SINGLE COMMISSIONING BOARD

Day: Tuesday
Date: 26 September 2017
Time: 3.30 pm
Place: Lesser Hall 2 - Dukinfield Town Hall

Item No.	AGENDA	Page No
1.	**WELCOME AND APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from members of the Single Commissioning Board.	
3.	**MINUTES OF THE PREVIOUS MEETING** To receive the Minutes of the previous meeting held on 22 August 2017.	1 - 6
4.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND** To consider the attached report of the Director of Finance, Single Commission.	7 - 24
5.	**QUALITY CONTEXT**	
a)	**PERFORMANCE REPORT** To consider the attached report of the Assistant Director (Policy, Performance and Communications).	25 - 62
6.	**COMMISSIONING FOR REFORM**	
a)	**SAVINGS ASSURANCE: GRANTS REVIEW** To consider the attached report of the Interim Director of Commissioning.	63 - 78
b)	**ATRIAL FIBRILLATION** To consider the attached report of the Interim Director of Commissioning.	79 - 98
7.	**URGENT ITEMS** To consider any items which the Chair is of the opinion shall be considered as a matter of urgency in accordance with legal provisions as set out in the Local Government Act 1972 (as amended).	
8.	**DATE OF NEXT MEETING** To note that the next meeting of the Single Commissioning Board will take place on Tuesday 31 October 2017 commencing at 2.00 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

22 August 2017

Commenced: 3.00 pm **Terminated: 4.30 pm**

PRESENT: Dr Alan Dow (Chair) – NHS Tameside and Glossop CCG
Councillor Gerald Cooney – Tameside MBC
Steven Pleasant – Tameside Council Chief Executive and Accountable Officer for NHS Tameside and Glossop CCG
Dr Alison Lea – NHS Tameside and Glossop CCG
Dr Jamie Douglas – NHS Tameside and Glossop CCG
Dr Christina Greenhough – NHS Tameside and Glossop CCG
Carol Prowse – NHS Tameside and Glossop CCG

IN ATTENDANCE: Sandra Stewart – Director of Governance
Kathy Roe – Director of Finance
Stephanie Butterworth – Director of Children and Adult Services
Ali Lewin – Deputy Director of Commissioning
Ali Rehman – Head of Business Intelligence and Performance
Lynn Jackson – Head of

APOLOGIES: Councillor Brenda Warrington – Tameside MBC
Councillor Peter Robinson – Tameside MBC

40. DECLARATIONS OF INTEREST

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

41. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 11 July 2017 were approved as a correct record.

42. 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 3 financial position at 30 June 2017 and the projected outturn at 31 March 2018.

The Director of Finance stated that the projected year end deficit across the economy was currently £10.949m. 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 Quality, Innovation, Productivity and Prevention target there were £18m of savings which it was certain would be met, leaving £5.86m still to be delivered and therefore significant risk attached to fully realising this residual target. After optimism bias it was anticipated that savings of £3.38m could be made from schemes leaving post optimism savings of £2.47m still to find. Whilst this was an improvement since last month, it needed to be put into context against a £4m pressure in relation to continuing health care and there was still significant risk to fully achieving the Quality, Innovation, Productivity and Prevention target in 2017/18. In addition, reference was made to the challenging Quality, Innovation, Productivity, Prevention target of £2.5m against prescribing and emerging national concerns regarding CAT M drugs which was currently being investigated.

It was reported that the risk share of the projected year end single commission deficit by constituent organisations 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 Care Fund Financial Framework.

The Integrated Care Foundation Trust was working to a £24.5m deficit position for 2017/18 but this had not yet been agreed with the National Health Service Improvement and delivery of £10.4m efficiencies was required to meet this control total.

It was further reported that Children's Services had been subject to an unprecedented demand on service provision and despite the inclusion of £9.3m additional funding in 2017/18, there was currently a £5.2m projection of net expenditure in excess of revenue budget provision by 31 March 2018. A group to review the Borough wide early help offer was seeking to reduce demand for service in the medium term. The service had and will be implementing initiatives to intervene early with families, reduce service demand together with associated ongoing expenditure and these were detailed in the report for information. There were stringent monitoring arrangements and procedures in place relating to performance and associated budget of the service and a further update on the projected 2017/18 budget positon at 31 March 2018 would be reported to the Council's Executive Cabinet during the autumn of 2017.

RESOLVED

(i) That the 2017/18 financial year update on the month 3 financial position at 30 June 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.

43. UPDATE ON CHILDREN'S SERVICE INSPECTION

Consideration was given to a report of the Executive Member (Children and Families) / Director (Children and Adult Services), which updated Members on the progress to date following the Ofsted Inspection in September 2016. The report also detailed the findings of the monitoring visit undertaken in June. Members were informed that the letter from this monitoring visit, attached at Appendix 1 to the report, had been published on the Ofsted website on 6 July 2017.

It was explained that in response to the findings from the second Ofsted monitoring visit a 12 week action plan had been developed. The action plan set out a planned escalation to the improvement work, to build on the progress made to date and to accelerate the improvement journey. The 12 week action plan was attached at Appendix 3 to the report.

It was stated that the acceleration plan did not replace the existing improvement plan rather it drew out a number of specific actions to be delivered over the next 12 weeks (July – September 2017) that would ensure progress against, and achievement of, the most time critical elements of the improvement plan. There was a key focus on ensuring compliance, continuing recruitment of appropriately skilled staff which in turn would impact on the caseload numbers and continuing the work on improving quality to remove variance.

Implementation of the 12 week action plan had commenced from the beginning of July and would be monitored on a weekly basis by the Director of Children's Services. This included significant data points which were monitored on a daily or weekly basis as necessary, for example caseload information, compliance with statutory timescales and recruitment data.

The Board was informed of the outcome of discussions on progress that had taken place at the six-monthly update meeting with Department for Education Advisors. Ofsted had advised that the next monitoring visit would take place on 12 and 13 September 2017.

Members discussed at length the implications of the outcome of the June visit and the work that needed to be done to focus on dealing with the concerns set out in the Ofsted letter and the specific actions over the next few weeks were vital to this. In particular, reference was made to the staffing levels and what was the optimum level and qualities of staff required to deliver the service to the required standard.

RESOLVED

(i) That the progress update and the content of the letter from Ofsted in relation to their monitoring visits in March and June 2017 be noted.

(ii) That the delivery of the 12 week action plan be supported.

44. PERFORMANCE REPORT

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

The evolving report would include elements on quality from the Nursing and Quality directorate and align with the other Greater Manchester Health and Social Care Partnership and national dashboard reports.

The following were highlighted as exceptions:

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

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

The content of the Quality and Safeguarding monthly exception report and responses were provided to questions from Members of the Board.

In conclusion, the Board requested that children's performance data be included in future reports.

RESOLVED

(i) That the content of the performance and quality report be noted.

(ii) That children's performance data be included in future reports.

45. INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP

Consideration was given to a report of the Director of Commissioning explaining that a system wide strategy for Intermediate Care for Tameside and Glossop was required to enhance the delivery of intermediate care in the locality. The vision was for the support to be delivered at home wherever possible and the model should include an element of bed-based care, clear links with the Integrated Neighbourhoods (including 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 integrated care were detailed as follows:

- Maximising independence;
- Preventing unnecessary hospital admissions;
- Preventing unnecessary admissions to long term residential care;

- Following hospital admissions, optimising discharges to usual place of residence.

A number of factors and service reviews had led to the identification of Intermediate Care as a priority for Tameside and Glossop and the development of the model outlined. The report outlined the work undertaken to date, a proposed model for Intermediate Care for Tameside and Glossop including financial considerations, and details of the recommended consultation process.

It was explained that the 'Home First' model, detailed in the report, ensured that people were supported through the most appropriate pathway with care provide in the home always being the preferred option. However, it was recognised that not all individuals' intermediate care needs could be managed safely in their own home. In some cases there was a need for a 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 without going into hospital.

Tameside and Glossop Integrated Care Foundation Trust had identified four core interfaces where services were provided to patients making up the Intermediate Care Model:

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

A description of how these services would be provided at each of these interfaces was detailed in the report. In particular, reference was made to the options for delivery of bed based intermediate care and the identification of three options for the delivery of a flexible community bed base as follows:

- Option 1 – Maintain the 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.

In considering the above options, it was noted that Option 2 was the preferred option from the assessment carried out by the Single Commission and the Integrated Care Foundation Trust and the reasons were highlighted in detail in the report. Alongside the ongoing development and delivery of the Integrated Neighbourhoods and intermediate tier services and the implementation of the Home First model Option 2 proposed that the community beds should be located in single location in order to utilise the resource flexibly to meet the needs of people in Tameside and Glossop. Offering services from a single site provided the opportunity for a more holistic, flexible and skilled workforce. Staffing resources would be focused on one site so able to work across and with a wide range of conditions, providing resilience and responsiveness.

If the preferred option was implemented with intermediate care provided in one central location in the Stamford Unit, the Integrated neighbourhood and specialist services would provide Glossop with a community based offer of care in addition to the service provided by the Stamford Unit.

Option 3 relied on their being the engagement form providers to invest locally in increasing capacity. Should this be available there would be a lead in time to any new building, which would require a short term solution until additional bed capacity was developed. A number of providers had indicated their interest in working on developments

Members of the Board were advised that the view of the Single Commission and Integrated Care Foundation Trust that Option 1 – Maintain the current arrangements – was not a sustainable model going forward. As described in the report, the economy was not functioning to its optimum and the current service was fragmented with beds being delivered across two sites at Shire Hill and the Stamford Unit at Darnton House. In view of this, the Board considered whether Option 1 should be included in the consultation as it was unlikely to be a viable option as it was not affordable.

Following discussion of all options, the Board agreed to support the model outlined in the report 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.

RESOLVED
That the model outlined in the report be supported and approval given to consult on the three Options for Intermediate Care in Tameside and Glossop, with Option 2 as the preferred option for the Single Commission and Integrated Care Foundation Trust.

46. URGENT ITEMS

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

47. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 26 September 2017 commencing at 3.30 pm at Dukinfield Town Hall.

CHAIR

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	26 September 2017
Officer of Single Commissioning Board	Kathy Roe – Director of Finance – Single Commission Ian Duncan – Assistant Director of Finance – Tameside Metropolitan Borough Council Finance Claire Yarwood – Director of Finance – Tameside and Glossop Integrated Care NHS Foundation Trust
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2017/18 CONSOLIDATED FINANCIAL MONITORING STATEMENT AT 31 JULY 2017 AND PROJECTED OUTTURN TO 31 MARCH 2018**
Report Summary:	This is a jointly prepared report of the Tameside & Glossop Care Together constituent organisations on the consolidated financial position of the Economy. The report provides a 2017/2018 financial year update on the month 4 financial position (at 31 July 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 4 financial position (at 31 July 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)

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 31 July 2017 (Month 4 – 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 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 Clinical Commissioning Group.

Legal Implications: **(Authorised by the Borough Solicitor)**	Given the implications for each of the constituent organisations this report will be required to be presented to the decision making body of each one to ensure good governance.
How do proposals align with Health & Wellbeing Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Health and Wellbeing Strategy
How do proposals align with Locality Plan?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Locality Plan
How do proposals align with the Commissioning Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Single Commissioning Strategy
Recommendations / views of the Professional Reference Group:	A summary of this report is presented to the Professional Reference Group for reference.
Public and Patient Implications:	Service reconfiguration and transformation has the patient at the forefront of any service re-design. The overarching objective of Care Together is to improve outcomes for all of our citizens whilst creating a high quality, clinically safe and financially sustainable health and social care system. The comments and views of our public and patients are incorporated into all services provided.

Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	The reconfiguration and reform of services within Health and Social Care of the Tameside and Glossop economy will be delivered within the available resource allocations. Improved outcomes for the public and patients should reduce health inequalities across the economy.
What are the Equality and Diversity implications?	Equality and Diversity considerations are included in the re-design and transformation of all services
What are the safeguarding implications?	Safeguarding considerations are included in the re-design and transformation of all services
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report and therefore a privacy impact assessment has not been carried out.
Risk Management:	Associated details are specified within the presentation
Access to Information :	Background papers relating to this report can be inspected by contacting :

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 e-mail: stephen.wilde@tameside.gov.uk

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 Telephone:0161 922 4624

 e-mail: David.Warhurst@tgh.nhs.uk

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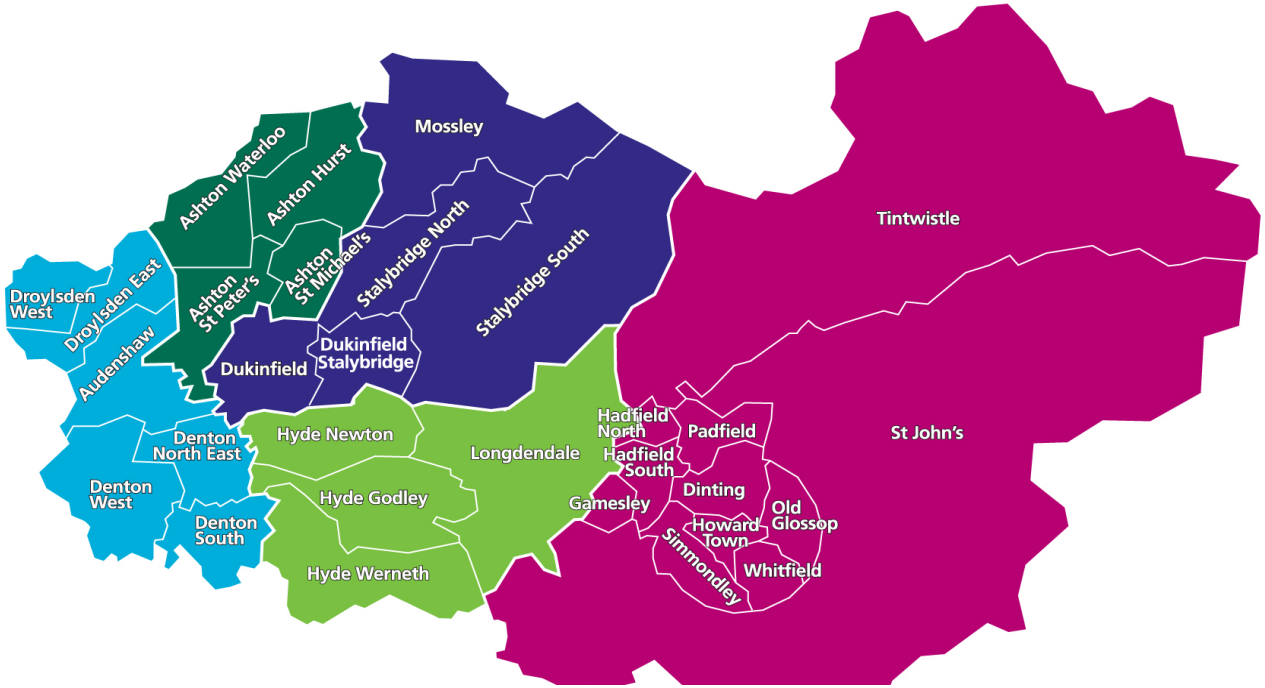
TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position

Financial Monitoring Statements

Period Ending 31st July 2017 [Month 4]

Kathy Roe
Ian Duncan
Claire Yarwood



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Care Together Economy Revenue Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

Organisation	YTD Position			Forecast Position			Forecast Position	
	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Single Commission	164,050	165,892	-1,842	486,227	497,597	-11,370	-10,949	-421
ICFT	-8,827	-9,115	-288	-24,506	-24,506	0	14	-14
Total Economy	155,223	156,777	-2,130	461,675	473,045	-11,370	-10,935	-435
Integrated Commissioning Fund	164,050	165,892	-1,842	486,227	497,597	-11,370		
A: Section 75 Services	93,686	94,545	-858	266,514	270,838	-4,324		
B: Aligned Services	59,179	60,466	-1,286	185,854	192,537	-6,684		
C: In Collaboration Services	11,184	10,881	303	33,860	34,222	-363		

Key Headlines:

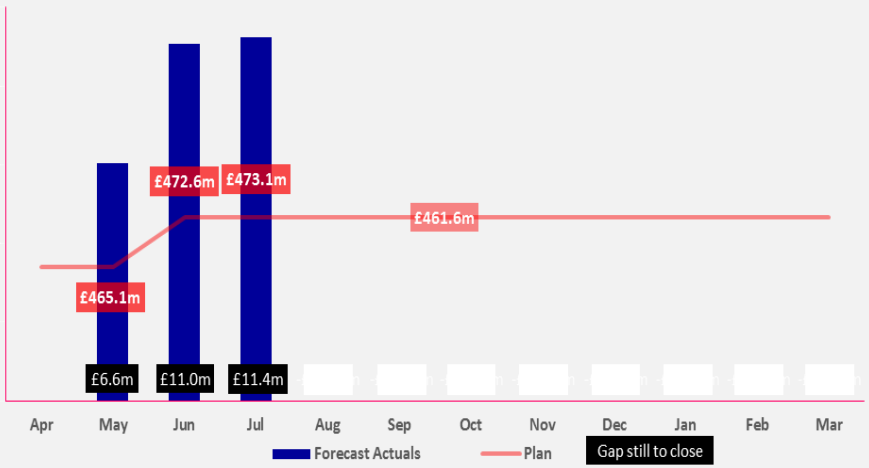
- YTD Position across the economy is currently: **£2,130k Deficit**
- 2017/18 Projected year end position across the economy is currently: **£11,370k Deficit**
- Movement in forecast year end position is: **£435k Adverse**

Single Commission - Risk Share	£'000
TMBC - Non Recurrent Contribution	-5,000
CCG	-1,000
TMBC	-5,370
Total	-11,370

- Non Rec repayable contributions between CCG/TMBC across 4 year period
- 80:20 Risk share arrangement between CCG/ TMBC as per contributions to ICF
- £500k upper threshold on CCG contribution to TMBC & £2m cap on TMBC contribution to CCG

Revenue Forecast Position

Forecast detail - £m's



Financial Summary – Forecast Position

- The CCG are reporting that all financial control totals will be met, however there is significant risk attached to the QIPP programme which is forecast £5.6m shortfall to plan
- The ICFT are still working to a deficit of £24.5m for 2017/18. This is yet to be agreed by NHSI. Trust efficiencies of £10.4m are required in order to meet this control total.
- Under terms of the Integrated Commissioning Fund financial framework, a non-recurrent contribution of c£5m can be accessed from council reserves towards the finance position of the CCG in 17/18. This would need to be repaid within a 4 year period.

Tameside & Glossop CCG Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

Organisation	YTD Position Budget	YTD Position Actual	YTD Position Variance	Forecast Position Budget	Forecast Position Actual	Forecast Position Variance	Forecast Position Previous Month	Forecast Position Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Acute	66,408	66,372	35	203,014	202,983	31	- 457	488
Mental Health	9,843	9,997	- 154	29,483	30,398	- 914	- 978	64
Primary Care	27,892	27,184	708	85,150	85,135	15	57	- 42
Continuing Care	4,556	6,421	- 1,864	13,671	17,206	- 3,534	- 3,217	- 318
Community	9,146	9,005	141	27,455	27,548	- 93	- 161	68
Other	10,170	9,141	1,030	20,684	16,188	4,496	4,756	- 260
QIPP			-		5,605	- 5,605	- 5,860	255
CCG Running Costs	2,017	1,833	184	5,197	5,197	-	-	-
CCG Expenditure	**130,032**	**129,953**	**80**	**384,655**	**390,260**	**- 5,605**	**- 5,860**	**255**
CCG Surplus	4,261	4,261	-	7,174	7,174	-	**- 5,860**	**255**

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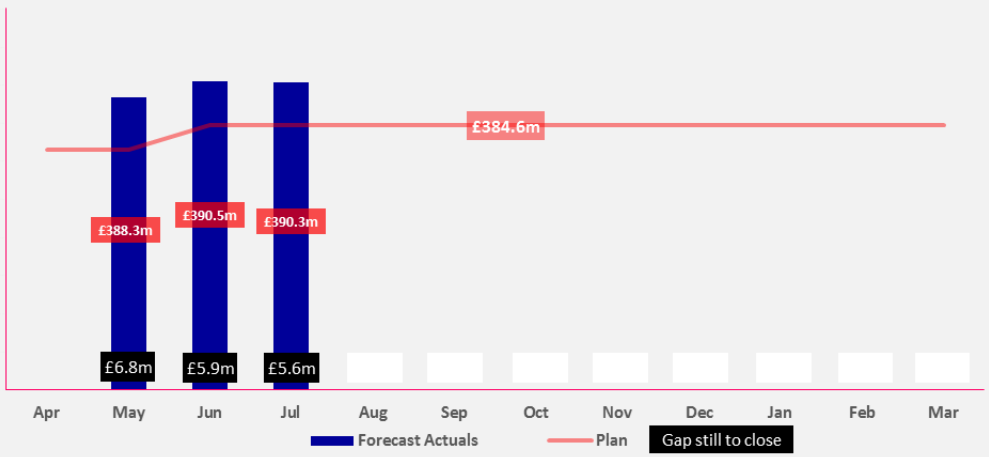
Key Headlines:

- 2017/18 Projected year end position across the economy is currently: **£5.605m Deficit** (i.e. QIPP savings still to be delivered to meet financial control totals)
- Movement in forecast year end position is: **£255k Favourable**
- YTD Position across the CCG is currently: **£80k Favourable.** Monthly profile of budgets is currently under review

Revenue Forecast Position

Forecast detail - £m's



Financial Summary – Forecast Position

- £3.5m projected overspend on continuing care causing significant pressures
- Impact of all cross year benefits/pressures included in M4 position
- Reporting that financial control totals will be met, but significant risk attached to this:
  - Deliver a surplus of 1% against opening allocation (£3,496k), plus carry forward of £3,678k from 16/17
  - Achieve a £23,900k QIPP target.
  - Keep 0.5% of allocation uncommitted to fund a national system risk reserve
  - Demonstrate growth in Mental Health spend of 2%
  - Remain within the running costs allocation

Tameside & Glossop CCG Financial Position

Overall Risk Rating - Medium

Theme	Highlights	Key Risks
Acute	• Overspend at Christies, Salford & South Manchester, offset by underspend at Central Manchester, Stockport & Pennine • £200k released to QIPP at M4 relating to reduced elective activity	• Increasing C&V spend in independent sector (diagnostics & MSK) caused by shift in activity from ICFT • Change in charging arrangement for stroke • Profile of plans may understate pressures
Mental Health	• £914k overspend relates to OOA ,managed by individualised commissioning and within scope of CHC recovery plan • Meeting MHIS with 3.15% increase in spend (2% target)	• Work ongoing to look at investment required in order to meet commitments around the five year forward view for mental health
Primary Care	• £170k QIPP realised in YTD position - Repeat Prescribing, COPD Pathway, DNP/Grey/Red list items • £56k cross year benefit reflected in position	• Paul Bauman letter – benefit of unplanned drug price reductions to be held centrally • NCSO pressure of £680k - Quetiapine and Olanzapine
Continuing Care	• Underlying forecast stable since significant pressures at M3 • Adverse movement of £313k relates to cross year pressure • Recovery Plan progressing and new system being procured	• Transforming Care – movement from specialist to CCG's • Fast track patients • Forecast assumes 7% growth. 16/17 growth was 14%
Community	• Contract variation with ICFT for flexible community beds following termination of Grange View contract. • £68k cross year benefit from non-medical prescribing	• Awaiting outcome of VAT reclaim on wheelchairs
Other	• Variance figures relate to treatment of reserves • Negative reserve of £1m to clear over and above the outstanding QIPP still to be delivered	• Nothing in position for additional critical care costs associated with Healthier Together • Estates schedules from Propco still outstanding
QIPP	• £10.3m (43%) of targeted savings banked at M4 • £1m reduction in planned savings since M3 (red schemes) • Expected savings stable due to increase in banked schemes	• Still need to deliver further £5.6m savings (plus clear the negative reserve) • Only 55% of expected savings delivered on recurrent basis
CCG Running Costs	• QIPP savings of £526k released at M4 • On track to remain within running cost allocation	• YTD Underspend relates to vacancies – conversation needed with budget holders about releasing to QIPP

TMBC Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

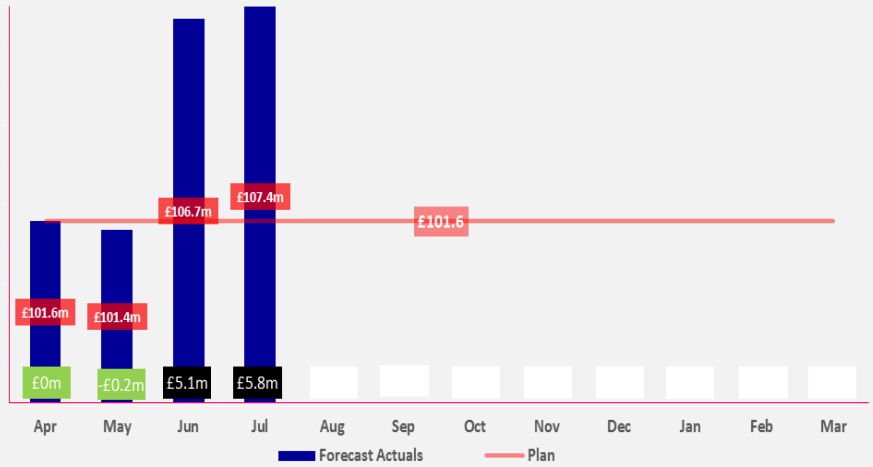
Organisation	YTD Position			Forecast Position			Forecast Position	
	Budget	Actual	Variance	Budget	Actual	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Adult Services	14,475	14,431	44	49,672	49,541	131	107	24
Children's Services	10,293	12,258	- 1,965	35,192	41,088	- 5,896	- 5,196	- 700
Public Health	9,250	9,250	-	16,708	16,708	-	-	-
Total Net Expenditure	34,017	35,939	- 1,922	101,572	107,337	- 5,765	- 5,089	- 676

Key Headlines:

- YTD Position is currently: **£1,922k Deficit**
- 2017/18 Projected year end position : **£5,765k Deficit**
- Movement to Forecast year end position is: **£676k Adverse**

Revenue Forecast Position

Forecast detail - £m's



Financial Summary – Forecast Position

Children's Services remains a high risk area . The majority of the projected additional net expenditure relates to placements within independent sector provision of £5.0m. It is currently estimated that on average there will be an additional 68 children in need of external placement provision above the number of placements estimated when the 2017/18 budget was approved by the Council in February 2017.

