SINGLE COMMISSIONING BOARD

Day: **Tuesday**
Date: **31 October 2017**
Time: **2.00 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 26 September 2017.	1 - 4
4.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND** To consider the attached report of the Director of Finance, Single Commission.	5 - 22
5.	**QUALITY CONTEXT**	
a)	**PERFORMANCE REPORT** To consider the attached report of the Assistant Director (Policy, Performance and Communications).	23 - 60
6.	**COMMISSIONING FOR REFORM**	
a)	**TAMESIDE AND GLOSSOP PROPOSAL FOR EFFECTIVE URGENT CARE: CASE FOR CHANGE** To consider the attached report of the Interim Director of Commissioning and Care Together Programme Director.	61 - 162
b)	**IMPROVING DEMENTIA SERVICES IN THE NEIGHBOURHOODS** To consider the attached report of the Director of Adults Services.	163 - 184
c)	**PERSONAL HEALTH BUDGETS** To consider the attached report of the Director of Quality and Safeguarding.	185 - 204
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).	

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.

8. DATE OF NEXT MEETING

To note that the next meeting of the Single Commissioning Board will take place on Tuesday 14 November 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.

TAMESIDE AND GLOSSOP
SINGLE COMMISSIONING BOARD

26 September 2017

Commenced: 3.30 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

In Attendance: Kathy Roe – Director of Finance
Stephanie Butterworth – Director of Adult Services
Anna Moloney – Consultant in Public Health Medicine
Ali Rehman – Head of Business Intelligence and Performance
Lynn Jackson – Quality and Patient Experience Lead

Apologies: Councillor Brenda Warrington – Tameside MBC
Councillor Peter Robinson – Tameside MBC
Dr Christina Greenhough – NHS Tameside and Glossop CCG
Carol Prowse – NHS Tameside and Glossop CCG

48. DECLARATIONS OF INTEREST

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

49. MINUTES OF THE PREVIOUS MEETING

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

50. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

Consideration was given to a joint 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 4 financial position at 31 July 2017 and the projected outturn at 31 March 2018.

The Director of Finance stated that the Clinical Commissioning Group was reporting that all financial control totals would be met. However, there was significant risk attached to the Quality, Innovation, Productivity and Prevention programme which was forecast £5.6m shortfall to plan. Overall the value of planned savings had reduced the majority of which related to continuing health care and elective services. Under the terms of the Integrated Commissioning Fund financial framework, a non-recurrent contribution of c£5m could be accessed from Tameside Council reserves towards the finance position of the Clinical Commissioning Group in 2017/18. This would need to be repaid within a 4 year period.

Children's Services remained a high risk area. The majority of the projected additional net expenditure related to placements within the independent sector provision of £5m. It was currently estimated that on average there would 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 had increased since the budget was approved and this equated to a projected increase of £0.6m in the current financial year.

The Single Commissioning Board discussed the financial positon of the Integrated Care Foundation Trust. The Trust had still to agree a financial control total with its regulator, NHS Improvement. The Trust had agreed with NHS Improvement, due to the volatility of risk, that a detailed forecast would be presented at Month 6 and the Trust was developing an action plan to mitigate risk of delivery. However, this was affecting the Trust's eligibility to access the targeted element of Sustainability and Transformation funding as providers must have accepted an agreed control total.

The Chief Executive and Accountable Officer reported that the Health and Wellbeing Board, at its meeting on 21 September 2017, had also expressed its discontent at the Trust not being able to access Sustainability and Transformation funding which was now affecting transformation plans and had resolved to write to Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership. In order to progress matters, he proposed that consideration be given to exploring a local solution and the possibility of a single control total across the economy.

RESOLVED

(i) That the 2017/18 financial year update on the month 4 financial position at 31 July 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.

51. PERFORMANCE REPORT

Consideration was given to a report of the Assistant Director (Policy, Performance and Communications) 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 positon. This was based on the latest published data at the end of June 2017.

Discussion took place on the following which 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 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.

Reference was also made to the Quality and Safeguarding monthly exception report.

RESOLVED

That the quality and performance update report be noted.

52. SAVINGS ASSURANCE: GRANTS REVIEW

Consideration was given to a report of the Interim Director of Commissioning explaining that 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 were known in case there were duplications. The Single Commissioning Board agreed that Voluntary and Community sector grants were extended for a further 3 months to 30 September 2017. An exploration of the Asset Based Grants Programme had shown that:

- It was unlikely that there would be any duplication;
- It would be some time before the grants would be in place.

Concerns about duplication were unfounded as the small grants awarded through the Asset Based Grants Programme would be provided to support unmet needs identified through the findings from Social Prescribing and aimed to promote community development, not provide statutory functions. Decisions on funding through the asset based approach and social prescribing programmes would 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. A summary of the programme was provided in **Appendix 1** to the report.

The Single Commission had funded a range of services that provided a valuable contribution to the health and social care through Conditional Grants or Service Level Agreements. The funding had been based on NHS England regulations that supported Clinical Commissioning Groups to use grants to provide financial support to a voluntary organisation which provided or arranged for the provision of services which were similar to those in respect of the Clinical Commissioning Group had statutory functions. The schemes funded through Grants or Service Level Agreements were detailed in **Appendix 2** to the report. 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.

A proposed way forward was outlined on the basis that:

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

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

RESOLVED

(i) The value of the Voluntary and Community Sector in achieving Care Together aims and the need for the revised Voluntary and Community Sector Compact be embraced by the whole system to support a thriving voluntary and community sector be recognised.

(ii) That the recommendations in terms of each Voluntary and Community Sector Grant allocation outlined in Appendix 2 to the report be approved.

53. ATRIAL FIBRILLATION

Consideration was given to a report presented by Dr Alison Lea which explained that Atrial Fibrillation was a common heart condition which caused an irregular and often abnormally fast heart rate. It could increase the risk of a blood clot forming inside the heart. If the clot travelled to the brain it could lead to a stroke. Atrial Fibrillation increased stroke risk by around four to five times.

Single Commission officers and clinical leads were members of the Tameside and Glossop Heart Disease Board led by the Tameside and Glossop Integrated Care Foundation Trust and reported 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 at the Single Commissioning Board in January 2017.

It was reported that 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 was outlined in the report. The report also provided an update on action taken to date and a summary of the proposed activities for 2017-18 with a view to seeking the support of the Board for the project.

The aim of the project was 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 proposed project was being funded by the Academic Health Science Network and would require input from the 39 Tameside and Glossop member practices, led by the Single Commission, supported by the Network. Tameside and Glossop was the only locality in Greater Manchester receiving funding for an Atrial Fibrillation project and was being seen by the Network as a test site for their work which linked into the Greater Manchester Health and Social Care Partnership. The monitoring of the project would be supported by the Academic Health Science Network to ensure progress and delivery of the project aims and objectives could be reported.

The Clinical Leadership for the project would be provided by Dr Tom Jones, partner at Lockside Medical Centre and Clinical Commissioning Group Clinical Lead for Long Term Conditions. He would provide medical / clinical input to the project and would do so from the perspective of having carried out the reviews proposed in his own practice as part of the testing and development of the proposals.

In recognising that this was a well targeted project presenting opportunities to work with the Academic Health Science Network, the Chair commented that the proposal was asking General Practice to do more with no more resource and was concerned that some practices might not participate based on prevailing manageability or that it might be undertaken at the expense of something else.

RESOLVED
That the project outlined in the report be supported and proceed as described.

54. URGENT ITEMS

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

55. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 31 October 2017 commencing at 3.30 pm at Dukinfield Town Hall.

CHAIR

Report to: **SINGLE COMMISSIONING BOARD**

Date: 31 October 2017

Officer of Single Commissioning Board

Kathy Roe – Director Of Finance – Tameside & Glossop CCG and Tameside MBC

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 AUGUST 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 5 financial position (at 31 August 2017) and the projected outturn (at 31 March 2018).

The Tameside & Glossop Care Together Single Commissioning Board are required to manage all resources within the Integrated Commissioning Fund. The CCG and the Council are also required to comply with their constituent organisations' statutory functions.

A summary of the Tameside and Glossop Integrated Care NHS Foundation Trust financial position is also included within the report. This is to ensure members have an awareness of the overall financial position of the whole Care Together economy and to highlight the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the financial gap next year and through to 2020/21.

Recommendations:

Single Commissioning Board Members are recommended to note / acknowledge:

- The 2017/2018 financial year update on the month 5 financial position (at 31 August 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 August 2017 (Month 5 – 2017/18) together with a projection to 31 March 2018 for each of the three partner organisations.

The report explains that there is a clear urgency to implement associated strategies to ensure the projected funding gap is addressed and closed on a recurrent basis across the whole economy.

A risk share arrangement is in place between the Council and CCG relating to the residual balance of net expenditure compared to the budget allocation at 31 March 2018, the details of which are provided within the report.

It should be noted that the Integrated Commissioning Fund for the partner Commissioner organisations will be bound by the terms within the Section 75 agreement and associated Financial Framework agreement which has been duly approved by both the Council and CCG.

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

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

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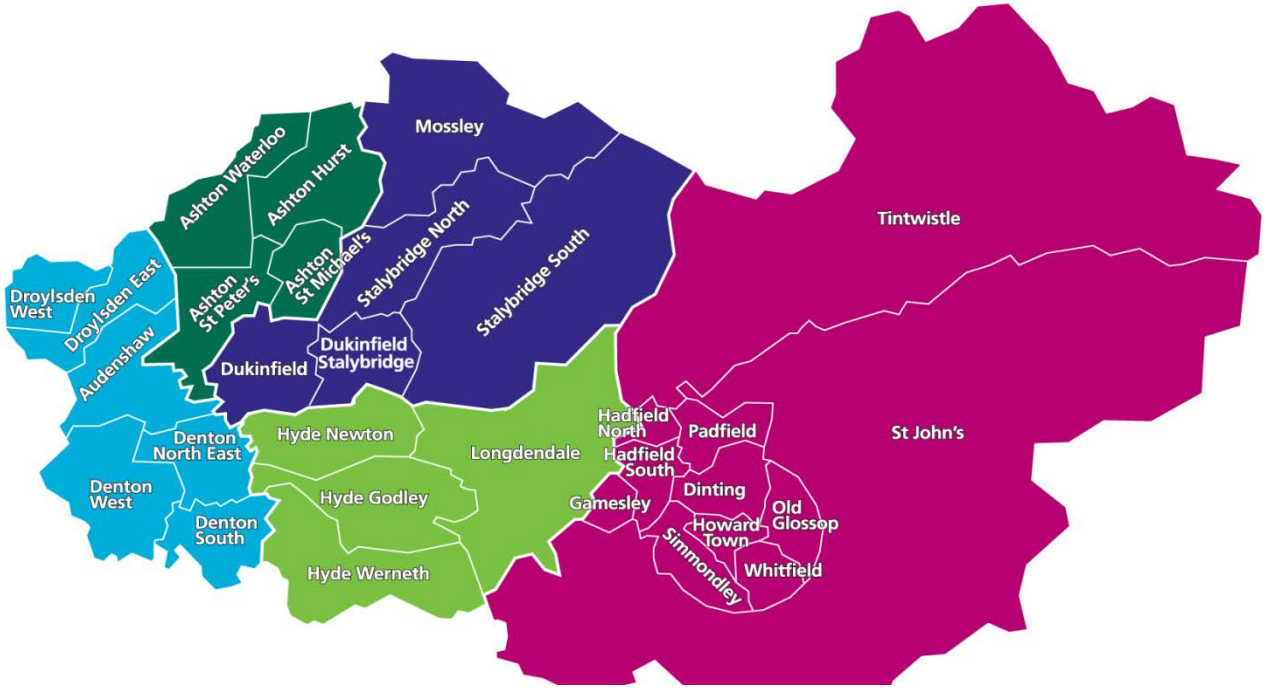
TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position

Financial Monitoring Statements

Period Ending 31st August 2017 [Month 5]

Kathy Roe
Claire Yarwood



Contents

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
Tameside & Glossop CCG	162,127	162,129	-2	386,657	391,835	-5,178	-5,605	427
Tameside MBC	41,830	44,257	-2,427	96,207	102,032	-5,825	-5,765	-60
Total Single Commissioner	203,957	206,386	-2,429	482,864	493,867	-11,003	**-11,370**	**367**
ICFT	-11,096	-11,738	-642	-24,506	-24,506	0	0	0
Total Economy Position	192,861	194,648	-3,071	458,358	469,361	-11,003	**-11,370**	**367**
Integrated Commissioning Fund	203,957	206,386	-2,429	482,864	493,867	-11,003		
A: Section 75 Services	113,775	115,475	-1,700	262,681	267,081	-4,400		
B: Aligned Services	76,204	77,775	-1,571	186,319	192,684	-6,365		
C: In Collaboration Services	13,978	13,137	841	33,865	34,103	-238		

Key Headlines:

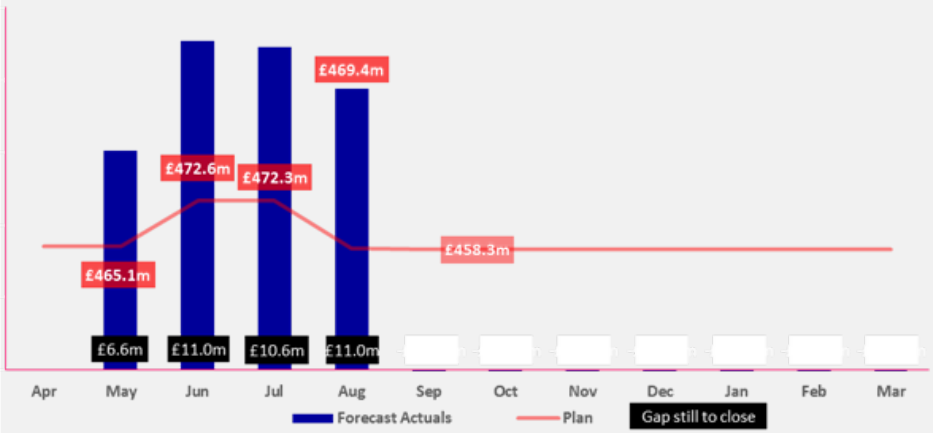
- YTD Position across the economy is currently: **£3,071k Deficit**
- 2017/18 Projected year end position across the economy is currently: **£11,003k Deficit**
- Movement in forecast year end position is: **£367k Favourable**

Single Commission Risk Share	£000's
TMBC - Non Recurrent Contribution	5,000
CCG	642
TMBC	5,361
	11,003

- 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 forecast financial deficit of £11m on the single commissioner budgets and is mostly driven by CHC and Children. We continue to report that we will meet financial control totals, however there are significant risks associated with this.
- 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.
- The Integrated Commissioning Fund will receive extra non-recurrent contributions, in line with the joint risk share arrangement for 2017-18, to ensure a balanced position is maintained.

Tameside & Glossop CCG Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

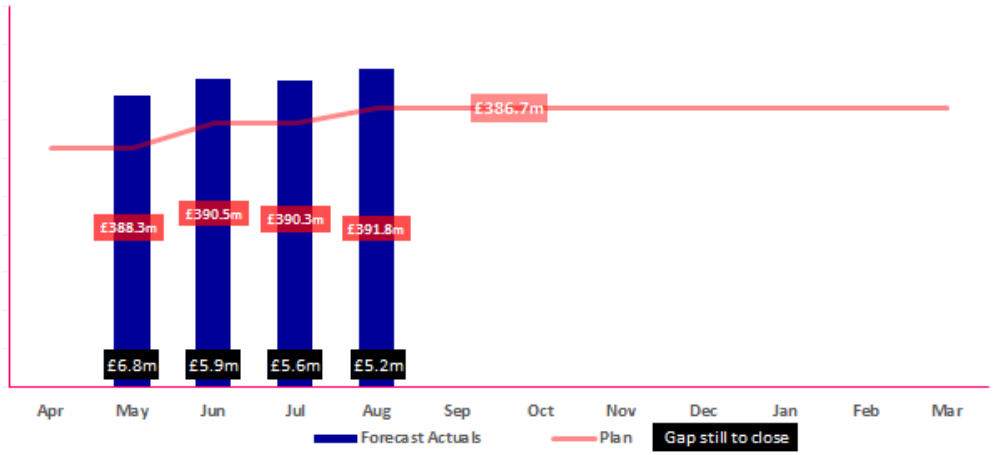
Organisation	YTD Position			Forecast Position			Forecast Position	
	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Acute	83,157	83,848	- 691	202,644	203,346	- 702	31	- 732
Mental Health	12,298	12,423	- 125	29,483	30,162	- 679	- 914	236
Primary Care	34,890	32,757	2,133	84,987	84,874	112	15	98
Continuing Care	5,687	7,726	- 2,039	13,662	18,645	- 4,982	- 3,534	- 1,448
Community	11,434	11,318	116	27,455	27,548	- 93	- 93	0
Other	12,264	11,670	594	23,229	16,886	6,343	4,496	1,847
QIPP			-		5,178	- 5,178	- 5,605	427
CCG Running Costs	2,397	2,388	10	5,197	5,197	-	-	-
CCG Expenditure	**162,127**	**162,129**	**- 2**	**386,657**	**391,835**	**- 5,178**	**- 5,605**	**427**
CCG Surplus	2,990	- 2	2,992	7,174	7,174	-	-	-

Key Headlines:

- 2017/18 Projected year end position across the economy is currently: **£5.178m Deficit** (i.e. QIPP savings still to be delivered to meet financial control totals)
- Movement in forecast year end position is: **£427k Favourable**
- YTD Position across the CCG is currently: **£2k adverse.**

Revenue Forecast Position

Forecast detail - £m's



Financial Summary – Forecast Position

- £5.0m projected overspend on continuing care is causing significant pressures
- 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, Central Manchester & South Manchester, offset by underspend at Stockport & Pennine • £477k – The in-depth review of individualised commissioning identified some neuro-rehab costs • Expected IAT from Salford for Spinal and Neuro treatments	• Increasing C&V spend in independent sector (diagnostics & MSK) caused by shift in activity from ICFT • Possible pressures within Sepsis and Vascular pathways • More discharges of neuro rehab patients to specialists private providers
Mental Health	• Reduction in forecast overspend following in-depth review of individualised commissioning which has resulted in reclassification of costs • Work ongoing to develop investment plan which allows us to meet requirements of five year forward view	• Possible costs increases due to Transforming Care programme(national programme transferring patients from acute into community setting)
Primary Care	• 332k QIPP realised in YTD position - Repeat Prescribing, COPD Pathway, DNP/Grey/Red list items • Finance/Meds team engaging practices around QIPP & Performance	• Paul Bauman letter – benefit of unplanned drug price reductions to be held centrally • NCSO pressure of £680k - Quetiapine and Olanzapine

Continuing Care	• Forecasts overspend up by £1.4m. Some highlights are:
	  • Previous months' forecasts assumed the CHC financial recovery programme would reduce forecasts growth (from 14% to about 7%). This assumption is now considered risky and full growth shown in month adding £1.2m to forecast
	  • £331k increase in costs due to additional growth mostly in Fast Track patients
	  • £160k costs of restitution costs above 16/17 provision
		• Transforming Care – movement from specialists and other block contracts onto spot purchases
		• Continuing growth in fast tracks

Community	• Contract variation with ICFT for flexible community beds following termination of Grange View contract	• Awaiting outcome of VAT reclaim on wheelchairs
Other	• The second tranche of 17/18 Transformation Funding from GM Devolution of £2m received in M5 • £1m of negative reserve still to clear over and above the outstanding QIPP still to be delivered	• Estates schedules still outstanding values of pressure not yet available
QIPP	• £11m (46%) of targeted savings banked at M5 • £1m reduction in planned savings since M3(red schemes) • Expected savings stable due to increase in banked schemes	• Still need to deliver further £5.2m savings (plus clear the negative reserve) • Only 55% of expected savings delivered on recurrent basis
CCG Running Costs	• QIPP savings of £690k released at M5 • On track to remain within running cost allocation	• YTD Underspend transferred to QIPP

TMBC Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

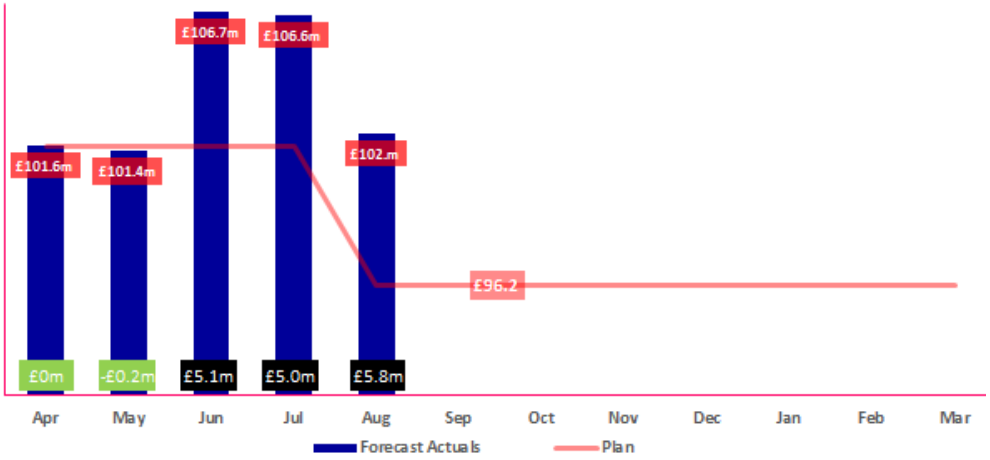
Organisation	YTD Position Budget	YTD Position Actual	YTD Position Variance	Forecast Position Budget	Forecast Position Forecast	Forecast Position Variance	Forecast Position Previous Month	Forecast Position Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Adult Social Care & Early Intervention	18,544	18,514	30	44,307	44,236	71	131	- 60
Childrens services, Strategy & Early Intervention	13,287	15,744	- 2,457	35,192	41,088	- 5,896	- 5,896	-
Public Health	9,999	9,999	-	16,708	16,708	-	-	-
TMBC Expenditure	**41,830**	**44,257**	**- 2,427**	**96,207**	**102,032**	**- 5,825**	**- 5,765**	**- 60**
A: Section 75 Services	27,845	27,815	30	59,579	59,508	71		
B: Aligned Services	13,985	16,442	- 2,457	36,628	42,524	- 5,896		
C: In Collaboration Services	-	-	-	-	-	-		
	41,830	**44,257**	**- 2,427**	**96,207**	**102,032**	**- 5,825**		

Key Headlines:

- YTD Position across the economy is currently: **£2,427k Deficit**
- 2017/18 Projected year end position at council: **£5,825k Deficit**
- Movement to Forecast year end position is: **£60k Adverse**

Revenue Forecast Position

Forecast detail - £m's



Financial Summary – Forecast Position

- Children's Services remains a high risk area . Majority of the projected additional net expenditure relates to placements within independent sector of £5.0m. An estimated 68 children may need external placement provision above the number of placements estimated when the 2017/18 budget was approved by the Council in February 2017.
- Adult Social Care Out of Borough residential placement costs have increased. This increase has been partly absorbed by a reduction in homecare costs.

ICFT Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

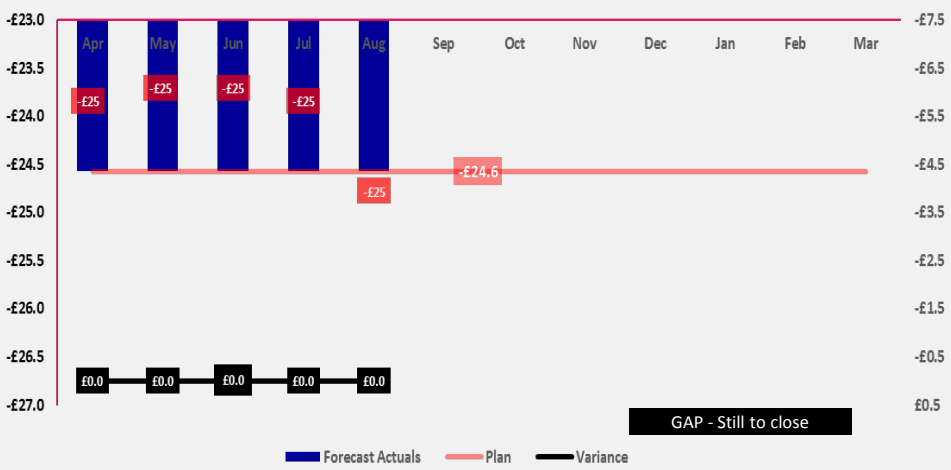
Organisation	YTD Position			Forecast Position		
	Budget	Actual	Variance	Budget	Forecast	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Income	84,983	86,205	- 1,222	204,701	204,701	-
Expenditure	92,296	94,031	- 1,734	219,916	219,916	-
EBITDA	**- 7,314**	**- 7,826**	**513**	**- 15,215**	**- 15,215**	**-**
Financing	3,715	3,843	- 128	9,129	9,129	-
Normalised Surplus/ (Deficit)	**- 11,028**	**- 11,669**	**641**	**- 24,344**	**- 24,344**	**-**
Exceptional Items	68	69	- 1	162	162	0
Net Deficit after Exceptional Costs	**- 11,096**	**- 11,738**	**642**	**- 24,506**	**- 24,506**	**- 0**

Key Headlines:

- The ICFT reported a YTD overspend of **£642k**
- This is an adverse movement in month of **c£290k**
- 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.

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
CFT	3,301	3,088	(213)	5,882	2,755	1,327	2,118	0	12,083	9,964	10,397	(432)	
T&GCCG	10,968	10,994	26	10,994	7,728	2,711	5,846	0	27,279	21,433	23,900	(2,467)	
LOCAL AUTHORITY	322	322	0	322	248	202	0	0	773	773	773	0	
TOTAL	14,591	14,403	(187)	17,198	10,731	4,241	7,965	0	40,135	32,170	35,070	(2,900)	

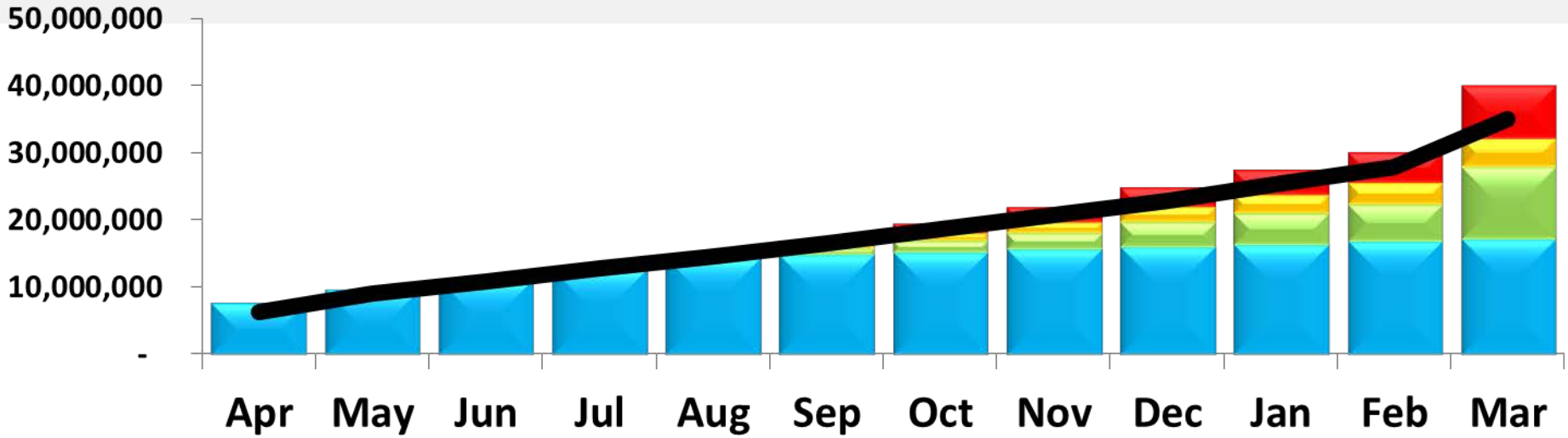
In Month/YTD Position

- 17/18 YTD Delivery across the economy is currently: **£14,403k**
- This is an overachievement against plan of **£187k**

Forecast Position

- 2017/18 Projected Economy saving forecast: **£2,900k Shortfall to plan**
- 2018/19 Projected Economy saving forecast: **£7,793k Shortfall to plan**

Phasing of Forecast - Cumulative



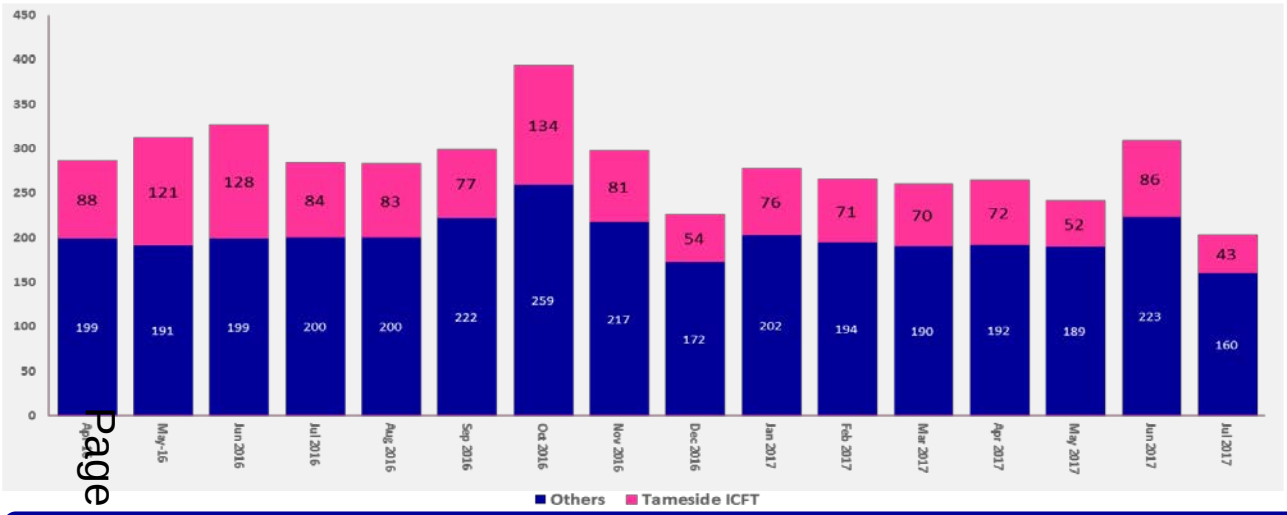
NB: Red Schemes are not included within the forecast savings figures due to high risk of non-financial delivery

Performance data– EUR Referrals

Overall Risk Rating - Medium

EUR Performance

Rolling 16 months EUR Activity (All Providers)



YTD 2016/17 v YTD 2017/18:

- Although overall YTD activity is down in 2017/18 compared to 2016/17, Tameside ICFT activity shows a bigger reduction compared to other providers
- All providers - YTD activity down by 16.0% (1210 vs 1017)
- Tameside ICFT - EUR activity down by **39.9%** (421 vs 253) when comparing like for like Apr – Jul data
- Other providers - EUR activity down by **3.2%** (789 vs 764) when comparing like for like Apr – Jul data
- July 2017 has seen a significant reduction in activity. CCG employed EUR administrator started work mid-May. Unclear these are related, but will continue to monitor over next few months to determine if data anomaly or start of trend

EUR – Tameside NHSFT and Other Providers

EUR Activity: 10 Key Procedures (2015/16 vs 2017/18 FOT)

Key 10 Procedures	2017/18 FOT	2016/17	2015/16	*% reduction (since 15/16)*	GM Ranking 2017/2018 at Q1	GM Ranking 2015/2016 *(12 CCGs)*
Bunion Surgery	87	97	117	*-26%*	8	12
Cataract Surgery	1806	1940	2338	*-23%*	9	11
common benignskin lesions	198	201	206	*-4%*	6	9
Dupuytrens Contracturganglion	51	69	94	*-46%*	8	10
Ganglion Cyst Removal	36	51	51	*-29%*	3	9
hyaluronic acid injections	96	114	100	*-4%*		
Hyperhidrosis	84	83	79	*6%*	10	11
Persistent Non specific Lower Back Pain	321	572	812	*-60%*		
Tonsillectomy	117	90	79	*48%*	8	12
Varicose Veins	90	109	163	*-45%*	5	10

GM ranking base on spend per 10k pop
Reductions in most procedures but rates of reduction vary **(4% - 60%)**
Biggest reductions in **(60%)** in Persistent Non specific Lower back pain
Most operations performed at Tameside ICFT
Reduction of 61% between 15/16 and 17/18 FOT (Tameside)

Increases in Hyperhidrosis **(6%)** and Tonsillectomy **(48%)**

Tonsillectomy activity at Tameside ICFT growth at **32%**. Central Manchester at **100%** (15/16 vs 17/18 FOT)

Tameside ranked in the bottom half in GM for most procedures (except Ganglion Cyst Removal and Varicose veins)

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	518	780	262	1,016	665	0	0	1,681	1,681	1,243	439	Grn	43	455	0	455	412	Grn
Pharmacy	113	273	159	406	161	0	49	616	567	392	175	Grn	282	397	142	256	(26)	Amb
Divisional Target - Corporate	404	409	5	843	16	202	55	1,116	1,061	1,020	41	Grn	461	465	68	397	(64)	Amb
Divisional Target - Surgery	253	211	(42)	511	106	23	0	640	640	640	0	Grn	560	560	0	560	0	Grn
Transformation Schemes	0	110	110	453	547	0	574	1,574	1,000	1,000	0	Grn	1,000	2,223	1,537	686	(314)	Amb
Workforce Efficiency	51	70	19	70	0	51	0	121	121	121	(0)	Amb	121	0	0	0	(121)	Red
Estates	120	61	(58)	166	306	80	6	559	553	557	(5)	Amb	557	351	6	344	(213)	Amb
Medical Staffing	225	129	(97)	354	262	70	105	791	686	716	(30)	Amb	661	806	225	581	(80)	Amb
Divisional Target - Medicine	336	281	(55)	589	149	0	345	1,083	737	803	(66)	Amb	803	820	445	375	(428)	Amb
Paperlite	52	0	(52)	0	16	15	94	125	31	125	(94)	Red	125	153	0	153	28	Grn
Nursing	387	314	(73)	361	0	449	161	971	810	975	(165)	Amb	375	556	113	443	68	Grn
Procurement	208	77	(131)	195	379	143	356	1,073	717	1,073	(356)	Amb	1,073	1,328	0	1,328	254	Grn
Demand Management	634	373	(262)	919	148	294	371	1,732	1,360	1,732	(371)	Amb	1,682	1,682	345	1,336	(345)	Amb
TOTAL ICFT - TEP	3,301	3,088	(213)	5,882	2,755	1,327	2,118	12,083	9,964	10,397	(432)	Amb	7,744	9,794	2,881	6,913	(830)	Amb

Performance to date and forecast:

Key issues and recovery:

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
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
Neighbourhoods	781	781	0	781	0	0	0	781	781	781	0	Grn	781	781	0	781	0	Grn
Single Commissioning	432	690	258	690	447	0	0	1,137	1,137	1,137	0	Grn	1,137	1,246	386	861	(277)	Amb
Effective Use of Resources	625	315	(310)	315	440	373	373	1,500	1,128	1,500	(373)	Amb	1,500	1,500	750	750	(750)	Amb
Other	724	724	0	724	0	60	540	1,324	784	1,324	(540)	Amb	724	724	0	724	0	Grn
Acute Services - Elective	586	557	(29)	557	0	15	15	586	572	1,116	(545)	Amb	1,116	1,086	450	636	(480)	Amb
Mental Health	294	296	2	296	0	10	90	396	306	994	(688)	Red	994	1,007	630	377	(617)	Red
GP Prescribing	923	332	(591)	332	325	568	853	2,078	1,225	2,516	(1,292)	Amb	2,516	3,772	2,550	1,222	(1,295)	Amb
Back Office Functions and Enabling Schemes	218	0	(218)	0	524	100	900	1,524	624	2,024	(1,400)	Red	2,024	1,524	700	824	(1,200)	Amb
Demand Management	3,124	2,101	(1,023)	2,101	2,149	1,419	2,881	8,550	5,669	8,885	(3,216)	Amb	7,057	9,513	4,757	4,757	(2,300)	Amb
Sub Total CCG QIPP	10,968	10,994	26	10,994	7,728	2,711	5,846	27,279	21,433	23,900	(2,467)	Amb	19,427	22,793	10,329	12,464	(6,963)	Amb
Adult Social Care	140	140	0	140	35	161	0	336	336	336	0	Grn	336	336	0	336	0	Grn
Public Health	182	182	0	182	213	41	0	437	437	437	0	Grn	437	437	0	437	0	Grn
Sub Total Local Authority	322	322	0	322	248	202	0	773	773	773	0	Grn	773	773	0	773	0	Grn
Total Single Commission	11,290	11,316	26	11,316	7,977	2,914	5,846	28,052	22,206	24,673	(2,467)	Amb	20,200	23,566	10,329	13,237	(6,963)	Amb

Performance to date and forecast:

- Savings delivered are on YTD basis are broadly in line with plan
- Below target on demand management, particularly in savings from associate providers. This is because we are not seeing the desired level of reduction in activity.
- Also behind target on prescribing, which is partly because we only have Q1 data despite monitoring against M5 target.
- Non recurrent savings from budget management have bridged the gap.

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

	Unified Position (Including Prescribing & Delegated Co-Commissioning)										Prescribing PMO Values					
	Budget					Actual	Actual		YTD	Prior Month	Budget		Actual	Variance	YTD	Prior month
	M1 Fixed Initial Budget	QIPP Achievements	Annual Budget (Jun)	Y-T-D (Jun)	HC Patient Y-T-D (Jun)	HC Patient Y-T-D (Jun)	Y-T-D (Jun)	Y-T-D Variance (Jun)	%	%	Annual Budget	Y-T-D (Jun) Budget	Y-T-D (Jun)	Y-T-D (Jun)	%	%
FE9003 ALSION MEDICAL PRACTICE	19,457,882	59,176	19,815,314	3,988,145	(16,445)	(40,050)	4,233,324	(245,181)	(6)%	(9)%	1,795,104	432,499	450,707	(18,208)	(4)%	(1)%
FE9006 BEDFORD HOUSE MEDICAL CENTRE	11,206,031	30,626	11,357,017	2,697,100	(11,956)	0	2,946,466	(249,366)	(9)%	(11)%	1,303,026	313,942	312,814	1,128	0%	1%
FE9011 GORDON STREET MEDICAL CENTRE	7,059,799	16,571	7,121,216	1,619,132	(7,496)	0	1,730,296	(111,165)	(6)%	(7)%	616,562	197,223	202,898	(5,675)	(3)%	(3)%
FE9017 CHAPEL STREET MEDICAL CENTRE	8,214,891	20,044	8,306,504	2,121,590	(8,750)	0	2,311,766	(190,176)	(9)%	(12)%	955,221	230,144	246,242	(16,098)	(8)%	(11)%
FE9020 HT PRACTICE	12,483,774	35,162	12,828,737	3,226,477	(13,297)	0	3,146,524	79,955	2%	1%	1,481,605	349,739	345,480	4,259	1%	3%
FE9030 WEST END MEDICAL CENTRE	7,228,805	16,832	7,312,376	1,667,240	(7,700)	0	1,910,820	(243,580)	(2)%	(5)%	840,560	203,516	206,462	(3,945)	(2)%	0%
FE9033 TAME VALLEY MEDICAL CENTRE	10,164,455	26,576	10,282,095	2,626,625	(10,827)	0	2,630,966	(4,341)	(0)%	0%	1,161,916	284,765	281,317	3,446	1%	2%
FE9609 STAMFORD HOUSE	6,450,370	16,933	6,525,070	1,666,919	(6,871)	0	1,603,516	65,403	4%	5%	750,044	180,710	181,339	(629)	(0)%	(2)%
FE9613 WATERLOO MEDICAL CENTRE	4,054,029	11,086	4,101,421	1,048,095	(4,316)	0	1,059,555	(11,460)	(1)%	(1)%	471,599	115,575	112,887	688	1%	1%
YG2566 ASHTON GP SERVICE	4,667,566	14,627	4,945,783	1,264,607	(5,206)	0	1,259,601	5,206	0%	(3)%	566,501	136,922	131,264	5,658	4%	5%
Ashton	87,167,453	229,436	88,177,531	22,525,629	(92,845)	(40,050)	23,232,635	(706,006)	(3)%	(5)%	10,135,761	2,442,036	2,479,231	(31,195)	(1)%	0%
FE9010 MEDLOCK VALE MEDICAL PRACTICE	11,097,784	27,661	11,234,855	2,666,445	(11,821)	0	3,075,010	(208,566)	(7)%	(8)%	1,290,441	310,909	338,117	(27,208)	(9)%	(7)%
FE9018 MILLGATE MEDICAL PRACTICE	30,192,577	74,251	30,557,225	6,831,374	(32,159)	(155,556)	7,715,555	(882,561)	(13)%	(26)%	3,310,769	795,375	831,977	(36,602)	(5)%	(39)%
FE9016 DENTON MEDICAL PRACTICE	10,600,605	29,151	10,734,691	2,740,756	(11,291)	0	2,906,549	(165,793)	(6)%	(7)%	1,232,650	296,961	300,764	(3,803)	(1)%	3%
FE9019 CHURCHGATE SURGERY	0	0	0	966,055	0	0	836,094	129,961	15%	15%	0	50,464	57,295	(6,811)	(13)%	5.5%
FE9029 MARKET STREET MEDICAL PRACTICE	5,776,444	24,700	5,879,745	2,269,690	(9,345)	0	2,459,502	(189,812)	(8)%	(15)%	1,010,516	245,876	239,642	6,234	3%	4%
YG2665 DROYLSDEN MEDICAL PRACTICE	4,765,269	15,135	4,821,080	1,232,076	(5,076)	0	1,396,596	(164,516)	(13)%	(15)%	554,102	133,501	156,026	(22,525)	(17)%	(14)%
YG2713 GUIDE BRIDGE MEDICAL PRACTICE	4,835,009	14,500	4,892,810	1,251,282	(5,150)	0	1,342,257	(90,976)	(7)%	(7)%	562,211	135,455	126,217	9,238	7%	10%
FE9616 ASHTON ROAD (BUTLER)	0		0	0	0	0	(0)	0	0%	0%	0	0	2		0%	0%
Denton	70,267,688	183,396	71,080,379	18,157,678	(74,845)	(133,338)	19,729,742	(1,572,064)	(9)%	(10)%	8,170,670	1,968,581	2,050,058	(81,476)	(4)%	(2)%
GE1077 HOWARD MEDICAL PRACTICE	4,634,396	15,061	4,676,575	1,195,569	(4,926)	0	1,155,901	40,068	3%	1%	557,721	139,555	131,092	8,463	7%	0%
GE1081 MANOR HOUSE SURGERY	16,659,455	41,231	16,849,915	4,302,662	(17,745)	(14,461)	4,676,740	(376,059)	(9)%	(12)%	1,957,152	488,725	525,769	(39,048)	(13)%	(15)%
GE1106 LAMBGATES HEALTH CENTRE	7,705,647	20,574	7,795,414	1,991,197	(8,206)	0	2,091,670	(100,673)	(5)%	(6)%	835,797	215,627	222,405	(6,778)	(3)%	(3)%
GE1615 COTTAGE LANE SURGERY	5,096,475	10,846	5,157,066	808,427	(3,500)	(22,405)	782,282	21,145	3%	7%	360,255	88,805	87,720	(915)	(1)%	1%
GE1640 SIMMONDLEY MEDICAL PRACTICE	3,645,107	9,472	3,685,206	941,569	(3,660)	0	1,125,484	(184,115)	(20)%	(22)%	423,616	102,065	124,951	(22,886)	(22)%	(22)%
GE1650 HADFIELD MEDICAL CENTRE	3,835,234	12,644	3,882,214	995,883	(4,055)	(15,895)	994,298	(614)	(0)%	0%	445,957	107,446	52,912	54,534	51%	51%
Glossop	33,564,334	107,826	40,026,389	10,228,327	(42,142)	(50,765)	10,828,575	(600,249)	(6)%	(6)%	4,600,532	1,108,418	1,134,847	(26,429)	(2)%	(4)%
FE9002 THE BROOKE SURGERY	14,105,885	34,417	14,266,610	3,642,659	(15,025)	(14,154)	3,930,682	(287,975)	(8)%	(10)%	1,640,219	395,182	451,417	(56,235)	(14)%	(14)%
FE9004 AMBURN HOUSE MEDICAL PRACTICE	9,292,546	22,675	9,396,440	2,399,681	(9,896)	0	2,576,985	(177,303)	(7)%	(9)%	1,080,550	260,335	305,389	(45,054)	(17)%	(15)%
FE9012 GLAREDON MEDICAL CENTRE	12,044,291	29,567	12,181,542	3,110,283	(12,829)	(16,956)	3,288,407	(165,125)	(5)%	(7)%	1,400,500	337,426	401,169	(63,743)	(19)%	(19)%
FE9013 HATTERSLEY GROUP PRACTICE	9,764,977	26,525	9,876,957	2,524,582	(10,401)	0	2,388,824	137,559	5%	5%	1,135,464	273,570	241,514	32,056	12%	14%
FE9014 HAUGHTON THORNLEY MEDICAL CENTRE	17,711,762	43,216	17,915,596	4,573,835	(18,868)	(45,626)	4,796,565	(224,730)	(5)%	(7)%	2,059,509	496,205	546,104	(49,901)	(10)%	(8)%
FE9016 DONNEYBROOK MEDICAL CENTRE	14,704,322	35,676	14,871,886	3,797,102	(15,662)	0	3,961,317	(164,115)	(4)%	(10)%	1,709,807	411,946	441,167	(29,219)	(7)%	(5)%
FE9021 DUCKINFIELD MEDICAL CENTRE	15,866,573	38,718	16,049,405	4,097,855	(16,902)	0	4,192,459	(94,604)	(2)%	(4)%	1,845,155	444,965	446,966	(2,401)	(1)%	0%
FE9602 THE SMITHY SURGERY	5,478,205	13,566	5,540,650	1,414,676	(5,835)	0	1,472,840	(58,165)	(4)%	(2)%	637,001	153,474	166,838	(13,364)	(9)%	(8)%
Hyde	98,970,539	244,184	100,101,069	25,560,574	(105,417)	(81,718)	26,613,046	(1,052,472)	(4)%	(6)%	11,508,215	2,772,705	3,000,364	(227,659)	(8)%	(7)%
FE9005 LOCKSIDE MEDICAL CENTRE	10,206,605	27,611	10,327,659	2,656,945	(10,874)	(32,054)	2,694,075	(55,130)	(2)%	(5)%	1,167,046	283,599	253,473	32,126	12%	12%
FE9007 STAVELEIGH MEDICAL CENTRE	9,905,825	27,455	10,021,690	2,561,261	(10,531)	0	2,759,782	(198,521)	(8)%	(9)%	1,181,826	277,506	262,461	15,047	5%	4%
FE9022 KING STREET MEDICAL CENTRE	5,461,197	16,028	5,526,153	1,412,867	(5,817)	0	1,405,374	7,413	1%	(3)%	625,024	152,998	152,068	930	1%	3%
FE9023 ST ANDREWS HOUSE	7,729,781	19,445	7,818,450	1,996,700	(8,233)	0	2,120,830	(124,130)	(6)%	(7)%	896,813	216,555	223,921	(7,366)	(3)%	(3)%
FE9025 TOWN HALL SURGERY	4,772,836	14,547	4,829,725	1,235,174	(5,054)	(21,272)	1,262,075	(27,900)	(2)%	(12)%	554,956	135,706	112,646	23,062	16%	17%
FE9026 GROSVENOR MEDICAL CENTRE	5,721,501	23,982	5,823,590	1,254,916	(9,290)	(14,162)	1,315,700	(56,782)	(5)%	(2)%	1,014,129	244,337	244,212	125	0%	3%
FE9612 MOSSLEY MEDICAL PRACTICE	2,718,936	9,920	2,755,206	708,416	(2,896)	0	755,275	(49,858)	(7)%	(10)%	316,156	76,172	60,984	15,188	20%	19%
FE9618 PIKE MEDICAL CENTRE	2,752,759	8,419	2,786,631	715,867	(2,932)	0	715,154	414	0%	(3)%	310,069	77,120	78,404	1,716	2%	5%
YG2556 MILLBROOK MEDICAL PRACTICE	5,826,847	12,040	5,875,159	990,937	(4,076)	0	937,651	53,306	5%	(2)%	444,965	107,211	89,399	17,812	17%	16%
Stalybridge	56,097,786	160,248	56,760,424	14,509,908	(59,752)	(67,469)	14,963,094	(453,190)	(3)%	(3)%	6,523,005	1,571,605	1,474,568	97,037	6%	7%
Total	352,068,000	925,092	356,146,092	90,988,110	(375,000)	(373,340)	95,367,092	(4,380,981)	(5)%	(5)%	40,938,184	9,863,346	10,133,068	(269,722)	(3)%	(2)%

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	31 October 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 July 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 are 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 (July 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 decreased 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 10.8% compared to the same period last year and other referrals have increased by 9.0% compared to the same period last year for referrals at Tameside and Glossop Integrated Care Foundation Trust. Referrals to all providers have decreased by 11.5% compared to the same period last year and other referrals have increased by 10.8%.

