

**STRATEGIC COMMISSIONING BOARD**

**Day:** Wednesday  
**Date:** 24 October 2018  
**Time:** 1.00 pm  
**Place:** Lesser Hall 2 - Dukinfield Town Hall

<b>Item No.</b>	<b>AGENDA</b>	<b>Page No</b>
1.	<b>WELCOME AND APOLOGIES FOR ABSENCE</b> To receive any apologies for the meeting from Members of the Board.	
2.	<b>DECLARATIONS OF INTEREST</b> To receive any declarations of interest from Members of the Board.	
3.	<b>MINUTES OF THE PREVIOUS MEETING</b> To receive the Minutes of the previous meeting held on 19 September 2018.	1 - 6
4.	<b>FINANCIAL CONTEXT</b>	
a)	<b>FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND</b> To consider the attached report of the Director of Finance.	7 - 18
5.	<b>QUALITY AND PERFORMANCE CONTEXT</b>	
a)	<b>QUALITY ASSURANCE</b> To consider the attached report of the Director of Quality and Safeguarding.	19 - 36
b)	<b>PERFORMANCE UPDATE</b> To consider the attached report of the Assistant Director (Policy, Performance and Communications).	37 - 52
6.	<b>COMMISSIONING FOR REFORM</b>	
a)	<b>TENDER FOR CONTRACT TO EVALUATE TAMESIDE AND GLOSSOP GREATER MANCHESTER FUNDED TRANSFORMATION SCHEMES</b> To consider the attached report of the Interim Director of Commissioning.	53 - 122
b)	<b>PRIMARY CARE ACCESS SERVICE PROCUREMENT: EVALUATION OUTCOME</b> To consider the attached report of the Interim Director of Commissioning.	123 - 140
7.	<b>URGENT ITEMS</b> To consider any additional items the Chair is of the opinion shall be dealt with as a matter of urgency.	
8.	<b>DATE OF NEXT MEETING</b>	

To note that the next meeting of the Strategic Commissioning Board will take place on Wednesday 28 November 2018.

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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 STRATEGIC COMMISSIONING BOARD

19 September 2018

Commenced: 1.00 pm

Terminated: 2.05 pm

**Present:** Dr Alan Dow (Chair) - NHS Tameside and Glossop CCG  
Steven Pleasant - Tameside MBC Chief Executive and Accountable  
Officer for NHS Tameside and Glossop CCG  
Councillor Warrington - Tameside MBC  
Councillor Fairfoull - Tameside MBC  
Councillor Bray - Tameside MBC  
Councillor Feeley - Tameside MBC  
Councillor Gwynne - Tameside MBC  
Councillor Ryan - Tameside MBC  
Dr Vinny Khunger - NHS Tameside and Glossop CCG  
Dr Alison Lea - NHS Tameside and Glossop CCG  
Dr Ashwin Ramachandra - NHS Tameside and Glossop CCG  
Carol Prowse - NHS Tameside and Glossop CCG

**In Attendance:**

Jeanelle De Gruchy	Director of Population Health
Kathy Roe	Director of Finance
Sandra Stewart	Director of Governance and Pensions
Sandra Whitehead	Assistant Director (Adults)
Elaine Richardson	Head of Assurance and Delivery
Simon Brunet	Policy Manager

**Apologies for Absence:** Councillor Cooney - Tameside MBC  
Councillor Wharmby - Derbyshire CC  
Dr Jamie Douglas - NHS Tameside and Glossop CCG

### 48. DECLARATIONS OF INTEREST

There were no declarations of interest.

### 49. MINUTES OF THE PREVIOUS MEETING

That the Minutes of the previous meeting held on 29 August 2018 were approved as a correct record.

### 50. FINANCIAL CONTEXT

#### a) Financial Position of the Integrated Commissioning Fund

Consideration was given to a report of the Director of Finance providing an overview on the financial position of the Tameside and Glossop economy in 2018/19 at 31 July 2018 with a forecast projection to 31 March 2019 including the details of the Integrated Commissioning Fund for all Council services and the Clinical Commissioning Group with a total net revenue budget value for 2018/19 of £581 million.

The Commission was currently forecasting that expenditure for the Integrated Commissioning Fund would exceed budget by £5.84 million by the end of 2018/19 due to a combination of non-delivery

savings and cost pressures in some areas, particularly in respect of Continuing Healthcare, Children's Social Care and the Growth directorate. Supporting details of the projected variances were explained, as outlined in Appendix 1 to the report. The excess was offset slightly by savings in other areas, such as the success of the GP Prescribing Costs scheme, a dividend from investment in Manchester Airport and lower than expected borrowing.

In particular the Director of Finance explained that the Clinical Commissioning Group was planning to deliver a surplus of £9.347 million broken down into two parts:-

- £3.668 million mandated 1% surplus; and
- £5.679 million cumulative surplus brought forward from previous years.

The 1% in year surplus was a requirement of business rules and the cumulative surplus brought forward was built up in 2016/17 and 2017/18 when Clinical Commissioning Groups had to contribute to national risk reserves offsetting overspend in the provider sector. There was no national risk reserve in 2018/19 but there was still a significant financial gap nationally, which needed to be addressed. Whilst the cumulative surplus brought forward remained on the Clinical Commissioning Group's balance sheet, there was currently no mechanism through which Tameside and Glossop were able to drawdown or use any of this resource.

However, there were emerging proposals that could potentially allow Clinical Commissioning Groups who were able to increase their 2018/19 surplus to drawdown some of their cumulative surplus in 2019/20. Where a Clinical Commissioning Group agreed to underspend its allocation in a year they would receive a guaranteed surplus drawdown the following year on a two for one basis, subject to the cumulative surplus being available. A draft proposal detailed in the report had been circulated to Clinical Commissioning Groups across Greater Manchester and discussed at the Finance and QIPP Assurance Group in August, where it was suggested to use headroom in the Integrated Care Fund risk share to increase the 2018/19 Clinical Commissioning Group surplus up to £3 million. This would enable a potential drawdown of £6 million in 2019/20, reducing the cumulative surplus and improving the financial position of the integrated commissioner on a recurrent basis. The Director of Finance agreed to keep the Board advised of developments.

## **RESOLVED**

- (i) That the significant level of savings required during 2018/19 to deliver a balanced recurrent economy budget together with the related risks, which were contributing to the overall adverse forecast, be acknowledged.**
- (ii) That the significant cost pressures facing the Strategic Commission, particularly in respect of Continuing Healthcare, Children's Social Care and Growth, be acknowledged.**
- (iii) That the use of headroom in the Integrated Care Fund risk share to increase the Clinical Commissioning Group surplus in 2018/19 to enable drawdown of cumulative surplus in 2019/20 be authorised.**

## **51. COMMISSIONING FOR REFORM**

### **a) Banding Payment System and Age Policy Change for Shared Lives Placements**

Consideration was given to a report of the Executive Leader and Assistant Director (Adult Services). The report was seeking permission to introduce a banding payment system for Shared Lives carers to reflect the complexity of need of those cared for, and also change the age of entry into Shared Lives from 18 years of age to 16 years of age to improve transition and continuity of care for young people. This was part of a wider transformation plan focused on improving access to Shared Lives for people with more complex needs and young people coming through transition.

The Council faced significant budgetary challenges over the foreseeable future, which meant it must diversify service delivery by looking at new and innovative approaches to deliver better outcomes

whilst also reducing the cost of provision. This could also include a cost benefit analysis across the health and social care system identifying where efficiencies can be made.

Shared Lives supported some of the most vulnerable individuals across the borough to maximise their independence through a family based community support network. Throughout the service offer Shared Lives carers could support service users to maintain independence in the community and as a support to family carers to maintain their roles. As people progressed into long term placements Shared Lives carers offered an asset based approach as a less costly alternative to traditional services. The Shared Lives Scheme was currently in a period of transformation to expand the provision to a more diverse range of Service Users and relieve pressure on other provisions. Recruitment of skilled carers was pivotal to these aims.

The proposed banding payment system for Shared Lives carers ensured the payment made to carers was reflective of the levels of need of the service users in their care, and providing a choice to carers of the amount of assistance they wanted to, or could, provide at a certain cost.

A banding payment system would also support the attraction of a larger number of prospective carers to meet the varying degrees of need. There was a need to review the fixed payments that were currently offered to carers and consider a payment mechanism that was more reflective of the complexity of service users that carers currently supported, and could support in the future as services were expanded. It would also support recruiting more carers to the service. Some individuals might be willing to provide accommodation but not much support while others might be willing and want to provide a substantial amount of support on the basis that the level of support and commitment was financially recognised. Some kind of differential pay system segments the market and should have the effect of attracting a larger number of carers to the role.

By changing the age of access to 16 years this allowed a wider range of young people to consider Shared Lives as a viable alternative to other support approaches. This would include Looked After Children and also young people with complex needs who were currently in placements or with Foster carers. Foster carers who cared for young people with complex needs would, in the interests of continuity, be encouraged to become Shared Lives carers. As the young person became an adult the banding system would offer a more comparable payment system reflecting the complexity of need that a fixed rate system did not recognise.

The aim was to expand the Shared Lives offer to provide more person centred care as an alternative to other high cost alternatives such as placements in supported housing or out of area placements.

All service users would be reviewed against the proposed banding scheme that would be implemented by 1 April 2019 and existing Shared Lives carers payments would be protected if the banding for an existing service user was assessed at a lower rate than their existing payment for the duration that they were caring for that individual.

It was proposed that in an emergency carers would receive the higher banding rate until the banding assessment had been completed. If the person's banding was lowered carers would not be expected to refund the difference. The decision of which band would be applicable to the service user would be agreed between the Shared Lives Social Worker and the Care Coordinator who had assessed the needs of the individual.

#### **RESOLVED**

- (i) That a new banding payment system for Shared Lives carers be introduced.**
- (ii) That the age of entry to Shared Lives be changed from 18 to 16 years in the Shared Lives Policy.**
- (iii) That existing Shared Lives arrangements be protected if the banding for an existing service user was assessed as being Band 1.**
- (iv) That the banding system be implemented by 1 April 2019.**
- (v) That where an emergency place was made this would initially be paid at the higher rate until an assessment was completed.**

## **b) NHS England Consultation on Evidence Based Interventions: GM Response**

The Interim Director of Commissioning presented a report summarising the NHS England consultation on evidence based interventions and proposed a Greater Manchester response that would be submitted on behalf of Tameside and Glossop and other Greater Manchester Clinical Commissioning Groups.

It was stated that the NHS England proposal was to stop routinely funding four category one interventions and set qualifying criteria for a further thirteen category two interventions, which were detailed in the report. Greater Manchester had policies for three of the four category one interventions with a local policy for the fourth and policies for 12 of the 13 category two interventions with stricter criteria than what was being proposed by NHS England. It was confirmed that Tameside and Glossop was not in the top 50 Clinical Commissioning Groups for spend in this area and Tameside and Glossop Integrated Care Foundation Trust was not one of the top 50 providers for activity in this area.

The interventions would not be routinely offered to NHS funded patients or offered only if specific criteria applied. However, clinicians would be able to apply for funding for category one interventions if they could demonstrate exceptionality and for prior approval for all category two interventions. The expectation was that the GP would apply for funding rather than the provider clinician.

Category one interventions would be removed from the scope of National Tariff price or a national variation would be used so that providers were not paid for activity unless they had an individual funding request number. The proposal was that this would apply from April 2019.

With effect from 1 April 2019 the NHS Standard Contract would be amended to mandate compliance with the Evidence-Based Interventions policy. The proposed additions to the Contract would require both commissioners and providers to comply with the Evidence-Based Interventions policy and enable the commissioner to withhold payment for the relevant procedure where the provider treats a patient without evidence of individual funding request approval (category one) or other prior approval (category two).

NHS England proposed aligning the e-referral system with the new programme by excluding category one interventions from the e-referral system except where an individual funding request has been agreed. They intended to work with Clinical Commissioning Groups and GPs on how best to implement this.

The proposed Greater Manchester response to the NHS England consultation on Evidence Based Interventions, as outlined in section 6 of the report, was discussed with the Board.

### **RESOLVED**

- (i) That the report and implications be noted.**
- (ii) That the response to NHS England as set out in section 6 of the report be agreed.**

## **52. CLOSING REMARKS**

Dr Alison Lea advised that as she would be stepping down from the Governing Body of the Clinical Commissioning Group, this was her last Strategic Commissioning Board meeting. Members of the Board joined the Chair in thanking Dr Lea for her contribution to the work of Strategic Commissioning Board.

## **53. URGENT ITEMS**

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

**54. DATE OF NEXT MEETING**

It was noted that the next meeting of the Strategic Commissioning Board would take place on Wednesday 24 October 2018.

**CHAIR**

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**Report to:** STRATEGIC COMMISSIONING BOARD

**Date:** 24 October 2018

**Officer of Strategic Commissioning Board:** Kathy Roe – Director of Finance – Tameside & Glossop CCG and Tameside MBC

**Subject:** STRATEGIC COMMISSION AND NHS TAMESIDE AND GLOSSOP INTEGRATED CARE FOUNDATION TRUST – CONSOLIDATED 2018/19 REVENUE MONITORING STATEMENT AT 31 AUGUST 2018 AND FORECAST TO 31 MARCH 2019

**Report Summary:** This report has been prepared jointly by officers of Tameside Council, NHS Tameside and Glossop Clinical Commissioning Group and NHS Tameside and Glossop Integrated Care Foundation Trust (ICFT).

The report provides a consolidated forecast for the Strategic Commission and ICFT for the current financial year. Supporting details for the whole economy are provided in **Appendix 1**.

The Strategic Commission is currently forecasting that expenditure for the Integrated Commissioning Fund will exceed budget by £3.916 million by the end of 2018/19 due to a combination of non-delivery savings and cost pressures in some areas.

**Recommendations:** Strategic Commissioning Board Members are recommended to:

1. Acknowledge the significant level of savings required during 2018/19 to deliver a balanced recurrent economy budget together with the related risks which are contributing to the overall adverse forecast.
2. Acknowledge the significant cost pressures facing the Strategic Commission, particularly in respect of Continuing Healthcare, Children's Social Care and Growth.

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

This report provides the 2018/19 consolidated financial position statement at 31 August 2018 for the Strategic Commission and ICFT partner organisations. For the year to 31 March 2019 the report forecasts that service expenditure will exceed the approved budget in a number of areas, due to a combination of cost pressures and non-delivery of savings. These pressures are being partially offset by additional income in corporate and contingency which may not be available in future years.

The report emphasises that there is a clear urgency to implement associated strategies to ensure the projected funding gap in the current financial year is addressed and closed on a recurrent basis across the whole economy. The Medium Term Financial Plan for the period 2019/20 to 2023/24 identifies significant savings requirements for future years. If budget pressures in service areas in 2018/19 are sustained, this will inevitably lead to an increase in the level of savings required in future years to balance the budget.

It should be noted that the Integrated Commissioning Fund (ICF) for the Strategic Commission is bound by the terms within the Section 75 and associated Financial Framework agreements.

**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 Strategic Commissioning Strategy

**Recommendations / views of  
the Health and Care Advisory  
Group:**

A summary of this report is presented to the Health and Care Advisory 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:**

Failure to properly manage and monitor the Strategic Commission's budgets will lead to service failure and a loss of public confidence. Expenditure in excess of budgeted resources is likely to result in a call on Council reserves, which will reduce the resources available for future investment. The use and reliance on one off measures to balance the budget is not sustainable and makes it more difficult in future years to recover the budget position.

**Access to Information:**

Background papers relating to this report can be inspected by contacting:

Tom Wilkinson, Assistant Director of Finance, Tameside Metropolitan Borough Council



Telephone:0161 342 5609



e-mail: [tom.wilkinson@tameside.gov.uk](mailto:tom.wilkinson@tameside.gov.uk)

Tracey Simpson, Deputy Chief Finance Officer, Tameside and Glossop Clinical Commissioning Group



Telephone:0161 342 5626



e-mail: [tracey.simpson@nhs.net](mailto:tracey.simpson@nhs.net)

David Warhurst, Associate Director Of Finance, Tameside and Glossop Integrated Care NHS Foundation Trust



Telephone:0161 922 4624



e-mail: [David.Warhurst@tgh.nhs.uk](mailto:David.Warhurst@tgh.nhs.uk)

## 1. INTRODUCTION

- 1.1 This report aims to provide an overview on the financial position of the Tameside and Glossop economy in 2018/19 at 31 August 2018 with a forecast projection to 31 March 2019. Supporting details for the whole economy are provided in **Appendix 1**.
- 1.2 The report includes the details of the Integrated Commissioning Fund (ICF) for all Council services and the Clinical Commissioning Group. The total net revenue budget value of the ICF for 2018/19 is currently £582.2 million.
- 1.3 It should be noted that the report also includes details of the financial position of the Tameside and Glossop Integrated Care NHS Foundation Trust. This is to ensure members have an awareness of the overall Tameside and Glossop economy position. Reference to Glossop solely relates to health service expenditure as Council services for Glossop are the responsibility of Derbyshire County Council.
- 1.4 Please note that any reference throughout this report to the Tameside and Glossop economy refers to the three partner organisations namely:
- Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT)
  - NHS Tameside and Glossop CCG (CCG)
  - Tameside Metropolitan Borough Council (TMBC)
- 1.5 This period there continues to be a focus on delivery of current Targeted Efficiency Programme (TEP) programmes as well as the challenge of delivering future TEP plans enabling the economy to close the financial gap. These challenges were presented to the Board to Board to Board meeting on 11 September 2018 comprised of the Integrated Care Foundation Trust (ICFT) and the Strategic Commission members.
- 1.6 Across the economy there is a “Do Nothing” financial gap of £124 million by 2022/23. Plans are in place which will deliver expected savings of £57 million, but even in this ‘do something’ scenario there is still a financial gap of £67 million to close.
- 1.7 To start to address this gap the Strategic Commission has generated 114 savings proposals. Of these ideas 56 have a value totalling £8.42 million that are expected to go towards closing the gap.
- 1.8 The remainder of the schemes need to be developed further including some larger schemes focusing on End of Life / Palliative Care and Frailty to understand the potential savings behind these. The economy has access to 20 days consultancy from NHS England’s Quality, Innovation, Productivity and Prevention (QIPP) programme and it is important we direct this resource optimally.
- 1.9 All the savings ideas will be presented at the Star Chambers taking place in October 2018 where the detail of the schemes will be reviewed and viable schemes will be taken forward to help deliver the savings required.
- 1.10 In addition to the future saving plans, there continues to be challenges in the economy that require attention to achieve the financial position in 2018/19. On-going work is taking place to address these areas as part of the in-year TEP efforts.

## 2. FINANCIAL SUMMARY

- 2.1 Table 1 provides details of the summary 2018/19 budgets and net expenditure for the ICF and Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT) projected to 31 March 2019. The Strategic Commission is currently forecasting that expenditure for the

Integrated Commissioning Fund will exceed budget by £3.916 million by the end of 2018/19 due to a combination of non-delivery savings and cost pressures in some areas.

**Table 1: Summary of the ICF and ICFT – 2018/19**

Organisation	Net Budget £'000	Forecast £'000	Variance £'000	Previous Month Variance £'000	Movement in Month £'000
Strategic Commission (ICF)	582,220	586,136	(3,916)	(4,061)	145
ICFT	(19,149)	(19,149)	0	0	0
<b>Total</b>	<b>563,071</b>	<b>566,987</b>	<b>(3,916)</b>	<b>(4,061)</b>	<b>145</b>

- 2.2 The Strategic Commission risk share arrangements remain in place for 2018/19. Under this arrangement the Council has agreed to increase its contribution to the ICF by up to £5.0 million in 2018/19 in support of the CCG's Quality, Innovation, Productivity and Prevention (QIPP) savings target. There is a reciprocal arrangement where the CCG will increase its contribution to the ICF in 2020/21.
- 2.3 Any variation beyond is shared in the ratio 68 : 32 for CCG : Council. A cap is placed on the shared financial exposure for each organisation (after the use of £5.0 million) in 2018/19, which is a maximum £0.5 million contribution from the CCG towards the Council year end position and a maximum of £2.0 million contribution from the Council towards the CCG year end position. The CCG year end position is adjusted prior to this contribution for costs relating to the residents of Glossop (13% of the total CCG variance) as the Council has no legal powers to contribute to such expenditure.
- 2.4 A summary of the financial position of the ICF analysed by service is provided in **Appendix 1**. The projected variances arise due to both savings that are projected not to be realised and emerging cost pressures in 2018/19. Further narrative on key variances is summarised in sections 3 and 4.

### **3. STRATEGIC COMMISSIONER FINANCIAL POSITION**

#### **Acute Services**

- 3.1 The overall forecast position for acute services is £0.6 million. This is an increase of £0.4 million from last month. The key driver in contract performance remains with Manchester FT (MFT). The forecast for MFT is now £1.4 million over plan and is a continuation in demand within the urgent care pathway and the increasing risk associated with Referral to Treatment (RTT) trajectories.
- 3.2 Underspends continue at Stockport Foundation Trust (FT), which is largely due to maternity and the number of strokes. The other area is within planned care for cardiology, which is due to the decommissioning of this service in April 2018 which transferred to Wythenshawe hospital and is referenced within the MFT deep dive. The number of births in the first 4 months of 2018/19 is lower when compared against last year.
- 3.3 Pennine Acute and Salford FT contract performance continues to come down and in particular Pain Management at Salford as patients are put on either a 16 or 30 consecutive session programme. Salford FT have confirmed that there is unlikely to be any further Tameside and Glossop patients on the programme until the end of the financial year, which has reduced our forecast.

- 3.4 Independent sector forecast has increased by £0.1 million this month as we start to see an increase in nerve conduction studies, MRI scans and termination of pregnancy. Other changes include the shift in activity away from SpaMedica and into GM Primary Eye Care, and the decrease in activity at Care UK / InHealth for Dexa scans, which is transferred to NHS providers as part of the CCG's commissioning intention.

#### **Mental Health**

- 3.5 An additional £2.5 million of recurrent investment was agreed in 2018/19 in order to meet requirements of the Five Year Forward View. While this recurrent commitment remains in place, there is likely to be some non-recurrent slippage against this, which can count towards TEP this year.
- 3.6 Budgets included an expectation that 5 specialist mental health placements would be required. There have been 2 new admissions this month which, based on average lengths of stay, has created a £0.1 million pressure.
- 3.7 The position this month also includes £0.2 million for Mental Health beds at Pennine Care. This creates additional capacity and has been agreed across all Pennine commissioners. Both the specialist placements and MH beds are contained within the additional £2.5 million investment and do not impact upon expected slippage forecast within TEP.

#### **Primary Care**

- 3.8 Category M Drugs (Cat M) price increases of £15 million per month have been agreed at a national level from August. Prices expected to change again from October, but unclear what the impact of this will be. Estimated price increase will cost the CCG around £0.1 million per month for as long as the prices remain at new rates. Current position assumes pressure will persist until March.
- 3.9 Significant progress against the Targeted Efficiency Plan, particularly for repeat ordering protocols means the Cat M pressure has been contained and we have actually increased expected achievement at Month 5.

#### **Continuing Care**

- 3.10 Growth in the cost and volume of individualised packages of care is amongst the biggest financial risks facing the Strategic Commission. Expenditure growth in this area was 14% in 2017/18, with similar double digit growth rates seen over the previous two years. When benchmarked against other CCGs in GM on a per capita basis spend in Tameside & Glossop spends significantly more than average in this area. A continuation of historic growth rates is not financially sustainable and should not be inevitable that the CCG is an outlier against our peers across GM in the cost of individualised commissioning. Therefore budgets, which are reflective of this and assume efficiency savings, have been set for 2018/19.
- 3.11 A financial recovery plan is now in place and progress against this is reported to the Finance and QIPP Assurance Group on a regular basis.
- 3.12 Further work is required to develop and realise the savings associated with these schemes. However there is clear evidence that progress is being made on fast track placements where marked reductions in both the number of active packages and the duration of each package can be seen.

#### **CCG Other**

- 3.13 Services within this directorate such as BCF, estates, safeguarding and patient transport are spending broadly in line with budget and do not present a risk to the CCG position. We have received £1.6 million of the approved £6.3 million transformation funding so far this year. Allocations for the remainder will be transacted later in the year and we have plans in

place to spend. The significant favourable variance has been calculated in order to balance the CCG position and can only be delivered if the CCG is able to fully achieve the £19.8 million Targeted Efficiency Plan (TEP) target.

#### **CCG Targeted Efficiency Plan Shortfall**

- 3.14 The CCG has a TEP target (also known as the QIPP), of £19.8 million for 2018/19. Against this target, £9.626 million (49%) of the required savings have been achieved in the first four months of the year. A further £6.592 million is rated green and will be realised in future months. After the application of optimism bias, anticipated further savings of £2.014 million from schemes currently rated as amber or red, reducing the net gap to £1.568 million.

#### **Children's Services**

- 3.15 As reported in previous months, Children's Social Care continues to face significant financial pressure due to unprecedented levels of service demand. Despite significant financial investment, the forecast outturn remains at almost £3.1 million in excess of the approved budget. A detailed review is to take place in month 6.

#### **Growth Directorate**

- 3.16 The service continues to face pressures due to non-delivery of savings and additional cost pressures.
- 3.17 Following the liquidation of Carillion the appointed liquidator PwC has been managing the contracts to enable the smooth transfer to other providers. This transfer took place on 31 July 2017 but significant costs were incurred up to this date, which were not included in the budget.
- 3.18 Significant pressures are also being experienced in relation to loss of income due to the sale of assets and utilisation of assets for Council purposes, income from advertising and income from Building Control and Development Control is currently forecast to be less than budget.
- 3.19 Non delivery of savings is also creating further pressures. The additional Services contract with the Local Education Partnership (LEP) was due to end at the end of October 2018, it was anticipated that savings as a result of a new provision would be achievable. As a result of the collapse of Carillion the existing contract with the LEP has been extended until July 2019 to enable a full review of the Service. Savings anticipated will therefore not materialise in 2018/19. In addition, the purchase of the Plantation Industrial Estate is no longer proceeding and the anticipated additional income will not be realised.

#### **Operations and Neighbourhoods**

- 3.20 The forecast outturn position has improved slightly due to staffing posts remaining vacant, however the service continues to forecast an overspend of £0.4 million due to non-delivery of savings (relating to additional car parking income) and cost pressures.

#### **Capital Financing, Contingency and Corporate Costs**

- 3.21 The 2018/19 budget assumed some of the prior year capital expenditure would be financed from borrowing and that additional borrowing would be required. Continued use of reserves and capital receipts to finance capital expenditure has meant that this borrowing is not yet required and interest charges in 2018/19 will be lower than budget.
- 3.22 Interest earned to date on cash investments is higher than budget due to an increase in the average rate of interest being achieved. This is due to a combination of increase rates overall and a more proactive investment strategy, together with the new investment in Manchester Airport.

#### **4. INTEGRATED CARE FOUNDATION TRUST FINANCIAL POSITION**

##### **Control Total**

- 4.1 The Trust now has an agreed control for 2018/19 of £19.149 million, this assumes the Trust will be in receipt of the full Provider Sustainability Fund (PSF) and deliver the performance and financial requirements set by NHS Improvement (NHSI). Please refer to **Appendix 3**.

##### **Provider Sustainability Fund**

- 4.2 The Trust must achieve its financial plan at the end of each quarter to achieve 70% of the PSF, the remainder is predicated on achievement of the A&E target for each quarter based on the improvement trajectories stated by NHS Improvement.

##### **Targeted Efficiency Plan (TEP)**

- 4.3 The Trust is currently forecasting an underachievement against its in year TEP delivery of c£1.5 million and recurrently of c£1.8 million. Failure to achieve TEP will result in the Trust not achieving its plan. Work is on-going with Theme groups to develop high risk schemes and generate hopper ideas to improve this forecast position.

##### **Loan Liability**

- 4.4 The Trust had a loan of £75.4 million at the end of 2017/18. The Trust may be required to repay part of this liability in 2018. To do this the Trust would require a new loan, now the Trust has agreed a control total this now would be at the standard borrowing rate of 1.5%.

#### **5. RECOMMENDATIONS**

- 5.1 As stated on the report cover.





