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Tameside Metropolitan Borough

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STRATEGIC COMMISSIONING BOARD

Day: Wednesday
Date: 27 November 2019
Time: 1.00 pm
Place: Committee Room 1 - Tameside One

Item No.	AGENDA	Page No
1.	**WELCOME AND APOLOGIES FOR ABSENCE** To receive any apologies for the meeting from Members of the Strategic Commissioning Board	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from Members of the Strategic Commissioning Board	
3.	**MINUTES OF THE PREVIOUS MEETING** The Minutes of the meeting of the Strategic Commissioning Board held on 23 October 2019 to be signed by the Chair as a correct record.	1 - 4
4.	**FINANCIAL CONTEXT**	
a)	**MONTH 6 INTEGRATED FINANCE REPORT** To consider the attached report of the Executive Member (Finance and Economic Growth)/CCG Chair/Director (Finance).	5 - 56
5.	**QUALITY CONTEXT**	
a)	**ENGAGEMENT UPDATE** To consider the attached report of the Executive Leader/CCG Chair/Assistant Director, Policy Performance and Communications.	57 - 66
6.	**COMMISSIONING FOR REFORM**	
a)	**PHASED EXTENSION OF THE NATIONAL LUNG HEALTH CHECKS** To consider the attached report of the Executive Member (Adult Social Care and Health)/CCG Chair/Director of Commissioning/Director of Population Health.	67 - 130
7.	**URGENT ITEMS** To consider any additional items the Chair is of the opinion shall be dealt with as a matter of urgency.	

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Carolyn Eaton, Principal Democratic Services Officer, to whom any apologies for absence should be notified.

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STRATEGIC COMMISSIONING BOARD

23 October 2019

Comm: 1.00pm **Term: 1.55pm**

Present:
Dr Ashwin Ramachandra – NHS Tameside and Glossop CCG (Chair)
Councillor Gerald Cooney – Tameside MBC
Councillor Leanne Feeley – Tameside MBC
Councillor Allison Gwynne – Tameside MBC
Councillor Oliver Ryan – Tameside MBC
Councillor Brenda Warrington – Tameside MBC
Councillor Eleanor Wills – 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
Carol Prowse – NHS 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**
	Stephanie Butterworth	**Director of Adults Services**
	Jessica Williams	**Director of Commissioning**
	Ian Saxon	**Director of Operations and Neighbourhoods**
	Jayne Traverse	**Director of Growth**
	Michelle Walsh	**Deputy Director, Quality and Safeguarding**
	Simon Brunet	**Head of Policy, Performance and Intelligence**

Apologies for Absence:
Councillor Warren Bray – Tameside MBC
Councillor Bill Fairfoull – Tameside MBC

32 DECLARATIONS OF INTEREST

There were no declarations of interest.

33 MINUTES

RESOLVED
That the minutes of the meeting of the Strategic Commissioning Board held on 25 September 2019 be approved as a correct record and signed by the Chair.

34 MONTH 5 REVENUE MONITORING STATEMENT

Consideration was given to a report of the Executive Member for Finance and Economic Growth / CCG Chair / Director of Finance providing an overview on the financial position of the Tameside and Glossop economy in 2019/20. For the year to 31 March 2020 the report forecast that service expenditure would exceed the approved budget in a number of areas, due to a combination of cost pressures, shortfalls in income and non-delivery of savings.

It was explained that for the 2019/20 financial year the Integrated Commissioning Fund was forecast to spend of £619 million, against a net budget of £617 million. The forecast overspend at month 5 was now £1.7 million, which was an improvement of £255K. The main key areas for improvement were within Governance and the reduction in the CCGs net risk. Other areas across

the CCG and Council had seen very little movement in the forecast outturn form last month. Further detail on the economy wide position was included in an Appendix to the report.

RESOLVED:

(i) That the significant level of savings required during 2019/20 to deliver a balanced recurrent economy budget together with the related risks which are contributing to the overall adverse forecast, be acknowledged.

(ii) That the significant financial pressures facing the Strategic Commission, particularly in respect of Children's Social Care, Acute, Operations & Neighbourhoods, and Growth, be acknowledged.

35 BI-MONTHLY QUALITY ASSURANCE REPORT

Consideration was given to a report of the Executive Member for Adult Social Care and Population Health / CCG Chair / Director Quality and Safeguarding providing the Strategic Commissioning Board with assurance that robust quality assurance mechanisms were in place to monitor the quality of the services commissioned' to highlight any quality concerns and to provide assurance as to the action being taken to address such concerns.

With regard to the Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT): CQC Inspection Report, it was reported that the Trust was rated as 'Good' overall, across all domains.

In respect of Primary Care, it was explained that a new model of locally commissioned services had been introduced for 2019 – 2021, consisting of a number of bundles for practices to sign up to. One of the bundles was a Quality Improvement (Q1) bundle that all 37 Tameside and Glossop practices had signed up to. It had been designed to further develop and embed quality improvement in the business model of the practices.

In Adult Care, Auden House and Able Care and Support Services had been rated as 'Outstanding', following inspection.

Quality improvement across the system was detailed and particular mention was made of the Red Bag Scheme, which was recognised as a valued initiative across the locality which improved the quality of communication and transfer of information, and, in doing so, supported a safer transition and patient experience.

Details of the Quality Premium Scheme 2017/19 were summarised and it was reported that there would be no Quality Premium Scheme for 2019/20.

RESOLVED
That the report be noted.

36 TERMS OF REFERENCE – GREATER MANCHESTER HEALTH AND CARE JOINT COMMISSIONING BOARD

Consideration was given to a report of the Executive Member (Adult Social Care and Health) / CCG Chair / Director of Commissioning presenting the Terms of Reference for formal adoption.

RESOLVED
That the content of the report be noted and the Terms of Reference for the Greater Manchester Health and Care Joint Commissioning Board, be ratified.

37 TAMESIDE AND GLOSSOP LOCAL PILOT – INCREASING PHYSICAL ACTIVITY THROUGH ACTIVE NEIGHBOURHOODS

The Executive Member (Adult Social Care and Population Health) / CCG Chair / Director of Population Health submitted a report explaining that Greater Manchester had been selected as one of 12 Local Delivery Pilots by Sport England in December 2017. This followed a competitive 12 month application process. The Local Pilot work formed an important strand of the implementation of Greater Manchester Moving and would test and explore what it takes to secure population scale change in physical activity behaviour.

The work would be focused on three key audiences:

- Children and young people aged 5-18 in out-of-school settings;
- People out of work and people in work but at risk of becoming workless; and
- People aged 40-60 with, or at risk of, long term conditions: specifically cancer, cardiovascular disease and respiratory disorders.

Members were informed that Tameside and Glossop had been allocated £767,931 towards reducing inactivity amongst residents. The funding had been provided from Sport England via Greater Sport. The local model of delivery implementation plan and the proposed funding mechanisms, with suggested local lead organisations, was presented to Greater Sport in June 2019 and accepted. The report set out the proposed local model of delivery of the programme using the principles of co-design.

RESOLVED

(i) That the £767,931 funding allocated to Tameside and Glossop from Greater Sport be noted;

(ii) The proposed programmes as detailed in Section 5 of the report, be approved;

(iii) The proposed funding allocation distribution, as follows, be agreed:

- **£200,000 of the funding be awarded directly to Action Together from Greater Sport for distribution in communities;**
- **£96,000 of the funding be awarded directly to High Peak Borough Council from Greater Sport for delivery of Glossop programmes; and**
- **That £120,000 of the funding be awarded directly to Active Tameside from Greater Sport for scale up of the Live Active Programme**
- **That £351,931 be allocated to Tameside Council further to ratification at the meeting of Executive Cabinet, immediately following this meeting.**

38 WHEELCHAIR SERVICE – CONTRACT EXTENSION

A report of the Executive Member (Adult Social Care and Health) / CCG Lead (Ageing Well) /Director of Commissioning was submitted, seeking authorisation for approval to be given to extend the above contract by two years, from 1 April 2020 to 31 March 2022, where this was provided for within the terms of the contract.

The report outlined the service being provided and indicated outcomes being achieved for provision of wheelchairs thereby making the case to extend the current contract as allowed in the existing agreement.

Concerns were raised in respect of difficulties encountered with the current referral process, which the Director of Commissioning agreed to feedback to the provider.

RESOLVED

That a contract extension for two years from 1 April 2020 be approved.

39 RIGHT BY YOU

Consideration was given to a report of the Executive Member (Adult Social Care and Health) / CCG Chair / Director of Commissioning providing a brief update of the new Right By You pilot, which was designed in collaboration between the Person and Community Centred Approaches Team (PCCA) within NHS Tameside and Glossop Integrated Care Foundation Trust, NHS Tameside and Glossop Clinical Commissioning Group and Macmillan.

Board Members were informed that Macmillan Cancer Support would provide funding to establish a community based service for people with Cancer, which focused on similar principles to social prescribing, considering the wider determinants of health and the wider issues affecting their wellbeing.

Beyond the initial funding period there was an expectation from Macmillan that NHS Tameside and Glossop Clinical Commissioning Group provided a commitment to sustain the outcomes from this pilot, pending a full evaluation.

RESOLVED

(i) That the delivery of the programme, out outlined in the report, be endorsed;

(ii) That the Clinical Commissioning Group signing up to sustain the outcomes of the pilot (assuming its success), be endorsed.

40 FUTURE PROVISION OF NHS 111 SERVICES

The Executive Member for Adult Social Care and Population Health / CCG Chair / Director of Commissioning submitted a report, which explained that the current contract for NHS111 service in the North West region expired in September 2020. The report proposed how these services should be commissioned in the future.

RESOLVED

That the direct award of core NHS111 services to NWAS, be approved in principle, subject to the development and funding of an agreed service specification.

41 CORPORATE PLAN UPDATE

Consideration was given to a report of the Executive Leader / CCG Chair / Director of Governance and Pensions providing an update on progress to implement and embed the Corporate Plan Performance Monitoring Framework across Tameside and Glossop Strategic Commission.

It was explained that the report provided an update on the 56 indicators being monitored to measure the performance of the Corporate Plan. Key headlines in terms of any changes in performance since the last report in August 2019, were highlighted and a copy of the scorecard was appended to the report, which showed the position as at 9 September 2019.

Board Members were informed that, of the 56 indicators being measured in the Corporate Plan; 45 could be measured against the national average. Of these 45 indicators; 12 were performing better that the national average, 26 were performing worse than the national average and 7 were in line with it. Key changes in performance were detailed and discussed.

RESOLVED

That the content of the report and the progress being made across the range of indicators, be noted.

CHAIR

Report To:	**STRATEGIC COMMISSIONING BOARD**
Date:	27 November 2019
Executive Member /	Cllr Ryan – Executive Member (Finance and Economic Growth)
Reporting Officer:	Ashwin Ramachandra – Lead Clinical GP Kathy Roe – Director of Finance
Subject:	**STRATEGIC COMMISSION AND NHS TAMESIDE AND GLOSSOP INTEGRATED CARE FOUNDATION TRUST – CONSOLIDATED 2019/20 REVENUE MONITORING STATEMENT AT 30 SEPTEMBER 2019 AND FORECAST TO 31 MARCH 2020**
Report Summary:	With a gross budget for 2019/20 in excess of £945m, as at month 6 the Integrated Commissioning Fund has a forecast net spend of £617,914k, against a net budget of £617,425k. The forecast overspend of £489k is a significant improvement from the position at month 5 but is net of a number of significant variances. Further detail on the economy wide position is included at **Appendix 1**. Children's Services is now forecasting to exceed the approved budget by £6,674k. This is offset by significant favourable variances including additional investment income, one-off reductions to the Waste and Transport Levies, and the release of contingencies. Additional pressures are emerging in Mental Health and Adults services, alongside existing pressures in Growth. The forecast outturn for Operations and Neighbourhoods has improved due to the one-off reductions to the Levies. Further detail is included at **Appendix 2**. **Appendix 3** details the Council's irrecoverable debts over £3,000 that have been written off in the period April to June 2019. The Collection Fund forecast position is reported in **Appendix 4.**
Recommendations:	Members are recommended to : (i) Acknowledge the significant level of savings required during 2019/20 to deliver a balanced recurrent economy budget together with the related risks which are contributing to the overall adverse forecast. (ii) Acknowledge the significant financial pressures facing the Strategic Commission, particularly in respect of Children's Social Care and Operations & Neighbourhoods, and Growth; and (iii) Approve the proposed changes to mobile phone financing arrangements set out in Section 5.
Links to Community Strategy:	Budget is allocated in accordance with the Community Strategy
Policy Implications:	Budget is allocated in accordance with Council Policy
Financial Implications: (Authorised by the Section 151 Officer & Chief Finance	This report provides the 2019/20 consolidated financial position statement at 30 September 2019 for the Strategic Commission and ICFT partner organisations. For the year to 31 March 2020

Officer)	the report forecasts that service expenditure will exceed the approved budget in a number of areas, due to a combination of cost pressures, shortfalls in income and non-delivery of savings. These pressures are being partially offset by savings and additional income in Capital and Financing, Corporate and Contingency budgets 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 2019/20 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 requirement for the Council to deliver a balanced budget whilst ensuring all services deliver value for money. 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.
Risk Management:	Associated details are specified within the presentation. Failure to properly manage and monitor the Strategic Commission's budgets will lead to service failure and a loss of public confidence. Expenditure in excess of budgeted resources is likely to result in a call on Council reserves, which will reduce the resources available for future investment. The use and reliance on one off measures to balance the budget is not sustainable and makes it more difficult in future years to recover the budget position.
Background Papers:	Background papers relating to this report can be inspected by contacting : Tom Wilkinson, Assistant Director of Finance, Tameside Metropolitan Borough Council Telephone:0161 342 5609 e-mail: tom.wilkinson@tameside.gov.uk Tracey Simpson, Deputy Chief Finance Officer, Tameside and Glossop Clinical Commissioning Group Telephone:0161 342 5626 e-mail: tracey.simpson@nhs.net David Warhurst, Associate Director Of Finance, Tameside and Glossop Integrated Care NHS Foundation Trust Telephone:0161 922 4624 e-mail: David.Warhurst@tgh.nhs.uk

1. BACKGROUND

1.1 This report aims to provide an overview on the financial position of the Tameside and Glossop economy in 2019/20 at the 30 September 2019 with a forecast projection to 31 March 2020. 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 gross revenue budget value of the ICF for 2019/20 is currently £945.377 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 As at 30 June 2019 the Integrated Commissioning Fund is forecasting to spend £617.914m against an approved net budget of £617.425m, **an over spend of £0.489m**. This forecast is an improved position from the previous month but masks significant and increased pressures in **Children's Services which is forecasting expenditure to be £6.674M in excess of budget**. Pressures remain in Acute, Mental Health and Growth services, with further pressures emerging in Adults. The forecast position for Operations and Neighbourhoods has improved significantly as a result of a one-off return of reserves from GMCA in respect of the Levies. Further information on the economy wide position is included at **Appendix 1** and further detail on Directorate areas is at **Appendix 2.**

2.2 **Appendix 2** also provides further detail on progress in the delivery of savings for the 2019/20 financial year. Good progress is being made to deliver the required quantum of savings for the year, although some savings remain at risk and are rated red or amber. Just over £1m of planned savings are not expected to be delivered, but alternative savings have been identified to mitigate this.

3. IRRECOVERABLE DEBTS

3.1 **Appendix 3** details the Council's irrecoverable debts over £3,000 that have been written off in the period 1 July to 30 September 2019.

4. COLLECTION FUND

4.1 **Appendix 4** details the current forecast position on the Collection Fund at 31 March 2020. The Council Tax collection fund is expected to retain a surplus of approximately £3.7m at 31 March 2020 due to the brought forward surplus being higher than the original estimate. This surplus will be transferred to the General Fund in 2020/21.

4.2 The forecast position on the Non-Domestic Rate (NDR) collection fund is a deficit of approximately £2.8m due to reductions in rateable value across the borough and an increase in unoccupied property relief, with the collapse of Thomas Cook having a significant impact. The Council maintains a smoothing reserve to mitigate the impact of any

unexpected deficits, but any permanent reductions to NDR income will increase pressure on future year budgets.

5. CHANGES TO MOBILE PHONE FINANCING ARRANGEMENTS

5.1 Historically, mobile phone handsets have been purchased by service areas outright at the beginning of the contract, with line rental/call costs paid monthly over a period of 2 or 3 years. Whilst it is generally more cost effective to buy the handsets up front, outright purchase by services results in uneven spend across financial years.

5.2 Purchasing options for mobile phones have recently been reviewed as part of the current replacement programme and it has been identified that significant cost savings can be achieved by purchasing mobile phones outright at the beginning of the contract period. However, rather than a one-off charge to services, it is proposed that reserves are utilised to fund the initial purchase. Services will then be charged over the life of the contract, smoothing the impact on revenue budgets, and replenishing the reserves.

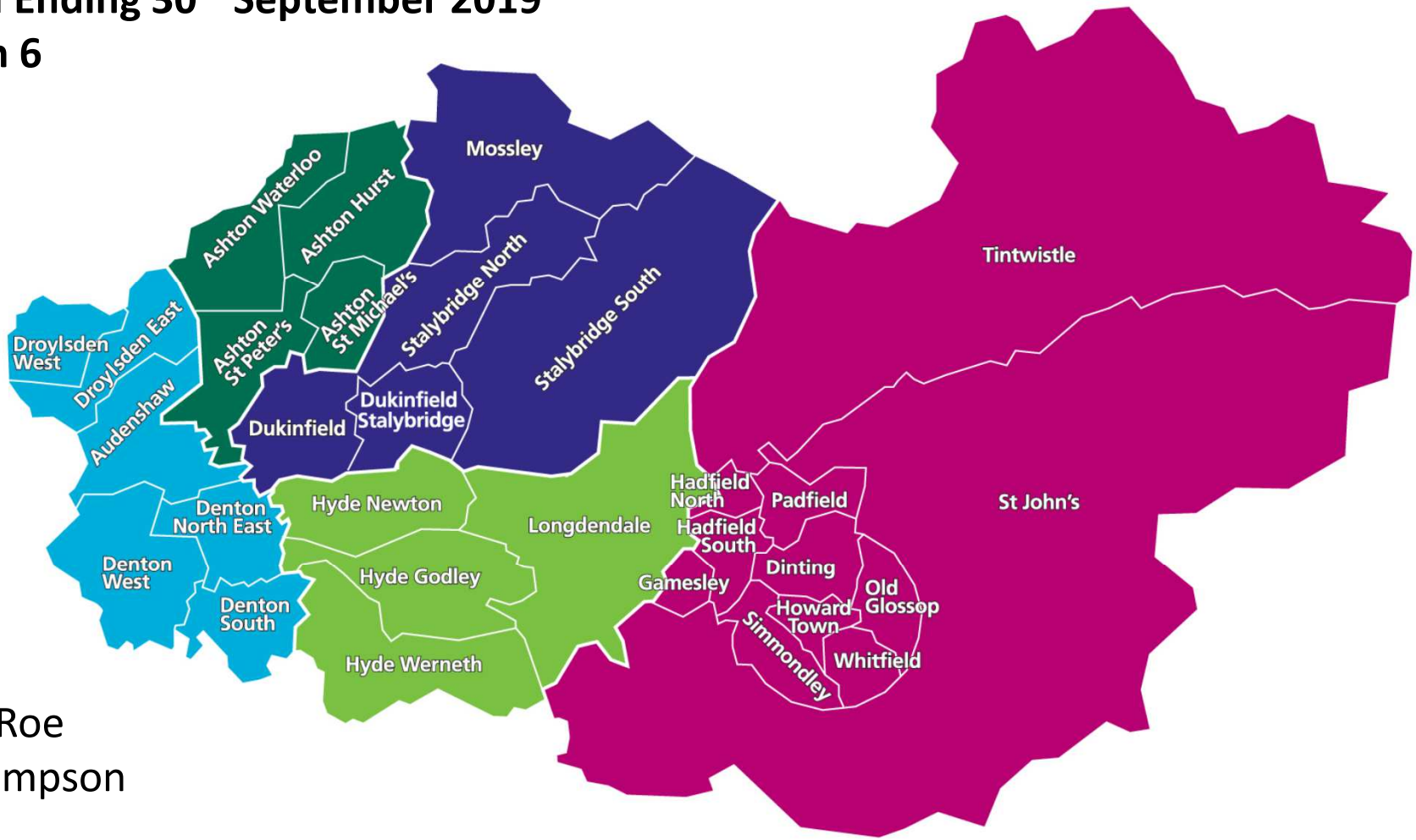
6. RECOMMENDATIONS

6.1 As stated on the front cover of the report.

Tameside and Glossop Integrated Financial Position

financial monitoring statements

Period Ending 30th September 2019
Month 6



Kathy Roe
Sam Simpson

Period Ending 30th September 2019

Integrated Financial Position Summary Report

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.

Tameside & Glossop Integrated Economy Wide Financial Position

Message from the Directors of Finance

At the halfway point in the financial year, the forecast outturn is beginning to look more positive overall, although it should be noted that this is largely due to a significant one off return of levy reserves from the Greater Manchester Combined Authority (GMCA).

Within the overall forecast position, we continue to experience significant financial pressures, particularly in Children's Social Care services due to increased numbers of looked after children (LAC). The forecast outturn position for Children's of £6.674m in excess of budget reflects an anticipated further increase in LAC numbers by the end of the financial year.

Delivery of in year Targeted Efficiency Plans (TEP) continues to be closely monitored. Good progress is being made in most areas, although some areas of significant risk remain.

The focus on 2020/21 budgets is now accelerating. Funding announcements in September 2019 provide greater clarity for Council budgets in 2020/21, but significant uncertainty remains for future years, making planning for the medium term increasingly difficult. The cost pressures already identified and emerging for future years means there remains a significant gap to close to balance 2020/21.

Integrated Financial Position

£1.177m

The overall forecast outturn position for the Strategic Commission is on overspend of £0.489m against a net budget of £617.425m.

The overall positive movement since month 5 is net of a number of significant movements including:

£2.152m Children's Social Care Services – adverse movement due to forecast increases in the number of looked after children

£1.672m Operations and Neighbourhoods – improved position due to a one-off return of reserves from GMCA relating to the levies.

£1.460m Contingency – improved position due to a one-off return of reserves from GMCA and the release of contingencies.

Forecast Position £000's	Forecast Position					Net Variance	
	Expenditure Budget	Income Budget	Net Budget	Net Forecast	Net Variance	Previous Month	Movement in Month
CCG Expenditure	420,622	0	420,622	421,006	(384)	(649)	265
TMBC Expenditure	524,755	(327,952)	196,803	196,908	(105)	(1,017)	911
Integrated Commissioning Fund	**945,377**	**(327,952)**	**617,425**	**617,914**	**(489)**	**(1,666)**	**1,177**

Tameside & Glossop Integrated Commissioning Fund

With a gross budget for 2019/20 in excess of £945m, as at month 6 the Integrated Commissioning Fund has a forecast net spend of £617.914m, against a net budget of £617.425m. The forecast outturn at month 6 is now an overspend of £0.489m, an improvement of £1.2m since period 5. The overall improvement is due to significant one-off reductions to the Waste and Transport Levies, and the release of contingencies. This overall improvement masks a significant deterioration in the forecast for Children's services which is now forecast to exceed the approved budget by £6.674m.

	Forecast Position					Net Variance	
Forecast Position £000's	Expenditure Budget	Income Budget	Net Budget	Net Forecast	Net Variance	Previous Month	Movement in Month
Acute	214,407	0	214,407	215,033	(626)	(642)	16
Mental Health	38,058	0	38,058	38,698	(640)	(509)	(131)
Primary Care	85,028	0	85,028	84,851	177	2	175
Continuing Care	16,317	0	16,317	15,854	463	406	57
Community	33,413	0	33,413	33,416	(3)	(3)	0
Other CCG	28,235	0	28,235	27,607	629	746	(117)
CCG TEP Shortfall (QIPP)	0	0	0	384	(384)	(649)	265
CCG Running Costs	5,164	0	5,164	5,164	0	0	(0)
Adults	84,083	(46,750)	37,333	37,973	(640)	(274)	(366)
Children's Services	53,756	(5,199)	48,556	55,230	(6,674)	(4,522)	(2,152)
Education	28,109	(22,104)	6,005	6,045	(41)	(49)	9
Individual Schools Budgets	115,558	(115,558)	0	0	0	0	0
Population Health	16,262	(170)	16,092	16,327	(235)	(280)	45
Operations and Neighbourhoods	78,840	(28,213)	50,627	49,857	770	(902)	1,672
Growth	42,791	(33,828)	8,964	9,806	(842)	(1,046)	204
Governance	74,144	(64,896)	9,248	9,091	158	315	(158)
Finance & IT	9,330	(2,237)	7,092	6,359	733	600	133
Quality and Safeguarding	440	(304)	136	136	(0)	(0)	0
Capital and Financing	10,788	(7,986)	2,803	(680)	3,483	3,217	266
Contingency	5,551	(235)	5,316	2,293	3,023	1,563	1,460
Corporate Costs	5,104	(473)	4,631	4,471	160	361	(201)
Integrated Commissioning Fund	**945,377**	**(327,952)**	**617,425**	**617,914**	**(489)**	**(1,666)**	**1,177**

Tameside & Glossop Integrated Commissioning Fund

Forecast Position £000's	Forecast Position					Net Variance	
	Expenditure Budget	Income Budget	Net Budget	Net Forecast	Net Variance	Previous Month	Movement in Month
A: Section 75 Services	376,418	(46,820)	329,598	330,621	(1,023)	(817)	(207)
B: Aligned Services	318,978	(100,424)	218,554	215,346	3,208	2,884	324
C: In Collaboration Services	250,008	(180,735)	69,273	71,946	(2,673)	(3,733)	1,060
Integrated Commissioning Fund	**945,405**	**(327,980)**	**617,425**	**617,914**	**(489)**	**(1,666)**	**1,177**

Further detail on all service areas is set out in appendix 1 to this report

Growth £842k

Pressures remain in the Growth directorate relating mainly to shortfalls in budgeted income and additional costs relating to buildings and utilities.

Capital Financing £3,483k & Contingency £3,023k

Interest earned on investments continues to exceed budget and there has been a one-off return of reserves from GMCA which has improved the overall forecast. The amount returned from GMCA is earmarked for investment in bus reform.

Operations and Neighbourhoods £770k

The overall position has improved significantly due to the return of reserves from GMCA. Pressures remain due to shortfalls in car park income and additional costs related to the construction of new car parks.

Mental Health £640k

The forecast outturn position for Mental Health has worsened since period 5 but remains as a forecast overspend of £640k. Most of this pressure relates to Individualised Commissioned packages of care, with two extremely high cost new packages resulting in a significant forecast pressure against the budget.

Acute £626k

Pressures exist within the independent sector and a number of Acute providers continue to over-perform.

Children's Services £6,674k

Increased demand since the 2019/20 budget was approved by the Council is the principal reason for the significant adverse projected outturn variation. There has been an increase of 8%, which as at October 2019 equates to 700 children looked after. The projected outturn includes a further estimated increase of 4% in the number of children looked after to 31 March 2020. This is based on the demand increase during the first six months of 2019/20 adjusted for the estimated number of children that are expected to leave the care system.

Tameside Integrated Care Foundation Trust Financial Position

Financial Performance Metric	Month 6 Plan £000	Month 6 Actual £000	Month 6 Variance £000	YTD Plan £000	YTD Actual £000	YTD Variance £000	Annual £000
Normalised Surplus / (Deficit) Before PSF	(1,975)	(1,996)	(22)	(14,331)	(13,997)	333	(25,368)
Provider Sustainability Fund (PSF)	315	315	0	1,654	1,654	0	4,727
Financial recovery Fund (FRF)	987	987	0	5,182	5,182	0	14,807
Surplus / (Deficit) post PSF	(673)	(694)	(22)	(7,495)	(7,161)	333	(5,834)
Capital Expenditure	360	225	(135)	924	751	(173)	3,826
Cash and Equivalents	1,220	1,211	(9)				1,220
Trust Efficiency Savings	1,089	1,114	22	4,429	4,566	133	11,580
Use of Resources Metric	**3**	**3**		**3**	**3**		**3**

- **Revenue -** The Trust has agreed a control with NHSI of **c.£5.686m** after Financial Recovery Fund (FRF) and Provider Sustainability Funding (PSF)**;** for the financial period to **30th September 2019**, the Trust has reported a net deficit of **£0.694m** post FRF and PSF, which is £22k above plan

- **Trust Efficiency Programme (TEP) -** the Trust has a TEP target in 2019/20 of **£11.580m** including carried forward schemes from 2018/19. The Trust is forecasting at month 6 to deliver **c.£11.337m** by the end of the year. Schemes are being developed across the Trust to mitigate the shortfall of **c.£243k (2.1%)**.

- **Agency cap -** The Trust has an agency cap of **c.£9.454m**, but a plan of **£7m**. During Month 6 the Trust spent **£233k** against a plan of **£622k**, reporting an underspend of **£389k** and reporting below the trust plan cap.

- **Capital** – Capital expenditure is behind plan **by c.£135k** year to date.

- **Cash** – The cash balance was **£9k** better than plan at the end of Month 6, the Trust has received Q1 PSF and FRF in September M6.

