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Tameside Metropolitan Borough

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STRATEGIC COMMISSIONING BOARD

Day: Wednesday
Date: 25 August 2021
Time: 1.00 pm
Place: Zoom Meeting

Item No.	AGENDA	Page No
1.	**WELCOME AND APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST**	
	To receive any declarations of interest from Members of the Board.	
3.	**MINUTES**	
a)	**MINUTES OF THE PREVIOUS MEETING**	1 - 8
	The Minutes of the meeting of the Strategic Commissioning Board held on 28 July 2021 to be signed by the Chair as a correct record.	
b)	**MINUTES OF EXECUTIVE BOARD**	9 - 26
	To receive the Minutes of the Executive Board held on: 14 July and 4 August 2021.	
4.	**CONSOLIDATED 2021/22 REVENUE MONITORING STATEMENT AT 30 JUNE 2021**	27 - 80
	To consider the attached report of the Executive Member, Finance and Economic Growth / CCG Chair / Director of Finance.	
5.	**DOMESTIC ABUSE ACT FUNDING PROPOSAL**	81 - 102
	To consider the attached report of Executive Member, Adult Social Care and Health / Director of Population Health / Assistant Director of Operations and Neighbourhoods.	
6.	**NHS SYSTEM OVERSIGHT FRAMEWORK**	103 - 164
	To consider the attached report of the Executive Member, Adult Social Care and Health / CCG Co-Chair / Director of Commissioning.	
7.	**POPULATION HEALTH EARLY YEARS - PEER SUPPORT PROGRAMMES COMMISSIONING**	165 - 178
	To consider the attached report of the Executive Member, Adult Social Care and Health / Starting Well Clinical Lead / Assistant Director of Population Health.	

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Carolyn Eaton, Principal Democratic Services Officer, 0161 342 3050 or carolyn.eaton@tameside.gov.uk, to whom any apologies for absence should be notified.

Item No.	AGENDA	Page No
8.	**COMMISSIONING INTENTIONS - HEALTH IMPROVEMENT SERVICE** To consider the attached report of the Executive Member, Adult Social Care and Health / Clinical lead Long Term Conditions / Director of Population Health.	179 - 218
9.	**GRANT NO. 31/5110: LOCAL AUTHORITY EMERGENCY ASSISTANCE GRANT FOR FOOD AND ESSENTIAL SUPPLIES** To consider the attached report of the Assistant Director, Children's Services.	219 - 222
10.	**URGENT ITEMS** To consider any items the Chair considers to be urgent.	

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Carolyn Eaton, Principal Democratic Services Officer, 0161 342 3050 or carolyn.eaton@tameside.gov.uk, to whom any apologies for absence should be notified.

STRATEGIC COMMISSIONING BOARD

28 July 2021

Comm: 1.00pm **Term: 2.20pm**

Present:	**Dr Ashwin Ramachandra – NHS Tameside & Glossop CCG (Chair)** **Councillor Brenda Warrington – Tameside MBC** **Councillor Gerald P Cooney – Tameside MBC** **Councillor Bill Fairfoull – Tameside MBC** **Councillor Allison Gwynne – Tameside MBC** **Councillor Oliver Ryan – Tameside MBC** **Councillor Eleanor Wills – Tameside MBC** **Steven Pleasant – Tameside MBC Chief Executive & Accountable Officer** **Dr Christine Ahmed – NHS Tameside & Glossop CCG** **Dr Kate Hebden – NHS Tameside & Glossop CCG** **Dr Vinny Khunger – NHS Tameside & Glossop CCG** **Carol Prowse – NHS Tameside & Glossop CCG**

In Attendance:	**Sandra Stewart**	**Director of Governance & Pensions**
	Kathy Roe	**Director of Finance**
	Richard Hancock	**Director of Children's Services**
	Steph Butterworth	**Director of Adults Services**
	Ian SaxonJeanelle	**Director of Operations and Neighbourhoods**
	De Gruchy	**Director of Population Health**
	Tim Bowman	**Director of Education (Tameside & Stockport)**
	Caroline Barlow	**Assistant Director of Finance**
	Ian Duncan	**Interim Assistant Director of Finance**
	Debbie Watson	**Assistant Director of Population Health**
	Ilys Cookson	**Assistant Director – Exchequer Services**
	Sarah Threlfall	**Assistant Director, Policy Performance & Communications**
	Paul Smith	**Assistant Director, Strategic Property**
	Pat McElvey	**Head of Mental Health and Learning Disabilities – Tameside & Glossop CCG**
	Gill Gibson	**Director of Nursing, Quality & Safeguarding Tameside & Glossop Strategic Commission**

Apologies for absence:	**Councillors Feeley and Kitchen – Tameside MBC who participated in the meeting virtually** **Councillor Bray – Tameside MBC** **Asad Ali – NHS Tameside & Glossop**

Further to the decision of Tameside Metropolitan Borough Council (Meeting of 25 May 2021), to enable the Clinical Commissioning General Practitioners to take part in decisions of the Strategic Commissioning Board, whilst they continue to support the NHS in dealing with the pandemic that all future meetings of the SCB remain virtual until further notice with any formal decisions arising from the published agenda being delegated to the chair of the SCB taking into the account the prevailing view of the virtual meeting and these minutes reflect those decisions.

10. CHAIR'S INTRODUCTORY REMARKS

The Chair welcomed everyone to the meeting and explained that to enable the Clinical Commissioning General Practitioner to take part in decisions of the Strategic Commissioning Board, whilst they continued to support the NHS in dealing with the pandemic, the meeting would be a hybrid of remote and physical presence.

As a physical presence is required to formally take decisions, any formal decisions arising from the published agenda have been delegated to the Chair, taking into the account the prevailing view of the virtual meeting.

The only people in the room were the Executive Members, the Chief Executive and Accountable Officer, Monitoring Officer, Democratic Services Officer and the Chair.

The Chair announced that Dr Kailash Chand, OBE and Tameside GP, had very sadly passed away on Monday 26 July 2021. On behalf of the Strategic Commissioning Board, he extended sincere condolences to the family, friends and colleagues of Dr Chand, who would be sadly missed. Members then stood and observed a minutes silence in memory of Dr Chand.

The Chair was pleased to announce the following shortlisted nominations for the LGC Awards 2021:

- Community Involvement – Tameside & Glossop Partnership Engagement Network (PEN)
- Outstanding Individual Contribution (Dr Jane Harvey)
- Public Health (Vaccination Rollout)

The Chair and Members congratulated all involved for this national recognition of hard work/initiatives in Tameside & Glossop.

11. DECLARATIONS OF INTEREST

There were no declarations of interest submitted by Board members.

12. MINUTES OF THE PREVIOUS MEETING

RESOLVED
That the minutes of the meeting of the Strategic Commissioning Board held on 23 June 2021 be approved as a correct record.

13. MINUTES OF THE EXECUTIVE BOARD

RESOLVED
That the Minutes of the meetings of the Executive Board held on: 9 June 2021 and 7 July 2021, be noted.

14. CONSOLIDATED 2021/22 REVENUE MONITORING STATEMENT AT 31 MAY 2021

Consideration was given to a report of the Executive Member of Finance and Economic Growth / Lead Clinical GP / Director of Finance. The report covered the Month 2 2021/22 financial position, reflecting actual expenditure to 31 May 2021.

It was reported that at Period 2, the Council was forecasting an overspend against budget of £5.8m. Children's Services were still the biggest area of financial concern, with expenditure forecast to exceed budget by £4.717m. The overspend was predominantly due to the number and cost of external placements. There was also a pressure of £198k in the Growth Directorate, resulting from a shortfall in customer and client receipts. A pressure of £891k had been reported for Operations and Neighbourhoods due to a combination of additional costs and non-recovery of income, including an income shortfall on car parks.

It was further reported that CCG was reporting an overspend of £194k, this related to reimbursable Covid expenses for which a future allocation should be received. A financial envelope for the first 6 months of the year had been agreed at a Greater Manchester level, from which the CCG had been

allocated £221.3m of resource. It was not yet clear what the financial regime would look like in the second half of the year. As such it was difficult to estimate what the full year allocation would ultimately become.

Members were advised that the Council had recently received notification of grant allocations for Capital Investment in Schools. Members were asked to note the Education Capital Grants and approve the inclusion of these amounts on the Capital Programme for the financial years 2021/22 and 2022/23, as follows:

- £264,244 of Devolved Formula Capital grant for 2021/22
- £1,328,013 of School Condition grant for 2021/22
- £1,223,336 of High Needs Provision Capital grant for 2021/22.
- £12,231,816 of Basic Need grant for 2021/22
- £6,348,338 of Basic Need grant for 2022/23.

RESOLVED

(i) That the forecast outturn position and associated risks for 2021/22 as set out in Appendix 1 to report, be noted;

(ii) That the indicative 2021-22 Integrated Commissioning Fund be approved and the roll forward of the existing Section 75 Agreement and Financial Framework which has been to reflect the transition year of the CCG, be agreed; and

(iii) That the recent notifications of Education Capital Grants be noted and the inclusion of the amounts set out in paragraph 4.1 on the Capital Programme for the financial years 2021/22 and 2022/23, be approved.

15. PRPOSALS FOR THE USE OF THE RING-FENCED GRANT TO HELP THOSE WITH OBESITY TO LOSE WEIGHT

Consideration was given to report of the Executive Member for Adult Social Care and Population Health / Clinical Lead for Long Term Conditions / Assistant Director of Population Health, outlining the proposals to spend the £209,741 provided to Tameside council as part of the Government's Adult Weight Management Tier 2 services grant fund 2021/22. The report also provided information on a recent bid to expand weight management services for children and families.

It was reported that the investment was one-off funding in the financial year 2021/22. Following advice received from STAR procurement, it was proposed that the Be Well tier 2 service expansion be delivered via a contract variation with Pennine Care NHS Trust. Further, it was proposed that Active Tameside should be awarded a grant to expand the tier 2 Live Active provision, this was allowed within the terms of the grant.

It was explained that Be Well Tameside provided the current self-referral tier 2 weight management service. The grant funding would be used to increase the 1:1 support they provided for people in the community.

Members were advised that, based on the grant criteria, Tameside Council had submitted an application of £153,468 to support healthy weight in children and families via extended brief intervention and Tier 2 weight management services.

RESOLVED

That the content of the report be noted and the proposals outlined in the report be agreed.

16. SUBSTANCE MISUSE SERVICE CONTRACT NOVATION TO CGL SERVICES LTD

Consideration was given to a report of the Executive Member for Adult Social Care and Population Health / Clinical Lead / Consultant in Public Health / Director of Population Health, providing background information on the borough's substance misuse service, provided by Change Grow Live

(CGL), and the proposal to novate the existing contract from CGL to CGL Service Ltd, part of the same organisation.

It was stated that the proposal was to novate the contract held with Change Grow Live (CGL) to its wholly owned, non-charitable, trading subsidiary, Change Grow Live Services Ltd (CGL Services). This would mean that CGL Services was then able to charge VAT on all supplies and charges. This would include the contract they held with the council, resulting in approx. £613k annual VAT charged, but this would be fully recoverable by the council, and therefore cost neutral to Tameside MBC. CGL Services would need to pay HMRC VAT they charged but would also be able to reclaim VAT charged by their suppliers, resulting in a financial benefit of approx. £50k pa. This would allow CGL to divert all the reclaimed funds into the service contract and focus spend on areas that improved service delivery and met demands, rather than paying unnecessary VAT.

It was explained that this process would ensure the best use of the public funds allocated to CGL for frontline service delivery. In considering this approach to meet the financial challenges facing CGL, and ensuring the most effective use of public funds, we had sought advice from VAT experts (LAVAT), finance team and Legal team throughout this process.

It was further explained that the amount of VAT to be reclaimed would be variable, however based upon the service invoice amount and ongoing use of supplies, the financial benefit was estimated at around £50,000 per annum. These savings would only be realisable within the duration of the existing contract.

RESOLVED
That approval be given for the novation of the contract for Drug and Alcohol treatment 'My Recovery Tameside' from CGL to CGL services Limited.

17. DEVELOPMENT OF AN INTEGRATED CARE SYSTEM IN TAMESIDE & GLOSSOP

Consideration was given to a report of the Executive Member for Adult Social Care & Population Health / Co Chair for T&G CCG / Director of Commissioning, which articulated the work programme, underway to deliver the required changes in T&G in response the development of local NHS Integrated Care Systems.

It was explained that the next stage of the transformation would be the response to the recent White Paper "Integration and Innovation – working together to improve H&SC for all" which set out legislative proposals for changes to the health and care system including a duty to collaborate across the NHS, social care and public health systems. The report detailed the initial response to the White Paper and outlined the work programme at this early stage, for the development of local NHS Integrate Care Systems.

The report sought approval for the draft terms of reference for the T&G Integrated Care Transition Board attached at Appendix 1. Members were advised that the ICTB was the system-wide accountable group to oversee the transition into the GMICS. This involved building on current locality arrangements to establish a new locality operating model as part of the establishment of a statutory GMICS. The ICTB would take place prior to the Strategic Commissioning Board and would be chaired by the Co-chair of T&G CCG.

Discussion ensued in respect of the content of the report and the Chair and Members reflected on the complex nature of the work undertaken to date, whilst acknowledging that this was a work in progress. The Chair thanked the Team for their hard work during very difficult circumstances, whilst dealing with the pandemic.

RESOLVED
That the content of the report be noted and the Draft Terms of Reference, (as appended to the report) for the T&G Integrated Care Transition Board, be approved. Further it be

recognised that this work programme is progressing at pace despite the lack of final legislation and that this creates associated risk.

18. PREVENTION AND PROMOTION FUND FOR BETTER MENTAL HEALTH – GRANT FUNDING

Consideration was given to a report of the Executive Member for Health, Social Care and Population Health / Director of Population Health / Assistant Director of Population Health, outlining proposals to spend the £317,623.00 provided to Tameside Council as part of the government's 'Prevention and Promotion Fund for Better Mental Health 2021/22' grant. The proposals were one off schemes due to the non-recurrent nature of the grant from government.

It was reported that on 27 March 2021 the Department of Health and Social Care announced the COVID-19 Mental Health and Wellbeing Recovery Action Plan for 2021 to 2022 to mitigate and respond to the impact of the COVID-19 pandemic on mental health. The government announced a Prevention and Promotion Fund for Better Mental Health of £15 million to be distributed to the most deprived (IMD) upper tier local authorities in England to preventing mental ill health and promoting good mental health. The Prevention and Promotion Fund for Better Mental Health Grant was a one-off contribution for the 2021/22 financial year and was made under Section 31 of the Local Government Act 2003.

Members were advised that the report proposed spending £295,000 on five mental health initiatives, plus £20,000 in evaluation costs. The total cost was fully funded by an external grant of £317,623 from the Department of Health and Social Care (DHSC), and there would be no overall budget impact to the Council. £75,000 of the costs would be internal to the Council, with the remainder disbursed to third-sector partners co-ordinated by the CCG.

RESOLVED
That the Strategic Commissioning Board be recommended to approve the spending proposals outlined in the report.

19. TAMESIDE AND GLOSSOP CHILDREN AND YOUNG PEOPLE'S EMOTIONAL AND MENTAL WELLBEING COMMUNITY OFFER – CONTRACT AWARD

Consideration was given to a report of the Executive Member for Adult Social Care and Health / Director of Commissioning, summarising the progress to date and the outcomes of the process following the awarding of the contract for the Children and Young Peoples Emotional and Wellbeing Community Offer.

The Head of Mental Health and Learning Disabilities, Tameside & Glossop CCG, advised that the refreshed Tameside and Glossop Children and Young People's Emotional Wellbeing and Mental Health Transformation Plan was approved at the Strategic Commissioning Board in April 2020, with one of the priorities being to develop a new co-produced Children and Young People's Emotional and Mental Wellbeing Community Offer. The commissioning and procurement approach for the Children and Young People's Emotional and Mental Wellbeing Community Offer was taken through Strategic Commissioning Board (SCB) in September 2020 and an update in January 2021 to outline progress, including the co-designed model, principles and specification.

It was reported that Tameside and Glossop Single Commission had co-produced the new Emotional Wellbeing and Mental Health Community Offer with children, young people, families and stakeholders since Summer 2020. Tameside and Glossop Clinical Commissioning Group (CCG) was the lead commissioner with Tameside Council being associate commissioner, as the budget for the Offer were pooled together. The contract awarded would be a 3+2 year contract at £250,000 per annum. The Offer would be live from 1 December 2021.

Discussion ensued with regard to the content of the report and Members commended everyone involved in developing the Offer. Members further acknowledged Pat McElvey, Head of Mental Health and Learning Disabilities – Tameside & Glossop CCG, who was retiring at the end of August. They thanked Pat for her dedicated work with Children and Young People in the locality and across Greater Manchester over many years and wished her well for the future.

RESOLVED

(i) That the robust procurement process undertaken and extensive co-production to develop the Offer, be acknowledged;

(ii) That the contract award report at appendix 1 to the report, be approved; and

(iii) That the delay in awarding the contract be acknowledged and the extension of the existing community contracts/grants by 3 months to enable appropriate mobilisation, be approved.

20. ENGAGEMENT UPDATE

Consideration was given to a report of the Executive Leader / T&G CCG Co-chairs / Assistant Director for Policy, Performance and Communications, providing an update on the delivery of engagement and consultation activity in 2020/21.

It was stated that much of the Engagement work had been 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. Each of the three agencies undertook work individually where necessary and appropriate for the purposes of specific projects.

It was further explained that the onset of the Covid-19 pandemic had also meant that different ways to engage local communities had to be identified. The report sets out some examples of the ways in which this had been achieved, including the establishment of both the Community Champions programme and the Inequalities Reference Group.

The Assistant Director Policy, Performance and Communications highlighted the key headlines from June 2020 to date:

- Facilitated 32 thematic Tameside and/or Glossop engagement projects
- Received 4,186 engagement contacts (excluding attendance at virtual events)
- Supported 27 engagement projects at the regional and Greater Manchester level
- Promoted 33 national consultations where the topic was of relevance to and/or could have an impact on Tameside and/or Glossop
- Established the Community Champions Network to provide residents and workforces with the coronavirus information they need to lead the way in their community, with over 250 members now registered
- Established the Tameside & Glossop Inequalities Reference Group in response to how the coronavirus pandemic, and the wider governmental and societal response to this, has brought equalities (and indeed inequalities) into sharp focus
- Delivered two virtual Partnership Engagement Network (PEN) conferences attended by over 150 delegates in total
- Delivered four virtual Partnership Engagement Network sessions focusing on the impact of COVID-19 and how we can build back better. These were attended by over 50 participants.
- Held a virtual engagement session with young people to understand the impact of the pandemic on them and how they feel things can be done differently in the future.
- Undertook the third joint budget conversation exercise for Tameside Council and NHS Tameside and Glossop Clinical Commissioning Group
- Achieved 'Green Star' top rating for public and patient engagement as part of the CCG Improvement and Assessment Framework (IAF). Tameside and Glossop CCG attained the highest score possible, one of only 40 out of 195 areas in the country to do so *

RESOLVED
That the content of the report be noted and future engagement and consultation activity with the communities of Tameside and Glossop, as detailed in the report, be supported.

21. PERFORMANCE SCORECARD

A report was submitted by the Assistant Director, Policy, Performance and Communications, giving details of the Corporate Plan scorecard, as attached to the report, which provided evidence to demonstrate progress towards the achievement of the Corporate Plan and improving the services provided to residents, businesses and key stakeholders within the locality.

It was explained that, supporting the corporate scorecards were thematic scorecards which were monitored by services to inform their ongoing delivery and improvement work. The thematic scorecards were:

- Corporate
- Health and care (incl. adult care)
- Children and family
- Inclusive economic growth (incl. planning and transport)
- Community and culture
- Environment and place

It was noted that the Corporate Plan scorecard would be reported on a regular basis to the Overview Panel and the Strategic Commissioning Board / Executive Cabinet, and then subsequently to the two Scrutiny Panels to inform their work programmes.

RESOLVED
That the content of the scorecard, as attached to the report, be noted and reported on a regular basis to the Overview Panel and the two Scrutiny Panels – Place and External Relations; and Integrated Care and Wellbeing – to inform their work programmes.

22. URGENT ITEMS

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

CHAIR

BOARD

14 July 2021

Present:	**Elected Members**	**Councillors Warrington (In the Chair), Bray, Cooney Fairfoull, Feeley, Gwynne, Kitchen, Ryan and Wills**
	Borough Solicitor	**Sandra Stewart**
	Assistant Director of Finance Deputy Section 151 Officer	**Caroline Barlow**

Also in Attendance: **Tim Bowman, Stephanie Butterworth, Ilys Cookson, , Jeanelle de Gruchy, Ian Duncan, Richard Hancock, Dr Ashwin Ramachandra, Ian Saxon, Jayne Traverse, Debbie Watson, and Sandra Whitehead.**

53 DECLARATIONS OF INTEREST

Member	Subject Matter	Type of Interest	Nature of Interest
Councillor Gwynne	**Agenda Item 4m: FOSTER CARER OFFER**	**Prejudicial**	**Special Guardianship**

54 MINUTES OF PREVIOUS MEETING

The minutes of the Board meeting on the 10 July 2021 were approved as a correct record.

55 2021/22 INTEGRATED FINANCE REPORT MONTH 2

Consideration was given to a report of the Executive Member for Finance and Economic Growth / Lead Clinical GP / Director of Finance. The report covered the Month 2 2021/22 financial position, reflecting actual expenditure to 31 May 2021.

It was reported that at Period 2, the Council was forecasting an overspend against budget of £5.8m. Children's Services were still the biggest area of financial concern, with expenditure forecast to exceed budget by £4.717m. The overspend was predominantly due to the number and cost of external placements. There was also a pressure of £198k in the Growth Directorate, resulting from a shortfall in customer and client receipts. A pressure of £891k had been reported for Operations and Neighbourhoods due to a combination of additional costs and non-recovery of income, including an income shortfall on car parks.

It was stated that CCG was reporting an overspend of £194k, this related to reimbursable Covid expenses for which a future allocation should be received. A financial envelope for the first 6 months of the year had been agreed at a Greater Manchester level, from which the CCG had been allocated £221.3m of resource. It was not yet clear what the financial regime would look like in the second half of the year. As such it was difficult to estimate what the full year allocation would ultimately become.

AGREED
That Executive Cabinet and Strategic Commissioning Board be recommended to:
(i) Note the forecast outturn position and associated risks for 2021/22 as set out in Appendix 1.
(ii) Approve the indicative 2021-22 Integrated Commissioning Fund and agree the roll forward of the existing Section 75 Agreement and Financial Framework which has been to reflect the transition year of the CCG.

(iii) To note the recent notifications of Education Capital Grants and approve the inclusion of the amounts set out in paragraph 4.1 on the Capital Programme for the financial years 2021/22 and 2022/23.

56 SAVINGS DELIVERY 2021/22

Consideration was given to a report of the Executive Member for Finance and Economic Growth / Director of Finance, which provided Members with an update on the savings monitoring exercise for delivery of 2021/22 savings, and highlighted any risks or delays to delivery.

Members were reminded that if savings of £8.930m were delivered in 2021/22 and a further £4.921m of savings delivered in 2022/23, the Council still faced a forecast budget gap of more than £14m in 2022/23. It was therefore important that the Council embarked on early forward planning for 2022/23 and beyond. In order to meet the challenges of the 2022/23 financial year it was vital that all the proposed savings for 2021/22 be delivered.

It was stated that progress on the delivery of proposed savings as part of the 2021/22 budget process was being monitored on a monthly basis, with a proportion of schemes reviewed in detail at different points during the year. Members were advised that Appendix 1 and 2 provided further detail on the current status of savings to be delivered during 2021.

AGREED
That Executive Cabinet note the progress report and risk areas for delivery in 2021/22 and future years savings.

57 REVIEW OF FINANCIAL REGULATIONS AND PROCEDURES

Consideration was given to a report of the Executive Member for Finance and Economic Growth / Director of Finance. The report sought approval of the updated Council's Financial Regulations and Procedures.

Members were advised that the revised format was intended to allow easy navigation of the regulations so that quick reference could be made and so that the reader could fully understand the importance and reason for the regulations in safeguarding the finances of the Council. This should be particularly helpful to new officers to the Council. The Financial Regulations and Procedures covered all areas of the financial management of the Council's affair. The updated Financial Regulations were attached to the report at Appendix 1.

AGREED
That Executive Cabinet be recommended to approve the updated Financial Regulations and Procedures and refer them to Full Council for formal adoption.

58 COUNCIL TAX SUPPORT SCHEME 2022-2023

Consideration was given to a report of the Executive Member for Finance and Economic Growth / Assistant Director for Exchequer Services. The report detailed the procedural requirement in deciding if changes were required to the Council Tax Support scheme (CTS).

Members were reminded that additional monies were made available to all Local Authorities by MHCLG in April 2020 in response to the COVID 19 pandemic. The additional monies had to be used primarily on reducing CTS claimants Council Tax liability by £150 for the 2020/2021 financial year with remaining monies supporting Council Tax payers suffering hardship. In total £2m assisted 12,691 all working age CTS claimants and £344k supported non-CTS claimants with a Council Tax liability.

Further additional monies had been made available in the current financial year by MHCLG in respect of COVID and which could be used towards Council Tax Support for 2021/22. The total monies for Tameside were £2.025m. Unlike last year there was no clear stipulation on how this money had to be used however, guidance stated that the money was aimed directly at supporting councils to meet the anticipated additional costs of providing Local Council Tax support in 2021-22, resulting from increased unemployment".

Members were advised that caseloads fluctuated throughout the year and on a daily basis and last year a total of 12,691 claimants of CTS at some point in the year benefitted from the reduction. The report detailed matters that had to be taken into consideration in terms of how the grant monies could be best used in the context of a potential shortfall on the Council Tax collection fund at the end of the year.

It was explained that there was a need to balance the needs of those already claiming CTS and managing to pay and those who were just above the CTS threshold and in financial difficulty. There was generally less overall cost to the Councils budget to support such claimants by the award a one off Section 13a Hardship Policy payment than to claim CTS longer term.

The report detailed 2 options to be considered:
- Option A considered using 75% of £2.025m to support residents and 25% into budget
- Option B considered using 50% of £2.025m and 50% in the budget

The Assistant Director of Exchequer Services presented the Board with the preferred options which struck a balance between benefitting existing and new Council Tax Support claimants and those just above the threshold and were experiencing significant financial hardship and unable to pay Council Tax.
- Option A Proposal 3, 75% of the £2.025m would be allocated for Council Tax Support claimants and the financially vulnerable. There would be £75 for each CTS claimant at an estimated cost of 951k. It was estimated that this proposal would leave £567k remaining for further new claims and hardship cases.
- Option B Proposal 2, 50% of the £2.025m for Council Tax Support claimants and the financially vulnerable. There would be £50 for each CTS claimant at an estimated cost of £634k. It was estimated that £3678k would remain for further new claims and hardship cases.

AGREED
That Executive Cabinet be recommended to agree that:
(i) The Council Tax Support scheme for 2022/23 in principle remains the same scheme as that set effective from April 2019, subject to annual benefit uprating as detailed in the scheme and any further guidance which may be issued by MCHLG.
(ii) The Local Council Tax Support grant monies for 2021/22 should be used as set out at the preferred variation of Option B as detailed at section 3.13 of the report.

59 PERFORMANCE SCORECARDS

Consideration was given to a report of the Executive Leader / Co-chairs of T&G CCG / Director of Governance and Pensions / Assistant Director for Policy Performance and Communications. The report detailed two corporate scorecards which, provided evidence to demonstrate progress towards the achievement of the Corporate Plan and improving the services provided to residents, businesses and key stakeholders within the locality.

It was stated that the Corporate Plan outcomes scorecard attached at Appendix 1, followed the structure of the Corporate Plan, and contained indicators focused on long term outcomes across the plan's priorities. The scorecard had been reviewed and a number of additional measures related to the Covid-19 pandemic had been included; the new measures acted as proxy indicators for some of those issues related to the pandemic which would take significantly longer to be

reflected in the other, longer term measures. Further, the corporate health scorecard attached at appendix 2, contained a range of measures for tracking the short to medium term health and activity of the organisation.

AGREED
That Executive Cabinet be recommended to agree that the two scorecards attached are reported on a regular basis to the Overview Panel, the two Scrutiny Panels and the Strategic Commissioning Board / Executive Cabinet.

60 ENGAGEMENT UPDATE

Consideration was given to a report of the Executive Leader / T&G and CCG Co-chairs / Assistant Director for Policy, Performance and Communications. The report provided an update on the delivery of engagement and consultation activity in 2020/21,.

It was stated that much of the Engagement work had been 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. Each of the three agencies undertook work individually where necessary and appropriate for the purposes of specific projects. The Assistant Director for Policy and Communications highlighted the key headlines from June 2020 to date:

- Facilitated 32 thematic Tameside and/or Glossop engagement projects
- Received 4,186 engagement contacts (excluding attendance at virtual events)
- Supported 27 engagement projects at the regional and Greater Manchester level
- Promoted 33 national consultations where the topic was of relevance to and/or could have an impact on Tameside and/or Glossop
- Established the Community Champions Network to provide residents and workforces with the coronavirus information they need to lead the way in their community, with over 250 members now registered
- Established the Tameside & Glossop Inequalities Reference Group in response to how the coronavirus pandemic, and the wider governmental and societal response to this, has brought equalities (and indeed inequalities) into sharp focus
- Delivered two virtual Partnership Engagement Network (PEN) conferences attended by over 150 delegates in total
- Delivered four virtual Partnership Engagement Network sessions focusing on the impact of COVID-19 and how we can build back better. These were attended by over 50 participants.
- Held a virtual engagement session with young people to understand the impact of the pandemic on them and how they feel things can be done differently in the future.
- Undertook the third joint budget conversation exercise for Tameside Council and NHS Tameside and Glossop Clinical Commissioning Group
- Achieved 'Green Star' top rating for public and patient engagement as part of the CCG Improvement and Assessment Framework (IAF). Tameside and Glossop CCG attained the highest score possible, one of only 40 out of 195 areas in the country to do so *

AGREED
That the Strategic Commissioning Board and Executive Cabinet be recommended to note the contents of the report and support future engagement and consultation activity with the communities of Tameside and Glossop.

61 GM CLEAN AIR FINAL PLAN

Consideration was given to a report of the Executive Member for Neighbourhoods, Community Safety and Environment / Director of Operations and Neighbourhoods. The report set out the proposed Greater Manchester Final Clean Air Plan and policy following a review of all of the

information gathered through the GM CAP consultation and wider data, evidence and modelling work which is to be agreed by the ten Greater Manchester local authorities.
It was stated that the proposed final GM CAP policy, which was summarised in the report, was attached at Appendix 1. In relation to the Clean Air Zone (CAZ), it covered the operation and management of the GM CAZ. The anticipated implementation date of the charging CAZ was Monday 30 May 2022 when the charges would apply to non-compliant buses, HGVs, and Hackney Carriages and Private Hire Vehicles licensed outside of Greater Manchester. Non-compliant LGVs, minibuses and coaches, and GM-licensed Hackney Carriages and Private Hire Vehicles would be subject to the charges from 1 June 2023 when a temporary exemption expired.

It was explained that feedback from the consultation and consideration of the impact of COVID-19 on Greater Manchester had been used to better understand the requirements of those businesses, individuals and organisations who most needed the support to upgrade. It was therefore proposed to amend the support funds from those consulted upon. The final proposed policy increased the funding per vehicle for Private Hire Vehicles, coaches, HGVs and vans whilst remaining the same for other vehicle types. There were also more options for replacement and retrofit for hackney carriages, PHVs, minibuses and vans.

AGREED
That Executive Cabinet be recommended to:

1. **Note the progress of the Greater Manchester Clean Air Plan;**
2. **Note the progress in the distribution of Bus Retrofit funding;**
3. **Note Ministers' agreement to include the sections of the A628/A57 in Tameside which form part of the Strategic Road Network within the Greater Manchester's Clean Air Zone (CAZ) and their request for Tameside MBC, TfGM and Highways England to establish the most appropriate solution for the charging mechanism to be applied on this section of the Strategic Road Network (SRN);**
4. **Approve the GM Clean Air Plan Policy, at Appendix 1 noting that the policy outlines the boundary, discounts, exemptions, daily charges of the Clean Air Zone as well as the financial support packages offered towards upgrading to a compliant vehicle, including the eligibility criteria to be applied.**
5. **Agree the Equalities Impact Assessment, as set out at Appendix 2;**
6. **Agree the AECOM Consultation Report, as set out at Appendix 3;**
7. **Agree the proposed Response to the Consultation at Appendix 4 which has been prepared by TfGM on behalf of the ten GM local authorities;**
8. **Agree the Impacts of COVID-19 Report, as set out at Appendix 5;**
9. **Agree the Modelling report of the final CAP package, as set out at Appendix 6, and in particular that the modelling outputs of the final plan scheme show the achievement of compliance with the legal limits for Nitrogen Dioxide in the shortest possible time and by 2024 at the latest as required by the Ministerial Direction;**
10. **Agree the economic implications of the CAP Report, as set out at Appendix 7;**
11. **Note the update on the GM Minimum Licensing Standards, set out in section 3.1, and in particular that licensing conditions will not be used to support delivery of the GM Clean Air Plan;**
12. **Approve a 6-week public consultation on the inclusion of motorhomes classified as MSP1 in the GM Clean Air Zone and on the inclusion of the A575 and A580 at Worsley commencing on 1 September 2021 and delegate authority to the Executive Member (Neighbourhoods, Community Safety and Environment) to approve the consultation materials;**
13. **Note that the GM Clean Air Charging Authorities Committee has the authority to make the Charging Scheme Order which establishes the GM Charging Scheme in line with the agreed GM Clean Air Plan Policy;**
14. **Note that the GM Charging Authorities Committee has the authority to vary the Charging Scheme Order if this is established as the most appropriate charging mechanism to be applied on sections of the A628/A57 part of the Strategic Road Network (SRN) in Tameside;**

15. **Note that the Air Quality Administration Committee has the authority to agree the final form of the Operational Agreement for the Central Clean Air Service, and to authorise the making of the Agreement, on behalf of the ten GM local authorities;**

16. **Note that the Air Quality Administration Committee has the authority to:**

(a) **establish and distribute the funds set out in the agreed GM Clean Air Plan policy;**

(b) **approve the assessment mechanism agreed with JAQU to ensure that Clean Air Funds can be adapted if necessary;**

(c) **keep the use of the funds under review and to determine any changes in the amounts allocated to each and their use and**

(d) **Monitor and evaluate the joint local charging scheme.**

17. **Approve the reallocation of funding from the Try Before You Buy scheme to provide additional electric vehicle charging points dedicated for use by taxis;**

18. **Delegate to the GM Charging Authorities Committee the authority to determine the outcome of the consultation on both the inclusion of motorhomes classified as MSP1 within the scope of Clean Air Zone charges and on the inclusion in the GM Clean Air Zone of the A575 and A580 at Worsley following the conclusion of that consultation;**

19. **Agree the Clean Air Zone ANPR and signage locations, as set out at Appendix 10;**

20. **Agree a delegation to the Director of Operations and Neighbourhoods to approve the submission of the Interim Full Business Case if required and Executive Member (Neighbourhoods, Community Safety and Environment) the Full Business Case (FBC) to the Government's Joint Air Quality Unit to support the GM Clean Air Plan and any supplementary information to that Unit .**

62 REVIEW OF WASTE SERVICES

Consideration was given to a report of the Executive Member for Neighbourhoods, Community Safety and Environment / Director of Operations and Neighbourhoods. The report proposed a pilot scheme to evaluate the viability of adjusting the collections frequency of the paper and cardboard and co-mingled recycling bins from two weekly to three weekly. The report provided a detailed plan of the pilot scheme and corresponding consultation process and to seek approval for its commencement.

The Director of Operations and Neighbourhoods advised Members that the pilot areas had been chosen as they will provide invaluable information due to the varied housing stock, illustrative of the borough, and varied population demographics. Residents would be engaged in the process by way of a public consultation and by the services following a detailed Communications Plan.

It was explained that both the operational results from the pilot areas and the feedback from the consultation process would be evaluated to inform the suitability of a wider rollout of the scheme. A further report detailing these findings would be presented for the consideration of Members at a later date.

AGREED
That Executive Cabinet be recommended to:

(i) **Approve the chosen areas for the pilot scheme as detailed in section 2. The collections frequency of the paper and cardboard (blue) and co-mingled (black) recycling bins in these areas will be adjusted from two weekly to three weekly collections for a duration of 12 weeks. The impact and viability of the trial will then be reviewed.**

(ii) **Note that a future report evaluating the pilot scheme's suitability for a wider rollout across the borough will be presented to Members at a later date.**

(iii) **Approve the commencement of a consultation process that will run in parallel with the 12 week trial pilot period; to review the wider Waste Services offer to residents, via the Waste Policy and Enforcement Strategy, which includes the charging for all wheeled bins and the potential collection frequency change for blue and black bins across the borough.**

63 PERMANENTLY EXCLUDED YOUNG PEOPLE AT RISK OF NEET

Consideration was given to a report of the Executive Member for Lifelong Learning, Equalities, Culture and Heritage / Director of Education. The report explained the exacerbated risk of a cohort of young people becoming Not in Education, Employment or Training (NEET) and set out the proposed support programme developed by Education, Growth and Policy.

The Director of Education advised Members that Young people in Alternative Provision (AP) to mainstream education were often at higher risk of becoming NEET (Not in Education, Employment or Training). The impact of COVID and lockdown period's on attendance had exacerbated this risk. As at May 2021 12.2% of Tameside young people aged 16-24 years were claiming out of work benefit, according to the Office of National Statistics, this show an increase of 7.2% from April 2018 and highlighted the significant impact of the pandemic. This was above the Northwest average of 9.4% and national rate of 8.3%.

It was explained that a group of 46 young people both with a Social Worker and on roll in AP had been highlighted as presenting a significantly high risk due to poor/non attendance, 22 of these young people are Looked After Children. It was further explained that 25 of these young people were in Year 11 presenting a short time period to engage and move into education, apprenticeship or employment.

The Director of Education stated that Funding was needed to create the support programme for the 25 identified young people in Year 11 at risk of NEET. Members were advised that whilst not all would have employment as their preferred route this was costed at the maximum to ensure all were able to access this route should they wish to do so. Remaining funding could be utilised to support other young people including a focus on the Leaving Care cohort. Total funding requested was £285,880 to allow National Living Wage (NLW), based on previous YES placements for 16-24 year olds the average payment per 6 month period was £6,000 which could create an underspend of £58,500 or the opportunity to create additional job roles for other NEET or at risk of NEET young people

AGREED

(i) That Executive Cabinet be recommended to approve a Budget allocation of a maximum of £285,880 from the COVID budget to support this programme;

(ii) That Members note that this initial project would act as a proof of concept for future support to those young people who had been permanently excluded from mainstream education. Further reports would be prepared for Cabinet to measure the success to date and consider the longer-term proposals following the timetable shown.

64 STALYBRIDGE CIVIC HALL ROOF REPLACEMENT

Consideration was given to a report of the Executive Member for Finance and Economic Growth / Director for Growth / Assistant Director for Strategic Property. This report provided an update on the status Stalybridge Civic Hall Roof project and sought approval for an additional budget of £1,138,721.

Members were advised that following inspection of the site by Robertson surveyors and specialist contractors, a number of additional items had been identified and added to the scope of works and were subsequently included in Robertson's indicative price. This included replacement of existing roof lights/ windows, replacement of the roof access and fall arrest systems which had deteriorated beyond safe reuse, and new cast iron guttering to two of the external slopes.

Inclusive of the revised scope, the indicative price now stood at £1,697,671, Appendix 1 detailed a breakdown of the indicative price. It was explained that following approval the Council would instruct the LEP to commence design and tendering work, confirm a programme and to submit a

request for Listed Building Consent. An Executive Decision Notice would then be prepared for approval to enter into a contract.

AGREED
That Executive Cabinet be recommended to approve an additional budget of £1,138,721 to be allocated to the Stalybridge Civic Hall roof replacement project (Stalybridge High Street Heritage Action Zone scheme) and added to the approved capital programme.

65 AMENDMENTS TO SCHOOL ADMISSION ARRANGEMENTS FOR COMMUNITY AND VOLUNTARY CONTROLLED SCHOOLS

Consideration was given to a report of the Executive Member for Lifelong Learning, Equalities, Culture and Heritage / Director of Children's Services. The report detailed the determination following a referral to the School Adjudicator and the implications for the school admission arrangements for community and voluntary schools.

Members were reminded that the admission arrangements for community and voluntary controlled schools were determined on an annual basis and the Executive Cabinet last considered them at the January 2021 meeting for admission in September 2022. Subsequent to that meeting and following school budget planning, the Council was approached by Buckton Vale Primary School who were making plans to avoid a potential budget deficit that was being projected for future years due to falling numbers coming into the school.

It was explained that in order to address the issue of a potential future funding gap, the school requested that the published admission number be reduced to 30 from September 2022. This was supported to avoid the potential for significant budget deficit in future years.

Members were advised that as part of the process of considering the proposal, the School Adjudicator reviewed the council's guidance in relation to schools admissions and raised a number of issues, set out in this report for the council to address to ensure that its admission arrangements were as clear as possible as required under the School Admission Code.

