence direction of travel). Three clear priorities have been agreed, namely caseloads, complaince and quality of practice.
- Feedback from the OFSTED monitoring visits.

**30 June 2017**

**July to September 2017 Actions**

This delivery document (in part a response to the findings from the Ofsted monitoring visit in June 2017) builds on the existing Tameside Children's Improvement Plan currently in place and sets out a planned escalation to our improvement work.

This set of deliverables will contiunue to be actively monitored to ensure direct impact on both outputs for children and outcomes in data reports building on the key arrangements which we have put in place including performance clinics, practitioner group and whole workforce sessions

| Ref | Activity | Lead | Date |
|---|---|---|---|
| **AP1** | DCS and AED have met with all front line managers and teams to refocus as a priority, the absolute need for compliance with statutory requirements. The key indicators which are the focus in this 12 week period are;<br>• Contacts authorised within 24 hours<br>• Referrals allocated withing 24 hours of receipt<br>• Timeliness of social work assessment<br>• Child in need reviews within timescale<br>• Initial child protection conferences in timescale<br>• Review child protection conferences in timescale<br>• Reviews for Looked After children in timescale<br>• Pathway Plans for care leavers in place<br>• Children and young people are seen at least according to statutory visiting timescales<br>• Implement clear and meaningful visual presentation of team performance and business (i.e. flow) data – e.g. information centres<br>• Showcase the outcomes for children of improved performance | **Stephanie Butterworth**<br>**Dominic Tumelty**<br>**Sarah Dobson** | **Staff session – 28 June**<br>**Performance clinics – 20 July / 17 August / 14 September** |
| **AP2** | Undertake an independent diagnostic to identify key issues and root causes relating to statutory and local compliance and the relationship to quality.<br>The output from the work to provide a root map for changes to compliance and quality processes that will underpin measurable improvements in both areas. | **Dominic Tumelty**<br>**Sarah Dobson** | **July – August 17** |
| **AP3** | Further develop the audit process to ensure and accelerate the translation of an improvement in the quality of audit into a measurable improvement in practice – i.e. learning from audit leading to sustainable improvement in practice.<br>Head of Quality Assurance to roll out the QA framework with particular reference to monitoring of audit outcomes so that they become tangible learning actions that are then followed up and checked for measurable improvement. | **Katherine Mackay** | **July 2017** |

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| | Alongside the practice / operational activity about shared understanding of learning, action and impact to be collated and reviewed by Children's Management Team Head's of Service.<br><br>• Supervision , both frequency and quality<br>• Recording of decisions<br>• Inconsistency of decisions<br>• Quality of assessment<br>• Use of HR proceedures to address deficits | | |
| **AP4** | Undertake a date and intelligence review to develop a clearer understanding of what is driving the increase in demand on services. This will include a review of source and route of cases with a view to ensuring work is being directed to the right places to avoid duplication and/or drift and delay.<br><br>This will also include a wider look at the determinants affecting Tameside as a Borough and the impact of Council wide strategies, e.g poverty<br><br>To include a review of caseloads understanding historical patterns, expected performance and future projections.<br><br>The outputs will inform the development of the early help offer (i.e. reduce demand), review of the Hub and access to protection services (i.e. right work in the right place) and flow through the system (i.e. management of caseloads and compliance with timescales). | **Dominic Tumelty**<br><br>**Sarah Dobson** | **July- August 17** |
| **AP5** | Revise the workforce strategy and develop a specific and measurable action plan to deliver the following by early September 2017:<br><br>• Turnover reduced and stability increased<br>• Induction embedded<br>• Supervision compliance – both completion of supervision and its quality.<br>• Exit interview compliance and learning<br>• Accelerating conversion of quality agency workers to permanent employees<br>• Reduce caseloads overall and ensure caseload allocation effectively matches experience and skills.<br>• Demonstrate that staff sickness levels are stable | **Tracy Brennand**<br><br>**Dominic Tumelty** | **July- August 17** |
| **AP6** | Re-launch and embedded compliance with practice standards across all work streams.<br><br>• Articulate what is acceptable and what is not and monitor<br>• When do we expect to see improvement and by | **Dominic Tumelty** | **July- August 17** |

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| | what degree<br>• Review and bring together once a week for review by Children's Management Team. | | |
| **AP7** | Ensure that the Thresholds Management Group which reports to TSCB and Improvement Board reports in a timely manner on the issues which drive partner referrals, CAF implementation and partner agency training needs | **David Niven**<br><br>**Stewart Tod** | **July 17** |
| **AP8** | Undertake a further comprehensive review of learning from other areas, with a particular focus on those improving following an inadequate judgement to gain qualitative insight into what made the difference and put actions in place.<br><br>Output to be a menu of opportunities and ideas for Children's Services Management (CMT) to adopt and implement. | **Sarah Dobson** | **July 17** |

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| **Report to:** | **SINGLE COMMISSIONING BOARD** |
| **Date:** | 22 August 2017 |
| **Reporting Member / Officer of Single Commissioning Board** | Anna Moloney, Consultant, Public Health |
| **Subject:** | **DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – GOVERNING BODY PERFORMANCE UPDATE** |
| **Report Summary:** | This paper provides the Single Commissioning Board with a quality and performance report for comment.<br><br>Assurance is provided for the NHS Constitutional indicators. In addition Clinical Commissioning Group information on a range of other indicators are included to capture the local health economy position. This is based on the latest published data (at the time of preparing the report). This is as at the end of May 2017.<br><br>The format of this report will include elements on quality from the Nursing and Quality directorate. As this report evolves.<br><br>This report also includes Adult Social Care indicators.<br><br>This evolving report will align with the other Greater Manchester Health and Social Care Partnership and national dashboard reports.<br><br>The following have been highlighted as exceptions:<br>• A&E Standards were failed at Tameside Hospital Foundation Trust.<br>• Diagnostic standard failed.<br>• Ambulance response times were not met at a local or at North West level.<br>• 111 Performance against Key Performance Indicators.<br><br>This report also includes the Quality and safeguarding monthly exception report.<br><br>Attached for info is the Draft Greater Manchester Partnership dashboard and the latest NHS England Improvement And Assessment Framework (IAF) Dashboard. |
| **Recommendations:** | The Single Commissioning Board are asked to note the contents of the performance and quality report. |
| **Financial Implications:**<br><br>**(Authorised by the statutory Section 151 Officer & Chief Finance Officer)** | The updated performance information in this report is presented for information and as such does not have any direct and immediate financial implications. However it must be noted that performance against the data reported here could potentially impact upon achievement of CQUIN and QPP targets, which would indirectly impact upon the financial position. It will be important that whole system delivers and performs within the allocated reducing budgets. Monitoring performance and obtaining system assurance particularly around budgets will be key to ensuring aggregate financial balance. |

| | |
|---|---|
| **Legal Implications:**<br><br>**(Authorised by the Borough Solicitor)** | As the system restructures and the constituent parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all parts to account and understanding best where to focus resources and oversight. This report and framework needs to be developed expediently to achieve this. It must include quality and this would include complaints and other indicators of quality. |
| **How do proposals align with Health & Wellbeing Strategy?** | Should provide check & balance and assurances as to whether meeting strategy. |
| **How do proposals align with Locality Plan?** | Should provide check & balance and assurances as to whether meeting plan. |
| **How do proposals align with the Commissioning Strategy?** | Should provide check & balance and assurances as to whether meeting strategy. |
| ***Recommendations / views of the Professional Reference Group:*** | This section is not applicable as this report is not received by the professional reference group. |
| **Public and Patient Implications:** | Patients' views are not specifically sought as part of this monthly report, but it is recognised that many of these targets such as waiting times are a priority for patients. The performance is monitored to ensure there is no impact relating to patient care. |
| **Quality Implications:** | As above. |
| **How do the proposals help to reduce health inequalities?** | This will help us to understand the impact we are making to reduce health inequalities. This report will be further developed to help us understand the impact. |
| **What are the Equality and Diversity implications?** | None. |
| **What are the safeguarding implications?** | None reported related to the performance as described in report. |
| **What are the Information Governance implications? Has a privacy impact assessment been conducted?** | There are no Information Governance implications. No privacy impact assessment has been conducted. |
| **Risk Management:** | Delivery of NHS Tameside and Glossop's Operating Framework commitments 2016/17 |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting<br><br>Ali Rehman,<br><br>Telephone: 01613663207<br><br>e-mail: alirehman@nhs.net |

## 1. INTRODUCTION

1.1 The purpose of this iterative report is to provide the Board with a quality and performance report for comment. The quality and performance report format aims to provide a dashboard view of indicators and provide exception reporting as appropriate. This evolving report will align with the other Greater Manchester Health and Social Care Partnership and national dashboard reports.

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

1.3 It should be noted that providers can refresh their data in accordance with national guidelines and this may result in changes to the historic data in this report.

## 2. CONTENTS – QUALITY AND PERFORMANCE REPORT

2.1 NHS Tameside & Glossop Clinical Commissioning Group: NHS Constitution Indicators (May 2017).

2.2 Adult Social services indicators. (Quarter 4 2016/17). These will be further expanded on in future iterations of this report.

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

- A&E Standards were failed at Tameside Hospital Foundation Trust;
- Diagnostic standard not achieved;
- Ambulance response times were not met at a local or at North West level;
- 111 Performance against KPIs

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

2.4 This report also includes the quality and safeguarding monthly exception report.

2.5 Greater Manchester Combined Authority / NHS Greater Manchester Performance Report:

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

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

2.6 There are a number of indicators where the Clinical Commissioning Group is deemed to be in the lowest performance quartile nationally. These indicators have been highlighted in light orange on the dashboard and are as follows:

**Better Health**

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

**Better Care**

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

**Sustainability**

- Digital interactions between primary and secondary care.

## 3. KEY HEADLINES-HEALTH

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

**Referrals**

3.2 GP referrals have increased this month compared to last month and have continued to decrease overall and have decreased compared to the same period last year. Other referrals have increased compared to last month and have increased compared to the same period last year. Year to date GP referrals have decreased by 16.7% compared to the same period last year and other referrals have increased by 2.8% compared to the same period last year for referrals at Tameside and Glossop Integrated Care Foundation Trust. Referrals to all providers have decreased by 17.9% compared to the same period last year and other referrals have increased by 6.8%.

**18 Weeks Referral to Treatment Incomplete Pathways**

3.3 Performance continues to be just above the national standard of 92%, currently achieving 92.76% during May. The specialties failing are Urology 86.57%, Trauma and Orthopaedics 90.06%, Ear Nose and Throat 90.59%, Plastic Surgery 72.32% and Cardiothoracic Surgery 87.8%. There were no patients waiting longer than 52 weeks during May.

**Diagnostics 6+ week waiters**

3.4 This month the CCG failed to achieve the 1% standard with a 1.51% performance. Of the 73 breaches 32 occurred at Central Manchester (CT, Colonoscopy, Gastroscopy and MRI), 25 at North West CATS Inhealth (MRI), 5 at Tameside and Glossop Integrated Care Foundation Trust (Audiology assessments, Non obstetric ultrasound and Gastroscopy), 5 at Pioneer healthcare (Neurophysiology), 3 at South Manchester (MRI and Urodynamics), 1 at Pennine Acute (MRI), 1 at Stockport (Urodynamics) and 1 at Salford Trust (Neurophysiology). Central Manchester performance is due to an ongoing issue with endoscopy which Greater Manchester are aware of. Tameside and Glossop Integrated Care Foundation Trust performance is primarily due to audiology struggling with capacity. North West CATS Inhealth performance is as a result of a number of scanner breakdowns. Additional capacity put in place.

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

3.5 The A&E performance for May was 84.5%, which is below the target of 95% nationally. The key issue is medical bed capacity which not only cause breaches due to waiting for beds but the congestion in A&E then delays first assessment. There is still medical cover and specialty delays when teams are in Theatres. The Trust reports acuity is high which can lead to people needing more than 4 hours for a decision to be reached on their care need.

**Ambulance Response Times Across North West Ambulance Service area**

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

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

**111**

3.7 The North West NHS 111 service is performance managed against a range of Key Performance Indicators reported as follows for May:

- Calls Answered (95% in 60 seconds) = 80.86%
- Calls abandoned (<5%) = 6.21%
- Warm transfer (75%) = 46.13%
- -Call back in 10 minutes (75%) = 36.03%

3.8 The benchmarking data shows that the North West NHS 111 service was ranked 38th out of 40 for calls answered in 60 seconds (81%). This is compared to East London and City 111 which is the highest ranked for calls answered in 60 seconds (98%).

3.9 Looking at the dispositions we are also ranked 39th out of 40 for % recommended to dental/pharmacy (3%) compared to the highest ranked provider York and Humber (13%). Percentage recommended home care (3%) we are ranked 38th out 40 compared to the highest ranked provider, North West London (7%).

3.10 In May the North West NHS 111 service experienced a number of issues, which led to poor performance in the month against the four Key Performance Indicators. Performance was particularly difficult to achieve over the weekend periods.

**Cancer**

3.11 All of the cancer indicators achieved the standard during May except 62 day consultant upgrades, where there were 7 breaches. Reasons for the breaches were late CARP referrals and late referrals to The Christie.

**Improving Access To Psychological Therapies (IAPT)**

3.12 Performance continues to be above the Quarterly Standard for the IAPT access rate (75%) achieving 4.09% during Quarter 4. We can report the Quarter 4 performance for IAPT recovery rate remains is now achieving the standard at 50.0%. In terms of IAPT waiting times the Quarter 4 performance is above the standard against the 18 week standard (95%) which was reported as 97.7%. The Quarter 4 performance for the 6 week wait standard (75%) was reported as 79.7%.

**Healthcare Associated Infections**

3.13 Clostridium Difficile: The number of reported cases during May was below plan. Tameside & Glossop Clinical Commissioning Group had a total of 5 reported cases of clostridium difficile against a monthly plan of 9 cases. For the month of May this places Tameside and Glossop Clinical Commissioning Group 4 under plan. Of the 5 reported cases, 2 were apportioned to the acute (1 at Tameside and Glossop Integrated Care Foundation Trust and 1 at Central Manchester University Hospitals Foundation Trust) and 3 to the non-acute. To date (April to May 2017) Tameside and Glossop Clinical Commissioning Group had a total of 11 cases of clostridium difficile against a year to date plan of 14 cases. This places Tameside and Glossop Clinical Commissioning Group 3 case under plan. Of the 11 reported cases, 4 were apportioned to the acute (3 at Tameside and Glossop Integrated Care Foundation Trust and 1 at Central Manchester Foundation Trust) and 7 to the non-acute. In regards to the 2017/18 financial year, Tameside and Glossop Clinical Commissioning Group have reported 11 cases of clostridium difficile against an annual plan of 97 cases. This currently places the Clinical Commissioning Group 87 cases under plan with 10 months of the financial year remaining.

3.14 MRSA: In May 2017 Tameside and Glossop Clinical Commissioning Group have reported 2 cases of MRSA against a plan of zero tolerance. To date (April to May 2017) Tameside and Glossop Clinical Commissioning Group have reported 2 cases of MRSA against a plan of zero tolerance.

**Mixed Sex Accommodation**

3.15 This month there were no breaches reported against the Mixed Sex Accommodation standard of zero breaches for Tameside and Glossop Clinical Commissioning Group patients.

**Dementia**

3.16 We continue to perform well against the estimated diagnosis rate for people aged 65+ for May which was 83.8% against the 66.7% standard.

## 4. ADULT SOCIAL CARE INDICATORS

**Introduction**

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

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

**Proportion of People Using Social Care who Receive Direct Payments**
**Performance Summary**

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

4.4 Performance in Tameside in 2015/2016 was 15.43% compared to 23.5% regionally and 28.1% nationally.

4.5 Tameside performance in 2016/2017 was 12.47%, which is a reduction of 47 people since 2015/2016.

**Actions**

4.6 Additional Capacity to be provided within the Neighbourhood Teams over a 12-18 month period to carry out an intensive piece of work to promote Direct Payments. This post will be funded from the Adult Social Care transformation funding

**People with Learning Disabilities in Employment**
**Performance Summary**

4.7 The measure is intended to improve the employment outcomes for adults with learning disabilities reducing the risk of social exclusion. There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing and financial benefits.

4.8 Performance in Tameside in 2015/2016 was 2% compared to 4.1% regionally and 5.8% nationally. Tameside performance in 2016/2017 was 4.95%, this is an increase on

2015/2016 and brings us above the regional average for 2015/2016 – we await published Regional and National figures for 2016/2017 to be able to get a true comparison.

4.9 In 2015/2016, six Greater Manchester authorities had less than 3% of People with Learning Disabilities in Employment, with only Trafford, Stockport and Rochdale achieving above 4%. Nationally and regionally, we are seeing a steady decline in this indicator - 2012/2013 region 5.5%, national 7%.

4.10 Performance in this area has been a concern for some time and has been impacted upon the reduction of the Learning Disability Employment Support Team due to financial restraints.

**Actions**

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

## 5. CONSIDERATIONS OF THE QUALITY AND PERFORMANCE ASSURANCE GROUP

5.1 The Quality and Performance group recommended a systematic review of quality & performance reporting. This is essential to clarify reporting requirements and expectations across the Single Commissioning Board, Clinical Commissioning Group Governing Body and Council Board governance, with a view to minimising duplication and providing assurance at the most appropriate system level.

## 6. RECOMMENDATIONS

6.1 The Single Commissioning Board are asked to note the contents of the performance and quality report, and comment on the revised format.

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# Key Messages

## Positive trends

**18 Weeks RTT Incomplete Pathways:** Performance continues to be above the national standard of 92%, currently achieving 92.4% during May.
**Cancer:** All of the cancer indicators achieved standard during May apart from 62 day consultant upgrades.
**IAPT Access Rate:** Performance continues to be above the Quarterly standard (3.75%) achieving 4.09% during Quarter 4.
**IAPT Waiting Times:** Quarter 4 performance is above standard for 18 week waiting times and 18 week waits is reported as 97.7% (Standard 95%)
**IAPT Waiting Times:** Quarter 4 performance is above the standard for 6 week waiting times. IAPT 6 week waits is reported as 79.7% (standard 75%).
**IAPT Recovery Rate:** Quarter 4 performance was above the standard (50%) achieving 50.0%.
**Dementia:** Estimated diagnosis rate for people aged 65+ for May was 83.8% against the 66.7% standard.
**Referrals:** GP referrals have increased this month compared to last month and have continued to decrease overall and have decreased compared to the same period last year. Other referrals have increased compared to last month and have increased compared to the same period last year.
**18 Weeks RTT 52+ Week Waits:** There were no patients waiting longer than 52 weeks during May.
**Healthcare Associated Infections Clostridium Difficile:** The number of reported cases during May (5) was below plan.

## Challenges

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

**A&E Waits Total Time Within 4 Hours At T&G ICFT:** May performance at Tameside And Glossop Integrated Care NHS FT (T&GICFT) is below the 95% target, at 84.47%. A total of 7,665 patients attended A&E in the month, of which 1194 did not leave the department within 4 hours.
**Ambulance Response Times Across NWAS Area:** Performance against all three response times across the North West Ambulance Service (NWAS) area are worse than the national standards in May. Responses to Red1 and Red2 calls within 8 minutes were below the 75% standard, at 65.92% and 64.43%, respectively. Responses to all Red calls within 19 minutes were also below the 95% standard, at 90.08%.
**111:** The North West NHS 111 service is performance managed against a range of KPIs reported as follows for May:- Calls Answered (95% in 60 seconds) = 80.86%- Calls abandoned (<5%) = 6.21%- Warm transfer (75%) = 46.13% Call back in 10 minutes (75%) = 36.03%
**Diagnostics 6+ Week Waiters:** Performance was higher (worse than) the national standard of 1.00%, currently achieving 1.51% during May.
**Healthcare Associated Infections MRSA:** There have been 2 reported cases of MRSA during May.

# NHS Tameside & Glossop CCG: NHS Constitution Indicators (July 2017)

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

## Better Health

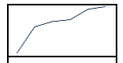
| Description | Indicator | F | Level | Better is... | Threshold | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Exceptions | GM | England | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Utilisation of the NHS e-referral service to enable choice at first routine elective referral | M | T&G CCG | H | | 11.6% | 11.2% | 11.1% | 11.6% | 10.4% | 10.7% | 10.0% | 10.1% | 11.1% | 13.3% | 11.4% | 13.4% | 14.6% | | | 51.1% (Sept) | |
| | Number of women Smoking at Delivery. | Q | T&G CCG | L | England | 13.6% | | 16.9% | | | 15.3% | | | 15.7% | | | | | | 13.3% (Q3) | 10.60% | |
| | Personal health budgets | Q | T&G CCG | H | | 4.0 | | 4.1 | | | 3.6 | | | 5.8 | | | | | | 30 (Q2) | 18.7 (Q2) | |
| | Percentage of deaths which take place in hospital | Q | T&G CCG | <> | | 47.6% | | 49.0% | | | 50.4% | | | | | | | | | 50% (Q4 15/16) | 47.1% (Q1 16/17) | |
| | Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions | Q | T&G CCG | L | | | | | | | | | | | | | | | | | 929 | |
| | Inequality in emergency admissions for urgent care sensitive conditions | Q | T&G CCG | L | | | | | | | | | | | | | | | | | 2168 | |
| | Anti-microbial resistance: appropriate prescribing of antibiotics in primary care | Q | T&G CCG | <> | | | | 1.1 | | | | | | | | | | | | | 1.1 | |
| | Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care | Q | T&G CCG | <> | | | | 7.8% | | | | | | | | | | | | | 9.10% | |
| | Injuries from falls in people aged 65 and over | A | T&G CCG | L | | | 2159 | | | | | | | | | | | | | | 1985 | |

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

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

## Better Care

| Description | Indicator | F | Level | Better is... | Threshold | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Exceptions | GM | England | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer 2 Week Wait | Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP | M | T&G CCG | H | 93% | 97.1% | 96.1% | 94.3% | 94.6% | 95.4% | 96.5% | 97.5% | 98.1% | 94.4% | 95.6% | 95.3% | 95.9% | 94.3% | | 96.90% | 94.00% | |
| | 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% | 98.0% | 95.8% | 94.0% | 96.7% | 97.3% | 100.0% | 100.0% | 98.8% | 100.0% | 93.6% | 98.3% | 98.0% | 99.0% | | 96.30% | 90.50% | |
| 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% | 98.9% | 100.0% | 100.0% | 98.8% | 98.9% | 98.0% | 98.2% | 100.0% | 98.9% | 100.0% | 97.7% | 100.0% | 100.0% | | 97.80% | 97.40% | |
| | 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% | 94.4% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 96.60% | 96.10% | |
| | 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. | 99.60% | 99.30% | |
| | 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% | 96.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100% | 96.60% | |
| 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% | 88.6% | 91.5% | 89.6% | 91.3% | 74.4% | 91.1% | 90.4% | 88.0% | 89.1% | 87.3% | 82.4% | 98.4% | 89.8% | There were 10 breaches out of a total of 39 seen in Sept 16. | 88.30% | 80.80% | |
| | 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% | 60.0% | 100.0% | 100.0% | 100.0% | 100.0% | 92.9% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 90.00% | 92.00% | |
| | Maximum 62 day wait for first treatment following a consultants decision to upgrade the priority of the patients (all cancer) | M | T&G CCG | H | 85% | 86.7% | 94.4% | 82.4% | 100.0% | 53.8% | 78.3% | 94.4% | 78.6% | 75.0% | 87.5% | 85.2% | 86.7% | 69.6% | 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 | 86.50% | 87.00% | |
| 18 Weeks RTT | Patients on incomplete non emergency pathways (yet to start treatment) | M | T&G CCG | H | 92% | 92.5% | 92.4% | 92.4% | 92.1% | 92.1% | 92.1% | 92.7% | 92.6% | 93.0% | 92.6% | 92.6% | 92.4% | 92.8% | CCG target (92%) achieved. Failing specialties are Urology (86.57%), Trauma & Orthopaedics (90.06%), Ear, Nose & Throat (ENT) (90.59%), Plastic Surgery (72.32%), Cardiothoracic Surgery (87.80%). | 92.30% | 90.40% | |
| | Patients waiting 52+ weeks on an incomplete pathway | M | T&G CCG | L | Zero Tolerance | 0 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | In Apr 17 we have 3 over 52 week waiters on an incomplete pathway. 1 at University Hospital South Manchester for 160 plastic surgery and 2 at Central Manchester for X01 Other. The patient waiting under the speciality plastic surgery has now been seen. We are awaiting an update on the other 2. | | 0.04 | |
| Diagnostics < 6 Weeks | Patients waiting for diagnostic tests should have been waiting less that 6 weeks from referral | M | T&G CCG | L | 1% | 1.55% | 2.36% | 1.70% | 1.20% | 1.24% | 1.34% | 1.29% | 1.85% | 1.88% | 1.40% | 0.70% | 0.86% | 1.51% | In May 73 patients (69 patients waiting 6-13 weeks and 4 patients >13 Weeks). | 1.50% | 1.90% | |
| Dementia | Estimated diagnosis rate for people aged 65+ | M | CCG | H | 66.70% | 69.80% | 70.50% | 70.3% | 71.3% | 72.8% | 75.3% | 74.4% | 74.9% | 74.8% | 75.3% | 75.1% | 83.8% | 82.3% | | 77.20% | 67.90% | |
| A&E < 4 Hours | Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department - THFT | M | THFT | H | 95% | 92.2% | 86.5% | 85.0% | 90.5% | 82.7% | 84.1% | 86.6% | 76.2% | 76.7% | 86.9% | 88.3% | 81.7% | 84.5% | 2015-16 performance shows that 12,737 patients waited more than 4 hours (denominator 84,303). Breached by 8,522 patients. June 2016 performance is 86.54% breached by 967 patients. July 2016 performance is 84.98% breached by 1143 patients. August 2016 performance is 90.5% breached by 646 patients. September performance is 82.7% breached by 1224 patients. October performance is 84.1% breached by 1,176 patients. November performance is 86.6% breached by 943 patients. December performance is 76.2% breached by 1703 patients. January performance is 76.7% breached by 1638 patients. February performance is 86.85% breached by 835 patients. March performance is 86.27% breached by 867 patients. 2016-17 performance shows that 12,263 patients waited more than 4 hours (denominator 85,638). April performance is 81.6% breached by 1,279 patients (6,965). May performance is 84.5% breached by 1,194 patients (7,665). | 86.00% | 89.70% | |
| | Delayed transfers of care per 100,000 population | M | T&G CCG | L | | | | | 21.2 | | | 24 | | | | | | | | 16.3 | 15 | |

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral | M | | H | | 45.5% | 62.1% | 65.4% | 66.7% | 73.3% | 75.0% | 89.0% | | | | | | | | 78.0% | 77.20% |  |
| | Achievement of milestones in the delivery of an integrated urgent care service | M | | H | | | | | 4 | | | | | | | | | | | | | |
| IAPT-Improving Access to psychological services | Access | Q | T&G CCG | H | 3.75% | 3.95% | | 3.92% | | | 3.90% | | 4.1% | | | | | | | | 4.12% | |
| | Recovery | Q | T&G CCG | H | 50% | 45.75% | | 46.00% | | | 42.20% | | 50.0% | | | | | | | 47.50% | 50.97% | |
| | Waiting times less than 6 weeks | Q | T&G CCG | H | 75% | 62.75% | | 73.40% | | | 78.40% | | 79.7% | | | | | | | 79.30% | 89.64% | |
| | Waiting times less than 18 weeks | Q | T&G CCG | H | 95% | 91.50% | | 98.60% | | | 100.0% | | 97.7% | | | | | | | 95.40% | 98.81% | |
| | Reliance on specialist inpatient care for people with a learning disability and/or autism | Q | | L | | 62 | | | | | | | | | | | | | | 62 (Q1) | 58 (Q1) | |
| | Emergency admissions for urgent care sensitive conditions | Q | | L | | | | | | | | | | | | | | | | | 2359 | |
| | Population use of hospital beds following emergency admission | Q | | L | | 1.2 | | | | | | | | | | | | | | | 1.0 | |
| | Management of long term conditions | Q | | L | | | | | | | | | | | | | | | | | 795 Q4 15/16 | |
| | People eligible for standard NHS Continuing Healthcare | Q | | H | | 63.9 | | 62.7 | | | | | | | | | | | | 53.5 | 46.2 | |

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

| Description | Indicator | | Level | Better is... | Threshold | 12/13 | 13/14 | 14/15 | 15/16 | | | | | | | | | Exceptions | GM | England | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Neonatal mortality and stillbirths | A | T&G CCG | L | | 6.4 | 7.8 | 7.8 | | | | | | | | | | | 8.0 fy 14/15 | 7.1 FY 14/15 | |
| | Dementia Care Planning and Post-Diagnostic Support | A | T&G CCG | H | | | | 79.4% | | | | | | | | | | | 79.6% FY 14/15 | 77.0% FY 14/15 | |
| | Patient experience of GP services | A | T&G CCG | H | | 85.7% | 83.4% | 81.2% | 83.2% | | | | | | | | | | 85.40% | 83.20% | |
| | Proportion of people with a learning disability on the GP register receiving an annual health check | A | T&G CCG | H | | | 44.6% | 34.0% | | | | | | | | | | | 47.5% FY 13/14 | 37.1% FY 15/16 | |

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

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

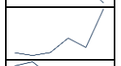
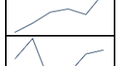
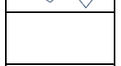
# Better Care - Adult Social Care

| Description | Indicator | F | Level | Better is... | Threshold | 1st Quarter 2016-17 | | 2nd Quarter 2016-17 | | | 3rd Quarter 2016-17 | | | 4th Quarter 2016-17 | | | Exceptions | GM | England * | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | | | | |
| ASCOF 1C - Proportion of people using social care who receive self-directed support, and those receiving direct payments. | **Part 1a - % of service users who receive self directed support** | Q | LA | H | 86.9 | 97.59% | | 97.51% | | | 96.63% | | | 96.15% | | | Cumulative year to date performance reported | - | 86.9 | |
| | **Part 1b - % of carers who receive self directed support** | Q | LA | H | 77.7 | 99.57% | | 99.79% | | | 100.00% | | | 100.00% | | | Cumulative year to date performance reported | - | 77.7 | |
| | **Part 2a - % of service users who are in receipt of direct payments** | Q | LA | H | 28.1 | 14.91% | | 14.74% | | | 13.62% | | | 12.47% | | | Cumulative year to date performance reported | - | 28.1 | |
| | **Part 2b - % of carers who are in receipt of direct payments** | Q | LA | H | 67.4 | 77.87% | | 73.43% | | | 75.93% | | | 95.61% | | | Cumulative year to date performance reported | - | 67.4 | |
| ASCOF 1E - Proportion of adults with learning disabilities in paid employment. | **Total number of Learning Disability service users in paid employment** | Q | LA | H | 5.8 | 1.99% | | 1.92% | | | 1.89% | | | 4.95% | | | Cumulative year to date performance reported | - | 5.8 | |
| ASCOF 1G - Proportion of adults with learning disabilities who live in their own home or with their family. | **Total number of Learning Disability service users in settled accomodation.** | Q | LA | H | 75.4 | 94.69% | | 93.80% | | | 93.90% | | | 93.27% | | | Cumulative year to date performance reported | - | 75.4 | |
| ASCOF 2A - Permanent admissions to residential and nursing care homes, per 100,000 population. | **Total number of permanent admissions to residential and nursing care homes per 100,000 aged 18-64** | Q | LA | L | 13.3 | 1.49 (2 Admissions) | | 2.98 (4 Admissions) | | | 7.44 (10 Admissions) | | | 12.65 (17 Admissions) | | | Cumulative year to date performance reported | - | 13.3 | |
| | **Total number of permanent admissions to residential and nursing care homes per 100,000 aged 65+** | Q | LA | L | 628.2 | 153.87 (59 Admissions) | | 307.75 (118 Admissions) | | | 453.8 (174 Admissions) | | | 628.54 (241 Admissions) | | | Cumulative year to date performance reported | - | 628.2 | |
| | **Total number of permanent admissions to residential and nursing care homes aged 18+** | Q | LA | H | - | 61 | | 122 | | | 184 | | | 258 | | | Cumulative year to date performance reported | - | - | |
| ASCOF 2B - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/ rehabilitation services. | **Proportion of older people (65 and over) who were still at home 91 days after discharge from Hospital** | Q | LA | H | 82.7 | - | | - | | | - | | | - | | | Based on a sample period of discharges from hospital between October - December each year. | - | 82.7 | |
| | **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital compared against the HES data (hospital episode stats)** | Q | LA | H | 2.9 | - | | - | | | - | | | - | | | Based on a sample period of discharges from hospital between October - December each year. | - | 2.9 | |
| Early Help | **Number of people supported outside the Social Care System with prevention based services.** | Q | LA | H | - | 8406 | | 8308 | | | 8180 | | | 7536 | | | Cumulative year to date performance reported | - | - | |
| Helped To Live At Home | **Number of people helped to live at home and remain independent with support from Adult Services in community based services** | Q | LA | H | - | 3027 | | 3000 | | | 3008 | | | 2977 | | | Cumulative year to date performance reported | - | - | |
| Early Help - Re-ablement Services | **% of people completing re-ablement who leave with either no package or a reduced package of care.** | Q | LA | H | - | 85.98% | | 87.76% | | | 87.94% | | | 86.14% | | | Cumulative year to date performance reported | - | - | |
| REVIEWS D40 - Proportion of service users with a completed review in the financial year | **Service users needs change and frequent reviews ensure that they receive services which are suitable for their needs, and that LA's can utilise resources in the most efficient and appropriate way.** | Q | LA | H | - | 22.39% | | 41.09% | | | 62.78% | | | 70.49% | | | Cumulative year to date performance reported | - | - | |

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

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

## Sustainability

| Description | Indicator | F | Level | Better is... | Threshold | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Exceptions | GM | England | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals | GP Referrals-Total | M | T&G CCG | L | | 5494 | 5724 | 5359 | 5142 | 5310 | 5086 | 5192 | 4421 | 5132 | 4951 | 5564 | 4369 | 5087 | Variance from Monthly plan | | |  |
| | Other referrals- Total | M | T&G CCG | L | | 2748 | 2730 | 2751 | 2853 | 2786 | 3060 | 3085 | 2434 | 2822 | 2508 | 3004 | 2496 | 3539 | Variance from Monthly plan | | |  |
| | GP referrals- T&G ICFT | M | T&G CCG | L | | 3971 | 4053 | 3766 | 3452 | 3611 | 3566 | 3673 | 3142 | 3615 | 3469 | 3824 | 3117 | 3600 | Variance from previous year | | |  |
| | Other referrals - T&G ICFT | M | T&G CCG | L | | 1428 | 1521 | 1637 | 1670 | 1612 | 1836 | 1854 | 1431 | 1626 | 1412 | 1725 | 1411 | 1756 | Variance from previous year | | |  |
| Activity | Outpatient Fist Attend | M | T&G CCG | L | Plan | 7137 | 7441 | 6755 | 6903 | 7205 | 7265 | 7606 | 6394 | 6620 | 6406 | 7259 | 5846 | 6885 | Variance from Monthly plan | | |  |
| | Elective Inpatients | M | T&G CCG | L | Plan | 2890 | 3022 | 2871 | 2876 | 2915 | 2956 | 3201 | 2624 | 2778 | 2766 | 3054 | 2611 | 2678 | Variance from Monthly Plan | | |  |
| | Non-Elective Admissions | M | T&G CCG | L | Plan | 2409 | 2314 | 2267 | 2336 | 2244 | 2337 | 2431 | 2444 | 2470 | 2256 | 2390 | 2284 | 2612 | Variance from Monthly Plan | | |  |
| | In-year financial performance | Q | | H | | | | | | | | | | | | | | | | | | |
| | Outcomes in areas with identified scope for improvement | Q | | H | | | | | | | | | | | | | | | | | 58.30% | |
| | Digital interactions between primary and secondary care | Q | | H | | | | 52.6 | | | 53.7 | | | | | | | | | | | |
| | Local strategic estates plan (SEP) in place | A | | H | | Yes | | | | | | | | | | | | | | | | |
| | Financial plan | A | | H | | AMBER | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |

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

## Well Led

| Description | Indicator | F | Level | Better is... | Threshold | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Exceptions | GM | England | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Quality of CCG leadership | Q | | H | | | | | | | | | | | | | | | | | | |
| **Description** | **Indicator** | | **Level** | **Better is...** | **Threshold** | **2012** | **2013** | | **2014** | | **2015** | | | | | | | | **Exceptions** | **GM** | **England** | **Trend** |
| | Staff engagement index | A | | H | | | | | | | 3.9 | | | | | | | | | | 3.8 | |
| | Progress against workforce race equality standard | A | | L | | | | | | | 0.3 | | | | | | | | | | 0.2 | |
| **Description** | **Indicator** | | **Level** | **Better is...** | **Threshold** | **12/13** | **13/14** | | **14/15** | | **15/16** | | | | | | | | **Exceptions** | **GM** | **England** | **Trend** |
| | Effectiveness of working relationships in the local system | A | | H | | | | | | | 66.9 | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |

**Indicates the lowest performance quartile nationally.**

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

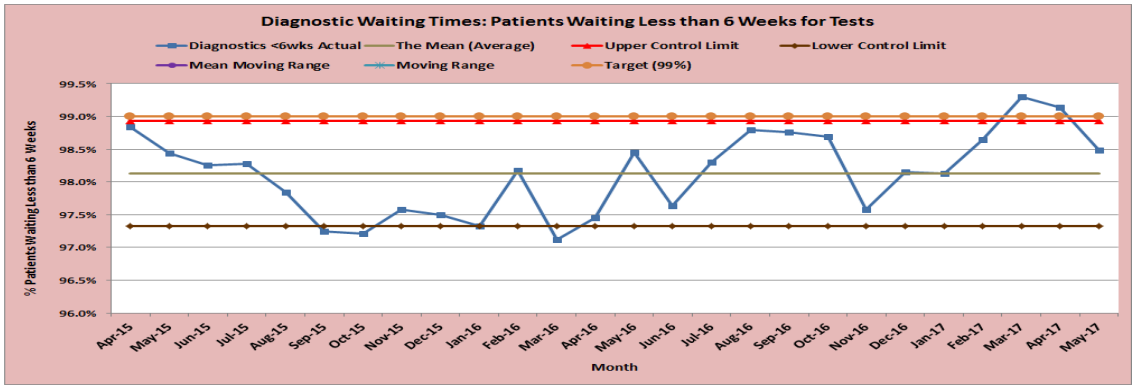
# Other Indicators

| Description | Indicator | F | Level | Better is... | Threshold | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Exceptions | GM | England | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mixed Sex Accommodation** | MSA Breach Rate | M | T&G CCG | L | 0 | 0 | 0.1 | 0.2 | 0 | 0 | 0 | 0.1 | 0 | 0.3 | 0.0 | 0.0 | 0.0 | 0.0 | Total of 1 breach in June 16, 2 breaches in July 16, 1 breach in Nov 16 and 2 breaches in Jan17 for T&G CCG. This is an unjustified mixing in relation to sleeping accommodation. Data shows the breach rate per 1,000 finished consultant episodes. | | 0.48 | |
| **Cancelled Operations (Elective)** | The number of last minute cancelled elective operations in the quarter for non-clinical reasons where patients have not been treated within 28 days of last minute elective cancellation | Q | THFT | L | 0 | 2 | | 0 | | | 0 | | | 0 | | | | | Number of last minute cancellations at THFT;<br>15-16 Q1 = 63, Q2 = 54, Q3 = 86, Q4 = 96<br>16-17 Q1 = 85, Q2 = 60, Q3 = 78 | | 1668 | |
| **Care Programme Approach (CPA)** | The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period | Q | T&G CCG | H | 95% | 94.5% | | 96.7% | | | 100.0% | | | 92.9% | | | | | 16-17 Q1 52 patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care out of a total of 55 patients = 94.5% | | 96.70% | |
| | **Other Indicators** | | | | | | | | | | | | | | | | | | | | | |
| **Other Indicators** | Avoidable admissions- People | | T&G CCG | L | | | | | | | | | | | | | | | | | | |
| | Avoidable admissions-Cost | | T&G CCG | L | | | | | | | | | | | | | | | | | | |
| | Re admissions | | T&G CCG | L | | | | | | | | | | | | | | | | | | |
| | Average LOS | M | T&G CCG | L | | 5.38 | 5.22 | 5.00 | 4.20 | | | | | | | | | | | | | |
| | DTOCS (Patients) | M | LA | L | | 49 | 37 | 47 | 42 | 47 | 71 | 52 | 61 | 55 | 54 | 31 | | | | | | |
| | DTOCS (Patients) | M | Trust | L | | 38 | 25 | 32 | 29 | 38 | 61 | 45 | 50 | 42 | 35 | 27 | | | | | | |
| | **Other Indicators-111** | | | | | | | | | | | | | | | | | | | | | |
| **111 KPIs** | Calls answered (60 Seconds) | M | NW | H | 95.00% | 85.00% | 90.00% | 83.0% | 90.0% | 89.0% | 71.4% | 67.5% | 64.7% | 77.5% | 79.5% | 81.9% | 80.9% | 80.9% | | | 90.60% | |
| | Calls abandoned | M | NW | L | <5% | 4.00% | 2.00% | 4.0% | 2.0% | 2.0% | 6.4% | 6.9% | 10.8% | 7.1% | 6.2% | 5.7% | 5.7% | 6.2% | | | 2.30% | |
| | Warm Transfer | M | NW | H | 75% | 33.0% | 32.0% | 33.0% | 35.0% | 36.0% | 33.2% | 35.0% | 31.3% | 32.9% | 29.3% | 32.8% | 46.3% | 46.1% | | | 49.10% | |
| | Call back in 20 mins | M | NW | H | 75% | 41.00% | 40.00% | 38.0% | 39.0% | 34.0% | 34.7% | 36.0% | 33.5% | 38.4% | 37.1% | 38.1% | 38.3% | 36.0% | | | 42.80% | |
| | **Ambulance** | | | | | | | | | | | | | | | | | | | | | |
| **Ambulance** | Red 1 < 8 Minutes (75% Target) | M | T&G CCG | H | 75.00% | 71.10% | 69.50% | 75.6% | 66.7% | 65.9% | 68.3% | 60.4% | 61.3% | 59.4% | 63.6% | 66.0% | 66.4% | 62.0% | High levels of demand and lengthening turn around times. | 63.00% | 73.00% | |
| | Red 2 < 8 Minutes (75% Target) | M | T&G CCG | H | 75% | 58.00% | 63.10% | 58.60% | 65.80% | 60.00% | 60.48% | 54.76% | 53.50% | 54.50% | 56.91% | 60.20% | 67.44% | 64.92% | High levels of demand and lengthening turn around times. | 57.10% | 66.20% | |
| | All Reds <19 Minutes (95% Target) | M | T&G CCG | H | 95% | 89.9% | 91.1% | 89.9% | 91.0% | 89.1% | 86.4% | 83.1% | 82.9% | 83.3% | 88.4% | 90.8% | 92.1% | 91.6% | High levels of demand and lengthening turn around times. | | 92.30% | |
| | Red 1 < 8 Minutes (75% Target) | M | NWAS | H | 75% | 74.3% | 73.1% | 70.5% | 72.6% | 69.5% | 64.6% | 62.8% | 61.6% | 61.8% | 64.7% | 65.6% | 70.1% | 65.9% | High levels of demand and lengthening turn around times. | 63.00% | 73.00% | |
| | Red 2 < 8 Minutes (75% Target) | M | NWAS | H | 75% | 66.3% | 66.2% | 62.7% | 65.3% | 61.8% | 63.0% | 60.4% | 57.3% | 58.8% | 61.0% | 63.4% | 68.9% | 64.4% | High levels of demand and lengthening turn around times. | 57.10% | 66.20% | |
| | All Reds <19 Minutes (95% Target) | M | NWAS | H | 95% | 91.50% | 91.50% | 89.8% | 91.1% | 89.0% | 88.2% | 86.8% | 85.4% | 85.7% | 88.4% | 90.2% | 92.5% | 90.1% | High levels of demand and lengthening turn around times. | | 92.30% | |
| | **Quality** | | | | | | | | | | | | | | | | | | | | | |
| **Quality** | Clostridium Difficile-Whole Health Economy | M | | L | Plan | 7 | 3 | 9 | 10 | 5 | 13 | 6 | 6 | 5 | 4 | 9 | 6 | 5 | | | 1004 | |
| | Clostridium Difficile-Acute | M | | L | Plan | 2 | 2 | 4 | 5 | 2 | 8 | 5 | 4 | 2 | 3 | 5 | 2 | 2 | | | 410 | |
| | Clostridium Difficile-Non-Acute | M | | L | Plan | 5 | 1 | 5 | 5 | 3 | 5 | 1 | 2 | 3 | 1 | 4 | 4 | 3 | | | 594 | |
| | MRSA-Whole Health Economy | M | | L | 0 | 0 | 2 | 1 | 3 | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 0 | 2 | | 4 | 92 | |
| | MRSA-Acute | M | | L | 0 | 0 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | | | 39 | |
| | MRSA-Non Acute | M | | L | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | | | 53 | |

# Exception Report

## Tameside & Glossop CCG- July

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




**Key Risks and Issues:**

**As a CCG**
This month the CCG failed to achieve the 1% standard with a 1.51% performance.
Of the 73 breaches. 32 occurred at Central Manchester (CT, Colonoscopy, Gastroscopy and MRI), 25 at North West CATS Inhealth (MRI), 5 at T&G ICFT (Audiology assessments, Non obstetric ultrasound and Gastroscopy), 5 at Pioneer healthcare (Neurophysiology), 3 at South Manchester (MRI and Urodynamics), 1 at Pennine Acute (MRI), 1 at Stockport (Urodynamics) and 1 at Salford Trust (Neurophysiology).