18 Weeks RTT Incomplete Pathways

3.3 Performance continues to be above the national standard of 92%, currently achieving 92.51% during July. The specialties failing are Urology 89.88%, Trauma and Orthopaedics 87.99%, ENT 91.59%, Neurosurgery 85.37%, Cardiology 91.83%, Plastic Surgery 75.12% and Cardiothoracic Surgery 90.77%. There were no patients waiting longer than 52 weeks during July.

Diagnostics 6+ week waiters

3.4 This month the Clinical Commissioning Group failed to achieve the 1% standard with a 1.62% performance. Of the 73 breaches 20 occurred at Central Manchester (CT, Colonoscopy, Gastroscopy, Flexi Sigmoidoscopy and MRI), 32 at North West CATS Inhealth (MRI and NOUS), 14 at Tameside and Glossop Integrated Care Foundation Trust (Audiology assessments), 1 at Pennine Acute (Colonoscopy), 1 at Salford Trust (Urodynamics), 1 at Stockport Trust (Cardiology) and 4 at Other (Neurophysiology, Colonoscopy, Flexi Colonoscopy). Central Manchester performance is due to an ongoing issue with endoscopy which GM 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 July was 93.56% for Type 1 & 3 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 NWAS area

3.6 In July 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 NWAS 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 KPIs reported as follows for July:

- Calls Answered (95% in 60 seconds) = 83.6%
- Calls abandoned (<5%) = 4.1%
- Warm transfer (75%) = 42.98%
- Call back in 10 minutes (75%) = 42.2%

3.8 The benchmarking data shows that the North West NHS 111 service was ranked 37th out of 40 for calls answered in 60 seconds (83%). This is compared to North Essex 111 which is the highest ranked for calls answered in 60 seconds (98%).

3.9 Looking at the dispositions we are ranked 39th out of 40 for % recommended to dental (3%) compared to the highest ranked provider York and Humber (13%). Percentage recommended home care (3%) we are ranked 39th out 40 compared to the highest ranked provider, Outer North West London (8%).

3.10 In July 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. Call Pickup and call abandonment performance has been sustained. Patient access to urgent care has remained good despite not meeting the headline Key Performance Indicators.

Cancer

3.11 All of the cancer indicators achieved the standard during July except 62 day consultant upgrades, where there were 8 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 (IAPT) access rate (75%) achieving 4.09% during Quarter 4. We can report the Quarter 4 performance for IAPT recovery rate remains is now achieving the standard at 50.0%. In terms of IAPT waiting times the Quarter 4 performance is above the standard against the 18 week standard (95%) which was reported as 97.7%. The Quarter 4 performance for the 6 week wait standard (75%) was reported as 79.7%.

Healthcare Associated Infections

3.13 Clostridium Difficile: The number of reported cases during July was on plan. Tameside & Glossop Clinical Commissioning Group had a total of 11 reported cases of clostridium difficile against a monthly plan of 11 cases. For the month of July this places Tameside and Glossop Clinical Commissioning Group on plan. Of the 11 reported cases, 6 were apportioned to the acute (2 at Tameside and Glossop Integrated Care Foundation Trust and 4 at Central Manchester Foundation Trust) and 5 to the non-acute. To date (April to July 2017) Tameside and Glossop Clinical Commissioning Group had a total of 34 cases of clostridium difficile against a year to date plan of 29 cases. This places Tameside and Glossop Clinical Commissioning Group 5 case over plan. Of the 34 reported cases, 18 were apportioned to the acute (10 at Tameside and Glossop Integrated Care Foundation Trust,1 at Royal Free London 1 at South Manchester Trust and 6 at Central Manchester Foundation Trust) and 16 to the non-acute. In regards to the 2017/18 financial year, Tameside and Glossop Clinical Commissioning Group have reported 34 cases of

clostridium difficile against an annual plan of 97 cases. This currently places the Clinical Commissioning Group 63 cases under plan with 8 months of the financial year remaining.

3.14 MRSA: In July 2017 Tameside and Glossop Clinical Commissioning Group have reported 1 case of MRSA against a plan of zero tolerance. To date (April to July 2017) Tameside and Glossop Clinical Commissioning Group have reported 3 cases of MRSA against a plan of zero tolerance.

Mixed Sex Accommodation

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

Dementia

3.16 We continue to perform well against the estimated diagnosis rate for people aged 65+ for July 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 Adult Social Care 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.

4.8 Tameside performance in 2016/2017 was 4.95%, this is an increase on 2015/2016 and brings us above the regional average for 2015/2016 – we await published Regional and National figures for 2016/2017 to be able to get a true comparison.

4.9 In 2015/2016, six GM authorities had less than 3% of People with Learning Disability in Employment, with only Trafford, Stockport and Rochdale achieving above 4%.

4.10 Nationally and regionally, we are seeing a steady decline in this indicator - 2012/2013 region 5.5%, national 7%.

4.11 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.

4.12 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.

5. RECOMMENDATIONS

5.1 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 92.51% during July.
Cancer: All of the cancer indicators achieved standard during July 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 July was 82.0% against the 66.7% standard.
Referrals: GP referrals have decreased 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.
Weeks RTT 52+ Week Waits: There were no patients waiting longer than 52 weeks during July.
Healthcare Associated Infections Clostridium Difficile: The number of reported cases during July (11) was on plan.

Challenges

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

A&E Waits Total Time Within 4 Hours At T&G ICFT: July performance at Tameside And Glossop Integrated Care NHS FT (T&GICFT) is below the 95% target, at 89.3% (Type 1 only). A total of 7,629 patients attended A&E in the month, of which 818 did not leave the department within 4 hours. Type 1 & 3 performance at 93.56%.
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 July. Responses to Red1 and Red2 calls within 8 minutes were below the 75% standard, at 64.67% and 64.17%, respectively. Responses to all Red calls within 19 minutes were also below the 95% standard, at 89.80%.
111: The North West NHS 111 service is performance managed against a range of KPIs reported as follows for July:- Calls Answered (95% in 60 seconds) = 83.6%- Calls abandoned (<5%) = 4.1%- Warm transfer (75%) = 42.98% 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 1.62% during July.
Healthcare Associated Infections MRSA: There has been 1 reported case of MRSA during July.

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

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

Better Health

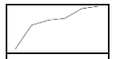
Description	Indicator	F	Level	Better is...	Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Exceptions	GM	England	Trend
	Utilisation of the NHS e-referral service to enable choice at first routine elective referral	M	T&G CCG	H		11.6%	11.2%	11.1%	11.6%	10.4%	10.7%	10.0%	10.1%	11.1%	13.3%	11.4%	13.4%	14.6%	15.2%	17.7%			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	Jul-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%	94.29%		93.40%	94.05%	
	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%	98.13%		88.80%	93.51%	
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%	100%		98.80%	97.56%	
	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%	95%		98.40%	96.00%	
	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%	100%	Breach due to deferred treatment in Jan-16.	99.50%	99.55%	
	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%	100%		99%	96.87%	
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%	86.67%	There were 10 breaches out of a total of 39 seen in Sept 16.	81.70%	81.22%	
	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%	100%		94.80%	90.53%	
	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%	70.37%	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%	87.65%	
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%	92.5%	CCG target (92%) achieved. Failing specialties are Urology (89.88%), Trauma & Orthopaedics (87.99%), Ear, Nose & Throat (ENT) (91.59%), Neurosurgery (85.37%), Plastic Surgery (75.12%), Cardiothoracic Surgery (90.77%), Cardiology (91.83%).	92.80%	89.90%	
	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	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%	1.62%	In July 73 patients (62 patients waiting 6-13 weeks and 11 patients >13 Weeks).	1.40%	1.80%	
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%	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%	93.6%	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). July performance is 89.3% breached by 818 patients (7,629) For Type 1 attendances. 93.6% for Type 1 & 3.	88.90%	90.30%	
	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			
						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		GM	England *	Trend
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	Jul-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	5242	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	3084	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	3646	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	1848	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	6588	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	2738	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	2459	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		

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	Jul-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

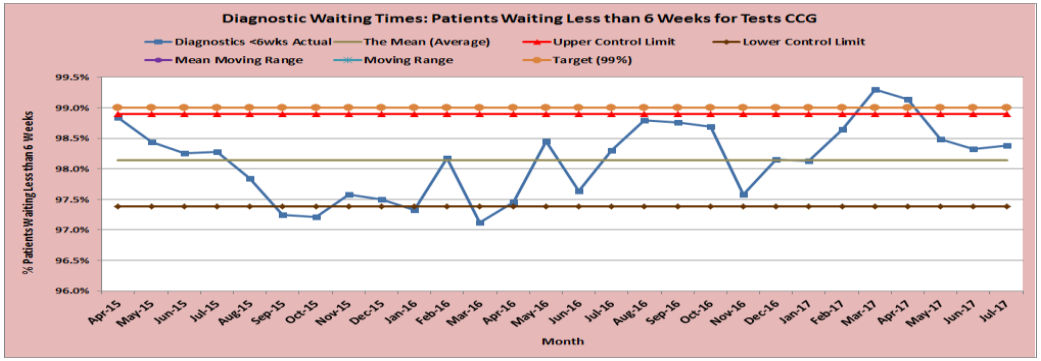
Other Indicators

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	Jul-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	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.		0.55	
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%	83.6%			89.70%	
	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%	4.1%			1.80%	
	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%	43.0%			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%	42.2%			42.30%	
	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%	63.3%	High levels of demand and lengthening turn around times.	62.10%	67.90%	
	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%	62.89%	High levels of demand and lengthening turn around times.	65.90%	60.48%	
	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%	89.7%	High levels of demand and lengthening turn around times.		89.67%	
	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%	64.7%	High levels of demand and lengthening turn around times.	62.10%	67.90%	
	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%	64.2%	High levels of demand and lengthening turn around times.	65.90%	60.48%	
	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%	89.8%	High levels of demand and lengthening turn around times.		89.67%	
	Quality																							
Quality	Clostridium Difficile-Whole Health Economy	M		L	Plan	7	3	9	10	5	13	6	6	5	4	9	6	5	11	11			1004	
	Clostridium Difficile-Acute	M		L	Plan	2	2	4	5	2	8	5	4	2	3	5	2	2	7	6			410	
	Clostridium Difficile-Non-Acute	M		L	Plan	5	1	5	5	3	5	1	2	3	1	4	4	3	4	5			594	
	MRSA-Whole Health Economy	M		L	0	0	2	1	3	0	0	0	0	2	2	0	0	2	0	1		4	92	
	MRSA-Acute	M		L	0	0	2	0	2	0	0	0	0	1	1	0	0	1	0	0			39	
	MRSA-Non Acute	M		L	0	0	0	1	1	0	0	0	0	1	1	0	0	1	0	1			53	

Exception Report

Tameside & Glossop CCG- September

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



Key Risks and Issues:

As a CCG
This month the CCG failed to achieve the 1% standard with a 1.62% performance.
Of the 73 breaches. 20 occurred at Central Manchester (CT, Colonoscopy, Gastroscopy, Flexi sigmoidoscopy and MRI), 32 at North West CATS Inhealth (MRI and NOUS), 14 at T&G ICFT (Audiology assessments), 1 at Pennine Acute (Colonoscopy), 1 at Salford Trust (Urodynamics), 1 at Stockport (Cardiology), and 4 at Other (Neurophysiology, Colonoscopy, Flexi sigmoidoscopy).

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:

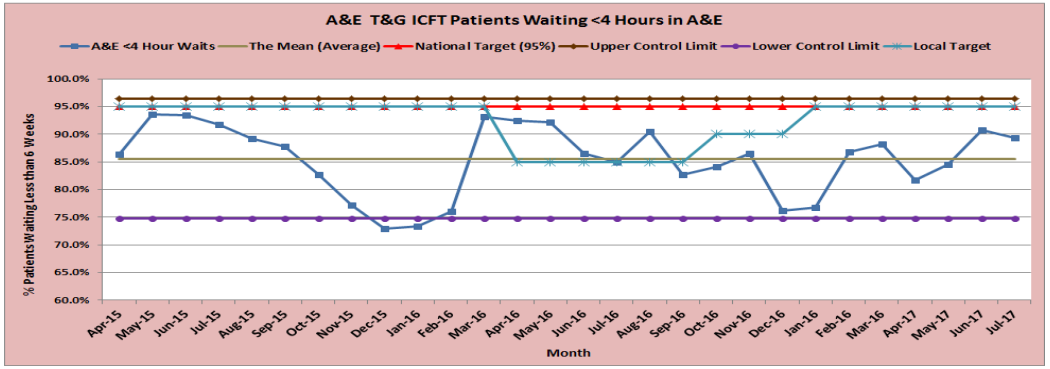
Failure of the standard will negatively impact on the CCG assurance rating. The CCG can Levey penalties through contract with those providers who fail the target.

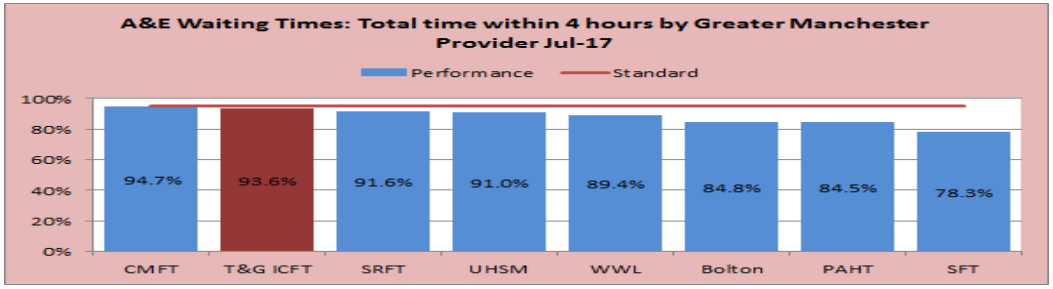
Diagnostics Waiting Times Patients Waiting > 6 Weeks by GM CCG

	Jul-17			
CCG	Waiting > 6 Weeks	Total Waiting List	Performance	Standard
NHS Oldham CCG	100	4365	2.29%	1%
NHS Salford CCG	98	4544	2.16%	1%
NHS Bury CCG	77	3742	2.06%	1%
NHS Heywood, Middleton & Rochdale CCG	89	4392	2.03%	1%
NHS Manchester CCG	195	9900	1.97%	1%
NHS Tameside and Glossop CCG	73	4500	1.62%	1%
NHS Stockport CCG	81	5710	1.42%	1%
NHS Wigan Borough CCG	84	6130	1.37%	1%
NHS Trafford CCG	51	5801	0.88%	1%
NHS Bolton CCG	36	4202	0.86%	1%

Unvalidated -Next month FORECAST

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





July Performance: 93.56%

16/17 ytd: 88.78%

17/18 ytd: 88.42%

Key Risks and Issues:

The A&E Type1 and type 3 performance for July was 93.56% 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 means that the inclusion of this data will add to the overall performance.

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

Operational and Financial implications:

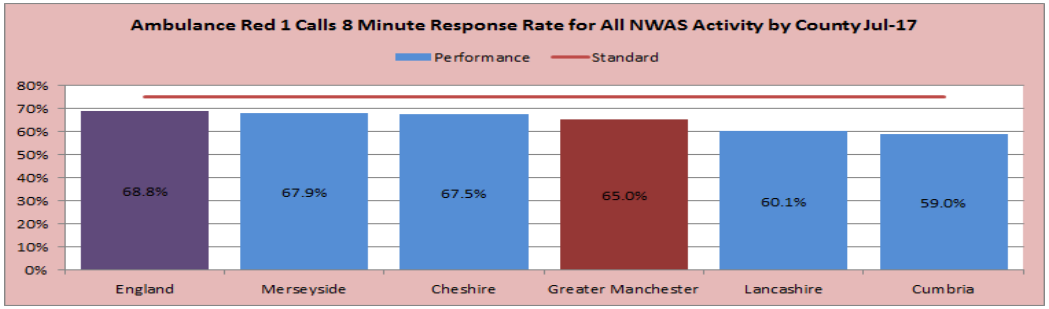
Failure of the standard will negatively impact on the CCG assurance rating. However regular contact is maintained with GMHSCP and the local work being undertaken is recognised.

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

Next month FORECAST

* Please note that Tameside Trust local trajectory for 17/18 is Q1, Q2 and Q3 90%, and Q4 95%.
* Type 1 & 3 attendances included from July 2017.

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



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

	Jul-17			
CCG	**<8 Mins**	**Total**	**Performance**	**Standard**
NHS Wigan Borough CCG	100	146	68.8%	75%
NHS Oldham CCG	71	105	67.6%	75%
NHS Manchester CCG	228	342	66.8%	75%
NHS Stockport CCG	76	116	65.5%	75%
NHS Bolton CCG	70	109	63.9%	75%
NHS Salford CCG	58	91	63.3%	75%
NHS Tameside and Glossop CCG	62	98	63.3%	75%
NHS Bury CCG	43	68	63.2%	75%
NHS Heywood Middleton & Rochdale CCG	66	105	63.0%	75%
NHS Trafford CCG	63	107	58.5%	75%
Data source; NWAS PES report				

July Performance: 64.67%

16/17 ytd: 73.56%

17/18 ytd: 65.76%

Key Risks and Issues:

In July the North West position (which we are measured against) was 64.67% however locally we achieved 63.27% 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.

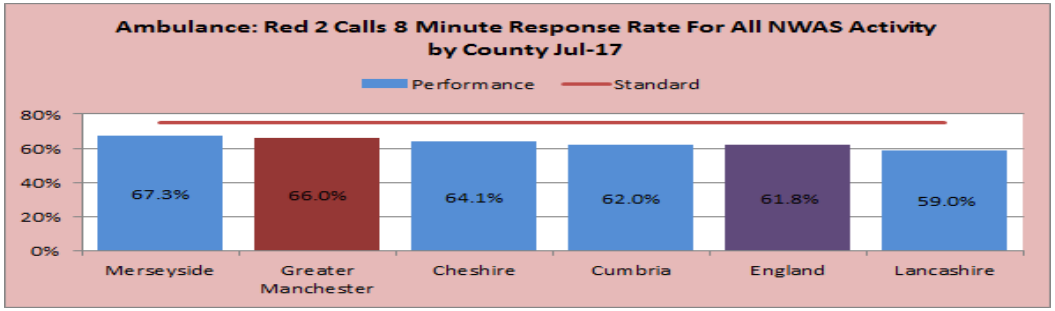
Operational and Financial implications:

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

Unvalidated next month FORECAST

*

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



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

	Jul-17			
CCG	**<8 Mins**	**Total**	**Performance**	**Standard**
NHS Manchester CCG	2732	3814	71.6%	75%
NHS Bury CCG	727	1058	68.7%	75%
NHS Heywood Middleton & Rochdale CCG	916	1341	68.3%	75%
NHS Oldham CCG	938	1389	67.5%	75%
NHS Bolton CCG	1007	1498	67.2%	75%
NHS Salford CCG	897	1391	64.5%	75%
NHS Wigan Borough CCG	1075	1705	63.1%	75%
NHS Tameside and Glossop CCG	951	1512	62.9%	75%
NHS Stockport CCG	989	1645	60.1%	75%
NHS Trafford CCG	624	1079	57.8%	75%
Data source; NWAS PES report				

July Performance: 64.17%

16/17 ytd: 65.61%

17/18 ytd: 65.51%

Key Risks and Issues:

In July the north west position (which we are measured against) was 64.17% however locally we achieved 62.89% 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.
Contract penalties applied by lead commissioner (Blackpool CCG).

Unvalidated next month FORECAST

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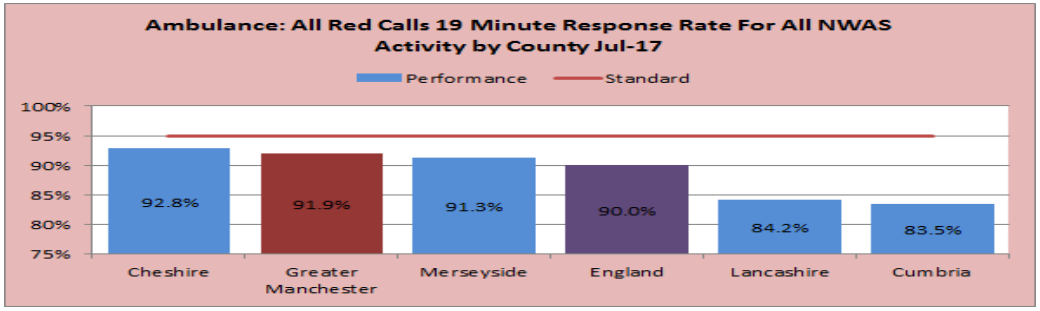
Ambulance performance- | **Lead Officer: Elaine Richardson** | **Lead Director:** Jess Williams | **Governance: A&E Delivery Board**



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

	Jul-17			
CCG	**<19 Mins**	**Total**	**Performance**	**Standard**
NHS Manchester CCG	3886	4156	93.5%	95%
NHS Bolton CCG	1494	1607	93.0%	95%
NHS Salford CCG	1377	1482	92.9%	95%
NHS Oldham CCG	1383	1494	92.6%	95%
NHS Heywood Middleton & Rochdale CCG	1335	1446	92.3%	95%
NHS Stockport CCG	1609	1761	91.3%	95%
NHS Bury CCG	1022	1126	90.7%	95%
NHS Wigan Borough CCG	1671	1851	90.3%	95%
NHS Trafford CCG	1066	1186	89.8%	95%
NHS Tameside and Glossop CCG	1445	1610	89.7%	95%
Data source; NWAS PES report				

July Performance: 89.80%

16/17 ytd: 91.17%

17/18 ytd: 90.43%

Key Risks and Issues:

In July the north west position (which we are measured against) was 89.80% however locally we only achieved 89.74% 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:** Jess Williams **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							
Calls per month via 111 per 1,000 people							
Of all calls offered, % abandoned after at least 30 seconds[1]		4%	2	Luton and Bedfordshire	12%	South Essex	0%
Of calls answered, % in 60 seconds		83%	37	North Essex	98%	Luton and Bedfordshire	66%
Of calls answered, % triaged							
Of answered calls, % transferred to clinical advisor		32%	30	North Central London	66%	South East Coast excluding East Kent	21%
Of transferred calls, % live transferred		9%	20	North Central London	22%	Buckinghamshire	4%
Average NHS 111 live transfer time[1]							
Average warm transfer time							
Of calls answered, % passed for call back		12%	29	Devon	20%	Lincolnshire	1%
Of call backs, % within 10 minutes		41%	21	East London and City	77%	Dorset	15%
Average episode length							
Of answered calls, % calls to a CAS clinician		20%	34	Devon	33%	Lincolnshire	8%

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	15%	15%	6	Cornwall	17%	Hertfordshire	8%
111 dispositions: % Recommended to attend A&E	9%	9%	25	East London and City	15%	Lincolnshire	5%
Recommended to attend primary and community care	56%	57%	31	Cambridgeshire and Peterborough	66%	Lincolnshire	49%
Of which - % Recommended to contact primary and community care		42%	19	Cambridgeshire and Peterborough	50%	Nottinghamshire	33%
- % Recommended to speak to primary and community care		12%	17	Somerset	15%	Hertfordshire	4%
- % Recommended to dental		3%	39	Yorkshire and Humber	13%	Devon	1%
- % Recommended to pharmacy		0.4%	21	East London and City	0.8%	Cambridgeshire and Peterborough	0.1%
111 dispositions: % Recommended to attend other service	2%	2%	30	Lincolnshire	20%	Bristol, North Somerset & South Gloucestershire	1%
111 dispositions: % Not recommended to attend other service	17%	17%	6	North Essex	19%	North East	9%
Of which - % Given health information		5%	1	NW inc. Blackpool	5%	Yorkshire and Humber	0.1%
- % Recommended home care		3%	39	Outer North West London	8%	Lincolnshire	1%
- % Recommended non clinical		9%	11	Buckinghamshire	12%	Luton and Bedfordshire	2%

Key Risks and Issues:

The North West NHS 111 service is performance managed against a range of KPIs reported as follows for July:
- Calls Answered (95% in 60 seconds) = 83.6%
- Calls abandoned (<5%) = 4.1%
- Warm transfer (75%) = 42.98%
Call back in 10 minutes (75%) = 42.2%

In July 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 month of July 2017

Quality Indicator	Y/N	**Comments**
Has a local provider been rated as inadequate by the CQC/OFSTED	N	
Has a local provider been subject to regulatory notice e.g. CQC alert, Reg 28,	N	
Does the CCG and / or partner originations have concerns about the ability of a provider to deliver safe, quality care?	Y	**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. **Update: The suspension at the home was lifted on the 2 August 2017 following demonstration of sustained improvements**. **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. **The home has secured a manager however they are not yet currently in post .Recruitment of nurses continues but remains problematic. Individualised Commissioning team continue to have weekly visits to the home .Next commissioner's meeting is the 23/08/17.** **Jabulani** residential home (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. **Improvements have been made however, until the outcome of the police investigation is known, the suspension by DCC remains in place.** **Pennine Care Centre (Glossop).** The suspension has been lifted as a result of sustained improvements however close monitoring by DCC remains in place. NB Staley House (Residential Care) was rated Good on the 6 July 2017 (an improvement from the previous Requires Improvement rating). **PCFT:** In response to the Trust's detailed CQC improvement action plan and revised Quality Strategy, a new joint Quality Assurance Board has been establish as a sub group of the newly established Quality Improvement Board chaired by NHSI. The Quality Assurance Board includes representatives from the Clinical Commissioning Groups and the Trust. The Terms of Reference has been agreed. 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?	Y	For July 2017 Tameside and Glossop CCG have reported 1 cases of MRSA against a plan of zero tolerance. To date (April 2017 to July 2017) Tameside and Glossop CCG have reported 3 cases of MRSA against a plan of zero tolerance cases (1 at T&G ICFT and 2 non acute case). Post infection review (PIR) was undertaken on the 3 MRSA cases notified since April 2017. All cases have been found to be unavoidable, as no intervention carried out by either community or hospital care staff would have prevented infection. However the PIR process is an opportunity to review the care we provide and this has highlighted the need for staff to improve their documentation processes.
Has a provider reported more C difficile cases than trajectory?	N	For July 2017 Tameside & Glossop CCG had a total of 11 reported cases of clostridium difficile against a monthly plan of 11 cases. For the month of July this places Tameside and Glossop CCG on plan. Of the 11 reported cases, 6 were apportioned to the acute (2 at Tameside ICFT and 4 at CMFT) and 5 to the non-acute. To date (April to July 2017) Tameside and Glossop CCG has a total of 34 cases of clostridium difficile against a year to date plan of 29 cases. This places Tameside and Glossop CCG 5 cases over plan. Of the 34 reported cases, 18 were apportioned to the acute (10 at T&G, 1 at SMFT ICFT, 1 at Royal Free London and 6 at CMFT) and 16 to the non-acute. In regards to the 2017/18 financial year, Tameside and Glossop CCG have reported 34 cases of clostridium difficile against an annual plan of 97 cases. This currently places the CCG 63 cases under plan with 8 months of the financial year remaining. The findings from the root cause analyses undertaken was reviewed internally and at the WHE Quality

		Improvement Group; the group did not identify any cases where lapses in care contributed to the CDIF cases. However lapses in care were identified which did not contribute to the CDIF case but did provide opportunity for improvements to be made including ensuring appropriate sampling and working closely with antibiotic pharmacists in both acute and community to support clinicians in their antibiotic prescribing decisions.
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	
Has a provider reported any maternity diverts?	N	
Does performance indicate any concerns about meeting PoUAC (Previously Un-assessed Periods of Care) targets.		
Does performance indicate any concerns about meeting Transforming Care targets?		
Are there any areas rated RED in the CCGs NHSE Safeguarding Assurance Framework?	N	

Are there any new Serious Case Reviews, Domestic Homicide Reviews, Safeguarding Adult Reviews or Mental Health Homicide Reviews?	N	
Does feedback from the Friends and Family test (or any other patient experience feedback) indicate any causes for concern?	N	
Have any quality / patient safety concerns been identified during CCG Quality visits?	N	
Any new items added to SCF Risk Register relating to quality or patient safety.	N	

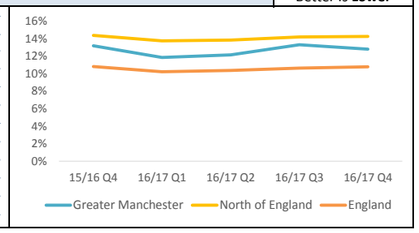
Better Health

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

Maternal Smoking at Delivery

Better Is **Lower**

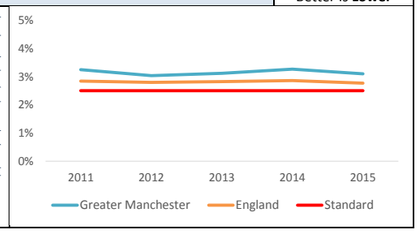
Trafford	7.5%
Central	8.0%
Stockport	11.2%
North	12.5%
South	13.0%
Bury	13.1%
Salford	13.3%
Bolton	13.9%
Wigan	14.1%
Oldham	15.1%
HMR	15.4%
T&G	15.7%



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%

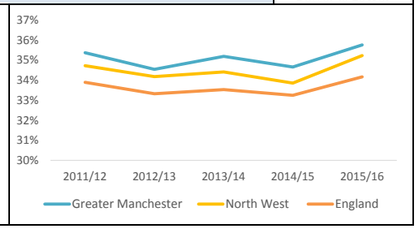


More GM Children Will Reach a Good Level of Development Cognitively, Socially & Emotionally

Children Aged 10-11 Classified as Overweight or Obese

Better Is **Lower**

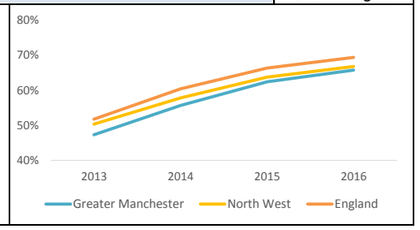
Bolton	35.4%
Bury	34.5%
Mancheste	40.2%
Oldham	36.7%
Rochdale	35.7%
Salford	39.6%
Stockport	30.3%
Tameside	33.9%
Trafford	30.9%
Wigan	35.7%



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??

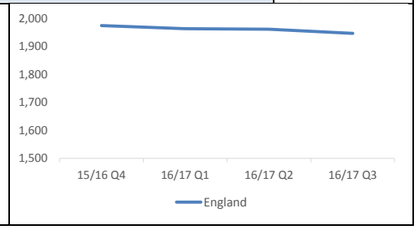
Better Is **Higher**

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

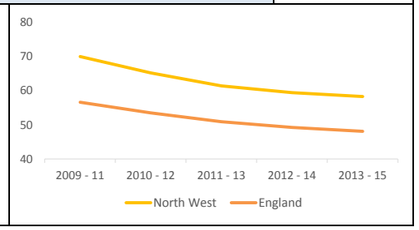
Better Is **Lower**

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

Under-75 Mortality Rate Considered Preventable - CVD

Better Is **Lower**

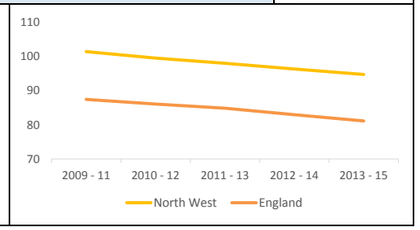
Bolton	60.5
Bury	55.8
Oldham	74.5
Rochdale	70.6
Salford	75.4
Stockport	43.1
Tameside	80.5
Trafford	45.2
Wigan	59.8
Mancheste	89.5



Under-75 Mortality Rate Considered Preventable - Cancer

Better Is **Lower**

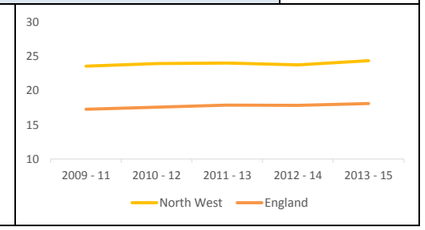
Bolton	92.9
Bury	89.9
Oldham	105.9
Rochdale	101.2
Salford	118.7
Stockport	84.7
Tameside	103.5
Trafford	84.0
Wigan	91.8
Mancheste	129.3



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

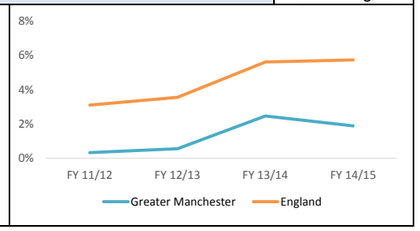
Better Is **Higher**

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**

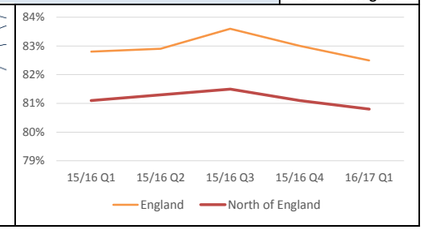
Bolton	0.1%
Bury	0.0%
Central	0.0%
HMR	0.0%
North	2.5%
Oldham	0.8%
Salford	1.0%
South	0.6%
Stockport	1.6%
T&G	0.0%
Bury	0.0%
HMR	0.0%



Diabetic Eye Screening

Better Is **Higher**

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

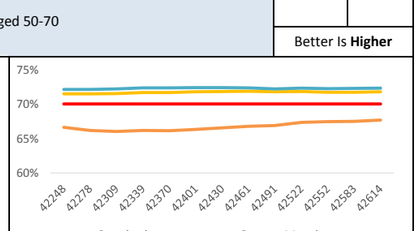


(Placeholder TBC)

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

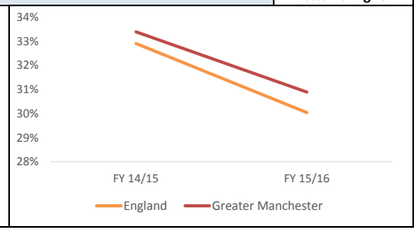
Better Is **Higher**

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**

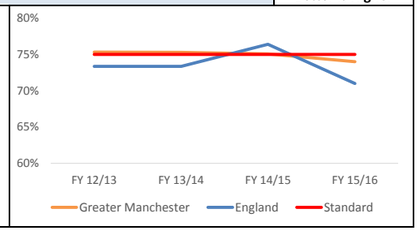
Bolton	27.2%
Bury	28.6%
Central	27.4%
HMR	32.3%
North	28.0%
Oldham	31.1%
Salford	28.3%
South	20.2%
Stockport	37.1%
T&G	32.1%
Trafford	41.8%
Wigan	32.7%



Flu Immunised aged 65 and over

Better Is **Higher**

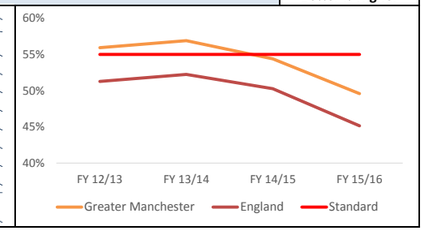
Bolton	73.3%
Bury	75.1%
Central	70.4%
HMR	74.6%
North	70.6%
Oldham	73.2%
Salford	73.8%
South	69.2%
Stockport	76.8%
T&G	75.0%
Trafford	77.4%
Wigan	72.0%



Flu Immunised in clinical risk groups

Better Is **Higher**

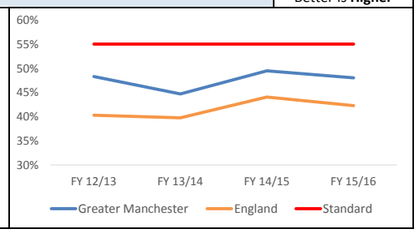
Bolton	49.6%
Bury	47.9%
Central	48.1%
HMR	54.1%
North	49.2%
Oldham	49.6%
Salford	42.8%
South	46.3%
Stockport	56.5%
T&G	52.8%
Trafford	51.7%
Wigan	45.2%



Flu Immunised in pregnant women

Better Is **Higher**

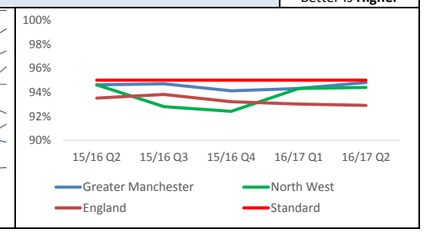
Bolton	46.1%
Bury	48.3%
Central	44.1%
HMR	50.4%
North	41.7%
Oldham	50.6%
Salford	37.7%
South	47.1%
Stockport	63.7%
T&G	52.3%
Trafford	50.3%
Wigan	45.4%



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

Better Is **Higher**

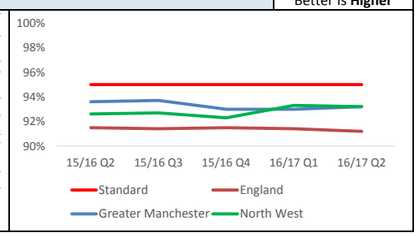
Wigan	97.4%
T&G	97.3%
Trafford	96.8%
Oldham	96.6%
Bolton	96.5%
Salford	95.7%
HMR	95.6%
Bury	94.7%
Stockport	94.4%



Mumps, Measles & Rubella (MMR)

Better Is **Higher**

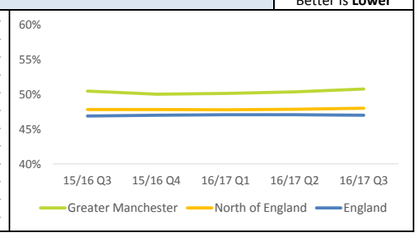
T&G	97.3%
HMR	95.8%
Salford	95.2%
Wigan	95.1%
Trafford	94.7%
Bolton	94.6%
Oldham	94.4%
Stockport	93.5%
Bury	90.8%
Manchester	87.8%



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%



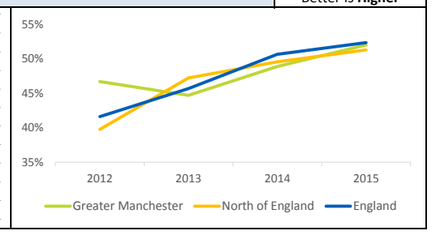
Better Care

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

Cancers Diagnosed at Early Stage

Better Is **Higher**

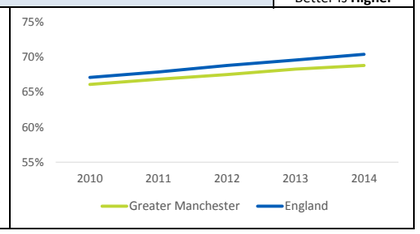
Trafford	56.1%
Stockport	55.4%
Wigan	52.7%
HMR	52.6%
Bolton	52.0%
Oldham	52.0%
South	51.8%
North	51.5%
Bury	50.2%
T&G	49.2%
Salford	48.7%
Central	48.4%



One-Year Survival From All Cancers

Better Is **Higher**

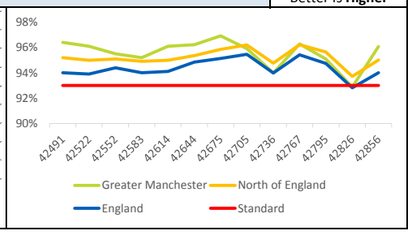
Stockport	71.9%
Trafford	71.7%
Bury	70.4%
HMR	69.3%
South	69.2%
Wigan	68.9%
Bolton	68.3%
Oldham	68.0%
Central	67.2%
T&G	67.1%
Salford	65.9%
North	64.8%



Cancer - Two week wait from cancer referral to specialist appointment

Better Is **Higher**

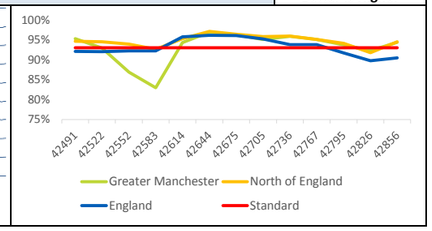
Bolton	98.7%
Stockport	97.9%
Wigan	97.2%
Salford	96.8%
Oldham	96.6%
Trafford	95.9%
Bury	95.4%
HMR	95.4%
T&G	94.3%
Mancheste	94.0%



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

Better Is **Higher**

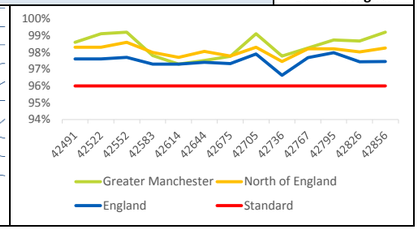
T&G	99.0%
Oldham	98.7%
Stockport	96.8%
Wigan	96.4%
Salford	94.3%
HMR	93.6%
Trafford	93.0%
Mancheste	92.4%
Bolton	91.3%
Bury	88.4%



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

Better Is **Higher**

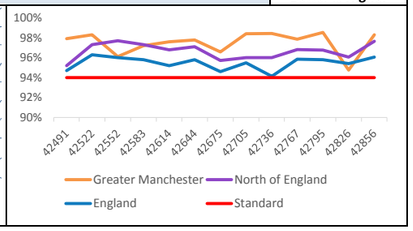
T&G	100.0%
Stockport	100.0%
Mancheste	100.0%
Bury	100.0%
Salford	100.0%
Bolton	99.1%
HMR	98.9%
Wigan	98.1%
Trafford	97.9%
Oldham	97.7%



Cancer - 31-day wait for subsequent surgery

Better Is **Higher**

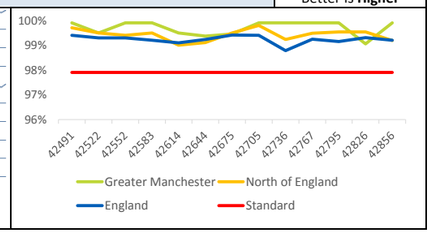
Mancheste	100.0%
Stockport	100.0%
Bolton	100.0%
Bury	100.0%
T&G	100.0%
HMR	100.0%
Oldham	100.0%
Wigan	97.4%
Salford	95.0%
Trafford	92.9%



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

Better Is **Higher**

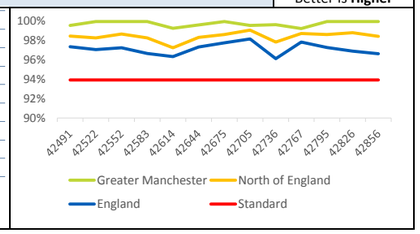
Bolton	100.0%
Bury	100.0%
HMR	100.0%
Oldham	100.0%
Salford	100.0%
Stockport	100.0%
T&G	100.0%
Trafford	100.0%
Wigan	100.0%
Mancheste	100.0%



Cancer - 31-day wait for subsequent radiotherapy

Better Is **Higher**

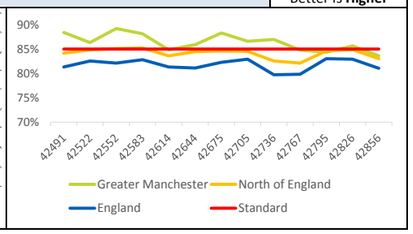
Bolton	100.0%
Bury	100.0%
HMR	100.0%
Oldham	100.0%
Salford	100.0%
Stockport	100.0%
T&G	100.0%
Trafford	100.0%
Wigan	100.0%
Mancheste	100.0%



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%

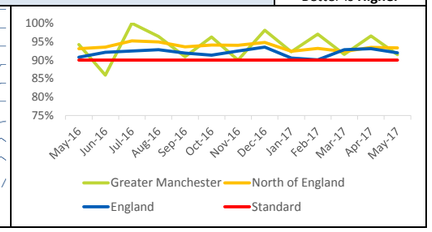


Decreased Variation In Quality Of Care Health Outcomes Across GM Localities

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

Better Is **Higher**

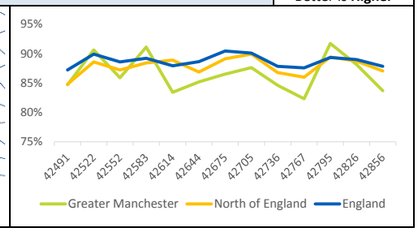
T&G	100.0%
Wigan	100.0%
Trafford	100.0%
HMR	100.0%
Oldham	100.0%
Bolton	100.0%
Bury	90.9%
Stockport	82.4%
Mancheste	81.8%
Salford	80.0%



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

Better Is **Higher**

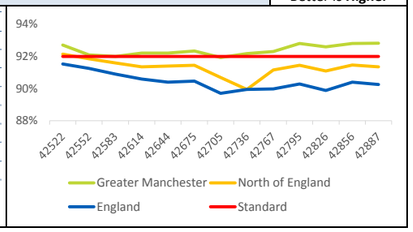
Bolton	70.0%
Bury	83.3%
HMR	60.0%
Mancheste	95.5%
Oldham	71.4%
Salford	75.0%
Stockport	85.0%
T&G	69.6%
Trafford	90.0%
Wigan	95.7%