The amendments proposed in this report were intended to address those issues to ensure that the process is as clear as it can be for those seeking admission for children. It also ensures that the council has confidence in its processes which were fair and robust against potential challenge.

It was reported that the Department for Education has notified admission authorities that there would be a new School Admissions Code from September 2021 subject to parliamentary approval. All admission authorities were required to amend their admission arrangements to comply with the new mandatory elements of the Code. The report set out the amendments that had been made to the in-year transfer section of the admission arrangements.

AGREED
That Executive Cabinet be recommended to approve the admission arrangements for Tameside primary, junior and secondary community and voluntary controlled schools be amended as set out in Appendices 2, 3 and 4

66 SEND CAPACITY RECOVERY PROPOSAL

Consideration was given to a report of the Director of Education Tameside and Stockport. The report provided an overview of the demands on Tameside's Statutory Assessment team and a request for additional capacity, to mitigate the risks this posed.

Members were advised that Tameside maintained 1780 Education Health and Care Plans (EHCPs). The number of plans maintained had been rising steadily since 2017. The number of EHCPs in Tameside had more than doubled since 2017, when the Local Authority maintained 828 plans. Tameside was now in line with statistical neighbours. The Director of Education explained that it would be confidently concluded that the growth in EHCP's was appropriate and necessary. However, increased and continuing growth in this area could present a significant financial risk to the authority

It was explained that whilst a short term investment would not provide a sustainable long term solution, it would address the most pressing immediate issues of statutory compliance and increasing costs. A long term solution to these capacity challenges would be investigated as part of the transformation and collaboration work with Stockport MBC. This was proposed as it would afford time to ensure that opportunities for economies of scale are maximised and to assess the actual level of future demand, as recent intelligence shows us that requests for new assessments are slowing down. By 2023-4 it was projected that the number of assessment requests would have dropped significantly, allowing more capacity within the team to manage and respond to other demands.

AGREED
That Executive Cabinet note the capacity challenges currently experienced by the SEND team are noted and agree the proposal to make a short term investment to support increased staffing at an estimated cost of the proposal is £280,091, to be funded by the Education Reserve.

At this juncture, Councillor Gwynne left the meeting during consideration of the following item of business, having declared a prejudicial interest as a Kinship Carer, and took no part in the discussion nor decision thereon.

67 FOSTER CARERS OFFER UPDATE AND IMPLEMENTATION PLAN

Consideration was given to a report of the Deputy Executive Leader / Assistant Director for Children's Services. The report provided a detailed review of the Foster Carer Offer that was a commissioned piece of work as part of the 7 Looked after Children sustainability projects.

The Director of Children's Services advised Members that in house foster care was widely recognised to provide the best option for the majority of children who required care from their Local Authority. It enabled children to remain local to their family, friends, home community and services such as schools and health and represented by far the best value for money, at significantly less than half the cost per placement when compared to independent (private) fostering providers.

It was explained that unfortunately over recent years the fostering service had not been given the attention that is required in order to grow its size or maintain or improve its performance and as a result the proportion of the cared for children who were placed with Independent Fostering Agencies (IFAs) had grown disproportionately and is now at close to 50%. The ambition of this investment proposal, which sat alongside an ambitious three year recruitment strategy, was to make it more attractive to become an in-house foster carer for Tameside Council, helping to ensure that children were able to be placed with local foster carers wherever possible by initially stabilising the fostering cohort and then to expand. To do nothing, would most likely lead to further reductions in capacity and an increased reliance on IFAs, children being more often placed out of Borough and the associated increased costs of both.

It was stated that it had to be recognised though that the Council were operating in an increasingly difficult context in terms of recruiting and retaining foster carers, as Local Authorities and IFAs competed for a largely finite resource of individuals who wished to foster against a nationally increasing number of children who required these placements. Whilst it was recognised the Council could not compete like for like with independent fostering agencies in terms of fees paid,

there could be better rates when compared to other Local Authorities and to compete with IFAs for those families who wanted to foster locally but for whom the difference in rates currently made it unaffordable. The ambition was to eventually realign the figures from a 50/50 split figures to the optimum provision of 85% in-house fostering placement capacity.

The Director of Children's Services reported that a financial uplift in level 2 skills payments of £30 per week per child would shift Tameside into the top half of GM median entry level skill payments to approved foster carers and to Increase Level 3 skill payments by 10% (£15 per week per child). This would also apply to the existing foster carers giving a much better chance of retaining those carers. The estimated costs of this uplift alongside a number of other improvements foster carers had told us would make Tameside a more attractive recruiter, the proposed investment for the revised fostering offer is £686,072. It was highlighted that in order to cover the increased costs of in house fostering allowances a transfer of 27 children from the Independent Fostering Agencies into in-house fostering care would cover the increased costs represented in this proposal, or 3 children from residential care into in-house fostering at the average cost.

Members were advised that there would also be a corresponding increase in payments to Special Guardianship Order (Special Guardianship) carers as a result of the Councils non-detriment policy, for foster carers who converted to Special Guardianship carer's. This was estimated to be £475,800. Therefore the total cost of this initiative was £1,161,872. The cost in the current year was recommended to be financed from the central contingency provision.

AGREED
That Executive Cabinet be recommended to agree:
- **(i) That the proposals for the foster carer offer are approved for consultation as set out in the report.**
- **(ii) That prior to any final decision being made as to the Foster Care Offer an implementation delivery plan will be presented to Cabinet together with the consultation feedback and an equality impact assessment.**
- **(iii) The cost in the current year is financed from the central contingency provision.**

68 DEVELOPMENT OF AN INTEGRATED CARE SYSTEM IN T&G

Consideration was given to a report of the Executive Member for Adult Social Care & Population Health / Co Chair for T&G CCG / Director of Commissioning. The report articulated the work programme, which was underway to deliver the required changes in T&G in response the development of local NHS Integrated Care Systems.

The Director of Commissioning explained that the next stage of the transformation would be the response to the recent White Paper "Integration and Innovation – working together to improve H&SC for all" which set out legislative proposals for changes to the health and care system including a duty to collaborate across the NHS, social care and public health systems. The report detailed the initial response to the White Paper and outlined the work programme at this early stage, for the development of local NHS Integrate Care Systems.

The report sought approval for the draft terms of reference for the T&G Integrated Care Transition Board attached at Appendix 1. Members were advised that the ICTB was the system-wide accountable group to oversee the transition into the GMICS. This involved building on current locality arrangements to establish a new locality operating model as part of the establishment of a statutory GMICS. The ICTB would take place prior to the Strategic Commissioning Board and would be chaired by the Co-chair of T&G CCG.

AGREED
That Executive Cabinet and the Strategic Commissioning Board be recommended to note the content of the report and approve the Draft Terms of Reference in the appendix for the

T&G Integrated Care Transition Board. Recognise that this work programme is progressing at pace despite the lack of final legislation and this creates associated risk.

69 PREVENTION AND PROMOTION FUND FOR BETTER MENTAL HEALTH - GRANT FUNDING

Consideration was given to a report of the Executive Member for Health, Social Care and Population Health / Director of Population Health / Assistant Director of Population Health. The report outlined the proposals to spend the £317,623.00 provided to Tameside Council as part of the government's 'Prevention and Promotion Fund for Better Mental Health 2021/22' grant. The proposals were one off schemes due to the non-recurrent nature of the grant from government.

It was reported that on 27 March 2021 the Department of Health and Social Care announced the COVID-19 Mental Health and Wellbeing Recovery Action Plan for 2021 to 2022 to mitigate and respond to the impact of the COVID-19 pandemic on mental health. The government announced a Prevention and Promotion Fund for Better Mental Health of £15 million to be distributed to the most deprived (IMD) upper tier local authorities in England to preventing mental ill health and promoting good mental health. The Prevention and Promotion Fund for Better Mental Health Grant was a one-off contribution for the 2021/22 financial year and was made under Section 31 of the Local Government Act 2003.

Members were advised that the report proposed spending £295,000 on five mental health initiatives, plus £20,000 in evaluation costs. The total cost was fully funded by an external grant of £317,623 from the Department of Health and Social Care (DHSC), and there would be no overall budget impact to the Council. £75,000 of the costs would be internal to the Council, with the remainder disbursed to third-sector partners co-ordinated by the CCG.

AGREED
That the Strategic Commissioning Board be recommended to approve the spending proposals outlined in the report.

70 TAMESIDE AND GLOSSOP CHILDREN AND YOUNG PEOPLE'S EMOTIONAL AND MENTAL WELLBEING COMMUNITY OFFER – CONTRACT AWARD

Consideration was given to a report of the Executive Member for Adult Social Care and Health / Director of Commissioning. The report summarised the progress to date and the outcomes of the process following the awarding of the contract for the Children and Young Peoples Emotional and Wellbeing Community Offer.

Members were reminded the refreshed Tameside and Glossop Children and Young People's Emotional Wellbeing and Mental Health Transformation Plan was approved at the Strategic Commissioning Board in April 2020, with one of the priority being to develop a new co-produced Children and Young People's Emotional and Mental Wellbeing Community Offer. The commissioning and procurement approach for the Children and Young People's Emotional and Mental Wellbeing Community Offer was taken through Strategic Commissioning Board (SCB) in September 2020 and an update in January 2021 to outline progress, including the co-designed model, principles and specification.

It was stated that Tameside and Glossop Single Commission had co-produced the new Emotional Wellbeing and Mental Health Community Offer with children, young people, families and stakeholders since Summer 2020. Tameside and Glossop Clinical Commissioning Group (CCG) was the lead commissioner with Tameside Council being associate commissioner, as the budget for the Offer were pooled together. The contract awarded would be a 3 +2 year contract at £250,000 per annum. The Offer would be live from 1 December 2021.

AGREED
That the Executive Cabinet and Strategic Commissioning Board be recommended to:
(i) acknowledge the robust procurement process undertaken and extensive co-production to develop the Offer
(ii) approve to the contract award report at appendix 1.
(iii) acknowledge the delay in awarding the contract and approves extension of the existing community contracts/grants by 3 months to enable appropriate mobilisation.

71 FORWARD PLAN

The forward plan of items for Board was considered.

CHAIR

BOARD

4 August 2021

Present:	**Elected Members**	**Councillors Warrington (In the Chair), Bray, Cooney, Feeley, Gwynne, Kitchen, Ryan and Wills**
	Borough Solicitor	**Sandra Stewart**
	Assistant Director of Finance Deputy Section 151 Officer	**Caroline Barlow**
Also in Attendance:	**Stephanie Butterworth, Jeanelle de Gruchy, Nick Fenwick, Richard Hancock, Sarah Threllfall, Emma Varnam, Debbie Watson and Jessica Williams.**	

Apologies for Absence: **Councillor Fairfoull**

72 DECLARATIONS OF INTEREST

There were no declarations of interest.

73 MINUTES OF PREVIOUS MEETING

The minutes of the Board meeting on the 14 July 2021 were approved as a correct record.

74 MONTH 3 INTEGRATED FINANCE REPORT

Consideration was given to a report of the Executive Member for Finance and Economic Growth / Lead Clinical GP / Director of Finance. The report was the second financial monitoring report for the 2021/22 financial year, reflecting actual expenditure to the 30 June 2021 and current forecasts to the 31 March 2022.

Members were advised that at period 3, Council Budgets were facing significant pressures which were not directly related to the Covid pandemic, with significant forecast overspends in Adults and Children's Social Care being the main contributors to a net forecast overspend of £6.850m. This position was after taking account of forecast underspends in some areas, and additional Covid related income in excess of forecast Covid costs. There was an underlying forecast 'Non-COVID' deficit of £8.238m.

It was reported that Children's Social Care and Adults were the greatest areas of concern with forecast overspends of £5.678m (Children's) and £2.234m (Adults). Further, the CCG was reporting an overspend of £519k which related to reimbursable Covid expenses for which a future allocated increase should be received.

The Assistant Director of Finance explained that the services that were projecting overspends had put forward mitigating actions. These actions would be included in the report for approval by Executive Cabinet.

AGREED
That Executive Cabinet be recommended to:
(i) Note the forecast outturn position and associated risks for 2021/22 as set out in Appendix 1 and detail for Council budgets as set out in Appendix 2.
(ii) Approve the reserve transfers set out on pages 27-28 of Appendix 2.

75 CIVIC EVENTS 2021

Consideration was given to a report of the Executive Member for Lifelong Learning, Equalities, Culture and Heritage / Assistant Director of Operations and Neighbourhoods. The report set out a vision for key events and activities in 2021.

The civic events programme spanned a full 12 months of a calendar year and featured the key events: Whit Friday Brass Band Contest, Armed Forces Day, Remembrance Services and Parades and the corporate lantern parade and town Christmas switch on events.

It was stated that with an increased focus on the Council's finances and the desire to continue to deliver events which were vibrant, safe and affordable the Events Panel had been created to oversee key civic events from Whit Friday Brass Band Contest, Armed Forces Day and Remembrance Services to the Borough's flagship Christmas celebration and its Town Switch On events. The Panel proposed that the civic event dates put forward in the report be noted and adopted.

Further, the Panel wished for the proposed plans to deliver Remembrance Services and Parades in line with 2019 to be adopted whilst it was noted that should the pandemic cause last minute alterations these could need to be considered. The report also included the proposed plans for the corporate 2021 Christmas celebrations. Whilst this had traditionally taken place in Ashton, the Panel proposed that the event continued to tour in 2021 and take place in Hyde to honour the commitment made to Hyde in 2020 due to the ongoing landscaping of Ashton Market Square.

AGREED
That Executive Cabinet be recommended to agree:
- **(i) The proposals relating to Town Christmas events 2021 are agreed.**
- **(ii) The proposal relating to Tameside's Christmas Celebration event 2021 is agreed.**
- **(iii) The plans for Summer Theatre are noted**
- **(iv) The considerations for Remembrance Sunday and the associated Services and Parades are noted.**

76 MOSSLEY NEIGHBOURHOOD PLAN – AREA DESIGNATION

Consideration was given to a report of the Executive Member for Housing, Planning and Employment / Director of Growth / Interim Assistant Director of Planning. The report considered the designation of the Mossley Neighbourhood Area in accordance with the Neighbourhood Planning (General) Regulations 2012 (as amended), following an application by Mossley Town (Parish) Council, as a relevant body for the purposes of section 61(G) of the Town and Country Planning Act 1990.

It was reported that an application to designate a Neighbourhood Area had been received by the Council as the Local Planning Authority from Mossley Town (Parish) Council. The application was submitted following a meeting and resolution of the Town (Parish) Council on 16 June 2021. The proposed Mossley Neighbourhood Area application complied with the requirements of the appropriate legislation and regulations and should be designated accordingly and the decision be publicised via the mechanisms as set out in **Appendix 3**.

It was explained that the Council as Local Planning Authority would, as was required and detailed within the 'Neighbourhood Planning Service Level Framework' at Appendix 4, liaise with the Town Council as their plan developed. The principal activities of the Council as Local Planning Authority, following designation of the area, arise once a draft of the Neighbourhood Plan had been submitted.

AGREED
That the report be deferred for further consideration at a future meeting of the Board to

address the issues of (a) how it fitted with Places for Everyone (b) a better understanding of what Mossley Town Council were trying to achieve and how such an approach would benefit Mossley and the Borough generally (c) clarification as to which other groups within the Borough could make such applications and the impact (d) who would pick up any shortfall in funding and (e) on what grounds the Council could refuse.

77 CAPITAL MONITORING REPORT 2021/22 - PERIOD 3

Consideration was given to a report of the Executive Member for Finance and Economic Growth / Lead Clinical GP / Director of Finance. This report was the first capital monitoring report for 2021/22 and summarised the forecast outturn at 31 March 2022 based on the financial activity to 30 June 2021.

It was reported that the approved budget for 2021/22 was £68.234m (after re-profiling approved at Outturn) and current forecast for the financial year was £66.123m. There were additional schemes that had been identified as a priority for the Council, and, where available, capital resource had been earmarked against these schemes, which would be added to the Capital Programme and future detailed monitoring reports once satisfactory business cases had been approved by Executive Cabinet.

It was explained that the current forecast was for service areas to spend £66.123m on capital investment in 2021/22, which was £2.111m less than the current capital budget for the year. This variation was spread across a number of areas, and was made up of a number of over/underspends on a number of specific schemes (£1.848m) less the re-profiling of expenditure in some other areas (£0.263m).

AGREED
That the Strategic Planning and Capital Monitoring Panel be recommended to:

- **(i) Note the forecast outturn position for 2021/22 as set out in Appendix 1.**
- **(ii) Recommend the approval of the re-profiling of budgets into 2022/23 as set out on page 4 of Appendix 1.**
- **(iii) Note the funding position of the approved Capital Programme as set on page 9 of Appendix 1.**
- **(iv) Note the changes to the Capital Programme as set out on page 10 in Appendix 1**
- **(v) Note the updated Prudential Indicator position set out on pages 11-12 of Appendix 1, which was approved by Council in February 2021**

78 ADULTS CAPITAL PLAN

Consideration was given to a report of the Executive Member for Health, Social Care and Population Health / Director of Adult Services. The report provided an update on the developments in relation to the Adults Capital Programme for schemes previously approved and the usage of the wider disabled facilities grant (DFG).

In regards to Moving with Dignity (Single Handed Care), following the review of the last year, the project was able to evidence a reduction of over 1,000 hours per week in homecare packages during financial year 2020/21.

It was stated that more recently there had been a shift in focus from the project team, who were now working collaboratively with health colleagues at the ‘front door’ and part of the hospital discharge process to provide more timely assessments. This was to target a reduction and avoidance at, or, as close to discharge as possible and to prevent the need for unnecessary spend on homecare provision.

It was explained that in the initial month of June, these focused Moving with Dignity assessments indicated two immediate avoidances, and a number of potential reductions within months of discharge.

In regards to the Disability Assessment Centre, a project group had been established and an outline plan of the business case and future requirements of the Disability Assessment Centre (DAC). Members were advised that a visit to Able World disability equipment retailer in Hyde had been completed. This was with a view to a potential joint venture, and unfortunately this was not a viable option going forward. Further, Loxley House and Rosscare had both been explored and neither facility had the available space required or capacity to accommodate the DAC.

It was stated that work was progressing on the replacement of ageing and obsolete equipment with Occupational Therapy staff. Further, the service was in the process of recruiting an additional Occupational Therapy post for 12 months to carry out this pro-active piece of work to avoid potential unplanned costs.

The Director of Adult Services delivered an update on disabled facilities grant and other related adaptations funding. It was reported that one aspect of the pandemic was an increase in referrals for more complex cases resulting in more requests to extend properties. The maximum grant for DFG was £30,000 and as all extension exceeded this amount, this was creating some issues with housing providers where contributions were required.

Members were advised that the current contract for delivery of building related adaptions would end in July 2022. A new framework would be required to ensure delivery of adaptations continues without disruption. The intention was to procure a new framework tender towards the end of 2021 – early 2022.

AGREED
That the Strategic Planning and Capital Monitoring Panel be recommended to ask Executive Cabinet to note the progress updates, and to approve the re-profiling of £98k of Housing Assistance works into FY22/23 owing to limited capacity within the Adaptations team as discussed in section 5 of the report.

79 CHILDREN SOCIAL CARE CAPITAL SCHEMES UPDATE REPORT

Consideration was given to a report of the Deputy Executive Leader / Assistant Director for Children's Social Care. The report provided an update on Children's Social Care Property Capital Scheme and set out details of the major approved property capital schemes in this directorate.

It was reported that the current capital programme as recommended by SPCMP on 9 October 2017 and subsequently approved by Executive Cabinet on 18 October 2017, included funding support Capital Investment in Children's Social Care. The total Capital funding earmarked was £950,000.

Members were advised that the purchase of a respite property had been delayed due to the fast movement of the housing market and had proved difficult as properties were being vended rapidly, either by investors or private purchases. Following conversation with Growth and the housing partner's there appeared to be suitable properties within the Tameside housing portfolio, to deliver a respite unit, this was begin explored. At this stage the cost was still unknown, therefore it was proposed the remaining budget be utilised to purchase a property for the respite unit. In regards to the Assessment Unit, works on the unit had been completed and the unit was in the process of being handed over to Children's Services and the Ofsted registration process was now underway. Furnishing of the building was underway and expected to come in on budget.

AGREED
Members are requested to note the progress update in the report.

80 DISPOSAL OF FORMER COTTON TREE PUBLIC HOUSE, 106 MARKET STREET, DROYLSDEN, M43 6DE.

Consideration was given to an exempt report of the Executive Member for Finance and Economic Growth / Director of Growth / Assistant Director for Strategic Property. The report sought approval to accept the highest offer for the property 106 Market Street, Droylsden, M43 6DE, which was declared surplus by the Council in March 2021.

It was reported that In March 2021, the subject former Cotton Tree Public House property was declared surplus in accordance with the disposal policy. Following on from this, the opportunity was immediately advertised for sale on the open market, using external agents Breakey & Nuttall in order to maximise the exposure.

The property had been actively marketed for approximately 3 months and with interest starting to slow, the Council asked for offers to be submitted to the agent by an agreed date. The Council received a total of 14 offers.

In accepting the offer from Brindle & Yam Solicitors, the proposed use of the site for employment purposes would help introduce a number of new jobs into the Borough. The employment and jobs provided would help sustain the nearby district centre.

AGREED
That subject to the amendments sought by the Borough Solicitor to complete the report that Executive Member for Finance and Economic Growth be recommended to approve:

(i) That following a period of marketing, the Council accept offer 11 submitted by Brindle & Yam Solicitors to acquire the subject property.
(ii) That the Council progress the disposal subject to the provisionally agreed heads of terms set out in Appendix 1.

81 FORWARD PLAN

The forward plan of items for Board was considered.

CHAIR

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Report To:	**STRATEGIC COMMISSIONING BOARD**
Date:	25 August 2021
Executive Member / Reporting Officer:	Councillor Oliver Ryan – Executive Member (Finance and Economic Growth) Dr Ash Ramachandra – Lead Clinical GP Kathy Roe – Director of Finance
Subject:	**STRATEGIC COMMISSION AND NHS TAMESIDE AND GLOSSOP INTEGRATED CARE FOUNDATION TRUST FINANCE REPORT** **CONSOLIDATED 2021/22 REVENUE MONITORING STATEMENT AT 30 JUNE 2021**
Report Summary:	This is the second financial monitoring report for the 2021/22 financial year, reflecting actual expenditure to 30 June 2021 and current forecasts to 31 March 2022. In the context of the on-going Covid-19 pandemic and the national restructuring exercise in the NHS, the forecasts have been prepared using the best information available, but is based on a number of assumptions which will inevitably evolve over the remainder of the financial year. However, indicative CCG budgets have been prepared for 2021-22 which combined with the 2021-22 Council budgets inform the 2021-22 Integrated Commissioning Fund. Forecasts for the Council cover the period to 31 March 2022, while CCG forecasts only cover the first 6 months of the year in line with confirmed allocations as part of some ongoing NHS national “command and control” procedures. Council Budgets are facing significant pressures which are not directly related to the COVID-19 pandemic, with significant forecast overspends in Adults and Children’s Social Care being the main contributors to a net forecast overspend of £6.850m. This position is after taking account of forecast underspends in some areas, and additional COVID related income in excess of forecast COVID costs. There is an underlying forecast ‘Non-COVID’ deficit of £8.238m. The CCG is reporting a forecast overspend of £519k, £320k of this relates to YTD Hospital Discharge Programme (HDP) expenses which will be refunded under COVID protocols. The £519k represents the full forecast for HDP. This is effectively a net breakeven position once reimbursement has been transacted in full.
Recommendations:	That Executive Cabinet be recommended to: (i) Note the forecast outturn position and associated risks for 2021/22 as set out in **Appendix 1** and detail for Council budgets as set out in **Appendix 2.** (ii) **Approve** the reserve transfers set out on pages 27-28 of **Appendix 2**.
Policy Implications:	Budget is allocated in accordance with Council/CCG Policy

Financial Implications:

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

The Council set a balanced budget for 2021/22 but this included £8.930m of savings and significant one-off funding from COVID related grants and additional one year Government funding. At the time of setting the 21/22 budget the MTFP forecast a £14m budget gap for 2022/23. This forecast gap assumes that planned savings are delivered in 2021/22, and that additional planned savings for 2022/23 in respect of service transformation are delivered, along with reduced expenditure on Children's Social Care.

Despite this, a significant pressure is currently forecast for 2021/22, which will need to be addressed within this financial year. A new financial turnaround process is being implemented across all budget areas to address financial pressures on a recurrent basis.

With the outbreak of COVID-19 last year, emergency planning procedures were instigated by NHSE and a national 'command and control' financial framework was introduced. While some national controls have been relaxed over time, normal NHS financial operating procedures have still not yet been fully reintroduced.

A financial envelope for the first 6 months of the year has been agreed at a Greater Manchester level, from which the CCG has an allocation. Nationally calculated contract values remain in place, while the CCG are still able to claim top up payments for vaccination related costs and for the Hospital Discharge Programme. While an overspend is currently being reported, this relates to reimbursable COVID expenses for which we should receive a future allocation increase.

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)

A sound budget is essential to ensure effective financial control in any organisation and the preparation of the annual budget is a key activity at every council.

Every council must have a balanced and robust budget for the forthcoming financial year and also a 'medium term financial strategy (MTFS). This projects forward likely income and expenditure over at least three years. The MTFS ought to be consistent with the council's work plans and strategies, particularly the corporate plan. Due to income constraints and the pressure on service expenditure through increased demand and inflation, many councils find that their MTFS estimates that projected expenditure will be higher than projected income. This is known as a budget gap.

Whilst such budget gaps are common in years two-three of the MTFS, the requirement to approve a balanced and robust budget for the immediate forthcoming year means that efforts need to be made to ensure that any such budget gap is closed. This is achieved by making attempts to reduce expenditure and/or increase income.

In challenging financial times it is tempting to use reserves to maintain day-to-day spending. However reserves by their very nature can only be spent once and so can never be the answer to long-term funding problems. Reserves can be used to buy the council time to consider how best to make efficiency savings and

can also be used to 'smooth' any uneven pattern in the need to make savings

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 :

Caroline Barlow, Assistant Director of Finance, Tameside Metropolitan Borough Council

Telephone:0161 342 5609

e-mail: caroline.barlow@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

1. BACKGROUND

1.1 Monthly integrated finance reports are usually prepared to provide an overview on the financial position of the Tameside and Glossop economy.

1.2 The report includes the details of the Integrated Commissioning Fund (ICF) for all Council services and the Clinical Commissioning Group. The gross revenue budget value of the ICF for 2021/22 is reported at £769 million. This includes a full 12 month of expenditure for the Council, but only 6 months for the CCG.

1.3 The value of the ICF will increase once more certainty is available on the NHS financial regime for the second half of the year and a full year allocation is in place. The full year indicative value of the ICF, assuming that expenditure in the second half of the year is the same as the first, would be £988 million

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 (REVENUE BUDGETS)

2.1 At Period 3, Council Budgets are facing significant pressures which are not directly related to the COVID-19 pandemic, with significant forecast overspends in Adults and Children's Social Care being the main contributors to a net forecast overspend of £6.850m. This position is after taking account of forecast underspends in some areas, and additional COVID related income in excess of forecast COVID costs. There is an underlying forecast 'Non-COVID' deficit of £8.238m.

2.2 Children's Social Care and Adults are the greatest areas of concern with forecast overspends of £5.678m (Children's) and £2.234m (Adults).

2.3 The CCG is reporting an overspend of £519k which relates to reimbursable COVID expenses for which we should receive a future allocation increase.

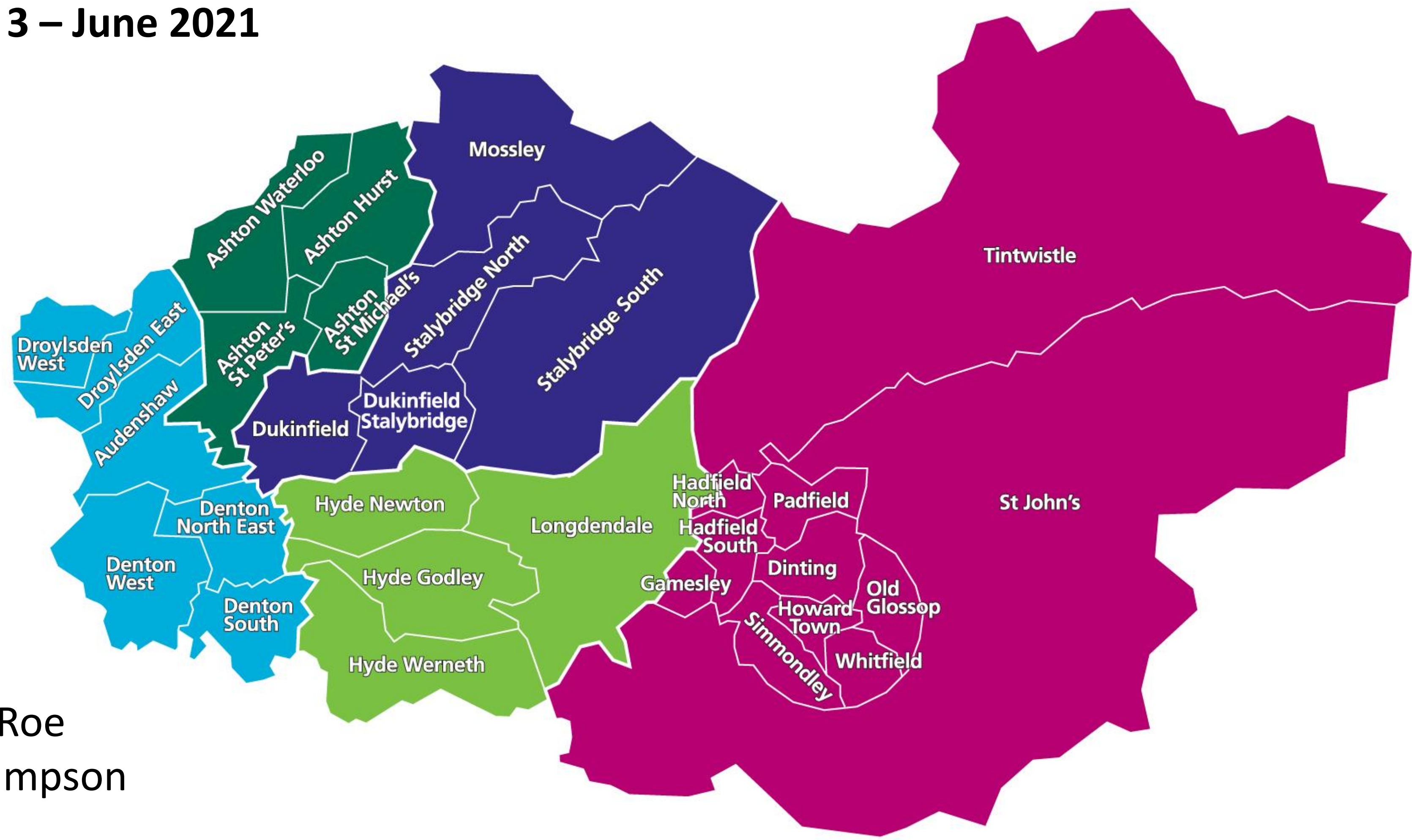
2.5 Further detail on the financial position can be found in **Appendix 1. Appendix 2** provides further detail on Council Budgets and savings for 2021/22.

3. RECOMMENDATIONS

3.1 As stated on the front cover of the report.

Tameside and Glossop Strategic Commission

Finance Update Report
Period Ending 31st March 2022
Month 3 – June 2021



Kathy Roe
Sam Simpson

Tameside and Glossop Care together

NHS Tameside and Glossop Clinical Commissioning Group

Tameside Metropolitan Borough

NHS Tameside and Glossop Integrated Care NHS Foundation Trust

Period 3 Finance Report

Executive Summary	3
Integrated Commissioning Fund Budgets	4 - 5
CCG Budgets & The Integrated Commissioning Fund	6
Integrated Commissioning Fund Highlights	7 – 8
ICFT Position	9 - 10

This report covers the Tameside and Glossop Strategic Commission (Tameside & Glossop Clinical Commissioning Group (CCG) and Tameside Metropolitan Borough Council (TMBC)). It does not capture any Local Authority spend from Derbyshire County Council or High Peak Borough Council for the residents of Glossop.

Forecasts reflect a full 12 months for TMBC, but only 6 months for the CCG

Finance Update Report – Executive Summary

This is the second financial monitoring report for the 2021/22 financial year, reflecting actual expenditure to 30 June 2021 and current forecasts to 31 March 2022.

Budgets continue to face significant pressures across many service areas. COVID pressures remain as a meaningful factor in this, with pressures arising from additional costs or demand (including the elective recovery programme), and shortfalls of council income. Targeted COVID funding continues into 2021/22 to address COVID related pressures.

Council Budgets are facing significant pressures which are not directly related to the COVID-19 pandemic, with significant forecast overspends in Adults and Children's Social Care being the main contributors to a net forecast overspend of £6.850m. This position is after taking account of forecast underspends in some areas, and additional COVID related income in excess of forecast COVID costs. There is an underlying forecast 'Non-COVID' deficit of £8.238m.

The NHS financial regime has still not fully normalised following the command and control response to the pandemic last year and NHS funding has only been confirmed for April to September 2021; as such we are only able to report 6 months of CCG budgets. The ICFT has a financial plan for the first 6 months of 2021/22, although there is uncertainty in forecasting expenditure due to the operational challenges of restoring elective services, whilst facing the ongoing uncertainty of the impact of responding to the pandemic. A full 12 month forecast is in place for the council. Forecasts are inevitably subject to change over the course of the year as more information becomes available, and there is greater certainty around NHS funding from October and other assumptions.

While the CCG is reporting an overspend of £519k, £194k of this relates to reimbursable COVID expenses for which a future allocation increase will be received.

Forecast Position	Forecast Position: Net Budget	Forecast Position: Net Outturn	Forecast Position: Net Variance	Net Variance: COVID Variance	Net Variance: Non-COVID Variance	Net Variance: Previous Month	Net Variance: Movement in Month
CCG Expenditure	443,644	222,341	(519)	(194)	(325)	(194)	(325)
TMBC Expenditure	194,494	201,344	(6,850)	1,388	(8,238)	(5,806)	(1,045)
Integrated Commissioning Fund	**638,138**	**423,685**	**(7,369)**	**1,194**	**(8,563)**	**(5,999)**	**(1,370)**

Integrated Commissioning Fund Budgets

Page 34

Forecast Position £000's	Forecast Position					Net Variance	
	Expenditure Budget	Income Budget	Net Budget	Net Outturn	Net Variance	COVID Variance	Non-COVID Variance
Acute	£114,637	£0	£114,637	£112,404	£2,233	£0	£2,233
Mental Health	£22,473	£0	£22,473	£22,396	£77	£0	£77
Primary Care	£46,465	£0	£46,465	£46,989	(£524)	£0	(£524)
Continuing Care	£7,538	£0	£7,538	£7,962	(£424)	£0	(£424)
Community	£17,276	£0	£17,276	£17,591	(£315)	£0	(£315)
Other CCG	£11,155	£0	£11,155	£12,721	(£1,566)	(£194)	(£1,372)
CCG TEP Shortfall (QIPP)	£0	£0	£0	£0	£0	£0	£0
CCG Running Costs	£2,278	£0	£2,278	£2,278	(£0)	(£0)	£0
Adults	£90,821	(50,607)	£40,214	£42,448	(£2,234)	£402	(£2,636)
Children's Services - Social Care	£65,276	(11,766)	£53,510	£59,188	(£5,678)	£0	(£5,678)
Education	£32,773	(25,534)	£7,239	£7,078	£161	(£113)	£274
Individual Schools Budgets	£123,054	(123,054)	£0	£0	£0	£0	£0
Population Health	£16,833	(1,436)	£15,397	£14,782	£615	£472	£143
Operations and Neighbourhoods	£78,839	(27,605)	£51,234	£52,168	(£934)	(£350)	(£584)
Growth	£44,448	(35,028)	£9,420	£9,401	£19	£132	(£113)
Governance	£71,470	(62,387)	£9,083	£9,709	(£626)	(£1,003)	£377
Finance & IT	£10,153	(1,827)	£8,326	£8,409	(£83)	£0	(£83)
Quality and Safeguarding	£383	(241)	£142	£135	£7	£0	£7
Capital and Financing	£8,964	(4,189)	£4,775	£4,358	£417	£0	£417
Contingency	£4,715	(756)	£3,959	£4,365	(£406)	£0	(£406)
Contingency - COVID Costs	£0	0	£0	£16,741	(£16,741)	(£16,741)	£0
Corporate Costs	£5,352	(301)	£5,051	£5,006	£45	£0	£45
LA COVID-19 Grant Funding	(£5,239)	(8,617)	(£13,856)	(£31,955)	£18,099	£18,099	£0
Other COVID contributions	£0	0	£0	(£489)	£489	£489	£0
Integrated Commissioning Fund	**769,663**	**(353,347)**	**416,316**	**423,685**	**(7,369)**	**1,194**	**(8,563)**

Integrated Commissioning Fund Budgets

Forecast Position £000's	Forecast Position			Net Variance		Net Variance	
	Net Budget	Net Outturn	Net Variance	COVID Variance	Non-COVID Variance	Previous Month	Movement in Month
Acute	£114,637	£112,404	£2,233	£0	£2,233	£2,378	(£145)
Mental Health	£22,473	£22,396	£77	£0	£77	£0	£77
Primary Care	£46,465	£46,989	(£524)	£0	(£524)	(£537)	£13
Continuing Care	£7,538	£7,962	(£424)	£0	(£424)	(£243)	(£181)
Community	£17,276	£17,591	(£315)	£0	(£315)	(£13)	(£301)
Other CCG	£11,155	£12,721	(£1,566)	(£194)	(£1,372)	(£1,778)	£212
CCG TEP Shortfall (QIPP)	£0	£0	£0	£0	£0	£0	£0
CCG Running Costs	£2,278	£2,278	(£0)	(£0)	£0	(£0)	£0
Adults	£40,214	£42,448	(£2,234)	£402	(£2,636)	£0	(£2,234)
Children's Services - Social Care	£53,510	£59,188	(£5,678)	£0	(£5,678)	(£4,717)	(£961)
Education	£7,239	£7,078	£161	(£113)	£274	£0	£161
Individual Schools Budgets	£0	£0	£0	£0	£0	£0	£0
Population Health	£15,397	£14,782	£615	£472	£143	£0	£615
Operations and Neighbourhoods	£51,234	£52,168	(£934)	(£350)	(£584)	(£891)	(£43)
Growth	£9,420	£9,401	£19	£132	(£113)	(£198)	£217
Governance	£9,083	£9,709	(£626)	(£1,003)	£377	£0	(£626)
Finance & IT	£8,326	£8,409	(£83)	£0	(£83)	£0	(£83)
Quality and Safeguarding	£142	£135	£7	£0	£7	£0	£7
Capital and Financing	£4,775	£4,358	£417	£0	£417	£0	£417
Contingency	£3,959	£4,365	(£406)	£0	(£406)	£0	(£406)
Contingency - COVID Costs	£0	£16,741	(£16,741)	(£16,741)	£0	(£630)	(£16,111)
Corporate Costs	£5,051	£5,006	£45	£0	£45	£0	£45
LA COVID-19 Grant Funding	(£13,856)	(£31,955)	£18,099	£18,099	£0	£630	£17,469
Other COVID contributions	£0	(£489)	£489	£489	£0	£0	£489
Integrated Commissioning Fund	**416,316**	**423,685**	**(7,369)**	**1,194**	**(8,563)**	**(5,999)**	**(1,370)**

Page 35

Integrated Commissioning Fund Key Messages

Children's Services (Social Care) (£5,678k)

The Directorate forecast position is an **overspend of £5,678k,** an overall adverse increase of £961K since period 2. The over spend is predominately due to the number and cost of external and internal placements. At the end of June the number of cared for children was 697, an increase of 15 from the previous month. The key variances are:

Cared for Children (External Placements): (£3,479k): As at 1st July there were 48 young people aged 18 and over in external residential placements paid for by Children Services. This is an increase of 2 from the previous month. In addition there are a number of care leavers in placements paid for by Children's Services that are tenancy ready but are unable to move on into their own property due a lack of social housing stock. Further work is underway to establish the impact of the housing benefit claims, it is expected this will reduce costs in this area. Adoption interagency fees are forecast to underspend by £185K which is offsetting some of the forecast overspend on residential placements.

Cared for Children (Internal Placements): (£2,056k): Employee costs are forecast to overspend by (£435k) in respect of Children's Homes due to additional staffing costs and sickness. Internal placements are forecast to overspend by (£1,622k). The forecast overspend is in relation to the payments that are made using the Softbox Payments Software and include in-house fostering allowances, adoption allowances, SGO allowances, care arrangement orders, staying-put allowances and Supported Lodging allowances.

Child Protection & Children In Need: (£116K): The over spend is in relation to internal transport recharges for children. Work is required to review these payments including the reason for the journeys and any cost reductions.

Operations & Neighbourhoods (£934k)

The overall forecast reflects shortfalls on income and delays to the delivery of savings, net of a small number of underspends. The key pressures are:

Car Parking Income (£701k) There has been an issue with the realisation of car parking income for a number of years (that has deteriorated further during COVID) . The reduction in forecast levels has been assumed to the end of the calendar year with an assumption that income levels start to recover from that point as a result of restrictions being lifted, public confidence returning for town centre shopping and successful implementation of the car parks review.