In addition the average cost of some external placements have increased since the budget was approved. This equates to a projected increase of £0.6m in the current financial year.

ICFT Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

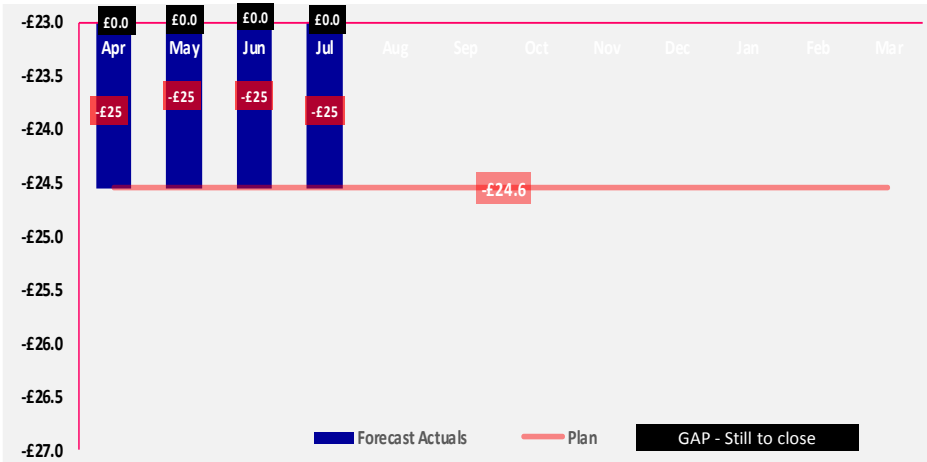
Organisation	YTD Position			Forecast Position		
	Budget	Actual	Variance	Budget	Forecast	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Income	68,072	68,867	- 796	204,701	204,701	-
Expenditure	73,887	74,862	- 975	219,916	219,916	-
EBITDA	**- 5,815**	**- 5,995**	**180**	**- 15,215**	**- 15,215**	**-**
Financing	2,957	3,064	- 107	9,129	9,129	-
Normalised Surplus/ (Deficit)	**- 8,772**	**- 9,059**	**287**	**- 24,344**	**- 24,344**	**-**
Exceptional Items	55	56	- 1	162	162	-
Net Deficit after Exceptional Costs	**- 8,827**	**- 9,115**	**288**	**- 24,506**	**- 24,506**	**-**

Key Headlines:

- YTD Position the ICFT is currently: **£288k overspent**
- The Trust has still to agree a control total with its regulator, NHSI.
- The Trust has agreed with NHSI, due to the volatility of risk that a detailed forecast will be presented at Month 6.
- The Trust is developing an action plan to mitigate risk of delivery.

Revenue Forecast Position

Forecast detail - £m's



Financial Summary – Key Risks

- The Trust is paying escalated rates to clinical staff due to gaps in medical rotas and a change in tax regulation. Consequently this is putting significant pressure on the Trusts financial position.
- The Trust has a number of escalated beds that are unfunded. Closing these beds will be difficult whilst the Trusts bed occupancy continues to be high.
- Income on smaller clinical contracts is falling and there is a focus on ensuring costs fall in relation to the loss of income.
- The Trusts efficiency programme is currently forecasting to underachieve, which will result in a financial pressure.

Health Economy Efficiency Position

Overall Risk Rating - Medium

Health Economy Position - At a glance

	YTD			2017/18 FORECAST BREAKDOWN £000'S									
	Target	Delivered	Variance	Delivered	Low	Medium	High	Hopper	Forecast Savings	Forecast Savings Excl High Risk	Target	Variance	Status
ICFT	2,599	2,300	(299)	4,440	2,619	1,906	2,118	0	11,083	8,965	10,397	(1,432)	
T&G CCG	9,823	10,296	474	10,296	7,999	3,123	6,800	0	28,218	21,418	23,900	(2,482)	
LOCAL AUTHORITY	258	258	0	258	284	231	0	0	773	773	773	0	
TOTAL	12,680	12,854	175	14,994	10,901	5,261	8,917	0	40,074	31,156	35,070	(3,913)	

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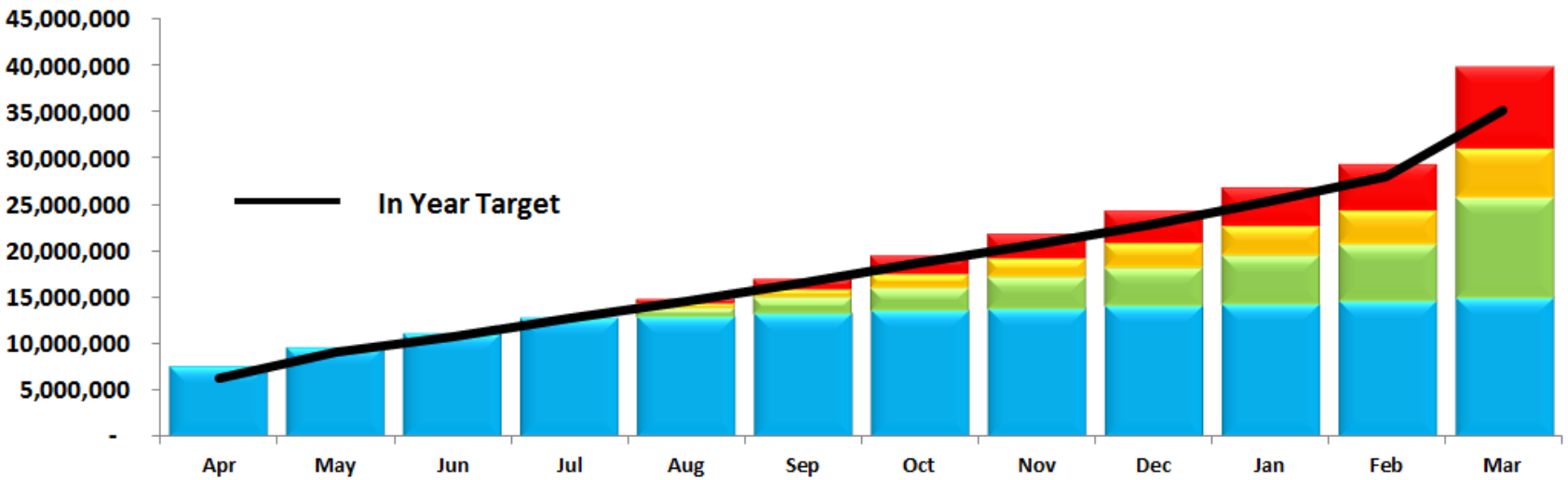
In Month/YTD Position

- 17/18 YTD Delivery across the economy is currently: **£12,854k**
- This is an overachievement against plan of **£175k**

Forecast Position

- 2017/18 Projected Economy saving forecast: **£3,913k Shortfall to plan**
- 2018/19 Projected Economy saving forecast: **£8,416k Shortfall to plan**

Phasing of Forecast - Cumulative



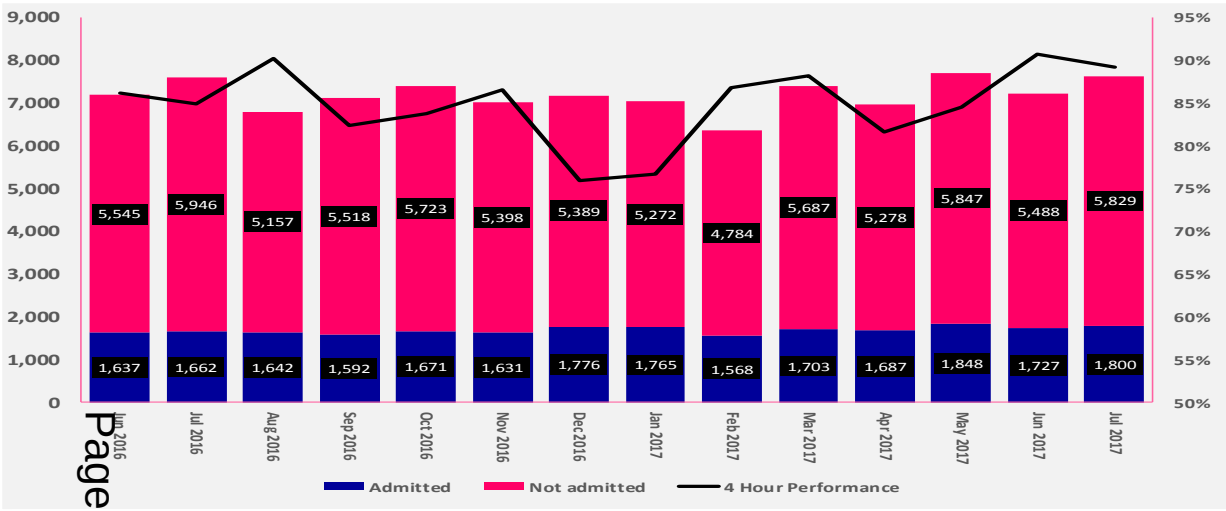
NB: Red Schemes are not included within the forecast savings figures due to high risk of non-financial delivery

Performance data– Emergency Attendances

Overall Risk Rating - Red

Emergency Department Performance – Tameside ICFT

Rolling 12 months ED performance:

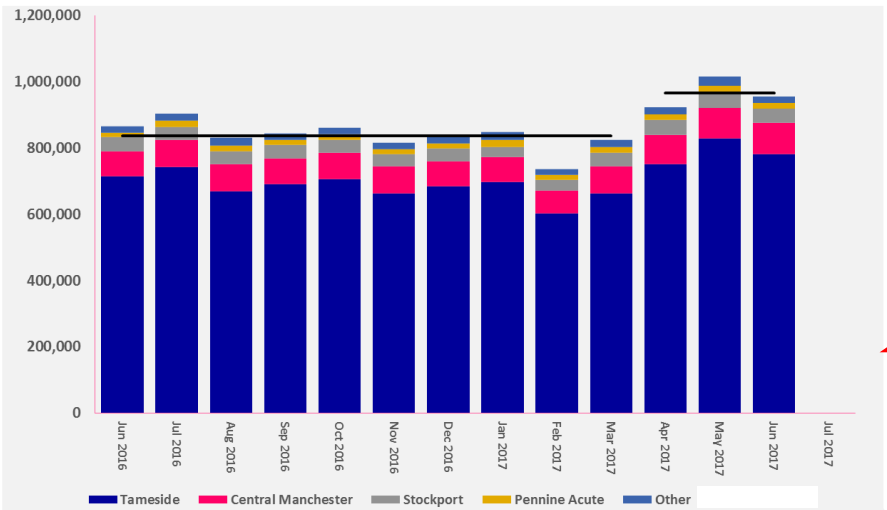


Q1 2016/17 v Q1 2017/18:

- A&E attendances up **1.6%** (359 attendances)
- Admissions up **8.2%** (406 admissions)
- 4 Hour up **0.5%** (88.1% - 87.6%)
- July ED performance **89.2%** of patients treated within 4 hours

Accident & Emergency Performance – Tameside Health Economy

Rolling 12 months PbR cost of A&E attendances:

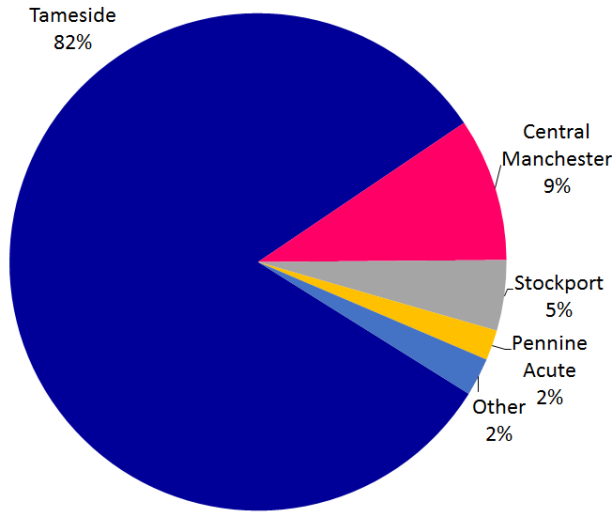


2016/17 v 2017/18:

- Average monthly PbR indicative spend in 16/17 **£837k**
- Average monthly PbR indicative spend in 17/18 **£966k**

An increase of **15.4%** (mainly driven by increase in tariff value)

Split of A&E spend by provider:

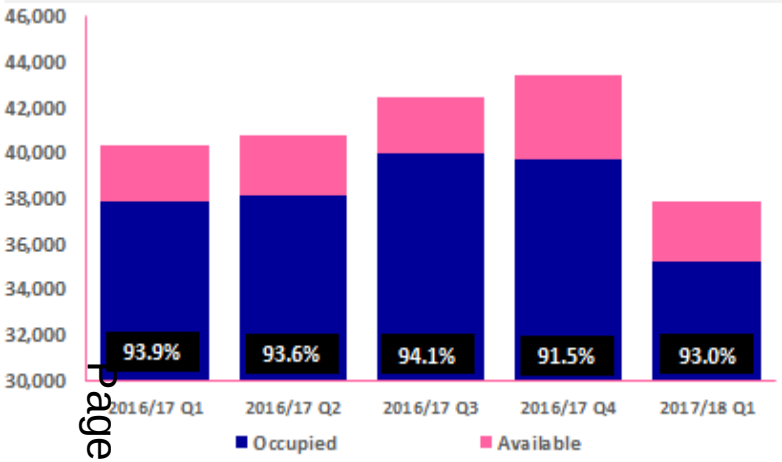


Performance data– Admissions

Overall Risk Rating - Red

Other key data - ICFT

Bed Occupancy:

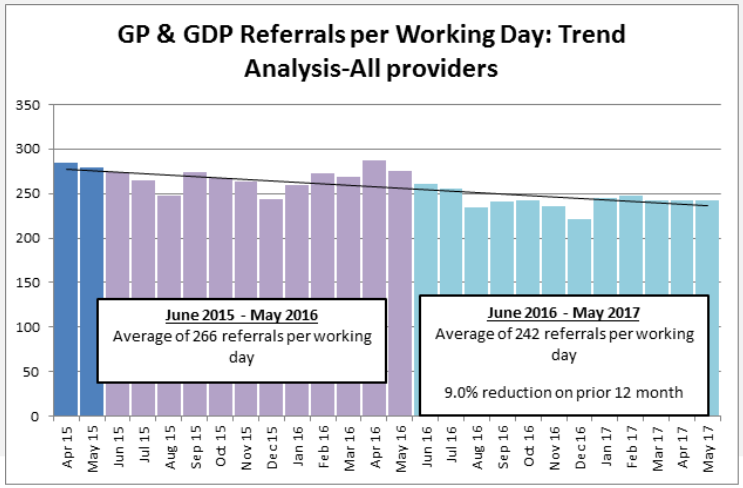


Finance:

- Whilst the Trust has a full establishment of Consultants (9 in total of which 7 are locums) – there is 6 vacancies at a speciality doctor level that are causing significant financial pressures.
  - As an example, speciality grade doctors on Agency are costing **£95ph** – Premium c. **£70k** per year per post.
  - Consultants having to step down, meaning we pay consultant rates+ for speciality level roles.
  - IR35 has been a significant pressure in ED, potentially above £300k.

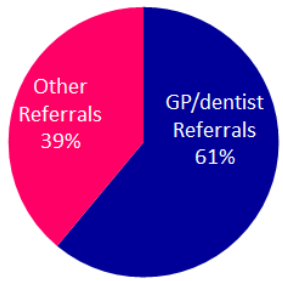
Other key data – Health Economy

Referrals:



- GP/dentist referrals have seen a significant reduction over the last year
- Other referrals, most notably consultant to consultant, at providers other than the ICFT have increased in the same period . Offsetting some of the benefit of the reduction in GP referrals.

	Apr & May 16/17	Apr & May 17/18	Variance	% Var
ICFT: GP Referrals	8,059	6,716	-1,343	-16.7%
ICFT: Other Referrals	3,068	3,155	87	2.8%
Other Providers: GP Referrals	3,453	2,740	-713	-20.6%
Other Providers: Other Referrals	2,584	2,880	296	11.5%
All Referrals	17,164	15,491	-1,673	-9.7%



Key/Emerging Risks

Children's services

Cost of Children's placements

Estates

Lack of fully developed plans in the estates strategy

TAMESIDE AND GLOSSOP
Caretogether

Transformation timeframes

GP Extensivists – Particularly Prescribing.

Areas of concern

Medical Staffing

Failure to recruit/IR35

CHC

Increased cost of CHC and social care assessments

Due Diligence

Complexities & timelines of due diligence to support transfer of services

Appendix 1 - ICFT Efficiency Position

Overall Risk Rating - Medium

ICFT Position - At a glance

	YTD			FORECAST BREAKDOWN £000'S								RECURRENT					
Theme	Target	Delivered	Variance	Delivered FYE	Low	Medium	High	Total Savings	Total Savings Excluding Red	Target	Variance	Status	Recurrent Target	Forecast	High	Total Savings Excluding Red	Variance	Status
Technical Target	414	628	214	752	765	0	0	1,517	1,517	1,243	274	Grn	43	235	0	235	193	Grn
Pharmacy	91	254	162	406	168	0	53	626	573	392	182	Grn	282	391	142	250	(32)	Amb
Divisional Target - Surgery	198	148	(50)	457	156	27	0	640	640	640	0	Grn	560	560	0	560	0	Grn
Estates	95	50	(45)	138	243	94	7	482	475	557	(82)	Amb	557	364	6	358	(199)	Amb
Divisional Target - Corporate	323	320	(3)	399	235	320	28	983	955	1,020	(65)	Amb	465	515	92	423	(42)	Amb
Medical Staffing	170	97	(74)	354	168	117	105	744	639	716	(77)	Amb	661	806	225	581	(80)	Amb
Workforce Efficiency	40	0	(40)	0	0	58	0	58	58	121	(63)	Amb	121	0	0	0	(121)	Red
Paperlite	42	0	(42)	0	21	9	86	116	30	125	(95)	Red	125	160	0	160	35	Grn
Nursing	300	242	(59)	255	0	506	224	985	760	975	(215)	Amb	375	556	175	381	6	Grn
Divisional Target - Medicine	268	224	(44)	589	132	0	379	1,100	721	803	(82)	Amb	803	820	445	375	(428)	Amb
Procurement	162	62	(100)	195	255	358	265	1,073	808	1,073	(266)	Amb	1,073	1,334	0	1,334	260	Grn
Demand Management	494	275	(219)	895	23	418	395	1,732	1,336	1,732	(395)	Amb	1,682	1,682	371	1,310	(371)	Amb
Transformation Schemes	0	0	0	0	453	0	574	1,028	453	1,000	(547)	Amb	1,000	2,223	1,537	686	(314)	Amb
TOTAL ICFT - TEP	2,599	2,300	(299)	4,440	2,619	1,906	2,118	11,083	8,965	10,397	(1,432)	Amb	7,747	9,646	2,993	6,653	(1,094)	Amb

Performance to date and forecast:

- Slightly behind the YTD target **c.£300k**, although for the third consecutive month the Trust has over delivered against its in month target,
- **42%** of the Target is actually delivered although the forecast is for the Trust to fail the Full Year target by **£1,432k**.
- Transformation has the biggest gap **£573k** and this is manly in relation to the Trust being unable to close beds.

Key issues and recovery:

- The trust is continuing to push themes in the Trust efficiency group.
- The Chief Executive has asked for more schemes to be escalated to both the Executive Committee and Finance and Performance Committee.
- Themes have been challenged to speed the development of hopper ideas into fully fledged schemes.