Referral to Treatment - 18 weeks

Better Is **Higher**

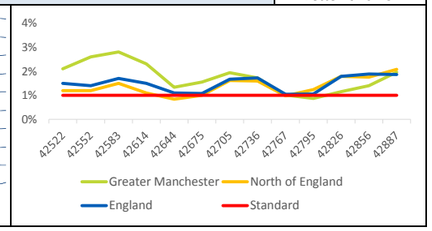
Wigan	95.2%
Oldham	93.7%
HMR	93.5%
Salford	93.5%
Bolton	93.0%
T&G	92.7%
Stockport	92.5%
Bury	92.4%
Mancheste	91.5%
Trafford	91.2%



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

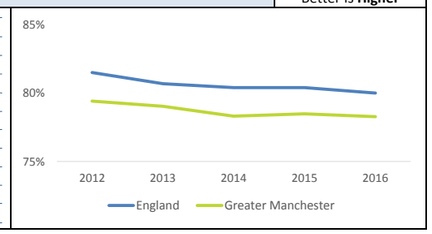
Better Is **Higher**

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%

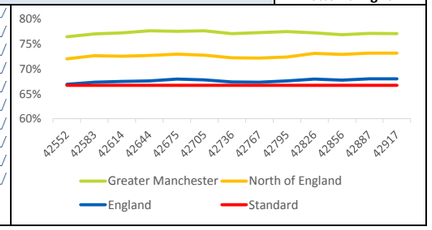


Improved Outcomes For People With Learning Disabilities/Mental Health Needs

Estimated Diagnosis Rate For People With Dementia

Better Is **Higher**

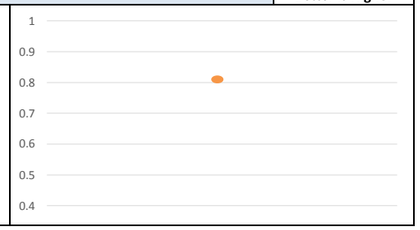
Salford	89.1%
Bury	84.6%
T&G	82.0%
Oldham	80.9%
Bolton	78.3%
Mancheste	75.9%
Stockport	75.4%
Trafford	74.8%
Wigan	68.6%
HMR	67.4%



Dementia Care Planning and Post-Diagnostic Support

Better Is **Higher**

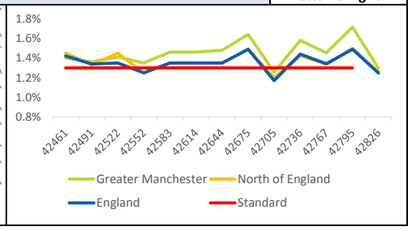
Bolton	83.4%
Bury	84.3%
Central	84.8%
HMR	77.5%
North	81.4%
Oldham	77.0%
Salford	79.0%
South	79.1%
Stockport	80.5%
T&G	80.6%
Trafford	80.2%
Wigan	77.3%



Improving Access to Psychological Therapies Access Rate

Better Is **Higher**

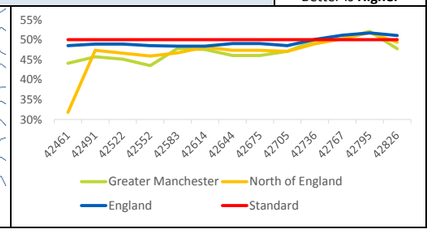
T&G	1.66%
Salford	1.64%
Wigan	1.49%
Oldham	1.46%
Bury	1.43%
Stockport	1.19%
Mancheste	1.10%
Trafford	1.06%
Bolton	0.94%
HMR	0.62%



Improving Access to Psychological Therapies Recovery Rate

Better Is **Higher**

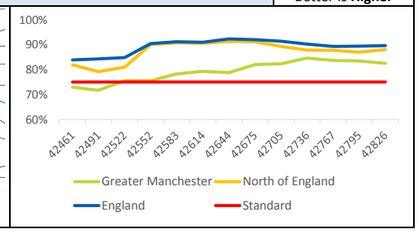
Bolton	60.0%
Wigan	56.1%
Trafford	51.6%
Stockport	51.1%
Bury	50.0%
HMR	50.0%
Oldham	50.0%
Salford	50.0%
T&G	46.4%
Mancheste	29.8%



Improving Access to Psychological Therapies Seen Within 6 Weeks

Better Is **Higher**

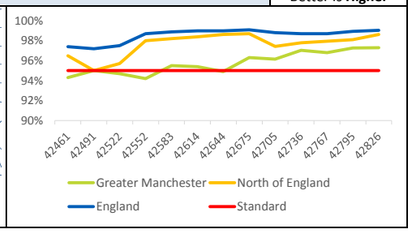
Wigan	100.0%
Oldham	93.3%
HMR	92.3%
Bury	86.2%
Trafford	85.7%
Salford	85.1%
Stockport	81.6%
T&G	79.3%
Bolton	74.1%
Mancheste	59.1%



Improving Access to Psychological Therapies Seen Within 18 Weeks

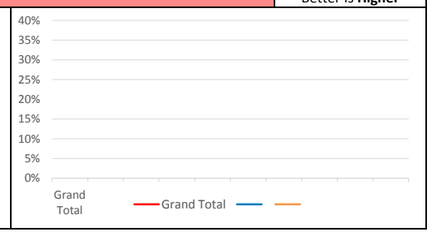
Better Is **Higher**

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

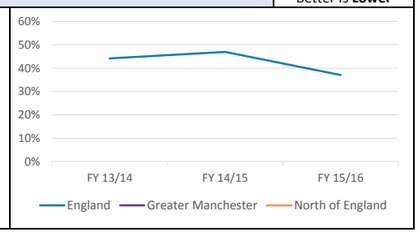
Better Is **Higher**



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

Better Is **Lower**

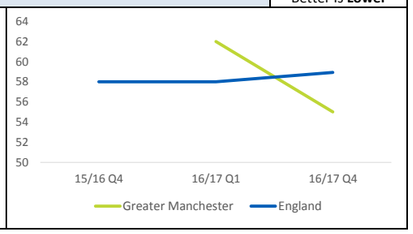
Bolton	64.1%
Bury	47.4%
Central	14.8%
HMR	28.8%
North	40.6%
Oldham	38.7%
Salford	23.1%
South	19.9%
Stockport	27.4%
T&G	41.4%
Trafford	31.9%
Wigan	41.2%



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

Better Is **Lower**

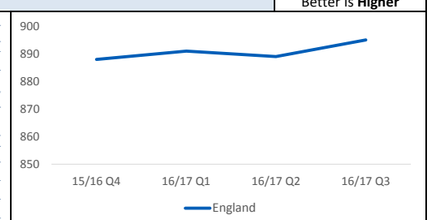
Bolton	55
Bury	55
Central	55
HMR	55
North	55
Oldham	55
Salford	55
South	55
Stockport	55
T&G	55
Trafford	55
Wigan	55



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

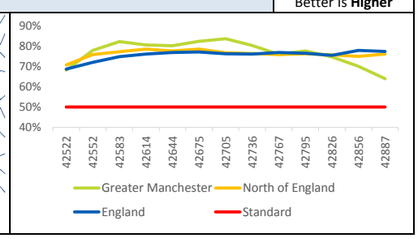
Better Is **Higher**

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%

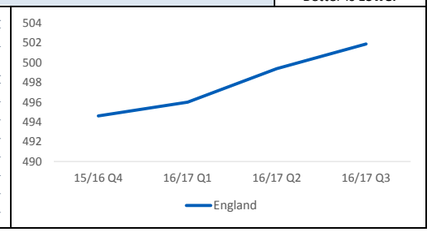


Decreased Need For Hospital Services With More Community Support

Population Use Of Hospital Beds Following Emergency Admission

Better Is **Lower**

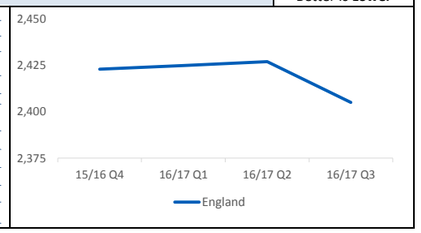
HMR	411.9
Wigan	449.1
Bury	454.3
Oldham	457.1
Bolton	507.5
North	568.5
Salford	604.1
T&G	610.6
Stockport	634.9
South	654.5
Central	703.4
Trafford	723.8



Emergency Admissions For Urgent Care Sensitive Conditions

Better Is **Lower**

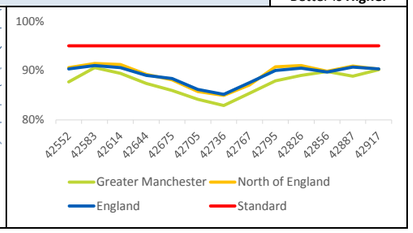
Bury	2,228
Trafford	2,547
Bolton	2,560
Oldham	2,709
HMR	2,739
Wigan	2,925
Stockport	2,974
T&G	3,212
South	3,376
North	3,456
Central	3,550
Salford	3,701



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

Better Is **Higher**

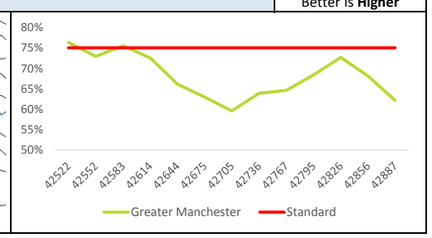
CM NHS FT	94.7%
Tameside N	93.6%
Salford Roy	91.6%
UHSM NHS	91.0%
WWL NHS	89.4%
Bolton NHS	84.8%
Pennine Ac	84.5%
Stockport N	78.3%



Ambulance in Red 1 in 8 mins

Better Is **Higher**

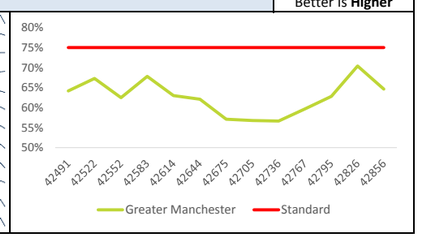
Bolton	62.8%
Bury	63.0%
HMR	65.0%
Oldham	57.5%
Salford	60.7%
Stockport	65.0%
T&G	57.1%
Trafford	42.3%
Wigan	63.8%
Mancheste	66.8%



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%

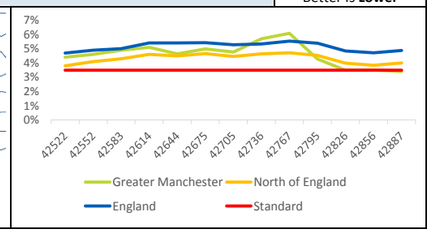


Improved Transition Of Care Across Health And Social Care

Delayed Transfers of Care - Bed Days

Better Is **Lower**

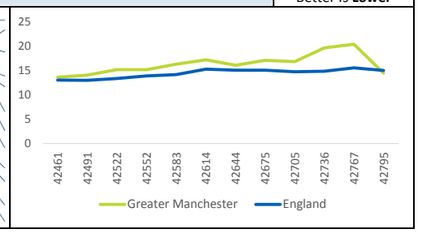
WWL NHS	1.2%
Pennine Ac	2.6%
Bolton NHS	2.9%
CM NHS FT	3.1%
Salford Roy	4.2%
Stockport N	4.6%
Tameside N	4.9%
UHSM NHS	7.8%



Delayed Transfers of Care per 100,000 Population

Better Is **Lower**

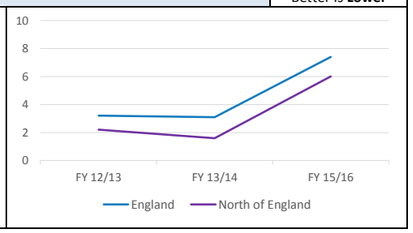
HMR	3.6
Oldham	7.2
Wigan	7.2
Bolton	11.5
Bury	16.3
South	16.9
North	17.9
Central	20.1
T&G	14.8
Salford	17.3
Stockport	12.6
Trafford	33.3



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

Better Is **Lower**

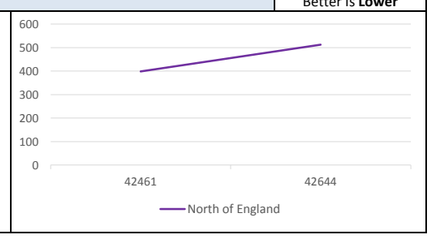
Bolton	4.4
Bury	5.5
Central	7.5
HMR	4.6
North	7.5
Oldham	2.3
Salford	4.2
South	7.5
Stockport	3.6
T&G	6.4
Trafford	14.5
Wigan	4.9



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

Better Is **Lower**

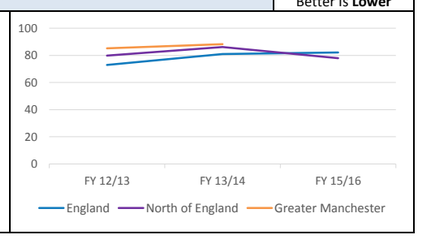
Bolton	496.0
Bury	297.0
Central	473.0
HMR	99.0
North	473.0
Oldham	214.0
Salford	175.0
South	473.0
Stockport	963.0
T&G	1065.0
Trafford	989.0
Wigan	178.0



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

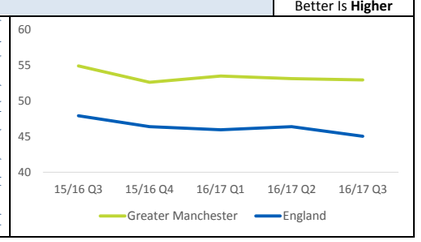
Better Is **Lower**

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

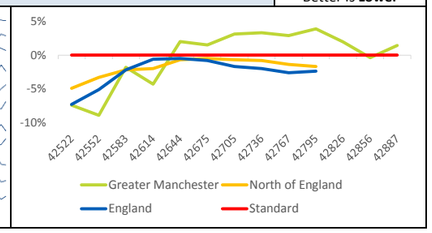


Placeholder TBC

C.Difficile (Ytd Var To Plan)

Better Is **Lower**

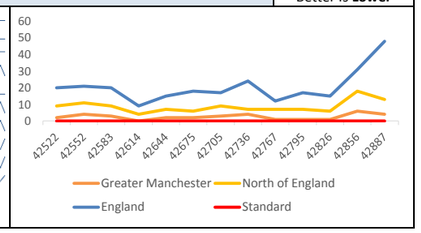
HMR	-34.7%
Wigan	-30.9%
Oldham	-20.9%
Bolton	-20.0%
Trafford	-12.5%
T&G	-5.2%
Mancheste	0.8%
Salford	48.4%
Stockport	50.7%
Bury	77.8%



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

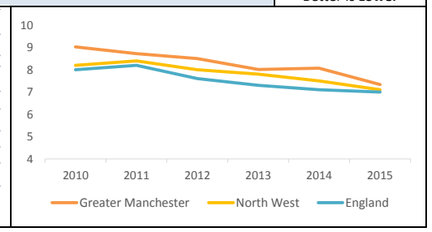
Better Is **Higher**

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**

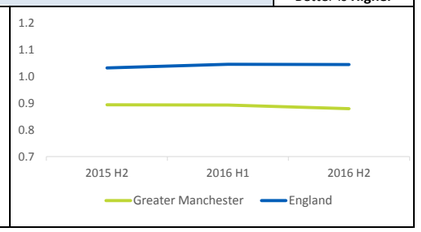
Trafford	3.9
Tameside	4.2
Rochdale	5.2
Wigan	6.1
Oldham	7.2
Bury	7.2
Salford	8.4
Bolton	8.9
Stockport	9.4



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

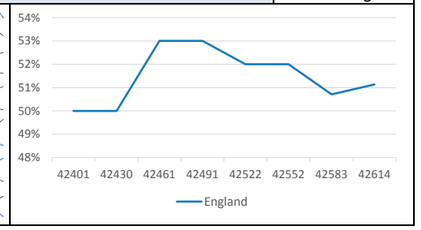
Better Is **Higher**

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**

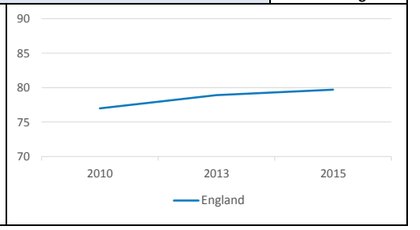
Bolton	99.1%
Bury	69.3%
Central	46.1%
HMR	60.3%
North	72.2%
Oldham	87.1%
Salford	97.7%
South	73.9%
Stockport	61.6%
T&G	10.4%
Trafford	66.3%
Wigan	56.8%



Women's Experience Of Maternity Services

Better Is **Higher**

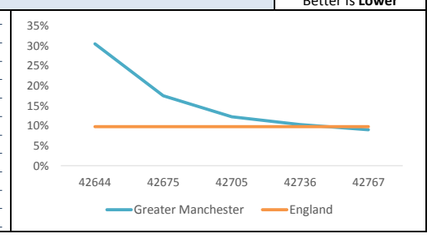
Salford	82.1
Trafford	82.2
Stockport	74.3
North	77.6
Bury	82.3
Bolton	76.9
South	83.5
Wigan	81.9
T&G	82.5
HMR	77.6
Oldham	83.1
Central	80.5



Number of Patients not treated for Atrial Fibrillation

Better Is **Lower**

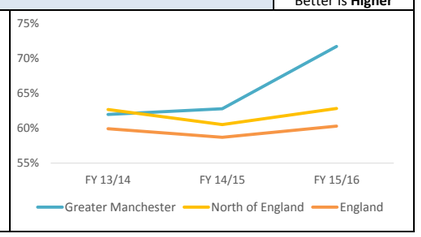
Bolton	7.3%
Bury	4.5%
Central	11.4%
HMR	9.7%
North	10.1%
Oldham	4.6%
Salford	8.4%
South	12.7%
Stockport	9.7%
T&G	10.3%
Trafford	10.4%
Wigan	9.8%



Stroke Unit Within 4 Hours

Better Is **Higher**

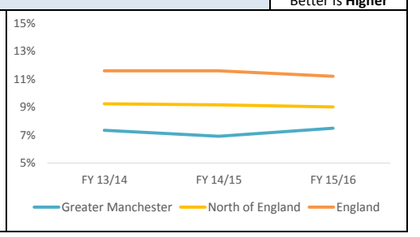
Bolton	76.4%
Bury	75.8%
Central	70.9%
HMR	72.5%
North	71.4%
Oldham	74.3%
Salford	63.3%
South	72.3%
Stockport	74.4%
T&G	66.4%
Trafford	70.5%
Wigan	71.6%



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%



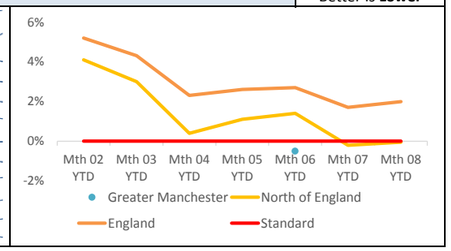
Sustainability

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**

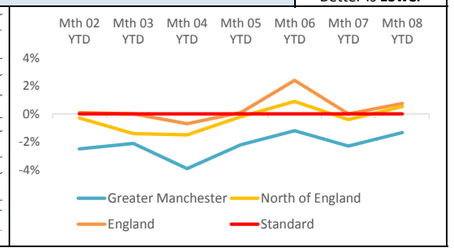
Bolton	14.1%
Bury	1.0%
Central	-6.4%
HMR	0.5%
North	-7.1%
Oldham	1.5%
Salford	-5.4%
South	-2.4%
Stockport	-3.0%
T&G	-5.4%
Trafford	-5.5%
Wigan	3.4%



Activity V Plan: Total OP Attends (Specific Acute)

Better Is **Lower**

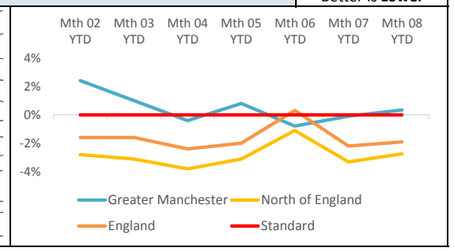
Bolton	3.5%
Bury	0.3%
Central	-4.0%
HMR	2.2%
North	1.0%
Oldham	-3.8%
Salford	3.2%
South	-5.2%
Stockport	-2.5%
T&G	-10.0%
Trafford	-5.9%
Wigan	6.8%



Activity V Plan: Total Elective Spells (Specific Acute)

Better Is **Lower**

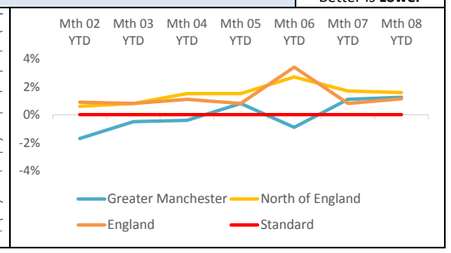
Bolton	6.1%
Bury	1.0%
Central	7.5%
HMR	-3.3%
North	-3.3%
Oldham	-5.1%
Salford	3.2%
South	1.6%
Stockport	5.8%
T&G	-13.1%
Trafford	3.2%
Wigan	2.0%



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

Better Is **Lower**

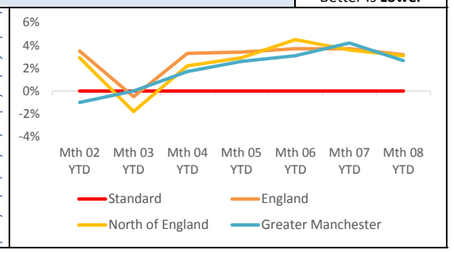
Bolton	1.9%
Bury	6.0%
Central	2.1%
HMR	4.3%
North	-1.5%
Oldham	-1.6%
Salford	3.3%
South	6.7%
Stockport	-2.6%
T&G	-5.5%
Trafford	-0.4%
Wigan	9.2%



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

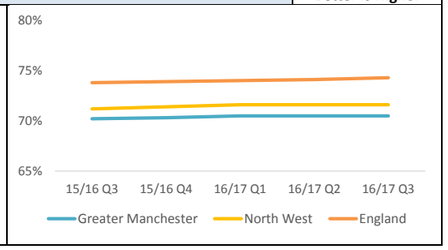
Outcomes In Areas With Identified Scope For Improvement (Placeholder)

Better Is **Higher**

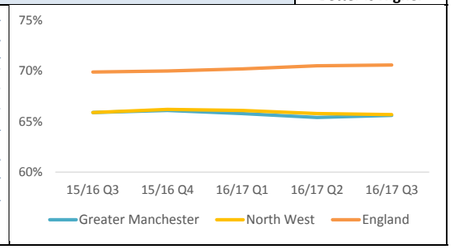
Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

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%	



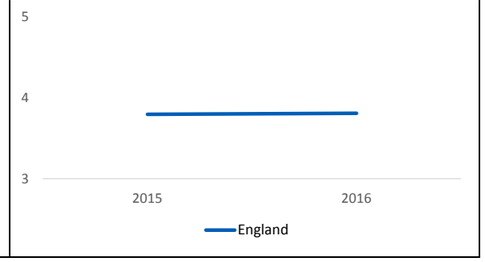
Well Led

Placeholder TBC

Staff Engagement Index

Better Is **Higher**

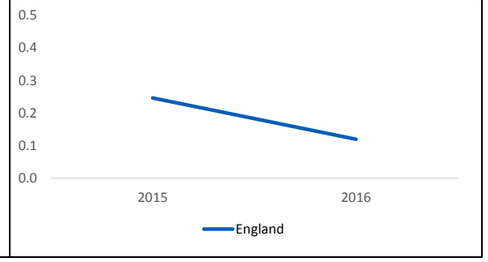
Wigan	3.9
T&G	3.9
Bolton	3.9
Central	3.8
Stockport	3.8
Trafford	3.8
South	3.8
Salford	3.8
Bury	3.7
North	3.7
HMR	3.7
Oldham	3.7



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

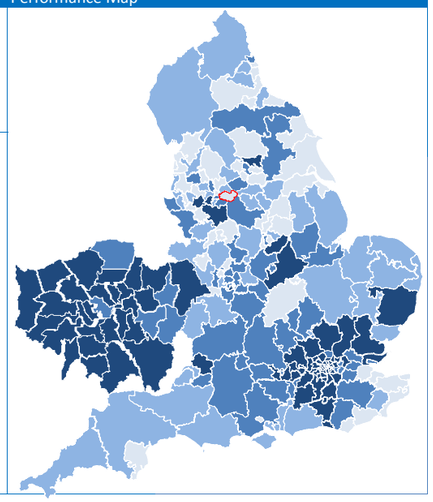
The 10 closest CCGs to NHS Tameside and Glossop CCG

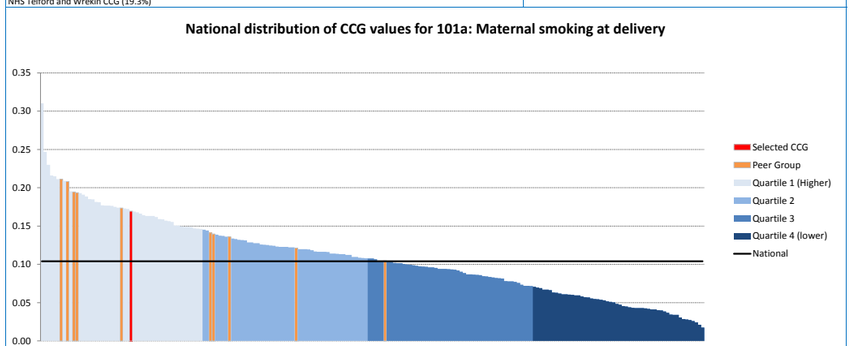
NHS Rotherham CCG (12.1%)
NHS Stoke on Trent CCG (19.4%)
NHS Bury CCG (10.5%)
NHS Wakefield CCG (20.8%)
NHS Hartlepool and Stockton-on-Tees CCG (14.1%)
NHS Barnsley CCG (14.0%)
NHS St Helens CCG (13.6%)
NHS Halton CCG (17.3%)
NHS South Tees CCG (21.1%)
NHS Telford and Wrekin CCG (19.3%)

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

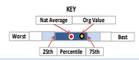




Please Note: If indicator is highlighted in GREY, this indicator will be available at a later date

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: 31 October 2107

Officer of Single Commissioning Board Jessica Williams, Interim Director of Commissioning and Care Together Programme Director

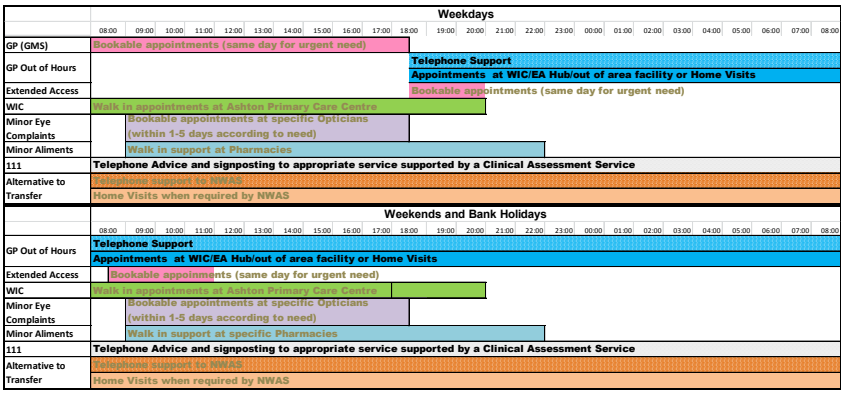
Subject: **TAMESIDE AND GLOSSOP PROPOSAL FOR EFFECTIVE URGENT CARE**

Report Summary:

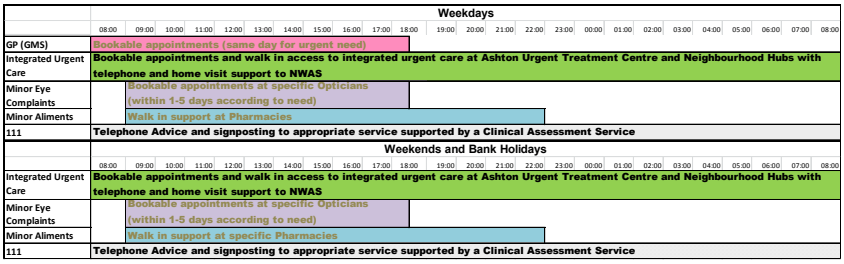
This report describes the vision for an enhanced offer of urgent care i.e. support for conditions that need prompt medical help to avoid them deteriorating but are not life threatening. It sets out the case for change summarising the national, Greater Manchester and local context; reflects the insights gained through previous pre-consultation engagement exercises and outlines potential scenarios for the enhanced urgent care offer.

Key to the proposal is the simplification of access to urgent care whilst improving the level of service available. Multiple access points will be replaced by telephone access through a patient's own GP practices to book appointments as well as a single location for urgent walk-in services. This will reduce the need for people to 'self-triage' i.e. decide if it is A&E or another service they need, and maximise opportunities for people to receive the right care in the right place at the first appointment. In addition, Neighbourhood support will be strengthened through increased evening and weekend appointments alongside advice and treatment available through local Opticians and Pharmacists.

We will move from our current multiple service arrangement shown below;



The proposed integrated urgent care service is;



The aim of the consultation will be to inform the public about the implementation of the Urgent Treatment Centre at Tameside and Glossop Integrated Care NHS Foundation Trust hospital site, the proposed relocation of the current Ashton Walk-In Centre service

to facilitate this and the locations for evening and weekend appointments. Two options are proposed within the consultation. All include the Urgent Treatment Centre operating 9 am to 9 pm, seven days a week at the hospital in Ashton-Under Lyne and offer a choice on additional evening and weekend appointments as follows;

Option 1		
Neighbourhood Care Hub	**Weekdays**	**Weekends**
North	6.30pm to 9.00pm	9.00am to 1.00pm
South	6.30pm to 9.00pm	9.00am to 1.00pm
Glossop	6.30pm to 9.00pm	9.00am to 1.00pm
Option 2		
Neighbourhood Care Hub	**Weekdays**	**Weekends**
North	6.30pm to 9.00pm	None*
South	6.30pm to 9.00pm	None*
West	6.30pm to 9.00pm	None*
East	6.30pm to 9.00pm	None*
Glossop	6.30pm to 9.00pm	9.00am to 1.00pm

* Able to book appointments at the Urgent Treatment Centre in Ashton or at Glossop Neighbourhood Care Hub

Both options provide:

- Additional bookable appointments at the Urgent Treatment Centre
- The ability for practices to arrange appointments directly at the Urgent Treatment Centre for patients likely to need diagnostics or additional hospital based care
- A single location for urgent walk in access that removes the need for the person attending to 'self-triage'
- Improved patient safety as people with emergency/serious conditions currently attending the Walk In Centre and then are transferred to A&E will already be in the correct place
- Access to urgent diagnostics

Recommendations:

The Single Commissioning Board is asked to approve the move to consultation on the options for the Tameside and Glossop urgent care offer and to note the Equality Impact Assessment and Quality Impact Assessment in **Appendices 1 and 2.**

Financial Implications:

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

Budget Allocation (if Investment Decision)	To be confirmed subject to the consultation and subsequent decision making process. Both proposed options are within the funding envelope - therefore deemed affordable and expected to deliver efficiencies.
CCG or TMBC Budget Allocation	CCG.
Integrated Commissioning Fund Section – S75, Aligned,	Section 75 and In Collaboration (NHSE delegated co-commissioning) funding sources of

In-Collaboration	the ICF.
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB for the S75 elements. CCG Governing Body for the delegated co-commissioning elements (via Primary Care Committee).
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Until consultation is completed and a decision on the chosen option is known, it is not possible to finalise costs. However, urgent care modelling work undertaken has identified both options as being affordable, with efficiencies being released and therefore value for money increased.

Additional Comments

The urgent care proposals within this paper sit within the context of the local economy optimising the use and impact of all the urgent care funding available.

Further efficiencies are expected from streamlining services and removing duplication to drive improved outcomes for Tameside and Glossop residents.

Legal Implications:

(Authorised by the Borough Solicitor)

An open and transparent consultation process is required to attract maximum public engagement to ensure the public sector equality duty has been complied with. This should be reflected in the Equality Impact Assessment which decision makers must have due regard to before making any decision.

Legal implications will need to be reviewed in a timely way once the consultation process has been completed, to ensure any final proposals arising out of the same are aligned to any proposed changes to National Health Service legislative requirements.

These will also need to be satisfied that value for money considerations which are not yet quantifiable by finance have been properly assessed, and appropriately weighed against the most important need to ensure that those requiring urgent care receive the priority treatment they require. As a public health service these considerations are highly relevant to the final outcome, to ensure there is no successful legal challenge to the final proposals, and that if there are concerns that those urgent health needs may be compromised by resources, or lack of them, they are raised at the highest level and ways of ensuring this does not happen are rationalised and clearly articulated. Given the legal structures of the two organisations a decision will be made by the CCG's Primary Care Committee following a recommendation by the Single Commissioning Body.

How do proposals align with Health & Wellbeing Strategy?

The Health and Wellbeing strategy requests equitable and accessible services which deliver high quality care as close to home as possible. Determining how primary care can deliver this effectively as well as ensuring a financially sustainable economy is key to successful implementation of the strategy.

	Urgent care combined with close liaison with enhanced primary care, Integrated Neighbourhoods and the wider Integrated Care Foundation Trust urgent care services will ensure appropriate care for those presenting with an urgent need.
How do proposals align with Locality Plan?	The proposal is fully aligned to our Care Together vision of people being treated as close to home wherever possible and providing a single access point for those people who choose to seek help outside of their neighbourhood or need a more specialist level of care. The key principle being people with urgent care needs are supported by the right person first time.
How do proposals align with the Commissioning Strategy?	In September 2016, all A&E Delivery Boards and Acute Trusts were nationally mandated to implement A&E streaming at the front door to Ambulatory and Primary Care. In August 2017 the National Service Specification for Integrated Urgent Care Services was released and confirmed the requirement to develop Urgent Treatment Centres. Greater Manchester has specified that each Locality should have an Urgent Treatment Centre. Greater Manchester has also confirmed they expect the following: • Core general practice will be able to utilise the urgent treatment centre to help manage their same day demand; • The A&E streaming service will be able to stream directly into the urgent treatment centre; • The principle in GM will be 'GP Practice First - 24/7'. This paper responds to these requirements whilst ensuring that where possible people will be able to access urgent care through their own GP or other neighbourhood based primary care services.
Recommendations / views of the Professional Reference Group:	Professional Reference Group supported the proposed model for urgent care and the move to consultation on the options.
Public and Patient Implications:	The detailed impact of the proposed options has been analysed through the Equality Impact Assessment in **Appendix 1**. The pre-consultation discussions (**Appendix 3**) have highlighted the fact people want a simple trusted arrangement that is well communicated to avoid confusion when an urgent need arises. The consistent opening times should help reduce confusion. Access through the registered practice should ensure people are seen in the most appropriate place whilst reducing travel and increasing choice. The access to a patient's record will improve the quality and safety of care. The single 'walk in' location on the same site as A&E will reduce the need for people to decide whether their need requires A&E or a Primary Care service and avoid people having to go to another site when diagnostics or more specialist care is needed. The use of Neighbourhood Care Hubs will provide increased access reducing the need for people to travel so far and offering more evening and weekend appointments.

Quality Implications:	The detailed quality Implications are set out in the Quality Impact Assessment in **Appendix 2**. Positive or neutral impacts are anticipated in: • Patient Safety; • Clinical effectiveness; • Safeguarding children or adults; • Public Access,; • Public Choice ; • Partnerships; and • Compliance with NHS Constitution. Through: The GP practice being the default number to contact for advice. The ability to book appointments in advance enabling people to be treated at the place that is best suited to meet the described need and ensure if urgent diagnostics may be required appointments are arranged at the Urgent Treatment Centre. Increased access to primary care clinicians who have access to the medical notes of the patient reducing the need for people to have to explain the wider health context and improving continuity of care. The single point of walk-in access reducing the risk of an individual selecting a service that cannot meet a person's need. Only emergency patients will need to be seen in A&E which should reduce A&E waiting times ensure the A&E staff can focus on those in greatest need. Increased patient control over the time and where they are seen. The negligible impact anticipated for patient experience is linked to the fact the new arrangement involves change as it relocates walk in access. It is expected that the proposed model will improve patient experience through alignment of access points and increased appointments. Those areas where a minor or moderate impact is identified relate to the operational management and will be mitigated when the final arrangements are agreed.
How do the proposals help to reduce health inequalities?	The service will be available to everyone within Tameside and Glossop and the final model will take into account the views of vulnerable groups.
What are the Equality and Diversity implications?	The service will be available to everyone registered with a Tameside and Glossop GP, those who are unregistered with a GP and those who are registered out of area. An Equality Impact Assessment has been completed and is an iterative document to be revised in line with the findings from the consultation.
What are the safeguarding implications?	The providers will be established healthcare providers who operate appropriate safeguarding procedures.
What are the Information Governance implications? Has a privacy impact	Ensuring appropriate and safe data sharing will be key in the development of the service. A privacy impact assessment will be undertaken when the provider develops the operational

assessment been conducted?	arrangements for the service.
Risk Management:	The requirement to consult is fully understood and our process will be in line with national expectations. It is not expected that there will be any increased clinical risk but this will be reviewed once the final model is understood. The financial envelope for urgent care will be worked up as the final model becomes clear. The financial envelop for the urgent care includes NHSE delegated co-commissioning budget funding for Extended Access which is subject to meeting certain eligibility criteria.
Access to Information :	The background papers relating to this report can be inspected by Contacting Janna Rigby:  Telephone: 07342056001  e-mail: janna.rigby@nhs.net

1. INTRODUCTION

1.1 Tameside and Glossop Health and Social Care economy recognised that because our health and social care services did not always work together optimally to meet local people's complex needs, local people were not always experiencing or receiving the best health and social care. Given increasing demand for services and demographic changes, unless we made some changes, the quality of care could potentially deteriorate.

1.2 The Tameside and Glossop Care Together programme was launched in 2015 as the programme through which we support changes to our health and social care system to improve healthy life expectancy, reduce inequalities, improve patient experience and improve financial sustainability. Through the programme, we will ensure that local people – rather than process and systems – are at the heart of their own care and people's holistic needs are considered rather than treating conditions 'one at a time'. .

1.3 Ensuring people are able to access appropriate care when an urgent or emergency medical or social need arises is an essential element of our Care Together programme. This includes providing services as locally as possible and ensuring people are maintained in their own homes whenever possible.

1.4 The primary purpose of this Urgent Care proposal is to:

- Summarise relevant national, Greater Manchester and local context;
- Reflect on the insights gained through previous and pre-consultation engagement exercises;
- Request authorisation for a public consultation process, scheduled to be launched on 1 November 2017, to engage with the public to help us decide on future provision of urgent care services;
- Outline potential options for an integrated urgent care offer to be used within the proposed consultation.

1.5 Through the consultation process, the Single Commission is seeking feedback and ideas on the clinical model and options contained within this document to help improve and refine the concepts for future Urgent Care commissioning.

2. PROPOSED TIMESCALE AND MILESTONES

2.1 The proposed consultation will commence on 1 November 2017 and conclude on 24 January 2018. Following analysis of the consultation responses, updated Equality Impact assessment, financial modelling, there will be a presentation of a proposed final model to the Single Commissioning Board in February 2018.

3. LOCAL CONTEXT

3.1 Through the Care Together programme, we are developing a new kind of NHS provider organisation known as an Integrated Care Foundation Trust. Tameside and Glossop Integrated Care NHS Foundation Trust is one of the first in England, bringing together a wide range of health and social care services for the benefit of local people. The Integrated Care Foundation Trust will manage a person's entire care in the future, by linking up hospital services with community care, mental health services and working closely with GPs, the voluntary sector and other primary care contractors.

3.2 In September 2014 Price Waterhouse Cooper (PwC), appointed by Monitor as a Contingency Planning Team to test the financial and clinical sustainability of the then

Tameside Hospital NHS Foundation Trust. This proposed a model of care that included an Urgent Integrated Care Services. The Urgent Integrated Care Services would support people who were seriously unwell or in a social crisis through a single point of access to get people well and back in most appropriate care setting as quickly as possible. The service would ensure support was available both in the community and a hospital setting to maximise opportunities to keep people in their own home whilst providing high quality diagnostics and expertise when required. An 'Urgent Care Village' was described as a combined A&E and GP-Led Urgent Care Centre, with a single front door and working as a single team under the same operational management to provide resilience and flexibility.

3.3 In 2015, the Tameside and Glossop Locality plan, 'A Place-Based Approach to Better Prosperity, Health and Wellbeing'[1] we set out our vision for people in crisis or who need urgent medical attention. This proposed a single urgent care service to align a range of urgent and out of hours care services around A&E to make it easier for people to access the most appropriate service.

4. OUR VISION FOR URGENT CARE

4.1 We aim to ensure people are seen by the right professional in the right place to meet their needs, with a strong focus on preventative and proactive care to reduce the risk of people requiring urgent care. Our plans for Care Together are fully aligned to the recent national and Greater Manchester guidance and we are in a strong position to deliver the expected services.

4.2 Our Neighbourhoods, with Primary Care at their centre, will support people in self-care with statutory and voluntary services able to wrap around those individuals that need additional help to keep them well. However, even with excellent preventative and proactive care, there will be times when people wish to access support urgently. Delivery of our vision will ensure that people get to the most appropriate service to meet their needs.

4.3 We want people who have an accident or need emergency acute health care to be seen quickly in A&E and discharged either back home or, if not possible, to an appropriate bed in the community or hospital all within 4 hours. We aim to achieve this by ensuring those in A&E are only those with an emergency need and that those with urgent or other needs can be seen in a different but aligned alternative.

4.4 By 2022 we expect people who develop an urgent care need to be assessed by the most appropriate person on the same day within primary care (whether this is registered GP practice, dentist or pharmacy or optician or through a Locality-wide service) and either a treatment plan agreed to manage the immediate need within the service or a safe transfer made to the care of another neighbourhood based service.

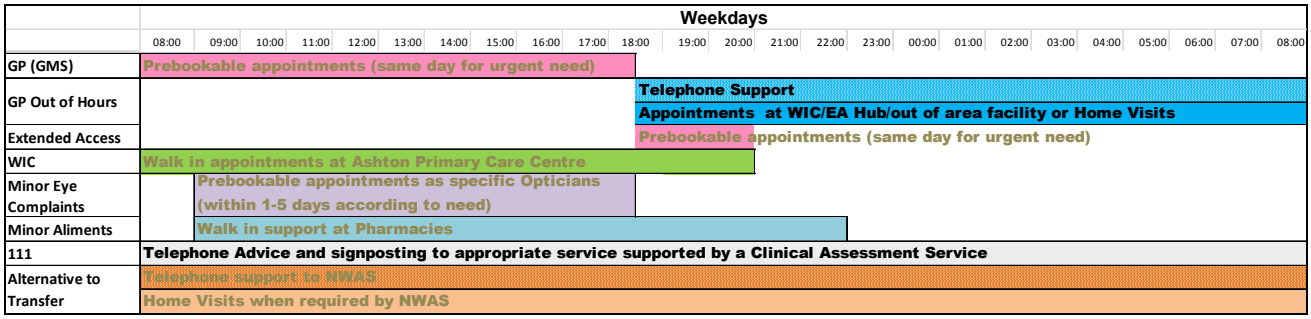
Key outcomes will include:

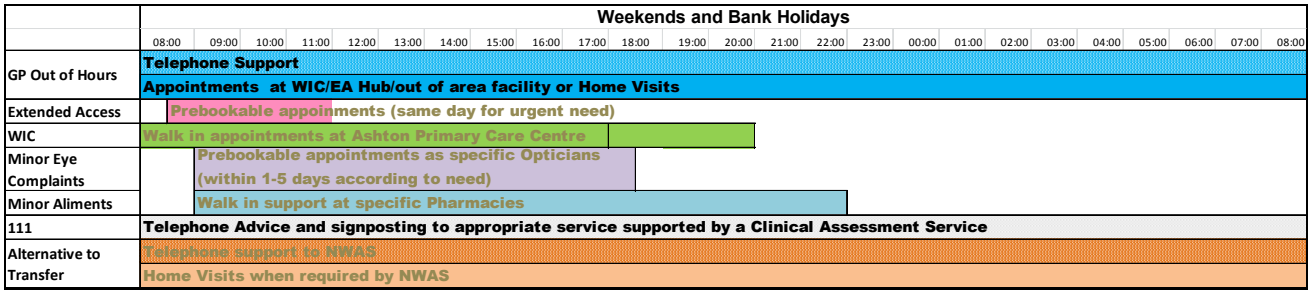
- People are supported to navigate the system so they receive effective care first time and do not represent to other services for the same issue.
- People are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams.
- People whose need can be met within a Neighbourhood do not attend A&E.
- People are equipped to reduce the risk of the same need arising in the future.

[1] A Place-Based Approach to Better Prosperity, Health and Wellbeing

5. THE CURRENT URGENT CARE SYSTEM IN TAMESIDE AND GLOSSOP

5.1 The current commissioned services which provide Primary Care support for people with an urgent need are complex and overlap considerably as seen below. This results in multiple access routes for people, who have an urgent need, and a significant level of duplication in the offer available.

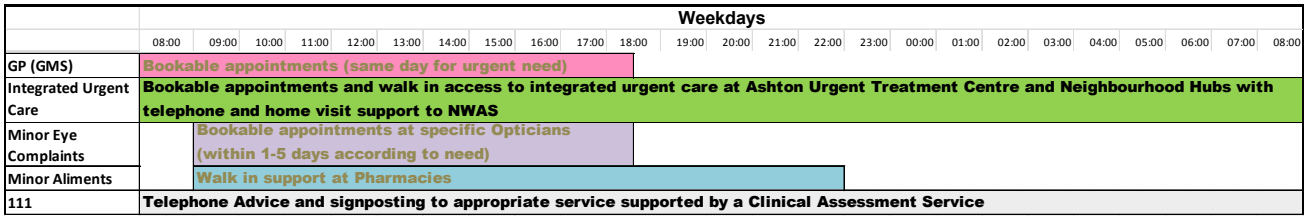


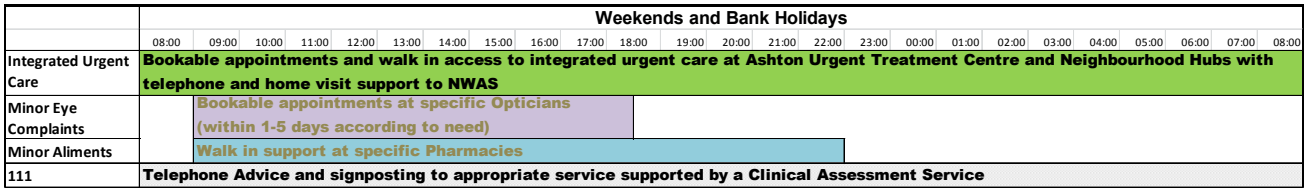


5.2 This complexity makes it harder for people to choose the most appropriate service and can led to people attending several places for the same need. People may also attend A&E when this is not optimal for their care and has the knock on effect of reducing access to emergency services for others who may need these.