Delays to savings delivery (£266k) Delays to the delivery of savings relating to 3 weekly wheeled bin collections and wheeled bin cost recovery due to period required for consultation.

Integrated Commissioning Fund Key Messages

Adults (£2,234k)

The forecast position is net of a number of significant under and overspends across the Directorate. Key variances include:

- £1,678k additional income forecast in respect of client fees for Residential Care, Nursing Care and Homecare. This corresponds to a general increase in demand for these services, reflected in forecast overspends in other areas.
- (£1,857k) increase in the forecast cost of residential and nursing care as vacancies in care homes begin to be re-filled in the aftermath of the pandemic. Most of the increased cost arises from a general increase in volumes (offset by additional client fee income) with further increases related to several new high cost Mental Health placements.
- (£528k) Substantial increases in cost are required to meet pressures on staffing and accommodation costs in the 24 Hour Supported Accommodation service. Additional costs are included here to cover transitional staffing for the Resettlement programme, with a further increase for property costs at two new facilities.
- (£734k) Off-contract Supported Accommodation costs have increased significantly, with several planned moves into more appropriate in-house provision currently on hold without alternatives identified, and a number of new high-cost placements now required outside of the original budget. Housing Benefit income is also reduced, albeit partially offset by an increase in client fee income.
- (£175k) Demand for Support at Home provision remains very high and has not significantly declined since the peak of the COVID pandemic, currently with around 10,900 hours delivered weekly against a initial forecast of 10,200. This is partially offset by the end of three high-cost off-contract packages, and by the increase in client fees and NHS income.
- (£286k) Staffing budgets in the Mental Health function are forecast to be overspent, with high overtime requirements in the Community Response Service and Out of Hours Team.

Governance (£626k)

The current forecast for the Directorate is (£626k) over budget. There are pressures of (£1,003k) included within the forecasts that relate to the impact of COVID on Housing Benefit overpayments debt recovery and reduced income from court costs recovery. If the impact of COVID pressures is excluded from the position there is an underlying underspend of £377k.

Contingency (£406k)

The forecast overspend reflects savings not allocated to Directorates in respect of staffing costs. These savings continue to be monitored and are expected to be realised against service area budgets. A contingency buffer is being held to mitigate against any further emerging pressures, and this will be released in future period if not required.

Capital Financing £417k

The forecast underspend is primarily due to interest costs being less than budget on the assumption that no external borrowing is required before 31 March 2022.

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APPENDIX 2 – Strategic Commission Detailed Analysis

Contents:

Overview of Progress	2
Local Authority Savings	2
Service Area Monitoring	3 –28
Adults Services	3
Children's Services – Children's Social Care	7
Children's Services – Education	12
Population Health	14
Quality and Safeguarding	16
Operations and Neighbourhoods	17
Growth	23
Governance	26
Finance and IT	29
Capital Financing, Contingency and Corporate Costs	30
Reserves	33

Local Authority Savings Progress

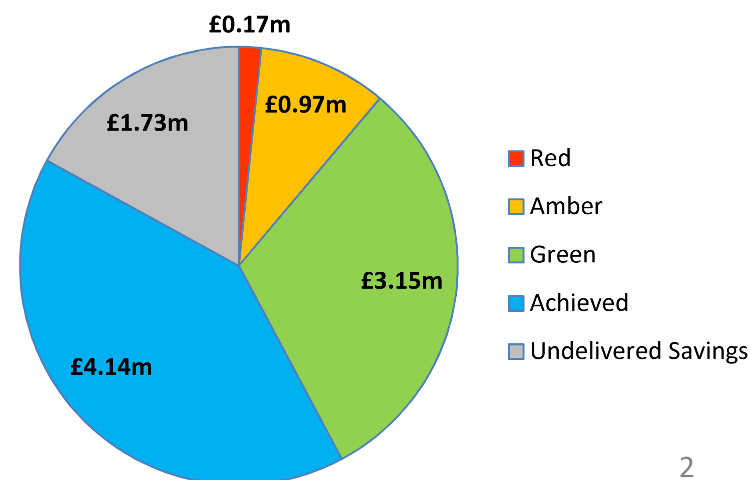
Directorate	Opening Target £000s	Underlivered Savings £000s	Red £000s	Amber £000s	Green £000s	Achieved £000s	Total forecast savings £000s
Adults	676	0	0	357	11	308	676
Children's Services	492	0	0	0	0	492	492
Children's - Education	212	85	0	0	90	127	217
Population Health	472	0	0	0	472	0	472
Operations and Neighbourhoods	2,180	445	167	522	370	979	2,038
Growth	1,454	852	0	0	442	160	602
Governance	355	18	0	57	0	280	337
Finance & IT	65	10	0	0	55	0	55
Quality and Safeguarding	0	0	0	0	0	0	0
Capital and Financing	2,874	13	0	0	1,578	1,339	2,917
Contingency	406	306	0	0	0	456	456
Corporate Costs	136	0	0	30	136	0	166
Total	**9,322**	**1,729**	**167**	**966**	**3,154**	**4,141**	**8,428**
%		**18.5%**	**1.8%**	**10.4%**	**33.8%**	**44.4%**	**90.4%**

SAVINGS PROGRESS

The 2021/22 Revenue Budget, approved by Full Council on 23 February 2021, included savings targets in respect of a vacancy factor and savings to be delivered by management. Combined with savings identified in previous years, the total savings target for the Council is £9,322k.

Vacancy Factor - The total vacancy factor for the year is £4,669k. As at the end of period 3, forecast underspends relating to vacant posts were £2,526k, however a number of these are being covered by agency staff which across the council is forecast to be (£4,208k) overspent. This gives a net forecast overspend across the council of (£1,681k) on employee costs.

Other Savings – Overall the Council is forecasting to achieve savings of £8,428k against a target of £9,322k, although £1,133k remains rated as Red or Amber with risks to delivery. Savings of £3,154k are rated green and £4,141 already achieved as at the end of June 2021. Planned savings of £1,729k aren't expected to be delivered with alternatives now being planned and delivered in place of the original targets.



Adults Services R

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 Commissioning Service	58,325	(21,153)	37,172	10,475	37,974	(802)
Adults Neighbourhood Teams	9,162	(323)	8,839	2,344	8,613	226
Integrated Urgent Care Team	2,144	(92)	2,052	557	2,126	(74)
Long Term Support, Reablement & Shared Lives	14,614	(1,192)	13,422	3,358	13,543	(121)
Mental Health / Community Response Service	5,402	(1,479)	3,923	394	3,966	(42)
Senior Management	1,174	(26,368)	(25,194)	(5,165)	(23,774)	(1,420)
TOTAL	**90,821**	**(50,607)**	**40,214**	**11,963**	**42,448**	**(2,234)**

BUDGET VARIATIONS

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

Underspends:

- **£1,678k** - There is an increase in the forecast for client fees for Residential & Nursing care (£1,165k) and Homecare (£512k) corresponding to the general increase in demand for those services.
- **£611k** - Contributions will be allocated to Adult Services from the Contain Outbreak Management and Infection Control & Testing Funds, to cover staffing, infection control and other operational costs arising the COVID pandemic.
- **£368k** - The Reablement function is forecast to underspending against staffing budgets, due to significant vacancies in the in-house homecare team that are out to advert but only expected to be filled later in the year. The position is partially offset by increased use of casual and agency staff.
- **£238k** - Several Day Services settings either remain closed or are operating reduced services, with the forecast revised on the assumption they will only fully open by September. Similarly, the related costs for Day Services transport are also reduced.
- **£137k** - The staffing forecast for Commissioning is reduced to account for several vacancies that may only be filled later in the year.
- **£99k** - External placement costs in Mental Health are forecast to reduce, with a reduction in unit costs and additional CHC income identified

Adults Services R

BUDGET VARIATIONS

Pressures:

- **(£1,857k) -** Residential and Nursing forecasts have substantially increased compared to budget setting as vacancies in care homes begin to be filled in the aftermath of the pandemic. Approximately £1.5m of the increased cost arises from a general increase in volumes, with further increases arising from several new high-cost Mental Health placements. This is offset by a small reduction in the cost of off-contract provision, and by the increase in client fees and NHS income identified elsewhere.

- **(£528k) -** Substantial increases in cost are required to meet pressures on staffing and accommodation costs in the 24 Hour Supported Accommodation service. The full budget of assessed hours will be used, with cover being provided by casual or agency staff and overtime. Additional costs are included here to cover transitional staffing for the Resettlement programme, with a further increase for property costs at two new facilities.

- **(£98k) -** NHS income forecasts for Continuing Healthcare and Funded Nursing Care are revised, with reductions against Support at Home budgets partially offset by additional income identified for Residential care and the Through the Night Service

- **(£734k) -** Off-contract Supported Accommodation costs have increased significantly, with several planned moves into more appropriate in-house provision currently on hold without alternatives identified, and a number of new high-cost placements now required outside of the original budget. Housing Benefit income is also reduced, albeit partially offset by an increase in client fee income.

- **(£99k) -** Staffing costs in the Integrated Urgent Care Team are forecast to be above budget, with very high demands on the service requiring agency staff to cover. Local needs are higher given the requirement to manage COVID, particularly the hospital discharge regime.

- **(£175k)** - Demand for Support at Home provision remains very high and has not significantly declined since the peak of the COVID pandemic, currently with around 10,900 hours delivered weekly against a initial forecast of 10,200. This is partially offset by the end of three high-cost off-contract packages, and by the increase in client fees and NHS income

Adults Services R

BUDGET VARIATIONS

Pressures:

- **(£286k)** - Staffing budgets in the Mental Health function are not forecast to achieve the vacancy factor given the pressures on the service overall. There are also high overtime requirements (£120k) in the Community Response Service and Out of Hours Team where the vacancy factor is likewise unlikely to be achieved.

- **(£111k)** - Staffing costs across the Long Term Support service have increased, alongside a reduction in housing benefit income for clients in Shared Lives arrangements and other Council accommodation

- **(£32k)** - Other minor variations across the service, including Internal Day Service and Shared Lives provision plus some management costs

- **(£1,445k)** - The initial budget setting at the end of 2020 identified a range of substantial pressures in Adults Services, including a number of high-needs placements coming into the service, increased unit costs of external placements, the residual costs of managing COVID, and general demographic growth. The department is reviewing options to manage these demands within its current level of resourcing.

SAVINGS

- £0k - The Resettlement programme is currently expected to deliver the full targeted saving of £665k over the course of the year, despite difficulties in implementing planned moves and the additional costs arising from the development of new accommodation options.

Scheme	Savings Target 21/22 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Out of borough savings	665	0		357		308	**665**
Oxford Park	11	0			11	0	**11**
Total	**676**	**0**	**0**	**357**	**11**	**308**	**676**

Adults Services R

BUDGET VARIATIONS

Mitigations:

- Review and Benchmarking of the fairer charging policy
- Review of COVID Grant criteria to utilise the current £3.2m potential slippage held within the COMF grant.
- £735k Pay Partner Holding Account.
- Day Services (create waiting list for new referrals, review existing packages to look at reductions)
- Supported Accommodation (anyway to speed up accommodation coming on line and bring forward OOB resettlements)
- Review of iBCF funding and criteria.
- Reablement (create waiting list for new referrals)
- Home care (create waiting list for new referrals and use capacity in care homes for Priority One cases)
- Respite Care (create waiting list for new referrals and convert short stays into long term placements in care homes for Priority One cases)
- Hospital Discharge Programme fund opportunities post September

Children's Services – Children's Social Care

R

Childrens Services- Social Care	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
Child Protection & Children In Need	8,179	(492)	7,688	1,993	7,895	(207)
Children's Social Care Safeguarding & Quality Assurance	1,966	(10)	1,956	375	1,884	72
Children's Social Care Senior	902	(7,269)	(6,367)	(1,089)	(6,359)	(8)
Early Help & Youth Offending	1,038	(603)	435	262	400	35
Early Help, Early Years & Neighbourhood	6,904	(2,577)	4,327	855	4,345	(18)
Looked After Children (External	28,538	(519)	28,020	5,757	31,499	(3,479)
Looked After Children (Internal	10,210	(184)	10,026	3,065	12,082	(2,056)
Looked After Children (Support Teams)	7,538	(112)	7,426	1,696	7,443	(17)
TOTAL	**65,276**	**(11,766)**	**53,510**	**12,913**	**59,188**	**(5,678)**

BUDGET VARIATIONS

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

Underspends:

- **£185k** - Forecast underspend on Interagency Adoption Fees. The forecast takes into account all the children waiting for adoption placements, those that may need to be placed for adoption and those children that may be placed through the regional adoption agency during the financial year
- **£103k** - Overall forecast underspend on children with disabilities; including personal care, homecare and community based short breaks. The forecast underspend is also partially due to additional continuing care funding.
- **£56k** - Other minor variations including additional grant income

Children’s Services – Children’s Social Care (R)

Pressures :

- **(£620k) -** Forecast overspend on staffing due to the following reasons: use of agency workers, unachievable vacancy factor for some teams, Ofsted discretionary one off payments. Also the in-house residential children's homes are forecasting an overspend due to staff sickness and additional hours.
- **(£3,664k) -** Forecast overspend on external residential placements due to the number of Cared for Children (CfC) and the cost of placements. In addition there are a number of care leavers in placements paid for by Children's Services that are tenancy ready but are unable to move on into their own property due a lack of social housing stock.
- **(£1,622k)** - Forecast overspend on internal placements due to the number of Cared for Children (CfC) and payments for children that are no longer looked after (adoption allowances, SGOs).
- **(£116k) -** Forecast overspend on transport costs for children. There will be a review undertaken of the transport needs for each child currently in receipt of transport paid for by children's social care.

Scheme	Savings Target 21/22 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Portage Review	10	0				0	**0**
Reduction in Signs of Safety Training Budget	0	0				10	**10**
Review of Contact Centre	70	0				70	**70**
Alignment of services to neighbourhoods model	64	0				64	**64**
Alignment of services to neighbourhoods model	32	0				32	**32**
Duty and Locality Teams	235	0				235	**235**
Review of staffing	81	0				81	**81**
Total	**492**	**0**	**0**	**0**	**0**	**492**	**492**

Children's Services R

BUDGET VARIATIONS

Childrens Services Q1 Revenue Monitoring Position – Context and Mitigation

The Directorate forecast position at period 3 is an over spend of (£5,678K). The over spend is predominately due to the number and cost of external and internal placements. It is noted that the Directorate outturn position for 2020/21 was an over spend of (£2,966K).

1. The increase in the forecast overspend since period 2, is predominantly due to an adverse forecast increase in the gross cost of external placements. It should be noted that Circa £525k of the increase relates to 1 new specialist agency residential placement, 1 move from fostering to agency residential and 1 move from semi-independent to agency residential. We also have 3 returning Care Leaver, whom we have a duty to accommodate (the level of costs for these though being linked to the limited availability of suitable accommodation as detailed below at 6&7) and a number of agency foster placements, which includes 1 group of 6 to enable them to be placed together, and a sibling group of 3 and a 4 that are in cultural matched placements. NB in the main these children do not require external placements and so the growth of our in house fostering provision would reduce numbers placed externally and the associated cost.

2. With regard to in house fostering provision significant work has been completed/ongoing designed to stabilise and then grow our in house fostering provision with a three year recruitment strategy launched in later 2020 and the linked revised fostering offer having been agreed at Executive Cabinet on 28th July 2021. This will over the next three years transform our in house provision, bringing us back into line with statistical neighbours in the proportion of Cared for Children placed with our own carers.

3. With regard to the disproportionate use of external residential provision, this is one of the focuses of the 7 Strands and is also one of the primary areas of focus for the Corporate Budget Turnaround Team (BTT), who will be working closely with Childrens Services on three relates areas: 1. The delivery of our new in house Respite and Assessment units designed to support the prevention of admissions to care, the more effective step down from external provision and improved assessment 2. The delivery of a redesign to our existing residential estate in order to more effectively support a reduced reliance on external provision and to reduce pressures in the current in-house residential staffing spend. 3. The enhancement of our commissioning and brokerage service in delivering on improved placement quality and sufficiency.

4. With regard to post 18 provision, as at 1st July there were 48 young people aged 18 and over in external placements funded by Children Services (39 of whom require move on in Tameside) due in large part to the lack of more appropriate alternatives. The combined weekly cost of these placements as at 1st July, equivalent to circa £2.5m per annum. In addition a further 11 young people in our core funded Transitional Support Scheme (TSS) are now "tenancy ready and can move on once units are available.

BUDGET VARIATIONS

5. The significant cost incurred here relates firstly to the lack of tenancies in the Borough for the circa 29 young people aged 18 years plus who are assessed at tenancy ready and require move on in Tameside (18 currently in external placements and 11 in the TSS) the latter of which would release these core funded TTS placements for step down/move on placements for the further 21 who require move on in Tameside, but are not yet tenancy ready.

6. This area is a focus for activity across Growth, O&Ns and Childrens and is one of the initial areas of primary focus for the Corporate Budget Turnaround Team, as it is anticipated that through the provision of a wider and more appropriate pool of accommodation options in the Borough this spend can be significantly reduced.

7. Further work is also underway to establish the impact of the housing benefit claims, it is expected this will further reduce costs in this area.

8. During period 3 detailed salary monitoring was completed for the Directorate which has also contributed to the overall increase in overspend. In particular there is a forecast overspend of (£435K) for employee costs for the 5 in-house Children's Homes. This is linked to point 5 above.

9. Internal placements overspend (£1,622k). The forecast overspend is in relation to the payments that are made using the Softbox Payments Software and include in-house fostering allowances, adoption allowances, SGO allowances, care arrangement orders, staying-put allowances and supported lodging allowances.

10. There are significant concerns regarding the information held in Softbox and the placement types that payments have been assigned to. Softbox does not interface with the LCS system and there is no report in LCS that details the children on SGOs. Softbox relies on Social Workers completing forms to update the placement codes recorded in Softbox leading to errors and significant difficulties in accurately tracking and reporting on spend. A comprehensive data cleanse is required so that the true cost of each placement type can be correctly recorded on the finance ledger and monitored against. An alternative finance module to softbox is currently being explored. This requires some significant investment of time and resources in reviewing the soft box system in detail (Finance and CSC) to fully understand the issues and where savings can potentially be made and/or where budgets need to be re-profiled.

BUDGET VARIATIONS

11. Linked to the point 12, work is also required and planned to review/develop procedures to bring greater structure and consistency in areas such as staying put payments, one off or hardship support to carers which it is anticipated will bring greater control to these budgets.

12. Transport costs for children which is forecast to overspend by £116K this year is also to be reviewed on an individual case basis.

13. In relation to the overall number of Cared for Childrens systems are in place to support CSC middle and senior management (and key partners) oversight of children entering the care of the LA, those children who are in external residential provision, those in pre proceedings, those who are 18 plus and requiring alternative accommodation and more recently the projections of this cohort going forward. Regular reporting is also in place in relation to Care Order discharge and Special Guardianship applications and this targeted activity is now projected forward for 2021/22.

Children’s Services – Education

G

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 Services	18,424	(14,683)	3,742	4,508	3,787	(46)
Assistant Executive Director - Education	436	(112)	324	31	153	171
Education Improvement and Partnerships	735	(495)	240	47	246	(6)
Schools Centrally Managed	1,876	(219)	1,657	393	1,567	90
Special Educational Needs and Disabilities	11,303	(10,026)	1,277	2,125	1,326	(49)
TOTAL	**32,773**	**(25,534)**	**7,239**	**7,103**	**7,078**	**161**

BUDGET VARIATIONS

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

Underspends:

- **£147k** - Staffing expenditure is £219k less than budget due to part and full year staffing vacancies partly offset by severance costs, for non-grant funded area. This is further offset by the £72k vacancy factor included for the service.
- **£149k** - A review of the spending has been undertaken to understand commitments in year,, which has resulted in a budget saving. This will be utilised to mitigate pressure on the delivery of savings in 2021/22, and support the shortfall anticipated on traded services income within Education. This identified saving has being offered towards the 2022/23 medium term financial budget gap.
- **£75k** - Additional Central Schools Service Support Grant received in 2021/22 areas has resulted a reduction in the budget the council have had to put into this area as the grant does not fully covered the cost of this work. This identified saving is being offered towards the 2022/23 savings.
- **£13k** - Other minor variations under £50k

Children's Services – Education G

BUDGET VARIATIONS

Pressures:

- **(£30k)** - This pressure relates to additional routes being supplied in relation to SEN transport in the Summer 21 term due to social distancing measures being put in place during the Covid 19 situation.
- **(£224k)** - The Education service is forecast to under achieve on its traded income target with schools by £224k due to a reduced buy in to services, £24k of the £224k is related to Covid and lockdown restrictions. This is being mitigated through the savings identified through budget review and the services involved in trading holding vacancies.
- **(£59k)** - There is a projected decrease in Education Welfare penalty notice income due to changes in government legislation during the Covid 19 lockdown periods.

SAVINGS

- **£90k** - There is reduced demand on the budget for Teachers retirement pension costs. This will be offered for additional savings in 2022/23.

Scheme	Savings Target 21/22 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Behaviour & Attendance Offer	124	85				39	**39**
Pensions Increase Act	88	0			90	88	**178**
Total	**212**	**85**	**0**	**0**	**90**	**127**	**217**

Population Health G

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
Population Health	16,833	(1,436)	15,397	2,217	14,782	615
TOTAL	**16,833**	**(1,436)**	**15,397**	**2,217**	**14,782**	**615**

BUDGET VARIATIONS

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

- **£100k** - The community services contract held with the Integrated Care Foundation Trust has realised a lower than expected inflation increase.
- **£21k** - An underspend is currently being forecast due to employee vacancies and a contribution received from Public Health England.
- **£6k** - It is currently anticipated that due to staff responding to the covid pandemic, some targeted schemes will have to be postponed resulting in a lower than anticipated expenditure.
- **£76k** - There has been a reduction to the demand of prescribed drug and smoking cessation treatment leading to a forecast underspend.
- **£487k** - A contribution from the Contain Outbreak Management grant is being forecast to fund employee costs for staff time spent on the covid response.

Population Health G

BUDGET VARIATIONS

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

- **(£5k) -** Agreed inflation increase for the Pennine Care Contracts for early attachment and the Be Well services.
- **(£21k) -** There has been an increase in Health Checks being carried out in this financial year resulting in a pressure against the budget, this is due to greater demand to these services as access becomes easier as covid restrictions are eased.
- **(£49k) -** There has been an increased demand of contraception within the local enhanced services resulting in a forecast spend above budget.

SAVINGS

- £0k - All savings targets are forecast to be achieved

Scheme	Savings Target 21/22 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Schools Health & Wellbeing Reductions	13	0			13	0	**13**
Health Improvement Recommissioning	93	0			93	0	**93**
CYP Emotional Health and Wellbeing	16	0			16	0	**16**
Sport and Leisure	150	0			150	0	**150**
Integrated Drug and Alcohol services	200	0			200	0	**200**
Total	**472**	**0**	**0**	**0**	**472**	**0**	**472**

Quality And Safeguarding G

Quality & 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
Safeguarding and Quality Assurance	383	(241)	142	(50)	135	7
TOTAL	**383**	**(241)**	**142**	**(50)**	**135**	**7**

BUDGET VARIATIONS

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

Underspends:

- **£5k -** Premises Related Expenditure: Reduced costs for room hire – A number of training courses have been delivered online.
- **£5k -** Transport Related Expenditure: Reduced transport related costs as a result of covid - training courses are being delivered online.
- **£16k -** Supplies and Services: Reduction in commissioned services for training courses and a number of training courses are being delivered online.
- **£2k -** Recharge Expenses: Reduction in printing and supplies & services recharges as a result of Covid, as staff are continuing to work from home.

Pressures:

- **(£10k)** - Employees: Vacancy factor unachievable (£14k), as there are only a few staff members and no vacant posts. Partially offset by opt out of pension contribution by one member of staff.
- **(£11k)** - Income: (£18k) Under achievement of income target from maintained and academy Schools Traded Services. Conversations are required with schools to remind them of the importance of safeguarding; this may lead to further take up in the new academic year. This is partially offset by £7k additional unbudgeted Health Income.

Operations and Neighbourhoods R

Operations and 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
Community Safety & Homelessness	7,649	(2,744)	4,905	(262)	4,905	0
Cultural & Customer Services	3,347	(358)	2,990	575	2,990	0
Engineers, Highways & Traffic Management	14,584	(10,844)	3,739	1,364	3,739	0
Management & Operations	1,384	(2,738)	(1,353)	(195)	(1,353)	0
Operations & Neighbourhoods Management	30,932	(31)	30,902	31,195	30,902	0
Operations & Greenspace	5,571	(439)	5,132	792	5,132	0
Public Protection & Car Parks	4,195	(3,027)	1,167	599	1,836	(669)
Waste & Fleet Management	10,208	(6,238)	3,970	323	4,236	(266)
Markets	969	(1,187)	(218)	(751)	(218)	0
TOTAL	**78,839**	**(27,605)**	**51,234**	**33,641**	**52,169**	**(935)**

BUDGET VARIATIONS

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

Underspends:

- **£32k -** Minor variations across the directorate

Pressures:

- **(701k) -** There has been an issue with the realisation of car parking income for a number of years (that has deteriorated further during COVID) .The reduction in forecast levels has been assumed to the end of the calendar year with an assumption that income levels start to recover from that point as a result of restrictions being lifted, public confidence returning for town centre shopping and successful implementation of the car parks review.

SAVINGS

Savings Performance:

- **(£136k)** - Delay the delivery of savings relating to 3 weekly wheeled bin collections (blue and black bins) due to period required for consultation.
- **(£130k) -** Delay the delivery of savings relating to wheeled bin cost recovery due to period required for consultation.
- **£0k** – A review of the Transport Levy budget will be carried out and reported at period 6 as it is envisaged compensating savings can be realised to mitigate the period 3 forecast 179k adverse variance on the Waste Levy. A nil variation has been reported in the period 3 forecast pending this review.

Operations and Neighbourhoods R

SAVINGS (continued)

Scheme	Savings Target 21/22 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Bring Statutory Housing Service in house	50	0		50			**50**
Removal of 1 Cemetery Operative	30	0				30	**30**
Reduction in costs for Dog Wardens	12	0				12	**12**
Bring Security Activities in House	10	0		10			**10**
Transfer processing of street sweepings into the waste levy	200	0			200		**200**
Reduction of budgets for vehicle costs	100	0			100		**100**
Grounds Maintenance Staffing	53	0				53	**53**
Street Cleansing Staffing	20	0				20	**20**
Cancellation of the Tour of Britain Series, Tour of Britain and associated cycling events	140	0				140	**140**
Markets Events	50	0				50	**50**
Public Protection staffing review	110	0		110			**110**
CCTV Equipment	49	0		49			**49**
Removal of Staffing budget for Museum of Manchester Regiment (MMR)	70	0				70	**70**
Removal of excess budget	9	0				9	**9**

Operations and Neighbourhoods R

SAVINGS (continued)

Scheme	Savings Target 21/22 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Reduce collection frequency - 3 weekly Blue Bin collections	130	68		62			**62**
Reduce collection frequency - Black bin collections to 3 weekly	130	68		62			**62**
Charge for all new bins ordered	190	130		60			**60**
STAR Procurement	50	0		50			**50**
Review of customer services face to face offer	51	0				51	**51**
Review of book access points in post office	6	0				6	**6**
Removal of surplus staffing budgets	157	0				157	**157**
Design Charges	70	0			70		**70**
Highways maintenance efficiencies	67	0	67				**67**
Work with STAR to ensure procurement in Stores is best value and on contract	69	0		69			**69**
Extending commercial offer	100	0	100				**100**
Waste levy reduction	257	179				78	**78**
Transport Levy Reduction	0	0				303	**303**
Total	**2,180**	**445**	**167**	**522**	**370**	**979**	**2,038**

Operations & Neighbourhoods R

BUDGET VARIATIONS

Mitigations:

Budget Area	Detail	Forecast Saving (£'000)
Vacant Posts / Recruitment Freeze	There are a number of vacant posts across the Directorate that were previously forecast as being filled. A decision has been taken to freeze recruitment to those posts which won't have a serious detrimental impact on front line services. The saving quoted will be in addition to the vacancy factor targets already forecast as achieved.	226
Street Cleansing Waste Disposal Costs	Street cleansing waste is now disposed of through the Waste Levy at a cost saving of approximately £115 per tonne. This budget has been reduced by £200k already as part of the Directorate savings plan. Based on the actual monthly costs to date this financial year, and allowing for an increase in the monthly average for additional leaf fall throughout the autumn months it is envisaged that costs can reduce further than the current forecast.	292
Waste Levy Rebate to support shortfall in refuse collection savings	The Council receives rebates on the Waste Levy which are held corporately. Discussions are taking place between the Executive Director and the Chief Finance Officer with regards to utilising some of the historic rebate to mitigate the shortfall in the expected refuse collection savings initiatives in the current financial year.	236
Reduced Spend on Library materials	The Libraries budget currently has an annual budget of £161k for replacement and renewal of books and materials. It has been agreed as a one off mitigation that this will be reduced in 21/22 top contribute to the Directorate recovery plan	57

Operations & Neighbourhoods R

BUDGET VARIATIONS

Mitigations:

Budget Area	Detail	Forecast Saving (£'000)
Transport Levy	Due to a timing issue when setting the budgets for the Transport and Waste Levies, it has become apparent that there will be a net underspend between the two this financial year. This hasn't previously been reported as part of P3 forecasts	124
TOTAL		**935**

**It should also be noted that the P3 forecast overspend includes a shortfall in Car Parks income of £350k which is attributable to COVID. Of this, approximately £105k has been claimed via the Fees and Charges Compensation Scheme and is held corporately.

Growth G

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
Growth Management	282	0	282	76	308	(26)
Development & Investment	1,799	(831)	969	285	784	185
Economy, Employment & Skills	2,300	(1,411)	889	(441)	843	46
Major Programmes	500	0	500	272	500	0
Infrastructure	200	0	200	22	204	(4)
Planning	1,643	(1,211)	432	168	513	(81)
BSF, PFI & Programme Delivery	24,126	(24,126)	0	1,697	0	0
Asset Management	611	(336)	275	(212)	228	47
Capital Programme	708	(440)	269	84	243	26
Corporate Landlord	8,184	(2,361)	5,822	1,800	5,798	24
Environmental Development	566	(28)	538	178	532	6
Estates	1,393	(2,154)	(760)	139	(556)	(204)
School Catering	2,136	(2,132)	4	(19)	4	0
Vision Tameside	0	0	0	0	0	0
TOTAL	**44,448**	**(35,028)**	**9,420**	**4,050**	**9,401**	**19**

BUDGET VARIATIONS

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

Underspends:

- **£44k –** Delayed recruitment to a number of vacant posts in Economy, Employment and Skills.
- **£47k –** Delayed recruitment to 3 vacant posts in Asset Management.
- **£84k –** Backdated fee income due for the Concord Suite relating to electricity costs associated with the telecoms mast
- **£331k -** Savings on premises related expenditure on closed buildings due to covid-19. This is £300k in relation to a reduction in building repairs and £31k saving in Utilities.
- **£86k –** Other minor variations

Growth (A)

BUDGET VARIATIONS

Pressures:

- **(£141k) -** Reduced income in Customer and Client Receipts from Shopping centres in Droylsden and Hyde. This is a result of tenants having to vacate shopping centres as a result of Covid-19. This is an estimated adverse variance awaiting the annual accounts due in September 2021
- **(£132) -** Loss of income on Hire of Rooms for public events

SAVINGS

- **(£300k)** - Savings to not be achieved in relation to leasing income on Tameside One.

Scheme	Savings Target 21/22 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Reduction in posts, income generation from management fees and restructuring external budgets.	76	0			43	33	**76**
Asset Management Accommodation Strategy (operational)/ WorkSmart	177	0			60	117	**177**
Relocation of Droylsden Library and Coming out of Hattersley Hub Offices and Community 7 Rooms	20	0			20	0	**20**
Lease Out of Tameside One Office Floor	300	300				0	**0**
Reduce Employment and Skills project budget by £10,000 (40%).	10	0				10	**10**
Future Income Generation – Contributions to post	52	52				0	**0**
Savings in Development Management pre-application advice and Planning Performance Agreements	7	0			7	0	**7**

SAVINGS (continued)

Scheme	Savings Target 21/22 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Recurrent income Review Land Charges fees aligned to completion of Land Registry digitisation project to ensure that the remaining chargeable services are at an appropriate up to date level	57	0			57	0	**57**
Planning and Transportation Restructure	55	0			55	0	**55**
Reduction in costs associated with the Tameside Additional Services Contract (TAS)	200	0			200	0	**200**
Estates Property Rent Reviews	500	500				0	**0**
Total	**1,454**	**852**	**0**	**0**	**442**	**160**	**602**

Governance A

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
Democratic Services	737	(119)	618	272	590	28
Executive Support	1,734	(158)	1,576	361	1,481	95
Governance Management	187	(90)	97	23	97	0
Legal Services	1,537	(34)	1,503	350	1,563	(60)
Exchequer	61,429	(60,108)	1,320	969	2,095	(775)
Policy, Performance & Communications	1,758	(295)	1,463	375	1,426	38
HR Operations & Strategy	1,293	(677)	616	56	729	(113)
Organisational & Workforce Development	711	(103)	608	116	503	105
Payments,Systems and Registrars	2,085	(803)	1,282	(1,676)	1,227	55
TOTAL	**71,470**	**(62,387)**	**9,083**	**847**	**9,709**	**(626)**

BUDGET VARIATIONS

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

- **£273k** - Employee related expenses including training are less than budget due to a combination of vacant posts held, posts being recruited to and costs forecast from later in the year, maternity leave, staff who are not in the Pension fund or may have opted out and the vacancy factor.
- **£57k** - There is a current forecast of £57k one off income for staff related time spent on Covid-19 related activities from the Contain Outbreak Management Fund.
- **£92k** - Budget of £92k to increase the bad debt provision for Housing Benefit is currently not being forecast to be utilised as the current provision is considered adequate.
- **£155k** - Other minor variation of less than £50k across all services across the directorate.
- **£27k** - The Quality, Innovation, Productivity and Prevention programme (QIPP) from the CCG for quarter 1 has resulted in additional income of £27k to TMBC; these will be monitored over the financial year.

Pressures:

- **(£532k) -** The net value of costs recovered in respect of council tax and business rates debt collections costs are forecast to be significantly less than budget due to delays and restrictions on the recovery processes due to the Covid-19 pandemic (£532k).
- **(£127k) -** Income is (£127k) less than budget due to a reduction in the number of schools purchasing HR, Payroll and Recruitment and Teacher Trade Union service.
- **(£25k) -** The Priority Account Service (Oxygen) has a net income target of £50k. Current forecast for the programmes expenditure and income along with the £50k income target results is a forecast shortfall of (£25k). This will be reliant on the number of our larger suppliers signing up to the scheme and will be monitored throughout the year.
- **(£528k) -** The forecast impact of a reduction in Housing Benefit overpayment identified and collected in year together with reduced collection of prior year overpayment debt recovery. Reduced debt collection is attributable to the economic impact of Covid 19 and restrictions on recovery processes in 21/22. It is hoped that recovery performance will increase over the course of the financial year. This is resulting in income recovery of (£528k) less than budget.

SAVINGS (continued)

- **(£10k)** - Saving not expected to be achieved in relation to the Discontinuation of Life in Tameside and Glossop Website and alternative savings will be made instead.
- **(£8k)** - Generation of income through promotion of design function externally has not yet been implemented and alternative savings will be made instead..

SAVINGS (continued)

Scheme	Savings Target 21/22 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
electoral registration	25	0		25		0	**25**
Review of staff structure - reducing staff hours	41	0				41	**41**
Review of staff structure	68	0				68	**68**
Review of workforce development budget - for one year and further review thereafter	20	0				20	**20**
Staff restructure	81	0				81	**81**
Review of staff structure	20	0		20		0	**20**
Review software licences	5	0		5		0	**5**
Discontinuation of Life in Tameside and Glossop Website	10	10				0	**0**
Review of external advertising	5	0		5		0	**5**
Generation of income through promotion of design function externally	10	8		2		0	**2**
Not replacing trainee solicitor post	70	0				70	**70**
Total	**355**	**18**	**0**	**57**	**0**	**280**	**337**

Finance and IT (A)

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
Financial Management	3,487	(1,051)	2,436	(202)	2,455	(19)
Risk Management & Audit Services	1,936	(250)	1,685	1,231	1,697	(12)
Digital Tameside	4,730	(525)	4,205	1,418	4,257	(52)
TOTAL	**10,153**	**(1,827)**	**8,326**	**2,447**	**8,409**	**(83)**

BUDGET VARIATIONS

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

Underspends:

- **£21k -** Employee related expenses including training is less than budget due to a combination of vacant posts held and costs forecast later in the year**.**

Pressures:

- **(£67k) -** Under recovery of income from Schools Trading within IT
- **(£27k) -** Other Minor variations across the Directorate

Savings Performance:

- **(£10k) -** The saving for STAR Procurement is forecast not to be achieved due to the fee not being reduced in 21/22.

Scheme	Savings Target 21/22 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Asset Valuation Services	55	0			55		**55**
STAR procurement	10	10					**0**
Total	**65**	**10**	**0**	**0**	**55**	**0**	**55**

Page 67

Capital Financing, Contingency and Corporate Costs G

Corporate	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
Chief Executive	259	0	259	62	288	(29)
Corporate and Democratic Core	3,628	(222)	3,406	623	3,360	45
Democratic Processes	1,465	(79)	1,386	316	1,357	29
Investment and Financing	8,964	(4,189)	4,775	(179)	4,358	417
Contingency	(524)	(9,373)	(9,897)	(18,620)	(11,338)	1,442
TOTAL	**13,792**	**(13,863)**	**(71)**	**(17,798)**	**(1,975)**	**1,904**

BUDGET VARIATIONS

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

- **£56k -** There are other minor variations across the Corporate Democratic Core service of under £50k
- **£52k -** MRP charges lower than initial budget due to reduced capital spend in 2020/21
- **£355k -** Projected interest charges reduced on the assumption that no further borrowing is required in year**.**
- **£14k -** Projected Manchester Airport land rental income increased on basis of 2020/21 outturn.
- **£1,433k –** Additional Collection Fund losses Compensation Grant arising from business rates income losses during the COVID 19 pandemic. We are forecasting to receive an additional £1,433k grant income more than what was estimated when the budget was set.
- **£436k –** Additional Income Compensation Grant arising from sales, fees & charges losses during the COVID-19 pandemic. We are forecasting to receive and additional £436k grant income more than what was estimated when the budget was set.

Pressures:

- **(£41k) -** There is an ongoing annual pressure of (£41k) for the I.T. related expenditure in relation to Graphnet
- **(£61k) -** Investment interest income forecast below budget due to continued low interest rate environment.

Capital Financing, Contingency and Corporate Costs G

SAVINGS

Savings Performance:

- **£30k -** A further additional saving of £30k is forecast on the Pension Increase Act payment we make to the Greater Manchester Pension Fund, this is in addition to the £50k saving for 21/22
- **£56k** - Additional savings from the prepayment of pension contributions to GMPF based on savings to date in year.
- **(£261k)** - Workforce cross cutting themes – work ongoing to identify savings.
- **(£45k)** - Salary Sacrifice Schemes - Level of savings unknown at this stage, total saving of £45k most likely won't fully materialise as a significant proportion was a saving associated with employees using The Council's car loan scheme which is unlikely to see high demand due to employees working from home.
- **£356k** - Council Tax Single Person Discount review - total savings forecast to be achieved is £456k which is an overachievement of £356k against the original £100k savings target. Over achievement due to the Single Person Discount review identifying more council tax claimants that needed correcting than originally anticipated. This saving will materialise as increased council tax income.
- **(£13k)** - Venture fund savings target not achievable as fund wasn’t established.