# APPENDIX 2

<b>Strategic Commission</b>	<b>Forecast Position</b>					<b>Net Variance</b>	
<b>Forecast Position £000's</b>	<b>Expenditure Budget</b>	<b>Income Budget</b>	<b>Net Budget</b>	<b>Net Forecast</b>	<b>Net Variance</b>	<b>Previous Month</b>	<b>Movement in Month</b>
Acute	204,827	0	204,827	205,441	-613	-238	-376
Mental Health	32,371	0	32,371	32,477	-107	-103	-3
Primary Care	84,604	0	84,604	84,575	29	75	-46
Continuing Care	14,474	0	14,474	17,390	-2,915	-2,937	22
Community	29,977	0	29,977	30,282	-305	-4	-301
Other CCG	24,243	0	24,243	20,332	3,911	3,207	704
CCG TEP Shortfall (QIPP)	0	0	0	1,546	-1,546	-1,546	0
CCG Running Costs	5,209	0	5,209	5,209	0	0	0
Adults	82,590	-42,098	40,492	40,514	-22	-15	-7
Children's Services	78,334	-29,005	49,330	52,403	-3,074	-3,074	0
Individual Schools Budgets	127,944	-127,944	0	0	0	0	0
Population Health	16,353	-121	16,232	16,192	41	35	5
Operations and Neighbourhoods	76,400	-26,021	50,379	50,792	-413	-545	132
Growth	42,669	-34,810	7,858	10,091	-2,233	-2,247	14
Governance	88,701	-79,882	8,819	8,819	0	0	0
Finance & IT	5,898	-1,410	4,488	4,602	-113	-113	0
Quality and Safeguarding	355	-288	67	73	-6	-6	0
Capital and Financing	10,998	-1,360	9,638	8,236	1,402	1,402	0
Contingency	4,163	-6,823	-2,660	-3,388	728	728	0
Corporate Costs	8,726	-6,857	1,870	550	1,320	1,320	0
<b>Integrated Commissioning Fund</b>	<b>938,838</b>	<b>-356,618</b>	<b>582,220</b>	<b>586,136</b>	<b>-3,916</b>	<b>-4,061</b>	<b>145</b>
CCG Expenditure	395,706	0	395,706	397,252	-1,546	-1,546	0
TMBC Expenditure	543,132	-356,618	186,514	188,884	-2,370	-2,515	145
<b>Integrated Commissioning Fund</b>	<b>938,838</b>	<b>-356,618</b>	<b>582,220</b>	<b>586,136</b>	<b>-3,916</b>	<b>-4,061</b>	<b>145</b>
A: Section 75 Services	306,932	-40,844	266,089	269,185	-3,097	-2,522	-575
B: Aligned Services	336,984	-96,115	240,869	242,708	-1,839	-981	-858
C: In Collaboration Services	294,923	-219,662	75,262	74,242	1,020	-558	1,578
<b>Integrated Commissioning Fund</b>	<b>938,839</b>	<b>-356,619</b>	<b>582,220</b>	<b>586,136</b>	<b>-3,916</b>	<b>-4,061</b>	<b>145</b>

<b>Integrated Care Foundation Trust</b>							
Financial performance metric	Plan M5 (£000)	Actual M5 (£000)	Variance M5 (£000)	YTD Plan (£000)	YTD Actual (£000)	YTD Variance (£000)	Annual Plan (£000)
Normalised Surplus/(Deficit) before PSF	-1,817	-1,656	161	-11,809	-11,615	195	-23,370
PSF	281	281	0	1,195	1,195	0	4,221
Surplus/(Deficit) post PSF	-1,536	1,375	161	-10,614	-10,420	195	-19,149
Capital Expenditure	447	238	-209	1,518	697	-821	4,600
Cash and Equivalents	1,220	1,701	481				
Trust Efficiency Savings	890	926	37	3,632	4,513	881	13,000
<b>Use of Resources Metric</b>	<b>3</b>	<b>3</b>		<b>3</b>	<b>3</b>		<b>3</b>

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**Report to:** **STRATEGIC COMMISSIONING BOARD**

**Date:** 24 October 2018

**Officer of Single Commissioning Board** Gill Gibson, Director of Safeguarding and Quality  
Lynn Jackson, Quality Lead Manager

**Subject:** **BIMONTHLY QUALITY ASSURANCE REPORT**



**Report Summary:** The purpose of the report is to provide the Strategic Commissioning Board with assurance that robust quality assurance mechanisms are in place to monitor the quality of the services commissioned; to highlight any quality concerns and to provide assurance as to the action being taken to address such concerns.

**Recommendations:** The Strategic Commissioning Board is asked to note the content of the report.

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

ICF Budget	S 75 £'000	Aligned £'000	In Collab £'000	Total £'000
CCG				
<b>Total</b>				<b>£577m Net Resource</b>
<b>Section 75 - £'000</b>		£267million Net Resource		
<b>Strategic Commissioning Board</b>				
<b>Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparison</b>				
<p>There is no direct financial implications within the content of this report but the Strategic Commission have an integrated commissioning fund with a net value of £577m of which £267m is within the Section 75 pooled budget. Quality is an important factor in determining value for money services, mitigating risk and providing assurance that our residents are receiving the best outcomes from investment. The content of this report highlights the controls and monitoring systems currently in place to maintain high quality services and instigate remedial action as required. This is particularly crucial in high risk areas such as continuing healthcare and children’s services. Furthermore, this level of rigour and control facilitates the potential for additional income from the CCG Quality Premium.</p>				

**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, understanding where best to focus resources and oversight. A framework needs to be developed to achieve this. It must include complaints and other indicators of quality.

<b>How do proposals align with Health &amp; Wellbeing Strategy?</b>	Strengthened joint working in respect of quality assurance aim to support identification or quality issues in respect of health and social care services.
<b>How do proposals align with Locality Plan?</b>	Quality assurance is part of the locality plan.
<b>How do proposals align with the Commissioning Strategy?</b>	The service contributes to the Commissioning Strategy by providing quality assurance for services commissioned.
<b>Recommendations / views of the Health and Care Advisory Group:</b>	This section is not applicable as the report is not received by the Health and Care Advisory Group.
<b>Public and Patient Implications:</b>	The services are responsive and person-centred. Services respond to people's needs and choices and enable them to be equal partners in their care.
<b>Quality Implications:</b>	The purpose of the report is to provide the SCB with assurance that robust quality assurance mechanisms are in place to monitor the quality of the services commissioned and promote joint working.
<b>How do the proposals help to reduce health inequalities?</b>	As above.
<b>What are the Equality and Diversity implications?</b>	None currently.
<b>What are the safeguarding implications?</b>	Safeguarding is part of the report.
<b>What are the Information Governance implications? Has a privacy impact assessment been conducted?</b>	There are no information governance implications. The reported data is in a public domain. No privacy impact assessment has been conducted.
<b>Risk Management:</b>	No current risks identified.
<b>Access to Information :</b>	The background papers relating to this report can be inspected by contacting Lynn Jackson, Quality Lead Manager, by:  Telephone: 07800 928090  e-mail: lynn.jackson7@nhs.net

## 1. PURPOSE

- 1.1 The purpose of this report is to provide the Strategic Commissioning Board with assurance that robust quality assurance mechanisms are in place to monitor the quality of the services they commission; to highlight any quality concerns and to provide assurance as to the action being taken to address such concerns.

## 2. TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST (Acute and Community Services):

### Key Issues and Concerns

#### Community Services

- 2.1 The Strategic Commission (SC) has raised concerns in relation to staffing capacity within Integrated Care Foundation Trust (ICFT) community services. The ICFT is currently undertaking a review of community services; they have been asked to present the findings of the review alongside assurance that they have capacity to provide good quality community services at the November Quality and Performance Contract Meeting.

#### Health Visiting Service

- 2.2 Health visiting is a proactive, universal service that provides a platform from which to reach out to individuals and vulnerable groups, taking into account their different dynamics and needs, and reducing inequalities in health. Pre-school children and their families are a key focus. There is current concern around a deterioration in performance within the service against National Key Performance Indicators.

- 2.3 As a number of children are not receiving assessments in a timely manner, or are not being assessed using ASQ there is concern that opportunities to intervene early with families may be missed. The Health Visiting Service delivers the universal Healthy Child Programme for 0-5 and is a mandatory service to be commissioned via local authority public health functions. The service has had high levels of vacancies that have led to reduced capacity across the whole service. The service has also reported additional pressures around safeguarding as a reason for reduced capacity.

- 2.4 An effective and high quality preventative programme such as this in childhood is the foundation of our local priorities on Best Start in Life and School Readiness. At a crucial time in life the Healthy Child Programme's universal reach provides an invaluable opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes.

#### Data quality

- 2.5 There are concerns around data quality and timeliness. It is important that public health receive data that is accurate, valid, reliable, complete and timely to support validation before submission to Public Health England, all levels of patient care, clinical governance, accountability, improved outcomes for children and families and future service planning.

#### Actions taken to improve:

- 2.6 Following the September Quality and Performance meeting with the ICFT the Director of Nursing, as Chair of this group, and the Deputy Director of Public Health (as accountable commissioner) escalated the ongoing concerns about the Health Visiting service to the Chief Nurse and Director of Operations at the Trust. The Trust were asked to provide the Health Visiting improvement plan by close of play 28 September 2018. The improvement plan has now been submitted to the accountable commissioner, alongside assurance that performance will be back on trajectory for quarter 3.

- 2.7 The improvement plan will continue to be monitored; the Strategic Commission may need to consider contractual levers should the Trust continue to fail to deliver against the

improvement plan. The Strategic Commission has also authorised an internal audit to be conducted on the health visiting service which will enable further insight into any performance and quality issues. This report will be ready with recommendations for improvement in November 2018.

#### **Looked After Children (LAC)**

- 2.8 Concerns remain about the overall timeliness of LAC statutory health assessments with performance remaining below expected target. Whilst service improvements have been made over last 12 months improvements have not been consistent or sustainable.

#### **Actions taken to improve**

- 2.9 Director of Quality and Safeguarding has formally escalated performance/contract concerns to the Chief Nurse and has requested a position statement and action plan to be submitted by 28 September 2018. The improvement plan has been received and is being reviewed. This will be monitored by the Designated Nurse for LAC.
- 2.10 Work is underway to review the current complex commissioning arrangements for looked after children including a full re-specification of the service to include more cohesive arrangements to improve timeliness and quality of services for LAC.

### **3. MENTAL HEALTH (PENNINE CARE NHS FOUNDATION TRUST (PCFT))**

#### **Key Issues and Concerns: Staffing Issues**

##### **Community Mental Health Team**

- 3.1 Staffing challenges and capacity has been acknowledged by the Community Mental Health Team (CMHT). The risk for CMHT has been reported on the risk register and staff vacancies are out to recruitment.

##### **IAPT (Healthy Minds)**

- 3.2 Staffing issues have been noted in relation to secondary delays in treatment (Step 3 interventions). These are being addressed jointly with the Clinical Commissioning Group, with additional investment in capacity in the psychological therapies service.

##### **Memory Assessment Service**

- 3.3 The Memory Assessment service did not reach their referral standard of 12 weeks in July. Issues around staffing during the summer have been reported to have impacted consultant capacity and there is currently a backlog of diagnostic appointments. The Strategic Commission has been advised that the service has negotiated additional consultant capacity for September/ October to address the backlog. Assurances have been received in relation to future planning for cover.

#### **Actions taken to improve**

- 3.4 Bank and agency staff are being utilised to increase capacity. Monthly updates will continue to be provided by Pennine Care Foundation Trust (PCFT ) in relation to workforce. There is a staffing assurance item planned for the October 2018 Quality Assurance Meeting (newly formed Quality Meeting involving all five CCG's and looking at Trust wide / strategic quality issues).

##### **Healthy Young Minds**

- 3.5 Pressures have been noted within the Neuro Developmental pathway due to the volume of referrals for both Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder assessment. This is impacting on waiting lists for first contact and commencement of treatment.



### **Actions taken to improve**

- 3.6 Discussions ongoing with CCG leads with regards the pressures within the Neuro Developmental pathway to consider how capacity can be enhanced and partnership working can be more effective.

### **24 Hour Discharge Notifications**

- 3.7 There is a remedial action plan in place to address the need for discharge notifications to be sent within 24 hours of an inpatient leaving hospital for Tameside and Glossop. A number of actions relating to process and communication are being progressed over the August/september period. Ongoing monitoring will continue via the Tameside and Glossop Locality Meeting.

### **Regulation 28 – QPAG Only**

- 3.8 A Regulation 28 was received by Pennine Care Foundation Trust and Tameside and Glossop CCG in June 2018. The Coroner outlined her concerns in relation to the waiting time for Cognitive Behavioural Therapy, capacity issues had been cited by the Trust at the Coronial Inquest.

### **Actions taken to improve**

- 3.9 A response has been sent from both Pennine Care Foundation Trust and the Lead Commissioner for Mental Health addressing concerns raised. This includes confirmation of recurrent investment to extend the capacity in the Healthy Minds service. Additionally, further developments including the 101 Days for Mental Health Project, the New Step 1 Service, and increased mental health nurse support at the Crisis Drop-in centre were also noted.

### **Horizon Scanning**

- 3.10 Pennine Care Foundation Trust held a quality strategy stakeholder event on Friday 20 September 2018. The purpose of the event was to enable stakeholder involvement in the further design and implementation of the draft Quality Strategy. Stakeholders, including staff, users, family and carers and commissioners participated in workshop to explore potential local measures to define and measure good quality services for Pennine Care Foundation Trust.

## **4. PUBLIC HEALTH**

### **CGL – My Recovery Tameside**

- 4.1 CGL/My Recovery Tameside provide an integrated all age recovery and treatment service for substance misuse. The service was initially provided by Lifeline from August 2015, novating to CGL (Change, Grow, Live) in May 2017. Treatment services were subcontracted by Lifeline, but taken in house by CGL in October 2017.
- 4.2 Following notation of the contract, the Strategic Commissioning Board agreed an enhanced monitoring framework with a particular focus on financial stability and additional clinical measures. In response, additional quarterly reports have been provided by CGL. Progress has been reviewed by the Health and Care Advisory Group, and assurance received that a re-tender of the contract was not indicated. Future governance oversight via the Quality, and Performance Assurance Group was confirmed.
- 4.3 Whilst a change in clinical information system, integration of the recovery and treatment elements, and restructuring have impacted on performance measures during the past year, My Recovery Tameside has continued to make progress with its transformation programme that aims to increase access, early intervention and develop an extensive recovery community, so as to reduce the need for treatment and long term maintenance. Detailed quarterly reporting is in place, and an annual report by the service for 2017/18 is due in the next month.

4.4 Progress with developing a new primary care model with an increased alcohol element has been slow, but a proposed model is due for sharing with Neighbourhood Teams in November 2018.

4.5 There is a National shortage of buprenorphine is affecting supply for a small number of local service clients – all are currently receiving required treatment.

#### **Actions taken to improve**

4.6 Public Health Outcomes Framework indicator performance: In response to slow recovery from a local dip in performance, a trajectory for improvement in treatment completions and representations for the next twelve months has been agreed and is monitored via the contract meeting.

#### **Good practice**

4.7 A peer review: involving the commissioning lead at Haringey Council has been arranged for Oct 18.

**The scope:** is broad and includes prevention, commissioning, sustainability, integration, and outcomes for local people.

#### **Aims:**

- Overview of current challenges
- Appreciation of good practice
- Identification of key areas for improvement

**The Peer Review process** involves:

- self assessment
- document review
- interviews and visits
- feedback and identification of issues to be worked into our local action planning

**Interviewees** include:

- Tameside Strategic Alcohol and Drug Group
- Commissioning: Children's Services; Neighbourhoods; Population Health; Mental Health; Adult Social Care; Primary care lead GPs
- Providers

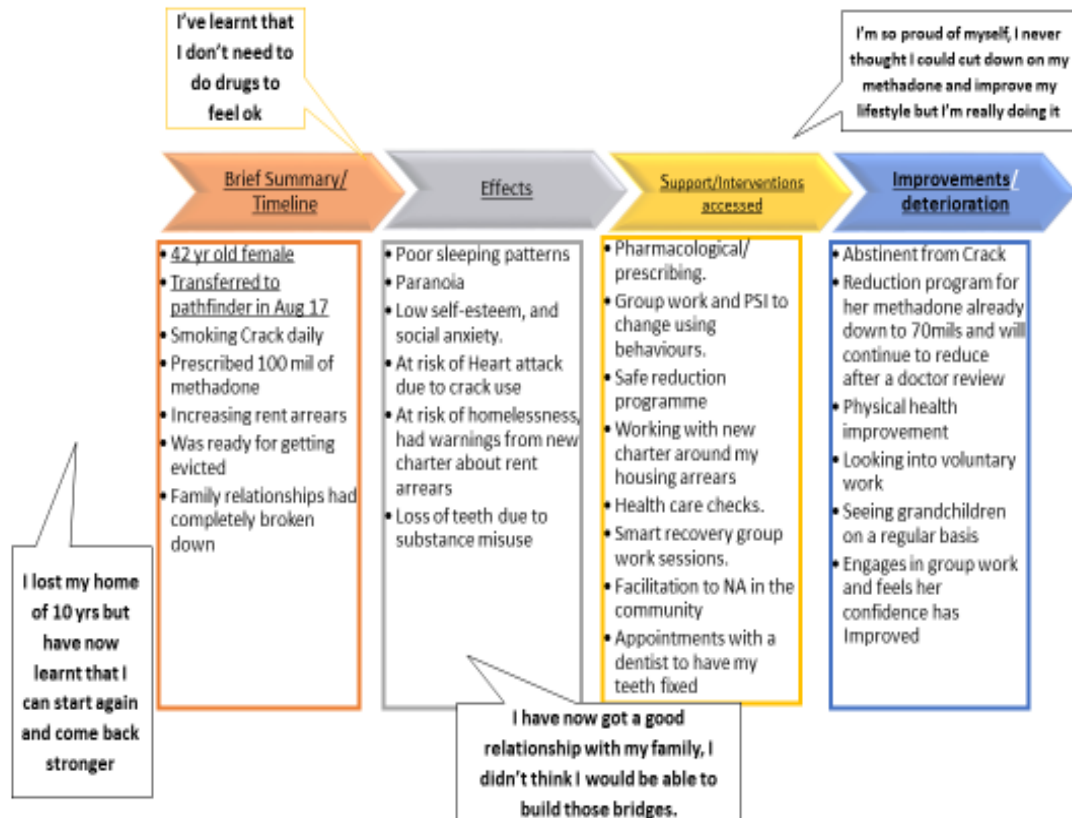
#### **Feedback**

A short summary report will be produced with recommendations for next steps. There will be a feedback session on 25 October 2018.

4.8 Communities in Charge of Alcohol: Public Health England pilot community champions programme in 9/10 GM authorities. Tameside team commenced in May, recruitment has gone well with further training event planned for Oct 18.

4.9 Alcohol Effected Pregnancies: local Maternal Alcohol Monitoring Algorithm has been adopted as a GM initiative. Local programme will be enhanced with additional social marketing and communications activity.

## User Experience:



### Horizon scanning:

- 4.10 Rough Sleepers Initiative: GM programme due to commence in 2018. CGL part of multi-agency approach. Recruitment of outreach worker complete and recruitment of local health worker in progress.

## 5. OFF THE RECORD (children and young people's counselling service)

### Key points / Issues of concerns

- 5.1 Capacity of service vs demand; there is a current waiting list of approx. 12 weeks. The service does see young people at all levels of need due to thresholds of other organisations, there is a danger that if referrals are not appropriate the quality and impact of service will be compromised.

### Actions taken to improve

- 5.2 Off the Record is an equal partner in the local Mental Health Transformation Plan. Off the Record have quarterly monitoring meetings where performance, quality and capacity are monitored.

### Horizon scanning

- 5.3 Service will be up for tender in the next 12 months; with this a new performance framework will be created.
- 5.4 There is a piece of work being initiated to review the counselling offer in line with the evidence base, THRIVE requirements and also the wider Local Transformation Plan offer, to review needs and new models of care.
- 5.5 There is a need to review pathways and thresholds across organisations supporting children and young people's mental health as well as demand vs capacity/resources.

**User Experience: A number of user experiences are captured below: -**

(Please use back of sheet if required)

OTR has been a lifeline for my daughters. My older daughter had a very difficult time transitioning from primary to secondary, thanks to JOTR she is doing really well at school now and her anxiety is greatly reduced. She is happy & never

P.T.O

(Please use the back of the sheet if required?)

I think its helped to get things off his chest and hear from a 'third party' that things will be ok and not just friends and family who he thinks say it because we have to and because we love him. Also to know he is not the only one who feels upset or different at times has made him feel less isolated I think.

Thank you :)

(Please use the back of the sheet if required?)

Every young person should have access to this service if they have a problem, it is excellent. The boy I am coming for has lots of anger issues and was getting involved with gangs. He has now been given the confidence to walk away and show some self control. Very good.

Thank you :)

confidence was increased.  
I am here with my younger daughter who is finding puberty anxiety provoking. As a parent we don't always have the skills to cope without outside support. Hopefully this will help her too!  
I just wish the waiting list was shorter.  
Thank you for all you do! ☺

## 6. PRIMARY CARE

### Good Practice

- 6.1 The GP Patient Survey was published in August 2018. Cottage Lane in Glossop was named as one of the top 10 practices in Greater Manchester based upon the responses to all the indicators. In addition, five practices – Awburn House Medical Practice, Hadfield Medical Centre, Mossley Medical Practice, Simmondley Medical Practice and Staveleigh Medical Centre – were higher than the CCG average in all indicators.
- 6.2 Medlock Vale Medical Centre was rated as requires improvement in a Care Quality Commission (CQC) report published in January 2018. CQC re-inspected Medlock Vale on 9 August 2018, with the report being published on 21 September 2018. The practice was rated as good in all key lines of enquiry and good overall. All Tameside and Glossop practices are now rated good or outstanding.

### Primary Care Extended Access Hubs

- 6.3 The Extended Access Service provides access to routine and same day pre-bookable appointments to general practice essential services 7 days per week (weekday evenings and at weekends). The service in Tameside and Glossop is currently delivered across three hubs – Ashton Primary Care Centre, Glossop Primary Care Centre and Thornley House Medical Centre (Hyde) with each hub providing appointments 7 days per week.
- 6.4 The procurement of a Primary Care Access Service (PCAS), incorporating Extended Access provision, will increase the delivery of this service from 3 to 5 hubs. The additional hubs will be located in Denton (Ann Street Clinic) and Stalybridge (St Andrew's Medical Practice), ensuring a hub location in each of the five neighbourhoods which will improve access to primary care for all Tameside and Glossop residents, wherever they live. The procurement process is ongoing and the new Primary Care Access Service contract is expected to be live on the 1 April 2019.
- 6.5 The proposed PCAS, which has been subject to a full public consultation, takes into account the challenges facing health and social care now and in the future. Implementation of PCAS will ensure a patient centred, responsive, safe, resilient, and fit for purpose service to support our population to receive the right care, in the right place, at the right time.
- 6.6 PCAS will simplify access to urgent care and improve the level of service available. The current arrangement of multiple access points to urgent care will be replaced by telephone access through a patient's own GP practices. Each GP will be able to book appointments directly into the PCAS. There will also be 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, local neighbourhood support will be strengthened through the development of two additional locations for evening appointments.
- 6.7 The successful provider will deliver a single urgent care service, 24 hours a day. This single service includes the current Extended Access Service, the General Practice Out of Hours Service and the Alternative to Transfer services (care closer to home, care in the community).

### General Practice Workforce

- 6.8 General Practice in Tameside and Glossop consists of 37 individual practices that are responsible for employment and decisions relating to the skill mix of clinical and non-clinical staff at their practices. There are no levers within the GMS contract to compel these contractors to provide CCGs with their workforce information, however practices do provide workforce information under the mandatory workforce Minimum Data Set (wMDS) collection. This can either be done using the National Workforce Reporting System

(NWRS) module of the Primary Care Web Tool or to Health Education England (HEE) via separate regional collections of data. HEE will forward the data they collect NHS Digital.

- 6.9 CCGs are only able to see this data through the annual workforce report published by HEE in October of each year. This information provides a snapshot of the primary care workforce at the time it is uploaded by practices. The CCG primary care team is building a more robust picture regarding workforce in general practice across the locality, however there is more work to be done to fully understand the overall position.
- 6.10 The October 2017 HEE workforce report highlighted a year on year reduction in the reported number of GPs within Tameside and Glossop, reducing from 51 to 43 GPs per 100 000 population in the previous year. For context, the Greater Manchester average was 47 per 100 000 and the North West average was 50 per 100 000 as at October 2017. Tameside and Glossop has the lowest reported number of GPs per 100 000 across Greater Manchester.
- 6.11 The October 2017 HEE workforce report also highlighted a year on year reduction in the reported number of Practice Nurses within Tameside and Glossop, reducing from 25 to 24 GPs per 100 000 population in the previous year. For context, Tameside and Glossop has the joint third highest number of nurses per 100 000 along with Oldham and Salford. There are currently five practice nurse vacancies in Tameside and Glossop.
- 6.12 The CCG has engaged with the GM workforce reference group, and is aware that primary care workforce is a pressing issue. Collaborative working across the Tameside and Glossop system, work is underway to develop a robust primary care workforce strategy. The strategy for Tameside and Glossop will be designed to support individual contractors into the future but will also set out how the Integrated Neighbourhood model will enable resilience within primary care workforce going forward.

#### **Primary Care Clinical Variations**

- 6.13 90% of all NHS contact is with general practitioners, so this information on clinical variations across Tameside and Glossop will concentrate on the following eight areas.

#### **Palliative Care and End of Life Registers**

- 6.14 Approximately 1% of the UK population dies each year. Consequently it is believe that practices should have 1% of their register on their palliative care and end of life register. Once identified, these patients should be supported to have Advance Care Plans in place and end their lives in their chosen place of care, including their home. However, while the aspiration is 1%, not all practices achieve it. Across Tameside and Glossop the percentage of patients on a palliative and end of life care register ranges from 0.09% to 1.27% with a CCG average of 0.58%.
- 6.15 The CCG has embarked upon a process of encouraging practices to identify the number of patients who require palliative and end of life care, so they can be added to the registers and receive the dedicated care their health requires. This is part of a wider CCG commissioning intention to support people to die in their usual place of residence.

#### **Diabetes**

- 6.16 There are currently 3.4 million people with Type 2 diabetes in England with around 200,000 new diagnoses every year. While Type 1 diabetes cannot be prevented and is not linked to lifestyle, Type 2 diabetes is largely preventable through lifestyle changes. If nothing changes, more than five million people will have diabetes in the UK by 2025.
- 6.17 While the national prevalence of diabetes is 6.9% (Quality and Outcomes Framework (QOF) 2016/17), not all practices achieve this. Across Tameside and Glossop the prevalence ranges from 11.74% to 4.88% with a CCG average of 7.37% (QOF 2016/17).

- 6.18 During 2018, the roll out of the National diabetes prevention programme (NDPP) has taken place in Tameside & Glossop. Practices were asked to identify patients that are Non – Diabetic Hyperglycaemia (NDH) and support staged referrals. Patients who were identified were sent an invitation to contact the national training provider. Around 17% of the identified patients have self-referred on to the programme. Those referred received tailored, personalised help to reduce their risk of Type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing the disease.
- 6.19 Practices in Tameside & Glossop have participated in the National Diabetes Audit (NDA), which shows individual practice performance against a range of indicators relating to diabetes care in General Practice. The results of the most recent NDA were the topic of a TARGET session, with areas of improvement identified to be taken forward by the Diabetes Improvement Group. The NDA data shows significant variation across the locality between Practices. Commissioning officers as members of the T&G Diabetes Improvement Group and the Primary Care Delivery & Improvement Group are supporting work in practices where there is room for improvement.

#### **Respiratory Disease: Chronic obstructive pulmonary disease (COPD)**

- 6.20 An estimated 3 million people have chronic obstructive pulmonary disease (COPD) in the UK. About Approximately 900,000 have diagnosed COPD and an estimated 2 million people have COPD which remains undiagnosed.
- 6.21 The national prevalence of COPD is 1.93% (QOF 16/17). Across Tameside and Glossop the prevalence ranges from 4.9 % to 1.3% with a CCG average of 2.78% (QOF 16/17). As COPD is a quality and performance indicator considerable work has been done over the past 18 months to increase prevalence. An additional 455 patients were added onto practice registers from April 2017 - September 2018. From March 2018 a further 167 newly diagnosed patients were added to the register. The greatest increase has been in the Hyde and Denton neighbourhoods.

#### **Cardiovascular Disease: Atrial Fibrillation**

- 6.22 While the national prevalence of Atrial Fibrillation (AF) is 1.8% (QOF 16/17), not all practices achieve this. Across Tameside and Glossop prevalence ranges from 2.8% to 0.4 % with a CCG average of 1.79% (QOF 16/17. In October 2017, Tameside and Glossop Clinical Commissioning Group and Health Innovation Manchester partnered with Interface Clinical Services (ICS) to undertake a quality improvement initiative in general practice. This resulted in an additional 168 patients being added to QOF registers across 38 practices increasing the CCG prevalence to 1.92%. Work is ongoing to address the variation across practices and to continue the work to increase the recorded prevalence of AF and the management of patients identified.

#### **Cardiovascular Disease: Hypertension**

- 6.23 Hypertension has been an area of focus for the Public Health team and Primary Care Quality Clinical Lead. Improvement work is ongoing in this area, with some improvements already being seen in Practice recorded prevalence.
- 6.24 The Cardiovascular Disease (CVD) indicator looks at the number of patients with newly diagnosed hypertension since 1st April 2009. While the national prevalence of CVD is 13.8 % ( QOF 2017), not all practices achieve this. Across Tameside and Glossop the prevalence ranges from 20% to 7% % with a CCG average of 16% (QOF August 2018).

#### **Primary Care Estates**

- 6.25 The 37 practices of the CCG covers 43 sites, with five multi-site practices, there is a mix of owner occupied and leased premises, with 7 private leases and 8 Community Health Partnership (CHP) or NHS Property Services (NHSPS) leases. The quality and fitness for

purposes of buildings vary with some older estate and some new build Primary Care Centres.

6.26 The estates workstream across the Strategic Commission has a focus both on estates rationalisation and also the development of neighbourhood hubs as part of the Integrated Neighbourhood offer. The primary medical services provision is therefore a key part of this and the primary care team are represented in the working group.

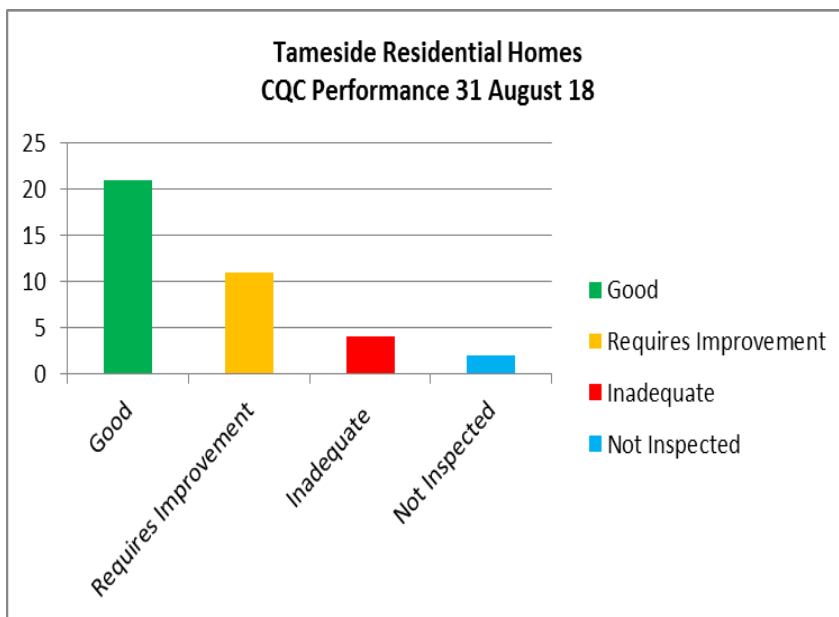
6.27 Two neighbourhoods, Ashton and Glossop have a Primary Care Centre facility with therefore a natural 'hub' location; the Ashton site has two GP Practices. The Extended Access Service (EAS) already delivers from both centres. Hub, or hub and spoke, locations are being considered for the remaining three neighbourhoods – with consideration for the existing owned premises across the Strategic Commission and the existing provision of services across the whole locality, including acute, community and mental health services.

