Tameside & Glossop Care Together

STRATEGIC COMMISSIONING BOARD

Day: Wednesday
Date: 23 January 2019
Time: 1.00 pm
Place: Lesser Hall 2 - Dukinfield Town Hall

Item No.	AGENDA	Page No
1.	**WELCOME AND APOLOGIES FOR ABSENCE**	
2.	**URGENT ITEMS OF BUSINESS** To determine whether there are any additional items of business which, by reason of special circumstances, the Chair decides should be considered at the meeting as a matter of urgency.	
3.	**ITEM FOR EXCLUSION OF PUBLIC AND PRESS** To determine any items on the agenda, if any, where the public are to be excluded for the meeting.	
4.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from Members of the Strategic Commissioning Board.	
5.	**MINUTES OF THE PREVIOUS MEETING** To receive the Minutes of the previous meeting held on 12 December 2018.	1 - 4
6.	**FINANCIAL CONTEXT**	
a)	**CONSOLIDATED REVENUE MONITORING STATEMENT - MONTH 8** To consider the attached report of the Director of Finance.	5 - 24
7.	**QUALITY AND PERFORMANCE CONTEXT**	
a)	**TAMESIDE SEXUAL AND REPRODUCTIVE HEALTH: IN FOCUS REPORT** To consider the attached report of the Director of Population Health.	25 - 70
8.	**COMMISSIONING FOR REFORM**	
a)	**TAMESIDE SEXUAL AND REPRODUCTIVE HEALTH: CONTRACT EXTENSION AND FUTURE INVESTMENT** To consider the attached report of the Director of Population Health.	71 - 88
b)	**ALLOCATION OF £1.154 MILLION ADULT SOCIAL CARE WINTER PLANS FUNDING FOR 2018-19** To consider the attached report of the Assistant Director (Adults).	89 - 96

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.

c) INTERMEDIATE CARE 97 - 118

To consider the attached report of the Interim Director of Commissioning.

9. DATE OF NEXT MEETING

To note that the next meeting of the Strategic Commissioning Board will take place on Wednesday 13 February 2019.

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.

STRATEGIC COMMISSIONING BOARD

12 December 2018

Commenced: 1.00 pm **Terminated:** 2.20 pm

Present: Dr Alan Dow (Chair) – NHS Tameside and Glossop CCG
Councillor Brenda Warrington - Tameside MBC
Councillor Bill Fairfoull - Tameside MBC
Councillor Leanne Feeley - Tameside MBC
Councillor Gerald Cooney - Tameside MBC
Councillor Allison Gwynne - Tameside MBC
Councillor Warren Bray - Tameside MBC
Councillor Oliver Ryan - Tameside MBC
Steven Pleasant - Tameside MBC Chief Executive and Accountable Officer for NHS Tameside and Glossop CCG
Dr Jamie Douglas - NHS Tameside and Glossop CCG
Carole Prowse - NHS Tameside and Glossop CCG
Dr Ashwin Ramachandra – Tameside and Glossop CCG
Dr Christine Ahmed – Tameside and Glossop CCG

In Attendance: Sandra Stewart – Director of Governance and Pensions
Kathy Roe – Director of Finance
Jeanelle De Gruchy – Director of Population Health
Gill Gibson – Director of Quality and Safeguarding
Jessica Williams – Interim Director of Commissioning

Apologies for Absence: Dr Vinny Khunger – NHS Tameside and Glossop CCG

75 DECLARATIONS OF INTEREST

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

76 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 28 November 2018 were approved as a correct record.

77 CHAIR'S OPENING REMARKS

In opening the meeting the Chair welcomed Dr Christine Ahmed to this her first meeting of the Strategic Commissioning Board following her recent appointment to the CCG Governing Body.

The Chair was delighted to announce that Kathy Roe, joint Director of Finance for NHS Tameside and Glossop Clinical Commissioning Group and Tameside Council had won Finance Director of the Year at the Healthcare Financial Management Association Awards 2018. Members of the Board joined the Chair in extended their congratulations which was a testament to Kathy's exceptional financial leadership.

78 STRATEGIC COMMISSION AND NHS TAMESIDE AND GLOSSOP INTEGRATED CARE FOUNDATION TRUST - CONSOLIDATED 2018/19 REVENUE MONITORING STATEMENT AT 31 OCTOBER 2018 AND FORECAST TO 31 MARCH 2019

The Director of Finance presented a report providing an overview of the financial position of the Tameside and Glossop economy in 2018/19. As at 31 October 2018, the Integrated Commissioning

Fund was forecast to spend £582.3 million against an approved budget of £580.4 million, an overspend of £1.9 million. This was an improvement on the position reported at month 6 and was due to a combination of improved savings delivery and the release of corporate contingency budgets. However, the forecast masked significant risks and pressures in a number of areas, including Continuing Heathcare, Children's Services and Operations and Neighbourhoods and Growth.

She reported that the opening economy wide savings target for 2018/19 was £35.920 million. Against this target, £18.9 million of savings had been realised in the first seven months, 53% of the required savings. Expected savings by the end of the year were £32.8 million, a shortfall of £3.1 million against target and a small improvement on the position reported last month. The Medium Term Financial Plan for period 2019/20 to 2023/24 identified significant savings requirements for future years. If budget pressures in service areas in 2018/19 were sustained, this would inevitably lead to an increase in the level of savings required in future years to balance the budget.

Reference was made to a letter that had been sent from NHSE to all CCGs asking them to reduce their costs by 20%. The Board commented that Tameside and Glossop Strategic Commission had already taken decisions to work more efficiently and collaboratively to maximise the money that could be spent across the system to transform health and care services.

RESOLVED

(i) That the content of the report be noted.

(ii) That the significant level of savings required during 2018/19 to deliver a balanced recurrent economy budget together with the related risks contributing to the overall adverse forecast be acknowledged.

(iii) That the significant cost pressures facing the Strategic Commission, particularly in respect of Continuing Healthcare, Children's Social Care and Operations and Neighbourhoods and Growth be acknowledged.

79 QUALITY ASSURANCE REPORT

The Director of Quality and Safeguarding presented a report providing the Strategic Commissioning Board with assurance that robust quality assurance mechanisms were in place monitoring the quality of the services commissioned. It also highlighted any quality concerns and provided assurance as to the action being taken to address such concerns.

In particular, she explained the role of the Quality Improvement Team who were now offering support to homes with preparation for their CQC inspections. She was pleased to advise that there was an improved locality position since the report had been produced with three more care homes now rated as Good.

In addition, reference was made to the Quality Premium Scheme 2017/18, intended to reward clinical commissioning groups for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. Details of the provisional award for Tameside and Glossop CCG were provided and it was noted that there had been a significant improvement on performance compared to previous years.

The Director of Quality and Safeguarding responded to questions from Board Members relating to staff capacity within the Integrated Care Foundation Trust, increase in cases of MRSA bacteraemia across the economy, mortality data and the work being undertaken with General Practices to understand the challenges being faced in achieving a higher Quality Outcomes Framework score and reduce variations.

RESOLVED

That the content of the Quality and Assurance update report be noted.

80 PERFORMANCE UPDATE

The Assistant Director (Policy, Performance and Communications) presented a report providing the Strategic Commissioning Board with a Health and Care performance update at December 2018. The Health and Social Care dashboard was attached at Appendix 1 to the report and the measures for exception reporting and those on watch were highlighted as follows:

EXCEPTIONS (areas of concern)	1	A&E- 4 hour Standard
	3	Referral To Treatment-18 Weeks
	40	Direct Payments
	45	65+ at home 91days
ON WATCH (monitored)	7	Cancer 31 day wait
	11	Cancer 62 day wait from referral to treatment
	41	Learning Disability service users in paid employment

Reference was made to updates on issues raised by Members of the Board which were outside the Health and Care Dashboard and other data or performance issues that the Strategic Commissioning Board needed to be aware of relating to:

- NHS 111;
- 52 Week Waiters;
- A&E at Manchester University Hospital NHS Trust;
- Elective Waiting Lists; and
- Referrals.

RESOLVED
That the content of the performance update report be noted.

81 COMMISSIONING INTENTIONS 2019/20: TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST, PENNINE CARE NHS FOUNDATION TRUST AND ALL OTHER PROVIDERS FOR TAMESIDE AND GLOSSOP RESIDENTS

Consideration was given to a report of the Director of Commissioning and draft letters to the Tameside and Glossop Integrated Care NHS Foundation Trust, Pennine Care Foundation Trust and all other providers for Tameside and Glossop residents. The letters set out, in high level terms, how Tameside and Glossop Strategic Commission intended to commission services from providers in 2019-20. Details of specific commissioning intentions, in terms of activity and financial planning, would be shared with appropriate providers during contract negotiations.

These commissioning intentions were in line with the 'Approach to Planning' guidance issued by NHS Improvement and NHS England on 16 October 2018, setting out the timetable for 2019/20.

The Strategic Commission was committed to early intervention, prevention and tackling unacceptable inequalities and these were the bedrock for the strategic commissioning intentions and long term commitment to deliver sustainable improvement to healthy life expectancy. The Director of Commissioning outlined the content of the letters making particular reference to the following sections:

- Tameside and Glossop Financial Context 2019/20;
- Aligning health and social care with wider public sector reform;
- Prevention and Population Health;
- Starting Well;
- Living Well;
- Ageing Well; and
- Additional Commissioning Intentions for 2019/20.

The Board was pleased to support the Commissioning Intentions 2019/20 which continued to drive the commissioning agenda and aimed to support the implementation of a new model of care, based on place and realign the system to support the development of preventative, local, high quality services. There had been significant inroads into delivering the Strategic Commission's ambitions, thinking about the future and how this could be taken forward after 2019/20 would be influenced not only by what was happening in Greater Manchester, such as the development of the Local Industrial Strategy, but also key national events, not least the forthcoming publication of the 10 Year NHS Plan and the conduct of the Comprehensive Spending Review.

RESOLVED
That the commissioning intentions 2019/20 be supported and the Strategic Commission continue to work with its providers towards delivering a stable economy and its long term commitment to delivering sustainable improvement to healthy life expectancy.

82 COMMUNITY HEALTH ESTATE AND INTEGRATION

The Director of Commissioning presented a report setting out a strategic vision for the modernisation of the Community Healthcare Estate and the development of Integrated Neighbourhood Hubs.

In each neighbourhood, there was a variety of estate options and differing pressures to be considered. With increasing housing developments and ageing NHS infrastructure, there was a need to ensure that all neighbourhoods benefitted from modern and fit for purpose healthcare facilities and the report detailed the main issues surrounding the community and primary care estate and outlined a developing plan to modernise the estate in combination with delivering multi-agency services in a co-located or hub format in each neighbourhood.

Due to the prioritisation of estates and integrated hubs within Greater Manchester, resource had been made available centrally to develop opportunities further. Tameside and Glossop Strategic Commission had submitted a number of funding bids based on specific neighbourhoods and all had been successful. The funding allocations awarded ranged from between £25,000 to £80,000 with a total sum of external monies secured amounting to £250,000. It was proposed to use these funds to develop more detailed assessment of potential opportunities.

The Board was pleased to learn that external funding had be secured for the purpose of developing Outline Business Cases, to be agreed in advance by the Strategic Commissioning Board, which aimed to provide more aligned care for each of the neighbourhoods, making access to health and social care more streamlined for all.

RESOLVED
(i) That the prioritisation of estates and neighbourhood integrated hubs within Greater Manchester be noted and the availability centrally of external resources to develop opportunities.
(ii) That Tameside and Glossop had been successful in securing some of this resource via funding bids ranging from £25,000 to £80,000 and totalling £250,000.
(iii) That approval be given to the spending of these funds to gain more detailed understanding of potential neighbourhood opportunities leading to the development of Outline Business Cases.

83 DATE OF NEXT MEETING

To note that the next meeting of the Strategic Commissioning Board will take place on Wednesday 23 January 2019.

CHAIR

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	23 January 2019
Executive Member/Officer of Strategic Commissioning Board	Councillor Bill Fairfoull – Deputy Executive Leader 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 30 NOVEMBER 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 £1 million by the end of 2018/19 due to a combination of non-delivery savings and cost pressures in some areas.
Recommendations:	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 30 November 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)**	There is a statutory duty to ensure the Council sets a balanced budget and that it is monitored to ensure statutory commitments are met. There are a number of areas that require a clear strategy to ensure in the face of demand they achieve this. 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. It is necessary that any cost sharing arrangements and implications of the same are agreed in advance with external auditors.
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:	Associated details are specified within the presentation.
Access to Information :	Background papers relating to this report can be inspected by contacting : Tom Wilkinson, Assistant Director of Finance, Tameside Metropolitan Borough Council

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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 the 30 November 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 £580.816 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).

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 £1m by the end of 2018/19 due to a combination of non-delivery savings and cost pressures in some areas. Supporting details of the projected variances are explained in **Appendix 1**.

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

Organisation	Net Budget £000s	Forecast £000s	Variance £000s
Strategic Commission (ICF)	580,816	581,853	(1,037)
ICFT	(19,139)	(19,139)	0
Total	**561,677**	**562,714**	**-1,037**

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 £5.0m in 2018/19 in support of the CCG's 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 £5.0m) in 2018/19 which is a maximum £0.5m contribution from the CCG towards the Council year end position and a maximum of £2.0m 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 Table 2. 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 below with further detail in **Appendix 1**.

Table 2: 2018/19 ICF Financial Position

Service	Net Budget £000s	Forecast £000s	Variance £000s
Acute	203,804	204,615	(811)
Mental Health	32,726	33,415	(689)
Primary Care	83,664	83,237	427
Continuing Care	14,279	16,937	(2,658)
Community	29,913	30,119	(206)
Other CCG	24,707	20,770	3,936
CCG TEP Shortfall (QIPP)	0	411	(411)
CCG Running Costs	5,209	5,209	0
Adults	40,480	40,276	204
Children's Services	49,330	56,630	(7,300)
Population Health	16,232	16,160	72
Operations and Neighbourhoods	50,333	51,198	(865)
Growth	7,846	10,293	(2,447)
Governance	8,813	7,711	1,102
Finance & IT	4,553	4,286	267
Quality and Safeguarding	79	94	(15)
Capital and Financing	9,638	8,058	1,580
Contingency	(2,660)	(7,365)	4,705
Corporate Costs	1,870	(201)	2,071
Integrated Commissioning Fund	**580,816**	**581,853**	**(1,037)**
CCG Expenditure	394,302	394,713	(411)
TMBC Expenditure	186,514	187,140	(626)
Integrated Commissioning Fund	**580,816**	**581,853**	**(1,037)**
A: Section 75 Services	266,571	268,693	(2,122)
B: Aligned Services	240,841	247,310	(6,469)
C: In Collaboration Services	73,404	65,850	7,554
Integrated Commissioning Fund	**580,816**	**581,853**	**(1,037)**

3. BUDGET VARIATIONS

3.1 The forecast variances set out in Table 2 includes a number of variances driven by cost pressures arising in the year and risks or non-delivery of savings. The key variances by service area are summarised below.

Continuing Care (£2.658m)

3.2 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.

3.3 A financial recovery plan was put in place and progress against this is reported to the Finance and QIPP Assurance Group on a regular basis. Since the recovery plan was put in place we have seen a reduction in forecast of circa £0.3m.

CCG Other £3.936m

3.4 Services within this directorate such as Better Care Fund, 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 £3.2m of the approved £6.3m 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.

3.5 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 £19.8m Targeted Efficiency Plan (TEP) target. As reported in **Appendix 1**, there is a £0.4m risk attached to fully closing this gap.

CCG TEP Shortfall (£0.400m)

3.6 The CCG has a TEP target (also known as the QIPP), of £19.8m for 2018/19. Against this target, £13.803m (70%) of the required savings have been achieved in the first eight months of the year. A further £5.023m is rated green and will be realised in future months. After the application of optimism bias, anticipated further savings of £1.126m from schemes currently rated as amber, as the CCG no longer has any schemes as red (high risk), reducing the net gap to £0.4m.

Children's Services (£7.300m)

3.7 The Council continues to experience extraordinary increases in demand for Children's Social Care Services, placing significant pressures on staff and resources. The number of Looked after Children has gradually increased from 612 at 31 March 2018 to 654 at 30th November 2018. Despite the additional financial investment in the service in 2017/18 and 2018/19, the service is projecting to exceed the approved budget for Third Party Payments by £6.475m; due to the additional placement costs. It should be noted that the 2018/19 placements budget was based on the level of Looked After Children at December 2017 (585); the current level at 30th November is 654; a resulting increase of 69 (11.8%). This should also be considered alongside the current average weekly cost of placements in the independent sector with residential at £4,009 and foster care £786.

Growth (£2.447m)

3.8 The service continues to face pressures due to non-delivery of savings and additional cost pressures.

3.9 Following the liquidation of Carillion the appointed liquidator PwC managed the contracts to effect a 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.

3.10 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.

3.11 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 although there was no robust review of these proposals. 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 proposed 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.

4. TARGETED EFFICIENT PLAN (TEP)

4.1 The economy wide savings target for 2018/19 is £35.920m. This consists of:

- CCG £19.800m
- TMBC £3.119m
- ICFT £13.001m

Table 3 : 2018/19 Targeted Efficiency Plan (TEP)

Organisation	High risk	Medium risk	Low risk	Savings posted	total	target	Post bias expected savings	Post bias variance
CCG	0	1,126	5,023	13,803	19,952	19,800	19,389	(411)
TMBC	547	280	543	941	2,311	3,119	1,679	(1,440)
Strategic commissioner	**547**	**1,406**	**5,566**	**14,744**	**22,263**	**22,919**	**21,068**	(1,851)
ICFT	726	180	4,056	8,233	13,195	13,001	12,469	(533)
Economy total	**1273**	**1,586**	**9,622**	**22,977**	**35,458**	**35,920**	**33,536**	(2,384)

4.2 Against this target, £22.977m of savings have been realised in the first eight months, 64% of the required savings. Expected savings by the end of the year are £33.536m, a shortfall of £2.384m against target. Slides 10 and 11 of **Appendix 1** provide a summary of the associated risks relating to the delivery of these savings for the Strategic Commission. It is worth noting that there is a risk of under achievement against this efficiency target across the economy at this reporting period.

4.3 More work is required to identify new schemes and turn red and amber schemes green. As things stand we would need to fully deliver all of the amber rated schemes and half of the red rated schemes to fully close the gap. It is therefore essential that additional proposals are considered and implemented urgently to address this gap on a recurrent basis thereafter.

4.4 There are high risk savings proposals of £1.273m which are currently at risk of non-delivery in 2018/19. **Appendix 1** summarises risks by service area, which for the Strategic Commission includes:

- For Adults the remaining £0.318m of the savings is due to delays in the delivery which has had an impact on the achievement. Other savings are being identified across the service which it is expected will compensate for non-delivery of the planned savings.
- Governance - £0.129m savings target red rated relates to summons fee increases not being achievable as a result of a reduction in the number of summons being issued due to changes in approach to recovery processes under revised government guidance. The non-delivery of this saving is being offset by other cost savings elsewhere in the service.
- Operations and Neighbourhoods - Most of this savings target relates to the new Car parking provision at Darnton Road which was expected to generate additional income per annum. A delay in the construction of the spaces has resulted in the forecast additional income for this financial year being reduced.

5 CCG SURPLUS

5.1 In 2018/19 the CCG is now planning to deliver a surplus of £12.347m, a £3m increase from the original £9.347m as set out by national guidance. This overall surplus is broken down into three parts:

- **£3.668m** Mandated 1% surplus;
- **£5.679m** Cumulative surplus brought forward from previous years;
- **£3.000m** Agreed increase in Surplus to support national financial risks.

5.2 The 1% in year surplus is a requirement of the business rules. It is calculated on the basis of 1% of opening allocations, excluding the allocation for delegated co-commissioned primary care.

5.3 The cumulative surplus brought forward was built up in 2016/17 and 2017/18, when CCGs had to contribute into a national risk reserve offsetting overspend in the provider sector. While the cumulative surplus brought forward remains on the CCG balance sheet, there is currently no mechanism through which Tameside and Glossop are able to drawdown or use any of this resource.

5.4 There is no national risk reserve in 2018/19. However there is still a significant financial gap nationally, which needs to be addressed. Greater Manchester Health and Social Care Partnership have been in discussions with national bodies to address this gap and has confirmed and agreed that any CCG who could increase their surplus for 2018/19 would be able to drawdown some of their cumulative surplus in 2019/20. Using the flexibility of the ICF we have increased our surplus by £3m, which will allow for a potential of up to £6m drawdown in 2019/20, under the 2 for 1 offer by NHS England.

5.5 Under the terms of the GM proposal, increasing the 18/19 surplus by £3m would enable drawdown of £6m in 2019/20, reducing the cumulative surplus to £6.3m. The money drawn down would be paid back into the ICF through increased CCG contributions to the pool.

5.6 An additional benefit from this proposal would be an improvement in the aggregate GM financial position in 2018/19. Any underspend against the GM system control total would attract 48p of additional Provider Sustainability Funding for every £1 of underspend.

5.7 5 year financial plans have been built on the assumption that there will be no mechanism to access the CCGs cumulative surplus. If we are able to drawdown some of our surplus in 2019/20 through the GM proposal, the financial position of the integrated commissioner will improve on a recurrent basis and the reported gap will reduce.

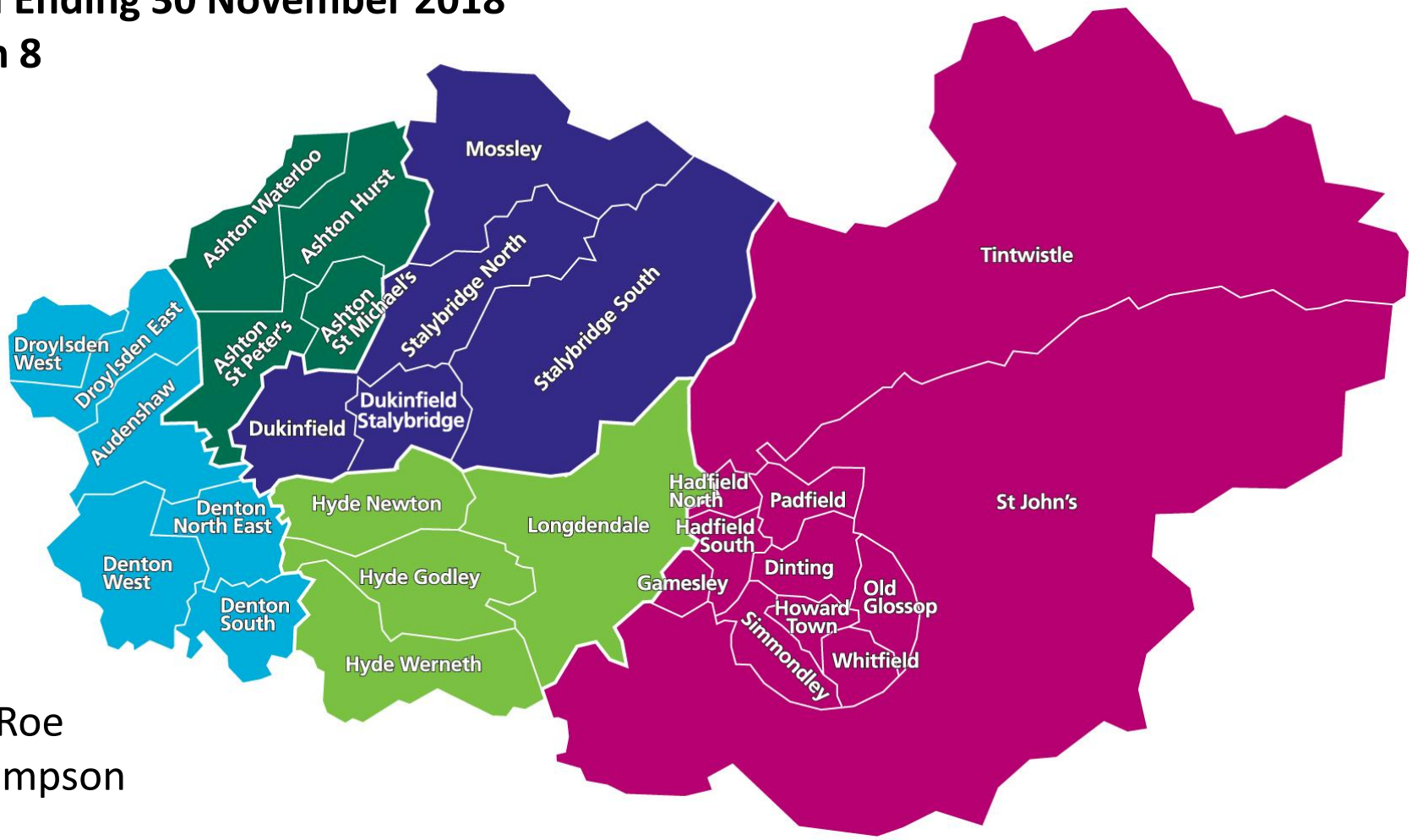
6 RECOMMENDATIONS

6.1 As stated on the report cover**.**

Tameside and Glossop Integrated Financial Position

financial monitoring statements

Period Ending 30 November 2018
Month 8



Kathy Roe
Sam Simpson

Integrated Financial Position Summary Report

Tameside & Glossop Integrated Economy Wide Financial Position

£7.3m

Children's Services

Unprecedented levels of demand in Children's Social Care continue and place significant pressures on staff and resources. **Placement costs are the main driver of the forecast £7.3m in excess of approved budget.**

Message from the DOFs

Congratulations to Kathy Roe who has won the prestigious HfMA award for Finance Director of the Year. This award is a testament to Kathy's exceptional financial leadership of our ground-breaking integration work here in Tameside & Glossop. This award is a testament to the amazing work of the finance team and wider colleagues.

As we head towards winter, we are feeling fairly comfortable with the economy wide financial position as it continues to improve this month. Whilst we remain optimistic that we have covered most of our risks, there will be elements that will be out of our control such as any unexpected severe weather, which will add additional pressures to our front line services.

Whilst we are confident that we can meet financial control totals and deliver an in-year balanced position, savings delivery for 2018/19 and future years remains a key priority. Financial plans for 2019/20 and beyond are now being refined and savings required next year remain significant.

£0.9m

Strategic Commission Forecast

Overall forecast outturn for the Strategic Commission has improved by £0.9m due mainly to the delivery of further savings. The forecast is now for an overspend of £1m.

This report covers all spend at Tameside & Glossop Clinical Commissioning Group (CCG), Tameside Metropolitan Borough Council (TMBC) and Tameside & Glossop Integrated Care Foundation Trust (ICFT) . It does not capture any Local Authority spend from Derbyshire County Council or High Peak Borough Council for the residents of Glossop.

	Forecast Position			Variance	
Forecast Position £000's	Budget	Forecast	Variance	Previous Month	Movement in Month
CCG Expenditure	394,302	394,713	-411	-926	515
TMBC Expenditure	186,514	187,140	-626	-967	341
Integrated Commissioning Fund	**580,816**	**581,853**	**-1,037**	**-1,893**	**856**
ICFT - post PSF Agreed Deficit	-19,139	-19,139	0	0	0
Economy Wide In Year Deficit	**-19,139**	**-20,176**	**-1,037**	**-1,893**	**856**

Tameside & Glossop Integrated Commissioning Fund

As at 30 November 2018 the Integrated Commissioning Fund is forecasting to spend £581.8m, against an approved budget of £580.8m, an **overspend of £1.0m,** which is an improvement of £0.9m since last month. Whilst we have seen another month of improvement to the integrated commissioning fund, there still remains significant risks within Children's services that has seen another adverse movement of £0.7m due to the significant increase in placements over the past couple of weeks. Whist we are seeing unpresented levels of children being placed in care, there is a further risk of an increase over the Christmas period. The improved position from month 7 is due to a combination of savings exceeding expectations and the release of corporate contingency budgets and reduced corporate costs.

	Forecast Position					Net Variance	
Forecast Position £000's	Expenditure Budget	Income Budget	Net Budget	Net Forecast	Net Variance	Previous Month	Movement in Month
Acute	203,804	0	203,804	204,615	-811	-1	-810
Mental Health	32,726	0	32,726	33,415	-689	-672	-16
Primary Care	83,664	0	83,664	83,237	427	286	141
Continuing Care	14,279	0	14,279	16,937	-2,658	-2,766	108
Community	29,913	0	29,913	30,119	-206	-327	122
Other CCG	24,707	0	24,707	20,770	3,936	3,481	456
CCG TEP Shortfall (QIPP)	0	0	0	411	-411	-926	515
CCG Running Costs	5,209	0	5,209	5,209	0	-0	0
Adults	82,653	-42,172	40,480	40,276	204	213	-9
Children's Services	78,173	-28,843	49,330	56,630	-7,300	-6,575	-725
Individual Schools Budgets	116,029	-116,029	0	0	0	0	0
Population Health	16,912	-680	16,232	16,160	72	61	11
Operations and Neighbourhoods	76,306	-25,973	50,333	51,198	-865	-777	-88
Growth	42,614	-34,768	7,846	10,293	-2,447	-2,447	0
Governance	88,619	-79,807	8,813	7,711	1,102	1,102	0
Finance & IT	6,103	-1,550	4,553	4,286	267	231	36
Quality and Safeguarding	367	-288	79	94	-15	0	-15
Capital and Financing	10,998	-1,360	9,638	8,058	1,580	1,580	0
Contingency	4,163	-6,823	-2,660	-7,365	4,705	4,358	347
Corporate Costs	8,726	-6,857	1,870	-201	2,071	1,287	784
Integrated Commissioning Fund	**925,965**	**-345,150**	**580,816**	**581,853**	**-1,037**	**-1,893**	**856**

Integrated Commissioning Fund – Movements since month 7

£810k Acute

As the RTT issue remains a real concern for the CCG and the impact on the achievement of QPP, the CCG has seen a real increase in the level of activity going through the independent sector providers. This increase and our expectation that we will make some headway towards meeting the national targets has resulted in an increase in the forecast outturn of £498k. Key providers are BMI Healthcare, Spire and Spamedia, in particular with day case surgery and ophthalmology.

Salford Royal FT contract has increased by £94k due to an increase in high costs patients. This has been seen in critical care, neuro and bariatric surgery. In connection with Salford Royal the forecast with the Priory Group has increased by £100k this month to account for a patient due for discharge from critical care but will be admitted into neuro rehab.