Capital Financing, Contingency and Corporate Costs G

SAVINGS

Savings Performance:

Scheme	Savings Target 21/22 £000's	Not expected to be delivered £000s	Red £000's	Amber £000's	Green £000's	Achieved £000's	Total £000's
Contingencies and Mayoral Support	136	0		30	136	0	**166**
MRP overpayment	1,299	0				1,299	**1,299**
Manchester Airport Investments	1,062	0			1,062	0	**1,062**
Pension Advanced Payment	460	0			516	0	**516**
SPD Review	100	0				456	**456**
Workforce Cross Cutting theme (Excluding VF increase)	261	261				0	**0**
Salary Sacrifice Schemes	45	45				0	**0**
Capital Financing	40	0				40	**40**
Venture fund	13	13				0	**0**
Total	**3,416**	**319**	**0**	**30**	**1,714**	**1,795**	**3,539**

Page 70

Reserve Transfers

The table below details the reserve transfers that need approval;

Service	Details of request	Transfer to/from reserves	Amount to be transferred £
Education	Dedicated Schools Grant (DSG) High Needs forecast surplus to be transferred to the DSG reserve to support the current overspend position. The grant is ringfenced for schools.	Transfer to	178,446
Education	Health income allocated to support the neurodevelopmental pathway assessment being provided by the Specialist Support Service within the SEND Service.	Transfer from	65,000
Growth	The continued development of Tameside's Local Plan reprofiled to 2021/22.	Transfer from	10,268
Growth	Targeted Investment for the development of strategies including the Strategic Asset Management Plan, Inclusive Growth Strategy, and Investment in Strategic sites reprofiled to 2021/22.	Transfer from	300,000
Growth	Targeted Investment for the development of a Housing Delivery Strategy reprofiled to 2021/22.	Transfer from	21,928
Growth	Targeted Investment for Godley Green Garden Village Development reprofiled to 2021/22.	Transfer from	351,169
Growth	Targeted Investment for St Petersfield Ashton - Strategic Site Development reprofiled to 2021/22.	Transfer from	150,000
Growth	Transpennine upgrade of Mottram by pass impact assessment reprofiled to 2021/22.	Transfer from	75,000
Growth	Targeted Investment in Town Centre Masterplanning including Ashton Under Lyne, Stalybridge, Droylsden, and Hyde reprofiled to 2021/22.	Transfer from	200,000
Growth	Targeted Investment for Ashton Moss master planning reprofiled to 2021/22.	Transfer from	250,000
Population Health	Drawdown of reserves from the ringfenced Health Equalities Reserve towards the Health Improvement Programme	Transfer from	93,000

Reserve Transfers (continued)

Service	Details of request	Transfer to/from reserves	Amount to be transferred £
COVID	Unused grant funding from 20/21 in relation to Covid 19 (Emergency Assistance for Food and Essential Supplies), is to be utilised this year.	Transfer from	148,557
COVID	Unused grant funding from 20/21 in relation to Covid 19 (Community Champions) is to be utilised this year.	Transfer from	367,375
COVID	Unused grant funding from 20/21 in relation to Covid 19 (Clinically Extremely Vulnerable) is to be utilised this year.	Transfer from	282,965
Children's Services	Youth on Remand grant underspend	Transfer to	15,200
Children's Services	Youth Justice Community safety grant monies	Transfer from	(61,337)
Children's Services	Youth Justice Board Grant underspend	Transfer to	21,504
Children's Services	Troubled Families Grant underspend	Transfer to	30,735
Finance & IT	Expected contribution to Insurance reserves based on annual actuarial assessment of insurance provision and reserve requirements.	Transfer to	165,270
Finance & IT	Drawdown from reserve for the amount not to be billed by Salford Computer Audit Services in 20/21 that was put into Contingency as work now being completed in 21/22	Transfer from	13,890

APPENDIX 3

IRRECOVERABLE DEBTS OVER £3000

1 April 2021 to 30 June 2021
Note individuals are anonymised

REF:	DEBT:	FINANCIAL YEAR(S)	BALANCE	REASON
16657275	Council Tax	2014 – 2015 £539.12 2015 – 2016 £1036.72 2016 – 2017 £1073.60 2017 – 2018 £1129.36 2018 - 2019 £1187.46 2019 – 2020 £1249.03 2020 – 2021 £1304.12	£7519.41	Individual Voluntary Arrangement approved 02/12/2020
17250891	Council Tax	2017 – 2018 £50.91 2018 – 2019 £827.59 2019 – 2020 £1022.18 2020 – 2021 £1212.28	£3112.96	Individual Voluntary Arrangement approved 16/12/2020
15490933	Council Tax	2017 – 2018 £254.98 2018 – 2019 £1103.46 2019 – 2020 £958.27 2020 – 2021 £999.59	£3316.30	Individual Voluntary Arrangement approved 15/12/2020
16422764	Council Tax	2015 – 2016 £800.00 2016 – 2017 £773.59 2017 – 2018 £986.41 2018 – 2019 £1027.74 2019 – 2020 £1117.88	£4705.62	Individual Voluntary Arrangement approved 17/11/2020
17215063	Council Tax	2017 – 2018 £651.31 2018 – 2019 £933.36 2019 – 2020 £1249.03 2020 – 2021 £1218.12	£4051.82	Individual Voluntary Arrangement approved 27/11/2020
16929491	Council Tax	2016 – 2017 £712.59 2017 – 2018 £827.60 2018 – 2019 £777.26 2019 – 2020 £1103.94 2020 – 2021 £1304.12	£4725.51	Individual Voluntary Arrangement approved 30/11/2020
15490933	Council Tax	2014 - 2015 £256.62 2015 – 2016 £1122.02 2016 – 2017 £240.03 2017 – 2018 £1270.08 2018 – 2019 £522.01	£3410.76	Individual Voluntary Arrangement approved 27/11/2020
12792729	Council Tax	2013 – 2014 £107.39 2014 - 2015 £340.70 2015 – 2016 £696.67 2017 – 2018 £972.64 2018 – 2019 £1094.14 2019 – 2020 £1249.03 2020 – 2021 £1304.12	£5764.69	Individual Voluntary Arrangement approved 30/11/2020
16890342	Council Tax	2016 – 2017 £566.29 2017 – 2018 £96.98 2018 – 2019 £426.33 2019 – 2020 £777.88 2020 – 2021 £1421.16	£3288.64	Individual Voluntary Arrangement approved 21/09/2020

12203015	Council Tax	2008 – 2009 £382.58 2009 – 2010 £528.09 2010 – 2011 £747.87 2011 – 2012 £754.87 2013 – 2014 £609.37 2014 – 2015 £407.44 2015 – 2016 £695.10	£4125.32	Individual Voluntary Arrangement approved 31/07/2019
16297665	Council Tax	2013 - 2014 £106.07 2014 – 2015 £469.31 2015 – 2016 £650.57 2016 – 2017 £375.99 2017 – 2018 £790.92 2018 - 2019 £911.59 2019 – 2020 £958.27 2020 – 2021 £999.59	£5262.31	Individual Voluntary Arrangement approved 28/01/2021
14264678	Council Tax	2017 – 2018 £630.43 2018 – 2019 £1371.38 2019 – 2020 £1442.87 2020 – 2021 £1507.16	£4951.84	Individual Voluntary Arrangement approved 09/02/2021
17087035	Council Tax	2016 – 2017 £20.92 2017 – 2018 £196.00 2018 – 2019 £917.47 2019 – 2020 £958.27 2020 – 2021 £999.59	£3092.25	Individual Voluntary Arrangement approved 06/04/2021
17355375	Council Tax	2018 – 2019 £910.36 2019 – 2020 £1442.87 2020 – 2021 £1507.16	£3860.39	Individual Voluntary Arrangement approved 25/03/2021
COUNCIL TAX		**SUB TOTAL – Individual Voluntary Arrangement**	**£61,187.82**	
16419636	Council Tax	2013 – 2014 £153.35 2014 - 2015 £726.60 2015 – 2016 £990.43 2016 – 2017 £1073.60 2017 – 2018 £868.02 2018 – 2019 £288.00 2019 – 2020 £715.76 2020 – 2021 £388.83	£5204.59	Bankruptcy Order made 19/01/2021
14628309	Council Tax	2010 – 2011 £243.57 2011 – 2012 £109.41 2013 – 2014 £879.59 2014 – 2015 £1109.62 2015 – 2016 £157.25 2016 – 2017 £51.40 2017 – 2018 £1227.02 2018 – 2019 £677.48	£4455.34	Bankruptcy Order made 11/06/2020
13880444	Council Tax	2013 – 2014 £848.04 2014 – 2015 £1206.42 2016 – 2016 £801.40 2016 – 2017 £902.66 2017 – 2018 £443.92 2018 – 2019 £482.76 2019 – 2020 £591.78 2020 – 2021 £322.00	£5598.98	Bankruptcy Order made 06/08/2020
COUNCIL TAX		**SUB TOTAL – Bankruptcy**	**£15,258.91**	

13530704	Council Tax	2014 - 2015 £50.54 2015 – 2016 £607.89 2016 – 2017 £868.23 2017 – 2018 £907.42 2018 – 2019 £616.68 2019 – 2020 £808.13 2020 – 2021 £725.69	£4584.58	Debt Relief Order granted 10/03/2021
COUNCIL TAX		**SUB TOTAL – Debt Relief Order**	**£4584.58**	
COUNCIL TAX IRRECOVERABLE BY LAW TOTAL			**£81,031.31**	
65582219	Business Rates	Leon Transports Limited, Unit 3B at 2-5 Grey Street, Denton, M34 3RU Company Dissolved 03/11/2020	2018 - 2019 £1220.84 2019 – 2020 £4592.73	£5813.57
65569353	Business Rates	Fusion 4 Ladies Limited, 21 The Mall, Hyde, SK14 2QT Company Dissolved 17/11/2020	2018 – 2019 £3613.50 2019 – 2020 £4582.88	£8196.38
65511217	Business Rates	DPB Building Services Ltd, The Works, Tame Street, Stalybridge, SK15 1ST Company Dissolved 07/04/2020	2018 – 2019 £7271.32 2019 – 2020 £13,737.00	£21,008.32
65579336	Business Rates	Eat Drink Share Ltd, Gunn Inn, 2 Market Street, Hollingworth, Hyde, SK14 8LN Company Dissolved 27/10/2020	2019 - 2020 £8208.07	£8208.07
65531235	Business Rates	C.K Waste Limited, Unit 16 & 16A, Broadway Industrial Estate, Outram Road, Dukinfield, SK16 4XE Company Dissolved 12/01/2021	2017 – 2018 £7596.00 2018 - 2019 £15,977.55 2019 - 2020 £15,472.25 2020 – 2021 £13,842.96	£52,888.76
65582233	Business Rates	Sleep Lite Ltd, Unit 5 at 2-5 Grey Street, Denton, M34 3RU Company Dissolved 03/11/2020	2018 – 2019 £5455.03 2019 – 2020 £22,095.00 2020 – 2021 £4244.92	£31,794.95
65566835	Business Rates	Gazcam Ltd, T/A Slide & Seek, Unit A, SK14 Industrial Park, Broadway, Hyde, SK14 4QF Company Dissolved 03/03/2020	2019 – 2020 £9327.46	£9327.46
65594878	Business Rates	Bricbuilt Limited, 1 Hattersley Industrial Estate, Stockport Road, Hyde, SK14 3QT Company Dissolved 22/09/2020	2019 - 2020 £3767.61 2020 – 2021 £4393.38	£8160.99

BUSINESS RATES		SUB TOTAL – Company Dissolved	£145,398.50	
65506680	Business Rates	Northwest Flowers Ltd, Unit 3, Alexandria Court, Alexandria Drive, Ashton-under-Lyne, OL7 0QN Company in Liquidation 11/08/2020	2020 - 2021 £6677.03	£6677.03
65563430	Business Rates	Beer and Bagels Ltd, Prince of Orange, 109 Warrington Street, Ashton-under-Lyne, OL6 6DW Company in Liquidation 22/10/2020	2018 – 2019 £3929.63	£3929.63
BUSINESS RATES		**SUB TOTAL – Company in Liquidation**	**£10,606.66**	
65596522	Business Rates	BM Retail Limited, T/A Bonmarche, 18 Staveleigh Mall, Ashton-under-Lyne, OL6 7JQ Company in Administration 30/11/2020	2019 – 2020 £4400.61	£4400.61
BUSINESS RATES		**SUB TOTAL – Company in Administration**	**£4400.61**	
65576733	Business Rates	NS Travel Limited, Unit 22 The Arcades, Warrington Street, Ashton-under-Lyne, OL6 7JE Proposal to Strike Off 14/01/2020	2018 – 2019 £731.88 2019 – 2020 £3481.73	£4213.61
BUSINESS RATES		**SUB TOTAL – Proposal to Strike Off**	**£4213.61**	
BUSINESS RATES IRRECOVERABLE BY LAW TOTAL			**£164,619.38**	
221012 Anonymised as an individual	Sundry Debts Market Rent and Electricity Charges	2015-2016 - £624.25 2017-2018 - £1,076.24 2018-2019 - £283.76 2019-2020 - £7,430.65	£9414.90	Bankruptcy Order made 09/12/2019
4026172 Anonymised as an individual	Sundry Debts Residential Care Charges	2018-2019 - £41,911.76 2019-2020 - £1,076.91	£42,988.67	Bankruptcy Order made 17/08/2017
SUNDRY DEBTS		**SUB TOTAL – Bankruptcy**	**£52,403.57**	
SUNDRY DEBTS IRRECOVERABLE BY LAW			**£52,403.57**	

DISCRETION TO WRITE OFF OVER £3000

65014228	Business Rates Anonymised as an individual	2011 – 2012 £2635.10 2012 – 2013 £699.31	£3334.41	Absconded

65024164	Business Rates Anonymised as an individual	2009 – 2010 £4493.05 2010 – 2011 £1058.04	£5551.09	Absconded
65104282	Business Rates Anonymised as an individual	2007 – 2008 £3351.00 2008 – 2009 £2919.55	£6270.55	Absconded
65409291	Business Rates Anonymised as an individual	2016 - 2017 £4749.82	£4749.82	Absconded
65507003	Business Rates Anonymised as an individual	2011 - 2012 £3478.05	£3478.05	Absconded
65515721	Business Rates Anonymised as an individual	2014 – 2015 £5327.00 2015 – 2016 £7823.34	£13,150.34	Absconded
65513183	Business Rates Anonymised as an individual	2015 – 2016 £3488.03 2016 – 2017 £161.22	£3649.25	Absconded
65521085	Business Rates Anonymised as an individual	2016 – 2017 £4144.89	£4144.89	Absconded
65489648	Business Rates Anonymised as an individual	2014 – 2105 £5305.52 2015 – 2016 £11,817.16	£17,122.68	Absconded
65445709	Business Rates Anonymised as an individual	2012 – 2013 £1879.51 2013 – 2014 £1825.44	£3704.95	Absconded
65469453	Business Rates Anonymised as an individual	2015 – 2016 £2185.00 2016 – 2017 £1755.21	£3940.21	Absconded
65507010	Business Rates Anonymised as an individual	2011 – 2012 3214.01 2012 – 2013 £7128.49	£10,342.50	Absconded

65498413	Business Rates Anonymised as an individual	2016 – 2017 £3304.61	£3304.61	Absconded
65490921	Business Rates Anonymised as an individual	2013 – 2014 £2810.84 2014 – 2015 £1924.64 2015 – 2016 £6006.86 2016 – 2017 £7959.00 2017 – 2018 £7894.00 2018 – 2019 £7653.75 2019 – 2020 £3199.84	£37,448.93	Absconded
65495629	Business Rates Anonymised as an individual	2012 – 2013 £2149.40 2013 – 2014 £5212.06 2014 – 2015 £2041.49	£9402.95	Absconded
65555064	Business Rates Anonymised as an individual	2017 – 2018 £6877.11 2018 – 2019 £19,287.91 2019 – 2020 £10,799.32 2020 – 2021 £1841.10	£38,805.44	Absconded
65559011	Business Rates	Bangladeshi High Commission, Office Block, Seamark House, Edge Lane, Droylsden, M43 6BB Absconded	2016 – 2017 £21,838.04 2017 – 2018 £31,614.00 2018 – 2019 £32,538.00 2019 – 2020 £33,264.00 2020 – 2021 £33,792.00	£153,046.04
BUSINESS RATES		**SUB TOTAL – Absconded**	**£321,446.71**	
BUSINESS RATES DISCRETIONARY WRITE OFF TOTAL			**£321,446.71**	
74844377	Overpaid Housing Benefit	1999 – 2000 £3495.36	£3495.36	Deceased, no Estate
OVERPAID HOUSING BENEFIT		**SUB TOTAL – Deceased, no Estate**	**£3495.36**	
OVERPAID HOUSING BENEFIT DISCRETIONARY WRITE OFF TOTAL			**£3495.36**	
4022650	Sundry Debts Residential Care charges	2018 -2019 £3849.13 2019 - 2020 £6109.79	£9958.92	Deceased, no Estate
4027169	Sundry Debts Residential Care charges	2019 -2020 £3744.33	£3744.33	Deceased, no Estate
4005252	Sundry Debts Residential Care charges	2016 – 2017 £34.18 2017 – 2018 £4483.60	£4517.78	Deceased, no Estate

4018486	Sundry Debts Residential Care charges	2016 – 2017 £6105.71	£6105.71	Deceased, no Estate
4018811	Sundry Debts Residential Care charges	2016 – 2017 £5888.95	£5888.95	Deceased, no Estate
4002015	Sundry Debts Homecare charges	2017 – 2018 £5097.29	£5097.29	Deceased, no Estate
4003521	Sundry Debts Homecare charges	2017 – 2018 £1338.58 2018 – 2019 £2727.05	£4065.63	Deceased, no Estate
4020297	Sundry Debts Homecare and Residential care charges	2018 – 2019 £190.48 2019 – 2020 £2953.04	£3143.52	Deceased, no Estate
4021659	Sundry Debts Homecare and Residential care charges	2018 – 2019 £2692.56 2019 – 2020 £4511.80	£7204.36	Deceased, no Estate
4007088	Sundry Debts Direct Payment, Community Response and Residential Care charges	2015 – 2016 £15.99 2016 – 2107 £157.44 2017 – 2108 £192.59 2018 – 2019 £13,322.02 2019 – 2020 £5987.76	£19,675.80	Deceased, no Estate
SUNDRY DEBTS		**SUB TOTAL – Deceased, no Estate**	**£69,402.29**	
4011442	Sundry Debts Direct Payment	2014 – 2015 £5440.06	£5440.06	Unrecoverable Debt – Recovery Exhausted
SUNDRY DEBTS		**SUB TOTAL – Unrecoverable Debt – Recovery Exhausted**	**£5440.06**	
SUNDRY DEBTS RATES DISCRETIONARY WRITE OFF TOTAL			**£74,842.35**	

SUMMARY OF UNRECOVERABLE DEBT OVER £3000		
IRRECOVERABLE by law	Council Tax	£81,031.31
	Business Rates	£164,619.38
	Overpaid Housing Benefit	NIL
	Sundry	£52,403.57
	TOTAL	**£298,054.26**

DISCRETIONARY write off – meaning no further resources will be used to actively pursue	Council Tax	NIL
	Business Rates	£321,446.71
	Overpaid Housing Benefit	£3495.36
	Sundry	£74,842.36
	TOTAL	**£399,784.43**

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	25 August 2021
Executive Member:	Cllr Eleanor Wills – Executive Member Adult Social Care and Population Health
Reporting Officer:	Jeanelle de Gruchy, Director of Population Health Emma Varnam, Assistant Director of Operations and Neighbourhoods
Subject:	**DOMESTIC ABUSE ACT FUNDING PROPOSAL**

Report Summary:

This report sets out the commissioning intentions around domestic abuse services in Tameside in light of new funding available this year.

TMBC has been awarded a further £547,627 in grant funding to meet new duties under the Domestic Abuse Act 2021. This funding must be spent during 2021/22 on 'support within safe accommodation' for victims of domestic abuse and their children and expenditure related with complying with the new duties.

There was no advance notification of the amount the council was due to receive before this financial year and the funding was released under the stipulation that the money would be spent following the statutory domestic abuse needs assessment. Therefore, this funding was not included in the 21/22 budget. This funding is recurrent and the grant determination for future years will follow the annual Spending Review.

As a result, TMBC has £1,274,445 available to spend on domestic abuse in this financial year (2021/22). Of this, £656,818 is already committed to providing our core commissioned offer, support in safe accommodation and outreach services.

We propose the remaining £617,627 is spent meeting gaps highlighted in the statutory needs assessment. Primarily:

- Better availability of support within Safe Accommodation
- Workforce development, training and practice improvement
- Developing a local perpetrator response
- Piloting innovative approaches with Children and Young People that use violence
- Outreach services in the community and health settings for victim-survivors of Domestic Abuse
- System wide data improvement project to ensure we can discharge our duties under the Domestic Abuse Act 2021

There will be a further spending proposal once the grant amount for 2022/23 is determined pending the Spending Review in Autumn 2021.

Recommendations:

That Strategic Commissioning Board be recommended to approve domestic abuse spending in 2021/22 as follows:

Jointly commissioned Bridges contract	£	506,818
Domestic Abuse Act grant funding (safe accommodation only)	£	547,627

GMCA funding for Domestic Abuse roles	£	70,000
Covid-19 funds	£	30,000
Population Health and Children's Services CHIDVA funds	£	120,000
Total 2021/22 funding for Domestic Abuse	**£**	**1,274,445**
*Funding **committed** 2021/22 to date*		
Bridges contract - outreach	£	335,090
Bridges contract - safe accommodation duty	£	291,728
Covid-19 additional IDVA	£	30,000
Total 2021/22 committed for Domestic Abuse	**£**	**656,818**
Total 2021/22 funds still available	£	617,627
***Proposed** further spend 2021/22*		
Support in safe accommodation	£	255,899
Domestic Abuse transformation activity	£	291,728
GMCA funded IDVA posts	£	70,000
Total 2021/22 proposed further spend for Domestic Abuse	**£**	**617,627**
Total spend on Domestic Abuse 2021/22 if permission granted	**£**	**1,274,445**

Financial Implications:

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

Budget Allocation (if Investment Decision)	Annual Budget £1.3m
CCG or TMBC Budget Allocation	Council
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	
The financial implications in this report is to move resources within community safety (opps and neighbourhood) and pool within population health, whilst also being asked to commit to a further £617k of cost as part of the Domestic Abuse Programme. This additional cost is matched via the additional grant income outlined in the MOU. Of this, £256k is restricted as part of the Domestic Abuse Act to provide Enhanced sanctuary scheme and Dispersed accommodation support offer. There is a risk that these in particular go over the 6 months remaining in 21/22 and options may need to be considered to carry forward to 22/23. Not agreeing to support would avoid costs of £617k, but would mean TMBC fail its obligations as part of the Domestic Abuse Bill and Grant funding may be withdrawn.	
Additional Comments TMBC have been awarded a further £547,627 in grant funding to meet new duties under the Domestic Abuse Act 2021 for safe accommodation and must be spent in 2021/22. This is in	

	addition to recurrent funding in place, taking the total resource to £1.3m to meet the Domestic Abuse bill. STAR have been involved and contract plans and proposals are outlined in section 3.2 to support this programme.
Legal Implications: **(Authorised by the Borough Solicitor)**	The Domestic Abuse Act 2021 covers a wide range of issues with the aim of transforming the current response to domestic abuse. Key facts can be found here: [Domestic Abuse Act 2021: overarching factsheet - GOV.UK (www.gov.uk)]() The Act establishes a statutory definition of domestic abuse, emphasising that domestic abuse is not just physical violence, but can also be emotional, controlling or coercive, and economic abuse. The act also places a duty on local authorities in England to provide accommodation based support to victims of domestic abuse and their children in refuges and other safe accommodation. The project officers must ensure that the advice from STaR as set out in the main body of the report is complied with to ensure that the procurement processes are compliant both in terms of legislation and internal procedures and Standing Orders. There are some significant obligations placed on the Council and it would be useful to ensure that members generally have access to regular briefings and access to any frontline training as appropriate. Additionally future reports will be required in relation to member oversight, performance monitoring and allocation of budget to address priorities particularly as the act requires that the Council produces an annual report. It will be particularly key for integrated partnership working as evidence shows that more than 50% of abuse victims make their first report to health workers.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Starting Well, Living Well and Developing Well programmes for action as the services offered are inclusive of all ages and groups across Tameside
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care • Locality-based services
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Supporting our most vulnerable residents • Empowering citizens and communities • Commission for the 'whole person'
Recommendations / views of the Health and Care Advisory Group:	n/a
Public and Patient Implications:	Part of this proposal is to upskill frontline staff across the police, homelessness, social care and health sectors, which were identified in the recent domestic abuse needs assessment. This will improve the identification of domestic abuse, and therefore the services that victim-survivors in Tameside receive. Additionally, it will provide additional resources to better meet the needs of victim-survivors in Tameside including allowing victim-survivors and their children to

	stay safe in their homes and have a specialist accommodation offer that is accessible for male victims, those with more complex needs, those that are not suitable for refuge and victim-survivors who have larger families.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness
How do the proposals help to reduce health inequalities?	Evidence suggests that certain groups are disproportionately affected by domestic abuse such as women and children, which is directly addressed in some of the proposed areas of work. This will help to tackle the inequalities that women and children face around domestic abuse.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act. The commissioned domestic abuse service is available to Adults regardless of ethnicity, gender, sexual orientation, religious belief, gender re-assignment, pregnancy/maternity, and marriage/ civil and partnership.
What are the safeguarding implications?	This will support the multi-agency approach to managing risk around domestic abuse, enhancing our safeguarding approach by equipping staff with specialist training on identifying domestic abuse and practical support for working with perpetrators of domestic abuse.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report therefore a privacy impact assessment has not been carried out. N/A
Risk Management:	The purchasers will work closely with all external providers to manage and minimise any risk of provider failure consistent with the provider's contingency plan
Access to Information:	The background papers relating to this report can be inspected by contacting Samantha Jury-Dada, Strategic Domestic Abuse Manager Telephone: 07968473106 e-mail: Samantha.jury-dada@tameside.gov.uk

1. INTRODUCTION

1.1 The Domestic Abuse Act 2021 (Domestic Abuse Act) has resulted in new duties for local authorities. This includes establishing a local Domestic Abuse partnership board, a statutory duty to conduct a domestic abuse needs assessment and new duties to provide support in safe accommodation for victims of domestic abuse and their children.

1.2 TMBC was awarded £547,627 in grant funding in April 2021 to meet our new duties according to the new Act.

1.3 This funding is recurrent and future grant determinations decided in the Spending Review each year. As soon as the Spending Review is announced in 2021, there will be a report for 22/23 spend on Domestic Abuse presented to the Strategic Commissioning Board.

1.4 In April 2021 TMBC signed a memorandum of understanding on how this additional funding would be spent, as an uplift of funding to support victims of domestic abuse in Tameside.

1.5 It was stipulated that this funding should be allocated after a local statutory domestic abuse needs assessment had taken place. Guidance on how to conduct this was released in April 2021. Following the release of the Domestic Abuse needs assessment guidance, TMBC ran a tender exercise for an external Domestic Abuse Needs Assessment and the domestic abuse charity AVA (Against violence and abuse) was awarded the contract. The Domestic Abuse Act needs assessment was completed in June 2021.

1.6 This report is seeking permission around the proposed commissioning intentions, which will enable us to spend the Domestic Abuse Act grant funding and to create a Domestic Abuse Transformation Fund to improve outcomes for victims of domestic abuse in Tameside.

2. DOMESTIC ABUSE ACT FUNDING – SUPPORT WITHIN SAFE ACCOMODATION 2021/22

2.1 We have received £547,627 to meet our new duties under the Domestic Abuse Act 2021.

2.2 Bridges is the provider of our domestic abuse services in Tameside; we have a core contract that is jointly commissioned by Community Safety, Population Health and Children's Services.

2.3 Through the Bridges offer and existing contract variations, we currently have £291,728 allocated in 21/22 spending for 'support within safe accommodation'. This funds the following staff in our local refuge:

- 2x Customer Support Workers
- 1x Senior Support Worker
- 2x Night Workers
- 1x Senior Child Support Worker
- 1x Children and Young Person Worker
- 3x CHIDVA

2.4 Table 1: Bridges contract, spend break down 21/22:

Bridges Commissioned provision 21/22 to date	Amount (£)
Support in safe accommodation	£291,728
Outreach offer	£335,090
Total	**£626,818**

2.5 We propose the £291,728 already allocated from TMBC existing funds to 'providing support in safe accommodation' is transferred into a new cost centre, to fund wider domestic abuse improvement activity (section 6) and that this funding is replaced using the Domestic Abuse Act grant funding (total of £547,627).

2.6 We propose the remaining funding from our new allocation to meet the Domestic Abuse Act duties (£255,899) is used to provide support in safe accommodation and enabling the local authority to discharge its' new duties as per the requirements of the grant determination.

2.7 Table 2: Funding committed and proposed (2021/22)

Funding Sources for Domestic Abuse in 2021/22		
Jointly commissioned Bridges contract	£	506,818
Domestic Abuse Act grant funding (safe accommodation only)	£	547,627
GMCA funding for Domestic Abuse roles	£	70,000
Covid-19 funds	£	30,000
Population Health and Children's Services CHIDVA funds	£	120,000
Total 2021/22 funding for Domestic Abuse	**£**	**1,274,445**
*Funding **committed** 2021/22 to date*		
Bridges contract - outreach	£	215,090
Bridges contract - safe accommodation duty	£	335,090
Covid-19 additional IDVA	£	30,000
Total 2021/22 committed for Domestic Abuse	**£**	**656,818**
Total 2021/22 funds still available	£	617,627
***Proposed** further spend 2021/22*		
Support in safe accommodation	£	255,899
Domestic Abuse transformation activity	£	291,728
GMCA funded IDVA posts	£	70,000
Total 2021/22 proposed further spend for Domestic Abuse	**£**	**617,627**
Total spend on Domestic Abuse 2021/22 if permission granted	**£**	**1,274,445**

2.8 We recommend that any remaining underspend of the Domestic Abuse Act grant funding is committed to discharging our new duties under the Domestic Abuse Act 2021.

3. OVERVIEW OF PROPOSED SPEND – DOMESTIC ABUSE COMMISSIONING INTENTIONS 2021/22

3.1 We propose £617,627 is committed to meeting gaps highlighted in the statutory Domestic Abuse Needs Assessment and fulfilling our new duties under the Domestic Abuse Act 2021.

3.2 Table 5: Proposed additional spend 2021/22 on domestic abuse:

Domestic abuse outreach and transformation		
Provision	*Amount*	*Contract type (advice from STAR)*
Domestic Abuse training and workforce development programme (multi-disciplinary)	£100,000	Tender – 3 quotes via the Chest
Perpetrator needs assessment and tailored approach	£20,000	Tender – 3 quotes
Pilot – interventions for children that use violence against parents and carers	£100,000	Direct contract award to TLC (2/3 Home Office funded)
Working with perpetrators training for CSC and ASC frontline staff	£15,000	Tender – 3 quotes
Domestic abuse support uplift for Bridges (only if increased demand due to perpetrator work)	£15,000	Contract variation (Bridges, Jigsaw Support)
Target hardening pilot using new technologies to support prosecutions (2 years)	£20,000	No contract, direct purchase
A&E IDVA (12 months)	£21,000	Contract variation (Bridges, Jigsaw Support)
Medium risk IDVA (GMCA funded)	£30,000	Contract variation (Bridges, Jigsaw Support)
INS Keyworker (GMCA funded)	£40,000	Contract variation (Bridges, Jigsaw Support)
Domestic Abuse Act Funding (restricted)		
Provision	*Amount*	*Contract type*
Enhanced sanctuary scheme (12 months)	£110,000	Contract variation (Bridges, Jigsaw Support)
Dispersed accommodation support offer (6 months)	£100,000	Contract variation (Bridges, Jigsaw Support)
System-wide data project to support future needs assessment	£40,000	Tender – 3 quotes via the Chest
Discretionary domestic abuse fund	£6,627	Budget
Total	**£617,627**	

3.3 The following sections explain the commissioning approach and details of each of these proposals in detail.

4. DOMESTIC ABUSE PROPOSED SPEND 21/22 – COMMISSIONING AND PROCUREMENT OVERVIEW

4.1 The proposals within this document require commissioning and procurement activity. Therefore, we have sought advice from STAR procurement on all proposed commissioning and procurement activity. Procurement methods will align to the council's financial regulations procedures and guidance.

4.2 Bridges is currently commissioned to provide our specialist domestic abuse service, via a core contract with Jigsaw Support. This contract is in place between 1st April 2019 to 31st March 2024 and has a value of £2,694,090.

4.3 The proposed total variations within this report represents a 12.4% increase in the Bridges contract value. Alongside existing approved variations to the Bridges contract since 1st April 2019, the proposed variations in this report would brings the total contract variation to 19.8% of the total contract value, which is within the 50% variation threshold allowed within the

contract term. Advice from STAR procurement is that these variations are an acceptable level and would be managed via existing contract arrangements with our commissioning officers.

4.4 There is one proposed direct contract award within this report, which is to TLC, for the value of £100,000. This is for the programme of work for children that use violence against parents/carers. We are seeking permission for direct award rather than run a competitive procurement exercise. This is because:

- TLC already provide this intervention in 5 pilot sites in Greater Manchester
- TLC submitted the bid to the Home Office on behalf of GMCA for all perpetrator and children interventions
- TLC are the only provider for this specific intervention that we know of
- As an existing provider of this intervention, TLC will be able to provide this support without delay due to procurement exercises and project set up
- We will ensure that we are receiving value for money through outcome monitoring and contract management with commissioning officers

4.5 Within this report, there are 4 other proposals that require procurement. On the advice of STAR, we will run a competitive procurement exercise appropriate to the value of each of the contracts. All will require 3 quotes and the contracts will be managed by TMBC commissioning officers (further detail in Table 5). The four projects that will require procurement are:

- System-wide data project to support future needs assessment (£40,000)
- Domestic Abuse training and workforce development programme (multi-disciplinary) (£100,000)
- Perpetrator needs assessment and tailored approach (£20,000)
- Working with perpetrators training for CSC and ASC frontline staff (£15,000)

5. DOMESTIC ABUSE ACT FUNDING (SAFE ACCOMODATION DUTY) – ENHANCED SANCTUARY SCHEME 12 MONTHS

5.1 The majority of victim-survivors of domestic abuse do not require specialist domestic abuse accommodation, nor are they made homeless, however we have no current offer to support individuals to stay in their own homes.

5.2 We propose improving our offer for victim-survivors to enable them to stay in their own homes safely, and prevent victim-survivors becoming homeless. Victim-survivors have told us through the Domestic Abuse Needs Assessment the importance of being able to stay local, access their support networks and retain their employment.

5.3 We already have Sanctuary (Target Hardening) equipment, purchased by Community Safety in 20/21 and we are not permitted to spend the Domestic Abuse Act funds on Target Hardening devices. However, we want to create an enhanced Sanctuary Scheme offer, which provides a domestic abuse support element while making the home practically safe for victims of domestic abuse.

5.4 The Domestic Abuse Needs Assessment recommended that TMBC increases resources available so that Sanctuary measures can be deployed more quickly to support victim-survivors.

5.5 We are seeking permission to award £110,000 to Bridges for three Sanctuary Scheme workers for a 12 month period. These staff will fit the Sanctuary equipment, provide safety planning advice and signpost into other existing services. We expect with a fully staffed service, that there will be a significant number of referrals from partners such as GMP.

5.6 Following advice from STAR, the funding will be transferred to Jigsaw Support, who provide the Bridges service via a variation of the existing contract. This contract will be managed by

commissioning officers.

6. DOMESTIC ABUSE ACT FUNDING (SAFE ACCOMODATION DUTY) – DISPERSED ACCOMODATION OFFER 6 MONTHS

6.1 Our existing contract with Bridges has the provision for a specialist domestic abuse offer for those that are not able to use refuge, this is called 'dispersed accommodation'. This offer is suitable for male victims of domestic abuse, those with additional needs or disabilities, those with larger families and those for whom communal living in refuge is not suitable.

6.2 In 2019/20 there were 44 adults and 58 children that were refused refuge accommodation in Tameside. The reasons for the refusals were that; the location was too close to the perpetrator (19); there was no suitable space (35); the refuge could not manage client needs (9); Domestic abuse was not the presenting reason (5); and the individual had no recourse to public funds (2).

6.3 A dispersed accommodation offer based on the 'housing first' model would allow us to provide support in safe accommodation for a larger cohort of victim survivors. It would provide an offer of support within safe accommodation for the majority of those who were refused refuge in 2019/20.

6.4 The current provision within the core contract with Bridges allows dispersed units to be used where available. However, without the additional floating specialist domestic abuse support – this offer does not support victim-survivors appropriately and therefore this element of the contract is not being fully utilised and we are not meeting our duty to provide support within safe accommodation through this element of the contract.

6.5 On preliminary investigations, we estimate that up to 50 households are currently in dispersed units across Tameside that would be eligible for this support offer. We believe with an improvement in identification of domestic abuse victims as part of the workforce development work (section 8) that this number will increase.

6.6 We are seeking permission to award Bridges up to £100,000 for the remainder of the 2021/22 financial year to provide floating support services to victims of domestic abuse that require specialist accommodation through our dispersed offer.

6.7 The offer commissioned through Bridges will have parity with our refuge provision in terms of the level of support victim-survivors receive, therefore, we will be meeting our new duties to provide support in safe accommodation.

6.8 Following advice from STAR, the funding will be transferred to Jigsaw Support, who provide the Bridges service via a variation of the existing contract. This contract will be managed by commissioning officers.

6.9 Evidence of throughput, caseloads and support requirements will be reviewed and proposals for 2022/23 support will be based on levels demand for this new offer.

7. DOMESTIC ABUSE ACT FUNDING (SAFE ACCOMODATION DUTY) – DATA PROJECT

7.1 We have new statutory duties to conduct a needs assessment on domestic abuse. The AVA needs assessment (June 2021), identified a significant number of data recommendations. Indeed, 54% of the total recommendations were relating to data improvements that are required.

7.2 The Domestic Abuse Act 2021 requires us to keep up to date, relevant data and for the

Domestic Abuse Partnership Board to scrutinise that information and make decisions based on the information we collect. The council has a requirement under the new duties to review data pertaining to the needs assessment annually.

7.3 In order to run the domestic abuse needs assessment on an annual basis and understand the needs of our adult and child victim-survivor population we require specialist support to:

- Liaise with staff across health, social care, criminal justice and third sector providers
- Harmonise data collection across the system
- Create a Domestic Abuse dashboard for adult victim-survivors
- Create a Domestic Abuse dashboard for CYP victim-survivors
- Work with partners on the data recommendations from Domestic Abuse Needs Assessment to ensure we are compliant with our new duties

7.4 We are seeking permission to spend up to £40,000 on a data consultancy project to meet our new duties and ensure future compliance with the new Act.

7.5 Following advice from STAR, we will run a competitive tender process for this work by seeking direct quotes. We will transfer the funds to the successful applicant and the contract will be managed by commissioning officers.

8. DOMESTIC ABUSE TRANSFORMATION FUND 2021/22

8.1 We already have £291,728 committed in Community Safety and Population Health budgets in 21/22 as part of our core contract with Bridges to provide 'support within safe accommodation' through refuge provision.

8.2 TMBC received £547,627 in grant funding for new duties relating to the Domestic Abuse Act 2021, this includes a duty to provide support within safe accommodation. Therefore, we are proposing that we use the Domestic Abuse Act grant funding to offset already committed spend.

8.3 We are seeking permission to use the committed spend to create a Domestic Abuse Transformation fund for 21/22 which can be spent on improving the domestic abuse response in Tameside, which unlike the grant, will not be limited to 'support within safe accommodation'.

8.4 We are seeking permission for this cost centre to be within Population Health, with the Strategic Domestic Abuse Manager, which has been agreed by Senior Officers within Population Health and Operations and Neighbourhoods.

9. DOMESTIC ABUSE TRANSFORMATION FUND – WORKFORCE DEVELOPMENT

9.1 In January 2021 a workforce survey was conducted by the Strategic Domestic Abuse Manager of frontline professionals across health, social care, homelessness and criminal justice. The survey gathered feedback on:

- Attitudes and beliefs about domestic abuse
- Training and support requirements
- Professional responsibility on domestic abuse
- HR and workplace practice on Domestic Abuse

9.2 There were gaps in professionals understanding of domestic abuse, particularly around the dynamics of domestic abuse, coercion and control and identifying primary perpetrators. It was recommended that more regular, blended (online and in-person) training is made available for frontline staff. There were particular training needs highlighted for GMP, Homelessness and Adult Social Care.

9.3 When we asked Victim-Survivors what was important to them from professionals they said; being believed; having a good understanding of violence and abuse; being provided with information of how to seek support and being clear on confidentiality and information sharing. Unfortunately, the Domestic Abuse Needs Assessment highlighted significant gaps across these areas in most frontline services.

9.4 In the Domestic Abuse Needs Assessment there were a significant number of recommendations regarding the training and upskilling of the workforce in Tameside on Domestic Abus. The following were advised in order to improve outcomes and practice on domestic abuse:

- All frontline staff to receive training on understanding race, ethnicity and identity to better understand and support a range of ethnic groups of adult and child victim-survivors
- Local practicitioners should be upskilled on the impact of financial and economic abuse
- Housing and homelessness staff to receive training on how to identify victim-survivors
- Housing and homelessness staff to be trained on the MARAC process and how to engage in local safeguarding procedures
- GPs, reception staff and those who work in GP practices should be given training on identification of current and historic domestic abuse
- Training and support should be provided for triage and reception staff at A&E on how to enquire about domestic abuse
- Mental health practitioners should receive domestic abuse training to understand how victim-survivors are limited by perpetrators to receive support for mental health needs
- Adult social care workers should understand domestic abuse, including financial abuse and should be able to provide goal oriented work for these clients
- Additional training is required on the identification of victim survivors within ASC
- Professional development and training should be offered to staff in adult social care on the identification of perpetrators on domestic abuse
- Training and guidance for adult social care staff on safe and effective working with couples where there is domestic abuse and on how to manage perpetrators

9.5 We are seeking permission for a £100,000 workforce development programme on domestic abuse which is multi-disciplinary and targeted at the workforce gaps identified in the Domestic Abuse needs assessment and workforce survey 2021. The programme is ambitious, however we hope to prioritise the following:

Table 6: Priority staffing groups for workforce development activity

Service area	**Roles**	**Staffing #**
Primary Care	GP/registrars/locums	190
Housing	THA staff	10
Community Safety	Homelessness staff	10
	Offender staff	6
Children's Services	CiN and CP social workers	92
	Complex safeguarding	7
	ISCAN	8
	Early Help	107
	Early Years	28
	Youth Justice	15
Adult Social Care	Integrated Urgent Care Team	54
	Neighbourhood teams	111
	Shared Lives	5
	Mental Health workers	50
Policing	GMP officers	50
Total		**743**

9.6 We are seeking permission for £15,000 to commission a specialist provider to support social

work practice on working with perpetrators of domestic abuse in social work interventions, assessments and practice – as identified in the Domestic Abuse Needs assessment and workforce survey 2021. This would impact at least 400 frontline social care workers, with a plan to prioritise working with managers and identifying key areas of improvement through supervision and quality assurance activity throughout the year.