## 7. CARE AND NURSING HOMES

### CQC Performance

7.1 The Care Quality Commission (CQC) picture for Care Homes and with Nursing<sup>1</sup> is provided in the graph below.

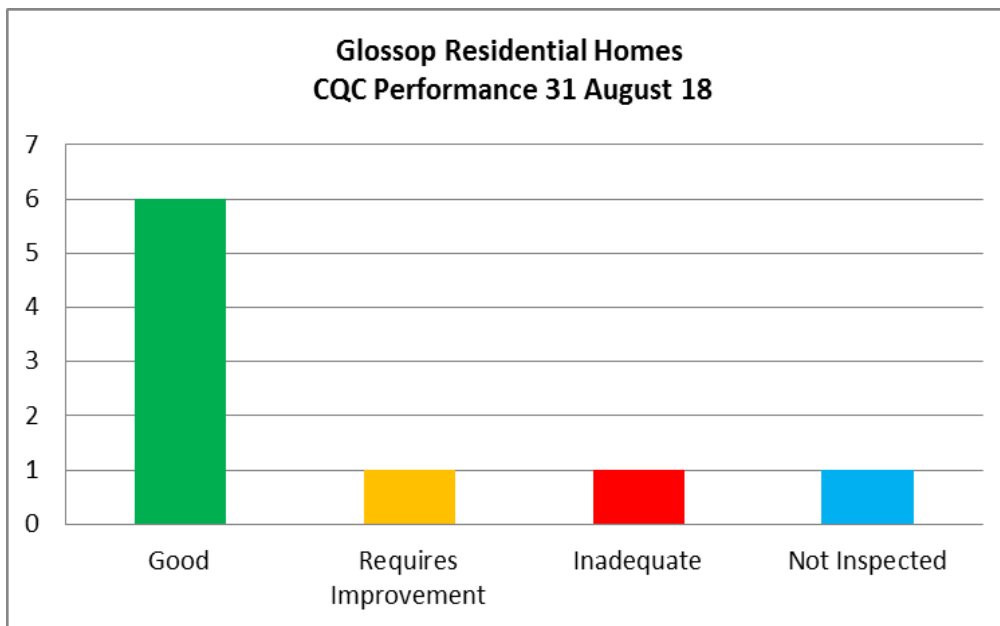
- **Tameside Position – 31 August 18**



**NB:** This data covers operational TMBC commissioned residential & nursing homes.  
**Glossop Position – 31 August 2018**

<sup>1</sup> Where ownership has changed this has been recorded as "not inspected" in line with CQC reporting. The Home will have been inspected under the revised CQC methodology under previous ownership.





*NB: St Christopher's and Jabulani are included in the data and are included in the scope of the Care Home Quality Review Group discussions.*

#### **Inadequate CQC Ratings**

- 7.2 There are currently five residential homes rated inadequate within the Tameside and Glossop locality, a short summary of key issues and support provided is given.
- 7.3 At Scrutiny Panel was held on 13 September 18 the Tameside Director of Adult Social Care in conjunction with the Director of Quality and Safeguarding, agreed that the Commissioners will not make new placements with Providers rated Inadequate by CQC (Tameside Care Homes) until such time the rating has improved.

#### **Oakwood Care Centre (Tameside MBC)**

- 7.4 The Home was rated Inadequate by the CQC on 22 March 18 (previously rated inadequate on 22 April 2017). Issues related to environmental risk assessments, incident reporting, systems/processes, medicines management, staffing and training. This Home has been a primary focus of the new Quality Improvement Team (QIT) with intense support being provided. Advice on safety and estates, leadership, systems processes, policy and guidelines, medicines, documentation and care planning, MCA and DOLS. Support with implementation plan and supportive audit. The CQC Inspection took place in September 2018; we are awaiting the outcome.

#### **Carson House (Tameside MBC)**

- 7.5 This Home was rated Inadequate by the CQC on 12 May 2018. Key issues highlighted in the CQC report related to fit and proper persons checks, lack of social support and meaningful activities, staff training and supervision, concerns regarding the financial position of the registered provider, environmental risk assessments, and robust quality and governance systems. Significant support has been provided to this Home in relation to care and support of the residents and improvements have been seen. This Home was suspended with effect from 28 March 18. In accordance with the Care Act, the Commissioners put plans in place for a potential provider failure which, following information from the manager at the home on the 18 September 2018; had to be fully enacted. Commissioners worked with residents & families to move residents to suitable alternative accommodation. All residents moved out of Carson House on the 25 September 2018.

### **Regency Hall (Glossop – Derbyshire County Council)**

- 7.6 The Home was suspended on a voluntary basis following a CQC inspection on 11 January 2018, the report was published on 7 April 2018 with an Inadequate rating. Key issues highlighted in the CQC report related to concerns over the high turnover of Home Managers, lack of leadership, poor documentation, cleanliness and staffing levels. A new Manager has been appointed and a Management Consultancy firm is working with the Provider in response to the actions outlined by the CQC. The suspension was lifted on 12 March 2018 following significant improvements observed at a Contractual Visit on 8 March 2018. No recent concerns have been identified and the outcome of the CQC inspection is anticipated.

### **Bowlacre Home (Tameside MBC)**

- 7.7 This Home was rated Inadequate by the CQC on 24 August 2018 following an inspection on 6 & 7 June 2018. Key issues highlighted in the CQC report related to medicines management, environment, capacity and consent, governance, and care planning and risk assessment. The Home has been receiving significant support from the Quality Improvement Team with a key focus on processes for pre-admission assessments and ongoing risk assessments. The Home voluntarily suspended admissions in July 2018, this moved to a Local Authority imposed suspension in September 2018 applicable to all Tameside funded residents. An action plan is in place and the Quality Improvement Team continues to support the Home.

### **The Vicarage (Tameside MBC)**

- 7.8 The Home was rated Inadequate by the CQC on 21 August 2018 following inspection on 21 May 2018. A number of issues were identified across the five domains and ongoing support has been provided by the Quality Improvement Team. Concerns were raised around the speed of progress with the Improvement Plan and the Home was suspended from admissions in August 2018. Support from the Quality Improvement Team will continue.

### **Published CQC Ratings (July and August 18)**

- 7.9 As noted in the previous section Bowlacre and The Vicarage had CQC Ratings published in August 2018.

### **Clarkson House Residential Care Home**

- 7.10 This Home was rated as Requires Improvement on 7 August 18 following an Inspection on 27 June 2018. Key issues noted in the inspection related to the environment, and notifications to the CQC.

### **Action**

- 7.11 The Quality Improvement Team is working with this Home to support improvements.

### **Willowbank Residential Care Home (Glossop).**

- 7.12 This home was rated as Outstanding on the 16 August 2018. Previously the home was rated as Good.

### **Care Home Quality Group:**

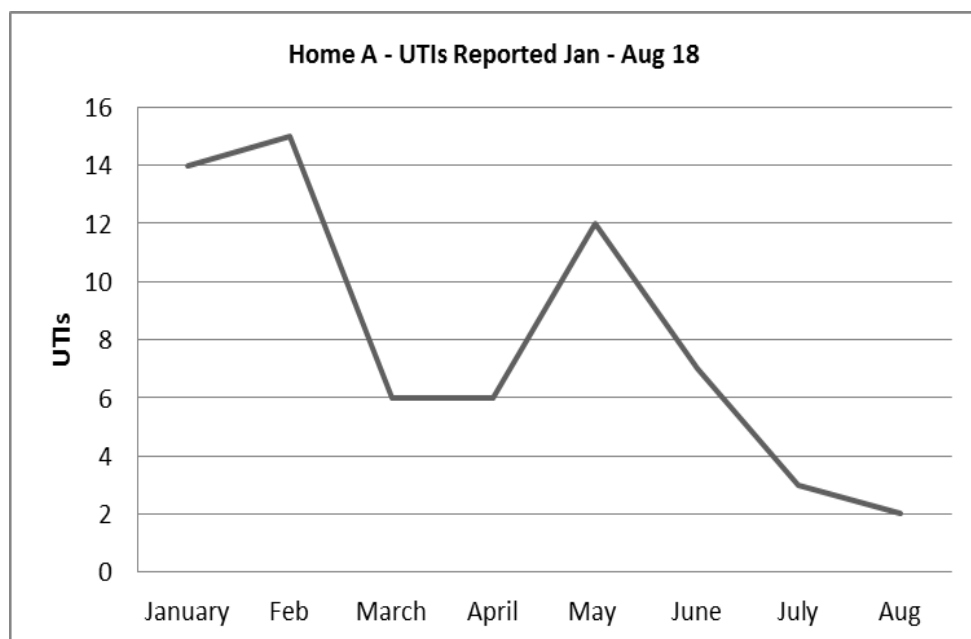
- 7.13 The Monthly contractual return has now been refined and implemented with support from Business Intelligence. The Annual Visit documentation will be reviewed in Quarter 4 following completion of all annual visits under the new documentation. A baseline of performance across all Homes will also be completed.

- 7.14 A full Action Log where key issues and actions in relation to the Care and Nursing Homes is maintained by the Group and updated monthly. Key actions from the log are reported to the Quality Performance and Assurance Group on a bi-monthly basis. A sub-group is also being established to look at how a risk rating can be formulated for each home.

### Good Practice

#### Care/Nursing Home UTI identification training project

- 7.15 The following piece of work is part of the whole health economy plan to reduce gram negative infections by 50% by 2021. A focus of the work is to improve the prevention off and identification of UTIs in the care home setting.
- 7.16 The Anti-biotic Specialist Pharmacist has been providing bespoke UTI Identification Training Sessions to Tameside and Glossop Care Homes since May 18. The training has been to ensure urine dipsticks are not being undertaken without reason and only in the appropriate patients. A training pack was developed that included algorithms (as per NICE guidance) on how to identify patients that may have a UTI and then what should be done.
- 7.17 The training has been provided as a bespoke package depending on the needs of the home and the staff. Homes have also been identified via the Care Home Quality Review Group based on the UTI data provided. Data from a Home where training was provided in May 18 is provided below.

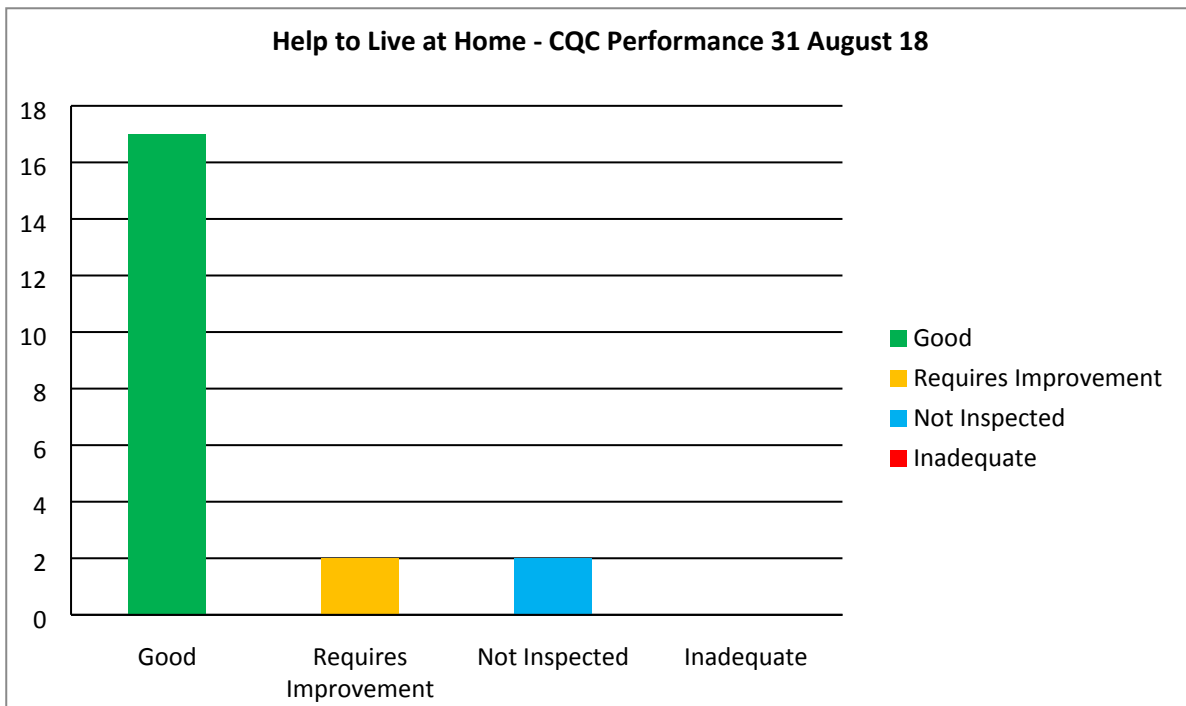


A further training session for all Homes was held on 20 September 2018.

## 8. SUPPORT IN THE COMMUNITY

### CQC Performance

- 8.1 The CQC picture of the providers used to supply support in the community in Tameside is noted in the graph below (please note this includes the providers used for the general support at home service (even if the office is not registered in Tameside) and supported living providers):



8.2 During the reporting period the following CQC reports have been published for the following commissioned providers.

**Direct Care (Help to Live at Home)**

8.3 This provider was rated as **good** in July 2018 following an inspection on 21 June 2018. The provider achieved a good rating across all five domains.

**Elite Care Services (ISF Agreement)**

8.4 This provider was rated as **good** in July 2018 following an inspection on 26 June 2018. The Elite Care achieved a good rating across all five domains.

**Tameside Link (ISF Agreement)**

8.5 This provider was rated as **good** in August 2018 following an inspection on 30 July 2018. Tameside Link achieved a good rating across all five domains.

**Careline (Help to Live at Home)**

8.6 This provider was rated as **Requires Improvement** in August 2018 following an inspection on 11 June 2018. Issues noted related to level of staffing, complaints and governance systems. The Provider achieved a good rating in the effective and caring domains.

**Support at Home Model**

8.7 The new support at home model continues to be rolled out across all six zoned providers (phase 2 started in July 2018) so the providers will be working to two models of care initially whilst the new model embeds. It anticipated that by the end of March 2019 all support at home services will be delivered using the new model.

**9. SAFEGUARDING**

**Children's**

9.1 A new Significant Case Review commissioned Sept 2018, 1st panel meeting has been held and Terms of Reference agreed.

### **Looked After Children**

- 9.2 See ICFT section. It is anticipated that the Greater Manchester Health & Social Care Partnership will soon be requesting expressions of interest from organisation(s) to undertake a review of Health Services for Greater Manchester's Population of Children Looked After, Care Leavers and Those Adopted. The outcomes will be utilised to inform system redesign that will be overseen by Greater Manchester's Children and Young People's Health and Wellbeing Board.

### **Adult Safeguarding Safeguarding Adult Reviews (SARS)**

- 9.3 There are currently no statutory Safeguarding Adult Reviews in Tameside & Glossop.

### **LeDer**

- 9.4 LeDer Reviews continue to be allocated to reviewers via the CCGs Local Area Contacts. There are currently 10 reviews allocated and 7 reviews awaiting allocation. We have a total of 11 reviewers from Tameside & Glossop Integrated Care Foundation Trust but are still awaiting reviewers from Adult Social Care to be nominated and attend training. There has been one completed review which identified some learning points with regards to Annual Health Checks and Local Providers using the Health Action Card.

### **Action**

- 9.5 The local learning from this review has been cascaded to the relevant Primary Care Practice and Provider via the Learning Disability Team and shared with the Bristol Team as per the process for identification of any emerging regional or national themes. It will inform the quality improvement work in relation to Learning Disability health checks.
- 9.6 A meeting was held in August 2018 with Local Area Contacts and the ICFT's Clinical Effectiveness and Governance lead and Senior Managers over Learning Disability Services. The purpose of the meeting was to discuss issues reviewers are having in completing timely reviews.

### **Action**

- 9.7 The outcome of the meeting was an agreement that a new local model was required for the allocation and management of LeDer Reviews. Local Area Contacts, Quality Leads and Senior Lead Reviewers will continue to develop this piece of work throughout Quarter 3.

## **10. CHILDREN'S**

- 10.1 The agreed assurance route for Children's Services is via [Tameside Children's Services Improvement Board](#).

## **11. ASSOCIATE CONTRACTS**

- 11.1 The quality of associate contracts are managed by the Lead CCG for that contract and assurance sought via the lead CCG's contracting processes. A working group has been established to strengthen internal processes in relation to the performance and quality of associate contracts.

## **12. SMALLER VALUE CONTRACTS**

- 12.1 Work has been initiated to review the current quality assurance arrangements for the smaller value contracts; this will include the use of a risk matrix to establish the levels of focus required from the Quality Team.

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**Report to:** STRATEGIC COMMISSIONING BOARD

**Date:** 24 October 2018

**Officer of Strategic Commissioning Board:** Sarah Dobson, Assistant Director Policy, Performance and Communications

**Subject:** DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – PERFORMANCE UPDATE

**Report Summary:** This report provides the Strategic Commissioning Board with a Health and Care performance report for comment.

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

- Health & Care Dashboard – including exception reporting for measures, which are areas of concern, i.e. performance is declining and / or off target
- Other intelligence / horizon scanning – including updates on issues raised by Strategic Commissioning Board members from previous reports, any measures that are outside the dashboard but which Strategic Commissioning Board are asked to note, and any other data or performance issues that Strategic Commissioning Board need to be made aware.
- In-focus – a more detailed review of performance across a number of measures in a thematic area.

This is based on the latest published data (at the time of preparing the report). This is as at the end of August 2018.

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

The following have been highlighted as exceptions:

- Referral To Treatment - 18 weeks

**Recommendations:** The Strategic Commissioning Board are asked to:-

- Note the contents of the report, in particular those areas of performance that are currently off track and the need for appropriate action to be taken by provider organisations which should be monitored by the relevant lead commissioner
- Support ongoing development of the new approach to monitoring and reporting performance and quality across the Tameside & Glossop health and care economy

<b>How do proposals align with Health &amp; Wellbeing Strategy?</b>	Should provide check & balance and assurances as to whether meeting strategy.
<b>How do proposals align with Locality Plan?</b>	Should provide check & balance and assurances as to whether meeting plan.
<b>How do proposals align with the Commissioning Strategy?</b>	Should provide check & balance and assurances as to whether meeting strategy.
<b>Recommendations / views of the Professional Reference Group:</b>	This section is not applicable as this report is not received by the professional reference group.
<b>Public and Patient Implications:</b>	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.
<b>Quality Implications:</b>	As above.
<b>Financial Implications: (Authorised by the statutory Section 151 Officer &amp; Chief Finance Officer)</b>	The updated performance information in this report is presented for information and as such does not have any direct and immediate financial implications. However it must be noted that performance against the data reported here could potentially impact upon achievement of CQUIN and QPP targets, which would indirectly impact upon the financial position. It will be important that the 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.
<b>Legal Implications: (Authorised by the Borough Solicitor)</b>	As the system restructures and the constituent parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all part sot account and understanding best where to focus resources and oversight. This report and framework needs to be developed expediently to achieve this. It must include quality and this would include complaints and other indicators of quality.
<b>How do the proposals help to reduce health inequalities?</b>	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.
<b>What are the Equality and Diversity implications?</b>	There are no equality or diversity implications associated with this report.
<b>What are the safeguarding implications?</b>	None reported related to the performance as described in report.
<b>What are the Information Governance implications? Has a privacy impact assessment been conducted?</b>	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 by:



Telephone: 01613425637



e-mail: [alirehman@nhs.net](mailto:alirehman@nhs.net)

## 1. BACKGROUND

1.1 This report provides the Strategic Commissioning Board with a health and care performance update at October 2018 using the new approach agreed in November 2017. The report covers:-

- Health & Care Dashboard – including exception reporting for measures, which are areas of concern, i.e. performance is declining and / or off target;
- Other intelligence / horizon scanning – including updates on issues raised by Strategic Commissioning Board members from previous reports, any measures that are outside the dashboard but which Strategic Commissioning Board are asked to note, and any other data or performance issues that Strategic Commissioning Board need to be made aware;
- In-focus – a more detailed review of performance across a number of measures in a thematic area.

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

## 2. HEALTH & CARE DASHBOARD

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

EXCEPTIONS (areas of concern)	3	Referral To Treatment-18 Weeks
ON WATCH (monitored)	7	Cancer 31 day wait
	11	Cancer 62 day wait from referral to treatment
	47	65+ at home 91days

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

### 18 Weeks Referral to Treatment

2.3 Performance for August is below the Standard for the Referral to Treatment 18 weeks (92%) achieving 91.8%. This is an improvement in performance compared to the previous month, July, which also failed to achieve the standard at 91.3%. The national directive to cancel elective activity was expected to reduce performance from January. The impact for Tameside and Glossop was expected to be greatest at Manchester University NHS Foundation Trust and the recovery plan submitted to Greater Manchester reflected that fact that failure at Manchester University NHS Foundation Trust could mean Tameside and Glossop performance would be below the required standard. Manchester University NHS Foundation Trust is failing to achieve the RTT national standard. Manchester University NHS Foundation Trust (formerly UHSM) revised its improvement trajectory and is currently on track. Manchester University NHS Foundation Trust (formerly CMFT) is slightly below target although there have been improvements in children's services. Discussions are taking place with lead commissioners regarding the need for comprehensive recovery plans.

### 3. OTHER INTELLIGENCE / HORIZON SCANNING

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

#### NHS 111

3.2 The North West NHS 111 service performance has deteriorated in all of the key performance indicators for August with none of the key performance indicators achieving the performance standards:-

- Calls Answered (95% in 60 seconds) = 70.13%
- Calls abandoned (<5%) = 8.11%
- Warm transfer (75%) = 22.39%
- Call back in 10 minutes (75%) = 40.84%

3.3 Average call pick up for the month was 2 minutes 2 seconds. Performance was particularly difficult to achieve over the weekend periods. The Service has had a challenging month and performance against key performance indicators reflects this. The performance improvement plan (approved by the Strategic Partnership Board) continues to be implemented and reviewed with additional actions being considered in collaboration with CCG Commissioners.

#### 52 Week waiters

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

		Better is...	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
CCG	Patients waiting 52+ weeks on an incomplete pathway	L	Zero Tolerance	0	1	2	3	2	1	4	4	4	27	20	14
Provider	Manchester Foundation Trust	L	Zero Tolerance	0	1	2	3	2	1	4	4	4	27	20	14
Specialty	Plastic Surgery	L	Zero Tolerance	0	1	2	3	2	1	4	4	4	6	6	6
Specialty	ENT	L	Zero Tolerance	0	0	0	0	0	0	0	0	0	17	9	7
Specialty	General Surgery	L	Zero Tolerance	0	0	0	0	0	0	0	0	0	2	2	1
Specialty	Ophthalmology	L	Zero Tolerance	0	0	0	0	0	0	0	0	0	1	1	0
Specialty	Other	L	Zero Tolerance	0	0	0	0	0	0	0	0	0	1	2	0

3.5 All of the breaches have occurred at Manchester Foundation Trust and in the speciality of Plastic Surgery, which has had capacity pressures. More recently there has been a further review of long waiters and investigation of the PAS system, identified further long waiters.

3.6 Manchester University NHS Foundation Trust has identified an emerging risk in relation to the management of waiting lists on the Manchester Royal Infirmary site.

- 3.7 Following a review of the longest waiting patients, and some subsequent investigation of our PAS system, they have identified that approximately 250 patients are waiting over 52 weeks for treatment, primarily in the specialties of General Surgery and ENT. These are in addition to the 30 DIEP plastic surgery patients.
- 3.8 Reasons are multi-factorial - around systems and processes
- 3.9 They recognise that these are clearly unacceptable delays for any patient, which is why they have been working intensely to investigate what happened and make the necessary changes and improvements.
- 3.10 They have taken a number of immediate actions across all hospitals:-
1. They have written to each patient identified as having waited more than 52 weeks for their treatment and apologised immediately.
  2. Undertaken a clinical review of the patients – so far they have not identified any significant patient harm as a result of the delay.
  3. Made plans to treat all the patients by the end of September.
  4. A Task Force has been set up to oversee immediate treatment of patients but also to review the IT and operational processes – a detailed action plan is in place.
  5. They are making plans to introduce a more modern version of the waiting list system although this will take up to two years to complete.
  6. They have informed regulators, GM and the Board of the plan.
  7. Director of Performance at MHCC is a member of the task force referenced above – weekly meetings are scheduled for the next few months and the performance team will be the single point of contact to CCGs and the GM Partnership in relation to this issue.
  8. A weekly briefing note will be provided to commissioners (via contracting leads) the GM partnership, NHSI and the CQC, updating on actions and patient numbers.
- 3.11 As at September 18, Tameside and Glossop is now down to 10 patients, as the Trust carries out urgent remedial action. We are informed following a clinical review that no patient harm to date, has occurred as a result of the delay. This is clearly unacceptable and are being assured by the host CCG that systems and improvements are being put in place. This is also being discussed and lead by the quality leads group.
- 3.12 Whilst this is a reduction since last month plans are in place to treat all patients over 52 weeks by the end of September. The current number of people waiting by specialty for Tameside and Glossop is tabled below.

Specialty	No Of Patients	Without a date	With a date
Plastic Surgery	5	5	0
ENT	4	1	3
General Surgery	1	0	1
<b>Total</b>	<b>10</b>	<b>6</b>	<b>4</b>

#### **A&E- Manchester University Hospital NHST**

- 3.13 A&E – There is an overall increase in the number of attendances of 7.2% when compared against the same time period in 17/18.
- 3.14 There is a real increase in activity of 7.2% when compared against last year. A deep dive has been conducted and it has since become clear that there is a change in casemix of patients turning up at A&E. It would appear that Tameside and Glossop patients are presenting at A&E with more serious conditions, which attracts a higher tariff and are of a category 2 or more with 1-3 further treatments. There is also a 10% increase in the number of patients presenting at A&E, which have resulted in 'No Investigation' and with 'No Significant Treatment'.

3.15 A detailed analysis will be undertaken to fully understand the details including the following:-

- Sharing of the patient details with Tameside and Glossop practices for investigation.
- Comparison of performance across all providers.
- Analysis of age and conditions.
- Have the list sizes for bordering practices changed.
- Analysis of other CCG performance at Manchester University NHS Foundation Trust.

3.16 An update will be provided at the next meeting.

**Elective waiting lists.**

3.17 The operating guidance Refreshing NHS Plans for 2018/19 section 3.7 states a more significant annual increase in the number of elective procedures compared with recent years means commissioners and providers should plan on the basis that their RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2019 than in March 2018 and, where possible, they should aim for it to be reduced.

3.18 The table below shows the RTT waiting list position for the CCG by month compared to the baseline of March 2018.

RTT	Mar 18 Base	Apr-18	% Variation from Mar 18	May-18	% Variation from Mar 18	Jun-18	% Variation from Mar 18	Jul-18	% Variation from Mar 18	Aug-18	% Variation from Mar 18
Bolton	5	2	-60.0%	4	-20.0%	5	0.0%	4	-20.0%	6	20.0%
Christie	81	97	19.8%	92	13.6%	130	60.5%	113	39.5%	109	34.6%
Manchester University FT	3,017	3,053	1.2%	3,096	2.6%	3,218	6.7%	3446	14.2%	3567	18.2%
NWCATS Care UK/Inhealth	370	401	8.4%	461	24.6%	417	12.7%	374	1.1%	385	4.1%
Other	184	237	28.8%	262	42.4%	300	63.0%	309	67.9%	289	57.1%
SPIRE MANCHESTER HOSPITAL	29	33	13.8%	30	3.4%	37	27.6%	45	55.2%	39	34.5%
BMI - THE ALEXANDRA HOSPITAL	123	152	23.6%	179	45.5%	177	43.9%	181	47.2%	202	64.2%
PAHT	412	370	-10.2%	371	-10.0%	366	-11.2%	403	-2.2%	407	-1.2%
Salford	472	462	-2.1%	427	-9.5%	449	-4.9%	415	-12.1%	484	2.5%
Stockport	949	1,011	6.5%	1,047	10.3%	1,020	7.5%	1035	9.1%	1028	8.3%
T&G ICFT	11,367	11,507	1.2%	11,761	3.5%	11,825	4.0%	11844	4.2%	11377	0.1%
WWL	94	86	-8.5%	79	-16.0%	87	-7.4%	96	2.1%	87	-7.4%
<b>Total</b>	<b>17,103</b>	<b>17,411</b>	<b>1.8%</b>	<b>17,809</b>	<b>4.1%</b>	<b>18,031</b>	<b>5.4%</b>	<b>18,265</b>	<b>6.8%</b>	<b>17,980</b>	<b>5.1%</b>
										Unvalidated	

3.19 This shows that the waiting list position as at the end of August 2018 is 5.1% higher than the March 2018 position. This is an improvement compared to the previous month where it was 6.8%. There are a number of providers where the waiting list is on the increase, Tameside and Glossop ICFT, Manchester University NHS Foundation Trust, Stockport and the Christie are the main contributors.