Central Manchester performance is due to increased demand and issues around decontamination have impacted endoscopy performance which GM are aware of. Performance in 2017/18 is expected to be impacted when work is undertaken to ensure they achieve the JAG rating as 6 week waits may build up again.

T&G ICFT performance is primarily due to audiology struggling with capacity.

North West CATS Inhealth performance is as a result of a number of scanner breakdowns.

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

**Actions:**

CMFT has recently deteriorated after a period where they were back on track and had seen improvements.
T&G ICFT is working to resolve the audiology waits.
North West CATs Inhealth-Additional capacity has been put in place to address the issue and expect to be back on track in July.

**Operational and Financial implications:**

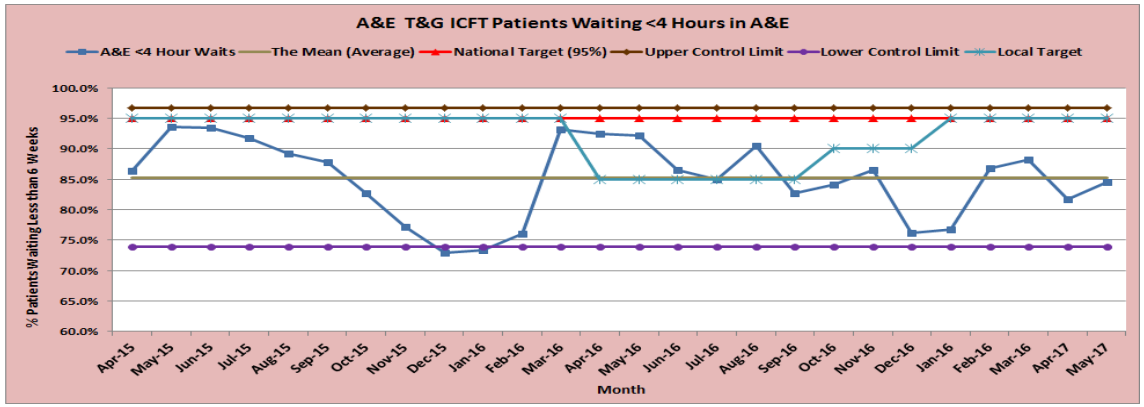
Failure of the standard will negatively impact on the CCG assurance rating. The CCG can Levey penalties through contract with those providers who fail the target.

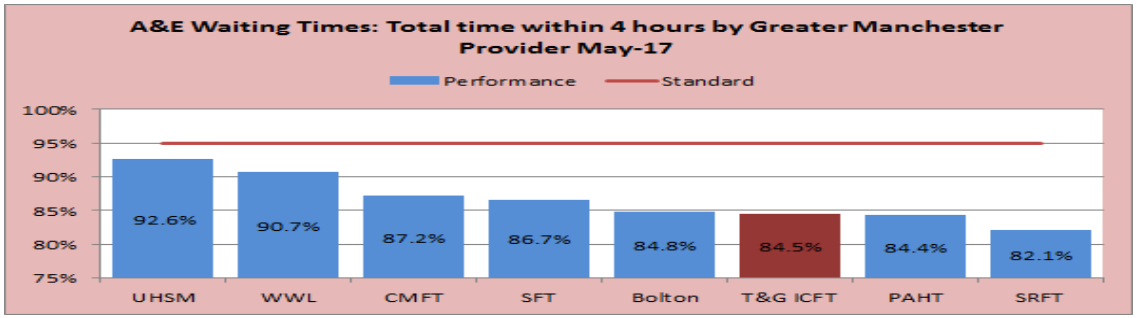
**Diagnostics Waiting Times Patients Waiting > 6 Weeks by GM CCG**

| | May-17 | | | |
|---|---|---|---|---|
| CCG | Waiting > 6 Weeks | Total Waiting List | Performance | Standard |
| NHS MANCHESTER CCG | 234 | 9794 | 2.39% | 1% |
| NHS Oldham CCG | 58 | 3832 | 1.51% | 1% |
| NHS Tameside and Glossop CCG | 73 | 4827 | 1.51% | 1% |
| NHS Bury CCG | 49 | 3567 | 1.37% | 1% |
| NHS Wigan Borough CCG | 73 | 5558 | 1.31% | 1% |
| NHS Heywood, Middleton & Rochdale CCG | 47 | 3957 | 1.19% | 1% |
| NHS Bolton CCG | 40 | 3941 | 1.01% | 1% |
| NHS Salford CCG | 43 | 4308 | 1.00% | 1% |
| NHS Trafford CCG | 56 | 5925 | 0.95% | 1% |
| NHS Stockport CCG | 45 | 5658 | 0.80% | 1% |

Unvalidated -Next month FORECAST

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




May Performance: 84.47%

16/17 ytd: 92.31%

17/18 ytd: 83.12%

**Key Risks and Issues:**

The A&E performance for May was 84.47% which is below the target of 95% and the GM agreed target of 90%.
Late asssssment due to lack of capacity in the department is the main reason for breaches.
• Bed capacity across the organisation was problematic (Medical bed-pool occupancy was routinely at >97%).;
• Delayed-transfers-of-care occupied >5% of the 'General and Acute' bed pool, a reduction from 10% in January;
• IAU remained escalated as a bedded area rather than functioning as originally planned;
• Reduced ambulatory-care service because of staffing shortages;
• Increased acuity, as measured using the Charlson Comorbidity Index (43% of patients with a Charlson comorbidity; 34% in 2009-10).

Overall the system has little resilience and so increased demand or reduced capacity in any one of the component Health and Social Care services can quickly reduce the A&E performance.
The local trajectory submitted to get back to the 90s in 1917/18 is Q1, Q2 and Q3 90% and 95% in March 18.

**Actions:**

Actions include:
• Organisational initiative 'Back to the 90s', commenced taking a whole-systems approach to patient flow;
• Additional beds temporarily opened on IAU (8 beds in use);
• Clinical Fellow now allocated to the Ambulatory Care area to enhance the service provision and handle GP calls;
• Additional medical staffing resources deployed, especially on days of expected increased activity (Monday/Tuesday).
• NHSI offering focused support concerning ED streaming;
• Further work concerning the handling of GP calls;
• Review of the speciality response times to ED and escalation processes.

**Operational and Financial implications:**

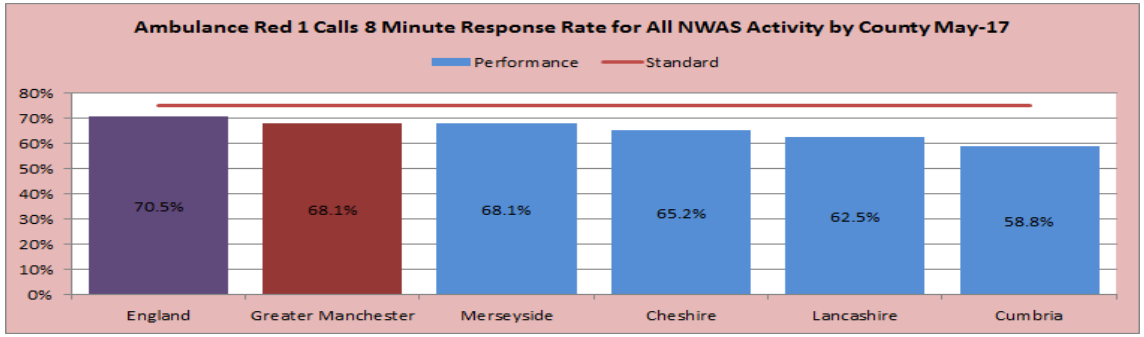
Failure of the standard will negatively impact on the CCG assurance rating. However regular contact is maintained with GMHSCP and the local work being undertaken is recognised.

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

Next month FORECAST

* Please note that Tameside Trust local trajectory for 17/18 is Q1, Q2 and Q3 90%, and Q4 95%.

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




May Performance: 65.92%

16/17 ytd: 75.40%

17/18 ytd: 67.96%

**Key Risks and Issues:**

In May the north west position (which we are measured against) was 65.92% however locally we achieved 62.04% Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

**Actions:**

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

NWAS have agreed the following actions including :

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

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

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

**Operational and Financial implications:**

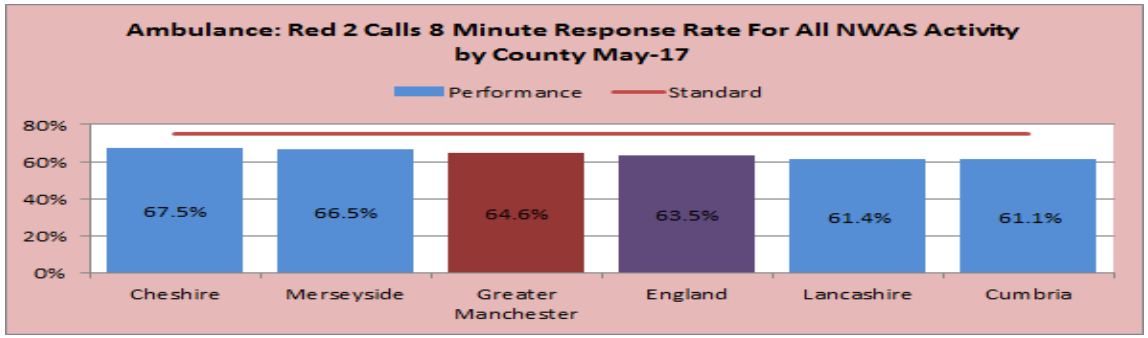
Failure of the standard will negatively impact on the CCG assurance rating.
The failure of this target will impact on the CCGs ability to obtain the money attached to this target for the Quality Premium Payment (QPP).

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

| | May-17 | | | |
|---|---|---|---|---|
| CCG | <8 Mins | Total | Performance | Standard |
| NHS Bury CCG | 52 | 69 | 75.8% | 75% |
| NHS Manchester CCG | 276 | 365 | 75.6% | 75% |
| NHS Oldham CCG | 67 | 96 | 69.8% | 75% |
| NHS Bolton CCG | 94 | 136 | 69.4% | 75% |
| NHS Salford CCG | 71 | 107 | 66.4% | 75% |
| NHS Wigan Borough CCG | 109 | 166 | 65.6% | 75% |
| NHS Tameside and Glossop CCG | 68 | 109 | 62.0% | 75% |
| NHS Heywood Middleton & Rochdale CCG | 62 | 100 | 62.0% | 75% |
| NHS Stockport CCG | 60 | 101 | 59.4% | 75% |
| NHS Trafford CCG | 49 | 83 | 58.5% | 75% |
| Data source; NWAS PES report | | | | |

Unvalidated next month FORECAST

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




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

| | May-17 | | | |
|---|---|---|---|---|
| **CCG** | **<8 Mins** | **Total** | **Performance** | **Standard** |
| NHS Manchester CCG | 2877 | 3914 | 73.5% | 75% |
| NHS Bury CCG | 700 | 1034 | 67.7% | 75% |
| NHS Oldham CCG | 858 | 1286 | 66.7% | 75% |
| NHS Heywood Middleton & Rochdale CCG | 815 | 1251 | 65.1% | 75% |
| NHS Tameside and Glossop CCG | 995 | 1533 | 64.9% | 75% |
| NHS Salford CCG | 903 | 1434 | 63.0% | 75% |
| NHS Stockport CCG | 1018 | 1677 | 60.7% | 75% |
| NHS Wigan Borough CCG | 985 | 1675 | 58.8% | 75% |
| NHS Bolton CCG | 946 | 1647 | 57.5% | 75% |
| NHS Trafford CCG | 604 | 1103 | 54.8% | 75% |
| Data source; NWAS PES report | | | | |

May Performance: 64.43%

16/17 ytd: 66.90%

17/18 ytd: 66.62%

**Key Risks and Issues:**

In Maythe north west position (which we are measured against) was 64.43% however locally we achieved 64.92% Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

**Actions:**

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

NWAS have agreed the following actions including :

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

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

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

**Operational and Financial implications:**

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

Unvalidated next month FORECAST

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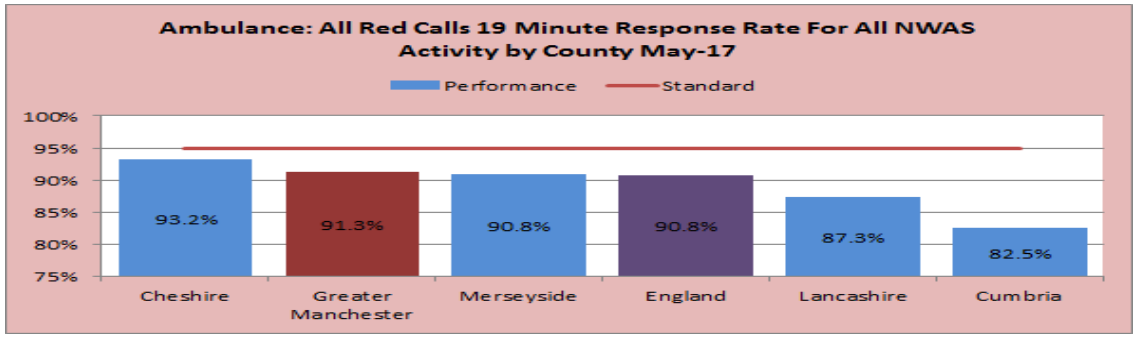
Ambulance performance- | **Lead Officer: Elaine Richardson** | **Lead Director:** Clare Watson | **Governance: A&E Delivery Board**




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

| | May-17 | | | |
|---|---|---|---|---|
| **CCG** | **<19 Mins** | **Total** | **Performance** | **Standard** |
| NHS Manchester CCG | 3997 | 4279 | 93.4% | 95% |
| NHS Oldham CCG | 1279 | 1382 | 92.5% | 95% |
| NHS Salford CCG | 1419 | 1541 | 92.1% | 95% |
| NHS Tameside and Glossop CCG | 1504 | 1642 | 91.6% | 95% |
| NHS Heywood Middleton & Rochdale CCG | 1238 | 1351 | 91.6% | 95% |
| NHS Stockport CCG | 1627 | 1778 | 91.5% | 95% |
| NHS Bury CCG | 992 | 1103 | 89.9% | 95% |
| NHS Bolton CCG | 1600 | 1783 | 89.8% | 95% |
| NHS Wigan Borough CCG | 1639 | 1841 | 89.0% | 95% |
| NHS Trafford CCG | 1034 | 1186 | 87.2% | 95% |
| Data source; NWAS PES report | | | | |

May Performance: 90.08%

16/17 ytd: 91.70%

17/18 ytd: 91.27%

**Key Risks and Issues:**

In May the north west position (which we are measured against) was 90.08% however locally we only achieved 91.62% Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

**Actions:**

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

NWAS have agreed the following actions including :

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

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

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

**Operational and Financial implications:**

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

Unvalidated next month FORECAST

*

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

| Indicators - access & quality | | NW inc. Blackpool | NW inc. Blackpool | Scoring out of 40 Areas Highest | | Lowest | |
|---|---|---|---|---|---|---|---|
| Calls per month per 1,000 people | | 23.3 | 24 | Isle of Wight | 49.9 | East London and City | 13.7 |
| Calls per month via 111 per 1,000 people | | 23.3 | 22 | Isle of Wight | 49.6 | East London and City | 13.7 |
| Of all calls offered, % abandoned after at least 30 seconds[1] | | 6% | 2 | Luton & Bedfordshire | 14% | South Essex | 0% |
| Of calls answered, % in 60 seconds | | 81% | 38 | East London and City | 98% | Luton & Bedfordshire | 65% |
| Of calls answered, % triaged | | 88% | 15 | North Central London | 108% | East London and City | 69% |
| Of answered calls, % transferred to clinical advisor | | 21% | 33 | East Kent | 44% | Lincolnshire | 7% |
| Of transferred calls, % live transferred | | 46% | 12 | Isle of Wight | 96% | York & Humber | 17% |
| Average NHS 111 live transfer time[1] | | 00:00:05 | | | | | |
| Average warm transfer time | | NCA | | | | | |
| Of calls answered, % passed for call back | | 11% | 28 | Devon | 20% | Lincolnshire | 1% |
| Of call backs, % within 10 minutes | | 36% | 21 | Cambridge and Peterborough | 71% | North Central London | 13% |
| Average episode length | | 00:14:56 | | | | | |
| Of answered calls, % calls to a CAS clinician | | 31% | 28 | North Central London | 65% | SEC exc. East Kent | 21% |

| Dispositions as a proportion of all calls triaged | T&G CCG | NW inc. Blackpool | NW inc. Blackpool | Scoring out of 40 Areas Highest | | Lowest | |
|---|---|---|---|---|---|---|---|
| 111 dispositions: % Ambulance dispatches | 16% | 15% | 5 | Cornwall | 17% | South Essex | 8% |
| 111 dispositions: % Recommended to attend A&E | 8% | 9% | 23 | East London and City | 14% | Leicestershire and Rutland | 5% |
| Recommended to attend primary and community care | 56% | 57% | 32 | Berkshire | 66% | Lincolnshire | 45% |
| Of which - % Recommended to contact primary and community care | | 42% | 22 | SEC exc. East Kent | 49% | Lincolnshire | 33% |
| - % Recommended to speak to primary and community care | | 12% | 19 | Cambridge and Peterborough | 17% | Outer North East London | 5% |
| - % Recommended to dental / pharmacy | | 3% | 39 | York & Humber | 13% | Devon | 1% |
| 111 dispositions: % Recommended to attend other service | 3% | 2% | 28 | Lincolnshire | 20% | East Kent | 1% |
| 111 dispositions: % Not recommended to attend other service | 17% | 17% | 11 | Milton Keynes | 23% | Mainland SHIP | 9% |
| Of which - % Given health information | | 4% | 1 | NW inc. Blackpool | 4% | Staffordshire | 0% |
| - % Recommended home care | | 3% | 38 | North West London | 7% | Lincolnshire | 1% |
| - % Recommended non clinical | | 9% | 11 | Lincolnshire | 15% | Cambridge and Peterborough | 2% |

**Key Risks and Issues:**

The North West NHS 111 service is performance managed against a range of KPIs reported as follows for May:
- Calls Answered (95% in 60 seconds) = 80.86%
- Calls abandoned (<5%) = 6.21%
- Warm transfer (75%) = 46.13%
Call back in 10 minutes (75%) = 36.03%

In May the NW NHS 111 service experienced a number of issues which lead to poor performance in the month against the four KPIs. Performance was particularly difficult to achieve over the weekend periods.

**Actions:**

NWAS has agreed a further remedial action plan with commissioners.
NWAS has continued to deploy all available staff, and is actively managing staff absence and attrition in order to best meet the service needs.
A range of process changes are being implemented this includes patients using telephone key pads to identify the most appropriate call handler e.g. call regarding children automatically go to a nurse and issues such as coughs and colds receive self care and advise.
As part of the GM arrangements appropriate T&G patients receive enhanced clinical assessment from GtD out of jours and Mastercall in hours.

Work continues to manage sickness rates which contributes to the inability to deliver national KPI on call pick up. A 111 health and wellbeing group has been formed to develop long term plans to support staff to maintain attendance at work.

**Operational and Financial implications:**

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

Unvalidated next month FORECAST

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**Quality & Safeguarding: Monthly Exception Report – July 2017 exception report**

**May 2017 data**

| **Quality Indicator** | Y/N | **Comments** |
|---|---|---|
| Has a local provider been rated as inadequate by the CQC/OFSTED | Y | Due to the poor performance of Tameside Care Homes under the revised CQC methodology the following actions have been taken:<br><br>Quality Improvement Team – the proposal for a dedicated quality improvement team for the Care Sector was approved by the Single Commissioning Board in May 17. The team will have varied skill mix and work within Provider Quality Improvement Programme (PQIP) framework to provide support and drive up quality within the sector.<br><br>Contractual Monitoring/Quality Assurance – an internal review of current processes has been initiated by the Single Commissioning Function. All contractual documentation, quality assurance processes, and governance is in the process of being reviewed and a subsequent action plan will be developed to ensure that processes are in line with CQC KLOEs, GM Standards and be proactive in identifying areas of support required from the Quality Improvement Team.<br><br>**Carson House** – CQC report published 17/05/17 - Inadequate<br>The home remains suspended (since January 2017) following concerns raised from a CQC inspection, which also resulted in a number of substantiated safeguardings. A number of issues were identified (poor environment, staff training, staff competencies, leadership, etc.) and the Commissioners have been meeting with senior people running the home. The home had been in receivership (since October 2016) and has recently been sold (back to the former owner) and a new manager has been in place for the last 3 months. Significant improvements have been made in the last couple of months with some good practice being noted at a recent contracts performance visit. a further commissioner /provider meeting took place on the 20/6/17 .The CCG has today 3/7/17 been informed that the manager has resigned with immediate effect.<br><br>**Charnley House** remains suspended (since September 2016) following a CQC inspection. The Commissioners have been working closely with the home and some progress is being made. A further CQC |

| | | |
|---|---|---|
| | | inspection (report published 08/06/17) did note some small improvements but the overall rating remains as 'Inadequate'. |
| Has a local provider been subject to regulatory notice e.g. CQC alert, Reg 28, | Y | ICFT have received 3 prevention of future death notices all relating to discharge information. The PFDs deaths relate to historical cases; they do not relate directly to the cause of death but identify additional opportunities for wider learning. The Trust will respond to the PFDs and provide assurance on appropriate improvement action taken. PFDs is a standard agenda item at the ICFT contract Quality and Performance Assurance meeting and assurance will be sought via this route.<br><br>It is worth noting that there has been a recent change in Coroner and there are some concerns that PFD notices are being issued for the same area without the ICFT having opportunity to provide assurance of the improvement action taken. The ICFT have arranged a meeting with the new Coroner to discuss the PFD process and to explore the existing mechanisms available to make recommendation for improvement that are not necessarily a PFD notice. |
| Does the CCG and / or partner originations have concerns about the ability of a provider to deliver safe, quality care? | Y | **A residential care home in Glossop** remains on a formal suspension issued by DCC following a safeguarding incident with two agency staff in April 17. The outcome of the police investigation and safeguarding investigation is currently awaited and DCC have taken the decision to suspend new admissions until these are completed. The home had previously been on a voluntary suspension following non-compliance with some training and record-keeping, this had been lifted following a contractual meeting on 18th April 17. No new admissions have taken place from T&G with the exception of one respite placement which had been a long-standing arrangement and requested the family who had been made aware of issues. Ongoing monitoring is being undertaken and the home remains suspended whilst the police investigation is ongoing.<br><br>**Healthy Young Minds (PCFT**) access targets were not achieved in May 17. The provider assured commissioners that from the start of June there will be a new waiting times initiative to meet the current demand on the service. This includes offering an extra 20 appointments per week to enable an assessment and agree a pathway for the individuals. The service has, therefore, not met the targets this month as the longer waiting cases have been prioritised. Over the course of 6 weeks these additional appointments should significantly reduce the backlog of cases currently 8 waiting. Discussions with commissioners are ongoing in relation to current capacity and demand on service. A trajectory and action plan has been provided and subsequently updated. |

| | | |
|---|---|---|
| Does the CCG and / partner organisations have concerns about the quality of any smaller value contracts? | | The process of contract monitoring and quality assurance is being finalised by the contracting team with a close cooperation from the quality team. |
| Has a local provider been subject to negative media attention particularly in relation to quality and / or patient safety concerns? | y | **Carson House** – when the report was published on the 17/05/17 rating the home 'Inadequate', the press (local & national) highlighted this as a very poor home. |
| Has a provider been identified as a 'negative outlier' on SMHI or HSMR? | N | |
| Has a provider reported MRSA cases above zero? | Y | For May 2017 Tameside and Glossop CCG have reported 2 cases of MRSA against a plan of zero tolerance - 1 at T&G ICFT and 1 non acute case. PIR investigations are being undertaken for both cases and will be reviewed at the HCAI Quality Improvement Group where assurance will be sought if lapses in care identified.<br>Case One has been considered 'unavoidable' and the second case is still being reviewed. The issues identified in relation to Case One relate to multiple courses of antibiotics prescribed for a specific condition. Case One has been attributed to the Community Services and Case Two is an acute- hospital case. The outcome of the root- cause analysis relating to Case Two will be known in time for the August HCAI Quality Improvement Group. |
| Has a provider reported more C difficile cases than trajectory? | N | |
| Has a provider declared any 'Never Events' during the last quarter? | N | |

| | | |
|---|---|---|
| Does the rate and consistency of serious incident reporting indicate any cause for concern? | | The ICFT is currently exceeding the 60 day investigation timeframes for a small number of incidents reported on STEIS. This relates to pressure ulcer incidents. In terms of assurance all investigations have been completed however the ICFTs internal scrutiny panel have requested further information in relation to a number of RCAs resulting in a delay in the CCG receiving the completed RAC. The ICFT have reviewed its process to ensure internal scrutiny is completed within expected timescales. |
| Has a provider reported any maternity diverts? | N | |
| Does performance indicate any concerns about meeting PoUAC (Previously Un-assessed Periods of Care) targets. | | |
| Does performance indicate any concerns about meeting Transforming Care targets? | | |
| Are there any areas rated RED in the CCGs NHSE Safeguarding Assurance Framework? | N | |
| Are there any new Serious Case Reviews, Domestic Homicide Reviews, Safeguarding Adult Reviews or Mental Health Homicide Reviews? | N | |
| Does feedback from the Friends and Family test (or any other patient experience feedback) indicate any causes for concern? | N | |
| Have any quality / patient safety concerns been identified during CCG Quality visits? | N | |

| | | |
|---|---|---|
| Any new items added to SCF Risk Register relating to quality or patient safety. | N | |

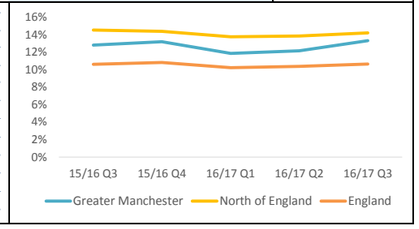
# Better Health

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

### Maternal Smoking at Delivery

Better Is **Lower**

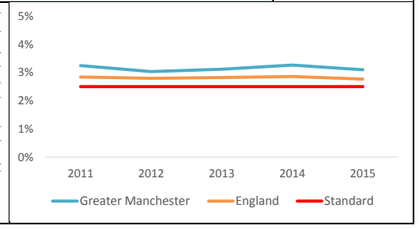
| | |
|---|---|
| Central | 6.6% |
| Trafford | 7.4% |
| Bury | 10.9% |
| Stockport | 11.2% |
| Bolton | 13.9% |
| Oldham | 14.2% |
| Salford | 15.0% |
| South | 15.2% |
| T&G | 15.3% |
| Wigan | 15.9% |
| North | 16.6% |
| HMR | 16.8% |




### Low Birth Weight of Term Babies

Better Is **Lower**

| | |
|---|---|
| Stockport | 2.2% |
| Bury | 2.5% |
| Rochdale | 2.9% |
| Salford | 2.9% |
| Trafford | 2.9% |
| Wigan | 3.1% |
| Bolton | 3.2% |
| Mancheste | 3.3% |
| Oldham | 3.5% |
| Tameside | 4.1% |

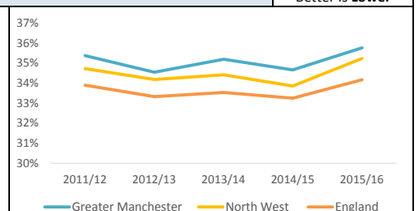



## More GM Children Will Reach a Good Level of Development Cognitively, Socially & Emotionally

### Children Aged 10-11 Classified as Overweight or Obese

Better Is **Lower**

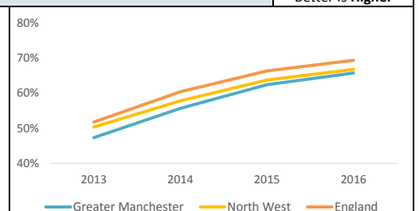
| | |
|---|---|
| Stockport | 30.3% |
| Trafford | 30.9% |
| Tameside | 33.9% |
| Bury | 34.5% |
| Bolton | 35.4% |
| Rochdale | 35.7% |
| Oldham | 36.7% |
| Salford | 39.6% |
| Wigan | 35.7% |
| Mancheste | 40.2% |




### Percentage Achieving Good Level of Development at Reception

Better Is **Higher**

| | |
|---|---|
| Trafford | 73.8% |
| Stockport | 69.6% |
| Bury | 68.9% |
| Salford | 65.3% |
| Bolton | 64.6% |
| Mancheste | 63.7% |
| Wigan | 67.0% |
| Tameside | 63.0% |
| Rochdale | 63.3% |
| Oldham | 60.5% |




### (Placeholder) - Combine Flu Imms Aged 2-4??

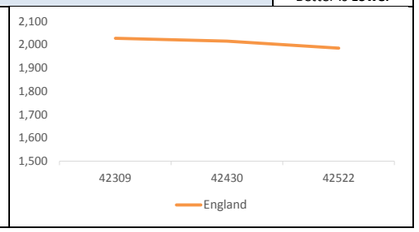
Better Is **Higher**

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

### Injuries From Falls in People Aged 65 and Over

Better Is **Lower**

| | |
|---|---|
| Bolton | 1,610 |
| Bury | 1,910 |
| Central | 2,821 |
| HMR | 2,326 |
| North | 2,899 |
| Oldham | 2,375 |
| Salford | 3,328 |
| South | 2,743 |
| Stockport | 2,563 |
| T&G | 2,159 |
| Trafford | 2,175 |
| Wigan | 2,776 |




### (Placeholder) - Excess Winter Deaths (Over 65's?)

Better Is **Lower**

### (Placeholder) - Fuel Poverty

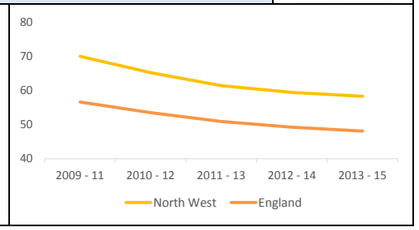
Better Is **Lower**

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

### Under-75 Mortality Rate Considered Preventable - CVD

Better Is **Lower**

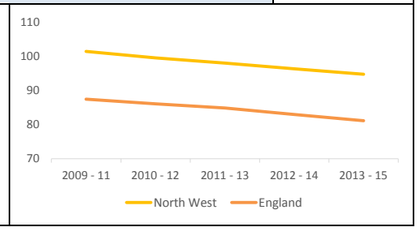
| | |
|---|---|
| Stockport | 43.1 |
| Trafford | 45.2 |
| Bury | 55.8 |
| Wigan | 59.8 |
| Bolton | 60.5 |
| Rochdale | 70.6 |
| Oldham | 74.5 |
| Salford | 75.4 |
| Tameside | 80.5 |
| Mancheste | 89.5 |




### Under-75 Mortality Rate Considered Preventable - Cancer

Better Is **Lower**

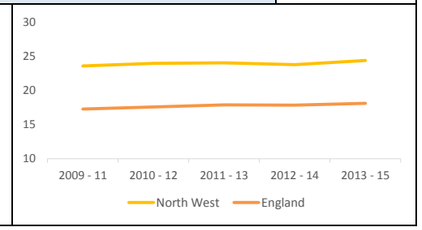
| | |
|---|---|
| Trafford | 84.0 |
| Stockport | 84.7 |
| Bury | 89.9 |
| Wigan | 91.8 |
| Bolton | 92.9 |
| Rochdale | 101.2 |
| Tameside | 103.5 |
| Oldham | 105.9 |
| Salford | 118.7 |
| Mancheste | 129.3 |




### Under-75 Mortality Rate Considered Preventable - Respiratory

Better Is **Lower**

| | |
|---|---|
| Stockport | 16.7 |
| Trafford | 19.1 |
| Wigan | 22.7 |
| Bury | 23.9 |
| Tameside | 24.8 |
| Oldham | 26.9 |
| Bolton | 27.6 |
| Rochdale | 31.3 |
| Salford | 33.9 |
| Mancheste | 45.9 |



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

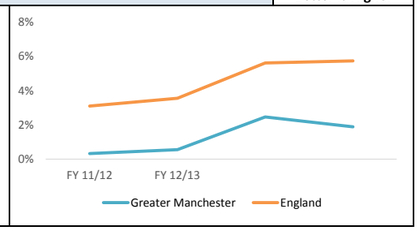
Better Is **Higher**

| | |
|---|---|
| Bolton | 40.4% |
| Bury | 41.4% |
| Central | 36.6% |
| HMR | 40.5% |
| North | 40.1% |
| Oldham | 40.7% |
| Salford | 40.7% |
| South | 38.7% |
| Stockport | 43.7% |
| T&G | 42.5% |
| Trafford | 37.8% |
| Wigan | 45.6% |


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

Better Is **Higher**

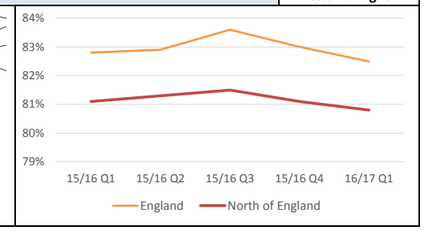
| | |
|---|---|
| Bolton | 0.1% |
| Bury | 0.0% |
| Central | 0.0% |
| HMR | 0.0% |
| North | 2.5% |
| Oldham | 0.8% |
| Salford | 1.0% |
| South | 0.6% |
| Stockport | 1.6% |
| T&G | 0.0% |
| Bury | 0.0% |
| HMR | 0.0% |




## Diabetic Eye Screening

Better Is **Higher**

| | |
|---|---|
| Bolton | 85.0% |
| Wigan | 89.9% |
| North East | 79.9% |
| South Man | 77.9% |

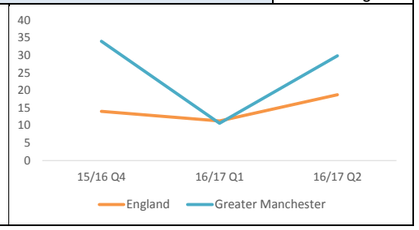



(Placeholder TBC)

## Personal Health Budgets Per 100,000 Population

Better Is **Higher**

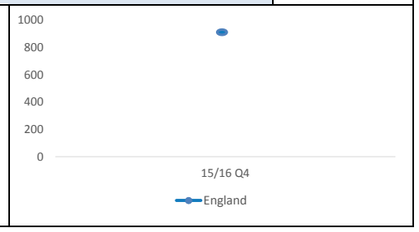
| | |
|---|---|
| HMR | 222 |
| Trafford | 25 |
| North | 24 |
| Central | 24 |
| South | 24 |
| Wigan | 20 |
| Bury | 17 |
| Stockport | 8 |
| T&G | 7 |
| Bolton | 7 |
| Oldham | 4 |
| Salford | 0 |




## Inequality In Unplanned Hospitalisation For Chronic Ambulatory Care Sensitive Conditions

Better Is **Lower**

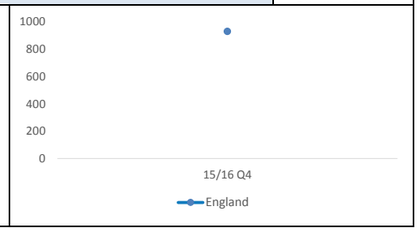
| | |
|---|---|
| Bury | 1,837 |
| Trafford | 1,939 |
| Oldham | 2,354 |
| Bolton | 2,418 |
| HMR | 2,479 |
| Wigan | 2,762 |
| T&G | 3,144 |
| Salford | 3,156 |
| Central | 3,409 |
| South | 3,422 |
| North | 3,583 |
| Stockport | 3,735 |




## Inequality In Emergency Admissions For Urgent Care Sensitive Conditions

Better Is **Lower**

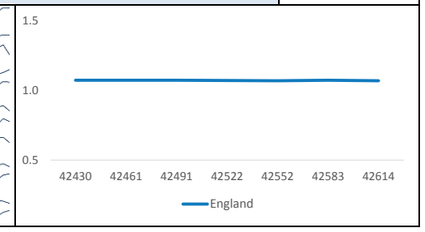
| | |
|---|---|
| Bury | 904 |
| Wigan | 1,048 |
| Oldham | 1,057 |
| Bolton | 1,103 |
| Trafford | 1,126 |
| HMR | 1,185 |
| Salford | 1,386 |
| Stockport | 1,422 |
| T&G | 1,475 |
| North | 1,700 |
| Central | 1,834 |
| South | 1,922 |




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

Better Is **Lower**

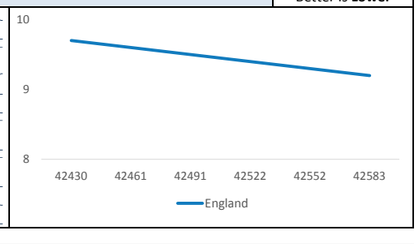
| | |
|---|---|
| Bolton | 1.2 |
| Bury | 1.2 |
| Central | 1.1 |
| HMR | 1.3 |
| North | 1.3 |
| Oldham | 1.4 |
| Salford | 1.2 |
| South | 1.2 |
| Stockport | 1.2 |
| T&G | 1.1 |
| Trafford | 1.1 |
| Wigan | 1.1 |




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

Better Is **Lower**

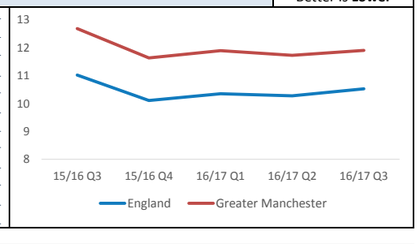
| | |
|---|---|
| Bolton | 8.2 |
| Bury | 6.0 |
| Central | 8.0 |
| HMR | 7.9 |
| North | 7.8 |
| Oldham | 9.0 |
| Salford | 9.7 |
| South | 7.9 |
| Stockport | 5.0 |
| T&G | 7.7 |
| Trafford | 12.2 |
| Wigan | 8.1 |




## Prescribing Costs per ASTRO-PU

Better Is **Lower**

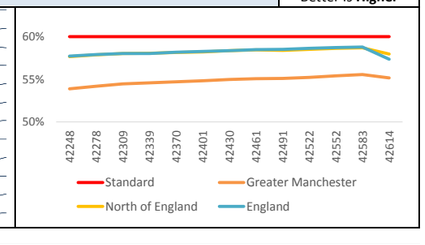
| | |
|---|---|
| Bury | 9.8 |
| Stockport | 10.4 |
| Trafford | 11.3 |
| Central | 11.3 |
| Salford | 11.4 |
| Bolton | 11.5 |
| HMR | 12.1 |
| Wigan | 12.2 |
| South | 12.3 |
| T&G | 12.5 |
| Oldham | 12.8 |
| North | 13.6 |




## Bowel Screening Uptake Aged 60-74

Better Is **Higher**

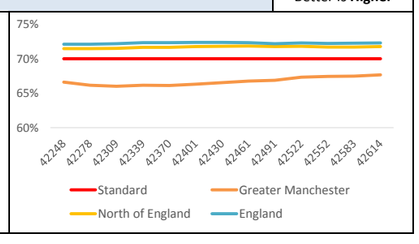
| | |
|---|---|
| Trafford | 56.4% |
| Stockport | 58.2% |
| Wigan | 57.5% |
| Bolton | 56.7% |
| Bury | 58.7% |
| HMR | 56.2% |
| Salford | 53.9% |
| T&G | 55.5% |
| Oldham | 57.3% |
| South | 45.9% |
| North | 45.9% |
| Central | 42.1% |




## Breast Screening Coverage Aged 50-70

Better Is **Higher**

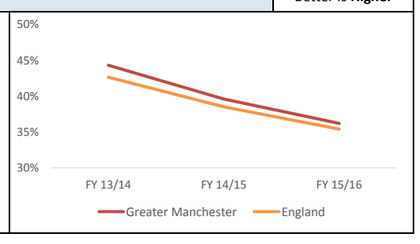
| | |
|---|---|
| Bury | 73.8% |
| Bolton | 73.1% |
| Wigan | 71.8% |
| HMR | 69.8% |
| Oldham | 69.3% |
| Stockport | 68.4% |
| Trafford | 66.0% |
| T&G | 65.1% |
| South | 64.2% |
| Salford | 63.7% |
| Central | 59.7% |
| North | 54.6% |




## Flu Immunised 2 Year Olds

Better Is **Higher**

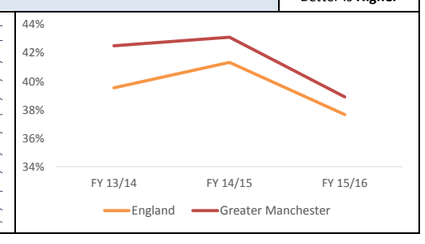
| | |
|---|---|
| Bolton | 32.4% |
| Bury | 35.7% |
| Central | 32.8% |
| HMR | 36.9% |
| North | 32.6% |
| Oldham | 34.7% |
| Salford | 32.3% |
| South | 25.2% |
| Stockport | 41.2% |
| T&G | 40.0% |
| Trafford | 49.1% |
| Wigan | 38.8% |




## Flu Immunised 3 Year Olds

Better Is **Higher**

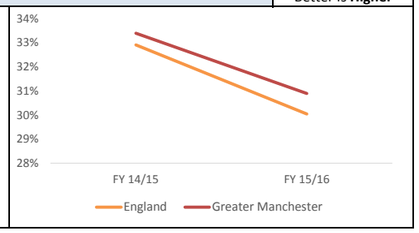
| | |
|---|---|
| Bolton | 34.1% |
| Bury | 39.6% |
| Central | 35.4% |
| HMR | 39.3% |
| North | 34.8% |
| Oldham | 40.0% |
| Salford | 32.3% |
| South | 29.9% |
| Stockport | 46.8% |
| T&G | 42.4% |
| Trafford | 47.6% |
| Wigan | 41.3% |



## Flu Immunised 4 Year Olds

Better Is **Higher**

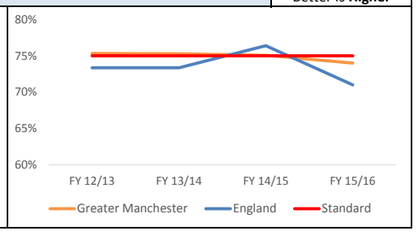
| | |
|---|---|
| Bolton | 27.2% |
| Bury | 28.6% |
| Central | 27.4% |
| HMR | 32.3% |
| North | 28.0% |
| Oldham | 31.1% |
| Salford | 28.3% |
| South | 20.2% |
| Stockport | 37.1% |
| T&G | 32.1% |
| Trafford | 41.8% |
| Wigan | 32.7% |