NHSI Feedback - Given the current **financial deficit** it is likely that the Trust will be rated

Requires Improvement

Tameside Integrated Care Foundation Trust Financial Position

Performance Metric - Month 5	Plan YTD	Actual YTD	Annual Plan	Forecast
Capital service cover rating	4	4	4	4
Liquidity rating	4	4	4	4
I&E margin rating	4	4	4	4
I&E margin: distance from financial plan		1		1
Updated agency rating	1	1	1	1
Risk Rating after overrides		3		3

Capital servicing capacity – The degree to which generated income covers financial obligations. If any Trust has a deficit and also any borrowing, this will always be at 4.

Liquidity - Days of operating costs held as cash or cash equivalents. To improve to just 3 (Requires Improvement) – the Trust would need to spend at least £6m less.

I&E margin - Degree of surplus/(deficit). The Trust deficit, at current income levels would need to be c. £17m less than it currently is i.e. around £2m.

Distance from financial plan - Variance between the planned and actual I&E position. The Trust **MUST** achieve this, by achieving the control total, the Trust can score a 1 and help to offset the others.

Agency spend – Distance from cap, this is the something the Trust **MUST** achieve and is currently achieving.

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APPENDIX 2 – Strategic Commission Detailed Analysis

Contents:

Local Authority Savings Progress

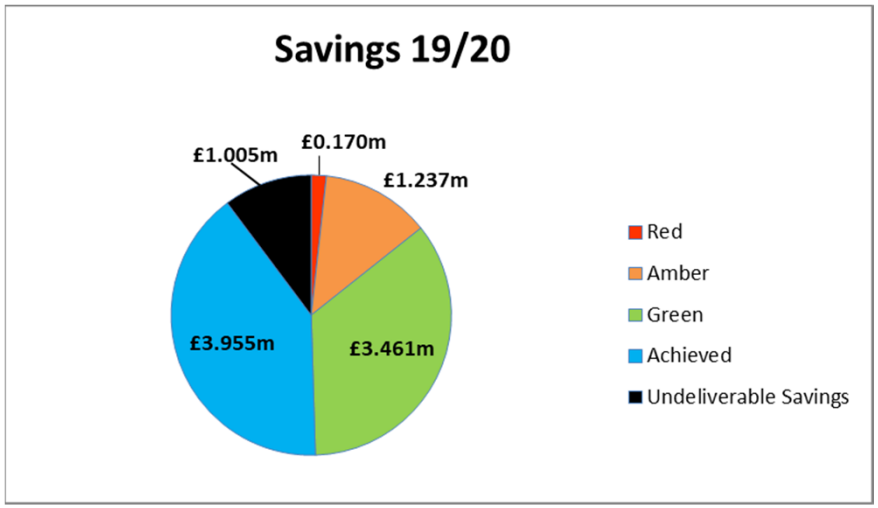
Directorate	Opening Target £000s	Not expected to be delivered £000s	Red £000s	Amber £000s	Green £000s	Achieved £000s	Total forecast savings £000s
Adults	1,778	669	70	747	292	0	1,109
Children's Services	696	0	0	0	696	0	696
Children's - Education	235	0	0	115	0	230	345
Population Health	375	95	0	0	280	0	280
Operations and Neighbourhoods	1,217	0	100	5	511	601	1,217
Growth	285	207	0	0	78	0	78
Governance	1,125	27	0	193	347	558	1,098
Finance & IT	411	0	0	7	693	283	983
Quality and Safeguarding	10	0	0	10	0	0	10
Capital and Financing	1,764	0	0	125	564	1,766	2,455
Contingency	100	0	0	0	0	100	100
Corporate Costs	424	7	0	35	0	417	452
Total	**8,420**	**1,005**	**170**	**1,237**	**3,461**	**3,955**	**8,823**

SAVINGS PROGRESS

The 2019/20 Revenue Budget, approved by Full Council on 27 February 2019, included savings targets in respect of a vacancy factor, additional fees and charges, and savings to be delivered by management. Combined with savings identified in previous years, the total savings target for the Council in 2019/20 is £8,420k.

Vacancy Factor - The total vacancy factor for the year is £2,387k. As at the end of period 6, total underspends relating to vacant posts were £2,099k, therefore overachieving the annual target.

Other Savings – Overall the Council is forecasting to achieve savings of £8,823k against a target of £8,420k, although £1,407k remains rated as Red or Amber with risks to delivery. Savings of £3,461k are rated green and £3,955k already achieved as at the end of September 2019. Just over £1m of planned savings will not be delivered with alternatives now being delivered in place of the original targets.



Local Authority Pressures

PRESSURES

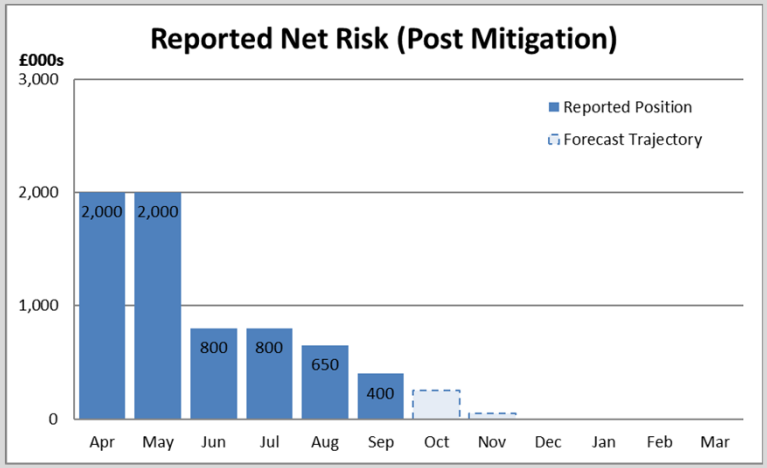
The 2019/20 Council Revenue Budget included funding for pressures across the services of £20,166k. As at month 3 total forecast pressures have increased across a number of areas as set out below. Further narrative on increased pressures in each area is included in the narrative for each service later in this report. The main reduction in pressures relates to funding setting aside for increased staffing costs as a result of the implementation of the new NJC pay structure on 1 April 2019. This funding will be used to offset pressures in other areas.

Directorate	Pressures funded in budget £000s	Pressures materialised to date £000s	Total pressures forecast £000s	(Increase)/decrease in pressures £000s
Adults	1,401	701	1,401	0
Children's Services	9,300	7,987	15,973	(6,673)
Children's - Education	631	448	985	(354)
Population Health	67	34	67	0
Operations and Neighbourhoods	1,501	1,026	1,450	52
Growth	741	847	841	(100)
Governance	903	245	705	198
Finance & IT	185	93	185	0
Quality and Safeguarding	0	0	0	0
Capital and Financing	242	242	242	0
Contingency	5,001	2,381	4,417	584
Corporate Costs	194	56	96	98
Total	**20,166**	**14,060**	**26,361**	**(6,195)**

2019/20 Financial Risk & TEP Update: M6 – September 2019

NHS Tameside and Glossop Clinical Commissioning Group

- The CCG has a Targeted Efficiency Plan (TEP, also known as QIPP) target for 2019/20 of £11m.
- In submitted plans at the start of the year, the CCG reported that financial control totals would be met, but that there was material risk (£2m) associated with this.
- Based on the latest assessment of TEP achievement, the CCG is reporting net risk of £400k at M6. An improvement of £250k relative to the M5 position:



- As shown in the chart above we are optimistic that over the next few months we will be in a position to further reduce reported risk.
- The trajectory above assumes that net risk can be reduced internally using CCG resources. However, as part of our wider Integrated Commissioning Fund (ICF), the CCG has entered into a risk share agreement with TMBC. This would allow the Local Authority to increase contributions into the pooled budget, in order to balance the CCG position on a non-recurrent basis if required.

- Any increase in council contribution this year would result in an increased CCG contribution in future years. Therefore it is not appropriate to use the ICF as justification to reduce reported net risk in 2019/20.
- The table below summarises expected achievement at M6, together with a comparison to the position reported last month:

Planned Savings (before application of optimism bias)

	Recurrent	Non Recurrent	Total	Prior Month	Movement
High Risk	729,833	200,000	**929,833**	929,833	0
Medium Risk	1,048,000	300,000	**1,348,000**	1,870,000	-522,000
Low Risk	1,484,848	2,746,401	**4,231,249**	4,611,320	-380,071
Saving Posted	2,050,969	3,567,002	**5,617,971**	4,711,900	906,071
Total	**5,313,650**	**6,813,403**	**12,127,053**	**12,123,053**	**4,000**

Expected Savings (after application of optimism bias)

	Recurrent	Non Recurrent	Total	Prior Month	Movement
High Risk	72,983	20,000	**92,983**	92,983	0
Medium Risk	524,000	150,000	**674,000**	935,000	-261,000
Low Risk	1,484,848	2,746,401	**4,231,249**	4,611,320	-380,071
Saving Posted	2,050,969	3,567,002	**5,617,971**	4,711,900	906,071
Total	**4,132,800**	**6,483,403**	**10,616,203**	**10,351,203**	**265,000**

QIPP Target	**11,000,000**	**11,000,000**	**0**
Savings Still to Find	**383,797**	**648,797**	**265,000**

Value of savings about which we are certain (i.e. blue & green schemes) 9,849,220

Adults Services A

Adults	Gross Expenditure Budget £000's	Gross Income Budget £000's	Net Budget £000's	Actual to date £000's	Forecast £000's	Variance £000's
Adults - Out of Hours Team	158	0	158	63	118	40
Adults Senior Management	1,568	(1,159)	409	(2,612)	354	55
BCF	8	(20,339)	(20,331)	(5,486)	(20,331)	0
Community Response Service	1,172	(688)	484	(159)	508	(24)
Funded Nursing Care	1,930	(1,930)	0	49	0	0
Homecare - Support at Home	7,930	(6,031)	1,899	2,424	2,306	(407)
Improved Better Care Fund	1,633	(1,633)	0	506	0	0
Joint Commissioning Service	3,677	(1,221)	2,456	1,418	2,473	(17)
Localities	9,431	(150)	9,281	5,308	9,281	0
Long Term Support	7,289	(416)	6,873	3,762	7,509	(636)
Mental Health	3,882	(486)	3,396	1,839	3,541	(145)
Reablement	2,441	0	2,441	1,169	2,426	15
Residential & Nursing Placements	26,540	(9,437)	17,103	9,605	16,722	381
Sensory Services	293	(48)	245	131	279	(34)
Shared Lives & Property Management	2,565	(717)	1,848	827	1,748	100
Supported Accomodation	11,546	(2,494)	9,052	4,372	9,020	32
Urgent Integrated Care	2,019	0	2,019	985	2,019	0
TOTAL	**84,082**	**(46,749)**	**37,333**	**24,201**	**37,973**	**(640)**

BUDGET VARIATIONS

The net variance reflects a number of underspends and pressures including:

Underspends:

- **£740k-** Residential and Nursing Care placements: increased income
- **£100k-** Shared Lives : increased income (£50k) , reduction in staffing costs (£50k)
- **£136k-** Minor variations

Adults Services A

BUDGET VARIATIONS

Pressures:

- **(142k)-** Town Lane - OOB Resettlement - staffing requirements
- **(145k)-** Mental Health service: over budget on out of hours and agency staff due to lag in recruitment
- **(170k)-** Residential and Nursing Care placements: increased expenditure
- **(490k)-** Long Term support : increase in homemakers assessed hours

SAVINGS

Savings Performance:

- **(£26k)** - Review of out of borough LD placements: currently projected to make a part year saving in 2019-20. Currently identifying placements to meet this target as there is scope
- **(79k)-** Oxford Park: will not be delivered as scheme is being reassessed.
- **(164k)-** Review of residential placements: currently not projected to make this saving but identifying placements to meet this target as there is scope
- **(400k)-** Review of manual handling – single handed: currently not projected to make this saving but identifying packages to address the projected shortfall

Scheme	Savings Target 19/20 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Review of out of borough LD placements	125	26		99			**99**
Oxford Park	79	79					**0**
Review of residential placements	191	164		27			**27**
Review of manual handling	540	400	70	70			**140**
Vacancy Factor	551			551			**551**
Fees & charges increase 2019/20	292				292		**292**
Total	**1,778**	**669**	**70**	**747**	**292**	**0**	**1,109**

Children's Services – Children's Social Care R

Children's Services	Gross Expenditure Budget £000's	Gross Income Budget £000's	Net Budget £000's	Actual to date £000's	Forecast £000's	Variance £000's
Assistant Executive Director - Children's	1,238	(2,009)	(771)	1,445	413	(1,183)
Specialist Services	32,464	(774)	31,691	17,360	36,757	(5,066)
Childrens Safeguarding	2,001	(10)	1,991	880	2,010	(20)
Early Help, Early Years & Neighbourhoods	3,623	(1,727)	1,897	1,705	2,006	(109)
Looked After Children	5,341	(28)	5,313	2,551	5,472	(159)
Child Protection & Children In Need	8,123	0	8,123	4,201	8,218	(96)
Youth Offending Team	965	(652)	312	450	353	(41)
TOTAL	**53,756**	**(5,199)**	**48,556**	**28,591**	**55,230**	**(6,673)**

SAVINGS

Scheme	Savings Target 19/20 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Vacancy Factor	676				676		**676**
Fees & charges increase 2019/20	20				20		**20**
Total	**696**	-	**0**	**0**	**696**	**0**	**696**

Children's Services – Children's Social Care R

BUDGET VARIATIONS

Pressures:

As previously reported, the level of increased demand since the 2019/20 budget was approved by the Council is the principal reason for the significant adverse projected outturn variation. There has been an increase of 8%, which as at October 2019 equates to 700 children looked after. The projected outturn includes a further estimated increase of 4% in the number of children looked after to 31 March 2020. This is based on the demand increase during the first six months of 2019/20 adjusted for the estimated number of children that are expected to leave the care system. Further financial modelling has also taken place on a further increase in demand for the first six months of the 2020/21 financial year, the details of which will be included in the 2020/21 Council budget report and medium term financial planning assumptions of the Strategic Commission.
Members should note that there is a separate report on the agenda with supporting context on the related Children's Services Improvement Programme sustainability projects currently in progress. These include :
Strengthening early help and prevention across the locality

-Supporting the spread, scale and sustainability of Team Around the School

-The development of a Family Intervention service) across the continuum of need Early Help, Children In Need, Child Protection, Looked After Children and to also enable Family Group Conference services to intervene at an earlier point on the continuum

-The development of a core multi-disciplinary early help service in each neighbourhood / locality

-The restructure of duty/ locality teams

-The development of residential respite and assessment unit capacity

-The implementation of a Fostering Service improvement plan

-The improvement of LAC sustainability and the implementation of the placements sufficiency action plan for LAC

-The development and enhancement of the Independent Reviewing Officer role to ensure that robust oversight and challenge is provided to children's care planning and that permanency options are considered at the earliest opportunity

-The development of the role of Social Workers and managers in permanency planning to support the most effective progress of children through the care system and where appropriate exit to permanency

Children's Services – Education A

Education	Gross Expenditure Budget £000's	Gross Income Budget £000's	Net Budget £000's	Actual to date £000's	Forecast £000's	Variance £000's
Access & Inclusion	16,110	(13,741)	2,369	7,189	2,529	(160)
Assistant Executive Director - Education	384	(89)	296	54	189	107
Schools Centrally Managed	2,596	(760)	1,836	(4,375)	1,724	112
Schools Centrally Managed - DSG Funded	(1,078)	1,081	3	(58,790)	3	0
School Performance and Standards	538	(294)	245	33	245	(0)
Pupil Support Services	9,558	(8,302)	1,256	3,668	1,356	(99)
TOTAL	**28,109**	**(22,104)**	**6,005**	**(52,221)**	**6,045**	**(41)**

BUDGET VARIATIONS

The variance is a net position and reflects a number of underspends and pressures including:

Underspends:

- **£139k -** There is a projected under spend in the overall Education service due to utilisation of grant funding and surplus budget identified to support pressures within the overall service.
- **£64k -** Other minor variations.

Pressures:

- **(£315k)-**SEN Transport - pressure has materialised. A further pressure of £315k is projected for the service in 19/20. The demand for SEN Transport continues to rise. It is suggested the additional savings on teachers retirement pension costs assist in offsetting this additional pressure in-year.
- **(£39k) -**Education Psychology - pressure has materialised. A further pressure of £39k is projected for the service in 19/20. The increase in ECHPs and panel hearings continues.

Children's Services – Education A

SAVINGS

Savings Performance:

- **0k-** The traded services saving is projected to be achieved due to an increase in traded income from academies, partially negated by a decrease in maintained schools traded income. The change in position since last reporting is due to increase in trade for Education Psychology and the School Library Service.
- **£110k** – There is further reduced demand on the budget for Teachers retirement pension costs. It is suggested that this additional saving is supports the pressure occurring on SEN Transport.
- **£0k -** The Central DSG grant saving has been achieved by reducing initial budget.

Scheme	Savings Target 19/20 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Traded Services to Tameside schools and academies	5	0	0	5	0	0	**5**
Teachers Pension	130	0	0	110	0	130	**240**
Central DSG grant	100	0	0	0	0	100	**100**
Total	**235**	**0**	**0**	**115**	**0**	**230**	**345**

Population Health A

Population Health	Gross Expenditure Budget £000's	Gross Income Budget £000's	Net Budget £000's	Actual to date £000's	Forecast £000's	Variance £000's
Public Health	16,262	(170)	16,092	4,941	16,327	(235)
TOTAL	**16,262**	**(170)**	**16,092**	**4,941**	**16,327**	**(235)**

BUDGET VARIATIONS

Pressures

The variance is a net position and reflects a number of underspends and pressures including:

- **(35k)** - Pennine Care contracts- inflation uplift
- **(200k)** – Community Services contract- inflationary uplift due to revised grading on NHS pay scales

SAVINGS

Savings Performance:

- **(25k)-** Recommissioning of sexual health services - forecast to be achieved
- **(200k)-** Integrated Drug and Alcohol services - forecast to be achieved
- **(28k)-** Prescribing - forecast to be achieved
- **(27k)-** Vacancy Factor - forecast to be achieved
- **0k-** Reduction to Active Tameside management fee

Scheme	Savings Target 19/20 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Recommissioning of sexual health services	25				25		**25**
Integrated Drug and Alcohol services	200				200		**200**
Prescribing	28				28		**28**
Reduction to Active Tameside management fee	95	95					**0**
Vacancy Factor	27				27		**27**
Total	**375**	**95**	**0**	**0**	**280**	**0**	**280**

Quality And Safeguarding G

Quality and Safeguarding	Gross Expenditure Budget £000's	Gross Income Budget £000's	Net Budget £000's	Actual to date £000's	Forecast £000's	Variance £000's
Quality & Safeguarding - Adults	116	(32)	84	59	84	(0)
Quality & Safeguarding - Childrens	324	(272)	52	23	52	0
TOTAL	**440**	**(304)**	**136**	**82**	**136**	**(0)**

SAVINGS

Scheme	Savings Target 19/20 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Vacancy Factor	8			8			**8**
Fees & charges increase 2019/20	2			2			**2**
Total	**10**	-	**0**	**10**	**0**	**0**	**10**

Operations and Neighbourhoods G

Operations & Neighbourhoods	Gross Expenditure Budget £000's	Gross Income Budget £000's	Net Budget £000's	Actual to date £000's	Forecast £000's	Variance £000's
Operations and Emergency Planning	1,298	(2,578)	(1,279)	(491)	(1,220)	(60)
Community Safety & Homelessness	5,388	(1,806)	3,582	(146)	3,582	0
Cultural and Customer Services	3,529	(332)	3,197	1,240	3,051	147
Design and Delivery	11,470	(9,650)	1,820	3,189	1,842	(22)
Environmental Services Management	31,305	(32)	31,273	25,217	29,697	1,576
Highways & Transport	8,862	(9,660)	(798)	(1,000)	203	(1,001)
Markets	1,040	(1,532)	(492)	(467)	(212)	(280)
Operations and Greenspace	5,979	(447)	5,531	2,705	5,066	466
Public Protection	3,633	(948)	2,685	1,166	2,607	79
Waste Management	5,890	(1,184)	4,706	2,502	4,774	(68)
Youth	446	(43)	403	147	468	(65)
TOTAL	**78,840**	**(28,213)**	**50,627**	**34,061**	**49,857**	**770**

BUDGET VARIATIONS

The net variation reflects a number of underspends and pressures across the service, including:

Underspends:

- **£64k** – Saving on disposal of street sweepings expected to be achieved from January due to new method of disposal
- **£1,032k** -There are a number of vacancies across Operations and Neighbourhoods. Within Culture & Customer Services there have been difficulties with recruitment however, this service getting closer to being fully staffed. There have also been some vacancies held for a period of time within the Call Centre and Customer Services to allow a full assessment of demand following the move into Tameside One. Within the engineers service there is a large level of vacancies however the saving on this is offset by additional spend on subcontractors. (This is net of vacancy factor)
- **£341k** -One off in year savings on vehicle costs within operations and greenspace have been identified.
- **£311k-** GMCA have approved an adjustment to this year's Transport Levy resulting in a reduction to Tameside of £311k.
- **£1,262k**- GMCA have approved the use of some reserves to reduce the levy cost in this financial year resulting in a one off rebate.

Operations and Neighbourhoods G

BUDGET VARIATIONS

Pressures:

- **(£766k)** – There is a projected shortfall in income from car parks. Of this, (£408k) relates to the new Darnton Road car parks which is in part as a result of delays in these car parks becoming operational. A further (£150K) relates to the non delivery of charges being applied to additional car parks.
- **(£199k)** - Additional construction costs of £199k will materialise in this year relating to the new hospital car parks. This is in part due to the cost of electric charging points.
- **(£165k)** - The cameras on bus lanes are working well as a deterrent to stop people using the bus lanes inappropriately. However this means that there is a projected shortfall in expected income.
- **(£217k)** - Nationally, markets have experienced a decline and alongside this, there is the ongoing development of Ashton Town Centre. Overall, footfall is reduced and the market ground is suffering from a reduction in traders resulting in a shortfall in projected income.
- **(£80k)** - Additional costs incurred for the Tour of Britain and associated events.
- **(£751k)** - Increased spend on subcontractors within the engineers service in order to maintain capacity.
- **(62k)**-Other Minor Variations including increases in skip charges, system upgrades within Transport Services and an increase in security costs for opening and closing the cemeteries.

Operations and Neighbourhoods A

SAVINGS

Scheme	Savings Target 19/20 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Recovery of expenditure from new car parks	100		100				**100**
LED Street Lighting	250				250		**250**
Review of contracts and purchasing – using STAR/Oxygen	50	0			8	42	**50**
Advertising on Vehicles	5			5			**5**
Vacancy Factor	559					559	**559**
Fees & charges increase 2019/20	253				253		**253**
Total	**1,217**	**-**	**100**	**5**	**511**	**601**	**1,217**

Growth

R

Growth	Gross Expenditure Budget £000's	Gross Income Budget £000's	Net Budget £000's	Actual to date £000's	Forecast £000's	Variance £000's
Development Growth & Investment	315	0	315	(270)	191	124
Employment & Skills	2,068	(882)	1,187	(53)	1,126	60
Estates	1,920	(2,689)	(769)	(443)	(367)	(403)
Investment & Development	2,166	(1,122)	1,044	914	927	117
Planning	1,170	(998)	171	100	468	(296)
Strategic Infrastructure	637	(188)	449	102	368	81
School Catering	2,776	(2,772)	4	(36)	64	(60)
Corporate Landlord	8,414	(2,219)	6,195	2,931	6,673	(478)
Environmental Development	447	(79)	369	136	357	12
BSF, PFI & Programme Delivery	22,878	(22,878)	0	2,673	0	0
TOTAL	**42,791**	**(33,828)**	**8,964**	**6,056**	**9,806**	**(842)**

BUDGET VARIATIONS

The net variation reflects a number of underspends and pressures across the service, including:

Underspends:

- **£117k** – Expenditure less than budget due to vacancies in Investment and Development recruited to part way through the year.
- **£136k** - Expenditure less than budget due to vacancies in the Estates team. Recruitment is underway and a number of posts have been filled. There is also an over achievement of income on commercial investments.
- **£81k** - Expenditure less than budget due to vacancies in Strategic Infrastructure.

Pressures:

Estates budget pressures relate to a shortfall in income due to a number of factors.

- **(£539k) -** A number of posts have been vacant and this has led to a reduction in the number of chargeable hours within the service. There is also a hold on disposals and there are several vacant industrial units.

There are budget pressures in Corporate Landlord

- **(£478k) -** Rental income for tenants in Tameside one will not be realised in the early years. This has been anticipated and will be funded from contingency. There is uncertainty around the costs of operating Tameside One. This is reflected in high forecast spend for gas and electricity. There were additional costs as a result of keeping Two Trees open later in the year than planned.

Growth

R

BUDGET VARIATIONS

Planning Services

- **(£296k)** - Fee income from building control fees is less than budget. The planned recruitment of additional staff is underway as following a review of the service. The service plans to undertake another review following this

SAVINGS

Savings Performance:

- **(£60k)** Growth savings of £60k will not be delivered in 2019/20 due to delays recruiting staff to review Industrial rents and fewer large scale planning applications being made.
- **(£147k)** Increases in Fees and Charges will not be delivered due to staff vacancies and other issues highlighted above.

Scheme	Savings Target 19/20 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Sponsorship of events	2	0			2		**2**
Planning fees income	30	30					**0**
Review of rents and leases	30	30					**0**
Vacancy Factor 2019/20	76	0			76		**76**
Fees & charges increase 2019/20	147	147					**0**
Total	**285**	**207**	**0**	**0**	**78**	**0**	**78**

Governance G

Governance	Gross Expenditure Budget £000's	Gross Income Budget £000's	Net Budget £000's	Actual to date £000's	Forecast £000's	Variance £000's
Governance						
Executive and Business Support	1,726	(111)	1,615	666	1,453	161
Democratic Services	1,043	(311)	732	407	732	(0)
Governance Management	174	(88)	86	90	95	(8)
Legal	1,355	(82)	1,273	573	1,385	(112)
	4,298	**(593)**	**3,705**	**1,737**	**3,665**	**41**
Exchequer						
Exchequer Services	64,309	(62,733)	1,576	6,217	1,318	259
	64,309	**(62,733)**	**1,576**	**6,217**	**1,318**	**259**
People & Workforce Development						
People and Organisational Development	3,810	(1,325)	2,484	1,003	2,625	(141)
	3,810	**(1,325)**	**2,484**	**1,003**	**2,625**	**(141)**
Marketing & Communications						
Policy, Performance and Communications	1,728	(245)	1,483	714	1,483	(0)
	1,728	**(245)**	**1,483**	**714**	**1,483**	**(0)**
TOTAL	**74,144**	**(64,896)**	**9,248**	**9,671**	**9,091**	**158**

Underspends
The variance is a net position and reflects a number of underspends and pressures including:

- **£553k** – Employee related expenditure including training related expenses is less than budget due to a number of vacant posts and maternity across the service over the course of the year
- **£90k** - Cost Collection for Council Tax and Business rates are forecast under budget

Governance G

- **£146k** - The Housing Benefit overpayment collection team have collected cash of £701k, this is in excess of expectations which has resulted in an over achievement of the in-year saving allocated, the effect on the revenue account has resulted in the service being able to forecast a reduction in the bad debt provision by £54k, which gives an overall total underspend of £146k in this area.
- **£19k** - Other net minor variations across the individual service areas of less than £50k

Pressures

- **(£147k)** – Currently there is no forecast draw down of the £120k reserve funding in relation to the Workforce Development Service Review in 19/20 and £27k in relation to the Early Help Module.
- **(£42k)** - Government Grant related income is less than budgeted income target
- **(£71k)** - Projected income is less than budgeted Income target due to non take up of HR, Payroll and Recruitment and various other income streams
- **(£56k)** - There is current forecast spend in relation to Population Health Marketing and Communication activities, where funds are held in reserve
- **(£307k)** - Based on the Housing Benefit Mid-Year Estimate the forecast is currently £307k in excess of budget

SAVINGS

Savings Performance:

- **(£27k)** - Priority Account Service (Oxygen) savings target of £50k will not be fully achieved, current forecast £23k

Scheme	Savings Target 19/20 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Continuous Improvement	550					550	**550**
Oxygen Finance Project	50	27		15		8	**23**
Recovering of overclaims/old debts	175			175			**175**
Vacancy Factor	347				347		**347**
Fees & charges increase 2019/20	3			3			**3**
Total	**1,125**	**27**	**0**	**193**	**347**	**558**	**1,098**

Finance and IT G

Finance and IT	Gross Expenditure Budget £000's	Gross Income Budget £000's	Net Budget £000's	Actual to date £000's	Forecast £000's	Variance £000's
FINANCE						
Financial Management	2,993	(538)	2,455	720	2,234	221
Risk Management & Audit Services	3,554	(1,067)	2,486	559	1,884	602
	6,546	**(1,605)**	**4,941**	**1,279**	**4,118**	**823**
IT						
Digital Tameside	2,784	(632)	2,151	1,205	2,241	(90)
	2,784	**(632)**	**2,151**	**1,205**	**2,241**	**(90)**
TOTAL	**9,330**	**(2,237)**	**7,092**	**2,483**	**6,359**	**733**

BUDGET VARIATIONS

The net variance reflects a number of underspends and pressures including:

Underspends:

- **£268k** – Staffing underspends due to vacancies, timing of recruitment and staff having not taken up the pension option. This includes the combined vacancy factor of £128k.
- **£78k** - Projected reduction in spend on Cashier related payment systems.
- **£171k** - Projected additional MFD Income to the service and spend is anticipated to be lower than budget.