Based on the current levels of activity for acute out of area treatment and the trajectory for winter, the forecast has seen an increase of £100k

£725k Children's Services – Social Care

The Council continues to experience extraordinary increases in demand for Children's Social Care Services, placing significant pressures on staff and resources. The number of Looked after Children has gradually increased from 612 at 31 March 2018 to 654 at 30th November 2018. Despite the additional financial investment in the service in 2017/18 and 2018/19, the service is projecting to exceed the approved budget for Third Party Payments by £6.475m; due to the additional placement costs. It should be noted that the 2018/19 placements budget was based on the level of Looked After Children at December 2017 (585); the current level at 30th November is 654; a resulting increase of 69 (11.8%). This should also be considered alongside the current average weekly cost of placements in the independent sector with residential at £4,009 and foster care £786.

Integrated Commissioning Fund – Movements since month 7

£784k Corporate Costs

Corporate Costs budgets include dividend income from the Council's shareholding in Manchester Airport Group. In previous months, the forecast outturn for corporate costs was based on the level of dividend received in the previous year. The Council now has confirmation of the dividend that will be paid in December 2018 which results in total dividend receipts in 2018/19 being £800k in excess of the previous forecast. This additional income will be used to offset overspends in other service areas but is one-off in nature and cannot be guaranteed in future years.

£347k Contingency

The Corporate Contingency budget includes an annual provision for risks and unforeseen costs. Year-end projections for the use of contingency budgets are reviewed and updated each month. The revised forecast at month 8 has released further contingency budget which offsets forecast overspends in other areas..

£515k CCG TEP

The net risk has reduced down from £926k last month to £411k in Month 8. This is an improved position of £515k. Based on our expectations, we anticipate that our net risk will reduce to zero in month 9 with the full achievement of TEP.

One of the key benefits to the TEP position this month is the successful review of prescribing for patients with respiratory which has exceeded expectations.

Additional non-recurrent benefit is due to the achievement of the Quality Premium, which is the highest ever seen in Tameside & Glossop and the success of the Primary Care Access tender which has now gone live sooner than anticipated.

Other benefits have been through the NHS associate contract performance and budget management.

Tameside & Glossop Integrated Commissioning Fund

Forecast Position £000's	YTD Position			Forecast Position			Variance	
	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
Acute	134,978	135,715	-737	203,804	204,615	-811	-1	-810
Mental Health	21,932	22,379	-447	32,726	33,415	-689	-672	-16
Primary Care	55,178	54,826	352	83,664	83,237	427	286	141
Continuing Care	9,270	10,454	-1,184	14,279	16,937	-2,658	-2,766	108
Community	19,941	19,895	46	29,913	30,119	-206	-327	122
Other CCG	20,558	18,601	1,958	24,707	20,770	3,936	3,481	456
CCG TEP Shortfall (QIPP)	0	0	0	0	411	-411	-926	515
CCG Running Costs	2,613	2,600	13	5,209	5,209	0	-0	0
Adults	30,987	31,408	-421	40,480	40,276	204	213	-9
Children's Services	28,886	31,055	-2,168	49,330	56,630	-7,300	-6,575	-725
Population Health	12,321	12,474	-152	16,232	16,160	72	61	11
Operations and Neighbourhoods	33,555	34,598	-1,043	50,333	51,198	-865	-777	-88
Growth	7,231	9,225	-1,995	7,846	10,293	-2,447	-2,447	0
Governance	15,375	14,801	574	8,813	7,711	1,102	1,102	0
Finance & IT	3,036	3,043	-8	4,553	4,286	267	231	36
Quality and Safeguarding	53	-92	144	79	94	-15	0	-15
Capital and Financing	0	1	-1	9,638	8,058	1,580	1,580	0
Contingency	-1,773	-871	-902	-2,660	-7,365	4,705	4,358	347
Corporate Costs	1,246	-262	1,508	1,870	-201	2,071	1,287	784
Integrated Commissioning Fund	**395,387**	**399,850**	**-4,464**	**580,816**	**581,853**	**-1,037**	**-1,893**	**856**
CCG Expenditure	264,470	264,470	0	394,302	394,713	-411	-926	515
TMBC Expenditure	130,917	135,380	-4,464	186,514	187,140	-626	-967	341
Integrated Commissioning Fund	**395,387**	**399,850**	**-4,464**	**580,816**	**581,853**	**-1,037**	**-1,893**	**856**
ICFT - post PSF Agreed Deficit	-14,755	-14,693	62	-19,139	-19,139	0	0	0
Economy Wide In Year Deficit	**-14,755**	**-19,157**	**-4,402**	**-19,139**	**-20,176**	**-1,037**	**-1,893**	**856**

The CCGs net risk at the start of the financial year was £3m, which was a significant challenge against an overall TEP target of £19.8m. To report the net risk of £0.4m at month 8 is a massive achievement, but recognise that there is still the longer term recovery plan to deliver.

Tameside Integrated Care Foundation Trust Financial Position

SUMMARY

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

- For the financial period to the **30th November 2018**, the Trust has reported a net deficit of c.£16.2m (Pre PSF), which is c.£0.1m better than plan. The in month position for November reported a £1.6m net deficit, £142k worse than plan.
- The Trust delivered c.£1.6m of savings in month, this is an overachievement against target of c.£331k in month, cumulatively the Trust is reporting an overachievement against plan of c£0.9m
- To date the Trust has spent c.£5.0m on Agency, against a plan of £6.0m; based on this run rate, spend should be within the agency cap of £9.5m.

	Month 8			YTD			Outturn
Financial Performance Metric	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000s
Normalised Surplus / (Deficit) Before PSF	-1,455	-1,597	-142	-16,231	-16,169	62	-23,360
Provider Sustainability Fund (PSF)	281	281	0	1,476	1,476	0	4,221
Surplus / (Deficit)	-1,174	-1,316	-142	-14,755	-14,693	62	-19,139
Trust Efficiency Savings	1,316	1,646	331	7,298	8,233	934	13,000
Use of Resources Metric	3	3		3	3		3

KEY RISKS

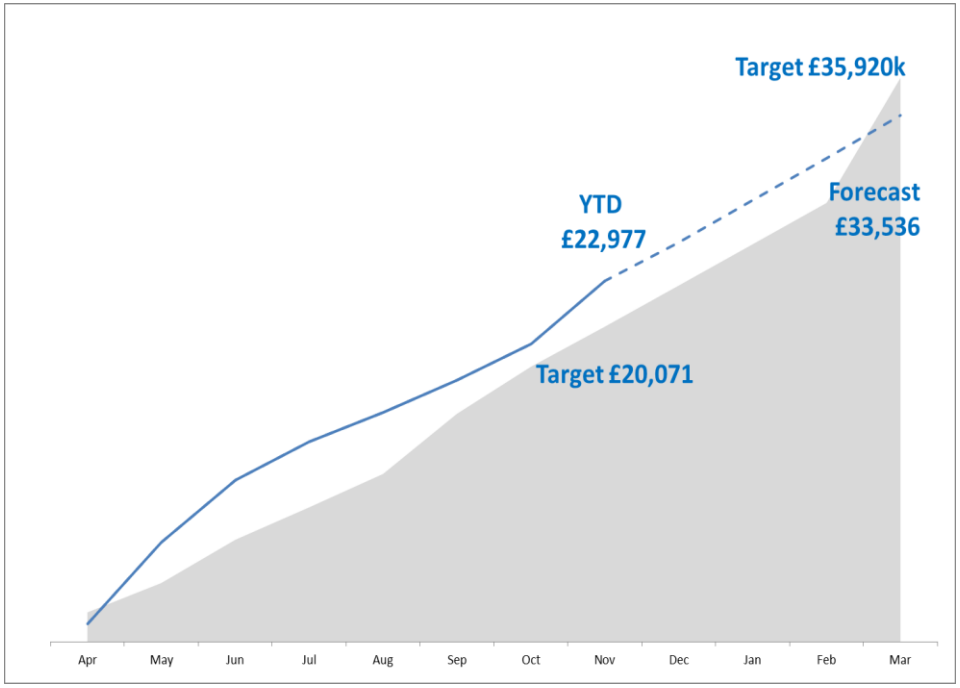
- **Control Total –** The Trust now has an agreed control for 2018/19 of **c£19.1m**, this assumes the Trust will be in receipt of the full Provider Sustainability fund.
- **Provider Sustainability Fund** - The Trust must achieve its financial plan at the end of each quarter to achieve 70% of the PSF, the remainder is predicated on achievement of the A&E target. If the Trust fail to deliver the financial and/or performance targets it will need to borrow additional cash at 1.5%
- **TEP** – The Trust is currently forecasting an underachievement against its in year TEP delivery of **c£0.5m** and recurrently of **c£1.2m**. **Failure of delivering the TEP target will challenge the Trust's ability to deliver its control total**. Work is on-going with Theme groups to progress high risk schemes and hopper ideas to improve this forecast position.

TEP – Targeted/Trust Efficiency Plan

Organisation	High Risk	Medium Risk	Low Risk	Savings Posted	Total	Target	Post Bias Expected Saving	Post Bias Variance
CCG	0	1,126	5,023	13,803	19,952	19,800	19,389	(411)
TMBC	547	280	543	941	2,311	3,119	1,679	(1,440)
Strategic Commissioner	**547**	**1,406**	**5,566**	**14,744**	**22,263**	**22,919**	**21,068**	**(1,851)**
ICFT	726	180	4,056	8,233	13,195	13,001	12,469	(533)
Economy Total	**1,273**	**1,586**	**9,622**	**22,977**	**35,458**	**35,920**	**33,536**	**(2,384)**

Progress Against Target

- The opening economy wide savings target for 2018/19 is £35,920k:
  - Commissioner £22,919k (£19,800k CCG & £3,119k TMBC)
  - Provider £13,001k
- Against this target, £22,977k of savings have been realised in the first eight months, £2,906k above plan
- Expected savings by the end of the year are £33,536k, a shortfall of £2,384k against target. This is an improvement of £721k on the position reported last month.
- More work is required to identify new schemes and turn red and amber schemes green.
- The scale of the financial gap in future years mean there must be a continued focus on identifying schemes for 2019/20 and beyond.



TEP – Targeted/Trust Efficiency Plan

£1,862k CCG

The expected savings reported last month has improved by £515k. This is largely attributable to prescribing for patients with respiratory conditions which has exceeded expectations and the earlier than anticipated Go-Live date of the new Primary Care access service following the successful tender, along with the QPP achievements. Actual savings achieved in month are in the table opposite.

Theme	Savings Posted
Reverse Demographic Growth	207
GP Prescribing	268
Individualised Commissioning Recovery Plan	46
Associate Provider Demand Management Schemes	250
Running Costs Savings	52
Primary Care Access Service	173
Budget Management	365
Release of reserves	500
TOTAL	**1,862**

Org	Theme	High Risk	Medium Risk	Low Risk	Savings Posted	Total	Target	Post Bias Expected Saving	Post Bias Variance
CCG	Emerging Pipeline Schemes	0	0	0	0	0	3,239	0	-3,239
	GP Prescribing	0	615	797	1,695	3,107	2,000	2,800	800
	Individualised Commissioning Recovery Plan	0	0	347	346	693	1,326	693	-633
	Other Established Schemes	0	261	581	2,869	3,711	4,283	3,580	-703
	Tameside ICFT	0	0	827	1,653	2,480	2,480	2,480	0
	Technical Financial Adjustments	0	250	2,471	7,240	9,961	6,472	9,836	3,364
CCG Total		**0**	**1,126**	**5,023**	**13,803**	**19,952**	**19,800**	**19,389**	**-411**
TMBC	Adults	318	0	0	379	697	697	411	-286
	Growth	0	25	340	0	365	898	353	-546
	Finance & IT	50	0	0	122	172	172	127	-45
	Governance	129	0	0	25	154	154	38	-116
	Childrens (Learning)	0	0	90	0	90	90	90	0
	Operations & Neighbourhoods	50	255	0	0	305	580	133	-448
	Pop. Health	0	0	113	415	528	528	528	0
TMBC Total		**547**	**280**	**543**	**941**	**2,311**	**3,119**	**1,679**	**-1,440**
Strategic Commissioner Total		**547**	**1,406**	**5,566**	**14,744**	**22,263**	**22,919**	**21,068**	**-1,851**

TEP – Targeted/Trust Efficiency Plan

£1,647k ICFT

Overall expected savings have improved from the previous month with savings posted in month of £1.6m. The Trust is currently forecasting an underachievement against its in year TEP delivery of **c£0.5m** and recurrently of **c£1.2m**. **Failure of delivering the TEP target will challenge the Trust's ability to deliver its control total**. Work is on-going with Theme groups to progress high risk schemes and hopper ideas to improve this forecast position.

Org	Theme	High Risk	Medium Risk	Low Risk	Savings Posted	Total	Target	Post Bias Expected Saving	Post Bias Variance
ICFT	Community	6	11	195	107	318	363	312	(51)
	Corporate	12	0	207	836	1,054	805	1,043	238
	Demand Management	320	0	302	776	1,398	1,474	1,078	(396)
	Estates	28	6	214	267	514	569	486	(83)
	Finance Improvement Team	80	0	366	1,180	1,626	1,067	1,546	480
	Medical Staffing	3	83	33	166	286	1,103	282	(820)
	Nursing	132	0	274	791	1,198	1,243	1,065	(178)
	Paperlite	27	0	26	72	124	250	97	(153)
	Pharmacy	43	80	430	164	717	450	674	224
	Procurement	76	0	325	96	496	752	420	(331)
	Transformation Schemes	0	0	1,225	2,211	3,436	3,000	3,436	436
	Technical Target	0	0	58	430	488	375	488	113
	Vacancy Factor	0	0	401	1,139	1,539	1,550	1,539	(11)
ICFT Total		**726**	**180**	**4,056**	**8,233**	**13,195**	**13,001**	**12,469**	**(533)**

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Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 23 January 2019

Reporting Member / Officer of Strategic Commissioning Board Councillor Brenda Warrington – Executive Leader

Jeanelle De Gruchy, Director of Population Health

Subject: **SEXUAL AND REPRODUCTIVE HEALTH IN TAMESIDE**

Report Summary: This report sets out an overview of the sexual and reproductive health of the Tameside resident population. The report also provides an update on the commissioning and provision of sexual and reproductive health services.

Recommendations: The Board is asked to note the report and provide feedback

Financial Implications:

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

Integrated Commissioning Fund Section	Section 75 (TMBC) Aligned (CCG)
Decision Required By	Strategic Commissioning Board for s75 allocation CCG Governing Body
Organisation and Directorate	TMBC – Population Health CCG
Budget Allocation	TMBC - £ 1.65 million CCG - £ 0.46 million
Additional Comments	
The report provides members with an update on the commissioning and provision of sexual and reproductive health services across the locality. All services are delivered within the existing budget of the Strategic Commission as detailed above. The CCG budget refers to section 9.83 of the report (Termination Of Pregnancy).	

Legal Implications:

(Authorised by the Borough Solicitor)

The Board has two roles to determine priorities and strategy to meet statutory duties and improve the health and wellbeing of the population and secondly to monitor the delivery of the strategy and review whether the allocation of budget and resources is having the necessary impact. This report serves the second purpose by reviewing the impact of the services commissioned by the SCB. It is a very helpful review and deep dive of the provision and the next stage needs to be setting out clearly what good looks like, whether we are meeting minimum standards together with value for money and what the next steps should be looking to the future.

How do proposals align with Health & Wellbeing Strategy? The proposals align with the Starting Well and Developing Well programmes for action

How do proposals align with Locality Plan? The provision of sexual and reproductive health services is consistent with the following priority transformation programmes:

- Enabling self-care

	• Locality-based services • Planned care services
How do proposals align with the Commissioning Strategy?	The provision of sexual and reproductive health services contributes to the Commissioning Strategy by: • Empowering citizens and communities • Commission for the 'whole person' • Create a proactive and holistic population health system
Recommendations / views of the Health and Care Advisory Group:	The report was supported by the clinical lead for sexual health, Dr Jane Harvey at the Health and Care Advisory Group and the contents were noted.
Public and Patient Implications:	None
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness
How do the proposals help to reduce health inequalities?	Provision of Sexual and reproductive health services has a positive effect on health inequalities. Poor sexual health and lack of access to contraception contributes to inequalities, with more deprived populations experiencing worse sexual health
What are the Equality and Diversity implications?	The sexual and reproductive health services provided are available to Adults regardless of ethnicity, gender, sexual orientation, religious belief, gender re-assignment, pregnancy/maternity, marriage/ civil and partnership. Some service provision is targeted to address health inequalities experienced by more marginalised groups.
What are the safeguarding implications?	Sexual and Reproductive Health Services have an important role in the identification and response to abuse. The service has explicit resources for this, is linked into Child Sex Exploitation and Domestic Abuse services and has pathways to safeguard children and vulnerable adults
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report therefore a privacy impact assessment has not been carried out
Risk Management:	The purchasers will work closely with the provider to manage and minimise any risk of provider failure consistent with the provider's contingency plan.
Access to Information:	The background papers relating to this report can be inspected by contacting the report writer Richard Scarborough, Planning and Commissioning Officer Telephone: 0161 342 2807 e-mail: Richard.scarborough@tameside.gov.uk

1. INTRODUCTION

1.1 This report sets out an overview of the sexual and reproductive health of the Tameside resident population. The report also provides an update on the commissioning and provision of sexual and reproductive health services including:

- Northern Sexual Health, Contraception and HIV Service;
- RuClear;
- Passionate about Sexual Health Programme;
- Youthink - Tameside's sexual health intervention and prevention team;
- National HIV self-sampling Service;
- Contraceptive services in Primary Care;
- Emergency Hormonal Contraception services in Pharmacies;
- Termination of pregnancy.

1.2 Responsibility for commissioning sexual and reproductive health services transferred to Local Authorities from Health in 2013. The provision of termination of pregnancy services remain with the CCG. This report covers the responsibilities of Tameside Council with the respect of sexual and reproductive health and Tameside and Glossop CCG with respect to Termination of Pregnancy.

1.3 Improving the sexual and reproductive health of the local population is a Population Health priority.

1.4 Sexual and reproductive ill-health can have a detrimental effect on people's relationships and on their emotional and physical wellbeing. Good sexual and reproductive health is dependent on a positive and respectful attitude to sex, relationships and sexuality; pleasurable and safe sexual experiences free from coercion; the absence of infection and dysfunction; and the avoidance of unintended conceptions.

1.5 Sexually transmitted infections (STIs) can be passed from an infected person to their partner during sexual intercourse. Sexually transmitted infections can lead to long-term health problems if not detected and treated. Infections such as HIV can be managed but not cured.

1.6 The correct and consistent use of a reliable method of contraception is important for protection from an unintended conception. Over the last decade, there has been an increase in the proportion of women opting to use a long acting, reversible method of contraception (such as the contraceptive implant) though the contraceptive pill is still a popular choice.

2. SUMMARY

2.1 Sexually Transmitted Infections (STIs) Summary

- Rate of diagnosis of STIs for Tameside residents down from 765 per 100,000 in 2016 to 653 in 2017. Rate is lower than rate for GM (771) and England (743). Part of reduction may be due to previous inaccurate reporting of chlamydia data.
- Excluding Chlamydia 992 new STI infections diagnosed to Tameside residents in 2017, down from 1031 in 2016. Diagnosis rate down from 724 per 100,000 in 2016 to 697 in 2017.
- Young people aged 15-25 account for 55% of new cases.
- Gay and bisexual men account for around 12% of infections.
- Local Chlamydia data included some double counting until mid-2016 so data shows substantial falls as this is corrected.

- 692 new cases of chlamydia in Tameside in 2017 compared to 888 in 2016.
- 2017 Chlamydia rate of diagnosis 310 per 100,000 lower than GM rate 378 and England rate 361.
- Tameside chlamydia detection rate in 2017 was 1,794, lower than GM 1,853 and England rate of 1,882.
- Nationally the largest increase in STI diagnoses between 2016 and 2017 was for gonorrhoea with a 22% increase, there were 132 cases in Tameside in 2017 a 10% increase from the 118 cases in 2016.
- Nationally the cases of genital warts is decreasing -7% between 2016 and 2017 due to numbers receiving quadrivalent HPV vaccine when aged 12 or 13. In Tameside there were 139 new cases down from 162 in 2016 a decrease of -16%.
- Nationally cases of syphilis are up 17% between 2016 and 2017. Tameside cases are down -8.7% in this period (down from 25 to 23 cases) with a rate of 10.3 per 100,000 compared to 17.2 for GM and 12.5 for England.
- 11 Tameside residents aged over 15 received a diagnosis of HIV in 2017 a decrease on the previous two years (2015 17, 2016 19).
- Nationally there has been a decrease in new HIV diagnosis which has occurred alongside the introduction of PREP (Pre exposure Prophylaxis).
- The GM HIVE project aims to end new cases of HIV in GM within a generation. Increased testing and awareness in the initial phases of this project should see an increase in the numbers of people diagnosed. It is estimated that 13% of cases are undiagnosed.
- 269 Tameside residents received HIV treatment and care in 2017. 48% were exposed to the virus by sex between men and 48% from sex between men and women.
- Tameside's HIV diagnosed prevalence rate per 100,000 aged 15-59 is 1.87. 10% of the Middle Super Output Areas have a prevalence rate higher than 2.00
- The proportion of new HIV diagnosis of Tameside residents diagnosed early has increased and continues to increase.

2.2 **Contraception Summary**

- Provision of Contraception, particularly the more effective Long Acting Reversible Contraception (LARC) has fallen in GM over the last 4 years. .The reductions are related to the tendering and implementing of new Sexual Health services across the region and reductions in the number of practitioners in General Practice qualified to fit and remove LARCs.
- Between 2015 and 2016 the number of LARCs provided by General practice in Tameside reduced by 21%, however, there was an increase in user dependant methods (pill and injection) meaning that over the period there was a slight increase in the provision of contraception by General Practice.
- The rate of LARC prescribed at GP practices was 28.6 per 1000 which is higher than the GM rate of 17.7 and similar to England
- In 2016 the rate of LARC prescribed for Tameside residents was 45.8 per 1000 women aged 15-44 down from 55.1 in 2015.
- The Tameside rate of LARC prescribed at sexual health clinics was 17.2 per 1000 this is similar to the England rate of 17.
- 630 Tameside residents prescribed Emergency Hormonal Contraception (EHC)by sexual health services in 2016. Of these 9.5% were prescribed it more than once in the year.
- General Practice prescribed EHC pills on 900 occasions in 2016
- Approximately 1360 prescriptions of EHC were provided by pharmacy services in 2017.

2.3 **Abortion Summary**

- Numbers of abortions for women living in Tameside has been rising since 2014. There were 978 abortions performed for Tameside in 2017 and increase of 3%.

- The rate of abortions per 1000 women aged 15-44 in Tameside has risen from 19.2 in 2014 to 22.6 in 2017
- The T&G abortion rate is 21.6 the second highest CCG rate in GM. GM rate is 19.7, North West 19.5 and England 17.2
- 82.2% of abortions performed for T&G patients in 2017 were between 3 and 9 weeks gestation compared to 77% for England which indicates good access and waiting times.

2.4 **Teenage Conceptions Summary**

- Under 18 conceptions in Tameside peaked in 2005 with a fall of 64% since then.
- There were 98 conceptions recorded to under 18 year olds in 2016 compared to 274 in 2005. The 2016 annual rate per 1000 was 26.0
- Q3 2017 conception data shows a rolling annual rate over the last 4 quarters of 23.6 with 87 conceptions in the period. The North west rate is 20.3
- The under 16 conception rate peaked at 15.3 per 1000 in 2009 and was 5.0 in 2016.18 conceptions were recorded to under 16s in 2016 compared to 23 in 2015.

2.5 **Developments**

- The PHE Teenage pregnancy self-assessment tool is being completed.
- In 2018 a Sex and relationships curriculum was developed for Tameside primary and secondary schools and is now being implemented.
- The provision of Ullipristral (Ella One) EHC is being proposed for implementation via pharmacy services. Ella One is more effective than progesterone only EHC and can be used in the period between 72 and 120 hours following unprotected sexual intercourse.
- Stalybridge neighbourhood have implemented neighbourhood LARC model with one practice is now running a weekly contraception clinic on behalf of all practices in the neighbourhood
- We are currently looking at options to increase LARC capacity in General Practice.

2.6 **Services**

- The main Sexual Health Service is provided by Manchester FT under “The Northern” brand at the Orange Rooms at Ashton Primary Care Centre
- Contract commenced in September 2016 following a competitive tender.
- Service has had some reductions in capacity due to staffing issues. During this time vulnerable young people and symptomatic patients have been prioritised.
- Implemented new IT system – quicker results management, patient visibility across all Northern services, less clinical time spent inputting information.
- Implemented a digital offer with the provision of STI testing kits posted to patient’s home address
- Refreshed Your Welcome accreditation
- Updated safeguarding processes
- 100% of patients with an urgent clinical need offered an appointment within 48 Hours.
- 94% of patients attending walk-in clinic seen within 90 minutes
- 97% of surveyed patients said the level of respect and courtesy shown by reception staff was good or excellent
- 99% said they felt assured their visit was private and confidential
- 94% extremely likely or likely to recommend service to friends and family
- 91% rated care received as excellent or very good.

3. SEXUALLY TRANSMITTED INFECTIONS (STIS)

3.1 The Orange Rooms at Ashton Primary Care Centre, part of Manchester University Foundation Trust’s (MFT) Northern Sexual Health, Contraception and HIV Service, is the main provider of sexual and reproductive health services in Tameside. They offer a

comprehensive range of services for people of all ages including screening and of HIV and sexually transmitted infections (STIs). They also provide HIV treatment and Care which is commissioned by NHS England.

3.2 The Contract with MFT commenced in September 2016 and was procured in collaboration with Trafford and Stockport with Stockport as the Lead Commissioner.

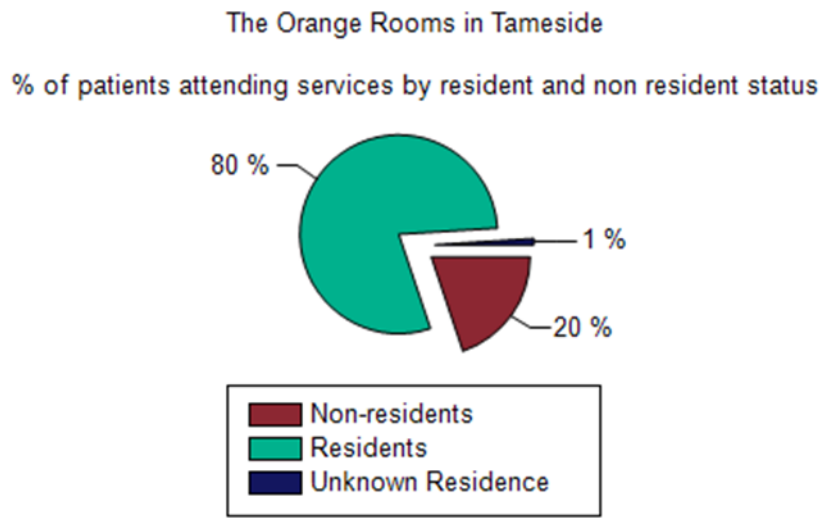
3.3 The Orange Rooms recorded 9223 attendances during 2017. Of these 7523 were for Tameside residents and 1764 for non-Tameside residents. Overall, residents of Tameside attended sexual and reproductive health services on 9540 occasions during 2017 with 2017 attendances out of Borough.

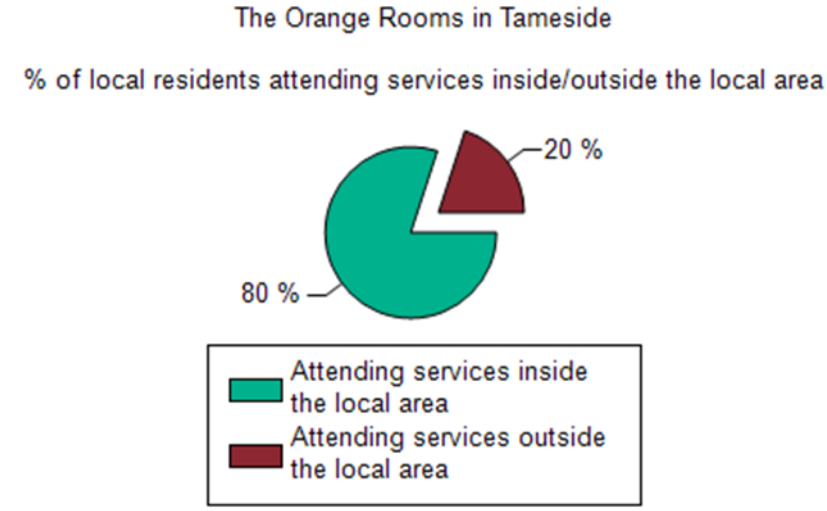
3.4 The table below details the number and proportion* of contraceptive and other Sexual and Reproductive health (SRH) services provided among residents of Tameside, North West Public Health England (PHE) Centre and England by service provided: 2016.