Appendix 2 - Single Commission Efficiency Position

Overall Risk Rating - Red

Single Commission Position - At a glance

	YTD			FORECAST BREAKDOWN £000'S								RECURRENT					
Theme	TARGET	Delivered	Variance	Delivered FYE	Low	Medium	High	Total Savings	Total Savings Excluding Red	Target	Variance	Status	Recurrent Target	Forecast	High	Total Savings Excluding Red	Variance	Status
Technical Target	1,635	3,197	1,562	3,197	3,844	120	120	7,280	7,160	1,875	5,285	Grn	455	455	0	455	0	Grn
Neighbourhoods	781	781	0	781	0	0	0	781	781	781	0	Grn	781	781	0	781	0	Grn
Primary Care	1,625	2,000	375	2,000	0	47	75	2,123	2,047	1,748	300	Grn	1,123	1,185	107	1,079	(44)	Amb
Single Commissioning	346	527	181	527	-35	323	323	1,137	814	1,137	(323)	Amb	1,137	1,246	386	861	(277)	Amb
Mental Health	294	296	2	296	0	300	300	896	596	994	(398)	Amb	994	1,007	630	377	(617)	Red
Effective Use of Resources	500	252	(248)	252	503	373	373	1,500	1,128	1,500	(373)	Amb	1,500	1,500	750	750	(750)	Amb
Acute Services - Elective	586	557	(29)	557	29	0	0	586	586	1,116	(530)	Amb	1,116	1,086	450	636	(480)	Amb
Other	724	724	0	724	0	60	540	1,324	784	1,324	(540)	Amb	724	724	0	724	0	Grn
Back Office Functions and Enabling Schemes	175	0	(175)	0	524	100	900	1,524	624	2,024	(1,400)	Red	2,024	1,524	700	824	(1,200)	Amb
GP Prescribing	713	171	(542)	171	678	381	1,287	2,516	1,229	2,516	(1,287)	Amb	2,516	3,054	2,191	863	(1,654)	Red
Demand Management	2,444	1,792	(652)	1,792	2,456	1,420	2,882	8,550	5,668	8,885	(3,217)	Amb	7,057	9,513	4,757	4,757	(2,300)	Amb
Sub Total CCG UPP	9,823	10,296	474	10,296	7,999	3,123	6,800	28,218	21,418	23,900	(2,482)	Amb	19,427	22,075	9,970	12,105	(7,322)	Amb
Adult Social Care	112	112	0	112	40	184	0	336	336	336	0	Grn	336	336	0	336	0	Grn
Public Health	146	146	0	146	244	47	0	437	437	437	0	Grn	437	437	0	437	0	Grn
Sub Total Local Authority	258	258	0	258	284	231	0	773	773	773	0	Grn	773	773	0	773	0	Grn
Total Single Commission	10,080	10,554	474	10,554	8,283	3,355	6,800	28,991	22,191	24,673	(2,482)	Amb	20,200	22,848	9,970	12,878	(7,322)	Amb

Performance to date and forecast:

- Slightly ahead of schedule overall – this relates to non recurrent savings achieved as a result of budget management
- Only 2 months of data available for prescribing. This limits the savings available to bank in M4 data above
- M3 data available for associates, which again limits the value banked for demand management

Key issues and recovery:

- More work required to bring forward new schemes addressing the short fall

Appendix 3 – Practice Budget Statements

Overall Risk Rating - Medium

CCG Monthly Summary Report Month 2(May) 2017/18	Unified Position (Including Prescribing & Delegated Co-Commissioning)								Prescribing PMD Values					
	Budget				Actual	Actual	Actual	Actual	Variance	Budget		Actual	Variance	YTD	Prior month
	M1 Fixed Initial Budget	Annual Budget (May)	Y-T-D (May)	HC Patient Y-T-D (May)	HC Patient Y-T-D (May)	Y-T-D (May)	Y-T-D Variance (May)	%	%	Annual Budget	Y-T-D (May) Budget	Y-T-D (May)	Y-T-D (May)	%	%
P89003 ALBION MEDICAL PRACTICE	15,437,882	15,438,101	2,532,957	(10,962)	(40,050)	2,765,004	(232,046)	(9)%	0%	1,795,821	282,589	286,756	(4,167)	(1)%	0%
P89008 BEDFORD HOUSE MEDICAL CENTRE	11,206,031	11,206,191	1,838,620	(7,957)	0	2,039,092	(200,472)	(11)%	0%	1,303,549	205,125	202,821	2,304	1%	0%
P89011 GORDON STREET MEDICAL CENTRE	7,039,799	7,039,899	1,155,049	(4,999)	0	1,236,235	(81,186)	(7)%	0%	818,909	128,863	132,200	(3,337)	(3)%	0%
P89017 CHAPEL STREET MEDICAL CENTRE	8,214,891	8,215,007	1,347,851	(5,833)	0	1,504,377	(156,525)	(12)%	0%	955,602	150,373	166,686	(16,313)	(11)%	0%
P89020 HT PRACTICE	12,483,774	12,483,952	2,048,265	(8,865)	0	2,021,112	27,152	1%	0%	1,452,183	228,514	221,134	7,380	3%	0%
P89030 WEST END MEDICAL CENTRE	7,228,805	7,228,908	1,186,060	(5,133)	0	1,245,264	(59,204)	(5)%	0%	840,895	132,323	132,751	(428)	(0)%	0%
P89033 TAME VALLEY MEDICAL CENTRE	10,164,485	10,164,630	1,667,729	(7,218)	0	1,675,588	(7,858)	(0)%	0%	1,182,390	186,060	181,831	4,229	2%	0%
P89609 STAMFORD HOUSE	6,450,370	6,450,462	1,058,339	(4,580)	0	1,030,283	28,056	3%	0%	750,343	118,073	120,002	(1,929)	(2)%	0%
P89613 WATERLOO MEDICAL CENTRE	4,054,029	4,054,087	665,161	(2,879)	0	670,253	(5,092)	(1)%	0%	471,587	74,209	73,542	667	1%	0%
Y02586 ASHTON GP SERVICE	4,887,386	4,887,455	801,894	(3,470)	0	826,145	(24,252)	(3)%	0%	568,528	89,463	85,355	4,108	5%	0%
Ashton	**87,167,453**	**87,168,691**	**14,301,926**	**(61,897)**	**(40,050)**	**15,013,353**	**(711,427)**	**(5)%**	**(2)%**	**10,139,809**	**1,595,593**	**1,603,078**	**(7,485)**	**(0)%**	**0%**
P89010 MEDLOCK VALE MEDICAL PRACTICE	11,097,784	11,097,941	1,820,859	(7,880)	0	1,962,247	(141,388)	(8)%	0%	1,290,957	203,144	217,623	(14,479)	(7)%	0%
P89015 WINDMILL MEDICAL PRACTICE	18,416,743	18,417,005	3,021,712	(13,078)	(101,706)	3,794,235	(772,523)	(26)%	0%	2,142,339	337,117	469,093	(131,976)	(39)%	0%
P89018 DENTON MEDICAL PRACTICE	10,600,605	10,600,755	1,739,285	(7,527)	0	1,866,858	(127,573)	(7)%	0%	1,233,122	194,043	188,782	5,261	3%	0%
P89019 CHURCHGATE SURGERY	11,775,834	11,776,001	1,932,110	(8,362)	0	1,672,188	259,922	13%	0%	1,369,831	215,556	100,967	114,589	53%	0%
P89029 MARKET STREET MEDICAL PRACTICE	8,776,444	8,776,569	1,439,988	(6,232)	0	1,623,771	(183,783)	(13)%	0%	1,020,925	160,652	153,722	6,930	4%	0%
P82663 DROYLSDEN MEDICAL PRACTICE	4,765,269	4,765,337	781,857	(3,384)	0	902,662	(120,804)	(15)%	0%	554,323	87,228	99,802	(12,574)	(14)%	0%
P82713 GUIDE BRIDGE MEDICAL PRACTICE	4,835,009	4,835,078	793,300	(3,433)	0	850,455	(57,155)	(7)%	0%	562,436	88,504	79,471	9,033	10%	0%
P89616 ASHTON ROAD (BUTLER)	0	0	0	0	0	0	0	0%	0%	0	0	0		0%	0%
Denton	**70,267,688**	**70,268,686**	**11,529,112**	**(49,896)**	**(101,706)**	**12,672,416**	**(1,143,305)**	**(10)%**	**(6)%**	**8,173,933**	**1,286,244**	**1,309,460**	**(23,216)**	**(2)%**	**0%**
C81077 HOWARD MEDICAL PRACTICE	4,624,398	4,624,463	758,744	(3,284)	0	753,650	5,094	1%	0%	537,936	84,649	84,636	13	0%	0%
C81081 MANOR HOUSE SURGERY	16,659,485	16,659,722	2,733,391	(11,830)	0	3,061,581	(328,190)	(12)%	0%	1,937,925	304,950	350,752	(45,802)	(15)%	0%
C81106 LAMBGATES HEALTH CENTRE	7,703,847	7,703,957	1,264,002	(5,470)	0	1,370,073	(106,071)	(8)%	0%	896,155	141,018	145,919	(4,901)	(3)%	0%
C81615 COTTAGE LANE SURGERY	3,098,473	3,098,517	508,379	(2,200)	0	470,632	37,748	7%	0%	360,432	56,717	56,362	355	1%	0%
C81640 SIMMONDLEY MEDICAL PRACTICE	3,643,107	3,643,159	597,740	(2,587)	0	732,137	(134,397)	(22)%	0%	423,787	66,687	81,568	(14,881)	(22)%	0%
C81660 HADFIELD MEDICAL CENTRE	3,835,224	3,835,278	629,261	(2,723)	0	627,997	1,264	0%	0%	446,135	70,203	34,198	36,005	51%	0%
Glossop	**39,564,534**	**39,565,096**	**6,491,518**	**(28,094)**	**0**	**7,016,069**	**(524,552)**	**(8)%**	**0%**	**4,602,370**	**724,225**	**753,435**	**(29,210)**	**(4)%**	**0%**
P89002 THE BROOKE SURGERY	14,105,865	14,106,066	2,314,408	(10,016)	0	2,556,279	(241,871)	(10)%	0%	1,640,874	258,207	294,545	(36,338)	(14)%	0%
P89004 AWBURN HOUSE MEDICAL PRACTICE	9,292,546	9,292,678	1,524,667	(6,599)	0	1,656,871	(132,204)	(9)%	2%	1,080,961	170,099	192,969	(22,870)	(13)%	0%
P89012 CLARENDON MEDICAL CENTRE	12,044,291	12,044,462	1,976,157	(8,553)	(18,938)	2,123,207	(147,050)	(7)%	0%	1,401,060	220,470	261,733	(41,263)	(19)%	0%
P89013 HATTERSLEY GROUP PRACTICE	9,764,977	9,765,115	1,602,180	(6,934)	0	1,554,604	47,576	3%	0%	1,135,917	178,747	154,067	24,680	14%	0%
P89014 HAUGHTON THORNLEY MEDICAL CENTRE	17,711,762	17,712,014	2,906,042	(12,577)	(48,626)	3,109,400	(203,358)	(7)%	0%	2,060,332	324,212	348,789	(24,577)	(8)%	0%
P89016 DONNEYBROOK MEDICAL CENTRE	14,704,322	14,704,531	2,412,599	(10,441)	0	2,658,626	(246,027)	(10)%	0%	1,710,490	269,161	283,848	(14,687)	(5)%	0%
P89021 DUKINFIELD MEDICAL CENTRE	15,868,573	15,868,798	2,603,623	(11,268)	0	2,712,537	(108,914)	(4)%	0%	1,845,922	290,473	290,193	280	0%	0%
P89602 THE SMITHY SURGERY	5,478,203	5,478,281	898,832	(3,890)	0	912,745	(13,914)	(2)%	0%	637,255	100,278	108,287	(8,009)	(8)%	0%
Hyde	**98,970,539**	**98,971,944**	**16,238,508**	**(70,278)**	**(67,564)**	**17,284,270**	**(1,045,762)**	**(6)%**	**0%**	**11,512,811**	**1,811,647**	**1,934,431**	**(122,784)**	**(7)%**	**0%**
P89005 LOCKSIDE MEDICAL CENTRE	10,208,603	10,208,748	1,674,968	(7,249)	(16,976)	1,760,560	(85,592)	(5)%	0%	1,187,522	186,868	164,744	22,124	12%	0%
P89007 STAVELEIGH MEDICAL CENTRE	9,905,525	9,905,666	1,625,241	(7,034)	0	1,766,785	(141,545)	(9)%	0%	1,152,266	181,320	173,556	7,764	4%	0%
P89022 KING STREET MEDICAL CENTRE	5,461,197	5,461,274	896,041	(3,878)	0	973,114	(77,073)	(9)%	0%	635,277	99,967	97,460	2,507	3%	0%
P89023 ST ANDREWS HOUSE	7,729,781	7,729,891	1,268,257	(5,489)	0	1,355,386	(87,129)	(7)%	0%	899,172	141,493	145,572	(4,079)	(3)%	0%
P89025 TOWN HALL SURGERY	4,772,636	4,772,703	783,066	(3,389)	(21,272)	875,329	(92,263)	(12)%	0%	555,180	87,363	72,558	14,805	17%	0%
P89026 GROSVENOR MEDICAL CENTRE	8,721,501	8,721,625	1,430,973	(6,193)	0	1,454,953	(23,980)	(2)%	0%	1,014,534	159,646	155,346	4,300	3%	0%
P89612 MOSSLEY MEDICAL PRACTICE	2,718,936	2,718,975	446,107	(1,931)	0	488,547	(42,440)	(10)%	0%	316,282	49,770	40,262	9,508	19%	0%
P89618 PIKE MEDICAL CENTRE	2,752,759	2,752,798	451,657	(1,955)	0	472,898	(21,241)	(5)%	0%	320,216	50,389	47,973	2,416	5%	0%
Y02936 MILLBROOK MEDICAL PRACTICE	3,826,847	3,826,902	627,887	(2,717)	0	637,917	(10,030)	(2)%	0%	445,160	70,050	57,311	12,739	18%	0%
Stalybridge	**56,097,786**	**56,098,583**	**9,204,197**	**(39,834)**	**(38,248)**	**9,785,489**	**(581,292)**	**(6)%**	**0%**	**6,525,610**	**1,026,865**	**954,782**	**72,083**	**7%**	**0%**
Total	**352,068,000**	**352,073,000**	**57,765,260**	**(250,000)**	**(247,569)**	**61,771,598**	**(4,006,339)**	**(7)%**	**0%**	**40,954,533**	**6,444,575**	**6,555,186**	**(110,611)**	**(2)%**	**0%**

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	26 September 2017
Reporting Member / Officer of Single Commissioning Board	Sarah Dobson, Assistant Director (Policy, Performance and Communications)
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. 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 June 2017. The format of this report will include elements on quality from the Nursing and Quality directorate as this report evolves. This report also includes Adult Social Care indicators. This evolving report will align with the other Greater Manchester Health and Social Care Partnership and national dashboard reports. The following have been highlighted as exceptions: • A&E Standards were failed at Tameside Hospital Foundation Trust. • Diagnostic standard failed. • Ambulance response times were not met at a local or at North West level. • 111 Performance against Key Performance Indicators. This report also includes the Quality and safeguarding monthly exception report. 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 is asked to note the contents of the performance and quality report.
Financial Implications: ***(Authorised by the statutory Section 151 Officer & Chief Finance Officer)***	The updated performance information in this report is presented for information and as such does not have any direct and immediate financial implications. However it must be noted that performance against the data reported here could potentially impact upon achievement of Commissioning for Quality and Innovation and Quality, Innovation, Productivity and Prevention targets, which would indirectly impact upon the financial position. It will be important that whole system delivers and performs within the allocated reducing budgets. Monitoring performance and obtaining system assurance particularly around budgets will be key to ensuring aggregate financial balance.

Legal Implications: **(Authorised by the Borough Solicitor)**	As the system restructures and the constituent parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all 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 2017/18
Access to Information :	The background papers relating to this report can be inspected by contacting Ali Rehman, Telephone: 01613663207 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 CCG: NHS Constitution Indicators (June 2017).

2.2 Adult Social services indicators. (Quarter 1 2017/18). 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 Key Performance Indicators.

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.

2.4 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 13.1% compared to the same period last year and other referrals have increased by 8.1% compared to the same period last year for referrals at Tameside and Glossop Integrated Care Foundation Trust. Referrals to all providers have decreased by 14.4% compared to the same period last year and other referrals have increased by 10.3%.

18 Weeks Referral to Treatment Incomplete Pathways

3.3 Performance continues to be above the national standard of 92%, currently achieving 92.66% during June. The specialties failing are Urology 89.98%, Trauma and Orthopaedics 89.62%, Ear, Nose and Throat 90.89%, Neurosurgery 90.00%, Cardiology 91.86%, Neurology 87.50% Plastic Surgery 71.30% and Cardiothoracic Surgery 80.39%. There were no patients waiting longer than 52 weeks during June.

Diagnostics 6+ week waiters

3.4 This month the Clinical Commissioning Group failed to achieve the 1% standard with a 1.68% performance. Of the 82 breaches 28 occurred at Central Manchester (CT, Colonoscopy, Gastroscopy, Flexi Sigmoidoscopy and MRI), 35 at North West CATS Inhealth (MRI and NOUS), 8 at Tameside and Glossop Integrated Care Foundation Trust (Audiology assessments, CT, Gastroscopy, NOUS and Respiratory physiology), 4 at Pennine Acute (Colonoscopy and NOUS), 3 at Salford Trust (MRI), 2 at South Manchester Trust (Dexa and NOUS) and 2 at Other (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 June was 90.7% 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 June 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 June:

- Calls Answered (95% in 60 seconds) = 82.6%
- Calls abandoned (<5%) = 4.5%
- Warm transfer (75%) = 42.9%
- Call back in 10 minutes (75%) = 42.2%

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 June the North West NHS 111 service experienced a number of issues which lead 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 June except 62 day consultant upgrades, where there were 7 breaches. Reasons for the breaches were late CARP referrals and late referrals to Christie.

Improving Access to Psychological Therapies

3.12 Performance continues to be above the Quarterly Standard for the Improving Access to Psychological Therapies access rate (75%) achieving 4.09% during Quarter 4. We can report the Quarter 4 performance for Improving Access to Psychological Therapies recovery rate remains is now achieving the standard at 50.0%. In terms of 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 June was above plan. Tameside and Glossop Clinical Commissioning Group had a total of 11 reported cases of clostridium difficile against a monthly plan of 4 cases. For the month of June this places Tameside and Glossop Clinical Commissioning Group 7 over plan. Of the 11 reported cases, 7 were apportioned to the acute (5 at Tameside and Glossop Integrated Care Foundation Trust, 1 at South Manchester Trust and 1 at Central Manchester Foundation Trust) and 4 to the non-acute. To date (April to June 2017) Tameside and Glossop Clinical Commissioning Group had a total of 22 cases of clostridium difficile against a year to date plan of 18 cases. This places Tameside and Glossop Clinical Commissioning Group 4 case over plan. Of the 22 reported cases, 11 were apportioned to the acute (8 at Tameside and Glossop Integrated Care Foundation Trust, 1 at South Manchester Trust and 2 at Central Manchester Foundation Trust) and 11 to the non-acute. In regards to the 2017/18 financial year, Tameside and Glossop Clinical Commissioning Group have reported 22 cases of

clostridium difficile against an annual plan of 97 cases. This currently places the Clinical Commissioning Group 75 cases under plan with 9 months of the financial year remaining.

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

Mixed Sex Accommodation

3.14 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

3.15.1 We continue to perform well against the estimated diagnosis rate for people aged 65+ for June which was 82.0% 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

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

People with Learning Disabilities in Employment
Performance Summary

4.6 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.

4.7 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.

4.8 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%.

4.9 Performance in this area has been a concern for some time and has been impacted upon the reduction of the Learning Disabilities 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.

4.10 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 As set out on the front of the report.

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Key Messages

Positive trends

18 Weeks RTT Incomplete Pathways: Performance continues to be above the national standard of 92%, currently achieving 92.7% during June.
Cancer: All of the cancer indicators achieved standard during June 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 June was 82.0% 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 Healthcare Associated Infections MRSA: There have been Zero reported cases of MRSA during June.
Weeks RTT 52+ Week Waits: There were no patients waiting longer than 52 weeks during June.

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: June performance at Tameside And Glossop Integrated Care NHS FT (T&GICFT) is below the 95% target, at 90.7%. A total of 7,215 patients attended A&E in the month, of which 671 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 June. Responses to Red1 and Red2 calls within 8 minutes were below the 75% standard, at 62.53% and 64.68%, respectively. Responses to all Red calls within 19 minutes were also below the 95% standard, at 89.39%.
111: The North West NHS 111 service is performance managed against a range of KPIs reported as follows for June:- Calls Answered (95% in 60 seconds) = 82.6%- Calls abandoned (<5%) = 4.5%- Warm transfer (75%) = 42.9% Call back in 10 minutes (75%) = 42.2%
Diagnostics 6+ Week Waiters: Performance was higher (worse than) the national standard of 1.00%, currently achieving 1.68% during June.
Healthcare Associated Infections Clostridium Difficile: The number of reported cases during June (11) was Above plan.

NHS Tameside & Glossop CCG: NHS Constitution Indicators (September 2017)

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

Better Health

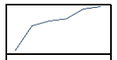
Description	Indicator	F	Level	Better is...	Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Exceptions	GM	England	Trend
	Utilisation of the NHS e-referral service to enable choice at first routine elective referral	M	T&G CCG	H		11.6%	11.2%	11.1%	11.6%	10.4%	10.7%	10.0%	10.1%	11.1%	13.3%	11.4%	13.4%	14.6%	15.2%			51.1% (Sept)	
	Number of women Smoking at Delivery.	Q	T&G CCG	L	England	13.6%		16.9%			15.3%			15.7%			15.1%				12.8% (Q4)	10.80%	
	Personal health budgets	Q	T&G CCG	H		4.0		4.1			3.6			5.8							46 (Q4)	27 (Q4)	
	Percentage of deaths which take place in hospital	Q	T&G CCG	<>		47.6%		49.0%			50.4%										50.8% (Q3 16/17)	47.0% (Q3 16/17)	
	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q	T&G CCG	L				1468			1404											904	
	Inequality in emergency admissions for urgent care sensitive conditions	Q	T&G CCG	L				2906			2872											1758	
	Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Q	T&G CCG	<>				1.11	1.11	1.11	1.11	1.12	1.12	1.13	1.12						1.20	1.07	
	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	Q	T&G CCG	<>				8.0	7.9	7.8	7.8	7.8	7.7	7.7	7.7						8.1	8.90%	
	Injuries from falls in people aged 65 and over	A	T&G CCG	L			2159	2210			2081											1946	

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%	42.5%										41.0% FY 15/16	39.0% FY 15/16	
	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%										66.60%	64.30%	
	Quality of life of carers	A	T&G CCG	H		80.7%	77.70%	80.00%	77.5%										70.3% (2016)	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	Jun-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%	94.90%		93.40%	94.10%	
	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%	100.00%		88.80%	91.60%	
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%	99%		98.80%	97.50%	
	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%	100%		98.40%	96.60%	
	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%	100%	Breach due to deferred treatment in Jan-16.	99.50%	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%		99%	96.70%	
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%	82.50%	There were 10 breaches out of a total of 39 seen in Sept 16.	81.70%	80.40%	
	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%	100%		94.80%	91.90%	
	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%	94.70%	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	86.20%	86.80%	
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%	92.7%	CCG target (92%) achieved. Failing specialties are Urology (89.98%), Trauma & Orthopaedics (89.62%), Ear, Nose & Throat (ENT) (90.89%),Neurosurgery (90.00%), Plastic Surgery (71.30%), Cardiothoracic Surgery (80.39%), Cardiology (91.86%) and Neurology (87.50%)	92.80%	90.30%	
	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	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%	1.68%	In June 73 patients (62 patients waiting 6-13 weeks and 11 patients >13 Weeks).	1.40%	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%	82.0%		77.10%	68.00%	
A&E < 4 Hours	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department - THFT	M	THFT	H	95%	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%	90.7%	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). June performance is 90.7% breached by 671 patients (7,215).	88.90%	90.70%	
	Delayed transfers of care per 100,000 population	M	T&G CCG	L					21.2			24.2	21.5	25.9	20.7	14.8					14.4	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%								74.7%	75.50%	
	Achievement of milestones in the delivery of an integrated urgent care service	M		H					4			4		5								
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		63			58			55						55 (Q4)	59 (Q4)	
	Emergency admissions for urgent care sensitive conditions	Q		L				3336			3212										2405	
	Population use of hospital beds following emergency admission	Q		L		603.0		602.0			610.6										501.9	
	Management of long term conditions	Q		L				1301			1266										895 Q3 16/17	
	People eligible for standard NHS Continuing Healthcare	Q		H		63.9		62.7			63.6									52.9	45.0	
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		49.2									52.00%	52.40%	
	One-year survival from all cancers	A	T&G CCG	H		67.6	66.6		67.1											68.80%	70.40%	
	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%		80.6%									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%		83.5%							85.70%	84.80%	
	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%		41.4%									35.3% FY 15/16	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									0.88	1.04	

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			1st Quarter 2017-18			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	Apr-17	May-17	Jun-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%			96.66%			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%			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%			12.76%			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%			78.29%			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%			4.71%			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%			93.65%			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)			3.71 (5 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)			143.77 (56 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			61			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	-		-			-			81.76%			-			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			2944			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%			80.87%			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%			81.67%			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	Jun-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	5302	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	3212	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	3780	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	1825	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	7239	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	2822	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	2333	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			52.6									
	Local strategic estates plan (SEP) in place	A		H		Yes															Yes		
	Financial plan	A		H		AMBER															Green		

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	Jun-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											0.12	
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