5.3 The national directives, outlined in section 6, are to provide A&E streaming on hospital sites by October 2017 and to have an Urgent Treatment Centre ideally co-located with A&E as soon as possible. Adding in these services to our already complex urgent care system would result in significant duplication if we did not change delivery of our existing services.

5.4 Key to our proposal set out in detail in section 11 is the simplification of how to access urgent care services. In addition, the proposal extends the hours people can book into GP appointments and provides access to urgent diagnostics. A single integrated urgent care service will work alongside the urgent access provided by GPs, Pharmacists and Opticians as seen below.





5.5 The integrated urgent care service has been developed from analysis of existing services (section 9) and public and patient feedback (section 10) to deliver the national and Greater Manchester expectations (sections 6 and 7).

6. NATIONAL CONTEXT

6.1 The 'NHS Five Year Forward View' published in October 2014 [2]described three improvement opportunities: a health gap, a quality gap, and a financial sustainability gap and proposed a series of measures to bring about the 'triple integration' of primary and specialist hospital care, of physical and mental health services, and of health and social care. In 2016/17 the 'Next Steps On The NHS Five Year Forward View' [3] was published in recognition that, whilst progress had been made, demands on the NHS are higher than envisaged when the Five Year Forward Review was published. The 'Next Steps on the Five Year Forward View' sets out the NHS' main national service improvement priorities, within the constraints of what is necessary to achieve financial balance across the health service.

6.2 Two of the national service improvement priorities for the NHS that relate to urgent care are:

- Improving A&E performance - This also requires upgrading the wider urgent and emergency care system so as to manage demand growth and improve patient flow in partnership with local authority social care services.
- Strengthening access to high quality GP services and Primary Care, which are far and away the largest point of interaction that people have with the NHS each year.

6.3 These priorities are interlinked with around 85 million of the annual 110 million urgent same-day patient contacts being urgent GP appointments, and the rest A&E or minor injuries-type visits. In addition it is suggested that between 1.5 and 3 million people who attend A&E each year could have their needs addressed in other parts of the urgent care system but people use A&E because it seems like the best or only option.

6.4 The key deliverables for 2017/18 and 2018/19 that will enable the above priorities to be achieved include:

- Every hospital having comprehensive front-door clinical streaming by October 2017, so that A&E departments are free to care for the sickest people, including older people.
- The use of Clinical Assessment by NHS 111 to ensure people are not directed to A&E when other services are more appropriate.
- NHS 111 being able to book people into urgent face to face appointments where this is needed.
- New 'Urgent Treatment Centres' which will open 12 hours a day, seven days a week, integrated with local urgent care services.
- Evening and weekend GP appointments (including through collaborative arrangement) available.

6.5 The current contract for General Medical Services includes the requirement for practices to, 'have in place arrangements for its patients to access (essential) services throughout the core hours in case of emergency'. The Evening and Weekend appointments will also provide the same essential service access.

[2] Five Year Forward View

[3] Next steps on the five year forward view

6.6 By expanding multidisciplinary primary care as well as the hours during which primary care can be accessed individuals will be able to see the most appropriate clinician at a time that is more convenient. Practices are increasingly 'streaming' people so as to offer convenient same day urgent appointments, while preserving continuity of care for people with more complex long term conditions. Through this, more people should be able to access the care they need through their registered practice rather than attending A&E.

6.7 The draft NHS England Urgent and Emergency Care Delivery Plan sets out seven priorities as shown below. The first four of which will work together to ensure people have access to urgent care and the latter three focus on meeting more complex needs.

1. NHS 111 Online	2. NHS 111 Calls	3. GP Access	4. Urgent Treatment Centre
• Online triage services that enable people to enter their symptoms and receive tailored advice or a call back from a healthcare professional • Services closely connected to NHS 111 calls (and other services including Primary Care over time) • Offer an increasingly personalised experience to people	• Increase the percentage of calls transferred to a clinician when a patient calls the NHS 111 service • The service will better support the number of people who can be dealt with as 'self-care' • Where applicable people will be referred on to an appropriate point of care • NHS 111 Care Home Line will enable dedicated access for healthcare professionals (starting with care home staff) to get urgent advice from a GP out of hours	• Continued provision of urgent care services by general practice • Additionally by March 2019 the public will have access to pre-bookable evening & weekend appointments with general practice • Delivering this aims to secure: ➢Transformation in general practice ➢Step change in use of digital technologies ➢The foundations for a model of more integrated services	• Urgent Treatment Centres across the country will be: ➢Open at least 12 hours a day ➢Staffed by doctors and nurses ➢Will do blood tests, and most will have x-ray facilities ➢People will be able to book an appointment via NHS 111, their own GP, or walk in ➢Able to give a prescription, when needed

5. Ambulances	6. Hospitals	7. Hospital to Home
• More clinically focused response for people • Quicker recognition of life threatening conditions • Telephone advice, treatment on scene or conveyance to hospital • End to long waits for an ambulance and handover delays at hospitals	• Highly skilled emergency department workforce to deliver life-saving care for our most sick people • Variation between hospitals will be reduced • People streamed by a highly trained clinician to the most appropriate service • Rapid, intensive support to those people at highest risk of admission • Use of a wide range of ambulatory care services. • Effective metrics used in oversight of hospitals	• People only stay in hospital for as long as they need to be • Earlier planning of discharge and further joint working across different sectors • With liaison across sectors, coordinated and timely transfer of care from hospital to the most appropriate setting • Provide people with comprehensive packages of health and social care

6.8 Priority 3, GP Access and Priority 4 Urgent Treatment Centres are at the heart of our plans in this document.

6.9 The Urgent Treatment Centres – Principles and Standards published July 2017 [4] describes in more detail what it expects to be available to the public in the Urgent Treatment Centres and how commissioners need to ensure they 'end the confusing variation in opening times, the types of staff present and what diagnostics may be available in urgent treatment centres'.

6.10 The report describes an opportunity for commissioning a genuine integrated urgent care service, aligning NHS 111, Urgent Treatment Centres, GP Out of Hours and routine and urgent GP appointments with face to face urgent care. It states, "Commissioners should align thinking for Urgent Treatment Centres with the core requirements for Extended Access, as well as opportunities with the clinical assessment service that supports NHS 111. There are many opportunities to integrate wider primary care with urgent care, to rationalise the service offer, reduce duplication and flex the workforce to provide urgent and primary care services which meet the needs of the local population."

6.11 Co-located Urgent Treatment Centres with primary care facilities, including GP extended hours/ GP Access Hubs or Integrated Urgent Care Clinical Assessment Services are seen as key to the above with even greater benefits available if they are also located alongside the hospital A&E department and other urgent care services, such as mental health crisis support, community pharmacy, dental, social care and the voluntary sector. A central site that enables access to multiple services will ensure that people quickly get to the service that best serves their need.

6.12 The report also explains that the Urgent Treatment Centre could be commissioned as an integral part of a service delivery model which contributes towards the GP access commitment (minimum of 30 minutes per 1000 population, rising to 45 minutes per 1000 population) by providing routine pre-bookable and same day appointments as part of a hub and spoke model. So Clinical Commissioning Groups could plan a hybrid model where some of the routine access appointments could be delivered in Urgent Treatment Centres to maximise resources and estates.

7. GREATER MANCHESTER CONTEXT

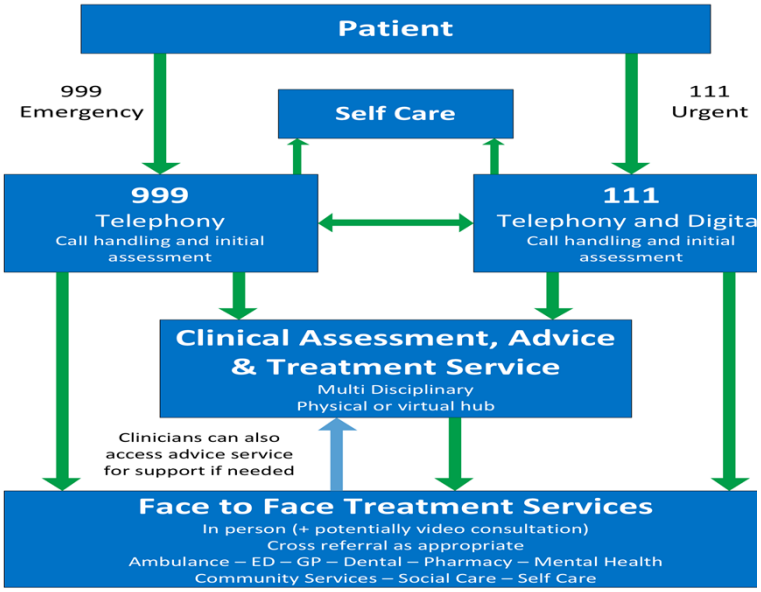
7.1 Local commissioners have always worked together across Greater Manchester to enable cost effective commissioning of key urgent care services. Some services, such as the Paramedic Emergency Service of 999 and NHS 111 have until April 2017 been commissioned on a North West footprint managed by NHS Blackpool but the contracts are now being managed through Greater Manchester Health and Social Care Partnership.

7.2 Greater Manchester Health and Social Care Partnership have already progressed several of the seven key national priorities one of which is the NHS 111 Clinical Assessment. Greater Manchester implemented an Acute Patient Assessment Service (APAS) in 2016/17 to provide an enhanced clinical assessment to people identified as possibly requiring support from A&E but not as an emergency. This assessment is via the telephone with a clinician within an Out of Hours provider who is then able to support people who, on further discussion, can be more appropriately managed in primary care. In a similar way people who ring 999 and the Urgent Care Desk identifies they would be a Low Acuity ambulance transfer will be passed to Out of Hours for an enhanced clinical assessment.

[4] Urgent Treatment Centres Principles and standards

7.3 Locally the Acute Patient Assessment Service initially operated between 18:30 and 08:00 Monday to Friday and 24 hours Saturday and Sunday but since July 2017 a Greater Manchester wide pilot has been operating during in-hours namely between 08:00 and 18:30 Monday to Friday. If proved effective the expectation is pilot will be fully implemented to provide a 24/7 service.

7.4 The integrated working across NHS 111, 999 and Out of Hours enables people to receive the advice and care that is most suited to their need and reduces the risk of people being directed to A&E unnecessarily.



7.5 The Greater Manchester Health and Social Care Partnership has also undertaken a review of all primary care out of hours provision and has developed a Greater Manchester framework to support commissioners. This contains three themes:

Theme 1: Urgent & Out of Hours Primary Care should be provided at scale

Theme 2: Urgent & Out of Hours Primary Care should be integrated with other local services

Theme 3: Access Routes for Urgent & Out of Hours Primary Care should be simplified and rationalised

7.6 Each theme has three underlying principles with actions identified as summarised below.

Theme 1: Urgent & Out of Hours Primary Care should be provided at scale

Urgent Primary Care (UPC) services will be provided through a single provider (or alliance of providers) within a locality	➢ Extended Access, OOH, walk-in/ Urgent Care Centres (UCC) & ED streaming should be provided by a single provider or alliance of providers within a locality to provide care in an integrated fashion, in-line with developing arrangements within local Local Care Organisations (LCOs). ➢ A single contract for UPC services should be let on a locality (or wider) basis – to include extended access, OOH, ED streaming, walk-in/ UCC centres (let either to single organisation or to some form of provider alliance). ➢ At scale UPC contracts should to give consideration to the impact on the wider primary care workforce.
At scale UPC services will support in-hours statutory services (e.g. core primary care, community services & social care)	➢ At scale UPC services should demonstrate how they provide additional capacity and support to in-hours primary care. ➢ At scale UPC services should, wherever possible, be provided alongside (or jointly) with community and social care services (such as reablement and rapid community response), and focused on complex cases of care, consideration must be given to how diagnostics are provided for. Commissioners will need to justify why, if they elect not to do so. ➢ Core primary care staff should be fully engaged with throughout the life-cycle of the UPC contract, including pharmacy and dental.

UPC provision will be rationalised across localities, or wider geographical footprints wherever possible	⇨	➢ At a minimum, the "at scale" UPC contracts should cover the entire locality. E.g. Bury or Bolton. ➢ Consideration should be demonstrated to broadening UPC provision across a wider geographical footprint e.g. across multiple GM localities. ➢ The NHS 111 (or equivalent) Clinical Advice Service (CAS) should be developed in-line with current plans to provide robust clinical advice as appropriate across the whole of GM.

Theme 2: Urgent & Out of Hours Primary Care should be integrated with other local services

UPC services should work to provide care at the most convenient point of resolution for patients	⇨	➢ Patient's should be fully engaged in the co-design of the new UPC contracts across GM. Improving patient experience of the total UPC system within a locality should be a key priority and monitored closely through the life-cycle of the UPC contract. Focus should be given to maximising service utilisation. ➢ UPC & NHS 111 (or equivalent) should make full use of late opening pharmacies directing patients to them rather than into UPC services whenever appropriate, with these services being accurately profiled in the NHS 111 DoS. A consistent approach should be taken across GM. ➢ UPC & NHS 111 (or equivalent) contracts should demonstrate how they will better integrate with urgent dental services and ensuring links to pharmacies for pain relief for patients with dental pain (potentially linked through the NUMSAS pilot).
Service hours within the UPC/ OOH primary care space will not duplicate or overlap, with capacity being rationalised	⇨	➢ Extended access, Directed Enhances Services, OOH provision, ED streaming & walk-in centre/ UCC provision should be rationalised, opening times and service provision must not overlap. This should include rationalisation of type of appointment e.g. routine versus urgent in the OOH timeframe must not overlap and must be rationalised. Services will need to meet national requirements. ➢ Localities should show consideration to digital integration between providers of UPC within the contract, including booking appointments interoperable and to view/update records.
UPC services will be well integrated with acute services and embedded in the LCO	⇨	➢ The UPC contract should be designed to reduce inappropriate ED attendances within outside-of-core hours as a priority. Where ED streaming isn't co-located with an UTC they need to have the facility for warm transfer through whatever means is deemed appropriate locally. ➢ ED streaming & co-located services should operate as a single team with the wider ED teams within hospitals, with agreed MoUs in place for how to ensure fully integrated operations included within the UPC contract. Consideration should be given to how these teams can operate as MDTs within the context of wider LCO delivery plans. ➢ GPs and wider primary care teams must be heavily engaged with the design of ED streaming services from inception to delivery.

Theme 3: Access Routes for Urgent & Out of Hours Primary Care should be simplified and rationalised

There will be a single point of access for Urgent primary care, this will be standardised across GM	⇨	➢ There is an ambition that eventually primary care in GM will transition to the gatekeeper of ED services in out-of-core hours for all minors' presentations (excluding children). No individual should be presenting within and ED for 'minor' incidences without prior authorisation/referral from the single primary care provider/ alliance within a locality. ➢ This will be underpinned by a Single Point of Access (SPA) for urgent primary care within a locality, this will be a single point of access for urgent primary care within a locality, for example through NHS 111 or through GP numbers. ➢ Localities should explore digital access routes for services at a GM level, e.g. NHS 111 apps as piloted elsewhere in the country.
The physical and virtual locations of services will be rationalised, with services being co-located wherever possible.	⇨	➢ All types of urgent/OOH primary care appointments should be directly bookable/ referable to through NHS 111 (or equivalent) this includes telephone appointments, this will not replace clinical triage e.g. through OOH services. ➢ There is currently a requirement for one UCC per locality to be developed by December 2019 (although policy is still developing) It's strongly encouraged that where appropriate "at scale" urgent primary care provision is located alongside other service provision, either within community hubs or co-located on A&E site, maximising the impact of the UCC development on the wider resilience of the primary care system
Patients will be actively engaged with to ensure continual improvement in access and quality	⇨	➢ Effective communications methods should be developed to communicate access options for UPC on a locality basis, pre and post implementation, where possible this should be planned at a GM level. These should be embedded within the UPC contract. ➢ All services provided should actively signpost the most appropriate access routes for urgent primary care, providing consistent messaging to patients. ➢ Contracts should allow for formal continual engagement with patients and should demonstrate how this engagement will be used to continually improve patient experience of access to and the quality of UPC services.

7.7 All Greater Manchester Localities are developing plans to deliver the above themes and it is understood that the majority are thinking of co-locating their UTC with A&E. Oldham's proposal 'Right Care, Right Time, Right Place' explains that they will be developing plans for a more effective urgent and emergency care offer and they will be consulting the public on the provision of urgent care services in Oldham for 8 weeks between 9 October and 4 December 2017. The consultation will include street surveying in Mossley as some residents currently use Oldham urgent care services.

8. FINANCIAL CONTEXT

8.1 Tameside and Glossop have a history of strong financial performance. However over recent years, a combination of increasing demand and reduced growth in funding have placed significant pressures on our financial position. We calculate there will be an in year recurrent deficit of £70m by 2021 unless we act now to close the gap.

8.2 Through Care Together, we have developed transformative plans (and secured some non-recurrent transformation funds from the Greater Manchester Health and Social Care Partnership) are key considerations when assessing the future of urgent care within the locality. The aspiration of the economy is to deliver the objectives and services outlined within this this paper at a lower cost than the services we deliver today.

8.3 National evidence set outs a base upon which we can build efficiency into our model. For example the 'Next Steps Five Year Forward View' has identified there were opportunities to cut waste and increase efficiency within urgent care. It also sets out the expectation that the Single Commissioning Function and local providers will work collaboratively to optimise efficiencies by removing duplication and streamlining services which will improve patient experience. This approach maximises opportunities for economies of scale ensuring each organisation works efficiently, effectively and economically within their financial control totals demonstrating strong stewardship of the public purse.

8.4 As we are still negotiating the overall costs of implementing urgent care, we must accept that at this stage, we are prioritising resources available towards the preferred option chosen through the consultation process. This however, may divert funding away from other elements of primary care, if ultimately, the funding proves to be inadequate. Initial financial analysis of both options shows that both options are affordable within the current funding envelope.

8.5 We expect efficiencies to be made through the bringing together of these services and therefore the risk of system affordability should be low, but nevertheless still needs to be recognised whilst negotiations continue.

9. EXISTING USAGE OF URGENT CARE SERVICES

9.1 People make use of the full range of services available as summarised below. Further detail can be found in the Equality Impact Assessment in **Appendix 1** along with the expected impact of the new arrangement for urgent Care services.

9.2 Our 39 General Medical Practices see a significant number of people with urgent needs through same day access for their registered population. How practices manage this demand varies with a range of offers such as: open surgeries where people can walk-in without an appointment, booking same day appointments via the telephone or online and undertaking a telephone triage and only booking appointments for those people they believe need to be seen by a practice clinician.

9.3 Around 19,000 people a year also receive urgent help from the GP Out of Hours service when the practice is closed (between 6.30pm and 8am Monday to Friday or anytime Saturday and Sunday).

9.4 Extended Access to General Medical Services currently operates across three hubs, each providing 7 day access with people able to book appointments through their GP. The appointments are available with a range of General Practice staff. The hours vary across the different hubs with, at times, variation depending on the day due to staffing or premises constraints. Generally appointments are available until 8.30 or 9 pm weekdays

9.5 The purpose of extended access was primarily to enable people to book routine appointments outside of core general practice hours but appointments are being used for same day/urgent access. In the last twelve months, 28% of appointments have been booked for same day access, 25% by practices and 3% by Out of Hours.

9.6 The other urgent care services available in Neighbourhoods include Minor Aliments, the Minor Eye Conditions Service and Dental Services.

9.7 Minor Aliments operates in all local pharmacies and is well used as people are able to walk in to any pharmacy in Tameside and Glossop for support. Around 9,200 people with minor aliments are supported by pharmacies each year.

9.8 The Minor Eye Conditions Service is offered in all neighbourhoods but not by all optometrists. People can book appointment by telephone or directly during normal working hours which may include weekends. It started in July 2016 and in the first twelve months; it has seen around 1700 people with urgent eye conditions.

9.9 In-hours Urgent Dental Services are provided by Dental Practices for those with a regular dentist. For those who do not have a regular dentist, an in-hours urgent dental service is in place to ensure access is available for everyone. In addition, there is a Dental Out of Hours Service available to all patients and this is commissioned by the Greater Manchester Health and Social Care Partnership.

9.10 Many people use the Community Pharmacists (Minor Aliments), Optometrists (Minor Eye Conditions Service) and Emergency Dental services through direct self-referral but most practices also advise people of the alternative support when it would be more appropriate to meet their needs. This helps avoid the need for people to attend multiple appointments and makes best use of the expertise available. Of the 898 people advised by a practice to contact an Optometrist, 56% had not seen their GP first.

9.11 The Walk-in service at Ashton Primary Care Centre is another key access point where people self-refer or are advised to attend by NHS 111, Out of Hours, another clinician or their own practice. This is also where people who are not registered with a Tameside and Glossop GP can attend as an alternative to A&E. In the twelve months, 1 June 2016 to 31 May 2017, the service supported around 3750 individuals who were not registered with any GP (includes people who are overseas visitors and people who chose not to register). A further 5800 people who were registered with a GP outside of Tameside and Glossop also used the service. This represents 27% of the individuals who used the service.

9.12 Only around 10% of all Tameside and Glossop registered patients (26,253) used the Walk-in service in the twelve months, 1 June 2016 to 31 May 2017, with some attending on multiple occasions.

9.13 The NHS 111 service is well used by local people with around 43,000 calls made in 2016/17. There were a significant number of calls during general practice opening hours but the majority of calls were out of hours and in particular on Saturday and Sunday.

9.14 NHS 111 triages calls and assesses what support is most appropriate for that individual based on the information given. Approximately 57% of local callers were advised they needed Primary Care support. Others received self-care advice, were advised to attend another service or A&E or were transferred to 999.

9.15 When people need Primary Care there are three recommendations:

- Recommended to speak to primary and community care (GPs, practice clinical staff, health visitors, community nurses or MH nurses);
- Recommended to contact primary and community care;
- Recommended to dental / pharmacy.

9.16 The time frames given for contact could be, 1, 2, 4, 6, 12 or 24 hours which relate to the sense of urgency of a condition. The 2 hour timeframe is generally used for people when it has not been possible to rule out a potentially urgent or serious condition and the addition assessment available through Primary Care would be able to differentiate further. Less urgent but still troubling symptoms may need assessment within next 6 or 12 hours and 24 hours relate to minor problems.

9.17 Dental or Pharmacy is advised for dental related problems and minor ailments.

9.18 The majority (75%) of local people who needed Primary Care support were advised to speak to a primary/community care service.

9.19 Our usage analysis shows us that some people decide to go directly to a specific service because they believe that is the best service to meet their particular need and others seek advice on which service to use before attending. As our access to urgent diagnostics is currently limited people requiring X-ray or other more specialist diagnostics have to attend the hospital site with some being advised to attend A&E.

9.20 Feedback on services also suggests that some people attend walk-in services because they were unable to secure an appointment with their own practice in what they perceived to be a timely way. It may therefore be that how practices support their urgent demand is a factor in the usage of other urgent care services.

9.21 However, the patterns of usage by Neighbourhood also suggest geography has an influence particularly on the services delivered from Ashton Primary Care Centre as shown below.

	Usage per 1,000 Registered population over 12 months		
Neighbourhood	**OOH**	**WIC**	**Key**
North	80	289	Above CCG Rate
West	88	214	Below CCG Rate
South	85	121	
East	78	145	
Glossop	58	31	
CCG Rate	**79**	**171**	

9.22 North Neighbourhood registered patients account for 41% of the WIC usage by Tameside and Glossop registered patients and Glossop accounts for 2%. Usage of A&E (Ashton

based) for minor conditions whilst not so high is 10% and 3% respectively. There are some anecdotal reports that Glossop people use the New Mills Walk-In services but there is no data to demonstrate how extensive this use is.

9.23 It is suspected that some individuals using the Walk–in service at Ashton also attend other services for the same conditions. A Greater Manchester Academic Health Sciences Network Literature Review (unpublished) of research into what happens after attending a walk-in centre suggests that almost 40% of people may have duplicate attendances in other primary or urgent care services rather than only using the walk-in centre. One study reported that 30% of people attending an A&E facility over a 4 week period stated that the A&E was not their first point of contact.

9.24 Having a variety of options available to people for urgent care lead to confusion and for some people result in multiple trips being made to different locations to access the diagnostics and treatment support needed. Consolidation of service locations whilst maintaining the range of support should improve patient experience.

9.25 People utilise services seven days a week but we are unable to be sure whether people would decide to wait until the next working day if a service was not available or would use the 24/7 access available through A&E. Ensuring there is access all day and every day to advice and support should reduce anxiety when a person feels they urgently need help and help people use the most effective service.

9.26 Knowing why local people choose to use particular services and what they want when an urgent need arises was a key part of understanding local needs around urgent care. Our pre-consultation conversations have been invaluable in providing that insight.

10. PRE-CONSULTATION PUBLIC AND STAKEHOLDER INVOLVEMENT

10.1 We have been having conversations with a range of public groups since 2014 as we developed our Care Together plans. In May 2017, we held further meetings with Practice Neighbourhood Groups specifically around Urgent Care to validate the previous feedback and gather further ideas. The following key messages around urgent care services have been taken from all these conversations and more detailed feedback can be found in **Appendix 3**.

10.2 The findings show that generally people do differentiate between an ‘emergency need’ which is thought of a life threatening and something that they want advice on quickly in case it is serious. The term ‘Urgent’ is not easily defined but it was thought that it is the patient’s perspective that was important and a prompt response was essential to allay fears even if the advice involved a more routine response.

10.3 The service used depended on what people knew existed and any previous experience/perceptions.

10.4 Key factors in deciding where to go were:

- how serious the need was;
- trust in the person they will be seen by;
- ease of getting to a service; and
- the time it would take.

10.5 A&E and 999 were seen as the option for Emergency support and not somewhere to go for other needs. However, it was thought that when seeking help for a dependant a more cautious approach would be taken which may increase the tendency to use 999 or A&E.

10.6 Confidence in the person treating them was important with bad publicity and poor previous experience impacting on this decision. There was increased confidence when the service treating had access to an individual's key medical information. It was felt that the people providing the care need to be appropriately skilled both in the treatment itself and also in dealing with the individual/their carers and family who may be vulnerable, have difficulty understanding or just be scared.

10.7 People wanted access to a local trusted person who can advise and or treat/resolve an urgent need, with the registered General Medical Practice frequently seen as best placed to fulfil that role.

10.8 Car parking, distance and public transport links were highlighted as factors that influence where people attend and concerns were raised about the accessibility of the Ashton Primary Care Centre Walk in Centre site. For Glossop in particular, the hospital site was easier to access than Ashton Primary Care Centre.

10.9 The time support was available was not raised but the long waiting time at A&E was, as was the fact people who could not get through to/get an appointment with their practice would utilise A&E or the Walk in Centre. Timely access to General Practice and Pharmacy were seen as important.

10.10 Having access to other services such as Mental Health and Social Care through a more integrated service was also seen as beneficial.

10.11 Overall people value quick access to someone they trust to calm fears and direct them to necessary treatment. Knowing that they will, if needed, be treated in a timely manner is key with fewer concerns about where they will be seen.

10.12 The early ideas developed from the feedback were discussed by a Local Design Group made up of representatives from the following groups.

Organisation/Representing	**Type of Organisation / Representing**
T&G ICFT Council of Governors	Veteran
Hyde Bangladesh Welfare Association	Bangladeshi Community Group
Infinity Initiatives	Support homelessness, substance instance, financial and debt problems, isolations, loneliness, anti-social behaviour victims and perpetrators
Anthony Seddon Centre	Peer-led community mental health project
Greystone Housing Group	Homelessness
Change, Grow, Live	Provides help and support to adults, children, young people and families. Services cover a wide variety of areas including health and wellbeing, substance use, mental health, criminal justice, domestic abuse and homelessness.
Adullam Homes	
Glossop Practice Neighbourhood Group	GP Registered Patients
Stroke.org	Support for people who have had a stroke and their family and carers.

10.13 The feedback from the Local Design Group, in **Appendix 3**, has been used to develop the options with consistent opening times and services being seen as very important even if it reduced the number of places where the service was available.

10.14 People though having too much choice often leads to confusion and that could mean people just ring 999 or attend A&E/the hospital site regardless. But it was thought that if there was somewhere in every neighbourhood more people would be able to access the support without having to travel far.

10.15 The hospital site was seen as well-known and the fact people would be assessed and seen outside of A&E if appropriate was liked.

10.16 Concerns were raised about whether there were enough doctors and nurses to staff multiple hubs and whether it would be affordable.

11. ENHANCED OFFER FOR URGENT CARE

11.1 The usage of our current services and feedback from local people suggests that a simplified service that builds on the trusted relationship between people and their registered practice would enable people to be seen in the most appropriate place by the most appropriate professional.

11.2 If we can ensure that the first contact with urgent care is in the most appropriate place and delivers the outcome a person needs, it should mitigate the need for people to attend multiple locations.

11.3 Strong neighbourhood based access to General Practice will provide trusted advice and reassurance and enable people to be booked into an appropriate appointment 7 days a week. It will support a seamless transfer for people who identify as urgent but would be best managed as routine within their own neighbourhood as well as ensuring people who need access to urgent diagnostics can attend a local Urgent Treatment Centre in a timely manner.

11.4 We are committed to providing walk-in access for people who are not registered with a Tameside and Glossop GP or who prefer not to book in advance. However, a Greater Manchester Academic Health Sciences Network Literature Review (unpublished) suggests a separate Walk-in Centre has minimal impact on the demand for other urgent care or primary care services, not significantly affecting either A&E attendances or activity at primary care services and may increase overall demand for urgent care as people who would previously have self-treated minor illnesses or injuries may instead attend the walk-in centres.

11.5 By providing walk-in access through an integrated service on the same site as A&E with access to diagnostics i.e. an Urgent Treatment Centre, those people who on assessment need more specialist diagnostics e.g. X-ray or treatment e.g. Mental Health, Ambulatory Care, Early Pregnancy Assessment will receive the care they need promptly without the need to travel to another location. This should improve outcomes and patient experience. It will also remove the need for the person attending to 'self-triage' and decide if their need requires A&E or could be better managed in urgent care which may particularly help carers and parents by reducing anxiety around making the 'right' choice. Having the ability to book an appointment also gives greater certainty about when someone will be seen which will help people plan their visits.

11.6 Creating a single walk-in service on the hospital site will also prevent further duplication and confusion as the national requirement for a Primary Care service at the hospital site

seven days a week for A&E Streaming and an Urgent Treatment Centre with access to diagnostics would mean if nothing else changed we would have two walk-in access points for similar, but not identical services, within the same neighbourhood approximately 1.5 miles away from each other.

11.7 Our urgent care service will integrate the existing Walk-in Centre, OOH, Extended Access with the soon to be live Primary Care Streaming at A&E and the planned Urgent Treatment Centre all of which provide/will provide direct support to people along with our Alternative to Transfer service that works with paramedics (shown in 5.1). This will provide a key access point at the hospital site in Ashton, through the Urgent Treatment Centre, alongside neighbourhood based access through GPs, Pharmacies, Opticians, Dentists and Neighbourhood Care Hubs.

11.8 People will get 24/7 phone access to support through their practice directly or via, NHS 111 or OOH and will be booked into an appropriate appointment. If a same day home visit is required it will be through either the practice/neighbourhood offer, an OOH GP or the Integrated Urgent Care Team. Health care professionals such as paramedics and care home nurses will continue to get 24/7 access through the Health Care Professionals helpline or Alternative to Transfer.

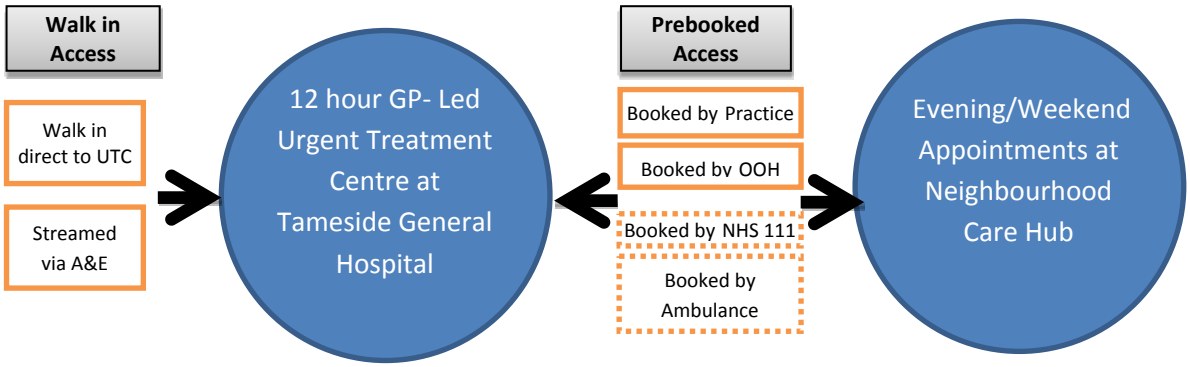
11.9 The key point of contact 'in hours' (8 am to 6:30 pm weekdays) will be an individual's GP practice. People will make initial contact with their own practice and appropriate advice/appointment will be provided to enable them to be seen by the right professional on the same day or at a later date as required. Out of Hours (6.30 pm to 8.00 am weekdays and all day weekends) people will continue to ring NHS 111 which, along with the Clinical Assessment service, will direct people with a primary care need to their own practices or the integrated urgent care services, Minor Eye Condition Service (MECS), Local pharmacies and dentists as appropriate. People can also ring NHS 111 anytime 24/7.

11.10 If a patient needs to be seen by a GP or another practice professional, an appointment will be made either at that practice during it's opening hours or at a Neighbourhood Care hub where there will be appointments 6.30 pm to 9 pm Monday to Friday and 9 am to 1 pm Saturday and Sunday (as shown in the options in section 13) or at the Urgent Treatment Centre 9 am to 9 pm seven days a week. People who may need diagnostics or could need to be transferred to a hospital based specialist service may be advised to book an appointment at the Urgent Treatment Centre rather than having a choice of all locations.

11.11 If people have eye conditions, minor aliments or dental needs they will be directed to other Primary Care Providers and those with other more social care needs will be advised of the appropriate voluntary or statutory sector support.

11.12 People who chose to walk-in rather than book an appointment will need to attend the Urgent Treatment Centre at the hospital site will be seen between 9 am and 9 pm seven days a week but may have to wait for up-to 2 hours for treatment or may be booked into an appointment.

11.13 In summary the Urgent Treatment Centre will provide 'Walk-in' Access with Bookable access available at both the Urgent Treatment Centre and the Neighbourhood Care Hubs as below.



11.14 The services at all access points will include General Medical Primary Care with both routine and urgent needs accommodated through appointments available with GPs or members of the wider Primary Care Team. In addition, the Urgent Treatment Centre will be able to directly access urgent diagnostics e.g. urinalysis, ECG and in some cases X-ray. The colocation of the Urgent Treatment Centre on the hospital site will ensure patients who require more specialist urgent care are transferred promptly.

11.15 It is expected that the majority of people will contact their GP first and will be given choice of all available appointments reducing the need for people to have to 'walk-in' to the Urgent Treatment Centre and wait to be seen. People who are not registered with a Tameside and Glossop GP will be able to 'walk-in' to the Urgent Treatment Centre.

11.16 There are national projects to enable Ambulance services and NHS 111 to book into Urgent Treatment Centres, GP and Extended Access appointments so in time unregistered people and visitors may have more options regarding where they are seen. Examples of how people may access the services are given in Appendix 4.

11.17 The impact of the proposed changes has been initially analysed as set out in the Equality Impact Assessment in **Appendix 1**. This analysis will be refreshed during consultation to ensure that any potential risks and mitigations have been identified so that no one loses the ability to access effective urgent care.

11.18 The single walk in access point on the hospital will be well communicated and we know that A&E is already used by people who registered and unregistered with a GP.

11.19 Access for homeless people has been a key feature of our plans with representatives involved in the pre-consultation stakeholder groups. An address is not required to register at a GP practice and we know that there are a number of homeless people who are registered but are not clear how many are not. We know that homeless people are less likely to attend for routine care for their health, and so access to same day services is important to ensure health care to be delivered.

11.20 The Urgent Treatment Centre will be the main point of access for homeless people who are not registered with a GP and will be able to meet both primary and more complex needs on a single site ideally within a single visit. The close working with other services such as mental health, drug and alcohol, social care and the voluntary sector should also improve access to the most appropriate service to meet the holistic needs of a homeless person presenting.

11.21 Our proposed Integrated Urgent Care service is fully in line with national expectations and will enable Tameside and Glossop to use the resources available to deliver an excellent service for local people.

12 URGENT CARE OUTCOMES AND STANDARDS

12.1 Urgent care will be delivered across practices, the Neighbourhood Care Hubs, the Urgent Treatment Centre and the Out of Hours GP service. These will operate as an integrated service to ensure that people:

- Are able to access urgent care support 24/7 and are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams;
- Whose need can be met by Primary Care do not need to access A&E;
- Have access to an average of 45 minutes of evening and weekend/bank holiday appointments per 1000 register population per week;
- Are able to book routine and urgent appointments at the Urgent Treatment Centre and agreed Neighbourhood Care Hub sites;
- Can be seen at the Urgent Treatment Centre 12 hours a day seven days a week including Bank Holidays either by booking an appointment or presenting as a 'Walk-in';
- Receive definitive treatment, which may include self-care advice, prescription issue or treatment of the presenting condition appropriate to primary care and people are equipped to reduce the risk of the same need arising in the future;
- Are supported to navigate the system so they receive effective care first time and do not represent to other services for the same issue;
- Who require urgent investigations/diagnostics receive these through the Urgent Treatment Centre;
- Who need a same day home visit out of hours will either be seen by a GP or another appropriate service;
- Can expect, following consent, that the treating clinician has access to their up-to-date electronic patient care record.

12.2 Services at all sites will be expected to meet standards set out nationally and deliver effective high quality and safe care.

12.3 Local standards will include:

- Patients who have a pre-booked appointment should be seen and treated within 30 minutes of their appointment time;
- Patients who 'walk-in' to the Urgent Treatment Centre should be clinically assessed within 15 minutes of arrival and given an appointment slot which will not be more than two hours after the time of arrival. They should only be prioritised for treatment, over pre-booked appointments, where this is clinically necessary;
- The service is advertised to patients so that it is clear to patients how they can access appointments;
- Patients will be able to access alternative modes of consultation e.g. telephone, online, webex;
- Utilisation of Neighbourhood Care hubs will be managed to 98% usage of all appointments/ capacity.

13 URGENT CARE SERVICE OPTIONS

13.1 There are two options for the delivery of the new urgent care service. All options create an Urgent Treatment Centre based at the hospital site open 12 hours a day, seven days a week from 9 am to 9 pm. This will offer bookable, same day/urgent and routine general practice appointments, walk in access for urgent care and be able to provide direct access to urgent diagnostics along with safe transfer to more specialist services when necessary. In all options, this will replace the existing Walk-in services at Ashton Primary Care Centre which will relocate to the hospital site and be developed to deliver the Urgent Treatment Centre.

13.2 The options vary in the number of Neighbourhood Care hubs where bookable appointments can be made in addition to the Urgent Treatment Centre and when those hubs will be open.

13.3 These options are shown below:

Option 1

	Opening Hours		Access		Location
	Weekday	**Sat and Sun**	**Booked appointments**	**Walk-in**	
Urgent Treatment Centre	9am to 9pm	9am to 9pm	Yes	Yes	Hospital Site in Ashton
North Hub	6.30pm to 9pm	9am to 1pm	Yes	No	To be Confirmed
South Hub	6.30pm to 9pm	9am to 1pm	Yes	No	To be Confirmed
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Glossop Primary Care Centre

Option 2

	Opening Hours		Access		Location
	Weekday	**Sat and Sun**	**Booked appointments**	**Walk-in**	
Urgent Treatment Centre	9am to 9pm	9am to 9pm	Yes	Yes	Hospital Site in Ashton
North Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
South Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
West Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
East Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Glossop Primary Care Centre

* Able to book appointments at the Urgent Treatment Centre in Ashton or at Glossop Neighbourhood Care Hub

13.4 Both options have:-

- Additional bookable appointments at the hospital based Urgent Treatment Centre;
- The option of an appointment on the hospital site for patients that are likely to need additional hospital based care e.g. diagnostics or a period of observation.
- A single location for walk in access that removes the need for the person attending to 'self-triage' and decide if their need requires A&E or could be better managed in urgent care.
- increased patient safety for people who walk in through direct transfer to A&E and hospital based care when required.
- Access to urgent diagnostics.

14. RECOMMENDATION

14.1 As set out on the front of the report.

Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

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

Subject / Title	Urgent Care

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

Start Date	**Completion Date**
June 2017	October 2017

Project Lead Officer	Elaine Richardson
Contract / Commissioning Manager	Janna Rigby
Assistant Director/ Director	Jess Williams

EIA Group (lead contact first)	**Job title**	**Service**
Elaine Richardson	Head of Delivery and Assurance	Commissioning
Jessica Williams	Interim Director of Commissioning and Care Together Programme Director	Commissioning
Janna Rigby	Head of Primary Care	Commissioning
Jody Stewart	Policy, Research and Improvement Manager	Policy and Communications

PART 1 – INITIAL SCREENING

Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

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

1a.	**What is the project, proposal or service / contract change?**	The proposal sets out a vision for urgent care within Tameside and Glossop and how services will be configured to deliver the vision. The final arrangement will be decided following a public consultation with a decision being made at the February 2018 Single Commissioning Board. This assessment will be refreshed in response to the consultation and included in the documents presented at the February Board meeting.

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1b.	**What are the main aims of the project, proposal or service / contract change?**	The vision is that: **People with an urgent care need are assessed by an appropriate Primary Care service and advice or a treatment plan is provided to support their recovery**. By 2022 we expect people who develop an urgent care need to be assessed by the most appropriate person on the same day within primary care (whether this is registered GP practice, dentist or pharmacy or optician or through a Locality-wide service) and either a treatment plan agreed to manage the immediate need within the service or a safe transfer made to the care of another neighbourhood based service. Our proposed urgent care service will integrate the existing Walk-in Centre and OoH with Primary Care Streaming at A&E and the planned Urgent Treatment Centre all of which provide/will provide direct support to people along with our Alternative to Transfer service that works with paramedics. This will provide a key access point at the Tameside Hospital site alongside neighbourhood based access through GPs, Pharmacies, Opticians, Dentists and Neighbourhood Care Hubs People will have 24/7 access to urgent care within Tameside and Glossop. They with be able to book same day appointments in their own practice, in a Neighbourhood Care Hub or at the Urgent Treatment Centre on the hospital site. People who are not registered with a Tameside and Glossop GP or who prefer not to book in advance will be able to walk-in to the Urgent Treatment Centre. People who need to be seen by a GP when practices, the Neighbourhood Care Hubs and Urgent Treatment Centre (i.e. 9pm to 8 am weekdays and 9pm to 9am weekends and Bank Holidays) are closed, will be seen on the hospital site. Key Outcomes will include:- • People are able to access urgent primary care 24/7 and are supported to navigate the system so they receive effective care first time and do not represent to other services for the same issue. • People are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams. • People whose need can be met within a Neighbourhood do not attend A&E.

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Clinical Commissioning Group

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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			Urgent care services, including the Walk-in Centre are accessible and available to the whole population of Tameside and Glossop. However the age profile of attendances at the Walk-in centre shows that attendances are predominantly younger people, with 75.8% of attendances under 45 years old. The greatest percentage of attendances is the Under 16 age bracket (31.9%) of which the majority (55.9%) are aged 4 and under. The consultation process will be inclusive and accessible to ensure the views of this age group are sought, and effort will be made to ensure a representative response is received. Service user demographics are shown at appendix 1.
Disability	x			There is disabled access to both Ashton Primary Care Centre and the hospital and both sites are accessible by car and public transport. 2015/16 Fingertips data suggests that Chapel Street MP have 73.4% and Hattersley Group Practice have 72.2% of patients with a long standing condition that is significantly different to the England average. All other practices (including those with highest Walk-in Centre attendances) have patient numbers that are not statistically significant to the England average.

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Ethnicity		x		The neighbourhoods with the highest levels of attendance at the Walk-in Centre are North and West, and for A&E these are North and South. 2016 Fingertips data shows that the practices with the highest walk-in centre usage have ethnicity profiles as follows; Albion Medical Centre: 1.6% mixed, 14.3% Asian, 1.1% Black Bedford Medical Practice: 1.6% mixed, 13.5% Asian, 1.0% Black Tame Valley: 1.6% mixed, 14.9% Asian, 1.1% Black Medlock Vale 1.5% mixed, 3.1% Asian, 1.0% Black Denton Medical Practice: 1.7% mixed, 2.5% Asian, 1.1% Black Market Street Medical Practice:1.7% mixed, 3.3% Asian, 1.9% Black Guide Bridge: 1.7% mixed, 6.9% Asian 1.3% Black HighlandsTrafalgar: 1.7% mixed, 16.2% Asian, 1.6% Black Chapel Street: 1.6% mixed 12.5% Asian, 1.3% Black This is compared to 91.8% White, 1.4% Mixed, 5.9% Asian, 0.7% Black and 0.2% Other for Tameside & Glossop overall (Census 2011).
Sex / Gender		x		Walk-in Centre data shows that there are more female service users than male, with 58.7% being female. This is compared to the Tameside & Glossop overall population which is 49% male and 51% female (2014 mid-year population estimates ONS)
Religion or Belief			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on religion or belief in any significant

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				sense.
Sexual Orientation			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on sexual orientation in any significant sense.
Gender Reassignment			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on gender reassignment in any significant sense.
Pregnancy & Maternity		x		Walk-in Centre usage data shows that there were 260 pregnancy related attendances at the Walk-in Centre during 2016-17. We also know that the greatest percentage of attendances is in the Under 16 age bracket (31.9%), of which the majority (55.9%) are aged 4 years and under and a proportion of these will be babies.
Marriage & Civil Partnership			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on marriage and civil partnership in any significant sense.
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health	x			Tameside and Glossop's Mental Health prevalence rate is 0.83% (2024 people); and the national prevalence is 0.9%. Depression; 10.71% (20969 people) for Tameside &Glossop and 8.3% nationally. The proposed consultation will include targeted engagement with these groups. Access and transport times may be affected by the relocation of services. Changes to location and access points will have clear links to mental health pathways for this group to maintain

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				quality of care. There are 7 (Medlock Vale, Awburn House, Lockside, Churchgate, The Smithy, The Hollies and Simmondley) practices in Tameside and Glossop whose Mental Health prevalence is significantly different (lower) than the average. All other practices are within the normal range and this includes those practices whose Walk-in Centre attendances are highest.
Carers	x			Access and transport times may be affected by the relocation of services. Change in location of the walk-in centre may impact on accessibility for those being cared for and therefore their carers. Of the practices identified with the highest usage of the Walk in Centre, the % of carers registered is as follows: Albion:19.1% Bedford House MP: 16.3% Tame Valley: 25% West End MP: 20.8% Medlock Vale: 17.1% Donneybrook: 15.6% Denton MP: 21.7% Market St MP: 16.8% Guide Bridge MC: 13.5% Highlands Trafalgar; 18.1% The CCG average is 18.6% and the England average is 17.8%. The majority of the higher user practices have above average carer populations on their registered lists.
Military Veterans			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on military veterans in any significant sense.