Pressures:

- **(£319k)** – The Corporate Costs budget covers equipment, software and maintenance for the Council's network, including security and backup software. It also covers the cost of operating system licence for laptops. The overspend is due to increased costs such as the operating system, extra power costs for the Data Centre, Wi-Fi and backup software as well as additional requirements for security systems. Costs have further increased in this area due to the requirement to upgrade essential software for the server infrastructure, which is used by all council systems, in order to remain secure and supported by the supplier.
- **(£37k)** - Other minor variations below £50k.

Finance and IT G

SAVINGS

Savings Performance:

- **£565k** - Insurance Review - Further to actuarial review in 2018/19 savings have been identified in relation to insurance provision.
- **£7k** - External Audit Fees - It is anticipated there will be a further £7k saving on top of the £69k planned saving. This is based on current projected spend.

Scheme	Savings Target 19/20 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Insurance review	150				565	150	**715**
External audit fees	69			7		69	**76**
Internal audit restructure	12					12	**12**
Central DSG grant	50					50	**50**
Vacancy Factor	128				128		**128**
Fees & charges increase 2019/20	2					2	**2**
Total	**411**	-	**0**	**7**	**693**	**283**	**983**

Capital Financing, Contingency and Corporate Costs G

Capital Financing, Contingency and Corporate Costs	Gross Expenditure Budget £000's	Gross Income Budget £000's	Net Budget £000's	Actual to date £000's	Forecast £000's	Variance £000's
Capital and Financing	10,788	(7,986)	2,803	(4,129)	(680)	3,483
Contingency	5,551	(235)	5,316	(3,377)	2,293	3,023
Corporate Costs	5,104	(473)	4,631	1,203	4,471	160
TOTAL	**21,443**	**(8,693)**	**12,750**	**(6,303)**	**6,084**	**6,665**

BUDGET VARIATIONS

The variance is a net position and reflects a number of underspends and pressures including:

Underspends:

- **£2,113k-** Anticipated income from investment in Manchester Airport Group
- **£572k-** Revised Minimum Revenue Position (MRP) calculations
- **£697k-** Anticipated reduction in interest costs due to planned borrowing not being taken up and revised interest projections
- **£50k-** Included within corporate costs are anticipated savings of £50k in respect of the coroners service based on updated projections provided by Stockport MBC.
- **£75k-** Other minor variations under £50k
- **£1,573k-** Release of contingency budgets to offset service overspends
- **£1,450k-** Waste & transport levy one-off benefit in year

Pressures:

- **(£70k)-** Increase internal interest charges based on final 2018/19 figures
- **(14k)-** Minor Variations transferred from CDC

Capital Financing, Contingency and Corporate Costs G

SAVINGS

Savings Performance:

- **35k** - Pensions Increase Act - These historic pension costs have reduced and it is anticipated there will be a further £35k saving on top of the £90k planned saving. This is based on current projected spend.
- **(£12k)** - Venture Fund no longer being progressed

Scheme	Savings Target 19/20 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Venture fund	12						**0**
Treasury Investment Income	130			125		255	**380**
Minimum Revenue Provision (MRP)	375					947	**947**
Capital Financing	232						**0**
Manchester Airport Investment (Exec Cabinet Approved Feb 18) £11m investment	1,015				564	564	**1128**
Income Generation - Increased income from Council Tax Rates	100					100	**100**
AGMA/GMCA	302					302	**302**
Pensions Increase Act	90			35		90	**125**
Review of the Town Council support	25					25	**25**
Vacancy Factor	7	7					**0**
Total	**2,288**	**7**	**0**	**160**	**564**	**2,283**	**3,007**

Capital Expenditure

- This is the second capital monitoring report for 2019/20, summarising the forecast outturn based on the financial activity to 30 September 2019.
- The detail of this monitoring report is focused on the budget and forecast expenditure for fully approved projects in the 2019/20 financial year. The approved budget for 2019/20 is £76.764m. Additional schemes will be added to future detailed monitoring reports once business cases have been approved by Executive Cabinet.
- The current forecast is for service areas to have spent £55.484m on capital investment in 2019/20, which is £21.280m less than the current capital budget for the year. This variation is spread across a number of areas, and is made up of a number of additional costs due to overspend against a number of specific schemes (£1.610m) less the re-phasing of expenditure in other areas totalling £22.890m.

CAPITAL MONITORING STATEMENT – SEPTEMBER 2019

	2019/20 Budget £000	Actual to 30 September 2019 £000	Projected 2019/20 Outturn £000	Projected Outturn Variation £000
Growth				
Investment & Development	5,848	1,037	3,100	2,748
Corporate Landlord	421	97	225	196
Estates	114	0	50	64
Operations and Neighbourhoods				
Engineers	13,350	4,467	13,047	303
Vision Tameside	8,708	1,153	3,156	5,552
Environmental Services	3,640	233	2,059	1,581
Transport (Fleet)	260	94	260	0
Stronger Communities	27	0	27	0
Children's				
Education	17,539	2,070	12,850	4,689
Finance & IT				
Finance	5,700	0	5,700	0
Digital Tameside	3,959	999	4,310	(351)
Population Health				
Active Tameside	15,970	5,560	10,360	5,610
Adults				
Adults	1,228	20	340	888
Total	**76,764**	**15,730**	**55,484**	**21,280**

Acute

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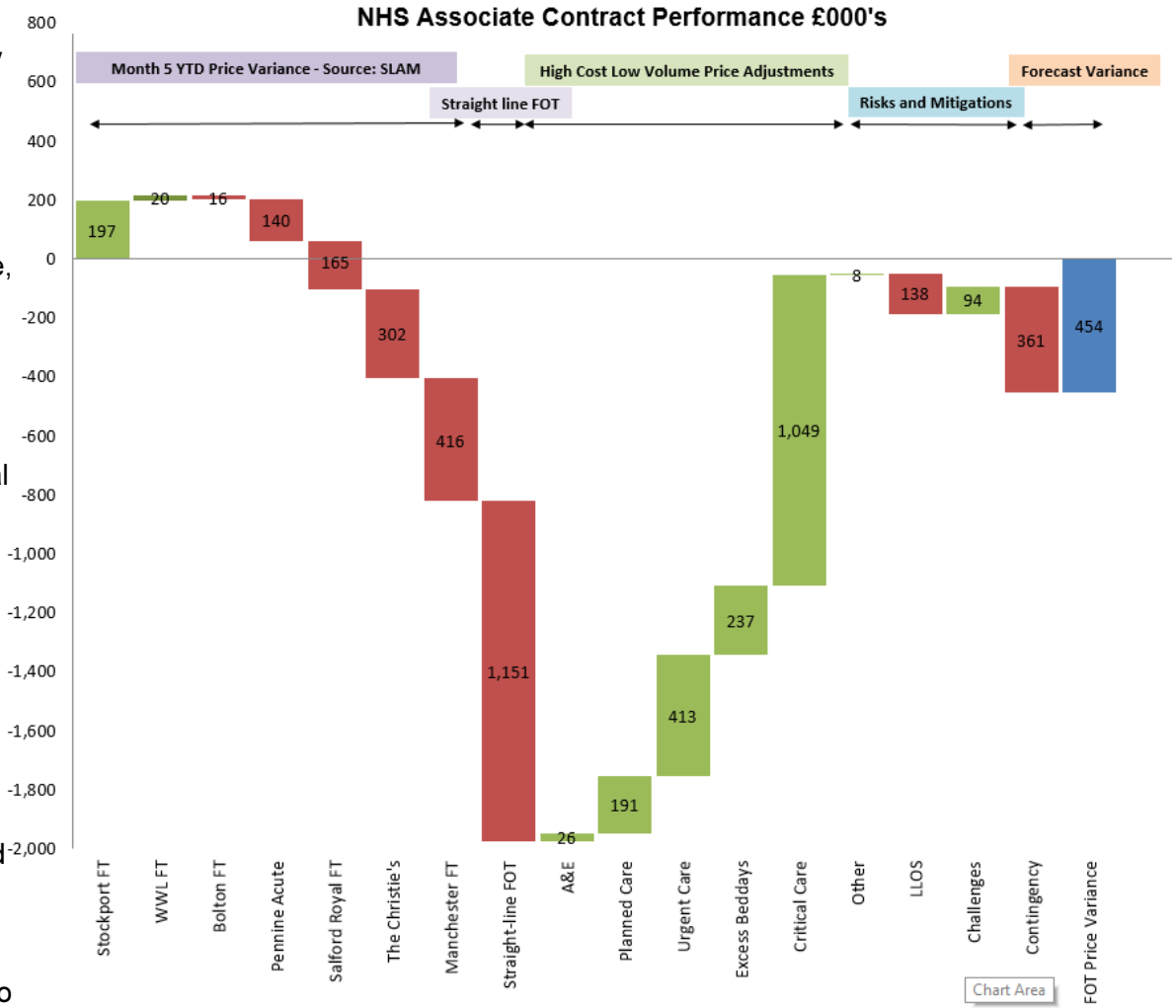
£000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Annual Budget £000's	Forecast Outturn £000's	Forecast Variance £000's	Movement from M5
Acute Commissioning	**99,426**	**100,221**	**(795)**	**200,798**	**201,278**	**(480)**	**7**
Tameside & Glossop ICFT	67,995	68,040	(45)	135,991	135,991	0	0
Manchester FT	16,209	16,279	(70)	32,922	33,066	(145)	(221)
Stockport FT	4,741	4,416	325	9,755	9,111	644	87
Salford Royal FT	2,969	3,127	(157)	5,865	6,015	(150)	28
Pennine Acute	1,757	1,954	(197)	3,496	3,690	(194)	110
The Christie	1,021	1,370	(349)	2,028	2,637	(609)	5
BMI Healthcare	1,236	1,312	(76)	2,473	2,634	(161)	(14)
Wrightington, Wigan & Leigh	444	420	24	974	912	62	9
Spamedica	602	781	(179)	1,204	1,499	(295)	(70)
Other Providers	2,451	2,521	(70)	6,092	5,724	368	72
Ambulance Services	**4,707**	**4,698**	**8**	**9,450**	**9,439**	**11**	**8**
Clinical Assessment & Treatment Centres	**795**	**871**	**(76)**	**1,591**	**1,705**	**(114)**	**0**
Collaborative Commissioning	**187**	**184**	**3**	**252**	**249**	**3**	**0**
High Cost Drugs	**68**	**101**	**(32)**	**136**	**182**	**(46)**	**0**
NCAS/OATS	**1,000**	**1,000**	**0**	**2,000**	**2,000**	**0**	**0**
Winter Resilience	**127**	**127**	**0**	**180**	**180**	**0**	**0**
Total - Acute	**106,310**	**107,202**	**(892)**	**214,407**	**215,033**	**(626)**	**16**

- **Independent sector** – IS contracts are a key driver of overspend within the Acute forecast. Two key specialties stand out:
  - *Ophthalmology*. Spa Medica is forecast to over perform by £295k, while we also have pressures with other ophthalmology providers. The full detail of this pressure was discussed as part of the deep dive report to FQAG in August. The increase in activity is largely attributable to an ageing population, but also because previously untreatable conditions which have recently become treatable.
  - *Orthopaedics*. Pressures at BMI and In Health (CATs) are dominated by MSK. This is a specialty which NHS providers are struggling to meet RTT targets within. Therefore under patient choice, more activity is being generated in the independent sector.
- **Associate Providers** – On the face of things, the forecast for the Acute commissioning cost centre may appear odd. With a forecast over performance of £480k, against a YTD over spend at the mid point of the year of £795k. Performance at associate providers (i.e. NHS providers in Greater Manchester other than the ICFT) lies behind this anomaly. The chart below attempts to explain the movement between YTD position at M5 (the latest data available from providers) and the forecast outturn position:
  - *Stockport FT* - £197k under plan. This is mainly within Day Case and Elective (£158k under in Orthopaedics), Outpatients First of £40k and Outpatient Follow Ups of £15k
  - *WWL FT* - £20k under plan. £106k under plan relates to Elective T&O, which is off set by over performance in Critical Care £11k, Excess Bedday of £15k and Non-Elective T&O of £40k.

Acute

G

- *Bolton FT* - £16k over plan. This is all critical care which is unusual, T&G had zero critical care activity at Bolton last year.
- *Pennine Acute* - £140k over plan. The key driver behind the PAHT performance is Ophthalmology, following changes to the sub-contract arrangement with the ICFT previously. But also obstetrics
- *Salford FT* - £165k over. £179k over in Critical Care, with no other material variances against contract.
- *The Christie* - £302k over plan. This is completely driven by the two main speciality areas, Clinical Haematology of £171k over plan and £71k in Medical Oncology.
- *Manchester FT* - £416k over plan. £368k on Critical Care. £105k on Excess Bed days. All other points of delivery are broadly in line with contract.



- At M5 total overspend on associate contracts is £822k (£577k of which relates to critical care including a single patient with 134 days care).
- Based on this data, a straight line extrapolation would result in a forecast over spend of £1,973k, which does not feel intuitively correct.
- As such adjustments have been made for high cost low volume items. Most notably for critical care and excess bed days, which by their very nature are difficult to plan for. But also for urgent and planned care, where high cost admissions have occurred in the first half of the year, which we wouldn't expect to be replicated in the second half of the year (e.g. pain management programme at Salford or unusual/complex procedures).
- Finally we add back risks and mitigations. This includes anticipated costs for long length of patients not yet billed to the CCG, contract challenges for non T&G registered patients and additional contingency in relation to the Christie over performance, Neuro Rehab patients and as a result of concerns around elective and day case activity.
- While the position includes some provision clear RTT backlogs in 19/20. The CCG has seen a 12.6% increase in people on the waiting lists versus the adjusted March 18 baseline. This presents a financial risk to the CCG as while the backlog is cleared.
- After all of above, associate contracts are forecast over performance by £454k, which against a combined plan of £55.4m represents a 0.8% pressure.

Mental Health

A

	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Annual Budget £000's	Forecast Outturn £000's	Forecast Variance £000's	Movement from M5
Child & Adolescent Mental Health	232	215	18	325	325	0	0
Improving Access To Psychological Therapies	96	97	(1)	192	193	(1)	(1)
Learning Disabilities	359	358	1	688	688	0	0
Mental Capacity Act	63	58	5	127	124	3	3
Mental Health Contracts	13,037	13,037	0	25,932	25,932	0	0
Mental Health Services - Adults	3,180	3,099	81	6,301	7,093	(792)	(338)
MH - Collaborative Commissioning	1,061	1,062	(1)	1,061	1,061	0	(0)
MH - Non Contracted Activity	37	54	(17)	75	100	(25)	(20)
Mental Health Services - Other	1,029	1,022	7	2,266	2,041	225	225
MH - Specialist Services	411	486	(75)	822	872	(50)	0
Mental Health Transformation	270	270	0	270	270	0	0
Total - Mental Health	**19,776**	**19,760**	**16**	**38,058**	**38,698**	**(640)**	**(131)**

- To comply with NHS planning guidance for 2019/20, the CCG has to demonstrate increased expenditure in mental health through the Mental Health Investment Standard. Forecast spend in the core Mental Health directorate, together with MH spend in Primary Care, CHC, Community and Acute shows that the CCG will be MHIS compliant for 2019/19. However, because of changes around the categorisation of dementia and learning disabilities we are forecasting that MH spend will increase by 5.8%, which is the minimum required under MHIS.
- As such MHIS could be at risk in the event of significant slippage against any of our current expenditure plans. To safeguard against this, commissioners are in the process of developing a series of non recurrent schemes (e.g. waiting list initiative's and pump prime schemes) which would be available for immediate mobilisation if required.
- At M6 the core MH position is broadly in line with plan. With £75k over spend relating to the additional patients in the Step Down Unit offset by an under spend of £77k relating to Adult Individualised Commissioned (IC) packages of care in the first half of the year.
- While IC packages may be underspending on a YTD basis, September saw two new individual packages of care commissioned at an exceptionally high cost. This included a 2:1 PICU package at a cost of £16k per week with no definite end date, which has resulted in a significant pressure against the budget.
- Across a Pennine Care commissioner footprint, NICHE have recently presented phase 2 findings from their review of the cost of mental health services. Further work is required to establish a definitive position that all 5 commissioners and Pennine Care can agree upon. However once complete the intention is that contracts are re-based in accordance with this definitive version of the truth, which may present a risk to the CCG financial position in future years.

Primary Care

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	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Annual Budget £000's	Forecast Outturn £000's	Forecast Variance £000's	Movement from M5
Prescribing	18,969	18,956	13	40,753	40,751	2	0
Delegated Co-commissioning	16,813	16,511	303	34,371	34,045	326	203
Out of Hours	1,155	1,299	(145)	2,309	2,454	(145)	0
Local Enhanced Services	988	940	47	1,931	1,882	49	0
Primary Care Investments	681	681	(0)	1,377	1,377	0	0
Primary Care IT	688	596	93	1,376	1,377	(1)	0
Central Drugs	568	591	(23)	1,193	1,239	(46)	(36)
Medicines Management - Clinical	233	228	4	484	480	4	1
Oxygen	224	208	16	477	477	0	0
GP FORWARD VIEW	472	472	(0)	472	472	0	0
Commissioning Schemes	142	150	(8)	285	297	(12)	8
Total - Primary Care	**40,933**	**40,632**	**301**	**85,028**	**84,851**	**177**	**175**

- **Prescribing** – Based on four months of prescribing data, £522k TEP has been achieved. This is against an annual target of £1,500k, meaning that the current trajectory is encouraging and that we are theoretically on tract to meet and exceed our target.
- However caution should be exercised around attainment of savings in future months, because of expected Category M price changes and potential impacts on supply and costs that will be caused by Brexit. Which is making it difficult to accurately forecast future expenditure.
- Pressure caused by items classified as No Cheaper Stock Obtainable (NCSO) seems to have reduced in the last two months but this may escalate as the date for Brexit approaches. It also remains to be seen whether there will be pressure caused by a particularly severe winter.
- The forecast for the remainder of the year does include some contingency relating to Brexit/Cat M and the situation continues to be closely monitored. We are currently forecasting that £1.25m of TEP will be achieved by year end. This includes additional budget (£22k for Q1) provided by NHSE for additional costs incurred in increasing the number of type 1 diabetes patients using flash glucose sensors
- Work continues to maximise TEP achievement this year including further reductions to unnecessary repeat prescriptions, while an additional Technician has been recruited to target prescribing of items which are routinely available over the counter.

- **Delegated Co-Commissioning** – Budgets have been set based on current commitments, and include an anticipated growth in list sizes through the financial year. Against this budget we are forecasting underspend of £326k at M6 (an improvement of £203k since last month). This underspend is generated via a non recurrent benefit in relation to estates which will not impact on delivery of front line services.
- Built into the position is £535k of contingency. A paper looking at how this will be spent was approved at Primary Care Committee in September. New initiatives including GP demand review, expansion of long term conditions function and diabetic foot screening now be funded in line with the CCG's 5 year forward view for primary care.

- **Out of Hours** – The £145k pressure relates to dual running costs following delays in opening the Urgent Treatment Centre.

Continuing Care

G

	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Annual Budget £000's	Forecast Outturn £000's	Forecast Variance £000's	Movement from M5
CHC Adult Fully Funded	4,301	3,836	465	10,103	9,838	265	551
CHC Adult Joint Funded	268	246	22	536	472	63	(4)
CHC Adult Personal Health Budgets	1,217	1,051	165	2,434	2,399	34	(292)
CHC Assessment & Support	520	497	23	1,105	1,058	47	(7)
Children's CHC Personal Health Budgets	15	15	(0)	30	16	13	0
Children's Continuing Care	52	70	(18)	104	151	(47)	(9)
Funded Nursing Care	1,003	974	29	2,006	1,918	88	(184)
Total - Continuing Care	**7,375**	**6,690**	**686**	**16,317**	**15,854**	**463**	**57**

- At M6 £500k of TEP has been realised against a full year target of £1m. Savings have been achieved as a result of the continued work of the Individualised Commissioning team. The team are continuing to closely monitor and review the appropriate use of fast track and high cost packages of care.

- Budgets are seasonally profiled on the basis of historic activity, with adjustments for provider uplifts and demographic growth. In addition to this, budgets include an assumption of additional activity during winter and incorporate some contingency calculated on the probability of exceptional high cost packages occurring.

- The main reason for our YTD underspend is that we have not had any exceptional high cost patients charged to CHC budgets this year (though there are two exceptional mental health packages being managed by the team). These exceptional packages can cost in the region of £20k per week, making forecasting difficult and meaning an apparent underspend can quickly turn into an over spend. It is on this basis that we are presenting the variance as underspend, rather than moving to TEP.

- Demand continues to be the main driver of uncertainty around Continuing Care. Home of choice, out of area placements, exceptional high cost packages and personal health budgets are all risks that have been factored into the forecast position. The CCG is anticipating that the additional activity will start to appear as the Winter months approach and this has been assumed in our Forecast outturn estimate. Over the Winter months, the impact of additional Winter pressures will be monitored closely and reviewed each month to ascertain if the assumed increase in demand materialises.

- Based on this data we are now confident that Individualised Commissioning will achieve it's full TEP target of £1m. Subject to winter and the emergence of any exceptional high cost patients there is potential for this figure to increase.

Community

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	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Annual Budget £000's	Forecast Outturn £000's	Forecast Variance £000's	Movement from M5
Community Services	15,798	15,808	(10)	32,250	32,269	(19)	0
Hospices	294	294	(0)	638	638	0	0
Wheelchair Service	181	181	0	438	438	0	0
Palliative Care	43	28	16	87	71	16	(0)
Total - Community	**16,316**	**16,310**	**6**	**33,413**	**33,416**	**(3)**	**0**

- The majority of the community services budget relates to services provided by the ICFT within the scope of the block contract. Payments are fixed and are not expected to change throughout the year
- Other services have delivered broadly in line with budget. The slight underspend on palliative care relates to a temporary change in working hours of the post holder.

Other

G

	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Annual Budget £000's	Forecast Outturn £000's	Forecast Variance £000's	Movement from M5
Better Care Fund	6,415	6,415	0	12,830	12,830	0	0
Programme Projects	4,463	4,460	3	4,686	4,671	15	11
Property Services	2,185	2,120	65	4,254	4,325	(72)	40
Commissioning Reserve	(305)	0	(305)	2,281	1,631	650	(156)
Patient Transport	596	548	48	1,193	1,180	13	15
Transformation Funding	1,162	1,156	6	1,162	1,162	0	(4)
NHS 111	326	327	(1)	659	668	(9)	8
Safeguarding	258	240	18	519	505	14	(2)
Clinical Leads	153	150	3	340	325	15	0
Nursing and Quality Programme	109	106	3	218	215	3	0
Commissioning - Non Acute	53	24	29	76	76	0	(29)
Interpreting Services	17	17	0	17	17	0	0
Total - Other	**15,432**	**15,565**	**(134)**	**28,235**	**27,607**	**629**	**(117)**

- **Programme Projects** – Includes the increased contribution to the Integrated Commissioning Fund of £4,200k offset by smaller budget transfers to TEP for unrequired funding.

- **Transformation Fund** – Following increased transformation funding received in 2018/19 the total funding for 2019/20 reduced by £3.8m to accommodate a re-profiling of expenditure on Support at Home. Forecast spend until programme completion has been adjusted accordingly and the outstanding £2,323k will be received equally for each quarter of 2019/20 (£1,156k at Q2)

- **Property Services** – Work is still ongoing relating to outstanding disputes with NHS Property Services (NHSPS) – some of which date back to FY 2017/18 'true up' charges. Budgets and forecasting is based on historic intelligence, with uplifts applied. This may result in a small benefit, should the challenges put into the system, come into fruition. We have an expectation that resolution of historic disputes will contribute to TEP achievement this year.

- **Commissioning Reserve** – This represents in year contingency set aside to manage risk and provide for known pressures. The apparent underspend is required to ensure that the reported CCG position is balanced. This will reduce as TEP achievement increases. Specific contingencies currently in the position include healthier together, overseas visitors, neuro rehab, cancer transformation and GM levy.

CCG Running Costs

G

	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Annual Budget £000's	Forecast Outturn £000's	Forecast Variance £000's	Movement from M5
Finance	488	485	3	991	983	7	(3)
Commissioning	445	442	3	909	909	1	(6)
QIPP	0	0	0	893	893	0	0
CEO/Board Office	276	273	3	573	550	23	4
ADMINISTRATION & BUSINESS SUPPORT	127	127	0	341	304	37	5
Corporate Costs & Services	137	134	3	280	280	0	0
IM&T	140	140	0	280	272	8	3
Communications & HR	104	104	0	208	202	6	(4)
Nursing	69	68	1	138	136	2	0
Corporate Governance	63	62	1	126	126	0	0
Chair & Non Execs	65	65	0	111	110	1	7
Estates & Facilities	52	52	0	104	104	0	0
General Reserve - Admin	0	0	0	1	86	(85)	(85)
IM&T Projects	38	36	3	77	78	(2)	76
Contract Management	32	32	0	64	64	0	(0)
Human Resources	21	21	(0)	41	41	0	0
Equality & Diversity	14	14	0	28	26	2	2
Total - CCG Running Costs	**2,071**	**2,053**	**17**	**5,164**	**5,164**	**(0)**	**(0)**

- The CCG receives an earmarked allocation of £5,164k to fund running costs. We are not allowed to exceed this limit, but any underspend on running costs can be used to offset pressures across the CCG as a whole.
- Savings of £893k have been made in the first half of the year. £787k of this is recurrent and includes:
  - Integration Benefits: Staffing e.g. single CEO, Co-location
  - Corporate Re-organisation (lay members & board)
  - Renegotiated Contracts (e.g. GMSS, Audit, Vodafone)
- From 2020/21 running cost allocations nationally will be reduced by 20%. The recurrent savings above will contribute towards the CCG managing within the 2020/21 allocation.
- Total running costs savings for 19/20 are forecast at £1,034k.