9.7 Following advice from STAR, we will run a competitive tender process for both programmes of work and transfer the funds to the successful applicant. The contract will be managed by commissioning officers.

10. DOMESTIC ABUSE TRANSFORMATION FUND – PERPETRATOR NEEDS ASSESSMENT AND APPROACH

10.1 In Tameside, we have no commissioned offer for those who perpetrate domestic abuse. The only programme of work is court mandated through probation, Building Better Relationships.

10.2 The 2019 Peer Review and 2021 Domestic Abuse Needs Assessment highlights that in Tameside we require a more consistent approach to managing and responding to perpetrators.

10.3 In the workforce survey, when frontline staff were asked what they needed in order to support victims of domestic abuse better – the most common response was having a perpetrator approach.

10.4 We know from data collected through our commissioned services that we have some unmet needs around perpetrators. When victim-survivors were asked what those needs were they said:

- Substance misuse
- Mental health
- Housing
- Parenting and relationships
- Wider health needs

10.5 However, as a system we do not collect enough information about perpetrators to make an informed and evidence-based decision on a future perpetrator approach. This was a key recommendation in the Domestic Abuse Needs Assessment.

10.6 We seek permission to commission a specialist provider to conduct a needs assessment on perpetrators, identify best practice and design a model for working with perpetrators in Tameside for £20,000. This will result in commissioning recommendations for 2022/23.

10.7 Following advice from STAR, we will run a competitive tender process for this work by seeking direct quotes and transfer the funds to the successful applicant. This contract will be managed by commissioning officers.

11. DOMESTIC ABUSE TRANSFORMATION FUND – CHILDREN THAT USE VIOLENCE TOWARDS PARENTS AND CARERS 21/22

11.1 We have been offered an opportunity to submit a bid to the Home Office via GMCA to pilot programmes that are targeted at children that use violence against their parent or carer.

11.2 There is an existing pilot in 5 boroughs in Greater Manchester run by TLC that works with young people between the ages of 10 and 16 years old. In Tameside, we have identified through our needs assessment, engagement with frontline staff in Early Help and the CHIDVA service that there is a gap in our offer for this cohort of children.

11.3 The proposal for Tameside is to target three cohorts of children with this programme:

- Referrals from multi-agency partners, including children that use violence against parents identified through Youth Justice police notifications
- Children at the Edge of Care
- Children that are looked after and are at risk of placement breakdown

11.4 This will align with and further enhance our already well established Early Help and specialist Edge of Care services adding real value in terms of capacity and expertise to support this cohort of children and families.

11.5 As of August 2nd 2021, we have been notified that our bid has been successful. As a result, 225 children and their families in Tameside will be supported through this project over a 12-month period. We believe this programme would be able to demonstrate in-year cost-avoidance for Children's Services as placement costs are a significant challenge for the borough, as is demand for Children's Services.

11.6 The Home Office will provide 2/3 match funding for the proposal, we are expected to fund the remaining 1/3. We are seeking permission to spend £100,000 on this pilot.

11.7 Following advice from STAR the funding will be transferred to TLC as a direct award. We are not proposing a competitive route for this work as TLC are the existing provider of this pilot in Greater Manchester, they led and submitted the bid on behalf of GMCA and are the only provider of this work. An additional benefit is that as an existing provider, they will be able to begin the work with young people and their families in Tameside quickly, which would not be the case if we were required to complete a competitive procurement exercise. We will ensure we are receiving value for money through outcome monitoring and contract management by our commissioning officers.

12. DOMESTIC ABUSE TRANSFORMATION FUND – TARGET HARDENING TRIAL 2 YEAR PILOT (2021/22 IN-YEAR SPEND)

12.1 The majority of domestic abuse victims supported by specialist services in Tameside continue to live in their own homes. However, we know that for many victim-survivors of abuse home is not a safe place.

12.2 Our Domestic Abuse Needs assessment identified that we should increase the use of Sanctuary (target hardening) devices in order to improve our offer for victim-survivors that do not become homeless or access specialist support services such as refuge.

12.3 Community Safety has invested in a number of devices that enable target hardening, which are located within the Women and Families centre and the CSU. This includes:

- Window alarms
- Door wedge alarms
- Key ring alarms
- Door chimes
- Pink panic alarms
- Light timers
- Spy holes
- Padlocks
- Dome CCTV cameras
- Security lights
- Letterbox restrictors

12.4 Innovative approaches to Sanctuary have been trialled in local authorities elsewhere, with impressive outcomes for victim-survivors and criminal justice agencies. For example, Smart

Water has been used in South Yorkshire, West Mercia and Sheffield. The forensic marking system was used to protect victims of domestic abuse by linking perpetrators to the scene of the crime – in South Yorkshire they found a 69% reduction in reported incidents and a 94% reduction in harm from those incidents reported.

12.5 We seek permission to create a £20,000 fund to trial innovative technology in our Sanctuary offer to improve criminal justice outcomes, protect victim-survivors from further abuse and hold perpetrators accountable for their actions.

12.6 This funding is capital and will be used to purchase equipment via the established routes.

13. DOMESTIC ABUSE TRANSFORMATION FUND – A&E IDVA 12 MONTHS

13.1 In the SafeLives report 'Getting it right first time', 23% of victims at high risk of harm and 1 in 10 victims at medium-risk went to Accident and Emergency (A&E). AVA estimate that there are nearly 20,000 attendances at Tameside A&E by victims of domestic abuse, and there is no current data to suggest that these victim-survivors are being identified and supported appropriately.

13.2 In Tameside, our suicide rate among the female population is higher than 2/3 of the statistical neighbours and national average. SafeLives research that victims that attended A&E are more likely to have been suicidal or to have self-harmed and a pilot of an A&E IDVA at St Mary's in Manchester found that the victims they supported through this intervention had more complex needs.

13.3 In the Tameside Domestic Abuse Needs Assessment the lack of investment in domestic abuse interventions in health settings was highlighted as an area of risk in the system. The report also contained testimony from two victim survivors who had felt failed by the lack of identification of their domestic abuse in A&E; one who attended A&E for serious sexual and physical violence and the other who attended A&E in a state of mental health crisis due to the domestic abuse in his relationship.

13.4 The Domestic Abuse Needs Assessment recommended that training and support should be provided for triage and reception staff at A&E on how to enquire about domestic abuse and that an A&E IDVA pilot of routine enquiry should be trialled at Tameside Emergency Department.

13.5 We seek permission to spend £21,000 of the Domestic Abuse Transformation fund on piloting an A&E IDVA for 12 months. The remaining £19,000 will be funded by the CCG.

13.6 Evidence on the success of this pilot will be used to inform our future domestic abuse commissioning and our core offer.

13.7 Following advice from STAR, the funding will be transferred to Jigsaw Support, who provide the Bridges service via a variation of the existing contract. This contract will be managed by commissioning officers.

14. DOMESTIC ABUSE TRANSFORMATION FUND – BRIDGES UPLIFT

14.1 In this report, we recommend that there are a number of programmes of work and pilots which we expect will increase the numbers of victim-survivors that we identify in Tameside and require specialist support.

14.2 The council is also running a number interventions with potential perpetrators in the homelessness service and in the substance misuse service. We anticipate that with an

increased awareness of domestic abuse, and a more targeted approach towards identifying perpetrators that we may see a rise in demand for our outreach services run by Bridges.

14.3 We seek permission to award up to £20,000 in uplift funding, if there is evidence to suggest that the domestic abuse transformation activity results in an unmanageable level of demand for Bridges.

14.4 The funding would be transferred to Jigsaw Support, who provide the Bridges service via a variation of the existing contract. This contract will be managed by commissioning officers.

15. GMCA FUNDED POSTS – 2X IDVA (12 MONTHS)

15.1 TMBC has been awarded £70,000 in funding from GMCA for the provision of two IDVA posts:

- INS Keyworker - £40,000
- Medium risk IDVA - £30,000

15.2 50% of the funding for the INS worker was given to Community Safety in April 2021 with the remaining amount due to be transferred in September 2021.

15.3 The medium risk IDVA funding has been transferred to Community Safety by GMCA.

15.4 We seek permission to award Bridges £70,000 for these two 12 month posts, as stipulated in the grant determination from GMCA.

15.5 Following advice from STAR, this funding will be transferred to Jigsaw Support, who provide the Bridges service via a variation of the existing contract. This contract will be managed by commissioning officers.

16. UNDERSPEND – DISCRETIONARY FUND FOR DOMESTIC ABUSE

16.1 There is a current underspend of £6,627. We seek permission to use any domestic abuse underspend to create a discretionary fund to support the local authority to discharge its' duties relating to the Domestic Abuse Act 2021, including activity to support the new statutory governance around domestic abuse to have a Domestic Abuse Partnership Board.

16.2 We recommend that this discretionary fund is allocated to Population Health with the Strategic Domestic Abuse Manager.

17. RECOMMENDATIONS

17.1 As set out at the front of the report.

APPENDIX – DOMESTIC ABUSE WORKFORCE SURVEY 2021 – SUMMARY SLIDES

Summary

Attitudes and Beliefs

Attitudes about domestic abuse are on the whole positive, areas for improved understanding is regarding 'grey areas', the power dynamics of domestic abuse and coercion and control.

Key statistics:

- **Most professionals were confident in their understanding of domestic abuse and felt it was important for their role.**
- **The number of professionals in Tameside that agreed there were lots of false allegations of domestic abuse was nearly equal to those that disagreed.** This includes 65% of the police officers that participated in the survey, who agreed or strongly agreed that there were a lot of false accusations of domestic abuse. This is a problematic myth about domestic abuse and we need to challenge these beliefs.
- **61% of participants believe that if both partners have been violent, they are both victims of domestic abuse** – this is despite our understanding of the dynamics of power and control in an abusive relationship and how violence can be exhibited by victims of abuse in retaliation.

Training

More regular, facilitated training is required to improve professionals understanding of domestic abuse.

Key statistics:

- **Only 28% of people had received recent training in the last 3 – 6 months.**
- **Half of participants had this training in person**, 36% completed an e-learning module on domestic abuse and 14% had a virtual training session
- **Most professionals felt that the training was up to date and relevant (59%).**

4

Summary

Practice

There needs to be better information for professionals about how to access specialist domestic abuse interventions locally – particularly around safe housing options.

Key statistics:

- **93% of professionals felt that they understood their obligations in regard to domestic abuse**
- **30% of professionals were not aware of refuge provision in Tameside or how to access it.** This was prevalent among GMP, midwifery and homelessness staff.
- Staff felt that having a **perpetrator intervention was the biggest gap** to be addressed in order to help them to support victim-survivors in Tameside

Our workplace

There is scope for better communication around HR policies, rights for victims at work and disclosures in the workplace – especially as a large number of professionals would disclose abuse to their manager.

Key statistics:

- **74% of professionals felt that domestic abuse would be handled appropriately by their employer.** An officer from GMP and a social worker in Adult Social Care did not believe that DA would be handled correctly in the workplace. Those that were unsure were from Tameside and Glossop CCG midwifery, GMP and social care.
- When asked who they would disclose abuse to if they were a victim, their Manager came second to Friends and Family.
- Only **41% were aware of their organisations domestic abuse policy, despite all of the main employers of these professionals having one.**

5

Conclusion and Next Steps

Key learning:

- Attitudes about domestic abuse are on the whole positive, areas for improved understanding is regarding 'grey areas', the power dynamics of domestic abuse and coercion and control
- More regular, facilitated training is required to improve professionals understanding of domestic abuse
- There needs to be better information for professionals about how to access specialist domestic abuse interventions locally – particularly around housing options.
- There is scope for better communication around HR policies, rights for victims at work and disclosures in the workplace – especially as a large number of professionals would disclose abuse to their manager.
- The services with the most opportunity for improvement in practice are GMP, Homelessness and Adult Social Care

Next Steps:

- Report to be circulated to Steering Group
- It is recommended that Steering group members consider the findings of report with their service and workforce development leads
- Working group to be established which will include HR and practice development leads (e.g.. Principle Social Workers) to create proposal for workforce development plan to go to Steering Group in September 2021

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Context and methodology

The AVA team have worked hard to provide you with usable data from a range of sources:

- Published local data
- National data set
- Survivor Survey and Interviews
- Semi-structured interviews and focus groups with staff

Overarching Recommendation on data collection:

Consistent demographic data categories and additional data sources for the DA Dashboard to get a system-wide view of DA.

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6

Key findings | Survivor feedback

- Survivors felt that there was a **shortage of housing and appropriate housing advice**
- Survivors identified **high levels of mental health need**, and yet difficulties accessing mental health support.
- Survivors reported **high rates of emotional abuse and coercive control.** In response to questioning around needs for improvement, survivors highlighted a better understanding around emotional abuse from professionals and society .
- Survivors highlighted the **impact of financial and economic abuse**, specifically the stress caused and additional hardship where debt is incurred during abuse.
- Survivors reported **higher than average rates of turning to the police** and/or criminal justice professionals for support around abuse. This is suggestive of **a high level of survivors reaching a crisis point**, and a potential lack of early intervention.
- Survivors reported the need for **better follow up and aftercare to deal with post-separation abuse.**

Key findings | Areas of good practice

Throughout the report we have highlighted local excellence in provision of services for domestic abuse victim-survivors

- Strong existing **multi-agency partnerships** – MARAC and MASH
- **Local service offers**
- **Community asset based and neighbourhood approach**
- **Attachment focused provision**
- Dedicated support for Children through the **CHIDVA service**
- Free, age appropriate, locally designed **healthy relationships and domestic abuse prevention resources** available to all schools

Key findings | Housing and homelessness

- 107/757 homelessness applications were due to DA – 48 of these individuals had children but **no records kept on the numbers of children**
- **No demographic detail available** for the residents making homelessness applications (significant data gap)
- Housing in Tameside deemed affordable but **survivors faced difficulties accessing the private rental sector**
- **No data kept on the tenancies of survivors** at point of entry (despite new duties)
- **Unsafe use of temporary accommodation** for victim survivors – no risk assessments for friends and family
- **Requirement for stringent outcome and impact monitoring of housing services going forward**

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9

Key findings | Adult Social Care

- **Just 3 cases of domestic abuse in last return**, significantly low considering the older population, mental health needs and substance misuse needs
- **No demographic data is reviewed locally about protected characteristics of those requiring ASC support**
- Adult safeguarding practices should be reviewed to contribute to **leadership on suicide prevention locally**
- Key areas for **workforce development** with staff:
  - Managing DA with couples who are still together
  - Improve understanding of service offer
  - Integrated working with ASC and other agencies

["Was your social worker helpful?] "Not really, they appear to be, but you can't talk to them, they never get back you. I think the social workers only wear one hat. They do not know about housing or benefits, there's loads of work that they do but and that but they do not know about domestic abuse".

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10

Key findings | Health

- **Health a significant area for development in terms of identifying domestic abuse victims, signposting and referring and supporting longer term recovery.**
- There are potentially 20,000 attendances at A&E each year of victim-survivors who are currently missed
- General Practice is dealing with high levels of mental health need and yet **no routine enquiry** into domestic abuse
- 10,000 IAPT referrals are made each year for residents but **no screening for trauma or domestic abuse**
- **No demographic data collected from health on domestic abuse victim-survivors (adult and child) or perpetrators**
- **Suicide prevention strategies, action plans and KPIs should include domestic abuse** and the coroners office should be invited to be part of domestic abuse partnerships

"There is a lack of mental health support available both short and long term. I have PTSD and can not access the therapy I need in Tameside via Pennine Care/Healthy Minds so pay privately which is not an option for all."

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11

Key findings | Police

- Despite higher than average records of recorded **crime as much as half of domestic abuse in Tameside might be unseen and uncounted**
- Survivors report **inconsistent approaches from the police** with many people channelled into a civil route rather than a criminal route (particularly if there are protected characteristics) with police rather then victims making decisions on prosecution success
- **MARAC data shows under representation in the following categories – older victims, B&ME victims, disabled victims and those with substance use issues**
- **MARAC should create better information capture and record keeping on perpetrators particularly around demographics**

Key findings | Children's Services

- Feedback on CSC is that the **non-abusive parent is often held accountable for change** and not the perpetrator
- **Demographic data** on CYP engaged in services not available
- **No data on which children are being supported with a history of DA** across Early Help services, YOT and the Family Nurse Partnership
- CYP are now legally recognised as victims in their own right therefore:
  - We will need a **dashboard on DA & CYP**
  - We need to monitor the **potential impact on social work practice** and care proceedings
  - There are consequences of '**victims protecting victims**'

"I get a lot of frustration from my clients when CSC are involved 'I feel like all these restrictions are on me, I won't have a drink, I won't go out with my friends, I won't leave my kids adults who don't have a police check' and he's walking around with nothing."
Bridges key worker interview

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13

Key findings | Substance Misuse

- **Tameside sits above both its statistical neighbours, and the national average, in relation to individuals in contact with both mental health and substance misuse services.**
- Tameside sits significantly above the national average in regards to **admission episodes for mental behavioural disorders due to use of alcohol.**
- High levels and strong service offer **hasn't resulted in high levels at MARAC**
- DA Score card demonstrates completion rates but **no analysis on who has completed** - perpetrators or victim-survivors, there is no disaggregation on sex, age or other protected characteristics.
- **Lack of local understanding on the needs of children living with parents who are accessing support for their substance**

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15

Key findings | Perpetrators

- From the data we did have regarding perpetrators, primary needs included: **mental health (and the link between suicide and suicidal ideation) and substance misuse.**
- There was a **lack of consistent data capture on perpetrators**, particularly high harm and serial perpetrators - this was of particular concern to **children's services, MARAC participants and specialist services**
- Early help and Midwifery safeguarding noted the **younger ages of perpetration**
- **There is a need for workforce development and training on the identification of primary perpetrators as a key outcome to building victim and child safety**

"You never really know if someone is a victim not a perpetrator. We have done work with both victim and the perpetrator in the service. We split them between workers, that is hard."

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14

Needs assessment | Key opportunities

- **Support for staff** to identify domestic abuse
- **Community champions as part of the preventative approach**
- **Campaigns** and awareness raising
- Specialist **health interventions**
- **Mental health buy-in and support**
- **Perpetrator approach** – substance misuse and mental health
- Supporting people to be **safe at home**
- Support in **safe accommodation**

And finally…**Data, a huge task ahead!**

Tameside Metropolitan Borough

16

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	25 August 2021
Executive Member:	Councillor Eleanor Wills – Executive Member (Adult Social Care and Health)
Clinical Lead:	Dr Ashwin Ramachandra – CCG Co-Chair
Reporting Officer:	Jessica Williams – Director of Commissioning
Subject:	**NHS SYSTEM OVERSIGHT FRAMEWORK**
Report Summary:	The report sets out NHS England and NHS Improvement's approach to oversight for 2021/22, one that reinforces system-led delivery of integrated care. This reflects the vision set out in the NHS Long Term Plan, Integrating care: Next steps to building strong and effective integrated care systems across England, the White Paper Integration and innovation: Working together to improve health and social care for all, and aligns with the priorities set out in the 2021/22 Operational Planning Guidance It describes the methodology that will be used to identify where ICSs and NHS organisations may benefit from or require support to meet the standards required of them in a sustainable way and describes an objective basis for decisions about when and how NHS England and NHS Improvement will intervene in cases where there are serious problems or risks to the quality of care.
Recommendations:	That Strategic Commissioning Board be recommended to note NHS England and NHS Improvement's approach to oversight of the CCG for 2021/22.

Financial Implications:

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

Budget Allocation (if Investment Decision)	
CCG or TMBC Budget Allocation	
Integrated Commissioning Fund Section – s75, Aligned, In-Collaboration	
Decision Body – SCB Executive Cabinet, CCG Governing Body	
Value For money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark	

Additional Comments

As this is a report outlining the NHS System Oversight Framework, there are no financial comments at this time. We are still awaiting formal NHS England guidance relating to the new finance regime and until that is received, we are unable to comment on any financial implications arising therein.

Legal Implications:
(Authorised by the Borough Solicitor)

On 24 June 2021 NHS England published the NHS Improvement's approach to oversight of Integrated Care Systems (ICSs), CCGs and trusts for 2021/22. Further information on the New System Oversight Framework can be

	found here. NHS England » NHS System Oversight Framework 2021/22
How do proposals align with Health & Wellbeing Strategy?	This is an update of a National Oversight Framework that will be used to assure the local system and has no direct impact on the strategy however Preventing ill health and reducing inequalities is one of the themes in the framework. The relationship between the CCG and Health & Wellbeing Board is included in the CCG assessment.
How do proposals align with Locality Plan?	The themes and metrics align with the Locality Plan
How do proposals align with the Commissioning Strategy?	The National Oversight Framework sets out the expectations of a Locality and will be used to provide assurance that the CCG along with the system are delivering to national expectations. The 80 metrics in the five oversight themes reflect the NHS Long Term Plan/People Plan and 2021/22 Planning guidance.
Recommendations / views of the Health and Care Advisory Group:	Not applicable
Public and Patient Implications:	How the CCG involves and consults with the public is one of the Key lines of Enquiry in the CCG self-assessment.
Quality Implications:	Quality is a key theme of the framework. How the CCG works with others (including the local health and wellbeing board(s)) to improve quality and outcomes for patients is a Key Line of Enquiry in the CCG self-assessment.
How do the proposals help to reduce health inequalities?	The engagement of the CCG with deprived communities, ethnic minority communities, inclusion of health populations and people with disabilities (people with learning disabilities, autism or both, people experiencing mental ill-health and people experiencing frailty) and the full diversity of the local population is part of the CCG self-assessment and METE
What are the Equality and Diversity implications?	None
What are the safeguarding implications?	None
What are the Information Governance implications? Has a privacy impact assessment been conducted?	None
Risk Management:	None
Access to Information:	The background papers relating to this report can be inspected by contacting the report writer

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1. INTRODUCTION

1.1 NHS England has a legal duty to assess annually the performance of each CCG against its duties to improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties.

1.2 Since 2019/20 the NHS Oversight Framework provided an approach whereby CCG performance was assessed in key areas that covered leadership, financial management and performance in priority areas. Based on this performance, NHS England provided each CCG with an overall assessment rating using the CQC rating terminology of 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'. A simplified approach focused on CCGs' contributions to local delivery of the overall system recovery plan operated in 2020/21. A narrative assessment, based on performance, leadership and finance, replacing the ratings system.

1.3 Tameside and Glossop CCG received feedback on 14 July (**Appendix 1** refers) this confirmed our significant record of achievement and focus throughout the year. Given the "light touch" and the Greater Manchester Health and Social Care Partnership (GM HSCP) have not made any changes to our current assessment, which in 2019/20 was Outstanding. Comments of particular note include:

(a) Recognition that the work done in previous years to build a resilient infrastructure strong relationships and collaborative culture underpinned the effectiveness of our COVID response and puts the CCG is in a strong position for recovery.
(b) Acknowledgment that Tameside & Glossop as a local economy is supportive of the GM agenda and directly influences and assists that agenda through its own leadership locally and in GM wide efforts.
(c) The quality of the relationships in Primary Care setting have strong foundations for future working and to resilient and effective models of provision today.
(d) Being at the forefront of innovation.
(e) Local leaders keen to ensure that within the new systems there is a built-in culture to support colleagues to be more innovative and creative and find reasons why you should rather than why you cannot.

1.4 In March 2021 NHS England and NHS Improvement launched a consultation on the proposed new approach to NHS system oversight. The consultation included a webinar on 27 April and Elaine Richardson attended on behalf of NHS Tameside and Glossop CCG.

1.5 The proposals reinforced the importance of system working and collaboration and were based on the principles of:

- working with and through ICSs, wherever possible, to tackle problems
- a greater emphasis on system performance and outcomes

1.6 There was a single NHS monitoring framework for ICSs, commissioners and providers with flexibility recognising significant differences in local delivery and governance arrangements across the country as well as different local challenges. The Provider quality and financial special measures guidance would be replaced with single approach across organisations and systems with support and intervention co-ordinated through a single Recovery Support Programme. The approach to annual CCG performance assessment would be simplified.

1.7 The intention was to implement the proposals from Q2 subject to outcome of the consultation and board approval.

1.8 In June 2021, the final version of the NHS System Oversight Framework 2021/22 (Appendix 2) was published. It aims to provide clarity to integrated care systems (ICSs), trusts and commissioners on how NHS England and NHS Improvement will monitor performance; set expectations on working together to maintain and improve the quality of care; and describe

how identified support needs to improve standards and outcomes will be co-ordinated and delivered. It will guide NHS England and NHS Improvement's oversight of ICSs at system, place-based and organisation level as well as decisions about the level and nature of delivery support they may require. It also describes how they will work with the Care Quality Commission (CQC) and other partners at national, regional and local level. Finally, it introduces a new integrated and system focused Recovery Support Programme (RSP) that replaces the previously separate quality and finance 'special measures' regimes for provider trusts.

2. NHS SYSTEM OVERSIGHT FRAMEWORK 2021/22

2.1 The approach to 2021/22 oversight is characterised by the following key principles:

(a) working **with and through ICSs**, wherever possible, to tackle problems

(b) a greater emphasis on **system performance and quality of care outcomes**, alongside the contributions of individual healthcare providers and commissioners to system goals

(c) matching **accountability for results** with improvement support, as appropriate

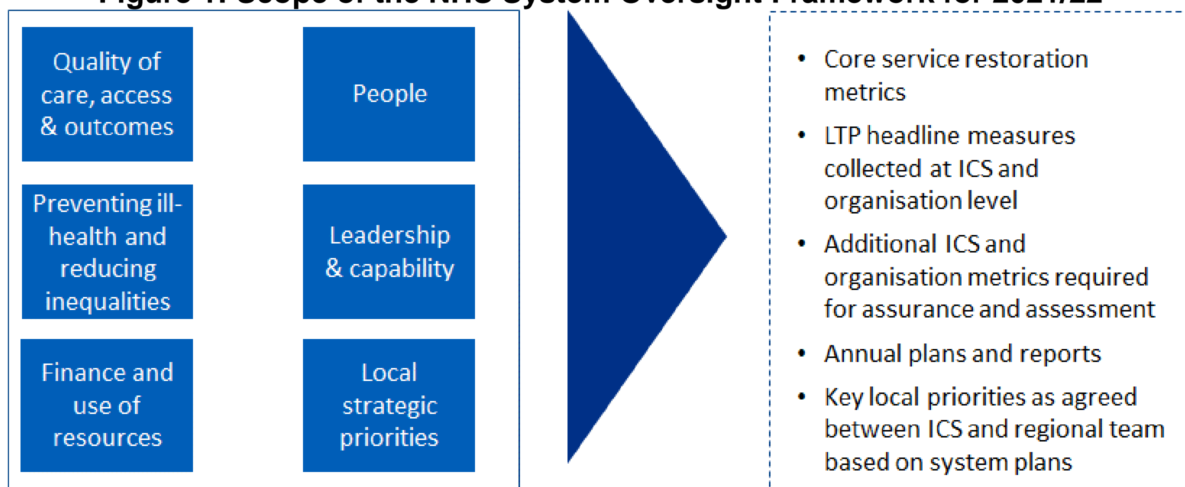
(d) **greater autonomy** for ICSs and NHS organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access

(e) **compassionate leadership behaviours** that underpin all oversight interactions.

2.2 In reality, the GM HSCP have been involved in oversight locally from the start and we have followed a whole system approach in Tameside and Glossop since being a CCG so it unlikely the approach will feel different.

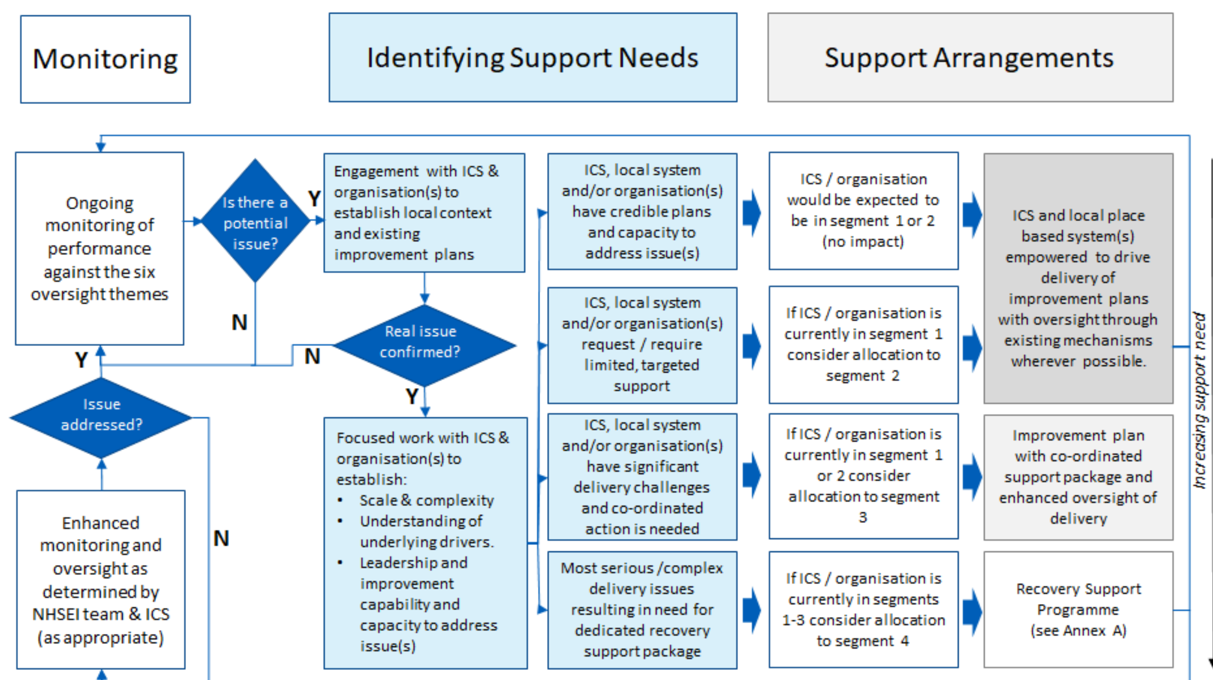
2.3 The framework has five national themes that reflect the ambitions of the NHS Long Term Plan with a single set of 80 metrics plus a sixth theme based on local strategic priorities that complement the national NHS priorities set out in the 2021/22 Operational Planning Guidance and align to the four fundamental purposes of an ICS. (Figure 1). Oversight conversations will reflect a balanced approach across the six oversight themes, including leadership and culture at organisation and system level.

Figure 1: Scope of the NHS System Oversight Framework for 2021/22



2.4 The process has three stages as shown in figure 2.

Figure 2: Oversight, diagnosis and support and intervention process



2.5 NHS England and NHS Improvement will monitor and gather insights about performance across each of the themes of the framework. Information will include annual plans and reports, regular financial and operational information; quality insight, risks and issues; and other exceptional or significant data, including relevant third-party material. Depending on the type of information, the collection and review of data may be monthly, quarterly or annual or by exception.

2.6 Regional teams will work with ICSs to ensure that oversight arrangements at ICS, place (including PCNs) and organisation level and the level of involvement of the ICS depends on their relative level of development and governance arrangements. Given the maturity of GM it is hoped that the ICS will lead the oversight of place based systems and individual organisations and co-ordinate any support and intervention carried out by NHS England and NHS Improvement, other than in exceptional circumstances and there will be the least number of formal assurance meetings possible.

2.7 There are four 'segments' as described in Table1 that ICSs, trusts and CCGs could be allocated to. Primary Care providers and PCNs will not be allocated to segments; however, the overall quality of Primary Care will inform ICS and CCG segmentation decisions.

Table 1: Support segments: description and nature of support needs

	Segment Decision			Support Needs
	ICS	**CCG**	**Trust**	
1	Consistently high performing across the six oversight themes. Capability and capacity required to deliver the ICS four fundamental purposes is well developed	Consistently high performing across the six oversight themes. Streamlined commissioning arrangements are in place or on track to be achieved	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities.	No specific support needs identified. Trusts encouraged to offer peer support. Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations.
2	On a development journey, but demonstrate many of	Plans that have the support of system	Plans that have the support of system	Flexible support delivered through peer support, clinical

Segment Decision				Support Needs
	ICS	CCG	Trust	
	the characteristics of an effective, self-standing ICS. Plans that have the support of system partners in place to address areas of challenge	partners in place to address areas of challenge. Targeted support may be required to address specific identified issues	partners in place to address areas of challenge. Targeted support may be required to address specific identified issues	networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs.
3	Significant support needs against one or more of the six oversight themes. Significant gaps in building the capability and capacity required to deliver on the ICS four fundamental purposes	Significant support needs against one or more of the six oversight themes. No agreed plans to achieve streamlined commissioning arrangements by April 2022	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)	Bespoke mandated support through a regional improvement hub, drawing on system and national expertise as required.
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support.	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support.	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support.	Mandated intensive support delivered through the Recovery Support Programme.

2.8 By default, all ICSs, trusts and CCGs will be allocated to segment 2 unless they meet the criteria for moving into segment 1, 3 or 4 as in Table 2 below.

Table 2: Support segments: Criteria for Segments 1, 3 and 4

Segment	**Objective, measurable eligibility** based on performance against the oversight themes using the relevant metrics	**Additional considerations** focused on the assessment of system leadership and behaviours, and improvement capability and capacity
1	Performance against the oversight themes typically in the top quartile nationally based on the relevant oversight metrics **And** On agreed financial plan and forecasting delivery against full year envelope **And** CQC 'Good' or 'Outstanding' overall and for well-led (trusts)	***For ICSs and/or CCGs*** - Success in tackling variation across the system and reducing health inequalities Whether the ICS consistently demonstrates that it has built the capability and capacity required to deliver on the four fundamental purposes of an ICS Whether the CCG has achieved streamlined commissioning arrangements aligned to the ICS boundary, or is on track to fully achieve these against an agreed plan. ***For trusts***: - Evidence of established improvement capability and capacity The degree to which the trust plays a strong, active leadership role in supporting and driving place-based priorities, provider collaboration and overall ICS priorities.
3	Performance against multiple oversight themes in the bottom quartile nationally based on the relevant oversight metrics **Or** A dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas **Or** An underlying deficit that is in the bottom quartile nationally and/or a negative	***For All:*** - Existence of other material concerns about a system's and/or organisation's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England and NHS Improvement (eg delivery against the national and local transformation agenda) Evidence of capability and capacity to address the issues without additional support, eg where there is clarity on key issues with an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions

Segment	**Objective, measurable eligibility** based on performance against the oversight themes using the relevant metrics	**Additional considerations** focused on the assessment of system leadership and behaviours, and improvement capability and capacity
	variance against the financial plan and/or not forecasting to meet plan at year end **Or** A CQC rating of 'Requires Improvement' overall and for well-led (trusts) **Or** No agreed plans to achieve streamlined commissioning arrangements aligned to ICS boundaries by April 2022 (CCGs)	There are other exceptional mitigating circumstances. **For ICSs:** -Evidence of collaborative and inclusive system leadership across the ICS, eg where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope Clarity and coherence of system ways of working and governance arrangements **For trusts**: - Whether the trust is working effectively with system partners to address the problems
4	In addition to the segment 3 criteria: - Longstanding and/or complex issues that are preventing agreed levels of improvement for ICSs, trusts or CCGs in SOF segment 3 **Or** A catastrophic failure in leadership or governance that risks damaging the reputation of the NHS **Or** A significant underlying deficit and/or significant actual or forecast gap to the financial plan **Or** CQC recommendation (trust)	

2.9 In line with the principle of earned autonomy those in segment 1 will benefit from the lightest oversight arrangements and greater autonomy. Specifically: a. ICSs will be able to request devolution of programme funding and greater control over the deployment of improvement resources made available through regional improvement hubs b. trusts and CCGs will be able to request access to funding to provide peer support to other organisations, and benefit from streamlined business case approval.

2.10 Those in segment 3 or 4 will be subject to enhanced direct oversight by NHS England and NHS Improvement (in the case of individual organisations this will happen in partnership with the ICS) and, depending on the nature of the problem(s) identified, additional reporting requirements and financial controls. For systems, trusts and CCGs allocated to segment 4, the new national Recovery Support Programme (RSP) will provide focused and integrated support, working in a co-ordinated way across the system, regional and national NHS England and NHS Improvement teams.

2.11 The CCG annual assessment will include a mid-year self-assessment with an end-of-year meeting between the CCG leaders and the NHS England and NHS Improvement regional team. It focuses on the six key lines of enquiry in figure 3 below - five of which are the themes in the oversight with the sixth a focus on engagement, performance against the oversight metrics and an assessment of how the CCG works with others (including the local health and wellbeing board(s)) to improve quality and outcomes for patients.

Figure 3: Key Lines of Enquiry for CCG Assessment 2021/22

Quality of care, access and outcomes
How has the CCG contributed to ensuring delivery of health services in the priority areas set out in the 2021/22 Operational Planning Guidance?
How has the CCG monitored oversight of quality and patient experience?
How has the CCG supported the system to respond to emergency demands and manage winter pressures?
Preventing ill-health and reducing inequalities
How has the CCG supported actions to address inequalities in NHS provision and outcomes?
Does the CCG have effective systems and processes for monitoring, analysing and acting on a range of information about quality, performance and finance, from a variety of sources, including patient feedback, analyses of access to services and experiences of service users, so that it can identify early warnings of a failing service?

How has the CCG taken account of lessons from managing COVID-19, in a way that locks in beneficial changes and explicitly tackles fundamental challenges, including support for staff, and action on inequalities and prevention?
People
How can the CCG evidence that it has supported the health and wellbeing of its workforce?
How has the CCG contributed to the delivery of the priorities for the NHS workforce set out in the NHS People Plan and 2021/22 Operational Planning Guidance, and the implementation of Our NHS People Promise?
Leadership
Has the CCG demonstrated effective system leadership and progressed partnership working, underpinned by governance arrangements and information-sharing processes, including evidence of multi-professional leadership?
Finance and use of resources
Evidence that the CCG has delivered its break-even target in-year and contributed to the reduction of system deficits. Evidence that the CCG has delivered the Mental Health Investment Standard.
Involve and consult with the public
How does the CCG identify and engage with deprived communities, ethnic minority communities, inclusion health populations and people with disabilities (people with learning disabilities, autism or both, people experiencing mental ill-health and people experiencing frailty) and the full diversity of the local population?

2.12 The final narrative assessment will identify areas of good and/or outstanding performance, areas of improvement, as well as areas of particular challenge across: quality (including reducing health inequalities), leadership, and finance and use of resources.

3. METRICS

3.1 The 81 metrics in the five oversight themes reflect the NHS Long Term Plan/People Plan and 2021/22 Planning guidance (Appendix 3). They are system wide with 63 being specifically associated with the CCG.

3.2 They cover a range of areas including access, service delivery, safety, vaccination and workforce. The metrics against each theme and the area they cover are shown in Tables 3 to 7 below. Many are metrics that systems have been working to before e.g. 62 day and 52week waiters; some are ones that are already part of recovery and COVID expectations e.g. elective activity levels and % of COVID vaccinations and others are not yet fully defined e.g. aggregate score for NHS Staff Survey questions that measure perception of leadership culture and Health and Well being index.