SRH service provided	*LA (n)±*	*LA (%)*	*PHE Centre (%)*	*England (%)*
Regular contraceptive care	8,650	43.1	43.7	43.7
Emergency contraceptive care	700	3.5	3.0	2.9
Pre-contraception consultation	185	0.9	4.2	5.6
Implant removal±	435	2.2	2.8	3.4
IUS Removal±	130	0.6	0.9	1.1
IUD Removal±	115	0.6	0.7	0.8
Sexual health advice	6,680	33.3	34.7	30.2
Pregnancy related care	860	4.3	5.4	6.7
Abortion related care	30	0.1	0.4	1.0
Cervical screening	40	0.2	1.8	1.4
Psychosexual related care	30	0.1	0.6	0.7
Sterilisation/vasectomy related care	0	0.0	0.1	0.1
IUS insertion (non-contraception)	0	0.0	0.0	0.0
IUS check (non-contraception)	0	0.0	0.1	0.1
Menopause management & treatment	0	0.0	0.0	0.1
Colposcopy related care	5	0.0	0.0	0.0
Ultra sound scan	45	0.2	0.3	0.6
Sub fertility treatment and care	0	0.0	0.0	0.0
Other Gynecology treatment and care	10	0.0	0.2	0.5
Alcohol brief intervention	2,040	10.2	0.5	0.3
Safe guarding children referral	10	0.0	0.0	0.0
CAF# Referral	0	0.0	0.0	0.0
Other Referrals	85	0.4	0.7	0.8
TOTAL	20,055			

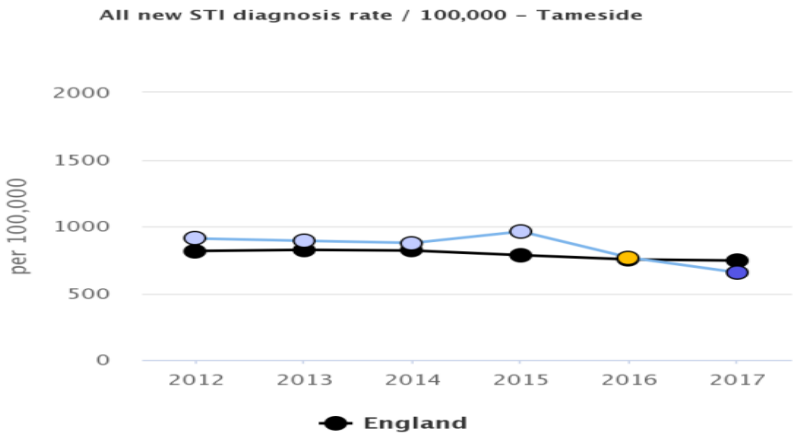
Source: SRHAD. Data from Sexual and Reproductive Health Services. Multiple services can be provided on the same attendance.
'Regular contraceptive care' includes all contraceptive consultations including new, change and maintenance of method and insertion and removal of devices for contraceptive purposes.
* Please note to prevent deductive disclosure the number of SRH services provided in the LA have been rounded to the nearest 5. Therefore the totals may not equal the sum of their parts.
Percentages will be distorted by rounding especially where small numbers are involved.
± Clinics can remove implants, intrauterine systems (IUS) and intrauterine devices (IUD) that they have not provided themselves, therefore it is possible that a clinic may remove more devices than they provide.

3.5 Attendance at the Orange Rooms in the 6 months to 30 June 2018 has been 5596 of which 4539 are Tameside residents.





3.6 There were 1457 new cases of sexually transmitted infections diagnosed to residents of Tameside at sexual health and related clinics in 2017, down from 1707 in 2016 (-6.8%). The rate of diagnosis was 653 per 100,000 population in 2017, down from 765 in 2016. This compares to a rate of 771 for Greater Manchester and 743 for England. The reduction in the number of new diagnoses may be due, in part, to a previous double counting of chlamydia data which was resolved when MFT commenced delivery of the new service in September 2016.



Recent trend:

Period	Count	Value	Lower CI	Upper CI	North West	England
2012	2,000	908	869	949	825	815
2013	1,965	891	852	931	810	823
2014	1,931	875	836	915	836	818
2015	2,127	960	920	1,002	786	783
2016	1,707	765	729	802	758	751
2017	1,457	653	620	687	730	743

3.7 Excluding Chlamydia 992 new cases of sexually transmitted infections were diagnosed to residents of Tameside at sexual health and related clinics in 2017, down from 1031 in 2016 (-3.7%). The rate of diagnosis was 697 per 100,000 population in 2017, down from 724 in 2016. This compares to a rate of 794 for England. The reduction in the number of new diagnoses reflects the impact of the implementation of the new service in September 2016 and the associated staffing restructure.

3.8 Young people aged 15-24 accounted for over half (55%) of new cases of common infections diagnosed to residents of Tameside in 2017. 84% were under the age of 34. Young people tend to have a higher turnover of sexual partners and can be less skilled at negotiating safer sex than older adults; this puts them at increased risk of acquiring an infection or re-infection.

3.9 The number of new cases of sexually transmitted infections diagnosed to gay and bisexual men has increased over the past decade. Gay and bisexual men accounted for around 12% of new cases of common infections diagnosed to male residents at sexual health clinics in 2017.

3.10 80% of new cases of common infections diagnosed to residents of Tameside in 2017 were diagnoses in the Tameside service, 9.4% in Manchester services, 3.6% in Stockport and 3.1% in Oldham with smaller numbers elsewhere.

3.11 Overall, the upward trend in diagnoses of common sexually transmitted infections observed over the last decade is a result, in part, of an increase in the number of people obtaining screening for STIs. The introduction of more sensitive tests and the expanded use of extra-genital testing have also meant that additional infections are being detected.

3.12 However, it also indicates that unsafe sexual behaviour remains an issue. Promoting the use of condoms as part of combination prevention (regular screening and the use of pre and/or post exposure prophylaxis for protection from HIV) remains essential to control and prevent the transmission of sexually transmitted infections.

3.13 Public Health England are continuing to run their sexual health campaign promoting condom use targeting 16-24 year olds. Campaign website - https://www.nhs.uk/protect-against-stis-use-a-condom/home

Chlamydia

3.14 Chlamydia is a bacterial infection that can be passed from an infected person to their partner(s) through sex. It is often asymptomatic and can lead to long-term health problems if undetected and untreated. 692 new cases of chlamydia were diagnosed to residents of Tameside in 2017, down from 888 in 2016 (-22%). 492 cases were diagnosed in sexual health clinics, of which 395 were diagnosed at the Orange Rooms and 200 cases were detected as a result of opportunistic screening in other settings. The rate of diagnosis was 310 per 100,000 population in 2017, down from 398 in 2016. This compares to a rate of 378 for Greater Manchester and 361 for England.

3.15 It is believed that the Chlamydia data for Tameside has previously been subject to double counting with information relating to screens conducted in the main sexual health service being counted by both the service and the chlamydia screening programme. Since MFT took over the sexual health service in September 2016 this has been corrected and the current figures now accurately reflect activity.

3.16 Indicators linked to the National Chlamydia Screening Pathway (NCSP) are included in the Public Health Outcomes Framework (PHOF) and the Public Health England Sexual and reproductive Health Profiles. The indicators assess progress in controlling chlamydia in sexually active young adults. Guidance recommends local areas achieve an annual chlamydia detection rate of at least 2,300 per 100,000 15-24 year old resident population to detect and treat sufficient asymptomatic infections to affect a decrease in incidence. Tameside achieved a detection rate of 1,794 in 2017, down from 2,619 in 2016 (-31%). This compares to a detection rate of 1,853 for Greater Manchester and 1,882 for England.

3.17 The chlamydia detection rate reflects both screening coverage levels and the proportion of tests that are positive at all testing sites, including primary care, sexual and reproductive health and specialist sexual health services. Areas achieving or above the 2,300 detection rate should aim to sustain or increase, with areas achieving below it aiming to increase their rate.

3.18 The Tameside chlamydia detection rate has previously been one of the highest nationally and highest in Greater Manchester but has fallen dramatically from 3789 in 2015, to 2619 in 2016 and 1794 in 2017 along with decrease in the number of tests and percentage of population covered. Whilst Tameside figures have dropped significantly they are now more in line with the rest of GM. There have been problems with the coding and reporting of chlamydia tests by laboratories via CTAD (Chlamydia Testing Activity Dataset) which are now being resolved following work by PHE with labs and RuClear. For some time it has been suspected that Tameside figures included a lot of double counting as our rates were extremely high but we could not justify them. It is likely that, prior to the commencement of our new contract for the Sexual and Reproductive health Service in September 2016, all screens initiated within this service were being double counted.

3.19 Percentage positivity rate is not a reported indicator but is contained within the data. Tameside's 2017 figure is 10.9% the third highest in GM. This may indicate that either the tests we do are more targeted or that the level of infection in the population is higher.

3.20 The pathway target positive detection rate is 2.3% (approximately 600 positives for Tameside) and it is estimated that 25-35% of the population needs to be tested to achieve this. In 2017 we achieved 453 positive test results with 16.5% of the population tested.

Gonorrhoea

3.21 Gonorrhoea is a bacterial infection that can be passed from an infected person to their partner(s) during sex. It can lead to serious health problems if it is not detected and treated. There were 132 cases diagnosed to residents of Tameside at sexual health clinics in 2017, up from 118 in 2016 (+10%). Gay and bisexual men accounted for 32% of cases. The rate of diagnosis was 59.2 cases per 100,000 population in 2017, up from 52.9 in 2016. This compares to a rate of 84.7 for Greater Manchester and 78.8 for England.

Genital herpes

3.22 Genital herpes can result from infection with the Herpes Simplex virus (HSV). People who contract this virus can develop painful blisters on or around their genitals. There were 139 new cases diagnosed to residents of Tameside at sexual health clinics in 2017, down from 162 in 2016 (-16%). The rate of diagnosis was 62.3 cases per 100,000 population in 2017, down from 72.6 in 2016. This compares to a rate of 53.2 for Greater Manchester and 56.7 for England.

Syphilis

3.23 Syphilis is a bacterial infection that can be passed from an infected person to their partner(s) during sex. It can lead to serious health problems if it is not detected and treated. There were 23 cases diagnosed to residents of Tameside at sexual health clinics in 2017, down from 25 in 2016 (-8.7%). Gay and bisexual men accounted for almost nine out of ten cases. The rate of diagnosis was 10.3 per 100,000 population in 2017, up from 11.2 in 2016. This compares to a rate of 17.2 for Greater Manchester and 12.5 for England.

3.24 Public Health England (PHE) is concerned about the ongoing increase in the number of new cases of gonorrhoea and syphilis as well as the implications of multi-drug resistant gonorrhoea. PHE is due to publish an action plan by the end of the year.

Genital warts

3.25 Genital warts can result from infection with the Human Papilloma virus (HPV). People who contract this virus can develop warts on or around their genitals. There were 222 new cases diagnosed to residents of Tameside at sexual health clinics in 2017, down from 241 in 2016 (-19%). The rate of diagnosis was 99.5 per 100,000 population in 2017, down from 108.0 in 2016 (-8.5%). This compares to a rate of 107.6 for Greater Manchester and 103.9 for England.

HIV

3.26 HIV is a virus. It can be found in the blood, semen and anal fluids of HIV positive men and the blood, vaginal and anal fluids, and breast milk of HIV positive women. The main route of transmission is via unprotected sex. The virus can damage the cells in the immune system.

3.27 Prescribing of anti-retroviral and related therapies (ART) has transformed HIV from a fatal infection to a chronic but manageable condition. People diagnosed at a prompt stage of infection can expect a normal life-span with few HIV related complications. People on treatment who have an undetectable viral load cannot pass on the virus. Undetectable=Untransmittable.

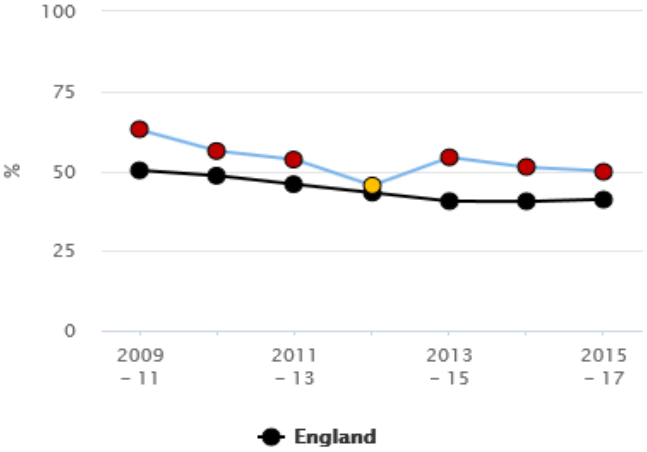
3.28 The GM HIVE project – Ending new transmission of HIV across Greater Manchester within a generation – aims to end new transmissions within twenty-five years. HIVE has £1.3m funding from the Greater Manchester Health and Social Care Partnership to deliver the first phase, and is being led by the GM Sexual Health Network and a steering group of community representatives, third sector partners, clinicians, General Practice and Local Authority Commissioners. (see appendix HIVE Briefing.)

3.29 There were 269 residents aged 15-59 receiving treatment and care for HIV in 2017, up from 254 in 2015. (196 in 2013) 11 residents aged 15+ received a diagnosis of HIV in 2017. This is less than the figure for 2016 (19) and 2015 (17). There have been 11 diagnosis of HIV in the local SRH clinic in the first 9 months of 2018. (NB people diagnosed locally may not be Tameside residents and Tameside residents may also be diagnosed on services outside the Borough)

3.30 Of residents receiving HIV-related care in 2017, 48% had been exposed to the virus through sex between men; 48% through sex between men and women with the remainder being injecting drug use, mother to child or unknown route of transmission. 60% are white British residents and 30% are residents from black African communities.

3.31 There has been an increase in the proportion of residents diagnosed with HIV at a prompt stage of infection. 50% of residents diagnosed in 2015-17 had a CD4 count higher than 350mm3; this compares to 48.8% in 2014-16. Latest annual data would indicate a much higher rate however this is not reported due to low numbers. The earlier HIV infection is detected, the lower the risk of damage to the immune system and other complications.

HIV late diagnosis (%) (PHOF indicator 3.04) source https://fingertips.phe.org.uk



3.32 Of Tameside residents seen for HIV care 98% are receiving ART. Of these, 91% were virally suppressed (VL<200) and were very unlikely to pass on HIV, even if having sex without condoms (untransmissible virus). The United Nations UNAIDS targets are that by 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression.

3.33 Tameside's HIV diagnosed prevalence rate per 1,000 aged 15-59 is 1.87. 10% of the middle super output areas (MSOAs) in this Tameside have a prevalence rate higher than 2 per 1,000 population, all ages (2016 data)

3.34 **Appendix 1** gives details of the Greater Manchester project to eliminate new infection of HIV in a generation.

4. CONTRACEPTION

4.1 Reducing the burden of unplanned pregnancy (whether this leads to maternity, miscarriage or abortion) requires a sustained public health response. This should be based around marketing; easy access to high quality information for informed decision-making; easy access to the full range of contraception (particularly the most effective long-acting reversible contraception (LARC), and accessible pregnancy testing with rapid referral to abortion services for unwanted pregnancy. These services should be delivered alongside promotion of safer sexual and health-care seeking behaviour.

4.2 Unplanned pregnancies can end in abortion or maternity. Many unplanned pregnancies that continue will become wanted. However, unplanned pregnancy can cause financial, housing and relationship pressures and have impacts on existing children.

4.3 LARC methods such as contraceptive injections, implants, IUS or IUD are more effective as they do not depend on daily concordance. They are also considered to be more cost effective than User Dependent Methods (UDM), and their increased uptake could further help to reduce unintended pregnancy (NICE Clinical Guideline CG30 https://www.nice.org.uk/guidance/CG30/). All currently available LARC methods are more cost effective than the combined oral contraceptive pill even at 1 year of use. Contraceptive injections are excluded from the LARC (long-term) categorisation, due to reliance on users' compliance to turn up promptly for subsequent dose every 12 weeks. This is a short duration compared to doses lasting for 3 years, 5 years and 10 years for implants, IUS and IUD respectively (https://www.nice.org.uk/guidance/cg30/chapter/Appendix-A-Features-of-the-LARC-meth ods-to-discuss-with-women/). Consequently, the failure rate of typical use of contraceptive injections is 6%, which is more comparable to that of combined oral

contraceptive at 9%, as documented in method specific FSRH guidance documents on (https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/method-specific/).[1]

4.4 The Orange Rooms Northern Sexual Health, Contraception and HIV Service is the main provider of sexual and reproductive health services in Tameside. Northern offers a comprehensive range of contraception services for women and men of all ages.

4.5 In 2016, residents of Tameside attended sexual and reproductive health services for contraceptive care on 8650 occasions. For women who received a method of contraception, 62% were aged 24 or under.

4.6 Long-Acting Reversible methods of Contraception (LARC) are the contraceptive implant, the intrauterine device (IUD) and the intrauterine system (IUS). These are more effective and cost effective than user dependent methods of contraception such as contraceptive pills and condoms. Women can obtain long-acting methods from selected GPs and from sexual and reproductive health clinics.

4.7 In 2016, residents of Tameside attended sexual and reproductive health clinics on 1685 occasions for long-acting methods of contraception: on 1050 occasions for the contraceptive implant; 320 occasions for the intrauterine device (IUD); and 315 occasions for the intrauterine system (IUS). There were 1290 attendances were related to the provision of the contraceptive injection and 8355 for user dependent methods including the contraceptive pill.

4.8 43% of LARC was provided for women aged 24 or under, 64% of contraceptive injections and 70% of oral contraception.

4.9 The table below details the contraception provided in 2016 and 2015 by General Practice. Between these two years the provision of LARC has reduced by 21% with 320 fewer LARC provisions. In 2016, Tameside was ranked 195 out of 326 local authorities in England for the rate of GP prescribed LARCs (1st has the highest rate), with a rate of 28.6 per 1,000 women aged 15 to 44 years, compared to 20.7 in North West and 28.8 in England. This rate is down from 36.0 in 2015 when Tameside were ranked 150 and the England rate was 29.8.

	2016			2015		
Method	Number	Percentage	England percentage	Number	Percentage	England percentage
LARC (excluding Injections)	1195	3.6%	3.6%	1515	4.6%	3.8%
Injectable contraception	6490	19.2%	11%	6195	18.7%	11%
User Dependant methods	26,040	77.3%	85.3%	25,485	76.8%	85.2%
Total contraception	33,700			33,195		

4.10 In 2016, the rate of long-acting methods of contraception (excluding the injection) prescribed for residents of Tameside was 45.8 per 1,000 women aged 15-44, down from 55.1 in 2015. The rate of long-acting methods prescribed at sexual and reproductive health clinics was 17.2 per 1,000; this is similar to the rate England (17.6). The rate of long-acting

[1] Tameside Local Authority HIV, sexual and reproductive health epidemiology Report (LASER): 2016. Public Health England December 2017

methods prescribed at GP practices was 28.6 per 1,000; this is higher than the rate for Greater Manchester (17.7) and similar to England (28.8).

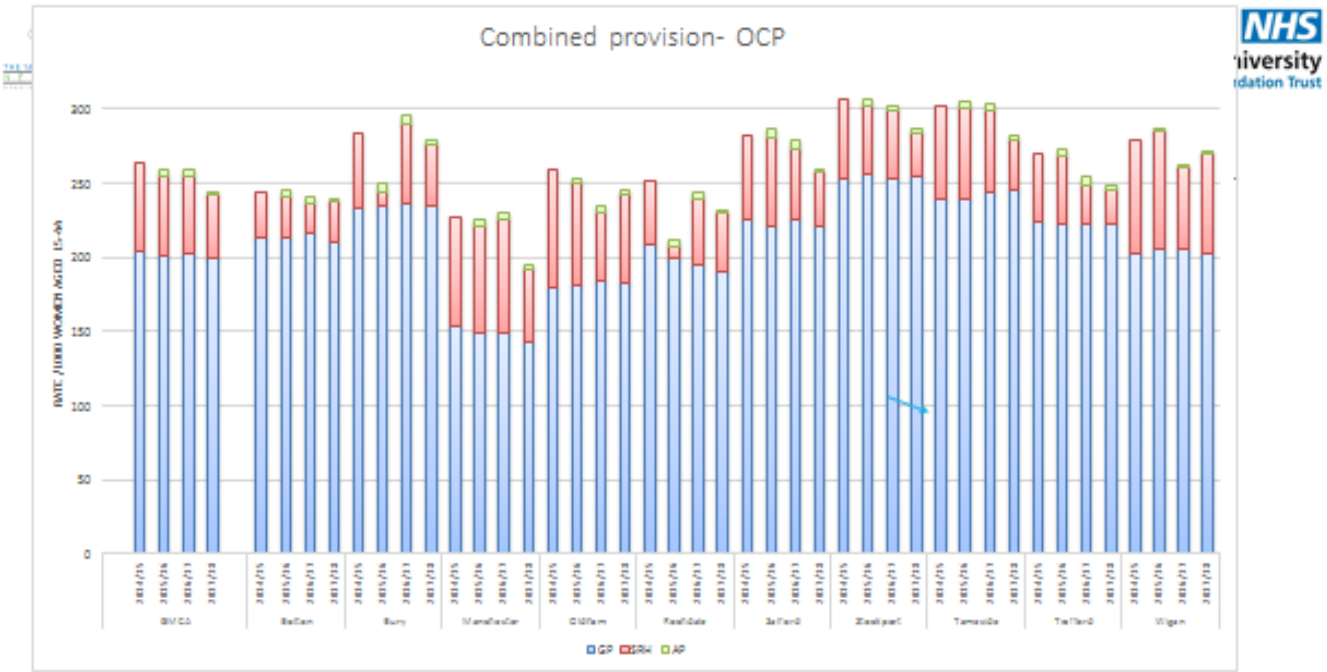
4.11 Emergency contraception can be used following unprotected sex to reduce the risk of an unintended conception. There are two methods: emergency contraceptive pills (EHC) and the intrauterine device (IUD). Women can obtain emergency contraceptive pills for free from GPs, selected pharmacies, and from sexual and reproductive health services. Sexual and reproductive health services can fit and remove IUDs.

4.12 There were 630 women recorded as residents of Tameside prescribed emergency contraception at sexual and reproductive health services in 2016. Of these 9.5% were prescribed it more than once in 2016.

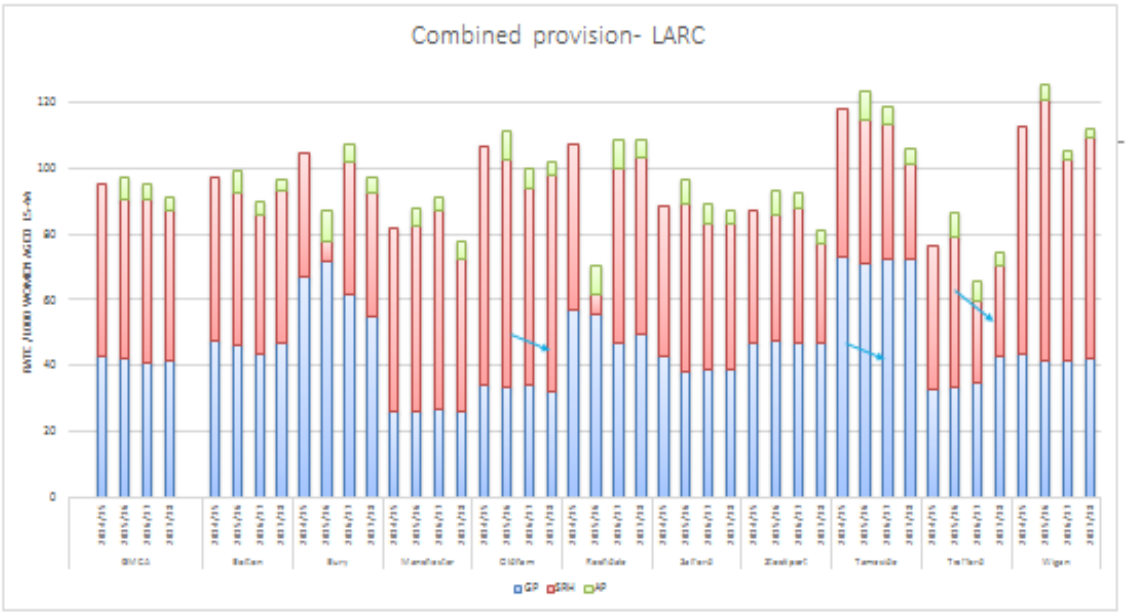
4.13 GPs based in Tameside prescribed emergency contraceptive pills on 900 occasions in 2016. Pharmacy provision of EHC is not included in this data.

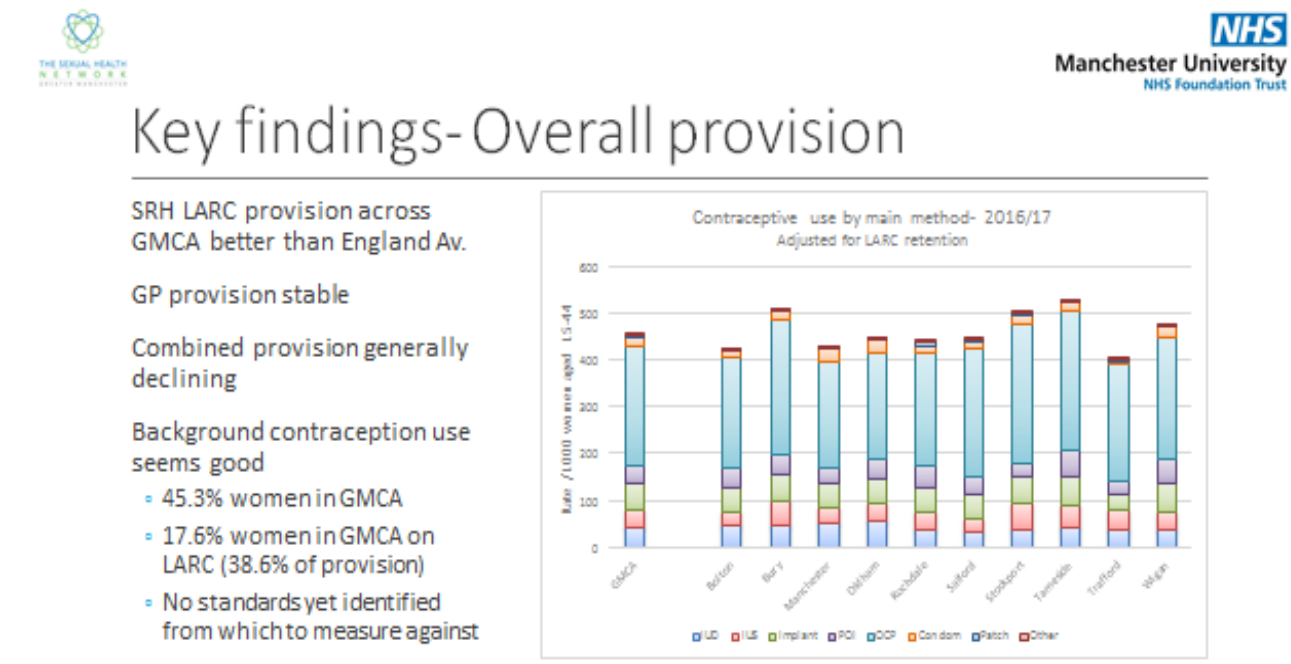
4.14 The following information is taken from a draft GM contraception needs assessment prepared by Thomas Hesse of MFT. It shows an overall declining provision of contraception in GM, including in Tameside, but Tameside rate of contraception provision is still one of the highest in GM.

4.15 The chart below shows the rates of oral contraceptive provision across Greater Manchester by GP, sexual and reproductive health services, and abortion providers. Provision of Oral contraception within the Sexual and reproductive Health service has declined with General practice not replacing all of this activity.



4.16 The table below shows reductions in the provision of LARC, particularly in the Sexual and reproductive Health service, in 2017/18.



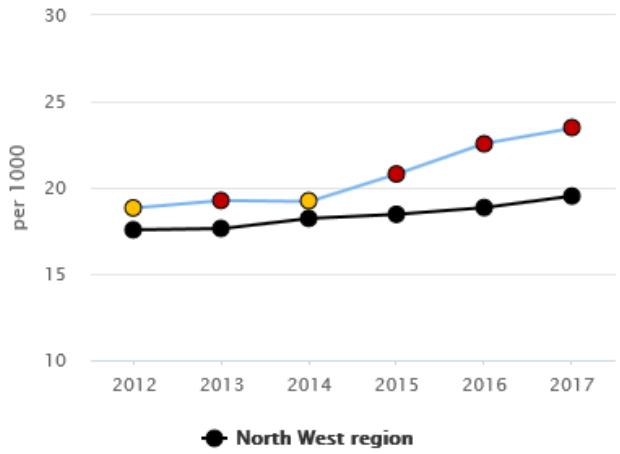


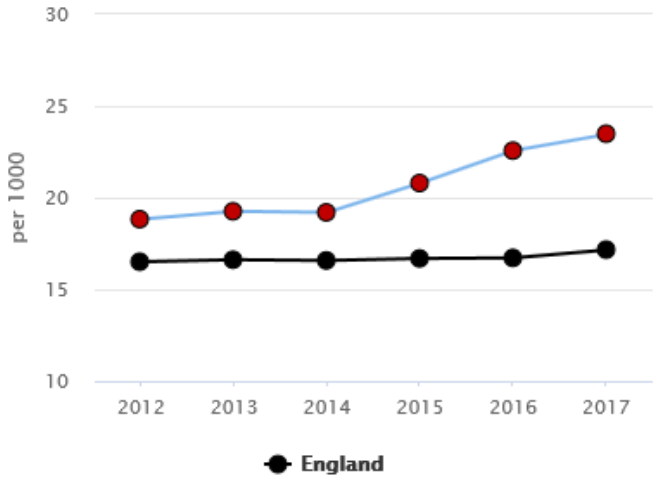
5. ABORTION

5.1 Abortion is a CCG responsibility so some of the data presented below relates to Tameside and Glossop activity rather than Tameside residents only. Data presented is sourced from 2017 abortion statistics.

5.2 There were 978 abortions performed for women living in Tameside in 2017, up from 944 in 2016 (+3%). There were 1061 abortions performed for Tameside and Glossop patients in 2017. An overall upward trend in the rate of abortions performed for residents of Tameside has been observed particularly since 2014. The crude rate of abortions per 1,000 women aged 15-44 for Tameside has risen from 19.2 per 1,000 in 2014 to 22.6 per 1,000 in 2017. Current England rate is 17.2.

5.3 The Tameside and Glossop rate per 1000 women is 21.6 the second highest CCG rate in Greater Manchester. GM rate is 19.7, North West rate 19.5 and England rate 17.2





5.4 Of abortions for patients of Tameside and Glossop in 2017, 82.2% were performed between 3 and 9 weeks gestation (compared to 77% for England). This indicates that residents have ease of access to clinics and that short waiting times for consultations and procedures are the norm.