## Flu Immunised aged 65 and over

Better Is **Higher**

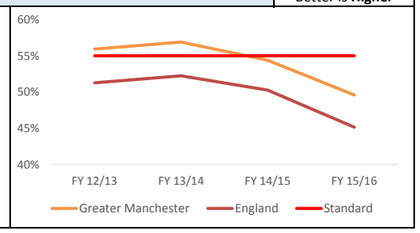
| | |
|---|---|
| Bolton | 73.3% |
| Bury | 75.1% |
| Central | 70.4% |
| HMR | 74.6% |
| North | 70.6% |
| Oldham | 73.2% |
| Salford | 73.8% |
| South | 69.2% |
| Stockport | 76.8% |
| T&G | 75.0% |
| Trafford | 77.4% |
| Wigan | 72.0% |




## Flu Immunised in clinical risk groups

Better Is **Higher**

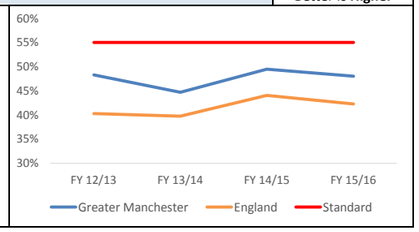
| | |
|---|---|
| Bolton | 49.6% |
| Bury | 47.9% |
| Central | 48.1% |
| HMR | 54.1% |
| North | 49.2% |
| Oldham | 49.6% |
| Salford | 42.8% |
| South | 46.3% |
| Stockport | 56.5% |
| T&G | 52.8% |
| Trafford | 51.7% |
| Wigan | 45.2% |




## Flu Immunised in pregnant women

Better Is **Higher**

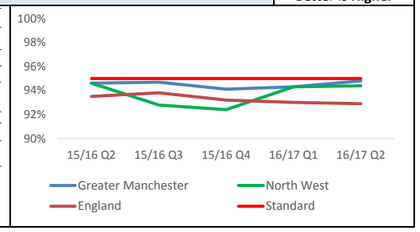
| | |
|---|---|
| Bolton | 46.1% |
| Bury | 48.3% |
| Central | 44.1% |
| HMR | 50.4% |
| North | 41.7% |
| Oldham | 50.6% |
| Salford | 37.7% |
| South | 47.1% |
| Stockport | 63.7% |
| T&G | 52.3% |
| Trafford | 50.3% |
| Wigan | 45.4% |




## Diphtheria, Tetanus, Polio, Pertussis, Hib (DTaP/IPV/Hib) 12 months

Better Is **Higher**

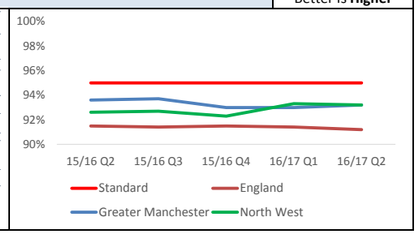
| | |
|---|---|
| Wigan | 97.4% |
| T&G | 97.3% |
| Trafford | 96.8% |
| Oldham | 96.6% |
| Bolton | 96.5% |
| Salford | 95.7% |
| HMR | 95.6% |
| Bury | 94.7% |
| Stockport | 94.4% |




## Mumps, Measles & Rubella (MMR)

Better Is **Higher**

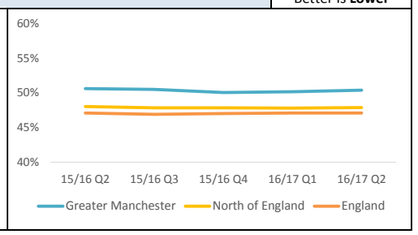
| | |
|---|---|
| T&G | 97.3% |
| HMR | 95.8% |
| Salford | 95.2% |
| Wigan | 95.1% |
| Trafford | 94.7% |
| Bolton | 94.6% |
| Oldham | 94.4% |
| Stockport | 93.5% |
| Bury | 90.8% |
| Manchester | 87.8% |




## Percentage Of Deaths Which Take Place In Hospital

Better Is **Lower**

| | |
|---|---|
| Bury | 45.8% |
| HMR | 46.2% |
| Oldham | 47.4% |
| Bolton | 47.5% |
| Stockport | 49.8% |
| Salford | 50.1% |
| T&G | 50.4% |
| North | 52.1% |
| Wigan | 52.5% |
| South | 54.7% |
| Central | 56.1% |
| Trafford | 56.4% |



GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS Greater Manchester

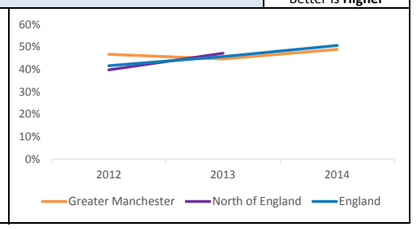
# Better Care

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

### Cancers Diagnosed at Early Stage

Better Is **Higher**

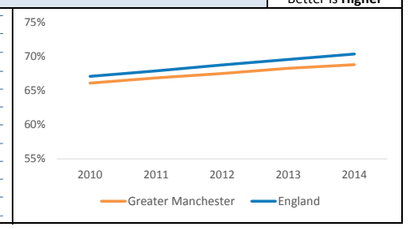
| | |
|---|---|
| Bury | 53.7% |
| Wigan | 51.7% |
| Bolton | 51.5% |
| Stockport | 50.8% |
| HMR | 50.1% |
| Oldham | 49.4% |
| North | 48.2% |
| Trafford | 47.3% |
| South | 47.2% |
| Salford | 46.3% |
| T&G | 44.2% |
| Central | 37.4% |




### One-Year Survival From All Cancers

Better Is **Higher**

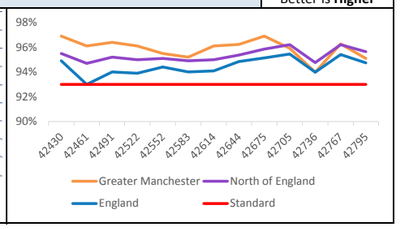
| | |
|---|---|
| Stockport | 71.9% |
| Trafford | 71.7% |
| Bury | 70.4% |
| HMR | 69.3% |
| South | 69.2% |
| Wigan | 68.9% |
| Bolton | 68.3% |
| Oldham | 68.0% |
| Central | 67.2% |
| T&G | 67.1% |
| Salford | 65.9% |
| North | 64.8% |




### Cancer - Two week wait from cancer referral to specialist appointment

Better Is **Higher**

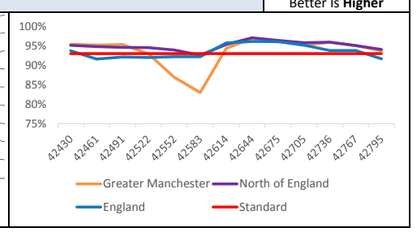
| | |
|---|---|
| Bolton | 98.6% |
| Stockport | 97.9% |
| Wigan | 97.2% |
| Trafford | 95.7% |
| T&G | 95.3% |
| HMR | 94.7% |
| Mancheste | 93.9% |
| Oldham | 93.5% |
| Salford | 93.2% |
| Bury | 90.6% |




### Cancer - Two week wait (breast symptoms - cancer not suspected)

Better Is **Higher**

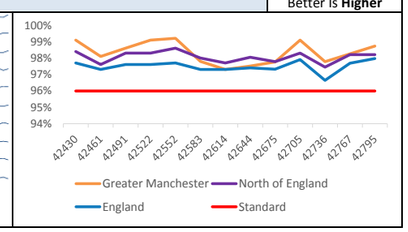
| | |
|---|---|
| T&G | 98.3% |
| Oldham | 97.9% |
| HMR | 97.5% |
| Trafford | 96.2% |
| Stockport | 94.8% |
| Salford | 93.3% |
| Wigan | 93.0% |
| Mancheste | 91.6% |
| Bolton | 90.3% |
| Bury | 89.5% |




### Cancer - 31-day wait from decision to treat to first treatment

Better Is **Higher**

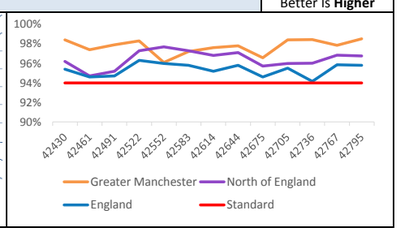
| | |
|---|---|
| Stockport | 100.0% |
| Wigan | 99.4% |
| Mancheste | 99.4% |
| Bolton | 99.2% |
| Salford | 99.0% |
| Trafford | 98.3% |
| Bury | 98.1% |
| HMR | 97.7% |
| T&G | 97.7% |
| Oldham | 96.6% |




### Cancer - 31-day wait for subsequent surgery

Better Is **Higher**

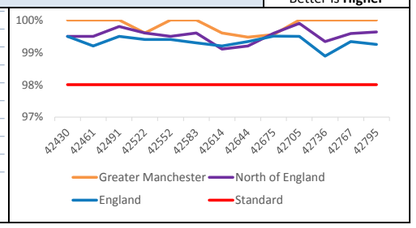
| | |
|---|---|
| Mancheste | 100.0% |
| Trafford | 100.0% |
| T&G | 100.0% |
| Bury | 100.0% |
| Wigan | 100.0% |
| HMR | 100.0% |
| Bolton | 100.0% |
| Stockport | 96.4% |
| Salford | 96.4% |
| Oldham | 95.2% |




### Cancer - 31-day wait for subsequent anti-cancer drug regimen

Better Is **Higher**

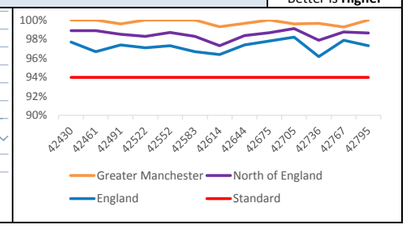
| | |
|---|---|
| Trafford | 100.0% |
| Stockport | 100.0% |
| Mancheste | 100.0% |
| Bury | 100.0% |
| T&G | 100.0% |
| HMR | 100.0% |
| Wigan | 100.0% |
| Oldham | 100.0% |
| Bolton | 100.0% |
| Salford | 100.0% |




### Cancer - 31-day wait for subsequent radiotherapy

Better Is **Higher**

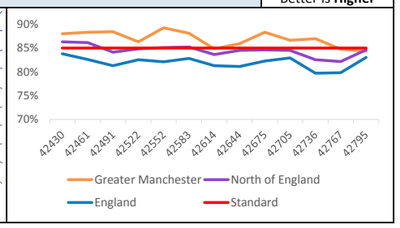
| | |
|---|---|
| Trafford | 100.0% |
| Stockport | 100.0% |
| Mancheste | 100.0% |
| Bury | 100.0% |
| T&G | 100.0% |
| HMR | 100.0% |
| Wigan | 100.0% |
| Oldham | 100.0% |
| Bolton | 100.0% |
| Salford | 100.0% |




### Cancer - 62-day wait from referral to treatment

Better Is **Higher**

| | |
|---|---|
| Wigan | 98.4% |
| Bolton | 93.8% |
| Trafford | 90.0% |
| Stockport | 89.0% |
| T&G | 82.9% |
| Bury | 81.6% |
| Salford | 79.5% |
| Mancheste | 78.7% |
| HMR | 75.9% |
| Oldham | 67.3% |

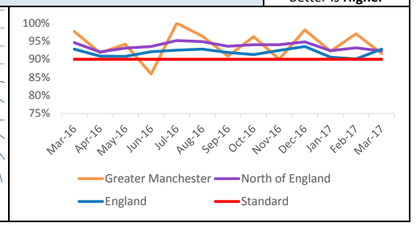


## Decreased Variation In Quality Of Care Health Outcomes Across GM Localities

### Cancer - 62-day wait for treatment following a referral from a screening service

Better Is **Higher**

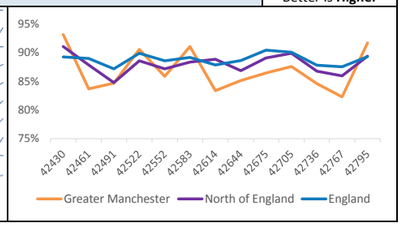
| | |
|---|---|
| Wigan | 100.0% |
| Trafford | 100.0% |
| T&G | 100.0% |
| Bolton | 100.0% |
| Mancheste | 93.8% |
| Oldham | 83.3% |
| Stockport | 83.3% |
| Bury | 81.8% |
| HMR | 66.7% |
| Salford | 0.0% |




### Cancer - 62-day wait for treatment following a consultant upgrade

Better Is **Higher**

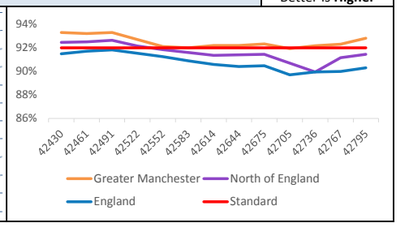
| | |
|---|---|
| Trafford | 100.0% |
| HMR | 100.0% |
| Wigan | 93.8% |
| Stockport | 92.6% |
| Salford | 92.6% |
| Mancheste | 91.3% |
| Bolton | 90.9% |
| Bury | 85.7% |
| T&G | 85.2% |
| Oldham | 75.0% |




### Referral to Treatment - 18 weeks

Better Is **Higher**

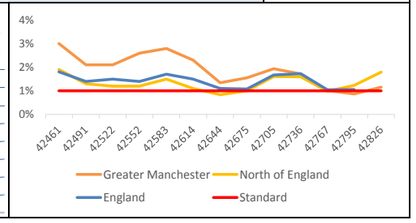
| | |
|---|---|
| Wigan | 94.6% |
| Oldham | 94.1% |
| Salford | 93.7% |
| HMR | 93.6% |
| Stockport | 93.0% |
| Central | 92.8% |
| T&G | 92.6% |
| Bolton | 92.6% |
| North | 92.4% |
| Trafford | 91.3% |
| Bury | 91.2% |
| South | 90.2% |




### Diagnostics Test Waiting Times

Better Is **Lower**

| | |
|---|---|
| North | 0.0% |
| Central | 0.0% |
| South | 0.0% |
| Stockport | 0.8% |
| T&G | 0.9% |
| HMR | 1.0% |
| Wigan | 1.0% |
| Trafford | 1.0% |
| Bury | 1.1% |
| Salford | 1.2% |
| Bolton | 1.2% |
| Oldham | 1.3% |




## Improved Patient/Carer Experience Of Care And Increased Patient Empowerment

### Primary Care Access (Placeholder)

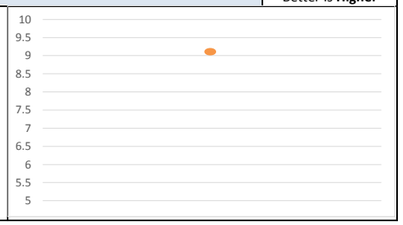
Better Is **Higher**

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

### Cancer Patient Experience

Better Is **Higher**

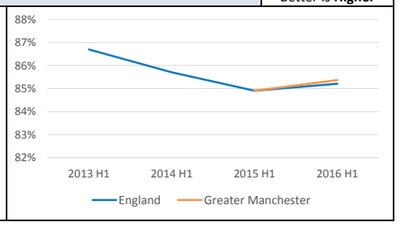
| | |
|---|---|
| Bolton | 8.8 |
| Bury | 8.7 |
| Central | 8.6 |
| HMR | 8.8 |
| North | 8.7 |
| Oldham | 8.7 |
| Salford | 9.0 |
| South | 8.7 |
| Stockport | 8.7 |
| T&G | 8.7 |
| Trafford | 8.6 |
| Wigan | 8.8 |




### Patient Experience Of GP Services

Better Is **Higher**

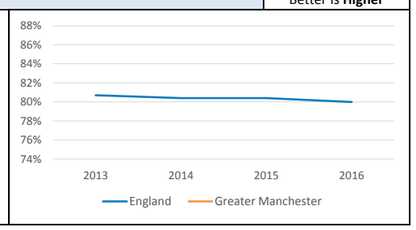
| | |
|---|---|
| Bolton | 87.2% |
| Bury | 86.9% |
| Central | 81.8% |
| HMR | 82.3% |
| North | 81.5% |
| Oldham | 84.7% |
| Salford | 85.3% |
| South | 84.0% |
| Stockport | 88.9% |
| T&G | 83.2% |
| Trafford | 86.5% |
| Wigan | 88.2% |




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

Better Is **Higher**

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

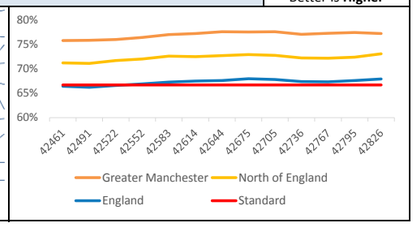


## Improved Outcomes For People With Learning Disabilities/Mental Health Needs

### Estimated Diagnosis Rate For People With Dementia

Better Is **Higher**

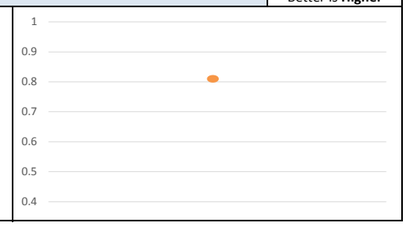
| | |
|---|---|
| Salford | 88.0% |
| Bury | 85.3% |
| T&G | 83.8% |
| Oldham | 82.1% |
| Bolton | 79.6% |
| Mancheste | 75.4% |
| Stockport | 75.2% |
| Trafford | 74.0% |
| Wigan | 68.6% |
| HMR | 67.0% |




### Dementia Care Planning and Post-Diagnostic Support

Better Is **Higher**

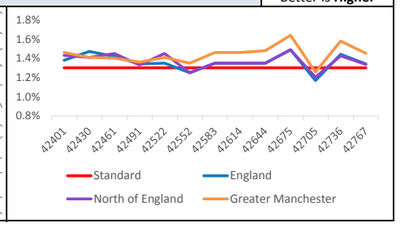
| | |
|---|---|
| Bolton | 83.4% |
| Bury | 84.3% |
| Central | 84.8% |
| HMR | 77.5% |
| North | 81.4% |
| Oldham | 77.0% |
| Salford | 79.0% |
| South | 79.1% |
| Stockport | 80.5% |
| T&G | 80.6% |
| Trafford | 80.2% |
| Wigan | 77.3% |




### Improving Access to Psychological Therapies Access Rate

Better Is **Higher**

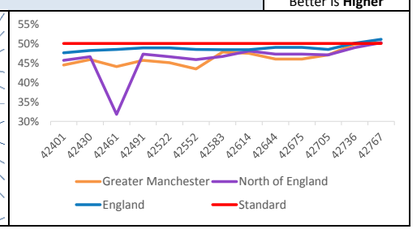
| | |
|---|---|
| Oldham | 2.34% |
| Salford | 1.87% |
| Bury | 1.71% |
| Wigan | 1.49% |
| Trafford | 1.38% |
| Stockport | 1.28% |
| T&G | 1.26% |
| North | 1.21% |
| South | 1.16% |
| Central | 1.14% |
| HMR | 1.06% |
| Bolton | 0.96% |




### Improving Access to Psychological Therapies Recovery Rate

Better Is **Higher**

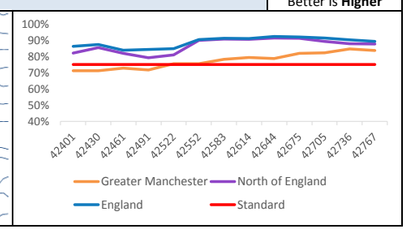
| | |
|---|---|
| Trafford | 68.8% |
| Oldham | 61.8% |
| Stockport | 54.1% |
| Wigan | 53.2% |
| Bolton | 52.6% |
| HMR | 51.5% |
| T&G | 51.4% |
| Bury | 48.4% |
| Salford | 42.0% |
| South | 39.1% |
| North | 38.7% |
| Central | 34.5% |




### Improving Access to Psychological Therapies Seen Within 6 Weeks

Better Is **Higher**

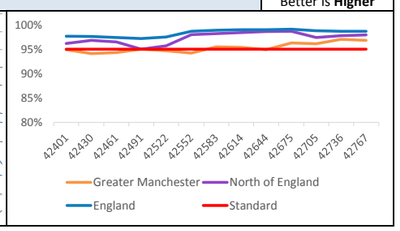
| | |
|---|---|
| Wigan | 100.0% |
| Oldham | 91.2% |
| HMR | 90.9% |
| Trafford | 88.9% |
| Stockport | 87.8% |
| Bury | 87.1% |
| Salford | 87.0% |
| Bolton | 78.0% |
| T&G | 77.1% |
| South | 65.2% |
| North | 59.4% |
| Central | 58.1% |




### Improving Access to Psychological Therapies Seen Within 18 Weeks

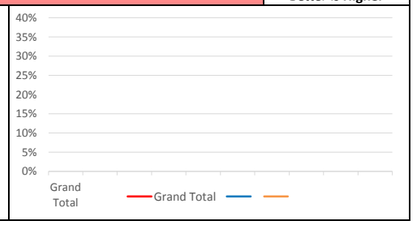
Better Is **Higher**

| | |
|---|---|
| Bury | 100.0% |
| Wigan | 100.0% |
| Oldham | 100.0% |
| Salford | 98.1% |
| Stockport | 97.6% |
| Bolton | 97.6% |
| Trafford | 97.2% |
| T&G | 97.1% |
| HMR | 97.0% |
| Central | 93.5% |
| North | 87.5% |
| South | 87.0% |




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

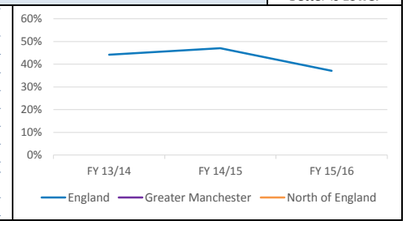
Better Is **Higher**




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

Better Is **Lower**

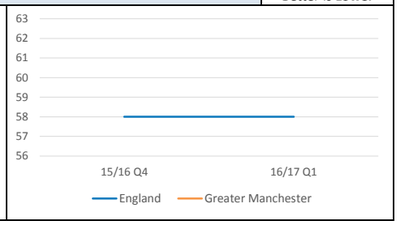
| | |
|---|---|
| Bolton | 64.1% |
| Bury | 47.4% |
| Central | 14.8% |
| HMR | 28.8% |
| North | 40.6% |
| Oldham | 38.7% |
| Salford | 23.1% |
| South | 19.9% |
| Stockport | 27.4% |
| T&G | 41.4% |
| Trafford | 31.9% |
| Wigan | 41.2% |




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

Better Is **Lower**

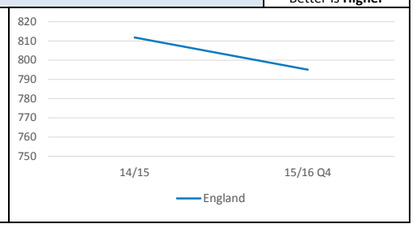
| | |
|---|---|
| Bolton | 63 |
| Bury | 63 |
| Central | 63 |
| HMR | 63 |
| North | 63 |
| Oldham | 63 |
| Salford | 63 |
| South | 63 |
| Stockport | 63 |
| T&G | 63 |
| Trafford | 63 |
| Wigan | 63 |




### Management Of Long Term Conditions

Better Is **Higher**

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




### Out Of Area Placements For Acute Mental Inpatient Care - Transformation

Better Is **Higher**

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

### Children And Young People's Mental Health Services Transformation

Better Is **Higher**

| | |
|---|---|
| Bolton | 85.0% |
| Bury | 85.0% |
| Central | 80.0% |
| HMR | 85.0% |
| North | 70.0% |
| Oldham | 90.0% |
| Salford | 75.0% |
| South | 70.0% |
| Stockport | 0.0% |
| T&G | 0.0% |
| Stockport | DQ Issue |
| Tamside | DQ Issue |

### Crisis Care And Liaison Mental Health Services Transformation

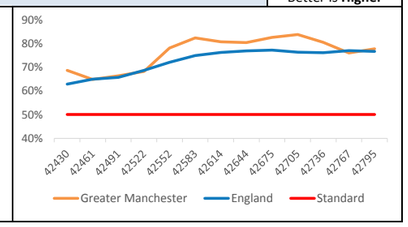
Better Is **Higher**

| | |
|---|---|
| Bolton | 87.5% |
| Bury | 72.5% |
| Central | 67.5% |
| HMR | 70.0% |
| North | 67.5% |
| Oldham | 80.0% |
| Salford | 97.5% |
| South | 67.5% |
| Stockport | 65.0% |
| T&G | 80.0% |
| Trafford | 82.5% |
| Wigan | 60.0% |

### Early Intervention in Psychosis - Treated Within 2 Weeks Of Referral

Better Is **Higher**

| | |
|---|---|
| North | 96.7% |
| South | 94.7% |
| Stockport | 90.0% |
| Bolton | 89.5% |
| Central | 89.3% |
| Bury | 83.3% |
| Wigan | 78.3% |
| Trafford | 76.2% |
| Salford | 75.6% |
| HMR | 55.6% |
| T&G | 52.9% |
| Oldham | 44.8% |

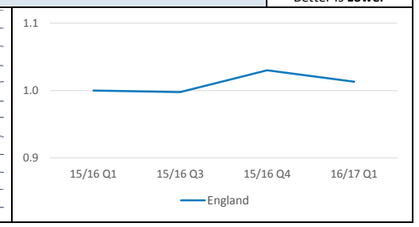


## Decreased Need For Hospital Services With More Community Support

### Population Use Of Hospital Beds Following Emergency Admission

Better Is **Lower**

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




### Emergency Admissions For Urgent Care Sensitive Conditions

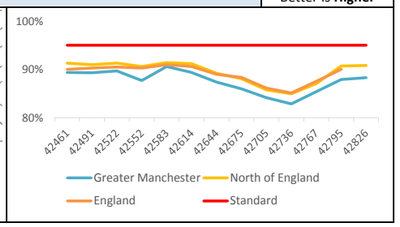
Better Is **Lower**

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

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

Better Is **Higher**

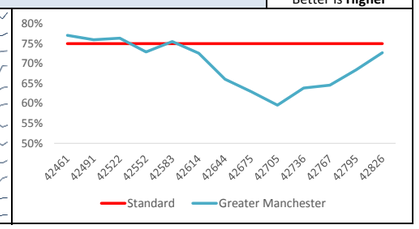
| | |
|---|---|
| UHSM NHS | 94.6% |
| CM NHS FT | 93.7% |
| WWL NHS | 92.7% |
| Salford Roy | 89.9% |
| Stockport N | 85.3% |
| Bolton NHS | 82.5% |
| Tameside N | 81.7% |
| Pennine Ac | 80.9% |




### Ambulance in Red 1 in 8 mins

Better Is **Higher**

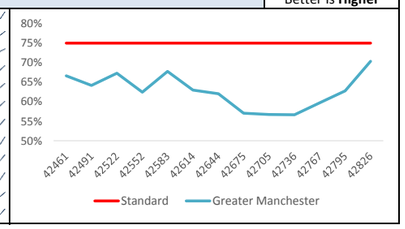
| | |
|---|---|
| Central | 80.0% |
| Bolton | 77.5% |
| North | 77.2% |
| Stockport | 74.8% |
| HMR | 73.4% |
| Oldham | 72.6% |
| South | 71.9% |
| Wigan | 70.5% |
| Salford | 68.5% |
| Trafford | 66.7% |
| T&G | 66.4% |
| Bury | 63.1% |




### Ambulance in Red 2 in 8 mins

Better Is **Higher**

| | |
|---|---|
| South | 79.7% |
| North | 77.4% |
| Central | 72.7% |
| Bolton | 71.6% |
| Oldham | 70.3% |
| Bury | 70.2% |
| Stockport | 69.9% |
| Wigan | 69.0% |
| T&G | 67.4% |
| Salford | 66.4% |
| HMR | 65.1% |
| Trafford | 64.7% |

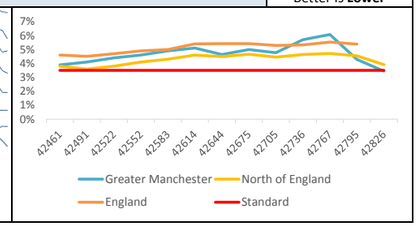



## Improved Transition Of Care Across Health And Social Care

### Delayed Transfers of Care - Bed Days

Better Is **Lower**

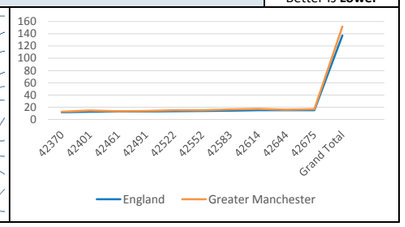
| | |
|---|---|
| WWL NHS | 1.3% |
| CM NHS FT | 2.6% |
| Pennine Ac | 2.9% |
| Salford Roy | 3.3% |
| Stockport N | 4.2% |
| Tameside N | 5.2% |
| Bolton NHS | 5.5% |
| UHSM NHS | 6.7% |




### Delayed Transfers of Care per 100,000 Population

Better Is **Lower**

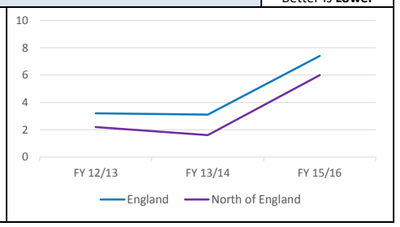
| | |
|---|---|
| Bolton | 16.1 |
| Bury | 11.3 |
| Central | 19.4 |
| HMR | 4.8 |
| North | 17.7 |
| Oldham | 8.4 |
| Salford | 12.2 |
| South | 16.7 |
| Stockport | 29.6 |
| T&G | 24.2 |
| Trafford | 37.7 |
| Wigan | 5.5 |




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

Better Is **Lower**

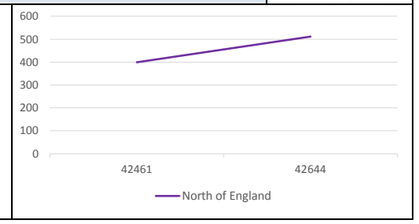
| | |
|---|---|
| Bolton | 4.4 |
| Bury | 5.5 |
| Central | 7.5 |
| HMR | 4.6 |
| North | 7.5 |
| Oldham | 2.3 |
| Salford | 4.2 |
| South | 7.5 |
| Stockport | 3.6 |
| T&G | 6.4 |
| Trafford | 14.5 |
| Wigan | 4.9 |




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

Better Is **Lower**

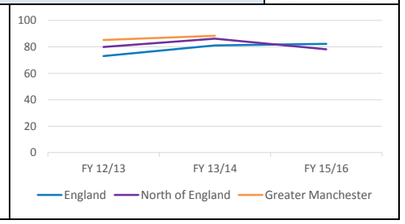
| | |
|---|---|
| Bolton | 496.0 |
| Bury | 297.0 |
| Central | 473.0 |
| HMR | 99.0 |
| North | 473.0 |
| Oldham | 214.0 |
| Salford | 175.0 |
| South | 473.0 |
| Stockport | 963.0 |
| T&G | 1065.0 |
| Trafford | 989.0 |
| Wigan | 178.0 |




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

Better Is **Lower**

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




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

Better Is **Lower**

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

### Percentage Of People Aged 65+ Discharged Direct To Residential Care

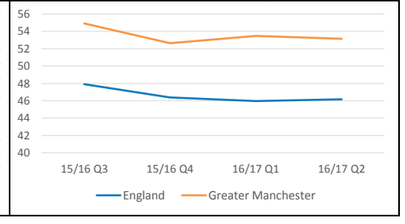
Better Is **Lower**

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

### People Eligible For Standard NHS Continuing Healthcare

Better Is **Higher**

| | |
|---|---|
| Bolton | 59.3 |
| Bury | 27.4 |
| Central | 29.3 |
| HMR | 28.7 |
| North | 31.1 |
| Oldham | 23.3 |
| Salford | 121.8 |
| South | 72.9 |
| Stockport | 27.0 |
| T&G | 62.7 |
| Trafford | 56.9 |
| Wigan | 81.1 |

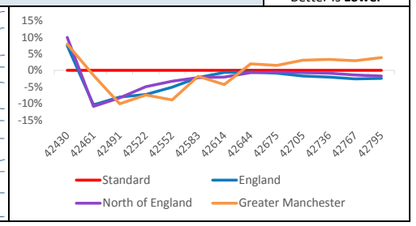


## Placeholder TBC

### C.Difficile (Ytd Var To Plan)

Better Is **Lower**

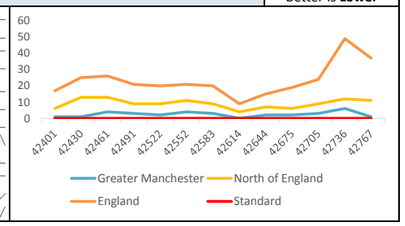
| | |
|---|---|
| Oldham | -22.0% |
| T&G | -16.5% |
| Trafford | -35.9% |
| Salford | -4.8% |
| Wigan | 22.2% |
| North | 5.1% |
| Stockport | 47.8% |
| Bolton | -3.8% |
| South | 2.1% |
| Central | 39.0% |
| Bury | 35.6% |
| HMR | 18.4% |




### MRSA

Better Is **Lower**

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




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

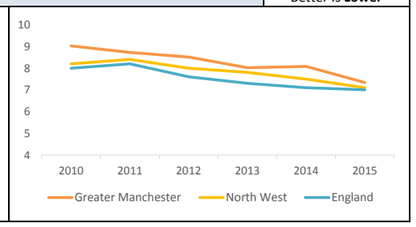
Better Is **Higher**

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

### Neonatal Mortality And Stillbirths

Better Is **Lower**

| | |
|---|---|
| Trafford | 3.9 |
| Tameside | 4.2 |
| Rochdale | 5.2 |
| Wigan | 6.1 |
| Oldham | 7.2 |
| Bury | 7.2 |
| Salford | 8.4 |
| Bolton | 8.9 |
| Stockport | 9.4 |




### Primary Care Workforce

Better Is **Higher**

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

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

Better Is **Higher**

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

### Choices In Maternity Services

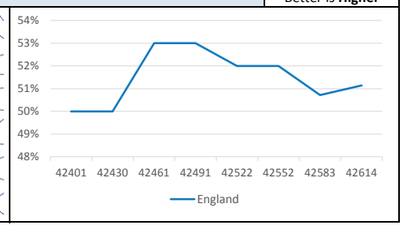
Better Is **Higher**

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

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

Better Is **Higher**

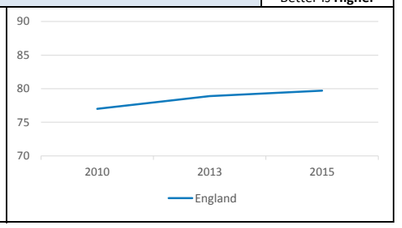
| | |
|---|---|
| Bolton | 99.1% |
| Bury | 69.3% |
| Central | 46.1% |
| HMR | 60.3% |
| North | 72.2% |
| Oldham | 87.1% |
| Salford | 97.7% |
| South | 73.9% |
| Stockport | 61.6% |
| T&G | 10.4% |
| Trafford | 66.3% |
| Wigan | 56.8% |




### Women's Experience Of Maternity Services

Better Is **Higher**

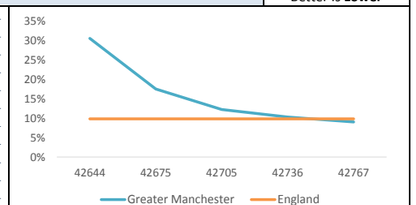
| | |
|---|---|
| Bolton | 82.1 |
| Bury | 82.2 |
| Central | 74.3 |
| HMR | 77.6 |
| North | 82.3 |
| Oldham | 76.9 |
| Salford | 83.5 |
| South | 81.9 |
| Stockport | 82.5 |
| T&G | 77.6 |
| Trafford | 83.1 |
| Wigan | 80.5 |




### Number of Patients not treated for Atrial Fibrillation

Better Is **Lower**

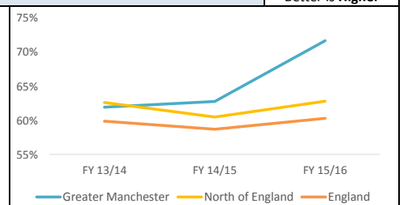
| | |
|---|---|
| Bolton | 7.3% |
| Bury | 4.5% |
| Central | 11.4% |
| HMR | 9.7% |
| North | 10.1% |
| Oldham | 4.6% |
| Salford | 8.4% |
| South | 12.7% |
| Stockport | 9.7% |
| T&G | 10.3% |
| Trafford | 10.4% |
| Wigan | 9.8% |




### Stroke Unit Within 4 Hours

Better Is **Higher**

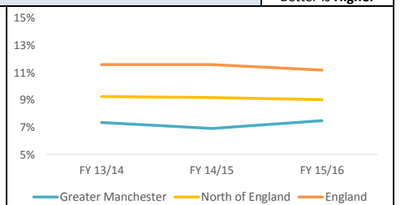
| | |
|---|---|
| Bolton | 76.4% |
| Bury | 75.8% |
| Stockport | 74.4% |
| Oldham | 74.3% |
| HMR | 72.5% |
| South | 72.3% |
| Wigan | 71.6% |
| North | 71.4% |
| Central | 70.9% |
| Trafford | 70.5% |
| T&G | 66.4% |
| Salford | 63.3% |




### Thrombylised Stroke Patients

Better Is **Higher**

| | |
|---|---|
| Oldham | 12.5% |
| Bury | 12.1% |
| HMR | 11.6% |
| T&G | 9.5% |
| Stockport | 9.1% |
| Bolton | 7.5% |
| Central | 6.2% |
| North | 6.0% |
| Trafford | 5.1% |
| Wigan | 4.5% |
| South | 3.4% |
| Salford | 2.9% |



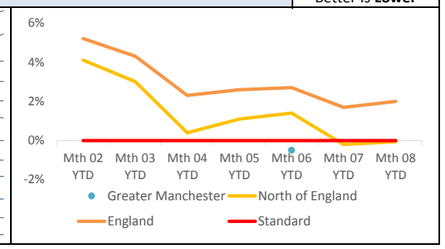
# Sustainability

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

### Activity V Plan: Total Referrals (Specific Acute)

Better Is **Lower**

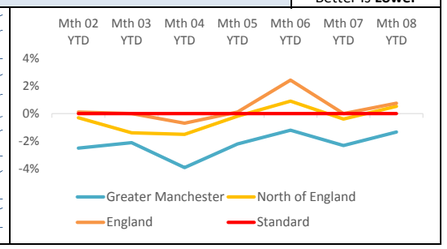
| | |
|---|---|
| Bolton | 14.1% |
| Bury | 1.0% |
| Central | -6.4% |
| HMR | 0.5% |
| North | -7.1% |
| Oldham | 1.5% |
| Salford | -5.4% |
| South | -2.4% |
| Stockport | -3.0% |
| T&G | -5.4% |
| Trafford | -5.5% |
| Wigan | 3.4% |




### Activity V Plan: Total OP Attends (Specific Acute)

Better Is **Lower**

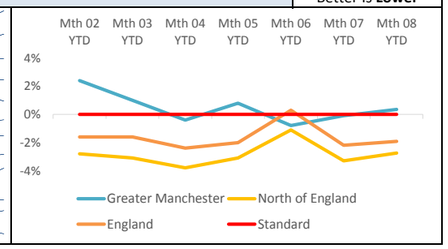
| | |
|---|---|
| Bolton | 3.5% |
| Bury | 0.3% |
| Central | -4.0% |
| HMR | 2.2% |
| North | 1.0% |
| Oldham | -3.8% |
| Salford | 3.2% |
| South | -5.2% |
| Stockport | -2.5% |
| T&G | -10.0% |
| Trafford | -5.9% |
| Wigan | 6.8% |




### Activity V Plan: Total Elective Spells (Specific Acute)

Better Is **Lower**

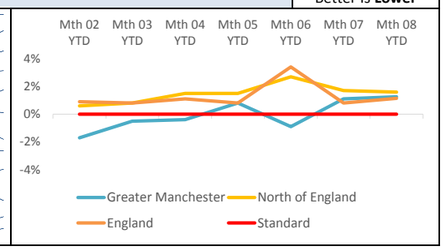
| | |
|---|---|
| Bolton | 6.1% |
| Bury | 1.0% |
| Central | 7.5% |
| HMR | -3.3% |
| North | -3.3% |
| Oldham | -5.1% |
| Salford | 3.2% |
| South | 1.6% |
| Stockport | 5.8% |
| T&G | -13.1% |
| Trafford | 3.2% |
| Wigan | 2.0% |




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

Better Is **Lower**

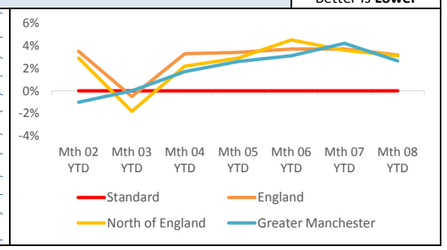
| | |
|---|---|
| Bolton | 1.9% |
| Bury | 6.0% |
| Central | 2.1% |
| HMR | 4.3% |
| North | -1.5% |
| Oldham | -1.6% |
| Salford | 3.3% |
| South | 6.7% |
| Stockport | -2.6% |
| T&G | -5.5% |
| Trafford | -0.4% |
| Wigan | 9.2% |




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

Better Is **Lower**

| | |
|---|---|
| Bolton | -1.8% |
| Bury | 3.8% |
| Central | 3.7% |
| HMR | 0.7% |
| North | 0.9% |
| Oldham | 2.4% |
| Salford | 3.8% |
| South | 1.1% |
| Stockport | 1.3% |
| T&G | 1.5% |
| Trafford | 3.0% |
| Wigan | -2.8% |




### Digital Interactions Between Primary And Secondary Care

Better Is **Higher**

| | |
|---|---|
| Bolton | 81.3% |
| Salford | 72.6% |
| Oldham | 71.5% |
| Bury | 70.0% |
| South | 69.1% |
| North | 67.7% |
| Stockport | 66.0% |
| HMR | 65.7% |
| Trafford | 65.1% |
| Wigan | 63.8% |
| Central | 56.0% |
| T&G | 53.7% |

### Financial Plan 16/17

| | | In-Year Financial Performance 16/17 Q1 | In-Year Financial Performance 16/17 Q2 | - |
|---|---|---|---|---|
| | | | | Better Is **Green** |
| Bolton | #REF! | Green | Green | ◀▶ |
| Bury | #REF! | Amber | Amber | ◀▶ |
| Central | #REF! | Green | Green | ◀▶ |
| HMR | #REF! | Green | Green | ◀▶ |
| North | #REF! | Green | Green | ◀▶ |
| Oldham | #REF! | Green | Green | ◀▶ |
| Salford | #REF! | Green | Green | ◀▶ |
| South | #REF! | Green | Green | ◀▶ |
| Stockport | #REF! | Red | Amber | ▲ |
| T&G | #REF! | Red | Amber | ▲ |
| Trafford | #REF! | Amber | Amber | ◀▶ |
| Wigan | #REF! | Amber | Amber | ◀▶ |

### Local Strategic Estates Plan (SEP) In Place

Better Is **Yes**

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

### Adoption Of New Models Of Care (Placeholder)

Better Is **Higher**

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

### Local Digital Roadmap In Place (Placeholder)

Better Is **Higher**

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

### Expenditure In Areas With Identified Score For Improvement (Placeholder)

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

### Outcomes In Areas With Identified Scope For Improvement (Placeholder)

Better Is **Higher**

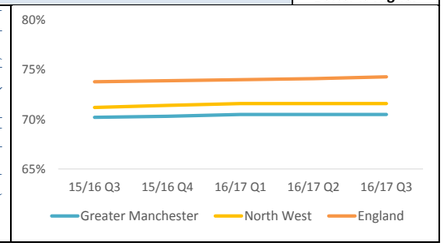
| |
|---|
| Bolton |
| Bury |
| Central |
| HMR |
| North |
| Oldham |
| Salford |
| South |
| Stockport |
| T&G |
| Trafford |
| Wigan |