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Breast Feeding			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on breast feeding in any significant sense.
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Patients not registered with a GP (either within T&G or within another area)	x			Data tells us that 10% of service users of the Walk-in Centre are unregistered. Communicating the changes to this group will be imperative, particularly to those that are homeless.
Socio-economic	x			The neighbourhoods with the highest levels of attendance at the Walk-in Centre are North and West, and for A&E these are North and South. Of the practices identified with the highest usage of the Walk in Centre, Deprivation Score (IMD 2015) as follows: Albion:34.1 Bedford House MP: 33.5 Tame Valley: 35.3 West End MP: 38.7 Medlock Vale: 24.3 Donneybrook: 31.0 Denton MP: 29.4 Market St MP: 26.9 Guide Bridge MC: 31.3 Highlands Trafalgar; 36.6 The CCG average is 27.9 and the England average is 21.8 The majority of the higher user practices have above CCG average deprivation scores.

There is no anticipation that the development or implementation of this model will impact directly or indirectly on military veterans in any significant sense. However we will continue to assess any

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potential impact this group could experience as a result of the proposals throughout the consultation period so these can be addressed accordingly.

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 constitutes a significant change to the way in which services are currently commissioned and delivered, however the model retains all of the elements of provision that are currently available. It is also a service that is universally available to everyone and decisions relating to the delivery of the service will affect a wide range of patients, public and stakeholders. A full EIA is required as the protected characteristics of age, disability, ethnicity, sex/gender, pregnancy and maternity, mental health and carers may be directly impacted by the proposed delivery model. There are also socio-economic factors to consider.	

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary
Our vision is that: **People with an urgent care need are assessed by an appropriate Primary Care service and advice or a treatment plan is provided to support their recovery**. Strong neighbourhood based access to General Practice with other support services readily accessible will reduce the need for people to attend A&E unless they have had an accident or need emergency care. It will also support a seamless transfer for people who present as urgent but would be best managed as more routine. Our vision will be delivered over the next 4 years as we develop both the range of support that can be delivered in General Medical Practices and other Primary Care providers and the services that can be

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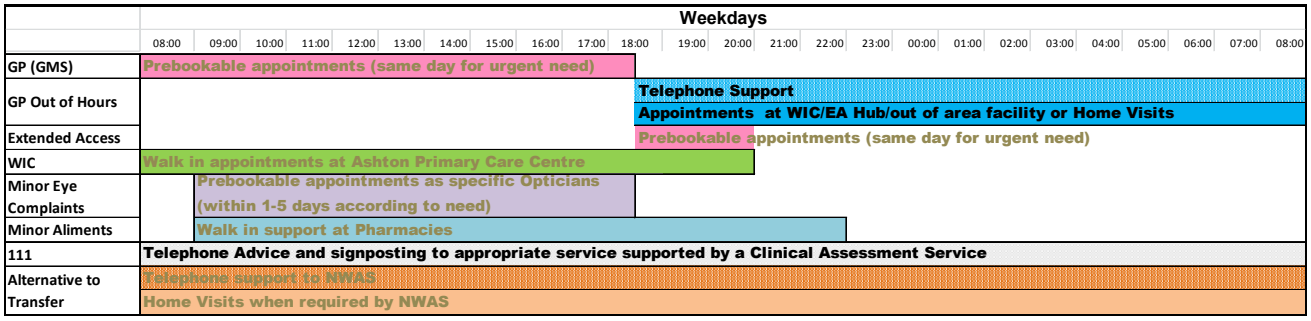
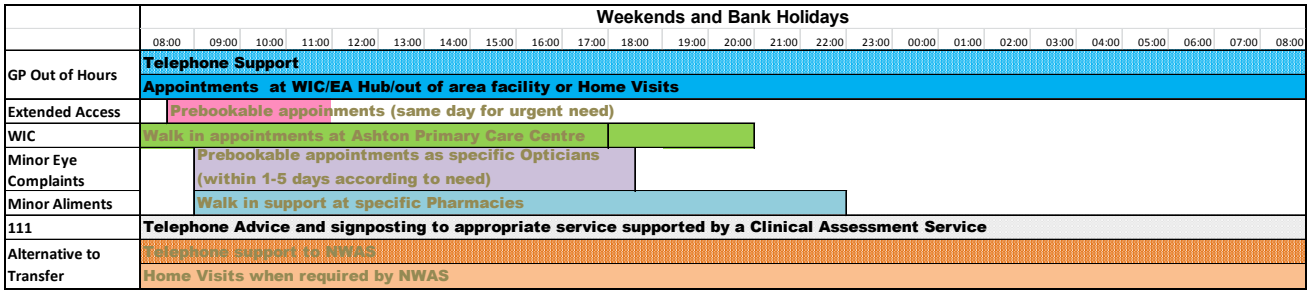
wrapped around a patient in their own home including care homes.

Existing services such as the Community Paramedic Service in Glossop, the Community Response Service, Digital Health and Integrated Urgent Care Team have demonstrated the opportunities to support people in their own homes when an urgent need arises. These working systematically with General Practice, community services and the voluntary sector will maximise the number of people who stay in their own home supported by Primary and Neighbourhood care which will benefit individuals and their carers/family through prompt recovery and help maintain independence.

In addition to this vision, there is a mandate from NHS England to implement Primary Care Streaming within the hospital. This was implemented on the 1st October 2017.

The current services that provide Primary Care support for people with an urgent need overlap as seen below. This means we have multiple access routes for patients who have an urgent but not accident or emergency need and a level of duplication in the offer available





Key to our proposal is the simplification of services whilst extending the hours people can book into appointments and providing access to urgent diagnostics. A single integrated urgent care service will work alongside the urgent access provided by GPs, Pharmacists and Opticians as seen below. This utilises the resources available to better effect, using the skill mix available to deliver care for our population.

Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

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Weekdays

	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00
GP (GMS)	Bookable appointments (same day for urgent need)																								
Integrated Urgent Care	Bookable appointments and walk in access to integrated urgent care at Ashton Urgent Treatment Centre and Neighbourhood Hubs with telephone and home visit support to NWAS																								
Minor Eye Complaints		Bookable appointments at specific Opticians (within 1-5 days according to need)																							
Minor Aliments		Walk in support at Pharmacies																							
111	Telephone Advice and signposting to appropriate service supported by a Clinical Assessment Service																								

Weekends and Bank Holidays

	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00
Integrated Urgent Care	Bookable appointments and walk in access to integrated urgent care at Ashton Urgent Treatment Centre and Neighbourhood Hubs with telephone and home visit support to NWAS																								
Minor Eye Complaints		Bookable appointments at specific Opticians (within 1-5 days according to need)																							
Minor Aliments		Walk in support at specific Pharmacies																							
111	Telephone Advice and signposting to appropriate service supported by a Clinical Assessment Service																								

There are several key drivers for change. Including the mandated requirement to introduce primary care streaming and develop an Urgent Treatment Centre. The model proposed for urgent care is designed to meet all national requirements whilst making provision more efficient and simpler to navigate for patients.

Urgent care will be delivered across practices, the Neighbourhood Care Hubs, the Urgent Treatment Centre and the Out of Hours GP service. These will operate as an integrated service to ensure that people:-

- Are able to access urgent care support 24/7 and are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams
- Whose need can be met by Primary Care do not need to access A&E
- Have access to an average of 45 minutes of evening and weekend/BH appointments per 1000 register population per week
- Are able to book routine and urgent appointments at the Urgent Treatment Centre and agreed Neighbourhood Care Hub sites
- Can be seen at the Urgent Treatment Centre 12 hours a day seven days a week including Bank Holidays either by booking an appointment or presenting as a 'Walk-in'
- Receive definitive treatment, which may include self-care advice, prescription issue or treatment of the presenting condition appropriate to primary care and people are equipped to reduce the risk of the same need arising in the future
- Are supported to navigate the system so they receive effective care first time and do not represent to other services for the same issue
- Who require urgent investigations/diagnostics receive these through the Urgent Treatment Centre
- Who need a same day home visit out of hours will either be seen by a GP or another appropriate service
- Can expect, following consent, that the treating clinician has access to their up-to-date electronic patient care record

Our urgent care service will integrate the existing Walk-in Centre, OoH, Extended Access with the soon to be live Primary Care Streaming at A&E and the planned Urgent Treatment Centre all of which provide/will provide direct support to people along with our Alternative to Transfer service that works with paramedics. This will provide a key access point at the hospital site in Ashton alongside

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neighbourhood based access through GPs, Pharmacies, Opticians, Dentists and Neighbourhood Care Hubs.

People will get 24/7 phone access to support through their practice (111 or OOH when the practice is closed) and will be booked into an appropriate appointment of if they need a same day home visit will be seen through the practice/neighbourhood offer, an OOH GP or the Integrated Urgent Care Team. Health care professionals such as paramedics and care home nurses will continue to get 24/7 access through the Health Care Professionals helpline or Alternative to Transfer.

The first point of contact in hours will be an individual's GP practice. People will make initial contact with their own practice and appropriate advice/ appointment will be provided to enable them to be seen by the right professional on the same day or at a later date as required. If a patient needs to be seen that day, it could either be by the General Medical Practice team or appropriate other primary care provider (dentist, optician, pharmacist) or if there is no capacity or due to reasons of convenience, the patients could be booked into a Neighbourhood Care hub.

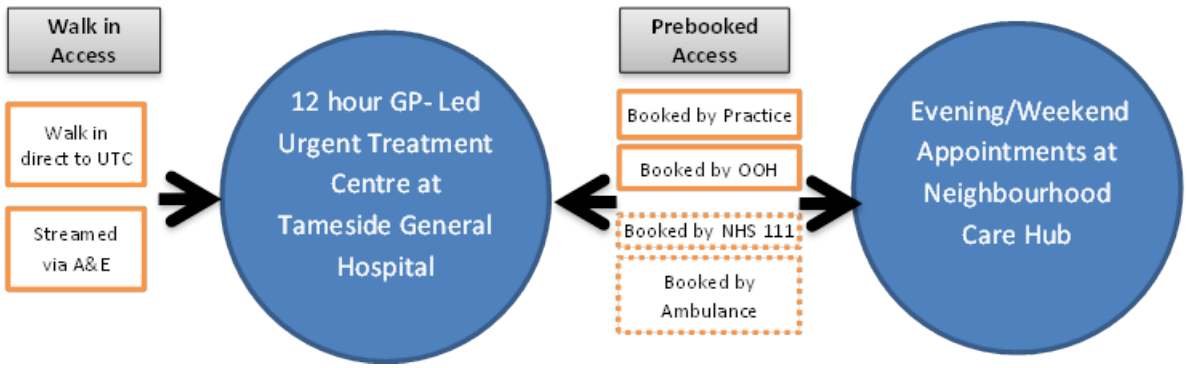
People will still have access to NHS 111 which will continue to direct people with a primary care need to practices/Out of Hours, Minor Eye Condition Service (MECS), Local pharmacies and dentists as appropriate but also to the Neighbourhood Care Hubs.

If a patient needs to be seen by a GP or another practice professional an appointment will be made either at that practice during it's opening hours or a Neighbourhood Care hub where there will be appointments 6.30pm to 9pm Monday to Friday and 9am to 1pm Saturday and Sunday or at the Urgent Treatment Centre open 9am to 9pm seven days a week. People who may need diagnostics or could need to be transferred to a hospital based specialist service may be advised to book an appointment at the Urgent Treatment Centre rather than having a choice of all locations.

If people have eye conditions, minor aliments or dental needs they will be directed to other Primary Care Providers and those with other more social care needs will be advised of the appropriate voluntary or statutory sector support.

People who chose to walk-in at the Ashton Urgent Treatment Centre site will be seen between 9am and 9pm seven days a week and may be booked into an appointment but may have to wait for up-to 2 hours for treatment.

In summary the Urgent Treatment Centre will provide 'Walk-in' Access with Bookable access available at both the Urgent Treatment Centre and the Neighbourhood Care Hubs as shown below.



The services at all access points will include General Medical Primary Care with both routine and

urgent needs accommodated through appointments available with GPs or members of the wider Primary Care Team. In addition the Urgent Treatment Centre will be able to directly access urgent diagnostics e.g. urinalysis, ECG and in some cases X-ray. The colocation of the Urgent Treatment Centre on the hospital site will also ensure that patients who require more specialist urgent care will be transferred promptly.

It is expected that the majority of people will contact their GP first and will be given choice of all available appointments reducing the need for people to have to 'walk-in' to the Urgent Treatment Centre and wait to be seen. People who are not registered with a Tameside and Glossop GP will be able to 'walk-in' to the Urgent Treatment Centre. There are national projects to enable Ambulance services and NHS 111 to book into Urgent Treatment Centres, GP and Extended Access appointments so in time unregistered people and visitors may have more options regarding where they are seen.

In Tameside and Glossop medical care is available via a number of access points to both the registered and non-registered population.

An address is not required to register at a GP practice and we do know that there are a number of homeless people who are registered, however the scale of this is not known. The population that are registered homeless are less likely to attend for routine care for their health, and so access to same day services is required to ensure there is a way for health care to be delivered.

In order to improve the way that patients can access same day and urgent care services, a detailed review of the total urgent primary care offer has been carried out and a new model of delivery with a single point of access to an Urgent Treatment Centre which will include all of the current provision and with access to diagnostics but in a single service, to simplify for patients where they should go if they have an urgent care need. In addition to the Urgent Treatment Centre, there will be further Neighbourhood Care Hubs offering Extended Access appointments that will be available to pre-book either on the same day or for a date in the near future. There is great potential for the homeless and unregistered populationsto benefit from the UTC as it will offer immediate and necessary treatment but also be able to access pre-bookable appointments (which those not registered with a GP cannot otherwise access at the moment), with a skill mix of workforce, which might include Care Navigators who can be trained to the needs of the people attending.

Our proposed integrated urgent care service is fully in line with national expectations and will enable Tameside and Glossop to use the resources available to deliver an excellent service for local people.

Consultation on our proposals will primarily be undertaken via the CCG website to ensure that all patients/service users across Tameside and Glossop can have input. Targeted work will be undertaken with specific groups reflecting the demographic profile of those more likely to be impacted directly by any proposals. Paper copies will also be provided at different locations e.g. Ashton Primary Care Centre, GP practices.

URGENT CARE SERVICE OPTIONS

There are two options for the delivery of the urgent care service both of which have the Urgent Treatment Centre based at the hospital site open 12 hours seven days a week 9am to 9pm. This will

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offer bookable same day/urgent and routine appointments and walk in access for urgent care and be able to provide direct access to urgent diagnostics along with safe transfer to other more specialist services when necessary. It will replace the existing Walk-in service at Ashton Primary Care Centre which will relocate to the hospital site ensuring that patients with an urgent care need will be able to be seen within Tameside and Glossop 24/7.
The options vary in the number of Neighbourhood Care hubs where bookable appointments can be made and when those hubs will be open as shown below.

Option 1

	Opening Hours		Access		Location
	Weekday	**Sat and Sun**	**Booked appointments**	**Walk-in**	
Urgent Treatment Centre	9am to 9pm	9am to 9pm	Yes	Yes	Hospital Site in Ashton
North Hub	6.30pm to 9pm	9am to 1pm	Yes	No	To be Confirmed
South Hub	6.30pm to 9pm	9am to 1pm	Yes	No	To be Confirmed
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Glossop Primary Care Centre

Option 2

	Opening Hours		Access		Location
	Weekday	**Sat and Sun**	**Booked appointments**	**Walk-in**	
Urgent Treatment Centre	9am to 9pm	9am to 9pm	Yes	Yes	Hospital Site in Ashton
North Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
South Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
West Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
East Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Glossop Primary

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					Care Centre

* Able to book appointments at the Urgent Treatment Centre in Ashton or at Glossop Neighbourhood Care Hub

The Key Points are:

- Relocation of the Walk-in access from Ashton PCC Walk-in Centre to the ICFT as an Urgent Treatment Centre which has additional diagnostics and direct access to other services.
- Bookable provision at the Urgent Treatment Centre seven days a week
- Bookable provision in Glossop 6.30-9pm Monday to Friday, and 9am-1pm Sat and Sun
- Bookable provision in other neighbourhoods dependent on options below.
- Out of Hours provision utilising bookable appointments where possible and seeing patients within Tameside and Glossop locality

The options have been developed having considered the feedback from a number of pre-engagement actions, including from a local design group made up of public and stakeholder representatives (28 July 2017).

2b. Issues to Consider

- Travel times
- Transport routes
- Parking (at the hospital site)
- Communications to ensure patients are able to navigate their way to the right services
- Access to appointments within general practice
- Our consultation and pre-engagement will need to be carefully planned and carried out to ensure all relevant groups, stakeholders are able to respond.
- Ensure that the final delivery model does not adversely affect accessibility and how patients are able to manage their usage

Key factors in deciding where to go for help included:

- How serious the need was perceived to be,
- Trust in the person they will be seen by, with trust in general practice being high

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- Ease of getting to a service, including transport links and car parking,
- The time it would take to be seen and
- Access to medical records was also seen as important in the quality of any response.

The relocation of the Ashton Primary Care Centre support service that delivers the Walk in element to the hospital site will mean a return to the position before the mandated implementation of A&E Streaming to Primary Care (October 2017) where there is one walk in arrangement for urgent care.

GM Academic Health Sciences Network have undertaken a Literature Review on Walk-In services and the findings suggest that the opening of walk-in centres has a minimal impact on the demand for other urgent care or primary care services, not significantly affecting either ED attendances or activity at primary care services. It is suggested that walk-in centres may instead increase overall demand for urgent care as patients who would previously have self-treated minor illnesses or injuries may instead attend the walk-in centres.

The finding of work based on patient questionnaires looking at what would have happened in an area if there had been no walk-in centre suggests, 50% of people would have attended a GP or requested a home visit, 26% would have attended the ED, 5% would have utilised the pharmacist and almost 10% would have self-treated rather than attended elsewhere and therefore would not increase demand on other services had the walk-in centre been unavailable. However, research into what happens after attending a walk-in centre suggests that almost 40% of patients may have duplicate attendances in other primary or urgent care services rather than using the walk-in centre as an alternative so activity may not increase as suggested from questionnaires. One study reported that 30% of patients attending an A&E facility over a 4 week period stated that the A&E was not their first point of contact. So by ensuring that the first contact delivers the outcome a patient needs it should mitigate any risk of activity increasing in A&E or other services and could decrease current A&E activity.

Access to the Tameside and Glossop Walk In Centre services is through people presenting at Ashton Primary Care Centre although some may be advised to attend by NHS 111, OOH, another clinician or their own practice. As with A&E, people who are not registered with a T&G GP can attend and between 1st June 2016 and 31st May 2017 the service supported around 3700 individuals who were not registered with a GP which represents 10% of the individuals who have used the service. This includes people who are overseas visitors and people who chose not to register.

Ensuring that unregistered people are able to access primary care when they feel they need it is important in maintaining their general health and widening what could be available to them when they attend could improve the level of support they receive and the health outcomes they experience.

	Usage between 1st June 2016 and 31st May 2017					
	T&G Registered	GM (exc T&G) Registered	Out of GM Registered	Unregistered	GP unknown	Total

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Unique Individuals	26253	3964	1678	3740	166	35801
	73%	11%	5%	10%	0.5%	

Several individuals have used the service on multiple occasions as shown. Not surprisingly visitors registered out of GM are less likely to attend multiple times.

	T&G Registered	GM (exc T&G) Registered	Out of GM Registered	Unregistered	GP unknown	Total
Attendances	40589	5708	2288	5353	238	54176
	75%	11%	4%	10%	0%	75%

It is suspected that some individuals using the WIC will also attend other services for the same conditions as a GM Academic Health Sciences Network Literature Review of research into what happens after attending a walk-in centre suggests that almost 40% of people may have duplicate attendances in other primary or urgent care services rather than using the walk-in centre. One study reported that 30% of people attending an A&E facility over a 4 week period stated that the A&E was not their first point of contact.

If we can ensure that the first contact with Urgent Primary Care is in the most appropriate place and delivers the outcome a person needs it should mitigate the need for people to attend multiple locations.

There is no real variation in usage by day for any particular cohort of people. The highest daily attendances at the WIC are recorded on a Monday and a Saturday although attendance levels are fairly consistent.

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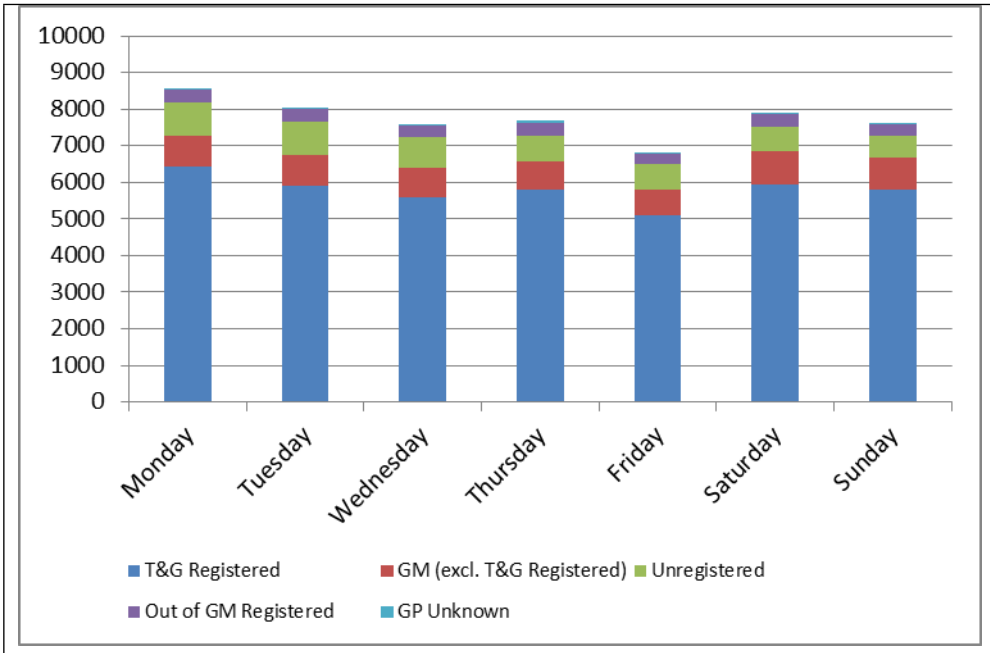

For our registered population weekend activity accounts for 30% of total weekly attendances.

Neighbourhood	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
North	2735	2502	2407	2523	2256	2108	1977	16508
West	1626	1473	1379	1396	1207	1381	1285	9747
South	1132	1121	1007	1005	875	1380	1376	7896
East	831	723	685	791	685	881	905	5501
Glossop	115	92	113	99	67	201	250	937
Total	6439	5911	5591	5814	5090	5951	5793	40589
Proportion	15.9%	14.6%	13.8%	14.3%	12.5%	14.7%	14.3%	

North is the only neighbourhood that sees a reduction in usage at the weekend.

The majority of WIC attendances by T&G registered Practices are from North (41%) and West (24%) neighbourhoods. Similarly North registered people are high users of A&E accounting for 28% of the last 12 months activity with 10% being for minor conditions and 18% for majors. South usage at A&E is similar to North.

Neighbourhood	WIC Usage	A&E Usage		
		Minor	Major	Total
North	41%	10%	18%	28%
West	24%	6%	12%	18%
South	19%	9%	18%	27%
East	14%	6%	12%	18%
Glossop	2%	3%	6%	9%

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Total	75%	34%	66%	

Geography may be a key factor in usage as Glossop is a lower user of all the services. There are some anecdotal reports that Glossop people use the New Mills WIC but there is no data to demonstrate how extensive this use is.

For the non-registered user, the data (above) shows that Data tells us that 10% of service users of the Walk-in Centre are unregistered. Communicating the changes to this group will be imperative, particularly to those that are homeless. In addition to this, A&E data also tells us that there are an average of 44 attendances at A&E each month is unregistered with a GP (activity data from April-September 2017, n=531). The tables below show the actual attendances per month and the average frequency by day of the week.

Unregistered Patient A&E Attendances Per Month	
Month	**Attendances**
Apr-17	33
Aug-17	57
Dec-16	56
Feb-17	35
Jan-17	45
Jul-17	48
Jun-17	41
Mar-17	30
May-17	34
Nov-16	49
Oct-16	49
Sep-17	54
Total	**531**

Unregistered Patient A&E Attendances by Day	
Attendance Day	**Attendances**
Friday	82
Monday	77
Saturday	86
Sunday	77
Thursday	66
Tuesday	80
Wednesday	63

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Total	**531**

At the Walk-in Centre there is a higher proportion of female to male attendances overall with 58.7% of attendances being by females.

Neighbourhood	Female Service Users	Total Female	Male Service Users	Total Male
North	9854	23973	6653	23862
West	5914	35305	3831	33,298
South	4677	24033	3219	22805
East	3270	29504	2231	28912
Glossop	547	16966	390	16211
Non T&G	7551	N/A	6035	N/A
Proportion	58.7%	50.9%	41.3%	49.00%

The WIC is predominantly used by younger people, with 75.8% of attendances under 45 years old. The greatest percentage of attendances is in the Under 16 age bracket (31.9%), of which the majority (55.9%) are aged 4 years and under.

	Females					
Neighbourhood	**Service Users Under 16**	**Total Population Tameside and Glossop Under 16**	**Service Users 16-45**	**Total Population Tameside and Glossop 16-45**	**Service Users 46-65**	**Total Population Tameside and Glossop 46-65**
North	2946	4914	4537	9433	1646	5817
West	1528	6256	2767	12767	1063	9472
South	1331	4864	2301	9102	733	6084
East	817	5567	1653	11149	585	7856
Glossop	155	2930	257	5997	99	4995
Non-T&G	1793	N/A	4047	N/A	1264	N/A
Total	8570	24531	15562	48448	5390	34224
Proportion	16%	9%	29%	19%	10%	13%

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	Females			
Neighbourhood	Service Users 66-75	Total Population Tameside and Glossop 66-75	Service Users Over 75	Total Population Tameside and Glossop Over 75
North	485	2086	240	1723
West	332	3,696	224	3,114
South	207	2227	105	1756
East	141	2853	74	2079
Glossop	26	1794	10	1250
Non-T&G	275	N/A	172	N/A
Total	1466	12656	825	9922
Proportion	3%	4%	2%	3%

	Males					
Neighbourhood	Service Users Under 16	Total Population Tameside and Glossop Under 16	Service Users 16-45	Total Population Tameside and Glossop 16-45	Service Users 46-65	Total Population Tameside and Glossop 46-65
North	3014	5223	2011	9308	1057	6133
West	1619	6269	1225	12289	660	9210
South	1292	4770	1201	8609	528	6083
East	838	5846	843	10895	403	7907
Glossop	150	3122	147	5857	67	4802
Non-T&G	1776	N/A	2788	N/A	1082	N/A
Total	8689	25230	8215	46958	3797	34135
Proportion	16%	9%	15%	18%	7%	13%

	Males			
Neighbourhood	Service Users 66-75	Total Population Tameside and	Service Users Over	Total Population

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		Glossop 66-75	75	Tameside and Glossop Over 75
North	367	2063	204	1135
West	216	3,342	111	2,188
South	135	2139	63	1249
East	108	2858	39	1406
Glossop	13	1627	13	803
Non-T&G	274	N/A	115	N/A
Total	1113	12029	545	6781
Proportion	2%	4%	1%	2%

2c. Impact

Age

Urgent Primary Care services, including the Walk-in Centre are accessible and available to the whole population of Tameside and Glossop. However the age profile of attendances at the Walk-in centres shows that attendances are predominantly younger people, with 75.8% of attendances under 45 years old. The greatest percentage of attendances is the Under 16 age bracket (31.9%) of which the majority (55.9%) are aged 4 and under (see tables in section 2b)

Disability

There is disabled access to both Ashton Primary Care Centre and the ICFT and both sites are accessible by car and public transport. 2015/16 Public Health England's Public Health Profiles (Fingertips data) suggests that Chapel Street MP and Hattersley Group Practice have % of patients with a long standing condition that is significantly different to the England average. All other practices (including those with highest Walk-in Centre attendances) have patient numbers that are not statistically significant to the England average.

Data from 2011 Census shows that 10.3% of people across Tameside and Glossop had some form of disability which limited day to day activities 'a lot' and a further 10.2% whose day to day activities were limited 'a little'.

Ethnicity

The neighbourhoods with the highest levels of attendance at the Walk-in Centre are North and West, and for A&E these are North and South.

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2016 Fingertips data shows that the practices with the highest walk-in centre usage have ethnicity profiles as follows;

- Albion Medical Centre: 1.6% mixed, 14.3% Asian, 1.1% Black
- Bedford Medical Practice: 1.6% mixed, 13.5% Asian, 1.0% Black
- Tame Valley: 1.6% mixed, 14.9% Asian, 1.1% Black
- Medlock Vale 1.5% mixed, 3.1% Asian, 1.0% Black
- Denton Medical Practice: 1.7% mixed, 2.5% Asian, 1.1% Black
- Market Street Medical Practice:1.7% mixed, 3.3% Asian, 1.9% Black
- Guide Bridge: 1.7% mixed, 6.9% Asian 1.3% Black
- HighlandsTrafalgar: 1.7% mixed, 16.2% Asian, 1.6% Black
- Chapel Street: 1.6% mixed 12.5% Asian, 1.3% Black
- This is compared to 91.8% White, 1.4% Mixed, 5.9% Asian, 0.7% Black and 0.2% Other for Tameside & Glossop overall (Census 2011).

Sex / Gender

Walk-in Centre data shows that there are more female service users than male, with 58.7% being female.

This is compared to the Tameside & Glossop overall population which is 49% male and 51% female (2014 mid-year population estimates ONS)

Pregnancy & Maternity

Walk-in Centre usage data shows that there were 260 pregnancy related attendances at the Walk-in Centre during 2016-17. We also know that the greatest percentage of attendances is in the Under 16 age bracket (31.9%), of which the majority (55.9%) are aged 4 years and under and a proportion of these will be babies.

Mental Health

Tameside and Glossop's Mental Health prevalence rate is 0.83% (2024 people); and the national prevalence is 0.9%. Depression; 10.71% (20969 people) for Tameside &Glossop and 8.3% nationally.
The proposed consultation will include targeted engagement with these groups.
Access and transport times may be affected by the relocation of services. Changes to location and access points will have clear links to mental health pathways for this group to maintain quality of care.

Carers

Access and transport times may be affected by the relocation of services.
Change in location of the walk-in centre may impact on accessibility for those being cared for and

therefore their carers.

Of the practices identified with the highest usage of the Walk in Centre, the % of carers registered is as follows:

- Albion:19.1%
- Bedford House MP: 16.3%
- Tame Valley: 25%
- West End MP: 20.8%
- Medlock Vale: 17.1%
- Donneybrook: 15.6%
- Denton MP: 21.7%
- Market St MP: 16.8%
- Guide Bridge MC: 13.5%
- Highlands Trafalgar; 18.1%
- The CCG average is 18.6% and the England average is 17.8%.

The majority of the higher user practices have above average carer populations on their registered lists.

Patients not registered with a GP (either within T&G or within another area)
Data tells us that 10% of service users of the Walk-in Centre are unregistered. Communicating the changes to this group will be imperative, particularly to those that are homeless. Data also tells us that there are an average of 44 attendances at A&E each month is unregistered with a GP (activity data from April-September 2017, n=531).

In Tameside and Glossop medical care is available via a number of access points to both the registered and non-registered population.

An address is not required to register at a GP practice and we do know that there are a number of homeless people who are registered, however the scale of this is not known. The population that are registered homeless are less likely to attend for routine care for their health, and so access to same day services is required to ensure there is a way for health care to be delivered.

In order to improve the way that patients can access same day and urgent care services, a detailed review of the total urgent primary care offer has been carried out and a new model of delivery with a single point of access to an Urgent Treatment Centre which will include all of the current provision and with access to diagnostics but in a single service, to simplify for patients where they should go if they have an urgent care need. In addition to the Urgent Treatment Centre, there will be further Neighbourhood Care Hubs offering Extended Access appointments that will be available to pre-book either on the same day or for a date in the near future. There is great

potential for the homeless to benefit from the UTC as it will offer immediate and necessary treatment but also be able to access pre-bookable appointments (which those not registered with a GP cannot otherwise access at the moment), with a skill mix of workforce, which might include Care Navigators who can be trained to the needs of the people attending.

Socio-economic

The neighbourhoods with the highest levels of attendance at the Walk-in Centre North and West, and for A&E these are North and South.

The urgent care services are provided universally for everyone resident and registered across Tameside and Glossop. However it is anticipated that changes to how the service is delivered may impact on those protected characteristics identified; age, disability, ethnicity, sex/gender, pregnancy and maternity, mental health, carers, the unregistered user and socio-economic. The issue anticipated to have the greatest impact is transport and travel times for all of these groups.

Accessibility of Services

Basemap's TRACC software has been used to calculate travel times to Ashton Primary Care Centre, Tameside & Glossop Integrated Care NHS Foundation Trust site and the example out of hours hubs using public transport at both peak and off peak time periods.

This covers all major public transport options across Tameside and Glossop including bus, train and tram.

TRACC was also used to calculate drive times at both peak and off peak time periods, and walk times.

Detailed drive time, public transport and walk time analysis (Including maps) is attached at appendix 1.

Travel time analysis for Ashton Primary Care Centre and Tameside and Glossop Integrated Care NHS Foundation Trust

Drive Time

For all time periods analysed the proportion of Tameside and Glossop residents who are within travelling distance by car to Ashton Primary Care Centre (APCC) is similar to or the same as the proportion who are within travelling distance by car to Tameside and Glossop Integrated Care NHS Foundation Trust (T&G ICFT).

On weekday mornings at peak times (Monday-Friday 0700-0900):

- 87.2% of residents can travel to APCC by car within 0-15 minutes and 86.3% can travel to T&G ICFT by car within 0-15 minutes.
- 99.8% of residents can travel to both locations by car within 0-30 minutes

On weekdays, off-peak (Monday-Friday 1000-1600):

- 88.4% of residents can travel to APCC by car within 0-15 minutes and 89.3% can travel to T&G ICFT by car within 0-15 minutes.
- Again 99.8% of residents can travel to both locations by car within 0-30 minutes

On weekday afternoon/evenings at peak times (Monday-Friday 1600-1900):,

- 86.5% can travel to APCC and 86.2% can travel to T&G ICFT within 0-15 minutes by car.
- Again, 99.8% of residents can travel to voth locations by car within 0-30 minutes

On weekends (Weekend 0700-1900

- 90.5% can travel to APCC and 92% can travel to T&G ICFT within 0-15 minutes by car.
- Again 99.8% can travel to both locations within 0-30 minutes by car

Public Transport

For all time periods analysed the proportion of Tameside and Glossop residents who are within travelling distance by public transport to Ashton Primary Care Centre (APCC) within 0-60 minutes is similar to the proportion who are within travelling distance by public transport to Tameside and Glossop Integrated Care NHS Foundation Trust (T&G ICFT) within the same time scale. However there are some differences in the proportion of residents who can access both locations via public transport within shorter time scales as outlined below.

On weekday mornings at peak times (example time of Tuesday 0700-0900):

- 97.1% of residents can access APCC and 96.4% of residents can access T&G ICFT within 0-60 minutes.
- Within 0-15 minutes 11.9% can access APCC and 9% ICFT;
- Within 0-30 minutes 58.1% can access APCC and 39.1% can access ICFT;
- Within 0-45 minutes 86.5% can access APCC and 71.6% can access ICFT.

On weekdays at off-peak times (example time of Tuesday 1000-1600):,

- 99.4% of residents can access APCC and 99.2% can access T&G ICFT within 0-60 minutes.
- Within 0-15 minutes 11.5% can access APCC and 9.2% can access ICFT;
- Within 0-30 minutes 62.4% can access APCC and 40.3% ICFT;
- Within 0-45 minutes 89.4% can access APCC and 79.6% can access ICFT.

On weekday afternoon/evenings at peak times (example time of Tuesday 1600-1900):

- 99.2% of residents can access APCC and 99% of residents can access ICFT within 0-60 minutes.
- Within 0-15 minutes 13.5% can access APCC and 8.5% ICFT;
- Within 0-30 minutes 62.4% can access APCC and 37.8% can access ICFT;
- Within 0-45 minutes 88.7% can access APCC and 77.7% can access ICFT.

On weekends (example time of Saturday 1000-1600

- 99.4% of residents can access APCC and 99% of residents can access ICFT within 0-60 minutes.
- Within 0-15 minutes 11.8% can access APCC and 9.2% ICFT;
- Within 0-30 minutes 62.4% can access APCC and 40.1% ICFT;
- Within 0-45 minutes 89.4% can access APCC and 78.7% can access ICFT.

Walk Time

By foot, 4.1% of residents can access APCC within 0-15 minutes, 18.1% within 0-30 minutes, 37.8% within 0-45 minutes and 54.5% within 0-60 minutes. In comparison 3.6% of residents can access the ICFT site within 0-15 minutes, 15.7% within 0-30 minutes, 31.8% within 0-45 minutes and 43.5% within 0-60 minutes.

Key Locations Analysis

Travel times between 14 key locations across Tameside & Glossop (Ashton, Mossley, Stalybridge, Dukinfield, Hyde, Broadbottom, Hattersley, Mottram, Denton, Audenshaw, Droylsden, Hadfield, Gamesley, and Glossop) to both Ashton Primary Care Centre (APCC) and Tameside and Glossop Integrated Care NHS Foundation Trust (T&G ICFT) were calculated for various modes of transport and time periods.

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

Drive Times

When travelling by car during weekday mornings at peak-time (Monday-Friday 0700-0900), weekday off-peak (Monday-Friday 1000-1600), weekday afternoons/evenings at peak time (Monday-Friday 1600-1900) or weekend (weekend 0700-1900) Ashton town centre was the shortest travel time of all 14 locations to both APCC and T&G ICFT, whilst Glossop town centre was the longest travel time to both sites.

For all four of the drive time time-periods the time in minutes between Glossop town centre and APCC was longer than the time between Glossop town centre and ICFT. For example on weekday mornings the time in minutes between Ashton town centre and APCC was 2.69 and the time in minutes between Ashton town centre and ICFT was 4.67. The time between Glossop town centre and APCC was 19.12 and the time between Glossop town centre and ICFT was 17.55.

Public Transport

When travelling by public transport during weekday mornings at peak time (example Tuesday 0700-0900) weekday off-peak (Tuesday 1000-1600), weekday afternoons/evenings at peak time (Tuesday 1600-1900) or weekend (Saturday 1000-1600) Ashton town centre was the shortest travel time for both APCC and T&G ICFT, whereas the longest travel time varied.

For all four public transport time-periods the travel time in minutes between Ashton town centre and APCC was 3.7, whereas the travel time in minutes between Ashton town centre and ICFT was 12.13 for three of the time-periods and 10.96 for the weekday afternoon/evenings peak time time-period.

For weekday mornings at peak time using public transport the longest time in minutes from APCC was to Gamesley (55.83 minutes) and from ICFT was also to Gamesley (48.65) minutes. For weekdays off-peak using public transport the longest time in minutes from APCC was to Gamesley (46.83 minutes) but from ICFT was to Broadbottom (47.93 minutes). For weekday afternoon/evenings peak-time using public transport the longest time in minutes from APCC was to Gamesley (46.83 minutes) but from ICFT was to Broadbottom (44.93 minutes). For weekends using public transport the longest time in minutes from APCC was to Gamesley (46.83 minutes) but from ICFT was to Broadbottom (47.93 minutes).

Walk Times

By foot, Ashton was the shortest walk time to APCC at 8.6 minutes, and the longest walk time for APCC was to Glossop at 158.48 minutes. For ICFT the shortest walk time was to Stalybridge at 22.49 minutes whereas the longest walk time was to Glossop at 137.32 minutes.

Car Availability Census Data

The following data taken from Census 2011 outlines some key information relating to car and van availability across Tameside & Glossop.

1.1% of households in Tameside and Glossop have 4 or more cars or vans, 4% of households

have 3 cars or vans, 22.4% have 2 cars or vans, 43.9% have 1 car or van and 28.6% have no car or van. Ashton Primary Care Centre is located in St Peter's ward, which has the highest percentage of any Tameside and Glossop ward for the category of households with no car or van (50.1%). The ward with the lowest percentage of households with no car or van was Simmondley (5.5%). The ward with the highest percentage of households with 4 or more cars or vans was St John's (4.7%). The ward with the lowest percentage of households with 4 or more cars or vans was Gamesley (0.2%).

Example Hubs Census Tables Analysis

The census population tables in appendix 3 show the percentage and count of Tameside and Glossop residents within the time bands of 15, 30, 45, 60 and 60 + minutes of the example hubs (Glossop Primary Care Centre, Haughton Thornley Medical Practice Denton Festival Hall and St Andrew's Medical Centre). The percentage figures are calculated for each mode of transport and time bracket that are displayed on the example hub maps.

Glossop Example Hub

For Glossop Primary Care Centre, when travelling by car:

- Weekdays 0700-0900: 28.2% of residents are within 0-15 minutes.
- Weekdays 1600-1900: 25.6% of residents are within 0-15 minutes.
- Weekend 0700-1900: 36.4% of residents are within 0-15 minutes.
- For all three drive time time-periods above, 99.8% of residents are within 0-30 minutes.

For Glossop Primary Care Centre, when travelling by public transport:

- Tuesday 0700-0800: 8.9% of residents are within 0-15 minutes and 47.3% are within 0-60 minutes.
- Tuesday 1830-2130: 9.6% of residents are within 0-15 minutes and 86.9% are within 0-60 minutes.
- Saturday 0900-1700: 10% of residents are within 0-15 minutes and 90.5% are within 0-60 minutes.

For Glossop Primary Care Centre, when travelling by foot 3.7% are within 0-15 minutes and 14% are within 0-60 minutes.

South Example Hub

For Haughton Thornley Medical Practice, when travelling by car:

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

- Weekdays 0700-0900: 87.6% are within 0-15 minutes.
- Weekdays 1600-1900: 82.4% are within 0-15 minutes.
- Weekend 0700-1900: 89.4% are within 0-15 minutes.
- For all three drive time time-periods above, 99.8% of residents are within 0-30 minutes.

For Haughton Thornley Medical Practice, when travelling by public transport:

- Tuesday 0700-0800: 7.2% are within 0-15 minutes and 87.2% are within 0-60 minutes.
- Tuesday 1830-2130: 10.9% are within 0-15 minutes and 98.8% are within 0-60 minutes.
- Saturday 0900-1700: 7.8% are within 0-15 minutes and 99.2% are within 0-60 minutes.

For Haughton Thornley Medical Practice, when travelling by foot 5% are within 0-15 minutes and 36.4% are within 0-60 minutes.

West Example Hub

For Denton Festival Hall, when travelling by car:

- Weekdays 0700-0900: 83.8% are within 0-15 minutes.
- Weekdays 1600-1900: 81.6% are within 0-15 minutes.
- Weekend 0700-1900: 86.3% are within 0-15 minutes.
- For all three drive time time-periods above, 99.8% of residents are within 0-30 minutes.

For Denton Festival Hall, when travelling by public transport:

- Tuesday 0700-0800: 9.7% are within 0-15 minutes and 81.1% are within 0-60 minutes.
- Tuesday 1830-2130: 13.6% are within 0-15 minutes and 96.3% are within 0-60 minutes.
- Saturday 0900-1700: 13.7% are within 0-15 minutes and 94.9% are within 0-60 minutes.

For Denton Festival Hall, when travelling by foot 3.9% are within 0-15 minutes and 42.2% are within 0-60 minutes.

East Example Hub

For St Andrew's Medical Centre, when travelling by car:

- Weekdays 0700-0900: 95.4% are within 0-15 minutes.
- Weekdays 1600-1900: 91.8% are within 0-15 minutes.
- Weekend 0700-1900: 96.7% are within 0-15 minutes.
- For all three drive time time-periods above, 99.8% of residents are within 0-30 minutes.

For St Andrew's Medical Centre, when travelling by public transport:

- Tuesday 0700-0800: 16.1% are within 0-15 minutes and 96.4% are within 0-60 minutes.
- Tuesday 1830-2130: 20.3% are within 0-15 minutes and 99.1% are within 0-60 minutes.
- Saturday 0900-1700: 15.6% are within 0-15 minutes and 99.5% are within 0-60 minutes.

For St Andrew's Medical Centre, when travelling by foot 4% of residents are within 0-15 minutes and 45.6% are within 0-60 minutes.

Tables show travel time in minutes between each example hub and key locations for each mode of transport and time period. The travel times are calculated for each mode of transport and time bracket that are displayed on the example hub maps. These can be found at appendix 3.

The current service delivery model has access points in Ashton Primary Care Centre (Walk-in Centre, GP Out of Hours and Extended Access appointments), Glossop Primary Care Centre (Extended Access appointments) and Haughton Thornley Medical Practice in Hyde (Extended Access appointment).

The tables below show the travel times from key locations to Ashton Primary Care Centre (APCC) and to the Hospital site (ICFT).