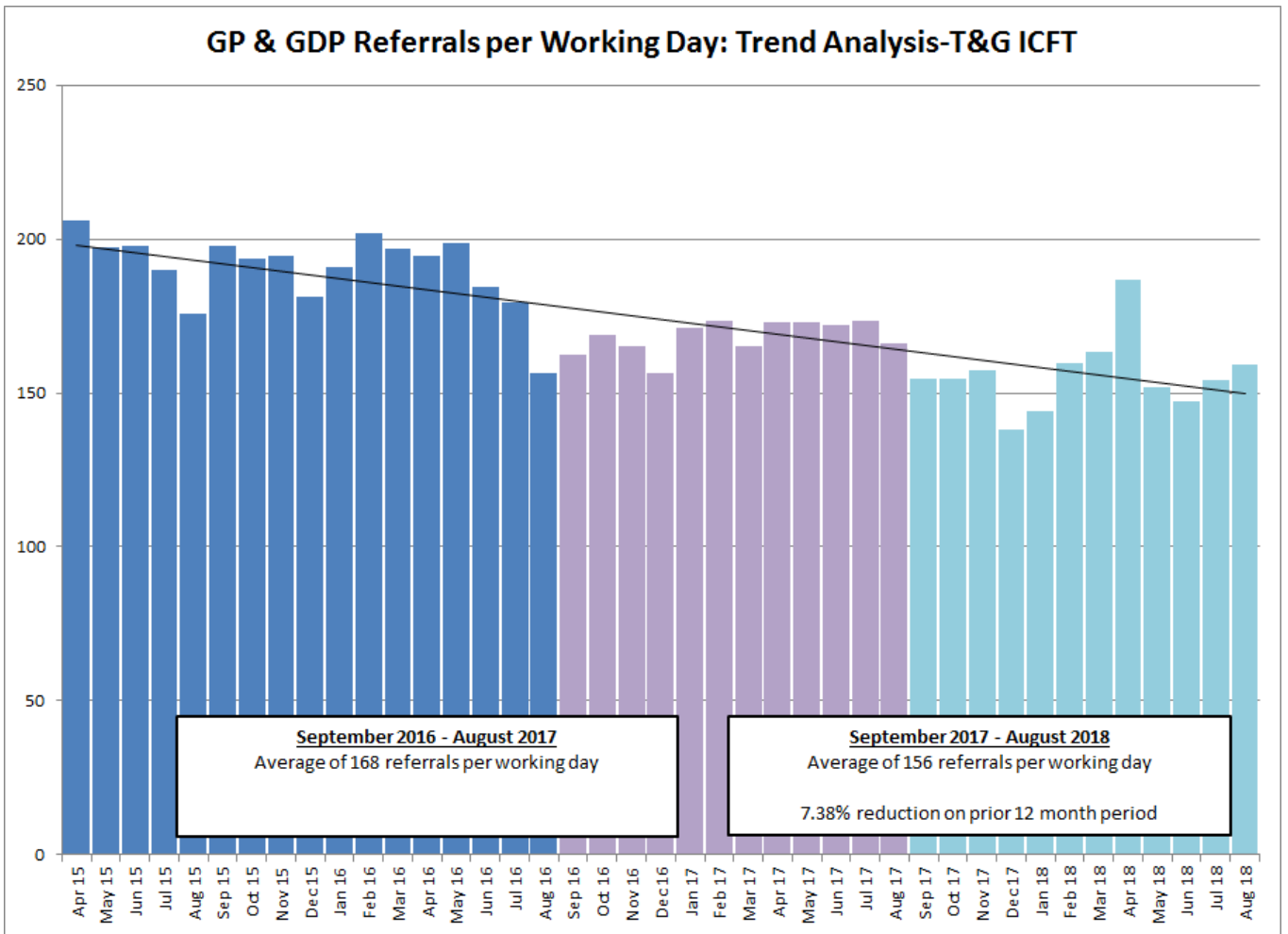
T&G CCG Total	March	April	May	June	July	August	Var Mar v Aug
100 - General Surgery	2172	2162	2276	2337	2364	2249	77
101 - Urology	1041	1122	1147	1072	1159	1144	103
110 - Trauma & Orthopaedics	2769	2751	2730	2776	2839	2646	-123
120 - Ear, Nose & Throat (ENT)	1342	1318	1388	1356	1335	1335	-7
130 - Ophthalmology	1258	1272	1427	1543	1677	1721	463
140 - Oral Surgery	0	0	0	0			0
150 - Neurosurgery	8	12	30	51	66	81	73
160 - Plastic Surgery	183	182	175	210	223	241	58
170 - Cardiothoracic Surgery	51	43	49	53	42	48	-3
300 - General Medicine	590	603	569	533	488	461	-129
301 - Gastroenterology	742	990	852	871	861	760	18
320 - Cardiology	1015	961	1043	1042	1035	1000	-15
330 - Dermatology	777	876	917	936	1004	1072	295
340 - Thoracic Medicine	491	513	576	584	556	575	84
400 - Neurology	6	6	7	6	7	1	-5
410 - Rheumatology	392	405	417	416	384	418	26
430 - Geriatric Medicine	12	15	15	18	22	20	8
502 - Gynaecology	1453	1412	1383	1343	1342	1430	-23
X01 - Other	2801	2768	2808	2884	2861	2778	-23
<b>Total</b>	<b>17103</b>	<b>17411</b>	<b>17809</b>	<b>18031</b>	<b>18265</b>	<b>17980</b>	<b>877</b>

3.20 The table above shows the waiting list position by specialty for the CCG. The main specialties where the waiting list is above the March 2018 position are general surgery, Urology, Ophthalmology, Dermatology. An analysis of the data at provider level has been undertaken, which shows which providers are contributing to this growth.

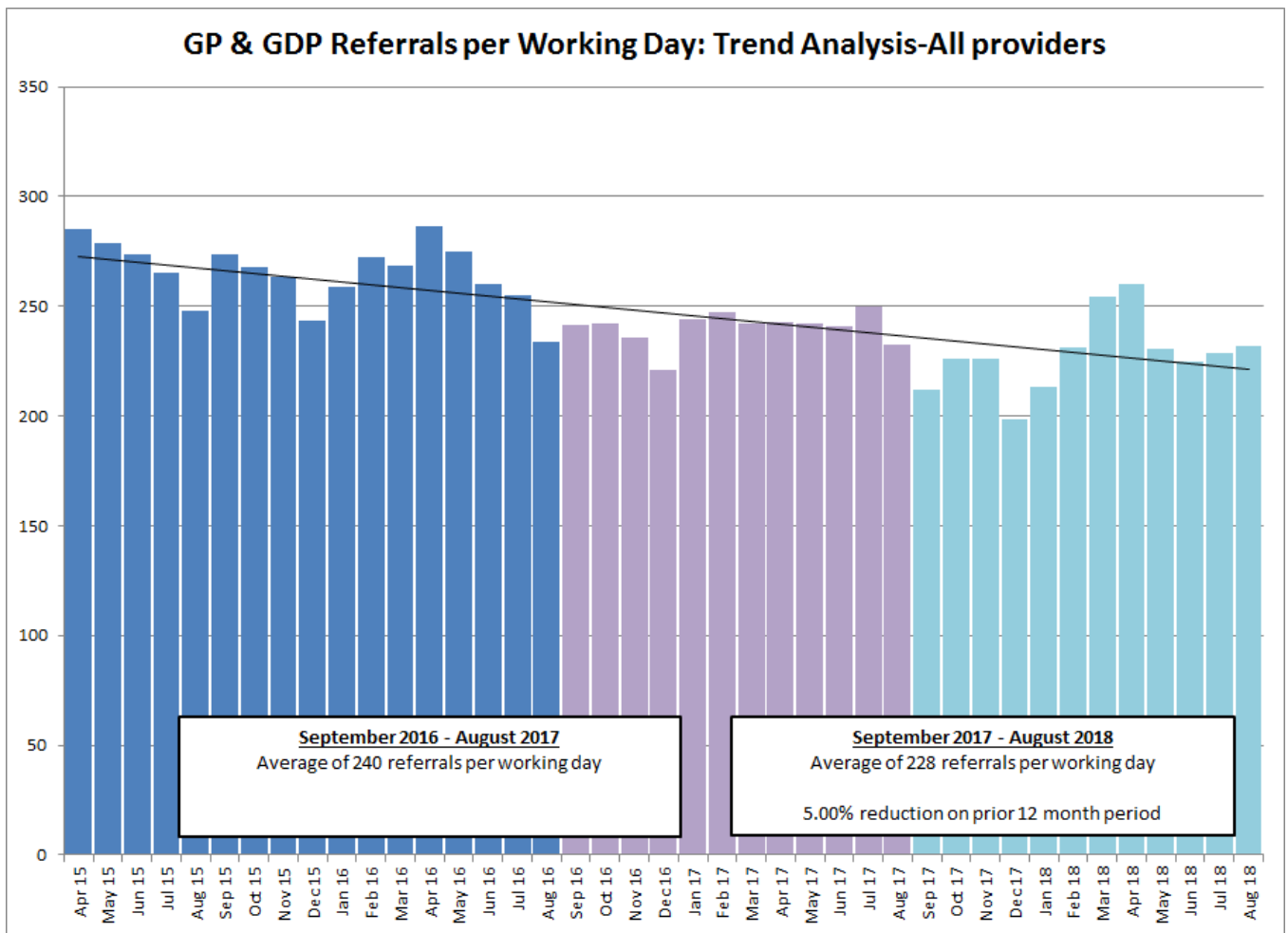
3.21 We are trying to understand what is driving the increase in increased demand, e.g. cancer activity following national cancer campaigns, or insufficient capacity. We are working with individual providers to ensure there is a plan to reduce the waiting lists as per the operating guidance. The ICFT have advised that such increases between April and July are usual and are predicting reductions in both waiting lists and backlog in the next few months.

#### **Referrals**

3.22 The chart below shows the GP referrals trend for Tameside and Glossop CCG at the ICFT. This shows that there has been a 7.38% reduction on the prior 12 month period (September to August). The average number of referrals per working day was 156 over the last 12 months compared to 168 for the same period last year.



3.23 The chart below shows the GP referrals trend for the CCG at all providers. This shows that there has been a 5% reduction on the prior 12 month period (September to August). The average number of referrals per working day was 228 over the last 12 months compared to 240 for the same period last year.



3.24 The table below shows the GP referral data for each CCG against plan. Tameside and Glossop CCG is 1% below plan as at Month 4 (July).

GP Referrals	YTD Actual Activity	YTD Planned Activity	YTD % Var. to Plan
GM	225,241	230,620	-2.3%
Stockport CCG	26,332	26,444	-0.4%
Bolton CCG	23,061	22,654	1.8%
Manchester CCG	42,092	40,608	3.7%
Tameside & Glossop CCG	19,134	19,320	-1.0%
Bury CCG	16,327	17,629	-7.4%
Oldham CCG	15,488	16,718	-7.4%
Trafford CCG	18,962	19,904	-4.7%
HMR CCG	16,620	19,228	-13.6%
Salford CCG	17,385	19,053	-8.8%
Wigan Borough CCG	29,840	29,062	2.7%
	<b>225,241</b>	<b>230,620</b>	<b>-2.3%</b>



3.25 The Table below shows GP referrals against the same period last year. This shows that Tameside and Glossop CCG has had a 4.4% reduction in GP referrals compared to the same period last year as at month 4 (July).

<b>GP Referrals</b>	YTD Actual 18/19 Activity	YTD Actual 17/18 Activity	YTD % Var. 17/18
GM	225,241	229,913	-2.0%
Stockport CCG	26,332	25,767	2.2%
Bolton CCG	23,061	<b>22,533</b>	2.3%
Manchester CCG	42,092	41,207	2.1%
Tameside & Glossop CCG	19,134	20,006	-4.4%
Bury CCG	16,327	<b>17,008</b>	-4.0%
Oldham CCG	15,488	16,514	-6.2%
Trafford CCG	18,962	20,383	-7.0%
HMR CCG	16,620	<b>19,420</b>	-14.4%
Salford CCG	17,385	18,929	-8.2%
Wigan Borough CCG	29,840	28,146	6.0%
	<b>225,241</b>	<b>229,913</b>	<b>-2.0%</b>

#### 4. RECOMMENDATIONS

4.1 As set out on the front of the report.

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# Health and Care Improvement Dashboard

## October 2018

	Indicator	Standard	Latest	Previous 2 data points		Latest	Direction of Travel	Trend
1	Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours	95%	Aug-18	93.3%	92.9%	95.0%	▲	
2	* Delayed Transfers of Care - Bed Days	3.5%	Mar-18	3.2%	3.2%	2.9%	▼	
3	* Referral To Treatment - 18 Weeks	92%	Aug-18	91.5%	91.3%	91.8%	▲	
4	* Diagnostics Tests Waiting Times	1%	Aug-18	0.6%	0.7%	0.9%	▲	
5	Cancer - Two Week Wait from Cancer Referral to Specialist Appointment	93%	Aug-18	96.3%	96.7%	95.3%	▼	
6	Cancer - Two Week Wait (Breast Symptoms - Cancer Not Suspected)	93%	Aug-18	96.8%	98.7%	99.0%	▲	
7	Cancer - 31-Day Wait From Decision To Treat To First Treatment	96%	Aug-18	98.0%	97.4%	99.2%	▲	
8	Cancer - 31-Day Wait For Subsequent Surgery	94%	Aug-18	100.0%	93.8%	93.8%	◀▶	
9	Cancer - 31-Day Wait For Subsequent Anti-Cancer Drug Regimen	98%	Aug-18	95.0%	100.0%	100.0%	◀▶	
10	Cancer - 31-Day Wait For Subsequent Radiotherapy	94%	Aug-18	100.0%	100.0%	100.0%	◀▶	
11	Cancer - 62-Day Wait From Referral To Treatment	85%	Aug-18	82.1%	89.3%	85.5%	▼	
12	Cancer - 62-Day Wait For Treatment Following A Referral From A Screening Service	90%	Aug-18	87.5%	87.5%	100.0%	▲	
13	Cancer - 62-Day Wait For Treatment Following A Consultant Upgrade		Aug-18	88.0%	93.6%	92.1%	▼	
14	MRSA	0	Aug-18	2	1	1	◀▶	
15	C.Difficile (Ytd Var To Plan)	0%	Jun-18	-37.5%	-50.0%	-33.3%	▲	
16	Estimated Diagnosis Rate For People With Dementia	66.7%	Aug-18	82.8%	80.4%	80.8%	▲	
17	Improving Access to Psychological Therapies Access Rate	1.25%	May-18	3.7%	3.5%	3.5%	▼	
18	Improving Access to Psychological Therapies Recovery Rate	50%	May-18	49.2%	48.7%	50.0%	▲	
19	Improving Access to Psychological Therapies Seen Within 6 Weeks	75%	May-18	89.1%	88.3%	88.6%	▲	
20	Improving Access to Psychological Therapies Seen Within 18 Weeks	95%	May-18	98.4%	99.2%	99.1%	▼	
21	Early Intervention in Psychosis - Treated Within 2 Weeks Of Referral	50%	Jun-18	66.7%	72.7%	63.2%	▼	
22	Mixed Sex Accommodation	0	Jul-18	0.13	0.00	0.10	▼	
23	Cancelled Operations		18/19 Q1	1.1%	1.3%	1.2%	▼	
24	Ambulance: Red 1 Calls Responded to in 8 Minutes	75%	Jul-17	62.0%	57.1%	63.3%	▲	
25	Ambulance: Red 2 Calls Responded to in 8 Minutes	75%	Jul-17	64.9%	60.6%	62.9%	▲	
26	Ambulance: Category A Calls Responded to in 19 Minutes	95%	Jul-17	91.6%	88.2%	89.7%	▲	
27	Cancer Patient Experience		2016	9.10	8.70	8.77	▲	
28	Cancer Diagnosed At An Early Stage		16/17 Q3	43.7%	54.2%	54.6%	▲	
29	General Practice Extended Access		Mar-18		82.1%	92.3%	▲	
30	Patient Satisfaction With GP Practice Opening Times		Mar-17		74.4%	76.0%	▲	

\* data for this indicator is provisional and subject to change

31	111 Dispositions- - % Recommended to speak to primary and community care (Ranking out of 40, 38 from March onwards)		Aug-18	11% (22nd)	11% (32nd)	11% (34th)	▼	
32	111 Dispositions- - % Recommended to dental (Ranking out of 40, 38 from March onwards)		Aug-18	2% (37th)	2% (37th)	3% (37th)	◀▶	

Indicator	Standard	Latest	Previous 2 data points		Latest	Direction of Travel	Trend
33 111 Dispositions- - % Recommended home care (Ranking out of 40, 38 from March onwards)		Aug-18	3% (35th)	4% (33rd)	3% (26th)	▲	
34 Maternal Smoking at delivery		18/19 Q1	16.7%	17.1%	14.4%	▼	
35 %10-11 classified overweight or obese		2014/15 to 2016/17	33.6%	33.6%	33.8%	▲	
36 Personal health budgets		17/18 Q4	6.50	10.10	11.40	▲	
37 Percentage of deaths with three or more emergency admissions in last three months of life		2017	7.80	6.40	6.80	▲	
38 LTC feeling supported		2016 03	62.90	62.40	61.40	▼	
39 Quality of life of carers		2016 03	0.80	0.77	0.78	▲	
40 Emergency admissions for urgent care sensitive conditions (UCS)		17/18 Q3	3037	2597	2951	▲	
41 Patient experience of GP services		2017	82.5%	83.2%	83.5%	▲	
<b>Adult Social Care Indicators</b>							
42 Part 2a - % of service users who are in receipt of direct payments	28.1%	18/19 Q1	13.48%	13.19%	12.84%	▼	
43 Total number of Learning Disability service users in paid employment	5.7%	18/19 Q1	4.39%	4.17%	4.05%	▼	
44 Total number of permanent admissions to residential and nursing care homes per 100,000 aged 18-64	13.3	18/19 Q1	11.86 (16 Admissions)	16.33 (22 Admissions)	2.22 (3 Admissions)	▼	
45 Total number of permanent admissions to residential and nursing care homes per 100,000 aged 65+	628	18/19 Q1	54.42 (177 Admissions)	656.41 (256 Admissions)	152.25 (60 Admissions)	▼	
46 Total number of permanent admissions to residential and nursing care homes aged 18+		18/19 Q1	193	278	63	▼	
47 Proportion of older people (65 and over) who were still at home 91 days after discharge from Hospital	82.7%	18/19 Q1	81.8%	77.4%	77.4%	▼	
48 % Nursing and residential care homes CQC rated as Good or Outstanding (Tameside and Glossop)		Aug-18	59%	58%	57%	▼	
49 % supported accommodation CQC rated as Good or Outstanding (Tameside and Glossop)		Aug-18	80%	80%	80%	◀▶	
50 % Help to live at homes CQC rated as Good or Outstanding (Tameside and Glossop)		Aug-18	67%	75%	81%	▲	

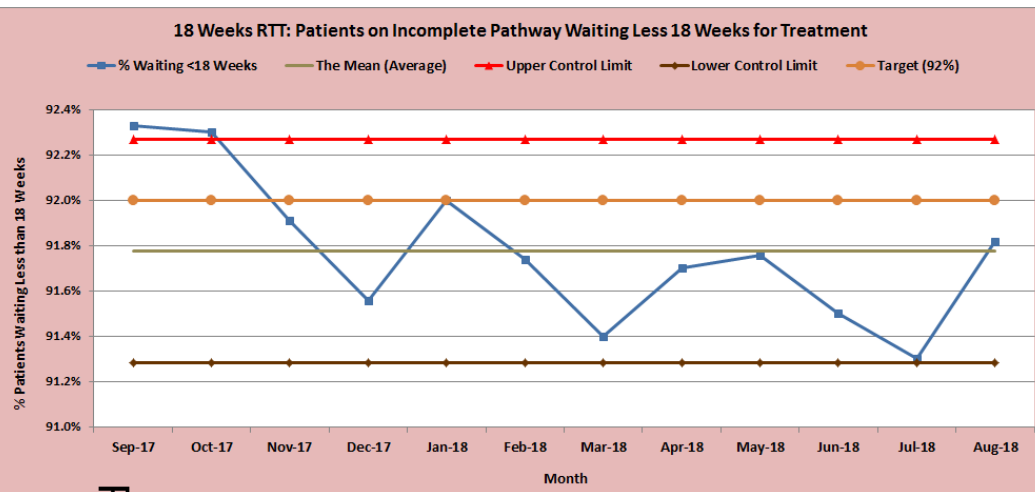
▼	Performance deteriorating and failing standard
▲	Performance improving and failing standard
▲	Performance improving and achieving standard
▼	Performance deteriorating and achieving standard
▼	Performance deteriorating no standard
▲	Performance improving no standard
◀▶	No change in Performance and achieving standard
◀▶	No change in Performance and failing standard
◀▶	No change in Performance and no standard

18 Weeks RTT: Patients on incomplete pathway waiting less than 18 weeks for treatment

Lead Officer: Elaine Richardson

Lead Director: Jess Williams

Governance: Contracts



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

CCG	Aug-18			
	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Target
NHS Wigan Borough CCG	20950	19513	93.14%	92%
NHS Salford CCG	23986	21886	91.24%	92%
NHS Tameside and Glossop CCG	17981	16510	91.82%	92%
NHS Bolton CCG	23443	21142	90.18%	92%
NHS Trafford CCG	16458	14826	90.08%	92%
NHS Oldham CCG	14812	13353	90.15%	92%
NHS Manchester CCG	43292	39094	90.30%	92%
NHSE North of England	1091378	968044	88.70%	92%
NHS Bury CCG	14165	12607	89.00%	92%
NHS Heywood, Middleton & Rochdale CCG	17692	15419	87.15%	92%
NHS Stockport CCG	28450	24435	85.89%	92%

\* Benchmarking data relates to August 2018

## Key Risks and Issues:

The RTT 18 weeks performance for August was 91.8% which is below the National Standard of 92% .  
 Failing specialties are, Urology (91.17%), Trauma & Orthopaedics (89.61%), ENT (91.84%), Plastic Surgery (79.67%), Cardio thoracic (83.33%), Cardiology (91.9%, Rheumatology (82.3%), Gynaecology (90.91%).  
 The performance at MFT at 88.65% is the key reason for the failure in August with 405 people breaching. Stockport, Salford and Pennine trusts also contributed to the failure accounting for a further 273 breaches. T&O continues to be a challenge across most providers. In MFT our concerns are around plastics, cardio thoracic, gynaecology and cardiology in addition a recent review of long waiters and their PAS highlighted 52 week waiters in general surgery, urology, T&O and ENT. As lead Commissioner. T&G ICFT as a provider are achieving the standard.

## Actions:

- MFT have advised the following.
- written to each patient identified and apologised immediately
- Undertaken a clinical review of the patients – so far not identified any significant patient harm as a result of the delay
- Made plans to treat all the patients by the end of September.
- A Task Force has been set up to oversee immediate treatment of patients and to review IT and operational processes – a detailed action plan is in place. Will be a single point of contact to CCGs and the GM Partnership in relation to this issue.
- will introduce a more modern version of waiting list system although this will take up to two years to complete
- informed regulators, GM and the Board of plan.
- weekly briefing note will be provided to commissioners

## Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating. However regular contact is maintained with GMHSCP and the local work being undertaken is recognised. The failure of this target will impact on the CCGs ability to obtain the money attached to this target for the Quality Premium Payment (QPP).

Unvalidated-Next month FORECAST

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**Report to:** STRATEGIC COMMISSIONING BOARD

**Date:** 24 October 2018

**Reporting Member / Officer of Strategic Commissioning Board** Jessica Williams, Director of Commissioning

**Subject:** TENDER FOR A CONTRACT TO EVALUATE THE TAMESIDE AND GLOSSOP GREATER MANCHESTER FUNDED TRANSFORMATION SCHEMES

**Report Summary:** The report summarises the procurement approach and evaluation of tenders received.

**Recommendations:** It is recommended that members note that a full and fair review of the potential partners has been performed and agree with the outcome of the procurement process that CLAHRC University of Manchester be appointed as the evaluation partner for the Greater Manchester funded transformation schemes.

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

<b>Budget Allocation (if Investment Decision)</b>	£200,000
<b>CCG or TMBC Budget Allocation</b>	CCG (from Greater Manchester Transformation funds)
<b>Integrated Commissioning Fund Section – s75, Aligned, In-Collaboration</b>	
<b>Decision Body – SCB Executive Cabinet, CCG Governing Body</b>	
<b>Value For money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark</b>	To assure success of the Integrated neighbourhood schemes
<b>Additional Comments:</b> The budget allocation is part of the agreed is agreed funding via the investment agreement with Greater Manchester Health and Social Care Partnership.	

**Legal Implications:**  
(Authorised by the Borough Solicitor)

In any procurement process officers are required to follow the Council’s Procurement Standing Orders to ensure transparency and fairness and avoid any successful challenge. Decision makers should be confident these rules have been complied with and properly applied before agreeing to any recommendation made on award of contract.


**How do proposals align with Health & Wellbeing Strategy?**

To ensure the success of the Integrated Neighbourhood schemes which support the Health and Wellbeing Strategy.

**How do proposals align with**

The evaluation will identify our success at integrated working

<b>Locality Plan?</b>	and achieving greater financial sustainability.
<b>How do proposals align with the Commissioning Strategy?</b>	The evaluation will identify our success at integrated working and achieving greater financial sustainability.
<b>Recommendations / views of the Health and Care Advisory Group:</b>	No recommendations were received from the Health and Care Advisory Group.
<b>Public and Patient Implications:</b>	Public and patients will be approached for feedback on their experience of the Neighbourhood Schemes as part of the evaluation will ensure benefits to public are released.
<b>Quality Implications:</b>	To ensure the Integrated Neighbourhood model is delivering to the required standards and identifies areas for improvement.
<b>How do the proposals help to reduce health inequalities?</b>	The Care Together Programme aims to reduce health inequalities, this contract will help to ensure the success of that.
<b>What are the Equality and Diversity implications?</b>	There are no equality and diversity implications associated with this report.
<b>What are the safeguarding implications?</b>	There are no safeguarding implications associated with this report.
<b>What are the Information Governance implications?</b>	Self-reported Information Governance compliance is included within the tender process and considered satisfactory. Further policy checks are completed at implementation.
<b>Has a privacy impact assessment been conducted?</b>	A privacy impact assessment has not been carried out.
<b>Risk Management:</b>	Contractual deliverables will be monitored across the partnership.
<b>Access to Information:</b>	The background papers relating to this report can be inspected by contacting the report writer Katie Flynn

 Telephone: 07342065644

 e-mail: [Katie.flynn@nhs.net](mailto:Katie.flynn@nhs.net)



## 1. INTRODUCTION

- 1.1 This report is regarding the procurement process conducted to select a provider (partner) to complete an evaluation of the Greater Manchester funded transformation schemes within the Tameside and Glossop Care Together Programme.
- 1.2 The Care Together Programme is Tameside and Glossop's approach to health and social care transformation. As part of the programme the health economy received £23.4 million in funding from the Greater Manchester Health and Social Care Partnership to deliver a series of transformation schemes. Care Together is a partnership between:-
- Tameside Metropolitan Borough Council (TMBC)
  - Tameside and Glossop Integrated NHS Care Foundation Trust (ICFT)
  - Tameside and Glossop Clinical Commissioning Group (CCG)
- 1.3 The Care Together Programme has the following stated aims:-
- To improve the healthy life expectancy through implementing a place based approach to better prosperity, health and wellbeing.
  - To deliver a clinically and financially sustainable health economy within five years.
- 1.4 The expected returns of the investment outlined above (both qualitative and financial) are detailed in the attached Investment Agreement (**Appendix A**). The Care Together Partnership requires an independent evaluation partner to assess the success and achievement of the programme.
- 1.5 The total budget allowed for this contract is £200,000.
- 1.6 The evaluation aims to provide an objective assessment of the impact of our transformation programmes and take account of some of the challenges involved in measuring an interdependent set of activities, many of which are designed to affect similar population groups.

## 2. BACKGROUND

- 2.1 The key features of the Care Together programme are:-
- Collective approach to improving health and care outcomes.
  - Driving up healthy life expectancy, reducing inequalities and creating financial sustainability.
  - Improving quality, access and reducing variation.
  - Development of a strategic, place based commissioner focus on public sector and health and wellbeing outcomes.
  - Creation of an Integrated Care Organisation using the FT licence.
- 2.2 The Care Together partnership serves a population of 255,000 people (with some of the population of Glossop also being served by Derbyshire County Council). The served population has a number of health challenges. Men and women in Tameside and Glossop have a healthy life expectancy three years lower than other areas in the North West and five years less than the average in England.
- 2.3 These lower rates of healthy life expectancy have a negative impact on residents' ability to engage in work, support themselves and their families, and ultimately lead healthy and fulfilling lives. The Care Together programme has a stated aim of increasing the healthy life expectancy to that of the North West average.

2.4 An evaluation methodology and framework will be developed in a collaborative manner between the selected evaluation partner and the Care Together programme. Given the nature of the transformation programme an innovative approach to the evaluation is expected as well as:-

- A theory-driven framework, which has been tried in other localities.
- A multiple-methods approach combining quantitative and qualitative analysis.

2.5 Consideration of the following are expected by the selected provider:-

- The use of currently existing or potentially new surveys of patients, people who access service carers, staff and citizens.
- The use of interviews and or focus groups with patients, people who access services, carers, staff and wider stakeholders, the use of observational methods.
- A review of existing programme documentation, consideration of existing literature relevant to the programme and analysis of existing datasets.
- To work with existing engagement structure i.e. Partnership Engagement Network, which is the approach to equalities and runs across the three Care Together organisations.
- At all times the evaluation partner is expected to identify and highlight at the earliest opportunity areas where the aims of the Care Together programme are not being met, the reason why and the potential control action that could be taken to rectify the issue. This also includes any unintended consequences.
- The evaluation approach will need to be designed in a way that will allow the Care Together partnership to continue the evaluation after the funding for the partner has ceased.
- The evaluation approach must be flexible enough to cover additional, discrete pieces of evaluation work that are identified after the evaluation partner is in place.
- The evaluation partner will endeavour to provide The Care Together Programme with the facilities and skills required to continue with evaluation after the contracted two year period.

### **3. DETAILS OF PROPOSED CONTRACTUAL ARRANGEMENTS**

3.1 The contract is expected to commence the week of 1 November 2018 or soon after depending, in part, on the successful suppliers' implementation plan.

### **4. PROCUREMENT APPROACH USED**

4.1 An open tender exercise was undertaken electronically using the Northwest Procurement Portal, "The Chest" with the opportunity being fully advertised on OJEU (Official Journal of the European Union) and Contracts finder in addition to within The Chest.

4.2 The tender was launched on 11 August 2018 with a closing date of 7 September 2018.

4.3 The tender had a fixed price of £200,000. Award and evaluation criteria are detailed in **Appendix C**.

4.4 Providers were required to meet a minimum standard demonstrating their technical and professional ability by providing information covering relevant experience and contract examples, previous experience of delivering similar evaluation work and subcontracting arrangements. Only providers assessed as providing sufficient detail of a good level of experience backed up with a clear evidence of past performance were taken through to have their full submission evaluated.

4.5 The two providers with the highest scoring submissions were invited to deliver a presentation of their proposal, which was used to moderate the provisional scoring of their written submission.

## 5. RESPONSE

5.1 There were 12 suppliers who applied for the tender. Of the 12 submissions four did not meet the minimum requirement for technical and professional ability and were disregarded.