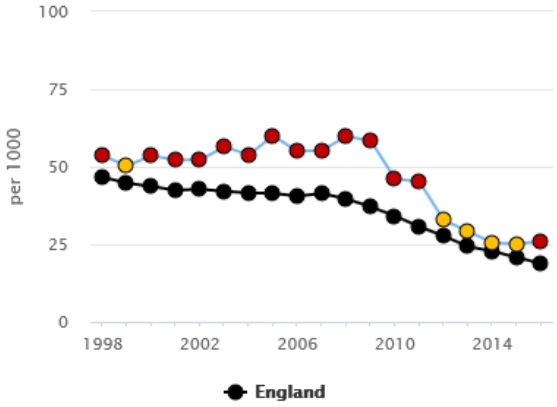
5.5 Of abortions performed for residents of T&G 71.2% were medical procedures (compared to 65% for England) and 28.8 % were surgical procedures (compared to 35% for England).

5.6 The NHS funded 99.7% of the abortions performed for residents of Tameside and Glossop in 2017. 84.5% of procedures were performed in independent clinics contracted to the NHS (compared to 72% for England) and 15.2% in NHS hospitals (compared to 26%).

6. UNDER-18 CONCEPTIONS

6.1 Significant progress has been made to reduce the number and rate of under-18 conceptions to residents of Tameside however the rate of decrease has stalled.

Under 18s conception rate / 1000 – source fingertips.



Recent trend: ⬇

Period	Count	Value	North West	England
1998	216	53.6	50.3	46.6
1999	204	50.3	48.8	44.8
2000	218	53.6	47.5	43.6
2001	219	52.2	45.1	42.5
2002	229	52.3	45.4	42.8
2003	253	56.4	45.2	42.1
2004	246	53.9	46.0	41.6
2005	274	60.0	46.9	41.4
2006	252	55.0	44.2	40.6
2007	249	55.3	46.6	41.4
2008	267	59.8	44.8	39.7
2009	255	58.4	42.6	37.1
2010	197	46.1	39.6	34.2
2011	183	45.2	35.3	30.7
2012	131	32.8	31.6	27.7
2013	115	29.2	27.6	24.3
2014	101	25.5	26.8	22.8
2015	95	25.2	24.7	20.8
2016	98	26.0	22.3	18.8

Source: Office for National Statistics (ONS)

6.2 The under-18 conception rate for Tameside peaked in 2005. Since 2005, a fall of almost two-thirds (64%) has been recorded; down from 60.0 per 1,000 in 2005 to 26.0 in 2016. There were 98 conceptions recorded to under-18s in 2016 compared to 274 in 2005. Data for 2017 will be published in March 2019.

6.3 ONS published under-18 conception data for Q3 2017 on the 15th November 2018. This shows a decrease in the rolling annual rate over the last 4 quarters to 23.6. In the last 4 quarters (December 2016-September 2017) there were 87 conceptions to women aged under 18. In the previous period (December 2015-September 2016) there were 90. Conceptions in the December 16 quarter were relatively high and, if the current trend continues with a lower figure for the December 17 period the next annual figure should see a large fall in the rate.

6.4 For the North West, comparing Quarter 3 2017 with Quarter 3 2016, the rate declined from 20.5 per 1,000 (611 conceptions) to 20.3 per 1,000 (593 conceptions). There is considerable variation between local areas. Annual data for 2017 is due to be published in February / March 2019.

6.5 Unlike the overall trend for England, the proportion of under-18 conceptions ending in abortion in Tameside has not increased over the last decade, falling from 43.8 % in 2005 to 41.8% in 2016. In 2016, 41 conceptions to under-18s ended in abortion and 57 resulted in a live birth. In 2015 the percentage of under 18 conceptions ending in abortion was 51.6% (count of 49)

6.6 The under-16 conception rate for Tameside peaked at 15.3 per 1,000 in 2009. The rate is falling and stood at 5.0 per 1,000 in 2016. 18 conceptions were recorded to under-16s in 2016 compared to 23 in 2015 and 62 in 2009.

6.7 The Public Health England Teenage Pregnancy self-assessment tool released in 2018 is being completed and actions to address any issues and improve performance are being identified.

6.8 In the summer of 2018 the development and production of a School Curriculum for SRE was completed and launched for Tameside schools. The resource includes lesson plans and a range of resources for teachers to use in the classroom. There are two versions one for primary and one for secondary.

7. OVERVIEW OF COMMISSIONING RESPONSIBILITIES

7.1 The Health and Social Care Act 2012 divided responsibilities for the commissioning and funding of sexual and reproductive health services between local authorities, Clinical Commissioning Groups and NHS England.

7.2 Local authorities are responsible for commissioning and funding the provision of most but not all sexual and reproductive healthcare provision. Local authorities are responsible for commissioning HIV testing services, STI testing and treatment services, and contraception services on an open access basis for all persons present in their area. Local authorities can choose to commission and fund other related services such as HIV prevention and support programmes.

7.3 NHS England is responsible for funding GP practices to offer routine methods of contraception including the contraceptive pill for their registered patients. GPs are also required to offer testing for HIV/STIs at the request of a patient; and to offer a test or treatment (excluding treatment for HIV) if indicated.

7.4 NHS England is also responsible for commissioning and funding HIV treatment and care.

7.5 Clinical Commissioning Groups are responsible for commissioning and funding abortion services. CCGs are also responsible for arranging for patients to obtain permanent methods of contraception including vasectomies.

7.6 As the statutory duty is to provide open access Sexual and Reproductive Health services residents may attend services in any area and local services are accessible to residents of other areas. For STI related services there is a cross charging regime in place whereby the provider can charge the residents local authority for the attendance however there is no cross charging for contraceptive services.

8. OVERVIEW OF COMMISSIONING ACTIVITIES

8.1 In 2016 Stockport Council issued a tender in collaboration with Tameside and Trafford, to appoint a provider to operate an integrated sexual and reproductive health service for each of the three Boroughs. The contract was awarded to Manchester University FT (MFT) and commenced in September 2016 under the banner of The Northern sexual health and contraception service. The initial contract term was until 31/3/2019 and permission has been granted to extend until 31/3/2021. MFT were also appointed to provide services in Manchester.

8.2 On behalf of all GM authorities Manchester Council acting as lead commissioner procured a provider for the opportunistic chlamydia screening programme by open tender in 2016. The contract was awarded to RuClear part of MFT. The initial contract term expires 31 March 2019 and authorisation is being sought to extend this contract until 31 March 2021

8.3 On behalf of all GM authorities Salford Council acting as lead commissioner procured a provider for the Greater Manchester Sexual Health Improvement Programme (GM-SHIP) by open tender in 2016. The contract was awarded to a partnership of BHA for Equality (lead) with George House Trust and LGBT Foundation (subcontractors) who provide the service

under the branding PaSH (Passionate about Sexual Health). The initial contract term expires 30 June 2019 and authorisation is being sought to extend this contract until 30 June 2021.

8.4 The Council has continued to contract with Pharmacies (Via CCG Contracts) to participate in the provision of free emergency hormonal contraception.

8.5 Qualified General Practices are contracted to provide Long Acting Reversible Contraception (implants and IUD/S).

8.6 Termination of pregnancy services are jointly procured by Manchester CCG as lead commissioner on behalf of all GM CCGs.

9. COMMISSIONED SERVICES

Northern Sexual and Reproductive Health Service

9.1 Tameside's sexual and reproductive health service is provided by Manchester Universities Foundation Trust at the Orange Rooms, Ashton Primary care Centre as part of their Northern Sexual Health Services. The contract commenced in September 2016.

9.2 Since contract commencement the service has undergone a major staffing restructure to integrate the Tameside service into the wider Northern service (implemented September 2017), implemented a new client management IT system across the Northern footprint and implemented a digital offer (July 2017)). They have also taken part in the HIV PREP trial which commenced in November 2017. This has resulted in a much more effective, resilient and robust service but has taken a considerable time to implement and bed in.

9.3 The service has refreshed and updated their "Your Welcome" accreditation for accessibility for young people and implemented new processes for management of safeguarding patients (January 2018)

9.4 Recent service developments have increased productivity. The new client management system has reduced the amount of time needed to key in data and freed up clinician time and new LARC processes mean many women are able to have their initial consultation via the telephone so that they only require one appointment slot rather than two.

9.5 The service is an integrated sexual and reproductive health service for women and men of all ages. It delivers routine, intermediate and specialist services including -:

- Information, advice and guidance about sexual and reproductive health issues.
- Provision of long-acting methods of contraception including the contraceptive implant and the intrauterine device.
- Provision of routine methods of contraception including the contraceptive pill.
- Provision of emergency contraception.
- HIV testing and counselling.
- Screening and treatment of sexually transmitted infections
- Management of recurrent conditions such as genital herpes and genital warts.
- Management of other related conditions including genital ulceration.

9.6 The Service also offers specialist services including:

- Management of complex contraceptive problems.
- Management of complicated STIs (including tropical STIs).
- Provision of PEP (Post-exposure prophylaxis for HIV).
- Provision of PrEP (pre-exposure prophylaxis for HIV) as part of the PrEP Impact Trial.

9.7 The Service is expected to contribute to achieving the following outcomes:

- Controlling and preventing the transmission of HIV and STIs.
- Reducing the prevalence of undiagnosed HIV and STIs.
- Reducing the proportion of residents diagnosed with HIV at a late stage of infection.
- Reducing the number of unintended conceptions to women of all ages.
- Reducing the number of under-18 conceptions.

9.8 The Service will contribute to achieving the desired outcomes through – for example:

- Ensuring that residents can obtain screening for STIs and HIV.
- Ensuring that residents can obtain treatment / management of STIs.
- Ensuring that residents can obtain other methods of prevention including Post Exposure Prophylaxis for HIV.
- Improving knowledge and understanding of the risks associated with unprotected sex.
- Improving awareness of sexually transmitted infections and the importance of regular screening in order to control transmission and to reduce the prevalence of undiagnosed infection.
- Improving awareness of HIV and the and the importance of regular screening in order to control transmission; to reduce the prevalence of undiagnosed infection; and to reduce the proportion of residents diagnosed at a late stage of infection.
- Improving awareness of contraception and the importance of using reliable methods in order to reduce the incidence of unintended conceptions.
- Ensuring that residents can obtain all methods of contraception and emergency contraception.

9.9 The service operates clinic sessions during the daytime and early evening on Thursdays. Northern offer walk-in and appointment slots for patient choice and to manage demand. Walk-in clinics are designed to ensure that patients with an urgent need can be seen on the day of presentation.

9.10 The Northern offers an STI self-sampling service for residents. Residents can order a self-sampling kit via www.thenorthernsexualhealth.co.uk. Residents collect their own samples and then return them to the lab for processing. This is a new and convenient option for residents who are asymptomatic; In quarter 2 2017/18, 270 kits were distributed.

9.11 The service has struggled with staffing having inherited a depleted staff team on contract commencement and has found recruitment a challenge. This has impacted on the capacity of the service and the planned Saturday morning young person's clinic and level two outreach clinic are still not being delivered although there are now plans to implement a contraceptive clinic in a community setting, probably Hattersley, in the coming weeks.

9.12 Due to the inability to recruit suitably trained staff the service has implemented an extended training programme and has recruited nurses which are being trained. Currently 91% of Northern nursing staff are dual trained and hold relevant qualifications in both disciplines. (contraception and STI)

9.13 During periods of staffing shortages clinicians have covered Tameside from the other Northern services and being part of the larger Northern service has been beneficial in improving resilience. Whilst some clinics have been reduced in capacity the service has prioritised young and vulnerable patients ensuring that they have always been offered appointments or been seen during walk in sessions and have prioritised patients who are symptomatic.

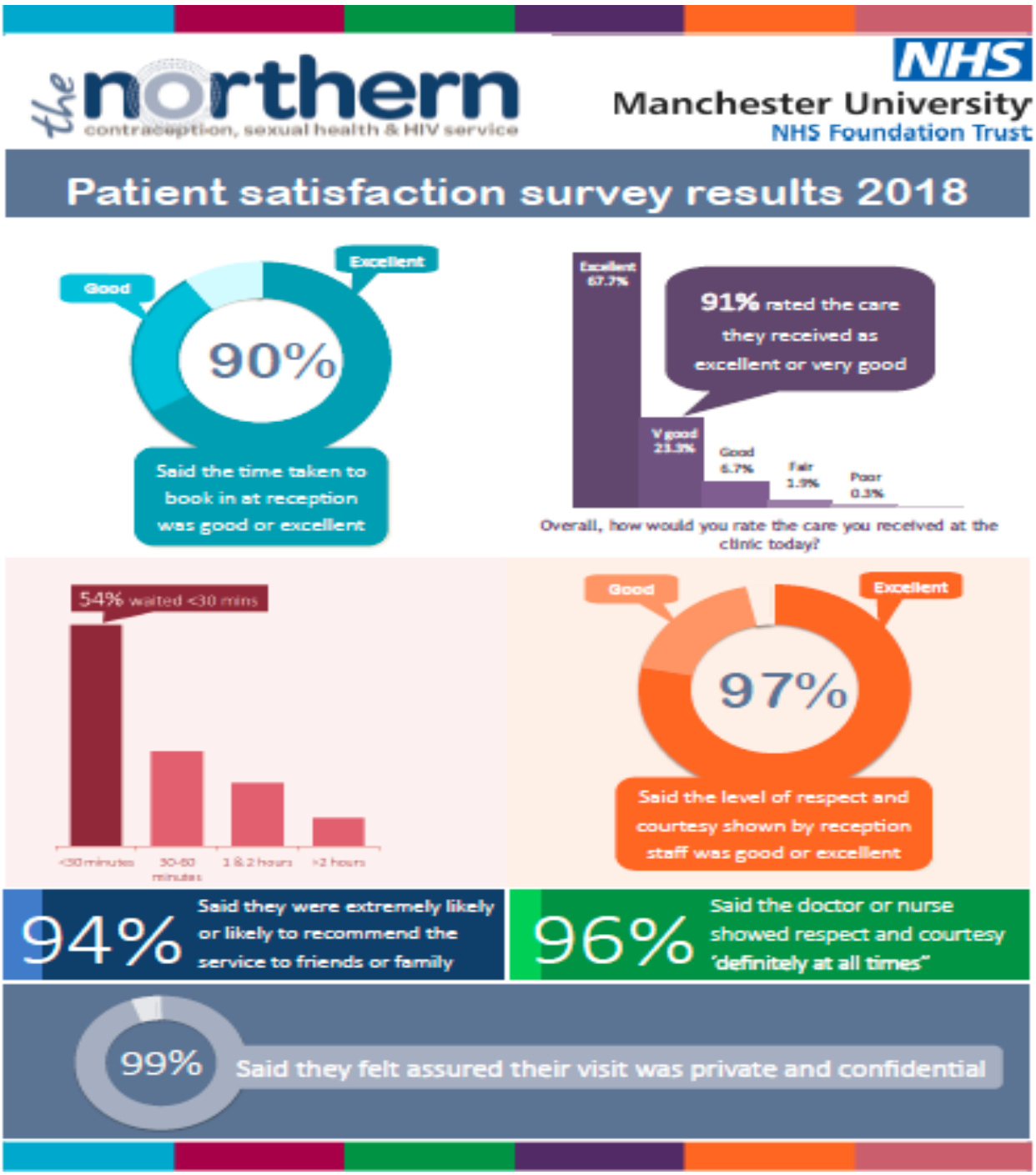
9.14 Appointment times for contraception did reach over ten weeks at one stage but are now below four weeks and capacity continues to increase.

9.15 Over the hotter summer months of 2018 an issue was identified with the lab room where drugs are stored and laboratory testing is performed not having air conditioning or the appropriate air flow. Due to the temperature raising to unacceptable levels some drugs had to be destroyed. The building was developed as a LIFT (Local Improvement Finance Trust) building as clinical space and is provided by us for MFT to occupy with the CCG paying the rent. MFT are continuing to work with the Health and Social Care Estates Business Manager, to find a resolution to the problem.

9.16 Summary of performance information

	Q4 17/18	Q1 18/19	Q2 18/19
Number of patients attending	2911	3137	3264
Percentage of patients attending a walk in seen within 90 minutes	70%	94%	94%
Percentage of patients with urgent clinical need offered an appointment within 48 hours	100%	100%	100%
Number of patients attending for contraceptive injection	164	181	175
Number of patients attending for contraceptive implant	151	137	150
Number of patients attending for contraceptive IUD/IUS	114	142	134
Number of prescriptions for oral contraception	500	524	520
Number of prescriptions for EHC	119	115	112
Number of full STI screens including HIV	898	948	1068
Number of screens for chlamydia and gonorrhoea	418	476	471

9.17 The following summarises the results of The Northern's patient satisfaction survey 2018. Please note this is across all Northern Sexual health services not just Tameside. Details of patient feedback from Tameside patients, which is all positive, is also available.



RuClear Chlamydia screening programme

9.18 On behalf of all of the local authorities of Greater Manchester, Manchester City Council holds a framework contract with Manchester University NHS Foundation Trust (MFT) for the provision of an opportunistic chlamydia screening programme for asymptomatic young people aged under-25 (branded as RuClear). The framework was procured via a competitive tender and the initial contract period is due to expire on the 31st March 2019 and has a further two year extension period and authorisation is being sought to extend this contract until 31 March 2021

9.19 The service has been reviewed by the GM Commissioners who have agreed some changes to the service delivery (detailed below) with contract prices for the provision of kits and testing remaining the same. The framework will be extended by Manchester and

individual Authorities can opt to continue with the framework or make alternative arrangements.

9.20 The service is subject to contract monitoring which is performed by Salford Council as contract holder. In addition there is a steering group for all the Greater Manchester jointly commissioned services, the Joint Contract Oversight Group (JCOG) which meets quarterly to analyse performance data for all jointly commissioned contracts and advises the lead commissioner. The Tameside commissioner attends the JCOG meetings on behalf of the Tameside, Stockport and Trafford cluster.

9.21 Ruclear provides an opportunistic chlamydia screening programme for asymptomatic young women and men under the age of 25 living in Greater Manchester. Ruclear is delivered in line with the requirements of the National Chlamydia Screening Programme (NCSP). The Programme recommends that all sexually active men and women under 25 years of age be tested for chlamydia annually or on change of sexual partner (whichever is more frequent)

9.22 The Chlamydia screening programme is a key service in assisting us in meeting the targets of the NCSP. Chlamydia is the most common bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It is estimated that one in ten young people are infected. By diagnosing and treating asymptomatic chlamydia infections, chlamydia screening can reduce the duration of infection, which will reduce an individual's chance of developing complications, and also reduce the time when someone is at risk of passing the infection on, which in turn will reduce the spread of chlamydia in the population.

9.23 Young people living in Greater Manchester can order a self-sampling kit for chlamydia and gonorrhoea from Ruclear. Ruclear posts the kit to the recipient and arranges for returned kits to be processed at the lab. Ruclear issues results and conducts contact tracing.

9.24 Young people can also obtain an opportunistic screen via Ruclear from a number of initiation services throughout Greater Manchester with the Authority where they are resident being billed for the activity. These include provision as part of termination of Pregnancy services, Brook in Manchester and selected GP practices.

9.25 Ruclear is expected to contribute to achieving the following outcomes:

- Preventing and controlling the transmission of chlamydia and gonorrhoea through the prompt detection and treatment of infection.
- Preventing the consequences of undiagnosed infection.

9.26 Ruclear contributes to achieving the desired outcomes through:

- Improving knowledge and understanding of chlamydia and gonorrhoea among young women and men.
- Effective partner notification
- Providing opportunities for young women and men to obtain an opportunistic screen for chlamydia and gonorrhoea via:
- Fulfilment of orders for self-sampling kits received via remote ordering.
- Distribution of self-sampling kits via outlets.
- Processing of screens initiated in selected services – e.g. GPs.

9.27 The RuClear service has two elements. A self-sampling service enabling individuals to request a screening kit online for delivery to their home address and a screening initiation service for clinical settings including General Practice, Termination of Pregnancy services, Midwifery services and Brooke. Activity is charged to the local authority based upon the address of the patient. (For example a Tameside resident using Brooke in Manchester or a

Termination of Pregnancy service in Trafford would be paid for by Tameside). Approximately one third of activity is via initiation sites and two thirds via self-sampling.

9.28 Across Greater Manchester the use of the screening initiation service within General Practice has been varied with the majority of practices making little or no use of the service. The service is only available to patients age 16 to 24 and is for screening purposes and not to be used where testing is indicated as part of differential diagnosis or for patients that are symptomatic. Where a Practice wishes to offer a screen to a young person a different sample kit is used and labels etc have to be manually created. A Practice may therefore use their regular sample testing system or the RuClear system depending upon the eligibility factors. This dual system may have proven to be too complicated within a busy practice environment.

9.29 Due to the low numbers of screens being initiated at most General Practice initiation sites across Greater Manchester the provider, RuClear, have stated that it is not viable to support sites that are issuing minimal numbers due to the overhead in training and support and the wastage of kits going out of date.

9.30 Two alternative models have been offered for sites with low activity levels, either a referral card that can be given a young person with the details of the RuClear digital service for them to access or the provision of a supply of take away kits that can be given to eligible patients. These kits could be used by the patient in the surgery and given to the receptionist to put in the sample bag or taken away to be completed and posted back. The expectation would be that any practice holding kits would promote the service to eligible patients and also give out kits to young people not registered with the practice that request them. The Practice would be promoted as a location where kits could be collected.

9.31 In Tameside, General Practices are currently paid based upon screens received by RuClear. In the 6 month period April to September 2018 a total of 39 screens were received from Tameside practices, all were negative.

9.32 Pharmacies delivering the Emergency Hormonal Contraception service also offer the RuClear service and should hold a stock of home sampling kits to give out. No additional payment is made to pharmacies for this service. In common with other areas of Greater Manchester the provision via pharmacy is minimal and experience has shown that, even where a young person takes a kit as part of an EHC consultation it is rarely completed and returned. It is being recommended that provision via pharmacy is ceased as the overheads to maintain the service are not affordable.

9.33 The RuClear service currently has no budget for the promotion or development of the service. The lead commissioner has agreed a contract variation to include an annual fee of £2000 per participating Authority to fund needed IT developments and promotion of the service. Activity levels for all participating areas are considerably lower than the indicative activity figures that were given when the service was procured which has affected the financial viability of the service. By giving the service additional resource, ring-fenced for targeted promotion, it is expected that activity levels will be increased. Promotion will be targeted such that once activity levels are at the level of the indicative volumes of activity it will be ceased.

9.34 RuClear activity in the 6 months April to September 2018 compared to original indicative figures

	Initiation test	Postal kits sent	Postal Kits returned
April-September	320	867	663
Indicative figures / projected spend	500	750	600

9.35 Since May 2017 RuClear have accepted requests for screens from Tameside residents aged over 24. A decision was taken to extend the offer in the Tameside, Trafford and Stockport cluster in order to ease pressure on the main Sexual and Reproductive health Services (SRHS) whilst there were capacity issues during service transformation as the new contract was being initiated. There was capacity to do this due to the underperformance of provision of screens compared to the indicative and budgeted levels of service. This extension of service is now being removed as capacity increases in the SRHS and the service has implemented a more comprehensive digital offer that people over 24 can access. The number of home test kits returned to the SRHS service has increased from 133 in Q4 17/18 to 270 in Q2 18/19.

9.36 In the 12 month period July 2016 to August 2018 356 RuClear kits were sent to Tameside residents aged over 24 with 348 being returned. There were 15 chlamydia positives and 2 Gonorrhoea positives detected from this activity. This activity will now be targeted at the age 16 to 24 client groups in order to improve performance against the chlamydia pathway. The targeted promotion of the service will be essential in increasing take-up of the service.

9.37 Selected RuClear Performance indicators

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
Number of screens initiated at partner services	185	189	151	138	156
Number of orders for self-sampling kits	297	338	397	417	412
Number of kits returned to lab for processing	207	250	258	305	316
% of kits returned to lab for processing within 30 days	73%	70%	72%	71%	82%
% of clients confirmed as receiving treatment within 6 weeks	92%	95%	93%	95%	95%

Passionate about Sexual Health (PaSH)

9.38 The GM Sexual Health Improvement Programme (branded as the Passionate about Sexual Health), is provided by a consortium led by BHA for Equality in partnership with George House Trust and the LGBT Foundation. It provides STI and HIV prevention and support services and support for people living with and affected by HIV and AIDS. The service targets our most vulnerable and high risk population in terms of sexual health needs and provides information and advice as well as initiatives like community HIV Point of Care Testing (POCT).

9.39 The contract was awarded by Salford Council (on behalf of all of the local authorities of Greater Manchester) following a competitive tender exercise and commenced in July 2016. The initial contract period was three years with an allowable two years extension. The service has been reviewed by the GM Commissioners who have agreed to extend the contract by two years. The service and partnership will be an important partner in in the new GM HIVE (Ending new transmission of HIV across Greater Manchester within a generation) project and the GM City Regions application to become a Fast Track City.

9.40 The Passionate about Sexual Health Programme (PaSH) offers a broad range of HIV/STI prevention interventions for residents at highest risk of acquiring HIV and interventions to support residents living with diagnosed HIV.

9.41 BHA for Equality is the lead for HIV/STI prevention work with heterosexual women and men (focus on residents from black African communities) and LGBT Foundation is the lead for work with men who have sex with men (MSM).

9.42 George House Trust is the lead for support for children, young people and adults living with diagnosed HIV.

9.43 PaSH partners are required to deliver a range of interventions and services including:

- One-to-one and group-level support for adults at risk of acquiring HIV via centre-based and outreach services.
- One-to-one and group-level support for adults living with HIV via centre based and outreach services.
- One-to-one and group-level support for children and young people living with HIV via centre-based and outreach services.
- Point of care testing for HIV via centre-based and outreach services.

9.44 PaSH partners are also required to:

- Ensure that information and advice about HIV/STIs is available online.
- Facilitate access to free and low-cost condoms and lubricants.
- Map community assets.

9.45 PaSH is expected to contribute to achieving the following outcomes:

- Controlling and preventing the transmission of HIV and other STIs.
- Reducing the prevalence of undiagnosed HIV and other STIs.
- Reducing the number of new cases of HIV.
- Reducing the proportion of residents who receive a diagnosis of HIV at a late stage of infection (PHOF indicator).
- Reducing HIV-related morbidity and mortality.

9.46 PaSH will contribute to achieving the desired outcomes through:

- Improving knowledge and understanding of HIV and STIs.
- Improving awareness of the risks associated with unprotected sex.
- Improving awareness of the importance of using condoms and other methods of prevention.
- Improving confidence and skills to practice safer sex.
- Improving uptake of screening for HIV and other STIs.
- Improving confidence and skills to manage HIV as a long-term condition.
- Improving confidence, skills and capabilities to adopt / maintain health promoting behaviours and to avoid / reduce health demoting behaviours

9.47 The service is subject to contract monitoring which is performed by Salford Council as contract holder. In addition there is a steering group for all the Greater Manchester jointly commissioned services, the Joint Contract Oversight Group (JCOG) which meets quarterly to analyse performance data for all jointly commissioned contracts and advises the lead commissioner. The Tameside commissioner attends the JCOG meetings on behalf of the Tameside, Stockport and Trafford cluster.

9.48 The majority of the funding for this service is provided by Manchester and Salford who have the areas of greatest need. The Tameside contribution to the contract is the lowest contribution of all participating authorities.

9.49 The PaSH consortium has developed and established the service across Greater Manchester and delivers services to the residents of Tameside both within the Borough and from locations outside the Borough. For example recent provision has included provision of POCT at a venue in Stalybridge, an information stall at MIND and information sessions at People First Tameside. In the first quarter 2018/19 they provided 26 Tameside residents with 1 to 1 brief interactions around HIV and sexual health and four with structured/extended information and advice, 25 residents attended group sessions, 3 residents took a HIV test and condoms were distributed to five outlets in the Borough.

9.50 During HIV testing week commencing 17 November 2018 PaSH will be delivering a HIV testing event at Twinkle bar in Stalybridge and they are hoping to have an information stall during the week of World AIDS Day 1 December 2018.

YOU Think

9.51 The YOUthink team is Tameside's sexual health intervention and prevention team, a specialist team which focuses on improving young people's sexual health.

9.52 The team is made up of youth workers who offer one to one individual support to young people aged under 25, with regards to their own sexual health and support young people under 25 to access local contraception and sexual health services.

9.53 The YOUthink team works closely with the Northern Sexual Health service to promote services and support young people into these services. The service runs promotion events alongside the Northern such as Fresher's fairs in colleges, and themed events throughout the year World Aids day and Sexual Health week.

9.54 YOUthink provides young people aged 13-25 with advice and information, Chlamydia and Gonorrhoea screening, condom distribution, pregnancy testing and provide advice & support. Working very closely with the Northern they aim to support all young people, particularly the most vulnerable, into their services. They concentrate on supporting young people to access all contraception, emergency contraception and treatments for Sexually Transmitted Infections (STI's).

9.55 A large focus of their work is preventative work, raising awareness of sexual health issues for young people and encouraging delay in sexual activity. They also provide YP with factual information and dispel myths to help them make informed choices related to their sexual health and overall well-being.

9.56 The service aims to present tutorials to all year 9 pupils in the Borough and at all further education settings. All but one faith based school in the Borough work with Youthink.

9.57 Most service users supported are aged 14 to 17 with gender evenly split.

9.58 In the second quarter of 2018/19 the service reached 727 young people, 28 received an assessment and had an individual action plan and 28 were supported into mainstream services.

National HIV Self-Sampling Service

9.59 The National HIV Self Sampling Service was commissioned by Public Health England. A framework contract was procured by public sector procurement organisation ESPO and is delivered by Preventx in partnership with Yorkshire Mesmac who provide the notification and support for people receiving reactive tests. Local authorities and other public bodies are able to use the framework to be included in the national web based service

9.60 The national HIV Self sampling service operates a website, www.test.hiv where HIV self-sampling kits can be ordered by individuals to be received through the post. During periods of major campaign activity around national HIV testing week and world AIDS day PHE fund all requests received. During this time there is substantial national promotion coordinated through the It Starts With Me campaign website https://www.startswithme.org.uk/ . Outside of this period kits are only supplied to people where the local authority of residence has contracted for the service. Current return rates are approximately 63%.

9.61 Between April 2017 and March 2018, Tameside residents ordered 255 kits from www.test.hiv. 62% (158) kits were returned to the lab. Of these 164 of which 70% (115) kits

were returned were funded by Tameside. Since the commencement of the service in 2016 697 kits have been issued with 410 returned and there have been 2 reactive tests.