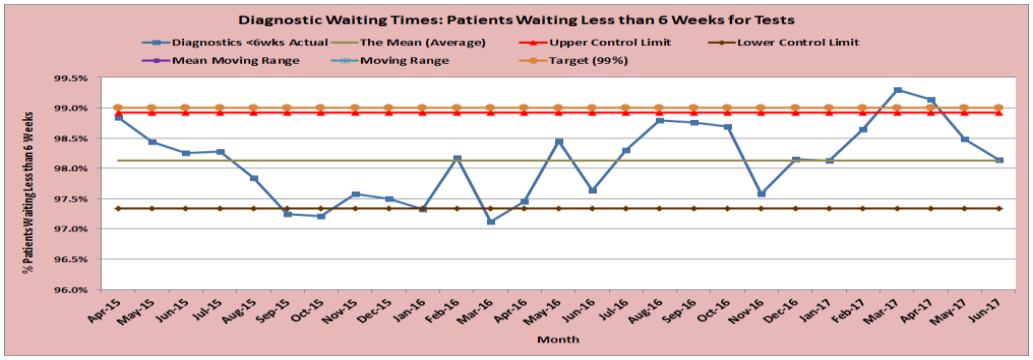
Other Indicators

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	Jun-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	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.		0.41	
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			0			Number of last minute cancellations at THFT; 15-16 Q1 = 63, Q2 = 54, Q3 = 86, Q4 = 96 16-17 Q1 = 85, Q2 = 60, Q3 = 78		1357	
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%	82.6%			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%	4.5%			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%	42.9%			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%	42.2%			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%	57.1%	High levels of demand and lengthening turn around times.	62.10%	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%	60.60%	High levels of demand and lengthening turn around times.	65.90%	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%	88.2%	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%	62.5%	High levels of demand and lengthening turn around times.	62.10%	68.80%	
	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%	64.7%	High levels of demand and lengthening turn around times.	65.90%	61.80%	
	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%	89.4%	High levels of demand and lengthening turn around times.		90.00%	
	Quality																						
Quality	Clostridium Difficile-Whole Health Economy	M		L	Plan	7	3	9	10	5	13	6	6	5	4	9	6	5	11			1004	
	Clostridium Difficile-Acute	M		L	Plan	2	2	4	5	2	8	5	4	2	3	5	2	2	7			410	
	Clostridium Difficile-Non-Acute	M		L	Plan	5	1	5	5	3	5	1	2	3	1	4	4	3	4			594	
	MRSA-Whole Health Economy	M		L	0	0	2	1	3	0	0	0	0	2	2	0	0	2	0		4	92	
	MRSA-Acute	M		L	0	0	2	0	2	0	0	0	0	1	1	0	0	1	0			39	
	MRSA-Non Acute	M		L	0	0	0	1	1	0	0	0	0	1	1	0	0	1	0			53	

Exception Report

Tameside & Glossop CCG- September

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 1.68% performance.
Of the 82 breaches. 28 occurred at Central Manchester (CT, Colonoscopy, Gastroscopy, Flexi sigmoidoscopy and MRI), 35 at North West CATS Inhealth (MRI and NOUS), 8 at T&G ICFT (Audiology assessments, CT Gastroscopy, NOUS and Rispiratory physiology), 4 at Pennine Acute (Colonoscopy and NOUS), 3 at Salford Trust (MRI), 2 at South Manchester (Dexa and NOUS), and 2 at Other (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:

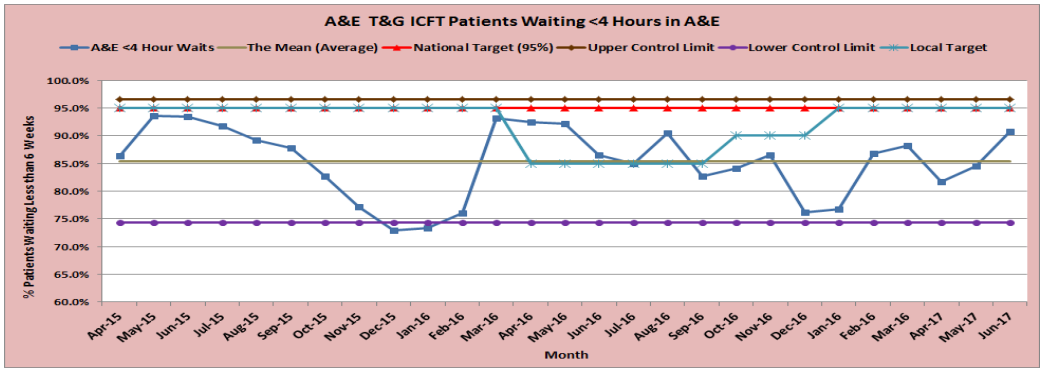
Failure of the standard will negatively impact on the CCG assurance rating. The CCG can Levey penalties through contract with those providers who fail the target.

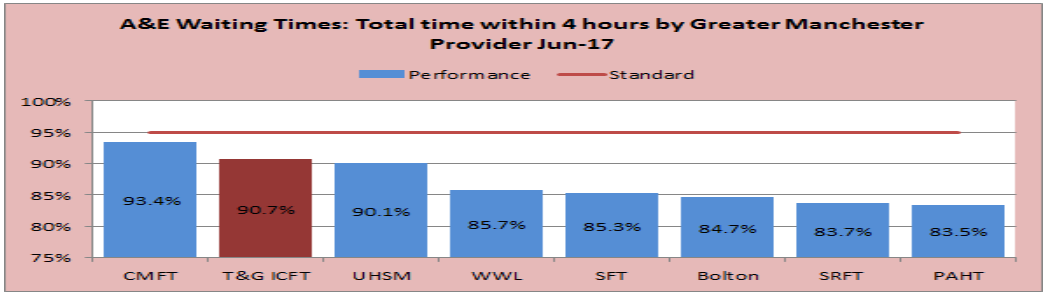
Diagnostics Waiting Times Patients Waiting > 6 Weeks by GM CCG

	Jun-17			
CCG	Waiting > 6 Weeks	Total Waiting List	Performance	Standard
NHS Oldham CCG	187	4466	4.19%	1%
NHS Manchester CCG	276	10121	2.73%	1%
NHS Heywood, Middleton & Rochdale CCG	95	4198	2.26%	1%
NHS Salford CCG	95	4314	2.20%	1%
NHS Bury CCG	78	3760	2.07%	1%
NHS Tameside and Glossop CCG	82	4883	1.68%	1%
NHS Trafford CCG	80	5808	1.38%	1%
NHS Stockport CCG	66	5677	1.16%	1%
NHS Wigan Borough CCG	57	6040	0.94%	1%
NHS Bolton CCG	30	4135	0.73%	1%

Unvalidated -Next month FORECAST

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





June Performance: 90.70%

16/17 ytd: 90.40%

17/18 ytd: 85.63%

Key Risks and Issues:

The A&E Type1 performance for June was 90.70% which is below the National Standard of 95% but above the GM agreed target of 90%.
Late assssment 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 >96%).;
- 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 GM agreed trajectory is 90% until Q4 with 95% in March 18.
The transfer of Type 3 activity to the ICFT from July will mean that the inclusion of this data will add to the overall performance.

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.

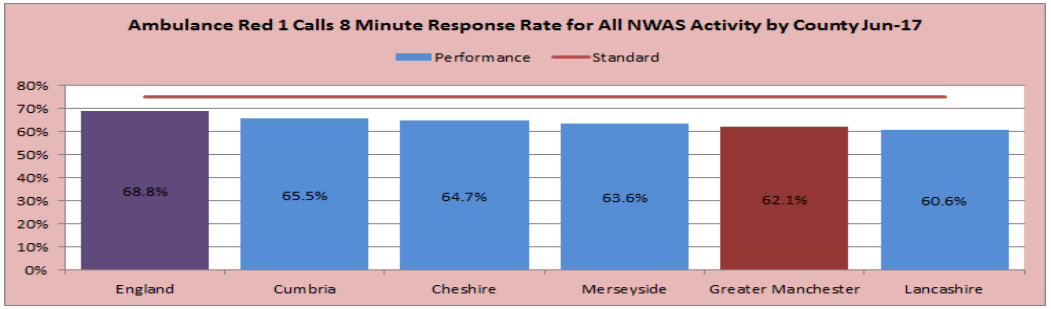
Operational and Financial implications:

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.

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**



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

	Jun-17			
CCG	**<8 Mins**	**Total**	**Performance**	**Standard**
NHS Manchester CCG	245	367	66.8%	75%
NHS Heywood Middleton & Rochdale CCG	81	124	65.0%	75%
NHS Stockport CCG	68	104	65.0%	75%
NHS Wigan Borough CCG	82	128	63.8%	75%
NHS Bury CCG	47	75	63.0%	75%
NHS Bolton CCG	87	139	62.8%	75%
NHS Salford CCG	66	108	60.7%	75%
NHS Oldham CCG	66	114	57.5%	75%
NHS Tameside and Glossop CCG	73	128	57.1%	75%
NHS Trafford CCG	31	73	42.3%	75%
Data source; NWAS PES report				

June Performance: 62.53%

16/17 ytd: 74.60%

17/18 ytd: 66.10%

Key Risks and Issues:

In June the North West position (which we are measured against) was 62.53% however locally we achieved 57.10% 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.
NWAS will implement the Ambulance Response Programme from 7th August which will mean that July will be the last report against this specific standard.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating.

Unvalidated next month FORECAST

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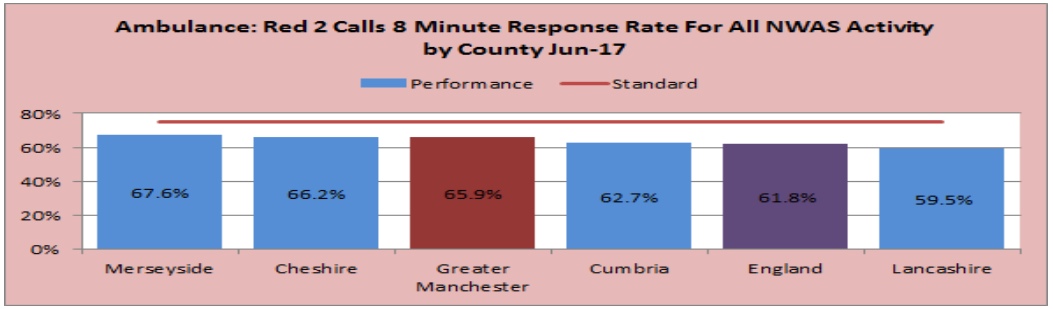
Ambulance performance- **Lead Officer: Elaine Richardson** **Lead Director:** Clare Watson **Governance: A&E Delivery Board**



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

	Jun-17			
CCG	**<8 Mins**	**Total**	**Performance**	**Standard**
NHS Manchester CCG	3182	4165	76.4%	75%
NHS Bolton CCG	987	1478	66.8%	75%
NHS Oldham CCG	822	1290	63.7%	75%
NHS Salford CCG	867	1391	62.3%	75%
NHS Bury CCG	641	1032	62.1%	75%
NHS Stockport CCG	954	1538	62.0%	75%
NHS Heywood Middleton & Rochdale CCG	748	1208	61.9%	75%
NHS Wigan Borough CCG	999	1645	60.7%	75%
NHS Tameside and Glossop CCG	869	1434	60.6%	75%
NHS Trafford CCG	584	1062	55.0%	75%
Data source; NWAS PES report				

June Performance: 64.68%

16/17 ytd: 66.60%

17/18 ytd: 66.00%

Key Risks and Issues:

In June the north west position (which we are measured against) was 64.68% however locally we achieved 60.60% 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.
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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.

NWAS will implement the Ambulance Response Programme from 7th August which will mean that July will be the last report against this specific standard.

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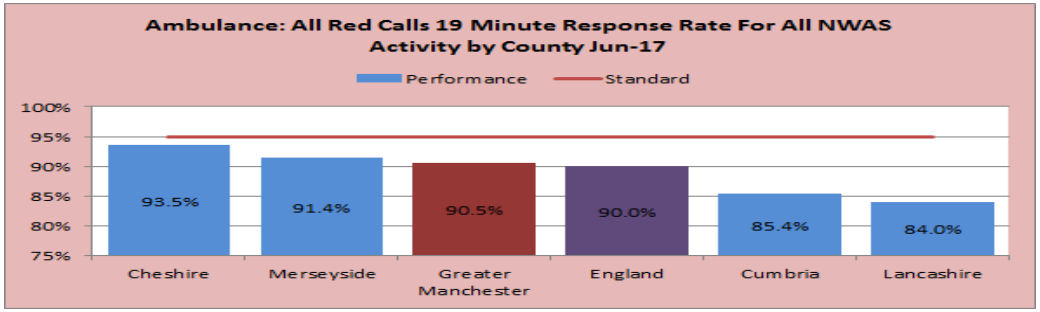
Ambulance performance- **Lead Officer: Elaine Richardson** **Lead Director:** Clare Watson **Governance: A&E Delivery Board**



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

	Jun-17			
CCG	**<19 Mins**	**Total**	**Performance**	**Standard**
NHS Manchester CCG	4224	4532	93.2%	95%
NHS Bolton CCG	1480	1617	91.5%	95%
NHS Stockport CCG	1488	1642	90.6%	95%
NHS Salford CCG	1357	1499	90.5%	95%
NHS Wigan Borough CCG	1605	1773	90.5%	95%
NHS Heywood Middleton & Rochdale CCG	1189	1332	89.3%	95%
NHS Oldham CCG	1251	1404	89.1%	95%
NHS Tameside and Glossop CCG	1378	1562	88.2%	95%
NHS Trafford CCG	987	1135	87.0%	95%
NHS Bury CCG	950	1107	85.8%	95%
Data source; NWAS PES report				

June Performance: 89.39%

16/17 ytd: 91.70%

17/18 ytd: 90.60%

Key Risks and Issues:

In June the north west position (which we are measured against) was 89.39% however locally we only achieved 88.20% 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.

NWAS will implement the Ambulance Response Programme from 7th August which will mean that July will be the last report against this specific standard.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating.

Unvalidated next month FORECAST

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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		20.7	24	Isle of Wight	45.7	East London and City	12.1
Calls per month via 111 per 1,000 people		20.7	24	Isle of Wight	45.4	East London and City	12.1
Of all calls offered, % abandoned after at least 30 seconds[1]		4%	3	Luton & Bedfordshire	15%	South Essex	0%
Of calls answered, % in 60 seconds		83%	38	East London and City	98%	Luton & Bedfordshire	70%
Of calls answered, % triaged		89%	10	North Central London	108%	Somerset	71%
Of answered calls, % transferred to clinical advisor		21%	35	East Kent	45%	Lincolnshire	10%
Of transferred calls, % live transferred		43%	12	Isle of Wight	94%	York & Humber	12%
Average NHS 111 live transfer time[1]		00:00:05					
Average warm transfer time		NCA					
Of calls answered, % passed for call back		12%	27	Devon	21%	Lincolnshire	1%
Of call backs, % within 10 minutes		43%	18	Cambridge and Peterborough	73%	North Central London	11%
Average episode length		00:13:48					
Of answered calls, % calls to a CAS clinician		31%	27	North Central London	62%	SEC exc. East Kent	22%

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%	6	Cornwall	17%	South Essex	10%
111 dispositions: % Recommended to attend A&E	10%	10%	24	East London and City	16%	Leicestershire and Rutland	6%
Recommended to attend primary and community care	55%	56%	32	Berkshire	64%	Lincolnshire	49%
Of which - % Recommended to contact primary and community care		41%	22	SEC exc. East Kent	47%	Nottinghamshire	34%
- % Recommended to speak to primary and community care		11%	20	Cambridge and Peterborough	17%	Outer North East London	5%
- % Recommended to dental / pharmacy		3%	39	York & Humber	14%	Devon	1%
111 dispositions: % Recommended to attend other service	2%	2%	29	Lincolnshire	20%	East Kent	1%
111 dispositions: % Not recommended to attend other service	17%	17%	8	Milton Keynes	20%	Mainland SHIP	9%
Of which - % Given health information		5%	1	NW inc. Blackpool	5%	Somerset	0%
- % Recommended home care		4%	38	South East London	8%	Lincolnshire	1%
- % Recommended non clinical		9%	12	York & Humber	12%	Luton & Bedfordshire	2%

Key Risks and Issues:

The North West NHS 111 service is performance managed against a range of KPIs reported as follows for June:
- Calls Answered (95% in 60 seconds) = 82.6%
- Calls abandoned (<5%) = 4.5%
- Warm transfer (75%) = 42.9%
Call back in 10 minutes (75%) = 42.2%

In June 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 for June 2017.

Quality Indicator	Y/N	Comments
Has a local provider been rated as inadequate by the CQC/OFSTED	N	NB CQC Reports on all the Tameside and Glossop GP practices have now been received; 39 of the practices have been rated as good and one, Lockside Medical Centre has received an outstanding report.
Has a local provider been subject to regulatory notice e.g. CQC alert, Reg 28,	**Y**	PCFT received a Regulation 28 dated 12 June 2017 relating the Tameside and Glossop Healthy Mind Service. The Stockport Coroner concerns related to the lack of documentation or system for recording the selection process for therapy including the options given and rationale for the choice of therapy, information sharing between the GP and Healthy Minds to identify if the correct services were being accessed or if a referral to a psychiatrist was required and a lack of referral to sleep clinic services to assist with insomnia. In addition the coroner found no evidence of a clear formal escalation process where concerns were held by a health professional. PCFT has been asked to provide a response by 31 July 2017. NB Fairfield View has been issued a Regulation 28 in July 17, primarily about quality of documentation. The home is now expected to formulate a response to the Coroner detailing the action it will take to prevent future deaths; an update on this will be provided in the July exception report.
Does the CCG and / or partner originations have concerns about the ability of a provider to deliver safe, quality care?	**Y**	**A Nursing Home** remains suspended (since May 2017) following a contracts performance visit, concerns raised by practitioners and a CQC visit. Main themes relate to clinical leadership/oversight and staffing (high use of agency staff). Commissioners have met with the management and discussed the action plan. Improvements have been noted resulting in partial lifting of the suspension (for Newton Court) and a further contracts performance visit took place w/c 3 July 2017 and improvements were noted; a commissioners meeting is being held on 12th July 2017 to discuss outcome of visit; as a result a recommendation has gone forward to lift the suspension across the whole home (with phased admissions). **Charnley House** (Residential care Home) 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'. Close contract and quality monitoring will continue and a further meeting with the owners is scheduled to take place on the 1 August 2017 to discuss the home.

		Carson House – (Residential Care Home) CQC report published 17/05/17 – Inadequate. 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 been informed that the manager has resigned with immediate effect (as of 3rd July 2017) and at the same time a number of nurses also left the home. It came to light at the Commissioners meeting on the 10 July 2017 that the new owner is also bankrupt; the Commissioners are therefore working closely with them to ensure that the service can be delivered. The CQC have also re-inspected the home (18, 19 & 20 July); we are awaiting the outcome of this inspection. **A** residential 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. On-going monitoring is being undertaken. A residential home in Glossop remains on suspension; the main problems at the home are poor care plans, gaps in training, general lack of knowledge around dementia care, currently no Home Manager in place and poor environment and infection control. DCC report that the home is making steady progress since the suspension last October and will review the suspension at the next review meeting. **PCFT** – In response to the Trust's CQC Inspection Outcome of 'requires improvement' a detailed CQC improvement action plan and revised Quality Strategy have been developed. A new joint Quality and Workforce Project Group has been established as a sub group of the already existing Transformation Board.

		The group includes representatives from the Clinical Commissioning Groups and the Trust. The Terms of Reference are being developed. It is envisage that the group main focus will be on the quality, safety, patients experience and safeguarding.
Does the CCG and / partner organisations have concerns about the quality of any smaller value contracts?	/	The process of contract monitoring and quality assurance for small value contracts is being finalised by the contracting team with a close cooperation of the quality team. It will follow the process of contract monitoring and quality assurance for contracts that were £5m plus in value.
Has a local provider been subject to negative media attention particularly in relation to quality and / or patient safety concerns?	N	
Has a provider been identified as a 'negative outlier' on SMHI or HSMR?	N	
Has a provider reported MRSA cases above zero?	**N**	For June 2017 Tameside and Glossop CCG have reported 0 cases of MRSA against a plan of zero tolerance. However, to date (April 2017 to June 2017) Tameside and Glossop CCG have reported 2 cases of MRSA against a plan of zero tolerance cases (1 at T&G ICFT and 1 non acute case). These cases were reported in the May exception report.
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?	**N**	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. 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.	**N**	
Does performance indicate any concerns about meeting Transforming Care targets?	**N**	
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	There are two reviews which will be presented to the children's Safeguarding Board on 24 July 2017. Child U - Serious Case Review – issues about child sexual exploitation There has also been a systems review of child sexual exploitation in Tameside. The findings will be presented to the Board on 24 July 2017. There is a continued focus on the Implementation of the Ofsted Improvement plan.
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	No visits undertaken
Any new items added to SCF Risk Register relating to quality or patient safety.	N	

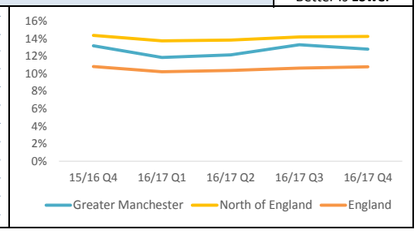
Better Health

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**

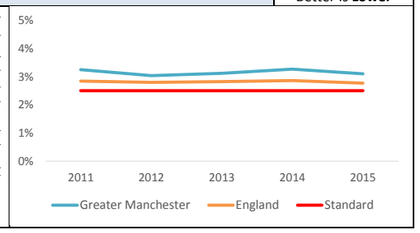
Trafford	7.5%
Central	8.0%
Stockport	11.2%
North	12.5%
South	13.0%
Bury	13.1%
Salford	13.3%
Bolton	13.9%
Wigan	14.1%
Oldham	15.1%
HMR	15.4%
T&G	15.7%



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%

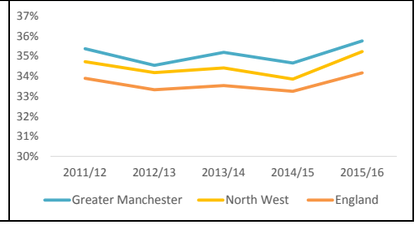


More GM Children Will Reach a Good Level of Development Cognitively, Socially & Emotionally

Children Aged 10-11 Classified as Overweight or Obese

Better Is **Lower**

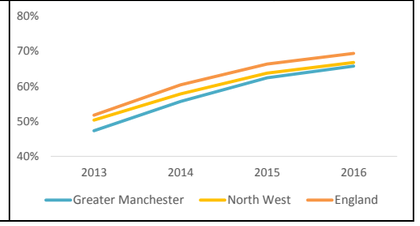
Bolton	35.4%
Bury	34.5%
Mancheste	40.2%
Oldham	36.7%
Rochdale	35.7%
Salford	39.6%
Stockport	30.3%
Tameside	33.9%
Trafford	30.9%
Wigan	35.7%



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??