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

Employment Rate, Resident Population Aged 16-64

Better Is **Higher**

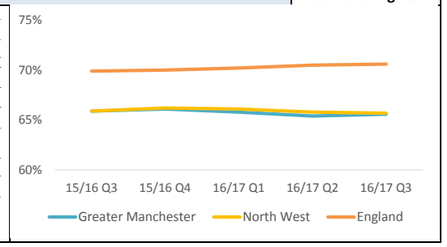
| | |
|---|---|
| Trafford | 79.8% |
| Stockport | 78.6% |
| Wigan | 75.3% |
| Bury | 72.3% |
| Bolton | 71.1% |
| Tameside | 70.3% |
| Salford | 69.5% |
| Oldham | 68.6% |
| Mancheste | 63.3% |
| Rochdale | 62.5% |




Employment Rate, Resident Population Aged 50-64

Better Is **Higher**

| | |
|---|---|
| Stockport | 71.5% |
| Wigan | 70.3% |
| Trafford | 69.0% |
| Oldham | 68.3% |
| Tameside | 66.6% |
| Bolton | 66.4% |
| Bury | 65.1% |
| Salford | 60.4% |
| Mancheste | 59.4% |
| Rochdale | 56.9% |



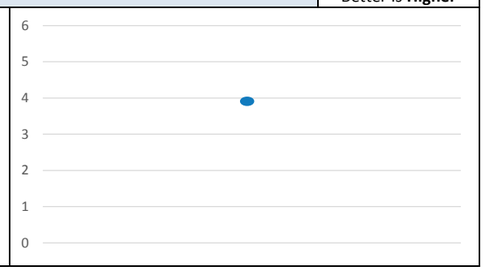
# Well Led

## Placeholder TBC

### Staff Engagement Index

Better Is **Higher**

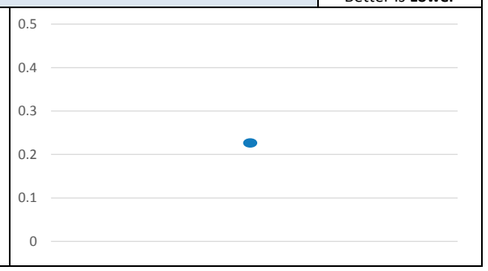
| | |
|---|---|
| Bolton | 3.9 |
| Bury | 3.7 |
| Central | 3.9 |
| HMR | 3.7 |
| North | 3.8 |
| Oldham | 3.7 |
| Salford | 3.8 |
| South | 3.8 |
| Stockport | 3.8 |
| T&G | 3.9 |
| Trafford | 3.8 |
| Wigan | 4.0 |




### Progress Against Workforce Race Equality Standard

Better Is **Lower**

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




### Effectiveness Of Working Relationships In The Local System

Better Is **Higher**

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

### Quality Of CCG Leadership

Better Is G**reen Star**

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

### Sustainability And Transformation Plan (Placeholder)

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

### Probity And Corporate Governance (Placeholder)

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

Select a CCG

1. North ← Select a region
2. STP ← Select STP or DCO
3. ← Select an STP or DCO
4. ← Select a CCG
5. ← Select an indicator

**Print Current CCG to PDF**
**(This will print rows 57 - 116 only)**

# NHS Tameside and Glossop CCG

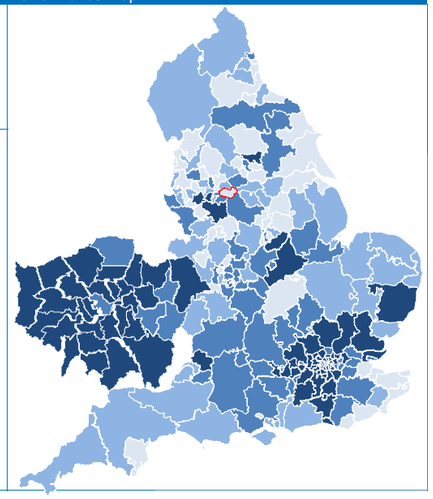
## The 10 closest CCGs to NHS Tameside and Glossop CCG

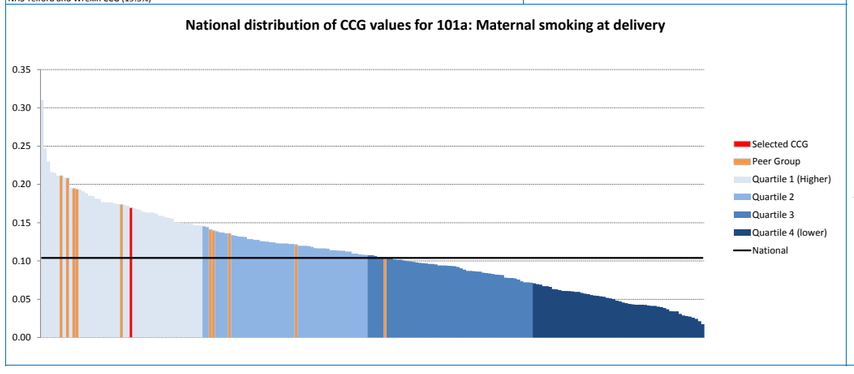
NHS Rotherham CCG (12.1%)
NHS Stoke on Trent CCG (19.4%)
NHS Bury CCG (10.5%)
NHS Wakefield CCG (20.8%)
NHS Hartlepool and Stockton-on-Tees CCG (14.1%)
NHS Barnsley CCG (14.0%)
NHS St Helens CCG (13.6%)
NHS Halton CCG (17.3%)
NHS South Tees CCG (21.1%)
NHS Telford and Wrekin CCG (19.3%)

## What you need to know...

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

## Performance Map

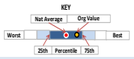





**Please Note**: If indicator is highlighted in GREY, this indicator will be available at a later date

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

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




| | Improvement and Assessment Indicators | Latest Period | CCG | England | Trend | Better is... | Range |
|---|---|---|---|---|---|---|---|
| | **Better Health** | | | | | | |
| ▲ | Maternal smoking at delivery | Q2 16/17 | 16.9% | 10.4% | | L | |
| ◀▶ | Percentage of children aged 10-11 classified as overweight or obese | 2014-15 | 34.1% | 33.2% | | L | |
| ▼ | Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) fo | 2014-15 | 46.8% | 39.8% | | H | |
| ◀▶ | People with diabetes diagnosed less than a year who attend a structured education course | 2014-15 | 0.0% | 5.7% | | H | |
| ▲ | Injuries from falls in people aged 65 and over | Jun-16 | 2,159 | 1,985 | | L | |
| ▼ | Utilisation of the NHS e-referral service to enable choice at first routine elective referral | Sep-16 | 10.4% | 51.1% | | H | |
| ▲ | Personal health budgets | Q2 16/17 | 7.3 | 18.7 | | H | |
| ▼ | Percentage of deaths which take place in hospital | Q1 16/17 | 49.8% | 47.1% | | <> | |
| ▼ | People with a long-term condition feeling supported to manage their condition(s) | 2016 | 61.4% | 64.3% | | H | |
| ▲ | Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions | Q4 15/16 | 1,475 | 929 | | L | |
| ▲ | Inequality in emergency admissions for urgent care sensitive conditions | Q4 15/16 | 3,144 | 2,168 | | L | |
| ▼ | Anti-microbial resistance: appropriate prescribing of antibiotics in primary care | Sep-16 | 1.1 | 1.1 | | <> | |
| ▼ | Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care | Sep-16 | 7.8% | 9.1% | | <> | |
| ▲ | Quality of life of carers | 2016 | 0.78 | 0.80 | | H | |
| | **Better Care** | | | | | | |
| ◀▶ | Provision of high quality care | Q3 16/17 | 55.0 | | | H | |
| ◀▶ | Cancers diagnosed at early stage | 2014 | 44.2% | 50.7% | | H | |
| ▼ | People with urgent GP referral having first definitive treatment for cancer within 62 days of referral | Q2 16/17 | 86.6% | 82.3% | | H | |
| ▲ | One-year survival from all cancers | 2013 | 67.6% | 70.2% | | H | |
| ◀▶ | Cancer patient experience | 2015 | 8.7 | | | H | |
| ▲ | Improving Access to Psychological Therapies recovery rate | Sep-16 | 46.0% | 48.4% | | H | |
| ▲ | People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral | Nov-16 | 89.5% | 77.2% | | H | |
| ◀▶ | Children and young people's mental health services transformation | Q2 16/17 | DQ Issue | | | H | |
| ◀▶ | Crisis care and liaison mental health services transformation | Q2 16/17 | 80.0% | | | H | |
| ◀▶ | Out of area placements for acute mental health inpatient care - transformation | Q2 16/17 | 100.0% | | | H | |
| ▲ | Reliance on specialist inpatient care for people with a learning disability and/or autism | Q2 16/17 | 63 | | | L | |
| ▲ | Proportion of people with a learning disability on the GP register receiving an annual health check | 2015/16 | 41.4% | 37.1% | | H | |
| ◀▶ | Neonatal mortality and stillbirths | 2014-15 | 7.8 | 7.1 | | L | |
| ◀▶ | Women's experience of maternity services | 2015 | 77.6 | | | H | |
| ◀▶ | Choices in maternity services | 2015 | 61.4 | | | H | |
| ▼ | Estimated diagnosis rate for people with dementia | Nov-16 | 74.4% | 68.0% | | H | |
| ▲ | Dementia care planning and post-diagnostic support | 2015/16 | 80.6% | | | H | |
| ◀▶ | Achievement of milestones in the delivery of an integrated urgent care service | August 2016 | 4 | | | H | |
| ▼ | Emergency admissions for urgent care sensitive conditions | Q4 15/16 | 3,269 | 2,359 | | L | |
| ▲ | Percentage of patients admitted, transferred or discharged from A&E within 4 hours | Nov-16 | 86.8% | 88.4% | | H | |
| ▼ | Delayed transfers of care per 100,000 population | Nov-16 | 24.2 | 15.0 | | L | |
| ▼ | Population use of hospital beds following emergency admission | Q1 16/17 | 1.2 | 1.0 | | L | |
| ▼ | Management of long term conditions | Q4 15/16 | 1,276 | 795 | | L | |
| ▲ | Patient experience of GP services | H1 2016 | 83.2% | 85.2% | | H | |
| ◀▶ | Primary care access | Q3 16/17 | 70.7% | | | H | |
| ◀▶ | Primary care workforce | H1 2016 | 1.0 | 1.0 | | H | |
| ▲ | Patients waiting 18 weeks or less from referral to hospital treatment | Nov-16 | 92.6% | 90.6% | | H | |
| ▼ | People eligible for standard NHS Continuing Healthcare | Q2 16/17 | 62.7 | 46.2 | | <> | |
| | **Sustainability** | | | | | | |
| ◀▶ | Financial plan | 2016 | Amber | | | <> | |
| ▲ | In-year financial performance | Q2 16/17 | Amber | | | <> | |
| ◀▶ | Outcomes in areas with identified scope for improvement | Q2 16/17 | CCG not incl | | | H | |
| ◀▶ | Expenditure in areas with identified scope for improvement | Q2 16/17 | Not included | | | H | |
| ◀▶ | Local digital roadmap in place | Q3 16/17 | Yes | | | <> | |
| ▲ | Digital interactions between primary and secondary care | Q3 16/17 | 53.7% | | | H | |
| ◀▶ | Local strategic estates plan (SEP) in place | 2016-17 | Yes | | | <> | |
| | **Well Led** | | | | | | |
| ◀▶ | Probity and corporate governance | Q2 16/17 | Fully complia | | | H | |
| ◀▶ | Staff engagement index | 2015 | 3.9 | 3.8 | | H | |
| ◀▶ | Progress against workforce race equality standard | 2015 | 0.3 | 0.2 | | L | |
| ◀▶ | Effectiveness of working relationships in the local system | 2015-16 | 66.9 | | | H | |
| ◀▶ | Quality of CCG leadership | Q2 16/17 | Green | | | <> | |

**Report to:** **SINGLE COMMISSIONING BOARD**

**Date:** 22 August 2017

**Officer of Single Commissioning Board** Clare Watson, Director of Commissioning

**Subject:** **INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP**

**Report Summary:**

The Locality Executive Group, at their meeting in March 2017, agreed to the development of a system wide strategy for Intermediate Care for Tameside and Glossop to enhance the delivery of intermediate care in the locality. The Single Commission have been asked to co-ordinate this work and to develop a clear timeline, bringing back a fully developed model to the Single Commissioning Board in December 2017.

The vision is for the support to be delivered at home wherever possible. The model should include an element of bed-based care, have clear links with the Integrated Neighbourhoods (including the Extensivists), a robust model for hospital discharge planning, and be able to offer a response to urgent care requests.

The outcomes expected from a model of intermediate care are:

- Maximising independence;
- Preventing unnecessary hospital admissions;
- Preventing unnecessary admissions to long term residential care;
- Following hospital admissions, optimising discharges to usual place of residence.

This report sets out the work undertaken to date, a proposed model for Intermediate Care for Tameside and Glossop, and details of the recommended consultation process.

**Recommendations:**

The Single Commissioning Board are asked to approve the model outlined in the attached report, and agree to consult with option 2 as the preferred option for the Single Commission and Integrated Care Foundation Trust.

**Financial Implications:**

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

| | |
|---|---|
| **Budget Allocation (if Investment Decision)** | £1.983 million (via GM Transformation Funding) |
| **CCG or TMBC Budget Allocation** | CCG |
| **Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration** | Section 75 |
| **Decision Body – SCB, Executive Cabinet, CCG Governing Body** | SCB |

| | |
|---|---|
| **Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons** | Expected savings to be realised of £0.453 million in 2017/18 (part year effect) and £ 0.686 million on a recurrent basis from 2018/19. |
| **Additional Comments**<br>The flexible bed base proposal has been subject to a stringent business case and has been supported by the Project Management Office gateway review process (Stage 2 complete).<br>It is essential that appropriate legal advice is sought in respect of the public consultation prior to inclusion of the report at the next Single Commissioning Board meeting. | |

| | |
|---|---|
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | An open and transparent consultation process is required to attract maximum public engagement in order to ensure the public sector equality duty has been complied with. This should be reflected in the Equality Impact Assessment, which decision makers must have due regard to before making any decision. What needs to be considered is that Option 1 is unlikely to be a viable option as it is not affordable. Therefore is unlikely to be legal. |
| **How do proposals align with Health & Wellbeing Strategy?** | The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy. |
| **How do proposals align with Locality Plan?** | Intermediate care has been identified as a key project for the locality in terms of the model of integrated care and savings assurance programme. |
| **How do proposals align with the Commissioning Strategy?** | The Care Together programme is focused on the transformation of the health and social care economy to improve healthy life expectancy, reduce health inequalities and deliver financial sustainability. This work is a critical part of the programme |
| **Recommendations / views of the Professional Reference Group:** | The Professional Reference Group supported the model outlined in the paper and the recommendation to consult on the 3 options for intermediate care in Tameside and Glossop, with option 2 as the preferred option for the Single Commission and Integrated Care Foundation Trust. |
| **Public and Patient Implications:** | This report outlines a clear intention to include a programme of engagement and formal consultation to ensure the patient and public implications are understood and taken into account. The report includes a full Equality Impact Assessment. |
| **Quality Implications:** | A Quality Impact Assessment has been completed and is attached to this report. |
| **How do the proposals help to reduce health inequalities?** | The proposal will ensure the delivery of intermediate care services which to meet individuals' needs across the locality and addresses health inequalities. |
| **What are the Equality and Diversity implications?** | A full Equality Impact Assessment has been undertaken and is attached to this report. |

| | |
|---|---|
| **What are the safeguarding implications?** | In the design and implementation of the model for intermediate care the commissioner and Integrated Care Foundation Trust will ensure that the model meets all appropriate safeguarding requirements. |
| **What are the Information Governance implications? Has a privacy impact assessment been conducted?** | As part of the implementation of this model of care, a data flow mapping exercise will be undertaken to understand what information will be transferred and to where; from that it will be possible to identify the requirements for robust data sharing agreements and protocols between the parties sending or receiving the data. Beyond that the commissioner will seek assurance from all parties involved in the delivery of intermediate care that appropriate arrangements are in place. The locality's IG Working Group will be used as a forum to sense check the data flows and IG requirements relating to this project. |
| **Risk Management:** | This programme will be managed via the Care Together Programme Management Office and therefore the risks will be reported and monitored via this process |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting Alison Lewin, Deputy Director of Transformation:<br>  Telephone: 07979 713019<br>  e-mail: alison.lewin@nhs.net |

## 1. BACKGROUND AND INTRODUCTION

1.1 The development of a system wide strategy for Intermediate Care for Tameside and Glossop is required to enhance the delivery of intermediate care in the locality.

1.2 The vision is for the support to be delivered at home wherever possible. The model should include an element of bed-based care, have clear links with the Integrated Neighbourhoods (including the Extensivists), a robust model for hospital discharge planning, and be able to offer a response to urgent care requests.

1.3 The outcomes expected from a model of intermediate care are:

- Maximising independence
- Preventing unnecessary hospital admissions
- Preventing unnecessary admissions to long term residential care
- Following hospital admissions, optimising discharges to usual place of residence

1.4 This report sets out the work undertaken to date, a proposed model for Intermediate Care for Tameside and Glossop, and details of the recommended consultation process.

## 2. PROPOSED TIMESCALE AND MILESTONES

2.1 Attached to this report at **Appendix 1** is the proposed timeline for the further development and consultation process, resulting in the presentation of a final model to the Professional Reference Group and Single Commissioning Board in December 2017.

2.2 The Single Commission will engage and consult on the proposed Intermediate Care model described in section 6 of this report, designed to deliver the requirements set in the strategy at **Appendix 2**. The outcome of the consultation will inform the model presented to the Single Commissioning Board in December.

## 3 DEFINITION OF INTERMEDIATE CARE

3.1 The definition of Intermediate Care included in the National Audit of Intermediate Care 2017 (developed with the assistance of the Plain English Campaign) is set out below. This is the definition which will be used in any communication, engagement and consultation work referred to in this report and associated strategy documents. [1]

**What is intermediate care?**
Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system –community services, hospitals, GPs and social care.

**What are the aims of intermediate care?**
There are three main aims of intermediate care and they are to:

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

[1] http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/NAIC%202017/NAIC2017overview.pdf

**Where is intermediate care delivered?**
Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

**How is intermediate care delivered?**
A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

## 4. CASE FOR CHANGE

4.1 A number of factors and service reviews have led to the identification of Intermediate Care as a priority for the Tameside and Glossop locality and the development of the model outlined in this paper.

4.2 **Intermediate Care – Halfway Home:** The Department of Health's 2009 intermediate care guidance, *Halfway Home*[2] defined intermediate care as follows: *Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.* The initial guidance set out definitions of intermediate care, service models, responsibilities for provision and charges and planning. The definition included services that met the following criteria:

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

The *Halfway Home* guidance clearly set intermediate care as an integrated part of a continuum or pathway of services, linking:

- health promotion;
- housing;
- low level support services in the community;
- early intervention and preventative services;
- social care;
- primary care;
- community health services;
- support for carers;
- acute hospital care.

The local intermediate care offer described in this report embraces the philosophy of the Halfway Home guidance, with a focus on delivering care and the required wrap-around support to maximise independence.

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2 http://webarchive.nationalarchives.gov.uk/20130124050747/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

4.3 **National Audit for Intermediate Care 2015:** The results of the National Audit for Intermediate Care from 2015 (based on 2013-14 data from providers and commissioners across the locality) identified the following in relation to the Tameside & Glossop intermediate care model (summary / selection of key indicators):

- An above average investment in intermediate care per 100,000 weighted population (4th highest of the 47 localities which participated);
- Above average beds commissioned per 100,000 weighted population (12th highest);
- Above average investment in bed based care compared with national average (£3.9m against a national average of £2.3m);
- A positive response was provided to 6 of the 13 quality standards;
- A negative response to the commissioning of integrated home and bed based intermediate care services.

The analysis of this report led to the early identification of Intermediate Care as a priority for the developing Care Together programme. A number of developments have taken place, informed in part by this review, which are included in the current model of intermediate care. The National Audit for Intermediate Care is taking place in 2017. The Single Commission and Integrated Care Foundation Trust are participating in the audit to support the ongoing review of the locality's intermediate care system.

4.4 **Tameside & Glossop NHS Foundation Trust Contingency Planning Team (CPT) Final Report September 2015[3]:** Price Waterhouse Cooper were appointed by Monitor to carry out a review of the Tameside and Glossop locality and produced a report which states that improving the way services are currently delivered, through an innovative, more joined-up approach across Tameside and Glossop, will improve the care patients receive and put Tameside NHS Foundation Trust back on to a sound clinical and financial footing. The Contingency Planning Team worked with a range of stakeholders across the locality to develop proposals for a model of care which included a new Urgent Integrated Care Service. Intermediate Care is described as a key element of the Urgent Integrated Care Service (now developed and implemented as IUCT and Home First). One of the features included in the Contingency Planning Team report is that the Urgent Integrated Care Service would be increasingly delivered in people's own homes.

4.5 **Tameside & Glossop Care Together Programme Model of Care:** The Tameside and Glossop Care Together model of care has been developed in response to the Contingency Planning Team report outlined in the section above. The analysis carried out by the Contingency Planning Team, and other reports detailed in this report, suggest that the current community bed base offer within the intermediate care service is not fit for purpose. The current service does not provide an adequate step up facility and does not offer any capacity for people with dementia or delirium following an acute episode. People remain in an acute bed for significantly longer than necessary, with poorer outcomes. It is expected that the remodelled service will offer improved quality for individuals, resulting in better outcomes and increased chances of returning home. The model described in this report would form a key element of the 'Home First' offer, a key strand of the Care Together programme. A key priority of the Care Together programme is to support people at home, wherever possible and safe to do so, or in a community bed where home is not appropriate, to avoid unnecessary hospital attendances, admissions and to ensure safe and prompt discharges. Where an admission has been appropriate, a prompt and safe discharge may require a short placement in a community bed for rehabilitation, reablement, recuperation or to facilitate discharge to assess.

4.6 'Step-Up' facilities: The level of demand for step beds to avoid admissions is not fully understood as the decision to admit is usually related to a clinical need but an alternative

3 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461261/Final_CPT_report.pdf

option may significantly reduce such admissions. Reviews undertaken in the past by the Elective Care Intensive Support Team and Utilisation Management have highlighted an issue with people being in an acute bed when a step up to a nursing bed may have been more suitable and enabled a more accurate assessment of on-going need.

4.7 For people with dementia or delirium, time for recuperation and assessment out of hospital will lead to not only better outcomes but a reduction in length of stay in hospital and reduced risk of premature admission to long term care. Undertaking assessment of people with dementia within an acute hospital setting often leads to inaccurate assumptions being made about their safety to return home, resulting in extended length of stay and increased risk of a permanent residential admission.

4.8 A point prevalence conducted by Utilisation Management in November 2012 at Tameside showed that 43 out of 272 could have been supported in a community bed-based facility and of these five only had a social need with a further eight having a social and therapy need. Thirteen people needed a level of mental health support with or without other therapeutic and nursing needs. The remaining seventeen required a level of health support.

4.9 The utilisation benchmarking analysis of acute and community beds undertaken in December 2015 identified from a cohort of 133 at Tameside that 68 individuals' needs could be better managed in an alternative care setting. Of these 6 could have been in the current community bed-base facility and a further 30 could have been supported in a more flexible bed-base, 19 with mental health support, 4 with nursing support, 4 with social support and two with stroke rehabilitation support.

4.10 The development of intermediate care services with the appropriate level of home and bed based care supports one of the key priorities identified as part of the Care Together programme – frailty – by reducing length of stay for some of the most vulnerable people and by offering an integrated, wrap around support package. We know that 20% of admissions of older people into hospital are inappropriate (National Audit for Intermediate Care 2015) and that 10 days spent in hospital leads to the equivalent of an additional 10 years ageing in the muscles of people aged over 80 (Giles et al 2004) so it is important that people are supported in a service that offers a therapeutic and reabling environment.

4.11 Current Management of the Urgent Care system: the locality operates a process whereby patient flow and delivery of key access requirements across the urgent care system are routinely monitored. One area which is included within this is the use of the intermediate care system. The current offer is used almost exclusively as step down resource, with little access to the beds for step up support, creating increased pressure on the economy when trying to support people in crisis in the community. This often results in unnecessary hospital admissions that result in significant pressure and cost to the wider economy, and reduces the long term prognosis, particularly for older people. There are also times when although the system is under pressure, there are vacancies in the intermediate care beds, as bed based intermediate care is not what is required for the patients in the system.

## 5. STRATEGY DEVELOPMENT AND ENGAGEMENT

5.1 The strategy attached at **Appendix 2** outlines national guidance, local expectations of intermediate care, and the action taken over the past 2 years as part of the Care Together programme to refine the Tameside and Glossop locality model. This document outlines the expectations from the Single Commission for the delivery of intermediate care at home wherever possible, therefore requiring a clear model of community based care and an appropriate level of bed based intermediate care.

5.2 The Single Commission have reviewed the outputs from previous consultation and engagement on intermediate care and the wider Care Together model to inform the model of

Intermediate Care. This includes information extracted from the engagement events facilitated by Action Together and the Glossop Volunteer Centre, and information from Care Together engagement events facilitated by the NHS Benchmark Consulting team during 2014/15.

5.3 A number of engagement activities took place during 2014-2016, through which 602 local people were involved in Care Together and the specific work streams. Action Together, Glossop Volunteer Centre and High Peak Community and Voluntary Support used a range of asset based techniques and engaged with a range of other voluntary, community and faith sector organisations. The methodology used included:

- Focus groups to reach a number service users with who have protected characteristics. 32 sessions where undertaken (15 in Tameside, 18 in Glossop). 330 people were involved.
- Large events which focused on developing a shared understanding of the concepts of Care Together and the development of solutions and aspirations for delivery. There were specific group events (such as the faith sector) and then Neighbourhood based events. Over 100 key community connectors where involved in the neighbourhood based events.
- 1:1 interviews with service users who had experience of the Home First and Discharge to Access Services. In addition, 8 members of staff were also interviewed.

Intermediate care crosses several of the work streams. Key messages from these engagement activities which relate to intermediate care and are addressed by the model described in this paper are:

- We experience health and social care that is disjointed and delivered in silos, and we would welcome more joined up services.
- People strongly support the work being done to co-ordinate and join up services and the importance of multi-agency working, people want to be treated as individuals not in a one size fits all approach or just by their condition and continuity of care also matters.
- Transport and travel to and from services, including voluntary sector support, is one of the biggest issues and influences how people experience and use services. Community based support is seen as a positive solution to address this.

Comments received which were specific to inpatient (bed-based) intermediate care include:

- Surrounding patients by what they have at home so they are confident to return home i.e. home equipment used not industrial.
- Socialising is an important aspect to recovery. The main socialising happens in the dining room, they help each other. They have a purpose to get up and go to it therefore gets people moving and getting stronger walking, therefore become more independent to go home and stay there.
- Social rehabilitation – helps with stand and transfer (people being stronger on their feet) making cups of teas, talking to people.
- People are able to socialise and make new friends – particularly around shared dining.
- There was a strong feeling that having a similar, medically led, set-up in the community would prevent A&E attendance, and provide a bridge between hospital and home.
- Staff understanding and being aware of individual's needs (not treating everyone the same, with the same routine) especially with rehabilitation.
- A co-ordinated approach to the care – caring together.
- Facilities that are homely to help build confidence that they can cope at home

Events were held in May 2014, under the Care Together banner, which were attended by 66 members of staff from across health, social care, independent sector and the 3rd sector. All staff were either providers of intermediate care services, or worked in services forming part

of the pathways using the intermediate care services. The objective of the events was to engage staff in sessions which were intended to:

- Achieve a shared understanding of the current pathway for patients requiring the support of intermediate care and associated admission avoidance schemes.
- Identify and prioritise the key issues to be addressed within the project scope regarding the review of intermediate care services and admission avoidance schemes.

In the sessions staff identified a range of issues relating to the delivery of care, including:

- Gap in the system with no 'step up' pathway into intermediate care which means patients are admitted to hospital, and community teams can't refer to the inpatient intermediate care units.
- Patients stay in hospital whilst they are assessed.
- Lack of consistency across the intermediate care units.

The pathway which was produced in the first of these sessions illustrated a system with multiple points of entry and 'hand offs'. The output from these sessions was a business case which illustrated a model of integrated admission avoidance and intermediate care which has informed the current delivery of services described in section 6 of this report, and which continues to inform the ongoing development of intermediate care services.

The Commissioning Directorate of the Single Commission have undertaken pre-consultation engagement conversations across the locality with the public and staff. The purpose of these sessions was to understand the views of staff and the public on the current system of intermediate care, and the proposed strategic direction and outcomes we expect to see from the model of intermediate care commissioned. Engagement has taken place with staff, the Patient Neighbourhood Groups, and with a range of stakeholders in the community via Glossop Volunteer Centre and Action Together. Attached at **Appendix 3** is the information which was shared with the groups to inform the discussions.

The session with staff currently working in the intermediate care system identified the following issues in discussions which took place during June 2017:

- Intermediate care services need to operate in a way which is 'goal driven' and with a clear end point.
- Patients with palliative care needs should not be excluded.
- Intermediate care needs to focus on the physical needs of the individual but also taken into consideration and be able to support the wider emotional needs, including people with mental health needs.
- The environment in which intermediate care is delivered needs to be conducive to interaction with the individual and provide this physical space to enable this.
- The 'step up' offer and admission avoidance element of intermediate care needs to be expanded, with the appropriate level of medical support.

5.4 The engagement has taken place to date with the 5 Patient Neighbourhood Groups. The general response to the proposed model and outcomes was positive and supportive. Comments received from the groups include:

- Services which patients could have in their own homes either in an attempt to keep them out of hospital, or return home quicker, should be publicised more in; order to make patients and their families/carers aware of these, and how to access them.
- the proposed model of intermediate care covers all elements required - we particularly discussed the use of 'step up' beds and those present felt that GPs should be able to use more step up beds rather than admitting to secondary care.
- Welcome the inclusion of dementia patients within the new model.

- Request that the commissioner considers the position of users of intermediate care in relation to support available at home – consider information to show whether users of services live alone and whether this is taken into consideration when determining an appropriate care plan.

At the request of the Single Commission, Action Together have arranged 7 sessions to discuss the intermediate care proposals, 4 of which have taken place at the time of writing this report. So far they have engaged 55 people in the discussions. Initial comments include the need to support people to be independent, but also safe; the model covers the very practical elements of supporting people to live independently but there needs to be a focus on emotional wellbeing, mental health, dementia, as issues that may have an adverse effect on people living independently; the need for a system which doesn't allow people to 'slip through the net'. Action Together will provide a full report of these activities and this will inform the next iteration of the consultation process.

5.5 Glossop Volunteer Centre have arranged 9 sessions with a range of stakeholders from the Glossop Neighbourhood to present the intermediate care strategy and proposed outcomes. The response to the proposed offer of intermediate care in people's homes was positive, with assurance requested regarding the need for good communication with patients, practical support, and ongoing monitoring to ensure people are safe. The need for 'bed based' care was acknowledged and supported, but with a preference expressed by a significant proportion of those involved for home based care where possible. The proposed aims and outcomes for intermediate care in Tameside and Glossop were supported unanimously, with the proposed addition of an outcome or aim relating to 'person centred care' and the need to acknowledge support for people once the period of intermediate care has been completed.

## 6. PROPOSED MODEL FOR INTERMEDIATE CARE IN TAMESIDE & GLOSSOP

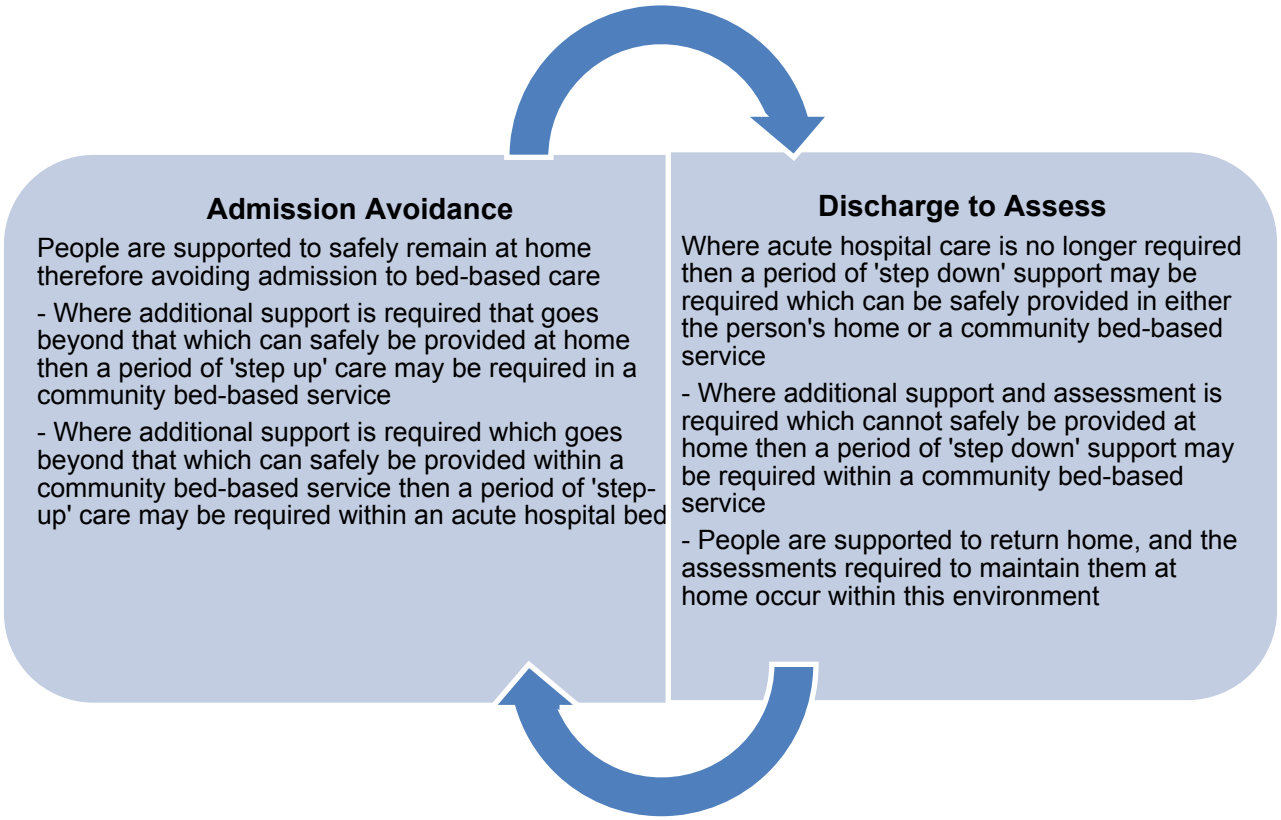
6.1 The proposals for Intermediate Care set out in this report have been prepared jointly by Tameside and Glossop Integrated Care NHS Foundation Trust and the Single Commission and have been designed to support delivery of the Commissioning Strategy for Intermediate care services. The strategy document describes the aim to support rehabilitation and recuperation, maximising people's ability to function independently, and enabling them to continue living at home in all but most challenging cases. With a requirement for:

- Home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) provided by an integrated team providing both health and social care input based on individual need.
- Community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.
- An ability to care for clients with all levels of dementia, in an appropriate setting.

6.2 **Home First:** One of the key principles within the Tameside and Glossop Care Together approach to integrated care is that wherever it is possible for a person to have their care requirements met within their own place of residence, the system will be responsive to meeting this need in a timely manner. This principle is embodied in this proposal for an intermediate care model. In order to be responsive to people's needs and deliver against this principle Tameside and Glossop Integrated Care Foundation Trust has implemented the "Home First" service model. This model will provide a response to meet an urgent/crisis health and/or social care need. Home first is fundamental to the intermediate care offer and is a key interface between the Integrated Neighbourhoods, community services and the acute setting, ensuring people are supported in the environment that is suited to their own care needs and most likely to achieve positive outcomes. This supports the intermediate care aims of:

- Helping people avoid going into hospital unnecessarily;
- Helping people be as independent as possible after a stay in hospital; and
- Preventing people from having to move into a residential home until they really need to.

The Home first model comprises of two key elements:




6.3 The Home First offer will ensure that people are supported through the most appropriate pathway with “home” always being the default position. However, it is recognised that not all individuals’ intermediate care needs can be managed safely in their own home. In some cases there is a need for an alternative community based bed, for a short period of time, to enable the appropriate interventions to be undertaken with the individual to enable them to return home, whether this be following an admission to the Hospital or to avoid the need for an admission in the first place.

6.4 Tameside and Glossop Integrated Care Foundation Trust has identified four core interfaces where services are provided to patients which make up the Intermediate Care model:

- **Integrated Neighbourhood services;**
- **Intermediate / Specialist Community Based Services;**
- **Community Bed Setting;**
- **Acute Hospital Setting.**

Below is a description of how services will be provided at each of these interfaces to make up a holistic intermediate care offer to the local population.

6.5 **Integrated Neighbourhood Services:** The Integrated Care Foundation Trust and the Commissioners are working collaboratively through the Care Together programme to develop five Integrated Neighbourhood Teams, which will be Multi-disciplinary teams comprising Primary care (including GP services and pharmacists), community services such as district nursing and therapy services, social care, Mental Health services and the voluntary/community sector. The vision of these Neighbourhood Teams is to provide place

based care to support neighbourhoods to deliver high quality and connected services which look after the whole neighbourhood population, to support self-care in order to improve outcomes, prosperity and wellbeing. The services will aim to:

- Optimise self-care and family/carers support;
- Help people live as independently as possible;
- Improve condition management;
- Co-ordinate delivery of services from all providers;
- Provide seamless support during periods of crisis and the transition to / from hospital based care;
- Ensure a multi-disciplinary case management approach;
- Use risk stratification data to identify those who may benefit from care co-ordination and put this into place;
- Reduce the need for crisis interventions.

In respect of intermediate care model the Integrated Neighbourhoods through the GP, social care services and community teams will provide a co-ordinated care and support service to people who live in their neighbourhood area who have intermediate care needs, long-term conditions, other ongoing care and support needs, or who are most at risk of unplanned admissions to hospital. The multi-disciplinary team will also link with the intermediate tier/specialist and urgent care services to provide additional care input where required, to step-up services to avoid a hospital admission or social care placement, or support people returning to their place of residence following an acute admission, with the aim of supporting people to be as independent as possible.

The Integrated Neighbourhood Teams will also include social prescribing navigators to help patients and carers to identify non-medical, voluntary and community services that will benefit their overall health and well-being, these might include social or physical services/clubs to encourage social inclusion and physical independence.

6.6 **Intermediate / Specialist Community Based Services:** The Integrated Care Foundation Trust has identified a range of more specialist community based services that are available which provide a link between acute services and the Integrated Neighbourhood Teams. These form a core element of the out of hospital intermediate care offer. The Intermediate Tier services will provide short term intensive interventions to people who require higher intensity or more specialist care than is available within the Neighbourhood services, and provide care to meet the specific aims of the intermediate care strategy of:

- Helping people avoid going into hospital unnecessarily;
- Helping people be as independent as possible after a stay in hospital.

Intermediate Tier services will be provided following a referral from a Neighbourhood service or from the acute setting, to support early discharge from hospital care, or to enable people to remain in their own home for treatment. Risk stratification data will in some cases identify those who may benefit from additional care input based on individual needs. The Intermediate Tier will take a proactive approach to care for people who have ongoing health and care needs, or are at a high risk of experiencing worsening health or unplanned admissions, and will in some circumstances accept self-referrals. The Intermediate Tier services which will provide services for the intermediate care offer include:

- A new Extensivist service has commenced to work with those individuals living with complex ongoing health and care needs, to improve their health and wellbeing and reduce demand on services by ensuring that their care is managed more effectively. This will offer a fundamentally different way of organising care around an individual's needs, including medical, social, psychological, functional, pharmaceutical and self-

care. This will be staffed by specialist Extensivist consultants or GPs, who will work with a cohort of high risk patients identified through risk stratification.

- 7 day Community IV therapy service to provide IV therapy in the home setting.
- Digital Health Service – a new innovative service which provides Care Homes and the Community Response Service with access via SKYPE to an Advanced Nurse Practitioner for clinical consultation and advice.
- Reablement which is a social care service which provides time limited care to intermediate care patients.
- Community Therapy services
- Integrated Urgent Care Team made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team works between the hospital and the community, supporting people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team will have a key role in responding to people with urgent care needs. Ongoing support will then be provided for up to 72 hours to allow for close working with the Neighbourhood Teams, who will manage their ongoing care and support needs where possible.
- Community Social Care services provided by Tameside Metropolitan Borough Council and Derbyshire County Council that will assess and provide care to patients to ensure they are able to remain independent for as long as possible and to delay placements into long term residential care. Social care is a fundamental part of the Integrated Care model in Tameside and Glossop. Progress is being made with proposals for Tameside MBC social care staff to transfer to the Integrated Care Foundation Trust in due course. Closer alignment of services is also planned with Derbyshire County Council for Glossop residents.

The intermediate tier services will focus on ensuring that people have access to specialised care in the community, to avoid unnecessary admissions, and will have a key role in helping coordinate care around an individual's needs, to allow them to return to their normal place of residence as quickly and easily as possible.

6.7 **Community Bed Setting - Overview:** The health and social care economy is currently commissioning community based beds from a range of sources from across the local economy. This includes intermediate care beds, spot beds and an arrangement for discharge to assess beds. In order to improve the community bed offer locally a revised model is being proposed in this report. The key principle of the flexible community bed base model is that support will be delivered through location-based community beds providing general nursing whilst encouraging independence and reablement, alongside in-reach from specialist teams such as therapy services, primary care and mental health. This will ensure individual centred management plans based on care needs that support people's transition back home effectively and ensure a smooth transfer of care, when necessary, to the Integrated Neighbourhood. A flexible community bed-base is key to effective intermediate care as it supports an individual's needs that cannot be met through home based intermediate care. By providing an enabling environment for further assessment, rehabilitation, completion of treatment and/or recuperation, it will prevent unnecessary admissions to hospital (through step up) or into long term care, and facilitate timely discharge to assess for those people not able to be assessed at home but do not require acute hospital based care. When home is not an option for the provision of care for an individual, the flexible community beds base will offer:

- Step down capacity for discharge to assess (including complex assessments);
- Step up capacity to avoid acute admission;
- Intermediate Care Capacity;
- Recuperation beds that offer an opportunity to re-stabilise prior to undertaking rehabilitation;
- Specialist assessment and rehabilitation for people with dementia.

The model will provide community beds for individuals with dementia who are at risk of being admitted to hospital or remaining in a hospital bed because they are awaiting assessments. At present there is no local provision to meet this requirement outside of the acute settings meaning that these individuals remain in hospital for longer than is necessary.

The Integrated Care Foundation Trust is the provider of all intermediate care beds for Tameside and Glossop as of 1 July 2017, and currently provides community beds from two locations: 64 beds in the Stamford Unit at Darnton House[4], which is a 3-floor 96 bedded purpose-built nursing home adjacent to the Tameside Hospital site (the Trust currently uses two floors, one for intermediate care and one for discharge to assess) and 36 intermediate care beds in Shire Hill Hospital located in Glossop.

6.8 **Acute Hospital Setting**: The Acute element of the Intermediate Care model forms part of the "Home First" service that responds the urgent/crisis health and/or social care need for patients. The Home First model is described in detail above, through the Integrated Urgent Care Team and the discharge to assess team, which ensures patients are supported through the most appropriate pathway with "home" always being the goal.

6.9 **Progress to date:** Through the Care Together programme significant progress has been made in implementing and integrating the services outlined in this proposal which will make up the intermediate care offer;

- Five Integrated Neighbourhood teams now established led by a primary care clinical lead and operational Manager and Neighbourhood delivery boards and governance in place.
- Digital Health service in place and rolled out to 15 nursing and residential homes with a plan to roll out to all Tameside and Glossop homes by December 2017.
- Extensivists recruited and service commences in July 2017.
- IV therapy seven day services commence in July 2017.
- Social Prescribing services commenced in Glossop and out to tender for Tameside.
- Provision of discharge to assess and intermediate care beds in Darnton House building.
- Home First Model rolled out and embedded in the Acute hospital and
- IUCT services in place in the community and Acute Hospital
- Reablement Service fully implemented and embedded in the Intermediate Tier structure

6.10 **Community Bed Model – the proposal:** All intermediate care models recognise the need for a bed-based offer. The National Audit of Intermediate Care 2014 showed that whilst locally we spend more than the national average on intermediate care, (beds and community based service) the balance is weighted toward beds with 79% more intermediate care beds than the national average. The Integrated Care Foundation Trust believes that the intermediate care model proposed in this paper redresses the balance to align more closely to the national average and restates the focus of intermediate care away from a purely bed based offer with the embedding of the 'home first' principles.