- AA Projects Ltd
- Arden and GEM commissioning support unit
- Niche Health and Social care Consulting Ltd
- Trueman Change

5.2 The eight shortlisted suppliers were:-

- Catalyze
- CLAHRC University of Manchester
- Cordis Bright
- Mott Mc Donald Ltd
- North of England Commissioning Support Unit (NECS)
- Office for Public Management Ltd (Trading as Traverse)
- RSM UK Consulting LLP
- SQW Ltd

## 6. PROCUREMENT PROCESS

6.1 Evaluation and scoring of the tender submissions was undertaken by a panel representing key stakeholders:-

- Peter Nuttall                      Director of Performance and Informatics
- Sandra Whitehead              Assistant Director, Adults, TMBC
- Chris Easton                      Head of Person and Community Centred approaches
- Stephanie Sloan                  Strategy and Business Planning Manager, ICFT
- Nigel Williams                  Deputy Director, Care Together
- Ali Lewin                          Deputy Director of Commissioning, CCG
- Hazel Chamberlain              Head of Safeguarding, CCG
- Anna Hynes                        Business and Strategy Manager. Action Together

6.2 The panel met to discuss the submissions and allocated a provisional consensus score for each of the scored elements. Each panel member signed a declaration stating that their viewpoint would be impartial and the review was overseen by an independent representative of procurement.

6.3 The two highest scoring organisations were invited to a give a presentation to talk through their proposals. Suppliers were instructed not to bring additional information or offers to the presentation; hence, presentations were based entirely on the proposal detailed in the written element. There was some scope for clarification questions to be asked based on issues identified by the evaluation panel as required.

6.4 The presentations were used to moderate the provisional panel scoring and confirmed the provisional scoring.

6.5 The members of the panel for the presentations consisted of:-

- Peter Nuttall Director of Performance and Informatics, ICFT
- Richard Scarborough Planning and Commissioning Manager, Adults, TMBC
- Katie Flynn Programme Manager, Care Together Programme

6.6 The presentation confirmed that the preferred evaluation partner would be CLAHRC University of Manchester.

## **7. RESULTS OF CHECKS ON PROVIDERS**

7.1 Any financial checks required on the successful provider will be completed prior to any contract award.

## **8. CONCLUSION**

8.1 **Appendix B** contains a full summary of the evaluation scores. The individual organisation's scores are available for scrutiny.

## **9. RECOMMENDATION**

9.1 As stated at the front of the report.

## GREATER MANCHESTER HEALTH AND SOCIAL CARE TRANSFORMATION TAMESIDE AND GLOSSOP INVESTMENT AGREEMENT

### CONTENTS

#### PARTIES

#### BACKGROUND

1. Definition and Interpretation of Terms
2. Timescales covered by this agreement
3. Objectives of the Agreement
4. Commitment to the Locality Plan
5. Purpose of the Programme
6. Confirmation of support for the Programme by the Health and Wellbeing Board
7. Agreed Milestones
8. Transformation Funding
9. Flow of Funding
10. Senior Leader responsible for delivery
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12. Performance
13. Variations
14. Confidentiality
15. Dispute Resolution
16. Publicity
17. Payment of legal costs
18. Third Party Rights
19. General

- |            |   |  |
|------------|---|--|
| SCHEDULE 1 | - | Locality Plan  |
| SCHEDULE 2 | - | The metrics and milestones for measuring performance                   |
| SCHEDULE 3 | - | Dispute Resolution   |
| SCHEDULE 4 | - | Terms of Reference for the GM Health and Social Care Partnership Board |
| SCHEDULE 5 | - | National Requirements  |
| SCHEDULE 6 | - | Locality management and governance arrangements                        |

## **PARTIES**

This is an agreement between:

- (1) NHS England, 3 Piccadilly Place, London Road, Manchester, M1 3BN
- (2) NHS Tameside and Glossop Clinical Commissioning Group (CCG)  
New Century House  
Progress Way, Off Windmill Lane  
Denton, Manchester  
M34 2GP
- (3) Tameside Metropolitan Borough Council  
PO Box 304  
Ashton-under-Lyne  
Tameside  
OL6 0GA
- (4) Tameside and Glossop Integrated Care NHS Foundation Trust  
Fountain Street,  
Ashton-under-Lyne,  
OL6 9RW

each a **Party** and together, the **Parties**.

## **BACKGROUND**

- (A) Pursuant to the GM devolution agreement between Government and GM local authorities and the MoU developed between GM local authorities, GM CCGs and NHS England (which created a framework for the delegation and ultimate devolution of health and social care responsibilities to GM), from April 2016, the NHS bodies and local authorities in GM have taken control of £6bn of public money to run health and social care throughout the region.
- (B) The Greater Manchester Health and Social Care Devolution Memorandum of Understanding ('MOU') sets out the ambition for full devolution of funding and decision making for health and social care in GM. It describes the principles for how partners will work together, including a commitment to collaborate and make decisions in the best interests of patients and the people of GM.
- (C) The NHS bodies and local authorities in GM have developed a comprehensive GM Strategic Plan ('Taking Charge') to address the key challenges facing health and social care. The GM Strategic Plan sets out how, in pursuing five transformation themes, the NHS bodies and local authorities in GM will achieve clinical and financial sustainability.

- (D) NHS England agreed in December 2015 that £450m would be made available over a five year period for the establishment of a 'Transformation Fund' on the basis that the GM HSCPBE would oversee the deployment of this fund within GM to deliver the major change programme set out in the GM Strategic Plan, whilst securing locally the outcomes to which NHS England is committed as a consequence of the November 2015 Comprehensive Spending Review.
- (E) The objectives of the Transformation Fund are to support solutions which deliver clinical and financial sustainability across GM and at locality level and improve the health and social outcomes included in the GM Strategic Plan.
- (F) The specific purpose of the Transformation Fund is: investment in new systems, processes and infrastructure; and/or additional costs involved in developing and implementing new services while existing services are decommissioned.
- (G) In order to access the Transformation Fund a Locality must have in place a robust Locality Plan agreed by all key parties in the Locality Area, which is wholly aligned to the broader vision for health and social care transformation in GM and the specific schemes identified in the GM Strategic Plan.
- (H) Access Criteria for the Transformation Fund have been developed and agreed by the GM HSCPBE.
- (I) These criteria have been adopted by the GM Chief Officer on behalf of NHS England.
- (J) The overall governance and accountability of the Transformation Fund is the responsibility of the GM Chief Officer and Head of Paid Service, GMCA, both supported by the GM HSCPBE.
- (K) The Transformation Fund will be subject to the GM Accountability Framework, which will specify a full range of outcomes across health and social care to be delivered by the Transformation Fund.
- (L) NHS England has delegated responsibility internally to the GM Chief Officer for allocating the awards from the Transformation Fund. The GM HSCPBE has considered the Transformation Fund proposal from the Locality and made a recommendation to the GM Chief Officer for action. The GM Chief Officer having considered the application accepted this recommendation on 23<sup>rd</sup> September 2016.
- (M) This Agreement sets out the terms and conditions upon which funding from the Transformation Fund has been awarded to the CCG for distribution within the Locality Area.

- (N) This Agreement should be read in association with other key documents:
- (i) SCHEDULE 1 - Locality Plan
  - (ii) SCHEDULE 2
    - A – Metrics
    - B – Milestones (Word)
    - B(i) – Milestones (Gantt)
    - C – Finance Roll Up
    - C (i) – Expenditure and benefit plan
    - C (ii) – Activity reduction schedule
  - (iii) SCHEDULE 3 - Dispute Resolution
  - (iv) SCHEDULE 4 - Terms of Reference GM Health and Social Care Partnership Board
  - (v) SCHEDULE 5 - National Requirements
  - (vi) SCHEDULE 6 - Locality management and governance arrangements

## 1. Definition and Interpretation of terms

- 1.1 The definitions and rules of interpretation in this clause apply in this Agreement

**Access Criteria:** criteria agreed on in March 2016 by the GM HSCP<sup>1</sup> and adopted by NHS England that must be satisfied in order for a Locality to be granted Transformation Funding:

- Deliver the GM vision
- Enable transformational change
- Consolidate resources
- Secure value for money
- Facilitate learning for others

**Agreement:** this agreement between the Parties comprising these terms and conditions together with all schedules attached to it

**CCG:** the Clinical Commissioning Group specified as a Party to this Agreement and which is receiving Transformation Funding in accordance with this Agreement

**Commencement Date:** 1<sup>st</sup> December 2016

**Expiry Date:** At the end of financial year 2019/2020

**Five Year Forward View:** the document published in October 2015 by NHS Improvement, the Care Quality Commission, Public Health England and

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<sup>1</sup> [https://www.greatermanchester-ca.gov.uk/download/meetings/id/753/04a\\_transformation\\_fund\\_criteria](https://www.greatermanchester-ca.gov.uk/download/meetings/id/753/04a_transformation_fund_criteria)



Health Education England setting out a new shared vision for the future of the NHS based around new models of care<sup>2</sup>

**GM:** the Greater Manchester region comprising 10 local authority areas: Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, and Wigan

**GM Accountability Framework:** A GM Accountability Framework to set the approach to be undertaken internal to GM describing thresholds and levels of intervention and how the GM system can have oversight of its own performance to inform any national requirements." Timescale for completion of the Framework is August 2016<sup>3</sup>

**GM Chief Officer:** means the NHS England officer appointed to lead the GM health and social care devolution programme

**GMCA:** Greater Manchester Combined Authority

**GM HSCP:** the Greater Manchester Health and Social Care Partnership Board governed by the terms of reference set out in Schedule 5, which is responsible for setting the overarching strategic vision for the GM health and social care economy

**GM HSCPBE:** the Greater Manchester Health and Social Care Partnership Board Executive a group comprised of members of the GM HSCP which was established to provide support to the GM HSCP

**GM Strategic Plan:** the GM Strategic Sustainability Plan – Taking Charge<sup>4</sup> and the implementation plan set out within, aligned to the Five Year Forward View, which sets out how GM will achieve clinical and financial sustainability during a five year period underpinned by a number of principles agreed in the MoU signed in February 2015<sup>5</sup>

**Health and Wellbeing Board:** the forum established by the Health and Social Care Act 2012 where key leaders from the health and care system work together to improve the health and wellbeing of their local population and

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<sup>2</sup> <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

<sup>3</sup> [https://www.greatermanchester-ca.gov.uk/download/meetings/id/1166/07\\_taking\\_charge\\_-\\_implementation\\_plan](https://www.greatermanchester-ca.gov.uk/download/meetings/id/1166/07_taking_charge_-_implementation_plan)

<sup>4</sup> [https://www.greatermanchester-ca.gov.uk/homepage/73/taking\\_charge\\_of\\_our\\_health\\_and\\_social\\_care\\_in\\_greater\\_manchester](https://www.greatermanchester-ca.gov.uk/homepage/73/taking_charge_of_our_health_and_social_care_in_greater_manchester)

<sup>5</sup> [https://www.greatermanchester-ca.gov.uk/downloads/download/40/greater\\_manchester\\_health\\_and\\_social\\_care\\_devolution\\_memorandum\\_of\\_understanding](https://www.greatermanchester-ca.gov.uk/downloads/download/40/greater_manchester_health_and_social_care_devolution_memorandum_of_understanding)

reduce health inequalities and, in the context of this Agreement, refers to the relevant Health and Wellbeing Board for the Locality Area.

**Inter Authority Transfer:** An Inter Authority Transfer (IAT), is the mechanism used by CCGs, NHS England and NHS England local area teams to transfer resource known as allocations. It cannot be used with other organisations such as NHS providers or LAs

A sending and receiving organisation is required (like a budget transfer between budget holders in a standard organisation)

**Key Milestones:** has the meaning set out in Clause 7.2

**Local Authority:** the local authority specified as a Party to this Agreement

**Local Authority Transformation Funding:** the proportion of the Transformation Funding payable to a Local Authority to enable it to deliver the Locality Plan

**Locality:** the GM Local Authority, the CCG and the Providers who are Parties to this Agreement

**Locality Area:** The geographical area covered by the Local Authority

**Locality Cost Benefit Analysis:** the detailed financial analysis and evaluation of the costs and benefits associated with the Locality Plan

**Locality Plan:** a 5 year plan for health and social care and wider public service reform, which has been developed and agreed between the commissioners and providers within the Locality Area [and which is attached at Schedule 1[A] to this Agreement] (now added to front page)

**Locality Plan Implementation Plan:** the plan describing the implementation of the Locality Plan, which was endorsed by the GM HSCP[B] [and which is attached at Schedule 1B to this Agreement]

**MoU:** the Greater Manchester Health and Social Care Devolution Memorandum of Understanding, an agreement between the GM local authorities, the GM CCGs and NHS England which was signed in February 2015 and which creates a framework for the delegation and ultimate devolution of health and social care responsibilities to GM

**NHS Act:** National Health Service Act 2006

**NHS England:** the National Health Service Commissioning Board established by section 1H of the NHS Act and known as NHS England

**NHS Improvement:** the operational name for the organisation bringing together Monitor, the NHS Trust Development Authority and certain patient safety and service change teams

**NHS Improvement Agreement:** any agreement entered into between NHS Improvement (or one of its constituent legal entities) and a provider in the Locality Area relating to an allocation from the Sustainability and Transformation Fund

**Programme:** The Care Together programme of reform (set out in Schedule 2) created in accordance with the Locality Plan or transformation theme, for which Transformation Funding has been awarded

**Provider:** the NHS Trust(s) or NHS Foundation Trust(s) specified as Parties to this Agreement

**Provider Transformation Funding:** the proportion of the Transformation Funding payable to a NHS Trust/Foundation Trust to enable it to deliver the Locality Plan

**Recipients:** those Parties who have been identified in the Locality Plan Implementation Plan as proposed recipients of the Transformation Funding

**Senior Leader:** the person appointed by the Locality responsible for delivering the Programme and for delivering value for money from the funds awarded to the Locality.

**Stronger Together:** the GM strategy published in 2013 by GMCA and the [Local Enterprise Partnership](#) (LEP) around the twin themes of Growth and Reform that sets out a series of priorities that will drive sustainable economic growth and reform the way that public services are delivered

**Sustainability and Transformation Fund:** the national transformation fund established to support delivery of the Five Year Forward View

**Taking Charge:** the GM Strategic Plan

**Transformation Fund:** the £450m fund that NHS England has agreed to allocate to GM to deliver the major change programme set out in the GM Strategic Plan, whilst securing locally the outcomes to which NHS England is committed as a consequence of the November 2015 Comprehensive Spending Review, and which represents GM's share of the available transformation budget over the period 2016 to 2021

**Transformation Funding:** the sum of funding allocated by NHS England from the Transformation Fund to the CCG to distribute to the Recipients

**Transformation Fund Proposal:** the proposal documentation that was submitted by the Locality to secure access to Transformation Funding [and which is attached at Schedule 8 to this Agreement]

- 1.2 Clause, Schedule and paragraph headings shall not affect the interpretation of this Agreement.
- 1.3 The Schedules form part of this Agreement and shall have effect as if set out in full in the body of this Agreement. Any reference to this Agreement includes the Schedules.
- 1.4 A reference to a statute or statutory provision is a reference to it as it is in force for the time being, taking account of any amendment, extension or re-enactment and includes any subordinate legislation for the time being in force made under it.
- 1.5 A reference to a document is a reference to that document as varied (other than in breach of the provisions of this Agreement) at any time.
- 1.6 References to clauses and Schedules are to the clauses and Schedules of this Agreement. References to paragraphs are to paragraphs of the relevant Schedule.

## **2. Term**

- 2.1 This Agreement shall take effect on the Commencement Date and shall continue until the Expiry Date, unless extended in accordance with clause 2.2 or terminated sooner in accordance with the provisions of this Agreement.
- 2.2 The Parties may extend this Agreement by such period as they agree.

## **3. Objectives of the Agreement**

- 3.1 By entering into this Agreement the Parties re-affirm their commitment to:
  - (i) deliver the transformation of health and social care services in GM and the wider reform of public services in GM as set out in the GM Strategic Plan.
  - (ii) collaborate and cooperate with each other, in line with the principles set out in the MOU, and work within the agreed GM Health and Social Care partnership governance arrangements.
- 3.2 Each Party confirms that implementation of its obligations under this Agreement is consistent with its statutory obligations, and that it has complied

with any relevant requirements imposed upon it by legislation or regulatory authority, and will continue to do so.

#### **4. Commitment to the Locality Plan**

- 4.1 The Locality affirms their commitment to the delivery of the Locality Plan set out in Schedule 1 noting that this Agreement:
- covers the metrics as set out in Schedule 2
  - supports the delivery of the broader locality objectives set out in Schedule 1, *although will not cover delivery of the entirety of the Locality Plan.*
- 4.2 The Locality is satisfied that the Locality Plan has a strong foundation and a good trajectory for improvement and delivery of health and social care services across the system.
- 4.3 The Locality commits to meeting the requirements of the Programme in support of the delivery of the Locality Plan and, as appropriate, the NHS Improvement Agreements.
- 4.4 The Locality affirms its commitment to the delivery of national outcome, quality and operational standards. Schedule 5 sets out the national NHS requirements and identifies those outcomes and standards that will be directly or indirectly supported by this Agreement.

#### **5. Purpose of the Programme**

- 5.1 As part of closing the financial and quality gaps set out in the Locality Plan and delivering both “Taking Charge” and “Stronger Together<sup>6</sup>”, the Locality has established the Care Together Programme.
- 5.2 By 2020/21 the purpose of the Programme is to:
- Improve Healthy Life Expectancy to average GM levels
  - Improve population outcomes and population experience
  - Create a financially sustainable health and social care economy
- 5.3 The Programme is set out in detail in Schedule 2 together with the metrics against which the Programme will be measured.

#### **6. Confirmation of support for the Programme by the Health and Wellbeing Board**

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<sup>6</sup> [https://www.greatermanchester-ca.gov.uk/downloads/file/8/stronger\\_together\\_-\\_greater\\_manchester\\_strategy](https://www.greatermanchester-ca.gov.uk/downloads/file/8/stronger_together_-_greater_manchester_strategy)

6.1 The Locality confirms that details of the Programme have been discussed at the Health and Wellbeing Board; and the Health and Wellbeing Board is supportive of the objectives and approach of the Programme as reflected in the Locality Plan. This plan was approved by the Health and Wellbeing Board in November 2015.

**7. Agreed milestones**

7.1 The Parties have agreed key milestones addressing:

- (i) expected reductions in demand;
- (ii) improvements in outputs, outcomes, prevalence and impacts (measured against specific metrics);
- (iii) expected decommissioning of existing resources and how resources will transfer between different organisations;
- (iv) ways the impact will be tracked and evaluated over time; and
- (v) expected changes in productivity

7.2 The key milestones for the period of the Term are set out in detail in Schedule 2 (“Key Milestones”).

**8. Transformation funding**

8.1 To support the delivery of the Programme the GM Chief Officer has agreed to allocate £23.2m of Transformation Funding to the Locality. (See Clause 9.1 for funding flow).

8.2 The profile of this funding is:

<b>Quarter</b>	<b>Funding</b>
Q4 2016/17	£5.226m
Q1 2017/18	£1.956m
Q2 2017/18	£2.002m
Q3 2017/18	£2.078m
Q4 2017/18	£1.937m
2018/19	£6.341m
2019/20	£3.659m
2020/21	0

*Note: The duration of the period of fixed funding and the profile of fixed funding will be determined by the GM Chief Officer (with the support and advice of the GM HSCPBE), in the light of the specific Locality Plan under consideration, and the proposed Key Milestones to meet under that Locality Plan. The Agreement may also include an illustrative guide to the anticipated level and profile of funding beyond the fixed period, but this will be subject to review and confirmation by the GM Chief Officer (with the support and advice*

*of the GM HSCPBE) no later than six months before the end of the fixed funding period.*

- 8.3 The Transformation Funding awarded may only be used for the purpose for which it is intended, as set in the Transformation Fund Proposal and Locality Cost Benefit Analysis as contained within Schedule 8 of this Agreement.
- 8.4 Recipients of Transformation Funding are required to adhere to their own Standing Financial Instructions. However, with the exception of reports prepared by advisors for regulatory purposes, expenditure incurred on external consultancy contracts in excess of £50,000 (advisory or management capacity) will be subject to the approval of the GM Chief Officer.

## **9. Flow of funding**

- 9.1 The Transformation Funding will be transferred to the CCG by means of an Inter Authority Transfer.
- 9.2 The CCG shall distribute the Transformation Funding to the Recipients as required to deliver the Programme as defined in Schedules 1 and 2.
- 9.3 The CCG shall effect the distribution of the Local Authority Transformation Funding to the Local Authority by exercising its powers under Section 256 (payments towards community services) of the NHS Act.
- 9.4 The CCG shall effect the distribution of the Provider Transformation Funding to the Provider by exercising its powers under Section 3A of the NHS Act and Section 2 of the NHS Act (as appropriate).

## **10. Senior leader responsible for delivery**

- 10.1 The Locality has appointed Steven Pleasant, Chief Executive, Tameside Metropolitan Borough Council and Chief Accountable Officer, NHS Tameside and Glossop CCG as the Senior Leader responsible for delivering the Programme and for delivering value for money from the funds awarded to the Locality as set out in in Clause 8 of this Agreement.

## **11. Reporting and evaluation**

- 11.1 The Senior Leader will provide regular updates to the GM HSCPBE and GM HSCPBE (in a form and at a frequency to be determined by the GM HSCPBE and GM HSCPBE) and to the Health and Wellbeing Board on the Locality's progress towards achieving the Key Milestones.

- 11.2 The Senior Leader will provide all such information, documents, records and other items and assistance as the GM Chief Officer may reasonably require in connection with the performance of any Party's obligations under this Agreement.
- 11.3 The CCG, Local Authority and the Provider agree that they will provide all such information and assistance as the Senior Leader may reasonably require to enable it to:
- (i) report to the GM HSCPBE in accordance with Clause 11.1; and
  - (ii) provide such information and assistance as may be required by the GM Chief Officer pursuant to Clause 11.2.
- 11.4 The Locality will undertake a formal annual review of the delivery of the Locality Plan with the support of, and in accordance with a process and format prescribed by, the GM HSCPBE. The annual review will, amongst other things to be prescribed by the GM HSCPBE, check that Transformation Funding has been used for the purposes for which it was allocated. The Locality will deliver the first formal annual review to the GM HSCPBE within 6 months of the Commencement Date.
- 11.5 The Locality will undertake a comprehensive evaluation of the Programme in a form to be agreed with the GM HSCPBE as part of the ongoing operation of the GM Accountability Framework.
- 11.6 The Locality will ensure the Locality Plan and the Programme associated with this Agreement is monitored through its governance and programme management arrangements, as set out in Schedule 6. The GM Chief Officer and / or their representatives will have the right to attend Locality meetings that relate to the distribution or use of the Transformation Funding and/or the delivery of the Programme.

## **12. Performance**

- 12.1 The GM HSCPBE and the Locality agree to work together for the successful implementation of the Programme and to work collaboratively to address any issues that arise or are foreseen.
- 12.2 If the Locality:
- (i) fails to deliver any Key Milestone;
  - (ii) delivers the Key Milestones outwith the timescales for delivery specified in Schedule 2; or
  - (iii) commits a material breach of this Agreement and either such breach is in the reasonable opinion of the GM Chief Officer not capable of remedy or such breach is in the reasonable opinion of the GM Chief



Officer capable of remedy and is not remedied to his reasonable satisfaction within such time period as he shall stipulate, acting reasonably,

then the GM Chief Officer (with advice and support from the GM HSCPBE and/or the GM HSCPBE) may:

- (a) specify additional or amended requirements on the Locality and make the allocation of further Transformation Funding contingent on performance of those additional requirements;
- (b) re-profile, pause, reduce or cease payment of some or all of further Transformation Funding;
- (c) seek the recovery of some or all of the Transformation Funding; and/or
- (d) terminate this Agreement by giving written notice to the Parties.

Before exercising any right under clause 12.2(a)-(d) inclusive, the GM Chief Officer shall have, at the least:

- (iv) considered whether any alternative options are available that would address the outstanding performance issue(s);
- (v) taken reasonable steps to meet with the Locality to discuss the performance issue(s) and seek alternative options to address them; and
- (vi) discussed the matter with the GM HSCPBE.

12.3 The GM Chief Officer and the GM HSCPBE may agree a package of non-financial support for the Locality to support it in delivering the Key Milestones. This support will be tailored to reflect the particular challenges and problems faced by the Locality.

12.4 For the avoidance of doubt, the GM Chief Officer, with the support of the GM HSCPBE shall have the final decision in relation to:

- (i) any package of non-financial support that is to be offered to the Locality pursuant to Clause 12.3; and
- (ii) any action that is to be taken pursuant to Clause 12.2.

12.5 The Locality recognises that any decision made by the GM Chief Officer pursuant to this Clause 12 shall be final.

12.6 If the GM Chief Officer and the GM HSCPBE require the repayment of some or all of the Transformation Funding then, subject to Clause 12.7 below, the CCG shall repay to NHS England the relevant amount of the Transformation Funding as soon as reasonably practicable.

12.7 The CCG would only be required to repay to NHS England:

- (i) any uncommitted Transformation Funding that it has not yet distributed to the Recipient; any Transformation Funding that the CCG has in turn been repaid by the Recipients.

12.8 If the CCG requests:

- (i) the Local Authority; and/or
- (ii) the Provider

to repay to it a proportion of the uncommitted Transformation Funding so that it can, in turn, repay some or all of the Transformation Funding to NHS England then the Local Authority and/ or the Provider (as applicable) agree to repay the relevant proportion of the Transformation Funding to the CCG as soon as reasonably practicable and in any event within [thirty (30)] days of the request.

**12.9** The GM Chief Officer will not be held liable for any misappropriation of funds, and/or any Third Party costs that would be incurred in relation to the same.

### **13. Variations**

13.1 This Agreement may be varied by the Parties at any time by agreement in writing in accordance with the Parties' internal decision-making processes.

### **14. Confidentiality**

14.1 The Parties agree to keep confidential all documents relating to or received from another Party under this Agreement that are labelled as confidential.

14.2 Clause 14.1 shall not apply to disclosure of information:

- (i) required by any applicable law;
- (ii) where a Party can demonstrate that such information is already generally available and in the public domain otherwise than as a result of a breach of Clause 14.1
- (iii) which is already lawfully in the possession of the receiving party, prior to its disclosure by the disclosing party.

14.3 Where a Party receives a request to disclose information that another Party has designated as confidential, the receiving Party shall consult with the other Parties before deciding whether the information is subject to disclosure.

### **15. Dispute Resolution**

15.1 Subject to Clause 15.2, if any dispute arises out of or in connection with this Agreement, the Parties must first attempt to settle the dispute in accordance with the procedures set out in Schedule 4.

15.2 A Party may seek an injunction in connection with any breach by another Party of its obligations under Clause 14.

## **16. Publicity**

16.1 The Parties shall use reasonable endeavours to consult one another before making any press announcements concerning the services or the discharge of any Party's responsibilities under this Agreement.

## **17. Payment of legal costs**

17.1 The Parties agree that each shall bear their respective legal costs incurred in connection with this Agreement.

## **18. Third Party Rights**

18.1 No person other than a Party to this Agreement shall have any right under the Contracts (Rights of Third Parties) Act 1999 to enforce any of the terms of this Agreement.

## **19. General**

19.1 Subject to clause 19.2, this Agreement is personal to the Parties and no Party shall, without the prior written consent of the other Parties, assign, transfer or vest, except by the operation of any statutory provision, the benefit of the Agreement to any other person.

19.2 The benefit and/or burden of this Agreement may be assigned or transferred by any Party to any successor of all or part of its functions, property, rights and liabilities.

19.3 The Parties agree that this Agreement shall not be interpreted as constituting a partnership between the Parties nor as constituting any agency between the Parties and the Parties agree that they shall not do cause or permit anything to be done which might lead any person to believe otherwise.

19.4 Any termination of this Agreement shall be without prejudice to any rights or remedies of the Parties in respect of any antecedent breach of this Agreement.

- 19.5 The termination of this Agreement shall not affect the coming into force or the continuation in force of any provision of this Agreement which is expressly or by implication intended to come into or continue in force on or after such termination or expiry.
- 19.6 Unless otherwise stated all sums stated in this Agreement are inclusive of all applicable tax, including any VAT.
- 19.7 The construction, validity and performance of this Agreement shall be governed by the laws of England.
- 19.8 This Agreement may be entered into in any number of counterparts and by the parties to it on separate counterparts, each of which, when so executed and delivered shall be an original.

## **Signatures**

**NHS England**

Signed on behalf of NHS England

Name: Jon Rouse

Role: GM Chief Officer

Signature:

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Date:

**The Greater Manchester Health and Social Care Partnership Board**

Signed on behalf of the Greater Manchester Health and Social Care Partnership Board

Name: Lord Peter Smith

Role: Chair

Signature:

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Date:

**The Locality**

Signed on behalf of the Locality (signatories must include the Leader of the Local Authority, Chief Executive of the Local Authority, Chair of the Clinical Commissioning

Group, Chief Executive of the Clinical Commissioning Group, Chair of the acute provider, Chief Executive of the acute provider).

**Signed on behalf of the Commissioners**

Name: Steven Pleasant OBE

Role: Chief Executive, Metropolitan Borough Council and Chief Accountable Officer, NHS Tameside and Glossop CCG

Signature: \_\_\_\_\_

Date:

Name: Dr. Alan Dow

Role: Chair, NHS Tameside and Glossop CCG

Signature: \_\_\_\_\_

Date:

**Signed on behalf of the Provider**

Name: Karen James

Role: Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust

Signature: \_\_\_\_\_

Date:

Name: Paul Connellan

Role: Chair, Tameside and Glossop Integrated Care NHS Foundation Trust

Signature: \_\_\_\_\_

Date:

**SCHEDULE 1 – LOCALITY PLAN**



Locality Plan - 2nd  
Iteration FINAL.pdf





## SCHEDULE 2A – PROGRAMME METRICS

Schedule 2A Programme Metrics for Tameside and Glossop need to read in conjunction with the (draft) Planning 2017/18 - 2018/19 CCG Monthly Activity and Other Requirements which was submitted to NHSE on 24<sup>th</sup> November. This is an extensive Excel spreadsheet and attached as Schedule 2A(i) which identifies trajectories on a range of performance metrics.

This will be finalised by 23<sup>rd</sup> December in line with the date requested by NHSE for contracts between CCGs and providers to be agreed. At this stage, Tameside and Glossop will also highlight the key trajectories in the table below. This will include prevalence, provider productivity, configuration/decommissioning and any additional in the category of activity not already highlighted below.