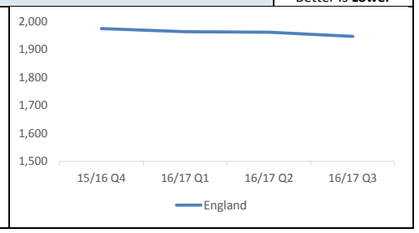
Better Is **Higher**

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	1,685
Bury	1,765
T&G	2,081
North	2,192
Central	2,204
HMR	2,209
Trafford	2,294
Stockport	2,417
Oldham	2,429
South	2,628
Wigan	2,734
Salford	3,186



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

Better Is **Lower**

(Placeholder) - Fuel Poverty

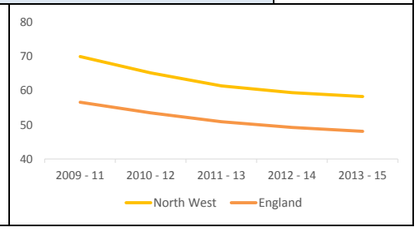
Better Is **Lower**

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

Under-75 Mortality Rate Considered Preventable - CVD

Better Is **Lower**

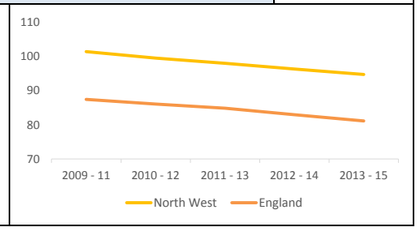
Bolton	60.5
Bury	55.8
Oldham	74.5
Rochdale	70.6
Salford	75.4
Stockport	43.1
Tameside	80.5
Trafford	45.2
Wigan	59.8
Mancheste	89.5



Under-75 Mortality Rate Considered Preventable - Cancer

Better Is **Lower**

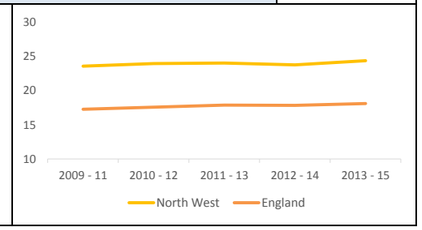
Bolton	92.9
Bury	89.9
Oldham	105.9
Rochdale	101.2
Salford	118.7
Stockport	84.7
Tameside	103.5
Trafford	84.0
Wigan	91.8
Mancheste	129.3



Under-75 Mortality Rate Considered Preventable - Respiratory

Better Is **Lower**

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

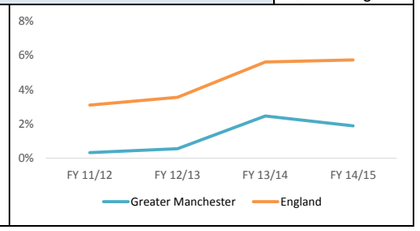
Better Is **Higher**

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**

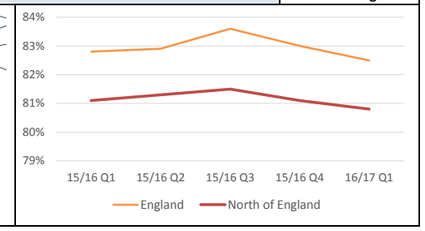
Bolton	0.1%
Bury	0.0%
Central	0.0%
HMR	0.0%
North	2.5%
Oldham	0.8%
Salford	1.0%
South	0.6%
Stockport	1.6%
T&G	0.0%
Bury	0.0%
HMR	0.0%



Diabetic Eye Screening

Better Is **Higher**

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

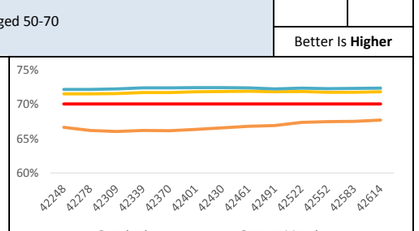


(Placeholder TBC)

Personal Health Budgets Per 100,000 Population

Better Is **Higher**

Salford	282
HMR	91
Bury	28
South	25
Wigan	25
North	24
Central	24
Stockport	14
Bolton	13
Trafford	13
Oldham	6
T&G	5



Inequality In Unplanned Hospitalisation For Chronic Ambulatory Care Sensitive Conditions

Better Is **Lower**

Bury	870
Wigan	930
Oldham	1,020
HMR	1,035
Trafford	1,056
Bolton	1,247
Salford	1,316
T&G	1,404
Stockport	1,496
Central	1,794
North	1,894
South	2,095

Inequality In Emergency Admissions For Urgent Care Sensitive Conditions

Better Is **Lower**

Bury	1,429
Trafford	1,970
Oldham	1,979
HMR	1,982
Bolton	2,299
Wigan	2,516
North	2,834
Salford	2,839
T&G	2,872
Stockport	3,144
Central	3,303
South	3,711

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

Better Is **Lower**

Bolton	1.25
Bury	1.16
Central	1.06
HMR	1.30
North	1.29
Oldham	1.39
Salford	1.22
South	1.19
Stockport	1.21
T&G	1.12
Trafford	1.10
Wigan	1.14

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

Better Is **Lower**

Stockport	5.1
Bury	6.0
HMR	7.7
T&G	7.7
North	7.8
South	8.0
Bolton	8.1
Central	8.2
Wigan	8.2
Oldham	9.1
Salford	9.9
Trafford	12.2

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**

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

Breast Screening Coverage Aged 50-70

Better Is **Higher**

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

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

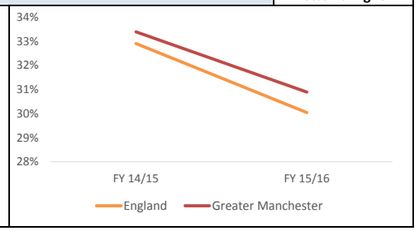
Better Is **Higher**

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**

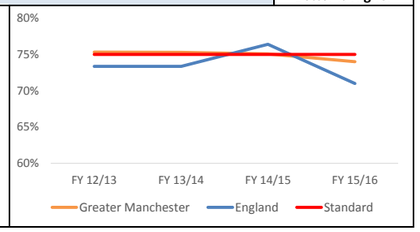
Bolton	27.2%
Bury	28.6%
Central	27.4%
HMR	32.3%
North	28.0%
Oldham	31.1%
Salford	28.3%
South	20.2%
Stockport	37.1%
T&G	32.1%
Trafford	41.8%
Wigan	32.7%



Flu Immunised aged 65 and over

Better Is **Higher**

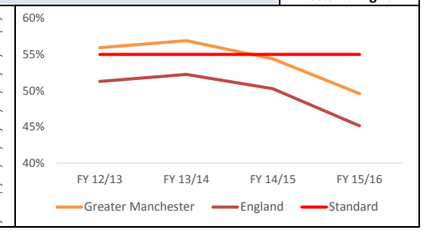
Bolton	73.3%
Bury	75.1%
Central	70.4%
HMR	74.6%
North	70.6%
Oldham	73.2%
Salford	73.8%
South	69.2%
Stockport	76.8%
T&G	75.0%
Trafford	77.4%
Wigan	72.0%



Flu Immunised in clinical risk groups

Better Is **Higher**

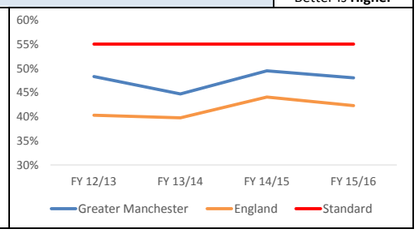
Bolton	49.6%
Bury	47.9%
Central	48.1%
HMR	54.1%
North	49.2%
Oldham	49.6%
Salford	42.8%
South	46.3%
Stockport	56.5%
T&G	52.8%
Trafford	51.7%
Wigan	45.2%



Flu Immunised in pregnant women

Better Is **Higher**

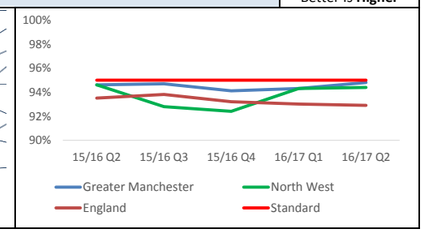
Bolton	46.1%
Bury	48.3%
Central	44.1%
HMR	50.4%
North	41.7%
Oldham	50.6%
Salford	37.7%
South	47.1%
Stockport	63.7%
T&G	52.3%
Trafford	50.3%
Wigan	45.4%



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

Better Is **Higher**

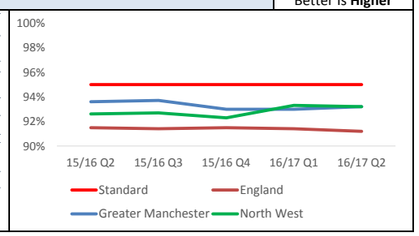
Wigan	97.4%
T&G	97.3%
Trafford	96.8%
Oldham	96.6%
Bolton	96.5%
Salford	95.7%
HMR	95.6%
Bury	94.7%
Stockport	94.4%



Mumps, Measles & Rubella (MMR)

Better Is **Higher**

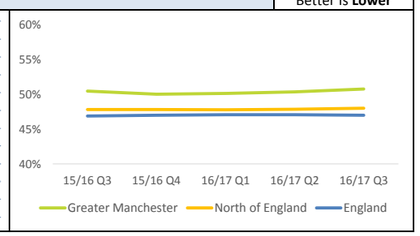
T&G	97.3%
HMR	95.8%
Salford	95.2%
Wigan	95.1%
Trafford	94.7%
Bolton	94.6%
Oldham	94.4%
Stockport	93.5%
Bury	90.8%
Mancheste	87.8%



Percentage Of Deaths Which Take Place In Hospital

Better Is **Lower**

Bury	45.7%
HMR	46.0%
Bolton	47.3%
Oldham	48.1%
T&G	49.7%
Stockport	50.8%
Salford	51.4%
Wigan	53.2%
North	53.4%
Trafford	55.7%
Central	56.7%
South	57.4%



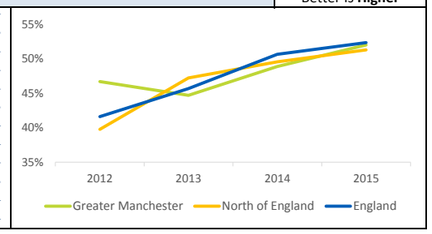
Better Care

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

Cancers Diagnosed at Early Stage

Better Is **Higher**

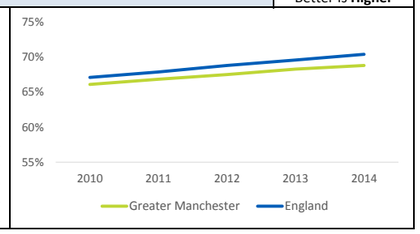
Trafford	56.1%
Stockport	55.4%
Wigan	52.7%
HMR	52.6%
Bolton	52.0%
Oldham	52.0%
South	51.8%
North	51.5%
Bury	50.2%
T&G	49.2%
Salford	48.7%
Central	48.4%



One-Year Survival From All Cancers

Better Is **Higher**

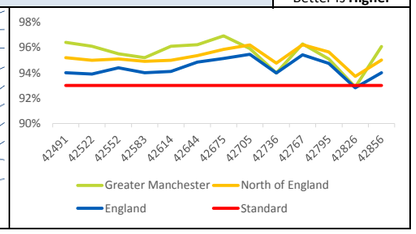
Stockport	71.9%
Trafford	71.7%
Bury	70.4%
HMR	69.3%
South	69.2%
Wigan	68.9%
Bolton	68.3%
Oldham	68.0%
Central	67.2%
T&G	67.1%
Salford	65.9%
North	64.8%



Cancer - Two week wait from cancer referral to specialist appointment

Better Is **Higher**

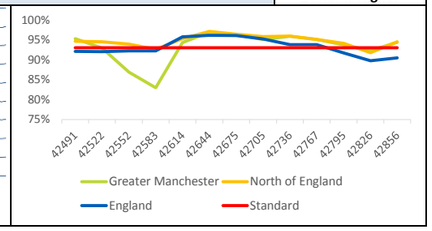
Bolton	98.7%
Stockport	97.9%
Wigan	97.2%
Salford	96.8%
Oldham	96.6%
Trafford	95.9%
Bury	95.4%
HMR	95.4%
T&G	94.3%
Mancheste	94.0%



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

Better Is **Higher**

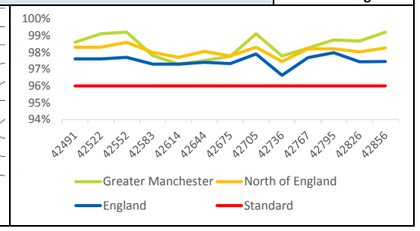
T&G	99.0%
Oldham	98.7%
Stockport	96.8%
Wigan	96.4%
Salford	94.3%
HMR	93.6%
Trafford	93.0%
Mancheste	92.4%
Bolton	91.3%
Bury	88.4%



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

Better Is **Higher**

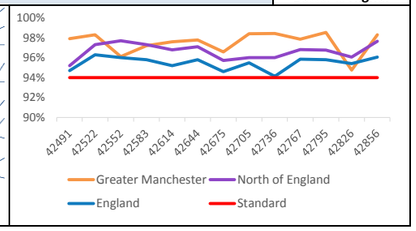
T&G	100.0%
Stockport	100.0%
Mancheste	100.0%
Bury	100.0%
Salford	100.0%
Bolton	99.1%
HMR	98.9%
Wigan	98.1%
Trafford	97.9%
Oldham	97.7%



Cancer - 31-day wait for subsequent surgery

Better Is **Higher**

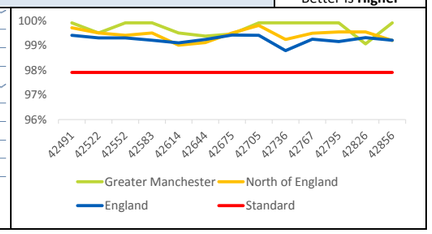
Mancheste	100.0%
Stockport	100.0%
Bolton	100.0%
Bury	100.0%
T&G	100.0%
HMR	100.0%
Oldham	100.0%
Wigan	97.4%
Salford	95.0%
Trafford	92.9%



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

Better Is **Higher**

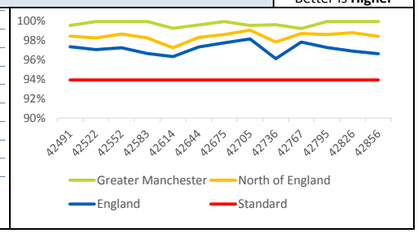
Bolton	100.0%
Bury	100.0%
HMR	100.0%
Oldham	100.0%
Salford	100.0%
Stockport	100.0%
T&G	100.0%
Trafford	100.0%
Wigan	100.0%
Mancheste	100.0%



Cancer - 31-day wait for subsequent radiotherapy

Better Is **Higher**

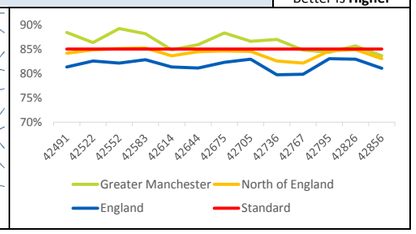
Bolton	100.0%
Bury	100.0%
HMR	100.0%
Oldham	100.0%
Salford	100.0%
Stockport	100.0%
T&G	100.0%
Trafford	100.0%
Wigan	100.0%
Mancheste	100.0%



Cancer - 62-day wait from referral to treatment

Better Is **Higher**

Wigan	91.8%
T&G	89.8%
Salford	88.5%
Bolton	88.5%
Trafford	87.8%
Oldham	85.4%
Bury	85.0%
Stockport	77.0%
Mancheste	74.1%
HMR	73.2%

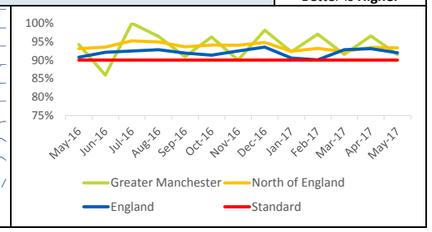


Decreased Variation In Quality Of Care Health Outcomes Across GM Localities

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

Better Is **Higher**

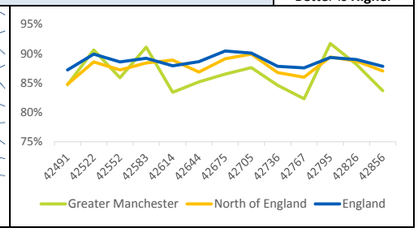
T&G	100.0%
Wigan	100.0%
Trafford	100.0%
HMR	100.0%
Oldham	100.0%
Bolton	100.0%
Bury	90.9%
Stockport	82.4%
Mancheste	81.8%
Salford	80.0%



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

Better Is **Higher**

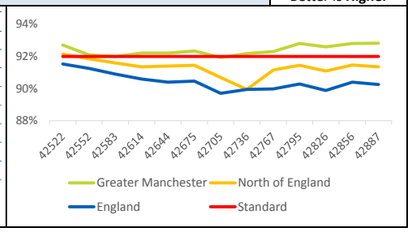
Bolton	70.0%
Bury	83.3%
HMR	60.0%
Mancheste	95.5%
Oldham	71.4%
Salford	75.0%
Stockport	85.0%
T&G	69.6%
Trafford	90.0%
Wigan	95.7%



Referral to Treatment - 18 weeks

Better Is **Higher**

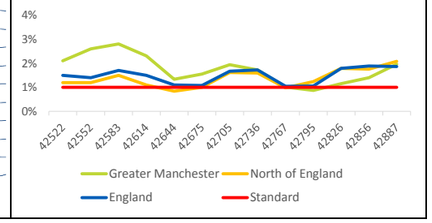
Wigan	95.2%
Oldham	93.7%
HMR	93.5%
Salford	93.5%
Bolton	93.0%
T&G	92.7%
Stockport	92.5%
Bury	92.4%
Mancheste	91.5%
Trafford	91.2%



Diagnostics Test Waiting Times

Better Is **Lower**

Bolton	0.7%
Wigan	0.9%
Stockport	1.2%
Trafford	1.4%
T&G	1.7%
Bury	2.1%
Salford	2.2%
HMR	2.3%
Mancheste	2.7%
Oldham	4.2%



Improved Patient/Carer Experience Of Care And Increased Patient Empowerment

Primary Care Access (Placeholder)

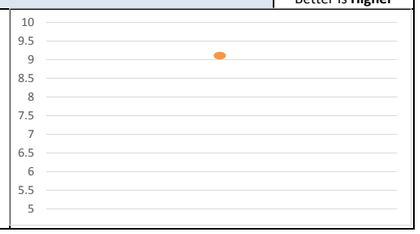
Better Is **Higher**

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

Cancer Patient Experience

Better Is **Higher**

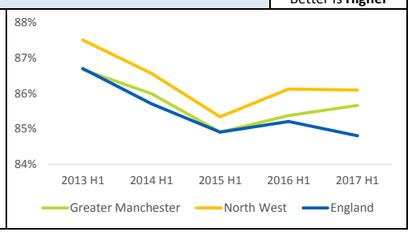
Bolton	8.8
Bury	8.7
Central	8.6
HMR	8.8
North	8.7
Oldham	8.7
Salford	9.0
South	8.7
Stockport	8.7
T&G	8.7
Trafford	8.6
Wigan	8.8



Patient Experience Of GP Services

Better Is **Higher**

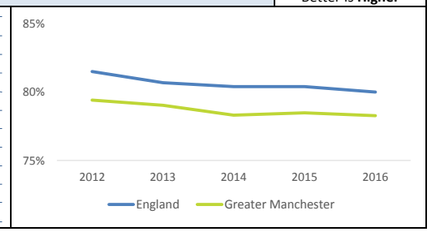
Stockport	89.4%
Wigan	87.7%
Bolton	87.1%
Bury	86.0%
Trafford	86.7%
Salford	84.2%
Oldham	85.5%
T&G	83.5%
Mancheste	83.7%
HMR	83.8%



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

Better Is **Higher**

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

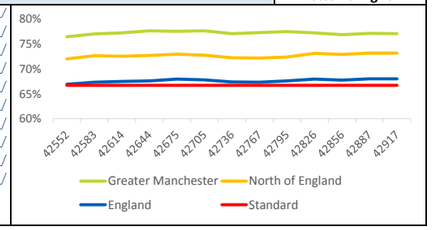


Improved Outcomes For People With Learning Disabilities/Mental Health Needs

Estimated Diagnosis Rate For People With Dementia

Better Is **Higher**

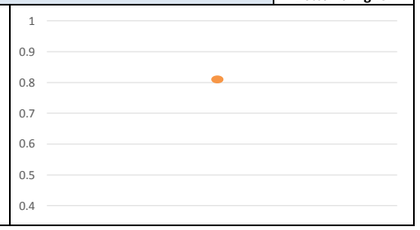
Salford	89.1%
Bury	84.6%
T&G	82.0%
Oldham	80.9%
Bolton	78.3%
Mancheste	75.9%
Stockport	75.4%
Trafford	74.8%
Wigan	68.6%
HMR	67.4%



Dementia Care Planning and Post-Diagnostic Support

Better Is **Higher**

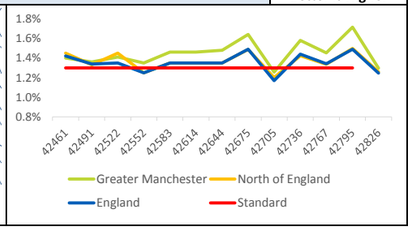
Bolton	83.4%
Bury	84.3%
Central	84.8%
HMR	77.5%
North	81.4%
Oldham	77.0%
Salford	79.0%
South	79.1%
Stockport	80.5%
T&G	80.6%
Trafford	80.2%
Wigan	77.3%



Improving Access to Psychological Therapies Access Rate

Better Is **Higher**

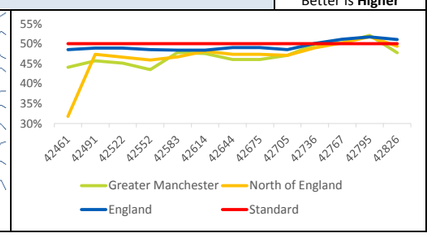
T&G	1.66%
Salford	1.64%
Wigan	1.49%
Oldham	1.46%
Bury	1.43%
Stockport	1.19%
Mancheste	1.10%
Trafford	1.06%
Bolton	0.94%
HMR	0.62%



Improving Access to Psychological Therapies Recovery Rate

Better Is **Higher**

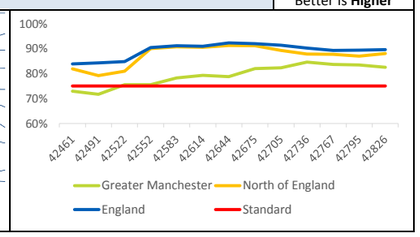
Bolton	60.0%
Wigan	56.1%
Trafford	51.6%
Stockport	51.1%
Bury	50.0%
HMR	50.0%
Oldham	50.0%
Salford	50.0%
T&G	46.4%
Mancheste	29.8%



Improving Access to Psychological Therapies Seen Within 6 Weeks

Better Is **Higher**

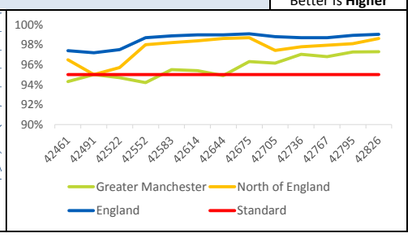
Wigan	100.0%
Oldham	93.3%
HMR	92.3%
Bury	86.2%
Trafford	85.7%
Salford	85.1%
Stockport	81.6%
T&G	79.3%
Bolton	74.1%
Mancheste	59.1%



Improving Access to Psychological Therapies Seen Within 18 Weeks

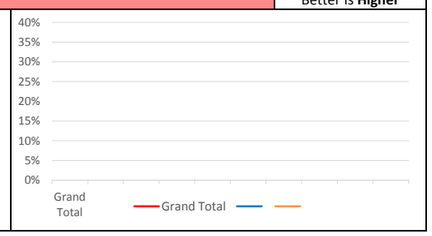
Better Is **Higher**

T&G	100.0%
Oldham	100.0%
Wigan	100.0%
Bury	100.0%
Salford	100.0%
Stockport	98.0%
Trafford	97.1%
Bolton	96.3%
HMR	96.2%
Mancheste	90.9%



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

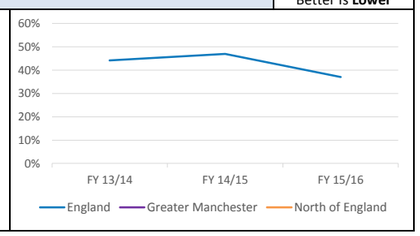
Better Is **Higher**



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

Better Is **Lower**

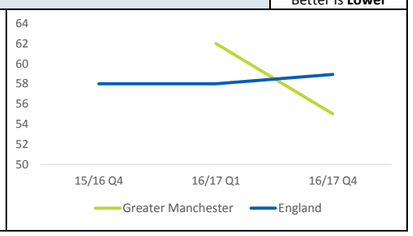
Bolton	64.1%
Bury	47.4%
Central	14.8%
HMR	28.8%
North	40.6%
Oldham	38.7%
Salford	23.1%
South	19.9%
Stockport	27.4%
T&G	41.4%
Trafford	31.9%
Wigan	41.2%



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

Better Is **Lower**

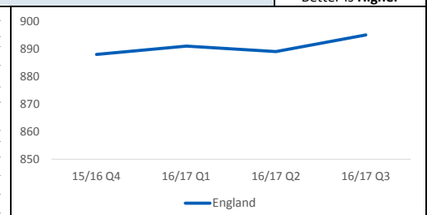
Bolton	55
Bury	55
Central	55
HMR	55
North	55
Oldham	55
Salford	55
South	55
Stockport	55
T&G	55
Trafford	55
Wigan	55



Management Of Long Term Conditions

Better Is **Higher**

Bolton	984
Bury	841
Central	1,640
HMR	1,146
North	1,446
Oldham	1,029
Salford	1,278
South	1,496
Stockport	1,145
T&G	1,382
Trafford	997
Wigan	986