[4] Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1st July 2016 with the CQC the location of The Stamford Unit at Darnton House. This was to provide a community in-patient facility as part its intermediate care services. Services in the Stamford Unit at Darnton House are accessed via agreed Trust patient pathways and it operates as community wards for medically stable patients who are having their discharge planned and enabled. They form part of services provided by the Trust as a provider of commissioned Acute and Community services for the population of Tameside and Glossop within the Integrated Care Foundation Trust.

If Tameside and Glossop intermediate care beds were in line with the national average for our population we assessed that we would need 65 beds.

The Integrated Care Foundation Trust is the provider of all intermediate care beds for Tameside and Glossop as of 1 July 2017, and currently provides community beds from two locations: 64 beds in the Stamford Unit at Darnton House and 36 intermediate care beds in Shire Hill Hospital located in Glossop. Therefore a total of 100 community beds in the system, 68 of which are currently 'intermediate care' beds.

Alongside the ongoing development and delivery of the Integrated Neighbourhoods and intermediate tier services, and the implementation of the Home First model (which ensures delivery of robust intermediate care services in the home setting) this paper proposes that all the community beds should be located in a single location in order to utilise the resource flexibly to meet the needs of people in Tameside and Glossop, and fully deliver the service model for intermediate care beds. Offering these services from a single site provides the opportunity for a more holistic, flexible and skilled workforce. Staffing resource would be focussed on one site so able to work across and with a wide range of conditions, providing resilience and responsiveness.

6.11 **Options for delivery of bed based intermediate care:** In order to deliver the proposed model, a number of options have been considered. The Single Commission and Integrated Care Foundation Trust identified 3 options for the delivery of a flexible community bed base. All options should be considered alongside the ongoing development and delivery of the Home Frist model, Integrated Neighbourhoods, the Intermediate / Specialist Community Based Services, and acute hospital based elements of intermediate care.

**Option 1**: **Maintain current arrangements**
Delivery of bed based intermediate care from the Stamford Unit at Darnton House (32 beds) and Shire Hill in Glossop (36 beds).

The view of the Single Commission and Integrated Care Foundation Trust is that this is not a sustainable model going forwards. As described in the report, the economy is not functioning to its optimum: people are in acute beds that do not need to be, they are in these beds for longer than they need to be, and they are unable to access the services they require at the time they need them. The current arrangements are fragmented – beds are delivered across 2 sites – Shire Hill and the Stamford Unit at Darnton House. At present staff are working from a number of bases, with the expectation that community and neighbourhood staff travel across the locality, diluting the capacity and time that could be inputted with individuals to maximise the potential for returning home promptly. This option does not deliver the vision of a single location for bed based intermediate care.

**Option 2: Use of available 96 bedded unit**
Transfer of all bed-based intermediate care to a single location in the Stamford Unit at Darnton House. This is the preferred option from the assessment carried out by the Single Commission and Integrated Care Foundation Trust for the following reasons:

- Whilst the aim of the home first model is to use the community beds flexibly to meet the demand at any point in time, the notional intermediate care bed figure proposed is 64 beds.
- Patient Environment - The Stamford Unit is 100% en-suite single room accommodation with significant communal space on each of the three wards which has been demonstrated to encourage social interaction and independence. Additionally one floor of the Stamford Unit in the Darnton Building has been designed as dementia friendly with access to outside space and wandering routes, which will enable the Trust to provide community beds for patients with Dementia.
- Accessibility – the Stamford Unit is located in a central location and is co-located close to the Tameside Hospital site and therefore has strong public transport links, ample parking

and is easily accessible for patients and relatives. Additionally easy access and short journey times for health care professionals and support services into Darnton Building will enable development of in-reach into the unit as proposed in the model.

- Recruitment and Retention – recruitment and retention of nursing and support staff at the Shire Hill hospital site is an ongoing risk due to the remote location at the edge of the conurbation and lack of public transport access.
- Single location – option 2 supports the delivery of bed based intermediate care from a single location to enable the flexible use of community beds to support the Home First model and enable the approaches to Discharge to Assess and Intermediate Care to be flexed depending on the demands in the system at any point in time.
- Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1 July 2016 with the Care Quality Commission the location of The Stamford Unit at Darnton House.
- This option meets the national definition of 'intermediate care' from a combination of home and bed-based services and is in line with the recommendations of the Contingency Planning Team report from 2015 (referred to in section 4.4).

**Option 3: Stimulation of the Local Market to Develop Single / Multi Site**
Engagement with local providers to develop capacity within existing care homes, or the development of capacity in new homes is an option. Whilst the benefits of a larger scheme would not be realised, it is possible that in the longer term, once the Integrated Neighbourhoods and Home First models have fully embedded, that there could be a benefit to developing capacity at a neighbourhood level. The maturity of the wider economy may mean that fewer community beds are required, and that services could be developed at a neighbourhood level to meet need.

This option relies on their being the engagement from providers to invest locally in increasing capacity. Should this be available there would be a lead in time to any new building, which would again require a short term solution until additional bed capacity is developed. There are a number of providers who have indicated their interest in working on developments with the Single Commission so this is something that is possible to negotiate. While the current capacity has been estimated, it is difficult to commit at this time to the capacity that may be required in the economy in 2-3 years' time, which is the information a provider would need in order for providers to invest in new capacity.

6.12 **Proposal**: The proposal is that the Single Commission with the Integrated Care Foundation Trust enter into a formal consultation programme, based on the 3 options outlined above, stating the case for the current preferred option as **Option 2**.

## *7.* FINANCIAL MODEL

7.1 The Care Together Project Management Office are supporting the locality's 'Savings Assurance' programme by ensuring a consistent approach is applied to all projects, using a gateway approach to scope and approve projects via the Finance Economy Workstream and Locality Executive Group.

7.2 **Financial Summary of Current Position:** The recurrent funding available for the provision of intermediate care inpatient services within Tameside and Glossop equated to c £8.7m per annum, with a total spend if we "did nothing" of £9.75m due to overspends on agency spend due to recruitment pressures. Spot beds were funded in 2016/17 non-recurrently, this equated to £0.75m.

7.3 **Financial Summary of Proposal – Flexible Community Beds:** The proposal requires funding for £8.26m for the provision of 96 flexible community beds at Darnton house. This delivers a saving on a recurrent basis of **£0.69m** against recurrent budget from 1 April 2018.

7.4 **Current Position vs Proposal –** Flexible Community Beds:

| | Proposed<br>£'000 | Current Budget<br>£'000 | Do Nothing Expenditure<br>£'000 |
|---|---|---|---|
| Budget | 8,032 | 8,718 | 9,746 |
| Variance | NA | *-686* | *-1,027* |

7.5 **Financial Summary of Transitional Costs – Flexible Community Beds:** It is assumed that there is **c £1.9m** available for this proposal in transitional funding (non-recurrently) as part of Greater Manchester transformation fund.

- The transitional costs required for this model are outlined in the paragraph below in bold font:
  - Temporary winter beds (32) between November 2016 to June 2017;
  - Double running costs from April 2017 to secure accommodation of Darnton house and facilitate a safe patient transition of service.

- The total cost of the schemes above equate to c £2.2m, leaving a balance of c£0.28m which will be required to pay for any transitional costs associated with relocation of services including:
  - Decanting/Dilapidation/ Removal costs;
  - One off setup costs, required in additional to what has been included within the financial model.

An analysis of the transformational funding costs by financial year is below;

| | 2016/17<br>£'000 | 2017/18<br>£'000 | Total<br>£'000 |
|---|---|---|---|
| Planned Spend of Transformational Funds | 851 | 1,132 | 1.983 |

## 8. CONSULTATION

8.1 The proposals included in section 6 include the intention to bring together a community bed provision on a single site that can be flexed and responsive to meet clinical demands, whilst supporting the principles of 'home first'. This is a level of change to service delivery which requires a period of formal consultation.

8.2 The consultation needs to offer local people the opportunity to comment on the proposals and options which have been developed and considered by the Single Commission and the Integrated Care Foundation Trust. The proposed options for consultation, the details of which can be seen in section 6.11, are:

- **Option 1:** Maintain current status.
- **Option 2:** Use of available 96 bed facility and co-location of all intermediate and community beds as 'flexible bed base' model (Stamford Unit, Darnton House).
- **Option 3:** Stimulation of the market to develop a single / multi-location base.

The 3 options will be presented along with the details of how the system came to the conclusion that the preferred option is the co-location of services in the Stamford Unit at Darnton House.

8.3 Details of the consultation questions are included at **Appendix 6** of this document. A consultation booklet and Frequently Asked Questions will be produced to support this consultation.

8.4 The content of this report will be used to produce summary documents to support the public consultation process.

8.5 The consultation will be in the form of a standard questionnaire with an introduction to explain the reason for the changes followed by a series of questions. Additionally there will be a free format text box to allow people to provide any comments, views and suggestions they wish to be taken into account.

8.6 The survey will form part of Tameside MBC's Big Conversation consultation which is prominently publicised via the Council's website. The consultation pack will also be available in paper format from any GP surgery and a range of hospital and community locations from which services are currently delivered.

8.7 In order to encourage as many people as possible to express their views contact will be made with a range of organisations with a request to make their service users, groups and members aware. Due to the identification of an impact on certain Protected Characteristic Groups, this work will include some focused discussions with representatives from stakeholder groups representing over 65s, those with dementia, carers, and people with disabilities. The link to the on-line consultation along with a word document version for printing in paper format will be provided.

8.8 Staff in the Integrated Care Foundation Trust, Tameside MBC and Derbyshire CC will be made fully aware of the consultation and will be encouraged to complete the survey so that their perspective can be included in the evaluation.

8.9 General Practice will be involved in the consultation via the 5 Neighbourhood Commissioning Forums and the Commissioning Business Managers. A Clinical Commissioning Group Governing Body clinical lead for this work has been identified to support the wider consultation process and the engagement with primary care colleagues (Dr Alison Lea).

8.10 Subject to approval from the Single Commissioning Board a programme of consultation will commence on 23 August, and will run for 12 weeks until 15 November 2017.

## 9. ALIGNMENT WITH REVIEW OF ESTATES

9.1 The Single Commission and Integrated Care Foundation Trust are working together, via the Strategic Estates Group, on a review of the 'Neighbourhood Assets' to ensure alignment between any proposals arising from the intermediate care strategy and the plans for the estate in the locality.

## 10. QUALITY AND EQUALITY IMPACT ASSESSMENTS

10.1 Detailed Quality and Equality Impact Assessments have been undertaken to support the proposals included in this document, which will be used to support the consultation process. These can be seen at **Appendices 4 and 5**

## 11. ONGOING AUDIT AND EVALUATION

11.1 The Single Commission are participating in the 2017 National Audit of Intermediate Care and will use the outputs of this audit, along with local performance and service quality

information, to ensure a system wide ongoing review of intermediate care services in the locality as part of the locality model of integrated care.

## 12. RECOMMENDATION

12.1 As set out on the front of the report.

# Appendix 1

**Timetable for Intermediate Care Model Development & Consultation**

| | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|
| Draft initial strategy | | | | | | | | | | |
| Ongoing development of strategy & model | | | | | | | | | | |
| Pre-consultation engagement | | | | | | | | | | |
| Paper to PRG & SCB - draft strategy & plan | | | | | | | | | | |
| Produce consultation documents/model | | | | | | | | | | |
| Consultation and engagement | | | | | | | | | | |
| Produce final proposal | | | | | | | | | | |
| Final proposal to SCB | | | | | | | | | | |

# Appendix 2

## Intermediate Care Strategy – Tameside & Glossop

### 1. Outline of this Strategy

This initial outline strategy sets out the intentions for the commissioning of intermediate care at home wherever possible, the model for bed-based services, and includes links with Integrated Neighbourhoods (including the Extensivists) and a robust model for hospital discharge planning.

This paper sets out an initial draft outline strategy. Commissioners will develop the detail, through wider engagement and consultation, with a view to having a detailed model agreed and ready to implement by late Autumn /early Winter 2017.

### 2. What is Intermediate Care?

The definition of Intermediate Care included in the National Audit of Intermediate Care 2017 (developed with the assistance of the Plain English Campaign) is as follows.

**What is intermediate care?**
Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system –community services, hospitals, GPs and social care.

**What are the aims of intermediate care?**
There are three main aims of intermediate care and they are to:

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

**Where is intermediate care delivered?**
Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

**How is intermediate care delivered?**
A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

### 3. Background

3.1. **National Audit of Intermediate Care findings 2015:** The results of the NAIC from 2015 (based on 2013-14 data from providers and commissioners across the locality) identified following in relation to the Tameside and Glossop intermediate care model (summary / selection of key indicators):

- An above average investment in intermediate care per 100,000 weighted population (4th highest of the 47 localities which participated)

.

- Above average beds commissioned per 100,000 weighted population (12th highest)

- Above average investment in bed based care compared with national average (£3.9m against a national average of £2.3m).

- A positive response was provided to 6 of the 13 quality standards

- A negative response to the commissioning of integrated home and bed based intermediate care services

The analysis of this report led to the early identification of Intermediate Care as a priority for the developing Care Together programme. A number of developments have taken place, informed in part by this review, which are outlined in section 5 of this strategy.

3.2. **Utilisation Management Review 2014/2015:** The Tameside and Glossop locality commissioned 2 reviews from the North West Utilisation Management Team (Academic Health Science Network) to increase understanding of Intermediate Care service demand and flow. The recommendations included in the 2 reports will be used as background information to support the 2017 review of Intermediate Care and the development of a system wide strategy. The 2015 was undertaken to support the Clinical Commissioning Group in establishing optimal Intermediate Care bed based service capacity.

3.3. **Staff and Public Engagement:** A summary of engagement work undertaken previously as part of the wider Care Together programme will be analysed and the information used in the further development of this model and strategy. This engagement involved patients, public and staff. Patient and service user satisfaction information held as part of the commissioner's ongoing contract monitoring will also be used.

## 4. National Audit for Intermediate Care (NAIC) 2017

The National Audit for Intermediate Care focuses on services which support, usually frail, elderly people, at times of transition when stepping down from hospital or preventing them being admitted to secondary or long term care. These services are a crucial part of the solution to managing increasing demand in the health and social care system.

This audit was last carried out in 2015, the results of which are summarised in section 3 above, and is being repeated in 2017 (data collection being undertaken during May and June). The audit shines a light on intermediate care and provides a stocktake of current service provision. The unique combination of organisational data and outcomes data collected in the audit enables us to address the following questions:

- Does intermediate care work?
- Is it cost effective?
- Do we have enough capacity to make a difference?
- What are the features of a "good" service?
- How do we make the case for investment?

The audit allows commissioners / funders and providers to consider both the national answers to these questions but also, importantly, how their local health and social care economy is performing on these key issues. Audit participants can access their local results via an online toolkit.[5]

The NAIC covers 4 categories for intermediate care: crisis response, bed based intermediate care, home based intermediate care and reablement.

The Clinical Commissioning Group/Single Commissioning Function are co-ordinating Tameside and Glossop registration and involvement in this audit for 2017 to ensure the data informs the review being undertaken by the economy. The results will be available in late autumn 2017.

[5] http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/NAIC%202017/NAIC2017auditproposal.pdf

Commissioners and the Integrated Care Foundation Trust have signed up to participate in the National Audit for Intermediate Care.

## 5. Progress to Date

This section outlines progress to date on the development of a system of intermediate care for the Tameside and Glossop Locality and the current position / provision.

5.1. **Home First:** The Single Commission and Integrated Care Foundation Trust undertook a piece of work in 2016-17 on the Home First model as part of the Care Together programme. The Tameside and Glossop Integrated Care Strategy will take into account the findings and outcomes from this piece of work in the initial draft / proposed model. In summary, the Home First model is the service offer that responds to meet an urgent/crisis health and/or social care need that cannot be managed within the Integrated Neighbourhood. It is a key interface between the Integrated Neighbourhood and the acute setting ensuring that people are supported in the environment that is suited to their own needs and most likely to achieve positive outcomes. It comprises of two key elements: Admission Avoidance and Discharge to Assess. A 'flexible community bed base scheme' is a key element of the home first model, and therefore needs to form part of this Intermediate Care Strategy. The main elements of Home First are:

- **Stamford Unit:** This will offer 32 beds for people who have been in hospital and who cannot immediately return home because they require further recuperation, or possibly further assessments that cannot be carried out at home.

- **Shire Hill and Grange View Intermediate Care beds:** These two facilities offer an ongoing period of rehabilitation to people who are unable to cope in their own home and require intensive rehabilitation to maximise the opportunity for them to return home either before an emergency admission is required or after a hospital admission. The maximum length of stay is 6 weeks and will vary dependant on the needs of an individual patient. Typically patients who need rehabilitation stay less than 26 days. Since April 2017 the number of Intermediate Care beds has reduced to reflect the level of need for bed based rehabilitation. This has resulted in the closure of the Grange View unit from 1 July.

- **Integrated Urgent Care Team (IUCT):** This is an integrated team made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team currently works between the hospital and the community and works with people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team is an urgent response team and plans to get to people within an hour of the request for help and support. Ongoing support will then be provided for up to 72 hours by when decisions will have been made about onward care and support needs

- **Intermediate Tier Development:** Work is underway within the Integrated Care Foundation Trust to develop an intermediate tier service that is more integrated in nature and as a starting point is beginning to co-locate many of the services that are identified as offering rehabilitation, reablement, urgent and early intervention. The service identified as having an input into an intermediate tier of service include the Integrated Urgent Care Team, Reablement Service, Home First and Digital Health, IV Therapy Team, Long Term Conditions Team, Extensivists, Community Neuro Rehabilitation Team, Community Physiotherapy and Pulmonary Rehabilitation Team, Speech and Language Therapy and Dietetics as well as the community beds currently provided at Shire Hill, Grange View and the Stamford Unit.

5.2. **Integrated Neighbourhoods:** The Integrated Care Foundation Trust have implemented a model of Neighbourhood working in response to the Single Commission's proposal for

Integrated Neighbourhoods (INs). The Integrated Neighbourhoods vision is to support neighbourhoods to deliver asset rich, high quality and connected services which look after the whole neighbourhood population to support all to have improved outcomes, prosperity and wellbeing. The key objectives are to:

- Proactively identify people at high risk of requiring access to services, through early intervention and prevention;
- Help people 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 each of the Neighbourhoods;
- Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely;
- Focus on improved condition management to avoid admissions;
- Help prevent people from having to move to a residential or nursing home (24 hour care) until they really need to.

5.3. **Extensive Care:** Extensive Care is a fundamentally different way of organising care around the needs of a specific cohort of people, which includes all aspects of need: medical, social, psychological, functional, pharmaceutical and self-care. The aim of an extensive care service model is to work closely with people with long term conditions, complex needs and those who are intensive users of the health and social care system. Within an agreed timeframe it aims to move to predicting exacerbations of underlying conditions, whilst helping people improve the management of their condition and their overall general health and well-being, therefore reducing the need for hospital admissions. The service implemented by Tameside and Glossop Integrated Care Foundation Trust will be led by a neighbourhood-based doctor (Consultant/GP) known as an Extensivist, supported by a multi-disciplinary team of health and social care professionals. The service includes health and well-being support that pulls together health and social support, including a range of community assets to ensure early intervention and proactive prevention. The service will also reduce the number of appointments that patients attend at different locations within our local health and social care system.

5.4. **Reablement:** The Reablement Service is currently provided by Tameside MBC Adult Services and has been in place for many years. The aim of the service is to enable people to attain or retain key skills for independent living. The service is provided by trained support workers who work with people for a period of up to six weeks following a period of ill health or trauma. The Reablement Service offers an intensive period of assessment and support that enables a person, in partnership with other clinicians and practitioners to realise their optimum potential for regaining, or in some cases learning or re-learning skills to enable them to live fuller lives and to have less dependency on more intrusive longer term services. Successful reablement will result in a person requiring less or no ongoing help and support in their daily living.

## 6. Future Model

Intermediate care services provide a crucial role in helping people to avoid going into hospital unnecessarily, helping people to be as independent as possible after a stay in hospital, and preventing people from having to move into a residential or care home until they really need to.

The overall aim of the intermediate care services is to support the rehabilitation and recuperation of patients maximising the patients' ability to function, to enable them to continue living at home in all but most challenging cases.

This should include home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) provided by an integrated

team providing both health and social care input based on individual need. The model should also include community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.

The delivery model for intermediate care, including the assessment processes, must have the ability to care for clients with all levels of dementia, in an appropriate setting.

The further development of a model for Tameside and Glossop will take account of the outputs from previous audits and reviews, and the learning from the developments which have taken place during 2016-17 (as outlined above).

## 7. Proposed Outcomes

The further development of this Intermediate Care strategy will include the proposal and agreement of a set of system-wide outcome measures to assess the impact on:

- Maximising independence
- Preventing unnecessary hospital admissions
- Preventing unnecessary admissions to long term residential care
- Following hospital admissions, optimising discharges to usual place of residence

Service user outcome measure: using the information included in the 2017 NAIC, local service user outcome measures will be developed and refined, initially in the workshops scheduled for June 2017, and then refined through the wider consultation process July-September.

# Appendix 3

**Pre-Consultation Engagement Material**

## Intermediate Care in Tameside & Glossop

The Clinical Commissioning Group are leading a review of Intermediate Care services in Tameside & Glossop and are seeking advice from patient and public representatives.

The work done so far has been informed to a significant degree by the engagement activities led by our 3rd sector through Action Together and Glossop Volunteer Centre. Comments made through the engagement work to support Care Together have been used to develop the current Strategy which informs the model we commission from Tameside and Glossop Integrated Care Foundation Trust, and the developments which have taken place over the past 18 months. The reports from the sessions have been analysed and any information which relates to intermediate care has been taken and used in the development of the full strategy presented to the Clinical Commissioning Group/Single Commission committees.

We are seeking further comments on our plans for Intermediate Care.

**What is Intermediate Care?**

The definition of Intermediate Care included in the National Audit of Intermediate Care 2017 (developed with the assistance of the Plain English Campaign) is as follows.

**What is intermediate care?**
Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system –community services, hospitals, GPs and social care.

**What are the aims of intermediate care?**
There are three main aims of intermediate care and they are to:

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

**Where is intermediate care delivered?**
Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

**How is intermediate care delivered?**
A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

Intermediate care services are currently delivered to the population of Tameside and Glossop Clinical Commissioning Group by the Integrated Care Foundation Trust as community, hospital and bed-based intermediate care services (the latter at Darnton House and Shire Hill), and by Tameside Metropolitan Borough and Derbyshire County Councils.

| | |
|---|---|
| **Question**: | The section below is a summary of the model we intend to commission / deliver in Tameside and Glossop. We would appreciate your comments on whether this is the right model, and any additional suggestions you may have. |

**Model of Intermediate Care**

Intermediate care services provide a crucial role in helping people to avoid going into hospital unnecessarily, helping people to be as independent as possible after a stay in hospital, and preventing people from having to move into a residential or care home until they really need to.

The overall aim of the intermediate care services is to support the rehabilitation and recuperation of patients maximising the patients' ability to function, to enable them to continue living at home in all but most challenging cases.

This should include home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) provided by an integrated team providing both health and social care input based on individual need. The model should also include community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.

The delivery model for intermediate care, including the assessment processes, must have the ability to care for clients with all levels of dementia, in an appropriate setting.

The further development of a model for Tameside and Glossop will take account of the outputs from previous audits and reviews, and the learning from the developments which have taken place during 2016-17.

| | |
|---|---|
| **Question:** | The section below is a summary of the outcomes we want to achieve from our Intermediate Care model. We would appreciate your comments on whether these are the right outcomes, and any additional suggestions you may have. |

**Proposed Outcomes**

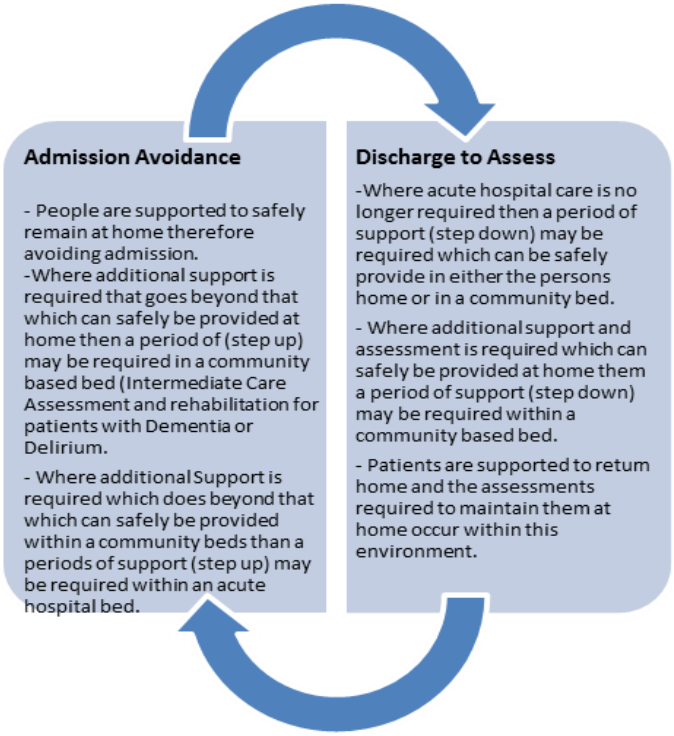
The further development of this Intermediate Care strategy will include the proposal and agreement of a set of system-wide outcome measures to assess the impact on:

- Maximising independence;
- Preventing unnecessary hospital admissions;
- Preventing unnecessary admissions to long term residential care;
- Following hospital admissions, optimising discharges to usual place of residence.

## Intermediate Care in Tameside & Glossop

This summary outlines progress to date on the development of a system of intermediate care for the Tameside and Glossop Locality and the current position / provision.

**Home First:** In summary, the Home First model is the service offer that responds to meet an urgent/crisis health and/or social care need that cannot be managed within the Integrated Neighbourhood. It is a key interface between the Integrated Neighbourhood and the acute setting ensuring that people are supported in the environment that is suited to their own needs and most likely to achieve positive outcomes. It comprises of two key elements: Admission Avoidance and Discharge to Assess. A 'flexible community bed base scheme' is a key element of the home first model.




The main elements of Home First are:

- **Stamford Unit:** Offers bed based support for people who have been in hospital and who cannot immediately return home because they require further recuperation, or possibly further assessments that cannot be carried out at home.

- **Intermediate Care beds:** These facilities offer an ongoing period of rehabilitation to people who are unable to cope in their own home and require intensive rehabilitation to maximise the opportunity for them to return home either before an emergency admission is required or after a hospital admission. The maximum length of stay is 6 weeks and will vary dependant on the needs of an individual patient. Typically patients who need rehabilitation stay less than 26 days.

- **Integrated Urgent Care Team (IUCT):** This is an integrated team made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team currently works between the hospital and the community and works with people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team is an urgent response team and plans to get to people within an hour of the request for help and support. Ongoing support will then be provided for up to 72 hours by when decisions will have been made about onward care and support needs

**Intermediate Tier Development:** Work is underway within the Integrated Care Foundation Trust to develop an intermediate tier service that is more integrated in nature and as a starting point is beginning to co-locate many of the services that are identified as offering rehabilitation, reablement, urgent and early intervention. The service identified as having an input into an intermediate tier of service include the Integrated Urgent Care Team, Reablement Service, Home First and Digital Health, IV Therapy Team, Long Term Conditions Team, Extensivists, Community Neuro Rehabilitation Team, Community Physiotherapy and Pulmonary Rehabilitation Team, Speech and Language Therapy and Dietetics as well as the community beds currently provided.

**Reablement:** The Reablement Services are currently provided by Tameside MBC Adult Services and Derbyshire County Council. The aim of the service is to enable people to attain or retain key

skills for independent living. The service is provided by trained support workers who work with people for a period of up to six weeks following a period of ill health or trauma. The Reablement Service offers an intensive period of assessment and support that enables a person, in partnership with other clinicians and practitioners to realise their optimum potential for regaining, or in some cases learning or re-learning skills to enable them to live fuller lives and to have less dependency on more intrusive longer term services. Successful reablement will result in a person requiring less or no ongoing help and support in their daily living.

**Appendix 4**

NHS
Tameside and Glossop
Clinical Commissioning Group

Tameside
Metropolitan Borough

# Quality Impact Assessment

**Title of scheme:** Intermediate Care in Tameside & Glossop
**Project Lead for scheme:** Alison Lewin
**Brief description of scheme:** The vision for intermediate care in Tameside & Glossop is for the support to be delivered at home wherever possible. The proposed model includes an element of bed-based care, has clear links with the Integrated Neighbourhoods (including the Extensivists), a robust model for hospital discharge planning, and offers a response to urgent care requests. The outcomes expected from a model of intermediate care are:

- Maximising independence
- Preventing unnecessary hospital admissions
- Preventing unnecessary admissions to long term residential care
- Following hospital admissions, optimising discharges to usual place of residence

The paper to be presented to PRG and SCB sets out the work undertaken to date, a proposed model for Intermediate Care for Tameside & Glossop (developed by the Single Commission and ICFT), and details of the recommended consultation process on 3 potential options.

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

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Safety** | 0 | | | | | | 0 | | | | | | 0 | | | The SCF will commission a service which ensures high levels of patient safety whether in patients' homes or bed based. The commissioner will ensure routine quality assurance mechanisms are in place to support the development and delivery of this strategy. The provider of the model of care outlined in the paper will be Tameside & Glossop Integrated Care NHS Foundation Trust, therefore we will monitor delivery of these services via our existing quality and contract monitoring processes. |
| **Clinical effectiveness** | 0 | | | | | | 0 | | | | | | 0 | | | The proposed model described in the paper will ensure delivery of clinically effective services which will be outlined in contractual documentation. The case for change included in the paper describes the reasons for the proposed changes, and the benefits are included in the description of the proposed model |
| **Patient experience** | | 1 | | | | | | 1 | | | | | 1 | | | There will be high levels of patient engagement and involvement in the development of this model, including a period of formal consultation. This QIA will be repeated to accompany the final paper to SCB in December, which will be recommending a model of intermediate care taking into account the outcome of the consultation and patient/public views. The commissioner and provider expectation is that the model commissioned and delivered will deliver improvements in patient experience. However we need to understand the patient / public perspective through the consultation process. |
| **Safeguarding children or adults** | 0 | | | | | | 0 | | | | | | 0 | | | The commissioned model will include all required elements of safeguarding legislation |

| Please consider any anticipated **impact** on the following additional areas only as appropriate to the case being presented.<br><br>**NB please see appendix 1 for examples of impact on additional areas.** | | | | | | | What is the **likelihood** of risk occurring? | | | | | | What is the overall **risk score** (impact x likelihood) | | | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Neutral / Positive Impact | Negligible | Minor | Moderate | Major | Catastrophic | No risk identified | Rare | Unlikely | Possibly | Likely | Almost certain | **Low** | **Moderate** | **High** | |
| | 0 | 1 | 2 | 3 | 4 | 5 | 0 | 1 | 2 | 3 | 4 | 5 | 0-5 | 6-12 | 15-25 | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Human resources/ organisational development/ staffing/ competence** | | | 2 | | | | | | | 3 | | | | 6 | | If the commissioner and provider's preferred option is the one which is ultimately recommended to SCB and subsequently implemented there will be an impact on staff from the perspective of the location from which they work. However there is also a positive impact on ALL staff working in the intermediate care services, as this will improve the effectiveness of their working model and reduce the current levels of travel time across the locality. Staff groups have been involved to some extent in the pre-consultation engagement and have supported the move towards a single location model for bed based intermediate care and the ongoing delivery of the Home First model of care. Staff will be included in the consultation process, including those staff currently working from the Shire Hill unit. |
| **Statutory duty/ inspections** | 0 | | | | | | 0 | | | | | | 0 | | | As the providers of the services will continue to be the ICFT, TMBC and DCC they are subject to statutory duties and inspections. The proposed location for the single site intermediate care service has been subject to CQC assessments via T&GICFT |
| **Adverse publicity/ reputation** | | | 2 | | | | | | | | 4 | | | 8 | | There is the potential for an adverse public reaction from a proportion of the population in the locality to one of the options included in the paper, due to the geographical location of the current vs proposed bed based services. This will be addressed via the formal consultation process proposed in the paper, which will run for 10 weeks from 23rd August. All areas of the locality will be covered by this consultation process, and a detailed EIA will be provided to support the PRG/SCB decision making process and the consultation. |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Finance** | 0 | | | | | | 0 | | | | | | 0 | | | This strategy is being developed to support key T&G locality Savings Assurance and Care Together programmes, and is being developed working closely with the locality finance team (commissioner and provider). Delivery of the proposals included in this paper are key to the delivery of a financially sustainable integrated care model. |
| **Service/business interruption** | 0 | | | | | | 0 | | | | | | 0 | | | The implementation of the model developed as a result of this work will be done with minimal service / business interruption. As the delivery of intermediate care is a time limited intervention – usually to a maximum of 6 weeks – there should be no requirement to transfer patients from one location to another. The commissioner and ICFT will ensure that the implementation of whichever model is approved by SCB has minimum service / business interruption and impact on patients / public. |
| **Environmental impact** | | 1 | | | | | 0 | | | | | | 1 | | | Travel times for car users and public transport routes are being considered as part of the EIA which will enable the consideration of the impact on car use and travel time as a result of the final proposal to be presented to PRG/SCB in December. |
| **Compliance with NHS Constitution** | 0 | | | | | | 0 | | | | | | 0 | | | The delivery of intermediate care services is part of the locality's wider 'urgent care' system, as it supports patient flow through local services, therefore supporting delivery of the NHS constitution relating to standards for urgent care / A&E |
| **Partnerships** | 0 | | | | | | 0 | | | | | | 0 | | | This is a key programme of work for Care Together and therefore involves key providers in the system. 3rd sector and patient groups are being included in this process, along with the public via the formal consultation process. |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Public Choice** | 0 | | | | | | 0 | | | | | | 0 | | | There has been and will continue to be significant public and patient involvement and engagement via the formal consultation process (in addition to the pre-consultation engagement which has taken place) |
| **Public Access** | 0 | | | | | | 0 | | | | | | 0 | | | Full mapping to be undertaken and included in the EIA, which will determine the impact on travel times and accessibility by car and public transport of any proposed option. Default position with this model will be home based care as the preferred option, thus minimising issues and negative impact regarding public access. |

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

**Sign off:**

| | |
|---|---|
| **Quality Impact assessment completed by** | **Alison Lewin** |
| **Position** | **Deputy Director of Commissioning** |
| **Signature** | **Alison Lewin** |
| **Date** | **20 July 2017** |

| **Nursing and Quality Directorate Review** | |
|---|---|
| **Name** | **Lynn Jackson** |
| **Position** | **Quality and Patient Experience Lead** |
| **Signature** | **Lynn Jackson** |
| **Date** | **21/07/2017** |

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Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

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

| | |
|---|---|
| **Subject / Title** | Intermediate Care |

| **Team** | **Department** | **Directorate** |
|---|---|---|
| Commissioning | Commissioning | Commissioning |

| **Start Date** | **Completion Date** |
|---|---|
| 16th May 2017 | 7th August 2017 |

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

| **EIA Group** (lead contact first) | **Job title** | **Service** |
|---|---|---|
| Clare Watson | Director of Commissioning | Commissioning |
| Alison Lewin | Deputy Director of Transformation | Commissioning |
| | | |
| | | |

## PART 1 – INITIAL SCREENING

| | | |
|---|---|---|
| | **What is the project, proposal or service / contract change?** | To deliver a model of intermediate care in Tameside & Glossop which is in line with the locality strategy and the national definition of Intermediate Care.<br>The Locality Executive Group, at their meeting in March 2017, agreed to the development of a system wide strategy for Intermediate Care for Tameside & Glossop to enhance the delivery of intermediate care in the locality. The Single Commission have been asked to co-ordinate this work and to develop a clear timeline, bringing back a fully developed model to the Single Commissioning Board in December 2017 |

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

| | | |
|---|---|---|
| 1b. | What are the main aims of the project, proposal or service / contract change? | The vision is for the support to be delivered at home wherever possible. The model should include an element of bed-based care, have clear links with the Integrated Neighbourhoods (including the Extensivists), a robust model for hospital discharge planning, and be able to offer a response to urgent care requests.<br><br>The outcomes expected from a model of intermediate care are:<br>• Maximising independence<br>• Preventing unnecessary hospital admissions<br>• Preventing unnecessary admissions to long term residential care<br>• Following hospital admissions, optimising discharges to usual place of residence |

**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 | ✓ | | | The majority of users of the current intermediate care services are frail / elderly people requiring additional support to regain/maintain their independence. The demographics of people accessing current services have been analysed fully as part of this project prior to the development of any proposed model. The age demographics are contained in Section 2c below, however, this highlights that during 2017 over 90% of those admitted at either Shire Hill or the Stamford Unit were over the age of 65 years<br><br>Almost 18% of the Tameside and Glossop population are over the age of 65 years. |
| Disability | ✓ | | | The people who will require support |

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

| | | | | |
|---|---|---|---|---|
| | | | | from these services could be those with existing disabilities. 18.5% (approx. 48,000) of the population of Tameside and Glossop over the age of 65 years have a long term condition or disability. |
| Ethnicity | | ✓ | | There could be an indirect impact as people across all ethnicities could be users of intermediate care services<br>Section S2c below highlights that over 85% of those admitted during 2017 were 'White British' at the Stamford Unit and over 55% (2015) were White British at Shire Hill.<br><br>For Shire Hill a large proportion of ethnicity data for service users is unknown (otherwise I think there could be an inference that the other 45% of service users are BME which isn't the case) |
| Sex / Gender | | ✓ | | There could be an indirect impact as people of any sex/gender could be users of intermediate care services. |
| Religion or Belief | | | ✓ | There is no anticipation that the development or implementation of this proposal will impact directly or indirectly on Religion or Belief in any significant sense |
| Sexual Orientation | | | ✓ | There is no anticipation that the development or implementation of this proposal will impact directly or indirectly on Sexual Orientation in any significant sense |
| Gender Reassignment | | | ✓ | There is no anticipation that the development or implementation of this proposal will impact directly or indirectly on Gender Reassignment in any significant sense |
| Pregnancy & Maternity | | | ✓ | There is no anticipation that the development or implementation of this proposal will impact directly or indirectly on Pregnancy & Maternity in any significant sense |

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

| | | | | |
|---|---|---|---|---|
| Marriage & Civil Partnership | | | ✓ | There is no anticipation that the development or implementation of this proposal will impact directly or indirectly on Marriage & Civil Partnership in any significant sense |
| **NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?** | | | | |
| Mental Health | ✓ | | | The commissioner's strategy and the locality proposals for an intermediate care model both include statements referring to the need to address the mental health needs of patients requiring intermediate care, including those with a diagnosis of dementia. There are currently 2,865 living with dementia in Tameside and Glossop and the diagnosis rate is 74.8%<br><br>Both Tameside and Glossop and England's prevalence for dementia is 0.8%.<br><br>Tameside and Glossop's Mental Health prevalence rate is: 0.83% (2024 people); and the national prevalence is 0.9% Depression: 10.71% (20969 people) for T&G; 8.3% Nationally. The proposed consultation will include engagement with these groups. |
| Carers | ✓ | | | Due to the demographics of users of intermediate care they are more likely to be in receipt of care. Therefore carers could be impacted as a result of any proposed changes to how the service is delivered. The proposed consultation will include engagement with these groups.<br><br>Carers data taken from Census 2011 for Tameside & Glossop CCG area around provision of unpaid care shows that 89.1% of the population do not provide unpaid care. A total of 10.9% of the population provide unpaid care - 6.5% receive no payment for 1-19 hours of care per week; 1.6% of the population receive no payment for 20- |

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| | | | | |
|---|---|---|---|---|
| | | | | 49 hours of unpaid care per week; and 2.8% of the population receive no payment for 50+ hours of unpaid care per week. |
| Military Veterans | | | ✓ | There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Military Veterans in any significant sense |
| Breast Feeding | | | ✓ | There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Breast Feeding in any significant sense |

**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?** | A full EIA is required as the protected characteristics of age, disability, mental health and carers may be impacted by the strategy and any proposed delivery model. | |

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# PART 2 – FULL EQUALITY IMPACT ASSESSMENT

## 2a. Summary

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

A number of factors and service reviews have led to the identification of Intermediate Care as a priority for the Tameside & Glossop locality. The health and social care economy is currently commissioning community based beds from a range of sources from across the local economy. This includes intermediate care beds, spot beds and an arrangement for discharge to assess beds. In order to improve the community bed offer locally a revised model is being proposed.

The proposals for Intermediate Care have been prepared jointly by Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT) and the Single Commission (SC) in support of the Commissioning Strategy for Intermediate care services. The strategy document (attached Appendix 1) describes the overall aim of the intermediate care services as being to support the rehabilitation and recuperation of patients maximising the patients' ability to function, to enable them to continue living at home in all but most challenging cases. With a requirement for:

- Home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) provided by an integrated team providing both health and social care input based on individual need
- Community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages
- An ability to care for clients with all levels of dementia, in an appropriate setting

One of the key principles within the Tameside & Glossop Care Together approach to integrated care is that wherever it is possible for a person to have their care requirements met within their own place of residence, the system will be responsive to meeting this need in a timely manner. This principle is embodied in this proposal for an intermediate care model. In order to be responsive to patients needs and deliver against this principle Tameside & Glossop ICFT has implemented the **"Home First"** service model, which responds to meet an urgent/crisis health and/or social care need for patients. Home first is fundamental to the intermediate care offer and is a key interface between the Integrated Neighbourhoods, community services and the acute setting ensuring that people are supported in the environment that is suited to their own care needs and most likely to achieve positive outcomes, and supports the intermediate care aims of:

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to

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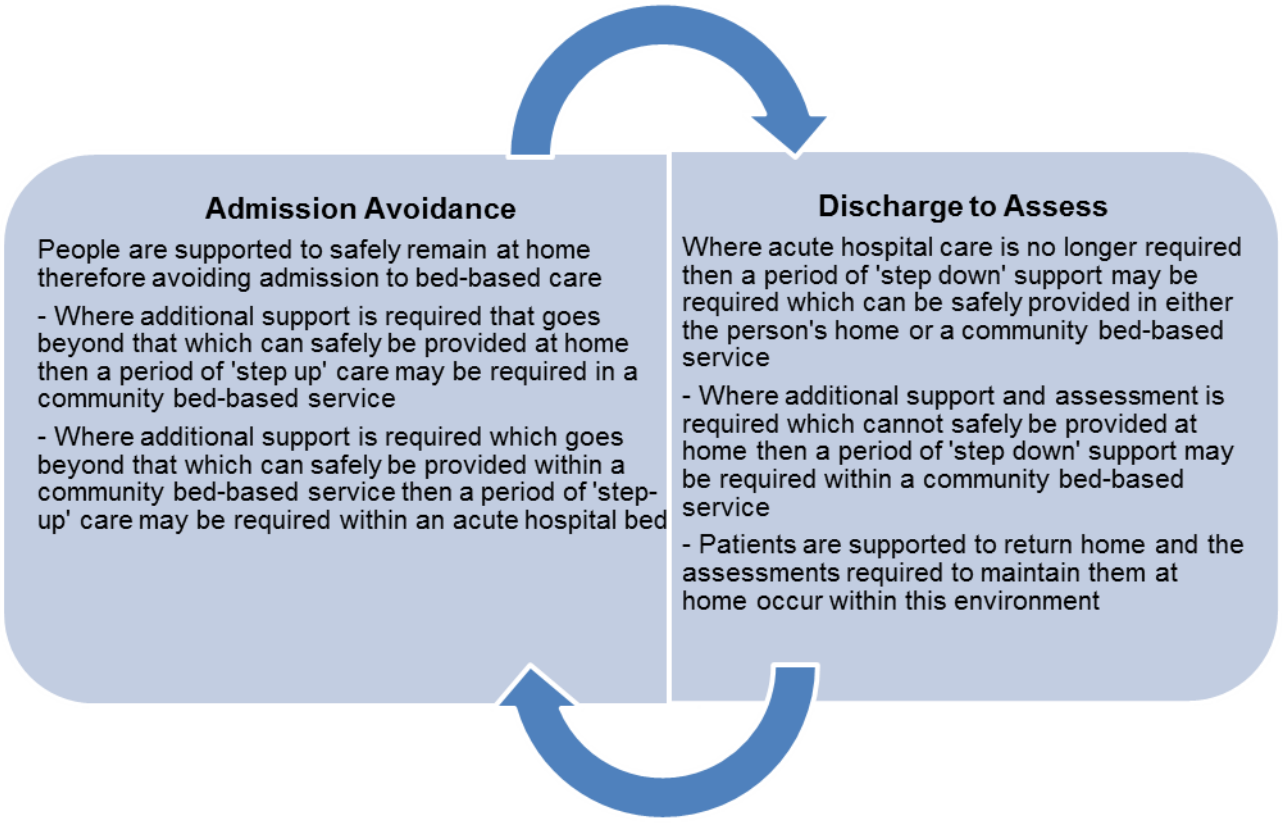
The Home first model comprises of two key elements:




The Home First offer will ensure that people are supported through the most appropriate pathway with "home" always being the default position. However, it is recognised that not all individuals' intermediate care needs can be managed safely in their own home. In some cases there is a need for an alternative community based bed, for a short period of time, to enable the appropriate interventions to be undertaken with the individual to enable them to return home, whether this be following an admission to the Hospital or to avoid the need for an admission in the first place.