Location	Drive Time Mon-Fri 0700-0900 (Time in Minutes)		Drive Time Mon-Fri 1000-1600 (Time in Minutes)		Drive Time Mon-Fri 1600-1900 (Time in Minutes)		Drive Time Weekend 0700-1900 (Time in Minutes)	
	APCC	ICFT	APCC	ICFT	APCC	ICFT	APCC	ICFT
Ashton	2.69	4.67	2.8	4.5	2.78	4.66	2.7	4.27
Mossley	9.19	7.11	9	7.18	9.39	7.09	8.37	7.02
Stalybridge	5.96	4.71	5.95	4.71	6.47	4.87	5.47	4.58
Dukinfield	3.37	5.98	3.87	5.79	3.97	6	3.31	5.46
Hyde	9.08	12.4	9.22	12.33	9.43	12.8	8.59	11.3
Broadbottom	16.03	14.45	15.63	14.14	16.2	14.43	14.54	13.41
Hattersley	14.12	12.54	13.51	12.02	14.28	12.51	12.7	11.57

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Mottram	11.53	9.96	11.03	9.54	11.95	10.18	10.34	9.22
Denton	7.32	10.64	7.21	10.41	7.36	10.73	6.68	9.77
Audenshaw	4.8	8.12	4.24	7.44	4.43	7.8	3.9	6.99
Droylsden	6.54	9.29	6.52	9.16	6.69	9.54	6.35	8.89
Glossop	19.12	17.55	19.62	18.13	20.74	18.98	18.59	17.47

Location	Public Transport Saturday 1000-1600 (Time in Minutes)		Public Transport Tuesday 1000-1600 (Time in Minutes)		Public Transport Tuesday 1600-1900 (Time in Minutes)		Public Transport Tuesday 0700-0900 (Time in Minutes)	
	APCC	ICFT	APCC	ICFT	APCC	ICFT	APCC	ICFT
Ashton	3.7	12.13	3.7	12.13	3.7	10.96	3.7	12.13
Mossley	24.81	14.5	24.81	14.5	24.81	17.5	22.81	15.5
Stalybridge	18.23	14.58	18.23	14.58	18.23	14.58	18.23	14.58
Dukinfield	8.25	25.32	8.25	25.32	7.25	27.14	8.92	28.06
Hyde	21.76	38.83	21.76	38.83	22.76	39.2	24.76	39.2
Broadbottom	36.83	47.93	36.83	47.93	36.24	44.93	39.83	45.81
Hattersley	39.41	34.79	39.41	34.79	41.41	34.79	42.41	32.79
Mottram	30.12	26.51	30.12	26.51	30.12	26.51	30.12	26.38
Denton	19.35	37.37	19.35	36.37	17.35	37.37	20.35	40.39
Audenshaw	15.73	31.77	15.73	31.77	15.73	32.42	14.73	33.92
Droylsden	16.97	31.14	17.97	31.14	16.97	33.34	15.97	31.14
Glossop	42.88	41.06	42.88	41.06	44.67	41.06	45.88	48.49

Location	Walk Time (Time in Minutes)	
	APCC	ICFT
Ashton	8.6	25.9
Mossley	77.12	56.05
Stalybridge	41.9	22.49
Dukinfield	15.2	37.22
Hyde	59.17	69.83
Broadbottom	122.77	101.61
Hattersley	98.44	89.88
Mottram	95.96	74.8
Denton	50.52	80.28
Audenshaw	30.61	60.69

Tameside & Glossop Single Commissioning Function
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Droylsden	42.61	73.01	
Hadfield	134.99	113.82	
Gamesley	136.32	115.16	
Glossop	158.48	137.32	

2d. Mitigations *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
Transport and travel times	A series of detailed maps have been produced to show the relative travel times if attending by car, public transport or walking (appendices 1-2). In addition to this, information relating from First Bus and Stagecoach, and Transport for Greater Manchester (appendices 4-9) is available. Community travel options include Ring and Ride which is available to those who hold a TfGM Concessionary Disabled Person Pass; or are 70 years old or over, have mobility issues and hold a TfGM Over 60 Concessionary Pass www.tfgm.com/ringandride/Pages/default.aspx and the Local Link service available to Dane Bank, Glossop and East Tameside through Transport for Greater Manchester www.tfgm.com/buses/local_link/Pages/index.html. There are also a number of buses from Glossop, Hyde, Stalybridge, Denton and Ashton that go to the hospital site.
Age	*The data in section 2c. shows that the predominant age group using urgent care services are under 45 years of age.* The WiC for example, is predominantly used by younger people, with 75.8% of attendances under 45 years old. The greatest percentage of attendances is in the Under 16 age bracket (31.9%), of which the majority (55.9%) are aged 4 years and under. Within the proposed model, access to urgent care will be available 24/7 to accommodate the working day and health care needs. To ensure the views of this cohort are taken into account, the consultation process will ensure local groups and sections of the population who are within this protected characteristic group are supported and encouraged to engage in the consultation, thus ensuring their views are included in the process. Engagement will be through online and paper based consultation formats, with access to the consultation information being encouraged at easily accessible points, e.g. internet connected computers within libraries.

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

<table>
<tr><td>Disability</td><td>The commissioner will ensure the consultation process is inclusive of people with disabilities to ensure they are involved in the development of the model of care. Data from 2011 Census shows that 10.3% of people across Tameside and Glossop had some form of disability which limited day to day activities ‘a lot’ and a further 10.2% whose day to day activities were limited ‘a little’.</td></tr>
<tr><td>Ethnicity</td><td>The neighbourhoods with the highest levels of attendance at the Walk-in Centre North and West, and for A&E these are North and South.</td></tr>
<tr><td>Sex/ gender</td><td>Walk-in Centre data shows that there are more female service users than male, with 58.7% being female.</td></tr>
<tr><td>Mental Health</td><td>We will work with commissioning leads for mental health to ensure the model of care we develop is appropriate for people with an urgent primary care need and support where they also have a mental health need. We will ensure that the consultation process is inclusive of people with mental health needs and their carers.</td></tr>
<tr><td>Carers</td><td>Carers data taken from Census 2011 for Tameside & Glossop CCG area around provision of unpaid care:

<table><tr><th>Care Provision</th><th>No.</th><th>%</th></tr><tr><td>Provides no unpaid care</td><td>224,820</td><td>89.1</td></tr><tr><td>Provides 1 to 19 hours unpaid care a week</td><td>16,435</td><td>6.5</td></tr><tr><td>Provides 20 to 49 hours unpaid care a week</td><td>4,036</td><td>1.6</td></tr><tr><td>Provides 50 or more hours unpaid care a week</td><td>7,123</td><td>2.8</td></tr></table>
To ensure the views of this cohort are taken into account, the consultation process will ensure local groups and sections of the population who are within this protected characteristic group are supported and encouraged to engage in the consultation, thus ensuring their views are included in the process.</td></tr>
<tr><td>Pregnancy and Maternity</td><td>Walk-in Centre usage data shows that there were 260 pregnancy related attendances at the Walk-in Centre during 2016-17. We also know that the greatest percentage of attendances is in the Under 16 age bracket (31.9%), of which the majority (55.9%) are aged 4 years and under and a proportion of these will be babies.
To ensure the views of this cohort are taken into account, the</td></tr>
</table>

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

	consultation process will ensure local groups and sections of the population who are within this protected characteristic group are supported and encouraged to engage in the consultation, thus ensuring their views are included in the process.
Unregistered service users	Data tells us that 10% of service users of the Walk-in Centre are unregistered. Data also tells us that there are an average of 44 attendances at A&E each month is unregistered with a GP (activity data from April-September 2017, n=531). Communicating the changes to this group will be imperative, particularly to those that are homeless. To ensure the views of this cohort are taken into account, the consultation process will ensure local groups and sections of the population who are within this protected characteristic group are supported and encouraged to engage in the consultation, thus ensuring their views are included in the process.
Socio-economic factors	The neighbourhoods with the highest levels of attendance at the Walk-in Centre North and West, and for A&E these are North and South.

2e. Evidence Sources

- Activity data supplied from current services including the Walk-in Centre, OOH, Extended Access, ATT and ED
- Travel time analysis and mapping for public transport and drive times – Basemap TRACC (attached)
- Greater Manchester Transport routes (attached)
- Staff and public engagement
- Census 2011
- Mid-year population estimates (ONS)
- Fingertips data 2016 http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2016,pat,153,par,E38000182,are,P89003,sid1,2000003,ind1,-,sid2,2000005,ind2,639-4

2f. Monitoring progress

Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

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

Issue / Action	Lead officer	Timescale
The project team will take ongoing responsibility for this work with reporting as required via the appropriate governance. We will ensure that progress on the monitoring of the consultation will be undertaken.	*Elaine Richardson*	*Ongoing*

Signature of Contract / Commissioning Manager	Date
Elaine Richardson	**10th October 2017**
Signature of Assistant Director / Director	**Date**

Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

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

EIA Appendices

Appendix 1	Service User Demographics
Appendix 2	Travel Time Maps
Appendix 3	Travel Time Maps (2)
Appendix 4	Derbyshire and High Peak Public Transport
Appendix 5	Buses to Tameside Hospital
Appendix 6	TFGM Public Transport routes map, Tameside
Appendix 7	First Bus Disability Access
Appendix 8	Stagecoach Disability Access
Appendix 9	Rail-network map
Appendix 10	North Neighbourhood Profile
Appendix 11	West Neighborhood Profile
Appendix 12	Glossop Neighbourhood Profile
Appendix 13	South Neighbourhood Profile
Appendix 14	East Neighbourhood Profile

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Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

Quality Impact Assessment

Urgent Care Review

September 2017

Quality Impact Assessment

Title of scheme: Urgent Care

Project Lead for scheme: Elaine Richardson

The proposal sets out a vision for urgent care within Tameside and Glossop and how services will be configured to deliver the vision. The final arrangement will be decided following a public consultation with a decision being made at the February Single Commissioning Board. This assessment will be refreshed in response to the consultation and included in the documents presented at the February Board meeting.

Our vision is that:

> **People with an urgent care need are assessed by an appropriate Primary Care service and advice or a treatment plan is provided to support their recovery.**

By 2022 we expect people who develop an urgent care need to be assessed by the most appropriate person on the same day within primary care (whether this is registered GP practice, dentist or pharmacy or optician or through a Locality-wide service) and either a treatment plan agreed to manage the immediate need within the service or a safe transfer made to the care of another neighbourhood based service.

Key Outcomes will include:-

- People are supported to navigate the system so they receive effective care first time and do not represent to other services for the same issue.
- People are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams.
- People whose need can be met within a Neighbourhood do not attend A&E.
- People are equipped to reduce the risk of the same need arising in the future.

People will have 24/7 access to urgent care within Tameside and Glossop with the GP telephone number being the key number to use for support and direction. People registered with a Tameside and Glossop practice with be able to book same day appointments in their own practice, in a Neighbourhood Care Hub or at the Urgent Treatment Centre on the hospital site. People who are not registered with a Tameside and Glossop GP or who prefer not to book in advance will be able to walk-in to the Urgent Treatment Centre. People who need to be seen by a GP when practices, the Neighbourhood Care Hubs and Urgent Treatment Centre i.e. 9pm to 8 am weekdays and 9pm to 9am weekends and Bank Holidays are closed will be seen on the hospital site.

What is the anticipated impact on the following areas of quality? NB please see appendix 1 for examples of impact on quality.							What is the likelihood of risk occurring?						What is the overall risk score (impact x likelihood			Comments
	Neutral / Positive Impact	Negligible	Minor	Moderate	Major	Catastrophic	No risk identified	Rare	Unlikely	Possibly	Likely	Almost certain	**Low**	**Moderate**	**High**	
	0	1	2	3	4	5	0	1	2	3	4	5	0-5	6-12	15-25	
Patient Safety	x						x						x			A positive impact is anticipated The ability to book appointments in advance through the registered GP will enable people to be treated at the place that is best suited to meet the described need and ensure if urgent diagnostics may be required appointments are arranged at the Urgent Treatment Centre. The ability to book appointments until 9 pm will support people to plan their access and so reduce congestion in walk-in services. People who chose to walk-in will attend the Urgent Treatment Centre will be assessed on arrival and seen by the most appropriate professional with prompt transfer to on the same site to emergency care when needed. Simplifying the pathways and locations will improve patient access to the most appropriate services including diagnostics. The single point of walk-in access will avoid the need for people to 'self-triage' and reduce the risk of an individual selecting a service that cannot meet a person's need. The increased access to urgent care and the initial assessment at the Urgent Treatment Centre will reduce the use of A&E for non-life threatening conditions and free up resources to manage people who require emergency treatment.

															The Urgent Treatment Centre and Neighbourhood Care hubs will be able to access patient records with the appropriate consent. The provider will be expected to ensure robust and consistent care and safety for patients. Safety incidents will be reported and monitoring of these will be carried out via provider governance and as part of the performance management and assurance of the contract. Access to patient notes will reduce risk when planning treatment. The provider will need to assure the SCF of its governance and quality assurance mechanisms.
Clinical effectiveness	X						x						x		A positive impact is anticipated The ability to book appointments in advance through the registered GP will enable people to be treated at the place by the most appropriate professional which will improve effectiveness. Access to urgent diagnostics at the Urgent Treatment Centre will improve diagnosis and treatment in a single appointment. Access to patient notes will improve the planning of treatment both immediate and any follow up care. Reduced minor activity in A&E will enable A&E specialists to focus on the most complex patients
Patient experience		x								x			x		Although it is expected that the proposed model will improve patient experience through alignment of access points and increased appointments, a degree of dissatisfaction from some people is anticipated as any change attracts negative responses. This is particularly noted due to negative media interest and patient feedback in other GM localities where there have been complete closure of their Walk-in Centres. The proposed model retains a walk-in element and is fully aligned with national and GM expectations. Through consultation we are collecting people's perception of the impacts so we can identify any areas where we will need to take action to mitigate risk. We will use the feedback and opinions to ensure effective communication when the final service arrangement is agreed and to support implementation in the summer.
Safeguarding children or adults	x						x						x		No impact expected as staff will be fully trained and the provider will have safeguarding procedures in place.

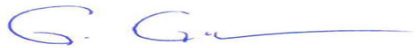
Please consider any anticipated impact on the following additional areas only as appropriate to the case being presented. NB please see appendix 1 for examples of impact on additional areas.							What is the likelihood of risk occurring?						What is the overall risk score (impact x likelihood)			Comments
	Neutral / Positive	Negligible	Minor	Moderate	Major	Catastrophic	No risk identified	Rare	Unlikely	Possibly	Likely	Almost certain	Low	Moderate	High	
	0	1	2	3	4	5	0	1	2	3	4	5	0-5	6-12	15-25	
Human resources/ organisational development/ staffing/ competence			x							x				x		The proposal will provide more flexibility in how skill sets and expertise can be utilised and reduce some of the risks around capacity that the duplication of services suffers. The relocation of the Walk-in services from Ashton Primary Care Centre will have an impact on some people but the services remain within Ashton so disruption should be minimal. The provider will need to carefully manage the transition period and the long term plans for workforce. HR and OD management.
Statutory duty/ inspections	x						x						x			No impact expected – this will be managed by the provider in line with guidance and contractual responsibilities. Any changes to CQC registration will need to be managed by the provider to ensure it is appropriate and up to date.

Adverse publicity/ reputation			x							x				x		The proposal included changes to existing provision at Ashton Primary Care centre and the Hospital site. This is expected to receive mixed responses during consultation including objections. Patients within Ashton Neighbourhood have the highest usage of the relocating services so may raise objections despite the services remaining within Ashton and access increasing. The options within the consultation include one which would mean a reduction in weekend access to booked appointments which may receive negative feedback. A robust communications plan will be in place for the life of this project and communications, engagement and consultation activity will be monitored and evaluated throughout the life of the plan. The data we have relating to current usage of existing services is known. Transport mapping has been done to demonstrate the impact of relocation by car and public transport – and this shows that more people will have a shorter journey to services located at the hospital site rather than Ashton Primary Care Centre. All of the mapping and data we have available will be shared as part of the consultation documentation.
Finance				x							x			x		Existing funding will be used with some funding linked specifically to the requirement to increase booked access. The national mandate for A&E Streaming and the GM requirement for an Urgent Treatment Centre in Tameside and Glossop have to be delivered within existing funding. By maximising efficiency and reducing duplication the risk of additional costs will be minimised and the new service should be able to contribute to financial recovery. A Capital funding requirement at the ICFT site has been identified as part of the A&E Streaming project and a submission has been made to NHSE.
Service/business interruption				x						x				x		Mobilisation phase of delivery will need to be robust and of sufficient duration to ensure transition is planned and managed to mitigate potential interruptions to service provision.
Environmental impact		x						x					x			There will be a change to the location of services within the proposed model (specifically Ashton PCC to ICFT). The travel in relation to this will increase footfall at the hospital site, with a greater number of cars on site. There will be a corresponding positive impact at the Ashton PCC site.

Compliance with NHS Constitution	x						x						x			The ability to focus A&E on Emergency patients will reduce the risk of failure of the national standard for A&E waiting times.
Partnerships	x											x	x			A positive impact is expected as the service will involve integrated and partnership working to deliver the service.
Public Choice	x						x						x			No negative impact on quality anticipated; the service will enable appointments to be made outside traditional working hours and at different locations which will provide more choice and convenience. The service will offer choice for urgent care access and enable people to be in more control of when they are seen. The consultation will collate feedback on impacts which will be used to identify and mitigate issues around choice. The consultation will include stakeholder meetings with those groups that may be impacted, either directly or indirectly, by the changes. The groups identified are for age, disability, carers, pregnancy and maternity. There may also be impact on those more deprived populations for socio-economic reasons. Representatives of the unregistered population, including the homeless, have been involved in pre-consultation and will be further involved during consultation.
Public Access	x						x						x			No negative impact on quality anticipated The service will enable appointments to be made outside traditional working hours and at different locations. In terms of transport and travel times this has been mapped and the findings suggest that a greater proportion of the population will have a shorter journey time, particularly in relation to the relocation of services from Ashton PCC to the ICFT. A key element of the mobilisation phase will be to ensure that those identified in the EIA to be impacted by this will have the information about the changes to enable them to plan how they will attend services in the future.

Has an equality analysis assessment been completed?	YES	
Is there evidence of appropriate public engagement / consultation?	YES	The consultation will inform a review of this document which will be submitted with the final proposal

Sign off:

Quality Impact assessment completed by	**Janna Rigby**
Position	**Head of Primary Care**
Signature	
Date	**10.10.17**
Nursing and Quality Directorate Review	
Name	**Gill Gibson**
Position	**Director of Safeguarding and Quality**
Signature	
Date	**10.10.17**

APPENDIX 3

Urgent Care Pre-Consultation Engagement Feedback

Discussion and questions put to members of the Patient Neighbourhood Group meetings.

1. **What do you understand by the term 'Urgent Care'? Have you ever had to contact a health service in Tameside & Glossop urgently? If yes, which service did you contact?**

Feedback:

- Urgent Care was described as any of the following, demanding an ambulance, unplanned need, care needed to prevent more urgent treatment needed. This could be delivered in primary care, in A&E or at the hospital or other settings e.g. Walk In Centres or GTD out of hours.
- Urgent Care is down to patient perception of care required to meet needs.
- If a patient has a chronic need the patient is best placed to decide if urgent care is required and where this can be met.
- Would probably use A&E if for a member of the family.
- A&E and hospital services are for more serious urgent cases and other urgent non serious cases should be accessible in community walk in centres etc.

2. **Accessing Urgent Care Services**

What is important to you when accessing urgent health care? How do you prioritise the factors affecting your choice? If there is more than one option to choose from when accessing urgent health care services, what factors affect your choice of service / provider?

Feedback:

- The way we access services depends on the circumstance and judgement call at the time.
- What treatment someone thinks they need and how easy it is to get to a service are key factors. Some patients in Glossop felt they are less likely to travel to Tameside Hospital when Stepping Hill is closer.
- Trust and confidence in the skills of the person treating them was seen as important with bad publicity and reputation cited as reasons for not using services.
- The way people use their local health services, as well as out of hours' emergency services, depends to some extent on how they feel about their GP. Where people feel that they are being criticised for their lifestyle choices, particularly relating to smoking, diet, alcohol and exercise there is evidence that they avoid regular contact with their GP and wait until a point of crisis before accessing health services.
- The use of additional services such as NHS 111, and out of hours was perceived to be low, as does people's confidence in using them.
- Often advised to use A&E especially if for a child.
- Some people said that they use A&E because 'gatekeepers' on reception at their GP practice made it difficult to get an appointment. There was a lot of discussion about people going to A&E because they were unable to get access to their GP when they needed it.

- Accessing the Walk In Centre in Ashton from Glossop (i.e. transport to and from) and the standard of service received once there were significant topics of discussion as to why people would choose to use A&E.
- People described when they had been to the WIC then had been sent to A&E - they said that they now go straight to A&E instead.
- Difficulty of getting to Ashton – number and frequency of buses, cost of taxis and parking.
- The challenges of getting from Glossop to Ashton if you need urgent care were raised as the same range of services isn't available in Glossop.
- A&E is not the best place to be sent with MH issue but no provision in Glossop for people experiencing a mental health crisis.
- Support around mental health and learning disability in urgent care could be improved. Some people feedback that A&E staff did not allow parents to support adults with a LD during consultations.
- There was a lot of discussion about waiting times at A&E especially about the waiting times after they had been seen by the triage nurse. An explanation about the processes taking place in A&E would help people understand why things take so long.
- Patients are not always aware where they can go and how quickly they will be seen.
- Practices and front line services need to know how to signpost patients to ensure their need is met and consider access to services e.g. extended access hub and what hours they are open this is widely known. If the need is related to a specific condition the patient is the best person to decide what needs to happen and when.
- The majority of people said that communication with the general public was key to ensuring that people understood the services available and how they could access them. Some of the suggestions include: information on the radio, leaflets through each door, public broadcasting and more information being given out at the GPs.
- Having volunteers based in the hospital who can help out including giving out information about services available in the community.
- Is there value in putting up a list in A&E to refer people elsewhere and gives examples of costs to services e.g. the antibiotic advert.
- Do patients need a mobile phone app that enables them to navigate the services / system?

3. Expectations of Urgent Care

What do you expect from services when you have an urgent care need? What do you think is currently working well in urgent care in Tameside & Glossop? How can we improve urgent care in the future?

Feedback:

- Positive feedback about pharmacists often able to gain some urgent non serious advice from pharmacists and find the private consultation area good.
- Positive experience of out of hours service although initially unaware it existed needs more publicity – limited awareness of OOH.
- Weekends and 'out of hours' service needed. More inclined to use local services and not go to A&E. Help to stop the stress of going to A&E.
- Many people would rather be seen locally than go to hospital if appropriate.
- NHS 111 – Felt not enough publicity.

- Wanted staff to be more approachable. It was felt that the people providing the care need to be appropriately skilled both in the treatment itself and also in dealing with the individual/their carers and family who may be vulnerable, have difficulty understanding or just be scared.
- Separate paediatric unit. Ensure that there is a service and different waiting room for children in the evenings.
- Want consistency – to see the same practitioner
- Want those treating to have access to clinical notes.
- Need to improve access to mental health support outside of the hospital.
- A Learning Disability liaison or link person to support the parent and the patient. The role could look at the wider picture, social, emotional and psychological.
- Improve accessible to hard of hearing patients.
- Need to reduce the fact people have to keep repeating their story
- Have a system (consent) which allows family to represent other family members during medical appointments
- Adopt a more holistic approach to health. Able to access a range of voluntary groups/services and support groups
- More integrated service between social services and GPs and social prescribing.
- Walk in Centre 7 days a week (6) (staffed by GP surgeries working together)
- A seamless provision across Glossop and Tameside
- Should include one stop information and advice about local services
- Information points in GP surgeries
- Effective prescription service
- Improved public transport links to hospitals
- Queries about confidence in health services delivered within the community rather than going to hospital. Would be confident if knowledgeable about what services are available locally. If they had a good triage system.
- George Street clinic is a wonderful resource but currently underutilised.

Local Design Group Feedback

A stakeholder group was convened involving representatives of the following groups to discuss the model of a single point of walk in access at the hospital and Neighbourhood Care Hubs where appointments could be booked.

Organisation/Representing	Type of Organisation / Representing
T&G ICFT Council of Governors	Veteran
Hyde Bangladesh Welfare Association	Bangladeshi Community Group
Infinity Initiatives	Support homelessness, substance instance, financial and debt problems, isolations, loneliness, anti-social behaviour victims and perpetrators
Anthony Seddon Centre	Peer-led community mental health project
Greystone Housing Group	Homelessness
Change, Grow, Live	Provides help and support to adults, children, young people and families. Services cover a

	wide variety of areas including health and wellbeing, substance use, mental health, criminal justice, domestic abuse and homelessness.
Adullam Homes	
Glossop Practice Neighbourhood Group	GP Registered Patients
Stroke.org	Support for people who have had a stroke and their family and carers.

The group considered what the difference was between Routine, Urgent and Emergency needs and where they would go for help.

Routine:	Urgent:	Emergency:
• GP • Pharmacy • Community Hub (Rossendale) • Manchester • Nurse (and Practitioner) • Pop up • The hospital for a routine appointment	• GP • Walk-In- Centre • A&E • Would ring 111 if unsure whether urgent or an emergency •	• A&E • Police • GP Practice • Depends on the emergency, e.g. Mental health issues are better dealt with at the Sanctuary • WIC for urgent prescription

Factors that would influence choice were:- opening times, access, convenience, distance, waiting times and past experience. People said, if there are no GP appointments they would go to the WIC and if A&E was full they would go to the WIC.

A range of scenarios for urgent care were discussed all of which included:-

- A single walk access location at the hospital seven days a week.
- Appointments that could be booked through the GP, Out of Hours and eventually NHS 111 at the hospital site.
- Appointments that could be booked through the GP, Out of Hours and eventually NHS 111 at a hub in the neighbourhoods.

The scenarios differed in the number of neighbourhoods that would have hubs where appointments could be booked and the times that the appointments could be booked.

People were asked to consider a range of factors such as coverage across 7 days, acceptability to patients, transport and staffing.

The following key points were raised:-

The scenarios that had consistent opening times across the hubs were preferred as it was felt that different opening times would be confusing.

It was felt that if it were confusing people would just walk in to the hospital or ring 999

Consistency in the type of appointments at different sites was seen as beneficial. Having less sites to ensure this was seen by some as important.

Being able to book appointments in more neighbourhoods was seen as good as it reduced the need for people to travel out of their local areas but the scenarios with all neighbourhoods having sites were seen potentially costly and difficult to staff especially if they all had weekend access.

Having no weekend access apart from at the hospital site was seen as less useful and high risk of people walking into the service at the hospital.

Being able to book appointments at the weekend was thought to be important.

The hospital as the walk in site was seen as positive as the hospital was well known and people would be triaged to the best service on the same site.

The arrangements will need to be clearly and consistently communicated with good public education so people know what is available.

Several groups suggested that a staged approach to implementation would be useful to ensure services worked well before extending across multiple sites.

General comments from the Group:
• What is the point of having more hubs, it would be a nightmare! The simpler the better. • Concentrate on getting it right with 2 or 3; you can then expand if needed. • We don't need more than 3, happy with 2, but 3 would be good if open 7 days a week, and if we can afford to staff and manage effectively. • Think of travel and parking. • With all scenarios there would need to have enough resources for the hubs, and all would need to provide some form of emergency care
• Three locations – 2 hubs and the hospital with consistent access covering am and pm at weekends was preferred option. Less confusion, more available treatment options. • Improved access – travel. Easy access is important. • Better access to treat in one place (Specialist care) rather than being re-referred. • More options = diluted offer
• Would public transport infrastructure change? Bus routes matter when locating hubs. • Make sure services will work before implementing all sites • Need information about best place to go/service to access. Different surgeries have different waiting times for appointments. • Need more education to inform people where there should go. Promotion of services

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Urgent Care Consultation

NHS Tameside & Glossop Clinical Commissioning Group is currently reviewing how Urgent Care can be best delivered across Tameside & Glossop. You can access further information about our proposals for Urgent Care in our information document available at www.tamesideandglossopccg.org/urgentcare

1. Are you currently registered with a GP in Tameside & Glossop? (Please tick one box only)

- ☐ Yes (Go to Q3)
- ☐ No (Go to Q2)

2. Are you registered with a GP in another area? (Please tick one box only)

- ☐ Yes
- ☐ No

3. Please indicate how recently you have used the following services when you have had an urgent health care need (Please tick one box per row)

	Within the last week	Within the last month	Within the last six months	Within the last year	More than one year ago	I have never used this service
NHS 111 service (telephone service available 24 hours a day)						
NHS Choices (internet based service available 24 hours a day)						
Pharmacies						
Minor eye conditions service within opticians						
GP practice appointments						
Out of hours GP service						
Walk-in Service at Ashton Primary Care Centre						
Walk-in Service outside of Tameside & Glossop						

	Within the last week	Within the last month	Within the last six months	Within the last year	More than one year ago	I have never used this service
Accident & Emergency department at Tameside & Glossop ICFT Hospital site (Tameside Hospital)						
Accident & Emergency department at a hospital outside of Tameside & Glossop						

The Proposal

With the mandatory introduction of a streaming service at A&E and the requirement to develop an Urgent Treatment Centre (UTC), we are proposing to move the Walk-in Service at Ashton Primary Care Centre (APCC) to the UTC at the hospital so that it becomes an enhanced Urgent Care service with access to diagnostics.

By providing an UTC on the same site as A&E we believe we will achieve the outcomes we want for our Urgent Care system. A key example of this is should you walk in to the UTC and on assessment, need more specialist diagnostics e.g. an X-ray, you will receive this promptly and without the need to travel to another location. Having one place to walk in to receive assessment on where to go for treatment will mean you do not have to decide where to go – a professional will support you, providing clarity which is likely to particularly help carers and parents.

Our proposal is to create an Urgent Treatment Centre based at Tameside Hospital which will provide walk-in and bookable access 12 hours a day (9.00am to 9.00pm), 7 days a week, 365 days a year. This service will be in addition to your local GP – it doesn't replace it.

	Urgent Treatment Centre (Hospital Site)	Walk in Centre (APCC)
Bookable same day / urgent and routine appointments	✓	×
Walk in access for urgent care	✓	✓
Access to urgent diagnostics	✓	×
Improved patient safety due to emergency services available on site	✓	×
Well known location within Tameside & Glossop	✓	×
Good transport links	✓	✓

In addition to the new streaming service and UTC, we propose to increase the level of same day and routine GP appointments and provide more access to Urgent Care locally through the Neighbourhood Care Hubs. We have two options on how we could do this and want to hear your views on these options. The two options are a combination of sites with variable hours available at each site. There is no preferred option.

4. When the walk in service currently provided at Ashton Primary Care centre is relocated to an Urgent Treatment Centre on the Tameside Hospital site what impact will this have for you? (Please explain in the box below)

Further to the relocation of urgent care services to the Urgent Treatment Centre on the Tameside Hospital site, we will also be looking at where to best place Neighbourhood Care Hubs. The Hubs will provide additional locations where people can book appointments. We are inviting your views on **two options** for how we can best deliver increased, local access to Urgent Care across Tameside and Glossop through our Neighbourhood Care Hubs. These are:

Option 1

In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access, Option 1 proposes Urgent Care access in **three** Neighbourhood Care Hubs; The North Hub (Ashton Primary Care Centre), The Glossop Hub (Glossop Primary Care Centre) and the South Hub (Hyde or Longdendale). These hubs will offer booked appointments via your own GP or via NHS 111. Option 1 offers opening hours as detailed below:

	Opening Hours		Access	
Neighbourhood Care Hub	**Weekdays**	**Weekends**	**Booked Appointments**	**Walk-in**
Urgent Treatment Centre at the hospital, Ashton	9.00am to 9.00pm	9:00am to 9:00pm (inc. Bank Holidays)	Yes	Yes
North Hub	6.30pm to 9.00pm	9.00am to 1.00pm	Yes	No
Glossop Hub	6.30pm to 9.00pm	9.00am to 1.00pm	Yes	No
South Hub	6.30pm to 9.00pm	9.00am to 1.00pm	Yes	No

Option 2

In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access, Option 2 proposes Urgent Care access in **five** Neighbourhood Care Hubs; The North Hub (Ashton Primary Care Centre), The South Hub (Hyde or Longdendale), The East Hub (Stalybridge, Dukinfield or Mossley), The West Hub (Denton, Droylsden, or Audenshaw) and The Glossop Hub (Glossop Primary Care Centre). This option has increased availability in more locations for weekday appointments but offers weekend appointments across fewer locations. This option will offer booked appointments via your own GP or via NHS 111 during the hours detailed below:

	Opening Hours		**Access**	
Neighbourhood Care Hub	**Weekdays**	**Weekends**	**Booked Appointments**	**Walk-in**
Urgent Treatment Centre at the hospital, Ashton	9.00am to 9.00pm	9:00am to 9:00pm (inc. Bank Holidays)	Yes	Yes
North Hub	6.30pm to 9.00pm	Appointments available at Urgent Treatment Centre or Glossop Hub	Yes	No
Glossop Hub	6.30pm to 9.00pm	9.00am to 1.00pm	Yes	No
South Hub	6.30pm to 9.00pm	Appointments available at Urgent Treatment Centre or Glossop Hub	Yes	No
East Hub	6.30pm to 9.00pm	Appointments available at Urgent Treatment Centre or Glossop Hub	Yes	No
West Hub	6.30pm to 9.00pm	Appointments available at Urgent Treatment Centre or Glossop Hub	Yes	No

5. Which of the two options above do you think best suit the urgent care needs of the population across Tameside & Glossop? (Please tick one box only)

- ☐ Option 1
- ☐ Option 2

6. Please tell us your reasons for selecting the option you have for Question 5 (Please explain in the box below)

7. If you have an alternative option on how Urgent Care could be delivered across Tameside & Glossop in the future please tell us in the box below. Please explain the benefits this alternative option will bring and any financial considerations.

8. Do you have any other comments you would like to make about Urgent Care services in Tameside & Glossop? (Please write your comments in the box below)

About You

9. Please tick the box that best describes your interest in this issue? (Please tick one box only)

- ☐ A member of the public
- ☐ A carer on behalf of someone else
- ☐ An employee of Tameside Council
- ☐ An employee of NHS Tameside & Glossop Clinical Commissioning Group
- ☐ An employee of Tameside & Glossop Integrated Care NHS Foundation Trust
- ☐ A GP who works in Tameside & Glossop
- ☐ A pharmacist, optician or dentist working within Tameside & Glossop
- ☐ A community or voluntary group
- ☐ A partner organisation
- ☐ A business / private organisation
- ☐ Other (please specify below)

10. What is your home postcode? (Please state)

11. What best describes your gender?

- ☐ Female
- ☐ Male
- ☐ Prefer to self-describe
- ☐ Prefer not to say

12. What is your age? (Please state)

13. Which ethnic group do you consider yourself to belong to? (Please tick one box only)

White

- ☐ English / Welsh / Scottish / Northern Irish / British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other White background (Please specify)

Mixed / Multiple Ethnic Groups

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed / Multiple ethnic background (Please specify)

Black / African / Caribbean / Black British

- ☐ African
- ☐ Carribbean
- ☐ Any other Black / African / Caribbean background (Please specify)

Asian / Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background (Please specify)

Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group (Please specify)

14. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age. (Please tick one box only)

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No

15. Do you look after, or give any help or support to family members, friends, neighbours or others because of either, long-term physical or mental ill-health / disability or problems due to old age? (Please tick one box only)

- ☐ Yes, 1-19 hours a week
- ☐ Yes, 20-49 hours a week
- ☐ Yes, 50+ hours a week
- ☐ No

16. Are you a member or ex-member of the armed forces?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

17. What is your marital status?

- ☐ Single
- ☐ Married / Civil Partnership
- ☐ Divorced
- ☐ Widowed
- ☐ Prefer not to say

18. Are you pregnant, on maternity leave or returning from maternity leave?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

REVIEW OF URGENT CARE IN TAMESIDE AND GLOSSOP

The right care, in the right place, at the right time

Caretogether
SINGLE COMMISSIONING FUNCTION

NHS
Tameside and Glossop
Clinical Commissioning Group

Have YOUR say

FIND OUT MORE AND HAVE YOUR SAY ON THE PROPOSALS AT
WWW.TAMESIDEANDGLOSSOPCCG.ORG/URGENTCARE

INTRODUCTION

NHS Tameside and Glossop Clinical Commissioning Group (CCG) is committed to ensuring our residents can access the right care, at the right time and in the right place should you or someone you care for have an urgent medical need. We want to make our urgent care system as simple as possible so that your journey through illness to recovery is clear, easy to access and of a high quality.

With an increasing demand on the health and social care system, health services want to ensure that those who are the sickest and in most need of emergency care receive the quickest treatment. To achieve this, there is now a national requirement to provide a streaming service at every Accident and Emergency (A&E) by October 2017. In addition, we have been mandated to provide an Urgent Treatment Centre (UTC) which is GP-led, open 12 hours a day, every day. This UTC needs to be equipped to diagnose and deal with many of the most common ailments which people attend A&E with that aren't a life-threatening emergency.

Once implemented in Tameside and Glossop, both of these nationally mandated services will relieve pressure on A&E by streaming people who arrive at our A&E into either the main A&E Department or the UTC ensuring they receive the right care and treatment in the right place. Those who are in most need of emergency care will therefore receive this quickly in A&E and those who do not have major or life threatening illness/injury will receive effective treatment in the UTC.

As commissioners of health and social care services in Tameside and Glossop, we need to look at the way we deliver our whole range of urgent care services so that we can deliver the streaming service and the UTC at the hospital in an affordable way. We also want to ensure that we have understandable and accessible urgent care which balances quality, access and makes the best use of our resources.

This document sets out our proposals for improving our urgent care system and we want your views.

WHAT IS URGENT CARE?

Any form of medical attention that you need on the same day but is not life-threatening is what we deem to be Urgent Care. This could include injuries, an illness (ailment) or any other medical condition where you seek advice from a health professional such as a GP, pharmacist, NHS 111, a walk-in centre or the out of hours GP service when your local doctor's surgery is closed.

WHAT IS A STREAMING SERVICE?

If you arrive at A&E at the Hospital, you will be greeted and assessed by an experienced professional who will make a decision as to whether you need emergency care or urgent care. If your need is assessed as urgent, you will be directed through to the UTC and if you need emergency treatment, you will stay in A&E and receive care there as quickly as possible. This means you, and all patients, will receive the right care, in the right place, delivered by the right healthcare professional.

OUR VISION FOR URGENT CARE

The current urgent care services in Tameside and Glossop overlap. This means there are numerous options for people trying to access Urgent Care which leads to confusion, complexity and duplication. We want to ensure our services are easy to understand so you receive effective care first time, in the right place and do not have to visit multiple services for the same issue.

Our vision for urgent care is part of our wider Care Together programme to improve the outcomes and experience of health and social care across Tameside and Glossop. This includes developing a strong focus on prevention and how to self-care as we aim to reduce the risk of people requiring Urgent Care in the first place. Care Together also aims to improve care closer to home by increasing local access to same day appointments through GP practices, pharmacists and Neighbourhood Care Hubs as well as the new Urgent Treatment Centre. We want to provide this range of appointments 7 days a week.

To enable us to achieve this ambition, we have identified the following outcomes for our urgent care system:

- **A simpler system** – telephone help to know where to go and only one place to walk in to receive effective care. Ring your GP first for help and advice. If out of hours, an automated message will tell you what to do.
- **An efficient System** - with your consent, your medical records will be available to clinicians in the Neighbourhood Care Hubs and the Urgent Treatment Centre. This means you won't have to tell your story twice, creating a better care experience.
- **Care closer to home** – increased choice of same day appointments locally either with your local GP, by visiting one of the Neighbourhood Care Hubs or the Urgent Treatment Centre at the hospital.
- **Reduce pressure on A&E** – an effective system to ensure A&E staff are able to focus on emergencies and life threatening situations and enable all who arrive at A&E to receive the appropriate level of treatment and care.
- **Sustainability** – less duplication and complexity to create a more cost effective approach to Urgent Care and ensure people feel better equipped and supported to reduce the risk of the same need arising in the future.

HOW HAVE WE DEVELOPED THE PROPOSALS?

The proposals have been developed following ongoing engagement with local communities and groups discussing Care Together and the approach to future service provision. In recent months, we have engaged specifically on the approach to Urgent Care through various patient/public groups and networks. These sessions identified the following:

- Logistical factors influence where people attend (distance, car parking, public transport)
- People who are unable to get an urgent appointment at their GP are likely to utilise A&E or the Walk In Centre (WiC)
- Confidence in the professional providing treatment influenced the decision whether to use a service or not
- Many people would rather be seen locally than go to hospital unless absolutely necessary
- Desire for social care support to work alongside health support when necessary
- The term "urgent" was not seen as easily understood.

Reflecting on the above, we have developed proposals for the future of Urgent Care and now want to hear your views.

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THE PROPOSAL

With the mandatory introduction of a streaming service at A&E and the requirement to develop an UTC, we are proposing to move the Walk-in Service at Ashton Primary Care Centre (APCC) to the UTC at the hospital so that it becomes an enhanced Urgent Care service with access to diagnostics.

By providing a UTC on the same site as A&E we believe we will achieve the outcomes we want for our Urgent Care system. A key example of this is should you walk in to the UTC and on assessment, need more specialist diagnostics e.g. an X-ray, you will receive this promptly and without the need to travel to another location. Having one place to walk in to receive assessment on where to go for treatment will mean you do not have to decide where to go – a professional will support you, providing clarity which is likely to particularly help carers and parents.

Our proposal is to create an Urgent Treatment Centre based at Tameside Hospital which will provide walk-in and bookable access 12 hours a day (9.00am to 9.00pm), 7 days a week, 365 days a year. This service will be in addition to your local GP – it doesn't replace it.

	Urgent Treatment Centre (hospital site)	Walk In Centre (APCC)
Bookable same day / urgent and routine appointments	✓	×
Walk in access for urgent care	✓	✓
Access to urgent diagnostics	✓	×
Improved patient safety due to emergency services available on site	✓	×
Well known location within Tameside & Glossop	✓	×
Good transport links	✓	✓

In addition to the new streaming service and UTC, we propose to increase the level of same day and routine GP appointments and provide more access to Urgent Care locally through the Neighbourhood Care Hubs. We have two options on how we could do this and want to hear your views on these options. The two options are a combination of sites with variable hours available at each site. There is no preferred option.

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OPTION 1

In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access, Option 1 proposes Urgent Care access in three Neighbourhood Care Hubs; The North Hub (Ashton Primary Care Centre), The Glossop Hub (Glossop Primary Care Centre) and the South Hub (Hyde or Longdendale). These hubs will offer booked appointments via your own GP or via NHS 111. Option 1 offers opening hours as detailed below:

	Opening Hours		Access	
	Weekdays	Weekends	Booked Appointments	Walk-in
Urgent Treatment Centre at the hospital, Ashton	9am to 9pm	9am to 9pm (inc Bank Holidays)	Yes	Yes
North Hub	6.30pm to 9pm	9am to 1pm	Yes	No
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No
South Hub	6.30pm to 9pm	9am to 1pm	Yes	No

OPTION 2

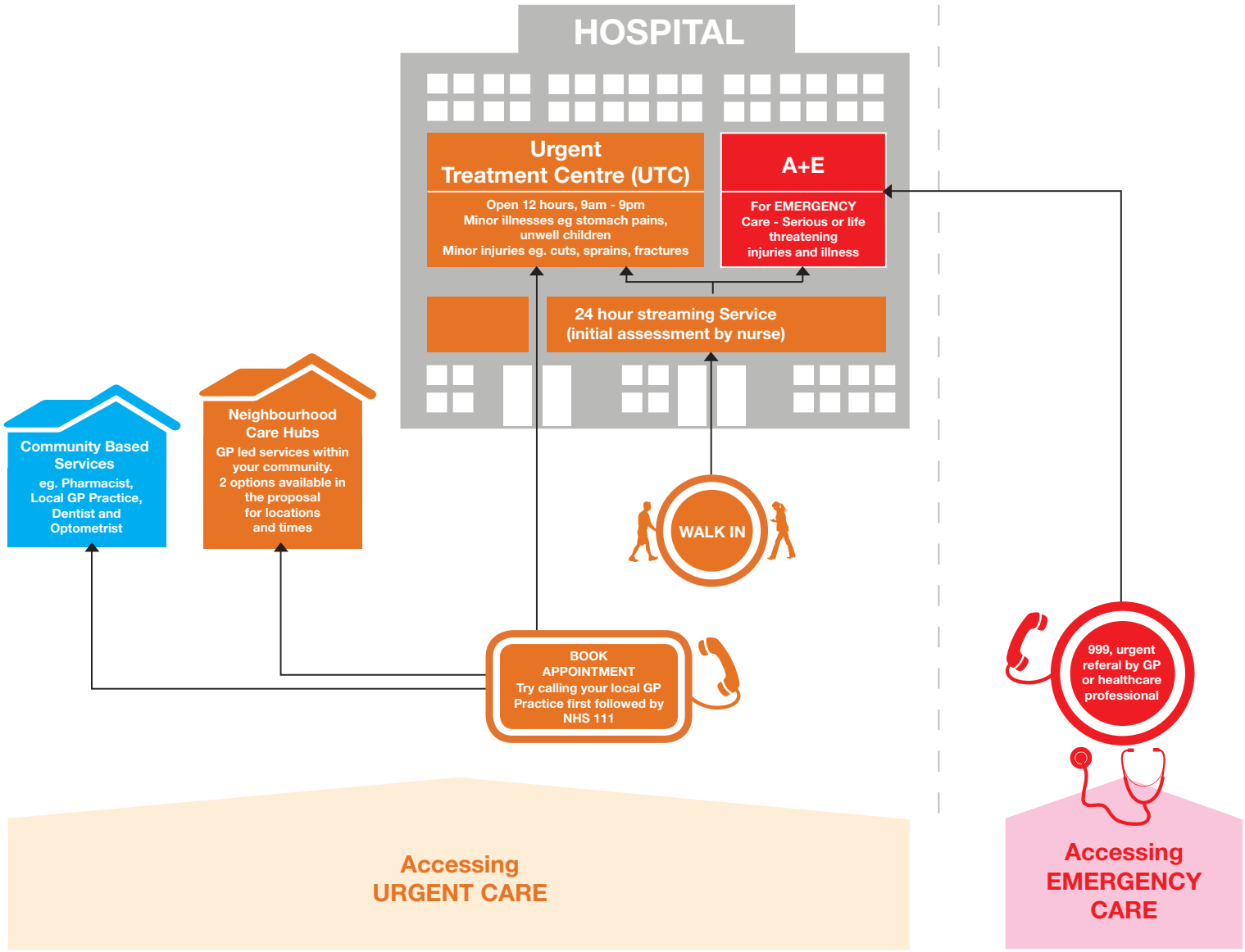
In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments and walk-in access, Option 2 proposes Urgent Care access in five Neighbourhood Care Hubs; The North Hub (Ashton Primary Care Centre), The South Hub (Hyde or Longdendale), The East Hub (Stalybridge, Dukinfield or Mossley), The West Hub (Denton, Droylsden or Audenshaw) and The Glossop Hub (Glossop Primary Care Centre). This option has increased availability in more locations for weekday appointments but offers weekend appointments across fewer locations. This option will offer booked appointments via your own GP or via NHS 111 during the hours detailed below:

	Opening Hours		Access	
	Weekdays	Weekends	Booked Appointments	Walk-in
Urgent Treatment Centre at the hospital, Ashton	9am to 9pm	9am to 9pm (inc Bank Holidays)	Yes	Yes
North Hub	6.30pm to 9pm	Appointments available at the UTC and Glossop Hub	Yes	No
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No
South Hub	6.30pm to 9pm	Appointments available at the UTC and Glossop Hub	Yes	No
East Hub	6.30pm to 9pm	Appointments available at the UTC and Glossop Hub	Yes	No
West Hub	6.30pm to 9pm	Appointments available at the UTC and Glossop Hub	Yes	No

ADVANTAGES AND DISADVANTAGES

Options	Advantages	Disadvantages
1	• Easily understandable opening hours as they are the same at the North, Glossop and South Neighbourhood Care Hub • No change in the current availability for evening or weekend bookable access	• Some people will need to travel outside of their neighbourhood
2	• Urgent Care access available in five Neighbourhood Care Hubs • Increased evening access in East and West • No change in Glossop availability for evening or weekend bookable access	• Weekend access at the Glossop Neighbourhood Care Hub and Urgent Treatment Centre only.