9.62 PHE commenced the procurement of a replacement service on 29 October 2018 with the intention of having a new service in place by 1 April 2019. The new service will be broadly the same as the current service with the addition of the provision of kits in bulk for local commissioners to distribute if required. Pricing will not be known until a new contract is awarded.

9.63 Offering a range of opportunities for people to test for HIV is a key component to tackling rates of HIV infection. The GM HIVE project will seek to increase testing rates across Greater Manchester. Early diagnosis of HIV is associated with better outcomes for the individual and less transmission to others.

Enhanced Services delivered in General Practice

9.64 General Practice provide two Locally Commissioned Services (LCS) for Sexual and Reproductive health; Long Acting Reversible Contraception (LARC) and Chlamydia screening.

9.65 Provision of LARC within General Practice is seeing a gradual decline as qualified practitioners leave and are not replaced. Currently 13 practices provide implants and 15 IUD/S

9.66 Commissioners are working with MFT and a range of other stakeholders to develop proposals to increase the training opportunities for General Practice staff to qualify to provide both implants and IUD/S

9.67 Within the Stalybridge neighbourhood one practice is now running a weekly contraception clinic on behalf of all practices in the neighbourhood.

Enhanced Services delivered in Pharmacy

9.68 Emergency Hormonal Contraception (EHC) is commissioned from a range of local Pharmacies as a Locally Commissioned Service (LCS). The number of pharmacies providing and the value of claims has increased in the last year since provision has been monitored electronically via the web based Neo system alongside all the CCG commissioned pharmacy services. The service has traditionally been available for delivery by any qualifying pharmacy and by pharmacist qualified to deliver the service. The greater visibility of the service via NEO has prompted more pharmacists to complete the training and commence delivery.

9.69 The service is delivered under a Patient Group Direction (PGD) to enable Pharmacists to supply or administer medication without a prescription. The current PGD was updated in September 2018 and has been issued to all participating pharmacists.

9.70 The current Pharmacy contract is for the supply of Levonorgestrel only. Pharmacies can sell EHC privately and EHC is also available via general Practice and the Sexual Health Service. Current annual spend on EHC would indicate approximately 1360 prescriptions being provided per year. This has increased over the last couple of years as additional pharmacies have started to provide.

9.71 Ulipristral (EllaOne) is a newer brand of emergency contraceptive pill that has until now not been commissioned from Pharmacies in Tameside. It must be taken within 120 hours (5 days) of having unprotected sex. Like all methods of emergency contraception it is most effective if it is taken soon after sex. If the pill is taken with 24 hours it will prevent 95% of pregnancies.

9.72 Ulipristral is more effective than Levonorgestrel particularly after 24 hours and can be used in the period between 72 and 120 hours when Levonorgestrel cannot be used. The table below details the effectiveness of Ulipristral versus Levonorgestrel.

	Levonorgestrel	Ulipristral
First 24hrs	95% effective	98% effective
Up to 48hrs	85% effective	98% effective
Up to 72hrs	58% effective	98% effective
Up to 120hrs	*Wouldn't have been supplied	98% effective

9.73 Given the greater effectiveness, and the extended timescales, provision of Ulipristral as an alternative to Levonorgestrel would have much better outcomes and impact for both the individuals and the local health and social care economy.

- more clinically effective;
- Reduction in unplanned pregnancy;
- Reduction in number of termination of pregnancies;
- reduction in women attending General Practice and the Sexual Health clinic for prescription of Ulipristral where they have been informed by pharmacy that it is too late for Levonorgestrel to be effective.

9.74 Modelling would indicate that approximately 440 prescriptions per annum could move from Levonorgestrel to Ulipristral if we implemented the provision of Ulipristral after the first 24 hours following UPSI in our pharmacy EHC service. A proposal is being prepared for PRG/SCB to recommend this.

Termination of Pregnancy

9.75 Many termination of pregnancy services are procured jointly across Greater Manchester. Manchester CCG is lead commissioner for Marie Stopes, BPAS and NUPAS and the BPAS central booking service. The central booking service provided by BPAS is utilised by all areas except Wigan and Bolton. Tameside and Glossop ICFT is our biggest provider of termination services. Patients can access termination services in any area with the patients registered CCG funding. All Termination providers provide abortion counselling and provision of LARC as part of the termination package.

9.76 There are a range of providers across Greater Manchester including both private sector and NHS organisations. Providers include -

- BPAS;
- Marie Stopes;
- NUPAS;
- Tameside and Glossop ICFT;
- Stockport FT;
- Manchester FT;
- Bolton FT;
- Salford FT;
- Stockport FT.

9.77 Manchester CCG performs contract monitoring of jointly commissioned termination services and there is a GM commissioners group that provides oversight and strategic direction of the system.

10. RECOMMENDATIONS

10.1 As set out at the front of the report.

APPENDIX 1

HIVE Project Briefing

HIVE - Ending new transmission of HIV across Greater Manchester within a generation

What are we aiming for?

We aim to reduce transmission of HIV in Greater Manchester and, ultimately, end new transmissions of HIV within twenty five years. HIVE has £1.3m funding from the GMHSCP to deliver the first phase, and is being led by the GM Sexual Health Network and a steering group of community representatives, third sector partners, clinicians, General Practice and Local Authority Commissioners.

Where are we starting from?

- Over 5,600 people living with HIV in Greater Manchester[2]
- Around 745 people in Greater Manchester unaware they are infected[3]
- Almost 300 new cases diagnosed every year[4]
- Higher than national average rates of infections[5], new diagnoses and late diagnoses[6].
- Manchester has more than double the national average number of infections, and Salford almost double[7].
- 44% of new cases classified as 'late diagnoses' when successful treatment is most costly and least likely to be successful[8]
- Risk of onward transmission: an estimated 13% of cases remain undiagnosed and therefore untreated and are at risk of transmitting the infection on.
- Prompt diagnosis: the evidence is clear that early diagnosis has long term health benefits and allows for cost effective management of HIV as a long term condition.
- Effects of late diagnosis: HIV symptoms are frequently subtle until the latter stages of the illness, resulting in a later diagnosis which impacts on both the individual and society:
- The health of the individual – late diagnosis is linked to poorer patient outcomes.
- The health of the population – later diagnosis results in an increased risk of onward transmission of HIV.
- Effect on the public purse: the lifetime cost of HIV is estimated to be £360,000. Compared to early diagnosis, late diagnosis is believed to increase the cost of treatment by 100% in the first year after diagnosis, and 50% in subsequent years.

How will we get there?

By working closely with communities most affected to substantially increase:

- uptake of testing – to pick up infection early, when management is easier and more effective both clinically and cost effectively

[2] 4,906 diagnosed and 745 undiagnosed, based on 2016 data
[3] Based on 2016 PHE estimates of 13% of people in England and Wales excluding London
[4] 296 new cases diagnosed earlier
[5] 2.93 per 1000 15-59 year olds; compared to England average 2.31. (PHE England data 2016)
[6] 12.9 per 100,000 over 15s
[7] 6.45 per 1000 in Manchester; 4.23 per 1000 in Salford. (PHE England data 2016)
[8] 2016 data

- awareness and uptake of prevention including PrEP – to reduce the risk of people acquiring HIV
- access to timely and effective treatment – increasing the number of people who have an undetectable viral load and levels of virus that are untransmittable (U=U)

How are we progressing?

- Our overall vision is set out in our Population Health Plan, published January 2017
- Signed up to the Fast Track City global partnership[9] and goals[10] in Autumn 2018
- Delivery of the first phase of activity is due to begin in Spring 2019
- We aim to realise our vision by 2043

[9] http://www.fast-trackcities.org/about

[10] 1. Attain 90-90-90 targets
Ensure that at least 90% of PLHIV know their status
Improve access to ART for PLHIV to 90%
Increase to 90% the proportion of PLHIV on ART with undetectable viral load
2. Increase utilization of combination HIV prevention services
3. Reduce to zero the negative impact of stigma and discrimination
4. Establish a common, web-based platform to allow for real-time monitoring of progress

Sexual and Reproductive Health in Tameside

January 2019

Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

Commissioning landscape

- Local Authority
  - Sexual Health services including most Contraception, STI testing and treatment, prevention
- Clinical Commissioning Group
  - Abortion, gynaecology, vasectomy, sterilisation
- NHS England
  - Contraception as part of GP contract, HIV treatment and care
- Greater Manchester Sexual Health Network
  - Strategy, Joint procurement, common specifications and standards

Greater Manchester Strategy

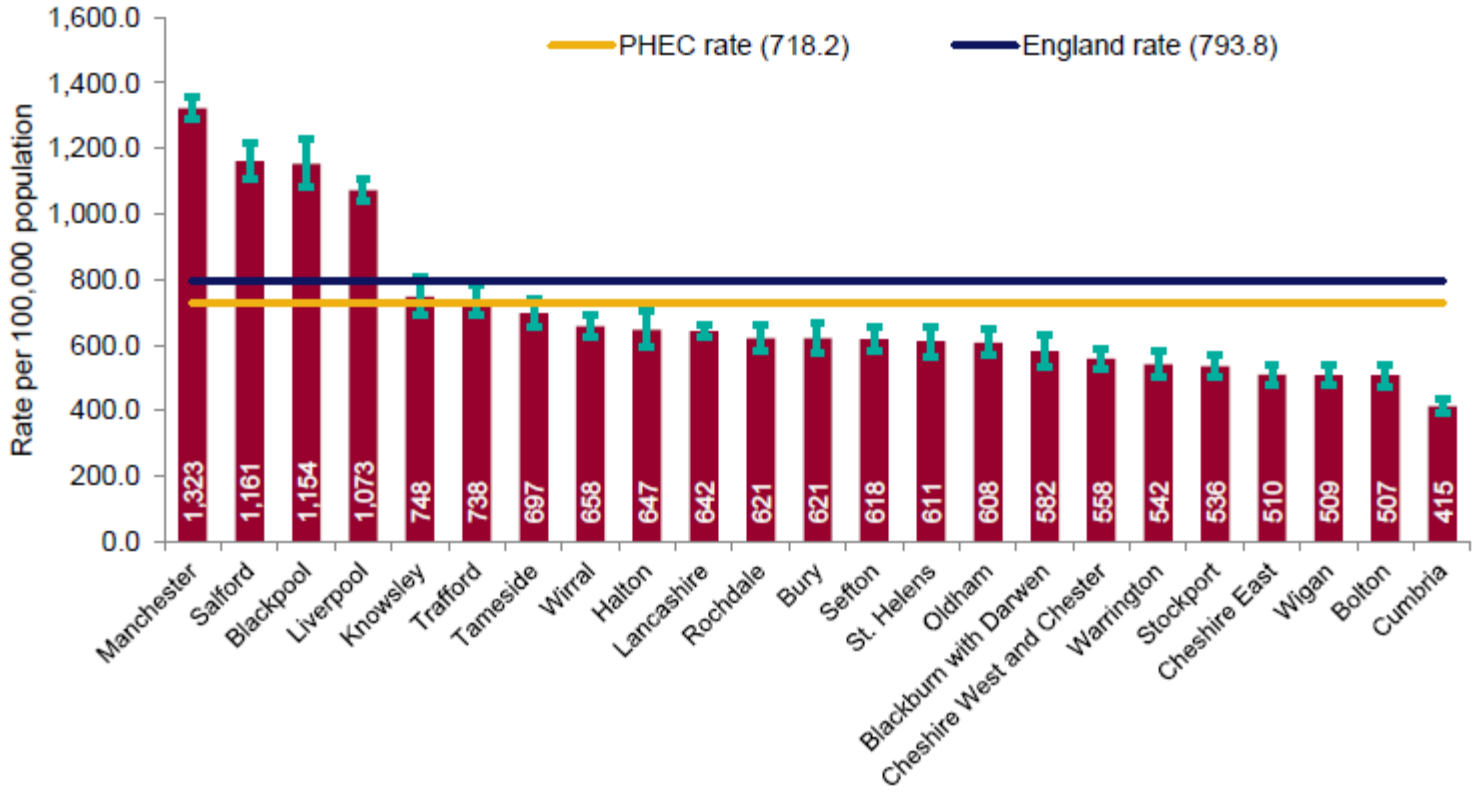
Greater Manchester Strategy for Sexual Health, Reproductive Health and HIV 2018 – 21

Our vision for Greater Manchester is that:

- all residents have the knowledge, skills and confidence to make informed choices about their sexual health, reproduction and relationships;
- sexual and reproductive health services are accessible, sensitive and appropriate for all;
- we see improved outcomes in sexual and reproductive health, bringing Greater Manchester to among the best in the country;
- we will work together to eradicate HIV in a generation

Rate of STI Diagnoses

Figure 8b: Rate of new STI diagnoses (excluding chlamydia diagnoses in persons aged 15-24 years) per 100,000 population aged 15-64 years among North West residents by upper tier local authority of residence: 2017. Data sources: GUMCAD, CTAD



Proportion of new STIs by age group and gender in Tameside: 2017

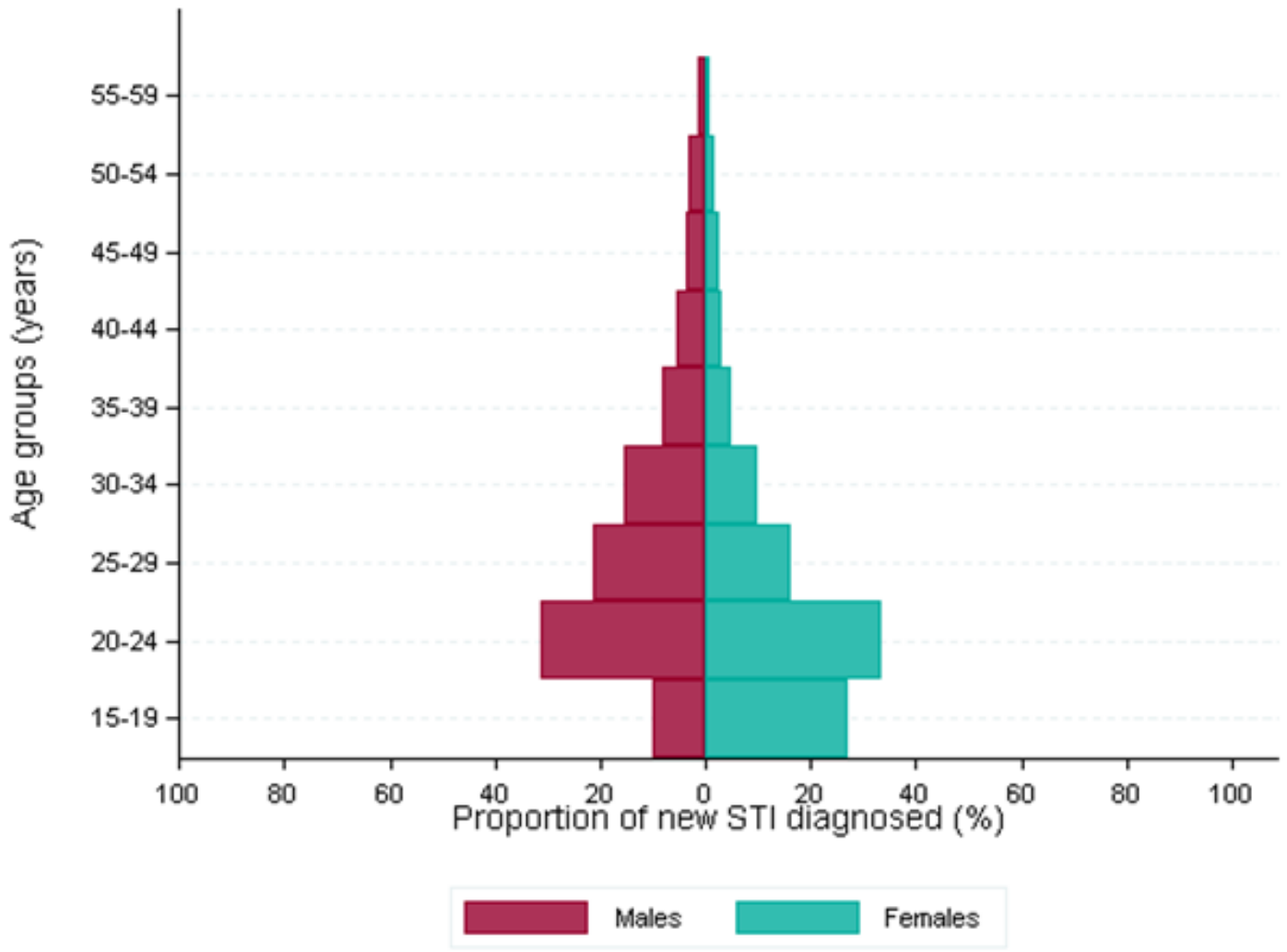
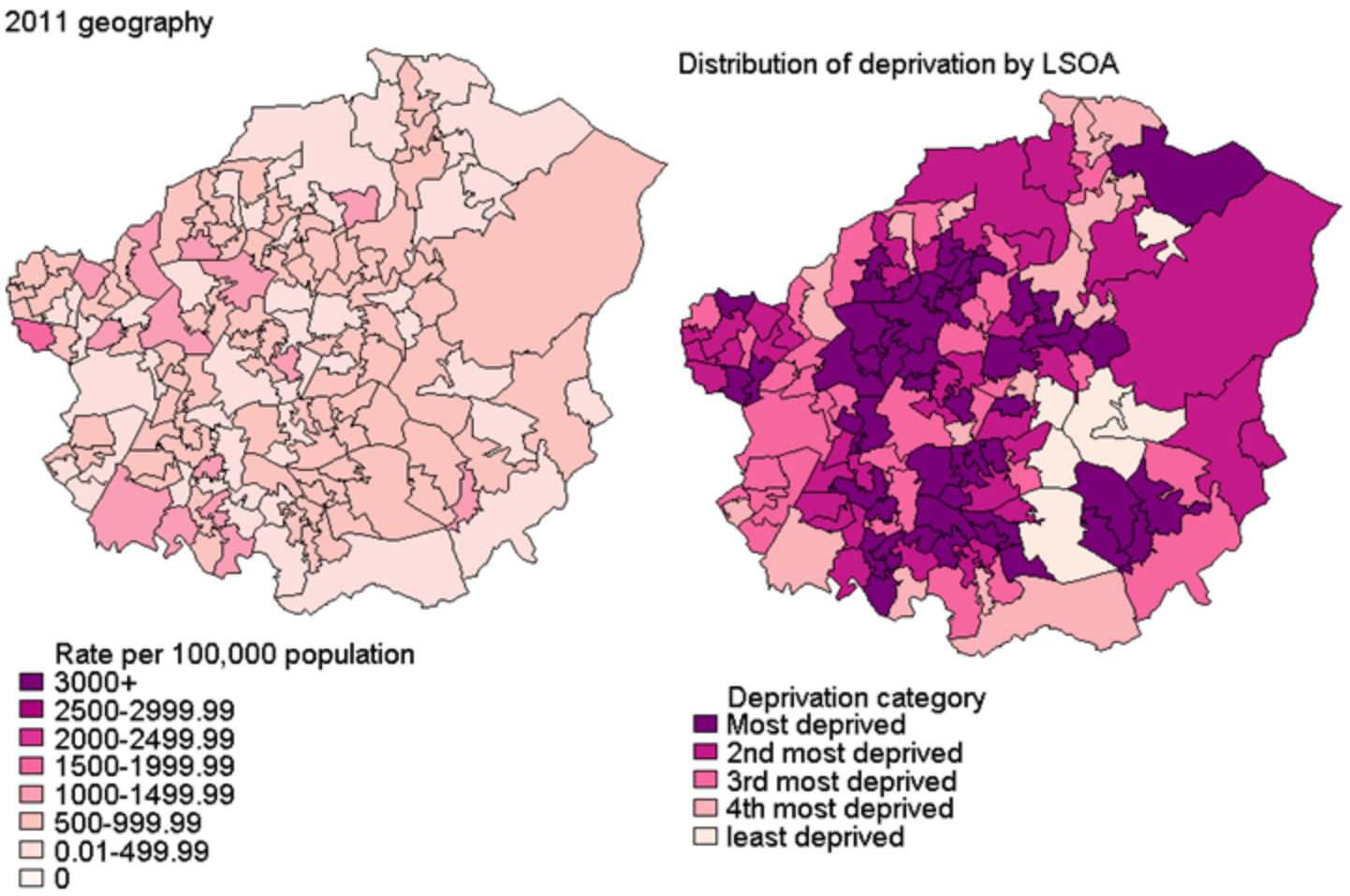


Figure 1.7. Rates per 100,000 population of new STIs and deprivation by LSOA* in Tameside (SHS diagnoses): 2017. (Please refer to the text and Appendix 5 to assess the extent to which clinic coding issues may have distorted this map)



Tameside Metropolitan Borough

NHS Tameside and Glossop Clinical Commissioning Group

HIV

- Fast Track Cities (WHO) and GM HIVE – Eradication of new cases of HIV within a generation.
- UNAIDS 90:90:90 Targets
  - 98% of Tameside residents diagnosed with HIV are receiving ART
  - 91% of these virally suppressed and therefore unable to pass on HIV. U=U
  - For Tameside residents diagnosed with HIV in 2017, 82% initiated treatment within 91 days. This compares to 74% in England.
- Tameside HIV Diagnosed prevalence rate 1.9 per 1000 population aged 15-59 (6th highest in GM)
- Between 2015 and 2017 50% of diagnosis were made at a late stage of infection – 5th highest in GM

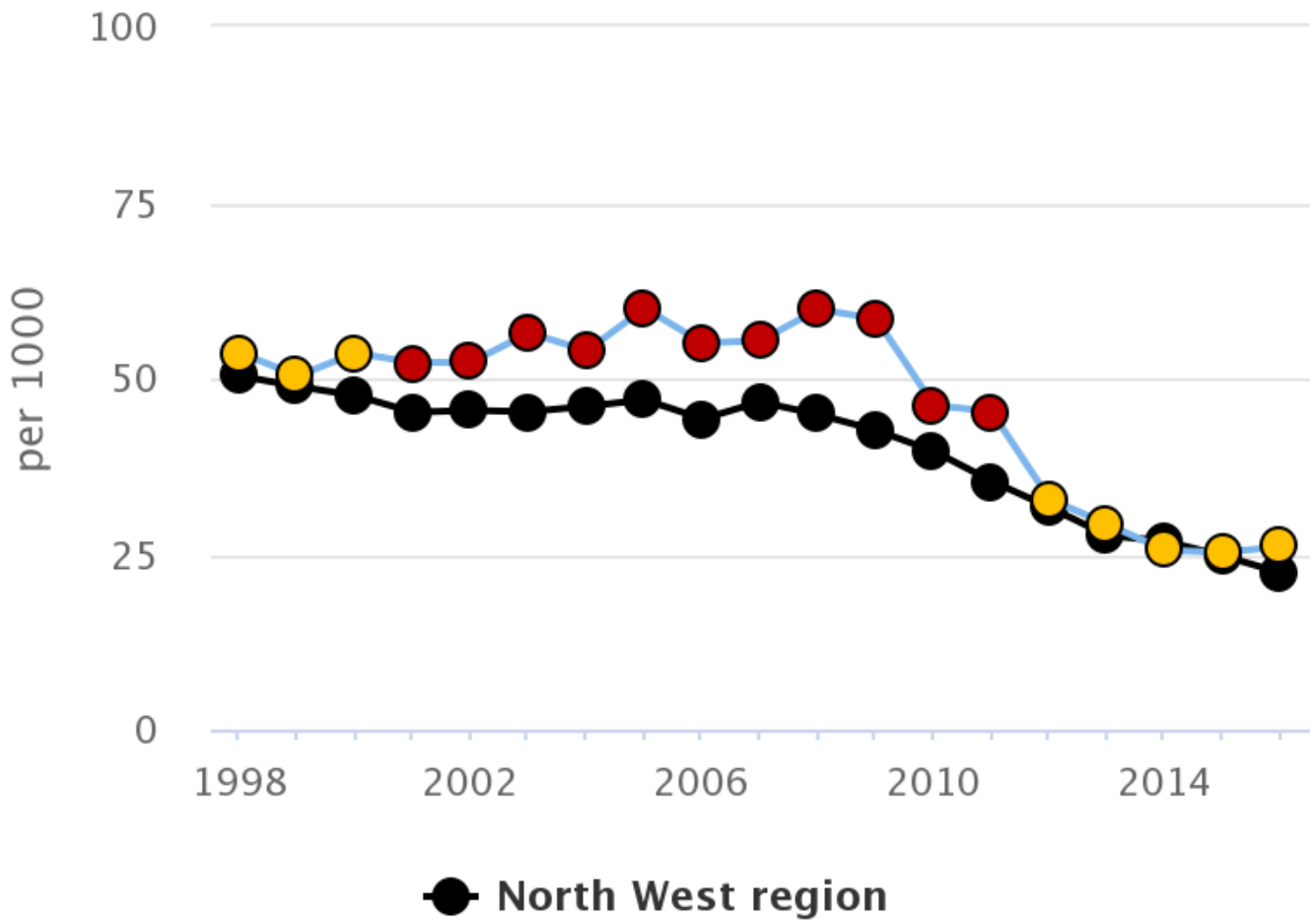
Tameside Contraception Summary

- 62% of Tameside residents attending Sexual and Reproductive Health Services for contraceptive care were aged 24 or under
- women under 25 account for 43% of LARC, 64% contraceptive injections and 70% of Oral contraceptive pill
- Total rate of Long Acting Reversible Contraception (LARC) 42.4 per 1000 women aged 15-44 in Tameside 6th highest in GM.
- In 2017 Tameside ranked 203 out of 326 LAs for rate of GP prescribed LARC with a rate of 27.9 per 1000 women
- SRHS LARC rate 14.4 per 1,000 women aged 15 to 44 years

Under 18s Conception Rate (PHOF Indicator)

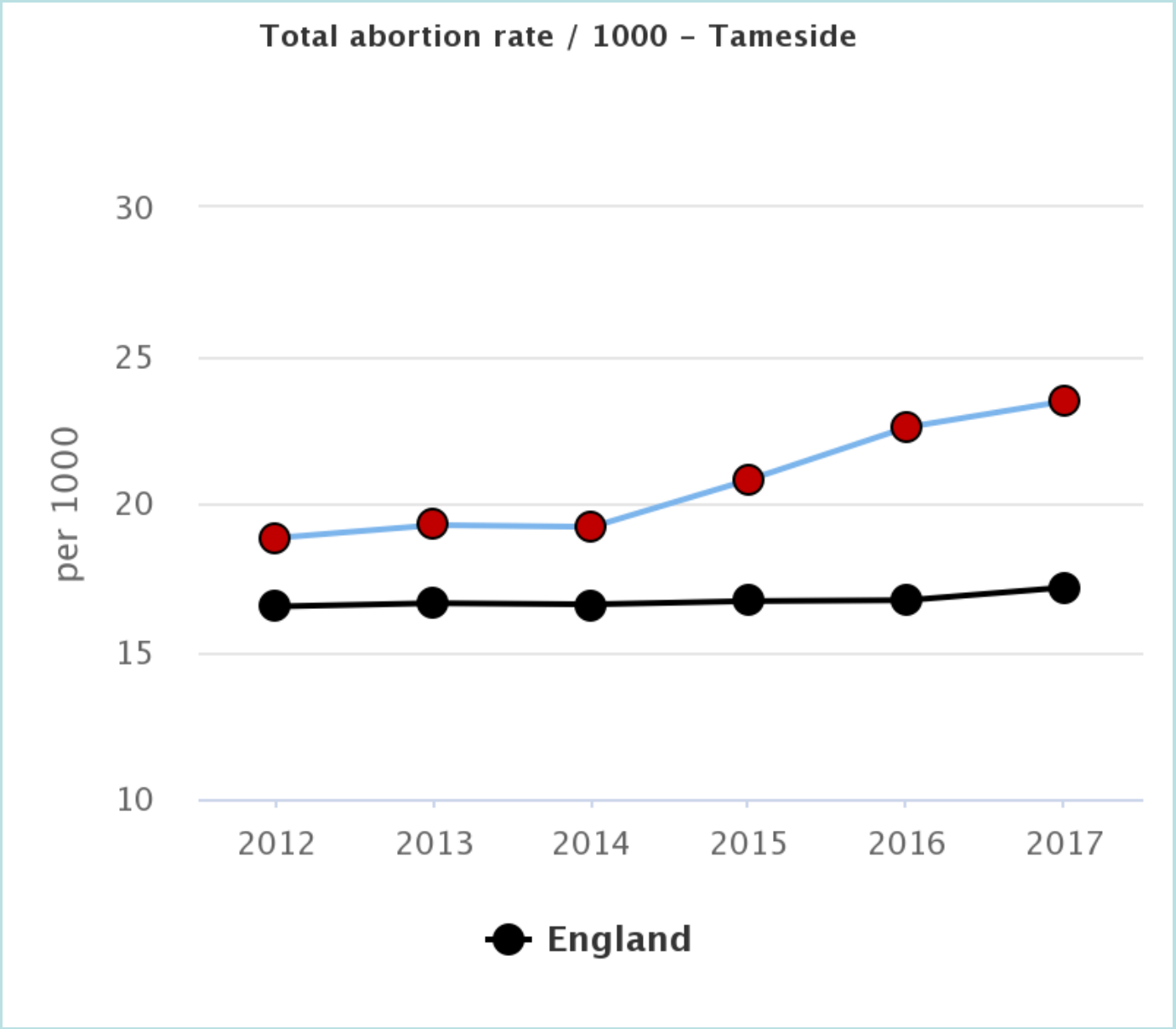
- 2016 under-18s conception rate 26.0 per 1,000 females
- Tameside rank 49 out of 323 within England for the under-18s conception rate (1st has the highest rate).
- Under 18s conceptions peaked in 2005 in Tameside with a fall of 64% since then.
- Of under 18 conceptions the percentage leading to abortion was 41.8% (England 51.8%)

Under 18s conception rate / 1,000 (PHOF indicator 2.04) - Tameside



Termination of Pregnancy

- 978 abortions performed for women (all ages) from Tameside in 2017
- Rate per 1000 women aged 15-44 in Tameside risen from 19.2 in 2014 to 23.5 in 2017
- Tameside and Glossop abortion rate 21.6 second highest CCG rate in GM.
- 82.2% between 3 and 9 week gestation compared to 77% for England.