Tameside & Glossop Integrated Care Foundation Trust (ICFT) has identified four core interfaces where services are provided to patients which make up the Intermediate Care model:

- **Integrated Neighbourhood services**
- **Intermediate / Specialist Community Based Services**
- **Community Bed Setting**
- **Acute Hospital Setting**

Below is a description of how services will be provided at each of these interfaces to make up a holistic intermediate care offer to the local population.

**Integrated Neighbourhood Services**: The ICFT and the Commissioners are working collaboratively through the Care Together programme to develop five Integrated Neighbourhood

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Teams, which will be Multi-disciplinary teams comprising Primary care (including GP services and pharmacists), community services such as district nursing and therapy services, social care, Mental Health services and the voluntary/community sector. The vision of these Neighbourhood Teams is to provide place based care to support neighbourhoods to deliver high quality and connected services which look after the whole neighbourhood population, to support self-care in order to improve outcomes, prosperity and wellbeing. The services will aim to:

- Optimise self-care and family/carers support
- Help people live as independently as possible
- Improve condition management
- Co-ordinate delivery of services from all providers
- Provide seamless support during periods of crisis and the transition to / from hospital based care
- Ensure a multi-disciplinary case management approach
- Use risk stratification data to identify those who may benefit from care co-ordination and put this into place
- Reduce the need for crisis interventions
- In respect of intermediate care model the Integrated Neighbourhoods through the GP, social care services and community teams will provide a co-ordinated care and support service to people who live in their neighbourhood area who have intermediate care needs, long-term conditions, other ongoing care and support needs, or who are most at risk of unplanned admissions to hospital. The multi-disciplinary team will also link with the intermediate tier/specialist and urgent care services to provide additional care input where required, to step-up services to avoid a hospital admission or social care placement, or support people returning to their place of residence following an acute admission, with the aim of supporting people to be as independent as possible.
- The Integrated Neighbourhood Teams will also include social prescribing navigators to help patients and carers to identify non-medical, voluntary and community services that will benefit their overall health and well-being, these might include social or physical services/clubs to encourage social inclusion and physical independence.

**Intermediate / Specialist Community Based Services:** The ICFT has identified a range of more specialist community based services that are available which provide a link between acute services and the Integrated Neighbourhood Teams. These form a core element of the out of hospital intermediate care offer. The intermediate tier services will provide short term intensive interventions to people who require higher intensity or more specialist care than is available within the Neighbourhood services, and provide care to meet the specific aims of the intermediate care strategy of:

- Helping people avoid going into hospital unnecessarily;
- Helping people be as independent as possible after a stay in hospital
- Intermediate Tier services will be provided following a referral from a Neighbourhood service or from the acute setting, to support early discharge from hospital care, or to enable people to remain in their own home for treatment. Risk stratification data will in some cases identify those who may benefit from additional care input based on individual needs. The Intermediate Tier will take a proactive approach to care for people who have ongoing health and care needs, or are at a high risk of experiencing worsening health or unplanned admissions, and will in some circumstances accept self-referrals. The intermediate tier services which will provide services for the intermediate care offer include:
- A new Extensivist service has commenced to work with those individuals living with

complex ongoing health and care needs, to improve their health and wellbeing and reduce demand on services by ensuring that their care is managed more effectively. This will offer a fundamentally different way of organising care around an individual's needs, including medical, social, psychological, functional, pharmaceutical and self-care. This will be staffed by specialist Extensivist consultants or GPs, who will work with a cohort of high risk patients identified through risk stratification.

- 7 day Community IV therapy service to provide IV therapy in the home setting.
- Digital Health Service – a new innovative service which provides Care Homes and the Community Response Service with access via SKYPE to an Advanced Nurse Practitioner for clinical consultation and advice.
- Reablement which is a social care service which provides time limited care to intermediate care patients.
- Community Therapy services
- Integrated Urgent Care Team (IUCT) made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team works between the hospital and the community, supporting people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team will have a key role in responding to people with urgent care needs. Ongoing support will then be provided for up to 72 hours to allow for close working with the Neighbourhood Teams, who will manage their ongoing care and support needs where possible.
- Community Social Care services provided by Tameside Metropolitan Borough Council (TMBC) and Derbyshire County Council that will assess and provide care to patients to ensure they are able to remain independent for as long as possible and to delay placements into long term residential care. Social care is a fundamental part of the Integrated Care model in Tameside & Glossop. Progress is being made with proposals for TMBC social care staff to transfer to the Integrated Care Foundation Trust in due course. Closer alignment of services is also planned with Derbyshire County Council for Glossop residents.
- The intermediate tier services will focus on ensuring that people have access to specialised care in the community, to avoid unnecessary admissions, and will have a key role in helping coordinate care around an individual's needs, to allow them to return to their normal place of residence as quickly and easily as possible.

**Community Bed Setting - Overview**: The health and social care economy is currently commissioning community based beds from a range of sources from across the local economy. This includes intermediate care beds, spot beds and an arrangement for discharge to assess beds. In order to improve the community bed offer locally a revised model is being proposed. The key principle of the flexible community bed base model is that support will be delivered through location-based community beds providing general nursing whilst encouraging independence and reablement, alongside in-reach from specialist teams such as therapy services, primary care and mental health. This will ensure individual centred management plans based on care needs that support people's transition back home effectively and ensure a smooth transfer of care, when necessary, to the Integrated Neighbourhood. A flexible community bed-base is key to effective intermediate care as it supports an individual's needs that cannot be met through home based intermediate care. By providing an enabling environment for further assessment, rehabilitation, completion of treatment and/or recuperation, it will prevent unnecessary admissions to hospital (through step up) or into long term care, and facilitate timely discharge to assess for those people not able to be assessed at home but do not require acute

hospital based care. When home is not an option for the provision of care for an individual, the flexible community beds base will offer:

- Step down capacity for discharge to assess (including complex assessments)
- Step up capacity to avoid acute admission
- Intermediate Care Capacity
- Recuperation beds that offer an opportunity to re-stabilise prior to undertaking rehabilitation
- Specialist assessment and rehabilitation for people with dementia
- The model will provide community beds for individuals with dementia who are at risk of being admitted to hospital or remaining in a hospital bed because they are awaiting assessments. At present there is no local provision to meet this requirement outside of the acute settings meaning that these individuals remain in hospital for longer than is necessary.
- The ICFT is the provider of all intermediate care beds for Tameside and Glossop as of 1st July 2017, and currently provides community beds from two locations: 64 beds in the Stamford Unit at Darnton House1, which is a 3-floor 96 bedded purpose-built nursing home adjacent to the Tameside Hospital site (the Trust currently uses two floors, one for intermediate care and one for discharge to assess) and 36 intermediate care beds in Shire Hill Hospital located in Glossop.

This EIA seeks to set out how the 3 delivery model options that we are proposing to consult on may impact on protected characteristic groups – specifically those groups who may be impacted directly by changes to how intermediate care is delivered.

This EIA also seeks to ensure that the consultation process is as inclusive as possible to enable all protected characteristic groups to be included and able to input.

Data has been collated to support this project which identifies current service users and their demographic details, including age/ethnicity and patient address/postcode/registered GP.

**2b. Issues to Consider**

The decision to carry out the work to develop a strategy for Intermediate Care for Tameside & Glossop has been taken in the context of national and local analysis of the current delivery model, and local progress already made to address these issues Key findings include:

[1] Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1st July 2016 with the CQC the location of The Stamford Unit at Darnton House. This was to provide a community in-patient facility as part its intermediate care services. Services in the Stamford Unit at Darnton House are accessed via agreed Trust patient pathways and it operates as community wards for medically stable patients who are having their discharge planned and enabled. They form part of services provided by the Trust as a provider of commissioned Acute and Community services for the population of Tameside and Glossop within the Integrated Care Foundation Trust.

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A number of factors and service reviews have led to the identification of Intermediate Care as a priority for the Tameside & Glossop locality and the development of a delivery model.

Intermediate Care – Halfway Home: The Department of Health's 2009 intermediate care guidance, Halfway Home[2] defined intermediate care as follows: Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. The initial guidance set out definitions of intermediate care, service models, responsibilities for provision and charges and planning. The definition included services that met the following criteria:

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols

The Halfway Home guidance clearly set intermediate care as an integrated part of a continuum or pathway of services, linking:

- health promotion
- housing
- low level support services in the community
- early intervention and preventative services
- social care
- primary care
- community health services
- support for carers
- acute hospital care.

The proposed local intermediate care offer embraces the philosophy of the Halfway Home guidance, with a focus on delivering care and the required wrap-around support to maximise independence.

**Acute Hospital Setting**: The Acute element of the Intermediate Care model forms part of the "Home First" service that responds the urgent/crisis health and/or social care need for patients. The Home First model is described in detail above, through IUCT and the discharge to assess team, which ensures patients are supported through the most appropriate pathway with "home" always being the goal.

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2 http://webarchive.nationalarchives.gov.uk/20130124050747/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

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National Audit for Intermediate Care 2015: The results of the NAIC from 2015 (based on 2013-14 data from providers and commissioners across the locality) identified the following in relation to the Tameside & Glossop intermediate care model (summary / selection of key indicators):

- An above average investment in intermediate care per 100,000 weighted population (4th highest of the 47 localities which participated)
- Above average beds commissioned per 100,000 weighted population (12th highest)
- Above average investment in bed based care compared with national average (£3.9m against a national average of £2.3m).
- A positive response was provided to 6 of the 13 quality standards
- A negative response to the commissioning of integrated home and bed based intermediate care services

The analysis of this report led to the early identification of Intermediate Care as a priority for the developing Care Together programme. A number of developments have taken place, informed in part by this review, which are included in the current model of intermediate care. The NAIC is taking place in 2017. The Single Commission and ICFT are participating in the audit to support the ongoing review of the locality's intermediate care system.

Tameside & Glossop NHS Foundation Trust Contingency Planning Team (CPT) Final Report September 20153: Price Waterhouse Cooper were appointed by Monitor to carry out a review of the Tameside & Glossop locality and produced a report which states that improving the way services are currently delivered, through an innovative, more joined-up approach across Tameside and Glossop, will improve the care patients receive and put Tameside NHS Foundation Trust back on to a sound clinical and financial footing. The CPT worked with a range of stakeholders across the locality to develop proposals for a model of care which included a new Urgent Integrated Care Service. Intermediate Care is described as a key element of the UICS (now developed and implemented as IUCT and Home First). One of the features included in the CPT report is that the UICS would be increasingly delivered in people's own homes.

**Tameside & Glossop Care Together Programme Model of Care:** The Tameside & Glossop Care Together model of care has been developed in response to the Contingency Planning Team report outlined in the section above. The analysis carried out by the CPT, and other reports, suggest that the current community bed base offer within the intermediate care service is not fit for purpose. The current service does not provide an adequate step up facility and does not offer any capacity for people with dementia or delirium following an acute episode. People remain in an acute bed for significantly longer than necessary, with poorer outcomes. It is expected that the remodelled service will offer improved quality for individuals, resulting in better outcomes and increased chances of returning home. The model described in this report would form a key element of the 'Home First' offer, a key strand of the Care Together programme. A key priority of the Care Together programme is to support people at home, wherever possible and safe to do so, or in a community bed where home is not appropriate, to avoid unnecessary hospital attendances,

3 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461261/Final_CPT_report.pdf

admissions and to ensure safe and prompt discharges. Where an admission has been appropriate, a prompt and safe discharge may require a short placement in a community bed for rehabilitation, reablement, recuperation or to facilitate discharge to assess.

'Step-Up' facilities: The level of demand for step beds to avoid admissions is not fully understood as the decision to admit is usually related to a clinical need but an alternative option may significantly reduce such admissions. Reviews undertaken in the past by ECIST and UM have highlighted an issue with people being in an acute bed when a step up to a nursing bed may have been more suitable and enabled a more accurate assessment of on-going need.

For people with dementia or delirium, time for recuperation and assessment out of hospital will lead to not only better outcomes but a reduction in length of stay in hospital and reduced risk of premature admission to long term care. Undertaking assessment of people with dementia within an acute hospital setting often leads to inaccurate assumptions being made about their safety to return home, resulting in extended length of stay and increased risk of a permanent residential admission.

A point prevalence conducted by Utilisation Management in Nov 2012 at Tameside showed that 43 out of 272 could have been supported in a community bed-based facility and of these five only had a social need with a further eight having a social and therapy need. Thirteen people needed a level of mental health support with or without other therapeutic and nursing needs. The remaining seventeen required a level of health support.

The utilisation benchmarking analysis of acute and community beds undertaken in December 2015 identified from a cohort of 133 at Tameside that 68 individuals' needs could be better managed in an alternative care setting. Of these 6 could have been in the current community bed-base facility and a further 30 could have been supported in a more flexible bed-base, 19 with mental health support, 4 with nursing support, 4 with social support and two with stroke rehabilitation support.

The development of intermediate care services with the appropriate level of home and bed based care supports one of the key priorities identified as part of the Care Together programme – frailty – by reducing length of stay for some of the most vulnerable people and by offering an integrated, wrap around support package. We know that 20% of admissions of older people into hospital are inappropriate (NAIC 2015) and that 10 days spent in hospital leads to the equivalent of an additional 10 years ageing in the muscles of people aged over 80 (Giles et al 2004) so it is important that people are supported in a service that offers a therapeutic and reabling environment.

Current Management of the Urgent Care system: the locality operates a process whereby patient flow and delivery of key access requirements across the urgent care system are routinely monitored. One area which is included within this is the use of the intermediate care system. The current offer is used almost exclusively as step down resource, with little access to the beds for step up support, creating increased pressure on the economy when trying to support people in crisis in the community. This often results in unnecessary hospital admissions that result in significant pressure and cost to the wider economy, and reduces the long term prognosis, particularly for older people. There are also times when although the system is under pressure, there are vacancies in the intermediate care beds, as bed based intermediate care is not what is required for the patients in the system.

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**Staff and Public Engagement**: A significant level of staff, public and wider stakeholder engagement has been undertaken to support the work of the Care Together programme, including pieces specific to the area of intermediate care. The outputs from this engagement have informed the recent developments in the locality and are outlined a pre-consultation engagement document was provided to support this work (Appendix 2)

A number of engagement activities took place during 2014-2016, through which 602 local people were involved in Care Together and the specific work streams. Action Together, Glossop Volunteer Centre and High Peak CVS used a range of asset based techniques and engaged with a range of other VCFS organisations. The methodology used included:

- Focus groups to reach a number service users with who have protected characteristics. 32 sessions where undertaken (15 in Tameside, 18 in Glossop). 330 people were involved.

- Large events which focused on developing a shared understanding of the concepts of Care Together and the development of solutions and aspirations for delivery. There were specific group events (such as the faith sector) and then Neighbourhood based events. Over 100 key community connectors where involved in the neighbourhood based events.

- 1:1 interviews with service users who had experience of the Home First and Discharge to Access Services. In addition, 8 members of staff were also interviewed.

  Intermediate care crosses several of the work streams. Key messages from these engagement activities which relate to intermediate care and are addressed by the proposed delivery model are:

  - We experience health and social care that is disjointed and delivered in silos, and we would welcome more joined up services
  - People strongly support the work being done to co-ordinate and join up services and the importance of multi-agency working […] people want to be treated as individuals not in a one size fits all approach or just by their condition and continuity of care also matters.
  - Transport and travel to and from services, including voluntary sector support, is one of the biggest issues and influences how people experience and use services. Community based support is seen as a positive solution to address this.

  Comments received which were specific to inpatient (bed-based) intermediate care include:

  - Surrounding patients by what they have at home so they are confident to return home i.e. home equipment used not industrial
  - Socialising is an important aspect to recovery. The main socialising happens in the dining room, they help each other. They have a purpose to get up and go to it therefore gets people moving and getting stronger walking, therefore become more independent to go home and stay there
  - Social rehab – helps with stand and transfer (people being stronger on their feet) making cups of teas, talking to people
  - People are able to socialise and make new friends – particularly around shared dining
  - There was a strong feeling that having a similar, medically led, set-up in the community would prevent A&E attendance, and provide a bridge between hospital and home.
  - Staff understanding and being aware of individual's needs (not treating everyone the same, with the same routine) especially with rehabilitation
  - A co-ordinated approach to the care – caring together

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- Facilities that are homely to help build confidence that they can cope at home

Staff engagement events were held in May 2014, under the Care Together banner, which were attended by 66 members of staff from across health, social care, independent sector and the 3rd sector. All staff were either providers of intermediate care services, or worked in services forming part of the pathways using the intermediate care services. The objective of the events was to engage staff in sessions which were intended to:

- Achieve a shared understanding of the current pathway for patients requiring the support of intermediate care and associated admission avoidance schemes
- Identify and prioritise the key issues to be addressed within the project scope regarding the review of intermediate care services and admission avoidance schemes

In the sessions staff identified a range of issues relating to the delivery of care, including:

- Gap in the system with no 'step up' pathway into intermediate care which means patients are admitted to hospital, and community teams can't refer to the inpatient intermediate care units
- Patients stay in hospital whilst they are assessed
- Lack of consistency across the intermediate care units

The pathway which was produced in the first of these sessions illustrated a system with multiple points of entry and 'hand offs'. The output from these sessions was a business case which illustrated a model of integrated admission avoidance and intermediate care which has informed the current delivery of services described in section 6 of this paper, and which continues to inform the ongoing development of intermediate care services.

The Commissioning Directorate of the Single Commission have since May 2017 undertaken pre-consultation engagement conversations across the locality with the public and staff. The purpose of these sessions was to understand the views of staff and the public on the current system of intermediate care, and the proposed strategic direction and outcomes we expect to see from the model of intermediate care commissioned. Engagement has taken place with staff, the Patient Neighbourhood Groups during June and July 2017, and with a range of stakeholders in the community via The Bureau, Glossop and Action Together (Tameside). The Bureau, Glossop received feedback from 100% of patients they engaged with Action Together (Tameside) have to date held 4 sessions with 3 more planned. They have consulted with 55 Tameside residents.

Following engagement the proposal is that the Single Commission with the ICFT enter into a formal consultation programme, based on the 3 options outlined below:

Options for delivery of bed based intermediate care: In order to deliver the proposed model, a number of options have been considered. The Single Commission and ICFT identified 3 options for the delivery of a flexible community bed base. All options should be considered alongside the ongoing development and delivery of the Home First model, Integrated Neighbourhoods, the Intermediate / Specialist Community Based Services, and acute hospital based elements of intermediate care.

**Option 1: Maintain current arrangements**
Delivery of bed based intermediate care from the Stamford Unit at Darnton House (32 beds) and Shire Hill in Glossop (36 beds).

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The view of the SC and ICFT is that this is not a sustainable model going forwards. As described in the report, the economy is not functioning to its optimum: people are in acute beds that do not need to be, they are in these beds for longer than they need to be, and they are unable to access the services they require at the time they need them. The current arrangements are fragmented – beds are delivered across 2 sites – Shire Hill and the Stamford Unit at Darnton House. At present staff are working from a number of bases, with the expectation that community and neighbourhood staff travel across the locality, diluting the capacity and time that could be inputted with individuals to maximise the potential for returning home promptly. This option does not deliver the vision of a single location for bed based intermediate care.

**Option 2: Use of available 96 bedded unit**
Transfer of all bed-based intermediate care to a single location in the Stamford Unit at Darnton House. This is the preferred option from the assessment carried out by the Single Commission and ICFT for the following reasons:
Whilst the aim of the home first model is to use the community beds flexibly to meet the demand at any point in time, the notional intermediate care bed figure proposed is 64 beds.
Patient Environment; - The Stamford Unit is 100% en-suite single room accommodation with significant communal space on each of the three wards which has been demonstrated to encourage social interaction and independence. Additionally one floor of the Stamford Unit in the Darnton Building has been designed as dementia friendly with access to outside space and wandering routes, which will enable the Trust to provide community beds for patients with Dementia.

- Accessibility – the Stamford Unit is located in a central location and is co-located close to the Tameside Hospital site and therefore has strong public transport links, ample parking and is easily accessible for patients and relatives. Additionally easy access and short journey times for health care professionals and support services into Darnton Building will enable development of in-reach into the unit as proposed in the model.
- Recruitment and Retention – recruitment and retention of nursing and support staff at the Shire Hill hospital site is an ongoing risk due to the remote location at the edge of the conurbation and lack of public transport access.
- Single location – option 2 supports the delivery of bed based intermediate care from a single location to enable the flexible use of community beds to support the Home First model and enable the approaches to Discharge to Assess and Intermediate Care to be flexed depending on the demands in the system at any point in time
- Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1st July 2016 with the CQC the location of The Stamford Unit at Darnton House.
- The Stamford Unit at Darnton House was originally furnished as a ‘dementia friendly’ building with furniture from the 1950s and décor to aid dementia patients.
- This option meets the national definition of ‘intermediate care’ from a combination of home and bed-based services and is in line with the recommendations of the Contingency Planning Team report from 2015

**Option 3: Stimulation of the Local Market to Develop Single/Multi Site**
Engagement with local providers to develop capacity within existing care homes, or the development of capacity in new homes is an option. Whilst the benefits of a larger scheme would not be realised, it is possible that in the longer term, once the Integrated Neighbourhoods and Home First models have fully embedded, that there could be a benefit to developing capacity at a neighbourhood level. The maturity of the wider economy may mean that fewer community beds

are required, and that services could be developed at a neighbourhood level to meet need.

This option relies on their being the engagement from providers to invest locally in increasing capacity. Should this be available there would be a lead in time to any new building, which would again require a short term solution until additional bed capacity is developed. There are a number of providers who have indicated their interest in working on developments with the Single Commission so this is something that is possible to negotiate. While the current capacity has been estimated, it is difficult to commit at this time to the capacity that may be required in the economy in 2-3 years' time, which is the information a provider would need in order for providers to invest in new capacity.

Consultation on the three options will primarily be undertaken via the CCG website to ensure that all patients/service users across Tameside and Glossop can have input. Targeted work will be undertaken with specific groups reflecting the demographic profile of service users as those more likely to be impacted directly by any proposals. Those in existing poor health will also be engaged as potential users of a future intermediate care service. Paper copies will also be provided at different locations e.g Shire Hill, Darnton House, GP practices.

Service user data has been analysed around the key protected characteristic groups to help understand how they may be impacted by any of the 3 options included within the proposed consultation. Potential impact is detailed in Section 2c (below)

## 2c. Impact

This EIA has identified that protected characteristic groups who could be directly affected by changes to an intermediate care delivery model are age, disability, mental health and carers. Data on local service use has been collated to review the demographics of the people using these services to quantify the potential demand on protected characteristic groups.

**Current Service Users**

**Age**

The focus of this work on the older population groups is consistent with the project's aims and the needs of the population. Intermediate care nationally is something which, in the main, is provided to support frail and / or elderly people. Activity data for the current facility on the hospital site in Ashton Under Lyne (the Stamford Unit, Darnton House) and Shire Hill Hospital shows the following spilt in terms of the age of the people accessing the bed based intermediate and discharge to assess models:

| | 2015 | | 2016 | | 2017 | |
|---|---|---|---|---|---|---|
| Age on admission | <65 | 65+ | <65 | 65+ | <65 | 65+ |
| Stamford Unit | 43 | 475 | 53 | 362 | 38 | 371 |
| % | 8.3 | 91.6 | 12.77 | 87.22 | 9.1 | 90.7 |
| Shire Hill | 19 | 263 | 21 | 352 | 12 | 141 |
| % | 6.7 | 93 | 5.6 | 94.3 | 7.8 | 92.1 |

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

The above table breaks down the age range of patients admitted to the Intermediate Care Units and shows that the 65+ age group are higher users of the Intermediate Care facilities.

The overall Tameside and Glossop population age breakdown is:

| Total Tameside and Glossop Population - latest figures available 2016 | | Total Population |
|---|---|---|
| <65 | 65+ | all ages |
| 207,597 | 46,110 | 253,707 |
| 81.80% | 18.10% | |

Almost 18% of the Tameside and Glossop population are over the age of 65 years.

Targeted work will be undertaken with specific groups including those over the age of 65 years who may be impacted directly by the proposals

## Ethnicity

The ethnicity of patients accessing the current intermediate care bed based services has been collated from the past 3 years and is as follows:

***2015-2017 Shire Hill***

| Any Other Ethnic Group | Asian/ Asian Brit - Indian | Not Known | Not Stated | Other Ethnic Group - Chinese | White - any other White b/g | White - British | White - Irish | Grand Total | % White British | % either not stated or not known |
|---|---|---|---|---|---|---|---|---|---|---|
| 3 | 2 | 123 | 118 | 2 | 5 | 308 | 5 | 556 | 55.39 | 43.34 |

**2015-2017 Stamford Unit, Darnton House**

| Other | Asian British Bangladesh | Asian British Indian | Asian British Pakistan | Asian British Other Asian | CC_MSGG | Mixed White Asian | Not Known | Not Stated | White Other | White British | White Irish | NULL | Grand Total | % White British | % either not stated or not known |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 11 | 1 | 19 | 4 | 1 | 1 | 3 | 78 | 58 | 13 | 1127 | 6 | 20 | 1342 | 83.9 | 10.1 |

The above tables highlight the 'White British' ethnicity has the majority of admissions in the community bed bases, and also shows the Stamford Unit, Darnton House having the most varied ethnic diversity for admissions.

Targeted work will be undertaken with the above ethnicity groups who may be impacted directly

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

The overall ethnicity breakdown for T&G from Census 2011 is also be included here for comparison:

| Ethnic Group | Number | % |
|---|---|---|
| **All Persons** | **252,414** | |
| White British | 225,792 | 89.5% |
| White Irish | 1,855 | 0.7% |
| Gypsy or Irish Traveller | 40 | 0.0% |
| White Other | 4,014 | 1.6% |
| **All White** | **231,701** | **91.8%** |
| Mixed: White & Black Carribean | 1,479 | 0.6% |
| Mixed: White & Black African | 565 | 0.2% |
| Mixed: White & Asian | 948 | 0.4% |
| Mixed: Other | 586 | 0.2% |
| **All Mixed** | **3,578** | **1.4%** |
| Asian: Indian | 3,738 | 1.5% |
| Asian: Pakistani | 4,954 | 2.0% |
| Asian: Bangladeshi | 4,296 | 1.7% |
| Asian: Chinese | 1,031 | 0.4% |
| Asian: Other | 804 | 0.3% |
| **All Asian** | **14,823** | **5.9%** |
| Black: African | 1,222 | 0.5% |
| Black: Carribean | 421 | 0.2% |
| Black: Other | 231 | 0.1% |
| **All Black** | **1,874** | **0.7%** |
| Other: Arab | 168 | 0.1% |
| Any Other Ethnic Group | 270 | 0.1% |
| **All Other** | **438** | **0.2%** |

Source: 2011 Census

Over 89% of the Tameside and Glossop population are White British and of these over 94% are over the age of 65 years.

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

**Disability**

The table below outlines long term limiting illness and disability data for Tameside & Glossop CCG area, Tameside MBC and High Peak (the local authority which Glossop is within) (Census 2011).

| Disability | NHS Tameside and Glossop | % of Total Population with day to day activities limited | High Peak | % of Total Population with day to day activities limited | Tameside | % of Total Population with day to day activities limited |
|---|---|---|---|---|---|---|
| **Day-to-day activities limited a lot** | 26,080 | 10.33 | 7,451 | 8.20 | 23,307 | 10.63 |
| **Day-to-day activities limited a little** | 25,757 | 10.20 | 9,013 | 9.92 | 22,624 | 10.32 |
| **Day-to-day activities not limited** | 200,577 | 79.46 | 74,428 | 81.89 | 173,393 | 79.06 |
| **All categories: Long-term health problem or disability** | 252,414 | 100.00 | 90,892 | 100.00 | 219,324 | 100.00 |

Census data 2011 provides details of people who live in Tameside who have a long term condition or disability. This shows that over 19,000 people aged 65+ (58% of those aged 65+) are limited in day to day activities, and the total number aged under 65 with day to activities limited are over 25,000 (13% of those aged 65 and under)

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

| Age | Total Population | Day-to-day activities limited | % of Total Population with Day-to-Day activities limited |
|---|---|---|---|
| All categories: Age | 217,736 | 44,504 | 20.4 |
| Age 65 to 69 | 10,486 | 4,609 | 43.95 |
| Age 70 to 74 | 8,420 | 4,420 | 52.49 |
| Age 75 to 79 | 6,294 | 3,942 | 62.63 |
| Age 80 to 84 | 4,262 | 3,152 | 73.96 |
| Age 85 and over | 3,481 | 2,989 | 85.87 |
| Total aged 65+ with day-to-day activities limited | 32,943 | 19,112 | 58.02 |
| Total under 65 with day-to-day activities limited | 184,793 | 25,392 | 13.74 |

Census data 2011 provides details of people who live in High Peak (the local authority which Glossop is within) who have a long term condition or disability. This shows that over 7,600 people aged 65+ (50% of those aged 65+) are limited in day to day activities, and the total number aged under 65 with day to activities limited are over 8,000 (13% of those aged 65 and under).

| **Age** | **Total Population** | **Day-to-day activities limited** | **% of Total Population with Day-to-Day activties limited** |
|---|---|---|---|
| **All categories: Age** | 89,867 | 15,801 | 17.6 |
| **Age 65 to 69** | 4,915 | 1,624 | 33.04 |
| **Age 70 to 74** | 3,662 | 1,548 | 42.27 |
| **Age 75 to 79** | 2,851 | 1,602 | 56.19 |
| **Age 80 to 84** | 2,056 | 1,461 | 71.06 |
| **Age 85 and over** | 1,619 | 1,377 | 85.05 |
| **Total aged 65+ with day-to-day activities limited** | 15,103 | 7,612 | 50.40 |
| **Total under 65 with day-to-day activities limited** | 74,764 | 8,189 | 10.95 |

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

**Postcode Data**

Attached are tables including postcodes of patients/service users between 2015-17 including which Tameside and Glossop neighbourhoods they were resident in at the time of admission.

The total number of admissions to the existing Intermediate Care Units are as follows:-

**Stamford Unit, Darnton House Summary**

| Year | Ward Stays | Notes |
|---|---|---|
| 2015 | 518 | Transitional Care Unit open March 15 to Nov 15 |
| 2016 | 415 | Stamford Unit open June 16 to December 16 |
| 2017 | 409 | Jan 17 to May 18th 2017 |

**Shire Hill Summary**

| Year | Ward Stays | Notes |
|---|---|---|
| 2015 | 293 | Apr 15 to Dec 15 |
| 2016 | 398 | Jan-16 to Dec 16 |
| 2017 | 161 | Jan 17 to May 18th 2017 |

Further analysis can be accessed via appendix 3 which contains the following documentation:

- Breakdown of patients/service users 2015-2017 to Shire Hill and the Stamford Unit, Darnton House including postcodes /registered GP practices
- Number of referrals to Shire Hill by postcode sector
- Number of referrals to Stamford Unit (Intermediate Care Unit) by postcode sector
- Table showing number of referrals per postcode sector to Shire Hill and Stamford Unit
- Number of referrals to Shire Hill from GP practices
- Number of referrals to Stamford Unit (Intermediate Care Unit) from GP practices

From the patients/service users admitted during 2015-17, the largest percentage of patients from the Hyde Neighbourhood were admitted to Shire Hill. The largest percentage of patients from the Denton Neighbourhood were admitted to the Stamford Unit, Darnton House.

Further analysis of the postcode data of patients/service users using intermediate care services at Shire Hill and Stamford Unit, Darnton House shows that of all Shire Hill patients between 2015 - May 2017, 7.4% lived within 1 mile of Shire Hill whereas 10.7% lived within 1 mile of Stamford Unit, Darnton House. For more information / analysis please see Appendix 3

Maps showing patients/service users living with within a 1, and 5 mile radius of Shire Hill and Stamford Unit, Darnton House are also included.

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

**Accessibility of Services**

Basemap's TRACC software was used to calculate travel times to both Shire Hill and Stamford Unit, Darnton House using public transport at both peak and off peak time periods. This covers all major public transport options across Tameside and Glossop including bus, train and tram.

TRACC was also used to calculate drive times at both peak and off peak time periods, and walk times.

Detailed analysis of this drive time, public transport and walk time analysis is attached. Some of the key headlines can be found below.

Drive Times

Further drive time analysis can be found on page 20 of appendix 3.

- During weekdays 0700-0900, 86.3% of Tameside and Glossop residents are within 0-15 minutes' drive of the Stamford Unit compared to 19.3% within 0-15 minutes' drive of Shire Hill.
- During weekdays 1000-1600, 89.3% of residents are within 0-15 minutes' drive of the Stamford Unit comparted to 20.8% within 0-15 minutes' drive of Shire Hill.
- During weekdays 1600-1900, 86.2% of residents are within 0-15 minutes' drive of the Stamford Unit compared to 20.2% within 0-15 minutes' drive of Shire Hill.
- At weekends 0700-1900, 92% of residents are within 0-15 minutes' drive of the Stamford Unit compared to 22.2% within 0-15 minutes' drive of Shire Hill.
- For all four of the above drive time periods 99.8% of residents are within 0-30 minutes drive of both the Stamford Unit and Shire Hill.

Public Transport

Further drive time analysis can be found on page 20 of appendix 3.

During weekdays 0700-0900 (Tuesday as an example):

- 9% of residents can reach the Stamford Unit by public transport within 0-15 minutes compared to 3.1% to Shire Hill.
- 39.1% of residents can reach the Stamford Unit by public transport within 0-30 minutes and 11.3% to Shire Hill.
- 71.6% of residents can reach the Stamford Unit by public transport within 0-45 minutes and 16.7% to Shire Hill.

- 96.4% can reach the Stamford Unit by public transport within 0-60 minutes and 35.9% to Shire Hill.

During weekdays 1000-1600 (Tuesday as an example), using public transport:

- Within 0-15 minutes, 9.2% of residents can reach the Stamford Unit and 1.9% to Shire Hill.
- Within 0-30 minutes, 40.3% can reach the Stamford Unit and 10.7% to Shire Hill.
- Within 0-45 minutes, 79.6% can reach the Stamford Unit and 24% to Shire Hill.
- Within 0-60 minutes, 99.2% can reach the Stamford Unit and 54.8% to Shire Hill

During weekdays 1600-1900 (Tuesday as an example), using public transport:

- Within 0-15 minutes, 8.5% of residents can reach the Stamford Unit and 1.9% to Shire Hill.
- Within 0-30 minutes, 37.8% can reach the Stamford Unit and 11.2% to Shire Hill.
- Within 0-45 minutes, 77.7% can reach the Stamford Unit and 25.3% to Shire Hill.
- Within 0-60 minutes, 99% can reach the Stamford Unit and 57.1% to Shire Hill.

During weekends 1000-1600 (Saturday as an example), using public transport:

- Within 0-15 minutes, 9.2% of residents can reach the Stamford Unit and 1.9% to Shire Hill
- Within 0-30 minutes, 40.1% can reach the Stamford Unit and 10.6% to Shire Hill
- Within 0-45 minutes, 78.7% can reach the Stamford Unit and 23.9% to Shire Hill
- Within 0-60 minutes, 99% can reach the Stamford Unit and 54.9% to Shire Hill

Walk Time

Further walk time analysis can be found on page 20 of appendix 3.

In terms of walk time alone:

- 3.6% of residents can walk to the Stamford unit within 0-15 minutes and 0.6% can walk to Shire Hill.
- 15.7% can walk to the Stamford Unit within 0-30 minutes and 4.5% can walk to Shire Hill.
- 31.8% can walk to the Stamford Unit within 0-45 minutes and 9.1% can walk to Shire Hill.
- 43.5% can walk to the Stamford Unit within 0-60 minutes and 13% can walk to Shire Hill.

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

Key Location Travel Time Analysis

Travel times between 14 key locations (Ashton, Mossley, Stalybridge, Dukinfield, Hyde, Broadbottom, Hattersley, Mottram, Denton, Audenshaw, Droylsden, Hadfield, Gamesley, and Glossop) and both the Stamford Unit and Shire Hill were calculated for various modes of transport and time periods.

Drive Times

Further key location travel time analysis can be found on page 21 of appendix 3.

For all four drive time time-periods (weekdays 0700-0900; weekdays 1000-1600; weekdays 1600-1900; weekends 0700-1900) the drive time between 10 of the key locations (Ashton, Mossley, Stalybridge, Dukinfield, Hyde, Hattersley, Mottram, Denton, Audenshaw and Droylsden) was quicker to the Stamford Unit than the drive time between these locations and Shire Hill. For all four drive time time-periods the drive time between Broadbottom, Hadfield, Gamesley and Glossop to Shire Hill was quicker than the drive time between these four locations and the Stamford Unit.

The longest drive time to Shire Hill across all time periods was from Droylsden:

- Weekdays 0700-0900: 25.87 minutes
- Weekdays 1000-1600: 25.2 minutes
- Weekdays 1600-1900: 25.89 minutes
- Weekends 0700-1900: 24.54 minutes

The shortest drive time to Shire Hill across all time periods was from Glossop:

- Weekdays 0700-0900: 3.73 minutes
- Weekdays 1000-1600: 3.99 minutes
- Weekdays 1600-1900: 3.98 minutes
- Weekends 0700-1900: 3.84 minutes

The longest drive time to the Stamford Unit across all time periods was from Glossop:

- Weekdays 0700-0900: 17.55 minutes
- Weekdays 1000-1600: 18.13 minutes
- Weekdays 1600-1900: 18.98 minutes

- Weekends 0700-1900: 17.47 minutes

The shortest drive time to the Stamford Unit across all time periods was from Ashton:

- Weekdays 0700-0900: 4.67 minutes
- Weekdays 1000-1600: 4.5 minutes
- Weekdays 1600-1900: 4.66 minutes
- Weekends 0700-1900: 4.27 minutes

Public Transport

Further key location travel time analysis can be found on page 22 of appendix 3.

For all four public transport time-periods (Tuesday 0700-0900; Tuesday 1000-1600; Tuesday 1600-1900; Saturday 1000-1600) the public transport travel time between Ashton, Mossley, Stalybridge, Dukinfield, Hyde, Hattersley, Mottram, Denton, Audenshaw and Droylsden to the Stamford Unit was quicker than the public transport travel time between these 10 locations and Shire Hill. For all four public transport time-periods the public transport travel time between Broadbottom, Hadfield, Gamesley and Glossop to Shire Hill was quicker the public transport travel time between these four locations and the Stamford Unit.

The longest public transport travel times to Shire Hill were:

- Tuesday 0700-0900: Droylsden: 76.26 minutes
- Tuesday 1000-1600: Droylsden: 65.69 minutes
- Tuesday 1600-1900: Droylsden: 67.69 minutes
- Saturday 1000-1600: Mossley: 65.18 minutes

The shortest public transport travel times to Shire Hill were:

- Tuesday 0700-0900: Glossop: 9.17 minutes
- Tuesday 1000-1600: Glossop: 9.44 minutes
- Tuesday 1600-1900: Glossop: 9.44 minutes
- Saturday 1000-1600: Glossop: 9.44 minutes

The longest public transport travel times to the Stamford Unit were:

- Tuesday 0700-0900: Gamesley: 48.65 minutes

- Tuesday 1000-1600: Broadbottom: 47.93 minutes
- Tuesday 1600-1900: Broadbottom: 44.93 minutes
- Saturday 1000-1600: Broadbottom: 47.93 minutes

The shortest public transport travel times to the Stamford Unit were:

- Tuesday 0700-0900: Ashton: 12:13 minutes
- Tuesday 1000-1600: Ashton: 12:13 minutes
- Tuesday 1600-1900: Ashton: 10.96 minutes
- Saturday 1000-1600: Ashton: 12:13 minutes

Walk Times

Further key location travel time analysis can be found on page 23 of appendix 3.

The walk time to Stamford Unit is shorter from Ashton, Mossley, Stalybridge, Dukinfield, Hyde, Hattersley, Mottram, Denton, Audenshaw and Droylsden than the walk time to Shire Hill.

The walk time to Shire Hill from Broadbottom, Hadfield, Gamesley, and Glossop is shorter than the walk time to Stamford Unit.

The longest walk time to Shire Hill is from Droylsden at 208.3 minutes and the shortest is from Glossop at 20.24 minutes.

The longest walk time to the Stamford Unit is from Glossop at 137.32 minutes and the shortest is from Stalybridge at 22.49 minutes.

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

**2d. Mitigations** *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*

Age

The data in section 2C shows that the age group using this type of service is predominantly aged 65+ years and over. Almost 18% (43,515) of the Tameside and Glossop population are over the age of 65 years broken down as follows:

| | No of Patients | % of population |
|---|---|---|
| **65-69 years** | 14,615 | 5.80% |
| **70-74 years** | 10,552 | 4.20% |
| **75-79 years** | 8,024 | 3.20% |
| **80-84 years** | 5,466 | 2.20% |
| **85-89 years** | 3,051 | 1.20% |
| **90 years and over** | 1,807 | 0.70% |

The focus of this work on the older population groups is consistent with the project's aims and the needs of the population. Intermediate care nationally is something which, in the main, is provided to support frail and / or elderly people. To ensure the views of this cohort of the local population are taken into account, the consultation process will ensure local groups and sections of the population who are within this protected characteristic group are supported and encouraged to engage in the consultation, thus ensuring their views are included in the process.

Engagement during the consultation will include service users/patients aged 65+. A number of engagement activities took place during 2014-2016, through which 602 local people were involved in Care Together and the specific work streams. Action Together, Glossop Volunteer Centre and High Peak CVS used a range of asset based techniques and engaged with a range of other VCFS organisations.