Out Of Area Placements For Acute Mental Inpatient Care - Transformation

Better Is **Higher**

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

Children And Young People's Mental Health Services Transformation

Better Is **Higher**

HMR	90.0%
Trafford	90.0%
South	90.0%
Bury	90.0%
Central	90.0%
Oldham	90.0%
Bolton	85.0%
Wigan	80.0%
T&G	40.0%
North	40.0%
Salford	35.0%
Stockport	35.0%

Crisis Care And Liaison Mental Health Services Transformation

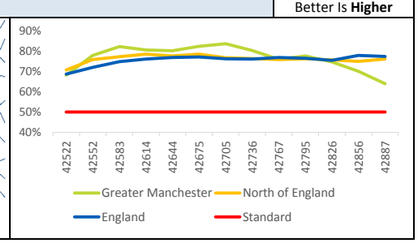
Better Is **Higher**

Salford	97.5%
Trafford	92.5%
Bolton	87.5%
T&G	80.0%
Oldham	80.0%
Bury	77.5%
Stockport	77.5%
HMR	70.0%
Central	67.5%
North	67.5%
South	67.5%
Wigan	60.0%

Early Intervention in Psychosis - Treated Within 2 Weeks Of Referral

Better Is **Higher**

Wigan	100.0%
Salford	100.0%
Bolton	90.0%
Stockport	83.3%
Mancheste	76.2%
Bury	66.7%
Trafford	60.0%
T&G	42.9%
HMR	20.0%
Oldham	18.2%

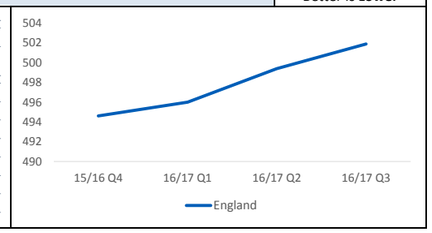


Decreased Need For Hospital Services With More Community Support

Population Use Of Hospital Beds Following Emergency Admission

Better Is **Lower**

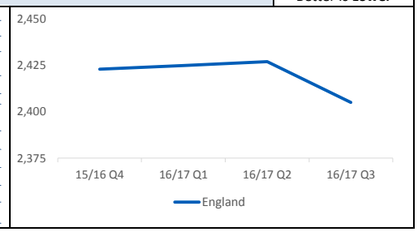
HMR	411.9
Wigan	449.1
Bury	454.3
Oldham	457.1
Bolton	507.5
North	568.5
Salford	604.1
T&G	610.6
Stockport	634.9
South	654.5
Central	703.4
Trafford	723.8



Emergency Admissions For Urgent Care Sensitive Conditions

Better Is **Lower**

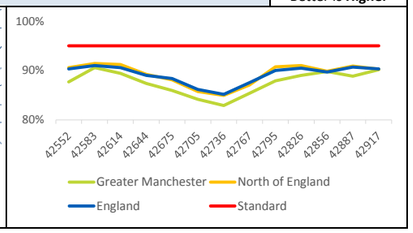
Bury	2,228
Trafford	2,547
Bolton	2,560
Oldham	2,709
HMR	2,739
Wigan	2,925
Stockport	2,974
T&G	3,212
South	3,376
North	3,456
Central	3,550
Salford	3,701



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

Better Is **Higher**

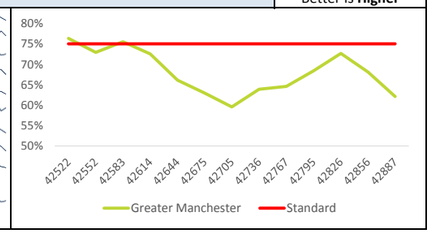
CM NHS FT	94.7%
Tameside N	93.6%
Salford Roy	91.6%
UHSM NHS	91.0%
WWL NHS	89.4%
Bolton NHS	84.8%
Pennine Ac	84.5%
Stockport N	78.3%



Ambulance in Red 1 in 8 mins

Better Is **Higher**

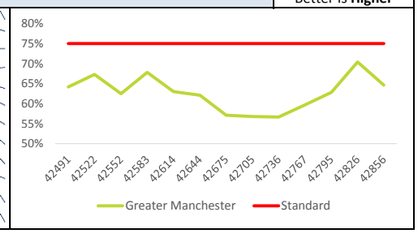
Bolton	62.8%
Bury	63.0%
HMR	65.0%
Oldham	57.5%
Salford	60.7%
Stockport	65.0%
T&G	57.1%
Trafford	42.3%
Wigan	63.8%
Mancheste	66.8%



Ambulance in Red 2 in 8 mins

Better Is **Higher**

Bolton	57.5%
Bury	67.7%
Central	72.6%
HMR	65.1%
North	74.1%
Oldham	66.7%
Salford	63.0%
South	73.5%
Stockport	60.7%
T&G	64.9%
Trafford	54.8%
Wigan	58.8%

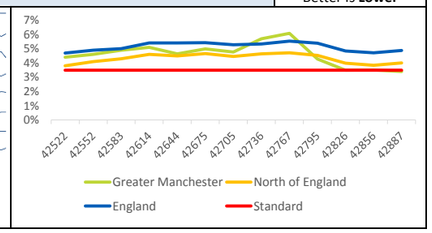


Improved Transition Of Care Across Health And Social Care

Delayed Transfers of Care - Bed Days

Better Is **Lower**

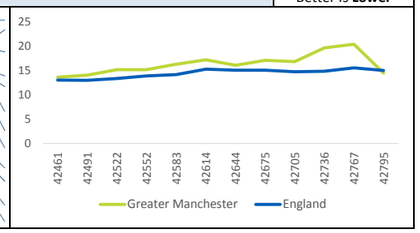
WWL NHS	1.2%
Pennine Ac	2.6%
Bolton NHS	2.9%
CM NHS FT	3.1%
Salford Roy	4.2%
Stockport N	4.6%
Tameside N	4.9%
UHSM NHS	7.8%



Delayed Transfers of Care per 100,000 Population

Better Is **Lower**

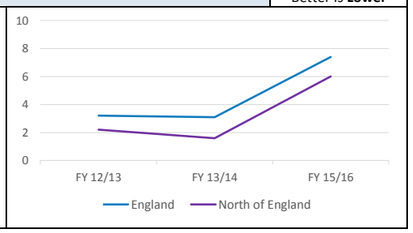
HMR	3.6
Oldham	7.2
Wigan	7.2
Bolton	11.5
Bury	16.3
South	16.9
North	17.9
Central	20.1
T&G	14.8
Salford	17.3
Stockport	12.6
Trafford	33.3



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

Better Is **Lower**

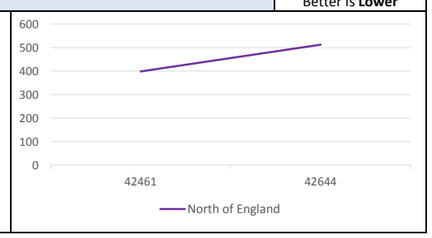
Bolton	4.4
Bury	5.5
Central	7.5
HMR	4.6
North	7.5
Oldham	2.3
Salford	4.2
South	7.5
Stockport	3.6
T&G	6.4
Trafford	14.5
Wigan	4.9



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

Better Is **Lower**

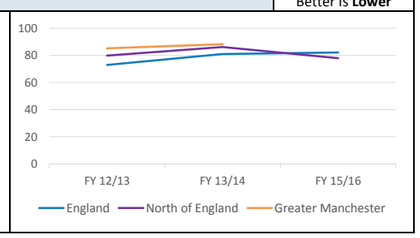
Bolton	496.0
Bury	297.0
Central	473.0
HMR	99.0
North	473.0
Oldham	214.0
Salford	175.0
South	473.0
Stockport	963.0
T&G	1065.0
Trafford	989.0
Wigan	178.0



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

Better Is **Lower**

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



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

Better Is **Lower**

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

Percentage Of People Aged 65+ Discharged Direct To Residential Care

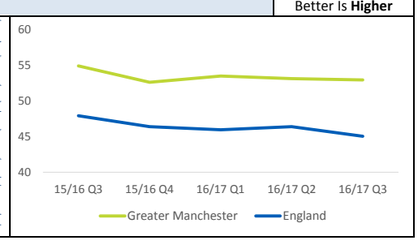
Better Is **Lower**

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

People Eligible For Standard NHS Continuing Healthcare

Better Is **Higher**

Salford	121.4
Wigan	82.2
T&G	63.6
South	63.1
Bolton	61.1
Trafford	60.0
HMR	31.1
North	30.0
Central	27.6
Bury	27.6
Stockport	25.3
Oldham	23.8

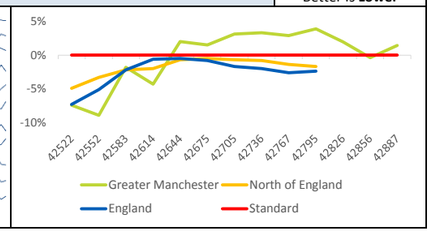


Placeholder TBC

C.Difficile (Ytd Var To Plan)

Better Is **Lower**

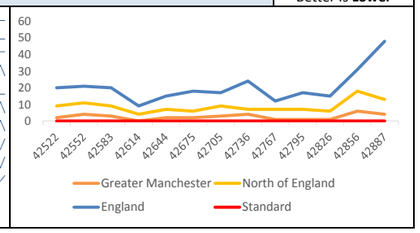
HMR	-34.7%
Wigan	-30.9%
Oldham	-20.9%
Bolton	-20.0%
Trafford	-12.5%
T&G	-5.2%
Mancheste	0.8%
Salford	48.4%
Stockport	50.7%
Bury	77.8%



MRSA

Better Is **Lower**

Salford	0
Stockport	0
Bury	0
T&G	0
HMR	0
Trafford	0
Bolton	0
Oldham	1
Wigan	1
Mancheste	2



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

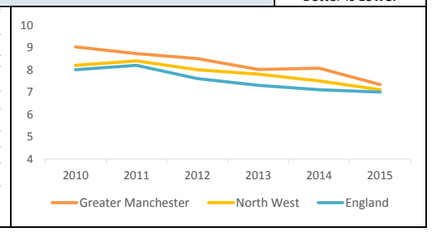
Better Is **Higher**

Bolton	5
Bury	5
Central	5
HMR	5
North	5
Oldham	5
Salford	5
South	5
Stockport	5
T&G	5
Trafford	5
Wigan	5

Neonatal Mortality And Stillbirths

Better Is **Lower**

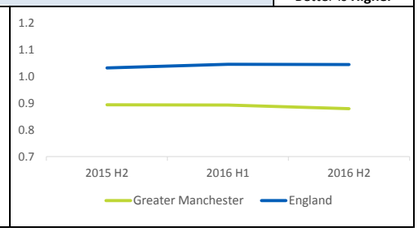
Trafford	3.9
Tameside	4.2
Rochdale	5.2
Wigan	6.1
Oldham	7.2
Bury	7.2
Salford	8.4
Bolton	8.9
Stockport	9.4



Primary Care Workforce

Better Is **Higher**

Salford	1.0
Bolton	1.0
T&G	0.9
Oldham	0.9
Stockport	0.9
Wigan	0.9
Bury	0.9
HMR	0.9
Central	0.8
North	0.8
Trafford	0.7
South	0.8



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

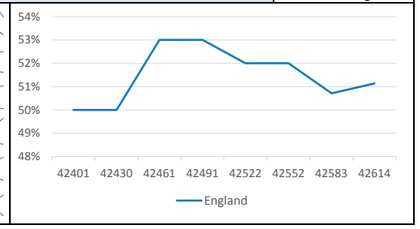
Better Is **Higher**

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**

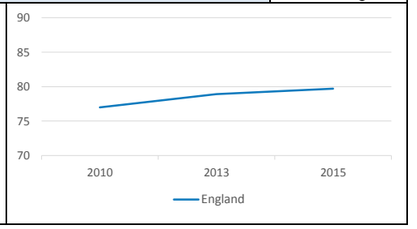
Bolton	99.1%
Bury	69.3%
Central	46.1%
HMR	60.3%
North	72.2%
Oldham	87.1%
Salford	97.7%
South	73.9%
Stockport	61.6%
T&G	10.4%
Trafford	66.3%
Wigan	56.8%



Women's Experience Of Maternity Services

Better Is **Higher**

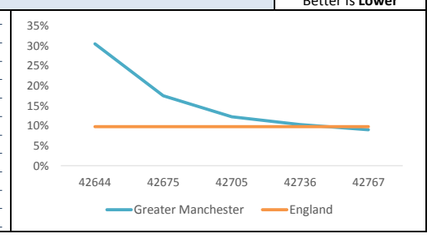
Salford	82.1
Trafford	82.2
Stockport	74.3
North	77.6
Bury	82.3
Bolton	76.9
South	83.5
Wigan	81.9
T&G	82.5
HMR	77.6
Oldham	83.1
Central	80.5



Number of Patients not treated for Atrial Fibrillation

Better Is **Lower**

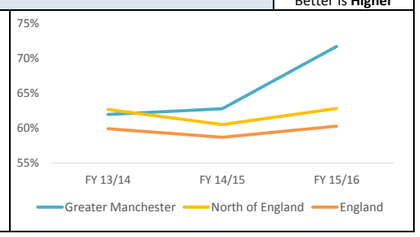
Bolton	7.3%
Bury	4.5%
Central	11.4%
HMR	9.7%
North	10.1%
Oldham	4.6%
Salford	8.4%
South	12.7%
Stockport	9.7%
T&G	10.3%
Trafford	10.4%
Wigan	9.8%



Stroke Unit Within 4 Hours

Better Is **Higher**

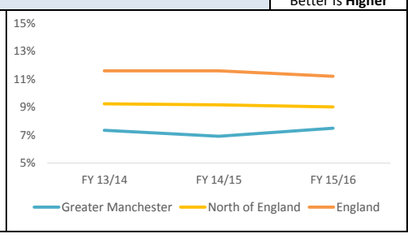
Bolton	76.4%
Bury	75.8%
Central	70.9%
HMR	72.5%
North	71.4%
Oldham	74.3%
Salford	63.3%
South	72.3%
Stockport	74.4%
T&G	66.4%
Trafford	70.5%
Wigan	71.6%



Thrombylised Stroke Patients

Better Is **Higher**

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



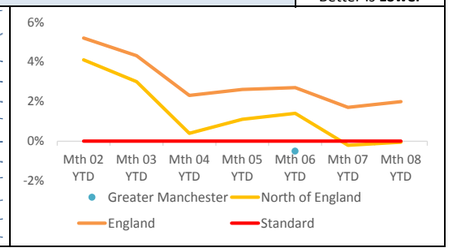
Sustainability

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**

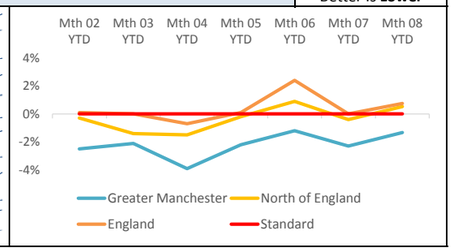
Bolton	14.1%
Bury	1.0%
Central	-6.4%
HMR	0.5%
North	-7.1%
Oldham	1.5%
Salford	-5.4%
South	-2.4%
Stockport	-3.0%
T&G	-5.4%
Trafford	-5.5%
Wigan	3.4%



Activity V Plan: Total OP Attends (Specific Acute)

Better Is **Lower**

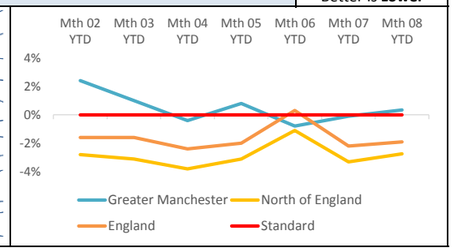
Bolton	3.5%
Bury	0.3%
Central	-4.0%
HMR	2.2%
North	1.0%
Oldham	-3.8%
Salford	3.2%
South	-5.2%
Stockport	-2.5%
T&G	-10.0%
Trafford	-5.9%
Wigan	6.8%



Activity V Plan: Total Elective Spells (Specific Acute)

Better Is **Lower**

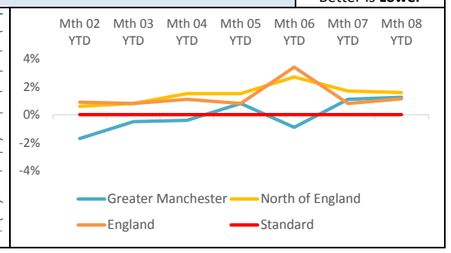
Bolton	6.1%
Bury	1.0%
Central	7.5%
HMR	-3.3%
North	-3.3%
Oldham	-5.1%
Salford	3.2%
South	1.6%
Stockport	5.8%
T&G	-13.1%
Trafford	3.2%
Wigan	2.0%



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

Better Is **Lower**

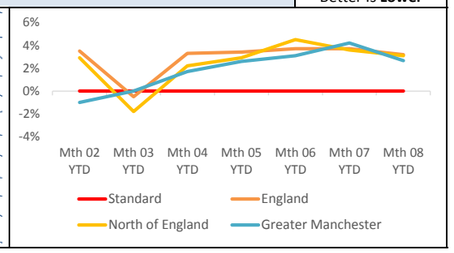
Bolton	1.9%
Bury	6.0%
Central	2.1%
HMR	4.3%
North	-1.5%
Oldham	-1.6%
Salford	3.3%
South	6.7%
Stockport	-2.6%
T&G	-5.5%
Trafford	-0.4%
Wigan	9.2%



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	77.1%
Oldham	74.5%
Salford	72.6%
Bury	72.1%
South	70.8%
North	70.3%
HMR	69.3%
Stockport	67.9%
Wigan	66.8%
Trafford	63.8%
Central	59.7%
T&G	52.6%

Financial Plan 16/17

		In-Year Financial Performance 16/17 Q3	In-Year Financial Performance 16/17 Q4	-
				Better Is **Green**
Bolton	#REF!	Green	Green	◀▶
Bury	#REF!	Green	Green	◀▶
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!	Green	Green	◀▶
T&G	#REF!	Green	Green	◀▶
Trafford	#REF!	Red	Amber	▲
Wigan	#REF!	Green	Green	◀▶

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**

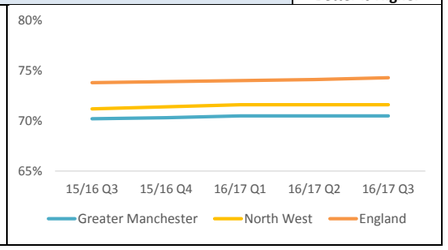
Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

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**

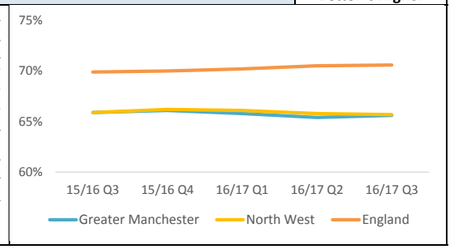
Trafford	79.8%
Stockport	78.6%
Wigan	75.3%
Bury	72.3%
Bolton	71.1%
Tameside	70.3%
Salford	69.5%
Oldham	68.6%
Mancheste	63.3%
Rochdale	62.5%



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%



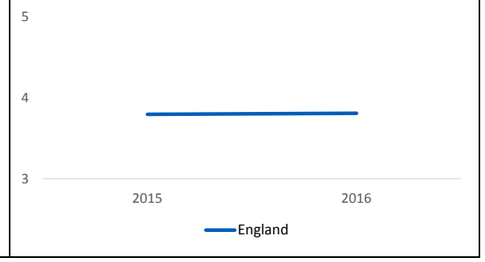
Well Led

Placeholder TBC

Staff Engagement Index

Better Is **Higher**

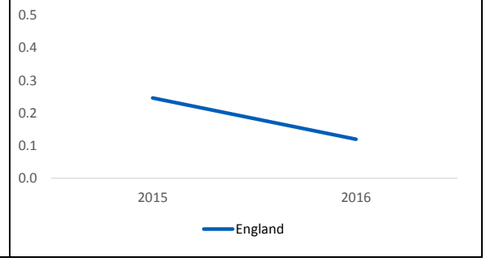
Wigan	3.9
T&G	3.9
Bolton	3.9
Central	3.8
Stockport	3.8
Trafford	3.8
South	3.8
Salford	3.8
Bury	3.7
North	3.7
HMR	3.7
Oldham	3.7



Progress Against Workforce Race Equality Standard

Better Is **Lower**

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



Effectiveness Of Working Relationships In The Local System

Better Is **Higher**

Bolton	71.9
Bury	62.5
Central	64.5
HMR	68.0
North	63.1
Oldham	67.8
Salford	70.0
South	62.6
Stockport	70.2
T&G	66.9
Trafford	66.3
Wigan	70.3

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

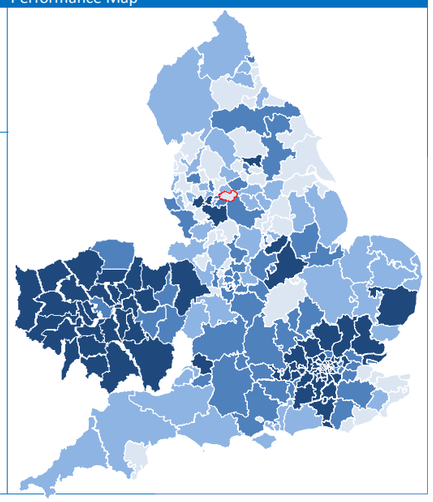
The 10 closest CCGs to NHS Tameside and Glossop CCG

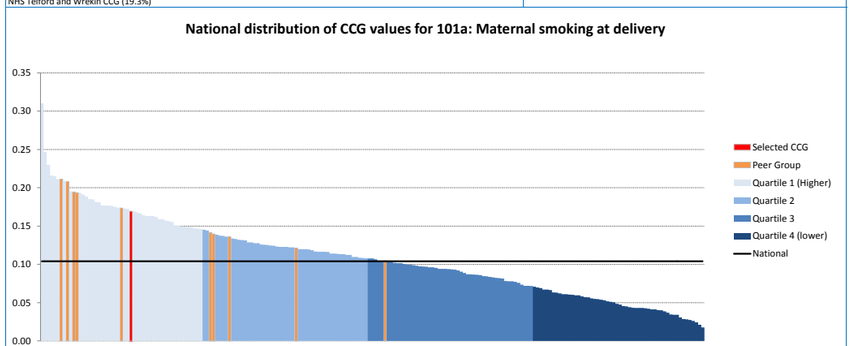
NHS Rotherham CCG (12.1%)
NHS Stoke on Trent CCG (19.4%)
NHS Bury CCG (10.5%)
NHS Wakefield CCG (20.8%)
NHS Hartlepool and Stockton-on-Tees CCG (14.1%)
NHS Barnsley CCG (14.0%)
NHS St Helens CCG (13.6%)
NHS Halton CCG (17.3%)
NHS South Tees CCG (21.1%)
NHS Telford and Wrekin CCG (19.3%)

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

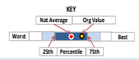




Please Note: If indicator is highlighted in GREY, this indicator will be available at a later date

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) fc	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:	26 September 2017
Officer of Single Commissioning Board	Jessica Williams – Interim Director of Commissioning
Subject:	**SAVINGS ASSURANCE : GRANTS REVIEW**

Report Summary:

This report follows the agreement at the Single Commissioning Board in June 2017 that a decision on Grant Funding should be delayed until the outcome of the Asset Based Grant developments are known on the basis that there may be duplication. All grant funded voluntary sector schemes were therefore informed that their funding would be extended by a further 3 months until 30 September 2017.

Further work has been done to:

- Understand the basis for the Asset Based Grant scheme;
- Identify schemes where there may be duplication;
- Identify opportunities for alternative approaches to commissioning.

The outcomes of this are presented in the report.