Total abortion rate / 1000 – Tameside
30
25
20
15
10
per 1000
2012
2013
2014
2015
2016
2017
England

Developments

- Implemented new IT system – quicker results management, patient visibility across all Northern services, less clinical time spent inputting information.
- Implemented a digital offer with the provision of STI testing kits posted to patient's home address
- Refreshed You're Welcome accreditation
- Updated safeguarding processes
- 100% of patients with an urgent clinical need offered an appointment within 48 Hours.
- 94% of patients attending walk-in clinic seen within 90 minutes

Developments

- Sex and Relationships curriculum developed for Tameside primary and secondary schools and being implemented.
- The provision of Ullipristral (Ella One) Emergency Hormonal Contraception to be implemented via pharmacy services.
- Stalybridge neighbourhood have implemented neighbourhood LARC model
- Looking at options to increase LARC capacity in General Practice.
- Saturday Morning clinic for Young People from February at Orange Rooms
- Participation in HIVE

Sexual and Reproductive Health Commissioning

- Extend RuClear chlamydia screening contract
- Change current chlamydia screening General Practice LCS
- Cease Chlamydia screening via pharmacy
- Extend HIV and STI screening support Service
- Extend Pharmacy Emergency Contraception Service to include Ulipristral
- Continue commitment to National HIV screening service.

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Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	23 January 2018
Reporting Member / Officer of Strategic Commissioning Board	Councillor Brenda Warrington – Executive Leader Jeanelle De Gruchy, Director of Population Health — Population Health
Subject:	**SEXUAL AND REPRODUCTIVE HEALTH SERVICES – CONTRACT EXTENSION AND FUTURE INVESTMENT**
Report Summary:	This report seeks approval for a range of contracts and changes to service delivery within sexual health services. It includes approval for contract extensions to continue using two contracts that are jointly commissioned across Greater Manchester (for the provision of chlamydia screening and for support for the most vulnerable groups for HIV and Sexually Transmitted Infection (STI)) and changes to the delivery of chlamydia screening within General Practice and the extension of the Pharmacy Emergency Hormonal Contraceptive service.
Recommendations:	That Strategic Commissioning Board be recommended to: (i) Approve the extension of the RuClear contract in line with the extension granted by the Lead Commissioner Manchester Council. (ii) Approve the extension of the HIV and STI screening and support service (GMPaSH) in line with the extension granted by the lead Commissioner Salford Council. (iii) Approve the ceasing of the current Locally Commissioned Service with general Practice for Chlamydia Screening and replace with a service for provision of self-sampling Kits and enhanced condom offer. (iv) Approve the removal of chlamydia screening from the Pharmacy Emergency Hormonal Contraception service. (v) Approve the extension of the Pharmacy Locally Commissioned Service to include Ulipristral (Ella One) Emergency hormonal Contraception. (vi) Approve the continued commitment to the national HIV screening service.

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

Integrated Commissioning Fund Section	Section 75
Decision Required By	Strategic Commissioning Board
Budget Allocation	The recommendations will be financed in line with existing budget allocations within the Population Health directorate:
Recommendation (i)	£0.075 million
Recommendation (iii)	£0.023 million
Recommendation (iv)	The current year budget

	allocation is £ 0.075 million (per recommendation i)
Recommendation (v)	No financial impact as pharmacies are not paid for distribution of kits
Recommendation (vi)	Estimated cost of £ 0.002 million will be financed from the existing Population Health service revenue budget
Recommendation (i)	£ 0.075 million

Legal Implications: (Authorised by the Borough Solicitor)

Under the Council's Procurement Standing Orders contracts can be (1) extended if there is extension provision in the contract (F.1.2) and (2) varied in certain circumstances including where the specification to achieve particular outcomes require changing so additional supplies/services are necessary, and it wouldn't make sense to change contractors for technical reasons, significant inconvenience or cost, and they are not more than 50% of the value of the contract (F.1.5). In all cases the achievement of best value for money is a key consideration.

How do proposals align with Health & Wellbeing Strategy?

The proposals align with the Starting Well and Developing Well programmes for action

How do proposals align with Locality Plan?

The provision of sexual and reproductive health services is consistent with the following priority transformation programmes:

- Enabling self-care
- Locality-based services
- Planned care services

How do proposals align with the Commissioning Strategy?

The provision of sexual and reproductive health services contributes to the Commissioning Strategy by:

1. Empowering citizens and communities
2. Commission for the 'whole person'
3. Create a proactive and holistic population health system

Recommendations / views of the Health and Care Advisory Group:

The Health and Care Advisory Group recommended that the Locally Commissioned Service (LCS) for the provision of Chlamydia testing by General Practice is included in the LCS Framework.

The contents of the report were supported at the Health and Care Advisory Group by the Sexual Health clinical lead Dr Jane Harvey.

Public and Patient Implications:

The recommendations will ensure continued access to services.

Quality Implications:

Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which

	requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness
How do the proposals help to reduce health inequalities?	Provision of Sexual and reproductive health services has a positive effect on health inequalities. Poor sexual health and lack of access to contraception contributes to inequalities, with more deprived populations experiencing worse sexual health. The proposed continuation of services will ensure the continued targeting of resources for those at greatest need. The proposed provision of additional Emergency Hormonal Contraception will extend and improve the service to address health inequalities.
What are the Equality and Diversity implications?	The sexual and reproductive health services provided are available to Adults regardless of ethnicity, gender, sexual orientation, religious belief, gender re-assignment, pregnancy/maternity, marriage/ civil and partnership. Some service provision is targeted to address health inequalities experienced by more marginalised groups.
What are the safeguarding implications?	Sexual and Reproductive Health Services have an important role in the identification and response to abuse. The service has explicit resources for this, is linked into Child Sex Exploitation and Domestic Abuse services and has pathways to safeguard children and vulnerable adults
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report therefore a privacy impact assessment has not been carried out
Risk Management:	The purchasers will work closely with the provider to manage and minimise any risk of provider failure consistent with the provider's contingency plan.
Access to Information:	The background papers relating to this report can be inspected by contacting the report writer Richard Scarborough, Planning and Commissioning Officer  Telephone: 0161 0161 342 2807  e-mail: Richard.scarborough@tameside.gov.uk

1. INTRODUCTION

1.1 Under the Health and Social Care Act 2012, Local Authorities have a statutory duty to commission confidential, open access services for Sexually Transmitted Infections and Contraception, as well as ensuring that the local population has reasonable access to all methods of contraception. A range of services are commissioned from NHS providers, General Practice, Pharmacy and third sector organisations in order to fulfil these obligations.

1.2 Improving the sexual and reproductive health of the local population is a public health priority. Sexual and reproductive ill-health can have a detrimental effect on our relationships and on our emotional and physical wellbeing. Good sexual and reproductive health is dependent on a positive and respectful attitude to sex, relationships and sexuality; pleasurable and safe sexual experiences free from coercion; the absence of infection and dysfunction; and the avoidance of unintended conceptions.

1.3 Sexually transmitted infections (STIs) can be passed from an infected person to their partner during sexual intercourse. Sexually transmitted infections can lead to long-term health problems if not detected and treated. Infections such as HIV can be managed but not cured.

1.4 The correct and consistent use of a reliable method of contraception is important for protection from an unintended conception. Over the last decade, there has been an increase in the proportion of women opting to use a long acting, reversible method of contraception (such as the contraceptive implant) though the contraceptive pill is still a popular choice.

1.5 An Executive Decision in January 2016 approved the joint procurement of a sexual and reproductive health service in a cluster arrangement with Stockport and Trafford Councils with Stockport leading the procurement and awarding the contract. A two year extension to this contract was approved in July 2018

1.6 This arrangement is in line with the Greater Manchester sexual health strategy, produced by the Greater Manchester Sexual Health Network, to recommission services in cluster based arrangements using a single Greater Manchester service specification.

1.7 The Greater Manchester Sexual Health Commissioners Group, a sub group of the Greater Manchester Sexual Health Strategic Partnership, collaborates to jointly commission additional services across Greater Manchester. Collaboratively commissioned services include an opportunistic chlamydia screening programme provided by RuClear and an STI and HIV screening and support service provided by the PaSH partnership. Both of these contracts are coming to the end of their initial term and the lead commissioners and the Partnership have agreed to extend as permitted within their contract terms subject to local agreements.

1.8 A national HIV self-sampling service operates under a framework procured by ESPO on behalf of Health Prevention England. This framework will expire on 31 March 2019 but has an available extension until 29 October 2019. A tender is in progress to procure a new framework with the intention of having a new service in place by 1 April 2019.

1.9 General Practice provide two Locally Commissioned Services (LCS) for Sexual and Reproductive health; Long Acting Reversible Contraception (LARC) and Chlamydia screening.

1.10 Pharmacies deliver one LCS, Emergency Hormonal Contraception (EHC) which includes a chlamydia screening element.

1.11 This report details the arrangements for each of these additional services and the proposed extensions and implications for Tameside and seeks authorisation to proceed as detailed in the recommendations. In summary these are

- To extend the RuClear contract in line with the extension granted by the Lead Commissioner Manchester Council
- To extend the HIV and STI screening and support service (GMPaSH) in line with the extension granted by the lead Commissioner Salford Council
- To cease the current LCS with general Practice for Chlamydia Screening and replace with an LCS for provision of self-sampling Kits and enhanced condom offer.
- To remove chlamydia screening from the Pharmacy EHC service
- To extend the Pharmacy LCS to include Ulipristral (Ella One) Emergency hormonal Contraception.
- To continue commitment to the national HIV screening service.

1.12 Clinical governance and oversight for sexual and reproductive health in Tameside is provided by Dr Jane Harvey. Dr Harvey has reviewed the clinical aspects of the proposals within this report and supports the recommendations made.

2. OPPORTUNISTIC CHLAMYDIA SCREENING PROGRAMME

2.1 Manchester City Council, on behalf of all of the local authorities of Greater Manchester, holds a framework contract with Manchester University NHS Foundation Trust (MFT) for the provision of an opportunistic chlamydia screening programme for asymptomatic young people aged under-25 (branded as RuClear). The framework was procured via a competitive tender and the initial contract period is due to expire on the 31st March 2019 and has a further two year extension period.

2.2 The service has been reviewed by the GM Commissioners who have agreed some changes to the service delivery (detailed below) with contract prices for the provision of kits and testing remaining the same. The framework will be extended by Manchester and individual Authorities can opt to continue with the framework or make alternative arrangements.

2.3 The Chlamydia screening programme is a key service in assisting us in meeting the targets of the national Chlamydia screening pathway. Chlamydia is the most common bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It is estimated that one in ten young people are infected. By diagnosing and treating asymptomatic chlamydia infections, chlamydia screening can reduce the duration of infection, which will reduce an individual's chance of developing complications, and also reduce the time when someone is at risk of passing the infection on, which in turn will reduce the spread of chlamydia in the population.

2.4 The National Chlamydia Screening Programme (NCSP) recommends that all sexually active men and women under 25 years of age be tested for chlamydia annually or on change of sexual partner (whichever is more frequent)

2.5 Indicators linked to the NCSP pathway are included in the Public Health Outcomes Framework (PHOF) and the Public Health England Sexual and reproductive Health Profiles. The indicators assess progress in controlling chlamydia in sexually active young adults. Guidance recommends local areas achieve an annual chlamydia detection rate of at least 2,300 per 100,000 15-24 year old resident population to detect and treat sufficient asymptomatic infections to affect a decrease in incidence.

2.6 The chlamydia detection rate reflects both screening coverage levels and the proportion of tests that are positive at all testing sites, including primary care, sexual and reproductive

health and specialist sexual health services. Areas achieving or above the 2,300 detection rate should aim to sustain or increase, with areas achieving below it aiming to increase their rate.

2.7 The Tameside chlamydia detection rate has previously been one of the highest nationally and highest in GM but has fallen dramatically from 3789 in 2015, to 2619 in 2016 and 1794 in 2017 along with decrease in the number of tests and percentage of population covered. Whilst Tameside figures have dropped significantly they are now more in line with the rest of GM. There have been problems with the coding and reporting of chlamydia tests by laboratories via CTAD (Chlamydia Testing Activity Dataset) which are now being resolved following work by PHE with labs and RuClear. For some time it has been suspected that Tameside figures included a lot of double counting as our rates were extremely high but we could not justify them. It is likely that, prior to the commencement of our new contract for the Sexual and Reproductive health Service in September 2016, all screens initiated within this service were being double counted.

2.8 Percentage positivity rate is not a reported indicator but is contained within the data. Tameside's 2017 figure is 10.9% the third highest in GM. This may indicate that either the tests we do are more targeted or that the level of infection in the population is higher.

2.9 The pathway target positive detection rate is 2.3% (Approximately 600 positives for Tameside) and it is estimated that 25-35% of the population needs to be tested to achieve this. In 2017 we achieved 453 positive test results with 16.5% of the population tested.

The RuClear Service

2.10 The RuClear service has two elements. A self-sampling service enabling individuals to request a screening kit online for delivery to their home address and a screening initiation service for clinical settings including General Practice, Termination of Pregnancy services, and Midwifery services and Brooke. Activity is charged to the local authority based upon the address of the patient. (For example a Tameside resident using Brooke in Manchester or a Termination of Pregnancy service in Trafford would be paid for by Tameside). Approximately one third of activity is via initiation sites and two thirds via self-sampling.

2.11 Across Greater Manchester the use of the screening initiation service within General Practice has been varied with the majority of practices making little or no use of the service. The service is only available to patients age 16 to 24 (in line with the National Chlamydia Screening Programme) and is for screening purposes and not to be used where testing is indicated as part of differential diagnosis or for patients that are symptomatic. Where a Practice wishes to offer a screen to a young person a different sample kit is used and labels have to be manually created. A Practice may therefore use their regular sample testing system or the RuClear system depending upon the eligibility factors. This dual system may have proven to be too complicated within a busy practice environment.

2.12 Due to the low numbers of screens being initiated at most General Practice initiation sites across Greater Manchester the provider, RuClear, have stated that it is not viable to support sites that are issuing minimal numbers due to the overhead in training and support and the wastage of kits going out of date.

2.13 Two alternative models have been offered for sites with low activity levels, either a referral card that can be given a young person with the details of the RuClear digital service for them to access or the provision of a supply of take away kits that can be given to eligible patients. These kits could be used by the patient in the surgery and given to the receptionist to put in the sample bag or taken away to be completed and posted back. The expectation would be that any practice holding kits would promote the service to eligible patients and also give out kits to young people not registered with the practice that request them. The Practice would be promoted as a location where kits could be collected.

2.14 In Tameside, General Practices are currently paid based upon screens received by RuClear at the rate of £4.50 for each kit received and £16 for each positive. In the 6 month period April to September 2018 a total of 39 screens were received from Tameside practices, all were negative. Practices will be paid payments totalling £175.50 for this activity.

2.15 Pharmacies delivering the Emergency Hormonal Contraception service also offer the RuClear service and should hold a stock of home sampling kits to give out. No additional payment is made to pharmacies for this service. In common with other areas of Greater Manchester the provision via pharmacy is minimal and experience has shown that, even where a young person takes a kit as part of an EHC consultation it is rarely completed and returned.

2.16 The RuClear service currently has no budget for the promotion or development of the service. The lead commissioner has agreed a contract variation to include an annual fee of £2000 per participating Authority to fund needed IT developments and promotion of the service. Activity levels for all participating areas are considerably lower than the indicative activity figures that were given when the service was procured which has affected the financial viability of the service. By giving the service additional resource, ring-fenced for targeted promotion, it is expected that activity levels will be increased. Promotion will be targeted such that once activity levels are at the level of the indicative volumes of activity it will be ceased.

2.17 RuClear spend and activity in the 6 months April to September 2018

	Initiation test	Cost	Postal kits sent	Cost	Postal Kits returned	Cost of testing	Total cost
April-September	320	£6476.80	867	£4681.80	663	£12,815.79	£23,974
Indicative figures / projected spend	500	£10,120	750	£4050	600	£11,598	£25,768

2.18 Since May 2017 RuClear have accepted requests for screens from Tameside residents aged over 24. A decision was taken to extend the offer in the Tameside, Trafford and Stockport cluster in order to ease pressure on the main Sexual and Reproductive health Services (SRHS) whilst there were capacity issues during service transformation as the new contract was being initiated. There was capacity to do this due to the underperformance of provision of screens compared to the indicative and budgeted levels of service. This extension of service is now being removed as capacity increases in the SRHS and the service has implemented a more comprehensive digital offer that people over 24 can access. The number of home test kits returned to the SRHS service has increased from 133 in Q4 17/18 to 270 in Q2 18/19.

2.19 In the 12 month period July 2016 to August 2018 356 RuClear kits were sent to Tameside residents aged over 24 with 348 being returned at a total cost of £8650. There were 15 chlamydia positives and 2 Gonorrhoea positives detected from this activity. This activity will now be targeted at the age 16 to 24 client groups in order to improve performance against the chlamydia pathway. The targeted promotion of the service will be essential in increasing take-up of the service.

2.20 **Recommendations for consideration – RuClear and Chlamydia screening**

- Extension of current RuClear contract.
- Cease provision of current GP LCS for chlamydia screening initiation.

- Implement a universal offer for General Practice by providing takeaway kits for with a payment of £5 for each kit distributed and returned. Or alternatively a neighbourhood offer with fewer General Practices participating with a single annual payment of £200 per participating practice.
- Cease provision within the Pharmacy EHC service.

Options related to RuClear contract

Recommendation - Extension of current RuClear contract.

2.21 The framework contract with RuClear has been extended by Manchester within the terms of the original procurement and contract. The contract is a key service in tackling the spread of Chlamydia in Greater Manchester and working towards the targets in the national Chlamydia pathway. RuClear have established a clear brand across Greater Manchester and have a well-managed clinical service. The service is subject to contract monitoring which is performed by Manchester council as contract holder. In addition there is a steering group for all the Greater Manchester jointly commissioned services, the Joint Contract Oversight Group (JCOG) which meets quarterly to analyse performance data for all jointly commissioned contracts and advises the lead commissioner. The Tameside commissioner attends the JCOG meetings on behalf of the Tameside, Stockport and Trafford cluster.

Alternate Option - Cease the contract with RuClear.

2.22 Ceasing this contract would have a severe impact upon our ability to control the spread of chlamydia and gonorrhoea in the Borough. The RuClear programme is a targeted screening programme; whilst some of this activity could be picked up by the Sexual and Reproductive Health Service there would be additional costs associated with developing this as an extension to the current contract. Alternative provision would not benefit from the clear GM wide branding and universal offer.

Options related to General Practice.

Recommendation - Implement a new General Practice neighbourhood offer using home screening kits

2.23 The RuClear programme can be provided within the general Practice setting with the provision of home screening kits for issue to eligible young people. (Further details see appendix One) General Practice is a trusted brand and young people are likely to take advice re screening in this environment.

Provision can either be universal, with all practices given the opportunity to take part, or be limited to a small number of practices per neighbourhood. Where a practice is not taking part they can be provided with information cards directing the young person to the online RuClear service.

- If a universal offer is implemented a remuneration rate of £5 for each kit returned to RuClear is proposed.
- If a neighbourhood model is implemented then a single fee of £200 per annum is proposed.

Advice is sought from SLT and HCAG as to the preferred option.

Alternate Option - Continue as is.

2.24 Continuing the current offer with all practices regardless of the level of uptake of the service is no longer an option as it has not proved to be viable for RuClear to supply the kits given the numbers that are expiring and the effort to sustain the service in training etc.

Alternate Option - Cease providing RuClear via General Practice

2.25 The provision of a service via General Practice is an important element of the provision, particularly for young people who do not want kits delivering to their home address. General

Practice are well placed to increase take-up of chlamydia screening in order for us to improve our performance on the chlamydia pathway. Without provision in community settings it will be difficult to reach all target groups and achieve desired outcomes.

Options related to Pharmacy

Recommendation - Implement a new Pharmacy Offer

2.26 A new pharmacy LCS based on the referral of young people to the digital offer as a standalone service could be implemented in selected pharmacies. This may generate more activity and provide an additional setting where engagement with Young People can take place. However, the additional resources in the RuClear service to promote the digital service using social media are expected to focus on the target population and increase take-up. It is proposed therefore that this option is not implemented at this time but can be considered if increased take up and targeting of the service is required in the future.

Alternate Option - Continue as is.

2.27 Continuing the current offer with all Pharmacies who deliver the EHC service regardless of the level of uptake of chlamydia screens is no longer an option as it has not proved to be viable for RuClear to supply the kits given the numbers that are expiring and the effort to sustain the service in training etc.

Alternate Option - Cease Pharmacy Provision

2.28 Only minimal numbers of chlamydia screens are initiated via pharmacies so the impact of ceasing will be negligible. Young people can be signposted to other services including the online offer and General Practice.

Summary of Recommendations - RuClear and Chlamydia screening

2.29 That participation in the RuClear contract is extended for two years from 1 April 2019 to include the additional £2000 per annum contribution towards IT development and promotion

2.30 That the Initiation Service is withdrawn from General Practice.

2.31 That the RuClear element of the Pharmacy EHC contract is removed.

2.32 That General Practices are offered the option of holding self-sampling kits with a payment of £5.00 made for each kit issued and returned to RuClear or Practices providing the service on behalf of their neighbourhood be paid a fee of £200 per annum.

3. GM SEXUAL HEALTH IMPROVEMENT PROGRAMME (PASH)

3.1 The GM Sexual Health Improvement Programme (branded as the Passionate about Sexual Health Programme; PaSH), is provided by a consortium led by BHA for Equality in partnership with George House Trust and the LGBT Foundation. It provides STI and HIV prevention and support services and support for people living with and affected by HIV and AIDS. The service targets our most vulnerable and high risk population in terms of sexual health needs and provides information and advice as well as initiatives like community HIV Point Of Care Testing (POCT).

3.2 The contract was awarded by Salford Council (on behalf of all of the local authorities of Greater Manchester) following a competitive tender exercise and commenced in July 2016. The initial contract period was three years with an allowable two years extension.

3.3 A memorandum of agreement is in place between Salford and the other nine GM authorities to set out and govern the relationship between the parties and their obligations. Any party may terminate its participation in the project with six months notice.

3.4 Participation in this contract was agreed by the Strategic Commissioning Board in November 2016.

3.5 The service has been reviewed by the GM Commissioners who have agreed to extend the contract by two years. The service and partnership will be an important partner in in the new GM HIVE (Ending new transmission of HIV across Greater Manchester within a generation) project and the GM City Regions application to become a Fast Track City.

3.6 The service is subject to contract monitoring which is performed by Salford council as contract holder. In addition there is a steering group for all the Greater Manchester jointly commissioned services, the Joint Contract Oversight Group (JCOG) which meets quarterly to analyse performance data for all jointly commissioned contracts and advises the lead commissioner. The Tameside commissioner attends the JCOG meetings on behalf of the Tameside, Stockport and Trafford cluster.

3.7 The majority of the funding for this service is provided by Manchester and Salford who have the areas of greatest need. The Tameside contribution to the contract is £22,560 per annum which is the lowest contribution of all participating authorities.

3.8 The PaSH consortium has developed and established the service across Greater Manchester and delivers services to the residents of Tameside both within the Borough and from locations outside the Borough. For example recent provision has included provision of POCT at a venue in Stalybridge, an information stall at MIND and information sessions at People First Tameside. In the first quarter they provided 26 Tameside residents with 1 to 1 brief interactions around HIV and sexual health and four with structured/extended information and advice, 25 residents attended group sessions, 3 residents took a HIV test and condoms were distributed to five outlets in the Borough.

3.9 The service is subject to quarterly contract monitoring which is performed by Salford council as contract holder. In addition there is a steering group for all the Greater Manchester jointly commissioned services, the Joint Contract Oversight Group (JCOG) which meets quarterly to analyse performance data for all jointly commissioned contracts and advises the lead commissioner. The Tameside commissioner attends the JCOG meetings on behalf of the Tameside, Stockport and Trafford cluster.

Options for consideration

Extension of current contract.

3.10 The contract with BHA for Equalities has been extended by Salford within the terms of the original procurement and contract. The contract provides a key service in tackling the spread of STIs and HIV in Greater Manchester and working with our most at risk populations. Continuation of this service is in line with the GM Sexual Health strategy.

Cease participation in the contract.

3.11 Ceasing participation in this contract would have an impact upon our ability to control the spread of STIs and HIV in the Borough amongst the populations that are most at risk. Alternative provision would not benefit from the GM wide branding and universal offer which maximises the relatively small level of resource we contribute to this service.

Recommendation

3.12 That participation in the PaSH contract is extended for two years from 1 July 2019

4. NATIONAL HIV SELF SAMPLING SERVICE

4.1 The National HIV Self Sampling Service was commissioned by Public Health England. A framework contract was procured by ESPO and is delivered by Preventx. Local authorities and other public bodies are able to use the framework to be included in the national web based service. The contract has an initial term until 31 March 2019 with a possible extension until 29 October 2019 however as yet this option to extend has not been exercised.

4.2 The national HIV Self sampling service operates a website, WWW.test.hiv where HIV self-sampling kits can be ordered by individuals to be received through the post. During periods of major campaign activity around national HIV Testing week and world AIDS day PHE fund all requests received. During this time there is substantial national promotion coordinated through the It Starts With Me campaign website https://www.startswithme.org.uk/ . Outside of this period kits are only supplied to people where the local authority of residence has contracted for the service. The cost of the service is £2.00 for each kit supplied and £6.00 for each kit processed on return. Current return rates are approximately 63%.

4.3 From the start of the national service in November 2015 until end of September 2018 Tameside residents visited the website 1365 times and 650 kits have been ordered. Tameside have been party to the contract since January 2016 and in that time 487 kits have been ordered with 303 tests being completed at a total cost of £2792. The remaining orders will have been funded by PHE during the free periods of campaign activity. The service has made two positive diagnoses for Tameside residents.

4.4 Public Health England commenced the procurement of a replacement service on 29 October 2018 with the intention of having a new service in place by 1 April 2019. The new service will be broadly the same as the current service with the addition of the provision of kits in bulk for local commissioners to distribute if required. Pricing will not be known until a new contract is awarded.

4.5 Offering a range of opportunities for people to test for HIV is a key component to tackling rates of HIV infection. The GM HIVE project will seek to increase testing rates across Greater Manchester. Early diagnosis of HIV is associated with better outcomes for the individual and less transmission to others.

4.6 Support for continued funding of this service is sought, on the assumption that funding requirements will be similar, so that once details of the replacement service are available a contract can be entered into with the new provider to ensure continuity of service. A contract award can be made based on Officer discretion due to the low financial value.

Options for consideration

Continue to provide funding for the national HIV self-sampling service

4.7 The replacement national service will be procured as a compliant framework by ESPO that is available for Local Authorities to utilise. A waiver to Tameside procurement standing orders is in place allowing the use of frameworks provided by a range of organisations and this includes ESPO.

4.8 The national HIV self-sampling service is promoted nationally and is now established as a national brand with links from a variety of other websites and information points to encourage individuals to test for HIV. The service has proved to be very cost effective and it is expected that the replacement service will continue to be similarly priced. The current framework contract allows for limits on spend to be set and for withdrawal from the contract with minimal notice period. The expectation is that this will feature in any replacement contract.

Cease participation in the contract.

4.8 Ceasing this contract would have an impact upon our ability to control the spread of HIV and to improve our late diagnosis rate. There are a range of other opportunities for Tameside residents to test including at the Sexual Health Service, General Practice and Point Of Care Testing events held by the PaSH partnership. However, the national service has an additional level of visibility and local participation capitalises on the national investment. The GM strategic approach and the HIVe project seek to increase opportunities for testing and the number of tests; ceasing this service would potentially reduce the number of tests by Tameside residents by approximately 150 tests a year.

Recommendation

4.9 That, subject to a requirement for similar funding level of approximately £2,000 per annum, participation is continued in the national HIV screening programme from 1 April 2019.

5. EMERGENCY HORMONAL CONTRACEPTION (EHC)

5.1 Emergency Hormonal Contraception is provided by a range of local Pharmacies as a Locally Commissioned Service. The number of pharmacies providing and the value of claims has increased in the last year since provision has been monitored electronically via the web based Neo system alongside all the CCG commissioned pharmacy services. The service has traditionally been available for delivery by any qualifying pharmacy and by pharmacist qualified to deliver the service. The greater visibility of the service via NEO has prompted more pharmacists to complete the training and commence delivery.

5.2 The service is delivered under a Patient Group Direction (PGD) to enable Pharmacists to supply or administer medication without a prescription.

5.3 The current Pharmacy contract is for the supply of Levonorgestrel only. We pay £10 for consultation and £6 for the prescription/supply. There are some consultations without prescriptions and some double prescriptions where clinically indicated. Pharmacies can sell EHC privately and EHC is also available via general Practice and the Sexual Health Service.

5.4 Current pharmacy annual spend on EHC is running at £21732 which would be approximately 1360 prescriptions. This has increased over the last couple of years as additional pharmacies have started to provide.

5.5 Ulipristral (EllaOne) is a newer brand of emergency contraceptive pill that has until now not been commissioned from Pharmacies in Tameside. It must be taken within 120 hours (5 days) of having unprotected sex. Like all methods of emergency contraception it is most effective if it is taken soon after sex. If the pill is taken with 24 hours it will prevent 98% of pregnancies.

5.6 Ulipristral is more effective than Levonorgestrel particularly after 24 hours and can be used in the period between 72 and 120 hours when Levonorgestrel cannot be used. The table below details the effectiveness of Ulipristral versus Levonorgestrel.

	Levonorgestrel	Ulipristral
First 24hrs	95% effective	98% effective
Up to 48hrs	85% effective	98% effective
Up to 72hrs	58% effective	98% effective
Up to 120hrs	*Wouldn't have been supplied	98% effective

5.7 Given the greater effectiveness, and the extended timescales, provision of Ulipristral as an alternative to Levonorgestrel would have much better outcomes and impact for both the individuals and the local health and social care economy.

- more clinically effective
- Reduction in unplanned pregnancy
- Reduction in number of termination of pregnancies
- reduction in women attending General Practice and the Sexual Health clinic for prescription of Ulipristral or copper coil where they have been informed by pharmacy that it is too late for Levonorgestrel to be effective.