APPENDIX 3

IRRECOVERABLE DEBTS OVER £3000
1 July 2019 to 30 September 2019
Note individuals are anonymised

REF:	DEBT:	FINANCIAL YEAR(S)	BALANCE	REASON
13967554	Council Tax	2017 – 2018 £1273.00 2018 – 2019 £1305.00 2019 – 2020 £1550.71	£4128.71	Individual Voluntary Arrangement approved 30/04/2019
16667627	Council Tax	2014 – 2015 £552.09 2015 – 2016 £1036.72 2016 – 2017 £1073.60 2017 – 2018 £1129.36 2018 – 2019 £1187.46	£4979.23	Individual Voluntary Arrangement approved 30/04/2019
12487188	Council Tax	2016 – 2017 £253.64 2017 – 2018 £1129.36 2018 – 2019 £1187.46 2019 – 2020 £1249.03	£3819.49	Individual Voluntary Arrangement approved 26/06/2019
11460452	Council Tax	2010 – 2011 £557.53 2011 – 2012 £251.25 2013 – 2014 £28.33 2014 – 2015 £779.88 2015 – 2016 £974.20 2016 – 2017 £1083.00 2017 – 2018 £1303.58 2018 – 2019 £1371.38 2019 – 2020 £1442.87	£7792.02	Individual Voluntary Arrangement approved 20/06/2019
COUNCIL TAX		**SUB TOTAL – Individual Voluntary Arrangement**	**£20,719.45**	
COUNCIL TAX IRRECOVERABLE BY LAW TOTAL			**£20,719.45**	
65561335 65561304 65561366 65561441 65561625 65561687	Business Rates	BAK Furniture Ltd Unit RM101A Ground Floor Ray Mill Clarence Street Stalybridge SK15 1QP Company Dissolved 09/01/2018	2015 – 2016 £11,411.21 2016 – 2017 £19,771.40 2017 – 2018 £9888.75	£41,071.36
65562857 65561823 65561892 65562437 65562604 65562628 65562673 65562727 65562895	Business Rates	PLAC Ltd Third Floor Ray Mill Stalybridge SK15 1QP Company Dissolved 07/11/2017	2015 – 2016 £15,187.00 2016 – 2017 £23,349.29	£38,536.29
65557084	Business Rates	GK Wholesale UK Ltd Unit 33 Market Arcade The Arcades Warrington Street Ashton under Lyne OL6 7JE Company Dissolved 20/11/2018	2017 – 2018 £8136.74	£8136.74

65571387	Business Rates	Junction 3 Motors Direct Ltd John Street Hyde SK14 2HB Company Dissolved 20/06/2017	2015 – 2016 £498.03 2016 – 2017 £5929.00	£6427.03
65525421	Business Rates	T & L Enterprise Ltd 15 Church Street Royton Oldham OL2 5LG Company Dissolved 10/10/2017	2017 – 2018 £3930.00 2018 – 2019 £5236.19	£9166.19
65543658 65546923	Business Rates	Red 60 Shops Ltd 477A Barlowmoor Road Manchester M21 8AG Company Dissolved 15/01/2019	2017 – 2018 £27,135.51 2018 – 2019 £27,150.87	£54,286.38
65489976	Business Rates	Appliances Centre Ltd Rear 1st Floor 39 – 41Market Street Hyde SK14 2AD Company Dissolved 18/08/2015	2014 – 2015 £4224.00 2015 – 2016 £352.02 2016 – 2017 £2695.54	£7271.56
65502770 65534937 65541959 65553303	Business Rates	Bond Street Shoe Company Ltd 4,20 & 22 – 24 Mercian Mall Ashton under Lyne OL6 7JH & Unit 3 The Arcades Ashton under Lyne OL6 7AD Company Dissolved 28/03/2018	2015 – 2016 £7069.98 2016 – 2017 £30,081.89 2017 – 2018 £40,754.16	£77,906.03
65537837	Business Rates	Indian Ocean Cuisine (North) Ltd 83 Stamford Street East Ashton under Lyne OL6 6QQ Company Dissolved 22/01/2019	2016 – 2017 £4452.62 2017 – 2018 £12,086.57 2018 – 2019 £13,166.22	£29,705.41
BUSINESS RATES		**SUB TOTAL – Company Dissolved**	**£272,506.99**	
65464717	Business Rates	F74 Derby Ltd 40 Staveleigh Mall Ladysmith Centre Ashton under Lyne OL6 7JJ Company in Liquidation 22/06/2018	2013 - 2014 £15,293.90 2014 - 2015 £18,328.46	£33,622.36
65567913	Business Rates	Integrity Retail Ltd Unit 3 Manchester Road Hyde SK14 1BA Company in Liquidation 11/06/2019	2018 – 2019 £16,714.08 2019 – 2020 £4152.05	£20,866.13
65391192	Business Rates	M A & J L Hughes Ltd Dog & Pheasant 528 Oldham Road Ashton under Lyne OL7 9PQ Company in Liquidation 24/04/2018	2016 – 2017 £7736.60 2017 – 2018 £5641.00 2018 – 2019 £596.09	£13,973.69
BUSINESS RATES		**SUB TOTAL - Company in Liquidation**	**£68,462.18**	
BUSINESS RATES IRRECOVERABLE BY LAW TOTAL			**£340,969.17**	
7132735	Overpaid Housing Benefit	2013 – 2014, 2015 – 2016, 2016 - 2017 £3809.22 2018 – 2019 £186.96	£3996.18	Individual Voluntary Arrangement

				approved 25/03/2019
7155149	Overpaid Housing Benefit	2012 – 2013, 2013 – 2014, 2014 – 2015 & 2015 – 2016 £4321.89	£4321.89	Individual Voluntary Arrangement approved 21/03/2019
OVERPAID HOUSING BENEFIT		**SUB TOTAL – Individual Voluntary Arrangement**	**£8318.07**	
7193897	Overpaid Housing Benefit	2012 – 2013, 2013 – 2014, 2014 – 2015 & 2015 – 2016 £3137.89	£3137.89	Debt Relief Order granted 07/11/2016
OVERPAID HOUSING BENEFIT		**SUB TOTAL – Debt Relief Order**	**£3137.89**	
OVERPAID HOUSING BENEFIT IRRECOVERABLE BY LAW TOTAL			**£11,455.96**	

DISCRETION TO WRITE OFF OVER £3000
1 April 2019 to 30 June 2019
Note individuals are anonymised

16055828	Council Tax	2012 – 2013 £243.69 2013 – 2014 £859.42 2014 – 2015 £946.40 2015 – 2016 £961.72 2016 – 2017 £998.60 2017 – 2018 £518.38	£4528.21	Deceased 12/07/2009, no estate
17223106	Council Tax	2014 – 2015 £884.17 2015 – 2016 £961.72 2016 – 2017 £998.60 2017 – 2018 £693.09	£3537.58	Deceased 29/11/2017, no estate
COUNCIL TAX		**SUB TOTAL – Deceased, no estate**	**£8065.79**	
COUNCI L TAX DISCRETIONARY WRITE OFF TOTAL			**£8065.79**	
7099933	Overpaid Housing Benefit	2008 – 2009, 2009 – 2010 & 2010 – 2011 £9300.06	£9300.06	Deceased 17/05/2018, no estate
7000511	Overpaid Housing Benefit	2001 – 2002 & 2002 -2003 £4285.84	£4285.84	Deceased 29/04/2017 no estate
7001484	Overpaid Housing Benefit	2004 – 2005, 2005 – 2006, 2006 – 2007, 2007 – 2008, 2008 – 2009 & 2009 – 2010 £6610.45	£6610.45	Deceased 16/07/2018 no estate
7174654	Overpaid Housing Benefit	2003 – 2004 & 2014 – 2015 £3682.41	£3682.41	Deceased 21/01/2017 no estate
7159145	Overpaid Housing Benefit	2015 – 2016 & 2016 - 2017 £5474.71	£5474.71	Deceased 14/08/2016 no estate

7092257	Overpaid Housing Benefit	2011 – 2012, 2012 – 2013 & 2016 – 2017 £3892.83	£3892.83	Both Parties Deceased 21/02/2018 & 23/07/2018, no estate
OVERPAID HOUSING BENEFIT		**SUB TOTAL – Deceased, no estate**	**£33,246.30**	
7221730	Overpaid Housing Benefit	2012 – 2013, 2014 – 2015 & 2015 - 2016 £5296.74	£5296.74	Absconded, no trace
OVERPAID HOUSING BENEFIT		**SUB TOTAL – Absconded, no trace**	**£5296.74**	
OVERPAID HOUSING BENEFIT DISCRETIONARY WRITE OFF TOTAL			**£38,543.04**	
494658	Sundry Debts, Residential Care charges	2008 – 2009 £3738.77 2009 – 2010 £1244.58	£4983.35	Deceased, 20/04/2011, no estate
399575	Sundry Debts, Residential Care charges	2008 – 2009 £3649.16	£3649.16	Deceased 10/10/2008, no estate
566007	Sundry Debts, Residential Care charges	2011 – 2012 £6472.45 2012 – 2013 £2260.44 2013 – 2014 £770.04 2014 – 2015 £247.58	£9750.51	Deceased 12/08/2014, no estate
4000803	Sundry Debts, Residential Care charges	2012 – 2013 £12,677.25	£12,677.25	Deceased 17/03/2015, no estate
547123	Sundry Debts, Residential Care charges	2008 – 2009 £6233.60 2009 – 2010 £497.60 2010 – 2011 £1594.28 2011 – 2012 £549.14	£8874.62	Deceased 15/03/2012, no estate
598088	Sundry Debts, Residential Care charges	2010 – 2011 £2632.57 2011 – 2012 £4927.11	£7559.68	Deceased 14/01/2015, no estate
4007573	Sundry Debts Overpaid Direct Payment	2015 – 2016 £30,005.91	£30,005.91	Deceased 14/11/2018, no estate
SUNDRY DEBTS		**SUB TOTAL – Deceased, no estate**	**£77,500.48**	
SUNDRY DEBTS DISCRETIONARY WRITE OFF TOTAL			**£77,500.48**	

SUMMARY OF UNRECOVERABLE DEBT OVER £3000		
IRRECOVERABLE by law	Council Tax	£20,719.45
	Business Rates	£340,969.17
	Overpaid Housing Benefit	£11,455.96
	Sundry	NIL
	TOTAL	**£373,144.58**

DISCRETIONARY write off – meaning no further resources will be used to actively pursue	Council Tax	£8065.79
	Business Rates	NIL
	Overpaid Housing Benefit	£38,543.04
	Sundry	£77,500.48
	TOTAL	**£124,109.31**

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APPENDIX 4 – Collection Fund Update

Council Tax

The Council has a significant historic surplus on the Council Tax Collection Fund, due to collection rates exceeding expectations. For 2019/20 the budget assumes the transfer of this surplus (as estimated in January 2019) to the General Fund, which resulted in a budgeted deficit for the 2019/20 financial year. Excluding this transfer, the Council Tax collection fund is expected to break even in 2019/20.

The actual surplus at 31 March 2019 was higher than the estimate, resulting in a forecast residual surplus on the collection fund at 31 March 2020. This will be transferred to the General Fund in 2020/21.

Non-Domestic Rates (NDR)

The 2019/20 budget assumed a small deficit on the NDR collection fund due to an increase in reliefs which are offset by additional grants. As at period 6, the NDR collection fund is forecast to be in deficit by £2.8m at the end of the financial year. This is in part due to a reduction in rateable values across the borough, and also due to an increase in unoccupied property relief, with the collapse of Thomas Cook having a significant impact. The Council maintains a smoothing reserve to mitigate the impact of unexpected deficits on NDR income, however any permanent reductions to NDR income will place further pressure on future budgets.

	BUDGET 1920			Forecast M6		
	31 March 2019			31 March 2019		
	Council Tax £000	NDR £000	Total £000	Council Tax £000	NDR £000	Total £000
(Surplus)/deficit for the year	**13,272**	**908**	**14,180**	**12,661**	**2,150**	**14,811**
Balance brought forward	(17,003)	657	**(16,346)**	(17,003)	657	**(16,346)**
(Surplus)/deficit for the year	13,272	908	**14,180**	12,661	2,150	**14,811**
(Surplus)/Deficit carried forward	**(3,731)**	**1,565**	**(2,166)**	**(4,342)**	**2,807**	**(1,535)**
Share of (surplus)/deficit						
The Council	(3,143)	1,549	**(1,593)**	(3,657)	2,779	**(878)**
Mayoral Police and Crime Commissioner	(424)	0	**(424)**	(493)	0	**(493)**
GM Fire and Rescue Authority	(165)	16	**(149)**	(191)	28	**(163)**
Total (Surplus)/Deficit	**(3,731)**	**1,565**	**(2,166)**	**(4,342)**	**2,807**	**(1,535)**

APPENDIX 4 – Collection Fund Update

	BUDGET 1920			Forecast M6		
	31 March 2019			31 March 2019		
	Council Tax £000	NDR £000	Total £000	Council Tax £000	NDR £000	Total £000
Income						
Income from Council Tax	(110,947)		**(110,947)**	(111,570)		**(111,570)**
Income from NDR		(58,074)	**(58,074)**		(57,135)	**(57,135)**
Total Income	**(110,947)**	**(58,074)**	**(169,021)**	**(111,570)**	**(57,135)**	**(168,705)**
Expenditure						
Council Tax						
The Council	91,579		**91,579**	91,579		**91,579**
Mayoral Police and Crime Commissioner	12,355		**12,355**	12,355		**12,355**
GM Fire and Rescue Authority	4,795		**4,795**	4,795		**4,795**
NDR						
The Council		51,805	**51,805**		51,805	**51,805**
GM Fire and Rescue Authority		523	**523**		523	**523**
Allowance for cost of collection		287	**287**		291	**291**
Transitional Protection Payments		942	**942**		937	**937**
Increase/(decrease) in:						
Allowance for non-collection	2,219	1,744	**3,963**	2,231	1,615	**3,846**
Provision for appeals		2,773	**2,773**		3,259	**3,259**
Surplus/deficit allocated/paid out in year:						
The Council	11,329	899	**12,228**	11,329	846	**12,175**
Mayoral Police and Crime Commissioner	1,397		**1,397**	1,397		**1,397**
GM Fire and Rescue Authority	545	9	**554**	545	9	**554**
Total Expenditure	**124,219**	**58,982**	**183,201**	**124,231**	**59,285**	**183,516**
(Surplus)/deficit for the year	**13,272**	**908**	**14,180**	**12,661**	**2,150**	**14,811**

Report to :	**STRATEGIC COMMISSIONING BOARD**
Date :	27 November 2019
Executive Member/Reporting Officers:	Cllr Brenda Warrington – Executive Leader Dr Ashwin Ramachandra / CCG Co-Chair Sandra Stewart – Director Governance and Pensions Sarah Dobson – Assistant Director Policy, Performance and Communications
Subject :	**ENGAGEMENT UPDATE**
Report Summary :	The report provides the Strategic Commissioning Board and Executive Cabinet with an update on the delivery of engagement and consultation activity in the last two years. Much of the work is undertaken jointly – coordinated through the Tameside and Glossop Partnership Engagement Network (PEN) – by NHS Tameside and Glossop Clinical Commissioning Group, Tameside Council and Tameside and Glossop Integrated Care NHS Foundation Trust. However, it should be noted that each of the three agencies undertake work individual where necessary and appropriate for the purposes of specific projects. Engagement is relevant to all aspects of service delivery, all the communities of Tameside and Glossop, and wider multi-agency partnership working. The approach is founded on a multi-agency conversation about 'place shaping' for the future prosperity of our area and its communities.
Recommendations :	The Strategic Commissioning Board and Executive Cabinet are asked to note the contents of the report and support future engagement and consultation activity with the communities of Tameside and Glossop.
Links to Corporate Plan:	Achieving the objectives and priorities of the Corporate Plan is dependent on effective service delivery which meets the needs of local residents. Undertaking engagement and consultation to inform service development makes for better services and improved impact.
Policy Implications :	There are no direct policy implications as a result of this report but the activity outlined ensures policies regarding engagement are delivered. Engagement activity (alongside other considerations) will inform policy development in the relevant thematic areas.
Financial Implications : **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	There are no direct financial implications as a result of this report.
Legal Implications : **(Authorised by the Borough Solicitor)**	Local government, NHS England, CCGs, and NHS trust/foundation trusts all have separate but similar legal obligations to consult or otherwise involve the public. Duties for local government to consider are that of: • overview and scrutiny • public sector equality duty

- health and wellbeing boards
- the legal requirement to hold meetings in public, except where it is permissible to exclude the public.

Due to the democratic accountability of local government, even where there is no legal duty, public consultation is a principle that it continually reinforced. The four main stakeholder groups it is important to reach are:

- service users and the wider public
- clinical staff
- the wider workforce
- local leaders and local politicians.

A well thought through and documented engagement approach, involving the public, communities and other stakeholders, even where there is no obligation by law to do so, is in most circumstances the right thing to do and will ensure services meet the needs of the population. Additionally where possible joint public involvement exercises are encouraged between local government and NHS partners as they reduce the burden on service users and the wider public. Effective communication and involvement throughout will help to build ownership and support for proposals.

Risk Management : The approach and activity outlined in the report ensures that both Tameside Council and Tameside and Glossop Clinical Commissioning Group meet their obligations with regards to engagement and consultation with local communities.

Access to Information : The background papers relating to this report can be inspected by contacting Simon Brunet, Head of Policy of Policy, Performance and Intelligence (Tameside and Glossop Strategic Commission)

 Telephone:0161 342 3542

 e-mail: simon.brunet@tameside.gov.uk

1. PURPOSE OF THE REPORT

1.1 The report provides the Strategic Commissioning Board and Executive Cabinet with an update on the delivery of engagement and consultation activity in the last two years. Much of the work is undertaken jointly – coordinated through the Tameside and Glossop Partnership Engagement Network (PEN) – by NHS Tameside and Glossop Clinical Commissioning Group, Tameside Council and Tameside and Glossop Integrated Care NHS Foundation Trust. However, it should be noted that each of the three agencies undertake work individual where necessary and appropriate for the purposes of specific projects.

1.2 Engagement is relevant to all aspects of service delivery, all the communities of Tameside and Glossop, and wider partnership working. The approach is founded on a multi-agency conversation about 'place shaping' for the future prosperity of our area and its communities.

2. KEY HEADLINES

2.1 The key headlines from 2018/19 are summarised in the box below.

- Facilitated over 39 thematic Tameside and/or Glossop engagement projects
- Received over 6,000 engagement contacts (excluding attendance at events / drop-ins) – 2,600 in 2017, 2,400 in 2018 and 1,200 so far for 2019.
- Delivered seven Partnership Engagement Network (PEN) conferences attended by over 450 delegates.
- Supported 36 engagement projects at the regional and Greater Manchester level
- Promoted 56 national consultations where the topic was of relevance to and/or could have an impact on Tameside and/or Glossop
- Continued to implement the Tameside and Glossop Engagement Strategy, which was co-designed with the Partnership Engagement Network (PEN)
- Continued to develop the Partnership Engagement Network (PEN) family, a database of residents, patients and stakeholders who receive a monthly digest of all live engagement and consultation for them to access from one place.
- Facilitated the NHS England 'What Matters to You?' campaign for the second year (an optional national campaign).
- Undertook the first joint budget consultation exercise for Tameside Council and NHS Tameside and Glossop Clinical Commissioning Group
- Delivered three stakeholder 'summits' bringing a range of public service leaders, VCFSE groups and public / patient representatives together to guide future planning on key issues – Green Summit (November 2018), Neighbourhood Summit (January 2019) and Co-operative Summit (October 2019).
- Achieved Green Star (with the highest possible score of 15 out of 15) in the 2018/19 public and patient participation Improvement and Assessment Framework (IAF) *

(*) Note: CCG only. The Council and ICFT are not assessed under an engagement IAF.

2.2 A table listing all engagement activity facilitated, supported or promoted in the last two years is attached at **Appendix 1** for information.

3. CROSS CUTTING THEMES

3.1 Responses to all thematic engagement and consultation activity is thoroughly analysed and the outputs used to information the specific project related to that piece of work. Clearly common themes occur across the difference thematic engagement activity. Similarly the strategic engagement work through the Partnership Engagement Network (PEN) provides an insight into views and opinions outside of the topic specific thematic work. These cross-cutting themes help to provide a direction of travel and under-pinning understanding of needs and aspirations.

3.2 Below is a summary of the key cross-cutting themes identified in 2018/19.

- Support for young people including learning opportunities and apprenticeships
- Availability of public transport giving access to services (routes and evenings/weekends)
- Transport costs, including the cost of public transport
- Parking at or close to service points – accessible and affordable
- Raising standards and quality of services
- Development of digital services but don't forgot older people and those with learning disabilities
- Availability of appointments for key services, and waiting times
- Service providers and professional listening to patients and service users
- Knowledge of what services are available and how to access them
- Impact of service changes on low income households, those with long term conditions and families
- Help with financial management and other issues for those at greatest risk
- Focus on long term support at the lower level to prevent need for intensive interventions
- More help, support and opportunities for children, young people and families
- Concerns about ageing population – more support for older people to reduce need for care
- Person-centred care: focus on the individual and their needs
- 'Tell it once' approach for patients and service users
- Need more mental health services
- Public/private/third sector need to work together
- Better signposting from services to other services

4. WHAT MATTERS TO YOU

4.1 'What Matters to You' is a national campaign led by NHS England that each year encourages and supports more conversations between those who commission health and social care and those who receive it. From 6 June to 31 July 2019, Tameside and Glossop Clinical Commissioning Group (alongside Tameside Council) jointly promoted and facilitated the 'What Matters to You' campaign.

4.2 Feedback cards were circulated across a wide range of platforms such as GP surgeries, voluntary, community, faith and social enterprise (VCFSE) sector organisations, care homes, town halls, local Healthwatch organisations, libraries and Patient Participation Groups (PPG). Those who attended the June 2019 conference of the Partnership Engagement Network were also engaged in a number of workshops.

4.3 In 2019, a total of 142 responses were received, an increase of nearly half on the year previous. The top 10 themes drawn out of the feedback were:

- Availability of GP appointments (a 15% increase on 2018)
- Thank you NHS (a 5% increase on 2018)
- Availability of appointments in general

- Better social care provision and better access to social care (a 2% decrease on 2018)
- More access to mental health, especially men's and pregnant women's mental health issue
- Waiting times for referrals (a 4% decrease on 2018)
- Importance of local services and knowledge of those services (a 2% decrease)
- Being listened to (a 9% decrease)
- Overall wellbeing, keeping myself healthy and having the knowledge of what services are in my area (a 10% decrease)
- More investment in the NHS

4.4 The findings from the 2019 campaign have been shared with senior leaders for their use to inform future service improvement.

5. PARTNERSHIP ENGAGEMENT NETWORK (PEN)

5.1 At its best, meaningful and effective public and patient engagement is a range of different activities where each element informs the development of specific projects or plan and the whole provides a strategic view to guide forward plans for the area – 'place shaping'. With this in mind, it was agreed to establish a Partnership Engagement Network (PEN) to deliver a strategic approach to engagement and consultation across Tameside and Glossop.

5.2 There have now been seven Tameside and Glossop Partnership Engagement Network (PEN) conferences. Feedback from the conferences is positive with 9 out 10 delegates rating them as very good or good overall, and 9 out of 10 delegates saying they were given enough opportunity to express their opinions.

5.3 The table below summarises the topics discussed at each of the conferences.

Conference	Presentations	Workshops
October 2017 (Over 60 delegates)	• Partnership Engagement Network Approach • Shared Priorities and Objectives • Care Together	• Integrated Neighbourhoods • Intermediate Care proposals • Patient voice in care and support planning • Mental Health • Preventing Homelessness Strategy • Air quality
February 2018 (Over 60 delegates *)	• Patient Choice • Active Ageing • Partnership Engagement Network Update	• Patient Choice • Active Ageing Strategy • One Equality Scheme • Preventing hateful extremism and promoting social cohesion • Development of a new 'Compact' • Public Behaviour Change (Self Care Alliance)

Conference	Presentations	Workshops
June 2018 (Over 80 delegates)	• Improving Access to Primary Care • Partnership Engagement Network Update • What Matters to You	• Working Together to Tackle and Prevent Homelessness • Identifying and Supporting Ex-Service Personnel in the Armed Forces Covenant • Increasing Digital Skills and Employment • Prescribing of Over the Counter Medicine • Planning at End of Life • Improving Access to Primary Care
October 2018 (Over 70 delegates)	• Frailty • PEN update	• Frailty • Community Safety • Patient Centred Diagnosis Discussions in Long Term Conditions • Collaborative Practice in Primary Care • Tameside's Big Food Debate • Children's Emotional Health and Wellbeing
February 2019 (Over 70 delegates)	• Corporate Plan • Living Life Well	• Living Life Well (All Attendees) • PEN Development Session (All Attendees) • Loneliness • Greater Manchester Moving Local Delivery Pilot • Corporate Plan • Building a Social Movement around Community Wellbeing • Social Prescribing and Asset Based Community Development
June 2019 (Over 80 delegates)	• Greater Manchester Clean Air Plan • Tackling Dementia in Tameside and Glossop	• Active Neighbourhoods, Greater Manchester Get Moving Campaign • Personalised Care Planning at the End of Life • Tackling Dementia in Tameside and Glossop • New Ways to Access General Practice • Tameside and Glossop Lung Health Checks • Tameside and Glossop Bereavement Booklet
October 2019	• Health Inequalities / Mayors Challenge Fund • Advanced Care Planning – You Said, We Did	• ICFT Health Inequalities – Closing the Gap • Active Parks • ICFT Patient Experience & Service User Engagement Strategy • ICFT Volunteer Strategy • Co-operative Councils • SAMMIE (Smoking, Alcohol, Mobility,

Conference	Presentations	Workshops
		Mental Health, Isolation and Elderly) campaign.

(*) Note: over 80 participants signed up to attend but a large number of apologies were received on the morning due to the adverse weather condition.

5.4 Full feedback reports are available for the conferences are posted on the Partnership Engagement Network (PEN) pages of both the council and CCG website. Similarly, for all thematic engagement and consultation activity a short feedback report is posted on the Big Conversation pages of the Tameside Council website (with links also included on the CCG website).

5.5 In addition to the conferences there have been six Partnership Engagement Network (PEN) forums (smaller focused groups). The topics covered by the forums include Palliative and End of Life Care; Age Friendly Tameside; MacMillan Recovery Services; Patient Experience and Equalities; and the joint Engagement Strategy.

5.6 Over the last year three large scale stakeholder 'summits' have been held on key themes. These bring together a range of public service leaders, members of voluntary, community, faith and social enterprise (VCFSE) groups and public and patient representatives to discuss and guide future planning in those areas. The three events are the Green Summit (November 2018), the Neighbourhood Summit (January 2019) and the Co-operative Summit (October 2019).

6. IMPROVEMENT AND ASSESSMENT FRAMEWORK (IAF)

6.1 Each year NHSE undertake an Improvement and Assessment Framework (IAF) regarding for public and patient engagement for every clinical commissioning group. Last year – 2017/18 – NHS Tameside and Glossop Clinical Commissioning Group achieved the top score of Green Star (with four out of the five domains rated as outstanding).

6.2 For the 2018/19 assessment Tameside and Glossop Clinical Commissioning Group has been given the top rating – Green Star (with the highest possible score of 15 out of 15) for patient and community engagement. Only 35 out of 195 areas in the country have received Green Star, and Tameside and Glossop is one of only 13 out of 195 go achieve the highest possible sore of 15 out of 15.

6.3 The Improvement and Assessment Framework (IAF) for public and patient engagement is only undertaken for Clinical Commissioning Groups. However a key element of the evidence base submitted for the 2018/19 assessment was the joint working through the Tameside and Glossop Partnership Network (PEN).

6.4 NHS North and NHS England asked Tameside and Glossop to showcase our approach at a number of IAF workshops and webinars to help other Clinical Commissioning Groups (CCGs) across England prepare for this year's Improvement and Assessment Framework (IAF) for public and patient engagement.

7. RECOMMENDATIONS

7.1 As set out on the front of the report.

APPENDIX 1

The table below summarises engagement and consultation activity in the last two years.