URGENT CARE PROPOSED MODEL



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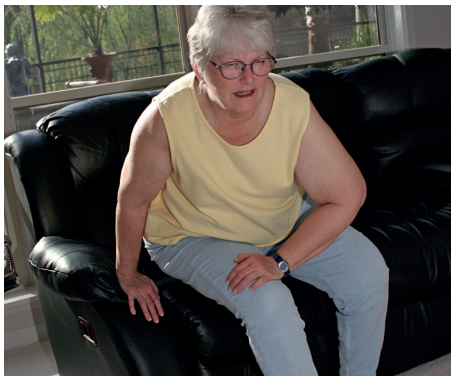
HOW WILL THIS WORK FOR YOU?



Jenny was worried about her mum Pauline who lives in Droylsden as she seemed off colour and was complaining that her legs really hurt. Jenny rang her mum's GP and when she explained what the matter was, the receptionist offered to book her an appointment at the practice at 3:30pm or at The South Neighbourhood Care Hub at 6:30pm. Jenny chose the appointment at The Hub as then her husband would be able to look after their children whilst she took Pauline to the doctors. At The Hub, the doctor was able to read Pauline's medical records and provide reassurance that this was a symptom of Pauline's ongoing condition as her own GP had recently increased her steroids. The GP advised Pauline to give it a bit more time and re-iterated the management plan in her medical notes.

Teckla and Michael were worried about Sasha their 3 year old daughter who has developed a rash after playing in the garden. Teckla rang NHS 111 as it was 10 am on a Sunday. The children's nurse she spoke to suggested they book an appointment to see a GP in one of the Neighbourhood Care Hubs and offered appointment times that day at The Glossop Hub or The North Hub. They decided to take the 11:30am appointment at The Glossop Hub in the Primary Care Centre where the GP examined Sasha, checked her medical records and prescribed some chlorphenamine for the rash and itch.

Peter was out running on Tuesday evening and tripped over. He felt sore when he went to bed but was not worried. The next morning his ankle and foot were very swollen and it was really difficult to put any weight on it. He rang his GP to see if he could get an appointment and they suggested he would be better going to the Urgent Treatment Centre on the hospital site in Ashton as he may need an X-ray. They offered to book an appointment for him and explained he could also just walk in if he would rather. He decided to book a 1pm appointment so his friend could take him. On arrival, Peter was assessed and had an X-ray which thankfully showed nothing was broken. He had sprained his ankle and was advised to rest, use ice and elevate his leg.

Asad was visiting his cousin Mahir in Denton when he developed a severe headache. Mahir suggested they go to the Urgent Treatment Centre at the hospital. When they arrived they were assessed and then seen by the Advanced Nurse Practitioner who took a full history and performed a neurological examination. The headache was in keeping with a tension type headache, and the family were under stress due to recent bereavements. Support and simple analgesia was offered.

HAVE YOUR SAY ON THE PROPOSALS

We are keen to hear your views on our proposals and whether you have any preferences about the opening hours or locations of our Neighbourhood Hubs. You can provide your views by:

- Completing the online survey at www.tamesideandglossopccg.org/urgentcare
- You can pick up a paper copy at local GPs and Libraries across Tameside and Glossop
- You can pick up a paper copy at the Ashton Primary Care Centre
- You can email TGCCG.Communications@nhs.net and we will send you a paper copy

HOW WILL WE USE YOUR COMMENTS?

The consultation will run for 12 weeks from 1 November 2017 until 26 January 2018. Once the consultation closes, we will analyse all responses received by the closing date. Your feedback along with a range of other factors including legal and financial considerations will be taken into account when preparing a final proposal on which option should be implemented.

We aim to submit a recommendation to the Single Commissioning Board in February 2018. This report will be available on the CCG's website: **www.tamesideandglossopccg.org**

WHERE CAN I GET MORE INFORMATION ABOUT THIS CONSULTATION?

Additional written information, including the detailed reports presented to the Tameside and Glossop Single Commissioning Board are available on the CCG website: **www.tamesideandglossopccg.org**

You can write to us at: NHS Tameside and Glossop Clinical Commissioning Group, Dukinfield Town Hall, King Street, Dukinfield, Tameside, SK16 4LA or email us at: **tgccg.communications@nhs.net**

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REVIEW OF URGENT CARE PROVISION IN TAMESIDE AND GLOSSOP

The right care, at the right time, in the right place

FACT SHEET

An Enhanced Service:

- Giving you increased choice and access to same day Urgent Care and routine appointments locally
- Access to diagnostics for Urgent Care such as X-rays on one site meaning you do not have to visit multiple services for the same issue.
- With your consent, your medical records will be available to clinicians in the Neighbourhood Care Hubs and the Urgent Treatment Centre. This means you won't have to tell your story twice, creating a better care experience.

A Simpler Service:

- Making your journey through illness to recovery clear, easy to access and of a high quality.
- Creating a single walk-in point at the hospital for Urgent Care will mean you receive effective care first time

Care Closer to Home

- Giving you more options locally for same day and routine appointments through your local GP, by visiting one of the Neighbourhood Care Hubs or the Urgent Treatment Centre at the hospital

Reducing Pressure on A&E

- Ensuring those who are the sickest and in most need of emergency care receive the quickest treatment.

A Sustainable Service

- Creating a simple, high quality and cost effective approach to Urgent Care
- Reducing duplication of services to ensure effective use of resources
- The new streaming service and the development of an Urgent Treatment Centre are mandated nationally to ensure those who go to A&E with a non-life threatening condition are directed to the best place for treatment and thus relieving pressures on A&E .

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1. Urgent Care means any form of medical attention that you need on the same day but is not life threatening. This could include injuries, an illness (ailment) or any other medical condition where you could seek advice from a Primary Care Service such as a pharmacist, NHS 111 or a GP.

2. The Review of Urgent Care is part of wider Care Together programme: Improving the individual's experience of health and social care by giving them better access to joined-up, high quality and affordable services. We want people to get the right treatment, in the right place, at the right time.

3. Using Urgent Care will reduce pressure on A&E and ensure that people are supported by the most appropriate person - fully utilising the skills of the wider Primary Care teams rather than unnecessarily going to A&E.

4. We are bringing care closer to home through an enhanced Urgent Care offer. The proposals will provide increased, local access to same day health advice and treatment. This will be through your local GP practices, the Neighbourhood Care Hubs, the Urgent Treatment Centre and increased use of Pharmacists, Opticians and Dentists when an urgent need arises.

5. The government want to ensure that those who are the sickest and in most need of emergency care receive the quickest treatment. They have therefore mandated nationally that every A&E has a Primary Care Streaming Service which is now in place at the hospital in Ashton. This will stream people who go to A&E with a non-life threatening condition to the best place for treatment.

6. The government have also mandated that every area has to have an Urgent Treatment Centre (UTC) that will be GP-led, open 12 hours a day, every day, and be equipped to diagnose and deal with many of the most common ailments people attend A&E for. This will ease the pressure on A&E leaving it free to treat the most serious cases.

7. We are proposing to move the Walk-in Service currently provided at the Ashton Primary Care Centre (APCC) and enhance it by locating it within the proposed Urgent Treatment Centre at the hospital so that those attending can also access a range of diagnostics.

8. Providing walk-in access to the Urgent Treatment Centre on the same site as A&E with access to diagnostics meaning those people who on assessment need more specialist diagnostics e.g. X-ray or treatment, will receive the care they need promptly without the need to travel to another location.

9. By bringing services together on the hospital site we are making better use of NHS resources in an increasingly challenging time. We will use staff and resources from the existing services to ensure that we have the right skills and capacity to effectively and efficiently treat patients both on the hospital site and the Neighbourhood Care Hubs.

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10 The proposed Urgent Treatment Centre at the hospital in addition to the two options for where and when you can book appointments at a Neighbourhood Care Hub will provide extended, more local access to Primary Care services – increasing the availability of same day appointments in the evenings and at weekends.

- Option one includes Hubs in the North (Ashton Primary Care Centre), the South Hub (Hyde or Longdendale) and Glossop (Glossop Primary Care Centre)
- Option two includes Hubs in the North (Ashton Primary Care Centre), the South (Hyde or Longdendale), the East (Stalybridge, Dukinfield or Mossley), the West (Denton, Droylsden or Audenshaw) and Glossop (Glossop Primary Care Centre)

The weekend opening hours in the two options vary and locations within the South, East and West are to be confirmed.

11 The current services that provide Urgent Care in Tameside and Glossop overlap. This means we have multiple access routes for patients who have an urgent need. This is not cost effective and we want to ensure that a patient's journey through care is simple so they receive effective care first time and do not represent to other services for the same issue.

12 The majority of users of the current Walk-In Service at Ashton Primary Care Centre (APCC) are from the North neighbourhood and hence this service is not used evenly across the borough. 73% of users are registered with a Tameside and Glossop GP(June 2017 - May 2017) while 10% are unregistered users.

13 The APCC will remain open and will house a range of GP and outpatient services such as Physiotherapy. It will also be the North Neighbourhood Care Hub with access to bookable same day appointments for Urgent Care in addition to the Urgent Treatment Centre at the hospital with walk-in and bookable access to Urgent Care and access to diagnostics.

14 Introducing the UTC at the hospital alongside the Neighbourhood Care Hubs mean that anyone who needs an appointment out-of-hours will be seen locally within Tameside and Glossop. This is not currently the case as under our current model residents can be sent to Oldham.

15 Our proposal is to relocate the Walk in Service from Ashton Primary Care Centre to an Urgent Treatment Centre at Tameside Hospital. Tameside hospital is 1.5 miles from the APCC which means there is no demonstrable difference in travel times for those travelling by car. Some people's journeys may be shorter and some longer. Our transport analysis shows that on average 99.8% of Tameside and Glossop residents are within 0-30 minutes drivetime of both APCC and the hospital whether travelling at peak time weekday morning, peak time weekday afternoon / evenings, off peak weekdays or weekends.

16 Our proposal is to relocate the Walk in Service from Ashton Primary Care Centre to an Urgent Treatment Centre at Tameside Hospital. Tameside hospital is 1.5 miles from the APCC. The proposed site for the UTC is well served by public transport including links from the Ashton Public Transport Hub.

17 Should the proposal go ahead, we will ensure a safe transition to the new model of care. The streaming at A&E is already in place and we will continue to learn from that what additional services we need to have available at the Urgent Treatment Centre. We will ensure we have strong arrangements for transferring people into more specialist services when they need them e.g. the Early Pregnancy Assessment Unit or Mental Health and social care services. Our plan is to keep the Walk-In Service at APCC running until Summer 2018 so that there is enough capacity during Winter 2017 when demands on health services will be high.

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REVIEW OF URGENT CARE PROVISION IN TAMESIDE AND GLOSSOP

The right care, at the right time, in the right place

FAQs

Q1 What is the consultation about?

A1 We are now mandated nationally to have a streaming service at the hospital and an Urgent Treatment Centre - we therefore need to look at the way we deliver our Urgent Care offer across Tameside and Glossop. We want to make sure our services are as simple as possible so that your journey through illness to recovery is clear, easy to access and of high quality. We are particularly keen to hear your views on the two options for locations and opening hours of Neighbourhood Care Hubs which will provide increased access to bookable Urgent Care appointments.

Q2 What is Urgent Care?

A2 Any form of medical attention that you need on the same day but is not life-threatening is what we deem to be Urgent Care. This could include injuries, an illness (ailment) or any other medical condition where you seek advice from a health professional such as a GP, pharmacist, NHS 111, a walk-in centre or the out of hours GP service when your local doctor's surgery is closed.

Q3 Are you reducing the number of sites where I can access Urgent Care?

A3 No. Currently the main site for urgent care is the Walk-in Service at Ashton Primary Care Centre (APCC) with a few practices and Out of Hours also booking people who need Urgent Care into evening and weekend appointments at Neighbourhood hubs in Glossop Primary Care Centre, Hyde and Ashton Primary Care Centre. In the proposal, the Walk-in Service will be moved to the hospital within the new Urgent Treatment Centre to improve the service by giving it access to diagnostics such as X-ray. In addition it will be possible for everyone to book appointments through their GP or Out of Hours at the Urgent Treatment Centre or at a Neighbourhood Care Hub and there are options in the proposal for a varying number and location of Neighbourhood Care Hubs offering bookable same day appointments

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Q4 I can't get an appointment now at my GP so how will this affect me?

A4 Rapid access to GP appointments can be a challenge but we are aware of this and are working hard to resolve in Tameside and Glossop. We are working closely with all our practices to ensure all of them are able to meet the GM primary care access standards by December 2018. In addition we will build on the evening and weekend access arrangements that we have already funded, increasing the number of places where appointments can be made and ensuring that all patients are offered evening and weekend appointments. We believe that all of our population will see the impact of this.

Q5 How will I be able to get an appointment at one of the hubs?

A5 Most people want to see their own GP or a GP within that practice if at all possible. We will support this by improving access to all practices where possible. However, we also realise that sometimes you may not be able to access your practice either due to no appointments being available or through your choice for convenience, urgency or due to having caring responsibilities. In which case, your GP practice will be able to book you directly into an evening or weekend slot within a hub or at the Urgent Treatment Centre based at the hospital. You will also be booked into the appointments by Out of Hours or NHS 111 if it is outside of your GP Practice hours.

Q6 Why is it necessary to move the Walk-in Service at the Ashton Primary Care Centre?

A6 We aim to have effective, high quality services. Moving the Walk-in Service to the hospital within the new Urgent Treatment Centre creates a better service as it will have access to diagnostics. This simplifies and improves a patients journey through care as it means people who on assessment need more specialist diagnostics e.g. X-ray or treatment, will receive the care they need promptly without the need to travel to another location.

Q7 What are the plans for Ashton Primary Care Centre if Urgent Care access moves to the hospital site?

A7 Ashton Primary Care Centre (APCC) will remain open and any space which becomes vacant will be filled by increasing community, social care, primary or acute services such as Physiotherapy. The APCC is also the North Neighbourhood Care Hub and will still offer bookable same day appointments for Urgent Care. We envisage that the APCC will always be a thriving health and social care hub at the heart of the community.

Q8 I can't park at the hospital now - what are you going to about this?

A8 We are all aware of the challenges of car parking at the hospital. We have already commenced a development scheme in partnership with the hospital which will provide an additional 240 parking spaces. We believe this will be complete by the end of December 2017 and therefore will ease car parking.

Q9 Will I still be able to go to A&E if I need to?

A9 If you have an urgent medical condition that can't be diagnosed/ treated via NHS 111, at your pharmacy or at your registered GP practice, then yes, you can still go to A&E. When assessed by the streaming service you may be treated within the Urgent Treatment Centre at the hospital rather than A&E

Q10 Where can I get more information about public transport to the locations where urgent care is provided?

A10 For Tameside go to: www.tfgm.com/Pages/default.aspx
For Glossop go to: www.derbysbus.info/times/tt_201_999.htm

Q11 Can I use any of the Neighbourhood Care Hubs across Tameside and Glossop?

A11 Yes, you can.

Q12 Where can I go to access Urgent Care?

A12 You can access Urgent Care through appointments at your local GP. If an appointment isn't available or convenient to you, you can access any of the Neighbourhood Care Hubs which best suits your needs – this may be because it is the closest to where you live, work, or the quickest available appointment.

Q13 Where will the Neighbourhood Care Hubs providing access to Urgent Care be located?

A13 Our proposals include Urgent Care access at Neighbourhood Care Hubs across Tameside & Glossop. Option 1 proposes access in three Neighbourhood Care Hubs in addition to the Urgent Treatment Centre based at the Tameside Hospital site. Option 2 proposes access in five Neighbourhood Care Hubs in addition to the Urgent Treatment Centre based at the Tameside Hospital site.

Our proposals are based on the North Hub being located at the Ashton Primary Care Centre and the Glossop Hub being based at the Glossop Primary Care Centre. The locations for hub in the East Neighbourhood (covering Stalybridge, Dukinfield and Mossley), the South Neighbourhood (covering Hyde and Longdendale) and the West Neighbourhood (covering Denton, Droylsden and Audenshaw) are still to be determined.

Travel time analysis for the potential access in the Hubs has been undertaken to assess any possible travel implications for residents. When modelling this travel time analysis indicative locations for the East, South and West Hubs have been used. These are – East Hub (St. Andrew's Medical Centre, Stalybridge), South Hub (Haughton Thornley Medical Practice, Hyde) and West Hub (Denton Festival Hall). The exact locations of the Neighbourhood Care Hubs will be determined following the consultation period.

Q14 Can I get an evening or weekend appointment for something that is not urgent?

A14 Yes, if you do not have an urgent medical need, you can book a routine appointment with your GP Practice or at one of the Neighbourhood Hubs.

Q15 What is the difference between the Hubs and the walk-in at the hospital?

A15 The Hubs are accessed through booked appointments only via your GP, Out of Hours or NHS 111. The walk-in service at the hospital means you will go through the streaming service and be assessed by a medical professional as to whether you have a non-urgent, urgent or emergency medical need. You will then be directed to the right place for the right treatment. For Urgent Care you will go to the Urgent Treatment Centre on site which has access to diagnostics such as X-rays so should you have this additional need you can be treated in one place. For emergency care you will be directed to A&E. If when you use the walk-in service and once assessed your need is not urgent you may be advised to contact your own GP or another service for support.

Q16 Is this just about closing services?

A16 No, we will retain all current Urgent Care services and enhance them. We need to make changes as outlined in the consultation booklet in order to deliver the mandated services while still providing the best health and social care and value for the people of Tameside and Glossop.

Q17 Why can't you leave things as they are?

A17 As commissioners of health and social care services in Tameside and Glossop, we need to look at the way we deliver our range of Urgent Care services so that we can provide the mandated streaming service and Urgent Treatment Centre at the hospital in an affordable way. We also want to ensure that we have an understandable and accessible Urgent Care offer built around this which balances quality, access and the best use of our resources.

Q18 How have you calculated how long it takes for people to travel to the location of the current Walk in Service at Ashton Primary Care Centre, the proposed site for the Urgent Treatment Centre at Tameside Hospital and the potential locations of the Neighbourhood Care Hubs?

A18 Basemap's TRACC software was used to calculate travel times to Ashton Primary Care Centre, Tameside hospital (Tameside and Glossop Integrated Care NHS Foundation Trust) and the potential locations of the Neighbourhood Care Hubs using public transport at both peak and off peak time periods. This covers all major public transport options across Tameside and Glossop including bus, train and tram.

TRACC was also used to calculate drive times at both peak and off peak time periods, and walk times.

The data processed through Tracc to extract the travel times is called Trafficmaster TM Speed. Trafficmaster TM Speed data is GPS sourced and centrally purchased by the Department of Transport

The drive time in minutes figures are bi-directional so are an average of both directions of travel. The drive time in minutes is by any available road route and Tracc calculates the 'fastest route' between the given locations

Trafficmaster TM Speed data is calculated annually, meaning that the figure is derived from the speed of sample cars travelling Monday-Friday throughout the entire year (this would include school holidays and bank holidays).

Full details of this public transport, drive time and walk time analysis (including maps) is included in the Equality Impact Assessment.

Q19 How will my responses to the consultation help you make a decision?

A19 There is no preferred option in the proposal for the location and opening hours of the Neighbourhood Hubs. We are therefore keen to hear your views so that we can take your feedback into account when making the final decision.

Q20 When will the final decision be made?

A20 Once the consultation period finishes on 26 January 2018, we will analyse all responses received. We aim to submit a recommendation to the Single Commissioning Board in February 2018. This report will be available on the CCG's website: www.tamesideandglossopccg.org

TAMESIDE AND GLOSSOP Caretogether SINGLE COMMISSIONING FUNCTION

NHS Tameside and Glossop Clinical Commissioning Group

Have YOUR say

FIND OUT MORE AND HAVE YOUR SAY ON THE PROPOSALS AT WWW.TAMESIDEANDGLOSSOPCCG.ORG/URGENTCARE

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	31 October 2017
Officer of Single Commissioning Board	Stephanie Butterworth, Director of Adult Services
Subject:	**IMPROVING DEMENTIA SERVICES IN THE NEIGHBOURHOODS**

Report Summary:

There are an estimated 2,691 people in Tameside and Glossop with dementia. As part of the Care Together development Tameside and Glossop committed to improving the lives of people living with dementia and, through this, reduce reactive costs associated with the high volume of activity in unscheduled and long term care. In 2016 in Tameside, the rate of emergency admissions, aged 65+ with dementia was 4,839 per 100,000 population, compared to the rate for England of 3,046 per 100,000 population.

10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80 Gill et al (2004) studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity and social activity.

The overall vision for Tameside and Glossop is linked to the development of a rich, post diagnostic support offer to support people living with dementia and their carers to make informed choices, be empowered to take control of their lives and maintain their well-being and independence for as long as possible.

This business case has three main objectives:

1. Establish a pilot with Alzheimer's Society for Dementia Support Workers (DSW) in each Neighbourhood in Tameside.
2. Establish Dementia Practitioners (DPs) in each neighbourhood team by investing in three new roles to add to existing Pennine Care Foundation Trust Community Mental Health Team nurses, Willow Wood Dementia Nurse and Integrated Care Foundation Trust Admiral Nurse capacity.
3. Agree an Executive Lead Champion for dementia. This individual will have delegated responsibility from the locality partnership to represent the locality in all regional discussions about the strategic direction and performance of dementia services.

It is proposed that Dementia expertise is embedded within the Integrated Neighbourhood Teams by integrating a Dementia Practitioner into each Neighbourhood Team.

Dementia support is increased in each of the Tameside Neighbourhoods by investing in a three-year Dementia Support Worker pilot from the Alzheimer's Society through Adult Social Care Transformation Funding.

This business case supports the Single Commission's Quality, Innovation, Productivity, and Prevention (QIPP) agenda. It is anticipated that as the cost savings from reduced unscheduled admissions will ultimately allow movement of money within the system that ensures the implementation is sustainable in the first instance, and cost saving in the medium and long terms.

Recommendations:

The Single Commissioning Board is recommended to:

(1) Recognise the current position regarding unscheduled admissions related to dementia and the need for additional resources and actions to enable us to progress towards reducing a figure that is an outlier at a national level and contradicts the progress delivered in diagnosis.

(2) Agree that the development of a rich post-diagnostic community offer supported by the clinical delivery of Dementia Practitioners and the co-ordinating role of the Dementia Support Workers will be a significant step in improving dementia care in Tameside.

(3) Agree to Phase 1 – the investment of non-recurrent Adult Social Care Transformation budget to establish a pilot with the Alzheimer's Society to embed Dementia Support Workers in the Tameside Neighbourhood Teams to support people living with dementia from diagnosis to end-of-life care.

(4) Recommend that compliance with procurement standing orders be waived to enable this pilot to be established from the Alzheimer's Society who are a specialist provider.

Financial Implications:

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

Budget Allocation (if Investment Decision)	Phase 1 funding requirement £0.326m total over initial 3 year period. £0.105m recurrent funding required from 2020-21 onwards Phase 2 funding requirement of £0.143m per annum to be agreed
CCG or TMBC Budget Allocation	Funding of £0.326m has been agreed from the Adult Social Care Non Recurrent Transformation Grant until 2019-20.
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	Single Commissioning Board
Value For Money Implications – e.g. Savings Deliverable, Expenditure	The current estimated cost of avoidable Dementia related acute admissions is £0.5m

Avoidance, Benchmark Comparisons	per year in Tameside. It is hoped that by increasing specialist Dementia support in the community a significant proportion of these costs can be avoided. Cost reductions in this area will allow continued community investment whilst also contributing towards closing the Tameside locality funding gap.

Additional Comments

Recurrent funding of £0.105m per annum from 2020-21 onwards requires further discussion as at this stage the proposal is not affordable. It is important to quantify and track the cash releasing benefits in acute to enable continued investment in the neighbourhood based speciality teams.

Legal Implications:

(Authorised by the Borough Solicitor)

The Council is obliged to follow its own procurement standing orders which include provision to make a direct award where there are exceptional circumstances to justify such a course of action and it will not contravene any legal obligation.

The proposed contract value is below the current threshold (£589,148) for Social or Other Services (which is also known as the light touch regime) and therefore there is no requirement to run an OJEU exercise.

Due to the nature of pilot, the specialisms of Alzheimer's Society and their current involvement in developing the Dementia United Strategy, driving quality across Greater Manchester in all sectors, it would not be unreasonable to proceed with the pilot. Any subsequent longer term contract must be let in accordance with the Public Contract Rules.

The proposed arrangements will undoubtedly involve the transfer of sensitive personal data about individuals. The contract between the parties should include appropriate information governance provisions to safeguard service user data.

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 "Improving Dementia Services in the Neighbourhoods" business case aligns with the following Health and Wellbeing Board strategic priorities:

- Integration;
- Improve the health and wellbeing of local residents throughout life;
- support to those with poor health to enable their health to improve faster;
- Prevention and early intervention;
- Local action and responsibility for everyone;

	• Public involvement in improving health and wellbeing.
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Healthy Lives (early intervention and prevention) • Community development • Enabling self-care
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Patients and communities being empowered to care for themselves and to work together to support local health and wellbeing; • Identification and support of "at risk" people; • Fewer overnight stays in hospital and more community based care.
Recommendations / views of the Professional Reference Group:	The Professional Reference Group recommends this paper is agreed by the Single Commissioning Board as the first step towards a much greater focus on supporting people with dementia in the community in order to reduce the high rate of unscheduled admissions and pressures on Continuing Healthcare.
Public and Patient Implications:	There are implications for people with dementia and their families/carers.
Quality Implications:	There is evidence that Improving Dementia Services in the Neighbourhoods will deliver the following patient outcomes: • **Better quality of life** and enhanced health and well-being; • **Fewer crises** that lead to unplanned hospital and institution care; • **Enhanced experience of care** through better coordination and personalisation of health, social care and other services.
How do the proposals help to reduce health inequalities?	By offering people living with dementia more support, choice, control and flexibility in relation to managing their own health.
What are the Equality and Diversity implications?	It is anticipated that the proposal will not have a negative effect on any of the protected characteristic group(s) within the Equality Act. An Equality Impact assessment has been completed and is attached (**Appendix 3**)
What are the safeguarding implications?	Safeguarding assurance is integral within all service delivery.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	This will be completed if required.
Risk Management:	No risks identified.

Access to Information :

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

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e-mail: sandra.whitehead@tameside.gov.uk

1. EXECUTIVE SUMMARY

1.1 The proposal is to build dementia expertise and support by embedding Dementia Practitioners (Dementia Nurses and Admiral Nurses) within each of the five Neighbourhood Teams and, in Tameside, commissions a pilot scheme from the Alzheimer's Society to provide a Dementia Support Worker in each neighbourhood through the Adult Social Care Transformation Funding.

1.2 It is recommended that post-diagnostic dementia provision is developed in two phases; Phase 1 includes allocating some capacity from the existing resources in the Older Peoples Mental Health Team in Pennine Care Foundation Trust and the Admiral Nurses in the Integrated Care Foundation Trust as well as commissioning a Dementia Support Worker Pilot from the Alzheimer's Society. To turn the curve on the high rate of unscheduled admissions for people with dementia it is recommended that dementia practitioner capacity is extended to focus on early intervention and prevention capacity in Phase 2.

1.3 The benefits and effectiveness of these recommendations is provided with an overview of wider NHS and Social Care policy contexts and drivers, as well as qualitative and quantitative evidence of the benefit to the health and social care system.

2. OUTLINE DESCRIPTION

2.1 There are an estimated 2,468 people in Tameside and Glossop with dementia. As part of the Care Together development, Tameside and Glossop committed to improving the lives of people living with dementia and, through this, reduce reactive costs associated with the high volume of activity in unscheduled and long term care.

2.2 10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80. Gill *et al* (2004) studied the association between bed rest and functional decline over 18 months; they found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity and social activity.

2.3 The Alzheimer's Society 'Counting the Cost: *caring for people with dementia on hospital wards' (2009)* reported:

- *Over a quarter of hospital beds in the UK are currently occupied by people with dementia;*
- *One third of people with dementia who go into hospital for an unrelated condition NEVER return to their own homes;*
- *47% of people with dementia who go into hospital are physically less well when they leave than when they went in;*
- *54% of people with dementia who go into hospital are mentally less well when they leave than when they went in.*

2.4 The overall vision for Tameside and Glossop is linked to the development of a rich, post diagnostic support offer to support people living with dementia and their carers to make informed choices, be empowered to take control of their lives and maintain their wellbeing and independence for as long as possible.

2.5 It is proposed that dementia expertise is embedded within the Integrated Neighbourhood Teams by integrating a Dementia Practitioner into each Neighbourhood Team. There are two phases to achieve this:

Phase 1	Phase 2
Integrating time from existing postholders (currently working in Pennine Care FT, Willow Wood Dementia Nurse and the ICFT Admiral Nursing Team) into each of the Neighbourhood Teams.	Increasing capacity with additional funding/redesigning neighbourhood team skill mix to ensure that sufficient dementia expertise is in place to reduce unscheduled care demand.

- The focus of these roles will be to reduce the rate of hospital admissions and to promote 'dying in usual place of residence.' Further work is required to identify the capacity and responsibilities for Dementia Nurses, Willow Wood Dementia Nurse and Admiral Nurses as the roles are complementary but different. See **Appendix 1** for a description.

- It is proposed to invest in additional dementia provision in each of the Tameside Neighbourhoods by funding a three-year Dementia Support Worker pilot from the Alzheimer's Society through Adult Social Care Transformation Funding. See **Appendix 2** for a description.

3. BACKGROUND

3.1 There are a number of national policy positions which have informed this business case; in 2009, the 'Living Well with Dementia: A National Dementia Strategy' provided the strategic framework within which to make quality improvements to dementia services and address health inequalities. In 2012, 'The Prime Minister's Challenge on Dementia' provided a challenge to the whole of society as well as government to focus on driving improvements and creating dementia friendly communities and better research. In 2013, 'A State of the Nation Report on Dementia Care and Support in England' acknowledged dementia as being one of the most important health and care issues the world faces as the population ages; and projected a doubling of prevalence nationally over the next 30 years.

3.2 The 'Prime Minister's Challenge on Dementia 2020' (2015) sets out what this government wants to see in place by 2020 in order for England to be the best country in the world for dementia care; it also sets out what people with dementia self-report as the type of society that is important to them, in which they are able to say:

- *I have personal choice and control over the decisions that affect me;*
- *I know that services are designed around me, my needs and my carer's needs;*
- *I have support that helps me live my life;*
- *I have the knowledge to get what I need;*
- *I live in an enabling and supportive environment where I feel valued and understood;*
- *I have a sense of belonging and of being a valued part of family, community and civic life;*
- *I am confident my end of life wishes will be respected. I can expect a good death;*
- *I know that there is research going on which will deliver a better life for people with dementia, and I know how I can contribute to it.*

3.3 NHS England has been prioritising equitable access to high quality services and support for people diagnosed with dementia and as a result, the National dementia team developed a 'Well Pathway for Dementia' which is being used as the benchmark for the GM dementia transformation programme - "Dementia United."

Current Situation

3.4 A focus on improving the dementia diagnosis rate from 69.6% in April 2016 to 75.1% in March 2017. Reducing waiting times from 24 weeks for the Memory Assessment Service

for a first appointment to the national target of six weeks has resulted in significant improvement; however there is a high rate of unscheduled hospital admissions.

3.5 In 2016, the rate of emergency admissions (aged 65+ with dementia) was 4,839 per 100,000 population, compared to the rate for England of 3,046 per 100,000 population.

3.6 The level of unscheduled admissions is considered to be a marker for good community care. Analysis provides evidence of the main causes of admission (falls and delirium), that will be used to support the development of a robust pathway and strengthening community care that will spot and prevent crisis leading to a reduction in unscheduled admissions.

What the business case seeks to commission/re-design

3.7 This business case has three key objectives within **Phase 1** as follows:

<table>
<tr>
<td>1. Establish a pilot with Alzheimer's Society for Dementia Support Workers (DSW) in each Neighbourhood in Tameside –December 2017 - Alzheimer's Society to establish a DSW as an integral member of each Tameside neighbourhood team, each supported by a volunteer. When fully operational the DSWs are expected to support 192 cases of people affected by dementia every month; the DSWs will:
- provide post diagnostic support to people and their families and work with dementia practitioners (DPs) to support an allocated caseload, providing emotional support and promoting access to emotional support/mental health pathways;
- be a consistent relationship across primary/acute/secondary care and collaborate with local resources and, with DPs, build capacity/capability in primary care, community services and the voluntary and community sector;
- liaise with and, through monitoring their role, provide advice to Primary Care annual care plan reviews and support access to advocacy services;
- provide a communication conduit for individuals admitted into hospital and ensure continuity of care plans and support discharge planning;
- link with Palliative Care Team;
- facilitate and support peer to peer support through a rich community offer
- support specialist DPs.

(Note: - Dementia support is available in Glossopdale through the High Peak Alzheimer's Dementia Support worker and through the Derbyshire Dementia Reablement Service).</td>
<td>2. Establish Dementia Practitioners (DPs) in each neighbourhood team by investing in three new roles to add to existing PCFT CMHT nurses, Willow Wood Dementia Nurse and ICFT Admiral Nurse capacity:
DPs will:
- provide expert training, advice and support to all colleagues regarding dementia assessment, monitoring, support and intervention;
- supervise the Dementia Support Workers in their role;
- Dementia Nurses will undertake assessments and provide care plans for people with complex dementia;
- carry a caseload of patients/and or carers who require additional support;
- work with Neighbourhood colleagues to monitor and take preventative action to reduce crisis. Where crisis occurs, provide support to reduce escalation, including preventing avoidable hospital admissions and expediting safe discharges;
- work with partners to deliver a rolling training programme in the locality;
- support the community and voluntary sector provision of a rich choice of carer and peer support;
- promote high quality psychosocial interventions;
- Willow Wood Dementia Nurse will also offer support and consultation for dementia end of life across Tameside and Glossop.</td>
</tr>
<tr>
<td colspan="2">3. Appoint an Executive Lead champion for dementia. This individual will have delegated responsibility from the locality partnership to represent the locality in all regional discussions about the strategic direction and performance of dementia services.</td>
</tr>
</table>

3.8 To turn the curve on the high rate of unscheduled admissions for people with dementia it is recommended that dementia practitioner capacity is extended to focus on early intervention and prevention capacity in **Phase 2.**

4. VALUE OF THE PROPOSAL

Phase 1	**Phase 2**
• Dementia Practitioners – move some existing resources into each of the Neighbourhood Teams; • Dementia Support Workers – commission a pilot from Alzheimer's Society; • The estimated costs for this option are **£117,295** (year 1), **£103,692** (year 2), **£104,753** (year 3) or **£325,740** for the three years requested within this business case.	Dementia Practitioners – add three additional roles. The estimated costs for this option are **£144,000** per annum.

5. REASONS: NATIONAL, STRATEGIC AND LOCAL CONTEXT

5.1 The Implementation Guide and Resource Pack for Dementia Care (formally known as the Evidence Based Treatment Pathway (EBTP), was published on the NHS England website July 2017) - priority areas identified for quality improvement by NICE are set out in the Support in Health and Social Care and Independence and Wellbeing Quality Standards for Dementia Care.

5.2 These state that people with:

- Suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia;
- Newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local areas;
- Dementia are enabled, with the involvement of their carers, to access services that help maintain their physical and mental health and wellbeing;
- Dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named coordinator of care and addresses their individual needs;
- Dementia with the involvement of their carers, have choice and control in decisions affecting their care and support;
- Dementia receive care from staff appropriately trained in dementia care.

5.3 The Five Year Forward View for Mental Health (2016) is based on economic evidence that investment in the priorities will result in savings within the system. The Mental Health Five Year Forward View is the basis for Greater Manchester Mental Health:

5.4 There are gaps in Mental Health provision:

- In primary care for low level mental health needs;
- between Healthy Minds and Secondary Care in both psychological therapy and mental health expertise;
- For people with chronic and relapsing mental health needs;

- In post-diagnostic dementia support.

5.5 As well as redesigning existing mental health investment there is new funding from GM, the Single Commission (CCG and Tameside MBC) and within Care Together – aligning this will ensure no duplication and no gaps.

5.6 This business case also links to Greater Manchester Mental Health and Well-being Strategy priorities for 2017/19 that include:

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

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

Links with Single Commission's Strategic Plan and Health and Wellbeing Board

5.7 This business case supports the "Care Together Commissioning for Reform Strategy 2016-2020" commissioning priorities for improving population health and supporting positive mental health.

5.8 This also supports the ambition to deliver integration of primary, community and secondary physical and mental health care, public health programmes and social care services as well as co-ordinating and commissioning services from other providers e.g. voluntary and faith sectors.

Supporting the Single Commission's Quality, Innovation, Productivity and Prevention Agenda

5.9 **Quality:**

- better service user and carer experience;
- better integrated health and social care approach;
- provision that meets NICE Dementia Quality Standards;
- better developed and trained workforce.

Innovation:

- integration of primary and secondary care, health and social care and physical and mental health care;
- reduction in unnecessary referral and administration;
- incorporates best evidence to support a whole-system change.

Productivity:

- reduced demand for acute inpatient provision
- reduced demand for specialist mental health inpatient provision
- increased discharge rates and shortened length of stay from acute and specialist mental healthcare to primary care and home support
- increased response times
- increased numbers of people receiving specialist assessment
- release of resources so that more treatment can be provided in the community and home settings

Prevention of

- inappropriate hospital admissions;
- people having to lose their independence;
- admissions to care homes;
- inappropriate drug prescribing;
- crises through good monitoring and early intervention in the community;
- delayed discharges.

Key Partners / Stakeholders involved in the business case

5.10 Further to the original dementia; "Care Together Programme - Business Case" in 2015, the development of this business case has involved the public, NHS and Social Care professionals and community and voluntary sector provision in Tameside and Glossop.

5.11 The dementia workstream has been developing over the last five years. Initially there were a series of public consultations (five documented) with carers and the public to develop the existing joint dementia strategy. In support of this the Dementia Local Implementation Group (LIG) took forward the intentions of the strategy with carer representation.

5.12 The post diagnostic offer has been further developed and agreed by the Dementia Strategic Group; chaired by the Clinical Lead for Dementia and attended by all the major stakeholders; Integrated Care Foundation Trust, Clinical Commissioning Group, Alzheimer's Society, Age UK, Pennine Care Foundation Trust, Tameside MBC Public Health and Adult Services.

6. OUTCOMES AND BENEFITS

Anticipated Outcomes

6.1 There are clear opportunities for innovation and improvement in the delivery of dementia care in Tameside and Glossop, which will:

- improve integration;
- deliver better outcomes for individuals;
- and achieve efficiencies across the local health economy.

6.2 The major outcomes described in section 2.3: 'QIPP' are all achievable, but the major outcome of improved care and monitoring within the community will be the reduction in unscheduled admissions for people living with dementia.

6.3 It is anticipated that as the cost savings from the unscheduled admissions will ultimately allow movement of money within the system that ensures the implementation is sustainable in the first instance, and cost saving in the medium and long terms.

6.4 The potential cost savings to the health and social care economy are outlined in **Appendices 1** and **2.**

Measurable Improvements

6.5

- The reduction in unscheduled admissions will be influenced by the addition of dementia expertise in the neighbourhoods.

- Unscheduled admissions are monitored at a Greater Manchester level through Dementia United and our Locality Dashboard.

- The other measures will include patient and carer satisfaction and the activity that is created as a result of having a single point of access to wider health and social care services for people with dementia from newly diagnosed to palliative/end of life care.

- These measures will be monitored through data collection on activity, staff and patient surveys and local patient satisfaction as of the measures being implemented as part of the Dementia United Programme.

- The National Expert Reference Group for Dementia recommended that three outcome tools should be used routinely in memory assessment services; these are equally applicable to community based dementia support services. These are:

    - **Health of the Nation Outcome Scale-65 (HoNOS-65):** a 12-item scale measuring behaviour, impairment, symptoms and social functioning in older adults.
    - **Friends and Family Test (FFT):** a single-item scale measuring service user experience.
    - **New Models for Measuring Patient Experience Questionnaire:** a 20-item scale that measures service user experience.

- The business case will be monitored on a monthly basis for the first 12 months to ensure that the progress is as expected.

7. EVIDENCE BASE

7.1 The financial cost of dementia is enormous. Today, it costs the UK economy over £26 billion annually and this is increasing (Alzheimer's Society, 2014).

7.2 The drive to deliver better integrated health and social care provides a unique opportunity to transform dementia services. Indeed a wide range of initiatives have already started to recognise the importance of dementia and are making dementia a key part of their delivery plans. These include:

- Sustainability and transformation plans;
- NHSE new models of care vanguards;
- Better care fund programmes.

7.3 The Department of Health's implementation plan to the Prime Minister's Challenge on Dementia 2020 stated, *"we heard a consistent message from people who reported that on receiving their diagnosis, they faced a bewildering future and felt alone in facing this. People with dementia and carers told us of their urgent need for information, advice and support both immediately after diagnosis and to help them through the stages of their journey with dementia*." (Department of Health, 2016).

7.4 The Alzheimer's Society commissioned 'NEF' Consulting to evaluate the dementia support worker role, using services in Bexley and West Lancashire as case study locations.

7.5 The Social Cost Benefit Analysis (SCBA) found that the key outcomes with the greatest value created were:

- a reduction in the cost of mental health services to the state, by avoiding carer breakdown;
- an increase in information and knowledge for carers as evidenced by their awareness of support services available in the community, knowledge of strategies that help them to cope with caring for someone with dementia, and their ability to keep the person they care for safe from harm;
- an increase in building peer support for both people with dementia and carers from having more contact with other people with dementia or carers.

7.6 The South West Dementia Partnership published "An evaluation of dementia support worker roles" in November 2011 and concluded the DSW role, *"…will not only improve the quality of life and independence of the increasing number of people living with dementia, but ensure that public resources are used effectively and delivering a significant value for money*."

7.7 The proof in Tameside will be developed as we gather evidence that the service has started to significantly reduce the 56 avoidable admissions and 7 readmissions per month that were reported the "Dementia Initial Baseline Data Report" published by the Greater Manchester Health and Social Care Partnership in 2016.

Local Consultation

7.8 People living with dementia and their carers were consulted to gather evidence to support the development of the original Care Together Dementia Business Case. Their comments included:

7.9 Patients and carers suggested that the following areas need to be prioritised to improve dementia care:

- ensure flexible, joined up services, with reduced bureaucracy and duplication; and better communication across services and departments, providing emotional as well as practical support, both one to one, peer support and dementia training, within primary care and community settings;
- better information on how to seek help; access to information about what services are available, support groups and signposting;
- offering a clear pathway; single point of access for advice and support;
- provision of a community based 'dementia adviser' and specialist staff to provide support throughout a person's entire dementia journey;
- ongoing consultation with carers, on a regular basis, in order to plan flexible and responsive services which support the caring role is needed; active inclusion of carers as 'partners' within a person's care package/treatment;
- reduced waiting times for memory assessment and diagnosis and equality of service provision;
- dementia specialist social work assessment, expertise and practice;
- reliable domiciliary care service, with alternate models of care, such as more flexible duties, emotional support, responding to needs of someone with dementia differently than people without memory or cognitive problems, better understanding of dementia from staff, creative activities and provision to provide support outside of the home;
- access to respite care, without disruption to a person's routine care package (e.g. day care); respite alternate to weekly blocks of bed-based care, considering 'day' respite
- social care support provided on a needs-led basis, rather than a diagnosis-led basis for specialist provision;
- prompt and flexible Adult Social Care response during crisis, offering reablement where needed;
- improved discharge planning and advanced care planning;
- access to medical records.

8. FINANCIAL CONSIDERATIONS

8.1 As stated in Section 1.3, the anticipated costs are outlined and broken down below:

Cost: Alzheimer's Society Dementia Support Workers	**17/18**	**18/19**	**19/20**
Dementia Support Workers x 112 hrs. pw	£73,444	£74,223	£75,010
Service Administrator x 4.2 hrs. pw	£2,449	£2,476	£2,503
Dementia Support Manager x 14 hrs. pw	Will be line managed in Neighbourhood Teams		
Service Manager x 3.5 hrs. pw	Funded by the Society		
Alzheimer's Society Supervision for workers x 7 hrs pw	£4,862	£4,916	£4,970
Volunteer Expenses	£806	£814	£822
Staff Mileage and Travel Costs	£7,158	£7,230	£7,302
Office Consumables, Phones IT Hardware & Software	£16,233	£3,000	£3,000
Learning & Development	£1,680	£1,697	£1,714
Organisational Overheads	£10,663	£9,336	£9,432
Total	**£117,295**	**£103,692**	**£104,753**
Phase 2 Cost: Dementia Practitioners/Admiral Nurse x 3 (5 Days)	**FYE**		
Dementia Practitioners/Admiral Nurse x 3 (Mid-Point Band 6)	£116,025		
Non-pay	£5,802		
Overheads/Surplus	£21,441		
Total	**£143,268**		

8.2 **Phase 1:** Adult Social Care Transformation Funding - The non-recurrent single commission Care Together transition budget. This was an initial non recurrent pooled budget sum of £6.38 million. This is a Section 75 collaborative commission for the Integrated Commissioning Fund Section.
Phase 2: To be agreed.

9. PERFORMANCE MONITORING, EVALUATION AND EXIT STRATEGY

9.1 The Single Commission will monitor performance against the anticipated outcomes as follows:

- Reporting will be on a monthly basis. This will allow us to closely monitor the development of the project within the agreed parameters and collate the evidence to demonstrate impact.

- Reporting on activity:
    - Report monthly on number of patients and carers and face to face contacts with supported and categorised against the Well Pathway elements: Living Well, Supported Well, Dying Well

- Contact 100% of the people newly diagnosed with dementia via the Memory Assessment Service in Tameside and offer opportunities to them to find out more about support available within their neighbourhood/Tameside
- Contact 20% of people living with a diagnosis of dementia and inform them of support available, in the first six months
- Contact 40% of people currently diagnosed with dementia and inform them of support available in the first 12 months
- Report on the number of people in each neighbourhood attending DSW facilitated group/activities

- Patient reported outcomes – through standardised outcome reporting tools, (to be agreed) e.g. PREM/PROM (based on I statements), Health Innovation Network (HIN) Ask Dementia Outcome Measure (ADOM), Carer's Stress Index, to demonstrate impact of the service on:
  - Carer Stress
  - Meaningful occupation such as engagement in regular activity that supports them and their carer's health and mental well-being; e.g. regular attendance at a Memory Café, Active Tameside (Health Walks), etc.
  - Satisfaction with services provided
  - Awareness of support available in the locality

- Reporting on partnership working/referrals and outcomes for people living with dementia and their carers and families.
  - Demonstrate effective working within the INTs through 360 degree review
  - Contact a wide range of partnership organisations (Health/Social Care Care/VCS/Faith/Private Sectors/etc.) in the first six months to inform them of the DSW Role for people living with dementia
  - Demonstrate effective partnership working with a wide range of partnership organisations within 12 months.