5.8 Modelling by Trafford, who have implemented pharmacy provision of Ulipristral, suggests that 32% of pharmacy EHC provision is Ulipristral. Within General Practice in Tameside and Glossop 23% of EHC prescription is Ulipristral. This would indicate that approximately 440 prescriptions per annum could move from Levonorgestrel to Ulipristral if we implemented the provision of Ulipristral after the first 24 hours following UPSI in our pharmacy EHC service.

5.9 The numbers of abortions for women living in Tameside has been rising since 2014. There were 978 abortions performed for Tameside in 2017 and increase of 3%. The rate of abortions per 1000 women aged 15-44 in Tameside has risen from 19.2 in 2014 to 22.6 in 2017, the Tameside and Glossop abortion rate is 21.6 the second highest CCG rate in GM and compares to England rate of 17.2. Investment in the provision of Ulipristral should have a positive effect on the budget for abortions.

5.10 An updated PGD for the supply of Ulipristral for emergency hormonal contraception has been approved. This can be easily implemented with existing Pharmacy providers of the EHC service.

5.11 In order to support the training of pharmacies the Centre for Pharmacy Postgraduate Education is able to run a local training session for up to 40 delegates.

5.12 **Cost implications - Emergency Hormonal Contraception**

- The cost of Ulipristral (Ellaone) is £14.05.
- We are currently paying £6 per dose of Levonorgestrel.
- Using the prescribing patterns experienced by Trafford there would be an increase in costs of approximately £3,500 per annum.
- Savings should be seen in a reduction in the number of abortions and reduction in General Practice activity.

Recommendation – Emergency Hormonal Contraception

5.13 It is recommended that the provision of Ulipristral by pharmacies in Tameside is implemented from 1 April 2019

6. PROCUREMENT STANDING ORDER SEEKING TO WAIVE / AUTHORISATION TO PROCEED

6.1 Authorisation for continued allocation of funding is required to

- enable us to give Manchester authority to extend the contract with RuClear for the provision of chlamydia screening;
- change the model of delivery of chlamydia screening via General Practice;
- enable us to continue participation in the GM Sexual Health Improvement Programme (PaSH);

- authorise continued participation in the National HIV Screening Programme;
- implement the provision of Ulipristral Emergency Hormonal Contraception by Pharmacies.

7. FINANCIAL SUMMARY

7.1 The recommendations detailed can all be achieved within current budget allocations and should have a positive impact on other budgets such as Abortion costs.

8. GROUNDS UPON WHICH WAIVER/AUTHORISATION TO PROCEED SOUGHT

8.1 The Contract with Manchester FT for the RuClear chlamydia screening programme was competitively tendered by Manchester and has been extended within the original terms of the procurement and contract. The contract is subject to contract and performance monitoring and performance is scrutinised by a GM commissioners group.

8.2 The contract with BHA for Equality for the PASH service was competitively tendered by Salford and has been extended within the original terms of the procurement and contract. The contract is subject to contract and performance monitoring and performance is scrutinised by a GM commissioners group.

8.3 The National HIV Screening Programme is currently being procured as a framework by ESPO and a waiver is in place to utilise frameworks published by ESPO.

8.4 Contracts are in place with General Practice and Pharmacies for the provision of Locally Commissioned Services. All sexual health services provided within primary care settings are available for delivery by all qualified practitioners subject to proof of training and accreditation where required.

8.5 Clinical oversight for sexual and reproductive health in Tameside is provided by Dr Jane Harvey. Dr Harvey has reviewed the clinical aspects of the proposals within this report and supports the recommendations made.

9. REASONS WHY USUAL REQUIREMENTS OF PROCUREMENT STANDING ORDERS NEED NOT BE COMPLIED WITH BUT BEST VALUE AND PROBITY STILL ACHIEVED:

9.1 The provision of open access services for Sexually Transmitted Infections and Contraception is a statutory duty under the Health and Social Care Act 2012.

9.2 Sexual health and contraception are health inequality issues with consequences that are serious and long-lasting. Failure to prevent or treat sexual ill health or to provide adequate contraception generates avoidable cost and demand across the health and social care system.

9.3 Effective sexual and reproductive health services reduce costs from a range of areas including:

- Health costs – including unintended pregnancies, abortion services and STI treatment, and additional costs for treating complications arising from undiagnosed STI infections.
- Other public sector costs – including children born from unintended pregnancies, social welfare expenditure (such as family tax credits), personal social services (such as interventions for those experiencing neglect or abuse), housing and education (GM Sexual Health Strategy 2018).

9.4 Services that promote good sexual health, test for and treat STIs and prove access to condoms all contribute to reducing the number of diagnoses of STIs and HIV. NICE health economic modelling estimated the costs of treating each episode of STIs, HIV and PID complications, as follows:

- £121.92 for chlamydia;
- £206.17 for gonorrhoea;
- £210.59 for syphilis;
- Treating 1 episode of pelvic inflammatory disease at £3,124;
- On average, it costs £13,900 a year to treat a case of HIV
  (GM Sexual Health Strategy 2018)

9.5 In addition to the benefits to the individual and the community of being sexual healthy, there are economic benefits. The Department of Health's *Framework for Sexual Health Improvement in England* concludes that there is an £11 saving for every £1 spent on contraception.

10. RECOMMENDATIONS

10.1 As set out at the front of the report.

APPENDIX ONE

General Practice neighbourhood offer for Chlamydia screening and condom distribution

Service Outline

- Each participating practice will be provided with a number of chlamydia home screening kits for issue to eligible young people.
- They will also be provided with promotional material - posters, information leaflets and other resources to include information on contraception.
- Borough wide promotion will advertise the availability of home test kits at general practice and other services will signpost young people to them.
- Practices will be expected to issue kits on demand to any eligible young people requesting them regardless of whether they are registered patients or not.
- Practices will be expected to promote the service opportunistically to their eligible registered patients.
- Kits may be taken away by the young person or be completed in the Surgery and returned to reception for return to RuClear.
- Any Practice issuing less than 6 kits per year will not be paid for the service and the service may be withdrawn.
- Each participating practice will also be issued with a supply of condoms for supply to young people. Supply of condoms to be independent of the supply of chlamydia screening kits.
- Condoms will be made available to practices via meetings such as the practice manager's forum and neighbourhood meetings.

Participating practices to be paid £5 for each kit distributed and returned where operating individually or alternatively where providing a neighbourhood service with fewer General Practices participating a single annual payment of £200 per participating practice.

APPENDIX TWO

GM HIVE briefing

HIVE - Ending new transmission of HIV across Greater Manchester within a generation

What are we aiming for?

We aim to reduce transmission of HIV in Greater Manchester and, ultimately, end new transmissions of HIV within twenty five years. HIVE has £1.3m funding from the GMHSCP to deliver the first phase, and is being led by the GM Sexual Health Network and a steering group of community representatives, third sector partners, clinicians, General Practice and Local Authority Commissioners.

Where are we starting from?

- Over 5,600 people living with HIV in Greater Manchester[1]
- Around 745 people in Greater Manchester unaware they are infected[2]
- Almost 300 new cases diagnosed every year[3]
- Higher than national average rates of infections[4], new diagnoses and late diagnoses[5].
- Manchester has more than double the national average number of infections, and Salford almost double[6].
- 44% of new cases classified as 'late diagnoses' when successful treatment is most costly and least likely to be successful[7]
- Risk of onward transmission: an estimated 13% of cases remain undiagnosed and therefore untreated and are at risk of transmitting the infection on.
- Prompt diagnosis: the evidence is clear that early diagnosis has long term health benefits and allows for cost effective management of HIV as a long term condition.
- Effects of late diagnosis: HIV symptoms are frequently subtle until the latter stages of the illness, resulting in a later diagnosis which impacts on both the individual and society:
- The health of the individual – late diagnosis is linked to poorer patient outcomes.
- The health of the population – later diagnosis results in an increased risk of onward transmission of HIV.
- Effect on the public purse: the lifetime cost of HIV is estimated to be £360,000. Compared to early diagnosis, late diagnosis is believed to increase the cost of treatment by 100% in the first year after diagnosis, and 50% in subsequent years.

How will we get there?

By working closely with communities most affected to substantially increase:

- uptake of testing – to pick up infection early, when management is easier and more effective both clinically and cost effectively

[1] 4,906 diagnosed and 745 undiagnosed, based on 2016 data
[2] Based on 2016 PHE estimates of 13% of people in England and Wales excluding London
[3] 296 new cases diagnosed earlier
[4] 2.93 per 1000 15-59 year olds; compared to England average 2.31. (PHE England data 2016)
[5] 12.9 per 100,000 over 15s
[6] 6.45 per 1000 in Manchester; 4.23 per 1000 in Salford. (PHE England data 2016)
[7] 2016 data

- awareness and uptake of prevention including PrEP – to reduce the risk of people acquiring HIV
- access to timely and effective treatment – increasing the number of people who have an undetectable viral load and levels of virus that are untransmittable (U=U)

How are we progressing?

- Our overall vision is set out in our Population Health Plan, published January 2017
- Signed up to the Fast Track City global partnership[8] and goals[9] in Autumn 2018
- Delivery of the first phase of activity is due to begin in Spring 2019
- We aim to realise our vision by 2043

[8] http://www.fast-trackcities.org/about

[9] 1. Attain 90-90-90 targets
Ensure that at least 90% of PLHIV know their status
Improve access to ART for PLHIV to 90%
Increase to 90% the proportion of PLHIV on ART with undetectable viral load
2. Increase utilization of combination HIV prevention services
3. Reduce to zero the negative impact of stigma and discrimination
4. Establish a common, web-based platform to allow for real-time monitoring of progress

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	23 January 2019
Reporting Member /Officer of Strategic Commissioning Board	Councillor Brenda Warrington – Executive Leader Stephanie Butterworth – Director of Adults
Subject:	**ALLOCATION OF £1.154 MILLION ASC WINTER PLANS FUNDING FOR 2018-19**
Report Summary:	This report provides a set of high level proposals that will address some of the unmet social care need in the system, and will transform a number of existing services. Many of the proposals will offer improvements to the whole system and will increase options and improve outcomes to people who access services.
Recommendations:	The Strategic Commissioning Board is recommended to approve the proposals detailed in section 2 of the report and delegate authorisation to the Director Of Adult Social Care, following discussions with the Director of Operations, Integrated Care Foundation Trust, to manage the unallocated balance of £0.315 million (as stated in **Appendix 1**) in accordance with the conditions of the funding which is awarded to 31 March 2019.

Financial Implications:

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

Integrated Commissioning Fund Section	Section 75
Decision Required By	Strategic Commissioning Board
Organisation and Directorate	Tameside MBC – Adult Services
Budget Allocation 2018/19	£1.154 million (non-recurrent)

Additional Comments

Section 2 of the report provides details of a number of proposals that will be funded via the Council's allocation of £1.154 million from the recently announced Adult Social Care winter funding (national allocation of £240 million).

It is essential that the initiatives satisfy the conditions of the funding awarded and are implemented on a non recurrent basis as the allocation is awarded for the 2018/19 financial year only.

It is also recommended that the programme of proposed initiatives is appropriately evaluated to ensure it has addressed the primary aim of the funding award. This being to reduce pressures on the NHS by getting patients home quicker and freeing up hospital beds across England.

Members should acknowledge that the plans within the report have been identified to ensure there is an impact on the locality health and social care system. These should ensure that people are supported to remain at home and reduce the number of hospital attendances. In addition that people who have required a stay in hospital have a supported, timely and safe discharge.

Legal Implications: (Authorised by the Borough Solicitor)	The rationale for the additional monies is so that Councils have more available to help ease winter pressures on the NHS and to use it to get people who don't need to be in hospital, but do need care, back home, back into their communities. The aim is that this will in turn free up hospital beds so that people who need to be in hospital get the hospital care they need. Members should be satisfied therefore that the proposals set out in this report will meet this expectation, and if there is a challenge as to how the monies are allocated there is evidence of a direct link back in support. The balance still not allocated should likewise be spent within the timeframe, i.e. by 31 March 2019, and outcomes of all allocations recorded where possible. It may be that the Department of Health, and others, will want to see a corresponding reduction in the number of beds traditionally blocked by patients no longer needing to stay, but unable to return home because of their environment created by the winter, and so the ability to measure this should be developed and readily accessible.
How do proposals align with Health & Wellbeing Strategy?	The proposals align the Developing Well, Living Well programmes for action.
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care; • Locality-based services; • Planned care services.
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'.
Recommendations / views of the Health and Care Advisory Group:	The report has not been presented at the Health and Care Advisory Group.
Public and Patient Implications:	It is anticipated that the investment over the winter impact will have a positive impact on the people who access and use the services that are funded through this money.
Quality Implications:	Through the delivery of this programme of investment it is anticipated that the quality of the response to people who are at risk of being socially isolated and who require support from ASC to determine their care when being discharged from hospital will see an improvement in the quality of the service offer as there will be a more prompt response..
How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside and Safe Tameside.
What are the Equality and Diversity implications?	The proposals will not affect protected characteristic group(s) within the Equality Act.

	The service will be available to Adults regardless of ethnicity, gender, sexual orientation, religious belief, gender reassignment, pregnancy/maternity, marriage/civil and partnership.
What are the safeguarding implications?	There are no anticipated safeguarding issues. Where safeguarding concerns arise as a result of the actions or inactions of the provider and their staff, or concerns are raised by staff members or other professionals or members of the public, the Safeguarding Policy will be followed.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	A privacy impact assessment has not been completed. Services adhere to the Data Protection Act when handling confidential personally identifiable information.
Risk Management:	Close oversight of spend against this non-recurrent funding will be ensured through Adult Management Team and the returns that will be submitted to the Department of Health and Social Care.
Access to Information :	The background papers relating to this report can be inspected by contacting the report writer Sandra Whitehead: Telephone: 0161 342 3414 e-mail: sandra.whitehead@tameside.gov.uk

1. INTRODUCTION

1.1 At the Conservative Party Conference in October 2018 the government announced £240 million for Adult Social Care to support winter pressures for 2018-19. The allocation to Tameside is £1.154 million.

1.2 The Department for Health and Social Care advices that the investment in adult social care this winter will help local authorities reduce pressures on the NHS by getting patients home quicker and freeing up hospital beds across England. '*The extra funding, announced by Secretary of State for Health and Social Care Matt Hancock, is aimed at reducing delayed transfers of care and will be allocated to councils based on the adult social care relative needs formula'*

1.3 This report sets out the high level plans that have been identified to have an impact on the system in terms of supporting people to remain at home, and by doing so to reduce the number of hospital attendances, and where people have had to have a stay in hospital a timely and safe discharge is supported.

1.4 The proposals have been discussed and agreed with the Director of Operations at the Integrated Care Foundation Trust and have also been shared with other service areas as appropriate, for example, the funding to support charities who support the homeless.

1.5 Approaches have also been made to third sector organisations and groups through Action Together to fund local initiatives that will reduce social isolation and thus reduce the chances of people accessing health services inappropriately.

2. SPENDING PROPOSALS

2.1 A number of schemes are proposed that will reduce social isolation, support people to remain living safely at home and to promote a timely and safe discharge from hospital:

2.2 Block booking 10 transitional care home beds – there are occasions where people are delayed in hospital because a bed at their home of choice is not available. Access to beds as an interim placement will support a timely discharge from hospital to a placement until the preferred choice of home is available. These beds will be sourced through an expression of interest exercise – this approach has been discussed and agreed with STAR Procurement.

2.3 In-house homecare service – there are occasions where people go into crisis at home, that may result in a hospital stay if appropriate support is not provided and also there are a number of people delayed in hospital, and some blockages in Reablement, due to the timescales for new packages of home care commencing. The offer of a short term in-house service will provide support to people who may otherwise end up in hospital due to a crisis at home, or be delayed. This service will be offered until the allocated home care provider can commence the care package. This will also include an additional through the night round.

2.4 Payment of 2019-20 fee uplift to care homes brought forward to 1 January 2019 – it is proposed that the 2019-20 fees be paid to care homes from 1 January 2019 with an expectation that care homes work with the health and social care economy to ensure good flow in the system – using the bed state tool, engaging with Digital Health, engaging with the Trusted Assessor model, undertaking prompt assessments and decisions and accepting weekend discharges.

2.5 Trusted Assessor Posts in IUCT – Two posts to be funded to carry out the trusted assessor role. These posts will build relationships with care providers and carry out assessments that

will be accepted by the care providers and as a result reduce the timescales for providers being in a position to accept a placement. Where an individual is in hospital it is estimated that this can reduce length of stay by up to 5 days, thus improving the experience for the individual and also freeing up bed capacity.

2.6 Additional Social Worker Capacity – looking to additional 3 wte posts across the Integrated Urgent Care Team to ensure prompt response to support admissions avoidance and prompt assessment and discharge from hospital. This resource will also support the timely review and closure of Reablement cases to maximise flow and capacity in the system.

2.7 Additional Occupational Therapy/Manual Handling Capacity – increased capacity will support he prompt assessment and reassessment of individuals to support people to remain at home safely and to support timely discharges from hospital.

2.8 Holding payment for beds at homes with high demand and low vacancies – there are a number of homes in the local market that rarely have vacancies, are very popular and beds are often filled with people from other local authorities. It is proposed that where beds become available in homes that rarely have vacancies they are secured financially pending an offer to a Tameside resident. This will prevent longer waits in hospital as people wait for home of choice, and will reduce the impact of placements being made locally by other authorities.

2.9 Projects with the voluntary and community sector – an approach has been made to the voluntary and community sector, through Action Together and Age UK, for schemes, existing and new, that could be upscaled to support the purpose of avoiding social isolation and thus avoiding hospital admission and/or supporting timely discharges. A range of proposals have been submitted that include:

- AGE UK TAMESIDE – Campaign to support older people over the winter months
  - Winter Warmer Packages
  - Storage and Distribution
  - Free Hot Meals
  - Linking with Supermarket Cafes as a venue for free meals
  - Wellbeing calls via volunteers
- ACTION TOGETHER – Expansion of the Miles for Smiles service to support vulnerable people through the provision of transport in inclement weather conditions.
- THE TOGETHER CENTRE @ LOXLEY HOUSE – Provision of free hot meals to local older and vulnerable people followed by a social activity
- BEATRIX HOUSE CAFÉ – Provision of free hot meals to local older people and vulnerable people
- WE SHALL OVERCOME – To provide additional nourishment and emergency survival kits to people who are homeless
- THE SANDWICH ANGELS – To provide sandwich fillers and emergency food provision to vulnerable and homeless people

2.10 Feedback is still awaited from a number of organisations and groups who may be able to mobilise an expanded service or a new offer with the offer of funding. It is requested that these requests are wrapped up and approved within this approval. Oversight of the budget will ensure that there is no overspend of the funding.

3. FINANCIAL OVERSIGHT

3.1 Funding proposals will be monitored via the Adult Services Management Team and Adult Services Transformation Board.

3.2 Regular returns will be required on the utilisation of the funding. Estimated proposal values were submitted in December 2018, with further submissions expected in January and April 2019.

3.3 Details of the proposals with approximate values to date are provided in **Appendix 1**. It should be noted that the final confirmed values may vary, however the total expenditure of all proposals will be within the allocated sum (£1.154 million).

4. CONCLUSION

4.1 The government has allocated £1.154 million to the Council to support the system with winter pressures.

4.2 As the funding is for the period ending 31 March 2019 there is an imperative to allocate the funding promptly and to commence the services/schemes in order to ensure impact during the winter period.

4.3 A set of schemes have been proposed that require approval. It is also expected that other pressures and suggestions will emerge during the next few months and flexibility to use the estimated funding balance of £0.315 million (**per Appendix 1**) would enable a prompt responsive approach to maximising the benefits of the funding awarded.

5. RECOMMENDATION

5.1 As stated on the report cover

APPENDIX 1

Proposal	Directorate Lead	Allocated	Estimate
			£
10x transition beds	Trevor Tench		115,000
Care Home Fee Uplift - In Advance - 1st Jan 2019	Trevor Tench		230,000
2 x Social workers (Grade H for 4 months) – additional capacity in IUCT	Sharon Davies		30,000
Additional Packages of home care - Internal Service	Alison White		170,000
Through the Night Service	Alison White		40,000
Trusted Assessor – staffing capacity at ICFT	Sandra Whitehead		53,745
Reserving Care Home Beds where high demand	Trevor Tench		20,000
Reablement - closure of cases	Sharon Davies		15,000
Manual handling/OT capacity	Carol Abrams		30,000
Support for people with COPD that flares in Winter. And Stamford Unit to support speedier discharge.	Vicki Gee		10,000
Supply Essential Emergency Care Kits to Support at Home Workers to ensure wherever possible visits can continue in extreme weather conditions	Dave Wilson / Trevor Tench		2,260
Digital Health - equipment cost to extend digital health access across all support at home providers	Dave Wilson / Trevor Tench		4,800

Voluntary Sector Support (£ 150,000 allocated in total)

Age UK - Campaign to support older people over the winter months	Trevor Tench		22,176
Sensory - Winter Warmer Package	Vicki Gee / Trevor Tench		2,608
Action Together - Transport - expansion of Miles for Smiles provision	Trevor Tench		11,283
MIND - Funding set aside for people with mental health conditions (hot meal, therapeutic support, welfare)	Vicki Gee - Janine Byron		28,500

"We Shall Overcome" - to provide additional nourishment and emergency survival kits to vulnerable people who are homeless	Trevor Tench		11,312
"*The Sandwich Angels"* - to provide sandwich fillers and emergency food provision to vulnerable and homeless people	Trevor Tench		19,664
"The Together Centre @ Loxley"- provision of free hot meals to local vulnerable people followed by a social activity	Trevor Tench		9,280
"Beatrix House Café" - Provision of free hot meals to local older people and vulnerable people			7,680
"Active Tameside Transport" - Provision of free transport for people from all areas of Tameside to access the meals at the Together Centre and Beatrix House.			5,338
"Ryecroft Hall Community Centre" - Audenshaw - provision of hot meals			700
"Hattersley Forum" - Hattersley Hub - provision of hot meals			TBC
"People First"			TBC

Total	**839,346**
Allocation	**1,154,000**
Balance	**314,654**

Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 23 January 2019

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

Subject: **INTERMEDIATE CARE IMPLEMENTATION UPDATE**

Report Summary:

In 2017-18 Tameside & Glossop Strategic Commission led the development of a locality strategy for Intermediate Care.

In August 2017, the Strategic Commissioning Board (SCB) agreed to consult on 3 options for the delivery of bed based Intermediate Care. Two of the options, one of which was proposed as the preferred option, involved the relocation of intermediate care beds from the Shire Hill site. The 3 options were the subject of public consultation over a 12 week period from 23 August to 15 November 2017.

A report containing the full detail of the consultation analysis, and an Equality Impact Assessment which responded to issues arising during the consultation and explored mitigations, was presented to the SCB in January 2018. On the basis of this report, the SCB approved Option 2, which resulted in the commissioning of the intermediate care beds for Tameside and Glossop into the Stamford Unit, adjacent to Tameside Hospital and part of Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT).

This report provides an update on the implementation of the decisions taken by the SCB in January and May 2018, including details of how the mitigations agreed have been addressed.

Recommendations:

This report is presented to provide an update on progress and assurance that the conditions set out in the report to SCB in May 2018 have been addressed.

Financial Implications:

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

ICF Budget	S 75 £'000	Aligned £'000	In Collab £'000	Total £'000
TMBC Adult Services	-	-	-	-
TMBC Children's Social Care	-	-	-	-
TMBC Population Health	-	-	-	-
TMBC Other Directorate	-	-	-	-
CCG	8,032	0	0	8,032
Total	**8,032**	**0**	**0**	**8,032**
Section 75 - £'000		Proposed recurrent budget of		

Strategic Commissioning Board	£8,032k, plus up to an additional £250k to support the purchase of up to 8 beds at any one time on an individual basis for residents of Glossop. £1,983k of non-recurrent transformation funding from GMHSCP is available to fund transition to the new arrangements.

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

A financial review of this business case is supportive of the implementation of option 2 (as the preferred option presented in the public consultation). £23.2m of transformation funding has been awarded by GM Health and Social Care Partnership to support transformation of health and social care in Tameside and Glossop and £1.983m of this non recurrent money has been earmarked for funding the transition to the new intermediate care arrangements. It is important to recognise that receipt of this funding is subject to the attainment of stretching quality and financial targets which are stringently monitored by the GM Health and Social Care Partnership.

Implementation of this proposal is anticipated to deliver a net recurrent saving to the Tameside and Glossop Locality of at least £436k per annum which will contribute towards the overall economy gap whilst providing a quality and clinically safe service.

However, it is critical that notice is served timely on Shire Hill and a prompt transfer to the new service arrangements aligned to coincide with the term of notice. Failure to do so will result in additional estates costs of circa £50k per month beyond the term of notice and additional staffing/cost pressures and quality risk from having to use agency staffing whilst existing staff finish their notice periods and are redeployed in other areas.

Legal Implications: **(Authorised by the Borough Solicitor)**	As this report is by way of an update to decisions previously made and designed to give assurance that the conditions set out in the report to SCB in May 2018 have been addressed, Members should satisfy themselves that the report adequately describes that this is the case.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	The intermediate care proposals are in line with the locality plan and the Care Together model of care
How do proposals align with the Commissioning Strategy?	The Care Together programme is focused on the transformation of the health and social care economy to improve healthy life expectancy, reduce health inequalities and deliver financial sustainability. This work is a critical part of the programme
Recommendations / views of the Health and Care Advisory Group:	The HCAG (in previous form as PRG) discussed and provided comments on the proposed options for Intermediate Care which were incorporated in the consultation documents and process.

Public and Patient Implications:	This report details the implementation of the new model of Intermediate Care following on from the public consultation and engagement with communities in Tameside & Glossop. Details of the consultation have been presented to SCB along with a full Equality Impact Assessment, and it was this detail which informed the decision taken in January 2018.
Quality Implications:	A Quality Impact Assessment was completed to accompany the report presented in January 2018. Tameside & Glossop ICFT will be required to participate, along with commissioner colleagues, in the annual National Audit of Intermediate Care. The results of this Audit will be presented to the SCB to provide ongoing assurance. The Director of Quality & Safeguarding chairs the Quality & Performance meetings held between the Strategic Commission and T&G ICFT which monitors process and enables commissioners to request specific quality reviews where there are areas of interest. Through these meetings the commissioners will ensure the continued delivery of home based intermediate care to all 5 neighbourhoods in the locality, in line with the National Audit of Intermediate Care 2018 (NAIC) expectations and the NICE quality standards referred to in section 4. The Interim Director of Commissioning recommends that a specific quality review be enacted in 2018-19 to review delivery of the new model for Intermediate Care. As described in the body of the report, safe staffing of intermediate tier services will also be monitored through quality and performance contract meetings to ensure a focus on quality and safety during and after transition.
How do the proposals help to reduce health inequalities?	The proposal will ensure the delivery of intermediate care services which to meet individuals' needs across the locality and addresses health inequalities.
What are the Equality and Diversity implications?	A full Equality Impact Assessment (EIA) was developed to support the report presented to the SCB in January 2018 and can be viewed here: http://www.tamesideandglossopccg.org/corporate/strategic-commissioning-board
What are the safeguarding implications?	The commissioned model will include all required elements of safeguarding legislation, as the provider will be Tameside & Glossop Integrated Care NHS Foundation Trust. The GM Safeguarding Standards are included in the ICFT contract.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	As part of the implementation of this model of care, a data flow mapping exercise will be undertaken to understand what information will be transferred and to where; from that it will be possible to identify the requirements for robust data sharing agreements between the parties sending or receiving the data. The commissioner will seek assurance from all parties involved in the delivery of intermediate care that appropriate arrangements are in place. The locality's Information Governance Working Group will sense check data flows and IG requirements relating to this project.

Risk Management:	This transformation programme will be managed via the Care Together Programme Management Office. The risks will be reported and monitored via this process.
Access to Information :	The background papers relating to this report can be inspected by contacting Jessica Williams, Interim Director of Commissioning:  Telephone: 0161 342 5511  e-mail: jessicawilliams1@nhs.net There are some documents attached to this report as Appendices where referred to specifically and not previously shared. Copies of previous reports presented to the Strategic Commissioning Board, and referred to in this report, can be accessed via the CCG website: https://www.tamesideandglossopccg.org/Corporate/Strategic-Commissioning-Board

1 INTRODUCTION & BACKGROUND

1.1 In 2017-18 Tameside and Glossop Strategic Commission led the development of a locality strategy for Intermediate Care.

1.2 In August 2017, the Strategic Commissioning Board (SCB) agreed to consult on 3 options for the delivery of bed based Intermediate Care. Two of the options, one of which was proposed as the preferred option, involved the relocation of intermediate care beds from the Shire Hill site. The 3 options were the subject of public consultation over a 12 week period from 23rd August to 15 November 2017.

1.3 Due to the richness of evidence arising from the public consultation and in particular from the Glossop neighbourhood, an interim report was presented in December 2017 to inform SCB of the consultation progress and process, initial themes and the next steps to ensure a final report to the SCB January meeting.

1.4 The report presented to the SCB in May 2018 included a review by the Interim Director of Commissioning of the Tameside and Glossop Integrated Care NHS Foundation Trust's (ICFT) response to the Commissioner's expectations, and concluded that the necessary processes and plans were in place to enable the SCB to support the move of the intermediate care beds to the Stamford Unit on the ICFT site, but that the Strategic Commission should review this position, including the annual presentation of the National Audit of Intermediate Care results to the SCB.

1.5 There are some documents attached to this report as Appendices where referred to specifically and not previously shared. Copies of previous reports presented to the Strategic Commissioning Board, and referred to in this report, can be accessed via the CCG website https://www.tamesideandglossopccg.org/Corporate/Strategic-Commissioning-Board

2 STRATEGIC COMMISSIONING BOARD DECISION

2.1 A report containing the full detail of the consultation analysis, and an Equality Impact Assessment which responded to issues arising during the consultation and explored mitigations, was presented to the SCB in January 2018. On the basis of this report, the SCB approved Option 2, which resulted in the commissioning of the intermediate care beds for Tameside and Glossop into the Stamford Unit, adjacent to Tameside Hospital and part of Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT).