STP Core Metrics 17/18 - 18/19 (once these are released by NHSE – estimated February 2017) will be incorporated in the trajectories and metrics before Q1 of 2017/18.

### Investment Agreement – Metrics and approach to monitoring

Below is a summary of the metrics proposed for the Tameside and Glossop Investment agreement along with the proposed approach to be taken by in conjunction with GM H&SC Partnership to monitor performance over the duration of the Agreement. These focus on financial and activity metrics as being the most likely to show progress of the transformational fund schemes and which can be reported quarterly.

As stated above, additional metrics will be added in once contract negotiations within Tameside and Glossop have concluded and a financial position for 2017/18 agreed.

Category	Measure	Threshold/target by 2020/21 (incl. baseline)	Lead & Organisation	Data Source	Monitoring mechanism	Frequency																		
Financial	Economy Gap as defined by and agreed by GM	<table border="1"> <thead> <tr> <th>Year</th> <th>Total Locality Gap: Do Nothing £'000s</th> <th>Do Something £'000s</th> </tr> </thead> <tbody> <tr> <td>2016/17</td> <td>56,212</td> <td>38,950</td> </tr> <tr> <td>2017/18</td> <td>82,489</td> <td>55,568</td> </tr> <tr> <td>2018/19</td> <td>88,867</td> <td>40,150</td> </tr> <tr> <td>2019/20</td> <td>94,478</td> <td>26,449</td> </tr> <tr> <td>2020/21</td> <td>101,507</td> <td>9,461</td> </tr> </tbody> </table>	Year	Total Locality Gap: Do Nothing £'000s	Do Something £'000s	2016/17	56,212	38,950	2017/18	82,489	55,568	2018/19	88,867	40,150	2019/20	94,478	26,449	2020/21	101,507	9,461	Directors of Finance  (Commissioner & T&GICFT)	Reporting via internal governance of CCG and FT as well as GM submissions	FEW / GM Assurance  Meetings	Monthly internally.  Quarterly to NHS/GM through IAF
Year	Total Locality Gap: Do Nothing £'000s	Do Something £'000s																						
2016/17	56,212	38,950																						
2017/18	82,489	55,568																						
2018/19	88,867	40,150																						
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2020/21	101,507	9,461																						

Category	Measure	Threshold/target by 2020/21 (incl. baseline)	Lead & Organisation	Data Source	Monitoring mechanism	Frequency																														
Financial	£'s spent on prescribing per 1000 population	Reduction in spend pa of: <table border="1"> <thead> <tr> <th>Year</th> <th>16/17 £m</th> <th>17/18 £m</th> <th>18/19 £m</th> <th>19/20 £m</th> <th>20/21 £m</th> </tr> </thead> <tbody> <tr> <td>Baseline (budget)</td> <td>40.28 8</td> <td>42.23 4</td> <td>43.43 6</td> <td>44.67 0</td> <td>45.93 8</td> </tr> <tr> <td>Reduction in spend</td> <td>0</td> <td>-1.000</td> <td>-1.500</td> <td>-2.000</td> <td>-2.500</td> </tr> <tr> <td>Plan</td> <td>40.28 8</td> <td>41.23 4</td> <td>41.93 6</td> <td>42.67 0</td> <td>43.43 8</td> </tr> <tr> <td>£'000s per 1000 pop</td> <td>164</td> <td>168</td> <td>171</td> <td>174</td> <td>177</td> </tr> </tbody> </table>	Year	16/17 £m	17/18 £m	18/19 £m	19/20 £m	20/21 £m	Baseline (budget)	40.28 8	42.23 4	43.43 6	44.67 0	45.93 8	Reduction in spend	0	-1.000	-1.500	-2.000	-2.500	Plan	40.28 8	41.23 4	41.93 6	42.67 0	43.43 8	£'000s per 1000 pop	164	168	171	174	177	Chair of Single Commissioning Board (Alan Dow)	CCG Financial System	Care Together Financial Monitoring Statement	Monthly internally, quarterly to GM
Year	16/17 £m	17/18 £m	18/19 £m	19/20 £m	20/21 £m																															
Baseline (budget)	40.28 8	42.23 4	43.43 6	44.67 0	45.93 8																															
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£'000s per 1000 pop	164	168	171	174	177																															

Category	Measure	Threshold/target by 2020/21 (incl. baseline)	Lead & Organisation	Data Source	Monitoring mechanism	Frequency																																				
Activity	Number of emergency admissions to Hospital (per 1000 population)	<ul style="list-style-type: none"> <li>Neighbourhoods would stem 25% of forecast growth in planned admissions (based on 2016/17 growth baseline) in 2017/18 increasing to 50% of forecast growth from 2018/19 onwards</li> <li>Digital Health would reduce NEL admissions by 455 admissions</li> </ul> Reduction on 16/17 baseline growth assumptions of: <table border="1"> <thead> <tr> <th>Year</th> <th>16/17</th> <th>17/18</th> <th>18/19</th> <th>19/20</th> <th>20/21</th> </tr> </thead> <tbody> <tr> <td>Baseline (admissions)</td> <td>33,165</td> <td>33,826</td> <td>34,399</td> <td>34,983</td> <td>35,866</td> </tr> <tr> <td>INs</td> <td>0</td> <td>-331</td> <td>-1,235</td> <td>-1,818</td> <td>-2,701</td> </tr> <tr> <td>Digital Health</td> <td>0</td> <td>-228</td> <td>-455</td> <td>-455</td> <td>-455</td> </tr> <tr> <td>Plan</td> <td>33,165</td> <td>33,267</td> <td>32,710</td> <td>32,710</td> <td>32,710</td> </tr> <tr> <td>per 1000 pop</td> <td>135</td> <td>136</td> <td>133</td> <td>133</td> <td>133</td> </tr> </tbody> </table>	Year	16/17	17/18	18/19	19/20	20/21	Baseline (admissions)	33,165	33,826	34,399	34,983	35,866	INs	0	-331	-1,235	-1,818	-2,701	Digital Health	0	-228	-455	-455	-455	Plan	33,165	33,267	32,710	32,710	32,710	per 1000 pop	135	136	133	133	133	Director of Integrated Neighbourhoods  (Director of Operations until appointed), ICFT	No of emergency admissions routinely collected through SLAM data	CCG and provider contract performance governance	Monthly internally.  Quarterly to GM
Year	16/17	17/18	18/19	19/20	20/21																																					
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Category	Measure	Threshold/target by 2020/21 (incl. baseline)	Lead & Organisation	Data Source	Monitoring mechanism	Frequency																																				
Activity	Number of ED attendances	<ul style="list-style-type: none"> <li>Neighbourhoods would stem 50% of forecast growth in planned admissions (based on 2016/17 growth baseline) in 2017/18 increasing to 100% of forecast growth from 2018/19 onwards</li> <li>Digital Health would reduce ED attendances by 1733 attendances.</li> </ul> Reduction on 16/17 baseline growth assumption of: <table border="1"> <thead> <tr> <th>Year</th> <th>16/17</th> <th>17/18</th> <th>18/19</th> <th>19/20</th> <th>20/21</th> </tr> </thead> <tbody> <tr> <td>Baseline (attendances)</td> <td>88,291</td> <td>90,052</td> <td>91,579</td> <td>93,131</td> <td>95,482</td> </tr> <tr> <td>INs</td> <td>0</td> <td>-880</td> <td>-3,287</td> <td>-4,840</td> <td>-7,191</td> </tr> <tr> <td>Digital Health</td> <td>0</td> <td>-867</td> <td>-1,733</td> <td>-1,733</td> <td>-1,733</td> </tr> <tr> <td>Plan</td> <td>88,291</td> <td>88,305</td> <td>86,558</td> <td>86,558</td> <td>86,558</td> </tr> <tr> <td>per 1000 pop</td> <td>360</td> <td>360</td> <td>353</td> <td>353</td> <td>353</td> </tr> </tbody> </table>	Year	16/17	17/18	18/19	19/20	20/21	Baseline (attendances)	88,291	90,052	91,579	93,131	95,482	INs	0	-880	-3,287	-4,840	-7,191	Digital Health	0	-867	-1,733	-1,733	-1,733	Plan	88,291	88,305	86,558	86,558	86,558	per 1000 pop	360	360	353	353	353	Director of Integrated Neighbourhoods  (Director of Operations until appointed), ICFT	No of emergency attendances routinely collected through SLAM data	CCG and Provider contract Performance governance	Monthly internally.  Quarterly to GM
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Category	Measure	Threshold/target by 2020/21 (incl. baseline)	Lead & Organisation	Data Source	Monitoring mechanism	Frequency																														
Activity	Hospital Bed days per 1000 population	<ul style="list-style-type: none"> <li>Digital Health would reduce 4380 bed days. (12 beds) by end of 31<sup>st</sup> March 2018</li> <li>Home First would reduce 9903 bed days (24 beds) 1<sup>st</sup> April 8 beds 2017</li> </ul> <p>30<sup>th</sup> Sept 16 beds 2017</p> <table border="1"> <thead> <tr> <th>Year</th> <th>16/17</th> <th>17/18</th> <th>18/19</th> <th>19/20</th> <th>20/21</th> </tr> </thead> <tbody> <tr> <td>Baseline (bed days)</td> <td>175,089</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>Digital Health / Home First</td> <td>0</td> <td>-14283</td> <td>-14283</td> <td>-14283</td> <td>-14283</td> </tr> <tr> <td>Plan</td> <td>175,089</td> <td>160,806</td> <td>160,806</td> <td>160,806</td> <td>160,806</td> </tr> <tr> <td>Per 1000 pop</td> <td>713.5</td> <td>655.3</td> <td>655.3</td> <td>655.3</td> <td>655.3</td> </tr> </tbody> </table>	Year	16/17	17/18	18/19	19/20	20/21	Baseline (bed days)	175,089	0	0	0	0	Digital Health / Home First	0	-14283	-14283	-14283	-14283	Plan	175,089	160,806	160,806	160,806	160,806	Per 1000 pop	713.5	655.3	655.3	655.3	655.3	Director of Operations, ICFT	No of bed days routinely collected through SLAM data	CCG and Provider contract Performance governance	Monthly internally. Quarterly to GM
Year	16/17	17/18	18/19	19/20	20/21																															
Baseline (bed days)	175,089	0	0	0	0																															
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Plan	175,089	160,806	160,806	160,806	160,806																															
Per 1000 pop	713.5	655.3	655.3	655.3	655.3																															
Activity	Intermediate Care Beds	<p>Community bed base restructuring would release 8395 bed days (23 beds) (by 18/19)</p> <table border="1"> <thead> <tr> <th>Year</th> <th>16/17</th> <th>17/18</th> <th>18/19</th> <th>19/20</th> <th>20/21</th> </tr> </thead> <tbody> <tr> <td>Baseline (beds)</td> <td>119</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Flexible Community Bed base</td> <td>0</td> <td>-11</td> <td>-23</td> <td>-23</td> <td>-23</td> </tr> <tr> <td>Plan</td> <td>119</td> <td>108</td> <td>96</td> <td>96</td> <td>96</td> </tr> </tbody> </table>	Year	16/17	17/18	18/19	19/20	20/21	Baseline (beds)	119					Flexible Community Bed base	0	-11	-23	-23	-23	Plan	119	108	96	96	96	<p>Director of Operations, ICFT</p> <p>Director of Commissioning, SCF</p> <p>Director of Estates, ICFT</p>	ICFT records of bed capacity	CCG and Provider contract performance governance	Monthly internally. Quarterly to GM						
Year	16/17	17/18	18/19	19/20	20/21																															
Baseline (beds)	119																																			
Flexible Community Bed base	0	-11	-23	-23	-23																															
Plan	119	108	96	96	96																															

Category	Measure	Threshold/target by 2020/21 (incl. baseline)	Lead & Organisation	Data Source	Monitoring mechanism	Frequency																														
Activity	% delayed transfers of care	4.5% by end of March 2017 <i>(subject to locality approval, and prior to GM submission on 2<sup>nd</sup> of Dec)</i>	Director of Operations, ICFT  Director of Integrated Neighbourhoods, ICFT	DTOCs are reported on a daily basis per UCIST data set	CCG and Provider contract Performance governance	Daily internally and quarterly to GM																														
Activity	Number of Planned Admissions	<ul style="list-style-type: none"> <li>Neighbourhoods would stem 25% of forecast growth in planned admissions (based on 2016/17 growth baseline) in 2017/18 increasing to 50% of forecast growth from 2018/19 onwards</li> <li>Linked to SCF recovery plan</li> </ul> Reduction on 16/17 baseline growth assumption of: <table border="1"> <thead> <tr> <th>Year</th> <th>16/17</th> <th>17/18</th> <th>18/19</th> <th>19/20</th> <th>20/21</th> </tr> </thead> <tbody> <tr> <td>Baseline (admissions)</td> <td>31,903</td> <td>32,539</td> <td>33,091</td> <td>33,652</td> <td>34,501</td> </tr> <tr> <td>INs</td> <td>0</td> <td>-159</td> <td>-594</td> <td>-875</td> <td>-1,299</td> </tr> <tr> <td>Plan</td> <td>31,903</td> <td>32,380</td> <td>32,497</td> <td>32,777</td> <td>33,202</td> </tr> <tr> <td>per 1000 pop</td> <td>130</td> <td>132</td> <td>132</td> <td>134</td> <td>135</td> </tr> </tbody> </table>	Year	16/17	17/18	18/19	19/20	20/21	Baseline (admissions)	31,903	32,539	33,091	33,652	34,501	INs	0	-159	-594	-875	-1,299	Plan	31,903	32,380	32,497	32,777	33,202	per 1000 pop	130	132	132	134	135	Director of Integrated Neighbourhoods  (Director of Operations until appointed), ICFT	Admissions routinely collected through SLAM	CCG and Provider contract Performance governance	Monthly internally.  Quarterly to GM
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per 1000 pop	130	132	132	134	135																															

Category	Measure	Threshold/target by 2020/21 (incl. baseline)	Lead & Organisation	Data Source	Monitoring mechanism	Frequency																														
Activity	Number of Outpatient Appointments	<ul style="list-style-type: none"> <li>Neighbourhoods would stem 50% of forecast growth in planned admissions (based on 2016/17 growth baseline) in 2017/18 increasing to 100% of forecast growth from 2018/19 onwards</li> <li>Neighbourhoods would stem 100% of growth in outpatients (based on 2015/16 growth baseline).</li> <li>Linked to SC Recovery plan</li> </ul> <p>Reduction on 16/17 baseline growth assumption of</p> <table border="1"> <thead> <tr> <th>Year</th> <th>16/17</th> <th>17/18</th> <th>18/19</th> <th>19/20</th> <th>20/21</th> </tr> </thead> <tbody> <tr> <td>Baseline (appointments)</td> <td>308,704</td> <td>314,860</td> <td>320,198</td> <td>325,626</td> <td>333,876</td> </tr> <tr> <td>INs</td> <td>0</td> <td>-3,078</td> <td>11,493</td> <td>16,921</td> <td>25,141</td> </tr> <tr> <td>Plan</td> <td>308,704</td> <td>311,782</td> <td>308,704</td> <td>308,704</td> <td>308,704</td> </tr> <tr> <td>per 1000 pop</td> <td>1258</td> <td>1271</td> <td>1258</td> <td>1258</td> <td>1258</td> </tr> </tbody> </table>	Year	16/17	17/18	18/19	19/20	20/21	Baseline (appointments)	308,704	314,860	320,198	325,626	333,876	INs	0	-3,078	11,493	16,921	25,141	Plan	308,704	311,782	308,704	308,704	308,704	per 1000 pop	1258	1271	1258	1258	1258	Director of Integrated Neighbourhoods  (Director of Operations until appointed), ICFT	Admissions routinely collected through SLAM	CCG and Provider contract Performance governance	Monthly internally.  Quarterly to GM
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per 1000 pop	1258	1271	1258	1258	1258																															

The 'Reduction in ambulance attendances from T&G Care Homes to the Emergency Department' is a subset of 'Number of Emergency Department Attendances' and the specific reduction trajectories for Digital Health are contained within it. Therefore, to avoid duplication, it has been removed from the schedule.

## SCHEDULE 2B – PROGRAMME MILESTONES

The programme milestones should be SMART with clear timelines and named responsible leads for each action over the term of the Investment Agreement. These milestones should align to your Locality Implementation Plan and linked to your outcomes outlined in Schedule 2A as appropriate. Please insert additional rows as required. A worked example has been provided to illustrate the level of detail required.

Activities / Deliverables	By When	Lead / Responsible Organisation
<b>Year 1: 2016/17 - Pre-mobilisation / set up</b>		
<ul style="list-style-type: none"> <li>Integrated Neighbourhoods Core Offer identified – including staff skill mix</li> </ul>	Oct 2016	Joint Locality
<ul style="list-style-type: none"> <li>New Homecare contract commences - 'as is' state</li> </ul>	Nov 2016	SCF
<ul style="list-style-type: none"> <li>Flexible Community Beds : Open 1st Floor of Stamford Unit</li> </ul>	Nov 2016	ICFT
<ul style="list-style-type: none"> <li>Digi Health: Agree Urgent Care/Medicine cost reductions to deliver financial benefits detailed in CBA</li> </ul>	Nov 2016	ICFT
<ul style="list-style-type: none"> <li>Digi Health Technology proof of concept</li> </ul>	Dec 2016	ICFT
<ul style="list-style-type: none"> <li>New Outcomes based Contract issued for ICFT for 2017/18</li> </ul>	Dec 2016	SCF
<ul style="list-style-type: none"> <li>Flexible Community Beds: Notice given on Grange View</li> </ul>	Dec 2016	ICFT
<ul style="list-style-type: none"> <li>Overarching Neighbourhood dash board in place to demonstrate CBA activity</li> </ul>	Dec 2016	ICFT
<ul style="list-style-type: none"> <li>Home First: complete staff recruitment &amp; training</li> </ul>	Dec 2016	ICFT



Activities / Deliverables	By When	Lead / Responsible Organisation
<ul style="list-style-type: none"> <li>Home First: Continue to engage with care homes providers to develop Home First community bed pathways</li> </ul>	-> Dec 2016	ICFT
<ul style="list-style-type: none"> <li>Delivery of Digital Health operational learning test</li> </ul>	Dec 2016 – Feb 2017	ICFT
<ul style="list-style-type: none"> <li>Delivery of PAM Pilot</li> </ul>	Dec 2016 – Q1 2017/18	ICFT
<ul style="list-style-type: none"> <li>IN Workforce Plan approved by the ICO</li> </ul>	Jan 2017	ICFT
<ul style="list-style-type: none"> <li>Quality Indicators Identified for extensivists</li> </ul>	Jan 2017	ICFT
<ul style="list-style-type: none"> <li>Outcome Framework agreed</li> </ul>	Jan 2017	Joint Locality
<ul style="list-style-type: none"> <li>Launch of PAM Recurrent Quarterly Training Programme</li> </ul>	Jan 2017	ICFT
<ul style="list-style-type: none"> <li>Volunteering Scheme Commences</li> </ul>	Jan 2107	ICFT
<ul style="list-style-type: none"> <li>Commence paediatric community upskilling process (planned care) (annually Q4)</li> </ul>	Jan 2017	ICFT
<ul style="list-style-type: none"> <li>Go live! for SPA</li> </ul>	Feb 2017	ICFT
<ul style="list-style-type: none"> <li>Co-location of teams for IN #1 Ashton</li> </ul>	Feb 2017	ICFT
<ul style="list-style-type: none"> <li>Co-location of team for IN #2 Denton / Audenshaw</li> </ul>	Feb 2017	ICFT
<ul style="list-style-type: none"> <li>Digital Health: Review impact of Home first phase 1 roll out on ED attendances and admissions from care homes</li> </ul>	Feb 2017	ICFT

Activities / Deliverables	By When	Lead / Responsible Organisation
<ul style="list-style-type: none"> <li>Home first: full implementation</li> </ul>	-> March 2017	ICFT
<ul style="list-style-type: none"> <li>Over 75's funding schemes identified to continue post March 2017</li> </ul>	Mar 2017	Joint Locality
<ul style="list-style-type: none"> <li>IN Managers in post</li> </ul>	Mar 2017	ICFT
<ul style="list-style-type: none"> <li>Home Care Supervisory Staff in place</li> </ul>	Mar 2017	ICFT
<ul style="list-style-type: none"> <li>Social Prescribing Procurement process complete</li> </ul>	Mar 2017	ICFT
<ul style="list-style-type: none"> <li>ABCD Procurement process complete</li> </ul>	Mar 2017	ICFT
<ul style="list-style-type: none"> <li>Commence Digital health phase 2 roll out</li> </ul>	March 2017 -> Q2 2017/18	ICFT
<b>Year 2: 2017/18</b>		
<ul style="list-style-type: none"> <li>Extensivist Clinicians in post</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>Community Pharmacists in post</li> </ul>	Q1	SCF
<ul style="list-style-type: none"> <li>Go Live! Team re-design and appointments complete to new posts, structure fully implemented for IN #1 Ashton</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>Go Live! Team re-design and appointments complete to new posts, structure fully implemented for IN #2 Denton / Audenshaw</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>Co-Location and Go Live! Team re-design and appointments complete to new posts, structure fully implemented for IN #4 Mossley/Stalybrige and Dukinfield</li> </ul>	Q1	ICFT

Activities / Deliverables	By When	Lead / Responsible Organisation
<ul style="list-style-type: none"> <li>Personalised Care Plans Rollout (duration: one full year)</li> </ul>	Q1 – Q1 2018/19	ICFT
<ul style="list-style-type: none"> <li>Extensivists proactive management of high risk stratification</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>Flexible Community Beds: Closure of Grange View Beds</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>Flexible Community Beds: Commence Consultation on the closure of Shirehill</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>Flexible Community Beds: Open ground floor of Stamford Unit</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>SPA: Expected to see reduction in community referrals, across health and social care</li> </ul>	Q1 -> onwards	ICFT
<ul style="list-style-type: none"> <li>SPA: Expected to see reduced contact points for service users</li> </ul>	Q1 -> onwards	ICFT
<ul style="list-style-type: none"> <li>Homecare new offer: locality #1 goes live with complete rollout to whole "zone"</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>Social Prescribing: Posts recruited to (Neighbourhoods / Hospital)</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>ABCD: Grant scheme/investment agreements into the VCFS commenced</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>IT Support for Social Prescribing procurement completed</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>Social Marketing: commence delivery of Programme</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>Expected to see neighbourhood teams referring to social prescribing with a % increase month on month</li> </ul>	Q1 -> onwards	ICFT
<ul style="list-style-type: none"> <li>Hospital social prescribing established in admissions avoidance and Darnton unit</li> </ul>	Q1	ICFT

Activities / Deliverables	By When	Lead / Responsible Organisation
<ul style="list-style-type: none"> <li>Home First: Close Beds in line with CBA (8 April 17) - 8 beds</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>Digital Health: Review delivery of benefits (decrease in ED attendances and admissions from baseline)</li> </ul>	Q1-Q4	ICFT
<ul style="list-style-type: none"> <li>Co-Location and Go Live! Team re-design and appointments complete to new posts, structure fully implemented for IN #3 Hyde</li> </ul>	Q2	ICFT
<ul style="list-style-type: none"> <li>Co-Location and Go Live! Team re-design and appointments complete to new posts, structure fully implemented for IN #5 Glossop</li> </ul>	Q2	ICFT
<ul style="list-style-type: none"> <li>Homecare new offer: locality #2 goes live with complete rollout to whole "zone"</li> </ul>	Q2	ICFT
<ul style="list-style-type: none"> <li>Social Prescribing Referrals processes in place and referrals commenced</li> </ul>	Q2	ICFT
<ul style="list-style-type: none"> <li>Social Prescribing Research and evaluation processes commenced</li> </ul>	Q2	ICFT
<ul style="list-style-type: none"> <li>Home First: Close Beds in line with CBA (16 Sept 17) - further 8 beds</li> </ul>	Q2	ICFT
<ul style="list-style-type: none"> <li>Commence PAM rollout post pilot and lessons learnt</li> </ul>	Q2 -> onwards	ICFT
<ul style="list-style-type: none"> <li>Volunteers recruited in each of the neighbourhoods</li> </ul>	Q2 - Q3	ICFT
<ul style="list-style-type: none"> <li>Homecare new offer: locality #3 goes live with complete rollout to whole "zone"</li> </ul>	Q3	ICFT
<ul style="list-style-type: none"> <li>ABCD Website Go Live!</li> </ul>	Q3	ICFT
<ul style="list-style-type: none"> <li>Flexible Community Beds: Close Shirehill</li> </ul>	Q3	ICFT

Activities / Deliverables	By When	Lead / Responsible Organisation
<ul style="list-style-type: none"> <li>Flexible Community Beds: Stamford Unit fully operational across 96 beds</li> </ul>	Q3	ICFT
<ul style="list-style-type: none"> <li>Homecare new offer: locality #4 goes live with complete rollout to whole "zone"</li> </ul>	Q4	ICFT
<ul style="list-style-type: none"> <li>Homecare new offer: locality #5 goes live with complete rollout to whole "zone"</li> </ul>	Q4	ICFT
<ul style="list-style-type: none"> <li>Social Prescribing: Expansion of the hospital model to all wards commences</li> </ul>	Q4 ->	ICFT
<ul style="list-style-type: none"> <li>ABCD take referrals through portal Go Live!</li> </ul>	Q4	ICFT
<ul style="list-style-type: none"> <li>Formal transfer of Adult Social care complete</li> </ul>	Q4	ICFT
<b>Year 3: 2018/2019</b>		
<ul style="list-style-type: none"> <li>Homecare new offer: locality #5 goes live with complete rollout to whole "zone"</li> </ul>	Q1	ICFT
<ul style="list-style-type: none"> <li>IN: Release of Estate</li> </ul>	Q3-Q4	Joint locality
<b>Year 4: 2019/2020</b>		
<ul style="list-style-type: none"> <li>INs: self-funding</li> </ul>	Q4	ICFT

## SCHEDULE 2C – FINANCIAL INFORMATION



schedule 2c  
OVERVIEW



Schedule 2C(i)  
PROGRAMME EXPENI

### **SCHEDULE 3 – DISPUTE RESOLUTION**

This Investment Agreement will be subject to a dispute resolution agreed by Greater Manchester.

This dispute resolution process is still in development, will be inserted at such time the agreed version is available.

## **SCHEDULE 4 – TERMS OF REFERENCE FOR GM HSC PARTNERSHIP BOARD**

### **AUTHORITY**

In February 2015 the Association of Greater Manchester Authorities (AGMA) and the Association of Greater Manchester Clinical Commissioning Groups (CCGs) signed a Memorandum of Understanding (MoU) with NHS England to create a framework for achieving the delegation and ultimate devolution of health and social care responsibilities to accountable and statutory bodies in Greater Manchester (GM).

The MoU outlined a process for collaborative working across health and social care making provision for arrangements to be in place (in shadow form) from November 2015. It also made provision for a programme of work to be undertaken during 2015/16 to move to fully devolved system from April 2016. This includes work to develop and agree the supporting governance.

Following the creation of the Standing Conference in April 2015, it was agreed subsequently that from the beginning of the Shadow Period this would be superseded by the formal establishment of a Strategic Partnership Board.

### **PURPOSE AND OBJECTIVES**

The Strategic Partnership Board will be responsible for setting the overarching strategic vision for the Greater Manchester Health and Social Care economy. As it is not a legal body, its decisions are not binding, but recommendations for its members to formally adopt following their own governance procedures which may include delegation to a group of its members where possible.

### **RESPONSIBILITIES**

The key responsibilities of the Partnership Board are:

- To set the framework within which the Strategic Partnership Executive will operate.
- To agree the GM Health and Social Care Strategic priorities in accordance with the NHS five year forward view. The priorities and vision as defined by the Strategic Partnership Board will be delivered by the GM Joint Commissioning Board and the localities.
- To approve the content of the GM Strategic Plan (for financial and clinical sustainability), and note the content of the 10 locality plans to deliver the Strategic Plan locally and the matters remaining for the GM Joint Commissioning Board's remit.
- To agree the criteria that determines access to the transformation funding and ask the fund allocators (NHS England and GMCA) and fund recipients (Local Authorities and CCGs) to adopt them.
- To ensure that there remains ongoing and significant organisational commitment across the GM health economy to both the devolution agenda and a devolved health system.
- To be responsible to the people of Greater Manchester and to each other for the financial and clinical sustainability of the Greater Manchester health economy, through the agreement and the delivery of the Strategic Plan. The Board will receive regular update reports from the Executive on the ongoing progress of the delivery of the Strategic Plan.



- To provide a mutual assurance function over the outcomes linked to the commissioning decisions taken by members to deliver the Strategic Plan. The Board will receive regular reports from the Executive about the commissioning decisions of the GM Commissioning Board, and the performance (via agreed outcomes) linked to those decisions.
- To agree an assurance framework, developed jointly with regulators where required, that reflects the outcomes required by Greater Manchester, because the formal assurance that each individual party is delivering on their commitments to the Strategic Plan will be provided in the usual way by the SPB relevant statutory body. The Board will receive regular reporting of GM's performance against agreed assurance metrics.
- To provide leadership across the GM health economy to ensure that the key strategic priorities for a GM health system are achieved.

## **MEMBERSHIP**

The membership of the Strategic Partnership Board is not a closed membership at this point but will include:

- GMCA (The Chair of the GMCA)
- 10 AGMA authorities (Leaders or Lead Members)
- 12 Clinical Commissioning Groups (Chairs or Chief Officers)
- 15 providers - all acute NHS Trusts and Foundation Trusts, mental health and community providers and NWAS (Chairs or Chief Officers)
- NHS England (as they determine).

## **OTHER MEMBERS**

Monitor/TDA (NHS Improvement), CQC, Public Health England, Health Education England, Greater Manchester Fire and Rescue Service (Chair), and Greater Manchester Police and Crime Commissioner will be invited to attend as non-voting members of the Board.

From October 2015 Primary care partners will be represented at the Board through the GMLMC. Further work will be undertaken from October to April 2016 the outcome of which will inform and determine the representation of primary care in the governance framework. This work will ensure that primary care is appropriately represented by accountable and representative bodies on an ongoing basis.

GMCVO will attend to represent the voluntary sector pending further discussion on third sector representation as set out below.