Table 3: Quality, Access and Outcome Metrics

Primary Care	Access to general practice - number of available appointments
	Proportion of the population with access to online GP consultations
	Patient experience of GP services
	Dental Activity
Urgent & Emergency	2-hour urgent response activity
	Discharges by 5pm
	Delayed transfers of care per 100,000 population
	Ambulance response times
	30-minute ambulance breaches

	UEC performance measure
	% of patients referred to an emergency department by NHS 111
	% of patients referred to an emergency department by NHS 111 that receive a booked time slot to attend
	% of zero-day length of stay admissions (as a proportion of total)
	% of unheralded patients attending EDs
Elective & Cancer	Elective activity levels
	Overall size of the waiting list
	Patients waiting more than 52 weeks to start consultant-led treatment
	Advice and guidance and patient initiated follow-up activity levels
	Cancer referral treatment levels
	People waiting longer than 62 days
	% meeting faster diagnosis standard
	Diagnostic activity levels
	Proportion of cancers diagnosed at stages 1 or 2
Maternal Health	% women on continuity of care pathway
	Number of stillbirths per 1,000 total births
	% of all outpatient activity delivered remotely via telephone or video consultation
	Number of neonatal deaths per 1,000 live births
Mental Health and LD	Deliver the mental health ambitions
	NHS Long Term Plan metrics for mental health
	Reliance on specialist inpatient care for adults/children with a learning disability and/or autism
	Number of people with a learning disability on the GP register receiving an annual health check
Personalisation	Number of personalised care interventions
	Personal health budgets
	Social prescribing unique patient referrals
Safety	Summary hospital-level mortality indicator
	Overall CQC rating (provision of high-quality care)
	Acting to improve safety (safety culture theme in NHS Staff survey)
	Potential under-reporting of patient safety incidents
	National Patient Safety Alerts not completed by deadline
	Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia infection rate
	Clostridium difficile infection rate
	E. coli bloodstream infections
	Venous thromboembolism (VTE) risk assessment
	Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care

Table 4: Preventing Ill Health and Reducing Inequalities Metrics

Vaccination	% of adults vaccinated - First COVID-19 vaccination dose offered to all adults by the end of July
	Population vaccination coverage – MMR for two doses (5 year olds) to reach the optimal standard nationally (95%)

	COVID-19 vaccination uptake for black and minority ethnic groups and the most deprived quintile compared to the national average
	Number of people receiving flu vaccination
Screening	Bowel screening coverage, aged 60–74, screened in last 30 months
	Breast screening coverage, females aged 50–70, screened in last 36 months
	Cervical screening coverage, females aged 25-64, attending screening within target period
Long Term Conditions	Number of people supported through the NHS Diabetes Prevention programme
	Diabetes patients that have achieved all the NICE-recommended treatment targets (adults and children)
	Number of people with CVD treated for cardiac high risk conditions
	Number of people receiving mechanical thrombectomy
	Number of referrals to NHS digital weight management services
Ethnicity	Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics
	Proportions of patient activities with an ethnicity code

Table 5: People Metrics

Experience	People promise index
	Health and wellbeing index
	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers, (b) other colleagues, (c) patients/ service users, their relatives or other members of the public in the last 12 months
	Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties
	Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns
	% of jobs advertised as flexible
	Staff retention rate (all staff)
	Sickness absence (working days lost to sickness)
	Proportion of staff who say they have a positive experience of engagement
Vaccination	Number of people working in the NHS who have had a ‘flu vaccination
Workforce	Proportion of staff in senior leadership roles who are (a) from a BME background, (b) women
	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age
	Number of registered nurses employed by the NHS (WTE)
	Number of doctors working in general practice (WTE)
	Additional primary care WTE through ARRS
	Number of healthcare support workers employed by the NHS
	Mental health workforce growth

Table 6: Finance and Use of Resources Metrics

Performance against financial plan
Underlying financial position
Run rate expenditure

Overall trend in reported financial position

Table 7: Leadership and Capability Metrics

Quality of leadership
Aggregate score for NHS Staff Survey questions that measure perception of leadership culture

4. CONCLUSION

4.1 Tameside and Glossop Locality should see minimal difference in the methodology used in the Oversight Framework and are in a strong position for many themes. Whilst some of the metrics may continue to be a challenge, if progress continues we may be moved from the default of Segment 2 into Segment 1.

5. RECOMMENDATIONS

5.1 As set out at the front of the report.

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Dear Colleagues,

2020/21 CCG annual assessment

Thank you for your time and production of evidence to inform the 2020/21 CCG annual assessment. I wanted to start by putting on record our recognition and thanks for the efforts you and your teams have applied to keep your residents and communities safe, and to support your staff and teams across the health and care economy, in this uniquely challenging and upsetting year.

The evidence provided in the self-assessment stands as a significant record of achievement and focus throughout the year. I would however highlight a few key points which were also recognised in the discussion:

- We reflected that the effectiveness of the COVID response is largely due to the infrastructure previously in place. Additionally, as we look to recovery, the CCG is in a strong position thanks to the collaborative models in place that have enabled an agile workforce. Indeed, you remarked that the CCG has been more efficient in its use of clinician and office time than ever before.
- We were keen to acknowledge that Tameside & Glossop as a local economy is supportive of the GM agenda and directly influences and assists that agenda through its own leadership locally and in GM wide efforts
- We noted that the quality of the relationships in Primary Care has led not only to strong foundations for future working but also to resilient and effective models of provision today – for example the T&G approach to the establishment of Hot Clinics with every practice working equally with unified systems and guidance to enable practices to work in a similar format to each other.
- Tameside & Glossop has been at the forefront of innovation especially in respect of the care home work undertaken and testing. Tameside & Glossop was the first locality in the first wave of COVID to offer drive through testing clearly illustrating the joined-up approach and collaborative working

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- The relationships and communication between the CCG, the acute and primary care throughout the pandemic has been strong. The CCG instigated twice weekly check ins with the acute to identify the number of patients admitted to the ICU which demonstrates that the locality had its finger on the pulse and although now a slimmed down version the meetings still take place
- Local leaders are keen to ensure that within the new systems there is a built-in culture to support colleagues to be more innovative and creative and find reasons why you should rather than why you cannot. The development of the existing arrangements certainly reflected that attitude as PCN's responded enthusiastically to the opportunities to drive locally relevant change.
- We touched on some points of detail where GM should seek to influence nationally to improve the conditions for success, or example better enabling PCNs to share staff in the interests of efficiency and resilience.

NHS England is legally required to review CCGs' performance on an annual basis. Historically, this has been carried out under the auspices of the CCG Improvement and Assessment Framework and, more recently, the NHS Oversight Framework, with the overall assessment ratings based on a CQC-style four label categorisation.

As a result of the continued impact of Covid-19 and the need for the NHS to set new and updated priorities across the different phases of the response, it has not been possible to apply the established arithmetic methodology to determine CCGs' ratings for 2020/21. Therefore, a simplified approach to the 2020/21 CCG annual performance review has been taken, taking account of the different circumstances and challenges CCGs have faced in managing recovery across the phases of the NHS response to Covid-19.

The Health and Social Care Act 2012 requires that the performance assessment must consider the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. For 2020/21, we have aligned these duties with the operational priorities set out in July and December 2020

This year the annual assessment has focused on CCGs' contributions to local delivery of the overall system plan for recovery, with emphasis on the effectiveness of working relationships in the local system. This review has included a CCG self-assessment and an end-of-year meeting.

Due to the need to prioritise the COVID-19 response, the CCG assessment process this year has been "light touch" and the we have not made any changes to current assessments.

The CCG may of course publish their individual assessment reports (or summary of key points) in the format they wish.

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I look forward to working with you over the coming months and jointly supporting each other in the next stage of development to integrate care in Tameside & Glossop and across GM.

In the meantime, please let me know if there is anything in this letter that you would like to follow up on.

Yours sincerely,

Sarah Price

Interim Chief Officer
Greater Manchester Health and Social Care Partnership

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NHS System Oversight Framework 2021/22

June 2021

Contents

1. Introduction....2
2. Purpose and principles....4
3. Role of integrated care systems....4
4. Approach to oversight....6
5. Oversight cycle....9
   Monitoring....9
   Identifying the scale and nature of support needs....12
   Identifying specific support needs....17
   Co-ordinating support activity....18
6. Recovery Support Programme....20
7. CCG assessment....22
8. Alignment with partner organisations....23
Annex A: Intervention and mandated support....24
Annex B: Key lines of enquiry for CCG assessment 2021/22....33

1. Introduction

1. In recent years it has become increasingly clear that the best way to manage NHS resources to deliver high quality, sustainable care is to focus on organising health at both system and organisation level.

2. This document describes NHS England and NHS Improvement's approach to oversight for 2021/22, one that reinforces system-led delivery of integrated care. This reflects the vision set out in the NHS Long Term Plan, Integrating care: Next steps to building strong and effective integrated care systems across England, the White Paper Integration and innovation: Working together to improve health and social care for all, and aligns with the priorities set out in the 2021/22 Operational Planning Guidance.

3. In 2021/22, the NHS will continue to manage the impact of COVID-19 and provide the full range of non-COVID services within an evolving local, regional and national context. The NHS System Oversight Framework:

   a. provides clarity to integrated care systems (ICSs), trusts and commissioners on how NHS England and NHS Improvement will monitor performance; sets expectations on working together to maintain and improve the quality of care; and describes how identified support needs to improve standards and outcomes will be co-ordinated and delivered

   b. will be used by NHS England and NHS Improvement's regional teams (regional teams) to guide oversight of ICSs at system, place-based and organisation level as well as decisions about the level and nature of delivery support they may require

   c. describes how NHS England and NHS Improvement will work with the Care Quality Commission (CQC) and other partners at national, regional and local level to ensure our activities are aligned

   d. introduces a new integrated and system focused Recovery Support Programme (RSP) that replaces the previously separate quality and finance 'special measures' regimes for provider trusts.

4. While the scope of this framework reflects the role of NHS England and NHS Improvement as a national regulator of NHS provided and/or commissioned services, it also recognises that:

   a. the vision for ICSs is based on the core principles of equal partnership across health and local government: subsidiarity, collaboration and flexibility

   b. delivering the priorities for the NHS depends on collaboration across health and care, both within a place and at scale.

5. We have heard a clear message from NHS leaders that they are looking for specificity in how oversight will operate within a system context. Set against this many are seeking a high degree of flexibility to design approaches that best reflect local circumstances and maintain ownership and engagement across the full range of system partners. This document aims to achieve both: to be clear and specific on the consistent requirements for NHS oversight within the current statutory framework and to define the parameters for tailoring to local circumstances which is key to success.

6. The ICS Design Framework sets out the headline ambitions for how we will ask NHS leaders and organisations to operate with their partners in ICSs from April 2022, enabled by legislation expected in this parliamentary session. We will continue to work with ICSs, trusts, commissioners and NHS partner organisations over the course of 2021/22 to further develop the approach to oversight set out in this document for future years. Subject to the parliamentary process, we will update this framework for 2022/23 to reflect the new statutory arrangements. We expect this updated framework will confirm ICSs' formal role in oversight including:

   a. bringing system partners together to identify risks, issues and support needs and facilitate collective action to tackle performance challenges

   b. leading oversight and support of individual organisations and partnership arrangements within their systems.

7. The existing statutory roles and responsibilities of NHS England and NHS Improvement in relation to trusts and commissioners remain unchanged for 2021/22. NHS England and NHS Improvement will continue to exercise their statutory powers where necessary to address organisational issues and support system delivery in line with the principles set out in this document. The accountabilities of individual NHS organisations also remain unchanged.

2. Purpose and principles

8. The purpose of the NHS System Oversight Framework is to:

   a. align the priorities of ICSs and the NHS organisations within them
   b. identify where ICSs and NHS organisations may benefit from or require support to meet the standards required of them in a sustainable way, and deliver the overall objectives for the sector in line with the priorities set out in the *2021/22 Operational Planning Guidance*, the *NHS Long Term Plan* and the *NHS People Plan*
   c. provide an objective basis for decisions about when and how NHS England and NHS Improvement will intervene in cases where there are serious problems or risks to the quality of care.

9. The approach to oversight is characterised by the following key principles:

   a. working **with and through ICSs**, wherever possible, to tackle problems
   b. a greater emphasis on **system performance and quality of care outcomes**, alongside the contributions of individual healthcare providers and commissioners to system goals
   c. matching **accountability for results** with improvement support, as appropriate
   d. **greater autonomy** for ICSs and NHS organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access
   e. **compassionate leadership behaviours** that underpin all oversight interactions.

3. Role of integrated care systems

10. *Integrating care: Next steps to building strong and effective integrated care systems across England* describes the role of ICSs in the delivery of integration to serve four fundamental purposes:

    a. improving population health and healthcare
    b. tackling unequal outcomes and access
    c. enhancing productivity and value for money
    d. helping the NHS to support broader social and economic development.

11. The *2021/22 Operational Planning Guidance* sets out the headline requirements for all ICSs from April 2021, including the collective management of system resources and performance, clearly defined at system, place-based and organisational level.

12. ICSs will therefore continue to be increasingly involved in the oversight process and support of organisations in their system, in partnership with NHS England and NHS Improvement. Oversight arrangements will reflect both the performance and relative development of an ICS. This framework is designed to support ICSs and NHS England and NHS Improvement regional teams to work together to develop locally appropriate approaches to oversight linked to the progression of an ICS (Table 1).

13. As part of the progressive development of ICSs, place-based and provider collaboration arrangements, including primary care networks (PCNs), are playing an increasingly important role in the co-ordination and delivery of joined-up care across populations. The oversight arrangements reflect an expectation for evidence of effective provider collaboration and the failure of individual trusts to collaborate in a system context may be treated as a breach of governance conditions and be subject to enforcement actions.

Table 1: ICS development and oversight approach

	Relative level of ICS development and governance arrangements →		
	By exception	**Typical oversight arrangement***	
ICS	ICS leadership will **work in partnership** with the regional team, attending and contributing to discussions relating to place-based[†] systems and individual organisations within the ICS Provide **advice and guidance** on place-based systems[†] and individual organisations within the ICS	**Jointly conduct** oversight and drive improved performance for place-based[†] systems and individual organisations within the ICS alongside regional teams **Participate** in any place-based system or organisational support and intervention carried out by NHS England and NHS Improvement, other than in exceptional circumstances	**Lead** the oversight of place-based[†] systems and individual organisations in line with the principles of this document **Co-ordinate** any support and intervention carried out by NHS England and NHS Improvement, other than in exceptional circumstances
NHS England and NHS Improvement	**Lead** the oversight of the ICS, and work in partnership on the oversight of place-based systems[†] and individual organisations in line with the principles of this document **Engage** with the ICS before any escalation action/ intervention is finalised and enacted through a single identified system lead	**Lead** the oversight of the ICS and contribute to the oversight of all place-based systems[†] and individual organisations alongside the ICS Only engage with organisations with the knowledge and participation of the ICS through a single identified lead (other than in exceptional circumstances)	Gain assurance of place-based systems[†] and individual organisations through the ICS, other than in exceptional circumstances[††] Undertake the least number of formal assurance meetings possible with individual organisations

*Where individual provider or commissioning organisations are subject to formal regulatory intervention, NHS England and NHS Improvement will take a direct role alongside ICSs in enhanced oversight.

[†] Where the ICS is built on more than one place-based system.

[††]This does not change the statutory roles and responsibilities of either NHS England and NHS Improvement or the system bodies.

4. Approach to oversight

14. Ongoing oversight will focus on the delivery of the priorities set out in the *2021/22 Operational Planning Guidance*, including the *NHS Mandate*, the aims of the *NHS Long Term Plan* and the *NHS People Plan*. As part of this, a set of oversight metrics will be used by NHS England and NHS Improvement and ICSs to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual trusts and commissioners.

15. To support this, the oversight framework is built around:

a. Five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts, commissioners and ICSs: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability (Figure 1).

b. A single set of metrics across ICSs, trusts, clinical commissioning groups (CCGs) and primary care, aligned to the five national themes.

c. A sixth theme, local strategic priorities, recognises:

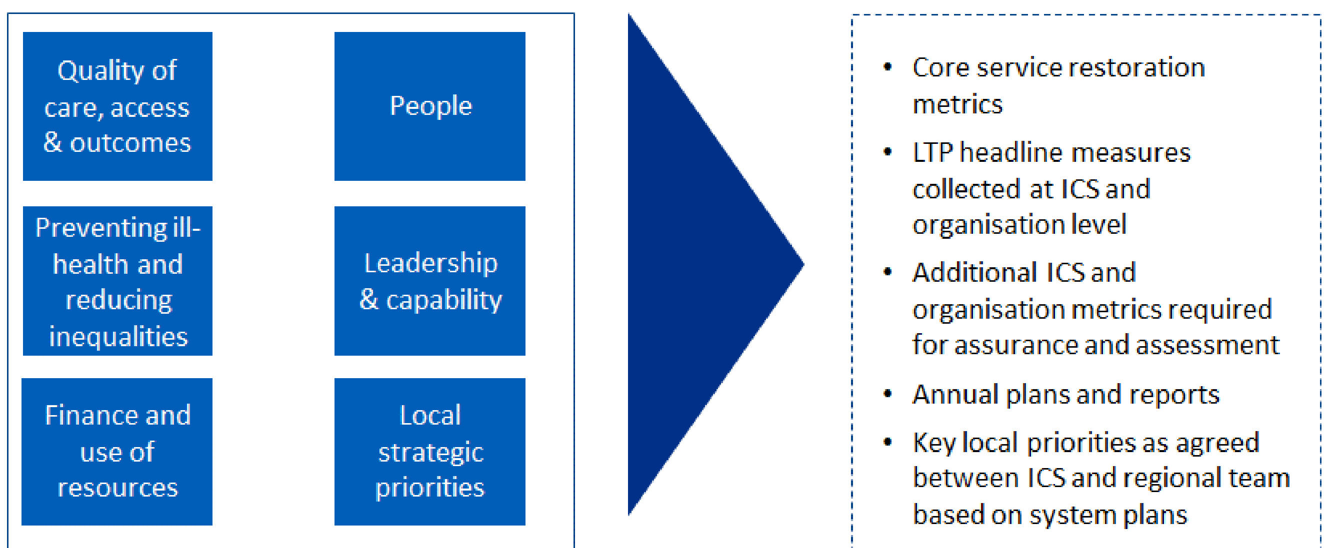
   i. that ICSs each face a unique set of circumstances and challenges in addressing the priorities for the NHS in 2021/22

   ii. the renewed ambition to support greater collaboration between partners across health and care, as set out in *Integrated care*, to accelerate progress in meeting our most critical health and care challenges and support broader social and economic development.

d. A description of how ICSs will work alongside regional and national NHS England and NHS Improvement teams to provide effective, streamlined oversight for quality and performance across the NHS.

e. A three-step oversight cycle that frames how NHS England and NHS Improvement teams and ICSs will work together to identify and deploy the right delivery support and intervention to drive improvement and address the most complex and challenging problems, respectively.

Figure 1: Scope of the NHS System Oversight Framework for 2021/22



16. ICSs will agree a **memorandum of understanding** with regional teams that sets out:

    a. The delivery and governance arrangements across the ICS, including:

        i. financial governance arrangements that will support the effective management of resources within the system financial envelope

        ii. quality governance arrangements. The National Quality Board's (NQB) *A shared commitment to quality* and *Position statement on quality in integrated care systems* set out specific requirements that ICSs are expected to have in place to support the proactive identification, monitoring and escalation of quality issues and concerns

        iii. the role of place-based partnerships and provider collaboratives in delivering the NHS priorities set out in the 2021/22 planning guidance.

    b. The oversight mechanisms and structures that reflect these delivery and governance arrangements, including the respective roles of the ICS and NHS England and NHS Improvement.

    c. The local strategic priorities that the ICS has committed to deliver in 2021/22 as a partnership. These must complement the national NHS priorities set out in the *2021/22 Operational Planning Guidance* and align to the four fundamental purposes of an ICS.

17. In some cases, oversight arrangements spanning more than one ICS will be required, eg for ambulance trusts and specialised services. Regional teams will work with trusts and ICSs to agree appropriate arrangements in line with this framework.

18. There will be a need for flexibility in how the oversight role is carried out within the principles of this framework. In some cases, this may involve adjusting the specifics of the approach, for example:

    a. as the NHS continues to rise to the challenge of restoring and transforming services, both tackling backlogs and meeting new care demands, in the context of the COVID-19 pandemic

    b. where there is a need to respond quickly and proactively to unexpected issues in individual organisations, to national policy changes, the introduction of new service planning or delivery models, or new sector pressures.

5. Oversight cycle

19. The oversight process follows an ongoing cycle (Figure 2) of:

    a. monitoring ICS and NHS organisation performance and capability under six themes (Figure 1)
    b. identifying the scale and nature of support needs
    c. co-ordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.

Monitoring

20. As part of the oversight of ICSs, trusts and commissioners, NHS England and NHS Improvement will monitor and gather insights about performance across each of the themes of the framework (Figure 1). The information reviewed and collected will include annual plans and reports, regular financial and operational information; quality insight, risks and issues; and other exceptional or significant data, including relevant third-party material. Depending on the type of information, the collection and review of data may be:

    a. **in year:** using monthly or quarterly collections and forums as appropriate
    b. **annual:** using annual submissions, surveys or other annually published information. In these cases, we expect that systems and regional teams will agree how they monitor progress on a timely basis linked to locally agreed plans and milestones
    c. **by exception:** where material events occur or we receive information that triggers our concern outside the regular monitoring cycle.

21. This information will be used to support ongoing monitoring at ICS, place and organisation level of:

    a. **current performance** and service quality (based on the most recent data and insight available)
    b. the **historical performance trend** to identify patterns and changes, including evidence of improvement in reducing clinical variation.

22. A key outcome of the successful implementation of the framework will be the early identification of emerging issues and concerns so that they can be addressed before they have a material impact or performance deteriorates further. ICSs, trusts and commissioners are expected to engage with regional teams on actual or

prospective changes in performance or quality risks that fall outside routine monitoring, where these are material to the delivery of safe and sustainable services.

23. Regional teams will work with ICSs to ensure that oversight arrangements at ICS, place (including PCNs) and organisation level incorporate regular review meetings as appropriate. Meetings will be informed by a shared set of information and regional teams will draw on national and other expertise as necessary (Table 2). Oversight conversations should reflect a balanced approach across the six oversight themes, including leadership and culture at organisation and system level.

24. Ongoing oversight meetings will be complemented by focused engagement with the ICS and the relevant organisations where specific issues emerge outside these meetings. Regional teams will work with systems to determine an appropriate enhanced associated level of oversight where this is required to monitor improvement alongside a package of support or intervention.

Table 2: Ongoing monitoring process – review meetings

	ICS	Place*	Individual organisations/collaboratives
Scope	• Performance against national requirements including the NHS Long Term Plan deliverables at ICS level across the five national themes of the NHS System Oversight Framework • Delivery against ICS 'local priorities' set out in ICS strategic plans and its local people plan • Extent to which system partners are working effectively together to deliver and improve	• Performance against national requirements including the NHS Long Term Plan deliverables at place and organisation level across the themes of the NHS System Oversight Framework • Delivery against place and organisation level priorities set out in ICS plans including primary/community care and population health • Any emerging organisational health issues that may need addressing • Extent to which place-based partners are working effectively together to deliver and improve	• Oversight of and support to: – individual organisations that span multiple ICSs, or have significant funding flows from outside an ICS, eg ambulance trusts and specialist trusts – collaboratives that span multiple places, including for the delivery of specialised services • Linked to NHS England statutory duty to annually assess CCGs • Occur by exception only for other organisations, with scope determined by the specific issues identified in discussion between the NHS England and NHS Improvement regional team and ICS leadership
Roles and participation	• Led by **NHS England and NHS Improvement regional team** with: – ICS leadership team – CEOs and AO(s) from system providers and commissioner(s)	• **Typically led by ICS** (with NHS England and NHS Improvement role linked to ICS maturity) with: – provider and commissioner leadership team – place-based system leaders as appropriate	• **NHS England and NHS Improvement, ICS and organisational teams as relevant** for cross ICS, provider collaborative and exceptional meetings • CCG leadership team, chair and governing body members for CCG assessment-related meetings
Frequency of review meetings	• The default frequency for these meetings will vary according to the governance arrangements agreed between the regional team and ICS, but should be at least quarterly • Regional team will engage more frequently where there are material concerns	• Determined in discussion between the regional teams and ICS based on local system architecture and governance arrangements • Regional and/or system team will engage more frequently where necessary, including focused meetings around specific themes (eg quality, finance) and/or with a subset of organisations	• Frequency determined based on need through discussion between NHS England and NHS Improvement regional team and ICS and organisational leadership • Annual meeting linked to CCG assessment process. CCGs are also expected to complete a mid-year self-assessment

* Including integrated care provider or other relevant local system level. For smaller ICSs built on a single overall place this may form part of the overall ICS review meetings.

Identifying the scale and nature of support needs

25. To provide an overview of the level and nature of support required across systems, inform oversight arrangements and target support capacity as effectively as possible, regional teams will allocate ICSs, trusts and CCGs to one of four 'segments' as described in Table 3. Primary care providers and PCNs will not be allocated to segments; however, the overall quality of primary care will inform ICS and CCG segmentation decisions. We will adopt a phased implementation to segmentation during 2021/22 with an initial focus on ICSs and trusts that meet the criteria for segments 3 and 4 (Table 3).

26. Segmentation decisions will be determined by assessing the level of support required based on a combination of objective criteria and judgement. For individual organisations, segmentation decisions will be taken having regard to the views of system leaders.

27. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. These will be identified as set out in the section 'Identifying specific support needs'.

28. The principles and approach to oversight will apply across all segments. By default, all ICSs, trusts and CCGs will be allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components (Table 4):

    a. objective, measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics
    b. additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

29. Where the objective, measurable eligibility criteria are met this will trigger consideration of the additional factors in determining the overall segmentation decision.

Table 3: Support segments: description and nature of support needs

	Segment description			Scale and nature of support needs
	ICS	CCG	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver the ICS four fundamental purposes is well developed	Consistently high performing across the six oversight themes Streamlined commissioning arrangements are in place or on track to be achieved	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective, self-standing ICS Plans that have the support of system partners in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in building the capability and capacity required to deliver on the ICS four fundamental purposes	Significant support needs against one or more of the six oversight themes No agreed plans to achieve streamlined commissioning arrangements by April 2022	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)	Bespoke mandated support through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

Table 4: Support segments: segmentation approach

	Eligibility criteria	Additional considerations
1	• Performance against the oversight themes typically in the top quartile nationally based on the relevant oversight metrics *and* • On agreed financial plan and forecasting delivery against full year envelope *and* • CQC 'Good' or 'Outstanding' overall and for well-led (trusts)	*For ICSs and/or CCGs:* • Success in tackling variation across the system and reducing health inequalities • Whether the ICS consistently demonstrates that it has built the capability and capacity required to deliver on the four fundamental purposes of an ICS • Whether the CCG has achieved streamlined commissioning arrangements aligned to the ICS boundary, or is on track to fully achieve these against an agreed plan. *For trusts:* • Evidence of established improvement capability and capacity • The degree to which the trust plays a strong, active leadership role in supporting and driving place-based priorities, provider collaboration and overall ICS priorities.
2	This is the default segment that all ICSs, trusts and CCGs will be allocated to unless the criteria for moving into another segment are met	
3	• Performance against multiple oversight themes in the bottom quartile nationally based on the relevant oversight metrics *or* • A dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas *or* • An underlying deficit that is in the bottom quartile nationally and/or a negative variance against the financial plan and/or not forecasting to meet plan at year end *or*	*For all:* • Existence of other material concerns about a system's and/or organisation's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England and NHS Improvement (eg delivery against the national and local transformation agenda) • Evidence of capability and capacity to address the issues without additional support, eg where there is clarity on key issues with an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions • There are other exceptional mitigating circumstances *For ICSs:* • Evidence of collaborative and inclusive system leadership across the ICS, eg where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope

	Eligibility criteria	Additional considerations
	• A CQC rating of 'Requires Improvement' overall and for well-led (trusts) *or* • No agreed plans to achieve streamlined commissioning arrangements aligned to ICS boundaries by April 2022 (CCGs)	• Clarity and coherence of system ways of working and governance arrangements *For trusts:* • Whether the trust is working effectively with system partners to address the problems
4	In addition to the segment 3 criteria: • Longstanding and/or complex issues that are preventing agreed levels of improvement for ICSs, trusts or CCGs in SOF segment 3 *or* • A catastrophic failure in leadership or governance that risks damaging the reputation of the NHS *or* • A significant underlying deficit and/or significant actual or forecast gap to the financial plan *or* • CQC recommendation (trust)	

30. In line with the principle of earned autonomy, ICSs, trusts and CCGs in segment 1 will benefit from the lightest oversight arrangements and greater autonomy. Specifically:

    a. ICSs will be able to request devolution of programme funding (removing the requirement to account for resource deployment in exchange for agreed outcomes), and greater control over the deployment of improvement resources made available through regional improvement hubs

    b. trusts and CCGs will be able to request access to funding to provide peer support to other organisations, and benefit from streamlined business case approval.

31. Where ICSs, trusts and CCGs have significant support needs that may require formal intervention and mandated support, they will be placed in segment 3 or 4. They will be subject to enhanced direct oversight by NHS England and NHS Improvement (in the case of individual organisations this will happen in partnership with the ICS) and, depending on the nature of the problem(s) identified, additional reporting requirements and financial controls. Full details are set out in Annex A: Intervention and mandated support.

    a. Mandated support consists of a set of interventions designed to remedy the problems within a reasonable timeframe. There are two levels depending on the severity and complexity of the issues:

        i. mandated support that is led and co-ordinated by NHS England and NHS Improvement regional teams with input from the national intensive support team where requested. This level of support means automatic entry to segment 3

        ii. mandated intensive support that is agreed with NHS England and NHS Improvement regional teams and delivered through the nationally co-ordinated Recovery Support Programme (see Section 6). This level of support means automatic entry to segment 4.

    b. While the eligibility criteria for mandated support will be assessed at ICS and individual organisation (trust and CCG) level, mandated support packages will always be designed and delivered within the relevant system context (eg place-based or provider collaboratives). Where the support need is triggered by an individual organisation, this means that local system partners will be expected to play their role in addressing system-related causes or supporting system solutions to the problem(s).

32. For ICSs and organisations in segments 1 and 2, overall support needs will be formally reviewed on a quarterly basis by the relevant regional team (in the case of individual organisations this will happen in partnership with the ICS). Where, by exception, ongoing monitoring suggests that the support needs may have changed, this will trigger a review of the segment allocation (see 'Identifying specific support needs' below).

33. For ICSs and organisations in segments 3 and 4, the agreed exit criteria will need to be met to move to a lower segment (see Annex A).

Identifying specific support needs

34. Where an ICS, place-based system or individual organisation (trust or CCG) is triggering a specific concern, the NHS England and NHS Improvement regional team will work with, or through, the ICS to understand why the trigger has arisen and if a support need exists. The regional team will involve system leads in this process – both to identify the factors behind the issues and whether local support is available and appropriate.

35. Teams will assess the seriousness, scale and complexity of the issues that the ICS, place-based system or individual organisation is facing using information gathered through quality surveillance, existing relationship knowledge and discussions with system members, and information from partners and evidence from formal or informal investigations. As part of this, regional teams will draw on the expertise and advice of national colleagues as required.

36. Regional teams, working with the ICS and place-based system leaders (as appropriate), will consider the:

    a. degree of risk and potential impact
    b. degree to which the ICS, place-based system or individual organisation understands what is driving the issue
    c. views of leadership, governance and maturity of improvement approach
    d. system's or organisation's capability and credibility of plans to address the issue
    e. previous steps to support the ICS, place-based system or individual organisation to rectify the issue
    f. extent to which the ICS, place-based system or individual organisation is delivering against a recovery trajectory.

37. Based on this assessment, teams will identify whether an ICS, place-based system or individual organisation has a specific support need and the level of support that is required. Support decisions will be taken having regard to the views of the system leadership.

38. Where appropriate this may lead to a review of the allocated support needs segment as set out above.

39. Specific support needs will be reviewed through regular ICS oversight meetings and additional enhanced oversight arrangements, where these are required to:

    a. track improvement and understand the effectiveness of the various support measures
    b. ensure support is targeted where it has the greatest impact.

Co-ordinating support activity

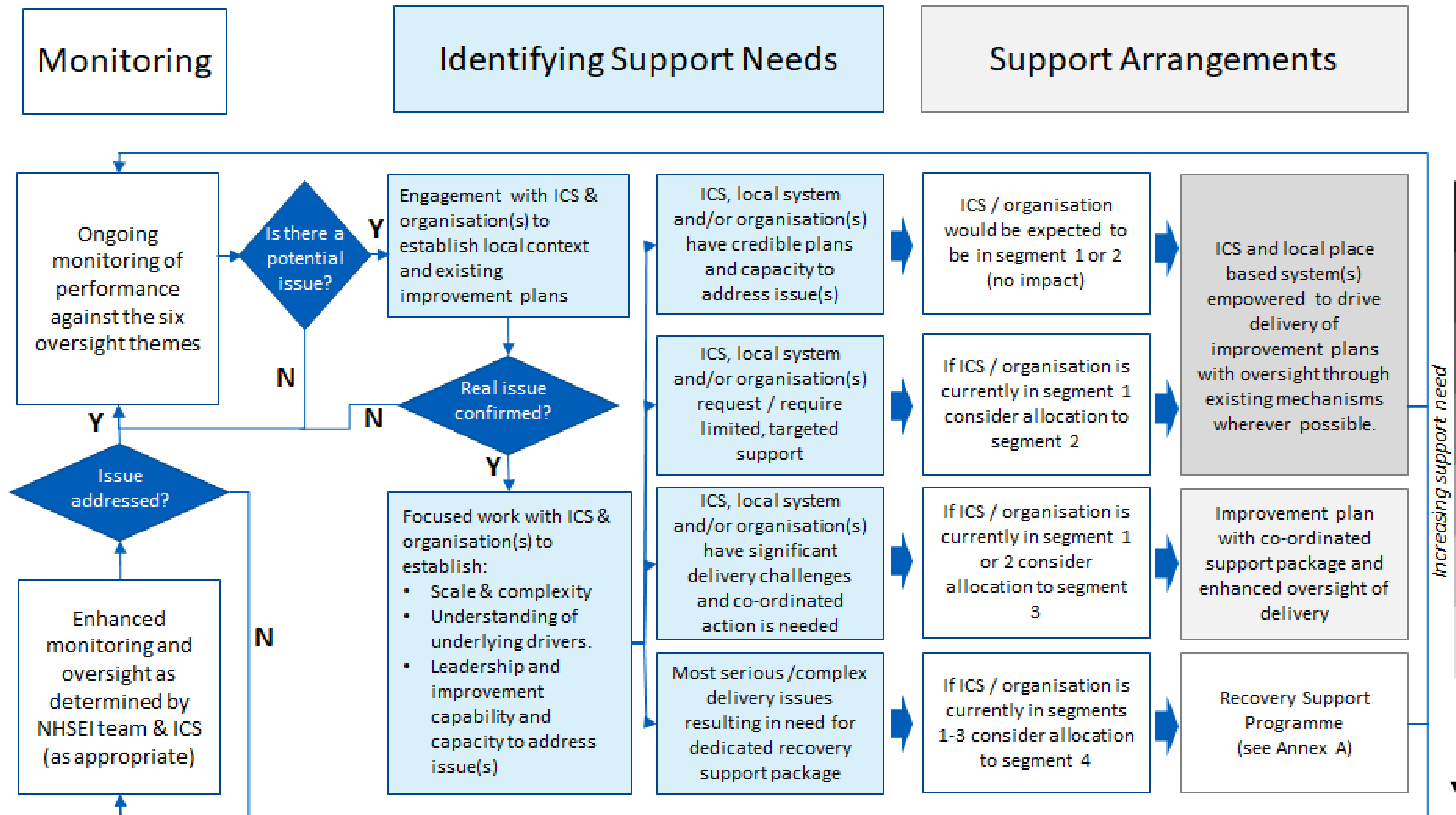
40. Regional system improvement teams will work flexibly with ICSs to deploy the right support through this ongoing cycle, drawing on the expertise and advice of national colleagues as appropriate. We will explore with ICSs the future role peer review could play in the oversight model.

41. In line with the principles governing the framework, regional system improvement teams will work with and through ICS leaders, wherever possible, to tackle problems and ensure that the oversight process is both proportionate and co-ordinated across ICSs.

42. Expertise, advice and support from wider regional colleagues will be drawn on as appropriate, including clinical quality teams. Regional teams will work to ensure that a co-ordinated support offer is provided to ICSs. Support requirements for ICSs, place-based systems and individual organisations will be considered in parallel so that any support activities (and where necessary interventions) are mutually reinforcing and can be deployed at the right level, eg where concerns affect multiple organisations a system-wide approach may be needed.

43. Where the operation of the ICS itself is deemed to be a causal part of the identified issue(s), this could result in a change to the oversight approach normally associated with that system's previously assessed maturity level.

Figure 2: Oversight, diagnosis and support and intervention process



6. Recovery Support Programme

44. For systems, trusts and CCGs allocated to segment 4, the new national Recovery Support Programme (RSP) will provide focused and integrated support, working in a co-ordinated way across the system, regional and national NHS England and NHS Improvement teams.

45. RSP replaces the separate quality and finance special measures programmes that have been in place since 2013. RSP differs from these special measures programmes in a number of important ways (details of the operation of the RSP as part of the overall approach to mandated support are set out in Annex A). It will:

    a. be system oriented, while still providing focused, intensive support to individual organisations
    b. focus on the underlying drivers of the problems that need to be addressed and those parts of the system that hold the key to improvement
    c. be nationally led by a credible, experienced system improvement director (SID) jointly appointed by the system, region and national intensive support team
    d. involve team-based support via an expert multidisciplinary team co-ordinated by the SID
    e. be time limited with clear exit criteria
    f. focus on system resilience with knowledge and skills transfer, providing sustainable capability within the system following exit.

46. Where entry to segment 4 and the RSP is triggered by an individual organisation, local system partners will be expected to play their role in addressing system-related causes or supporting system solutions to the problem(s).

47. On entering the RSP a diagnostic stocktake involving all relevant system, regional and national partners will:

    a. identify the root cause(s) of the problem(s) and the structural and strategic issues that must be addressed
    b. recommend the criteria that must be met for the system or organisation to exit mandated intensive support (exit criteria).

48. NHS England and NHS Improvement will review the capability of the ICS's, trust's or CCG's leadership. This may lead, if necessary, to changes to the management of the system/organisation to ensure the board and executive team can make the required improvements. Where changes are required, this will happen as soon as is practical and the necessary support will be provided to help facilitate this.

49. At the same time as helping to address the specific issues that triggered mandated intensive support, NHS England and NHS Improvement will consider whether long-term solutions are needed to address any structural issues affecting the ICS's, trust's or CCG's ability to ensure high quality, sustainable services for the public.

50. The SID will be jointly appointed by the system, NHS England and NHS Improvement regional and national intensive support teams, and will normally report to the system lead, with a reporting line to the Director of National Intensive Support to ensure sufficient independence. Specific arrangements will need to be agreed in each situation to ensure appropriate governance and independence.

51. The SID will support the ICS or relevant organisations with the development of the improvement plan, which will include an indicative timeline for exit from the RSP and segment 4 of the framework.

52. The SID will work with the trust, CCG and/or ICS to co-ordinate the necessary support from the system, NHS England and NHS Improvement teams, the broader NHS or, where appropriate, an external third party. This could include:

- intensive support for emergency and elective care
- intensive support to deliver the national programmes focused on reducing clinical variation across clinical pathways
- intensive support for workforce and people practices
- financial recovery support including specialist support, eg to reduce agency use, implement cost controls
- drivers of deficit review
- governance review
- governance and leadership programme for improvement in challenged organisations and systems

- tailored delivery of a range of improvement programmes such as ‘well led’, ‘better tomorrow’ and ‘making data count’.

53. Exit from the RSP and segment 4 of the framework will be decided by the NHS England and NHS Improvement System Oversight Committee on the recommendation of the relevant region and on the basis that the agreed exit criteria have been met in a sustainable way. Progress against the improvement plan will be reviewed on a six-monthly basis to ensure improvement is being achieved. Where entry into the RSP was on the recommendation of the CQC, then exit will also require CQC recommendation.

54. When a system or organisation exits the RSP, a package of support will be agreed to ensure that the improvement is sustained.

7. CCG assessment

55. NHS England has a legal duty to annually assess the performance of each CCG. The assessment must consider the duties of CCGs to improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties.

56. From 2015/16 to 2019/20, this was done first under the auspices of the *CCG Improvement and Assessment Framework* and for 2019/20 the *NHS Oversight Framework.* This provided an approach whereby CCG performance was assessed in key areas that covered leadership, financial management and performance in priority areas. On the basis of this performance, NHS England provided each CCG with an overall assessment rating using the CQC rating terminology of ‘Outstanding’, ‘Good’, ‘Requires Improvement’ and ‘Inadequate’.

57. For 2020/21, a simplified approach to the annual assessment of CCGs’ performance was taken as a result of the differential and continued impact of COVID-19. It provided scope to take account of the different circumstances and challenges CCGs faced in managing recovery across the phases of the NHS response to COVID-19 and focused on CCGs’ contributions to local delivery of the overall system recovery plan. A narrative assessment, based on performance, leadership and finance, replaced the ratings system previously used for CCGs.

58. This approach has been adapted for 2021/22 to provide greater flexibility to reflect both the continued uncertainty faced by the NHS in light of COVID-19 and the

increasingly significant differences between the size and nature of CCGs with the delivery of streamlined commissioning arrangements aligned to ICS footprints.

59. The annual assessment will include an end-of-year meeting between the CCG leaders and the NHS England and NHS Improvement regional team focused on:

    a. the key lines of enquiry set out in Annex B
    b. performance against the oversight metrics
    c. an assessment of how the CCG works with others (including the local health and wellbeing board(s)) to improve quality and outcomes for patients.

60. The final narrative assessment will identify areas of good and/or outstanding performance, areas of improvement, as well as areas of particular challenge across: quality (including reducing health inequalities), leadership, and finance and use of resources.

8. Alignment with partner organisations

61. As well as working with and through ICSs wherever possible to tackle problems, we recognise that the challenges facing the health and care system also require a joined-up approach and increased partnership with other organisations at national, regional and local levels. The NQB's A shared commitment to quality and Position statement on quality in integrated care systems emphasise the importance of having a common approach to quality and of organisations coming together to share intelligence though quality surveillance group (QSG) structures.