Recommendations:

It is recommended that the Single Commissioning Board:

1. Note there is expected to be little overlap between the new Asset Based Approach programme grants and the Single Commission Voluntary and Community Sector Grants.
2. Recognise that as the Asset Based Approach Programme is very new it is not possible to predict the need for grant funding that will be identified through Social Prescribing until the programme has been operational for some time.
3. Recognise the value of the Voluntary and Community Sector in achieving Care Together aims and the need for the revised Voluntary and Community Sector Compact to be embraced by the whole system to support a thriving voluntary and community sector.
4. Agree to the recommendations in terms of each Voluntary and Community Sector Grant allocation outlined in **Appendix 2.**

Financial Implications:

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

Budget Allocation (if Investment Decision)	Details provided within Appendix 2
CCG or TMBC Budget Allocation	CCG and TMBC
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75 and Aligned
Decision Body – SCB, Executive Cabinet, CCG Governing Body	Single Commissioning Board (Section 75) and Executive Cabinet (Aligned)

Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Savings and expenditure avoidance via the provision of a social prescribing / self management service delivered via a vibrant and sustainable Voluntary and Community sector.
Additional Comments It is essential that all existing investment within the voluntary and community sector is subject to ongoing review to ensure that commissioning intentions are delivered and that the sector is able to deliver a sustainable service which contributes towards the aims of Care Together. Alternative options will need to be developed where efficiencies are not expected to be realised to ensure investment is affordable within Care Together resources.	

Legal Implications: (Authorised by the Borough Solicitor)	As a public body the Single Commissioning Board must constantly be aware of the need to ensure value for money through effective monitoring of contracts and grant spending. Members must by law have regard to the Equality Impact Assessment attached to this report before making their decision.
How do proposals align with Health & Wellbeing Strategy?	The proposal to maintain a vibrant Voluntary and Community sector supports the Health and Wellbeing Strategy
How do proposals align with Locality Plan?	Investment within the Voluntary and Community sector is a key part of our Locality Plan to promote community, peer support and self-care and alternatives to statutory provision.
How do proposals align with the Commissioning Strategy?	The proposal contributes to the Commissioning Strategy by reviewing investment against priorities.
Recommendations / views of the Professional Reference Group:	The Professional Reference Group recommended that the Single Commissioning Board agree the recommendations in this paper.
Public and Patient Implications:	The risks to public and patients where grants are reduced are highlighted within the paper.
Quality Implications:	There are potential risks to quality where grants are reduced.
How do the proposals help to reduce health inequalities?	The work to align the total of the Single Commission investment against themes will provide clarity on investment against healthy inequalities.
What are the Equality and Diversity implications?	Depending on the decision regarding grant investment there may be an effect on services for protected characteristic group(s) within the Equality Act and an Equality Impact Assessment/s will be required before any reductions can be enacted.
What are the safeguarding implications?	None.

What are the Information Governance implications?	None.
Has a privacy impact assessment been conducted?	No.
Risk Management:	The risks of grant reductions to Voluntary and Community Sector organisations are highlighted in the report however further work will be required to ensure that the risks associated with any reductions are mitigated.
Access to Information :	The background papers relating to this report can be inspected by contacting Pat McKelvey, by: Telephone: 07792 060411 e-mail: pat.mckelvey@nhs.net

1.0 BACKGROUND

1.1 As part of the savings assurance process all NHS and Council investment and contracts have been reviewed to identify opportunities to contribute towards the gap in 2017/18 and ensure effective investment going forward. Voluntary and Community sector grants and Service Level Agreements were also reviewed.

1.2 A Voluntary and Community sector grants report was presented to the Single Commissioning Board in June 2017 and it was agreed that no decisions about Voluntary and Community sector investment should be made until the outcomes of the Social Prescribing and Asset Based Approaches Programme are known in case there are duplications. The Single Commissioning Board agreed that Voluntary and Community sector grants were extended for a further 3 months to 30 September 2017.

1.3 An exploration of the Asset Based Grants Programme has shown that :

- It is unlikely that there will be any duplication;
- It will be some time before the grants are in place.

1.4 Concerns about duplication are unfounded as the small grants awarded through the ABA Programme will be provided to support unmet needs identified through the findings from Social Prescribing and aim to promote community development, not provide statutory functions. Decisions on funding through the asset based approach and social prescribing programmes will be taken by an investment board with representation from the sector, patients, members of the public, the Integrated Care Foundation Trust and the Single Commission and all learning captured.

1.5 A Summary of the programme is provided in **Appendix 1**.

2 GREATER MANCHESTER DEVELOPMENTS

2.1 The Greater Manchester Health and Social Care Partnership has established a new Person and Community Centred Approaches Programme initiated through the population health plan. The full programme is in development but the scope includes person centred planning, community and asset based approaches; self-care and personal budgets. It is anticipated that this will align with our local model however additional learning may support new ways of working with the third sector.

3 SINGLE COMMISSION VCS GRANTS

3.1 The Single Commission has been funding a range of services that provide a valuable contribution to the health and social care through Conditional Grants or Service Level Agreements. The funding has been based on NHS England regulations that support Clinical Commissioning Groups to use grants 'to provide financial support to a voluntary organisation which provides or arranges for the provision of services which are similar to those in respect of which the Clinical Commissioning Group has statutory functions'.

The Schemes funded through Grants or Service Level Agreements are detailed in **Appendix 2**.

3.2 The Voluntary and Community organisations were engaged in an exercise to examine the impact of a 5%, 10% and 15% reduction in grant funding and all highlighted pressures across the sector.

4. PROPOSED WAY FORWARD

4.1 On the basis that:

- The priorities for grants from the Asset Based Approach Grants Programme will not be known until 2018;
- The Voluntary and Community Sector Compact is still under development;
- New approaches to commissioning from the Voluntary and Community Sector are underway (as indicated in the proposed actions section of **Appendix 2**);
- Learning will emerge from the Greater Manchester Person and Community Centred Programme

It is proposed that Voluntary and Community Sector Grant and Service Level Agreement funding is maintained at the 2016/17 level in 2017/18 for most organisations except where a reduction has been proposed as detailed in **Appendix 2**.

5. RECOMMENDATIONS

5.1 As stated on the front of the report.

APPENDIX 1

CARE TOGETHER SYSTEM WIDE SELF-CARE PROGRAMME

Within Care Together the Integrated Care Foundation Trust (ICFT) has established a System Wide Self-Care Programme. This includes the following schemes:-

- Social Prescribing Service
- Asset Based Approaches (ABA) Programme

In Glossop the schemes were awarded to The Bureau (previously Glossop Volunteer Centre) and the service commenced on 1 April 2017.

The Tameside schemes were tendered by the ICFT earlier this year and both were awarded to Action Together. It is expected that the Social Prescribing Service will be accepting referrals in October/November 2017 and the grant scheme by late 2017.

The basis of the Asset Based Approaches (ABA) Programme is to support the communities in Tameside and Glossop to utilise their own assets to take action to tackle the issues that affect their lives. It will be underpinned by a new relationship between the 'system' and communities and strategic investment in the voluntary, community and faith sector to develop activity and interventions that have a positive impact on people's health and wellbeing.

While the programme includes the provision of grants these are not intended to replace existing services but are to fund the development of new community-based services that fill gaps in provision, and to enable existing services to expand to meet additional demand.

The programme aims to develop, embed and deliver asset based approaches and principles across the four neighbourhoods of Tameside, and Glossop, building a resilient network of voluntary and community groups that enhance people's health and wellbeing. It is expected the investment from this programme will be predominantly distributed to voluntary, community and faith sector organisations to deliver work as outlined in the service specification.

The programme is a vehicle for investment in the voluntary and community sector to fund a range of activities that:

- Support people to achieve positive health and wellbeing outcomes;
- Are underpinned by an identified need and engagement with people across Tameside;
- Target groups of the population who access or are at risk of significant health and/or social care activity;
- Harness the power of communities to solve their own problems and work collaboratively with statutory agencies to do so.

The combined value of the ABA and Social Prescribing Programmes over the three year duration of the ICFT contract is £2,592,666. Approximately 52% of this figure will be made available to the VCS in the form of grants, small contracts and spot purchasing of support linked to social prescribing.

The proposition in Glossop is structured differently to take account of the geographical and political differences alongside the different VCS structures that exist. Over the three year period the total value of the ICFT contract is £390,000 of which approximately 30% will be made available to the VCS in the form of grants, small contracts and spot purchasing. The model is different, which accounts for the different percentage.

ABA Programme Outcomes

The ABA Programmes in Tameside and Glossop will be monitored against delivery of the following key outcomes.

- Community networks are strengthened along with relationships that can provide caring, mutual help and empowerment. This to be clearly linked to identified need in each of the Tameside Neighbourhoods.
- A culture is supported where community and voluntary organisations can flourish, work well together and actively participate in and have greater control over resources in their community. Support organisations to develop sustainable models of delivery.
- Voluntary, community and faith sector organisations are resourced to deliver services that are informed by thorough needs identification and public involvement. Activities should have a positive impact on residents' health and wellbeing which in turn will reduce activity across the health and care system;
- An environment will be created where there is ongoing conversation between communities and statutory services to co-design solutions to the issues affecting the neighbourhoods of Tameside.

The ICFT is commissioning an academic partner to evaluate the impact of the Programme.

APPENDIX 2

VCS Savings Assurance Grants

Theme	Provider	2016/17 Grant Value	2017/18 Proposed Grant Value	Comments
Grants where savings have already been identified/other funding streams				
MH	42nd Street	£49,500	£17,000*	*NB - Grant remains at £49,500 but now funded from ring-fenced CAMHS budget so saves £32,500 from CCG.
Health & Wellbeing	Age UK Tameside Falls Service	£34,400	£31,000	10% saving has been agreed with Provider as part of Falls Review
EOL children	Francis House	£18,000	£15,300	15% reduction has been agreed with Provider
OP	Age UK (Tameside)	£83,160	£83,160	20% reduction in core funding over last 3 years.
OP	Age UK (Tameside)	£55,922	£55,922	20% reduction in core funding over last 3 years.
Children's	Home-Start PIMH Glossop	£20,000	£20,000	Funded from ring-fenced CAMHS Local Transformation Plan so cannot be reduced
Time Banking	Action Together	£16,000	£15,200	5% reduction is proposed as Time Banking has had limited success so the service has been redesigned within the Action Together core offer - this will deliver the overall saving required.
Transport	Action Together: CCG	£51,000	£46,000	Reduction proposed for Miles of Smiles based on update in 2016/17. Proposed that this funding is included in the supported transport review described below.

Theme	Provider	2016/17 Grant Value	Proposed actions
Grants where no savings are proposed for 2017/18 – values to remain at 2016/17 allocations			
VCS Infrastructure	Action Together Tameside	£48,280	Proposed that VCS infrastructure is maintained to support capacity to work in partnership
VCS Infrastructure	High Peak CVS	£10,700	Proposed that VCS infrastructure is maintained to support capacity to work in partnership
EoL Specialist Dementia Nurse	Tameside and Glossop Hospice Limited (Willow Wood)	£57,000	Propose that this funding is included in the redesign of dementia services in the neighbourhoods.
Children's	Action Together Parent Carer respite	£100,000	Propose the investment of this funding is taken forward within the Carer Strategy.
MH	Age UK - Serious Mental Illness step down	£105,404	Propose that this service is considered as a contract in the future, potentially under the remit of Pennine Care Older Peoples Mental Health team
Children's	Home-Start Parent Infant Mental Health	£40,742	Potential for this to be included within the Public Health HomeStart contract to be explored.
MH	LGBT Foundation for counselling	£10,396	There is a plan for this service to be commissioned at a GM level
Stroke	Stroke Association	£94,472	This grant is on the list for transfer to the ICFT to be managed by the Stroke Rehab team.
EOL plus	Tameside and Glossop Hospice Limited (Willow Wood)	£569,462	Potential to move this onto an NHS Standard Contract to be explored.

Theme	Provider	2016/17 Grant Value	Proposed actions
MH	Tameside Oldham and Glossop Mind – counselling and information	£131,850	It is proposed that the counselling element of this SLA is included within the Care Together mental health in the neighbourhood development.
Transport	Action Together: TMBC	£13,000	It is proposed that the requirements for supported transport are reviewed and tendered to ensure the same approach is used for all residents of T&G taking into account all existing funding.
Transport	Glossop Volunteer Centre Car Scheme	£15,148	
Transport	Transport for Sick Children	£9,000	
EOL	Marie Curie Cancer Care Overnight sitting service	£45,675	Proposed to maintain this grant
Selfcare Education	Self Management Education	£27,403	Proposed all funding is retained and used within ICFT to support Self Care Education College development to achieve better VFM.

APPENDIX 3

Subject / Title	Savings Assurance: Voluntary Community Sector Grants

Team	Department	Directorate
MH and LD Commissioning Team	Commissioning	Commissioning

Start Date	Completion Date
30.6.17	ongoing

Project Lead Officer	Pat McKelvey
Director	Clare Watson

EIA Group (lead contact first)	**Job title**	**Service**
Pat McKelvey	Head of Mental Health and Learning Disabilities	Commissioning Team
Chris Easton	Head of Strategy Development	ICFT
Trevor Tench	Service Unit Manager	Commissioning Team

PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	Savings Assurance: Voluntary Community Sector Grants
1b.	**What are the main aims of the project, proposal or service / contract change?**	As part of the Single Commission Savings Assurance process a project team has been tasked with identifying savings within the Single Commission Voluntary Community Sector Grants/Service Level Agreements. A number of schemes have been identified where there are fewer risks to increasing costs elsewhere in the system if reductions are made, as detailed in the accompanying paper. The proposed changes to grant values are as follows:-

Proposed changes to VCS Grant funding

Theme	Provider	Grant value 16/17	Proposed Grant Value
End of Life	Tameside and Glossop Hospice Limited (Willow Wood) Specialist Dementia Nurse	£57,000	£55,000
Mental Health	Age UK - SMI step down	£105,404	£100,134
Mental Health	LGBT Foundation for counselling	£10,396	£9,876
Children's	Home-Start Parent Infant Mental Health	£40,742	£38,705
Children's	Action Together Parent Carer respite	£100,000	£95,000
Stroke	Stroke Association	£94,472	£89,748
Transport – Miles of Smiles	Action Together: CCG	£51,000	£46,000

August 2017

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

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age		x		The proposed changes to Grant funded services may have an impact on people of different ages.
Disability	x			The proposed changes may affect people with a disability – Stroke Association, Children with Disabilities Parent Carer respite and people with mental health needs.
Ethnicity			x	No direct impact is anticipated in terms of ethnicity
Sex / Gender			x	No direct impact is anticipated in terms of sex/gender
Religion or Belief			x	No direct impact is anticipated in terms of religion/belief
Sexual Orientation		x		A reduction in the small grant to the LGBT Foundation may have an impact on LGBT people
Gender Reassignment			x	No direct impact is anticipated in terms of gender reassignment
Pregnancy & Maternity		x		A reduction in the Parent Infant Mental Health grant to Home Start may have an impact on families in pregnancy and early years
Marriage & Civil Partnership			x	No direct impact is anticipated for those who are married or who are in a civil partnership

NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health	**X**			Reductions in mental health grants may have an impact on services for people with mental health needs
Carers	**x**			Reductions in the Children with Disability Parent Carer Respite grant may impact on carers
Military Veterans			**x**	No direct impact is anticipated in relation to military veterans
Breast Feeding		**X**		No direct impact is anticipated in terms of breastfeeding but there is an indirect link to the Parent Infant Mental Health grant.
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**
People on low income/with disabilities/long term conditions/ who need support to travel to appointments		**x**		Volunteer car schemes support attendance at health appointments thereby reducing missed appointments

1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
		x	
1e.	**What are your reasons for the decision made at 1d?**	The proposal to reduce grant funding to some schemes requires a full EIA.	

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary
On the completion of part 1, a need has been identified for a full Equality Impact Assessment (EIA) to be undertaken. The decision to complete a full EIA has been made because the project has been identified as having an impact on a number of protected characteristic groups.

2b. Issues to Consider
Reducing funding to Voluntary and Community Sector organisations may • Impact on the organisations ability to provide quality services • Impact on the organisations financial viability • Result in a reputational risk to the Single Commission/negative media coverage/complaints • Impact on the positive partnership working between the VCS and statutory sector.

2c. Impact
With the need to make significant savings difficult decisions have to be made in all health and social care organisations. VCS providers were asked to complete a matrix showing the impact of reductions on the schemes that are grant funded. This information will be used to work with each provider to agree how the impact of the reduced funding can be managed.

2d. Mitigations *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
Impact on the positive partnership working between the VCS and statutory sector.	The reductions in grant funding will be offset by the commitment to continue to invest in schemes that are delivering high impact areas within Care Together. The development of the whole system VCS Compact will provide reassurance about the nature and scope of the relationships going forward.
Impact on the organisations ability to provide quality services	All Grant Agreements will be revised in light of the funding. This will include the review of expectations and monitoring arrangements, aiming to identify and mitigate any risks together.
Impact on the organisations financial viability	Single Commission Leads will offer support to explore options to reduce costs/increase income.
Result in a reputational risk to the Single Commission/negative media coverage/ complaints	Clear communication to all VCS providers about the financial challenges facing the NHS and Council and the need for all organisations to make efficiencies.

2e. Evidence Sources – included in the box below are documents that are available to mitigate risks as explained in 2d
Savings Assurance Templates for the following services:- • Tameside and Glossop Hospice Limited (Willow Wood): Specialist Dementia Nurse • Age UK : Serious Mental Illness day support • LGBT Foundation: Counselling • Home-Start: Parent Infant Mental Health • Action Together: Parent Carer respite • Stroke Association • Action Together: Miles of Smiles Transport

2f. Monitoring progress		
Issue / Action	**Lead officer**	**Timescale**
Lead commissioner for each Grant funded scheme will work with the providers to rewrite the Conditional Grant Agreement in line with the changes in funding.	As per lead commissioner	1st October 2017

Signature of Contract / Commissioning Manager	**Date**
Pat McKelvey	21.7.17
Signature of Assistant Director / Director	**Date**

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Report to: **SINGLE COMMISSIONING BOARD**

Date: 26 September 2017

Officer of Single Commissioning Board Jessica Williams – Interim Director of Commissioning

Subject: **ATRIAL FIBRILLATION IN PRIMARY CARE**

Report Summary:

Atrial Fibrillation is a common heart condition which causes an irregular and often abnormally fast heart rate. It can increase the risk of a blood clot forming inside the heart. If the clot travels to the brain, it can lead to a stroke. Atrial Fibrillation increases stroke risk by around four to five times.

Single Commission officers and clinical leads are members of the Tameside and Glossop Heart Disease Programme Board. This group is led by Tameside and Glossop Integrated Care Foundation Trust, and reports via the Trust's governance through the Director of Operations.

The Heart Disease Programme Board identified Atrial Fibrillation as a priority area for their 2016-17 programme of work. As a result, a pathway for Atrial Fibrillation management was developed and approved via the Professional Reference Group and Single Commissioning Board in January 2017.

The Single Commission members of the Heart Disease Programme Board have been tasked with taking forward further work to address the identification and management of patients with Atrial Fibrillation in primary care. The proposal for doing this is outlined in this report. The purpose of the report is to provide an update on action taken to date and a summary of the proposed activities for 2017-18, with a view to seeking Single Commissioning Board support for the project.

Recommendations: That the Single Commissioning Board supports the project outlined in this report and proceeds as described.

Financial Implications:

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

Budget Allocation (if Investment Decision)	No funding in ICF, but external funding available to implement.
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Full determination of the value for money requires more information. But if scheme is funded externally and this ultimately results in reduced number of strokes VFM should be good, even if GP prescribing costs do increase.

	Additional Comments Finance Task and Finish group support this proposal, which links well with the strategic objectives of care together. It does not require up front funding from the Clinical Commissioning Group, and it has the potential to reduce the number of strokes. As referenced in section 5.5 of the document, the ownership of the equipment will be confirmed before distribution, and it is recommended that the practices are the owners of the equipment. There is no additional funding for the replacement, maintenance or calibration of the equipment and this will be confirmed with the practices prior to distribution.
Legal Implications: **(Authorised by the Borough Solicitor)**	The proposals if agreed and as set out in this report should be effectively monitored to ensure compliance with targets in achieving improved outcomes and reducing the costs to the system. Members must by law have regard to the Equality Impact Assessment attached to this report before making their decision.
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?	The proposals align with the Locality Plan through the delivery of improved early identification and management of conditions which will reduce the incidence and long term impact of stroke and long term health conditions.
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. The improved identification and management of AF and therefore the associated improvement in quality of life and reduction in the incidence of strokes aligns with the locality Commissioning Strategy.
Recommendations / views of the Professional Reference Group:	The Professional Reference Group supported the proposal, with the recommendation that the training element of the project focuses on the practical delivery of the project's aims and objectives, and not on the theory of the management of Atrial Fibrillation and the improved outcomes this can deliver. The financial comments were also reiterated, with assurance sought and given that the ownership of the equipment would be with the Practices, and therefore no financial consequences for the Clinical Commissioning Group / Single Commission relating to capital assets.
Public and Patient Implications:	The proposal has been developed with input from Patient Neighbourhood group representatives. We will continue to ensure engagement with / involvement of patients and the public in this project. We have included patient / user feedback and satisfaction reporting in the project objectives.

Quality Implications:	Quality Impact Assessment attached.
How do the proposals help to reduce health inequalities?	The incidence of Atrial Fibrillation increases with age. By identifying Atrial Fibrillation early, and by supporting and managing people appropriately, it will ultimately reduce the number of people who would go on to have a stroke
What are the Equality and Diversity implications?	Equality Impact Assessment attached.
What are the safeguarding implications?	The process outlined in this paper focuses on the delivery of care by the Tameside and Glossop member practices, therefore is covered by the existing safeguarding arrangements in place with General Practice. There is no expectation that this project will involve any safeguarding implications.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	This proposal is to be presented to the Information Governance Strategy Group to ensure all elements of IG have been identified and addressed, and the necessary assurance provided, particularly in relation to the practice review process.
Risk Management:	The project will ensure any potential risks are identified and monitored / reviewed, via the Clinical Commissioning Group risk management processes, and reporting to the Clinical Commissioning Group and / or Heart Disease Programme Board as appropriate.
Access to Information :	The background papers relating to this report can be inspected by contacting Alison Lewin, Deputy Director of Transformation  Telephone: 07979 713019  e-mail: alison.lewin@nhs.net

1 BACKGROUND AND INTRODUCTION

1.1 Atrial Fibrillation is a common heart condition which causes an irregular and often abnormally fast heart rate. It can increase the risk of a blood clot forming inside the heart. If the clot travels to the brain, it can lead to a stroke. Atrial Fibrillation increases stroke risk by around four to five times.

1.2 Single Commission officers and clinical leads are members of the Tameside and Glossop Heart Disease Programme Board. This group is led by Tameside and Glossop Integrated Care Foundation Trust, and reports via the Trust's governance through the Director of Operations.

1.3 The Heart Disease Programme Board identified Atrial Fibrillation as a priority area for their 2016-17 programme of work. As a result, a pathway for Atrial Fibrillation management was developed and approved via the Professional Reference Group and Single Commissioning Board in January 2017.

1.4 The NHS Right Care pathway for circulation has identified Atrial Fibrillation prevalence as an area where Tameside and Glossop are outliers in relation to the 10 comparator Clinical Commissioning Groups (see section 3 below) and where there are opportunities for improvement from a an outcome and financial perspective.

1.5 The Single Commission members of the Heart Disease Programme Board have been tasked with taking forward further work to address the identification and management of patients with Atrial Fibrillation. The proposal for doing this is outlined in this report. The purpose of the report is to provide an update on action taken to date and a summary of the proposed activities for 2017-18, with a view to seeking Single Commissioning Board support for the project.

2 WHAT IS ATRIAL FIBRILLATION[1]

2.1 Atrial Fibrillation is a common heart condition which causes an irregular and often abnormally fast heart rate. It can increase the risk of a blood clot forming inside the heart. If the clot travels to the brain, it can lead to a stroke. Atrial Fibrillation increases stroke risk by around four to five times. However, with appropriate treatment the risk of stroke can be substantially reduced. Anti-coagulant (blood thinning) drugs like warfarin and a newer class of drugs called NOACS are the most effective treatments to reduce the risk of stroke in people with Atrial Fibrillation.

2.2 Sometimes Atrial Fibrillation does not cause any symptoms and a person with it is completely unaware that their heart rate is not regular

2.3 The cause is not fully understood but it tends to occur in certain groups of people and may be triggered by smoking, drinking alcohol, and is more common as people get older. It is the most common form of heart rhythm disturbance.