**Tameside & Glossop Single Commissioning Function**
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| | |
|---|---|
| Public Transport/Accessibility of sites | The proposal covers home and bed-based intermediate care, with home being the preferred option wherever possible. We will look to manage any impact on service users/patients/carers by minimising the impact of any travel implications to the intermediate care sites<br>No patients will be moved to another base as a result of any of the proposals contained within this document.<br><br>Parking on both the Stamford Unit and Shire Hill sites is available free of charge.<br>Full analysis has been undertaken to around travel times to Stamford Unit, Darnton House and Shire Hill by public transport, drive time and walking.<br>However, in addition to public transport available, The Bureau Glossop does run a volunteer car scheme that provides transport to Tameside Hospital and other hospitals for Glossop residents. Derbyshire Community Transport operates across the county providing a variety of services to meet every need and all vehicles are wheelchair accessible. It enables people who are unable to use public transport to get out and about and make journeys most people take for granted<br>'aCTive' travel operates in Glossop - this is a door-to-door service catering for individual needs and is primarily for getting to health appointments and improving people's quality of life by assisting them to get to places they wouldn't otherwise be able to access. Either a small, wheelchair accessible vehicle, or a volunteer using their own car, will be used depending on a passengers mobility<br><br>Community Transport within Tameside is via 'Transport for Greater Manchester' – 'Local Link'. This is a flexible public transport service for local journeys, connecting people to a range of transport providers.<br><br>Local Link journeys can be made by shared minibuses from and to anywhere specified within each individual service area. Further information on Local Link can be found at:<br><br>http://www.tfgm.com/buses/local_link/Pages/index.html |

**Tameside & Glossop Single Commissioning Function**
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| | |
|---|---|
| Carers | We will ensure the consultation process includes carer groups. (Carers data taken from Census 2011 for Tameside & Glossop CCG area indicates that 10.9% of people across Tameside & Glossop provide unpaid care). |
| Mental Health | The commissioner will ensure that the consultation process is inclusive of people with disabilities to ensure they are involved in the development of the model of care. Data From 2011 Census shows that 10.3% of people across Tameside and Glossop had some form of disability which limited day to day activities 'a lot' and a further 10.2% whose day to day activities were limited 'a little'.<br>From the 2011 Census, 20.4% of the total population of Tameside have day to day activities limited; and similarly 17.6% in High Peak |
| Disability | The commissioner will ensure that the consultation process is inclusive of people with disabilities to ensure they are involved in the development of the model of care. Data From 2011 Census shows that 10.3% of people across Tameside and Glossop had some form of disability which limited day to day activities 'a lot' and a further 10.2% whose day to day activities were limited 'a little'.<br><br>From the 2011 Census, 20.4% of the total population of Tameside have day to day activities limited; and similarly 17.6% in High Peak |

| **2e. Evidence Sources** |
|---|
| - National Audit of Intermediate Care (2015)<br>- Utilisation Management Review (2014/15)<br>- Staff & Public Engagement<br>- Census 2011<br>- QOF 2015/2016<br>- Basemap – TRACC Software<br>- ONS 2014 health geography mid-year population estimates |

**Tameside & Glossop Single Commissioning Function**
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| **2f. Monitoring progress** | | |
|---|---|---|
| **Issue / Action** | **Lead officer** | **Timescale** |
| A project group is being established to support this work, led by the SCF Commissioning officer and reporting as required via the established Locality Care Together programme.<br><br>We will ensure that progress on the monitoring of the consultation will be undertaken. | Alison Lewin | Ongoing |

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

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

**Appendix 1**

## Intermediate Care Strategy – Tameside & Glossop

### 1. Outline of this Strategy

This initial outline strategy sets out the intentions for the commissioning of intermediate care at home wherever possible, the model for bed-based services, and includes links with Integrated Neighbourhoods (including the Extensivists) and a robust model for hospital discharge planning.

This paper sets out an initial draft outline strategy. Commissioners will develop the detail, through wider engagement and consultation, with a view to having a detailed model agreed and ready to implement by late Autumn /early Winter 2017.

### 2. What is Intermediate Care?

The definition of Intermediate Care included in the National Audit of Intermediate Care 2017 (developed with the assistance of the Plain English Campaign) is as follows.

**What is intermediate care?**
Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system –community services, hospitals, GPs and social care.

**What are the aims of intermediate care?**
There are three main aims of intermediate care and they are to:

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

**Where is intermediate care delivered?**
Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

**How is intermediate care delivered?**
A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

### 3. Background

3.1. **National Audit of Intermediate Care findings 2015:** The results of the NAIC from 2015 (based on 2013-14 data from providers and commissioners across the locality) identified following in relation to the Tameside & Glossop intermediate care model (summary / selection of key indicators):

- An above average investment in intermediate care per 100,000 weighted population (4th highest of the 47 localities which participated)

.

- Above average beds commissioned per 100,000 weighted population (12th highest)

- Above average investment in bed based care compared with national average (£3.9m against a national average of £2.3m).

- A positive response was provided to 6 of the 13 quality standards

- A negative response to the commissioning of integrated home and bed based intermediate care services

The analysis of this report led to the early identification of Intermediate Care as a priority for the developing Care Together programme. A number of developments have taken place, informed in part by this review, which are outlined in section 5 of this strategy.

3.2. **Utilisation Management Review 2014/2015:** The T&G locality commissioned 2 reviews from the North West Utilisation Management Team (Academic Health Science Network) to increase understanding of IC service demand and flow. The recommendations included in the 2 reports will be used as background information to support the 2017 review of IC and the development of a system wide strategy. The 2015 was undertaken to support the CCG in establishing optimal IC bed based service capacity.

3.3. **Staff and Public Engagement:** A summary of engagement work undertaken previously as part of the wider Care Together programme will be analysed and the information used in the further development of this model and strategy. This engagement involved patients, public and staff. Patient and service user satisfaction information held as part of the commissioner's ongoing contract monitoring will also be used.

## 4. National Audit for Intermediate Care (NAIC) 2017

The NAIC focuses on services which support, usually frail, elderly people, at times of transition when stepping down from hospital or preventing them being admitted to secondary or long term care. These services are a crucial part of the solution to managing increasing demand in the health and social care system.

This audit was last carried out in 2015, the results of which are summarised in section 3 above, and is being repeated in 2017 (data collection being undertaken during May and June). The audit shines a light on intermediate care and provides a stocktake of current service provision. The unique combination of organisational data and outcomes data collected in the audit enables us to address the following questions:

- Does intermediate care work?
- Is it cost effective?
- Do we have enough capacity to make a difference?
- What are the features of a "good" service?
- How do we make the case for investment?

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

The audit allows commissioners / funders and providers to consider both the national answers to these questions but also, importantly, how their local health and social care economy is performing on these key issues. Audit participants can access their local results via an online toolkit.4
The NAIC covers 4 categories for intermediate care: crisis response, bed based intermediate care, home based intermediate care and reablement.

The CCG/Single Commissioning Function are co-ordinating T&G registration and involvement in this audit for 2017 to ensure the data informs the review being undertaken by the economy. The results will be available in late autumn 2017. Commissioners and the ICFT have signed up to participate in the NAIC.

## 5. Progress to Date

This section outlines progress to date on the development of a system of intermediate care for the Tameside & Glossop Locality and the current position / provision.

5.1. **Home First:** The Single Commission and ICFT undertook a piece of work in 2016-17 on the Home First model as part of the Care Together programme. The T&G IC Strategy will take into account the findings and outcomes from this piece of work in the initial draft / proposed model. In summary, the Home First model is the service offer that responds to meet an urgent/crisis health and/or social care need that cannot be managed within the Integrated Neighbourhood. It is a key interface between the Integrated Neighbourhood and the acute setting ensuring that people are supported in the environment that is suited to their own needs and most likely to achieve positive outcomes. It comprises of two key elements: Admission Avoidance and Discharge to Assess. A 'flexible community bed base scheme' is a key element of the home first model, and therefore needs to form part of this Intermediate Care Strategy. The main elements of Home First are:

- **Stamford Unit:** This will offer 32 beds for people who have been in hospital and who cannot immediately return home because they require further recuperation, or possibly further assessments that cannot be carried out at home.

- **Shire Hill and Grange View Intermediate Care beds:** These two facilities offer an ongoing period of rehabilitation to people who are unable to cope in their own home and require intensive rehabilitation to maximise the opportunity for them to return home either before an emergency admission is required or after a hospital admission. The maximum length of stay is 6 weeks and will vary dependant on the needs of an individual patient. Typically patients who need rehabilitation stay less than 26 days. Since April 2017 the number of Intermediate Care beds has reduced to reflect the level of need for bed based rehabilitation. This has resulted in the closure of the Grange View unit from 1st July.

- **Integrated Urgent Care Team (IUCT):** This is an integrated team made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team currently works between the hospital and the community and works with people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team is

[4] http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/NAIC%202017/NAIC2017auditproposal.pdf

an urgent response team and plans to get to people within an hour of the request for help and support. Ongoing support will then be provided for up to 72 hours by when decisions will have been made about onward care and support needs

- **Intermediate Tier Development:** Work is underway within the Integrated Care Foundation Trust to develop an intermediate tier service that is more integrated in nature and as a starting point is beginning to co-locate many of the services that are identified as offering rehabilitation, reablement, urgent and early intervention. The service identified as having an input into an intermediate tier of service include the Integrated Urgent Care Team, Reablement Service, Home First and Digital Health, IV Therapy Team, Long Term Conditions Team, Extensivists, Community Neuro Rehabilitation Team, Community Physiotherapy and Pulmonary Rehabilitation Team, Speech and Language Therapy and Dietetics as well as the community beds currently provided at Shire Hill, Grange View and the Stamford Unit.

5.2. **Integrated Neighbourhoods:** The ICFT have implemented a model of Neighbourhood working in response to the Single Commission's proposal for Integrated Neighbourhoods (INs). The IN vision is to support neighbourhoods to deliver asset rich, high quality and connected services which look after the whole neighbourhood population to support all to have improved outcomes, prosperity and wellbeing. The key objectives are to:

- Proactively identify people at high risk of requiring access to services, through early intervention and prevention
- Help people 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 each of the Neighbourhoods
- Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely
- Focus on improved condition management to avoid admissions
- Help prevent people from having to move to a residential or nursing home (24 hour care) until they really need to

5.3. **Extensive Care:** Extensive Care is a fundamentally different way of organising care around the needs of a specific cohort of people, which includes all aspects of need: medical, social, psychological, functional, pharmaceutical and self-care. The aim of an extensive care service model is to work closely with people with long term conditions, complex needs and those who are intensive users of the health and social care system. Within an agreed timeframe it aims to move to predicting exacerbations of underlying conditions, whilst helping people improve the management of their condition and their overall general health and well-being, therefore reducing the need for hospital admissions. The service implemented by T&GICFT will be led by a neighbourhood-based doctor (Consultant / GP) known as an Extensivist, supported by a multi-disciplinary team of health and social care professionals. The service includes health and well-being support that pulls together health and social support, including a range of community assets to ensure early intervention and proactive prevention. The service will also reduce the number of appointments that patients attend at different locations within our local health and social care system.

5.4 **Reablement:** The Reablement Service is currently provided by Tameside MBC Adult Services and has been in place for many years. The aim of the service is to enable people to attain or retain key skills for independent living. The service is provided by trained support workers who work with people for a period of up to six weeks following a period of ill health or trauma. The Reablement Service offers an intensive period of assessment and support that enables a person, in partnership with other clinicians and practitioners to realise their optimum potential for regaining, or in some cases learning or re-learning skills to enable them to live fuller lives and to have less dependency on more intrusive longer term services. Successful reablement will result in a person requiring less or no ongoing help and support in their daily living.

## 6. Future Model

Intermediate care services provide a crucial role in helping people to avoid going into hospital unnecessarily, helping people to be as independent as possible after a stay in hospital, and preventing people from having to move into a residential or care home until they really need to.
The overall aim of the intermediate care services is to support the rehabilitation and recuperation of patients maximising the patients' ability to function, to enable them to continue living at home in all but most challenging cases.
This should include home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) provided by an integrated team providing both health and social care input based on individual need. The model should also include community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.

The delivery model for intermediate care, including the assessment processes, must have the ability to care for clients with all levels of dementia, in an appropriate setting.

The further development of a model for Tameside & Glossop will take account of the outputs from previous audits and reviews, and the learning from the developments which have taken place during 2016-17 (as outlined above).

## 7. Proposed Outcomes

The further development of this Intermediate Care strategy will include the proposal and agreement of a set of system-wide outcome measures to assess the impact on:

- Maximising independence
- Preventing unnecessary hospital admissions
- Preventing unnecessary admissions to long term residential care
- Following hospital admissions, optimising discharges to usual place of residence

Service user outcome measure: using the information included in the 2017 NAIC, local service user outcome measures will be developed and refined, initially in the workshops scheduled for June 2017, and then refined through the wider consultation process July-September.

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

**Appendix 2**

**Pre-Consultation Engagement Material**

**Intermediate Care in Tameside & Glossop**

The CCG are leading a review of Intermediate Care services in Tameside & Glossop and are seeking advice from patient and public representatives.

The work done so far has been informed to a significant degree by the engagement activities led by our 3rd sector through Action Together and Glossop Volunteer Centre. Comments made through the engagement work to support Care Together have been used to develop the current Strategy which informs the model we commission from Tameside & Glossop Integrated Care Foundation Trust, and the developments which have taken place over the past 18 months. The reports from the sessions have been analysed and any information which relates to intermediate care has been taken and used in the development of the full strategy presented to the CCG/Single Commission committees.

We are seeking further comments on our plans for Intermediate Care.

**What is Intermediate Care?**

The definition of Intermediate Care included in the National Audit of Intermediate Care 2017 (developed with the assistance of the Plain English Campaign) is as follows.

**What is intermediate care?**

Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system –community services, hospitals, GPs and social care.

**What are the aims of intermediate care?**

There are three main aims of intermediate care and they are to:

Help people avoid going into hospital unnecessarily

Help people be as independent as possible after a stay in hospital and

Prevent people from having to move into a residential home until they really need to.

**Where is intermediate care delivered?**

Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

**How is intermediate care delivered?**

A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

Intermediate care services are currently delivered to the population of Tameside & Glossop CCG by the Integrated Care Foundation Trust as

community, hospital and bed-based intermediate care services (the latter at Darnton House and Shire Hill), and by Tameside Metropolitan Borough and Derbyshire County Councils.

| | |
|---|---|
| **Question**: | The section below is a summary of the model we intend to commission / deliver in Tameside and Glossop. We would appreciate your comments on whether this is the right model, and any additional suggestions you may have. |

**Model of Intermediate Care**

Intermediate care services provide a crucial role in helping people to avoid going into hospital unnecessarily, helping people to be as independent as possible after a stay in hospital, and preventing people from having to move into a residential or care home until they really need to.

The overall aim of the intermediate care services is to support the rehabilitation and recuperation of patients maximising the patients' ability to function, to enable them to continue living at home in all but most challenging cases.

This should include home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) provided by an integrated team providing both health and social care input based on individual need. The model should also include community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.

The delivery model for intermediate care, including the assessment processes, must have the ability to care for clients with all levels of dementia, in an appropriate setting.

The further development of a model for Tameside & Glossop will take account of the outputs from previous audits and reviews, and the learning from the developments which have taken place during 2016-17.

| | |
|---|---|
| **Question:** | The section below is a summary of the outcomes we want to achieve from our Intermediate Care model. We would appreciate your comments on whether these are the right outcomes, and any additional suggestions you may have. |

**Proposed Outcomes**

The further development of this Intermediate Care strategy will include the proposal and agreement of a set of system-wide outcome measures to assess the impact on:

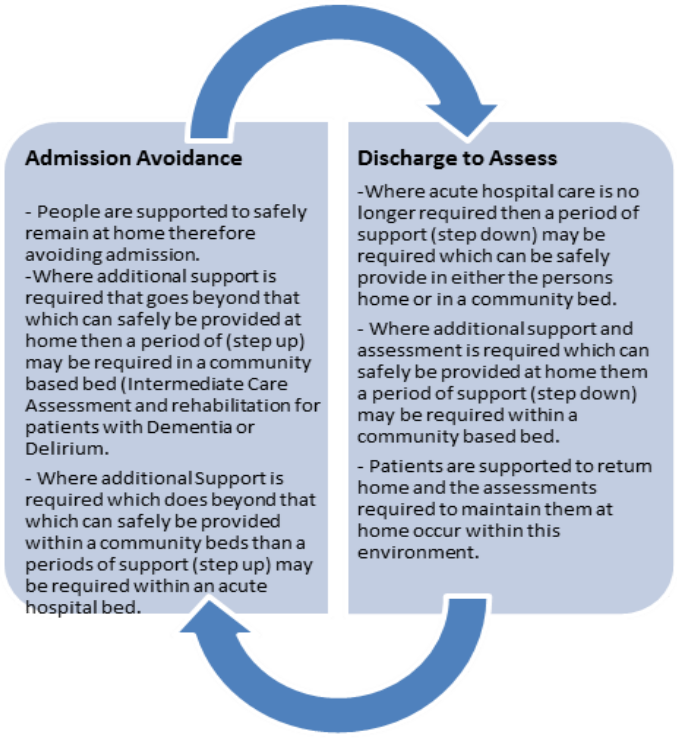
- Maximising independence
- Preventing unnecessary hospital admissions
- Preventing unnecessary admissions to long term residential care
- Following hospital admissions, optimising discharges to usual place of residence

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

## Intermediate Care in Tameside & Glossop

This summary outlines progress to date on the development of a system of intermediate care for the Tameside & Glossop Locality and the current position / provision.

**Home First:** In summary, the Home First model is the service offer that responds to meet an urgent/crisis health and/or social care need that cannot be managed within the Integrated Neighbourhood. It is a key interface between the Integrated Neighbourhood and the acute setting ensuring that people are supported in the environment that is suited to their own needs and most likely to achieve positive outcomes. It comprises of two key elements: Admission Avoidance and Discharge to Assess. A 'flexible community bed base scheme' is a key element of the home first model.




The main elements of Home First are:

- **Stamford Unit:** Offers bed based support for people who have been in hospital and who cannot immediately return home because they require further recuperation, or possibly further assessments that cannot be carried out at home.

- **Intermediate Care beds:** These facilities offer an ongoing period of rehabilitation to people who are unable to cope in their own home and require intensive rehabilitation to maximise the opportunity for them to return home either before an emergency admission is required or after a hospital admission. The maximum length of stay is 6 weeks and will vary dependant on the needs of an individual patient. Typically patients who need rehabilitation stay less than 26 days.

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

- **Integrated Urgent Care Team (IUCT):** This is an integrated team made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team currently works between the hospital and the community and works with people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team is an urgent response team and plans to get to people within an hour of the request for help and support. Ongoing support will then be provided for up to 72 hours by when decisions will have been made about onward care and support needs

**Intermediate Tier Development:** Work is underway within the Integrated Care Foundation Trust to develop an intermediate tier service that is more integrated in nature and as a starting point is beginning to co-locate many of the services that are identified as offering rehabilitation, reablement, urgent and early intervention. The service identified as having an input into an intermediate tier of service include the Integrated Urgent Care Team, Reablement Service, Home First and Digital Health, IV Therapy Team, Long Term Conditions Team, Extensivists, Community Neuro Rehabilitation Team, Community Physiotherapy and Pulmonary Rehabilitation Team, Speech and Language Therapy and Dietetics as well as the community beds currently provided.

**Reablement:** The Reablement Services are currently provided by Tameside MBC Adult Services and Derbyshire County Council. The aim of the service is to enable people to attain or retain key skills for independent living. The service is provided by trained support workers who work with people for a period of up to six weeks following a period of ill health or trauma. The Reablement Service offers an intensive period of assessment and support that enables a person, in partnership with other clinicians and practitioners to realise their optimum potential for regaining, or in some cases learning or re-learning skills to enable them to live fuller lives and to have less dependency on more intrusive longer term services. Successful reablement will result in a person requiring less or no ongoing help and support in their daily living.

**Contents**

## Shire Hill Summary

### 2015 Ward Stays by Postcode

| Patient Postcode | Number of Ward Stays |
|---|---|
| SK13 | 89 |
| SK14 | 48 |
| M34 | 39 |
| OL6 | 26 |
| SK15 | 24 |
| SK16 | 21 |
| M43 | 19 |
| OL5 | 14 |
| OL7 | 10 |
| SK23 | * |
| OL3 | * |
| CH2 | * |
| **Grand Total** | **293** |

### 2016 Ward Stays by Postcode

| Patient Postcode | Number of Ward Stays |
|---|---|
| SK13 | 113 |
| SK14 | 56 |
| M34 | 51 |
| SK15 | 44 |
| OL6 | 31 |
| SK16 | 28 |
| OL7 | 28 |
| OL5 | 25 |
| M43 | 21 |
| S73 | * |
| **Grand Total** | **398** |

### 2017 Ward Stays by Postcode (Jan to Date)

| Patient Postcode | Number of Ward Stays |
|---|---|
| SK14 | 42 |
| SK13 | 38 |
| M34 | 21 |
| SK15 | 17 |
| SK16 | 12 |
| OL7 | 10 |
| OL6 | 9 |
| M43 | 8 |
| OL5 | * |
| BS39 | * |
| **Grand Total** | **161** |

* = data of 5 or less has been suppressed

# Stamford Unit Summary

## 2015 Ward Stays by Postcode

| Patient Postcode | Number of Ward Stays |
|---|---|
| SK14 | 84 |
| OL6 | 70 |
| SK15 | 58 |
| SK16 | 48 |
| M43 | 35 |
| SK13 | 31 |
| OL7 | 28 |
| OL5 | 20 |
| M40 | * |
| OL9 | * |
| OL8 | * |
| OL4 | * |
| M11 | * |
| TS26 | * |
| BA13 | * |
| M20 | * |
| M18 | * |
| M33 | * |
| OL3 | * |
| CH2 | * |
| SS2 | * |
| M35 | * |
| WA14 | * |
| PE19 | * |
| CW12 | * |
| **Grand Total** | **518** |

## 2016 Ward Stays by Postcode

| Patient Postcode | Number of Ward Stays |
|---|---|
| M34 | 86 |
| SK15 | 59 |
| SK14 | 57 |
| OL6 | 50 |
| OL7 | 35 |
| SK16 | 32 |
| M43 | 32 |
| SK13 | 25 |
| OL5 | 10 |
| OL3 | * |
| SK6 | * |
| M12 | * |
| SK1 | * |
| M40 | * |
| CB9 | * |
| SK17 | * |
| M25 | * |
| SK7 | * |
| CW12 | * |
| M45 | * |
| ME3 | * |
| SK3 | * |
| NULL | * |
| SK8 | * |
| M35 | * |
| SK9 | * |
| TS4 | * |
| WN7 | * |

## 2016 Ward Stays Continued

| | |
|---|---|
| M33 | * |
| OL9 | * |
| **Grand Total** | **415** |

## 2017 Ward Stays by Postcode (Jan-Date)

| Patient Postcode | Number of Ward Stays |
|---|---|
| SK14 | 68 |
| M34 | 63 |
| OL6 | 51 |
| OL7 | 48 |
| SK15 | 45 |
| SK16 | 44 |
| SK13 | 39 |
| M43 | 34 |
| OL5 | * |
| SK6 | * |
| M11 | * |
| M33 | * |
| TF3 | * |
| BL9 | * |
| M25 | * |
| OL9 | * |
| BS39 | * |
| SK5 | * |
| **Grand Total** | **392** |

* = data of 5 or less has been suppressed

# Shire Hill Referrals by GP Practice

* = data of 5 or less has been suppressed

## 2015 Ward Stays by GP Practice

| Neighbourhood | GP Practice | Number of Ward Stays |
|---|---|---|
| Glossop | MANOR HOUSE SURGERY | 30 |
| N/A | WESLEY STREET | 19 |
| Hyde | MOTTRAM MOOR | 16 |
| Denton | DENTON MEDICAL PRACTICE | 14 |
| N/A | PENNINE MEDICAL CENTRE | 13 |
| Denton | MEDLOCK VALE MED. PRACT. | 11 |
| Hyde | THE BROOKE SURGERY | 11 |
| Hyde | DONNEYBROOK MEDICAL CTR | 11 |
| Glossop | HADFIELD MEDICAL CENTRE | 11 |
| Ashton | BEDFORD HOUSE MEDICAL CTR | 9 |
| Ashton | ALBION MEDICAL PRACTICE | 9 |
| Ashton | GORDON STREET MED.CTR. | 9 |
| Hyde | THORNLEY HOUSE MED/CTR | 8 |
| Denton | CHURCHGATE SURGERY | 8 |
| Hyde | HATTERSLEY HEALTH CENTRE | 8 |
| Glossop | HOWARD MEDICAL PRACTICE | 7 |
| Hyde | DAVAAR MEDICAL CENTRE | 7 |
| Glossop | SIMMONDLEY MED PRCTICE | 7 |
| Denton | WINDMILL MEDICAL PRACTICE | 7 |
| N/A | THE SURGERY | 6 |
| Stalybridge | STAVELEIGH MEDICAL CENTRE | 6 |
| Denton | 76 MARKET STREET | 6 |
| Stalybridge | LOCKSIDE MEDICAL CENTRE | 6 |
| Stalybridge | THE PIKE MED CTR | * |
| Ashton | CHAPEL STREET MEDICAL CTR | * |
| Hyde | THE SMITHY SURGERY | * |
| Hyde | WEST END MEDICAL CENTRE | * |
| Hyde | CLARENDON MEDICAL CENTRE | * |
| Hyde | HT PRACTICE, ASHTON PCC | * |
| Hyde | GROSVENOR MEDICAL CENTRE | * |
| Hyde | STALYBRIDGE RESOURCE CTR | * |
| Hyde | STAMFORD HOUSE | * |
| Hyde | TAME VALLEY MEDICAL CTR. | * |
| Hyde | THE HOLLIES SURGERY | * |
| Hyde | LIME SQUARE | * |
| Hyde | 1-3 ALBION DRIVE | * |
| Hyde | KING STREET MEDICAL CTR. | * |
| Hyde | TOWN HALL SURGERY | * |
| Hyde | THE FAMILY SURGERY | * |
| Hyde | BROKEN CROSS SURGERY | * |
| | **Grand Total** | **293** |

# 2016 Ward Stays by GP Practice

| Neighbourhood | GP Practice | Number of Ward Stays |
|---|---|---|
| Glossop | MANOR HOUSE SURGERY | 43 |
| Hyde | MOTTRAM MOOR | 24 |
| N/A | PENNINE MEDICAL CENTRE | 23 |
| N/A | WESLEY STREET | 18 |
| Denton | WINDMILL MEDICAL PRACTICE | 17 |
| Ashton | BEDFORD HOUSE MEDICAL CTR | 16 |
| Glossop | HADFIELD MEDICAL CENTRE | 15 |
| Stalybridge | GROSVENOR MEDICAL CENTRE | 14 |
| Hyde | DAVAAR MEDICAL CENTRE | 14 |
| Hyde | THE SMITHY SURGERY | 14 |
| Stalybridge | STAVELEIGH MEDICAL CENTRE | 13 |
| Denton | DENTON MEDICAL PRACTICE | 12 |
| Denton | MEDLOCK VALE MED. PRACT. | 12 |
| Ashton | TAME VALLEY MEDICAL CTR. | 11 |
| Glossop | HOWARD MEDICAL PRACTICE | 11 |
| Denton | 76 MARKET STREET | 11 |
| Denton | CHURCHGATE SURGERY | 10 |
| Hyde | DONNEYBROOK MEDICAL CTR | 10 |
| Ashton | ALBION MEDICAL PRACTICE | 10 |
| Ashton | HT PRACTICE, ASHTON PCC | 10 |
| Hyde | THE BROOKE SURGERY | 9 |
| Glossop | SIMMONDLEY MED PRCTICE | 9 |
| Stalybridge | KING STREET MEDICAL CTR. | 8 |
| Hyde | CLARENDON MEDICAL CENTRE | 8 |
| Glossop | THE SURGERY | 6 |
| Ashton | WATERLOO MEDICAL CENTRE | 6 |
| Hyde | THORNLEY HOUSE MED/CTR | * |
| Stalybridge | LOCKSIDE MEDICAL CENTRE | * |
| Hyde | HATTERSLEY HEALTH CENTRE | * |
| Stalybridge | STALYBRIDGE RESOURCE CTR | * |
| Ashton | CHAPEL STREET MEDICAL CTR | * |
| Ashton | WEST END MEDICAL CENTRE | * |
| Stalybridge | TOWN HALL SURGERY | * |
| Ashton | GORDON STREET MED.CTR. | * |
| N/A | CORNERSTONE CENTRE | * |
| Stalybridge | MOSSLEY MEDICAL PRACTICE | * |
| Ashton | STAMFORD HOUSE | * |
| Hyde | THE HOLLIES SURGERY | * |
| N/A | LIME SQUARE | * |
| Stalybridge | THE PIKE MED CTR | * |
| Denton | 1-3 ALBION DRIVE | * |
| | **Grand Total** | **398** |

# 2017 Ward Stays by GP Practice (Jan to Date)

| Neighbourhood | GP Practice | Number of Ward Stays |
|---|---|---|
| Glossop | MANOR HOUSE SURGERY | 17 |
| Hyde | DONNEYBROOK MEDICAL CTR | 10 |
| Hyde | MOTTRAM MOOR | 9 |
| Ashton | BEDFORD HOUSE MEDICAL CTR | 7 |
| Hyde | HATTERSLEY HEALTH CENTRE | 7 |
| Hyde | DAVAAR MEDICAL CENTRE | 7 |
| Denton | DENTON MEDICAL PRACTICE | 7 |
| Glossop | HOWARD MEDICAL PRACTICE | 7 |
| Denton | 76 MARKET STREET | 6 |
| Stalybridge | STAVELEIGH MEDICAL CENTRE | 6 |
| n/a | WESLEY STREET | 6 |
| Denton | WINDMILL MEDICAL PRACTICE | * |
| Ashton | ALBION MEDICAL PRACTICE | * |
| Hyde | THE BROOKE SURGERY | * |
| Hyde | THORNLEY HOUSE MED/CTR | * |
| Stalybridge | STALYBRIDGE RESOURCE CTR | * |
| Denton | CHURCHGATE SURGERY | * |
| Denton | MEDLOCK VALE MED. PRACT. | * |
| Stalybridge | KING STREET MEDICAL CTR. | * |
| Stalybridge | LOCKSIDE MEDICAL CENTRE | * |
| Hyde | THE SMITHY SURGERY | * |
| Glossop | HADFIELD MEDICAL CENTRE | * |
| Stalybridge | GROSVENOR MEDICAL CENTRE | * |
| Glossop | SIMMONDLEY MED PRCTICE | * |
| Ashton | WEST END MEDICAL CENTRE | * |
| Hyde | CLARENDON MEDICAL CENTRE | * |
| Ashton | HT PRACTICE, ASHTON PCC | * |
| Stalybridge | THE PIKE MED CTR | * |

| Neighbourhood | GP Practice | Number of Ward Stays |
|---|---|---|
| Ashton | CHAPEL STREET MEDICAL CTR | * |
| Ashton | TAME VALLEY MEDICAL CTR. | * |
| Ashton | WATERLOO MEDICAL CENTRE | * |
| Stalybridge | HOLLYBANK | * |
| n/a | PENNINE MEDICAL CENTRE | * |
| n/a | HARPTREE SURGERY | * |
| n/a | HGR OPENSHAW PCC | * |
| Glossop | THE SURGERY | * |
| n/a | THE FAMILY SURGERY | * |
| | **Grand Total** | **161** |

# Stamford Unit Referrals by GP Practice

## 2015 Ward Stays by GP Practice

| Neighbourhood | GP Practice | Number of Ward Stays |
|---|---|---|
| Denton | WINDMILL MEDICAL PRACTICE | 36 |
| Denton | HAUGHTON/THORNLEY MEDICAL CENTRES | 29 |
| Ashton | ALBION MEDICAL PRACTICE | 24 |
| Ashton | BEDFORD HOUSE MEDICAL CENTRE | 24 |
| Hyde | DONNEYBROOK MEDICAL CENTRE | 22 |
| Hyde | HAUGHTON/THORNLEY MEDICAL CENTRES | 20 |
| Ashton | CHAPEL STREET MEDICAL CENTRE | 18 |
| Hyde | HATTERSLEY GROUP PRACTICE | 18 |
| Hyde | CLARENDON MEDICAL CENTRE | 18 |
| Stalybridge | GROSVENOR MEDICAL CENTRE | 17 |
| Denton | CHURCHGATE SURGERY | 17 |
| Denton | DENTON MEDICAL PRACTICE | 16 |
| Denton | MEDLOCK VALE MEDICAL PRACTICE | 15 |
| N/A | LIME SQUARE MEDICAL CENTRE | 14 |
| Hyde | THE HOLLIES SURGERY | 12 |
| Hyde | THE BROOKE SURGERY | 12 |
| Stalybridge | ST.ANDREW'S HOUSE SURGERY | 12 |
| Hyde | AWBURN HOUSE MEDICAL PRACTICE | 12 |
| Denton | MARKET STREET MEDICAL PRACTICE | 12 |
| | STAVELEIGH MEDICAL CENTRE | 11 |
| | GORDON STREET MEDICAL CENTRE | 11 |
| | PENNINE MEDICAL CENTRE | 11 |
| | PIKE MEDICAL PRACTICE | 10 |
| | MANOR HOUSE SURGERY | 8 |
| | WATERLOO MEDICAL CENTRE | 8 |
| | KING STREET MEDICAL CENTRE | 8 |
| | TAME VALLEY MEDICAL CENTRE | 8 |
| | HADFIELD MEDICAL CENTRE | 7 |

| Neighbourhood | GP Practice | Number of Ward Stays |
|---|---|---|
| | LAMBGATES HEALTH CENTRE | 7 |
| | TOWN HALL SURGERY | 6 |
| | DAVAAR MEDICAL CENTRE | 6 |
| | DROYLSDEN MEDICAL PRACTICE | 6 |
| | GROUP PRACTICE CENTRE | * |
| | LOCKSIDE MEDICAL CENTRE | * |
| | WEST END MEDICAL CENTRE | * |
| | EASTLANDS MEDICAL CENTRE | * |
| | THE SMITHY SURGERY | * |
| | GUIDE BRIDGE MEDICAL PRACTICE | * |
| | STAMFORD HOUSE | * |
| | FLORENCE HOUSE MEDICAL PRACTICE | * |
| | DR MOKASHI | * |
| | FAMILY SURGERY | * |
| | CORNERSTONE FAMILY PRACTICE | * |
| | ALEXANDRA GROUP MED PRACT | * |
| | MOSSLEY MEDICAL PRACTICE | * |
| | THE MAZHARI & KHAN PRACTICE | * |
| | FIVE OAKS FAMILIY PRACTICE | * |
| | LINDLEY HOUSE HEALTH CENTRE | * |
| | ASHTON GP SERVICE | * |
| | EDENBRIDGE MED PRACTICE | * |
| | THE WEAVER VALE SURGERY | * |
| | PARK VIEW GROUP PRACTICE | * |
| | ARCHWOOD MEDICAL PRACTICE | * |
| | GORTON MEDICAL CENTRE | * |
| | THE SURGERY 1 | * |
| | COTTAGE LANE SURGERY | * |

## 2015 Ward Stays Continued

| | |
|---|---|
| BROKEN CROSS SURGERY | * |
| SIMMONDLEY MEDICAL PRACTICE | * |
| ALVANLEY FAMILY PRACTICE | * |
| SIDDIQUE & AGHA | * |
| **Grand Total** | **518** |

## 2016 Ward Stays by GP Practice

| Neighbourhood | GP Practice | Number of Ward Stays |
|---|---|---|
| Denton | WINDMILL MEDICAL PRACTICE | 39 |
| Denton | HAUGHTON/THORNLEY MEDICAL CENTRES | 24 |
| Ashton | ALBION MEDICAL PRACTICE | 21 |
| Stalybridge | STAVELEIGH MEDICAL CENTRE | 19 |
| Hyde | DONNEYBROOK MEDICAL CENTRE | 18 |
| Ashton | TAME VALLEY MEDICAL CENTRE | 16 |
| Denton | DENTON MEDICAL PRACTICE | 16 |
| Hyde | THE BROOKE SURGERY | 14 |
| Ashton | BEDFORD HOUSE MEDICAL CENTRE | 14 |
| Denton | MARKET STREET MEDICAL PRACTICE | 13 |
| Denton | CHURCHGATE SURGERY | 12 |
| Stalybridge | LOCKSIDE MEDICAL CENTRE | 12 |
| Ashton | CHAPEL STREET MEDICAL CENTRE | 10 |
| Hyde | AWBURN HOUSE MEDICAL PRACTICE | 10 |
| Ashton | STAMFORD HOUSE | 10 |
| Stalybridge | GROSVENOR MEDICAL CENTRE | 9 |
| Hyde | CLARENDON MEDICAL CENTRE | 9 |
| Ashton | HT PRACTICE | 9 |
| N/A | PENNINE MEDICAL CENTRE | 8 |
| N/A | LIME SQUARE MEDICAL CENTRE | 8 |
| Hyde | THE SMITHY SURGERY | 8 |
| Stalybridge | KING STREET MEDICAL CENTRE | 8 |
| Glossop | MANOR HOUSE SURGERY | 8 |
| Ashton | WEST END MEDICAL CENTRE | 7 |
| Glossop | COTTAGE LANE SURGERY | 6 |
| Stalybridge | TOWN HALL SURGERY | 6 |
| Ashton | GORDON STREET MEDICAL CENTRE | 6 |
| Stalybridge | ST.ANDREW'S HOUSE SURGERY | 6 |
| Denton | MEDLOCK VALE MEDICAL PRACTICE | 6 |

| Neighbourhood | GP Practice | Number of Ward Stays |
|---|---|---|
| Ashton | ASHTON GP SERVICE | * |
| Hyde | DAVAAR MEDICAL CENTRE | * |
| Hyde | HATTERSLEY GROUP PRACTICE | * |
| Glossop | SIMMONDLEY MEDICAL PRACTICE | * |
| Hyde | THE HOLLIES SURGERY | * |
| Glossop | LAMBGATES HEALTH CENTRE | * |
| N/A | SADDLEWORTH MEDICAL PRACTICE | * |
| Stalybridge | PIKE MEDICAL PRACTICE | * |
| N/A | THE MAZHARI & KHAN PRACTICE | * |
| Glossop | HADFIELD MEDICAL CENTRE | * |
| Denton | DROYLSDEN MEDICAL PRACTICE | * |
| N/A | CORNERSTONE FAMILY PRACTICE | * |
| N/A | FLORENCE HOUSE MEDICAL PRACTIC | * |
| N/A | DR MOKASHI | * |
| Glossop | GROUP PRACTICE CENTRE | * |
| N/A | PARK VIEW GROUP PRACTICE | * |
| Ashton | WATERLOO MEDICAL CENTRE | * |
| N/A | CHADSFIELD MEDICAL PRACTICE | * |
| N/A | NORTHENDEN GROUP PRACTICE | * |
| N/A | ARCHWOOD MEDICAL PRACTICE | * |
| N/A | ADDINGHAM SURGERY | * |
| N/A | THE VILLAGE SURGERY | * |
| Denton | GUIDE BRIDGE MEDICAL PRACTICE | * |
| N/A | THE ENDEAVOUR PRACTICE | * |
| N/A | WILKINSON PRACTICE | * |
| N/A | GATLEY MEDICAL CENTRE | * |
| N/A | ALVANLEY FAMILY PRACTICE | * |
| N/A | THE UPLANDS MEDICAL PRACTICE | * |
| N/A | FIVE OAKS FAMILIY PRACTICE | * |

## 2016 Ward Stays continued

| Neighbourhood | GP Practice | Number of Ward Stays |
|---|---|---|
| N/A | READESMOOR MEDICAL GROUP PRACTICE | * |
| N/A | BRINNINGTON HEALTH CENTRE 2 | * |
| N/A | FAILSWORTH GROUP PRACTICE | * |
| **N/A** | GORTON MEDICAL CENTRE | * |
| N/A | DR DD THOMAS' PRACTICE | * |
| Stalybridge | MILLBROOK MEDICAL PRACTICE | * |
| Stalybridge | MOSSLEY MEDICAL PRACTICE | * |
| | **Grand Total** | **415** |

## 2017 Ward Stays by GP Practice (Jan to Date)

* = data of 5 or less has been suppressed

| Neighbourhood | GP Practice | Number of Ward Stays |
|---|---|---|
| Ashton | BEDFORD HOUSE MEDICAL CENTRE | 20 |
| Hyde | DAVAAR MEDICAL CENTRE | 21 |
| Ashton | ALBION MEDICAL PRACTICE | 22 |
| Hyde | CLARENDON MEDICAL CENTRE | 16 |
| Denton | WINDMILL MEDICAL PRACTICE | 18 |
| Ashton | TAME VALLEY MEDICAL CENTRE | 13 |
| Hyde | DONNEYBROOK MEDICAL CENTRE | 17 |
| Ashton | CHAPEL STREET MEDICAL CENTRE | 14 |
| Glossop | MANOR HOUSE SURGERY | 17 |
| Hyde | AWBURN HOUSE MEDICAL PRACTICE | 14 |
| Denton | MEDLOCK VALE MEDICAL PRACTICE | 14 |
| Denton | DENTON MEDICAL PRACTICE | 13 |
| N/A | LIME SQUARE MEDICAL CENTRE | 11 |
| Stalybridge | GROSVENOR MEDICAL CENTRE | 9 |
| Stalybridge | KING STREET MEDICAL CENTRE | 13 |
| Ashton | STAMFORD HOUSE | 9 |
| Hyde | HAUGHTON/THORNLEY MEDICAL CENTRES | 17 |
| Glossop | LAMBGATES HEALTH CENTRE | 10 |
| Stalybridge | ST.ANDREW'S HOUSE SURGERY | 7 |
| Hyde | THE BROOKE SURGERY | 10 |
| Stalybridge | STAVELEIGH MEDICAL CENTRE | 12 |
| Glossop | SIMMONDLEY MEDICAL PRACTICE | 6 |
| Ashton | HT PRACTICE | 11 |
| Denton | CHURCHGATE SURGERY | 9 |
| Ashton | GORDON STREET MEDICAL CENTRE | * |
| Denton | GUIDE BRIDGE MEDICAL PRACTICE | 8 |
| N/A | PENNINE MEDICAL CENTRE | 9 |
| Glossop | GROUP PRACTICE CENTRE | * |
| Hyde | HATTERSLEY GROUP PRACTICE | 6 |
| Stalybridge | LOCKSIDE MEDICAL CENTRE | 7 |
| Denton | MARKET STREET MEDICAL PRACTICE | 7 |
| Ashton | WATERLOO MEDICAL CENTRE | * |
| Stalybridge | TOWN HALL SURGERY | 6 |
| Denton | DROYLSDEN MEDICAL PRACTICE | * |
| N/A | FIRSWAY HEALTH CENTRE | * |
| Ashton | ASHTON GP SERVICE | * |
| Hyde | THE SMITHY SURGERY | * |
| N/A | THE MISBOURNE SURGERY | * |
| N/A | SILVERDALE MEDICAL PRACTICE | * |
| N/A | CORNERSTONE FAMILY PRACTICE | * |
| N/A | FIVE OAKS FAMILIY PRACTICE | * |
| N/A | DR MOKASHI | * |
| N/A | WILKINSON PRACTICE | * |
| N/A | GORTON MEDICAL CENTRE | * |
| N/A | EASTLANDS MEDICAL CENTRE | * |
| Ashton | WEST END MEDICAL CENTRE | * |
| N/A | HARPTREE SURGERY | * |
| Glossop | HADFIELD MEDICAL CENTRE | * |
| | **Grand Total** | **409** |

# Number of Referrals to Shire Hill Intermediate Care Unit Per Postcode Sector April 2015-May 2017

N

OL5
42

OL6
66

OL7
48

T&G ICFT

SK15
85

M43
48

SK16
61

M34
111

SK14
146

SK13
240

Shire
Hill ICU

Number of Referrals from Postcodes outside T&G CCG Area: 5

Shire Hill ICU

T&G ICFT

0 0.4 0.8 1.6 2.4 3.2 Miles



Author: Michael Clegg - Policy & Communications

# Number of Referrals to ICFT Intermediate Care Unit Per Postcode Sector March 2015-May 2017

N

OL5
35
OL6
171
111
SK15
162
T&G ICFT
M43
101
OL7
124
SK16
M34
271
SK14
209
SK13
95
Shire Hill ICU