Ref	Topic	Lead
1	Intermediate Care	T&G
2	Urgent Care	T&G
3	Pharmacy Needs Assessment	T&G
4	Tameside Wellness Centre	T&G
5	The Plan for a Safer, Stronger Greater Manchester	GMCA
6	Care Home (on/off contracts)	T&G
7	Museum of Manchester Regiment – to support a funding bid to the Heritage Lottery Fund	T&G
8	NHS England Guidance on Over the Counter (OTC) Prescribing	NHSE
9	Statutory local authority budget consultation with business rate payers	T&G
10	Primary school meals	T&G
11	Open Libraries Plus evaluation and impact review	T&G
12	Over The Counter – to inform response to national consultation	NHSE
13	Working Carers – supporting working carers in the workplace	GMHSCP
14	Hypertension campaign evaluation and impact review	T&G
15	Trans-Pennine upgrade	Highways England
16	Promoting social cohesion and preventing hateful extremism	GMCA
17	Ageing Well Tameside Strategy – engagement to inform the development of the strategy	T&G
18	Personal Health Budgets	NHSE
19	Shared Lives – payment banding (complexity of need) and expanding service to those aged 16+	T&G
20	History Makers (make smoking history in GMCA)	GMCA
21	Transforming the response to Domestic Abuse	MoJ
22	Integrated Communities Strategy Green Paper Consultation	MHC&LG
23	Metrolink Zonal Fares	TfGM
24	Review of Greater Manchester Children's Hospital	GMHSCP
25	Benign Urology	GMHSCP
26	Consultation on proposed changes to the service specification for Tier 4 Child and Adolescent Mental Health Services (CAMHS)	NHSE
27	Government's Draft Clean Air Strategy	Defra
28	Planning at End of Life	T&G
29	Cross Country Rail Franchise	DfT
30	NHSE Guidance for which Over the Counter Medicine should not be routinely prescribed	T&G
31	Homelessness Prevention Strategy	Council
32	Hattersley and Mottram Public realm Vision	T&G
33	Beelines	TfGM
34	Reform of the Gender Recognition Act	GEO
35	GM Cardiology Service Redesign Project	GMHSCP
36	GM Respiratory Service Redesign Project	GMHSCP
37	Evidence Based Interventions Consultation	NHSE
38	Infant Feeding	T&G
39	Maternity Services	T&G
40	A new deal for social housing	MHC&LG
41	Consultation on contracting arrangements for Integrated Care Providers	NHSE
42	Insight & Perception Survey	GMHSCP
43	Have your say on taxi and private hire services	TfGM
44	Council Tax Support Scheme	T&G
45	Digital Skills	T&G
46	Housing Assistance Policy	T&G
47	Abnormally invasive placenta services	NHSE

Ref	Topic	Lead
48	Specialised gynaecology surgery and complex urogynaecology conditions service specifications	NHSE
49	Gluten-free food on NHS prescription in England	DHSC
50	Proposed changes to specialised severe intestinal failures services for adults	NHSE
51	Sale of Energy Drinks to Children	DHSC
52	Early Help Review	DCC
53	Calorie labelling for food and drink served outside the home	DHSC
54	Greater Manchester Culture Strategy	GMCA
55	Developing a good Employment Charter for Greater Manchester	GMCA
56	Proposals for the reform of the annual canvas	Cabinet Office
57	Stalybridge Town Centre Challenge	Council
58	Gambling Policy Consultation	Council
59	Developing good jobs and growth: Greater Manchester's Local Industrial Strategy	GMCA
60	Improving Adult Basic Digital Skills	DfE
61	Consultation on proposals to ban the distribution and/or sale of plastic straws, plastic stemmed cotton buds and plastic drink stirrers in England	Defra
62	Same-sex accommodation on in-patient mental health wards	Pennine Care
63	Changes to planning policy and guidance including the standard method for assessing local housing need	MHC&LG
64	Planning reform: supporting the high street and increasing the delivery of new homes	MHC&LG
65	Regulating basic digital skills qualifications	Ofqual
66	Strategy for our veterans: UK government consultation paper	MoD
67	The Big Alcohol Conversation	GMCA / GMHSCP
68	Extremism in England and Wales: call for evidence	CCT
69	Budget Conversation 2019-20	T&G
70	Items which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs	NHS England
71	Williams Rail Review	DoT
72	Council Tax Charge on Long Term Empty Dwellings	T&G
73	Developing a drug and alcohol strategy for Greater Manchester	GMCA
74	MEC SCN children and young people increasing confidence survey	GMEC
75	Developing a patient safety strategy for the NHS	NHSE
76	What Matters to You	T&G
77	Greater Manchester Spatial Framework	GMCA
78	Police Funding 2019-20	GMCA
79	Improving access to social housing for members of the armed forces	MHC&LG
80	Single Handed Care	T&G
81	Suicide Prevention Campaign Consultation	GMHSCP
82	Relationships education, relationships and sex education and health education	DfE
83	Cataract Survey	HW Derbyshire
84	Greater Sport Physical Activity Survey	Greater Sport
85	Implementing the NHS Long Term Plan - Proposals for possible changes to legislation	NHS England
86	Consultation on consistency in household and business recycling collections in England	Defra
87	Introducing a Deposit Return Scheme for Drinks Containers	Defra
88	Tameside Food Survey	T&G
89	Plastic waste and recycling in Greater Manchester	GMCA
90	Introducing further advertising restrictions of products high in fat, sugar and salt (HFSS) on TV and online	DoHSC
91	Tackling Homelessness	MfHCLG

Ref	Topic	Lead
92	Tameside Parenting Support Survey	T&G
93	Greater Manchester Fire & Rescue Service - Programme of Change	GMCA / GMFRS
94	Serious violence: new legal duty to support multi-agency action	Home Office
95	Healthwatch Tameside NHS Long Term Plan	Healthwatch
96	Deferred Payment Scheme Consultation	T&G
97	Recycle for Greater Manchester Campaign Feedback	Recycle 4 GM
98	Our Pass Opportunities	GMCA
99	Consultation on a new Rent Standard from 2020	Regulator of Social Housing
100	Greater Manchester Clean Air Plan	GMCA
101	Greater Manchester Vascular Services	GMHSCP
102	Children not in school	DfE
103	Greater Manchester Vascular Services Survey	GMHSCP
104	Wheelchair Survey	GMHSCP
105	Adding folic acid to flour	Department for Health and Social Care
106	What Matters to You?	T&G
107	Tameside Museums and Galleries: Planning for the future	T&G
108	Consultation on Proposed PSPO for Moorland	T&G
109	Local Studies and Archives Forward Plan	T&G
110	Shining a Light on Suicide	GMHSCP
111	Higher technical education consultation	DfE
112	Changing Places Toilets	MHCLG
113	Support for victims of domestic abuse in safe accommodation	MHCLG
114	Greater Manchester High Rise Residents Survey	GMCA
115	Redress for purchasers of new build homes and the new homes Ombudsman	MHCLG
116	Restraint in mainstream provision settings and alternative provision	DfE
117	Tenancy deposit reform: a call for evidence	MHCLG
118	Digital-first Primary Care: Policy consultation on patient registration, funding and contracting rules	NHSE
119	Supporting victims and witnesses every step of the way: experiences of police, court and support services	GMP
120	How we should engage and involve patients and the public in our work	Medicines and Healthcare Products Agency
121	VCSE in Greater Manchester – the next 10 years	GM VCSE Devolution Reference Group
122	A new deal for renting: resetting the balance of rights and responsibilities between landlords and tenants	MHCLG
123	Rogue Landlord Database Forum	MHCLG
124	Advancing our health: prevention in the 2020s	Department for Health and Social Care
125	Co-operative Councils Innovation Network Proposals	T&G
126	Transport and the Night Time Economy	GMCA
127	Improving Specialist Care Programme: GM Cardiology Services	GMHSCP
128	Home to School Travel and Transport: statutory guidance	DfE
129	Sprinklers and other fire safety measures in new high rise blocks of flats	MHCLG
130	Electric vehicle charge-points in residential / non-residential buildings	DfT
131	Measures to reduce personal water use	Defra

(T&G – 39; GM/NW – 36; National – 56)

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	27 November 2019
Executive Member/Clinical Lead/Officer of Single Commissioning Board	Councillor Eleanor Wills – Executive Member (Adult Social Care and Population Health) Dr Asad Ali – CCG Chair Jessica Williams –Director of Commissioning Jeanelle de Gruchy– Director of Public Health
Subject:	**TARGETED NATIONAL LUNG HEALTH CHECKS**
Report Summary:	Greater Manchester Cancer Alliance and National NHS Cancer Programme, NHS England (NHSE) nominated NHS T&G CCG to be part of the phased extension of the national Targeted Lung Health Check (LHCs). This report outlines the preferred model of delivery for the LHC programme within NHS Tameside and Glossop Clinical Commissioning Group (NHS T&G CCG). NHS T&G CCG working in partnership with NHS Tameside and Glossop Integrated Care Foundation Trust (NHS T&G ICFT) and Manchester University NHS Foundation Trust (MFT), will develop a pathway that incorporates a community based Lung Health Check service, delivered on a mobile unit sited within neighbourhoods to an agreed National Standard Protocol. National funding for the provision of a local service, in line with National Standard Protocol will be provided at an estimated cost of £6.3 million plus £55,000 for a project manager.
Recommendations:	Strategic Commissioning Board endorse and approve the preferred model of delivery for the Targeted Lung Health Checks within Strategic Commissioning Organisation. NHS T&G CCG consider varying the service specification into NHS T&G ICFTs contract for governance and assurance purposes. NHS T&G CCG will be accountable to Greater Manchester Cancer Alliance and National Cancer for delivery of the local service.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	**Budget Allocation (if Investment Decision)** As a nationally funded programme, the lung checks programme would not directly impact upon budgets within the single commissioner over the next 4 years.
	CCG or TMBC Budget Allocation CCG
	Integrated Commissioning Fund Section – s75, Aligned, In- s75

	Collaboration
	Decision Body – SCB Executive Cabinet, CCG Governing Body SCB Executive Cabinet
	Value For money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark This paper follows on from the initial paper to update the revised profiled trajectory, following the revised start date from October 19 to January 20. The significant national funding to implement a programme of lung health checks in Tameside and Glossop over a 4 year period will still be available, although the profiling of this may be revised to support the change in activity profiling. It is likely that the programme will identify residents who require treatment, who we would not otherwise have been aware of in the short term. Within the long term plan, there is £200k p.a., from 2020, to support funding these additional patients identified by the scheme.
Legal Implications: **(Authorised by the Borough Solicitor)**	Early intervention is evidentially known to reduce long term costs and generally improve outcomes. It will be important to have effective project management to fully understand the impact throughout both in terms of engagement with public, results and interim impacts on costs and service delivery given the expectation that through the checks a number of residents will be found who require intervention who we would not have known about until their illness required them to seek medical intervention.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Living Well and Working Well and Aging Well programmes for action.
How do proposals align with Locality Plan?	The proposals are consistent with the Healthy Lives (early intervention and prevention), enabling self-care, Locality based services strands and planned care services of the Locality Plan.
How do proposals align with the Commissioning Strategy?	The service follows the Commissioning Strategy principles to: - Empower citizens and communities; - Commission for the 'whole person'; - Create a proactive and holistic population health system - Take a 'place-based' commissioning approach to improving health, wealth and wellbeing - Target commissioning resources effectively
Recommendations / views of the Health and Care	HCAG were supportive and endorsed the approach taken in developing a local delivery model. HCAG to provide clinical

Advisory Group	oversight and support the development of clearly clinical pathways and protocols.
Public and Patient Implications:	Residents who are invited to a Lung Health Check will be provided with information about the service, to explain why the benefits outweigh any risks; this help them make an informed decision about having a Lung Health Check. Targeted Lung Health Checks may identify cancer at an early stage or identify other incidental findings in residents who may not have been aware they have an illness. Many of the cancers identified are at an early stage, are treatable and curable. Residents who have an illness will be supported to manage their condition and have access to interventions to help improve their lifestyle to ensure the best possible outcomes. The National Standard Protocol provides inclusion and exclusion criteria which may limit access to some of our residents. To ensure everyone has access to the support services they need a local campaigns and programmes of work will run alongside the LHCs to raise awareness of the signs and symptoms of cancer (and other health promotion programmes).
Quality Implications:	Adherence to the National Standard Protocol. The national Targeted Lung Health Checks phased extension is estimated to identify 3,400 cancers at an earlier stage (260 within NHS T&G), many of which are treatable with curative surgery, which is anticipated to prevent 1,500 deaths nationally.
How do the proposals help to reduce health inequalities?	Lung cancer is a major contributor to the inequality gap in life expectancy between affluent and deprived areas of the borough. This program aims to reduce early death from lung cancer and thereby contribute to a reduction in the inequality gap.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act. The service will be available to all residents regardless of ethnicity, gender, sexual orientation, religious belief, gender re assignment, pregnancy/maternity, marriage/ civil and partnership.
What are the safeguarding implications?	There are no anticipated safeguarding issues.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information Governance protocols will be developed to ensure the safe transfer and keeping of all confidential information between the data controller and data processor. A privacy Impact has assessment has not been carried out.

Risk Management:	Risks will be discussed through the agreed governance process to ensure action plans are in place to minimise or mitigate any risks identified.
Access to Information :	The background papers relating to this report can be inspected by contacting Louise Roberts, Commissioning Business Manager ☎ Telephone: 07342056005  e-mail: louise.roberts@nhs.net Or Debbie Watson, Assistant Director of Population Health ☎ Telephone: 07970 456 338  e-mail:debbie.watson@tameside.gov.uk

1. INTRODUCTION

1.1 The NHS Long Term Plan sets the ambition to increase early diagnosis of cancers with the aim to improve the diagnosis of cancers at an early stage from one in two to three in four. This translates as 55,000 more people each year surviving their cancer for five years or more by 2028.

1.2 As part of this national aim NHS England (NHSE) are supporting 10 sites across England to put into place a targeted Lung Health Check service over a 4-year period from 2019-2023. A national standard protocol (appendix 1) has been published to guide the implementation of this service alongside the recognition that local conditions and pathways will inform the local model. The protocol recognises the risk factors for lung cancer (which include smoking and age) and places a strong emphasis on the importance of linking patients into existing social prescribing teams who can offer advice and support, based on an asset based approach. The standard protocol recognises the importance of smoking cessation services and is very much a key part of this programme

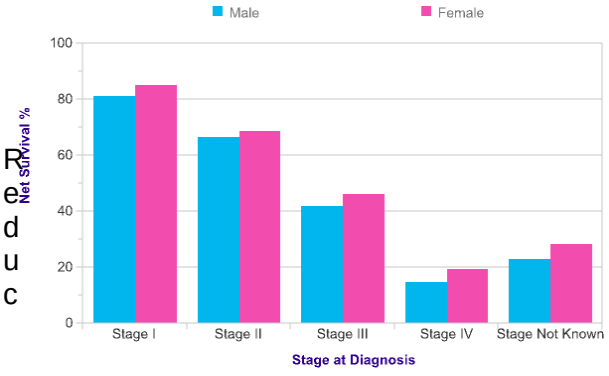
1.3 Tameside & Glossop is the area within the Greater Manchester Cancer Alliance selected as phase 1 of this programme to introduce a Targeted Lung Health Checks service.

1.4 Greater Manchester Cancer Alliance nominated NHS T&G CCG based on the following selection criteria, using Public Health Fingertips data:

- Age Standardised Cancer Mortality rates per 100,000 (Tameside 88.68, GM 63.20 and NHSE 57.68 in 2014-16)
- Directly standardised rates of Lung Cancer per 100,000 and (Tameside 120.6, NW 96.3 and NHSE 78.6)
- Directly Standardised Lung Cancer Death rates per 100,000(Tameside 85.4, NW 69.7 and NHSE 56.3

1.5 The programme is intended to:

- Increase identification of lung cancer and support early diagnosis (at an earlier stage)
- Improve outcomes: increased one year survival and reduce the number of preventable deaths from but diagnosing cancer at an earlier stage. Survival is better the earlier it's diagnosed, so their needs to remain a string focus in prevention and early better diagnosis.



	Survival from stage of diagnosis (%)	
Stage of diagnosis	One year	Five year
1	80	35
2	60	20
3	40	6
4	20	-

- Reduce smoking prevalence
- Run alongside local campaigns and programmes of work to raise awareness of the signs and symptoms of cancer (and other health promotion programmes) to ensure everyone has access to the support services they need.

2. BACKGROUND GREATER MANCHESTER

2.1 Lung cancer remains the biggest cause of premature death in Greater Manchester and 80-90% of lung cancers are caused by smoking.

2.2 In 2016, a pilot was conducted through the Macmillan Cancer Improvement Partnership (MCIP) and the three Clinical Commissioning Groups in Manchester involving 14 GP practices. This pilot tested a Lung Health Check programme offering people aged 55-74 at high risk of lung disease the opportunity to attend a lung health check. If this found their risk of developing lung cancer was high, they were offered an immediate low dose CT scan that same day. This service was provided in the community in mobile units.

2.3 2,541 people attended their lung health check and of these, 1,384 had a scan following the risk assessment. Of those that were screened, 3% had lung cancer. Vitally, of these, 80% were in early stage and 65% had surgical resection (Crosbie et al, 2018).

2.4 As part of the Greater Manchester Health and Social Care Partnership (GMHSCP) priority to prevent and detect cancer earlier, a Steering Group, chaired by Dr Richard Preece, oversaw the development of a prototype in collaboration with members of the Macmillan Cancer Improvement Partnership (MCIP) City of Manchester Pilot team, clinicians, commissioners including specialised commissioning, public health consultant expertise, primary care colleagues, the GM tobacco control programme and finance colleagues. This prototype offered a number of minimum standards for a Greater Manchester model and attempted to explore the costs, benefits and capacity implications for a full roll out across the system.

2.5 The prototype was presented to relevant stakeholders in late summer 2018. Using cautious interpretation, the total resource implication was modelled as being in the region of £147m. However, only some GM CCGs indicated that they were in a position to consider roll out of LHCs in 2019/20.

2.6 The following areas have plans for delivering LHCs in Greater Manchester in 2019/20 or have commenced delivery :

- North Manchester CCG Business Case approved and commenced service delivery in April 2019 (1.51% threshold, 55 – 80 years, current and ever smokers).
- Salford CCG Business Case approved in December 2017 and commenced service delivery in September 2019 ; initially planned 3% threshold but amended in light of national direction to <1.51%; age range 55 – 74 years; eligibility criteria smokers, ever smokers, smoking status not recorded on clinical systems.
- Tameside and Glossop CCG chosen as one of the areas nationally (one per Cancer Alliance) to receive funding (£6.3million over 4 years) to deliver lung health checks as per a national protocol (see above; 1.51% threshold, 55 – 74 age range)

2.7 Cancer Alliance Planning guidance states: 'The expectation is that no additional local projects will start outside of the National Programme from 2020/21 onwards' pending the four year evaluative period'.

2.8 A GM LHC steering group was established on 18 June 2019, members included representatives from Providers, Commissioners, Health and Social Care Partnership, Specialised Commissioning and GM Cancer Alliance to ensure services align across GM.

2.9 The models that have emerged/are emerging in the 3 CCGs in Greater Manchester are slightly different and the system may benefit from a discussion about if and how local protocols could be standardised, and how we can collectively evaluate the programmes to ensure we continue to learn from this emerging area of practice, building on the strong foundations that the Manchester pilot has already created.

2.10 A Greater Manchester steering group chaired by Sarah Price between commissioners, public health, specialised commissioning and providers will ensure the complexities of commissioning this programme and the interdependencies within the system to deliver the best outcomes for residents. The group established a Greater Manchester governance structure for LHCs and will liaise with Specialised Commissioning in NHSE as the costs of any treatment will be funded up by them and will need building into commissioning plans from 19/20.

3. BACKGROUND TAMESIDE & GLOSSOP

3.1 The SROs for the local programme implementation are Jeanelle de Gruchy and Jessica Williams from the Strategic Commission and Trish Cavanagh from T&GICFT. The SROs are being supported via a project team consisting of:

- Debbie Watson and Louise Roberts – T&G Strategic Commission
- Jackie McShane and Angela Brierley – T&G ICFT
- Susi Penney and Adrian Hackney – GM Cancer

A local Steering group was established on the 07th May 2019 to develop a delivery plan. Representatives from GM Cancer were members of the project steering group with clear lines of accountability for governance arrangements between the Alliance and CCG.

3.2 NHSE England set a challenging timeline for implementation of the local programme as outlined below:

Action	Key Date	T&G Status
National Event – Leeds (sharing and learning event and outlined plans for next phased extension of LHCs)	17 January 19	✓
GM Focus Meeting	17 April 19	✓
Outline delivery plan to be submitted to the regional team	23 April 19	✓
National Collaboration Event - London	2 May 19	✓
Finalise delivery plan (draft submit to Cancer Alliance)	3 May 19	✓
First T&G Monthly Steering Group	7 May 19	✓
Cancer Alliances to submit delivery plans to the regions	21 May 19	✓
British Thoracic Society Imaging Training	September 19 and November 2019	22 people attended in November
National Collaboration Event - Manchester	18 September 19	✓
National Lung Health Checks Programmes start to go live	October 19	January 20
National Collaboration Event - Leeds	15 January 20	

3.4 The national protocol does not dictate a specific model for LHC delivery, provided the standards in the protocol are met. Learning and insight from other established LHC services was built in to support a locally designed, delivery model.

3.5 Key stakeholders (including clinicians within secondary and primary care) and local people were involved in the planning phase to co-design the right delivery model and design principles for NHS T&G CCG.

3.6 Using data from T&G Primary Care records local modelling shows:

Stage			Comment
Total eligible population	54,613	100.0%	Aged 55-74/364
Ever smoked	20,207	37.0%	Of Total eligible population
Appointments booked	12,124	60.0%	Take Up of Ever Smoked
Non attendees	970	8.0%	Of Appointments Booked
LHC's performed	11,155	92.0%	Of Appointments Booked
Positive LHC's	6,247	56.0%	Of LHC's analysed
Excluded from CT scan	187	3.0%	Of Positive LHC's
Initial CT scans performed	6,059	97.0%	Of Positive LHC's
Indeterminate - require second scan 3 months	860	14.2%	Of Initial CT Scans performed
Indeterminate - require second scan 12 months	860	14.2%	Of Initial CT Scans performed
Negative CT Scan - 24 months follow-up	5,005	82.6%	Of Initial CT Scans performed

Activity Impact of Cancers Identified

Findings			Comment
Patients needing clinical investigation (following first scan, three months follow-up and 12 months follow-up)	357	5.9%	Of Initial CT Scans performed (including patients requiring investigation after second scan)
Cancers found	182	50.8%	Of Needing clinic investigation
24 months follow-up	5,005	82.6%	Of Initial CT Scans performed
Patient needing clinical investigation followign 24 month scan	120	2.4%	Of 24 month scans
Cancers found at 24 months follow-up	79	65.5%	Of Needing clinic investigation
Total cancers found	260	N/A	Including those found at initial, 3, 12 and 24 months scans

3.7 Local task and finish groups were established to develop a local service model, these included:

- Service Model Options appraisal
- Estates
- Clinical Pathways and Incidental findings
- Communications, Engagement & Marketing
- IT, Data Flow, Information Governance
- Participant & Primary Care Literature
- Activity and Financial modelling
- Service model development to include Partnership working with managed service provider

3.8 Due to the unique nature in which the GM Cancer Alliance is commissioned in GM, local commissioners are working with GM Cancer colleagues and NHSE within an agreed governance process for the flow of funding into the CCG and to give assurance that the project is delivering against the NHSE standard protocol.

4. RISKS/ISUES AND CHALLENGES

4.1 The main risk relates to delivery of this innovative LHC program with an emerging evidence base as outlined below:

- **At present there is no national screening programme for Lung cancer in the UK.** This is because:
  - it isn't clear that screening can save lives from lung cancer
  - the tests have risks
  - they can be expensive[1]

- **Risks associated with Low dose CT scans** - Tests like this have risks. The lungs are very sensitive to radiation and frequent scans might cause lung damage.

[1] Cancer Research UK https://www.cancerresearchuk.org/about-cancer/lung-cancer/getting-diagnosed/screening

Tests can also find lung changes that look like cancer and need to be checked by further tests, such as a biopsy. These further tests can also have risks.

- **Lung screening might also cause over diagnosis** – Over diagnosis means that some lung cancers found through screening might never become life threatening. So it is possible that some people go on to have lung cancer treatment that they would never have needed and of course they have the side effects and anxiety that anyone having cancer treatment goes through. In the design of the programme and working alongside researchers, it will be important to balance the benefits of the screening programme with the risk of over diagnosis

4.2 The main risks to implementing the program that were considered throughout the planning and design process are listed below:

- **Implementation timescales** – There is an expectation that all the initial Lung Health Checks will be complete by March 2021 to enable all follow up scans to be completed by March 2023 to enable a full evaluation of the programme.
- **Capacity for scanning and reporting** - There is a lack of Specialist Thoracic Lung Radiologists nationally. NHSE Cancer provided additional training courses and are reviewing workforce and recruitment issues at a National level.
- **Financial risk** – The funding envelope available includes a fixed element for staffing and a variable amount based on agreed trajectories. The local modelling is based on the national modelling and assumptions; this may differ within NHS T&G in real terms. Each project will receive £264 per CT scan to cover variable service line costs to include: CT scanning including the cost of providing mobile capacity, Teleradiology, Consumable costs associated with the lung health check and travel and other costs including legal.

NHS Tameside and Glossop CCG
£55,000 also provided to support Project management in addition to the variable costs shown below

	£000's				
	19/20	**20/21**	**21/22**	**22/23**	**Total**
Annual	1,660	1,831	1,533	1,361	6,385

- There will be additional costs to the Health and Social economy in diagnosing and treating other incidental findings. NHSE Cancer will continue to review the funding envelope.
- **Clinical Workforce capacity** – Lung Health Check Nurses, Thoracic Radiologists
- **Demand management** – Managing the activity and demand across GM to ensure sufficient capacity for tertiary treatment and surgery. There will be increased demand into primary care and other support services.
- **Focus on smoking cessation** – Access to specialist smoking cessation support and pharmacotherapy; with the levels of current prevalence of smoking being the second highest in GM, NHS T&G CCG would need to ensure every smoker undertaking a LHC has access to support.
- **Impact on Cancer waiting time standards –** ensure everyone on the lung pathway has access to timely diagnostics and treatment.
- **Organisational reputation** - Cancer Alliance Data, Evidence and Analysis Service **(**CADEAS) will support with evaluation (6 key evaluations: barriers and enablers, replicability and scalability, impact and patient outcomes, health inequalities and participation experience and satisfaction). NHS T&G CCG will need to build in QA tools locally and build the local programme to ensure NHS T&G CCG adhere to the T&G agreed design principles.

5. LOCAL DELIVERY MODEL

5.1 Following extensive engagement and consultation with key stakeholders and members of the public the preferred model of delivery for NHS T&G CCG is to provide Lung Health Checks, Smoking Cessation and CT scans all in one place (One Stop) on a Mobile Unit based within neighbourhoods.

5.2 The preferred model of delivery is similar to the 'One Stop' model Commissioned by North Manchester CCG from MFT (MFT are also the tertiary surgical provider across GM). North Manchester CCG are the Lead provider for the acute contract of which NHS T&G CCG are associates.

5.3 LHCs in Salford CCG are provided on a mobile unit with CT scans provided at Salford Royal NHS Foundation Trust, this alternative model was the less favourable option within NHS T&G CCG.

5.4 NHS T&G CCG working in partnership with NHS Tameside and Glossop Integrated Care Foundation Trust (NHS T&G ICFT) and Manchester University NHS Foundation Trust (MFT), will develop a pathways and protocols for delivery of community based Lung Health Checks, delivered on a mobile unit sited within neighbourhoods to an agreed National Standard Protocol. It is proposed that investment is transacted to NHS T&G ICFT to establish a Lung Health Check Programme within NHS T&G CCG.

5.5 The provision of the Lung Health Checks within the community will align to local campaigns to help raise awareness of the signs and symptoms of Lung Cancer, following feedback from various stakeholders.

5.6 Participants will be invited for a LHC via the MFT service on GP endorsed letter heads. Practices will provide a list of eligible participants following a data extract from their systems using a Data Quality search template developed by GM Shared Services (Data sharing agreement in place).

5.7 LHC participants who smoke will receive smoking cessation advice and support from a specialist nurse, while they are on the mobile unit. The LHC service will establish strong links with local services to ensure that participants continue to receive support from local services within the community.

5.8 NHS T&G ICFT in partnership with MFT will proactively manage the service on behalf of NHS T&G CCG to an agreed service specification (Appendix 2) and in line with the National Protocol.

5.9 Service operational procedures will be in place concerning the process and data collection in line with National timelines and requirements. NHS T&G CCG, GM Cancer Alliance and NHSE Cancer will have monitoring processes in place to ensure the service is running in line with the service specification incorporating all elements of the Standard Protocol.

5.10 Clinical pathways will be in place between primary, secondary and tertiary services to manage incidental findings and ensure people have access to the services they need in the most appropriate setting.

6. CONCLUSION

6.1 The preferred model of delivery in line with the agreed specification and in line with the National Protocol is planned to commence in January 2020.

6.2 Following endorsement and approval of the preferred model by Strategic Commissioning Board; the delivery, mobilisation and implementation of the Lung Health Check programme will be monitored through the agreed governance process.

6.3 NHS T&G CCG consider varying the service specification into NHS T&G ICFTs contract for governance and assurance purposes.

7. RECOMMENDATIONS

7.1 As set out at the front of the report.

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Targeted Screening for Lung Cancer with Low Radiation Dose Computed Tomography

Standard Protocol prepared for the Targeted Lung Health Checks Programme

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Targeted Screening for Lung Cancer with Low Radiation Dose Computed Tomography

Standard Protocol prepared for the NHS England Targeted Lung Health Checks Programme

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Niall Smith National Cancer Programme on 0113 825 0000.

1 Background and Introduction

1.1 Targeted Screening for Lung Cancer Standard Protocol

1.1.1 The purpose of this standard protocol is to ensure that there is a consistent and equitable approach to the provision and monitoring of targeted screening for lung cancer across England.

1.1.2 This document is designed to outline the service and quality indicators expected by NHS England to ensure that a high standard of service is provided. It therefore sets out the specific recommendations and standards that services are expected to meet.

1.1.3 The standard protocol is not for a systematic population screening programme. Any proposal to develop and run such a whole population programme would be made by ministers based on UK National Screening Committee (UKNSC) advice in the normal way. Rather this is an innovative mechanism by which the NHS intends to ensure that the identification, testing and surveillance of participants at high risk of lung cancer is done to very high and consistent standards.

1.1.4 Lung Health Check programmes offering low dose computed tomography (LDCT) should adhere to this standard protocol for targeted lung cancer screening.

1.1.5 Lung Health Check programmes may be titled to maximise participation, recognising that words like “cancer” may put participants off.

1.2 Definitions

1.2.1 Although targeted screening for lung cancer and population-based screening follow the same basic protocol, they differ in terms of intent and scope.

1.2.2 A national population-based screening programme covers the entire population and selects participants from a complete national electronic register, usually based on broad demographic criteria. Participants are invited and those agreeing are offered tests if at high enough risk. In England the service specifications, standards and data requirements are written by Public Health England (PHE) and delivered by the NHS via the section 7a agreement. The services are quality assured by PHE. All this in line with English health policy on advice from the UKNSC.

1.2.3 A targeted lung cancer screening programme selects participants from a local population at high risk of lung cancer and offers LDCT to eligible subjects. They report to NHS England and funding is through a variety of routes.

1.2.4 Programmes may involve other health interventions to increase cost effectiveness and in this context, are often referred to as “Lung Health Checks”.

1.3 Aims

1.3.1 The primary aim is to reduce mortality from lung cancer. This must be achieved with minimum physical and psychological harm. To do this the programmes should be delivered to meet or exceed nationally set standards and pathways that:

- define who should be invited (the cohort);

- have robust (preferably electronic) mechanisms to invite the cohort and recall for those that require surveillance or a routine screen after an interval;
- describe measures to improve uptake and reduce inequalities (while honouring the principle of informed choice);
- provides appropriate information for participants to allow them to make an informed choice about participating including recognition of any risks associated with the test itself and possible outcomes, such as referral for invasive procedures and any risks associated with that;
- describes the tests to be carried out;
- define the results of the tests including positive (abnormality), negative and indeterminate;
- describes (or points at) the follow up diagnostic and treatment pathways (e.g. NICE, British Thoracic Society) for all the categories of tests (including negative);
- are delivered and supported by suitably trained, competent, clinical and non-clinical staff who, participate in recognised on-going Continuing Medical Education, Continuous Professional Development, and External Quality Assessment (EQA) schemes;
- describes the level of training required for staff delivering all aspects of the programme;
- specify agreements to submit data as required, to allow for monitoring and operate within a framework of relevant data sharing permissions to enable pooled analyses to inform further design improvement;
- facilitate QA and audit activities;
- follow QA advice to improve the service;
- use the agreed common data records and definitions;
- describe how smoking cessation is integrated into the programme; and
- facilitate research studies into lung cancer early detection and screening.