62. Systems and individual NHS organisations will also continue to benefit from the health and well-being boards and local authority health overview and scrutiny committees reviewing and scrutinising their work.

63. At a regional and national level NHS England and NHS Improvement will continue to work alongside key regulators, CQC, Health Education England, General Medical Council and the Nursing & Midwifery Council through the Joint Strategic Oversight Group (JSOG) function to provide a dedicated space for regulators to share intelligence and develop aligned approaches to support organisations.

Annex A: Intervention and mandated support

Introduction

1. Mandated support applies when ICSs, NHS trusts and foundation trusts ('trusts'), or CCGs have serious problems and where there are concerns that the existing leadership cannot make the necessary improvements without support.

2. Mandated support consists of a set of interventions designed to remedy the problems within a reasonable timeframe. There are two levels depending on the severity and complexity of the issues:

   - mandated support that is led and co-ordinated by NHS England and NHS Improvement regional teams with input from the national intensive support team where requested. This level of support means automatic entry to segment 3 of the NHS System Oversight Framework
   - mandated intensive support that is agreed with NHS England and NHS Improvement regional teams and delivered through the nationally co-ordinated Recovery Support Programme (RSP). This level of support means automatic entry to segment 4 of the NHS System Oversight Framework.

3. While the eligibility criteria for mandated support will be assessed at ICS and individual organisation (trust and CCG) level, mandated support packages will always be designed and delivered within the relevant system context (eg place-based or provider collaboratives). Where the support need is triggered by an individual organisation, this means that local system partners will be expected to play their role in addressing system-related causes or supporting system solutions to the problem(s).

4. Mandated support involves the use of our enforcement powers:

   - a trust considered to be in need of mandated support will be subject to enforcement action that requires the trust to carry out specific actions as part of the intervention
   - a CCG that is failing or is at significant risk of failing to discharge its functions may be subject to directions
   - in the case of an ICS, this may involve enforcement action at the level of individual organisations (trusts and CCGs) where appropriate.

5. This annex explains:

- how NHS England and NHS Improvement determine the requirement for mandated support and the level of support
- what happens to an ICS or organisation when mandated support applies
- the roles and responsibilities of other key organisations involved, specifically the CQC
- how an ICS or trust exits from mandated support.

6. This annex supersedes the previously published policy described as 'special measures' and should be read in conjunction with the 2021/22 System Oversight Framework.

How NHS England and NHS Improvement determine the need for mandated support

7. NHS England and NHS Improvement determine which ICSs, trusts and CCGs require mandated support with reference to a set of objective criteria, but we also take into account other appropriate considerations. Any ICS, trust or CCG meeting the objective criteria set out below is eligible to be considered for the relevant level of mandated support, but may also be excluded from this in light of other relevant considerations.

Mandated support (segment 3)

8. An ICS, trust or CCG is eligible to be considered for mandated support and entry to segment 3 if:

- performance against multiple oversight themes is in the bottom quartile nationally based on the relevant oversight metrics

  or

- there has been a dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas

  or

- it has an underlying deficit that is in the bottom quartile nationally and/or is reporting a negative variance against the delivery of the agreed financial plan and/or it is not forecasting to meet plan at year end

or

- for trusts, there is a CQC rating of 'Requires Improvement' overall and for well-led

  or

- for CCGs, there are no agreed plans to achieve streamlined commissioning arrangements aligned to ICS boundaries by April 2022.

9. Where there are material concerns about a system's and/or organisation's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England and NHS Improvement (eg delivery against the national and local transformation agenda), this may also trigger consideration of mandated support. In these circumstances regional teams will also consider the extent to which the above eligibility criteria are met.

10. Meeting one of the eligibility criteria does not lead to automatic entry to segment 3. In considering whether an ICS, trust or CCG that has met the eligibility criteria would benefit from mandated support, regional teams will consider whether:

For all:

- there is the capability and capacity to address the issues without additional support, eg where there is clarity on key issues with an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions
- there are other exceptional mitigating circumstances.

For ICSs:

- there is evidence of collaborative and inclusive system leadership across the ICS, eg where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope
- there is clarity and coherence in ways of working and governance arrangements across the system.

For trusts and CCGs:

- whether the trust or CCG is working effectively with other system partners to address the problems.

11. NHS foundation trusts will only be placed in segment 3 where there is evidence they are in actual/suspected breach of their licence conditions (or equivalent for NHS trusts).

Mandated intensive support (segment 4)

12. An ICS, trust or CCG is eligible to be considered for mandated intensive support and entry to segment 4 if, in addition to the considerations for mandated support above, any of the following criteria are met:

    - longstanding and/or complex issues that are preventing agreed levels of improvement for ICSs, trusts or CCGs in segment 3

      or

    - a significant underlying deficit and/or a significant actual or forecast gap to the agreed financial plan

      or

    - a catastrophic failure in leadership or governance that risks damaging the reputation of the NHS

      or for trusts:

    - a recommendation by the CQC.

13. The CQC, through the Chief Inspector of Hospitals, will normally recommend to NHS England and NHS Improvement that a trust is mandated to receive intensive support when it is rated 'Inadequate' in the well-led key question (that is, there are concerns that the organisation's leadership is unable to make sufficient improvements in a reasonable timeframe without extra support) and 'Inadequate' in one or more of the other key questions (safe, effective, caring and responsive).

14. The evidence provided by the CQC will include the reasons why it is recommending the trust is mandated to receive intensive support, the specific areas of improvement where actions need to be taken and what improvements in quality need to be achieved.

15. Based on the full range of information, NHS England and NHS Improvement will decide, following national moderation, whether the trust will be placed in segment 4 and receive intensive support through the RSP.

What happens when NHS England and NHS Improvement mandate support for an ICS, trust or CCG

Mandated support (segment 3)

16. NHS England and NHS Improvement will communicate their decision to the ICS, trust or CCG and work with them to develop and deliver a bespoke mandatory support package through the relevant regional improvement hub, drawing on system and national expertise as required.

17. The NHS England and NHS Improvement regional team will agree the criteria that must be met for the ICS, CCG or trust to exit mandated support (exit criteria) and the ICS, CCG or trust will develop an improvement plan with an indicative timescale for meeting the exit criteria.

18. Typically, the following additional interventions will be put in place:

    - enhanced monitoring and oversight of the ICS, CCG or trust by the NHS England and NHS Improvement regional team
    - NHS England and NHS Improvement advisory role for senior appointments including shortlisting and as external assessor on interview panels.

19. Depending on the nature of the problem(s) identified and the support need, further interventions may include enhanced:

    - scrutiny/assurance of plans
    - reporting requirements
    - financial controls including lower capital approval limits.

Mandated intensive support (segment 4)

20. NHS England and NHS Improvement will communicate their decision to the ICS, trust or CCG and then make a formal public announcement.

21. Mandated intensive support will be agreed with the region and delivered through the nationally co-ordinated RSP. The RSP has been developed to provide intensive support either at organisation level (with system support) or across a whole system health and social care system.

22. A diagnostic stocktake involving all relevant system partners will:

- identify the root cause(s) of the problem(s) and the structural and strategic issues that must be addressed
- recommend the criteria that must be met for the system or organisation to exit mandated intensive support (exit criteria).

23. NHS England and NHS Improvement will review the capability of the ICS's, trust's or CCG's leadership. This may lead, if necessary, to changes to the management of the system/organisation to make sure the board and executive team can make the required improvements. Where changes are required, this will happen as soon as is practical and the necessary support will be provided to facilitate this.

24. At the same time as helping to address the specific issues that triggered mandated intensive support, NHS England and NHS Improvement will consider whether long-term solutions are needed to address any structural issues affecting the ICS's, trust's or CCG's ability to ensure high quality, sustainable services for the public.

25. NHS England and NHS Improvement will appoint an improvement director who will act on their behalf to provide assurance of the ICS's, CCG's or trust's approach to improving performance. The improvement director will support the ICS, trust or CCG to develop an improvement plan with an indicative timescale for meeting the exit criteria (typically within 12 months).

26. The improvement director will work with the trust, CCG and/or ICS to co-ordinate the necessary support from the system, NHS England and NHS Improvement teams, the broader NHS or, where appropriate, an external third party. This could include:

- intensive support for emergency and elective care
- intensive support to deliver the national programmes focused on reducing clinical variation across clinical pathways
- intensive support for workforce and people practices
- financial turnaround/recovery support including specialist support, eg to reduce agency use, implement cost controls
- drivers of deficit review
- governance review

- governance and leadership programme for improvement in challenged organisations and systems
- tailored delivery of a range of improvement programmes such as ‘well led’, ‘better tomorrow’ and ‘making data count’.

27. Typically, the following additional interventions will be put in place:

    - regular formal progress and challenge meetings with national-level NHS England and NHS Improvement oversight
    - board vacancies filled on the direction of NHS Improvement (trusts).

28. Depending on the nature of the problem(s) identified and the support need, further interventions may include:

    - NHS England and NHS Improvement-appointed board adviser
    - enhanced reporting requirements
    - enhanced financial controls including:
      - NHS Improvement control of applications for Department of Health and Social Care financing (trusts)
      - peer review of expenditure controls
      - reduced capital approval limits (trusts)
      - rapid roll out of extra controls and other measures to immediately strengthen financial control, including those set out in NHS England and NHS Improvement guidance (including the ‘Grip and Control’ checklist).

29. Where a trust is deemed to require mandated intensive support on the recommendation of the CQC, there will be close dialogue between the CQC, NHS England and NHS Improvement, the trust and ICS, which will include what improvements in quality would give assurance of progress being made. These improvements form the basis of joint reviews of progress during the mandated intensive support period, as well as the existing regular information exchange between the CQC and NHS England and NHS Improvement regional leads.

30. This process of information exchange and review will enable extra support or intervention to be considered as needed. These decisions need not wait until the next reinspection.

31. NHS Improvement will ensure that the trust addresses any urgent patient safety and quality issues identified as a priority. The CQC will continue to monitor quality at the trust. If at any time patients are at immediate serious risk of harm, the CQC can use its urgent powers to safeguard them.

32. The expectation is that the CQC will reinspect the trust within 12 months of the start of mandated intensive support. It will judge if the quality of patient care and the trust's leadership have improved.

How ICSs, trusts and CCGs exit from mandated support

Mandated support (segment 3)

33. To be considered for removal from mandated support, an ICS, trust or CCG must demonstrate that the exit criteria have been met. In deciding whether to accept a recommendation to approve exit, the NHS England and NHS Improvement regional team will also consider whether a targeted and time-limited post-exit support package is needed to ensure the improvement is sustained.

Mandated intensive support (segment 4)

34. To be considered for removal from mandated intensive support, an ICS, trust or CCG must demonstrate that the exit criteria have been met. In deciding whether to accept a recommendation to approve exit, NHS England and NHS Improvement will also consider the proposed post-exit support package that will be needed to ensure the improvement is sustained.

35. Where a trust is in receipt of mandated intensive support at the recommendation of the CQC, NHS England and NHS Improvement will only approve exit following a recommendation from the Chief Inspector of Hospitals. The Chief Inspector will usually recommend this where there is no reason on grounds of quality why a trust should remain in receipt of mandated intensive support – that is, if the quality of care is showing sufficient signs of improvement, even if it is not yet 'good', and if the trust leadership is robust enough to ensure that the trust will sustain current improvements and make further improvements. NHS England and NHS Improvement must also be confident that improvements will be sustained.

36. Before the CQC makes its recommendation, it will carry out an inspection which will include a well-led assessment. This will include taking account of the trajectory

of improvement where there are broader improvement plans across a health economy.

37. Sufficient improvement will normally be demonstrated when:

- all ‘Inadequate’ ratings across the five key questions at trust level, together with the overall trust rating, have improved to at least ‘Requires Improvement’
- for a trust with a single major site, no core service remains ‘Inadequate’ overall
- for multi-site trusts, no core service remains ‘Inadequate’ or – exceptionally – one or more core services remain ‘Inadequate’ but there is significant evidence of an ongoing trajectory of improvement across the organisation.

38. There may be specific extra improvements required by the CQC which reflect the trust’s individual circumstances. The CQC may also need to take into account structural problems in the local health economy, if they have contributed to the requirement for mandated intensive support.

39. Typically, an ICS, trust or CCG will exit with a mandated support package and automatically be allocated to segment 3.

40. Where NHS England and NHS Improvement are not satisfied that the exit criteria have been met, mandated intensive support will be extended for a short period to allow the ICS, trust or CCG to make the improvements needed. This might occur, for example, where there have been changes to the leadership team and more time is needed for the new team to bring about change. In the case of an extension, the ICS, trust or CCG will prepare a revised improvement plan that lists actions to address any outstanding or new concerns.

41. NHS England and NHS Improvement will inform the ICS, trust or CCG in question of their exit decision once their formal decision-making processes are complete. NHS England and NHS Improvement will then make a formal public announcement.

Annex B: Key lines of enquiry for CCG assessment 2021/22

Quality of care, access and outcomes
How has the CCG contributed to ensuring delivery of health services in the priority areas set out in the *2021/22 Operational Planning Guidance*?
How has the CCG monitored oversight of quality and patient experience?
How has the CCG supported the system to respond to emergency demands and manage winter pressures?
Preventing ill-health and reducing inequalities
How has the CCG supported actions to address inequalities in NHS provision and outcomes?
Does the CCG have effective systems and processes for monitoring, analysing and acting on a range of information about quality, performance and finance, from a variety of sources, including patient feedback, analyses of access to services and experiences of service users, so that it can identify early warnings of a failing service?
How has the CCG taken account of lessons from managing COVID-19, in a way that locks in beneficial changes and explicitly tackles fundamental challenges, including support for staff, and action on inequalities and prevention?
People
How can the CCG evidence that it has supported the health and wellbeing of its workforce?
How has the CCG contributed to the delivery of the priorities for the NHS workforce set out in the *NHS People Plan* and *2021/22 Operational Planning Guidance*, and the implementation of *Our NHS People Promise*?
Leadership
Has the CCG demonstrated effective system leadership and progressed partnership working, underpinned by governance arrangements and information-sharing processes, including evidence of multi-professional leadership?
Finance and use of resources
Evidence that the CCG has delivered its break-even target in-year and contributed to the reduction of system deficits.
Evidence that the CCG has delivered the Mental Health Investment Standard.
Involve and consult with the public
How does the CCG identify and engage with deprived communities, ethnic minority communities, inclusion health populations and people with disabilities (people with learning disabilities, autism or both, people experiencing mental ill-health and people experiencing frailty) and the full diversity of the local population?

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Classification: Official

NHS oversight metrics for 2021/22

June 2021

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Quality, access and outcomes	**Primary and community services including new community services response times**	All general practices to be delivering at, or above, pre-pandemic appointment levels, including through consolidating and maximising the use of digital consultation methods and technology	Access to general practice – number of available appointments	✓		✓
			Proportion of the population with access to online GP consultations	✓		✓
		Maximising dental activity and targeting capacity to minimise deterioration in oral health and reduce health inequalities	Dental activity	✓		✓
		Transforming community services and improving discharge	2-hour urgent response activity	✓	✓	✓
			Discharges by 5pm	✓	✓	✓
			Delayed transfers of care per 100,000 population	✓		✓
	Restoration of elective and cancer services*	Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services	Elective activity levels	✓	✓	✓
			Overall size of the waiting list	✓	✓	✓
			Patients waiting more than 52 weeks to start consultant-led treatment	✓	✓	✓
		Restore full operation of all cancer services	Cancer referral treatment levels	✓	✓	✓
			People waiting longer than 62 days	✓	✓	✓
			% meeting faster diagnosis standard	✓	✓	✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
		Maximise diagnostic activity focused on patients of highest clinical priority	Diagnostic activity levels	✓	✓	✓
	Improve cancer outcomes: early diagnosis and survival		Proportion of people who survive cancer for at least 1 year after diagnosis	✓		✓
			Proportion of cancers diagnosed at stages 1 or 2	✓		✓
	Outpatient reform: avoidance of up to a third of outpatient appointments	Embed outpatient transformation	Advice and guidance and patient initiated follow-up activity levels	✓	✓	✓
	Implementation of agreed waiting times		% of all outpatient activity delivered remotely via telephone or video consultation	✓	✓	✓
			UEC performance measure*	✓	✓	✓
			30-minute ambulance breaches	✓	✓	✓
			Ambulance response times		✓	
	Maternal and children's health**	Continue delivery of the maternity transformation measures set out in the NHS Long Term Plan	% women on continuity of care pathway		✓	
			Number of stillbirths per 1,000 total births			✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
		Implement the five elements of the Saving Babies' Lives care bundle	Number of neonatal deaths per 1,000 live births			✓
	Emergency care: on agreed trajectory for same day emergency care (SDEC) and integrated urgent care services (IUC)	Maximise the use of booked time slots in A&E	% of patients referred to an emergency department by NHS 111 that receive a booked time slot to attend	✓		✓
		Increase % of patients seen and treated on the same day or within 12 hours if this spans to midnight	% of zero-day length of stay admissions (as a proportion of total)		✓	✓
		Reduce avoidable A&E attendances by directing patients to more appropriate urgent care settings	% of unheralded patients attending EDs	✓		✓
	Mental health	Meet the MHIS and use the investment to grow the workforce and deliver transformation of care	Delivery of the mental health investment standard	✓		✓
		Deliver the mental health ambitions outlined in the NHS Long Term Plan, expanding and transforming core mental health services	NHS Long Term Plan metrics for mental health	✓	✓	✓
	Learning disability and autism: reducing	Continue to reduce reliance on inpatient care (adults and children)	Reliance on specialist inpatient care for adults/children with a learning disability and/or autism			✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
	inpatient rate and increasing learning disability physical health checks	Make progress on the delivery of annual health checks for people with a learning disability	Number of people with a learning disability on the GP register receiving an annual health check	✓		✓
	People will get more control over their own health by rolling out NHS personalised care model across the country	Systems should continue and, where possible, accelerate the delivery of existing requirements, including personalised health budgets, wheelchairs for children, social prescribing referrals and personalised care and support plans	Number of personalised care interventions	✓		✓
			Personal health budgets	✓		✓
			Social prescribing unique patient referrals	✓		✓
	Delivering safe, high quality care overall		Summary hospital-level mortality indicator		✓	
			Overall CQC rating (provision of high-quality care)		✓	
			Acting to improve safety (safety culture theme in NHS Staff survey)		✓	
			Patient experience of GP services	✓		✓
			Potential under-reporting of patient safety incidents		✓	
			National Patient Safety Alerts not completed by deadline		✓	

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
			Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia infection rate		✓	
			Clostridium difficile infection rate		✓	
			E. coli bloodstream infections	✓	✓	✓
			Venous thromboembolism (VTE) risk assessment		✓	
			Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care	✓		✓
Preventing ill health and reducing inequalities	**Screening and vaccination programmes meet base levels in the public health agreement or national goals**	First COVID-19 vaccination dose offered to all adults by the end of July	% of adults vaccinated			✓
		Maximise efforts to recover immunisation services that were paused or had reduced uptake due to the COVID-19 pandemic	Population vaccination coverage – MMR for two doses (5 year olds) to reach the optimal standard nationally (95%)	✓		✓
		Flu vaccination	Number of people receiving flu vaccination	✓	✓	✓
		Restore of NHS bowel cancer screening programme	Bowel screening coverage, aged 60–74, screened in last 30 months	✓		✓
		Restore the national breast screening service back to the key performance indicator threshold	Breast screening coverage, females aged 50–70, screened in last 36 months	✓		✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
		Restore cervical screening	Cervical screening coverage, females aged 25-64, attending screening within target period	✓		✓
	Improvements for people with conditions such as diabetes, CVD and obesity	Improved uptake of the NHS diabetes prevention programme	Number of people supported through the NHS Diabetes Prevention programme	✓		✓
			Diabetes patients that have achieved all the NICE-recommended treatment targets (adults and children)	✓		✓
		Make progress against the NHS Long Term Plan high impact actions to support stroke, cardiac and respiratory care	Number of people with CVD treated for cardiac high risk conditions	✓		✓
			Number of people receiving mechanical thrombectomy	✓		✓
		Increase referrals to NHS digital weight management services	Number of referrals to NHS digital weight management services	✓		✓
	Reducing inequalities	Restoring NHS services inclusively	Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics	✓	✓	✓
		Accelerating preventative programmes	COVID-19 vaccination uptake for black and minority ethnic groups and the most deprived quintile compared to the national average			✓
		Ensuring datasets are complete and timely	Proportions of patient activities with an ethnicity code	✓	✓	✓
	Leadership		Quality of leadership†	✓	✓	✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Leadership and capability			Aggregate score for NHS Staff Survey questions that measure perception of leadership culture††	✓	✓	✓
People	**People Promise**	Supporting the health and wellbeing of staff and taking action on recruitment and retention	People promise index††	✓	✓	✓
	Looking after our people		Health and wellbeing index††	✓	✓	✓
			Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers, (b) other colleagues, (c) patients/ service users, their relatives or other members of the public in the last 12 months	✓	✓	✓
			Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties	✓	✓	✓
			Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	✓	✓	✓
			% of jobs advertised as flexible	✓	✓	✓
			Staff retention rate (all staff)	✓	✓	✓

Page 162

Page 163

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
			Sickness absence (working days lost to sickness)	✓	✓	✓
			Proportion of staff who say they have a positive experience of engagement	✓	✓	✓
			Number of people working in the NHS who have had a 'flu vaccination	✓	✓	✓
	Belonging in the NHS		Proportion of staff in senior leadership roles who are (a) from a BME background, (b) women	✓	✓	✓
			Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	✓	✓	✓
	Growing for the future		Number of registered nurses employed by the NHS (WTE)			✓
			Number of doctors working in general practice (WTE)	✓		✓
			Additional primary care WTE through ARRS	✓		✓
			Number of healthcare support workers employed by the NHS			✓
			Mental health workforce growth	✓		✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Finance and use of resources	**The NHS will return to financial balance: NHS in overall financial balance each year**	Systems to manage within financial envelopes	Performance against financial plan	✓	✓	✓
			Underlying financial position	✓	✓	✓
			Run rate expenditure	✓	✓	✓
			Overall trend in reported financial position	✓	✓	✓

Note: This list may be updated in year to reflect planning guidance for the second half of the year.

* A response to the consultation to the UEC clinically-led review of standards will be published in due course.

** We will also monitor delivery against the other priorities set out in the planning guidance, including progress against implementing the immediate and essential actions from the Ockenden report.

† Based on CQC leadership rating for trusts and GP practices, and NHS England and NHS Improvement assessment for CCGs and ICSs.

†† Metric under development.

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Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	25 August 2021
Executive Member:	Councillor Eleanor Wills, Executive Member, Health, Social Care and Population Health
Clinical Lead:	Dr Christine Ahmed, Starting Well Lead
Reporting Officer:	Debbie Watson, Assistant Director of Population Health
Subject:	**POPULATION HEALTH EARLY YEARS - PEER SUPPORT PROGRAMMES COMMISSIONING**

Report Summary:

The report discussed the two Peer Support Programmes: The Family Peer Support Service and the Breastfeeding Peer Support Service.

Breastfeeding Peer Support:

Authorisation is required to jointly conduct a tender process with Oldham Council to recommission and secure an appropriate supplier to deliver a Breastfeeding Peer Support Service in Tameside and Oldham.

The current budget is £114,713 per annum from Tameside Council and £88,679 per annum from Oldham Council. It is proposed that the service should be commissioned for a further five years (3+2 contract).

Family Peer Support:

The report seeks authorisation to award HomeStart HOST, a direct contract award for the Family Peer Support Programme. It is envisaged the contact will run for 3 years at £75,000 per annum.

Recommendations:

That Strategic Commissioning Board be recommended to agree:

(i) That approval is given to recommission and tender the Breastfeeding Peer Support Service with a 3+2 contract jointly with Oldham Council (option E at section 6.1).
(ii) That approval is given to award HomeStart HOST with direct contract award for the Family Peer Support Programme (option E at 11.1).

Financial Implications:

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

Breastfeeding Peer Support:

The Breastfeeding Peer Support Service is funded under Nutritional Initiatives, with a gross budget of FY21/22 of £203k part-funded by an £89k annual contribution from Oldham Borough Council. The proposal is to retender this service on the current terms, and is therefore within the current budget envelope with no additional financial pressure arising.

As noted at 3.1 the Council is the lead commissioner for joint procurement with Oldham, and contractual and invoicing arrangements should be put in place to ensure OBC's contribution is received in a timely manner.

No savings proposal is associated with the Nutritional Initiatives budget. Alternative delivery options are set out at 6.1, but it is

considered that any cost reduction would not allow for a sustainable service and would impose costs on the wider health economy.

As noted at 4.1-2 procurement advice has been taken from STAR, with a competitive dialogue process helping to ensure that proposals align to the Council's requirements and provide value for money.

Family Peer Support:

The Family Peer Support Service is funded under the 0-5 Public Health Programme, with a gross budget of £75K per annum. The proposal is to grant a direct contract award for this service on the current terms, and is likewise within the current budget envelope with no additional financial pressure arising.

Alternative delivery options have been considered as set out at 11.1. It is thought undesirable to end the programme given its benefits to the wider health economy, and reducing the value or consolidating it into another programme would not be sustainable for the provider. A direct award provides certainty for the provider and avoids on ongoing procurement process.

As noted at 9.1-3 procurement advice has been taken from STAR, who have determined that a direct award is permitted under procurement rules, and that the award is well below any threshold that would require a competitive process.

Legal Implications:

(Authorised by the Borough Solicitor)

The project officers have sought legal and procurement advice for STAR. The legal implications are set out in sections 4 and 9 of the report. Officers should ensure that STARs advice is followed and all actions such as soft marketing are well documented especially where exemptions are being relied upon.

How do proposals align with Health & Wellbeing Strategy?

The retender of the Breastfeeding Peer Support Service supports in particular the starting well element of the life course approach and including the 'very best start in life' priority of the Corporate Plan. The retender also supports emotional wellbeing, as well as the food, nutrition and oral health work streams.

The direct award of the Family Peer Support Service to HomeStart HOST supports the priorities and the values of the Tameside Early Help Strategy, and the 'resilient families and supportive networks' priority of the Corporate Plan.

How do proposals align with Locality Plan?

Both plan align with the Locality Plan by supporting the Voluntary Community, Faith and Social Enterprise Sector and by ensuring the very best start in life for babies.

How do proposals align with the Commissioning Strategy?

The service contributes to the Commissioning Strategy by:

- Empowering citizens and communities;
- Commission for the 'whole person';
- Create a proactive and holistic population health system.

Recommendations / views of the Health and Care Advisory Group:

Report not been presented at the Health and Care Advisory Group.

Public and Patient Implications:

N/A

Quality Implications:	Tameside Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of quality, economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	The nature of the Breastfeeding Peer Support Service will ensure that parents will receive appropriate advice and support so that they are able to make an informed decision about breastfeeding and the benefits to the long term health and development of their child(ren). The nature of the Family Peer Support Service is to ensure families are supported with needs before the needs escalate further and more costly intervention are required. Both proposals have a vital role in reducing health inequalities supported by the Marmot Review. Early childhood is a critical time for development of later life outcomes, including health. Evidence shows that positive experiences early in life are closely associated with better performance at school, better social and emotional development, improved work outcomes, higher income and better lifelong health, including longer life expectancy.
What are the Equality and Diversity implications?	An Equality Impact Assessment has been completed for both proposals outlined.
What are the safeguarding implications?	There are no safeguarding implications associated with this report. Where safeguarding concerns arise as a result of the actions or inactions of the provider and their staff, or concerns are raised by staff members or other professionals or members of the public, the Safeguarding Policy will be followed. In both plans, the Providers will have a requirement to work in plan with national policy: Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (2018).
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of all contracts. The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider. A privacy impact assessment has not been carried out.
Risk Management:	The Council will work closely with the provider to manage and minimise any risk of provider failure consistent with the providers contingency plan
Access to Information:	The background papers relating to this report can be inspected by contacting the report writer, Charlotte Lee, Population Health Programme Manager Telephone: 0161 342 4136 e-mail: charlotte.lee@tameside.gov.uk

1. INTRODUCTION

1.1 The report details Population Health's two early years peer support programmes commissioning intentions. The report seeks authorisation to:

- Retender the Breastfeeding Peer Support Service jointly with Oldham MBC with Tameside MBC as the lead commissioner.
- Award a direct contract to HomeStart HOST for to the provision of the Family Peer Support Service.

2. BREASTFEEDING PEER SUPPORT

The Picture Of Health – Breastfeeding

2.1. There is overwhelming evidence that proves breastfeeding provides substantial health and wellbeing benefits for mothers and babies which are experienced well beyond the period of breastfeeding itself. As well as contributing significantly to reducing health inequalities, benefits of breastfeeding can be categorised to the following:

- **Infant health:** Breastfeeding protects children from a vast range of illnesses including infection, diabetes, asthma, heart disease and obesity, as well as cot death (Sudden Infant Death Syndrome).
- **Maternal health:** Breastfeeding protects mothers from breast and ovarian cancers and heart disease.
- **Relationship-building:** Breastfeeding supports the mother-baby attachment and relationship and the mental health of both baby and mother.

2.2. Despite this, 76% of all babies in England receive formula milk by 6 weeks. The cost to the NHS every year for treating just 5 illnesses linked to babies not being breastfed is at least £48 million and includes: ear infection, chest infection, gut infection, necrotising enterocolitis (gut infection in premature babies) and breast cancer.

2.3. Breastfeeding and breastfeeding for at least six months provides children with the best start in life and has the potential to reduce inequalities in health[1]. Children who are breastfed are less likely to experience many of the infections and allergies of infancy and have lower risks of obesity in childhood. Research suggests breastfeeding is particularly important for single and lower-income mothers, continuing to have a positive effect for these groups when their children were five years of age.[2]

2.4. To encourage, promotion and support Mothers to breastfeed, there are a range of initiatives, interventions and services recommended, including a Breastfeeding Peer Support Service which is recommended by NICE ([PH11] - Maternal and child nutrition (November 2014)) and is highlighted as good practice in the '*Commissioning infant feeding services: a toolkit for local authorities'* report, produced by Public Health England and UNICEF (2016).

2.5. The Greater Manchester (GM) and East Cheshire Maternity Transformation Plan, under the postnatal priorities list breastfeeding as a GM area of focus. Promotion of initiation and maintenance of breastfeeding is a policy directive as outlined in 'Better Births' National Maternity Review.[3]

2.6. In 2018/19, 53.3% of women initiated breastfeeding in Tameside, compared to 62.4% regionally and 67.4% nationally. For Tameside, there was a 5.3% increase in the percentage

[1] Department of Health (2009) Healthy Child Programme: pregnancy and the first five years of life. Department of Health. Crown Copyright. 133 Hennessy S

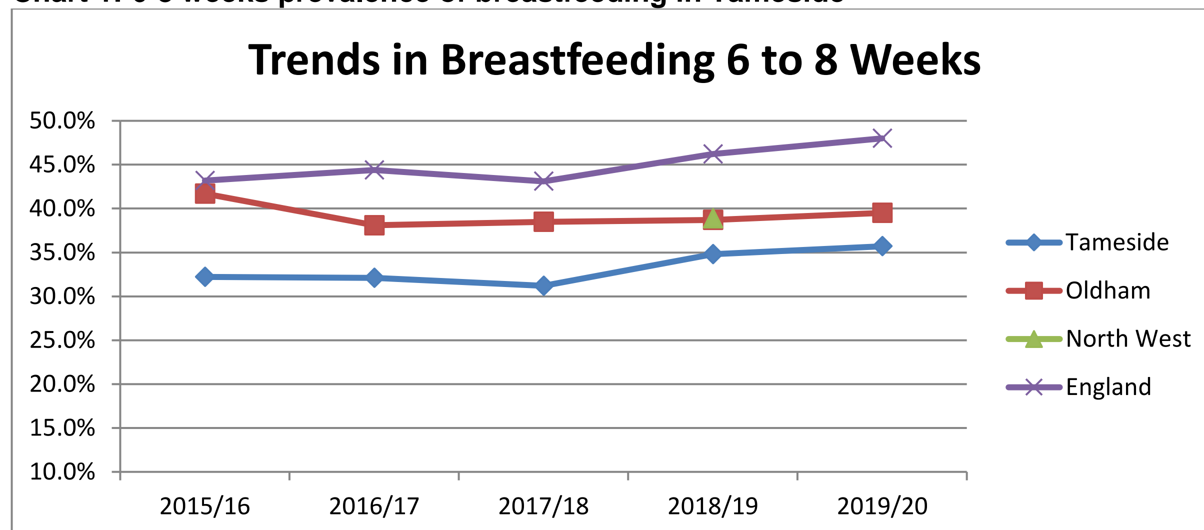
[2] Gutman L M, Brown J and Akerman R (2009) Nurturing Parenting Capability: The early years. Centre for research into the wider benefits of learning. Research report 30.

[3] Implementing Better Births: A resource pack for Local Maternity Systems NHS England (2017) https://www.england.nhs.uk/wp-content/uploads/2017/03/nhs-guidance-maternity-services-v1.pdf

of women initiating breastfeeding from the previous year.

2.7. Chart 1 below illustrates the trends of breastfeeding at 6-8 weeks over a 5 year period. In 2019/20, 35.7% of women continued to breastfeed at 6-8 weeks in Tameside, compared to 48% in England. Tameside has seen a 4.5% increase in this indicator compared to 2017/18. In England, there has been a 4.9% increase in this indicator in same time period. Highlighting that whilst Tameside is improving in this indicator, there remains a gap between Tameside and England, evidencing ongoing health inequalities.

Chart 1: 6-8 weeks prevalence of breastfeeding in Tameside



2.8. Health inequalities in breastfeeding is further evidence by the finding from the National Infant Feeding Survey 2010. The survey found that the highest rates of breastfeeding were found among mothers who are aged 30 or over (87%), are from minority ethnic groups, mothers who left education aged over 18 (91%), in managerial and professional occupations (90%) and living in the least deprived areas (89%). Whilst mothers of first babies are more likely to start breastfeeding than mothers of second or later babies (84% compared with 78%).

2.9. In Tameside approximately 70% of babies are born to mothers from the most deprived quintiles, highlighting health inequalities across Tameside are reflected in our breastfeeding rates.

2.10. It is therefore proposed to retender the Breastfeeding Peer Support Service to have a concentrated focus on wards with lower breastfeeding rates, whilst maintaining a universal service. The wards with the lowest rates include: Dukinfield, Denton West, Dukinfield Stalybridge, Denton North East and Denton South. The new service will also give additional targeted support to women from a low income or disadvantaged background who may need extra support to start and establish breastfeeding as recommended in the recent National Institute for Health and Care Excellence guideline NG194 on Postnatal Care[4].

3. THE CURRENT BREASTFEEDING PEER SUPPORT SERVICE

3.1. In 2017, Tameside Council (as lead commissioner) and Oldham Council jointly commissioned the Breastfeeding Support Service with the current contract due to end on the 31 March 2022. It is proposed to recommission this service for a further 5 years (3+2 contract) ensuring break clauses are built into the contract.

3.2. The Breastfeeding Peer Support Service in Tameside contributes to the promotion of a social and cultural shift to ‘breastfeeding as a norm’ across Tameside and Oldham, as well as

[4] p-breastfeeding-interventions-pdf-326764485980.pdf

supporting mothers to breastfeed for as long as possible.

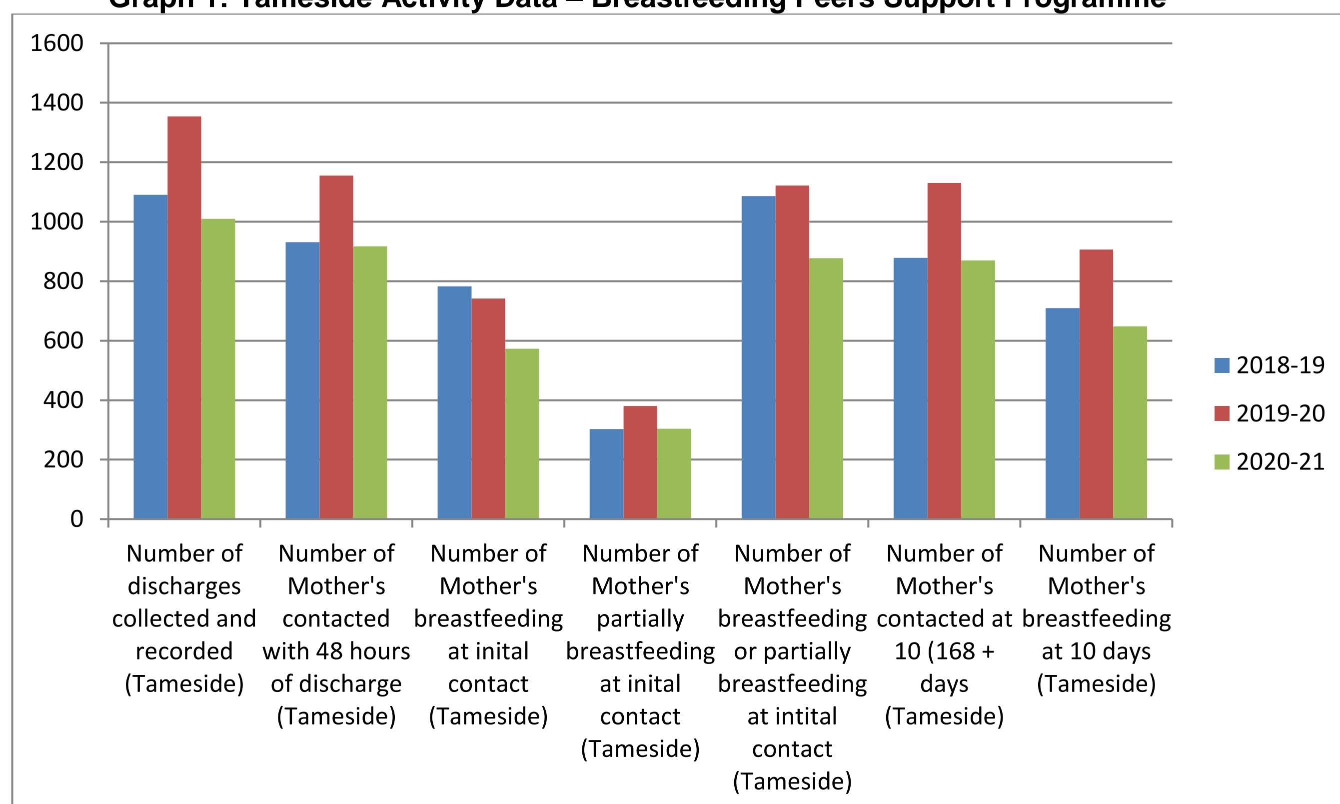
3.3. The Breastfeeding Peer Support Service works in close partnership, contributing to and developing accessible pathways with midwifery, health visiting and children's centre services, who all demonstrate best practice breastfeeding management through UNICEF Baby Friendly full accreditation standards.

3.4. The Breastfeeding Peer Support Service in an integral part of the Infant Feeding Programme in Tameside and contributes to the delivery of the implementation plan of the Tameside Infant Feeding Management Group.

3.5. The current Breastfeeding Peer Support Service consistently meets service targets and has received positive feedback from local parents. The service regularly provides case studies, an example of which can be found in **Appendix A**, where the second case study evidences the impact of Covid-19.

3.6. The current performance of the provider against the current contract specification is in line with the commissioners' expectations. The full years 2018/19 to 202/21 performance data can be found in the below graph.

Graph 1: Tameside Activity Data – Breastfeeding Peers Support Programme



3.7. There has been a reduction in activity in 20/21however, during the Covid-19 pandemic; the Breastfeeding Peer Support Service has been required to work differently to support families, including telephone support, Zoom Groups and individual tailored advice and support, which has not be captured in the data presented. The Service has now been able restored face-to-face visits and home visits within the first 48 hours of birth, and additional support on the Maternity Unit using robust risk assessments with families who are struggling with breastfeeding.

3.8. The current Breastfeeding Peer Support Service has also made significant steps in bringing about a 'breastfeeding welcome' culture in Tameside. Since the Service was commission in 2017, the provider has supported over 30 local businesses (mainly local cafés and

restaurants) to be welcoming of Mothers who breastfeeding in public. This is important aspect of the Service in the context of increasing the 6 to 8 weeks breastfeeding maintenance rates.

3.9. As part of pilot in the current year, the Breastfeeding Peer Support Service has provided breastfeeding awareness sessions within a number of Tameside secondary schools. Early evaluation data indicates a change in young people's attitudes of breastfeeding, and an increase awareness of the benefits associated with breastfeeding.

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

4.1. Joint work with STAR procurement has been ongoing with this project, including the completion of a Project Initiation Document (PID).It is the intention to run this exercise as a light touch regime under the 'health' Common Procurement Vocabulary (CPV) codes.

4.2. It is also intended to include an additional step in the procurement process to include a competitive dialogue with bidders. Previous procurements and soft market testing has told us that this is a narrow market of suppliers so a competitive dialogue process will allow bidders to develop alternative proposals in response to the Council's outline requirements. Only when the Council is satisfied that bidders proposals are developed to sufficient detail will tenderers be invited to submit competitive bids. The aims are to increase value by encouraging innovation and to maintain competitive pressure in bidding for specific contracts.

5. VALUE OF CONTRACT

5.1. The total cost for a period of up to five years will be £1,016,960 (£573,565 – Tameside Council & £443,395 – Oldham Council).