Any amendments to the membership of the Strategic Partnership Board will be agreed (by majority vote where necessary) by the Board.

## **CHAIR**

The Strategic Partnership Board will have an independent chair. However, Lord Peter Smith (AGMA/GMCA) will act as chair until such time that a process to appoint an independent chair is completed.

**QUORUM**

*The quoracy of the meeting has yet to be defined.*

**SUPPORT**

Officers from the Greater Manchester Integrated Support Team (GMIST) will provide policy and administrative support to the Partnership Board.

**MEETING FREQUENCY**

The Partnership Board will meet monthly or more frequently if required.

**ACCOUNTABILITY**

The Strategic Partnership Board is accountable to Greater Manchester. Its members are accountable to their own organisations and stakeholder grouping.

**REVIEW OF TERMS OF REFERENCE**

These terms of reference will be formally reviewed by the Partnership Board by mutual agreement of the membership. Such review will take place at any time to reflect changes in circumstances which may arise.

## SCHEDULE 5 – NATIONAL REQUIREMENTS

**Option A** = Aim to deliver and fund from the IA completely

**Option B** = IA will make a part contribution

**Option C** = Outside the scope of the IA – seeking separate funding source (e.g. through a cross-programme or Theme investment)

**Option D** = Outside the scope of the IA – separate funding source identified (please state what this is)

**Option E** = Already being achieved and/or within core funding so no additional resource required

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
1	Get back on track with access standards for A&E in line with STF trajectories and ensuring that more than 95 percent of patients wait no more than four hours in A&E,	B	Transformation fund supports Admission Avoidance and Discharge priority.  Capital funding is required to enhance “front door” and support streaming of patients at A&E. May need additional funding to support flow.	Current performance is below trajectory for Quarter 3 however the expectation is the changes implemented in November along with the transformation plans will deliver the necessary improvements and bring the system back on track for 95%. Addressing bed capacity is essential through reduced Length of Stay and reduced DTOC.  <b>November Changes</b>  New Home Care providers have absorbed previously unmet need and are ensuring packages can be recommenced in 24 hours and new ones delivered within 48hrs.  <b>Increased nursing assessment capacity</b>  32 additional community beds to support out of

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
				<p>hospital assessment of people who are unsafe to be assessed at home. 16 in place with remainder due mid December.</p> <p>Other transformation projects include Discharge to Assess, Flexible Community Bed Base development and increased capacity in the Integrated Urgent Care Team (IUCT) which alongside the use of SAFER and Red Green analysis will improve flow through the acute beds, reduce the risk of A&amp;E breaches due to bed availability and reduce Delayed Transfers of Care. Implementation has started with a focus for DtA on patients who can be safely assessed at home and all wards will be operating this by end of November. Additional IUCT capacity is supporting people in their own homes. The additional community beds will support more complex assessments out of the acute bed base. SAFER will be fully implemented by end of November and will support earlier discharge including the focus on simple discharges.</p> <p>IUCT and Digital Health for Care Homes will support increased admissions avoidance managing demand within the patient's home rather than attending A&amp;E.</p> <p>Existing schemes such as Alternative to Transfer (an AVS) and Glossop Community Specialist Paramedic</p>

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
				<p>supports effective use of ambulances and increases See and Treat so reducing A&amp;E demand. NWS (April to Sep) Hear and Treat 11.4%, See and Treat 17.5% and See and Convey 68.9%</p> <p>Integrated neighbourhoods will support demand reduction by reducing exacerbations of conditions.</p> <p>The Emergency Care Village development (once capital has been gained) will enable effective management of patients via NWS and self-presenters. It will enable full streaming and direct admissions to assessment facilities and ambulatory emergency care.</p>
	including making progress in implementing the urgent and emergency care review.	B	<p>Transformation for community bed base and INs.</p> <p>Additional capital funding is required for Emergency Care Village and planned care</p>	<p>1. Streaming patients on arrival at A&amp;E is a key element of plans for an Integrated Urgent Care service. A proposed estate solution through redesign of the current A&amp;E department will require capital funding and estate works. Alternative ways of delivering streaming at the front door continue to be developed. Current arrangement includes streaming to Ambulatory Emergency Care (AEC) with 19% increase in use of AEC.</p> <p>2. NHS 111 - Working with GM to support our 111 provider to deliver the Integrated virtual clinical hub.</p>

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
				<p>Current OoH undertakes enhanced triage on calls transferred. DoS in maintained to encourage use of A&amp;E alternatives</p> <p>3. Ambulances – DoD and code review pilots; NWS is modelling expected impact of the Dispatch on Disposition and Coding changes on Red performance to identify impacts at a County, CCG and Regional level and the effect on performance variation. T&amp;G are working with NWS as described below.</p> <p>4. Improved flow – T&amp;G ICFT are implementing SAFER across wards by end of November alongside RED and GREEN day monitoring</p> <p>5. Discharge – Discharge to Assess is operating across four wards with full roll out planned by end of November. Development of a more flexible community bed base will support discharge of patients who require respite and recuperation before they are safe to go home as well as step up provision to avoid emergency admissions.</p>
	75 percent of Category A <b>ambulance calls</b> responded to within 8 minutes.	B	<p>Transformational funding.</p> <p>May need additional funding for Acute</p>	<p>NWS is doing work internally to increase Hear and Treat and See and Treat and will be encouraging consistent use of the local AVS when appropriate. Locally the Alternative to Transfer (AVS) has been in</p>

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
			<p>Visiting Service (AVS).</p>	<p>place since 2014 and will continue as discussions take place as to the best model for commissioning across GM continue. Deflection remains 80-90% with approx. 200 referrals a month.</p> <p>The Community Specialist Paramedic in Glossop supports response times as well as working to reduce demand.</p> <p>Transformation projects include the integrated neighbourhoods adopting the learning from the Glossop CSP to develop appropriate services that increase the number of people maintained in their own home. Through Home First the Integrated Urgent Care Team will support people in their own homes where appropriate to reduce conveyances when a crisis occurs.</p> <p>The Hospital Ambulance Liaison Officer supports prompt ambulance turnaround to ensure release of ambulances to respond. HAS screen compliance has significantly improved and the interface between NWAS and the acute has enabled improved pathways and processes to be developed and is critical to the Emergency Care Village planning.</p> <p>The Digital Health in Care Homes work will enable a</p>

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
				virtual consultation to take place to help identify the need for transport to hospital and avoid unnecessary 999 calls.
2	Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from <b>referral to treatment</b> ,	B	IN transformation and possibly some transition funding for planned care development.	<p>The CCG has failed the target in several occasions in the past due to provider data validation or computer issues. However 2016/17 has seen sustained improvement and whilst not all specialities are meeting the national standard, overall the standard has been maintained.</p> <p>T&amp;G ICFT achieve the RTT standard in almost all specialties and have an improvement programme underway to offer choice for all first OPD appts. Also, increasing the uptake of e-referrals is a key workstream within the planned care programme</p> <p>Pathway development through the planned care workstream has focussed on specialities where capacity issues exist with a focus on advice and guidance and effective use of the wider professional base to ensure that individuals receive the prompt appropriate care and are able to return to independence and self-care.</p> <p>Integrated Neighbourhoods will provide holistic care to individuals with long term conditions to enable them to</p>



Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
				self-care effectively and reduce demand for acute care. The preventative focus in neighbourhoods will also reduce demand in the longer-term as people maintain positive health and wellbeing.
	..including offering patient choice	E	Being achieved currently.	<p>Patient Choice will continue to be offered where appropriate and the holistic nature of care planning will encourage shared decision making with individuals.</p> <p>Use of E-referrals has fallen as Primary Care and Provider expectations and capability has not been aligned. The level of use across Primary Care is variable and work is taking place to ensure that all parties are in a position to fully utilise E-referral in 2017/18.</p> <p>The Tameside and Glossop ICFT have an improvement plan in operation which aims to deliver choice to 100% of all first outpatient appointments.</p> <p>All patients eligible for Continuing Health Care (CHC) are offered a Personal Health Budget (PHB).</p> <p>Our PHB Coordinator is working with frontline staff to promote the offer of Personal Health Budgets to</p>

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
				patients with MH, LD and LTC. We are also considering how PHBs can support those patients who have been agreed as either amber or red within the locality risk stratification model. Growth in this area is expected to reduce demand on high use pathways, resulting in a reduction of cost and demand to the system. Modelling against cost savings is currently taking place.
3	Deliver the NHS Constitution <b>62 day cancer waiting standard</b> , including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and	E	No direct investment but referral pathway development project in place as part of the Planned Care workstream, including early diagnostics.	Cancer performance has been maintained.  Single Commission and T&GICO working together via GM infrastructure (GM Cancer) and T&G Cancer Board to ensure local implementation of national and GM models of care / pathways, including implementation and promotion of NICE guidelines.  Achieving national standard for 62 day waits, and monitor performance via the T&G Cancer Board.
	make progress in improving <b>one-year survival rates</b> by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.	B	No direct investment in diagnosis and treatment elements of cancer pathways, but integrated neighbourhood element of our model	Work is ongoing to review current performance and sourcing data to support this as part of the Quality Premium. 2013 survival data is 67.6% with 2014 diagnosis at 44.2% against 50.7% nationally.  Ensuring the Single Commission officers and clinical leads for cancer are working with colleagues in GM and TGICOFT on cancer service transformation (as

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
			<p>will enable improvements in delivery of messages around early presentation and therefore early diagnosis. Work ongoing as part of the planned care workstream to ensure adequate and robust early diagnostics pathways and capacity in place.</p>	<p>set out in latest planning guidance), engagement at all levels in GM Cancer, and local performance management and service improvement initiatives. T&amp;G Cancer Board meet monthly to ensure local implementation of national and GM priorities.</p> <p>This a long term issue that T&amp;G have been making progress with through key focuses:</p> <ul style="list-style-type: none"> <li>- Community cancer awareness programme: initially funded by Macmillan and now embedded in work of local health improvement team 'Be Well Tameside'</li> <li>- Bowel cancer screening programme: close collaboration by GM Bowel Cancer Screening Promotion Team with local cancer awareness and health improvement activities; focus on primary care role by CCG Quality Local Implementation Group Quality Initiative on cancer.</li> </ul> <p>Healthy lives and integrated neighbourhood elements of our integration model will enable improvements in delivery of messages and behaviour change around early presentation and therefore early diagnosis, by incorporation of 'Be Well Tameside' team members, social prescribing, asset based approaches and social marketing.</p> <p>CCG have appointed a Macmillan GP who is promoting best practice in primary care including follow up of bowel screening non-responders. T&amp;G collaborates with GM Screening and</p>

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
				Immunisation Team on initiatives to promote uptake of cancer screening programmes.
4	Deliver the <b>diagnostic standard</b> by ensuring that less than 1 percent of patients wait no more than six weeks, where this is not being met then recovery in line with the STF trajectory is to be achieved.	E		<p>Performance has significantly improved from quarter 1 but is below standard at 1.24% for September.</p> <p>Endoscopy remains a key challenge. Central Manchester generally accounts for the majority of endoscopy breaches with Tameside generally delivering against the standard.</p> <p>Audiology is another key issue and work is being undertaken to understand the level of demand in the reporting trusts compared to other AQP providers.</p> <p>MRI activity has increased and whilst performance is improving work is ongoing with GPs to understand they increase in Direct Access MRI demand.</p> <p>Improved guidance and increased E-Referral usage is expected to support improved performance through more accurate referring and improved timeliness of booking.</p>

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
5	<p>Achieve and maintain the <b>mental health access standards</b>:</p> <ul style="list-style-type: none"> <li>○ more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral;</li> </ul>	E	No direct relationship, although has a direct impact on spending on acute and primary care services	<p>The access standard for early intervention psychosis, currently 50%, rising to 53% by 2018, is being consistently met. July 16 65.4% is on an upward trend.</p> <p>Based on the current referral rate the access standard for EIP will be met within existing resources and does not require additional investment.</p>
	<ul style="list-style-type: none"> <li>○ 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks.</li> </ul>	C	No direct relationship, although has a direct impact on spending on acute and primary care services	<p>The current IAPT targets are being met</p> <p><b>6 and 18 week wait for first appointment Completed Treatment RTT</b></p> <p>The service has achieved 77.9% against a 75% target for 6 weeks and 99.8% against a 95% target for 18 weeks on cases completing treatment in October.</p> <p><b>IAPT rollout</b></p> <p>The service has in the early part of this year over achieved the 15% prevalence target and the CCG will work with the Provider to ensure this is sustained through 17/18 and 16.8% is achieved.</p> <p>To support this, the service will build on the program of community engagement and work with third sector providers to ensure effective access to IAPT provision is maintained.</p>

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
				<p>In accordance with the MH 5YFV, additional investment will be required to train more specialised practitioners and to increase service capacity to meet the growth targets from 2018/19 onwards.</p> <p>The CCG will develop a strategy to increase access further to address the new target of 25% by the end of 2020/21.</p> <p>We will continue to work with GM HSCP to support MH priorities.</p>
	<ul style="list-style-type: none"> <li>IAPT for children &amp; young people - to be on track for delivery 2018</li> </ul>	D	Part funded by GM agreed approaches, LTP funds and the announced non recurrent investment	The CYP Wellbeing and Mental Health Local Transformation Plan (LTP) is been implemented. The LTPs are 'living' documents and our plan has been in place for a year and is being updated to stretch our ambition and align with GM commitment to develop the current provision of Mental Health
	<ul style="list-style-type: none"> <li>Improvement in Mental Health Crisis Care for all ages</li> </ul>	E	No direct relation	Providing core 24 hour crisis services within acute hospital. T & G currently meet this standard
	<ul style="list-style-type: none"> <li>Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia, increase the numbers of people receiving a dementia diagnosis within six weeks of a GP</li> </ul>	B	Dementia was outlined in the investment proposition to support post-diagnostic	<p>Aug 16 71.3% against 67.3% national and work is ongoing to continue to exceed rather than to just meet the standard.</p> <p>Dementia post-diagnostic support is integral to our</p>

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
	referral; and improve quality of post-diagnosis treatment and support for people with dementia and their carers.		dementia support, and while not directly related to this outcome is key in our planning.	integrated neighbourhoods offer and will be delivered as part of our transformation projects.
6	Deliver actions set out in local plans to transform care for people with <b>learning disabilities</b> , including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.	D	None.  No key components identified at this time - part of GM ongoing work.	In relation to the transforming care agenda, the locality is on track with expectations and no additional funding is required at present. We monitor and track our out of borough patients effectively, so if additional funding is required in future for a different cohort, we can assess and plan for that accordingly.  We are working with the GM Fast Track team to deliver the milestone plan. Funding is currently allocated through work being led by Sandy Bering, for the commissioning of an acute LD crisis pathway to cover the GM footprint. This is identified as a GM group, and not just a locality led area of work.
7	To help create the <b>safest, highest quality health and care</b> service <ul style="list-style-type: none"> <li>○ Roll out of <b>seven-day services</b> in hospital to the population (four priority clinical standards in all relevant specialities, with progress also made on the other six</li> </ul>	C	Transformation Fund will support access to seven-day services but not deliver them in hospital.	The urgent care models of care included in the transformational bid will improve 24/7 access to out of hospital urgent care, and develop a community based preventative approach.  These actions will directly contribute to access to seven day services however they will not deliver

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
	standards), so that patients receive the same standards of care, seven days a week.			<p>seven-day services in hospital alone.</p> <p>T&amp;G ICFT continues to progress against its action plan and has submitted a business case detailing plans to deliver seven day services. Additional funding will be required to fully deliver this standard.</p> <p>We have plans to develop our 7 day services offer each year. This is cost neutral in 17/18. For future years, we will work with GM to identify additional resource and ensure we deliver the national trajectories within the required timeframes.</p>
	<ul style="list-style-type: none"> <li>○ Achieve a significant reduction in <b>avoidable deaths</b>, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements.</li> </ul>	D		<p>There is a system wide group under the leadership of the ICO's Palliative Care Consultant who ensures the necessary pathways and protocols are in place to support the management of patients requiring palliative / end of life care in the place of their choice. This includes rapid discharge pathways from a hospital setting to home / community where an individual's choice is to die at home.</p> <p>The recruitment to the Palliative Care Consultant vacancy in 2015 has been a significant benefit to the whole economy.</p>



Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
	<ul style="list-style-type: none"> <li>Measurable progress towards reducing the rate of <b>stillbirths, neonatal and maternal deaths and brain injuries</b> that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020.</li> </ul>	E	Local funded	<p>A significant proportion of preventable stillbirths in the North are linked to unrecognised fatal growth restriction (FGR) as such the hospital is improving the detection and management of these babies. Tameside has been active with the North region 'Saving Babies Lives' initiatives.</p> <p>The data does not reflect the improvements by Tameside provider in improving Neonatal mortality and reducing Stillbirths. The Regional (North West) Stillbirth Audit (November 2015) shows that Tameside Hospital is amongst the best performing hospital in North West in relation to low stillbirth number and positive downward trend reduction.</p>
	<ul style="list-style-type: none"> <li>Measurable improvement in antimicrobial prescribing and resistance rates.</li> </ul>	D	Not reliant on Transformation funding	<p>On target to achieve both indicators relating to appropriate prescribing of antibiotics in Primary Care Each month we receive an updated practice level report on Impact based on e-pact data. Any practices showing signs of increase or showing poor performance are audited by the CCG/Acute Trust antibiotic pharmacists and areas for improvement identified and an action plan produced.</p>
8	Measurable reduction in <b>child obesity</b> as part of the Government's childhood obesity strategy. Contribute to the agreed child	B	Part of the social prescribing/improved public health within	<p>In 2015/16 obesity at age 10-11 was 20.2% compared to 19.8% nationally. Current local approaches focus on nutrition and</p>

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
	obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese.		the INs	<p>physical activity:</p> <ul style="list-style-type: none"> <li>- Breastfeeding support</li> <li>- Appropriate weaning</li> <li>- Early Years/Children Centres programme including The Under 5s Food and Nutrition Award, delivered by the Children's Nutrition Team.</li> <li>- The food4life school food award supports schools in meeting the School Food Standards and to develop a healthier food culture.</li> <li>- Currently about 1/5 of Tameside schools have achieved an award and about 1/4 are working towards an award.</li> <li>- On-line School Health Check and Healthy Weight: roll out in progress.</li> <li>- Family Health Mentor service.</li> </ul>
9	Achieve full local implementation of the national <b>Diabetes Prevention Programme</b> , 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme and a measurable reduction in variation in management and care for people with diabetes.	B	Support for people with Long Term Conditions is a priority area for IN within the proposal to the GM Transformation Fund.	<p>Currently working with NHS England Health &amp; Social Care Partnership on GM Wide roll out of phase 2 of the National Diabetes Prevention Programme. Work ongoing during November to develop locality level prospectus</p> <p>Completion of National Diabetes Audit increased from 4.9% in 2015 to 80% in 2016. Results are due to be released in January 2017 but the CCG are using the recently released 2015-16 QOF data to produce a</p>

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
				local version to give indication of locality delivery of the NICE guidance. Have identified significant variation across the 41 practices and will deliver training and education to reduce this.
10	Implement agreed recommendations of the National <b>Maternity</b> Review in relation to safety, support progress on delivering	Not known		This Investment Agreement does not include maternity services and so will not contribute to delivery of this requirement.
	and significantly improve patient choice.		Any changes to choice in Maternity as a result of the GM Maternity review may require additional funding however, this is unlikely as patients already choose between providers.	In response to national review 'Better Birth's' (2016) Tameside provider has lead on developing an action plan. Information is provided to enable women to make informed choices based on evidence.  We are not in a position to offer full choice of place of birth, but working towards establishing a midwifery-led unit at Tameside. We are seeking to explore a partnership with another maternity service to enable an affordable model providing all choices of place of birth to be established.

Ref	National Requirements	Options (A, B, C or D)	Locality Response/ Comment on funding	Current progress and plans (November 2016)
11	<p>To improve <b>out-of-hospital care</b> with new models of care and general practice</p> <ul style="list-style-type: none"> <li>100 percent of population has access to weekend/evening <b>routine GP appointments</b>.</li> </ul>	B		Existing CCG resource already funds access to evening and weekend routine GP appointments through the Extended Access DES and Extended Access pilot provided by Orbit Healthcare (Federation) and both remain in 17/18, however Transformation Funding through neighbourhood workstreams also provides provision.
	<ul style="list-style-type: none"> <li>Measurable reduction in <b>age standardised emergency admission rates and emergency inpatient bed-day rates</b>; more significant reductions through the New Care Model programme covering at least 50 percent of population.</li> </ul>	B		<p>Integrated neighbourhoods will support demand reduction by reducing exacerbations of conditions.</p> <p>IUCT and Digital Health for Care Homes will support admissions avoidance. Individuals that cannot be managed safely in their own home but do not require acute care will be supported in the flexible community bed base. Individuals will be stepped up or stepped down into the bed base as appropriate.</p> <p>Proposal to the GM Transformation Fund included targets for measurable reductions in emergency admission rates for both the general population and specifically for patients over the age of 55.</p>

## **SCHEDULE 6 – LOCALITY MANAGEMENT AND GOVERNANCE ARRANGEMENTS**

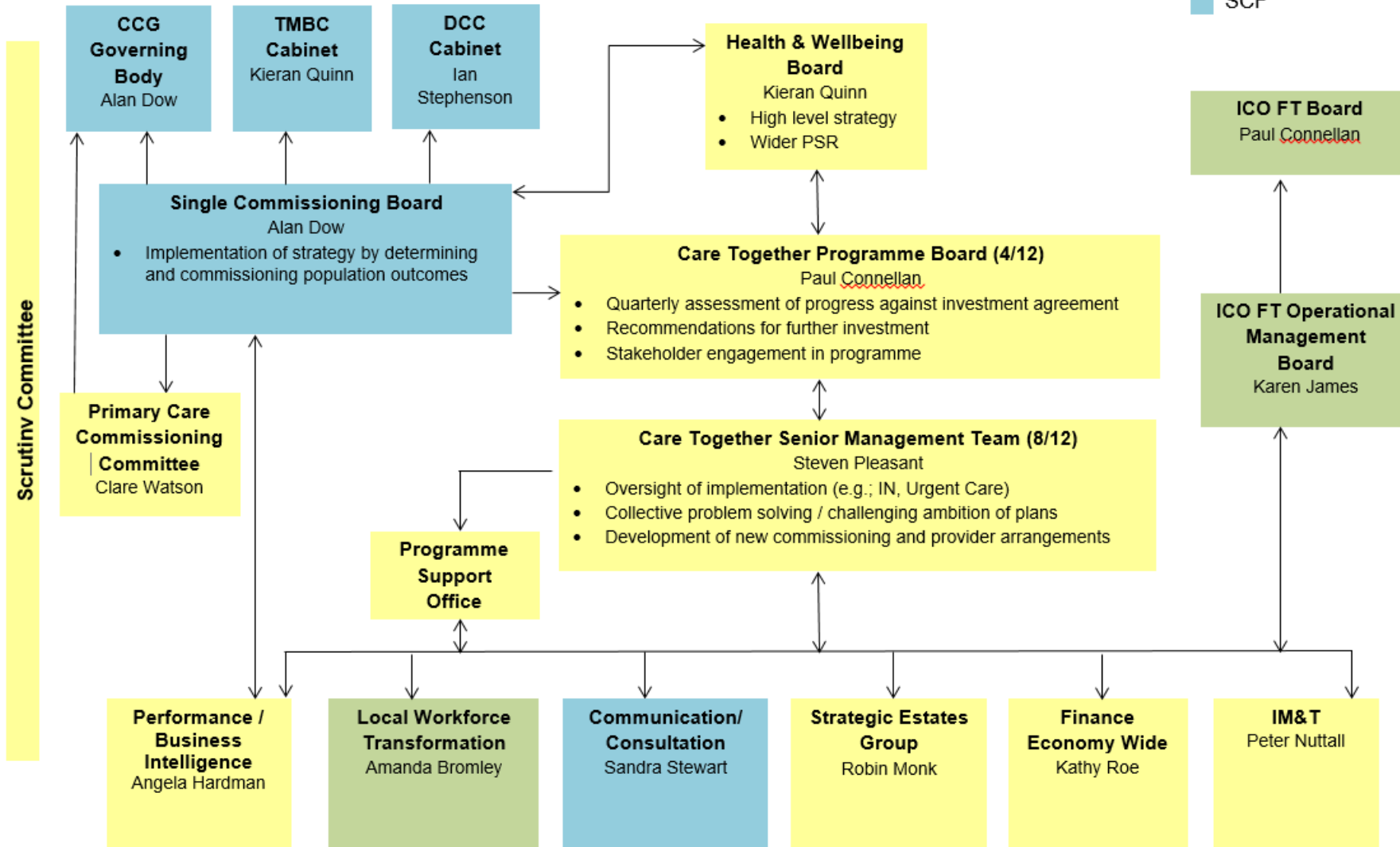
To reflect the transition from the design to the implementation phase of the Care Together programme, the Programme Board reviewed its governance arrangements in October 2016. The revised governance structure ensures focus on delivery of national and local quality and performance metrics, the drive for financial sustainability and ensures appropriate, timely mechanisms to provide the necessary assurance to GM Health and Social Partnership that progress against milestones is being made.

The attached slide shows the revised Care Together management and governance arrangement. Key management and governance meetings are highlighted and split by whether these are commissioner, provider or as is the case with most, an economy wide approach. Leads for each of these meetings are also identified (Chairs may be different) to provide clarity on responsibilities. Key relationships and accountabilities are shown by arrows.

All meetings are a minimum of monthly apart from where indicated.

### Proposed Care Together Programme Delivery Structure

Economy Wide  
 ICO  
 SCF



# APPENDIX B

## SUMMARY OF EVALUATION SCORES

PROJECT TITLE:		Evaluation of T&G transformation scemes																			
PROJECT QUALITY WEIGHTING:		100%		Maximum Budget		Date															
PROJECT PRICE WEIGHTING:		0%		£200,000																	
QUALITY SCORES																					
Tender Criterion	Criteria weight %	Catalyze		CLARCH U of M		Cordis Bright		Mott Mc Donald		NECS		Traverse		RSM		SQW		9		10	
		% max Score	w eighted score	% max Score	w eighted score	% max Score	w eighted score	% max Score	w eighted score	% max Score	w eighted score	% max Score	w eighted score	% max Score	w eighted score	% max Score	w eighted score	% max Score	w eighted score	% max Score	w eighted score
Tender question 1	25	40%	10.00	80%	20.00	40%	10.00	80%	20.00	40%	10.00	60%	15.00	60%	15.00	60%	15.00				
Tender question 2	30	40%	12.00	100%	30.00	40%	12.00	80%	24.00	40%	12.00	60%	18.00	40%	12.00	80%	24.00				
Tender question 3	20	40%	8.00	40%	8.00	40%	8.00	60%	12.00	40%	8.00	60%	12.00	40%	8.00	60%	12.00				
Tender question 4	10	40%	4.00	80%	8.00	60%	6.00	60%	6.00	40%	4.00	20%	2.00	40%	4.00	60%	6.00				
Tender question 5	10	40%	4.00	40%	4.00	20%	2.00	40%	4.00	60%	6.00	40%	4.00	40%	4.00	20%	2.00				
Platinum payment	5	5%	5.00	0%	0.00	0%	0.00	0%	0.00	0%	0.00	5%	5.00	0%	0.00	5%	5.00				
	0																				
	0																				
	0																				
<b>TOTALS:</b>	<b>100</b>		<b>43.00</b>		<b>70.00</b>		<b>38.00</b>		<b>66.00</b>		<b>40.00</b>		<b>56.00</b>		<b>43.00</b>		<b>64.00</b>		<b>0.00</b>		<b>0.00</b>
PRICE SCORES:																					
Price		1.00		1.00		1.00		1.00		1.00		1.00		1.00		1.00					
Less than or Equal to Maximum Budget?		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		No		No	
Order of tender prices (lowest first)		1		1		1		1		1		1		1		1					
% Difference from lowest tender		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00					
Price Score (100 - % difference from lowest tender)		100.00		100.00		100.00		100.00		100.00		100.00		100.00		100.00					
OVERALL SCORES:																					
Quality Weighting x Quality Score		43.00		70.00		38.00		66.00		40.00		56.00		43.00		64.00					
Price weighting x price score		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00					
Overall Score		43.00		70.00		38.00		66.00		40.00		56.00		43.00		64.00					
Order of Tenderers		<b>5</b>		<b>1</b>		<b>8</b>		<b>2</b>		<b>7</b>		<b>4</b>		<b>5</b>		<b>3</b>					

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# APPENDIX C

## Tender Award Criteria and Evaluation Criteria

Any Contract(s) awarded as a result of this procurement will be awarded on the basis of the offer that is the most economically advantageous to the Council. The Award Criteria (**Award Criteria**) are:-

- 100% technical or quality.
- 0% cost

Scores are arrived at following the application of the Evaluation Criteria (**Evaluation Criteria**) set out below to the Tenderer's Tender.

The Tender Evaluation Model showing the Evaluation Criteria and the maximum scores attributable to them is set out below.

Where specified, a minimum pass mark (**Threshold**) applies to the Evaluation Criteria. The Council shall reject any Tender which does not meet the relevant Threshold in respect of one or more criteria.

<b>Evaluation Criteria: Technical</b>	<b>Threshold</b>	<b>Criteria Weighting</b>	<b>Overall Technical Weighted Percentage 100%</b>	<b>Means of evaluation</b>	<b>Means of moderation</b>
Q1: Please demonstrate an understanding of the Care Together Programme aims and how this will be linked to the evaluation approach	N/A	25%	25%	written submission	presentation
Q2. Please state your approach to the evaluation of the Tameside and Glossop transformation funded schemes	N/A	30%	30%	written submission	presentation
Q3 Please describe how you would engage with members of the public and staff involved in health and social settings	N/A	20%	20%	written submission	presentation
Q4. Please describe plans for	N/A	10%	10%	written submission	presentation

handover of evaluation approach and how continuation of evaluation skill set can be ensured post contract						
Q5. Please describe your approach to evaluating social value (including what you define as social value)	N/A	10%	10%	written submission		
Rebate offered under the Platinum Payment Programme	N/A	5%	5%	Submission of the Form of Tender Part B(2)	Not applicable	
			100%			

### Technical or quality evaluation

The technical evaluation will be scored in accordance with the following.