- Quality assurance monitoring through case study narrative and comprehensive reporting requirements:
  - Against the Well Pathway elements: Living Well, Supported Well, Dying Well each DSW to develop 2 case studies per quarter illustrating the situation at the starting point of contact, the inputs required from them and partnership organisations to support the person living with dementia and their carers, and the immediate outcomes and medium and long term outcomes anticipated

- The evaluation of the newly funded DSW role will form part of a wider understanding and evaluation of the total changes within the system the impact on the health and social care of people living with dementia and their carer's.

9.2 The exit strategy and sustainability for this proposal is based upon the savings generated by reducing the unscheduled admissions and CHC requests. Formal evaluation of the proposal will seek to prove that savings generated are equal to or greater than the cost of implementation

10. SUPPORTING INFORMATION

10.1 Scarcity of public resources means that value-for-money for interventions for people with dementia requires closer scrutiny (Knapp, Lemmi, & Romeo, 2013). Studies suggest that peer support may lead to direct healthcare savings by equipping people with coping mechanisms and providing emotional support, which can lessen the risk of crises and subsequent, potentially avoidable and expensive interventions by the statutory sector (Arksey, 2003; Banerjee & Whittenberg, 2009; Clarke et al., 2013; Hall Long, Moriarty, Mittleman, & Foldes, 2014; Spijker et al., 2009). Traditionally, cost-effectiveness and cost-

benefit analyses have been used to assess value-for-money of health and social care interventions.

10.2 However, the value produced by participating in peer support groups can be subtle and is difficult to measure (Knapp et al., 2013). As such there is a scarcity of research on the wider social, economic or environmental value they create.

10.3 An integral part of this business case will involve facilitating and supporting existing peer to peer support for people with dementia and carers, which is routinely advocated in national strategies and policy as a post-diagnostic intervention.

10.4 A study "*Quantifying the benefits of peer support for people with dementia: A Social Return on Investment" (SROI)*" (Willis, Semple, & de Wall, 2016) looked at three dementia peer support groups in South London to evaluate what outcomes they produce and how much social value they create in relation to the cost of investment.

10.5 A Social Return on Investment (SROI) analysis was undertaken, which involves collecting data on the inputs, outputs and outcomes of an intervention, which are put into a formula, the end result being a SROI ratio showing how much social value is created per £1 of investment. Findings showed the three groups created social value ranging from £1.17 to £5.18 for every pound (£) of investment, dependent on the design and structure of the group. Key outcomes for people with dementia were mental stimulation and a reduction in loneliness and isolation. Carers reported a reduction in stress and burden of care.

11. RECOMMENDATONS

11.1 As set out on the front of the report.

APPENDIX 1

DEMENTIA PRACTITIONER / ADMIRAL NURSE ROLE

Dementia Practitioner/Admiral Nurse roles have a strong evidence base for efficacy in a range of different settings. An analysis of the caseload over one month (November 2013) in **NHS Telford and Wrekin** showed cost savings of over £17,000 in terms of savings on GP contacts and respite provision (Lee, T, et al, 2014). This evidence has been built upon by the most recent cost benefit analysis of the Norfolk Admiral Nursing Service which showed savings of over £440,000 over a 10 month period with a team of 3 Admiral Nurse/Dementia Practitioners (Aldridge and Findlay, 2014). These savings included delayed admissions to care homes, a reduction in hospital admissions (both acute and mental health), and a reduction in the referrals to psychological therapies. Additionally, surveys carried out as part of this evaluation showed 60% of GPs reporting a reduction in contact time as a result of the Admiral Nursing Service.

The results of the first year evaluation for Sutton have been extremely positive and indicate that the service is bringing positive outcomes for the families it aims to support as well as saving the health and social care economy in Sutton money by avoiding inappropriate admissions to hospital and care/nursing homes.

The independent evaluation of the specialist dementia support service in **Norfolk** found that the combination of the counselling role and knowledge and information provided by the Admiral Nurse/Dementia Practitioner had profound effects on the carers, improving their mental health and increasing their ability to carry on; 12 cases were identified which without the support of the Admiral Nurse/Dementia Practitioner would have resulted in the carer being referred to mental health services.

The evaluation suggested that Admiral Nurse/Dementia Practitioners reduced the contact time between other services and avoided eight mental health bed admissions.

Professionals reporting reduced contact time:

- 60% GPs
- 16% Nurses
- 100% Social Workers

A cost/benefit analysis undertaken as part of the evaluation estimated that the Admiral Nurse/Dementia Practitioner pilot resulted in direct savings to health and social care of over £443,593 over the period from June 2013 and April 2014.

- £63,074 Acute Health Care costs - reduced hospital admissions due to early identification and management of health conditions and support with end of life care.
- 8 mental health hospital admissions.
- £20,760 Continuing Health Care costs.
- £16,992 (approx.) Improving Access to Psychological Therapies /Counselling.
- £342,767 care home costs.

The evaluation concludes that the Admiral Nurse/Dementia Practitioner Service has achieved outstanding results throughout the pilot, providing much needed appropriate support and is a “life line” to carers and in addition to this has the potential to create savings for both Health and Social Care.

APPENDIX 2

DEMENTIA (MEMORY) SUPPORT WORKER/DEMENTIA NAVIGATOR ROLE

Published research from Professors Louise Robinson (2010), Dawn Brooker (2010), Sube Banerjee (2003 and 2007) and David Weimer et al. from the USA supports the provision of community dementia support and demonstrates genuine cost benefit.

Evidence shows that providing people with dementia and their families with a Memory Support Worker/Dementia Navigator to support them accessing the health and social supports available to them reduces stress and improves outcomes.

The South West Dementia Partnership has produced an evaluation that includes both qualitative and quantitative benefits to local health and social care systems.

The majority of existing Dementia Support Worker/Dementia Navigator roles function as named contacts for people with dementia, their carers and families. A few roles provide active liaison between primary care, secondary care and third sector providers, including advocacy. This seems to be particularly beneficial to carers, resulting in them being less susceptible to stress or depression and therefore less likely to stop being able to care for the person with dementia. A paper published by the Alzheimer's Society (2011) supports the commissioning of "brokerage" services to facilitate and empower access to personal budgets among people with dementia.

There is evidence that some people living with dementia have been able to stay in their homes for longer, some to end of life. Dementia Support Worker/Dementia Navigators have been shown to improve access to care, medication, services and support and to have delivered in partnership a more holistic service for the person with dementia and carers or families.

The full benefit realisation may not be possible for at least four years from the first provision of a new Dementia Support Worker/Dementia Navigator role (Department of Health, 2008). This is because there is a delay to measurable reduction in permanent care home placement cost, although there will be more immediate measurable savings/reduction in costs in areas such as acute hospital admission, prescribing and community mental health team referrals.

Within the South West Dementia Partnership report it has been difficult to estimate savings to the system but these vary between £5.27 and £300 per person with dementia.

The Alzheimer's Society study "Qualitative Analysis and Cost Benefit Modelling of Dementia Services" suggests that key savings result from three areas of improvement:

1. People with dementia
    - Building peer networks
    - Vitality
    - Reduced anxiety

2. Carers
    - Building peer networks
    - Knowledge and information
    - Reduced anxiety

3. Savings to the state
    - Reduced cost to mental health services through avoided carer breakdown

APPENDIX 3

Equality Impact Assessment

Subject / Title	**Improving Dementia Services in the Neighbourhoods**

Team	**Department**	**Directorate**
Personal Health Budgets	MH and LD Commissioning Team	Commissioning

Start Date	**Completion Date**
September 2017	*December 2017*

Project Lead Officer	Pat McKelvey
Contract / Commissioning Manager	Pat McKelvey
Assistant Director/ Director	Clare Watson

EIA Group (lead contact first)	**Job title**	**Service**
Pat McKelvey	Head of MH and LD	Commissioning
Dr Tim Dowling	Clinical Lead for Dementia	CCG
Geoff Holliday	Commissioning Development Manager	Commissioning
Sandra Whitehead	Assistant Executive Director	Adult Services

PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	1. Establish a pilot with Alzheimer's Society for Dementia Support Workers (DSW) in each Neighbourhood in Tameside 2. Establish Dementia Practitioners (DPs) in each neighbourhood team by investing in three new roles and developing existing PCFT CMHT nurses and ICFT Admiral Nurses.
1b.	**What are the main aims of the project, proposal or service / contract change?**	A focus on improving the dementia diagnosis rate from 69.6% in April 2016 to 82.0% in July 2017. Reducing waiting times from 24 weeks for the Memory Assessment Service for a first appointment to the national target of six weeks has resulted in significant improvement; however there is a high rate of unscheduled hospital admissions. In 2016 the rate of emergency admissions (aged 65+ with dementia) was 4,839 per 100,000 population, compared to the rate for England of 3,046 per 100,000 population. The level of unscheduled admissions is considered to be a marker for good community care. Analysis provides

		evidence of the main causes of admission (falls and delirium), that will be used to support the development of a robust pathway and strengthening community care that will spot and prevent crisis leading to a reduction in unscheduled admissions. Dementia expertise is embedded within the Integrated Neighbourhood Teams by integrating a Dementia Practitioner into each Neighbourhood Team. This will require the integration of an existing postholder (currently working within either Pennine Care FT or the ICFT Admiral Nursing Team) into each of the Neighbourhood Teams. Dementia support is increased in each of the Tameside Neighbourhoods by investing in a three-year Dementia Support Worker pilot from the Alzheimer's Society through Adult Social Care Investment Funding.

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**			There are currently around 850,000 people in the UK with dementia. It mainly affects people over the age of 65 (one in 14 people in this age group have dementia), and the likelihood of developing dementia increases significantly with age. However, dementia can affect younger people too.
Disability	**x**			People with learning disabilities, particularly those with Down's syndrome, are at increased risk of developing dementia. If a person with a learning disability develops dementia, they will face different and additional challenges to people who do not have a learning disability.
Ethnicity	**x**			More than 25,000 older black and minority ethnic (BME) people live with dementia in the UK, in part due to vascular risk factors such as hypertension often found in African-Caribbean and South Asian UK populations. In other ethnic groups such as Irish and Jewish, there is a demographically-older population so with the link between age and dementia, prevalence is likely to be higher.
Sex / Gender			**x**	Overall, dementia incidence is similar for men and women.
Religion or Belief			**x**	Dementia can be developed to people of all religion/beliefs so there may be an indirect impact but no direct impact is anticipated in terms of religion/belief.
Sexual Orientation			**x**	Dementia can be developed by people of all sexual orientations so there may be an indirect impact but no direct impact is

				anticipated in terms of sexual orientation
Gender Reassignment			**x**	No direct impact is anticipated in terms of gender reassignment
Pregnancy & Maternity			**x**	No direct impact is anticipated in terms of pregnancy/maternity due to the age range predominantly affected by dementia
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**			People with dementia and mental health needs will be impacted by the introduction of this service.
Carers	**x**			This business case will positively impact on carer health and will contribute to preventing carer breakdown
Military Veterans			**x**	Dementia can affect everyone so there may be an indirect impact but no direct impact is anticipated in relation to military veterans
Breast Feeding			**X**	Dementia usually directly affects those beyond child bearing age and there is no direct impact is anticipated in terms of this particular characteristic.
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**
None				The anticipated age range for people affected by dementia makes this unlikely.

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 changes proposed are seeking a positive impact and the contractual monitoring within the implementation of the proposal will monitor impacts for the target group.	

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	31 October 2017
Officer of Single Commissioning Board	Gill Gibson, Director of Quality and Safeguarding
Subject:	**PERSONAL HEALTH BUDGETS**

Report Summary:

A Personal Health Budget is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. The vision for personal health budgets is to enable people who are frequent users of healthcare to services to have greater choice, flexibility and control.

The expectation of Clinical Commissioning Groups to expand Personal Health Budgets was outlined in the Forward View into Action: Planning for 2015/16 and the NHS England mandate is that by 2020 0.1-0.2% of our population will hold a Personal Health Budget. In order to deliver the national mandate we have set local trajectories that seek to establish Personal Health Budgets for 99 patients by March 2018 rising to 153 by April 2019.

Greater Manchester is establishing a Personalisation Programme in which we plan to actively engage. It is hoped that this will expand from a health focus to encompass the national drive towards Integrated Personal Commissioning, a nationally led, locally delivered programme that is supporting healthcare empowerment and the better integration of services across health, social care and the voluntary and community sector. The programme aims to ensure that services are tailored to people's individual needs, building on learning from personal budgets in social care and progress with personal health budgets. Through Integrated Personal Commissioning, people, carers and families with a range of long-term conditions and disabilities are supported to take a more active role in their health and wellbeing, with better information and access to support in their local community, and greater choice and control over their care.

Despite having focused approaches to marketing Personal Health Budgets with frontline staff we have had very little update and currently have only 13 Personal Health Budgets awarded, the lowest rate in Greater Manchester. An analysis of our Personal Health Budget approach and process has raised a series of actions that are now being taken forward. It is recognised that if we are to increase numbers towards achieving the national target recurrent investment will be required, as well as the commitment to extract funding from block contracts to provide a viable budget to continue to expand Personal Health Budget numbers in the future. Due to the financial position, it is recommended that we work within existing resources rather than increase investment at this time.

Recommendations:

1. After assessing the risks, it is recommended that it would be better to delay the achievement of our local trajectories and agree a phased implementation plan for Personal Health Budgets. This would align more with the implementation of our transformation plans including the move towards a more

sophisticated contracting model and accountable care system.

2. To note that this will impact on the ability of the Clinical Commissioning Group to meet the Personal Health Budget target in 2017/8 and therefore the Improvement and Assessment Framework Standards, potentially resulting in reputational damage.
3. To escalate the risks associated with delay in achieving the Personal Health Budget target to the Clinical Commissioning Group Governing Body.
4. That the focus in 2017/8 is to expand the offer of Personal Health Budgets to patients who are already receiving individual packages of care, including Continuing Healthcare, Section 117 care and Transforming Care as this will be within existing resources.
5. That the Clinical Commissioning Group lead continues to work with Greater Manchester on the Personalisation agenda including taking developing Greater Manchester wide approaches to Personal Health Budgets (and integrated personal budgets) for other patient groups including, Personal Wheelchair Budgets, End of Life and Long Term Conditions.

Financial Implications:

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

Budget Allocation (if Investment Decision)	The report requested funding of £75k on a recurrent basis to fund administration costs associated with expanding PHB. Cost of the budgets themselves would need to be funded over and above this budget request (and could be significant). CCG currently has £50k committed in reserves on a non-recurrent basis to fund expansion of PHB.
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	Significant portion of historic healthcare costs (e.g. Pennine Care, ICFT) are paid via block contract. If patients with PHB's reduce use of traditional hospital services, we need to determine how costs from

	these traditional services can be reduced and funding transferred to PHB before making a value for money assessment.

Additional Comments Principles of Personal Health Budgets are firmly established at a national level, meaning that as a local economy we need to recognise the requirement to increase spend in this area. The national target is to increase the number of Personal Health Budget patients from 13 today to 153 by April 2019. Tameside and Glossop currently have the worst performance for take up of Personal Health Budgets across Greater Manchester.

Personal Health Budgets are high profile both nationally and in GM. We can assume that we would come under significant pressure and criticism at assurance meetings for not achieving targets or having credible plans in place for doing so. However there is no specific financial penalty or consequence in place should we fail against this target.

The Clinical Commissioning Group has non-recurrently committed £50k within reserves to fund the expansion of PHB in 2017/18. The report requested £75k to fund a band 7 post, a 0.5 X band 3 post and to provide a budget to support the work of this team. The band 7 will cost £46k and the band 3 £11k, leaving a residual £18k to fund the ancillary costs. While the part year effect of this in 2017/18 would be affordable from the £50k reserve, there would be a recurrent increase in administrative costs which will create a pressure for 2018/19 and beyond should this business case be approved.

However, the more significant funding pressure, would be the cost of the Personal Health Budgets themselves, which require funding over and above the administrative costs requested in the paper. Our understanding is that the next tranche of Personal Health Budget patients is focused on Continuing Healthcare, Section 117 patients, Transforming Care patients, people with long term conditions currently accessing acute hospital services and patients with mental illness using services at Pennine Care. The national theory around Personal Health Budgets for these patients is that they should be cost neutral to commissioners and funded from reductions in activity.

But as an economy Tameside and Glossop have moved away from traditional cost a volume PbR contracts. As such the key question for finance Task and Finish is how we maintain affordability as the number of Personal Health Budgets increases. Will the reduction in activity for the 153 patients be of sufficient scale to allow the provider to remove costs (e.g. by closing wards, reduce staffing rotas etc), which would in turn allow for a reduction in contract value to fund Personal Health Budgets. Or will the introduction of Personal Health Budgets result in an inevitable financial pressure for the economy. Which even using the 10% assumption in the paper, could be quite significant when multiplied up for high cost patients with long term conditions. By way of illustration,

	the economy could be facing a pressure of £500k per year if the average value of new Personal Health Budgets was £3k and we were unable to reduce the cost base. Therefore a key discussion point needs to be around the potential financial pressures associated with meeting the target, versus the regulatory and reputational damage that would result from failing to meet the target.
Legal Implications: **(Authorised by the Borough Solicitor)**	Since October 2014 health bodies in England have been under a duty to provide personal budgets and pay direct payments along similar lines to those paid by social care in relation to adults and children eligible for Continuing Health Care (CHC).[1] The NHS mandate 2012 contained a commitment that from 2015 Personal health budgets for healthcare should be an option for people "who could benefit from one" ie including people using NHS services outside of CHC. There are regulations and detailed guidance governing personal health budgets and direct payments.[2] The following are the key legal issues: • There is a presumption in favour of granting a Personal Health Budget and a direct payment and the policy governing this needs to clearly set out when a direct payment will not be given and what criteria will be used to exercise the discretion to grant one. • The regulations provide that decisions must be based on need and that a direct payment must be appropriate for the individual concerned with regard to his/her condition and the impact of that condition on his/her life. The direct payment must represent value for money and, where applicable, any additional cost must be outweighed by the benefit to the individual. • The policy will need to address issues such as the person's capacity to agree to a Personal Health Budget and direct payment and whether it is appropriate to involve a nominee or representative. The decision making process will need to be clear and publicised. The decision when made must be clearly communicated to the person and/or their representative. Provision must be made for the decision to be reviewed if the person and/or their representative is not satisfied with it.
How do proposals align with Health & Wellbeing Strategy?	Personal Health Budgets align with the following Health and Wellbeing Board strategic priorities: • Integration; • Improve the health and wellbeing of local residents throughout life; • support to those with poor health to enable their health to improve faster; • Prevention and early intervention; • Local action and responsibility for everyone;

[1] NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 SI. no 2996

[2] NHS (Direct Payments) Regulations 2013 and NHS (Direct Payments)(Amendment) Regulations 2013

	• Public involvement in improving health and wellbeing.
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Healthy Lives (early intervention and prevention); • Community development; • Enabling self-care;
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Patients and communities being empowered to care for themselves and to work together to support local health and wellbeing; • Identification and support of "at risk" people; • Fewer overnight stays in hospital and more community based care.
Recommendations / views of the Professional Reference Group:	The Professional Reference Group recommends: 1. That due to impact on the financial position associated with investing resources to meet the Personal Health Budget target, an incremental approach is taken to improve our current position, focusing on offering Personal Health Budgets to patients who are already receiving individual packages of care, including Continuing Healthcare, Section 117 care and Transforming Care. This can be done within existing resources. 2. That the Clinical Commissioning Group lead continues to work with Greater Manchester on the Personalisation agenda including taking developing Greater Manchester wide approaches to Personal Health Budgets for other patients groups including, Personal Wheelchair Budgets, End of Life and Long Term Conditions.
Public and Patient Implications:	There are implications for patients of all ages.
Quality Implications:	There is evidence that Personal Health Budgets deliver the following patient outcomes • **Better quality of life** and enhanced health and well-being; • **Fewer crises** that lead to unplanned hospital and institution care; • **Enhanced experience of care** through better coordination and personalisation of health, social care and other services.
How do the proposals help to reduce health inequalities?	By offering patients more choice, control and flexibility in relation to managing their own health.
What are the Equality and Diversity implications?	It is anticipated that the proposal will not have a negative effect on any of the protected characteristic group(s) within the Equality Act. An Equality Impact assessment has been completed and is attached (**Appendix 1**)

What are the safeguarding implications?	Safeguarding assurance is integral within all personal plans.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of the NHS. For reference a privacy impact assessment has been completed and has been signed off by the Clinical Commissioning Group's Governance Committee.
Risk Management:	The risks to not achieving Personal Health Budget numbers and risks of complaints are registered on the Clinical Commissioning Group Risk Matrix.
Access to Information :	The background papers relating to this report can be inspected by contacting Pat McKelvey, Head of Mental Health and Learning Disabilities: Telephone: e-mail: pat.mckelvey@nhs.net

1. BACKGROUND

1.1 The expectation of Clinical Commissioning Groups to expand Personal Health Budgets was outlined in the Forward View into Action: Planning for 2015/16.

1.2 The mandate to Clinical Commissioning Groups from NHS England is that by 2020 0.1- 0.2% of our population will hold a Personal Health Budget, which equates to 250-500 patients. In order to deliver the national mandate we have set local trajectories that seek 99 patients by March 2018. Our achievement of this is monitored through the mandatory personal budget data collection via NHS Digital and our progress features in the Clinical Commissioning Group Assurance process.

1.3 This year's planning guidance included requirements for Clinical Commissioning Groups to provide a challenging Personal Health Budget trajectory for 2017/9 (Table 1) and to outline in more detail the ambition set out in the Clinical Commissioning Group's Sustainability and Transformation Plans.

Table 1: NHSE Tameside and Glossop 2017/18 and 18/19 Planning Submission

PERSONAL HEALTH BUDGETS		Q1	Q2	Q3	Q4
2017/18 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	26	36	52	74
	2) New personal health budgets that began during the quarter (total number per CCG)	10	16	22	25
	3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**36**	**52**	**74**	**99**
	4) GP registered population (total number per CCG)	246,637	246,637	246,637	246,637
		Q1	**Q2**	**Q3**	**Q4**
2018/19 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	99	111	123	138
	2) New personal health budgets that began during the quarter (total number per CCG)	12	12	15	15
	3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**111**	**123**	**138**	**153**
	4) GP registered population (total number per CCG)	248,055	248,055	248,055	248,055

1.4 All requests for Personal Health Budgets are managed by a clinically led multi-agency risk panel, which meets monthly. The process followed can be found in **Appendix 2**.

2. CURRENT POSITION

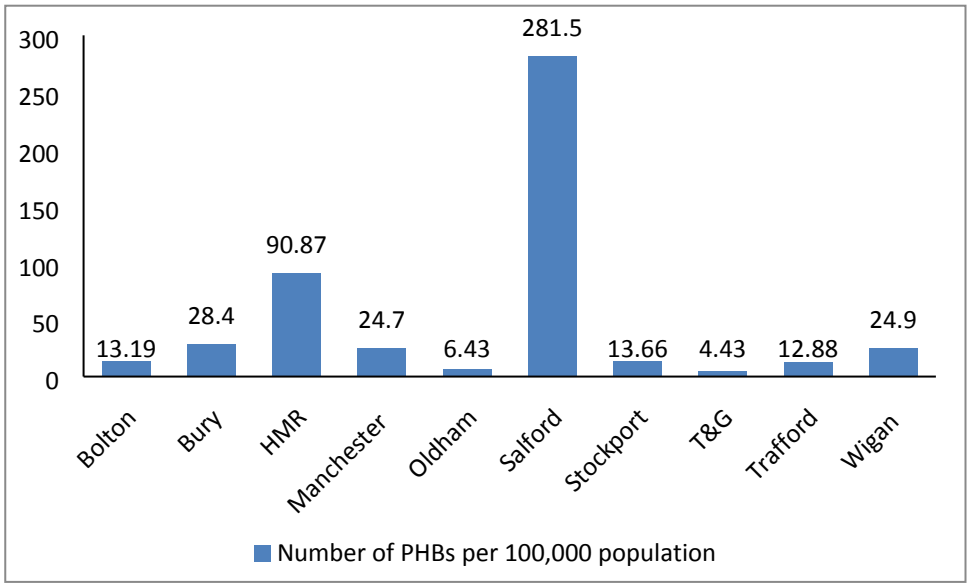
2.1. The Clinical Commissioning Group has been offering People who meet the Continuing Healthcare eligibility criteria the option of having a Personal Health Budget since 2014 and from December 2015 the Local Offer was developed to offer personal health budgets to people who **frequently use health services** such as:

- children with an Education Health and Care Plan;
- people needing long-term rehabilitation;
- people with long-term health conditions that use hospital services a lot;
- people with long term mental health needs;
- people with Learning Disability or Autism and Mental Health needs and/or who are at risk of hospital admission/are in hospital.

2.2. When developing the Local Offer the Clinical Commissioning Group agreed the principle that there would be no new funding for Personal Health Budgets but, in order to give time to move funding around the system based on the learning from Personal Health Budgets, a start-up budget of £150k was agreed for 2016/17 which included funding for a Personal health Budget Coordinator. This was later reduced to £75k and then £0 due to lack of demand.

2.3. The uptake of Personal Health Budgets in Tameside and Glossop for both Continuing Healthcare funded patients and the groups listed in 2.1 has been low despite a rolling staff training and marketing campaign. While there have been a number of people expressing an interest, few have been frequent users of health services and therefore they have not progressed.

2.4. At the present time we only have 13 Personal Health Budgets in place and therefore are not going to achieve the 99 in the trajectory this year. Although many Clinical Commissioning Groups report that they are struggling to increase their numbers, our current rate is the lowest in Greater Manchester:-



2.5. NHS England has established a mentoring programme to support Clinical Commissioning Groups to increase their rate and we are one of many who have signed up. We hope this will offer peer review of our approach and shared learning as we expand our programme.

2.6. An appraisal of this lack of progress has been done and the following issues identified:

(i) The approach to Personal Health Budgets requires reviewing in order to ensure that we are meeting the National Health Service (Direct Payments) Regulations 2013.
Action: - A member of the Legal team has been assigned to support this work.

(ii) Lack of a rigorous process and a protracted application process has meant that it has too long to get budgets in place. This has led to stress and potential complaints from patients.

Action: - A new time-focused process is in place and the Personal Health Budget Policy is currently being updated.

(iii) The Clinical Commissioning Group approach to budget setting has led to indicative budgets that are too small to implement change. The restrictions were agreed due to a request from the Personal Health Budget Panel for guidance on budget setting and the CCG Management Team agreed a paper that proposed that, for an individual who is a frequent user of healthcare services, the indicative budget be set at 10% or 15% of costs of the patients overall activity.
Action:- It is proposed that the Personal Health Budget Panel uses patient activity over the past 12 months to identify proactive positive care versus reactive/crisis care and from this identify with the patient and their healthcare worker which elements could be freed up to use in a Personal Health Budgets.

(iv) Direct Payment processes and support require strengthening – it is proposed to develop an integrated process within Tameside MBC to support Personal Health Budget Direct Payments for Tameside patients (Derbyshire County Council has established a process to support Direct Payments for all the Clinical Commissioning Groups). Additional Direct Payment capacity to ensure Care Act compliance has been agreed within the Adult Social Care Transformation Funding and it is proposed that this is developed further to support Integrated Personalised Budgets. The back office systems can support the development of Personal Health Budgets, joint marketing strategy, joint contract around payroll/pre-paid cards to provide more efficiency across the system.
Action:- A working group has been set up to take forward this work, including Legal support and internal audit as required.

(v) Stronger clinical leadership is required to support health professionals to engage in Personal Health Budgets as a solution rather than a threat and to support staff to undertake person centred personal support planning. As the Personal Health Budget Coordinator has returned to her substantive post it is proposed that the role is re-advertised with reviewed job description in order to cover all the requirements of the role. It is also proposed that leadership for Personal Health Budgets transfers from the Commissioning team to the Nursing and Quality team as in line with other individual commissioning.
Action:- The £75,000 Personal Health Budget is re-established to enable the recruitment of a full time Band 7 clinical Personal Health Budget Coordinator, and 0.5 whole time equivalent Band 3 administrator and to have a small working budget for the local Personal Health Budget Offer.

(vi) Greater emphasis on benefits of Personal Health Budget within Continuing Healthcare and more straightforward process for converting patients packages is required.
Action:- Continuing Healthcare and Personal Health Budgets paperwork is being reviewed so that Personal Health Budgets are offered as default for all community Continuing Healthcare cases and the process for converting is simplified.

(vii) Numbers taking up the offer of Personal Health Budgets is low in Tameside and Glossop so concerted effort is required to increase the numbers. It is proposed to focus on groups of patients who already have funded personalised healthcare packages including Continuing Healthcare, Section 117, and Transforming Care as a priority, including Integrated Personal Budgets for those in joint funded packages.
Action:- Nursing and Quality team are developing an action plan to increase the numbers.

(viii) Expansion of the offer to other areas such as Personal Wheelchair Budgets and End of Life planning can be supported through working with other Clinical Commissioning

Groups in the Greater Manchester Public Health Budget Working Group to develop a common approach across Greater Manchester. See 3.4 below.

(ix) To date there has been a lack of local partners with an interest in supporting Personal Health Budgets either though Support Planning or in provision of services (other localities have benefitted from having a strong voluntary and community sector interest e.g. Disability Derbyshire).
Action:- We are working with Greater Manchester leads to identify support available across Greater Manchester with the aim of having an approved list of providers and develop the support market.

3. GREATER MANCHESTER DEVELOPMENTS

3.1. Greater Manchester Health and Social Care Partnership have established a Personalisation programme which has been merged with a broader person and community centred approaches programme initiated through the population health plan. An Associate Lead for the programme (Giles Wilmore) is in place and a full programme is in development, on track for a September initiation. The scope of the programme includes person centred planning, community and asset based approaches; self-care and personal budgets. As part of the development of priorities Giles and colleagues are offering to visit each locality and meet with local leaders and stakeholder to understand programmes in this area, and discuss how we would work together productively and offer in useful support.

3.2. The programme is under development with both 'programme' and 'campaign' components spanning:

- Influence and Leadership;
- Partnership and co-production;
- Support and Delivery;
- Incentives and Enablers.

3.3. A call for people interested in being part of a core co-production group has been circulated and one of our Personal Health Budget patients is interested in joining. This is for people with lived experience (for themselves or a family member) of person and community centred approaches and/or personal budget approaches who would like to get involved in the programme and help shape and co-deliver it.

3.4. While the programme is still in a design phase, as committed to, certain elements of the programme are being established and set up ahead of initiation. These are summarised below:

- **Local innovation and change support using Rapid Results Methodologies.** We know that for real transform to happen, frontline staff and local communities need to own and drive the change. In partnership with NESTA we are working with Bolton, and Tameside and Glossop to launch 2 '100 Day Challenges' in Autumn. These approaches will focus on the people, relationships and networks that make up health and care systems locally. Teams of front-line staff come together for 100 days to focus on highly ambitious goals, and are given the freedom to test and develop new ideas and approaches (some of which will work, others will not). Leaders shift their focus from "coming up with solutions" to "permissioning" and creating the space and confidence for teams to begin owning and experimenting around tricky issues. Both localities are using the 100 Day Challenge to explore and innovate around the establishment of integrated person and community centred approaches at a neighbourhood team level. It is hoped that similar offers can be made to all Greater Manchester localities following formal agreement of the programme and resourcing.
Action:- We need to include a wide range of partners in the 100 Day Challenge, including Community Mental Health Teams, District Nurses, Long Term Conditions and

REHAB staff. The NESTA projects for Tameside and Glossop have been agreed as Preventing Diabetes in Hyde/Denton and end of life care in Glossop. There is a wider piece of work underway around person centred care and support planning/asset based assessment/asset based approaches. Ashton/Dukinfield, Mossley, Stalybridge will be piloting the roll out of the PAM tool in addition to the NESTA work.

- The **personal health budget and integrated personal budget project.** This will aim to support localities to be in a position to scale Personal Health Budgets in Continuing Healthcare and beyond, and work with local authority colleagues to create integrated personal budget delivery systems. Priority themes from a workshop on 5 June are being woven into the overall programme design and are:
    - Development of support planning and brokerage services – including, potentially, collaboration across GM on specs, a framework approach and market development;
    - Awareness and skills training and coaching for staff on personal health budgets, and on broader person centred approaches and planning;
    - Delegation of clinical tasks to Personal Assistants;
    - Outcomes development and tracking;
    - Co-production and peer support;
    - Provider and market development, particularly around personalised provision such as 3rd party budgets/ISFs;
    - Collaboration on expansion of Personal Health Budgets for Continuing Healthcare and beyond.

  Action:- Personal Health Budget leads to actively support Greater Manchester work to reduce discrepancies in Greater Manchester, promote a more integrated approach and eliminate duplication of effort.

4. RECOMMENDATIONS

4.1 As set out on the front of the report.

APPENDIX 1

Subject / Title	**Tameside and Glossop CCG – Personal Health Budgets**

Team	**Department**	**Directorate**
Personal Health Budgets	MH and LD Commissioning Team	Commissioning

Start Date	**Completion Date**
April 2016	*June 2017*

Project Lead Officer	Pat McKelvey
Contract / Commissioning Manager	Pat McKelvey
Assistant Director/ Director	Clare Watson

EIA Group (lead contact first)	**Job title**	**Service**
Pat McKelvey	Head of MH and LD	Commissioning
Jayne Wilkinson	Individualised Commissioning Team Manager	Nursing and Quality Team
Julie Moore	Integrated Neighbourhood Manager	ICFT

PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	NHS Tameside & Glossop CCG (NHST&GCCG) have been given a mandate from NHS England (NHSE)to develop and expand personal health budgets (PHBs) outside of but not excluding Continuing Healthcare from 2016.
1b.	**What are the main aims of the project, proposal or service / contract change?**	A personal health budget is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. Our vision for personal health budgets is to enable people with long term conditions and disabilities to have greater choice, flexibility and control over their health care and support they receive. From 2014 PHBs have been offered to people who meet the criteria for Continuing Healthcare (CHC). From 2016 the expectation from NHSE is for CCG's to expand the offer of PHBs locally outside of CHC. T&GCCGs local offer is offered to the following cohorts of people who **frequently use health services** such as:

		•Children with an Education Health and Care Plan •People needing long-term rehab •People with long-term health conditions who use hospital services a lot •People with long term mental health needs •People with Learning Disability or Autism and MH needs or at risk of hospital admission/are in hospital The mandate to NHSE is that the CCG will increase their PHBs from 9 to 30 by April 2017. The essential elements of a PHB are that the person with the PHB or their carer/representative will: • Be able to choose the health and wellbeing outcomes they want to achieve, in agreement with a healthcare professional • Know how much money they have for their health care and support • Be enabled to create their own care plan, with support if they want it • Be able to choose how their budget is held and managed, including the right to ask for a direct payment • Be able to spend the money in ways and at times that made sense to them, as agreed in their plan

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**			People of all ages are eligible to have a personal health budget including children. T&GCCG currently have 11 people with a personal health budget. 2 of the 11 are children with the remainder being adults under the age of 65 years. Early evidence suggests that younger patients might be more inclined to tailor make a service around their needs (a PHB) rather than those over the age of 65 who may be more inclined to choose a more traditionally commissioned service.

Disability	**x**			People with long term health conditions, long term rehabilitation needs, learning disabilities and physical disabilities will be impacted by personal health budgets, these are a cohort of patients identified in our local offer. We currently have 11 people with a personal health budget in T&G all of whom have some kind of learning disability and/or physical disability.
Ethnicity		**x**		PHBs are open to people of all ethnicity so there may be an indirect impact but no direct impact is anticipated in terms of ethnicity
Sex / Gender		**x**		PHBs are open to people of all sexes/genders so there may be an indirect impact but no direct impact is anticipated in terms of sex/gender
Religion or Belief			**x**	PHBs are open to people of all religion/beliefs so there may be an indirect impact but no direct impact is anticipated in terms of religion/belief
Sexual Orientation			**x**	PHBs are open to people of all sexual orientations so there may be an indirect impact but no direct impact is anticipated in terms of sexual orientation
Gender Reassignment			**x**	PHBs are open to everyone so there may be an indirect impact but no direct impact is anticipated in terms of gender reassignment
Pregnancy & Maternity			**x**	PHBs are open to everyone so there may be an indirect impact but no direct impact is anticipated in terms of pregnancy/maternity
Marriage & Civil Partnership			**x**	PHBs are open to everyone so there may be an indirect impact but 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**			People with mental health needs will be impacted by personal health budgets a cohort of patients identified in our local offer. From the 11 phbs we currently have in T&G over half have some kind of diagnosed mental health condition.
Carers		**x**		Personal health budgets can support carers. Early evidence suggests that carers benefit if the person being cared for opts for a personal health budget as the individual is choosing

				care tailored to their own needs. This means in some of our current live phb cases the personal health budget care plan has included more support from external agencies to enable more free time for the carer.
Military Veterans			**x**	PHBs are open to everyone so there may be an indirect impact but no direct impact is anticipated in relation to military veterans
Breast Feeding			**X**	PHBs are open to everyone there may be an indirect impact but no direct impact is anticipated in terms of this particular characteristic.

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**
Children with Education Health & Care Plans People with long-term rehab needs People with a long term condition People with long term mental health needs People who are at risk of hospital admissions	**x**			All of the groups stated are part of the CCGs local offer to expand personal health budgets so therefore all of these people will be directly affected. Personal Health Budgets does not exclude anyone who is vulnerable, isolated or from a low income household. Any of these people can apply and be deemed eligible to have a phb.

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 introduction of PHBs to a wider cohort of patients than those in receipt of Continuing Healthcare will potentially impact a number of protected characteristic groups either directly or indirectly (as outlined in table 1c). It is therefore necessary to undertake a full EIA to investigate these impacts further.	

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. However, although some groups will be affected it is deemed that the affect will be mainly of a positive nature and will not negatively or adversely affect any of the above protected characteristic groups due to the nature of the project PHBs will be an enabler for local people to have more choice, control and flexibility over their own healthcare.

For information the 5 key essential parts of a personal health budget to determine if a person is eligible are:

- The person knows up front how much money they have to spend, so they can use that information to plan and budget in an ongoing way
- The person chooses the personal health outcomes to be achieved, in agreement with their health professional
- The person is enabled to create their own care plan, with whatever support they may want, to meet care planning process criteria
- The person freely chooses the way in which their budget is held and managed (direct payment, notional budget or third party – or a combination of all three).
- Whichever option is chosen by the person, the person must be able to spend it at times and in ways that is agreed in their care plan

Nationally NHE's ambition for personal health budgets is that by March 2021, 1-2:1000 of the population will have a personal health budget in line with the national Mandate. Locally for Tameside and Glossop this equates to 250-500 people. The CCGs mandate to NHSE is by the end of April 2017 the CCG will have increased the number of Personal Health Budgets from 9 to 30.

Personal Health Budgets (PHB) will allow people to move from a world where others know best to one where their input is valued above all others, but not in isolation from others. It is a way people can be at the heart of the planning process, identifying with key health professionals the things that really matter to them, and which allow them to lead a safe and fulfilling life. This will lead to available budgets being used in a more innovative and creative way, rather than reliance on traditional NHS services.

2b. Issues to Consider

- Raising expectations with potential reputational risk to the CCG/negative media coverage/complaints
- Individuals consent to an element of risk in their personalised care plan
- Governance of individuals personal information

By offering a PHB outside of continuing healthcare the CCG must have clear and transparent PHB processes in place which all healthcare professionals can freely access.

Healthcare professionals communicating the potential of having a PHB to an individual must first fully understand the concept of having a PHB. Without this initial understanding and an awareness of the process expectations could be raised inadvertently to individuals, which could lead to a complaint, legal implication and/or negative media coverage should the PHB not be agreed to.

Empowering individuals to take control of their own health can generate a perception of increased risk and adverse consequences. However, in reality there is likely to be a reduced risk because individuals have been consulted on their choices, are actively involved in the decision making process and take ownership of, and some pride in, the responsibility for achieving their own health outcomes. Again the CCG must clearly identify and be transparent in their systems and processes in terms of how they will manage risk and how they will monitor risk.

2c. Impact
The wider introduction of PHBs will ensure people will have more choice, control and flexibility over their own healthcare. Rather than traditionally commissioned services which in some cases may not be working for individuals, the option of having a PHB would act as an enabler to tailor make a care plan that could potentially meet a desired health need and meet an agreed health outcome.

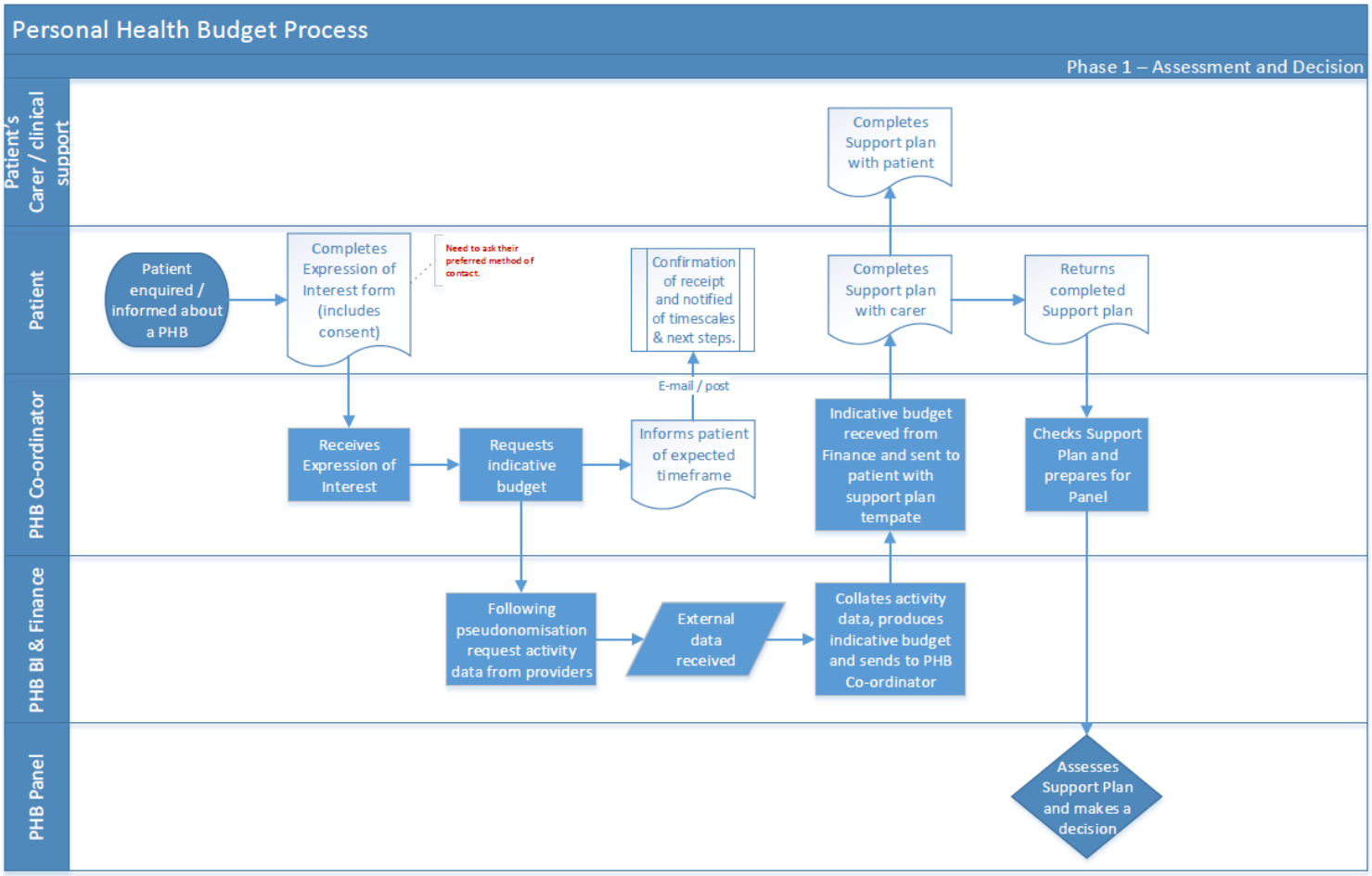
2d. Mitigations *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
Raising expectations, negative media coverage/complaints	Clear communication to staff re the concept of PHBs along with current systems and processes via awareness raising to all staff A page dedicated to personal health budgets on the CCGs internet site. This includes a leaflet explaining the concept of a PHB, who can have one and who can apply for one
Regular Management and Monitoring of Risks	Personal Health Budget Panel meets monthly. This will ensure regular monitoring and monitoring of risks relating to PHBs. This will also help identify whether any protected characteristic groups in particular are accessing PHBs and help monitor support around these accordingly.
Ensure robust Information Governance arrangements are in place	Information governance is a core element of the NHS. For reference a data processing agreement is in place, signed off by the CCGs Governance Committee

2e. Evidence Sources – included in the box below are documents that are available to mitigate risks as explained in 2d
Existing documents – NB These will be reviewed in line with the actions outlined in this paper  Tameside and Glossop personal hea    leaflet--tameside-per sonal-health-budget-    TOR_PHBpanel_Aug ust16_(ver3).doc    data_processing_agr eement_for_phb_bet

2f. Monitoring progress		
Issue / Action	**Lead officer**	**Timescale**
EIA will be refreshed after the actions identified in the report have been completed.	Pat McKelvey	December 2017

Signature of Contract / Commissioning Manager	Date
Signature of Assistant Director / Director	**Date**

APPENDIX 2


Personal Health Budget Process
Phase 1 – Assessment and Decision
Patient's Carer / clinical support
Patient
PHB Co-ordinator
PHB BI & Finance
PHB Panel
Patient enquired / informed about a PHB
Completes Expression of Interest form (includes consent)
Need to ask their preferred method of contact.
Receives Expression of Interest
Requests indicative budget
Following pseudonomisation request activity data from providers
External data received
Collates activity data, produces indicative budget and sends to PHB Co-ordinator
Indicative budget receved from Finance and sent to patient with support plan tempate
Informs patient of expected timeframe
E-mail / post
Confirmation of receipt and notified of timescales & next steps.
Completes Support plan with carer
Completes Support plan with patient
Returns completed Support plan
Checks Support Plan and prepares for Panel
Assesses Support Plan and makes a decision

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