2.4 Atrial Fibrillation can affect adults of any age, but it becomes more common as you get older. It affects about 7 in 100 people aged over 65, and more men than women have it. Atrial fibrillation is more likely to occur in people with other conditions, such as high blood pressure (hypertension). It can be treated, with the most effective method to reduce using medication.

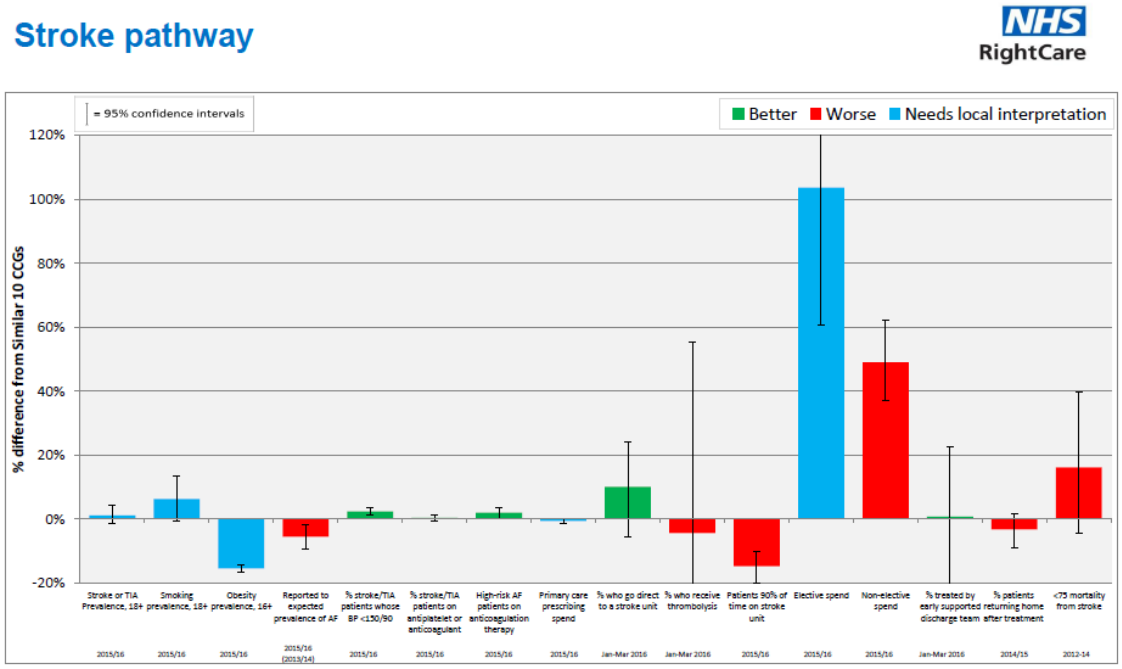
[1] http://www.nhs.uk/conditions/Atrial-fibrillation/Pages/Introduction.aspx
https://www.bhf.org.uk/heart-health/conditions/atrial-fibrillation

2.5 Although Atrial Fibrillation can greatly increase the risk of stroke, there are other lifestyle factors that can contribute to a stroke. These include smoking, high cholesterol, high blood pressure, physical inactivity, obesity and diabetes

3 THE CASE FOR CHANGE: TAMESIDE AND GLOSSOP STROKE AND ATRIAL FIBRILLATION DATA

3.1 This section outlines a sample of data sources which indicate why the identification and management of Atrial Fibrillation in primary care is an issue in Tameside and Glossop, and one which needs to be addressed.

3.2 The NHS Right Care data and Stroke pathway shows that Tameside and Glossop are an outlier, when compared with the 10 'comparator Clinical Commissioning Groups', for the reported to expected level of Atrial Fibrillation.



3.3 The General Practice Quality Outcome Framework includes data on the incidence, prevalence and management of AF in primary care. The 2015-16 report indicates that there were 4014 patients on an AF register[2] in Tameside and Glossop, with an average Tameside and Glossop prevalence of 1.52%. 12 Tameside and Glossop practices had a reduction in numbers of patients on AF registers in 2015/16 compared to the previous year (2014-15). According to the 2015-16 Quality Outcome Framework data, there is significant variation in the prevalence in Tameside and Glossop Practices, with prevalence ranging from 0.38% to 2.53%.

3.4 There were two Atrial Fibrillation Quality Outcome Framework indicators in 2015/16:

AF006 - The *percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more).*

All practices achieved maximum points, however, 53 patients were exception coded; and 82 patients did not receive treatment for this indicator. Exceptions per practice ranged from 10 patients in one practice and 0 exceptions in other practices.

[2] http://www.content.digital.nhs.uk/catalogue/PUB22266/qof-1516-prev-ach-exc-cv-prac-v2.xlsx

AF007 - In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy

All practices achieved maximum points, however, 228 were exception coded and 177 were either not treated or exception coded. Exceptions per practice ranged from 25 patients in one practice to 0 exceptions in other practices.

Practice achievement of Quality Outcome Framework indicators is measured according to the percentage of relevant patients who are treated in a certain way, or who have certain outcomes resulting from care provided by the practice. The Quality Outcome Framework includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. Patient exception reporting applies to those indicators in the clinical domain of the Quality Outcome Framework where level of achievement is determined by the percentage of patients receiving the designated level of care.

3.5 With the Practices' agreement the Clinical Commissioning Group are carrying out remote access reviews of current figures relating to Practices' Atrial Fibrillation data to ensure an up to date baseline is available at the start of the project.

3.6 The Sentinel Stroke National Audit Programme is the single source of stroke data in England, Wales and Northern Ireland. The clinical audit collects a minimum dataset for stroke patients in England, Wales and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of 6 month assessment. Data is reported at a provider and commissioner level. Data for the registered population of Tameside and Glossop on the incidence of strokes is as follows:

	2013-14	2014-15	2015-16	2016-17
Number of strokes	379	361	402	340
Gender				
Female	206	160	186	160
Male	173	201	216	180
Age				
<60	61	64	73	47
60-69	70	50	77	70
70-79	107	112	109	106
80-89	109	111	106	93
90+	32	24	37	24

3.7 The Sentinel Stroke National Audit Programme data reports the number of stroke patients recorded as having Atrial Fibrillation before their stroke, and details of how the Atrial Fibrillation was being managed.

AF before stroke	2013-14	2014-15	2015-16	2016-17
Number	56	59	52	46
% of total stroke patients	14.8	16.3	12.9	13.5
If AF before stroke, on antiplatelet medication:				
Yes	21	27	17	7
No	35	32	35	39
If AF before stroke, on anticoagulant medication:				
Yes	18	19	25	21
No	38	40	27	25
If AF before stroke, on anticoagulant and/or antiplatelet medication:				
Both anticoagulant and antiplatelet medication	3	2	4	0
Anticoagulant medication only	15	17	21	21
Antiplatelet medication only	18	25	13	7
Neither medication	20	15	14	18

3.8 This data describes a situation where only 14.3% of the people who had a stroke in the years 2013-17 had previously identified and recorded Atrial Fibrillation. And of these, the management of the Atrial Fibrillation varied, with 31% of those identified with Atrial Fibrillation receiving no medication for the management of their Atrial Fibrillation.

4 PROGRESS TO DATE

4.1 A pathway was developed using national guidelines (e.g. NICE 2014), other North West pathways (e.g. Cheshire and Merseyside SCN, 2015) and input from GPs and Cardiologists. This was presented to the Single Commissioning Board in January 2017 and approved for use in Tameside and Glossop.

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

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

4.3 The Heart Disease Programme Board has now asked that this work is taken further, with increased support provided to the primary care identification and management of Atrial Fibrillation.

4.4 A parallel piece of work is being led by the Integrated Care Foundation Trust to look at the identification of Atrial Fibrillation in the hospital setting, with discussions including the potential for an arrhythmia nurse supporting urgent care and elective care pathways and services.

5 THE PROPOSED PROJECT

5.1 The aim of this project is to reduce the number of Atrial Fibrillation related strokes in the population of Tameside and Glossop through the effective identification and management of patients with Atrial Fibrillation. The objectives to support this aim are:

- To increase the prevalence and number of people with Atrial Fibrillation identified and recorded on primary care systems;

- To improve the Time in Therapeutic Range for people with Atrial Fibrillation;
- To improve the management of the 'known not treated' patients with Atrial Fibrillation;
- To improve the competence and confidence of the current & future primary care workforce to help deliver improved levels of care around management and treatment of Atrial Fibrillation;
- To help support provision of and use of devices to improve levels of detection amongst identified patient cohorts;
- To improve the coding and record management in primary care of patients with Atrial Fibrillation.

5.2 The project team will ensure patient and staff satisfaction are monitored throughout the project and in the ongoing delivery of support to people with Atrial Fibrillation.

5.3 The Single Commission has been working closely with the Greater Manchester Academic Health Science Network on an approach to the identification and management of Atrial Fibrillation. The Greater Manchester Academic Health Science Network is one of 15 Academic Health Science Networks across England, established to spread innovation, improve health and generate economic growth. The Greater Manchester Academic Health Science Network brings together 33 members comprising NHS providers, commissioners and universities across Greater Manchester, East Lancashire Trust and East Cheshire. The Network is seeing the project with Tameside and Glossop as their 'flagship' Atrial Fibrillation project, and one in which they are investing significantly in terms of financial resource and manpower.

5.4 The proposed project is being funded by the Academic Health Science Network and the project will require input from the 39 Tameside and Glossop member practices, led by the Single Commission, supported by the Network. Any additional funding required is being provided by the Academic Health Science Network. Tameside and Glossop is the only locality in Greater Manchester receiving funding for an Atrial Fibrillation project, and is being seen by the Network as a test site for their work, which links into the Greater Manchester Health and Social Care Partnership.

5.5 There are 3 elements to the project:

Reviews – Academic Health Science Network to fully fund the cost of pharmacy led clinical reviews in ALL Tameside and Glossop practices. This will involve the use of the GRASP AF tool in all practices, and will provide the practices with a validated list of all Atrial Fibrillation patients and an action plan as to how to improve their prevalence and management. The intention is to complete these reviews by the end of the calendar year (2017). This approach has been successfully piloted at Lockside Medical Centre (Stalybridge). The aims and objectives of the reviews are:

To improve patient outcomes in conditions associated with anticoagulant use, such as stroke prevention and Atrial Fibrillation and treatment and prevention of Venous Thromboembolism. In summary:

- Counselling, support and education to patients for whom the decision has been made by the patients' GP, or other designated NHS prescribing authority, to transition patient(s) to a Noval Oral Anticoagulant.

- The prescribing of Novel Oral Anticoagulants is appropriate of patients on the basis of approved indications, patient suitability and avoiding the interruption of therapeutic anticoagulation during the transition.

- The facilitation of transition or initiation of novel oral anticoagulation therapy under the authorisation and specification of patients' GP, or NHS prescribing authority, as required to optimise safe and effective treatment.

By informing patients of treatment aims and options, a pharmacist led consultation involving patient assessment, enables NHS clinician(s) to implement safe and effective anticoagulation treatment interventions whilst ensuring informed patient consent and adherence to treatment.

Equipment – to improve levels of detection amongst identified patient cohorts the Academic Health Science Network have agreed to fund 96 devices for use in Tameside and Glossop. These devices will enable staff in practices to carry out 'near patient testing' of heart rhythms and detect the presence of Atrial Fibrillation. The proposed device is the AlivCor Kardia Mobile[3] device, which has been approved by the Academic Health Science Network as appropriate for use in this project. The project team will ensure that all appropriate assurance is provided by the Academic Health Science Network prior to release of equipment to our practices, and that any issues relating to ownership and maintenance (including calibration) are confirmed. The proposal is that the majority of the devices are used in General Practice, but the project team will also work with the Be Well service and Live Active to identify opportunities where these services can engage with the project.

GP Education – the Academic Health Science Network and the Single Commission (clinical lead) will design and deliver an interactive education session for the member practices in October 2017 which will outline the approach to the identification and management of Atrial Fibrillation outlined in this paper, and will reiterate the use of the pathway approved by Single Commissioning Board in January 2017. At this session, pending Single Commissioning Board approval of this report, practices will receive their 'Kardia Mobile' devices. The education session will include training on the use of this equipment. Ongoing support will be provided via the Academic Health Science Network as required.

5.6 The Integrated Care Foundation Trust, as leaders of the Heart Disease Programme Board, are aware of this project and this progress will be reported through the Heart Disease Programme Board and Integrated Care Foundation Trust governance as well as through the internal Clinical Commissioning Group governance. In addition, the Integrated Care Foundation Trust Clinical Directors are involved through the Neighbourhoods, particularly in the case of the Hyde Neighbourhood, where the use of the mobile equipment is being piloted.

5.7 The benefits of the Single Commission leading this project, as part of the work of the Heart Disease Programme Board, are that we can ensure it is aligned with the ongoing development of the primary care quality agenda, and the role of General Practice in the delivery of integrated care in Tameside and Glossop. And we can align this with the devolved contractual responsibilities held by the Clinical Commissioning Group. It also ensures the project is aligned with the primary care prescribing Quality, Innovation, Productivity and Prevention plans and budget management.

6 PROJECT MANAGEMENT AND TIMESCALES

6.1 Project management is being provided by the Single Commission Commissioning Directorate. Membership of the project team includes representation from the Integrated Care Foundation Trust, and officers from the 'long term conditions' and primary care commissioning teams. Reporting on the project is via the Heart Disease Programme Board. Updates will also be provided to the Single Commissioning Board as required.

6.2 The monitoring of the project will be supported by the Academic Health Science Network to ensure we can report progress and delivery of the project aim and objectives.

[3] https://www.alivecor.com/?gclid=EAIaIQobChMIvOOtrNLe1QIVR7XtCh1xfg6_EAAYASAAEgJh2_D_BwE

6.3 Baseline data will be collected, with monthly updates collated to indicate the impact of the project. This will include monitoring the number of patients with recorded Atrial Fibrillation, the prevalence, the number of 'known but not treated patients' (which should decrease), and the 'Time in Therapeutic Range'. Thus enabling the project to monitor and report on the delivery of the aims outlined in section 5.1 of this report. The Academic Health Science Network will support the design and population of a dashboard which will be presented to the Heart Disease Programme Board and Professional Reference Group following completion of the project.

6.4 Clinical Leadership – the Clinical Leadership for the project will be provided by Dr Tom Jones. Dr Jones is a partner at Lockside Medical Centre in Stalybridge, and is the Clinical Commissioning Group Clinical Lead for Long Term Conditions, supporting Dr Alison Lea (Governing Body GP Member). He will provide medical/clinical input to the project, and will do so from the perspective of having carried out the reviews proposed in this paper in his own practice as part of the testing and development of the proposals.

6.5 Medicines Management – the Head of Medicines Management for the Single Commission is a member of the project team. He will provide expert advice and assurance to the project team that the project (particularly the practice review process) is in line with local medicines management guidelines, is included within / aligned with the local prescribing budget management and Quality, Innovation, Productivity and Prevention plans (therefore not placing additional pressure on existing plans and prescribing budgets), and is delivered by appropriately qualified staff from a pharmacy perspective. The involvement of the medicines management team also enables the project to work with the Clinical Commissioning Group and Integrated Care Foundation Trust medicines management teams, and potentially the Neighbourhood Pharmacists as they come into post. This will facilitate the sustainability of the project.

6.6 The project members are working with the Academic Health Science Network to explore opportunities, and potentially additional funding, for the digital monitoring of patient compliance / concordance with treatment provided for identified Atrial Fibrillation.

7 RECOMMENDATION

7.1 As outlined in the front cover of this paper.

Equality Impact Assessment

Subject / Title	Atrial Fibrillation in Primary Care

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

Start Date	**Completion Date**
15.11.16	01.09.17

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

EIA Group (lead contact first)	**Job title**	**Service**
Alison Lewin	Deputy Director of Commissioning	Commissioning
Heather Palmer	Commissioning Business Manager	Commissioning
Dr Thomas Jones	GP and Clinical Lead	Commissioning
Contribution to work on initial EIA assessments for earlier work on Atrial Fibrillation (staff now left the CCG and Tameside MBC):		
Samantha Hogg	Commissioning Development Manager	Commissioning
Emily Parry-Harries	Speciality Registrar	Public Health, TMBC

PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	Atrial Fibrillation (AF) is a common heart condition which causes an irregular and often abnormally fast heart rate. It can increase the risk of a blood clot forming inside the heart. If the clot travels to the brain, it can lead to a stroke. AF increases stroke risk by around four to five times. Single Commission officers and clinical leads are members of the Tameside & Glossop Heart Disease Programme Board (HDPB). This group is led by Tameside & Glossop ICFT, and reports via ICFT governance through the Director of Operations. The HDPB identified Atrial Fibrillation (AF) as a priority area for their 2016-17 programme of work. As a result, a pathway for AF management was developed and approved via the Professional Reference Group and Single Commissioning Board in January 2017. There are a number of data sources which indicate why the identification and management of AF in primary care is an issue in Tameside & Glossop, and one which needs to be addressed, including the NHS Right Care data, Stroke Sentinel National Audit (SSNAP) data and General Practice QOF (Quality Outcome Framework) data. The Single Commission members of the HDPB have been tasked with taking forward further work to address the identification and management of patients with AF in primary care. The proposal for doing this is outlined in this paper. The purpose of the paper is to provide an update on action taken to date and a summary of the proposed activities for 2017-18, with a view to seeking PRG and Single Commissioning Board support for the project. There are 3 elements to the project: **Reviews** – clinical reviews in ALL Tameside & Glossop practices. This will involve the use of the GRASP AF tool in all practices, and will provide the practices with a validated list of all AF patients and an action plan as to how to improve their prevalence and management. **Equipment** – devices for use in Tameside & Glossop. These devices will enable staff in practices to carry out 'near patient testing' of heart rhythms and detect the presence of atrial fibrillation. **GP Education –** the Single Commission clinical lead will design and deliver an interactive education session for the member practices in October 2017 which will outline the approach to the identification and management of AF outlined in this paper, and will reiterate the use of the pathway approved by PRG and SCB in January 2017.

1b.	**What are the main aims of the project, proposal or service / contract change?**	The aim of this project is to reduce the number of AF related strokes in the population of Tameside & Glossop through the effective identification and management of patients with AF. The objectives to support this aim are: • To increase the prevalence and number of people with AF identified and recorded on primary care systems • To improve the Time in Therapeutic Range (TTR) for people with AF • To improve the management of the 'known not treated' patients with AF • To improve the competence and confidence of the current & future primary care workforce to help deliver improved levels of care around management and treatment of AF • To help support provision of and use of devices to improve levels of detection amongst identified patient cohorts • To improve the coding and record management in primary care of patients with AF The Single Commission has been working closely with the Greater Manchester Academic Health Science Network (GMAHSN) on an approach to the identification and management of AF. The GMAHSN is one of 15 Academic Health Science Networks across England, established to spread innovation, improve health and generate economic growth. Greater Manchester AHSN brings together 33 members comprising NHS providers, commissioners and universities across Greater Manchester, East Lancashire Trust and East Cheshire. The GM AHSN are seeing the project with Tameside & Glossop as their 'flagship' AF project, and one in which they are investing significantly in terms of financial resource and manpower.

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

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age	**X (positive)**			The likelihood of AF increases with age. The project will target people with AF, and therefore predominantly those over 65
Disability			**x**	It is not anticipated that there would be any impact to people with a disability.
Ethnicity			**x**	It is not anticipated there would be any impact. There is little evidence to suggest that different ethnicities will be more likely to develop AF.

Sex / Gender	**X (positive)**			Males are more likely to develop AF but females with AF are more likely to go on to have a stroke, therefore, there will also be a focus on identifying females and ensuring both are manages appropriately.
Religion or Belief			**x**	It is not anticipated that there would be any impact to people of different religions/beliefs.
Sexual Orientation			**x**	It is not anticipated that there would be any impact related to sexual orientation.
Gender Reassignment			**x**	It is not anticipated that there would be any impact related to gender reassignment
Pregnancy & Maternity			**x**	It is not anticipated that there would be any impact related to pregnancy/maternity
Marriage & Civil Partnership			**x**	It is not anticipated that there would be any impact related to marriage/civil partnership.
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health			**x**	It is not anticipated that there would be any impact related to mental health
Carers	**X (positive)**			AF is often a pre-cursor to stroke, and stroke will often require the person to need a carer. By reducing the likelihood of stroke, would reduce the need for someone to be cared for.
Military Veterans			**x**	It is not anticipated that there would be any impact related to military veterans
Breast Feeding			**x**	It is not anticipated that there would be any impact related to breastfeeding
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**

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1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
			x
1e.	**What are your reasons for the decision made at 1d?**	The proposals outlined in this project will improve the identification and management of AF. Therefore it is not anticipated that there will be any detrimental or negative impact from this project. The aim and objectives will be closely monitored by the project team leading this work.	

If a full EIA is required please progress to Part 2

Quality Impact Assessment

Title of scheme: Atrial Fibrillation in Primary Care
Project Lead for scheme: Ali Lewin and Dr Tom Jones (CCG Clinical Lead)
Brief description of scheme:
The Single Commission members of the Heart Disease Programme Board have been tasked with taking forward further work to address the identification and management of patients with AF. The aim of this project is to reduce the number of AF related strokes in the population of Tameside & Glossop through the effective identification and management of patients with AF. The objectives to support this aim are:

- To increase the prevalence and number of people with AF identified and recorded on primary care systems
- To improve the Time in Therapeutic Range (TTR) for people with AF
- To improve the management of the 'known not treated' patients with AF
- To improve the competence and confidence of the current & future primary care workforce to help deliver improved levels of care around management and treatment of AF
- To help support provision of and use of devices to improve levels of detection amongst identified patient cohorts
- To improve the coding and record management in primary care of patients with AF

The project team will ensure patient and staff satisfaction are monitored throughout the project and in the ongoing delivery of support to people with AF.

What is the anticipated impact on the following areas of quality?						**What is the likelihood of risk occurring ?**	**What is the overall risk score (impact x likelihood)**			
	Negligible 1	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**	**1-5**	**Low 1-5**	**Moderate 6-12**	**High 15-25**	**Comments**
Patient Safety	x					1	x			The new pathway would encourage GP Practices to identify, treat and manage patients in line

										with the appropriate guidance and pathways
Clinical effectiveness	x					1	x			Delivery of this project will help to identify and manage people with AF and reduce their risk of stroke
Patient experience	x					1	x			The project objective is to reduce the incidence of strokes in the local population, and improve the identification and management of AF in primary care. Patient satisfaction is a key aim of the project and will be monitored throughout.
Safeguarding children or adults	x					1	x			Local safeguarding policies would be followed

Please consider any anticipated impact on the following additional areas only as appropriate to the case being presented.	**What is the likelihood of risk occurring ?**	**What is the overall risk score (impact x likelihood)**	**Comments**

	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5	1-5	Low 1-5	Moderate 6-12	High 15-25	
Human resources/ organisational development/ staffing/ competence	x					1	x			Staff in primary care are already competent in the management of people with AF. This project will further enhance their ability to do this, and training will be offered where required, particularly with the use of the equipment
Statutory duty/ inspections	x					1	x			
Adverse publicity/ reputation	x					1	x			The pathway will help to support GPs to identify and manage people with AF therefore reducing the risk of stroke. Patient experience is a key part of the project reporting
Finance	x					1	x			Additional funding is being provided by the AHSN. Tameside & Glossop Single Commission finance colleagues support this

										project, and the potential financial benefits from the reduction in the number of strokes in the local population. It has been acknowledged that the patient benefits and outcomes outweigh the financial issues.
Service/business interruption	x					1	x			None expected
Environmental impact	x					1	x			It is not anticipated that there would be an impact on the environment
Compliance with NHS Constitution	x					1	x			No negative impact expected
Partnerships		x				1	x			The work has been developed and will be implemented working with the 39 T&G member practices and the ICFT
Public Choice	x					1	x			No negative impact expected

Public Access		x				1	x			This project will have no negative impact on public access

Has an equality analysis assessment been completed?	YES	Please submit to PRG alongside this assessment
Is there evidence of appropriate public engagement / consultation?		Yes via Patient Neighbourhood Groups at this stage, with more extensive patient involvement planned as the project progresses. Project will include patient reported outcome measures.

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