2.2 The SCB approved Option 2 with the following mitigations:

- The Glossop Integrated Neighbourhood team are asked to examine further opportunities to deliver enhanced rehabilitation and recuperation at home.
- In light of some Glossop patients possibly requiring intermediate bed based care as close to home as possible to maximise their recovery, the Strategic Commission will engage with local care providers to explore the potential for up to 8 beds for purchase on an individual basis for residents of Glossop, subject to these reaching the commissioner's required standards for quality.
- The Strategic Commission will commission the maximum appropriate health and social service provision from Glossop Primary Care Centre (GPCC).
- To review annually the Intermediate Care home based offer and bed requirement across Tameside and Glossop to ensure future demand is continually assessed and planning for future local provision is adapted accordingly.

2.3 The mitigation regarding the annual review of the intermediate care offer is the reason that this report is being presented to the SCB in January 2019 – 12 months after the initial decision was taken.

2.4 An interim report was presented to the February meeting of the SCB, including a letter from the Clinical Chair and Chief Executive of the CCG, which set out expectations with regard to assurance on the progress of mitigations required before implementing the new model and moving the bed based care from Shire Hill to the Stamford Unit. This letter was shared with the SCB report in May 2018 and includes the following:

- The development of a clear, documented process which the ICFT will follow to identify patients requiring support from an intermediate care bed in the Glossop neighbourhood. This will need to include how patients are identified, what information they receive with regard to their choice of inpatient intermediate care offer, how it will be agreed that their period of 'discharge to assess' in the Stamford Unit will conclude and the move to Intermediate Care take place and how this will be organised in conjunction with the patient, their carers, their GP, Glossop Integrated Neighbourhood team including Derbyshire County Council

- A view that the ICFT will wish to lead the commissioning of these Intermediate Care beds in Glossop and will be able to do so within the financial envelope already provided for Intermediate Care, as included in the January SCB report

- Strategic Commissioners will require assurance through our Contract, Quality and Performance meetings regarding delivery of the 4 elements of intermediate care throughout Tameside and Glossop, as set out in the National Audit of Intermediate Care and the basis for our new model of Intermediate Care.

- In regards to Glossop specifically, commissioners believed it would be important to communicate effectively and assure the local population on the delivery of Glossop Integrated Neighbourhood services as set out in the paper considered by the Strategic Commissioning Board and seek to agree with the ICFT how this can be done optimally.

- Commissioners have long accepted that the Glossop Primary Care Centre is under-utilised in terms of capacity and range of services offered and would like to work with the ICFT to facilitate the development and/or transfer of additional health services to the Glossop Primary Care Centre with the ambition of an 80% occupancy rate (a good standard usage for public sector buildings) and increased service provision.

3 IMPLEMENTING THE NEW OFFER

3.1 The report presented to the Strategic Commissioning Board in May 2018 included extensive detail on the process towards the move of intermediate care beds from the Shire Hill site to the Stamford Unit. This section of the report provides an update on progress and confirmation of the current position with regard to the delivery of Intermediate Care to the registered population of Tameside and Glossop.

3.2 Following the approval of Strategic Commissioning Board in May 2018 the ICFT commenced the transfer of bed based intermediate care services from Shire Hill to the Stamford Unit in June 2018. The Shire Hill site was vacant from 16 June 2018.

Project Management

3.3 In order to ensure that all actions and mitigations outlined in the letter to the Chief Executive of February 2018 were met, the ICFT established a dedicated Intermediate Care project

group led by the Chief Nurse and Director of Human Resources which reported into the Trust Executive Management Group.

3.4 Senior leads were identified and sub-groups established to progress these key actions prior to the relocation of services. These leads reported progress into the Intermediate Care workstream at a weekly meeting.

3.5 The Commissioner expectation was that this group would ensure there were clear criteria and referral mechanisms for patients to opt to receive bed-based care from the Glossop neighbourhood based option for bed-based intermediate care, as described in the section below.

3.6 These initial project management arrangements have become part of business as usual. Oversight of the clinical and operational functionality of the Stamford unit (including provision of intermediate care) is maintained via existing Divisional and Trust governance arrangements, including regular meetings focused on patient quality and experience.

Process for identification and referral of patients to intermediate care

3.7 A key principle of the intermediate care model is that wherever it is possible a person should have their care requirements met within their own place of residence and that the system will be responsive to meeting this need in a timely manner. The ICFT has implemented the "Home First" service model, which responds to meet an urgent/crisis health and/or social care need for patients.

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

3.9 The ICFT has a well-established and documented process for referring patients into intermediate care services from acute care to facilitate discharge and a referral document for step up from community to avoid an admission. This includes patient information on choice of inpatient intermediate care offer through the ticket home initiative for patients being discharged into intermediate care services from the acute setting or stepping up from the community. This documentation supports discussions with patients, carers and social care services on discharge planning and choice of services (available via May 2018 SCB report as referenced in section 1 of this report).

3.10 The plan for the relocation of bed based intermediate care from Shire Hill was to transfer the existing clinical model and staffing to Stamford Unit onto one 32 bedded floor. This was in response to the preferences indicated by the staff during consultation to relocate as a complete unit and to allow them to become familiarised with the unit and other services being provided from the flexible community bed base and understand the patient requirements. This plan was enacted on 16 June 2018.

3.11 The ICFT established a project group to develop a revised clinical model for the whole unit and agree policies and procedures for the new state. This included the process for identifying and referring patients into the specific Glossop bed based intermediate care. The operational policy was shared and agreed with commissioners at the time of development.

3.12 The intention outlined in the reports presented to SCB in January and May was that for patients stepping up into intermediate care services (home and bed-based) the referral could come from a range of individuals: GPs, neighbourhood teams, community services and the patient or carer. This would be facilitated by the Integrated Urgent Care Team (IUCT) who

are the team responsible for delivering the home first service model for both crisis response and home based intermediate care services. This pathway currently only happens from the Emergency Department (ED) to the Stamford Unit, but the ICFT are currently reviewing how this referral could be initiated by GPs. The main consideration has been the medical cover arrangements to ensure patient safety upon admission.

Commissioning of Intermediate Care Beds in Glossop

3.13 Whilst the clear recommendation was that the provision of all bed based intermediate care services should be from the Stamford Unit on the hospital site, the concerns voiced during the public consultation regarding provision for people living in Glossop were noted. As a result the May SCB report stated that there should be a process to commission and provide additional bed based intermediate care provision in Glossop for patients requesting to be close to their families/carers. This would be led by Tameside and Glossop ICFT.

3.14 The offer would be based on the principals of bed based intermediate care with additional nursing and therapy input delivered by community services within the IUCT and intermediate tier of the ICFT and be supported and supplemented by the staff and resources in the neighbourhood team including Derbyshire Social care services.

3.15 The use of telehealth solutions would be possible, to introduce individuals to the technology, its benefits and so that they are familiar with how to use it on discharge.

3.16 To date, when intermediate care is confirmed as the most appropriate pathway patients have been offered such beds in Glossop but none have requested or accepted the offer. It will continue to be offered for all relevant patients in order to offer care closer to home in line with patient or carer needs.

Delivery of all levels of Intermediate Care

3.17 The National Audit of Intermediate Care (NAIC) uses 4 categories for intermediate care: crisis response, home based rehabilitation, bed based intermediate care and re-ablement. This section of the report outlines the NAIC definitions and the ICFT's statements regarding delivery of intermediate care across all 4 categories.

3.18 Crisis Response:

Setting	Aim
Community based services provided to service users in their own home / care home	Assessment and short term interventions to avoid hospital admission

3.19 (NICE definition) - Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions. Crisis response usually involves an assessment, and may provide short-term interventions (usually up to 48 hours). Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals.

3.20 The urgent element of the Intermediate Care model for Tameside and Glossop provided through the Integrated Urgent Care Team (IUCT). IUCT is a joint service provided by the ICFT and Tameside MBC, which is made up of health and social care services for Tameside patients and healthcare services for Glossop patients (with interface with Derbyshire County Council social care services). IUCT provide the urgent response to the crisis health and/or social care need for patients. The IUCT ensures patients are supported through the most appropriate pathway into and out of acute hospital or care services with "home" always being the goal.

3.21 Home Based Rehabilitation:

Setting	Aim
Community based services provided to service users in their own home / care home	Intermediate care assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living

3.22 (NICE definition) - Community-based services that provide assessment and interventions to people in their own home or a care home. These services aim to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

3.23 A range of services come together to provide home based intermediate care services for Tameside and Glossop, these include IUCT, community and specialist intermediate care services (and new services being implemented as part of the Integrated Neighbourhoods). These are provided in the community setting to deliver the home based intermediate care offer to patients in their place of residence (whether that is at home or in a care home). Under the Home First model, the IUCT team aim to support patients to receive home based Intermediate care whenever possible and appropriate to the person's rehabilitation goals.

3.24 Following the crisis response IUCT provides on-going nursing and therapy care for up to six weeks until individuals are suitably rehabilitated for the community therapy and district nursing teams to take over ongoing care or the person no longer needs these services. The social care element of IUCT provide crisis response wrap around support for up to 72 hours, at which time, if the individual has not regained independence they would be referred to the Reablement Service. Reablement will be offered to an individual up to 6 weeks, though this could be a much shorter time, to support the individual to regain skills and confidence. Following this period of care a social worker will review the support package and if longer term support is required the social worker will commission a package of care and the neighbourhood teams would then take over ongoing care management.

3.25 Alongside this the intermediate tier services provide short term intensive interventions to patients who require higher intensity or more specialist intermediate care than is available within the Neighbourhood services. These services include District Nursing, therapy services such as Speech and Language therapy and Community Neuro-Rehabilitation and community IV therapy services.

3.26 Bed Based Intermediate Care:

Setting	Aim
Service is provided within an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, Independent sector facility, Local Authority facility or other bed based setting	Prevention of unnecessary acute hospital admissions and premature admissions to long term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital

3.27 (NICE definition) Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care facility, independent sector facility, local authority facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge

from hospital. For most people, interventions last up to 6 weeks. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

3.28 In line with the outcome of the consultation, bed based intermediate care for the population of Tameside and Glossop is now being delivered from the Stamford Unit on the Tameside Hospital site. A process for offering Glossop residents bed based care in the Glossop neighbourhood has been developed and is described above.

3.29 Re-ablement:

Setting	Aim
Community based services provided to service users in their own home / care home	Helping people recover skills and confidence to live at home, maximising their level of independence so that their need for ongoing homecare support can be appropriately minimised

3.30 (NICE definition) Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.

3.31 Reablement services are provided in Tameside and Glossop by Tameside Metropolitan Borough Council (TMBC) Adult Social Care, and for Glossop, by Derbyshire County Council.

Glossop Integrated Neighbourhood Services

3.32 The report presented to the SCB in January 2018 included details of services available to the Glossop neighbourhood.

Communication

3.33 The report presented to the SCB in May stated that through the Intermediate Care programme work stream, a full public and staff communication plan would be developed to ensure that staff and the local population were fully engaged in relocation plans. This would be finalised and enacted once the relocation date was confirmed. Below are updates from Tameside and Glossop ICFT on how this was enacted.

3.34 Patient information and a communication plan for patients and carers who are resident in Shire Hill in the lead up to the relocation which will include individualised patient information and discussions with patients on discharge and rehabilitation planning.

Update from Tameside and Glossop ICFT: 6 patients were moved from Shire Hill following a phased reduction in referrals to the unit. Those 6 patients had an individualised plan including family discussions facilitated by Integrated Urgent Care team. These discussions happened with the individuals who were transferring to Stamford Unit AND individuals who were being discharged in the week leading up to the move. A sample of the individual letter to patients and visitors is attached at **Appendix 1**. This is the initial letter. The planning process included very detailed discussions with the families and individuals about the move.

3.35 Public and stakeholder communication materials which will include, visual communication materials to be distributed to community estate, use of existing stakeholder communication channels (such as GP newsletters, target meetings, neighbourhood forums), communication information to be presented at existing neighbourhood led patient and public forums and use of social media platforms.

Update from Tameside and Glossop ICFT: Stakeholder communication was in the form of individualised letters. **Appendix 2** includes the letters which were specifically distributed to

as many local and regional stakeholders regarding the relocation. Letter one was distributed widely to local organisations who are not directly involved in patient care at Shire Hill but would have an interest in the information, the second letter is for stakeholders who are directly involved in patient care Information was included in the ICFT GP Newsletter, and posters were displayed in the Stamford Unit (**Appendix 3**).

Public communication was managed through the ICFT's social media page and 'latest news' section of the ICFT website.

3.36 Staff updates for all staff across the ICFT including Shire Hill, Stamford Unit, and Community and Neighbourhood team. As well as dedicated staff updates on the relocation, the ICFT used existing methods to communicate with the wider ICFT staff group including the weekly staff newsletter from the Chief Executive, the executive led open house forum and the dedicated staff social media channels.

Update from Tameside and Glossop ICFT: A specific consultation document for Shire Hill staff was prepared and all staff directly involved in the relocation had group consultation meetings and all were offered individual meetings. Updates were provided in the staff newsletter from the Chief Executive & through the staff social media page. Additionally staff in the Stamford Unit received localised briefings to update them on plans.

3.37 The ICFT stated that they would arrange a staff celebratory event to recognise the contribution of Shire Hill and the dedication of the teams.

Update from Tameside and Glossop ICFT: Photographs were taken of the Shire Hill teams and the site on the final week of the service being open (an example attached) and local press were invited. The ICFT held an afternoon tea celebration in the Stamford Unit to welcome the new team and thank them for their contribution.

Glossop Primary Care Centre Utilisation

3.38 The Strategic Commissioning Board requested assurance on progress towards an 80% occupancy rate and increased service provision from Glossop Primary Care Centre. The Health & Social Care estates team have confirmed that the utilisation of Glossop PCC has improved following the move of intermediate care services to the Stamford Unit.

3.39 Funding has been secured to give each locality in Greater Manchester a set of occupancy sensors to enable assessment of accurate utilisation; once these have been delivered with the appropriate training the ICFT shall be in a position to carry out a full assessment of utilisation and confirm a precise percentage figure.

Staffing Implications

3.40 The staff members directly affected by the proposals for bed-based intermediate care were briefed throughout the consultation process by the senior management team of the ICFT, and were involved in the public meetings held during the consultation period. Their views were incorporated in the consultation feedback included in the January SCB report.

3.41 The ICFT as the employing organisation of staff directly involved in the delivery of the existing bed based intermediate care services, have ensured the required staff engagement and consultation processes have been undertaken following confirmation of the Strategic Commissioning Board's decision.

3.42 The consultation process for the relocation of staff commenced in February 2018. All staff based at Shire Hill have been offered a 1:1 meeting and offered the opportunity to relocate to the Stamford Unit, or to be considered for redeployment opportunities within the Community setting; if travel to the acute site would be difficult. The one to one meetings have been successful, with most staff either confirming their transfer to the Stamford Unit and others being actively considered for redeployment opportunities. A number of staff have been

successful in obtaining redeployment opportunities within the organisation in community services.

3.43 A recruitment event was held to recruit to vacant posts and the Trust believes that there was sufficient staffing transferring to the Stamford Unit or commencing in post to ensure that the intermediate care beds can be safely staffed. Currently there are enough staff to support the existing Intermediate care beds at Shire Hill.

3.44 The report presented to the May meeting of the SCB stated that safe staffing of intermediate tier services would be monitored through quality and performance contract meetings between the Strategic Commission and Tameside and Glossop ICFT to ensure a focus on quality and safety during and after transition. Staffing levels continue to be monitored through divisional and corporate fora to ensure safety on the unit.

Financial Implications

3.45 The January SCB report included a proposal for a recurrent budget of £8,032k, plus up to an additional £250k to support the purchase of up to 8 beds at any one time on an appropriate individual basis for residents of Glossop. The report also stated that £1,983k of non-recurrent transformation funding from Greater Manchester Health and Social Care Partnership is available to fund transition to the new arrangements. With the additional (up to) £250k to support the beds in Glossop, this still represents a financial efficiency to the locality.

Estates Implications

3.46 The report to SCB in January 2018 stated that the decision of the Strategic Commissioning Board would be communicated to the ICFT who would then take any necessary action with regard to their estate and current contracts / arrangements.

3.47 Shire Hill is owned by NHS Property Services (NHSPS), a limited company owned by the Department of Health. The report presented to the SCB in January 2018 stated that if a decision was made to transfer services out of Shire Hill and dispose of the site, notice would need to be served to NHSPS and rental payments would stop at the end of the notice period. In line with the SCB decision, the Strategic Commission facilitated the final disposal of the estate, following a formal 'Commissioners Hand Back Process'.

3.48 The reports presented to SCB in January and May 2018 stated that at the end of this period the NHSPS would control the site and it will be for them to determine the future of the estate. Any capital receipts which result from a hypothetical sale of the site would accrue to NHSPS. As the asset is not owned within the local economy, there would be no financial benefit to either the ICFT or the strategic commissioner. The Strategic Commission estates team have confirmed that this is the position in December 2019 and that the disposals process is currently being undertaken by NHSPS. The Strategic Commission and Tameside and Glossop ICFT no longer have any association with the Shire Hill site.

3.49 The Strategic Commission estates team continue to work with colleagues in the Glossop neighbourhood and Derbyshire County Council on future options for developments in the neighbourhood.

Legal Implications

3.47 The May Report noted that in order to achieve a seamless and cost efficient transition to the new service arrangements the timelines with current contracts/arrangements and notice of termination by the Integrated Care Foundation Trust of the lease in relation to Shire Hill owned by NHS Property Services Ltd should be synchronised. The information relating to the estates implications set out in sections 3.46-3.48 outline the approach taken in relation to the termination of lease agreements.

3.48 Management of staffing will be key to the safety of patients and service users are not compromised in any way, as again this is an area with the potential for costly complaints and claims. This will be monitored via the contract and performance management arrangements between the commissioner and the ICFT.

3.49 In order to demonstrate quality standards current and future NICE guidance should be followed, built into contracts and reflected in contractual documentation particularly since there is currently a consultation exercise requiring consideration. Sections 3.51 and 3.52 below state that the NICE guidance is included in the Contract Variation between the commissioner and Tameside and Glossop ICFT.

3.50 Likewise the National Audit of Intermediate Care 2018 expects compliance with statutory and mandatory requirements for Clinical Audit and so contractual and monitoring arrangements, processes and procedures will need to reflect the same if the service is to demonstrate excellence, that it is fit for purpose and provides value for money in the four categories of crisis response, home based rehabilitation, bed based intermediate care and reablement. This will be addressed through the joint working between the commissioner and Tameside and Glossop ICFT as outlined in section 4.4 of this report.

Service Improvements and Outcome Measures

3.51 In the May report to the SCB it was confirmed that the Strategic Commission would ensure that the outcome of the consultation would result in the development of clear outcome measures in the contract with the ICFT, to enable the monitoring of the quality of intermediate care services in Tameside and Glossop. A Contract Variation has been produced and agreed between the commissioner and the ICFT to reflect this position.

3.52 NICE issued new guidance in September 2017 on **NG74:** ***Intermediate care including re-ablement*** and are currently consulting on the development of Quality Standards. This guidance has been included in the Contract Variation referred to in the section above.[1]

3.53 Tameside and Glossop ICFT provided the Strategic Commission with detailed assurance on the continued development and delivery of intermediate tier services, including intermediate care, at a Quality & Performance contract meeting in December 2018.

3.54 The Strategic Commission and Tameside and Glossop ICFT, with other partner organisations, will continue to work together to ensure ongoing review of options for the delivery of intermediate tier and intermediate care services for the population of the locality.

4 NATIONAL AUDIT OF INTERMEDIATE CARE (NAIC) 2018

4.1 The NAIC measures intermediate care service provision and performance against standards derived from government guidance and from evidence based best practice. The audit provides national comparative data for bed and home based intermediate care and re-ablement services provided by a range of health and social care providers including acute trusts, community service providers and Local Authorities.

4.2 In the report presented to the Strategic Commissioning Board in May 2018 it was stated that is was the commissioner expectation that the commissioner (Tameside & Glossop CCG) and provider organisations (Tameside & Glossop ICFT, Tameside MBC, Derbyshire CC) would participate in the 2018 National Audit of Intermediate Care to support the ongoing review and analysis of the Intermediate Care system in Tameside and Glossop.

[1] https://www.nice.org.uk/guidance/ng74 ; https://www.nice.org.uk/guidance/GID-QS10059/documents/draft-quality-standard

4.3 The Commissioner bespoke report was released by NHS Benchmarking on 14 November 2018. The report details the position of Tameside & Glossop as a commissioner against the national position. Key points from this audit are:

- Tameside and Glossop investment in Intermediate Care services for the period of the audit was £4.74m (range nationally £0.30m-£5.93m Mean £2.50m). All financial figures quoted in the report are per 100k registered population, therefore enabling comparison to other localities.

- Home based intermediate care spend per 100k registered population for Tameside and Glossop was £1.07m (range nationally £0.05m-£2.78m Mean £0.90m)

- Investment per 100k registered population in bed based intermediate care services in Tameside and Glossop is £2.87m (range nationally £0.10m-£3.46m Mean £1.21m).

- Reablement service spend in Tameside and Glossop is £0.80m (range nationally £0.09m-£1.61m Mean £0.67m).

- At 34, the number of intermediate care beds commissioned per 100k registered population in Tameside and Glossop exceeds the England mean value of 22.

- Tameside and Glossop investment in each of the 4 levels of intermediate care services exceeds the England averages, as indicated in the charts on pages 23 and 24.

- The balance of activity and spend across home (including crisis), bed and reablement services shows that when compared to the England mean we have a greater proportion of investment in bed based services (61% against an England mean of 44%) than home based services (23% against an England mean of 31%). Tameside and Glossop also has a lower proportion of investment in reablement (17% against an England mean of 25%).

4.4 The Strategic Commission and Tameside and Glossop ICFT will establish clear processes for the full assessment of the NAIC – provider and commissioner reports – and ensure issues are reported back for action via the Strategic Commission and ICFT governance as required.

5 EQUALITY IMPACT ASSESSMENT

5.1 A full Equality Impact Assessment (EIA) was produced to support the report presented to the SCB in January 2018, and was used to inform the decision taken. The EIA was produced to ensure a response to issues raised within the consultation, providing a full evaluation of the impact of the proposed model, and exploring the required mitigations. These mitigations form the basis of the implementation plan outlined in this latest report.

6 RECOMMENDATIONS

6.1 As set out on the front of the report.

Appendix 1

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Dear

As part of the continuing drive to improve the quality of services for our patients and following public Consultation, on Saturday 16th June 2018 we will undertake a ward relocation.

We will be opening a new ward on the second floor of the Stamford Unit at the Darnton Road area of the Tameside Hospital site. This ward will provide an excellent level of modern accommodation to care for patients who require rehabilitation or intermediate care in order for them to be ready to return home. These patients are currently cared for in the Shire Hill Hospital in Glossop.

By reorganising the wards in this way we can provide more effective patient care by concentrating specialist resources in specific areas. We can also provide a less clinical environment for those patients who no longer require it and whose rehabilitation needs can best be met in a more domestic environment.

We are providing you with this information because it is likely that you will be in the Shire hill hospital as a patient or visitor on one of the wards which will be moving on Saturday 16th June 2018. Whilst we will try to minimise any disruption, inevitably in transferring wards from one location to another, there will be some disturbance to the normal ward routine.

During the process of moving the ward, maintaining patient safety will remain our priority. Ward teams will continue to be focused on providing care to you, while other colleagues will be working alongside the ward team to help with the transfer to the new location. This will include transferring all patients and their belongings safely so please do not be concerned that you will be required to assist in this process.

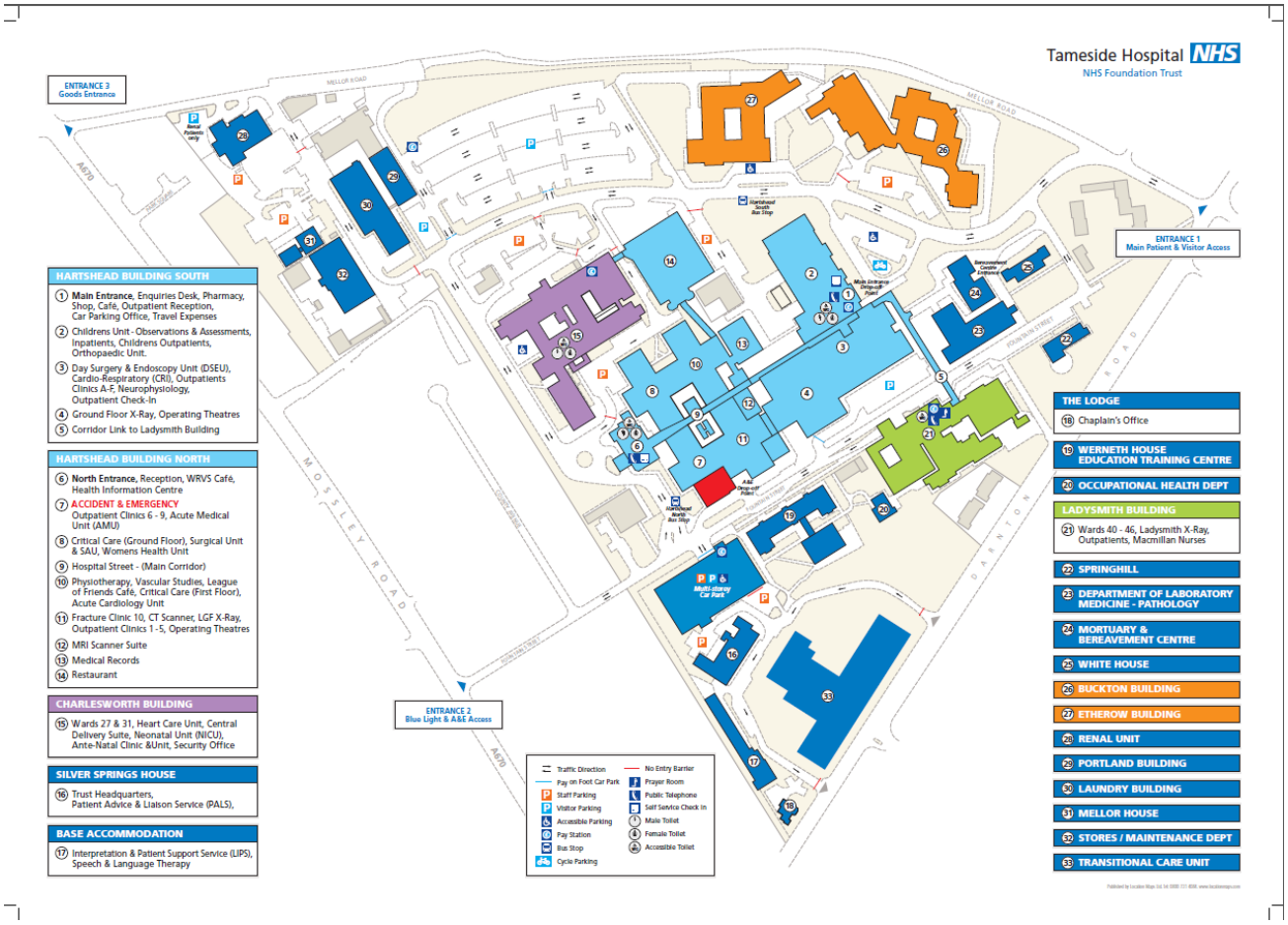
If you are intending to visit on Saturday 16th June 2018 please be advised that we expect to commence transferring patients from 9-30am onwards. It would be extremely helpful on the day if you were able to delay your visit until the relocation has taken place, therefore visiting the new location at the Tameside Hospital site after 4pm. If this is not possible please could you liaise with the Ward Manager who will be able to discuss in more detail with you.

A map of the Hospital site is attached to this letter to help visitors find their way to the new location (identified as location 33 on the map). The telephone numbers for the Stamford Unit will be different than the current telephone numbers at Shire Hill, the new numbers are **0161 922 5821** for the ward reception and **0161 922 5820** for the ward managers office. You may notice that over the next few days the ward teams will begin to prepare for the moves and we apologise in advance if this results in some areas appearing to have additional storage trolleys/boxes in the ward area. We will ensure that any disruption is kept to a minimum.

If you have any queries or concerns about the ward moves planned then please bring these to the attention of the ward manager.

Appendix 1

NHS
Tameside and Glossop Integrated Care
NHS Foundation Trust



Tameside and Glossop Integrated Care NHS Foundation Trust

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June 2018

Dear colleague,

Relocation of intermediate care and rehabilitation services in Tameside and Glossop

Following a recent consultation by Tameside and Glossop CCG, a decision has been reached to relocate intermediate care and rehabilitation services from Shire Hill Hospital in Glossop to the Stamford Unit on the Tameside and Glossop Integrated Care NHS Foundation Trust campus.

I am writing to let you know that these planned changes will take effect on 16 June 2018. From this date all intermediate care beds and rehabilitation facilities will be undertaken at the one location within the Stamford Unit.

The new facility will provide our patients with the ideal surroundings to rehabilitate and gain independence and confidence prior to their full discharge.

For further information on the consultation process, please visit:

http://www.tamesideandglossopccg.org/get-involved/intermediate-care-consultation

Yours sincerely,

Karen James
Chief Executive

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Tameside and Glossop Integrated Care NHS Foundation Trust

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June 2018

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I am writing to let you know that these planned changes will take effect on 16 June 2018. From this date all intermediate care beds and rehabilitation facilities will be undertaken at the one location within the Stamford Unit.

As a local provider organisation, which may refer into these intermediate care services, we are advising that should you wish to make a patient referral, please contact the Acute Integrated Urgent Care Team

- Jill Sutcliffe, Discharge Facilitator on 07825144175, or;
- Helen Beswick, Discharge Facilitator on 07384242157

who will forward you a referral form via email.

Please share this important information with colleagues affected by these changes.

If you would like further information around the consultation and the decision to centralise intermediate care and rehabilitation services, you can get this by visiting the following website:

http://www.tamesideandglossopccg.org/get-involved/intermediate-care-consultation

Yours sincerely,

Karen James
Chief Executive

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Right Patient, Right Bed, Right Time

As part of the continuing drive to improve the quality of services for our patients on **Sunday 20th May 2018** we will undertake a ward move.

Patients on 2nd Floor **Stamford Unit** will relocate to the ground floor **Stamford Unit**.

By relocating to the ground floor we will support the best possible patient care by putting patients in the right place to best meet their care needs.

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