### Scoring matrix for the technical and quality criteria

Assessment of Submission	Score
<b>Excellent response</b> - The submission provides comprehensive details of a particularly effective and robust approach which addresses the issue(s) raised in the question/criteria in all material respects and exceeds some or all of the major requirements. A high level of relevant information is provided backed up with a clear rationale, examples and evidence of past performance which may include supplementary evidence.	5
<b>Good submission</b> - The submission provides sufficient detail of a good approach which addresses the issue(s) raised in the question/criteria in all material respects and is backed up with a clear rationale and evidence of past performance which may include supplementary evidence	4
<b>Average submission</b> - The submission provides sufficient detail of an adequate approach which addresses the issue(s) raised in the question/criteria in all material respects in most material respects, but is lacking or inconsistent in others	3
<b>Below average submission</b> – The submission details an approach however this is limited and does not provide sufficient detail or evidence and falls short of addressing the issue(s) raised in the question/criteria in all material respects in a number of identifiable respects.	2
<b>Unsatisfactory</b> –Submission significantly fails to address the issue(s) raised in the question/criteria in all material respects and / or contains significant shortcomings or the submission is not relevant or is extremely limited.	1

Not answered - No response

0

### Platinum Payment Programme

Rebates are based on underlying payment terms of 30 days and a target acceleration of 20 days (payment issued 10 days after receipt of invoice).

Rebate Offered	Points Scored	Weighted Score or total 5%
0%*	0*	0%
0.50%	1	.5%
1.00%	2	1%
1.25%	5	2.5%
1.50%	8	4%
2.00%	10	5%

\*Excludes participation in the Platinum Payment Programme

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<b>Report to:</b>	<b>STRATEGIC COMMISSIONING BOARD</b>
<b>Date:</b>	24 October 2018
<b>Reporting Member / Officer of Single Commissioning Board</b>	Jessica Williams
<b>Subject:</b>	<b>PRIMARY CARE ACCESS SERVICE – RECOMMENDED BIDDER REPORT</b>
<b>Report Summary:</b>	Advise Strategic Commissioning Board of the outcome of the tender evaluations for the Primary Care Access Service.
<b>Recommendations:</b>	<ol style="list-style-type: none"><li>1. Approve the outcome to award a contract with effect from 1 April 2019 to Bidder 1 for the Primary Care Access Service as the submission was the most economically advantageous tender received. The contract value of the successful bidder's submission is £22,910,498 (Net Present Value) over a maximum duration of 10 years (i.e. 5 years plus a 60 month (5 years) optional year extension).</li><li>2. Approve the publication of the contract award notice following the 10 day standstill period without challenge to allow contract award on 6 November 2018.</li><li>3. Approve the mitigations highlighted in Section 8 with consideration of associated risks.</li><li>4. Approve contract performance management process to include formal annual review alongside regular performance management in acknowledgement of the contract value and potential duration of the contract.</li></ol>
<b>How do proposals align with Health &amp; Wellbeing Strategy?</b>	Improved model of delivery for patients accessing care out of hospital.
<b>How do proposals align with Locality Plan?</b>	An integrated approach to delivery of care is key to the service model in line with Care Together ethos.
<b>How do proposals align with the Commissioning Strategy?</b>	The service will provide improved access to services, simplifying the pathway to access care for patients. Consolidation of existing provision into a single contract will deliver financial efficiencies which are detailed within this paper.
<b>Public and Patient Implications:</b>	A full 12 week consultation and engagement was carried out in advance of this procurement taking place. Issues and mitigations were identified and subsequently built into the service specification.
<b>Quality Implications:</b>	The Primary Care Access Service specification includes a range of quality indicators and outcomes that the provider must deliver and which the commissioner will performance monitor. In addition to this, 75% of the evaluation weighting

for the procurement was related to quality.

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

<b>ICF Budget</b>	<b>S 75 £'0 00</b>	<b>Aligned £'000</b>	<b>In Collab £'000</b>	<b>Total £'000</b>
<b>CCG</b>	2,2 91	-	0	2,291
<b>Total</b>	<b>22 91</b>	-	<b>0</b>	<b>2,291</b>

### **Section 75 - £'000**

#### **Strategic Commissioning Board**

The successful bid of £2,291k is significantly lower than the recurrent budgets we have in place to fund legacy services. Historic budgets of £2,811k are all included in the Section 75 pool:

- Primary Out of Hours (£1,744k)
- Extended access (£807k)
- Alternatives to Transfer (£260k)

#### **Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparison**

On the assumption that the recommendations of this paper are approved £520k of recurrent savings will be realised.

Because the successful bid was for less than the maximum published funding envelope, ongoing savings will be £98k higher than forecast within the TEP model.

In the TEP model for 2018/19 we took a cautious approach and only forecast savings from Q4. Assuming that mobilisation runs smoothly and the service commences 1 October, in year savings will be £260k. This is £190k higher than post optimism bias expected savings in the model.

This is an outcomes based contract so cost will not fluctuate as a result of changes in activity

Within the Financial Modeling Tool completed by the successful bidder there were several lines which were questioned by the evaluators (e.g. set up costs included recurrently and back office costs). As such it is recommended that a condition is attached to the award of this contract to allow these issues to be resolved.

**Legal Implications:**  
(Authorised by the Borough  
Solicitor)

The report indicates that procurement has been carried out with due process and with assistance of external evaluation in order to mitigate the risk challenge on the basis of impartiality. The process has been set out in the report and the financial provision is available.

If there is satisfaction as to these matters and to the letting

of a contract for the services to be put in place, then the award as recommended in this report should be approved.

**How do the proposals help to reduce health inequalities?**

Provision across five neighbourhood based hubs to provide equity of access to the whole population. A single service model will simplify access to primary care outside of core hours provision.

**What are the Equality and Diversity implications?**

Full EIA completed as part of the consultation process identified transport and travel as a key factor affecting access. Mitigating actions identified to address concerns and included within the service specification to ensure these are addressed.

**What are the safeguarding implications?**

There are no safeguarding implications associated with this report.

**What are the Information Governance implications?**

There are no information governance implications associated with this report.

**Has a privacy impact assessment been conducted?**


No.

**Risk Management:**

Procurement risk register in place.

**Access to Information :**

The background papers relating to this report can be inspected by contacting Janna Rigby, Head of Primary Care

 Telephone: 07342 056001

 e-mail: [janna.rigby@nhs.net](mailto:janna.rigby@nhs.net)

## **1. PURPOSE**

- 1.1 Advise Strategic Commissioning Board of the outcome of the tender evaluations for the Primary Care Access Service.
- 1.2 Request approval of the Recommended Bidder in order to award the contract for the Primary Care Access Service with effect from 1 April 2019.
- 1.3 Request approval, on completion of the 10 day standstill period without challenge, to publish a contract award notice.
- 1.4 Request that the minutes of this meeting for this agenda item are forwarded to NECS for audit purposes via email [necsu.neprocurement@nhs.net](mailto:necsu.neprocurement@nhs.net)

## **2. BACKGROUND**

- 2.1 Two of the national service improvement priorities for the NHS that relate to urgent care are:-
  - Improving A&E performance - requires upgrading the wider urgent and emergency care system 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.
- 2.2 Tameside and Glossop have developed an Integrated Urgent Care Service, which is comprised of two component parts, which will work together and with General Medical Practices, to ensure people can access same day care when necessary. These are:-
  - The Urgent Treatment Centre; based alongside the A&E Department at Tameside Hospital; and
  - The Primary Care Access Service (PCAS).
- 2.3 The proposed PCAS, which has been subject to a full public consultation, takes into account the challenges facing health and social care now and in the future. Implementation of PCAS will ensure a patient centred, responsive, safe, resilient, and fit for purpose service to support our population to receive the right care, in the right place, at the right time.
- 2.4 PCAS will simplify access to urgent care and improve the level of service available. The current arrangement of multiple access points to urgent care will be replaced by telephone access through a patient's own GP practices. Each GP will be able to book appointments directly into the PCAS. There will also be 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, local neighbourhood support will be strengthened through the development of two additional locations for evening appointments.
- 2.5 The successful provider will deliver a single urgent care service, 24 hours a day. This single service includes the current Extended Access Service, the General Practice Out of Hours Service and the Alternative to Transfer services (care closer to home, care in the community).

## **3. PRIMARY CARE ACCESS SERVICE**



- 3.1 The Primary Care Access Service has been developed to meet the requirements of new national guidance for both Primary and Urgent Care. This includes:-
- Improving access to General Practice.
  - Providing extra capacity to ensure everyone has access to GP services (routine and same day) at evenings and weekends.
  - Commissioning weekday provision of access to pre-bookable and same day appointments to general practice services 6.30-9pm.
  - Commissioning weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays.
  - Ensuring services are advertised to patients.
- 3.2 The service specification details a further set of local outcomes at **Appendix A**.

#### 4. PROCUREMENT PROCESS

- 4.1 The Procurement and Evaluation Strategy was approved by the Strategic Commissioning Board on 20 June 2018 subject to the following amendments:-
- CSD02 – Equity of Service and Equality (5%) to be moved from the Clinical and Service Delivery section to become QTY06 Equity of Service and Equality (5%) detailed within the Quality section
  - GOV01 – Clinical Governance to be a red flag question.
- 4.2 The procurement process was completed in accordance with the timescale and objectives set out within this approved strategy. The evaluation of bids as part of the procurement process, was designed carefully to ensure that it achieved the correct outcome.
- 4.3 A Recommended Bidder Report was brought to the Strategic Commissioning Board on 29 August 2018. the Strategic Commissioning Board deferred their decision in order to receive a more detailed report and ensure rigor in the approval process. This paper demonstrates how the agreed evaluation process was applied, the relative consensus scores for each of the bidders and states the outcome including the recommended bidder.

#### 5. PROJECT AND GOVERNANCE TIMESCALES TO DATE

- 5.1 The table below summarises the project timetable to date.

Urgent Care Consultation carried out	October 2017 to January 2018
Consultation outcome approved by SCB	20 March 2018
SCB approval to carry out procurement for the Primary Care Access Service	20 March 2018 (Item 6(b))
Primary Care Access Service Procurement Initiation Notice presented to SCB for information	23 May 2018 (Item 5(g))
Procurement Evaluation Strategy presented to SCB for approval	June 2018 (Item 6 (e))
Tender submissions	23 July 2018
Tender opening (by NECS on our behalf)	24 July 2018
Evaluation	24 – 27 July 2018
Financial evaluation	26 July 2018
Consensus meetings	30 July – 1 August 2018
Bidder presentations and final consensus	6 August 2018
Recommended Bidder Report brought to SCB	29 August 2018

5.2 Further to the Strategic Commissioning Board decision to defer, contract extensions have been agreed with existing providers to ensure continuation of service. The extensions have been agreed for a period of six months (1/10/18 – 31/3/19) to maintain stability over winter. The recommended bidder will be expected to be fully operational from 1 April 2019.

## 6. EVALUATION

6.1 A recommended bidder must have:-

- submitted a compliant bid;
- passed all elements of the Capability and Capacity Assessment;
- achieved a score of at least 50% for all Red Flag questions;
- achieved a minimum of 50% from the 75% (37.5%) available for all non-finance related criteria excluding the bidder presentations (quality);
- achieved a Pass on Presentation question CSD04 – Premises and Estates; and
- offered the most economically advantageous tender, i.e. achieve the highest combined percentage score for both quality (including presentation) and finance in line with the evaluation criteria.

6.2 Bidder 1 submitted a compliant bid, submitted a bid within the affordability envelope, passed all elements of the Capability and Capacity Assessment and passed all Red Flag questions. In respect of Quality, Bidder 1 scored 59.75% of the available marks (80%) and passed the Premises and Estates question (CSD04). Bidder 1 achieved an overall combined score of 79.75%, which includes quality, presentation and finance. Bidder 1 offered the most economically advantageous tender i.e. achieved the highest combined score for Quality, including presentation and Finance in line with the published evaluation criteria.

6.3 Bidder 2 submitted a compliant bid, submitted a bid within the affordability envelope, passed all elements of the Capability and Capacity Assessment and passed all Red Flag questions. In respect of Quality, Bidder 2 scored 44.25% of the available marks (80%) and passed the Premises and Estates question (CSD04). Bidder 2 achieved an overall combined score of 64.25% which includes quality, presentation and finance. Bidder 2 did not offer the most economically advantageous tender.

6.4 The evaluation panel and the question allocation is shown at **Appendix B**.

6.5 Each evaluator determined their scores and justification in line with the Evaluation Criteria at **Appendix C**.

6.6 The PCAS procurement has delivered the stated procurement objectives in line with Regulation 2(a) (Securing the needs of the people who use the services), Regulation 2(b) (Improving the quality of the services) and Regulation 2(c) (Improving efficiency in the provision of the services) of the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013, in providing a single provider for the contract who submitted a bid that proposes to:-

- Provide a high quality, consistent and convenient service offering for patients who are entitled to access Primary Care, in line with patient requirements (in line with Regulation 2(a));
- Ensure that patients are supported in resolving general queries, cancellations and re-booking of patient transport (in line with Regulation 2(a));
- Deliver a Primary Care Access Service across the Tameside and Glossop geography, reducing diversity and variation in service quality (in line with Regulation 2(b));
- Ensure compliance with both the milestones and the standards articulated within national policy and guidance (in line with Regulation 2(b));

- Improve value for money through (i) enhanced resource and capacity management and (ii) strengthened contract management (in line with Regulation 2(c));
- Ensure compliance with the Department of Health's Eligibility Criteria for Primary Care (in line with Regulation 2(c)).

6.7 Final evaluation consensus scores are shown at **Appendix D**.

## 7. UPDATED PROCUREMENT TIMELINES

7.1 Following the August 2018 Strategic Commissioning Board meeting, at which the decision was to defer the Recommended Bidder report, the following revised timetable has been set.

Obtain approval of Recommended Bidder Report	24/10/2018
Send Successful/Unsuccessful Bidder Letters	25/10/2018
10-Day Standstill Period	26/10/2018 - 05/11/2018
Send Contract Award Letters to Bidders	06/11/2018
Finalise Contract Signature(s)	12/11/2018
Mobilisation/Transition Phase - 20 weeks	12/11/2018 - 31/03/2019
Contract Commencement	01/04/2019

## 8. RISKS – MANAGEMENT AND MITIGATION

8.1 As a consequence of the requirement to extend current contracts, the mobilisation period has increased from 2.5 weeks to 20 weeks. It is therefore expected that all 5 hubs will be operational from the 1 April 2019.

### Risk 1- Leases

8.2 The recommended bidder has confirmed at question CSD04 that they will utilise the premises identified by the CCG and that time has been built into their mobilisation plan to agree and finalise terms with existing landlords. However, no formal lease agreements were agreed or submitted as part of the tender process. Therefore, there is a low risk that premises cost maybe increased by NHS Property Services. This could impact on the sustainability of the provider to deliver the service throughout the whole lifetime of the contract.

8.3 Mitigation - Bidders were required to provide details of the premises costs as part of the FMT within their tender submissions. This element of the mobilisation phase will be supported by Strategic Commission Estates and Primary Care Officers.

8.4 Existing provision within 3 of the 5 identified locations are already utilised for current service provision of Extended Access and Out of Hours care. Premise costs at the two new sites will therefore be negotiated to comparable levels, in line with the bidder's financial modelling.

### Risk 2 – Challenge to the model

8.5 Risk of potential challenge to embedding new ways of working as a fully integrated delivery of access to urgent care for patients. It is a specified requirement that they will approach their delivery model with a view to collaboration and integration; this is a requirement within the service specification. The degree to which this risk may be an issue will become apparent during the standstill period.

8.6 Mitigation - the successful provider's approach to delivery of the service within the locality will be critical to ensuring a fully integrated delivery of access to urgent care for patients is achieved. PACS model was developed to ensure a fully integrated service for urgent primary care is delivered, in line with the Care Together Locality Plans and the GP Forward

View. The Strategic Commission will therefore support and facilitate all providers within the system to enable this to happen.

**Risk 3 – Challenge to the process**

8.7 Risk of challenge to the procurement process by an unsuccessful bidder. Any challenge made must relate to the procurement process and not the outcome. NECS expertise was commissioned to ensure a lawful and robust process throughout. However, further to the decision to defer the following risks have been identified:-

- As a result of the mobilisation period extending, the potential for the tender process to be viewed as no longer transparent and therefore open to challenge.
- Increased risk of challenge from a provider who may have bid for services if they were aware that the mobilisation period was 20 weeks rather than 2 weeks. The two week mobilisation could have been seen as a barrier to entry NECS are aware of a 6 providers who expressed an interest in the procurement but did not bid and it is possible this was due to the originally published mobilisation period.
- Increased risk of challenge from unsuccessful bidder as the winning bidder being treated differently to the advertised procurement process.

8.8 The consequences of receiving a challenge are as follows:-

- Requirement to extend the current contract further which would not deliver the financial savings required in 19/20.
- Potential for a suspension notice issued by the Court during standstill which could result in the Strategic Commission being unable to undertake contract signature.
- Time and resource to respond to the challenge.
- Potential claim for damages from an unsuccessful bidder / non bidder following contract award.
- Complaint raised to NHS Improvement who have the ability to set aside a contract.
- Reputational risk.

8.9 Mitigation - It is the recommendation of NECS that the Strategic Commission adheres to the original procurement timetable for the mobilisation period and that the CCG continues with 3 hubs being mobilised on the new contract start date with the other 2 hubs following two months later as stipulated in the tender.

8.10 An alternative approach would be to halt the current tender process and re-run the procurement with a 20 week mobilisation period.

**9. OUTCOMES OF THE PROCUREMENT PROCESS**

<p>Detail any financial efficiencies / savings achieved (<i>per annum</i>)</p>	<p>Total financial envelope available £2,389,000          Bidder 1 financial submission £2,291,049.81</p> <p><math>£2,389,000 - £2,291,049.81 = £97,950.19</math></p> <p>On the assumption that the recommendations of this paper are approved, £520k of recurrent savings will be realized.</p> <p>Because the successful bid was for less than the maximum published funding envelope, ongoing savings will be £98k higher than forecast within the TEP model.</p>
<p>Detail the main expected quality outcomes from the specification / service</p>	<p>The aim of the service is to deliver a comprehensive Primary Care Access Service for patients. The Primary Care Access Service will ensure a 24/7 access offer is available to patients within primary care for both routine and same day / urgent demand. Key to the delivery of the service is the simplification</p>

	<p>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 practice 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&amp;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.</p>
<p>Detail the quality outcomes from the procurement process</p>	<p>The procurement process enabled the delivery of the outcomes as detailed in the Procurement and Evaluation Strategy. This solution delivers a simpler, single integrated primary care access service which is available to all patients 24 hours a day, 7 days a week. The delivery of 5 hubs across the area of Tameside and Glossop also improve accessibility for patients.</p>
<p>Detail the expected social value outcomes</p>	<p>Improvements will be achieved in the following ways:-</p> <ul style="list-style-type: none"> <li>• The service will ensure the population has 24/7 access to primary urgent care provision within the Tameside and Glossop footprint;</li> <li>• The service will have quality outcomes aligned to the wider urgent care system and through commissioning a system service, consistency of quality delivery will be a given;</li> <li>• The Primary Care Access Service contract will incorporate access to activity which is currently provided through 3 separate services. The procurement will remove the layering of services and contracts, with single premise, workforce and IT costs; and</li> <li>• Simplification of access for patients will ensure they are provided with the appropriate care for the need that they present with. The service will be delivered from 5 hubs, one in each of the integrated neighbourhood areas within the locality.</li> </ul>

## 10. RECOMMENDATIONS

10.1 As stated at the front of the report.

# APPENDIX A

Overarching outcomes of the service are:

- 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.

NHS Tameside and Glossop CCG has set out that the Service must deliver the following:

- Be sustainable in terms of workforce. For the avoidance of doubt, adequate staffing to the standard set out in these specifications (including but not limited to including ratios and skill mix) are an absolute requirement and any failure in this regard will be treated as a material breach;
- Foster local clinical engagement;
- Be clinically safe and manage complaints effectively;
- Provide 'value for money';
- Make best use of and develop the skills of all professional groups;
- Meet and wherever possible exceed the National GP OOH Quality Requirements;
- Have appropriate access to patient records and systems to facilitate the sharing of information ;
- Reduce unnecessary attendances to acute providers of emergency care;
- Reduce unnecessary hospital admissions;
- Take a whole systems approach;
- Work collaboratively with partner organisations;
- Support the reduction in pressure on in-hours GP services;
- Support the reduction in pressure on 999 ambulance service;
- Support the reduction in pressure on A&E;
- Involve patients in planning;
- Provide an excellent patient experience and ensure that patients from particular protected characteristic groups do not have a poor experience in comparison to the general population;
- Equitable and accessible services;
- Innovative use of IM&T; and

- Promote and protect the welfare of vulnerable residents.

## Performance Outcomes and Standards

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

1.	Direct Booking must be available through GP practices, NHS 111 or the Primary Care Access Service.
2.	Patients should be linked to Neighbourhood based support for self-care and social prescribing to reduce the risk of the same need arising in the future.
3.	Patients whose needs could have been met by other Neighbourhood based services (including minor ailments, minor eye conditions services and other services with self-referral mechanisms) should be encouraged to utilise these in the future.
4.	Utilisation of pre-bookable appointments should be managed to a minimum of 98%.
5.	For patients who require an appointment in the Primary Care Access Service, this should be booked by a single phone call
6.	Patients who have a pre-booked appointment should be seen and treated within 30 minutes of their appointment time.
7.	The service will be solely or jointly led by a GP across each of the five hubs as per the specification.
8.	The multidisciplinary teams should ensure people are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams.
9.	The integrated nature of the service will enable people to receive a range of physical and mental health support promptly both in and out of hospital.
10.	The Primary Care Access Service should be able to issue prescriptions, including repeat prescriptions and e-prescriptions (e-prescribing should be in place in all sites by June 2019).
11.	The Primary Care Access Service should issue patients with prescriptions and sick notes as appropriate to avoid the need for representation at the practice for the same episode of care.
12.	The Primary Care Access Service should be able to provide emergency contraception, where requested and appropriate.
13.	The Primary Care Access Service must have direct access to local mental health advice and services, or links to community-based crisis services.
14.	The Primary Care Access Service clinicians will have access to the up-to-date electronic patient care record for a T&G registered patient following consent.
15.	There must be the ability for services other than the patients registered GP practice (such as NHS 111) to electronically book appointments at the Primary Care Access Service directly, and relevant flags or crisis data should be made available for patients
16.	A patient's registered GP should always be notified about the clinical outcome of a patient's encounter with the Primary Care Access Service via a real-time update of the electronic patient care record locally. For children the episode of care should also be communicated to their health visitor or school nurse, where known, within two working days
17.	Where available, systems interoperability should make use of nationally-defined interoperability and data standards; clinical information recorded within local patient care records should make use of clinical terminology (SNOMED-CT) and nationally-defined record structures.
18.	Primary Care Access Service hubs should make capacity and waiting time data available to the local health economy in as close to real-time as is possible for the purposes of system-wide capacity management; relevant real-time capacity information should also be made available for use across Integrated Urgent Care nationally.

19.	Patients are able to book routine and urgent appointments at the agreed Neighbourhood Care Hub sites
20.	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
21.	To provide the necessary range of services to enable people with communication challenges to access British Sign Language, interpretation and translation services.
22.	Where appropriate, patients attending a the Primary Care Access Service should be provided with health and wellbeing advice and sign-posting to local community and social care services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services).
23.	Patients should be linked to Neighbourhood and Tameside and Glossop-wide based support.
24.	Patients are supported to navigate the system so they receive effective care first time and do not represent to other services for the same issue
25.	Patients can expect, following consent, that the treating clinician has access to their up-to-date electronic patient care record
26.	Primary Care Access Service Hubs to ensure that Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan (CPP), Looked After Child (LAC) or in utero. This will ensure that information is shared with social care and other NHS colleagues to enable appropriate action to safeguard the child.
27.	The Primary Care Access Service should ensure that any adult safeguarding concerns are raised promptly through the appropriate process.
28.	Patients requiring urgent investigations/diagnostics are referred as appropriate via their GP practice or receive these through the Urgent Treatment Centre where appropriate (when this service is available).
29.	National Quality Requirements in the Delivery of Out-of-hours Services Department of Health July 2006 Gateway no. 6893 are met.
30.	Delivery of 33 minutes per 1000 population per week. This equates to 7650 minutes per week for a 250,000 patient population.
31.	Same day home visit out of hours will either be attended by a GP or another appropriate service
32.	Access to urgent care support provided 24/7 by the most appropriate person fully utilising the skills of the wider Primary Care teams.
33.	Ensure people whose need can be met by Primary Care do not need to access A&E



## APPENDIX B

Section	Question Ref.	Question Topic	Red Flag Question	Evaluator 1	Evaluator 2	Evaluator 3
Section 1 Clinical & Service Delivery	<b>CSD01</b>	Accessibility	Red Flag	Clinical Director, Bury CCG	Head of Primary Care	Commissioning Programme Lead, Manchester
	<b>CSD02</b>	Partnership working		Head of Primary Care	Commissioning Programme Lead, Manchester	
	<b>CSD03</b>	Referrals		Head of Assurance and Delivery	Head of Primary Care	Clinical Lead, GMHSCP
	<b>CSD04</b>	Estates		Health & Social Care Estates Business Manager	Head of Primary Care	
	<b>CSD05</b>	Mobilisation	Red Flag	Head of Primary Care	Head of Primary Care Finance	Primary Care IT Operations Manager
	<b>QTY01</b>	Performance		Head of Business Intelligence	Head of Primary Care	Head of Assurance and Delivery

Section 2 Quality	<b>QTY02</b>	Continuous Improvement		Lead Designated Nurse Safeguarding	Quality Lead Manager	Performance and Quality Improvement Manager, Manchester
	<b>QTY03</b>	Patient Involvement		Lay Member for Patient and Public Participation, T&G SC	Head of Primary Care	Commissioning Programme Lead, Manchester
	<b>QTY04</b>	Patient Experience		Lay Member for Patient and Public Participation, T&G SC	Head of Primary Care	
	<b>QTY05</b>	Medicines Management		Head of Medicines Management, T&G SC	Clinical Director, Bury CCG	
	<b>QTY06</b>	Equity of Service & Equality		Jody Smith	Quality Lead Manager	Head of Primary Care
Section 3 IM&T	<b>IMT01</b>	IT Systems		Primary Care IT Operations Manager	GP IM&T Project Manager	
	<b>IMT02</b>	Information Governance		GP IM&T Project Manager	Primary Care IT Operations Manager	
Section 4 Workforce	<b>WF01</b>	Organisational Structure and Workforce	Red Flag	Clinical Lead, GMHSCP	Head of Primary Care	Clinical Director, Bury CCG
	<b>WF02</b>	Recruitment & Retention		Head of Primary Care Finance	Head of Primary Care	
	<b>WF03</b>	Workforce Supervision & Training		Lead Designated Nurse	Clinical Lead, GMHSCP	Clinical Lead, Busy CCG

				Safeguarding		
Section 5	<b>GOV01</b>	Clinical Governance	Red Flag	Lead Designated Nurse Safeguarding	Performance and Quality Improvement Manager, Manchester	
	<b>GOV02</b>	Business Continuity		Head of Primary Care	Health & Social Care Estates Business Manager	Primary Care IT Operations Manager
		Presentation		Panel to include: NECS Procurement Officer Head of Primary Care Interim Director of Commissioning Primary Care IT Operations Manager Health & Social Care Estates Business Manager Head of Primary Care Finance		
		Finance		Head of Primary Care Finance	Senior Finance Business Partner	

## APPENDIX C

### Evaluation Criteria

#### On-line Questionnaire 2 Tender Response Evaluation Criteria

Grade Label	Value	Definition of Grade
Excellent	100% = 4	Excellent, addresses all issues raised and/or a thorough understanding of the requirements. The response is very detailed and well evidenced and is of a quality and level of understanding that provides certainty of delivery and permits full contractual reliance (where applicable). Fully identifies any system/stakeholder benefits with strong evidence /rationale.
High Degree of Confidence	75% = 3	High degree of confidence in the bidder's ability to do what is stated through a thorough and detailed understanding of what is being requested. Responses demonstrate that the bidder can do what they say they will; translates well into contractual terms (where applicable). Responses are detailed and supported by evidence as appropriate. Potential system/stakeholder benefits described with evidence/rationale.
Meets Requirements	50%= 2	The bidder understands the issues and requirements and addresses them appropriately with sufficient information, but lacking reliable substance so as to suggest more of a "model answer" than a true commitment, and so only some confidence that the bidder will be able to deliver in line with expectations. Potential system/stakeholder benefits may be described but with limited evidence or rationale.
Low Degree of Confidence	25%= 1	Some misunderstandings by the bidder and limited on relevant information, detail, and evidence. Does not provide sufficient confidence that bidder can fulfil or meet the requirements in line with expectations.
No Relevant Information	0% = 0	No or minimal relevant information and/or refusal to deliver requirements.

## APPENDIX D

Question	Weighting (%)	Bidder 1 Score	Bidder 1 % Score	Bidder 2 Score	Bidder 2 % Score
CSD01 – Red Flag	6	3	4.5	2	3.00
CSD02	6	3	4.5	2	3.00
CSD03	3	3	2.25	3	2.25
CSD04	Pass/ Fail	Pass	N/A	Pass	N/A
CSD05 – Red Flag	5	3	3.75	2	2.50
QTY01	6	3	4.5	3	4.50
QTY02	3	3	2.25	2	1.50
QTY03	4	4	4.00	3	3.00
QTY04	4	3	3.00	2	2.00
QTY05	3	3	2.25	2	1.50
QTY06	5	3	3.75	2	2.50
IMT01	5	2	2.50	3	3.75
IMT02	5	3	3.75	3	3.75
WF01 – Red Flag	5	2	2.50	2	2.50
WF02	3	4	3.00	1	0.75
WF03	2	4	2.00	1	0.50
GOV01 – Red Flag	6	3	4.50	2	3.00
GOV02	4	3	3.00	3	3.00
<b>Quality Total</b>	<b>75</b>		<b>56%</b>		<b>43%</b>
<b>Presentation PR01</b>	<b>5</b>		3.75%		1.25%
<b>Finance</b>	<b>20</b>		20%		20%
<b>Total Score</b>	<b>100</b>		<b>79.75%</b>		<b>64.25</b>

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