1.4 Capacity and infrastructure

1.4.1 There should be sufficient capacity and infrastructure to deliver the programme including:

- community facilities for siting of mobile CT scanners, if required;
- primary care facilities for supporting assessments for eligibility and health checks;
- scanning capacity;
- radiology reporting;
- clinical service for work up of referred participants;
- clinical service for treatment of participants;
- smoking cessation support and advice; and
- administrative support for the programme including data collection, collation and submission.

1.4.2 The implementation of the programme should be aligned with local services. This will involve working with regional and local healthcare management including:

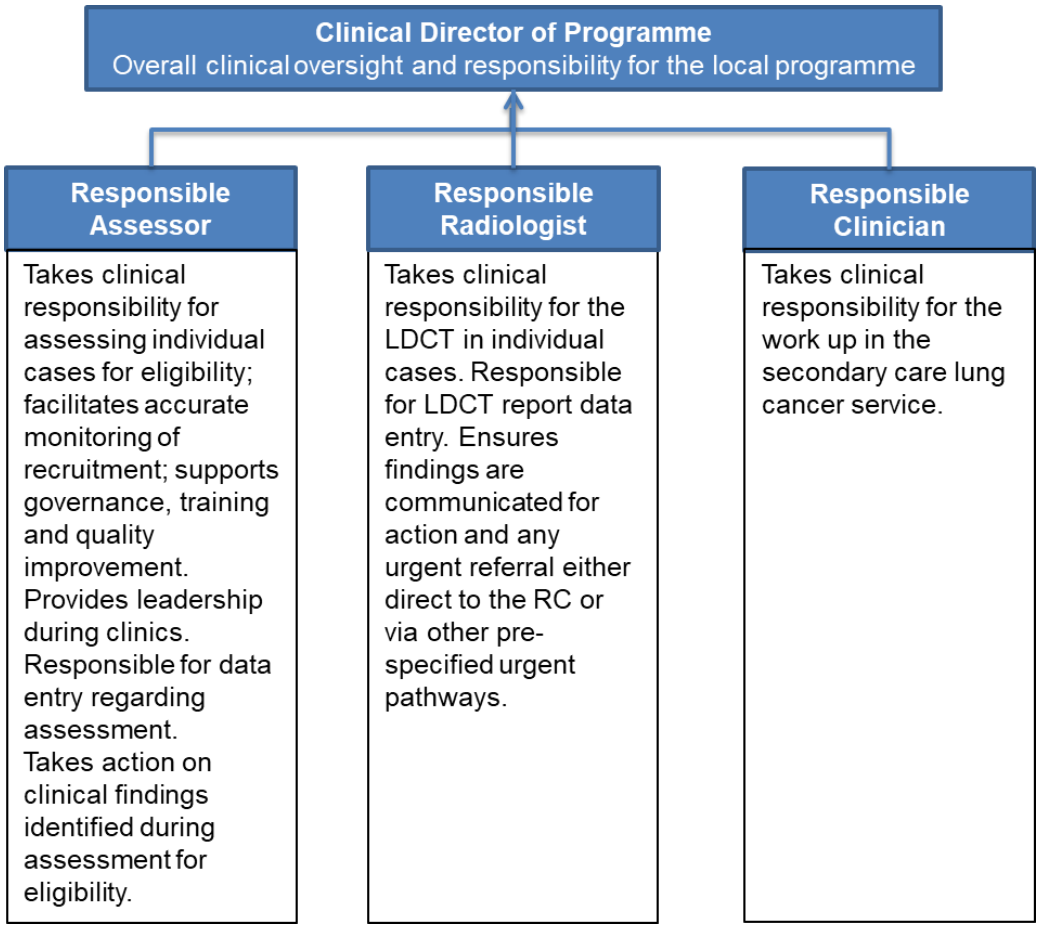
- Regional Office, NHS England;
- Cancer Alliances;
- STPs;
- CCGs;
- Local NHS Trusts; and
- Local Authorities.

2 Clinical governance

2.1 Clinical governance structure

2.1.1 Each programme will need to have in place robust clinical governance to ensure the effective delivery of care to patients who are invited to participate. This section outlines the key clinical roles which each programme will need to have in place.

Figure 1: Targeted Screening for Lung Cancer Clinical Governance Structure



2.2 Description of key clinical roles

2.2.1 **Clinical Director of Programme (DP):** There should be a single clinical director who takes overall responsibility for the safety of patients involved in the programme, including verifying the procedures for selection, scanning, acting on findings and communicating with participants. These procedures should include failsafe mechanisms to ensure that decisions to recall participants for assessment are actioned, including reminders for individuals who fail to attend.

2.2.2 **Responsible Assessor (RA):** There should be a named clinician who is responsible for the leadership of the process to select and assess the individual cases for entry into the programme, the lung health check and the risk assessment for lung cancer. The clinician can be a doctor, nurse or other professional with the appropriate clinical authority and accountability, from either the local primary or secondary care team. They will continually oversee and monitor the clinical programme, the management of participants and provide day to day leadership of the clinical service. They will ensure:

- appropriate action is taken when clinical findings are identified as part of the assessment for eligibility and during any add-on investigations such as spirometry and assessing cardiovascular risk. This may include further management in primary and/or secondary care.
- clinical data and information is entered into the appropriate clinical system with a focus on data completeness;
- improvements and corrective actions are implemented to support governance, training and improve quality;

2.2.3 **Responsible Radiologist (RR):** There should be a named radiologist who is responsible for the LDCT in individual cases and will normally be the first-read radiologist. The radiologist should urgently refer either direct to the rapid access lung clinic/ named consultant or via other urgent pathways in secondary care. The radiologist will accurately monitor reporting performance, and act on these results to support governance, training and improve quality. They will be responsible for data entry relating to the LDCT report and ensure findings are communicated for action.

2.2.4 **Responsible Clinician (RC):** There should be a named secondary care respiratory physician who is responsible for managing the referrals into the rapid access lung clinic and coordinating the clinical work up of participants in secondary care. This will normally be the respiratory physician who works in the lung cancer service and who receives referrals from the programme.

2.3 Responsibilities

2.3.1 The expected responsibilities of all roles should be followed as a minimum, ensuring governance is effective with a consistent approach across sites.

2.3.2 **Skills:** Professionals involved in screening assessment are expected to fulfil the requirements for individual professional training and for their continuing professional development. They should carry out assessments and procedures regularly, so they can maintain their skills and competence.

2.3.3 **Audit:** The DP is responsible for ensuring that the assessment process is appropriately carried out by all RAs, RRs adhere to the protocols and clinical work-up by RCs is monitored. This should be confirmed by audits of individual RA assessment performance, including:

- number of assessments performed (RAs);

- quality of data entry (RAs, RRs); and
- adherence to details of this protocol (RAs, RRs and RCs).

2.3.4 **National audit:** The DP is responsible for ensuring that all data are available for inclusion in a national audit with the purpose of comparing the programmes and measuring the overall success and impact. Data submission will be according to a national minimum dataset and submission is mandatory.

2.3.5 **Reporting:** The DP reports to NHS England through the Cancer Alliance Board.

2.3.6 **Steering group:** The DP, RAs, RRs and RCs will normally come together through a programme steering group, chaired by the DP. Membership of the programme steering group should include representatives drawn from primary care, Public Health and patient advocates. There should be access to expertise relevant to the Lung Health Check e.g. in smoking cessation, data collection etc.

Table 1: Summary of key responsibilities

Responsibilities	DP	RA	RR	RC
Ensure the assessment process is appropriately carried out by all RAs	√			
Adherence to details of the standard protocol		√	√	√
Quality of data entry		√	√	
Ensure the data is available for inclusion in a national audit	√			
Report to NHS England through the Cancer Alliance Board	√			

3 Assessment Process

3.1 Initial invitation

3.1.1 Participants aged between 55 and 74 and 364 days of age at the date of the first low dose CT scan, registered with a GP practice who have ever smoked will be invited for a Lung Health Check. Those who attend will be assessed to calculate their individual risk of developing lung cancer.

3.1.2 Invitation to attend for an assessment for suitability for LDCT may be by correspondence or telephone via primary or secondary care, or by offering assessment in a mobile setting in high-risk areas, as part of a Lung Health Check.

3.1.3 Individuals will be assessed for eligibility criteria by confirming medical, social and employment history and risk factors for lung cancer. Validated lung cancer risk assessment tools may be used to better quantify risk.

3.1.4 Where necessary, reasonable changes should be made to the approach to ensure the service is accessible to all, including those with physical and learning disability and mental illness e.g. easy read documentation, engaging key worker in invitation [1].

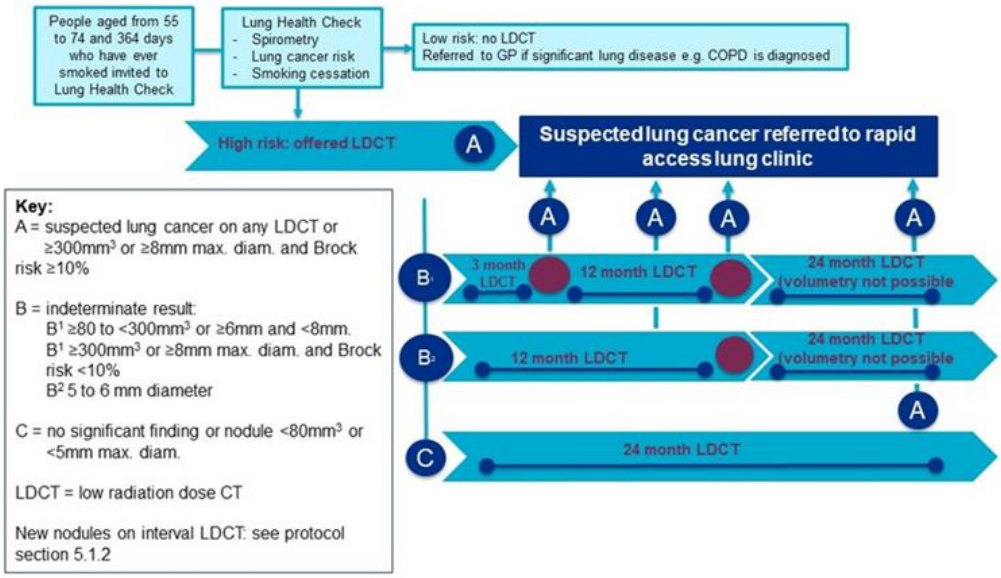
3.1.5 NHS translation services should be available where required for individuals without adequate English language skills (see 3.9).

3.1.6 Participants who have difficulty understanding the purpose of the programme should be able to access the programme (see 3.9).

3.2 Participant journey

3.2.1 Figure 2 illustrates the participant journey for both those assessed at the Lung Health Check as low risk of developing lung cancer and those at high risk. Appendix A provides a more detailed clinical pathway.

Figure 2: High level participant pathway



3.2.2 At the Lung Health Check, the participant will have a spirometry test and a discussion to assess the participant's individual lung cancer risk. This will include questions about smoking habits and they will also be offered smoking cessation advice and treatment. Those at low risk do not require a CT scan.

3.2.3 Any participant assessed as being at high risk of lung cancer will be invited to an immediate low-dose CT scan. The scan will show one of three things:

i. No significant findings or nodules <80mm³ or 5mm max diameter;
ii. Indeterminate results; or
iii. Something that requires further investigation.

Results	Action
No significant findings or nodules <80mm³ or 5mm max diameter	Second scan 24 months later
Indeterminate result	Second scan 3 months later, with follow up scan 12 months later
Requires further investigation	Referred to local specialist lung clinic

3.2.4 Participants with an abnormal spirometry result or other non-cancer related symptoms will be referred to their GP.

3.3 Risk assessment

3.3.1 Assessment of risk of lung cancer is essential to maximise the cost effectiveness of the intervention. There are a number of methods and further research may identify which is the best. This will form part of the evaluation of the Targeted Lung Health Check Programme.

3.3.2 The Targeted Lung Health Check Programme will use the Prostate Lung Colorectal and Ovarian (PLCO) $_{M2012}$ risk prediction model and the Liverpool Lung Project (LLP) version 2 [2, 3] to select participants to be offered a LDCT. The American PLCO$_{M2012}$ model has been adapted for use in the UK to reflect UK ethnic groups.

3.3.3 The latest evidence suggests that a risk threshold of ≥1.51% risk of lung cancer over 6 years is the minimum threshold for PLCO$_{M2012}$ and ≥2.00% risk of lung cancer over 5 years for LLPv2 [4, 5]. However, the latter has only been shown in modelling studies and may lead to substantially more LDCTs. Thus, a risk threshold for LLP of ≥2.5% is proposed.

3.3.4 This standard protocol uses two thresholds to identify participants: a risk threshold of ≥1.51% risk of lung cancer over 6 years as the minimum threshold for PLCO$_{M2012}$; and ≥2.5% risk of lung cancer over 5 years for LLPv2.

3.3.5 The factors used in these models that would need to be collected are shown in the table below.

Table 2: Factors included in two multivariable risk prediction models

LLPv2: ≥2.5% risk	$PLCO_{M2012:}$ ≥1.51% risk
Age Gender Smoking duration (years) Previous pneumonia/ COPD/ emphysema/ bronchitis/ TB Occupational asbestos exposure Previous history of malignancy Previous family history of lung cancer; and relative's age at onset i.e. <60 y or >60 years; whether first degree relative	Age (years) Education level Body mass index COPD/ chronic bronchitis/ emphysema Personal history of lung cancer Family history of lung cancer Ethnicity[1] Smoking status Average number of cigarettes smoked per day Duration smoked (years) Years having ceased smoking

3.3.6 For the purposes of the Targeted Lung Health Checks Programme, participants satisfying either LLPv2 or $PLCO_{m2012}$ are to be considered eligible for a low-dose CT provided they meet the inclusion criteria in 3.3.7 and do not have any of the exclusion criteria listed in 3.3.8.

3.3.7 **Inclusion criteria:**

- Aged range from 55 to 74 and 364 days;
- Willing and able to undergo LDCT; and
- $PLCO_{m2012}$ risk of ≥1.51% over 6 years or LLP_{ver2} 5-year risk of ≥2.5%.

For the Targeted Lung Health Checks Programme, due to its duration, at point of referral participants must be at least 55 years of age, and no older than 74 years and 364 days.

3.3.8 **Exclusion criteria:**

- Participant does not have capacity to give consent (standard criteria for assessing capacity apply);
- Full thoracic CT scan within the last 12 months or planned, for clinical reasons, in the next 3 months (Note, may still be included if CT essentially equates to a baseline scan and there are no other exclusion criteria);
- Weight exceeds restrictions for scanner (>200kg);
- Participant unable to lie flat; or
- Poor physical fitness such that treatment with curative intent would be contra-indicated; this may require a second opinion or advice from the local lung cancer MDT.

3.3.9 Participants previously assessed at below the threshold for LDCT, but who may meet eligibility criteria as they become older and/or accumulate pack years of smoking, should be reassessed at 2-year intervals.

3.4 Information for participants

3.4.1 Written and/or video information should be provided at all stages, with specific information on what is involved. For those eligible for LDCT, this should include the risks and benefits of the test. This should be followed by a discussion between the

[1] referred to as 'Race' in the original $PLCO_{M2012}$ risk model

individual and the clinician to facilitate informed decision-making and subsequent acceptance/decline of the test.

- Participant information leaflets should clearly state the risks and benefits of screening. Such information should have participant contributors as part of any team compiling it – not just healthcare professionals.
- The focus should be on informed choice.
- Information should be available at all relevant points throughout the pathway.
- A trained interpreter should be available during appointments where the functional language is not English.
- Participants with learning disabilities should be provided with appropriate support to enable them to understand all processes and results.
- All information will be provided in accessible font sizes and in plain English.
- Flexible appointments and all reasonable adjustments will be made for screening participants with learning disabilities.

3.4.2 As part of a Lung Health Check, both eligible and ineligible participants should be offered spirometry and advised on smoking cessation. Some of these participants may then go on to a lung cancer screening CT scan.

3.4.3 Smoking cessation advice should be incorporated into written correspondence and should be face-to-face where participants attend. Enhanced smoking cessation interventions are also encouraged including the use of pharmacotherapy.

3.4.4 Current smokers not meeting the inclusion criteria for LDCT, should be offered smoking cessation support.

3.5 Consent process

3.5.1 Consent for CT screening should be taken by a suitably trained clinician or non-clinician, familiar with the risks and benefits of the process. Participants should be informed that:

- The primary purpose for undergoing CT is to identify lung cancer at a stage when there may be options for curative treatment. An estimated chance of finding a lung cancer should also be provided;
- If lung cancer is identified; the participant will be directly referred to an appropriate lung cancer service and be managed according to the National Optimal Lung Cancer Pathway;
- The purpose of the scan is not to identify diseases other than lung cancer. However, if other significant conditions are identified that require action, then either an appropriate referral will be made and/or the GP and participant will be informed. Action on incidentally detected conditions will follow NICE guidance;
- Indeterminate pulmonary nodules requiring repeat CT or further investigation are often benign, appropriate estimated individual probability of malignancy should be determined;
- LDCT uses radiation with information about the associated risks;
- A negative CT scan does not exclude the possibility of having lung cancer in the future. Participants should be informed about the need to report future symptoms of lung cancer if they develop;
- That cancer may be identified that would not have led to harm (over diagnosis);
- That there are some risks of harm relating to the further investigation and treatment of findings on the CT;

- That protocols will be followed that minimise harms from over diagnosis, further investigation and false positives; and
- That they will be asked to consent the retention of clinical data and radiological images for evaluation and future research purposes, under the correct governance procedures. (However, participants not wishing to provide this level of consent would not be stopped from participating in this programme.)

3.6 Pathways for new symptoms

3.6.1 Participants at high risk of lung cancer often have comorbidities that cause symptoms; these may be unrelated to cancer and in the circumstances described below, in 3.65 permit continuing with the LDCT screen.

3.6.2 Those presenting with respiratory infection should be booked in for a deferred appointment in 6 weeks' time, to avoid false positive results. Evidence of respiratory infection will be assessed at time of appointment, including cough, new or changed sputum colour or volume, breathlessness, wheeze, chest pain, fever, sore throat and coryza.

3.6.3 If the individual presents with the following symptoms they should proceed directly to an urgent CT of the neck, thorax and abdomen with administration of intravenous contrast. This may be in a mobile scanning unit or urgently through the secondary care service:

- persistent haemoptysis;
- signs of superior vena cava obstruction (SVCO) (Face and/or neck and/or arm swelling, raised and non-pulsatile JVP);
- stridor; or
- signs of malignant cord compression (new onset back/shoulder pain, sensory and/or motor deficit, urinary and/or faecal incontinence, gait abnormalities).

3.6.4 If potential participants present with symptoms consistent with exacerbation of COPD or other chronic pulmonary conditions, they should proceed with the LDCT.

3.6.5 Participants who meet eligibility criteria for a LDCT but who have the following features or symptoms, as described in NICE referral criteria, should proceed with LDCT to avoid delay:

- cough;
- fatigue;
- dyspnea;
- chest pain;
- weight loss;
- appetite loss;
- persistent or recurrent chest infection;
- finger clubbing;
- supraclavicular lymphadenopathy or persistent cervical lymphadenopathy;
- chest signs consistent with lung cancer; or
- thrombocytosis.

3.6.6 Those ineligible should be managed according to the NICE NG12 cancer recognition and referral guidelines. Local arrangements for requesting urgent chest X-rays and direct referral for CT may reduce delays.

4 Low Dose Computed Tomography Acquisition and Reading

4.1 CT equipment and volumetry software requirements

4.1.1 The minimum specification is for a sixteen channel multi-detector CT, fixed site or mobile, and calibrated according to the manufacturer's specifications, capable of delivering low radiation dose protocols (see below). Most modern scanners exceed this specification and will achieve this.

4.1.2 Volumetric software should be used for assessment of pulmonary nodules and should remain constant to allow accurate comparison of volumes. Software updates should be recorded.

4.1.3 The supplier should provide evidence that the upgrade provides the same measurements or ensure that the user is prompted to re-measure nodules from preceding scans if the software upgrade provides altered (and likely improved) measurement capability.

4.1.4 Volumetric software must be directly or indirectly integrated into PACS systems, capable of automated image retrieval of historical imaging.

4.1.5 Other desirable features are high automated segmentation accuracy rates (>85%), automated volume doubling time calculation, and automated structured reporting.

4.1.6 If computer aided detection (CAD) systems are used, they should only be used in a concurrent or second reader format. A false positive rate of <2 per case is desirable for CAD systems.

4.2 CT Image Acquisition Protocol

4.2.1 **Subject Position:** Participants should lie supine on the CT table with arms above their head and thorax in the midline of the scanner. Subject comfort should be optimised, and maximal inspiration rehearsed prior to the scan to minimise motion during the CT. Imaging should be performed during suspended maximal inspiration. No intravenous contrast material will be administered.

4.2.2 **Localiser:** Sites should use their standard scanogram to localise the start and end positions of the scan. The frontal localiser should be performed in the PA projection and at the lowest possible setting to minimize breast dose.

4.2.3 **Volumetric CT scan:** The lung parenchyma (lung apices to bases) must be scanned in its entirety in a single cranio-caudal acquisition. The field of view selected as the smallest diameter as measured from widest point of outer rib to outer rib large enough to accommodate the entire lung parenchyma. Thin detector collimation (≤1.25mm) will be used.

4.3 Exposure factors

4.3.1 Radiation exposures will be as low as possible whilst maintaining good image quality. The CT dose index (CTDIvol) must be kept as low as possible with the effective radiation dose well below 2 mSv. The kVp and mAs settings will be varied according to participant body habitus. The height and weight of participants will be used to enable accurate selection of exposure factors. Ultra LDCT should be used where available and considered to be of equivalent diagnostic sensitivity to LDCT.

4.4 Image reconstruction

4.4.1 Image reconstruction should be standardised and used for any subsequent follow-up examinations where possible, with particular emphasis on ensuring that slice thickness, reconstruction increment, and reconstruction algorithm are identical.

4.4.2 Slice thickness should be ≤ 1.25mm. An example of reconstruction parameters used in low-dose screening CT are outlined in table 2.

4.4.3 If iterative reconstruction is used, this should be kept constant at follow up.

Table 3: Reconstruction parameters for LDCT

Reconstruction algorithm	Reconstruction slice thickness	Reconstruction increment	Reconstruction FOV
Moderate spatial frequency/soft tissue	1mm	0.7mm	Entire lung parenchyma

4.5 Image Interpretation

4.5.1 Image interpretation should be performed on systems which permit scrolling through the data set with variable thickness and orientation using multi-planar reformations (MPR) and Maximum Intensity Projection. Where volumetry is used, radiologists should check for appropriate segmentation of nodules.

4.5.2 All reconstructed scan data (according to minimum requirement for volumetric analysis) acquired from the participants should be archived and retained at a local or central site.

4.6 Thoracic CT reader

4.6.1 **Requirements**

Lung cancer screening CT reading requires both unique skills as well as those that overlap with clinical thoracic CT reading.

- Radiologist readers must regularly attend and lead at their local lung cancer MDT.
- Readers who do not lead the lung cancer MDT must report a substantial number of thoracic CTs annually as part of their normal clinical practice (>500), including a significant proportion of lung cancer CTs.
- Readers must be familiar with the use and limitations of nodule volumetry software and apply the BTS guidelines for nodule management in their usual practice.

- CT readers should attend education programmes on nodule management and LDCT screening as part of continuous professional development and training.

4.6.2 **Quality Assurance**

Each programme should have a documented quality assurance mechanism in place for CT reading. QA for CT reading may include:

- Stipulating and ensuring a minimum level of training and expertise of readers;
- Ensuring initial CT reads of radiologists without experience of LDCT screening are reviewed by more experienced readers (e.g. first 50 cases);
- Periodic review of CT readers reports by expert panels;
- Review of all initial MDT referrals of readers without experience of LDCT screening by more experienced readers; or
- Evaluation of all readers' recall rates, false positive rates and false negative rates, with identification of outliers.

4.6.3 **Lung Nodule Characterisation**

The nodule size threshold for characterization is ≥ 5mm or 80mm^3. Where multiple nodules are detected, at least two nodules, including the largest nodule, and where possible all nodules >200mm^3, should be recorded. Smaller nodules may be characterised for research purposes. All new nodules on interval LDCT ≥30mm^3 or ≥4mm max diameter should be reported as this determines scan interval in these nodules (see 4.6.3.1). At the last screen, all nodules including any new nodules should be reported as a further follow up LDCT may be indicated.

4.6.3.1 Nodules should be characterised in detail as follows (where multiple nodules are detected, at least two, including the largest should be characterised):

- Site (lobe, juxta-pleural, perifissural), volume, density and presence or absence of spiculation or a benign pattern of calcification.
- Nodule type should be classified as solid (SN), part-solid nodules (PSN) or pure ground glass nodules (pGGN).
- SN with benign features (such as popcorn calcification, intrapulmonary lymph nodes etc.) should be disregarded and may be mentioned in the report at the discretion of the reporter.
- The total number of nodules and other findings should be recorded.
- At follow up, nodules should be classified as old or new. New nodules should be differentiated from nodules present on prior CT, but previously ignored. There are different thresholds for nodule follow up for new nodules (section 5.1.2).
- Baseline scans that show nodule(s) that are <80mm^3 or 5mm max diameter should be classified as negative.

4.6.3.2 Readers should flag all cases where CTs are non-diagnostic or suboptimal (e.g.: due to motion artefact or inadequate coverage). Protocols should be in place for efficient recall of these participants.

4.6.4 **Other findings**

Programmes should have protocols in place for reporting and management of incidental findings (see section 7.4). Narrative/descriptive reports should be avoided. Clinically insignificant findings should either not be reported or clearly identified as such. An emphasis should be placed on reporting of findings where there are proven interventions for participant benefit.

4.7 Volumetric Analysis

4.7.1 Nodules should be measured using semi-automated volumetry. Where volumetry segmentation is not possible or judged to be inaccurate, maximal axial manual diameter measurements should be recorded on lung window settings, excluding any spiculation. Manual adjustment of volumetric analysis should be avoided as this may introduce unquantified variability.

4.7.2 Subsequent scans should measure volume in the same nodules and a volume doubling time (VDT) calculated for each where an increase ≥25% has occurred. A less than 25% increase may be within the margin of error. Where volumetry is not possible, the growth rate should be based on visual assessment or diameter measurements, accepting that this can be less accurate.

4.7.3 3D reformats showing reliable nodule volume segmentation, including size and VDT calculation where appropriate, should be sent to PACS. This assists with the reading process at follow up and ensures that the information is efficiently conveyed to the lung cancer or nodule MDT for relevant cases.

5 Repeat Low Dose Computed Tomography

5.1 Scan intervals

5.1.1 Nodule management should be protocolised and based upon the BTS 2015 pulmonary nodule guidelines [6] and NICE guidelines for the management of lung cancer [7]. Where local or regional programmes choose to modify nodule management guidelines, this should be clinically justifiable.

5.1.2 Participants with a CT scans showing nodules are managed according to nodule size. Volumetry is the preferred method except where not possible, when the maximum axial diameter is used. Note size thresholds change where nodules were not previously seen on a previous CT. Box 1 shows how the nodule size affects follow-up interval and referral.

Box 1:

Baseline CT Nodule size (measure)	Interval CT(s)	Final CT
No nodules		24 months
<80mm^3 or <5mm max. diam.		24 months
≥80 to <300mm^3	3 months	12 months
≥6mm and <8mm max. diam. (volumetry not possible)	3 and 12 months	24 months
5 to 6 mm max. diam. (volumetry not possible)	12 months	24 months
≥300mm^3 or ≥8mm max. diam. and Brock risk <10%	3 months / 12 diam. only	12 months / 24 diam. only
≥300mm^3 or ≥8mm max. diam. and Brock risk ≥10%	Refer	
New nodules found on any interval CT		
<30mm^3 or <4mm max. diam.	No change to FU	
≥30mm^3 <300mm^3	3 months	12 months
≥4mm <8mm (volumetry not possible)	3 and 12 months	24 months
≥300mm^3/≥8mm	Refer	

5.1.3 Interval surveillance scans for stable PSN and pGGN should occur at 1, 2 and 5 years (the latter if annual or biennial screen not planned due to exit from the programme). For programmes that do not plan to scan beyond 1 or 2 years, appropriate handover and recommendations should be made to the local respiratory service for continued management of these nodules. Similar processes should be in place for continued management of new nodules identified at the end of the programme.

6 Non-attendance and Exiting the Programme

6.1 Non-attendance

6.1.1 First-time attendance should be facilitated by offering LDCT that is easily accessible for the subject e.g. mobile scanners in community settings; easy transport links.

6.1.2 The process of changing appointments should be straightforward for those who request this.

6.1.3 There should be a formal process for contacting non-attenders.

6.1.4 Feedback from non-attenders should be sought to evaluate the reasons and improve access.

6.2 Exiting the programme

6.2.1 Subjects exit the programme at 75 or 76 years of age (depending on whether the timing of the final LDCT is 12 or 24 months from baseline).