Number of Referrals from Postcodes outside T&G CCG Area: 63

Shire Hill ICU
T&G ICFT

0 0.425 0.85 1.7 2.55 3.4 Miles



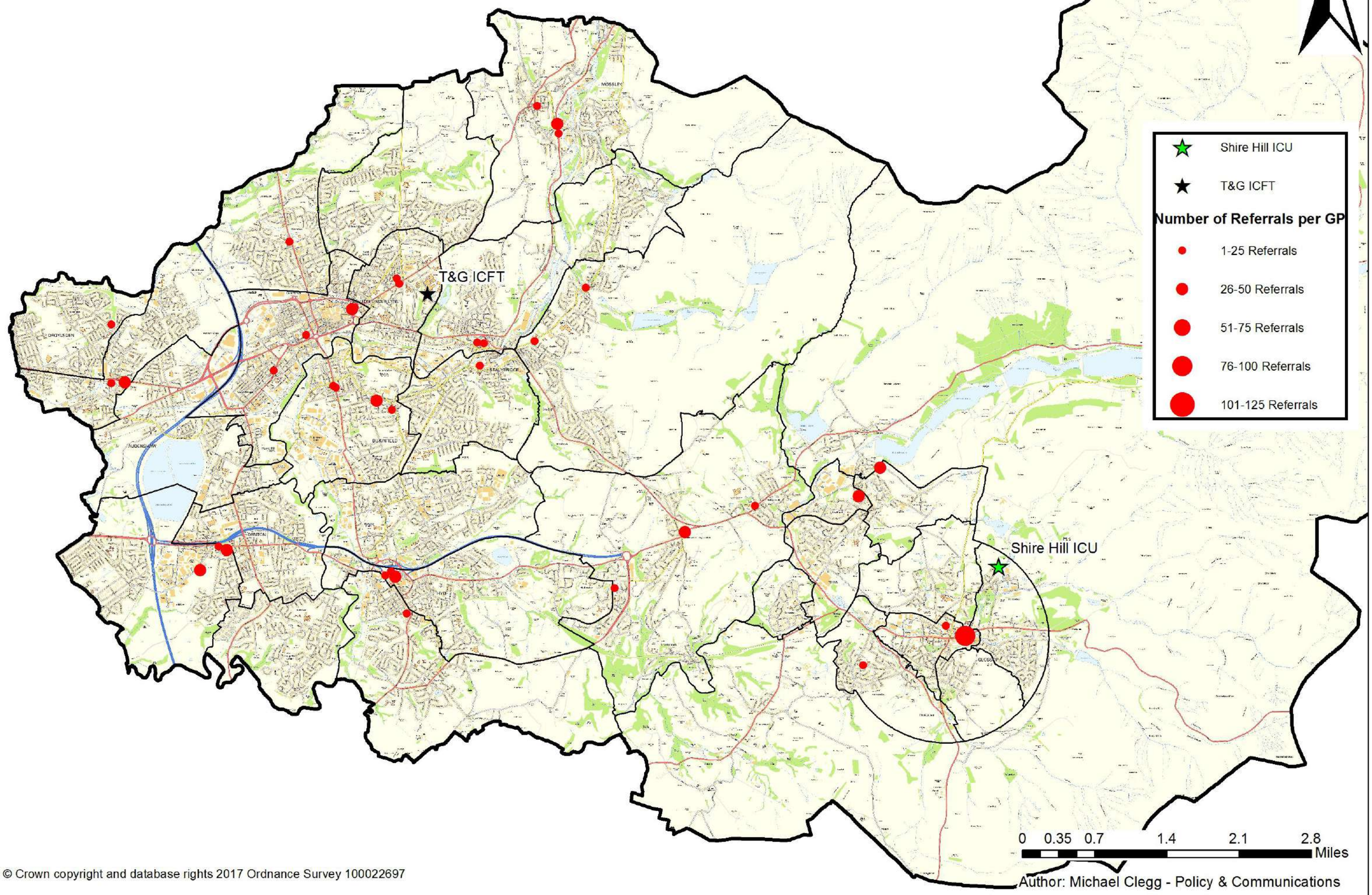
Author: Michael Clegg - Policy & Communications

| Postcode Sector | Shire Hill | |
|---|---|---|
| | Number of Referrals to Shire Hill (Apr 2015 - May 2017) | Percentage of Referrals to Shire Hill (Apr 2015 - May 2017) |
| M34 | 111 | 13.0 |
| M43 | 48 | 5.6 |
| OL5 | 42 | 4.9 |
| OL6 | 66 | 7.7 |
| OL7 | 48 | 5.6 |
| SK13 | 240 | 28.2 |
| SK14 | 146 | 17.1 |
| SK15 | 85 | 10.0 |
| SK16 | 61 | 7.2 |
| Other Postcodes | 5 | 0.6 |
| **Total** | **852** | **100.0** |

| Postcode Sector | ICFT | |
|---|---|---|
| | Number of Referrals to ICFT (Mar 2015 - May 2017) | Percentage of Referrals to ICFT (Mar 2015 - May 2017) |
| M34 | 271 | 20.2 |
| M43 | 101 | 7.5 |
| OL5 | 35 | 2.6 |
| OL6 | 171 | 12.7 |
| OL7 | 111 | 8.3 |
| SK13 | 95 | 7.1 |
| SK14 | 209 | 15.6 |
| SK15 | 162 | 12.1 |
| SK16 | 124 | 9.2 |
| Other Postcodes | 63 | 4.7 |
| **Total** | **1342** | **100.0** |

| Postcode Sector | Combined Shire Hill and ICFT | |
|---|---|---|
| | Total number of Referrals to Shire Hill and ICFT (Data periods as above) | Percentage of Total Referrals to Shire Hill and ICFT Combined (Data periods as above) |
| M34 | 382 | 17.4 |
| M43 | 149 | 6.8 |
| OL5 | 77 | 3.5 |
| OL6 | 237 | 10.8 |
| OL7 | 159 | 7.2 |
| SK13 | 335 | 15.3 |
| SK14 | 355 | 16.2 |
| SK15 | 247 | 11.3 |
| SK16 | 185 | 8.4 |
| Other Postcodes | 68 | 3.1 |
| **Total** | **2194** | **100.0** |

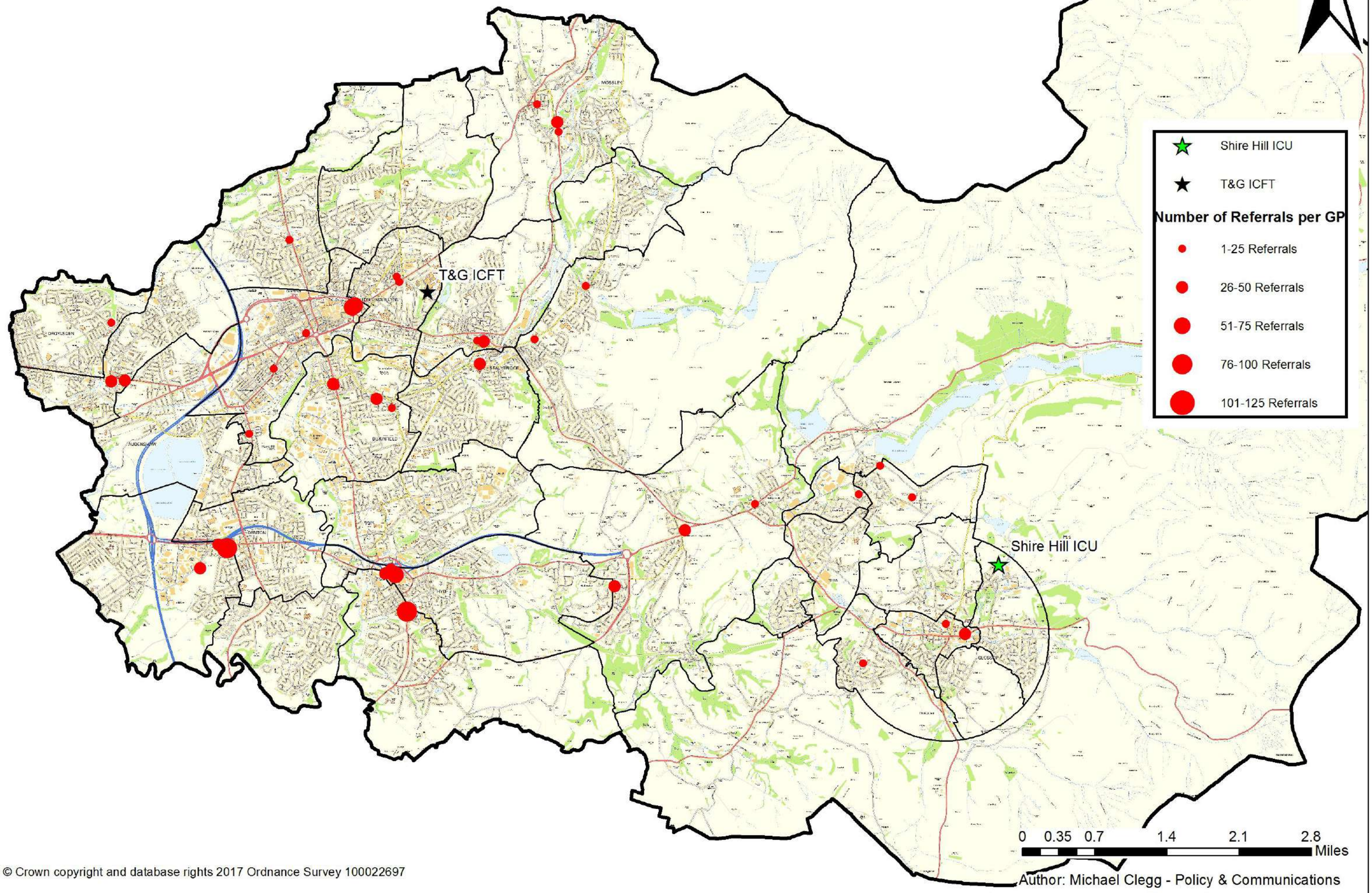
# Referrals from GP Surgeries to Shire Hill Intermediate Care Unit April 2015-May 2017



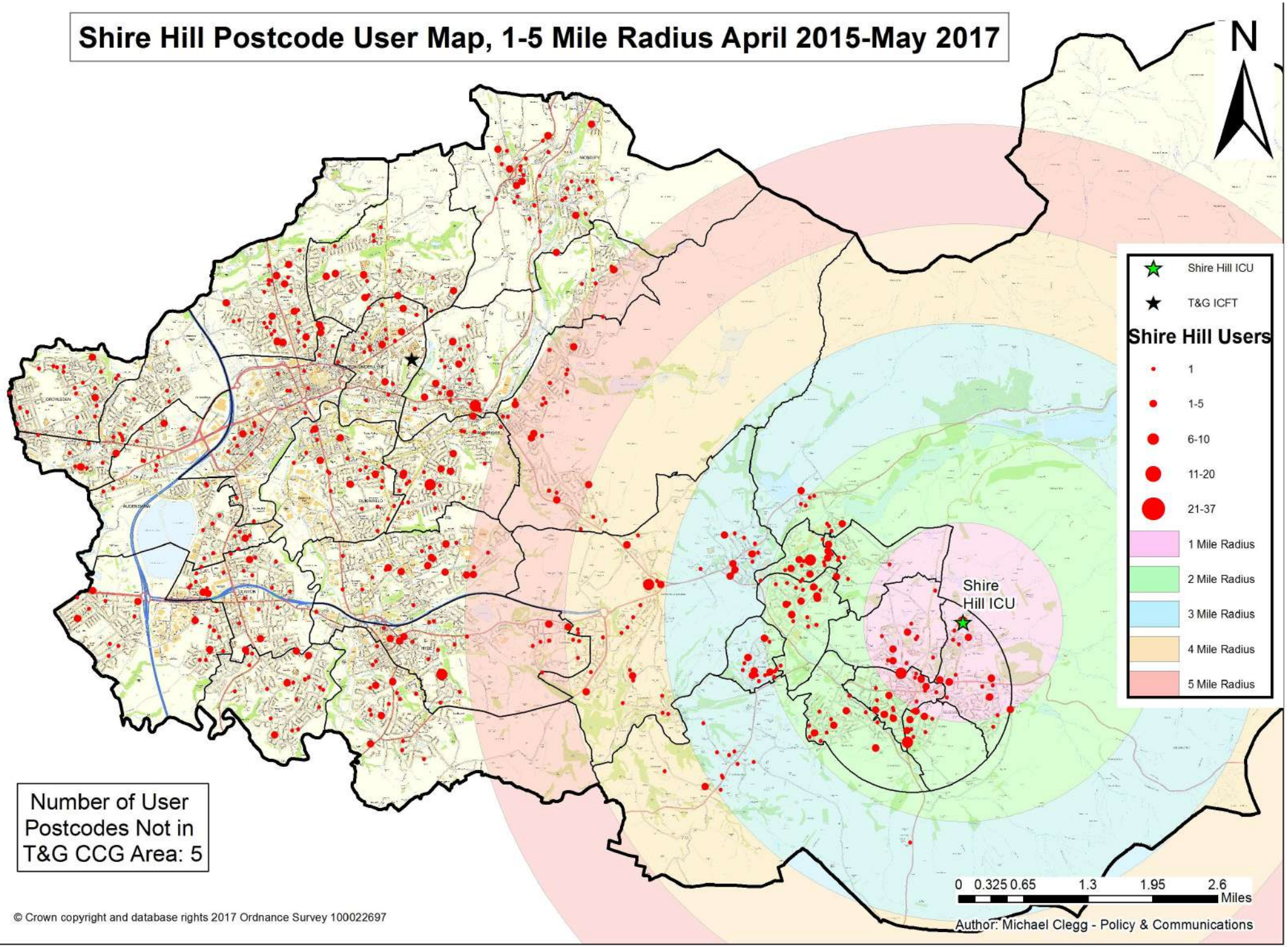



Author: Michael Clegg - Policy & Communications

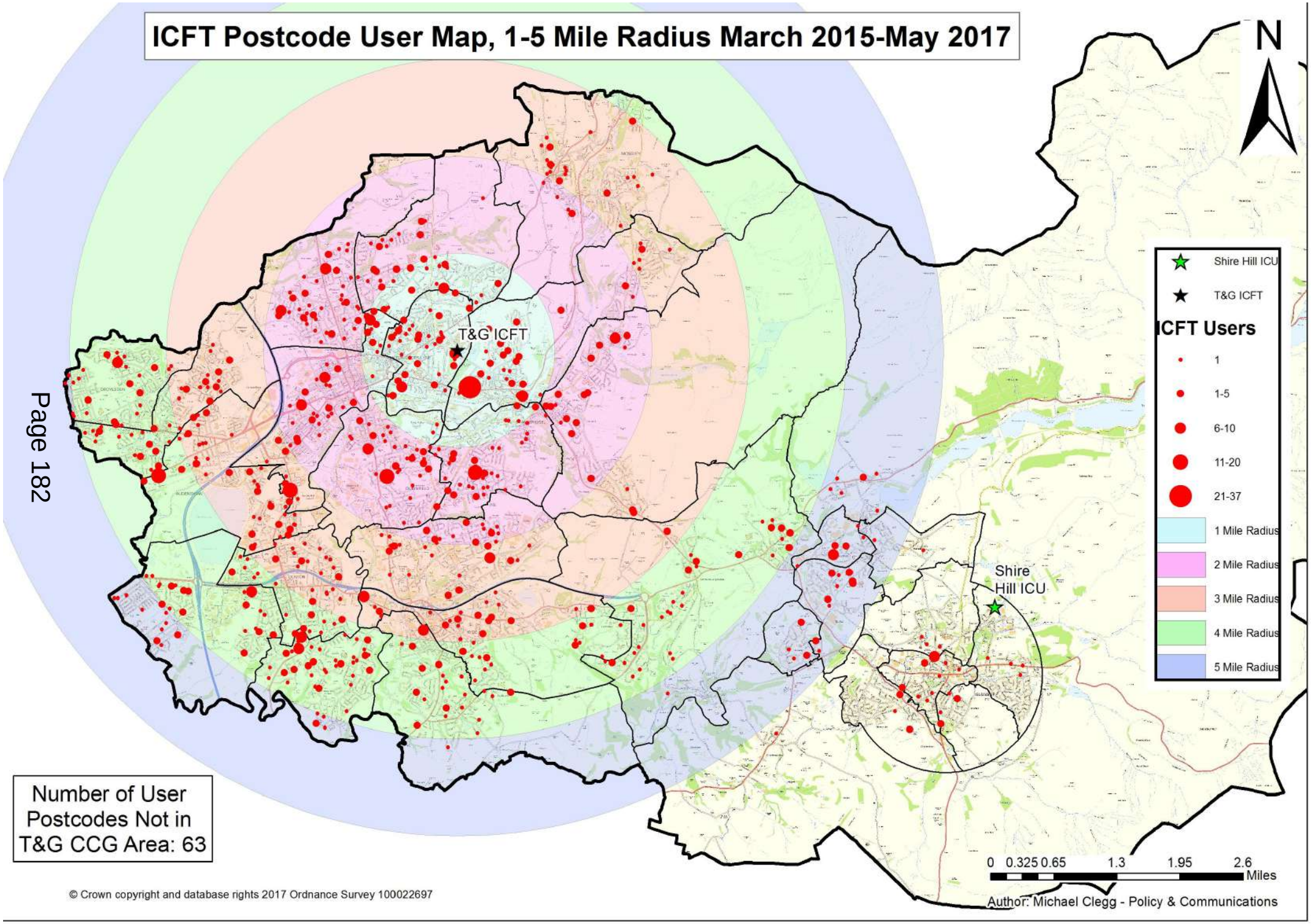
# Referrals from GP Surgeries to ICFT Intermediate Care Unit March 2015-May 2017



# Shire Hill Postcode User Map, 1-5 Mile Radius April 2015-May 2017




Number of User Postcodes Not in T&G CCG Area: 5


ICFT Postcode User Map, 1-5 Mile Radius March 2015-May 2017
N
T&G ICFT
Shire Hill ICU
Shire Hill ICU
T&G ICFT
ICFT Users
1
1-5
6-10
11-20
21-37
1 Mile Radius
2 Mile Radius
3 Mile Radius
4 Mile Radius
5 Mile Radius
Number of User Postcodes Not in T&G CCG Area: 63
0 0.325 0.65 1.3 1.95 2.6
Miles
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Author: Michael Clegg - Policy & Communications

| Intermediate Care Unit | Number of service users from Tameside and Glossop postcodes |
|---|---|
| Shire Hill (April 2015-May 2017) | 847 |
| ICFT (March 2015-May 2017) | 1279 |

| Shire Hill Users | Number of Shire Hill users within 1 mile radius of: | % within 1 mile radius of: | Number of Shire Hill users within 2 mile radius of: | % within 2 mile radius of: | Number of Shire Hill users within 3 mile radius of: | % within 3 mile radius of: | Number of Shire Hill users within 4 mile radius of: | % within 4 mile radius of: | Number of Shire Hill users within 5 mile radius of: | % within 5 mile radius of: | Number of Shire Hill users outside of 5 mile radius of: | % outside of 5 mile radius of: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Shire Hill | 63 | 7.4 | 209 | 24.7 | 255 | 30.1 | 296 | 34.9 | 339 | 40.0 | 508 | 60.0 |
| ICFT | 91 | 10.7 | 261 | 30.8 | 412 | 48.6 | 588 | 69.4 | 707 | 83.5 | 140 | 16.5 |

| ICFT Users | Number of ICFT users within 1 mile radius of: | % within 1 mile radius of: | Number of ICFT users within 2 mile radius of: | % within 2 mile radius of: | Number of ICFT users within 3 mile radius of: | % within 3 mile radius of: | Number of ICFT users within 4 mile radius of: | % within 4 mile radius of: | Number of ICFT users within 5 mile radius of: | % within 5 mile radius of: | Number of ICFT users outside of 5 mile radius of: | % outside of 5 mile radius of: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Shire Hill | 20 | 1.6 | 89 | 7.0 | 111 | 8.7 | 146 | 11.4 | 206 | 16.1 | 1073 | 83.9 |
| ICFT | 216 | 16.9 | 569 | 44.5 | 837 | 65.4 | 1156 | 90.4 | 1231 | 96.2 | 48 | 3.8 |

| Mode of Transport/Time Period | Location | % of Population within 0-15 Minutes | % of Population within 0-30 Minutes | % of Population within 0-45 Minutes | % of Population within 0-60 Minutes | % of Population 60 Minutes + |
|---|---|---|---|---|---|---|
| Drive Time Monday-Friday 0700-0900 | Shire Hill | 19.3 | 99.8 | 99.8 | 99.8 | 0.2 |
| | ICFT | 86.3 | 99.8 | 99.8 | 99.8 | 0.2 |
| Drive Time Monday-Friday 1000-1600 | Shire Hill | 20.8 | 99.8 | 99.8 | 99.8 | 0.2 |
| | ICFT | 89.3 | 99.8 | 99.8 | 99.8 | 0.2 |
| Drive Time Monday-Friday 1600-1900 | Shire Hill | 20.2 | 99.8 | 99.8 | 99.8 | 0.2 |
| | ICFT | 86.2 | 99.8 | 99.8 | 99.8 | 0.2 |
| Drive Time Weekend 0700-1900 | Shire Hill | 22.2 | 99.8 | 99.8 | 99.8 | 0.2 |
| | ICFT | 92.0 | 99.8 | 99.8 | 99.8 | 0.2 |
| Public Transport Tuesday 0700-0900 | Shire Hill | 3.1 | 11.3 | 16.7 | 35.9 | 64.1 |
| | ICFT | 9.0 | 39.1 | 71.6 | 96.4 | 3.6 |
| Public Transport Tuesday 1000-1600 | Shire Hill | 1.9 | 10.7 | 24.0 | 54.8 | 45.2 |
| | ICFT | 9.2 | 40.3 | 79.6 | 99.2 | 0.8 |
| Public Transport Tuesday 1600-1900 | Shire Hill | 1.9 | 11.2 | 25.3 | 57.1 | 42.9 |
| | ICFT | 8.5 | 37.8 | 77.7 | 99.0 | 1.0 |
| Public Transport Saturday 1000-1600 | Shire Hill | 1.9 | 10.6 | 23.9 | 54.9 | 45.1 |
| | ICFT | 9.2 | 40.1 | 78.7 | 99.0 | 1.0 |
| Walk Time | Shire Hill | 0.6 | 4.5 | 9.1 | 13.0 | 87.0 |
| | ICFT | 3.6 | 15.7 | 31.8 | 43.5 | 56.5 |

| Mode of Transport/Time Period | Location | Count of Population within 0-15 Minutes | Count of Population within 0-30 Minutes | Count of Population within 0-45 Minutes | Count of Population within 0-60 Minutes | Count of Population 60 Minutes + |
|---|---|---|---|---|---|---|
| Drive Time Monday-Friday 0700-0900 | Shire Hill | 48819 | 251913 | 251913 | 251913 | 505 |
| | ICFT | 217865 | 251913 | 251913 | 251913 | 505 |
| Drive Time Monday-Friday 1000-1600 | Shire Hill | 52371 | 251913 | 251913 | 251913 | 505 |
| | ICFT | 225274 | 251913 | 251913 | 251913 | 505 |
| Drive Time Monday-Friday 1600-1900 | Shire Hill | 51092 | 251872 | 251913 | 251913 | 505 |
| | ICFT | 217582 | 251913 | 251913 | 251913 | 505 |
| Drive Time Weekend 0700-1900 | Shire Hill | 55905 | 251913 | 251913 | 251913 | 505 |
| | ICFT | 232161 | 251913 | 251913 | 251913 | 505 |
| Public Transport Tuesday 0700-0900 | Shire Hill | 7773 | 28559 | 42178 | 90534 | 161884 |
| | ICFT | 22684 | 98597 | 180776 | 243314 | 9104 |
| Public Transport Tuesday 1000-1600 | Shire Hill | 4826 | 26892 | 60650 | 138329 | 114089 |
| | ICFT | 23323 | 101624 | 200858 | 250422 | 1996 |
| Public Transport Tuesday 1600-1900 | Shire Hill | 4854 | 28314 | 63845 | 144022 | 108396 |
| | ICFT | 21526 | 95450 | 196140 | 249866 | 2552 |
| Public Transport Saturday 1000-1600 | Shire Hill | 4826 | 26787 | 60266 | 138571 | 113847 |
| | ICFT | 23187 | 101098 | 198558 | 249998 | 2420 |
| Walk Time | Shire Hill | 1406 | 11339 | 22973 | 32825 | 219593 |
| | ICFT | 8960 | 39705 | 80157 | 109868 | 142550 |

**Travel Times from Key Locations within Tameside and Glossop**

| Location | Drive Time Mon-Fri 0700-0900 (Time in Minutes) | | Drive Time Mon-Fri 1000-1600 (Time in Minutes) | | Drive Time Mon-Fri 1600-1900 (Time in Minutes) | | Drive Time Weekend 0700-1900 (Time in Minutes) | |
|---|---|---|---|---|---|---|---|---|
| | Shire Hill | ICFT | Shire Hill | ICFT | Shire Hill | ICFT | Shire Hill | ICFT |
| **Ashton** | 22.49 | 4.67 | 21.33 | 4.5 | 22.91 | 4.66 | 20.11 | 4.27 |
| **Mossley** | 21.71 | 7.11 | 20.3 | 7.18 | 21.15 | 7.09 | 19.37 | 7.02 |
| **Stalybridge** | 17.49 | 4.71 | 16.36 | 4.71 | 17.03 | 4.87 | 15.61 | 4.58 |
| **Dukinfield** | 22.13 | 5.98 | 21.49 | 5.79 | 22.29 | 6 | 20.14 | 5.46 |
| **Hyde** | 17.45 | 12.4 | 17.38 | 12.33 | 17.04 | 12.8 | 16.56 | 11.3 |
| **Broadbottom** | 12.36 | 14.45 | 12.93 | 14.14 | 12.98 | 14.43 | 12.37 | 13.41 |
| **Hattersley** | 13.9 | 12.54 | 13.15 | 12.02 | 13.15 | 12.51 | 12.49 | 11.57 |
| **Mottram** | 11.17 | 9.96 | 10.49 | 9.54 | 10.59 | 10.18 | 9.93 | 9.22 |
| **Denton** | 20.56 | 10.64 | 19.92 | 10.41 | 20.11 | 10.73 | 19.13 | 9.77 |
| **Audenshaw** | 22.97 | 8.12 | 22.6 | 7.44 | 22.83 | 7.8 | 21.75 | 6.99 |
| **Droylsden** | 25.87 | 9.29 | 25.52 | 9.16 | 25.89 | 9.54 | 24.54 | 8.89 |
| **Hadfield** | 4.96 | 14.44 | 5.23 | 13.89 | 5.19 | 14.67 | 5.13 | 13.4 |
| **Gamesley** | 8.86 | 14.55 | 9.49 | 15.62 | 9.1 | 15.23 | 8.94 | 14.05 |
| **Glossop** | 3.73 | 17.55 | 3.99 | 18.13 | 3.98 | 18.98 | 3.84 | 17.47 |

**Travel Times from Key Locations within Tameside and Glossop**

| Location | Public Transport Tuesday 0700-0900 (Time in Minutes) | | Public Transport Tuesday 1000-1600 (Time in Minutes) | | Public Transport Tuesday 1600-1900 (Time in Minutes) | | Public Transport Saturday 1000-1600 (Time in Minutes) | |
|---|---|---|---|---|---|---|---|---|
| | Shire Hill | ICFT | Shire Hill | ICFT | Shire Hill | ICFT | Shire Hill | ICFT |
| **Ashton** | 56.7 | 12.13 | 51.56 | 12.13 | 51.56 | 10.96 | 51.56 | 12.13 |
| **Mossley** | 62.18 | 15.5 | 65.18 | 14.5 | 66.92 | 17.5 | 65.18 | 14.5 |
| **Stalybridge** | 43.7 | 14.58 | 41.7 | 14.58 | 39.82 | 14.58 | 41.7 | 14.58 |
| **Dukinfield** | 75.91 | 28.06 | 65.07 | 25.32 | 62.78 | 27.14 | 65.07 | 25.32 |
| **Hyde** | 61.18 | 39.2 | 50.94 | 38.83 | 49.55 | 39.2 | 50.94 | 38.83 |
| **Broadbottom** | 45.38 | 45.81 | 35.14 | 47.93 | 34.14 | 44.93 | 35.14 | 47.93 |
| **Hattersley** | 47.89 | 32.79 | 41.71 | 34.79 | 41.71 | 34.79 | 41.71 | 34.79 |
| **Mottram** | 28.38 | 26.38 | 30.38 | 26.51 | 29.66 | 26.51 | 30.38 | 26.51 |
| **Denton** | 70.9 | 40.39 | 59.66 | 36.37 | 57.66 | 37.37 | 59.66 | 37.37 |
| **Audenshaw** | 60.9 | 33.92 | 50.66 | 31.77 | 50.66 | 32.42 | 50.66 | 31.77 |
| **Droylsden** | 76.26 | 31.14 | 65.69 | 31.14 | 67.69 | 33.34 | 64.69 | 31.14 |
| **Hadfield** | 26.36 | 41.63 | 26.93 | 41.63 | 27.89 | 41.63 | 26.93 | 41.63 |
| **Gamesley** | 30.79 | 48.65 | 30.96 | 43.21 | 29.68 | 43.21 | 30.96 | 43.21 |
| **Glossop** | 9.17 | 48.49 | 9.44 | 41.06 | 9.44 | 41.06 | 9.44 | 41.06 |

**Travel Times from Key Locations within Tameside and Glossop**

| Location | Walk Time (Time in Minutes) | |
|---|---|---|
| | Shire Hill | ICFT |
| **Ashton** | 165.63 | 25.9 |
| **Mossley** | 168.63 | 56.05 |
| **Stalybridge** | 129.34 | 22.49 |
| **Dukinfield** | 162.31 | 37.22 |
| **Hyde** | 137.41 | 69.83 |
| **Broadbottom** | 83.58 | 101.61 |
| **Hattersley** | 97.97 | 89.88 |
| **Mottram** | 75.02 | 74.8 |
| **Denton** | 167.31 | 80.28 |
| **Audenshaw** | 189.64 | 60.69 |
| **Droylsden** | 208.3 | 73.01 |
| **Hadfield** | 34.31 | 113.82 |
| **Gamesley** | 53.94 | 115.16 |
| **Glossop** | 20.24 | 137.32 |

# Shire Hill ICU, Drive Time, Monday-Friday, 0700-0900

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
**Time Bands**
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4 Miles

Author: Michael Clegg - Policy & Communications

# T&G ICFT, Drive Time, Monday-Friday, 0700-0900

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
**Time Bands**
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4
Miles



Author: Michael Clegg - Policy & Communications

# Shire Hill ICU, Drive Time, Monday-Friday, 1000-1600

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
**Time Bands**
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4 Miles

Author: Michael Clegg - Policy & Communications

# T&G ICFT, Drive Time, Monday-Friday, 1000-1600

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
Time Bands
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4
Miles



Author: Michael Clegg - Policy & Communications

# Shire Hill ICU, Drive Time, Monday-Friday, 1600-1900

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
**Time Bands**
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4 Miles

Author: Michael Clegg - Policy & Communications

# T&G ICFT, Drive Time, Monday-Friday, 1600-1900

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
**Time Bands**
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4
Miles



Author: Michael Clegg - Policy & Communications

# Shire Hill ICU, Drive Time, Weekend, 0700-1900

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
**Time Bands**
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4 Miles

Author: Michael Clegg - Policy & Communications

# T&G ICFT, Drive Time, Weekend, 0700-1900

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
Time Bands
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4
Miles



Author: Michael Clegg - Policy & Communications

# Shire Hill ICU, Public Transport/Walking Times, Saturday, 1000-1600

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
Time Bands
0-15 Minutes
16-30 Minutes
31-45 Minutes
46-60 Minutes

0 0.4 0.8 1.6 2.4 3.2 Miles



Author: Michael Clegg - Policy & Communications

# T&G ICFT, Public Transport/Walking Times, Saturday, 1000-1600

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
**Time Bands**
0-15 Minutes
16-30 Minutes
31-45 Minutes
46-60 Minutes

0 0.4 0.8 1.6 2.4 3.2 Miles



Author: Michael Clegg - Policy & Communications

# Shire Hill ICU, Public Transport/Walking Times, Tuesday, 0700-0900

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
Time Bands
0-15 Minutes
16-30 Minutes
31-45 Minutes
46-60 Minutes

0 0.4 0.8 1.6 2.4 3.2 Miles



Author: Michael Clegg - Policy & Communications

# T&G ICFT, Public Transport/Walking Times, Tuesday 0700-0900

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
Time Bands
0-15 Minutes
16-30 Minutes
31-45 Minutes
46-60 Minutes

0 0.4 0.8 1.6 2.4 3.2 Miles

Author: Michael Clegg - Policy & Communications

# Shire Hill ICU, Public Transport/Walking Times, Tuesday, 1000-1600

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# Shire Hill ICU, Public Transport/Walking Times, Tuesday, 1600-1900

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Time Bands
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Author: Michael Clegg - Policy & Communications

# T&G ICFT, Public Transport/Walking Times, Tuesday, 1600-1900

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT

Time Bands
0-15 Minutes
16-30 Minutes
31-45 Minutes
46-60 Minutes

0 0.4 0.8 1.6 2.4 3.2
Miles

Author: Michael Clegg - Policy & Communications

# Shire Hill ICU Walk Time

N

T&G ICFT

Shire Hill ICU

Shire Hill ICU
T&G ICFT
Time Bands
0-15 Minutes
16-30 Minutes
31-45 Minutes
46-60 Minutes

0 0.4 0.8 1.6 2.4 3.2
Miles



Author: Michael Clegg - Policy & Communications

# T&G ICFT Walk Time

N

T&G ICFT

Shire Hill ICU

**Time Bands**

- 0-15 Minutes
- 16-30 Minutes
- 31-45 Minutes
- 46-60 Minutes

0 0.4 0.8 1.6 2.4 3.2 Miles



Author: Michael Clegg - Policy & Communications

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# Appendix 6

**1. Have you ever used Intermediate Care services in Tameside & Glossop?**

□ Yes (Go to Q2)

□ No (Go to Q4)

**2. When did you last use Intermediate Care services in Tameside & Glossop?**

□ Within the last month

□ Within the last six months

□ Within the last year

□ Within the last two years

□ More than two years ago

**3. Which Intermediate Care facility / services have you previously used? (Please tick all that apply)**

□ Shire Hill

□ Stamford Unit, Darnton House

□ Grange View

□Community services / Reablement e.g. you received treatment from a nurse / physiotherapist etc in your own home

□ Other (please state)

**4. Intermediate Care helps people avoid going into hospital unnecessarily and supports people to come out of hospital as quickly as possible. It helps people stay in their own homes and to keep their independence for as long as possible. The Intermediate Care offer across Tameside & Glossop will include a home-based service, which will give a more intensive amount of care in people's own home. This will be provided by a joint team of social care (carers and social workers) and health professionals (nurses and therapists).**

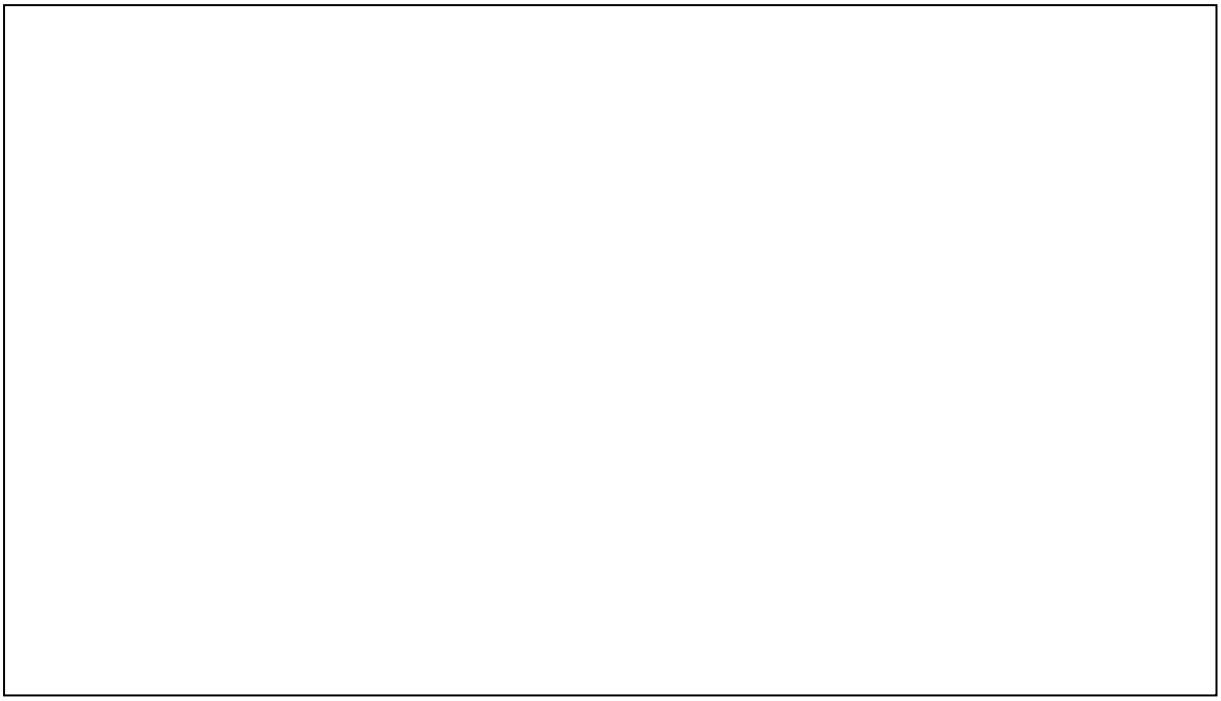
**What are your thoughts on a home based intermediate care service being provided across Tameside & Glossop? (Please write your comments in the box below)**

**5. There are three options in our model for how bed based Intermediate Care services could be delivered across Tameside & Glossop in the future. Please tell us what each of these options would mean for you if they were implemented? (Please write your comments in the box below each option)**

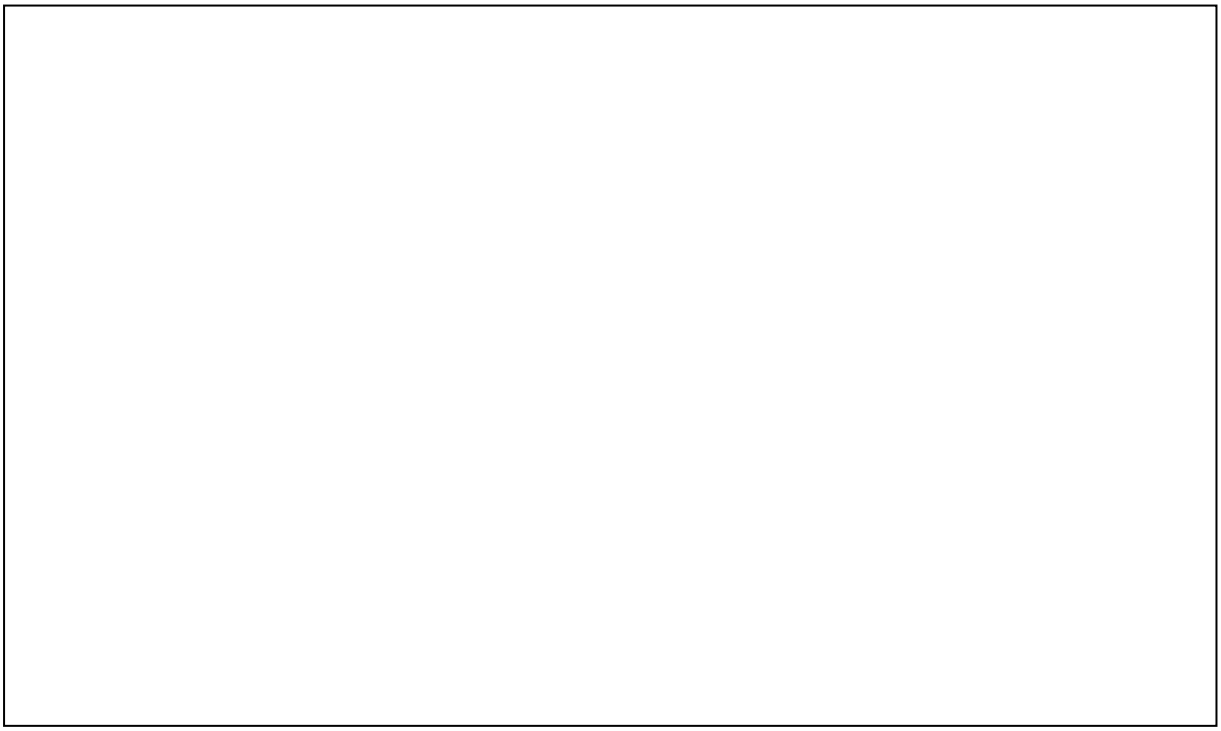
**<u>Before answering this question please ensure that you have read the 'XXXXX' document which provides further information about each option</u>**

**Option 1: Maintain current arrangements - delivery of bed based intermediate care from the Stamford Unit at Darnton House (32 beds) and Shire Hill in Glossop (36 beds).**

**Option 2 (PREFERRED OPTION): Transfer of all bed-based intermediate care to a single location in the Stamford Unit at Darnton House based at Tameside & Glossop Integrated Care NHS Foundation Trust site (96 bed unit). Whilst the aim of the home first model is to use the community beds flexibly to meet demand at any point in time, it is envisaged that 64 beds will be used for intermediate care purposes.**



**Option 3: Use of existing local care homes to develop single/multi sites - engagement with local care home providers to develop capacity within existing care homes**



**6. If you have an alternative option on how the Intermediate Care service could be delivered across Tameside & Glossop in the future please tell us in the box below, Please explain the benefits this alternative option will bring and any financial considerations.**

**7. Do you have any other comments you would like to make about Intermediate Care services in Tameside & Glossop? (Please write in the box below)**

**About You**

**8. Please tick the box that best describes your interest in this issue? (Please tick one box only)**

□ A user or previous user of Intermediate Care services in Tameside & Glossop

□ A family member or carer of someone who has used or is using Intermediate Care services in Tameside & Glossop

□ A member of the public

□ An employee of Tameside Council

□ An employee of NHS Tameside & Glossop Clinical Commissioning Group

□ An employee of Tameside & Glossop Integrated Care NHS Foundation Trust

□ An employee of Derbyshire County Council or High Peak Borough Council

□ A community or voluntary group

□ A partner organisation

□ A business / private organisation

□ Other (please specify below)

**9. What is your home postcode? (Please state)**

**10. What best describes your gender?**

□ Female

□ Male

□ Prefer to self-describe

□ Prefer not to say

**11. What is your age? (Please state)**

**12. Which ethnic group do you consider yourself to belong to? (Please tick one box only)**

**White**

□ English / Welsh / Scottish / Northern Irish / British
□ Irish
□ Gypsy or Irish Traveller
□ Any other White background (Please specify)

**Mixed / Multiple Ethnic Groups**
□ White and Black Caribbean
□ White and Black African
□ White and Asian
□ Any other Mixed / Multiple ethnic background (Please specify)

**Black / African / Caribbean / Black British**
□ African
□ Carribbean
□ Any other Black / African / Caribbean background (Please specify)

**Asian / Asian British**
□ Indian
□ Pakistani
□ Bangladeshi
□ Chinese
□ Any other Asian background (Please specify)

**Other ethnic group**

□ Arab
□ Any other ethnic group (Please specify)

**13. What is your religion?**

□ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)

□ Buddhist □ Hindu

□ Jewish □ Muslim

□ Sikh □ No religion

Any other religion, please state

**14. What is your sexual orientation?**

□ Heterosexual / Straight

□ Gay man

□ Gay woman / lesbian

□ Prefer not to say

□ Prefer to self-describe

**15. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age. (Please tick one box only)**

□ Yes, limited a lot

□ Yes, limited a little

□ No

**16. Do you look after, or give any help or support to family members, friends, neighbours or others because of either, long-term physical or mental ill-health / disability or problems due to old age? (Please tick one box only)**

□ Yes, 1-19 hours a week

□ Yes, 20-49 hours a week

□ Yes, 50+ hours a week

□ No

**17. Are you a member or ex-member of the armed forces?**

□ Yes

□ No

□ Prefer not to say

**18. What is your marital status?**

□ Single

□ Married / Civil Partnership

□ Divorced

□ Widowed

□ Prefer not to say