6.2.2 Subjects should have assessment of co-morbidity and fitness to confirm continued eligibility. This may be at the screening visit or via confirmation of eligibility through the subjects GP. They should exit the programme if no longer eligible.

7 Management of findings

7.1 Lung Nodule Management and Follow-up/Further Diagnostics

7.1.1 The protocol for management of participants with significant findings should follow the BTS 2015 pulmonary nodule guidelines and NICE guidelines for the management of lung cancer.

7.2 Multidisciplinary team meetings

7.2.1 There are two multidisciplinary meetings that are relevant. All programmes should have access to these MDTs:

- The LDCT Review MDT, which may also include the pulmonary nodule MDT. Here the management of all findings other that those previously identified as requiring urgent referral by the RR are discussed and management plans are devised and communication with the participant and any healthcare professionals coordinated. Pulmonary nodules may also be managed or referred to a separate Pulmonary Nodule MDT (see 7.3).
- The Lung Cancer MDT, where the outcome of investigation of higher risk nodules and suspected lung cancer is discussed, and treatment planned.

7.2.2 All pulmonary nodules that are suspicious should be discussed at the LDCT Review or Pulmonary Nodule MDT; these include:

- nodules that are ≥300mm^3 or ≥8mm diameter with a ≥10% chance of malignancy by Brock score; these usually require a PET-CT for further evaluation; and
- nodules that show significant growth after interval LDCT.
- Note that nodules that only require repeat CT as a further test should be managed by radiologists within the programme and do not require discussion at MDTs. (unless a second opinion is being sought).

7.3 Low Dose Computed Tomography Review MDT or Pulmonary Nodule MDT

7.3.1 Nodules requiring a PET-CT or that show growth will be managed within the clinical service. Management, in brief, will follow BTS guidelines:

- Nodules with confirmed VDT>600 days can be referred back for annual LDCT.
- Nodules with VDT 400-600days, surveillance or biopsy / resection can be offered depending on participant preference.
- Nodules with VDT<400 days should be further investigated (e.g. PET-CT, percutaneous biopsy, lung resection, according to participant preference).
- For PSN, any change in morphology or growth of solid component (≥2mm) as well as a Brock risk of malignancy of >10% should prompt consideration of a histological diagnosis and definitive management. Such lesions have a better prognosis, so further observation may be indicated to avoid over diagnosis.
- For pGGN, any change in morphology or growth of solid component (≥2mm) as well as a Brock risk of malignancy of >10% should prompt consideration of further imaging follow-up or histological diagnosis and definitive management, noting the very good prognosis of these lesions and potential for over diagnosis.

7.3.2 Nodules with a Herder risk score <10% will be referred for annual screening. The Herder tool is validated risk calculator that incorporates findings from FDG-PET scans (available in BTS pulmonary nodule app).

7.4 Management by Lung Cancer Service

7.4.1 Referral

LDCT suspicious for lung cancer will receive a consultant upgrade into the suspected lung cancer rapid assessment and diagnosis pathway [8]. This will be done immediately by the responsible radiologist who will ensure this information is passed to the responsible clinician and copied to the GP.

7.4.2 Incidental findings

Minor incidental findings are common on LDCT and have the potential to cause increased unnecessary investigations and anxiety to participants. Incidental finding reporting, and management should be based on the following principles:

- The finding should be clinically significant.
- Clinically insignificant findings should not be reported to the GP or participant.
- There should be agreement between the LDCT targeted lung cancer screening programme and primary care as to the nature and benefit of the recommended interventions.
- Recommendations for clinical correlation by primary care of CT findings should be avoided, and if made, should be specific.

7.4.2.1 Incidental findings can be broadly categorised as follows:

- Major findings that may be life threatening should prompt direct referral for admission to hospital by the LDCT targeted lung cancer screening programme.
- Findings mandating urgent referral (e.g. significantly dilated aortic aneurysm).
- Findings indicative of cancer at another site which should prompt urgent referral via the cancer pathway upgrade process.
- Other non-cancer findings requiring referral to secondary care (e.g. significant fibrotic interstitial lung disease).
- Non-cancer findings that may require management in primary care (e.g. minor bronchiectasis).
- Other findings that may prompt NICE recommended assessment to be done, where they have not been included in the assessment performed by the RA (e.g. significant coronary calcification on CT may prompt recommendation for cardiovascular Q-Risk assessment).
- Findings that are usually not directly associated with a beneficial intervention and that do not require communication (e.g. bronchial wall thickening).

7.4.2.2 Incidental findings will be reviewed by the LDCT Review MDT and clear recommendations will be made to the relevant clinicians and to the participant.

7.4.2.3 There should be a policy agreed between the targeted lung cancer screening service and primary care about management of LDCT findings, including the referral process for incidental findings.

8 Communication of results

8.1 Process

8.1.1 Subjects will be sent communication about the results of the LDCT and spirometry as shown in Appendix A.

8.2 Serious findings

8.2.1 Potentially serious findings will be acted on immediately and more indeterminate findings followed up as required.

8.3 Letters

8.3.1 Standard letters have been prepared, adapted from the UKLS and Lung Screen Uptake randomised controlled trials.

8.3.2 The outcome of the LDCT should be communicated by standard letter to the GP (preferably electronic to facilitate audit) with a copy of the CT report, with the action taken, if any, included.

8.3.3 The outcome should be communicated to the participants by standard letter, except in the unusual circumstance where direct admission is arranged. Letters will not include details of serious findings; this will be explained at clinic visits.

8.4 Telephone

8.4.1 There should be a support line for optional contact with an experienced nurse or administrator, based locally in primary or secondary care.

8.4.2 Telephone communication may also be offered as well as communication by letter.

8.4.3 There should be an advice line for participants to phone for further information and clarification when they receive their results.

8.5 Timeframe

8.5.1 The outcome should be communicated within a maximum of 2 weeks from the LDCT. Safety net processes should be in place to ensure that findings requiring urgent referral are flagged and communicated appropriately.

8.6 General

8.6.1 Generic, non-personalised, information about programmes should be available on the public NHS website.

8.6.2 For participants who are being given a “normal” result, the possible effect of over-reassurance will be mitigated by including information about continued risk of lung

cancer (which may be provided as a percentage based on a multivariable model), the importance of not ignoring red flag symptoms and the importance of not smoking.

9 Low Dose Computed Tomography Data Management

9.1 Collection

9.1.1 Data should be collected by the local team in a format that will allow submission to the National Cancer Registration and Analysis Service.

9.2 Handling

9.2.1 All data will be handled in adherence to the Data Protection Act 1998 and Information Governance (IG) legislation. Audit trails will be in place in order to fully trace data entry and edit.

9.3 Inputting

9.3.1 Inputting of data will comply with information governance legislation.

9.4 Consent

9.4.1 Written consent will be obtained from participants.

9.4.2 At the time of consent participants will be informed of the purpose of data collection and intentions for its use.

9.5 Dataset

9.5.1 A minimum mandatory dataset has been agreed.

10 Evolution of the Standard Protocol for the Targeted Lung Health Checks Programme

10.1 Updating the Standard Protocol

10.1.1 It is recognised that this Targeted Screening for Lung Cancer with Low Radiation Dose Computed Tomography and Standard Protocol prepared for the Targeted Lung Health Checks Programme will evolve over time.

10.1.2 This will be influenced by the Cancer CEG Lung Sub-Group in its role as an Expert Advisory Group for the Targeted Lung Health Checks Programme tasked with providing expert advice, support and guidance to the evaluation of the programme, implementation of the Standard Protocol, and bringing knowledge and expertise on innovation and developments which would impact on lung cancer outcomes.

10.1.3 Furthermore, as findings from the Dutch-Belgian NELSON randomised controlled trial emerge [9], and further work is done on interpreting these data and findings, this document will also adapt in line with this thinking.

10.1.4 It should also be noted that advice and consultation with the UKNSC will be ongoing and will also influence future iterations of this documentation.

11 References

1. Marriott, A. and Turner, S. (2015). Making Reasonable Adjustments to Cancer Screening. [online] London: Public Health England. Available at: https://www.ndti.org.uk/uploads/files/Updated_reasonable_adjustments_in_cancer_screening_report.pdf

2. Kovalchik SA, Tammemagi MC, Berg CD, Caporaso NE, Riley TL, Korch M, Silvestri GA, Chaturvedi AK, Katki HA: Targeting of Low-Dose CT Screening According to the Risk of Lung-Cancer Death. New England Journal of Medicine 2013, 369:250

3. Raji OY, Duffy SW, Agbaje OF, Baker SG, Christiani DC, Cassidy A, Field JK: Predictive accuracy of the Liverpool Lung Project risk model for stratifying patients for computed tomography screening for lung cancer: a case-control and cohort validation study. *Annals of Internal Medicine* 2012, 157:242-250.

4. Tammemagi MC, Katki HA, Hocking WG, Church TR, Caporaso N, Kvale PA, Chaturvedi AK, Silvestri GA, Riley TL, Commins J, Berg CD: Selection criteria for lung-cancer screening. *New England Journal of Medicine* 2013, 368:728-736.

5. Ten Haaf K, Jeon J, Tammemagi MC, Han SS, Kong CY, Plevritis SK, Feuer EJ, de Koning HJ, Steyerberg EW, Meza R: Risk prediction models for selection of lung cancer screening candidates: A retrospective validation study. *PLoS Med* 2017, 14: e1002277.

6. Callister, M. Baldwin, D. Akram, A. Barnard, S. Cane, P. Draffan, J. Franks, K. Gleeson, F. Graham, R. Malhotra, P. Prokop, M. Rodger, K. Subesinghe, M. Waller, D. Woolhouse, I. (2015). [online] London: BTS Guidelines for the Investigation and Management of Pulmonary Nodules. Available at: https://www.brit-thoracic.org.uk/document-library/clinical-information/pulmonary-nodules/bts-guidelines-for-pulmonary-nodules/

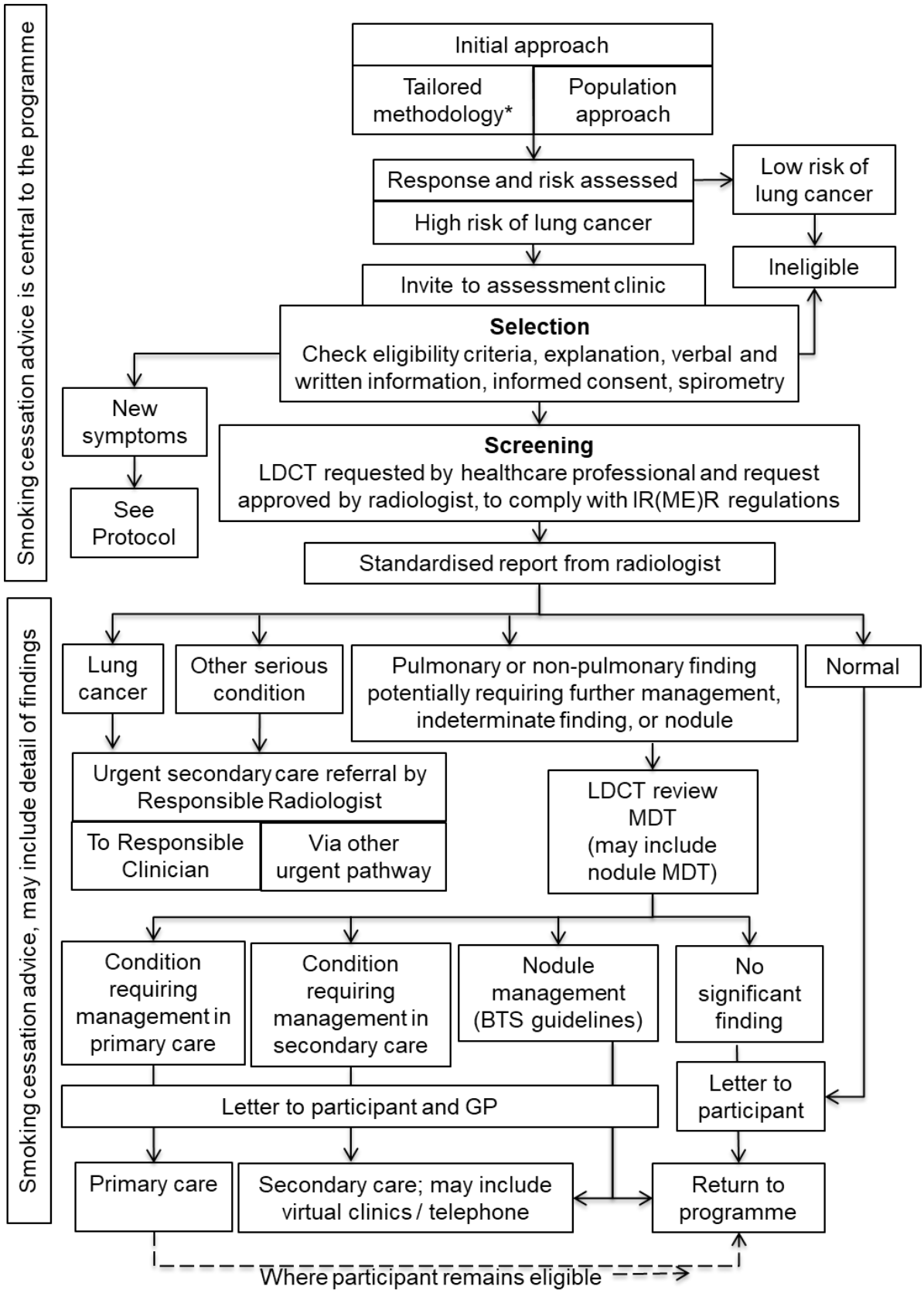
7. NICE (2011). [online] London: Lung Cancer: diagnosis and management clinical guideline (CG121). Available at: https://www.nice.org.uk/guidance/CG121

8. NHS England (2018). [online] London: Implementing a timed lung cancer diagnostic pathway. Available at: www.england.nhs.uk/wp-content/uploads/2018/04/implementing-timed-lung-cancer-diagnostic-pathway.pdf

9. Wclc2018.iaslc.org. (2018). NELSON Study Shows CT Screening for Nodule Volume Management Reduces Lung Cancer Mortality by 26 Percent in Men. [online] Toronto: The International Association for the Study of Lung Cancer

Appendix A

Patient pathway from invitation, through LDCT, and follow up:



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SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification	NHS Tameside and Glossop Community Based Lung Health Checks
Service	Phased Extension of the National Lung Health Checks within NHS Tameside and Glossop CCG
Commissioner Lead	NHS Tameside and Glossop CCG
T&G ICFT (Provider)Lead	NHS Tameside and Glossop Integrated Care Foundation Trust.
Period	January 2020 to March 2023
Date of Review	March 2023

1. Population Needs

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

The Targeted Lung Health Check (TLHC) service which is being commissioned involves identifying people between the ages of 55 – 74 and 364 days who have ever smoked. These people will be invited for a lung health check and a low dose CT scan (where necessary) for the earlier detection and treatment of lung cancer and earlier identification of other respiratory disease. The service fits with Domains 1, 2, 4, and 5 of the NHS Outcomes Framework.

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm

2.2 Locally Defined Outcomes

The objective of the programme is to achieve the requirements outlined in the Targeted Lung Health Checks Standard Protocol https://www.england.nhs.uk/wp-content/uploads/2019/02/targeted-lung-health-checks-standard-protocol-v1.pdf covering the following areas:

- Early diagnosis and treatment of lung cancer improving current staging diagnosis and improving survival rates.
- Reduction in lung mortality rate
- Early detection and diagnosis of other incidental findings such as cardiac, pulmonary disease as identified through previous lung health check pilots
- Patient monitoring /call back for participants with suspicious lung nodules
- Proactive promotion of participant self-management and smoking cessation
- Increase the number of people who quit smoking
- Reduction in A&E attendances and hospital admissions in future years

2.3 Data Collection Requirements

The service provider will be responsible for the collation and submission of TLHC data in line with the minimum dataset (attached) which sits within the Standard Protocol.


PARTIC1.docx


TLHC Dataset_V1.5.xlsx

The Provider will work with Cancer Alliance Data, Evidence and Analysis Service (CADEAS) http://www.ncin.org.uk/local_cancer_intelligence/cadeas who will support the service evaluation (6 key evaluations: barriers and enablers. Replicability and scalability, impact and patient outcomes, health inequalities and participation experience and satisfaction). To support this the Provider will be expected to build quality monitoring assessment tools into the programme.

The lung health check is a service for the registered population of NHS Tameside and Glossop CCG who meet the service criteria. The provision of the lung health check service will improve health outcomes and quality of life by enabling more people to be identified at an earlier stage for serious respiratory disease, with a better chance of putting in place positive ways to substantially reduce the risk of respiratory disease morbidity, premature death or disability. The lung health check service is not just a diagnostic service but is part of a wider process that should ensure that people with respiratory problems gain an accurate diagnosis and appropriate treatment and support, including, if they are smokers, support to help them quit.

The Provider will be expected to update Commissioners on the performance of the service against the service outcomes on a quarterly basis through the agreed governance process.

3. Scope

3.1 Aims and Objectives of the Service

The primary aim of the service is to reduce mortality from lung cancer. The Provider will ensure that a lung health check is offered to people who smoke or who have been previous smokers, aged 55 to 74 and 364 days in line with the standard protocol. The service will also aim to:

- Increase the number of people diagnosed with lung cancer at an early stage by accurately identifying people at an elevated risk of lung cancer who would benefit from having a low dose CT scan
- Increase the number of people registered at their GP with a correct diagnosis of COPD and in receipt of appropriate treatment
- Increased recognition of the number of people at risk of cardiovascular event in the next 10 years, who may benefit from intervention
- Reduce smoking in people within the targeted age group

The service objectives are:

- Correctly inform participants about the lung health check process and the need for a CT scan if lung cancer risk is equal to or above the set risk threshold
- Accurately calculate the lung cancer risk score of all participants
- Provide a high quality baseline Spirometry test to people at high risk of lung health problems
- Correctly assess people's lung health and refer them to the most appropriate service/s based on their diagnosis.
- Provide support and advice about lung health, in particular, the importance of not smoking and encourage people that express any interest in quitting to access smoking cessation therapy, counsellors services or their GP
- Provide a user friendly service to a diverse population of smokers and ex-smokers aged 55-74 and 364

days that results in high levels of customer satisfaction
- Offer all service participant a lung health check which is convenient and accessible
- Ensure that all participants are seen with the timescale set by the CCG & NHSE

The programme scope covers residents who are registered with a GP in NHS Tameside & Glossop CCG.

The Provider will work collaboratively to agree and establish local pathways for all eligible patients to ensure they access the right care, at the right time to meet the person's needs.

3.2 Inclusion Criteria:

- Age range from 55 to 74 and 364 days
- Willing and able to undergo LDCT; and
- PLCOm2012 risk of ≥1.51% over 6 years

3.3 Exclusion Criteria:

- Participant does not have capacity to give consent (standard criteria for assessing capacity apply);
- Full thoracic CT scan within the last 12 months or planned, for clinical reasons, in the next 3 months (Note, may still be included if CT essentially equates to a baseline scan and there are no other exclusion criteria);
- Weight exceeds restrictions for scanner (>200kg);
- Participant unable to lie flat; or
- Poor physical fitness such that treatment with curative intent would be contraindicated; this may require a second opinion or advice from the local lung cancer MDT
- Patients suspected of cancer (should be referred on the two week wait pathway)
- Patients on the Gold Standard Framework end of life register
- Patients who have had a lung cancer diagnosis within the last five years

3.4. Service Set Up & Delivery

The Provider will work with the Primary Care Network / GP Practices to ensure they invite the targeted population as per the agreed data quality search (attached below). Practices are able to run a search on their GP system (search to be developed by the CCG) to share with the Provider/s (in accordance with the data sharing agreement).

Healthy Lung Checks Data Quality

The desired expected service start date will be January 2020 when it the first invite letters will be sent out to participants. The exact date is still in the process of being agreed and the decision will take into account capacity at the tertiary centres.

The Provider/s will be required to implement robust booking, scheduling and administration processes and ensure that LHC minimum data requirements are collected across different systems or organisations and stored and transferred securely.

The Provider/s of the lung health check service will set up a system in line with the Standard protocol to provide CT scanning and reporting provision or work in partnership with a CT scan provider. The Provider will set up a process to transfer reports and CT images to Tameside & Glossop ICFT radiology system where necessary. This process will be agreed through the discussion and production of clinical pathways between the provider/s and the CCG. The time scale for image reporting and transfer will also be discussed, agreed and included in the

appropriate service operation procedure.

It is essential that the Provider builds good working relationships with other LHC providers, primary care and tertiary centres across GM. Clinical pathways will need to be developed and agreed to ensure seamless referral and treatment processes between service providers.

3.5 Service Preparation

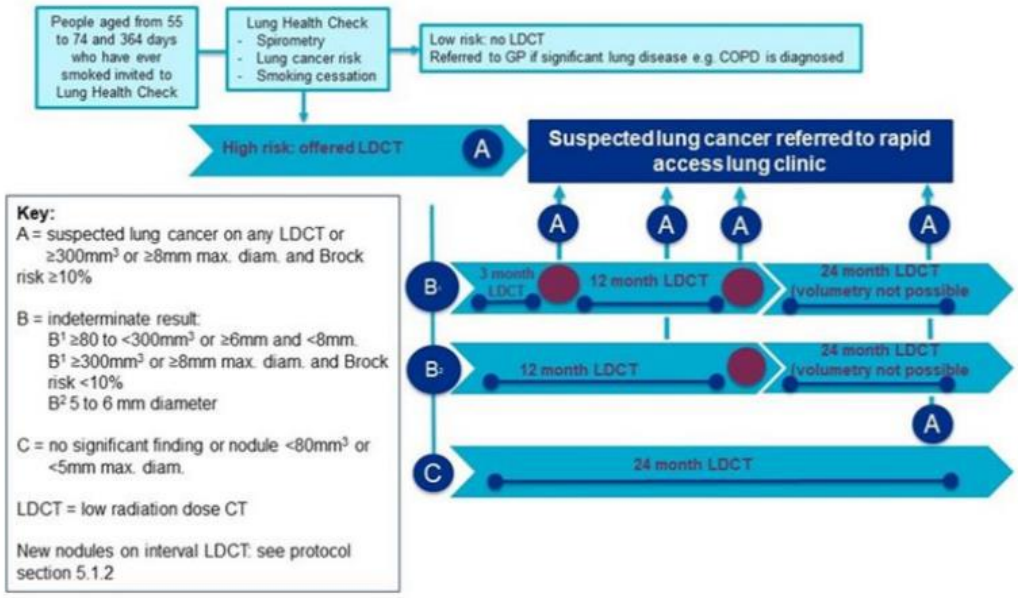
The Provider must ensure a full understanding of the Targeted Lung Health Check Service Protocol and ensure that the protocol is fully adhered to. Areas of concern which must be addressed to ensure excellent service uptake are:

- Participant address is checked as correct
- Process for changing appointments is easy and straight forward
- Follow up process for contacting non-attenders
- Participant is not deceased
- Participant is not an in-patient (participant should be contacted at a later date)
- Participant has not had a thoracic CT within the last 12 months or planned for clinical reasons in the next 3 months

The initial invitation process will be as follows:

1. Participants aged between 55 and 74 and 364 days of age at the date of the first low dose CT scan (LDCT), registered with a GP practice who have ever smoked will be invited for a Lung Health Check. Those who attend will be assessed to calculate their individual risk of developing lung cancer.
2. Invitation to attend for an assessment for suitability for LDCT may be by correspondence or telephone via primary or secondary care, or by offering assessment in a mobile setting in high-risk areas, as part of a Lung Health Check.
3. Individuals will be assessed for eligibility criteria by confirming medical, social and employment history and risk factors for lung cancer. Validated lung cancer risk assessment tools may be used to better quantify risk.
4. Where necessary, reasonable changes should be made to the approach to ensure the service is accessible to all, including those with physical and learning disability and mental illness e.g. easy read documentation, engaging key worker in invitation.
5. NHS translation services should be available where required for individuals without adequate English language skills.
6. Participants who have difficulty understanding the purpose of the programme should be able to access the programme.

The participant journey for both those assessed at the Lung Health Check as low risk of developing lung cancer and those at high risk is shown in the diagram below (Appendix A of the Standard Protocol provides a more detailed clinical pathway).



3.6 Capacity & Infrastructure

There should be sufficient capacity and infrastructure to deliver the programme including:

- Community facilities for siting of mobile CT scanners, if required
- Primary care facilities for supporting assessments for eligibility and health checks
- Scanning capacity
- Radiology reporting
- Clinical service for work up of referred participants
- Clinical service for treatment of participants
- Smoking cessation support and advice
- Administrative support for the programme including data collection, collation and submission

The implementation of the programme should be aligned with local services. This will involve working with regional and local healthcare management including:

- Regional Office, NHS England
- Cancer Alliances
- Sustainability and Transformation Partnerships (STPs)
- CCGs
- Local NHS Trusts
- Local Authorities
- Third Sector
- Voluntary Providers
- Social Prescribers

3.7 Overview of the Lung Health Check Assessment

The lung health check assessment is an opportunity for people to consider their lung health. Each person qualifying for a lung health check will have a basic examination focusing on lung symptoms, baseline spirometry, Qrisk2 score and have their risk of lung cancer calculated. Those calculated to have a risk of lung cancer above or equal to a set threshold of ≥1.51% will be eligible to enter the low dose CT scan service.

A nurse will interpret the results of the lung health check and use clinical judgment to decide whether or not the participant should visit their GP practice or be signposted elsewhere. The nurse will give reassurance and advice as required and put the patient in touch with on-site smoking cessation intervention as appropriate. The

smoking cessation advisor will ensure robust links with social prescribing providers. The Provider will be responsible for ensuring that results from the lung health check will be electronically processed and will flow into primary care IT systems so that the participant's medical record is updated.

The success of the service will depend upon:

- Attendance at the lung health check
- Correct assessment of lung health & Qrisk2
- Appropriate referral to CT scan
- Structured reporting of CT scans to identify lung cancer, emphysema or coronary disease etc.

3.8 Expected Patient Numbers

The expected number of service participants is shown in the table below. The data is based on Tameside & Glossop Demand Modelling taken from primary care data from 21st June 2019. The data search will need to be re-run as the service moves to different localities/neighbourhoods to take into account the service age range of 55 – 74 and 364 days.

Tameside & Glossop Lung Health Checks Activity Modelling	Modelled @ 60% Take Up (reflecting other programme results) re-affirmed @ 3/9/19 Steering Group		
Stage			**Comment**
Total eligible population	54,613	100.0%	Aged 55-74/364
Ever smoked	20,207	37.0%	Of Total eligible population
Appointments booked	12,124	60.0%	Take Up of Ever Smoked
Non attendees	970	8.0%	Of Appointments Booked
LHC's performed	11,155	92.0%	Of Appointments Booked
Positive LHC's	6,247	56.0%	Of LHC's analysed
Excluded from CT scan	187	3.0%	Of Positive LHC's
Initial CT scans performed	6,059	97.0%	Of Positive LHC's
Indeterminate - require second scan 3 months	860	14.2%	Of Initial CT Scans performed
Indeterminate - require second scan 12 months	860	14.2%	Of Initial CT Scans performed
Negative CT Scan - 24 months follow-up	5,005	82.6%	Of Initial CT Scans performed
Activity Impact of Cancers Identified			
Findings			**Comment**
Patients needing clinical investigation (following first scan, three months follow-up and 12 months follow-up)	357	5.9%	Of Initial CT Scans performed (including patients requiring investigation after second scan)
Cancers found	182	50.8%	Of Needing clinic investigation
24 months follow-up	5,005	82.6%	Of Initial CT Scans performed
Patient needing clinical investigation followign 24 month scan	120	2.4%	Of 24 month scans
Cancers found at 24 months follow-up	79	65.5%	Of Needing clinic investigation
Total cancers found	260	N/A	Including those found at initial, 3, 12 and 24 months scans
Surgery	133	51.0%	Of Cancers found
Stereotactic Body Radiation Therapy (SABR)	32	12.2%	Of Cancers found
Chemo-Radiation	24	9.1%	Of Cancers found
Radiation treatment (XRT)	24	9.1%	Of Cancers found
Surgery and Adj Chemo	20	7.7%	Of Cancers found
No Treatment	12	4.6%	Of Cancers found
Chemo	12	4.6%	Of Cancers found
Best Standard Care	4	1.5%	Of Cancers found

The allocation and booking of LHC appointments will be monitored through weekly CCG mobilising contract meetings (moving to monthly as the service is established). The Provider will communicate and advise the commissioners on the number and proportion of slots booked along with any potential for additional capacity. Contingency plans for overbooking will be developed and agreed based on the business case contingency

amount (TBC by finance lead).

The proposed trajectory for booking appointments within 15 months in the specified time period is shown in **Appendix A**. The modelling in appendix A has also been completed for 24 months but the extension of the service is not yet agreed with NHS England. The time period may change depending on possible service impact on tertiary providers. The Provider will continually link with the GM Cancer Alliance to ensure that the service dovetails with other services across GM and is provided at a safe and manageable pace. The Provider will update Commissioners on service roll out progress and identify and communicate service issues well in advance of them becoming unmanageable.

3.9 Initial Contact

The provider will work with Practices to identify patients in the appropriate age range of 55-74 and 364 days registered with a NHS T&G CCG GP practice. The Provider will identify the name, date of birth, home address and contact details whilst taking into account the inclusion and exclusion criteria within the standard protocol. Patients will then be invited to contact the booking service to agree an appointment for a community based lung health check.

The initial invitation letters and booking of any appointments will be managed by the Provider who will manage the end to end process for this service i.e. booking appointments to patient follow up and treatment if required. This will enable control over the whole pathway and mitigate any issues with onward referral.

3.10 Set up at Community Locations

The Provider will engage with Primary Care throughout the service planning and scheduling stage. The provider will identify suitable service locations that adequately cover the Tameside & Glossop footprint. The service is expected to be delivered in 3-4 locations and will target participants across a number of GP practices in the surrounding area. Practices will be informed well in advance of when their patients will be invited. This will give them time to prepare and run their data download and encourage participants to attend.

The provider will agree locations and duration on site with CCG Commissioners. The locations for service delivery will be selected so that they are convenient for the GP practice's patients to attend. The Provider will work with the Commissioner and in partnership with the CT scan service to agree suitable locations. The final locations at which the service will be delivered will be agreed with the Provider at least six weeks before commencement of the service.

The Provider will make all necessary assessments to ensure that a high quality lung health check service can be delivered safely and securely at the agreed locations. The Provider will work with the Commissioner to agree the schedule of service delivery and ensure that the service is ready to begin delivery at the agreed locations at the agreed times, on the agreed dates.

The Provider will work with the Commissioner and in partnership with the provider of the CT scan service to agree the times and days that the lung health check one stop service will operate.

3.11 Service Opening Hours

The LHC service must be available at convenient times for participants i.e.

- Over 6 days
- Early starts 8am
- Late finishes 8pm
- Weekend working i.e. Saturday morning/afternoon

3.12 Pathway Planning

The Provider will work in partnership with the CT scanner provider to deliver a welcoming, seamless and easily accessible pathway from LHC to CT scan through a one stop service. Participants meetings the criteria for a low does CT scan will be guided through this process with the intention of minimising and worries or concerns.

The Provider will work closely with GM Cancer Alliance and tertiary providers to plan service roll out so that the service is launched in a safe and methodical manner to prevent overburden and saturation of the full lung pathway. The service must not impact on local and GM cancer targets. The schedule will be discussed with the Commissioner and agreed with the NHS England National Team.

The Provider will produce service operational procedures (SOPs) covering all aspects of the LHC pathway both in and out of the service and will also cover incidental findings pathways i.e.

- Chronic Obstructive Pulmonary Disease (COPD)
- Emphysema
- Bronchiectasis
- Cardiovascular conditions
- Gastrointestinal conditions

Less Frequent

- Thyroid disorders
- Adrenal nodules
- Hepatic lesions
- Renal masses

The SOPs will be shared with the Commissioner to provide assurance.

3.13 Patient Literature

Patient literature should be available by request in a number of different formats i.e. braille, different languages, video with subtitles etc. Draft literature must be shared with patient groups and primary care for comments and co-production. Literature must include their rights under the Data Protection Act 2018, describe what information is being shared, how it is used, and the location of the Privacy Notice.

The Provider will ensure maximum uptake by implementing a booking process consisting of:

- Initial text message informing participants that they will be invited for a LHC
- Invite letter and information leaflet explaining the service, the lung health check and CT scan process
- Reminder letter/phone call
- Telephone call or text reminder on the day of the LHC

3.14 Arrival for Lung Health Check

- Participants will warmly welcomed in a non-judgmental way
- Participants will be offered a high quality effective service
- There will be a process in place for dealing with participants who may have a physical or mental disabilities
- Only participants with a pre-booked appointment will be seen
- A person asking for a lung health check who does not have an appointment should be signposted to the booking service, if eligible
- Adequate staffing must be in place to cover the service appointment schedule
- Waiting times must be kept to a minimum (no longer than 30 minutes)
- The participant waiting area will be comfortable and restroom facilities provided

3.15 Content of the Lung Health Check & Low Dose CT Consultation

The Provider will deliver a lung health check to each participant in line with the Standard Protocol in an electronic format ensuring that all aspect of the minimum dataset are covered. The data should flow into primary care IT systems in real time.

The LHC will consist of:

- Explanation of the LHC process
- Explanation of low dose CT scan and risk (if required)
- Consent for CT scan (if required)
- If a participant decides not to have a scan this should be recorded
- Consent to share data for service evaluation purposes
- A person that does not consent to their data being used for evaluation purposes is still eligible to have a lung health check but their decision for their data not to be shared must be clearly recorded
- Heart & lung symptom questionnaire
- Calculation of lung cancer risk score*
- Calculation of QRisk2 score for CVD
- Quality assured spirometry
- Brief consultation with respiratory nurse (including smoking cessation advice) to discuss findings and next steps
- Referral to a smoking cessation counsellor on the mobile unit or an appointment will be made prior to leaving

*Assessment of risk of lung cancer is essential to maximise the cost effectiveness of the intervention. There are a number of methods and further research may identify which is the best. This will form part of the evaluation of the Targeted Lung Health Check Programme. This standard protocol uses two thresholds to identify participants: a risk threshold of ≥1.51% risk of lung cancer over 6 years as the minimum threshold for PLCOM2012.

Due to their smoking history many participants are likely to have some lung health issues and it is important that **only those with indications of significant respiratory disease** are encouraged to attend their GP practice. The respiratory nurse should use the results of the lung health check and their clinical judgement to decide which of the following options is best suited to the participant. The options are:

Options	Action	Indications
1.Reassure the participant that their lung health check does not indicate the need for further follow-up at this time and that their risk of lung cancer is below the threshold needed for more tests	Participant leaves reassured but aware of the importance of not smoking and does not have a CT scan	Risk score below the threshold, no indications of cardio- respiratory disease, ex-smoker or no interest in smoking cessation support
2.Reassure the participant that their lung health check results do not indicate a need to see their GP but that they would benefit from a low dose CT scan because their risk of developing lung cancer is above the threshold for the scan	Participant goes on to have a CT scan but is not encouraged to visit their GP practice	Risk score is above the risk threshold 1.51% or greater. The lung health check does not indicate cardio-respiratory disease. Ex-smoker or no interest in smoking cessation support.
3.Recommend that the participant contact their GP practice to make an	Participant goes on to have a CT scan and is encouraged to contact their GP practice when	Lung cancer risk score is above the risk threshold 1.51% or greater. Spirometry result or answers to

appointment to discuss their lung health, spirometry or Qrisk2 score and that they also have a low dose CT scan because their risk of developing lung cancer is above the threshold for more tests	they can. The participant is provided with details about how best to contact their practice.	questions indicates a potential new diagnosis of lung disease e.g. COPD. Qrisk2 indicates risk of CV event over next 10 years that may require statin.
4.Recommend that the participant see their GP to discuss their lung health, spirometry or Qrisk2 score but they do not need a low dose CT scan	Participant does not have a low dose CT scan and is encouraged to contact their GP practice when they can. The participant is provided with details about how best to contact their practice.	Lung cancer risk score is below the risk threshold of 1.51%. Spirometry result or answers to questions indicates a new diagnosis of a lung disease e.g. COPD. Qrisk2 indicates risk of CV event over next 10 years that may require statin.
5.Refer the participant to urgently see their GP and use the threshold score to determine whether they should have a low dose CT scan	The respiratory nurse will telephone the participant's GP practice and inform the practice of the need to make an urgent appointment for the participant. The participant will be strongly encouraged to attend their GP practice. The participant may have a low dose CT scan if their risk score is above the threshold.	In exceptional circumstances when the results of the lung health check strongly indicate important undiagnosed disease and urgent action is indicated.
6.Recommend that the participant contact their GP practice / other resource to discuss stopping smoking	With option 6 other options may also apply. Depending upon which of the above Options also applies the person may also have a CT scan or be advised to see their GP because of indications of important respiratory disease.	The participant is a current smoker and has expressed an interest in getting support to quit smoking.

3.16 Staff Training & Competence

Before commencement of the service the Provider will ensure that all staff providing the service are fully trained and competent. It is also advisable to offer shadowing to the Respiratory Nurses covering the areas highlighted in the pilot for incidental findings (See section 4.8 above). There would be a benefit from additional enhanced training to ensure that staff are confident to relay sensitive information to participants.

Training must be provided in line with the Standard Protocol and is available via the Cancer Alliance Portal https://future.nhs.uk/connect.ti/canc/view?objectID=13365584 (registration required) and https://www.roycastle.org/for-healthcare-professionals/targeted-lung-health-checks/training/

The Lead Radiologist and Reading Radiologist/s will be required to provide the following information to the NHSE National Team & T&G ICFT before they are permitted to report for the T&G LHC service:

- How often they attend the lung nodule MDT
- How many other MDTs they attend (e.g. general chest) and how often
- Any specific interests (e.g. chest, GI, neuro)
- If BTS guidelines are used in clinical practice for incidental nodules
- If volumetry is used in clinical practice for incidental nodules
- The volumetry software used

The NHSE minimum standards and the LHC key performance outcomes framework (included in appendices in draft) in **Appendix B** must be adhered to by the Lung Health Check Nurses and The Lung Cancer Reading Radiologists and compliance must be overseen by the Responsible Assessor as per the Standard Protocol.

3.17 Equipment for LHC

Equipment used for the LHC must be calibrated (where necessary) to collect accurate readings i.e.

- Weighing scales (record in kilograms)
- Blood pressure equipment (recorded in mmHg in patient's right arm, where possible)
- Height (recorded in metres)

The nurse will assess the participants pulse and record regular / irregular. If irregular, and atrial fibrillation not know, this will be highlighted to the GP and AF used in the calculation of Qrisk2 score.

3.18 Respiratory Health Questions

The Provider will use a symptom questionnaire covering relevant aspects of the minimum dataset. The Provider will be responsible for ensuring that the answers to each question are recorded electronically on the structured data collection template and this information should flow or interface into primary care IT systems and the relevant Tameside and Glossop ICFT IT systems. Systems must be put in place for easy referral and appropriate transfer of data to third sector and social prescribing service.

3.19 Referrals to Smoking Cessation Services

The Provider will ensure that smoking cessation is an integral part of the service and will work with the subcontracted provider to ensure that the relevant aspects of the minimum dataset are recorded i.e. number of referrals verses number of quits. Smoking cessation will record the LHC data electronically and separately from all of their other data. This data will be provided electronically to Tameside & Glossop ICFT on a monthly basis.

3.20 Low Dose CT Scan

The low dose CT scan will be provided as part of an integral one stop mobile service. The scanner will comply with the CT equipment and volumetry software requirements and the CT image acquisition within the Standard Protocol.

3.21 Administrative Follow-up

The Provider will ensure:

- A robust record of attendance and outcomes is maintained for all people receiving a lung health check
- Keep a secure database which feeds into the production of reports regarding attendance and a participant's lung health check
- Brief activity report covering each month's activity as a routine electronic data return
- The return will include the number of lung health checks provided, non-attendance and the outcome of the health check
- This information will be presented to the CCG contracting team using an agreed electronic format

3.22. Security

The Provider will be responsible for the security of the mobile unit/s and will work with the subcontracted provider to plan security measures day and night. The security agreement will be agreed and documented in the tender agreement and contract.

4. Transfer of Data

The results of the lung health check will be captured on a data collection template developed by the Provider and approved by the commissioner. For those participants receiving a CT scan, the report and image must be transferred to Tameside & Glossop ICFT radiology system electronically and stored in NHS PACS systems. Data sharing agreements must be in place covering all data sharing and transfer processes across all service providers. The data sharing agreements must be written clearly and unambiguous.

The Provider will develop a reporting framework utilising NHS consultant radiologists (or international equivalents) and use a structured report to categorise the presence or absence of pulmonary nodules, coronary artery disease, emphysema or significant additional findings (NHSE in the process of drafting templates).

There should be sufficient radiology reporting capacity to ensure that reports are available within 14 calendar days of initial scan. Where possible Radiologists should be employed by the service or have the role built into their existing job plans. The reporting of pulmonary nodules will utilise volumetry, computer aided detection software and a nodule management algorithm based on British Thoracic Society (BTS) guidelines.

The Strategic Commission will develop a quality assurance programme for reporting and providing reports to the commissioners.

All data flows must be recorded by the Provider and include the data items being transferred, technology processing these flows, legal consent, and the location of the database.

5. Clinical Protocols & Pathways

Clinical protocols and pathways will be developed by the Provider in collaboration with appropriate colleagues (a sub-group of GPs, respiratory physicians, lung nurses, and radiologists). These will be in place before the commencement of the service.

Patients with a positive scan will be upgraded to the suspected lung cancer pathway within 1 working day of receipt of CT report for diagnostic work up. Patients with significant additional unexpected findings will be referred to an appropriate clinician in accordance with agreed pathways and protocols with the Commissioner.

The Provider will ensure a process is in place for notifying the patient's GP of the action taken.

The Provider will arrange telephone clinic appointments for participants with abnormal findings to fully explain the results and possible actions. These appointments will be followed by a patient letter, and a letter to the participants GP. Where possible standardised GP and patient template letters will be utilised to convey the results and actions of the nurse led LHC and CT scan as appropriate (NHSE templates are available).

6. Communication & Engagement

The provider will be responsible and accountable for the communication & engagement plan that will be developed and implemented in collaboration with the Strategic Commission. It is recognised that the success of this service is supported by a robust engagement strategy across all associated NHS providers, third sector, voluntary services and the local population.

Approach:
The Lung Health Check is promoted as a lung MOT and **not cancer screening**. The key messages and benefits of the lung health check:

- One stop service – everything in one place and CT scan being available immediately
- Accessible and very convenient

The Provider will use patient experience statistics to promote or improve uptake of the service, to include:

- Care and treatment, waiting time, location and communications of the Lung Health Check (LHC)
- Communications prior to CT scan
- Facilities at the LHC
- Would you recommend the service to a friend or family member?

Co-designed well researched patient information will be developed (align with NHSE materials) to include:

- GP invite letter
- Lung Health Check and LDCT scan leaflets
- Online resource portal for practices and patients to access information and resources about the services
- Information video about the lung health check process

6.1 Community engagement:

Co-ordinate community events to include:

- Community networks
- Leafleting and Macmillan bus
- Awareness sessions e.g. Breathe Easy groups
- Bookmakers, Vape/E-Cig shops
- Posters in community venues

6.2 GP Engagement:

GP practices play a pivotal role in communicating and engaging with patients. GP practice staff should proactively talk to their patients encouraging attendance and answering questions about the service.

- Briefing sessions/ staff encouragement
- Waiting room posters
- Messages on prescriptions
- Practice staff answering queries
- Training module to support practices prior to go-live

6.3 Media and advertising

The lung health check has already received a significant amount of local and national media attention. This provides a strong base of recognition from which to continue to promote the service.

- Local video
- Press release, Local radio and TV
- Social media
- Patient stories

7. NHS Patient Experience & Satisfaction Survey

The Provider will ensure that an appropriate Patient Satisfaction Survey is undertaken, asking a minimum of 20% of participants selected at random from each site location. The survey should be in line with Picker Institute Healthcare Commission standardised patient experience questionnaires. https://www.picker.org/wp-content/uploads/2014/10/Discussion-paper-...-hospital-outpatients.pdf

A robust complaints procedure must be in place so that participants understand the process. The provider will be expected to log complaints, respond swiftly and identify recurring issues that must be addressed. The provider must follow the procedure outlines in the NHS Constitution for England (2015). https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

8. Equality

Data Requirements

The service will be monitored on the collection of data of the following protected characteristics:

1. Race- Data to be collected referring to ethnicities
2. Disability - Data to be collected referring to type of disability and Data to be collected referring to carer
3. Sex - Data capture to be sensitive to main sub groups of gender and gender self-identification
4. Age
5. Sexual Orientation - Data capture to be sensitive to sub groups within sexual orientation self-identification
6. Religion or Belief - Data to be collected referring to type of religion or belief and sub-groups therein
7. Marriage & Civil Partnership
8. Carers - Data to be collected reflecting type of caring undertaken and details of disability or impairment of those who the carer cares for.
9. Pregnancy and maternity
10. Homelessness - Data to be collected reflecting type of accommodation status.
11. Carers

Although carers and homelessness are not one of the 9 Protected Characteristics they are priority areas for Greater Manchester and collection of this data is important in the planning of future services and monitoring access of current services.

9. Finance

The national team has allocated funding through a two-cost model:

- A fixed amount for each project to cover the cost of the core programme
- A variable amount calculated on the national reported size of the CCG population of 55 to 74-year and 364 days.

Fixed funding:

- Each CCG has funding for core staffing and clinical leadership for the 4-year programme
- CCGs with populations over 55,000 have received additional funding for project and
- programme management posts
- Funding allocated will ensure the projects have the resources to deliver the clinical service

The financial model uses three nationally agreed averages:

1. 54% of the eligible population of 55 to 74-year olds and 364 days, smoke or have smoked
2. 50% of those who smoke or have smoked, will take up the offer of a lung health check
3. 56% of those who attend a lung health check are at risk and offered a low dose CT

- CT scanning including the cost of providing mobile capacity
- Teleradiology.
- Consumable costs associated with the lung health check
- Travel and other costs including legal

Fixed funding:

The table below provides a breakdown of suggested roles based on NHSE assumptions:

Post	Band	WTE	Notes
Clinical posts	Medical consultant	1 wte	10 pa sessions/ week
Specialist lung health check nurse	Band 6	1 wte	
Practice nurse	Band 6	1 wte	Not required in yrs. 3 & 4
PACS support	Band 4	2 wte	
Administrator	Band 3	1 wte	
Project manager	Band 8a	1 wte	
Additional fixed funding for single CCGs with target population over 55,000			
Project manager	Band 8a	1 wte	Tameside & Glossop Doncaster Newcastle Gateshead
Programme manager	Band 8d	1 wte	Newcastle Gateshead

The finances associated with the programme is shown in schedule 3 of the contract.

10. Applicable Service Standards

10.1 Applicable national standards (e.g. NICE)

The Provider will deliver a lung health check to the adult population of NHS T&G CCG in accordance with the requirements as set out in this specification, in accordance with the National Standard Protocol, current guidelines and legislation.

Good Practice Standards

The Provider will comply with:

- Good clinical industry practice which will include but is not limited to: standards for better health, relevant NICE guidance, for example guidance supporting interventions to help people stop smoking

- The baseline spirometry will be undertaken in accordance with the guidance from the Association for Respiratory Technology and Physiology

http://www.artp.org.uk/en/professional/artp-standards/index.cfm/Quality%20Assured%20Spirometry

Time Standards

The Provider will:

- Ensure that for all people arriving before or on time for their appointment the lung health check begins within 30 minutes of the scheduled appointment time.
- Provide details of the daily attendance at the lung health check service to the weekly (moving to monthly as service develops) CCG contract meeting
- Provide outcome of the nurse led LHC +/- LD-CT within 14 calendar days to the participants GP; but aim to move to real time reporting in the future.

Information Management & Technology (IM&T) Requirements

The Provider will

- Enable referral information and reports to be received and delivered in electronic format, as outlined by the commissioner.
- Comply with the Information Governance requirements of NHS T&G CCG and the NHS for personal identifiable data.
- All new information assets and changes to service must be approved via the Change Control Advisory Board at T&G ICFT.

Clinical Safety and Medical Emergency Measures

The Provider will ensure that:

- They operate within a clinically safe environment ensuring safe practice and adequate levels of equipment to deal effectively with medical emergencies.
- All staff are appropriately trained and accredited including having a Life Support certificate which meets the standards set out by the Resuscitation Council (www.resus.org.uk)

Quality Requirements of Activity Outputs

The Provider will ensure the participant's GP receives the result of the lung health check to agreed or mandated timescales or in line with clinical appropriateness.

The Provider will communicate any unusual, unexpected, urgent, or clinically significant findings that may require immediate or urgent clinical decisions in accordance with the locally agreed protocol.

Clinical Contract Specification - Standards and Equipment

The Provider will ensure that equipment is provided and maintained to an adequate minimum level to fulfill the standards outlined within this specification.

The Provider will carry out daily quality assurance and quality control checks on equipment to ensure minimum standards of operations are maintained in line with legal, professional, industry and manufacturers specifications.

The Provider should use:

- A spirometer which meets the ISO standard 267823
- One-way mouthpieces and nose clips
- Bacterial and viral filters (as indicated in selected patients)

- Height measure and weighing scales – calibrated according to manufacturer's instructions.

Training and Education

The Provider will deliver education and training for all staff to attain competence and maintain those standards including the provision of professional registration requirements.

Quality Assurance

Undertake quality assurance of the Spirometry equipment in line with assured diagnostic spirometry (ARTP) guidance. This will include quality control checks at least weekly to ensure reliability and reproducibility of results.

Operating Manual

The Provider will have and adhere to an Operating Manual that contains effective policies and procedures covering service specific standards and any regulatory and legislative requirements.

11. Performance Monitoring

Key Performance Indicators from Business Case

In the process of being developed in line with the Standard Protocol.

12. Location of T&G ICFT (Provider)Premises

The Provider's premises are to be located at agreed community locations. The service will be delivered from suitable mobile units. The locations for service delivery will be convenient for the GP practice's patients to attend and must also be able to accommodate the size and other requirements of the mobile units, and the participants attending the service. Car parking facilities must be available for participants.

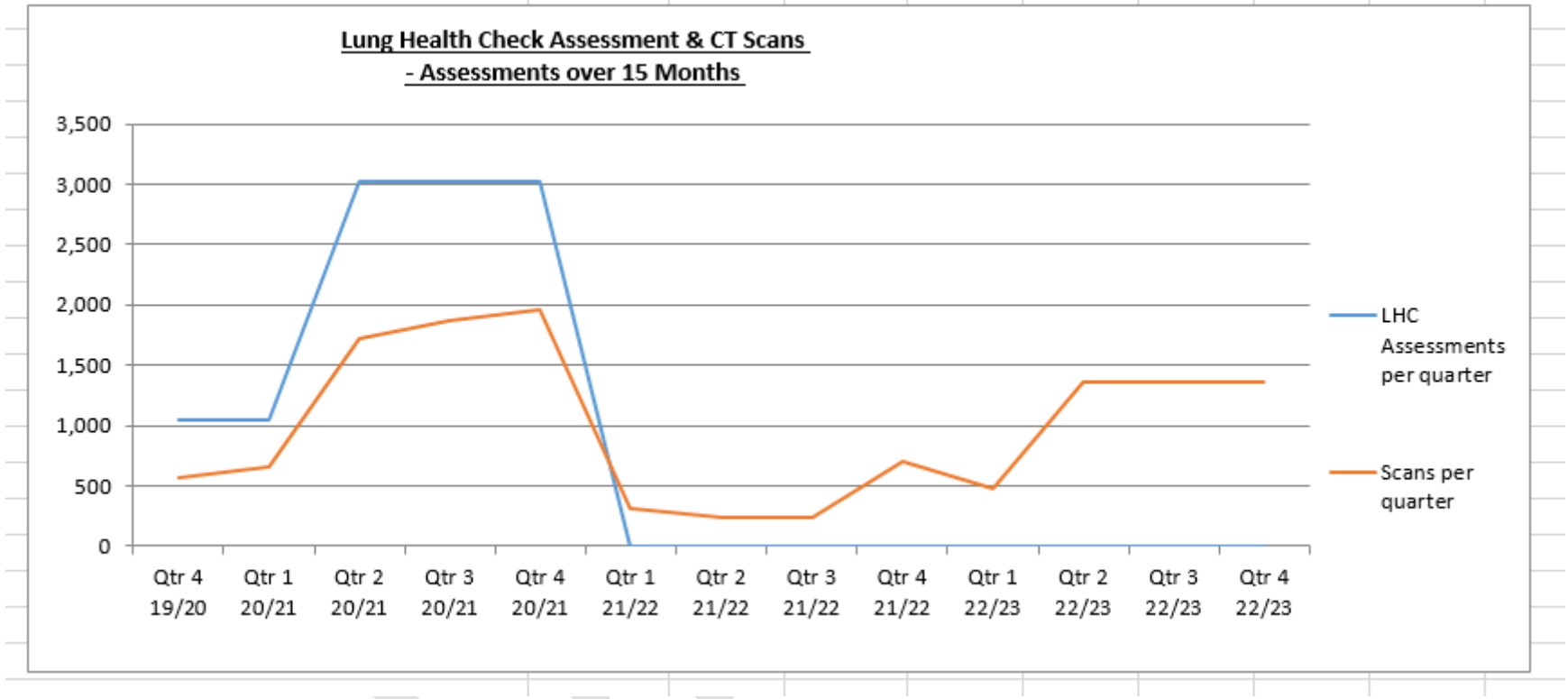
Please refer to the Indicative Activity Plan at Schedule 2B for the breakdown of activity (outline draft plan below). The time scales are still in the process of being agreed.

LHC Modelling Updated 111019 15

Dates	Activity – Assumes 6 Cohorts each cohort running for 3 months
April 2020 to March 2021	LHC and Initial CT scans performed
January 2020 to January 2022	3 month repeat scan booked (if intermediary results)
January 2021 June 2023	12 month follow-up scan (if had 3 month repeat scan)
October 2021 to March 2023	24 month follow-up scan (if first round of scans clear)

Appendix A

15 Month Profile with 60% Uptake:



Appendix B

Minimum Standards

Standard 1: Lung cancer screening nurses

1a. Description

Training and experience required for nurses conducting lung cancer screening lung health checks for the Targeted Lung Health Checks programme.

1b. Cross reference to NHS England Standard Protocol Sections 2.2 and 2.3.2

1c. Rationale

To make sure nurses delivering the targeted lung health check programme are qualified and experienced. To make sure the service is safe and effective.

1d. Definition

Minimum qualifications for nurses:

- Registered with the Nursing and Midwifery Council; and
- Registered with the national Spirometry Register from April 2020

Minimum additional training courses:

- Communicating with high-risk individuals about lung cancer screening
- National consent training
- IR(ME)R for Referrers

1e. Metric

100% of nurses conducting Lung Health Checks meet the minimum qualifications and minimum training requirements.

1f. Local audit

The Clinical Director of Programme (DP) will ensure all nurses meet the minimum training standard at all times. They will maintain a local minimum training and experience record for nurses delivering lung health checks for the Targeted Lung Health Checks programme.

1g. National Audit

The Responsible Assessor will report quarterly against this standard to the Targeted Lung Cancer Health Checks Delivery Group.

1h. Training courses

Training courses for nurses not experienced in delivering lung health checks to become qualified to perform Targeted Lung Cancer Health Checks.

Standard 2: Lung cancer screening radiologists

2a. Description
Training and radiological experience required for radiologists reporting low dose CT lung cancer screening scans for the Targeted Lung Health Checks programme.

2b. Cross reference to NHS England Standard Protocol Section 4.6.1

2c. Rationale
To make sure consultant radiologists delivering the targeted lung health check programme are qualified and experienced. To make sure the service is safe and effective.

2d. Definition
Minimum qualifications for consultant radiologists:

- Registered with the General Medical Council (GMC); and
- Fellow of the Royal College of Radiologists (RCR).

Minimum additional training course:

- British Society of Thoracic Imaging (BSTI) Lung Nodule Workshop.

Minimum experience:

- Reporting a minimum of 500 thoracic CTs per annum in their routine clinical practice, a significant proportion of which should be CTs performed for the evaluation of lung cancer.
- Regular attendance at a thoracic MDT meeting (which may include virtual attendance) or be part of a thoracic MDT as part of their routine clinical work.

2d. Metric
100% of consulting radiologists reporting thoracic CTs for the Targeted Lung Health Checks programme meet the minimum qualifications and training requirements.

2e. Local audit
The Responsible Radiologist (RR) will ensure all radiologists meet the minimum standard at all times. They will maintain a local minimum training and experience record for radiologists reporting low dose CT scans for the Targeted Lung Health Checks programme.

2g. National Audit
The Responsible Assessor will report quarterly against this standard to the Targeted Lung Cancer Health Checks Delivery Group.

2h. Training course
Training course for radiologists to gain specific experience in reading low dose CT lung cancer screening scans.

Standard 6: Communications

6a. Description

Communication relating to participant invitation, results, referrals and discharge from the programme must comply with the standard protocol. Communication to GPs regarding participants on the programme must as a minimum standard include details of results from lung health check appointment (lung health check assessment, risk assessment, spirometry assessment and smoking cessation or any other lifestyle advice) and low dose CT scan proforma as detailed in Standard 12.

6b. Cross reference to NHS England Standard Protocol

Sections 3.1, 3.4 and 8.

6c. Rationale

To ensure that all communication relating to invitational approach, results, referrals and discharge from the programme are consistent across the programme.

6d. Definition

Communication must comply with the Standard Protocol.

Communication to GPs programme must as a minimum standard include details of results from lung health check appointment (lung health check assessment, risk assessment, spirometry assessment and smoking cessation or any other lifestyle advice) and low dose CT scan proforma as detailed in Standard 12.

6e. Metric

Full compliance with standard communication methods as outlined in the standard protocol.

6f. Local audit

The Responsible Assessor will ensure that communication methods meet the minimum standard at all times.

6g. National Audit

The Responsible Assessor will report quarterly against this standard to the Targeted Lung Cancer Health Checks Delivery Group.

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