6. GROUNDS UPON AUTHORISATION TO PROCEED SOUGHT

6.1. The following options have been considered, with Option E preferred:

Option	Noting points
A End the contract	Whilst this would provide a financial saving, the service would not be available to develop local peer volunteers and support parents to initiate and maintain breastfeeding potentially increasing health inequalities.
B End contract and amalgamate the service with other services/contracts	Due to the specific nature of this service, it would be extremely difficult to undertake any form of amalgamation with other services/contracts as it was felt that the elements of the service could easily be consumed and the success of the service suffer as a result. It would be difficult to purchase the individual elements of the service for the financial commitment that is already provided, as outlined above.
C Extend contract on renegotiated terms	The current contract price is low in terms of the significance and impact of this work and reflects value for money. To reduce the current contract price would seriously jeopardise the service as the supplier would find it difficult to deliver the same levels of support.
D Extend contract on current terms	This is not an option under PSO's given that the contract ends on the 31 March 2022.
E End contract and re-tender (preferred option)	This is the preferred and required option under PSO C6.1 given that the contract will end on the 31 March 2021 Re-tender with current contract value: **£203,392 per annum (£114,713 – Tameside Council, £88,679 – Oldham Council) with a 3+2 year contract (1 April 2022 – 31 March 2025, with option to extra to 31**

	March 2027).

7. FAMILY PEER SUPPORT

The Picture Of Early Help In Tameside

7.1 Tameside Council and its partners are passionate and committed to improving the outcomes for children, young people and their families living in Tameside. The Early Help Strategy[5] updated in 2020, sets the vision for our support with families:

'We know that Tameside is a great place to grow up. We have strong communities, excellent schools and early education, good opportunities for work and much more.

But we can do better.

Most of our children and families grow up in a supportive environment that enables them to have the best start in life without the input of specialist services. When this is not the case children and families may need some extra support at different times in their lives.

We want every child, young person and family to get the help and support they need to succeed as early as possible.

Our vision is that every child and young person in Tameside has the best start in life, to grow, thrive, and be prepared for a successful adult life; and when the need or emerging problems occurs, communities and organisations work together with children, young people and families to co-ordinate support thereby improving the overall wellbeing and quality of life of all Tameside's children and young people.'

7.2 Since 2017, the Early Help Offer in Tameside has grown significantly, with the development of an Early Help Access Point, better Early Help Assessments tools, building 'Team Around' Approaches, Early Help Panels with joint decision-making and shared workforce development, such as Signs of Safety. Pivotal to the successes has been the integral and collaborative working with partners, including but not exclusive to: Tameside and Glossop Integrated Care NHS Foundation Trust, Pennine Care NHS Foundation Trust, Action Together, Greater Manchester Police, Tameside Safeguarding Children Partnership and Tameside and Glossop Clinical Commissioning Group.

7.3 The need for Early Help for families has never been greater[6] as highlighted by the recent Greater Manchester Health Inequalities review led by the Marmot team. Tameside has significantly worse outcomes for children and families compared to national average, which have been exacerbated by the COVID-19 pandemic[7]. Following on from an Early Help Peer Review late 2020, and the focus Ofsted Visit in May 2021, the emphasis to ensure children, young people and families are supported at the right time and in the right place has given greater evidence to support a system wide integration programmes for 0-19 services.

7.4 The Marmot Review shows that childhood and particularly early childhood, is a critical time for development of later life outcomes, including health. Evidence shows that positive experiences early in life are closely associated with better performance at school, better social and emotional development, improved work outcomes, higher income and better lifelong health, including longer life expectancy. Working with a child and their family to address their needs early on can help reduce, prevent and remove risk factors (the worries for the family) and increase protective factors (what is working well for the family). Protective factors can reduce risk to a child's wellbeing and may include:

[5] https://www.tameside.gov.uk/TamesideMBC/media/earlyyears/Early-Help-Strategy-2020.pdf

[6] https://www.instituteofhealthequity.org/resources-reports/greater-manchester-evaluation-2020/greater-manchester-evaluation-2020.pdf

[7] https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report/7-children-and-young-people

- developing strong social and emotional skills;
- having a strong social support network for the family;
- support for good parental mental health;
- having good income support, access to benefits and advice;
- having access to good community services and facilities[8].

7.5 Early help can take different forms, from home visiting programmes to support vulnerable parents and children, to school-based programmes to improve children's social and emotional skills, to mentoring schemes for young people who are vulnerable to involvement in crime.

8 THE CURRENT FAMILY PEER SUPPORT SERVICE

8.1 HomeStart Oldham, Stockport and Tameside (HOST) is a long-standing partner of the Council with a unique, tried and trusted peer support model, with a successful track record of grass-roots community volunteering, valued by volunteers and professionals alike.

8.2 HomeStart provides one-to-one peer support for families via a team of dedicated and supervised volunteers, who visit families' for a couple of hours per week and tailor support to meet the individual needs of the family. The trusted relationship that is developed between a parent and volunteer often leads powerful change within the family, as well as enabling the family to grow in confidence for accessing the wider community and universal early years offer. The Tameside Peer Support Programme will support families with children aged between 0-5 years. The families supported through the Peer Support Programme, may be families who have recently stepped down from Family Intervention Services, or families who need early support to prevent needs from escalating. As such families support should be either in Level 1 or 2 of the help, harm model outlined in the Early Help Strategy. The Family Peer Support Service has operated for a number of years on a grant-funding basis to HomeStart HOST from the Strategic Commission's Population Health Directorate. It is therefore the intention to move from a grant to a contract for service for 3 years.

8.3 In 2019/20, the Peer Support Service received 245 referrals, and supported 201 families, with 408 children. In 2020/21, the Peer Support Service has supported 281 families with 698 children, on a range of issues, including isolation, family conflict, managing budgets, and the health of the child and/or parent. HomeStart through their Peer Support Service has supported the difficulties and challenges that COVID-19 has brought to many families in Tameside. The organisation has worked in a 'COVID Safe' manner to provide emotional and social support, as well as providing food and home learning packages to vulnerable families. The current Peer Support Service consistently meets service targets and has received positive feedback from local parents, examples of which can be found in **Appendix B.**

8.4 HomeStart has been a significant partner in the development of the Early Help Offer, regularly attending panel meetings and providing a crucial pathway and intervening early to prevent family breakdown. They have adapted their service delivery and aligned to new ways of working, including asset based and relational approaches using Signs of Safety methodology. HomeStart are champions and deliver interventions supporting early attachment, infant feeding, child development and school readiness which all have strong evidence of effectiveness and return on investment.

9 PROCUREMENT STANDING ORDER SEEKING TO WAIVE / AUTHORISATION TO PROCEED

9.1 The Council have worked jointly with STAR Procurement colleagues to test the open market over a 4 week period, where one response was received by an interested organisation.

[8] https://www.eif.org.uk/why-it-matters/what-is-early-intervention

Utilising Contract Procedure Rule 9.1.3 (g), the Council can demonstrate that 1 bidder in the market can deliver this service. The Public Contract Rules are not applicable to this Procurement activity, as the Council have utilised the Light Touch Regime for this work. The threshold for such Services is £663,540 and this service is considerably below this commission.

9.2 The evidence supporting value for money regarding early intervention is strong[9]. Not intervening early can bring high costs to public services and a recent widely recognised estimate, is that this could be as great as £17 billion per annual[10] . Most of this cost falls to local authorities and their partners and previous reports and reviews such as those authored by: Munro[11] , Allen[12] , Marmot[13] , Tickell[14] , and Field[15] conclude that it is essential to prevent problems arising to reduce pressures on public services. The Council has ensure Value for Money by evaluating the service which has developed successful outcomes for families which has prevented them from need more costly interventions.

9.3 As the Council can demonstrate that 1 bidder (HomeStart HOST) can deliver the Family Peer Support Service, a direct contract award is sought. HomeStart HOST are enabled to support families in need of early help support, as well as collaborate on the programme for 0-19 integration services.

10 VALUE OF CONTRACT

10.1 The total cost for a period of up to three years will be £225,000.

11 GROUNDS UPON AUTHORISATION TO PROCEED SOUGHT

11.1 The following options have been considered with Option E preferred:

Option	Noting points
A End the grant	Whilst this would provide a significant financial saving, the service would not be available to develop local peer volunteers and support families with early help support.
B End the grant and amalgamate the service with other services/contracts	Due to the specific nature of this service, it would be extremely difficult to undertake any form of amalgamation with other services/contracts as it was felt that the elements of the service could easily be consumed and the success of the service suffer as a result. It would be difficult to purchase the individual elements of the service for the financial commitment that is already provided, as outlined above.
C Extend the grant on renegotiated terms	The current contract price is low in terms of the significance and impact of this work and reflects value for money. To reduce the current contract price would seriously jeopardise the service as the supplier would find it difficult to deliver the same levels of support.
D Extend the grant	The grant has been extended a number of times on an annual basis and which is challenging for collaborative working at a great scale

[9] House of Commons. Briefing Paper: Early Intervention. (2019). https://researchbriefings.files.parliament.uk/documents/CBP-7647/CBP-7647.pdf
[10] Early Intervention Foundation. (2016). https://www.eif.org.uk/report/the-cost-of-late-intervention-eif-analysis-2016
[11] Munro. (2011). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/180919/DFE-00177-2011.pdf
[12] Allen. (2011). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/284086/early-intervention-next-steps2.pdf
[13] Marmot. (2020). https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on
[14] Tickell. (2011). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/180919/DFE-00177-2011.pdf
[15] Field. (2010). https://webarchive.nationalarchives.gov.uk/20110120090141/http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf

	and security/planning for the provider.
E End grant and award a direct contract (preferred option)	This is the preferred option under PCR 9.1.3 (g). The contract would start from the 1 April 2022 for 3 years (1 April 2022 – 31 March 2025) with a value of: **£75,000 per annum (£225,000 in total).**

12. RECOMMENDATIONS

12.1 Recommendations are as outlined on the front sheet.

APPENDIX A

Breastfeeding Peer Support Service – Case Study

Mum A (Pre Covid)

Mum A gave birth to her daughter at Tameside hospital on 2 April 2019 and was discharged on 3 April. We telephoned mum following receipt of her discharge information and as she was struggling with all aspects of breast feeding we arranged to visit.

During the visit mum explained that her daughter was feeding for long periods and that she was sore and exhausted. Our peer supporter observed a feed and demonstrated an alternative position using a doll. Mum was able to adopt this position with ease and confirmed she was much more comfortable. We discussed signs of good milk transfer, hand expressing, feeding cues and stages of breastmilk. Mum had lots of questions about safe co-sleeping so we signposted her to information provided by the Lullaby Trust.

Two days later, mum rang the office to request a further home visit. Although feeding had been going well, she explained that her milk had come through and that she was sore and engorged. She said she felt that her milk was not satisfying her daughter as she had not settled well overnight, feeding or otherwise.

We visited mum at home and went through position and attachment again although this time paying particular attention to the cross cradle position as mum felt that her daughter was no longer comfortable feeding in the rugby position. We also discussed hand expressing a little prior to a feed as a self- help technique to minimise engorgement.

We rang mum when her daughter was 10 days old and she reported that feeding was going well although she had been advised by her midwife to introduce formula top ups as her daughter's weight gain was slow. Unfortunately this had lead to constipation so mum had asked if she could borrow an electric breast pump with a view to giving her daughter top ups of expressed breast milk instead.

We visited mum with a breast pump and demonstrated how to use it and discussed expressing and storing breast milk.

Mum returned the pump to our office a week later as she had bought her own and was successfully breast feeding and giving formula top ups. She confirmed that she was attending our support group at Hyde Flowery children's centre as her daughter's weight gain was being monitored by Fiona, Community Infant feeding Co-ordinator for Tameside. Mum confirmed that her daughter making small weight gains.

When we contacted mum at 6 weeks she confirmed that her daughter was still breastfeeding with regular top ups of expressed breast milk.

Mum B (during Covid)

Mum gave birth in Tameside General Hospital on 30 October 2020 and was discharged from hospital on 3 November. When we made the initial support call to mum on the same day, she told us that baby had latched well at birth and she was offering her breast regularly. We discussed continuing to do this every 2-3 hours, she told us there were plenty of wees and poos. We talked about lots of skin to skin, the changes in the milk from colostrum to milk and discussed positioning and attachment. We sent her links from kellymom to follow this up and our FB group link.

On 5 November we had a call from mum. She told us that her nipples were sore, and described a shallow latch and said she was feeling really sore. We asked more questions and gave support in case of a possible Tongue tie. We talked mum through the rugby ball hold as this would mean gravity would take baby's tongue down to allow for a deeper latch. We explained how to recognise

when her breasts were fully drained, and to look out for baby's jaw to be tucked down when approaching the breast.

When we called mum when baby was ten days old on 9 November mum told us feeding was going much better, we spoke about making sure baby's mouth was nice and wide before putting him on her breast and also about growth spurts where baby may cluster feed.

On 23 November we received a call from mum requesting support. We went through different positions she could try and mum asked about feeding lying down, which we described. We gave lots of reassurance and answered her questions about supply and the importance of regular feeds overnight to put the milk order in for the next day.

On 2 December, a health visitor called and asked us to give mum a call. We called mum and gave her some additional tips around feeding cues and Position and attachment information. We also sent her lots more links from the breastfeeding network and Kelly mom. Also our group information.

At 6 weeks mums is still breast-feeding but does give expressed breast milk using a bottle occasionally to top up. All was going well and mum has now joined our zoom group, which she says she is really enjoying, especially meeting other mums, gaining reassurance.

Appendix B – Peer Support Service – Feedback from Families

"Without Home-Start I really don't think we would have managed all we have achieved over the last 18 months' and 'they never judge me and give impartial advice."

"Home-start have been a lifesaver for me and my mental health, not only practically but emotionally. As well, the contact for me and my children has had an amazing impact on our lives, and I'm thankful for them every day."

"My Home-start visitor and the area manager have been a great support and help for my family. Having 3 young children and my eldest with additional needs means that family life can be very demanding, and even more stressful due to the covid pandemic. Home-start have been there to listen to my concerns and offer my family any help we need. I have found my Home-start visitor fabulous, she always puts me at ease and listens to my rants when I need to let off steam. In addition, Home-start are very good at matching you with someone who has had similar experiences/needs so you can easily relate and they can provide you with a wealth of knowledge/advice specific to your family situation. I have found having someone who is not a health or education professional extremely beneficial as they understand what is like to be in your shoes, and the actual realities of the situation which is not always easy to cope with or to change."

"I couldn't thank Home-start enough, when I was at my lowest and needed the most support, I had you to rely on. The support from my volunteer and the Home-start team has been fantastic, just a simple chat or a walk can instantly make you feel better about yourself or change your way of thinking. They have always been great with my little girl when I was having up and down days. Thank you to all the team, you are incredible."

"Thank you so so much for today. I couldn't have done it without you. You have no idea how much your support means to the boys and I."

"You're so good at calming me down, I always feel better after speaking to you. Thank you. "

"It helped me through a really rough patch."

"My volunteer was great at talking things through with me."

"You are so knowledgeable and i feel so comfortable talking to you cause you really understand my struggles."

"Knowing I have a listening ear when I need it really helps."

"I like how you help me to see what i can achieve and support me along the way in doing so."

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	25 August 2021
Executive Member:	Councillor Eleanor Wills – Executive Member (Adult Social Care and Population Health)
Clinical Lead:	Dr Ashwin Ramachandra – Co-Chair Tameside & Glossop CCG, Clinical lead Long Term Conditions
Reporting Officer:	Dr Jeanelle de Gruchy, Director of Population Health Dr Anne Whittington, Acting Consultant in Public Health
Subject:	**COMMISSIONING INTENTIONS – TAMESIDE HEALTH IMPROVEMENT SERVICE OFFER FROM APRIL 2022**

Report Summary:

Tameside experiences wide health inequalities, with life expectancy lower than the national average. Higher rates of cardiovascular disease (including stroke), cancer and respiratory disease all contribute to this and place additional burden on local health and social care services. Lifestyle and behaviours all contribute to these health outcomes and the importance of public health interventions for smoking, weight management and wellbeing have been highlighted in the recent Marmot cite region report. The Health Improvement service commissioned by public health provides support to the community on these and other lifestyle choices and behaviours.

In November 2020, the council's spending review identified Health Improvement Services for a 20% saving against the budget allocated for Smoking Cessation and Healthy Weight support. The budget reduction required changes to the service plans to be made. In order to carry out a full re-design of the service and a comprehensive public consultation exercise on the revised plans, an extension to the contract was agreed until 31 March 2022.

The report summarises the outcome of a recent public consultation with recommendations and outlines commissioning intentions for the Health Improvement Service from April 2022. It includes an appraisal of two options for consideration by Strategic Commissioning Board members and seeks to authorise the preferred option of transferring the service in-house.

Recommendations:

Strategic Commissioning Board be recommended to:

(i) Consider the outcome and recommendations of the 12 week public consultation held from 18 February, 2021 to 13 May 2021.

(ii) Agree the proposal to transfer the Oral Health service into the Council's Population Health team when the contract terminates on 31 March 2022.

(iii) Consider the options appraisal set out in section 5 with a recommendation of option 2 – to transfer the service in-house within the Council.

Financial Implications:

Budget Allocation (if Investment Decision)	

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)	CCG or TMBC Budget Allocation	
	Integrated Commissioning Fund Section – s75, Aligned, In-Collaboration	
	Decision Body – SCB Executive Cabinet, CCG Governing Body	
	Value For money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark	

Additional Comments

The budget allocation for the Health Improvement function is as stated at 1.7, with a total of £966k in budget for both Health Improvement and Oral Health services net of a £186k savings target to be achieved in FY22/23. This proposal is essentially to deliver the equivalent service in-house rather than re-commission, with these two options appraised at 4.1-10.

Option 1 would be to retender the contract on a similar basis as previously, albeit with the budget reduced by £186k. This would achieve the savings target, although it is not clear that an equivalent service would be deliverable within this envelope, and as acknowledged in **Appendix 2** some reduction in activity would be likely, given a 16% budget cut.

Option 2 would be to bring the service in-house, with the staff currently employed on the contract transferred through TUPE. The provisional budget requirement for the new service is set out at 4.11-12. The costs arising from this are provisionally estimated to be £849k, subject to further evaluation of headcount, pension costs, and other contractual obligations arising on transfer. In principle, this would allow the service to continue, with the full savings target achieved and a further £117k to cover extra overheads or be offered up as additional savings. The initial financial appraisal is in outline only, and further due diligence would be required as set out at 4.10.

The service delivery implications are set out at 4. A number of financial risks also arise from the transfer, as well as potential opportunities. The legal and regulatory obligations from TUPE require further review, and costs may be incurred for redundancy, sick pay, pension, and other liabilities. Accommodation and other support costs for the new team of up to 24 FTE are yet to be considered. If the TUPE did not progress on schedule, it is unlikely that the full savings would be achieved. The potential additional saving should not be counted on until further work is done.

Conversely, a retendering exercise would be subject to procurement risk in that it might not be possible to agree a new contract within the Council's service requirements and budget envelope, and in this instance the savings would likewise not be achieved. Neither approach is risk-free, but for the reasons set out at 4.8 onwards, the risks of bringing the service in-house may be more easily manageable for the Council. In the longer term this might allow for a better-resourced and more flexible

	service, with greater scope for new efficiencies and cost reductions.
Legal Implications: **(Authorised by the Borough Solicitor)**	This report sets out the outcome of the consultation for Members to consider as part of the decision making process in relation to the options being presented in this report. To ensure that there has been a robust decision making process careful consideration has to be given to the outcome of the consultation. In relation to the options as set out in the report the market has been tested and there is a concern that if the service were to be re-procured then either the market would not be able to provide the service or if it can then not be able to deliver the required savings. Therefore consideration has been given to the option, identified as the preferred option for the council to deliver the service. As set out in the financial implications this options still has some financial risks attached to it in relation particularly in relation to TUPE costs including pensions. Therefore the necessary due diligence will be required in relation to this. Appropriate advice will also have to be taken in relation to the expiry/termination of the current contract.
How do proposals align with Corporate Plan?	The proposals link with all priorities in the Corporate Plan, in particular Starting Well, Living Well and Ageing Well programmes. The service links into the Council's priorities for People: • Decrease smoking prevalence • Promote whole system approach and improve wellbeing and resilience • Improve satisfaction with local community • Increase access, choice and control in emotional self-care and wellbeing • Increase physical and mental healthy life expectancy • Improve the wellbeing for our population • Increase levels of physical activity • Increase levels of self-care/social prescribing • Prevention support outside the care system. • Reduce rate of smoking at time of delivery
How do proposals align with Locality Plan?	The proposals will support the locality plan objectives to: • Improve health and wellbeing for all residents • Address health inequalities • Protect the most vulnerable • Promote community development • Provide locality based services
How do proposals align with the Commissioning Strategy?	This supports the 'Care Together Commissioning for Reform Strategy 2016-2020' commissioning priorities for improving population health particularly: • Early intervention and prevention • Encourage healthy lifestyles • Supporting positive mental health

Recommendations / views of the Health and Care Advisory Group:	The report has not been reported to HCAG.
Public and Patient Implications:	The recommendations will ensure continued access to services to improve health and prevent long-term conditions.
Quality Implications:	The Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	The provision of Health Improvement Services has a positive effect on health inequalities. The proposed stronger focus on reaching individuals and groups who are at greater risk of poor health will help to reduce health inequalities.
What are the Equality and Diversity implications?	An Equality Impact Assessment has been undertaken and is included as **Appendix 2**. The Health Improvement Services provided are available regardless of age, race, sex, disability, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity, and marriage and civil partnership. Some service provision is targeted to address health inequalities experienced by more marginalised groups.
What are the safeguarding implications?	There are no safeguarding implications associated with this report. Where safeguarding concerns arise the Safeguarding Policy will be followed.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information Governance is a core element of all contracts. The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by the provider. A Data Protection Impact Assessment (DPIA) will be carried out as part of the procurement process. A privacy impact assessment has not been carried out.
Risk Management:	Risks will be identified and managed by the implementation team and through ongoing performance monitoring once the contracts have been awarded.
Access to Information:	The background papers relating to this report can be inspected by contacting the report writer Telephone: 0161 342 3358 e-mail: anne.whittington@tameside.gov.uk

1. INTRODUCTION

1.1 The Health Improvement service is commissioned by public health to improve health and reduce inequalities. As highlighted in the recent Marmot report[1], Greater Manchester, including Tameside, experiences wider health inequalities than many other areas of the country and these have been highlighted and worsened by the COVID-19 pandemic. The levels of excess weight (71.3%), smoking rates (18.2%) and physical activity (58.6%) among adults in Tameside are significantly worse than the national average[2] and we know that these are some of the leading causes of preventable ill health and death. Smoking and inequality are closely linked and although the city region has made strides to achieve a reduction in rates of smoking over the last few years, in Tameside we still have high rates of morbidity and mortality from smoking related disease such as strokes, heart disease and cancer. One in four Greater Manchester residents say they want help to stay active and eat healthily, and we know that levels of obesity in Tameside continued to rise between 2018/19 and 2019/20. Public health is one of the six areas of focus in the 'Build Back Fairer' framework in the Marmot report. Smoking prevalence, obesity, low self-reported health and low wellbeing were highlighted as four key beacon indicators that are critical in driving down health inequalities in Greater Manchester. The health improvement service targets these outcomes and behaviours, among others, so is very important if we want to improve health inequalities.

1.2 In Tameside, life expectancy is statistically significantly lower than the national average and the most recent data suggests that this gap is widening and life expectancy is stalling. Our higher rates of cardiovascular disease (including stroke), cancer and liver disease place additional strain on the local health and social care system, but many of the conditions are preventable. Those with multiple long-term health conditions often struggle to navigate the system and need support to manage their conditions and improve their wellbeing[3]. Our current integrated wellbeing service 'Be Well' is provided by Pennine Care and works with the community to improve health outcomes. It offers smoking cessation, weight management, NHS Health Checks, community engagement, workforce development and training on brief advice and interventions, and population oral health. Since delivering the service, Be Well has performed well achieving good outcomes and becoming a well-used and respected service in Tameside. The service is due to be re-commissioned by 1 April 2022. A report presented to the Strategic Commissioning Board on 3rd Feb 2021 agreed a 20% budget saving against the contract from April 2022, with a review of the service model informed by a 12 week public consultation.

1.3 The service provides good value for money. There are approximately 31,915 smokers in Tameside. It is estimated that smoking costs the Tameside economy £55.3 million including a cost to the local NHS of £11.8 million a year. Smoking cessation is known to be one of the most cost-effective interventions available, with NICE estimates suggesting that every £1 invested in smoking cessation saves £10 in future health care costs and health gains.

1.4 Weight loss interventions can be cost-effective by reducing the future risk of associated ill-health. A report for NICE estimates that for a weight loss intervention which achieves a 1kg weight loss, maintained for life (compared to the weight trajectory without the intervention), the programme would be cost-effective if costing less than £100 for 12 weeks. Further evidence shows that this magnitude of weight loss is realistic for a behavioural weight

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[1] Institute of Health Equity (2021) Build Back Fairer in Greater Manchester, https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-in-greater-manchester-health-equity-and-dignified-lives

[2] Public Health England (2021) Public Health Outcomes Framework – Health Improvement, Fingertips https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/

[3] The Richmond Group of Charities (2021) You Only Had to Ask: What people with multiple conditions say about health equity https://richmondgroupofcharities.org.uk/taskforce-multiple-conditions

management intervention over the medium- to long-term.

1.5 In Tameside, a five-year-old has an average of 1.17 decayed, missing or filled teeth, higher than the England average of 0.78 teeth per child. The impacts of poor oral health disproportionally affect vulnerable and socially disadvantaged individuals and groups in society and public bodies across the health sector in England have legal duties and responsibilities to address inequalities. Poor dental health is a leading reason for planned admission to hospital in childhood across England. In addition, vulnerable older adults, such as those with dementia, those with loss of motor skills after a stroke, and those in residential and nursing care are also at risk of poor oral health. In turn, those with poor oral health and gum disease have a higher risk of wider health problems including diabetes, stroke and heart disease.

1.6 The above highlight the importance of a service to improve these outcomes. Recognising the value of the service alongside the financial pressures faced by the Council, the 22/23 saving identified from the Health Improvement service is £185,800. The remaining budget is £965,910 per annum allocated below:

- Oral Health service - £80,000
- Health Improvement service (smoking cessation, weight management, NHS Health Checks, community outreach, training) - £885,910

2. THE CURRENT HEALTH IMPROVEMENT SERVICE

2.1 The current Health Improvement offer for Tameside residents is delivered through a holistic, integrated service. Following a 2015-16 service redesign, the contract remained with Pennine Care NHS Foundation Trust as a tender exercise to identify a new provider was unsuccessful. The team and service offer was reconfigured so that all health and wellbeing advisors were trained up to provide holistic support in a range of lifestyle issues, and refer on to more specialist support where appropriate. The new integrated model has many positive aspects and has had a lot of positive feedback from residents and partners.

2.2 The service in its current form began operating in March 2016 and forms part of the Pennine Care NHS standard contract, with Tameside & Glossop CCG as the lead commissioner and Tameside Council as an associate commissioner. In March 2019 it was extended until the end of September 2020 and subsequently to the end of March 2022, in light of the ongoing pandemic.

2.3 The current service has a number of aspects:

- Clients entering the Be Well integrated wellbeing service make a personal health plan supported by Health and Wellbeing advisors working in an asset based way. The service helps people with smoking, weight, alcohol, stress and sleep.
- Smoking cessation is a key part of the service delivered. Referrals are from a wide range of sources, including the CURE programme, primary care and self-referrals. It involves one-to-one and regular support from trained advisors, as well as access to local information and groups.
- The oral health aspect focuses on supporting the prevention of poor oral health among children and young people as well as advice on the care of oral health for the older population, with a particular focus on care homes and social care support.
- NHS Health Checks are a statutory function, and are offered every 5 years to everyone in England aged between 40 and 74 years who is not currently recorded as having a long-term health condition. The Health Check aims to identify those at high risk of, or with early signs of stroke, heart disease, kidney disease, dementia, or type 2 diabetes[4].

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[4] NHS (2019) NHS Health Check. Available online at: https://www.nhs.uk/conditions/nhs-health-check/

Health checks are delivered in various community locations and at local events, particularly in communities where people might not be as well served by healthcare interventions. Following the health checks, the team refer people on as required.
- In addition to the individual services, a community team attend events and locations to generate referrals to the Health Improvement advisors, to signpost and/ or refer to other services; offers training courses to professionals; and supports the delivery of a number of campaigns throughout the year. It has close links to community organisations and primary care.

2.4 Like others, the service has had to adapt delivery over the past 12-18months, in line with COVID-19 advice and regulations. As a result, a digital offer has been developed and delivered where delivery a face-to-face service has not been possible. As regulations have changed, some elements of the face-to-face have been re-established where it has been safe to do so. Certain elements of the service listed above have been more restricted by the pandemic than others.

2.5 There has been positive feedback from service users and staff on the expansion of the service to digital. There has been a reduction in non-attenders via telephone appointment, which makes the service more efficient and suggests accessibility is improved for many. Whilst there is a recognition this service is not suitable or preferable for all, it supports development of a hybrid offer in the future.

2.6 Despite the difficult circumstances, and some frontline services having to pause due to COVID-19, during 2020-21, Be Well Tameside has worked hard and had some really positive outcomes. These include:
- Attracted 804 new clients who have never accessed the service before and supported a further 892 people who have been in touch with the service previously.
- 1519 clients created their own personal health plans with their own personalised goals for health and wellbeing, with 55% of people achieving their goals and a further 29% part achieving them.
- After a concerted focus on smoking cessation through the pandemic, the service supported 692 clients to achieve a 4-week quit and encouraged 956 clients to sign up to the smoke free homes pledge 'Take 7 Steps Out', to reduce passive smoking.
- 338 clients were supported to achieve weight loss.
- In terms of wider lifestyle and wellbeing scores such as connecting with others, coping, money, jobs, training, volunteering and enjoying life, 1069 reported an increase in their personal scores of these measures.
- Promoted and supported 16 health and wellbeing campaigns and marketing initiatives.
- Pre-pandemic in 2019/20, the service carried out 1460 NHS Health Checks (these had to pause for 2020/21 as per national guidance but have recently restarted).

3. CONSULTATION, ENGAGEMENT AND MARKET TESTING

3.1 A public consultation ran for a period of 12 weeks from 18 February, 2021 to 13 May 2021. There were 131 respondents to the online survey component of the consultation. Feedback was also gathered from a series of 6 focus groups/workshops held with 4 different community organisations and also collected through a group session with staff from the Be Well service themselves. Concerted effort was made to gather feedback from under-represented and protected characteristic groups. The use of a mixed approach aimed to maximise opportunity for the public to take part in the consultation process.

3.2 From the data available, respondents to the online survey were majority female, aged 35-65 and primarily White British, although the ethnic mix was not dissimilar to that of the general population. Some respondents reported having a long-term health condition or disability and a proportion had caring responsibilities. The vast majority responded in their capacity as Tameside residents and over half had used or were using the service, with most of the

remainder having worked for or referred in to the service.

3.3 Throughout all aspects of the consultation the following themes were recurring. A more complete summary of all aspects of the consultation is included in **Appendix 1**:

- A need to maintain both a digital and face-to-face offer, as well as group and individual sessions to make the service more accessible to all. This included ensuring access to groups that experience inequalities.
- A general feeling that the integrated, broader wellness offer was beneficial and that whilst a more targeted offer had some benefits respondents preferred an integrated service.
- Community outreach and engagement and working with partners was considered a key benefit of the service and should not be lost.
- There was a great deal of positive feedback about the way the current service was run and people were grateful for the input they had received. A number said they would not have been able to quit smoking or lose weight without the service.
- Training and education sessions were felt to be important and there was a recognition that there should be at least an element of the service focusing on prevention.
- There was a general feeling that the service was well recognised and respected by the community and other professionals, but that work would need to be done to maintain relationships and promote the service more widely.

3.4 The results of the public consultation support the previously proposed changes to the service, the main features of which are:

- A mixed digital/telephone and face-to-face model.
- Group sessions alongside one-to-one support where required.
- Maintaining an integrated, broader wellness offer as well as smoking cessation and weight management services.
- Continuing to work with communities and other organisations to provide support and prevention of ill health.
- Targeting those that need the service most whilst ensuring access for all

3.5 An expression of interest (EOI) exercise was conducted with the support of STAR procurement as a form of soft market testing. The previous tender exercise for this service was unsuccessful, so the aim was to understand the optimum way of packaging the services to encourage providers, including charities, social enterprises and Small and Medium Enterprises (SMEs) and new entrants to the market, to bid. Providers were able to express interest in bidding for either the smoking cessation service or community wellness service in isolation, or for both services combined. A total of 24 companies expressed an interest but only 12 of these completed the accompanying questionnaire. Of these, 9 reported being interested in both services combined and 3 were interested in only the community wellness service. No respondents were interested in the smoking cessation service alone, although 2 who expressed an interest in the combined service said they would prefer the services to be offered as separate contracts. Therefore, it is not clear if some of the companies interested in both combined would consider bidding for or running the smoking cessation service in isolation. In addition, a number of the EOIs were from smaller voluntary sector organisations that could struggle to deliver the requirements of the total contract. Of the larger organisations, for the most part these were national companies rather than local businesses.

4. ORAL HEALTH SERVICE

4.1 It is proposed that the core oral health offer will continue unchanged with the service within the Council to enable closer integration and alignment with public health and children's services/early years when the contract is terminated on 31st March 2022. This will support a sustainable population approach to oral health, as capacity to deliver can be incorporated and increased within these services. Oral health will continue to be funded from the budget identified within this report with an annual budget of £80,000. The team consists of 1.6 WTE

staff and a revenue budget to deliver the following initiatives focused on reducing oral health inequalities:

- Targeted supervised-tooth brushing in childhood settings
- Targeted community-based fluoride varnish schemes
- Integration of oral health into targeted home visits by health and social care workers
- Targeted provision of toothbrushes and toothpaste by health visitors or post
- Healthy food and drink policies
- Oral health training for the wider professional workforce

4.2 It is important that the full spectrum of the oral health offer to both children and older adults is not reduced. As highlighted in the introduction, poor oral health is another driver of health inequalities, is linked to wider health conditions and disproportionately affects those in vulnerable and socially disadvantaged groups. Improved oral hygiene and good tooth brushing can reduce the risk of dental decay, gum disease and other health problems[5]. Work across children's and older people's settings will continue.

5. PROPOSAL AND OPTIONS APPRAISAL

5.1 The Council is facing significant financial pressures with increasing demand on services and the impact of the COVID-19 pandemic. The Council is required to improve its financial position by finding further in-year and future savings through a review of all spending as part of the Medium Term Financial Strategy (MTFS).

5.2 With the results of this consultation and the EOI exercise, the opportunity has been taken to review the options for service delivery. In addition to this, the ongoing and likely future impact of the COVID-19 pandemic has been taken into account and all original assumptions revisited. As a result, we have concluded that an element of flexibility will be required going forwards, in order to adapt and respond to the needs of the population and the Council's financial position. Maintaining a holistic service and keeping the smoking cessation and community wellness elements of the service together were also highlighted as important and more cost effective, and this has been taken into account when considering the options outlined below.

5.3 In collaboration with STAR procurement and taking advice from the Council's HR and legal teams, two options are proposed for the continued delivery of a Health Improvement offer for the residents of Tameside. Findings from the consultation and EOI exercise have also been taken into consideration. Regardless of approach, both services would undergo the service changes proposed previously. A financial assessment of the options has been undertaken to assist in establishing affordability and value for money.

5.4 The two options available to the Council in respect of the Health Improvement Service delivery are:

1. Re-tender the service for a contract period of up to 5 years commencing 1 April 2022 with an annual contract price of £885,910.
2. Terminate the contract and transfer the service in-house with the Council retaining all income and expenditure and control over the service.

OPTION 1: Re-tender the service for a contract period of up to 5 years commencing 1 April 2022 with an annual contract price of £885,910.

5.5 This option would re-tender the service for a contract period of up to 5 years commencing 1 April 2022 with an annual budget of £885,910 with a termination clause of six months. The Council will work jointly with STAR procurement to undertake the tender if this option is

[5] NHS (2018) The Health Risks of Gum Disease. Available online at: https://www.nhs.uk/live-well/healthy-body/health-risks-of-gum-disease/

deemed most appropriate. Consideration will also be given to maximising the social value of the contracts, following STAR procurement processes.

5.6 The table below outlines the advantages and disadvantages of this option.

Re-tender the service for a contract period of up to 5 years commencing 1 April 2022 with an annual contract price of £885,910.	
ADVANTAGES	**DISADVANTAGES**
Resource - external provider may be able to provide access to expertise, knowledge, innovation and specialists in the field but an inexperienced provider may take time to establish this.	Costs – providers will have additional overheads and costs to be covered that would impact on the budget and capacity for front line service delivery.
Increased reach – a larger provider may have access to capabilities and facilities otherwise not accessible or affordable and may have an established reputation and networks. A newer/smaller provider may experience the opposite.	Service delivery – quality of service may fall below expectation. This can be mitigated by having a robust contract performance framework in place but consideration needs to be given to the costs and time of managing this and the reputational damage to the Council should quality be compromised.
Social value opportunities – this option gives the council an opportunity to offer additional benefits to the community from a commissioning / procurement process e.g. opportunity to procure from a SME or local VCSE provider. Opportunity for providers to align their SV commitments to Tameside Council's priorities.	Lack of flexibility – contract could prove too rigid to accommodate change flexibly, this may be more likely to happen if the budget is compromised.
Costs – may be lower if additional recruitment, equipment, expenses and training are required. However, some of these costs may have been built into the bid for the service therefore the council may not achieve these savings.	Instability – the company could go out of business – this is mitigated by carrying out robust due diligence and checking organisations finances but these risks still need to be considered.
Flexible manpower - if additional staff are required, the council save on recruitment costs.	Procurement – costs and time of this exercise should this be unsuccessful/challenged. The tender of this service has been unsuccessful in the past due to an inability of the market to deliver on the preferred service model. This is also the case if only partially successful if the contract is split and no provider is found for one element, which is an additional risk, as highlighted by the EOI exercise.
Market stimulation - in terms of not having monopolies and allows different suppliers to develop and come up with innovation due to benefits of maintaining competition could include driving reduction in costs and keeping the market buoyant.	Fixed contract – the council are tied into a contract. The contract does have a termination clause but exercising this could prove costly.
	Competition – if a supplier submits a low bid to secure the contract there is a chance quality, service user experience and outcomes could be compromised.

OPTION 2: Terminate the contract and transfer the service in-house with the Council retaining all income and expenditure and control over the service.

5.7 This option would involve terminating the current contract with Pennine care NHS Foundation Trust and transferring the service and staff in-house, with the Council retaining all income and expenditure and control over the service. The current staffing establishment consists of

24 WTE roles to deliver the service with all staff eligible for TUPE to deliver the new service model. Initial financial modelling, considering staffing costs and revenue costs indicate additional savings of approx. £117,000 could be identified from the total available budget. The current provider is an NHS provider therefore staff are on NHS T&Cs. The future service would be subject to Population Health service reviews to ensure that effective service delivery is aligned to corporate priorities and delivers cost effective outcomes.

5.8 The table below outlines the advantages and disadvantages of this option.

Terminate the contract and transfer the service in-house with the Council retaining all income and expenditure and control over the service.	
ADVANTAGES	**DISADVANTAGES**
The Council retains all income and expenditure and control over the service. There will be a reduction in costs – for example costs of conducting a tender process, internal resource to manage and monitor the contract, quality issues, reputational damage, and use of the Council's existing assets (i.e. estate). Additional financial savings on top of 20% reduction have been calculated to be approximately £117K by bringing the service in-house. Future cost reductions may be achieved by service redesign, integrating services and reducing management overheads.	HR risks of TUPE: Redundancy would be higher. Under NHS T&C redundancy pay is calculated as one months' pay for every continuous year of service capped at 24 months, with a minimum salary level of £23k and a salary cap at £80k. Occupational sick pay - NHS scheme more beneficial. Consideration also needs to be given to the other occupational schemes (e.g. maternity) however they are less frequent and similar/less costly. Pension scheme - as part of a TUPE the Council can apply to the NHS pension fund to continue to offer the NHS pension scheme or the GMPF as an alternative. HR have advised that employer costs are comparable.
Improves opportunities for the Council to work collaboratively with communities in the design and delivery of public services which reflect what they need, recognising that service delivery is a core element of our relationship with residents.	
Ensures an integrated service offer can be delivered within existing population health team and prioritised, as outlined in consultation outcome.	
Quality control – can be easier to keep control over the quality of work leading to an increase in productivity hence achieving improved outcomes. Problems can be identified and resolved at an earlier stage.	Experience - not having some levels of expertise and wider partnership working from an external provider, although this is mitigated to an extent by the established partnerships that already exist with the Council.
Workforce - strengthening of the Council's public health organisational sustainability and resilience, by further developing the skills and knowledge of the Council's public health workforce, organisational capacity and infrastructure. Allows closer working with staff to know their strengths and weaknesses so work can be assigned by skillset. Also allows for greater flexibility in service delivery should priorities change. Greater control over the development of staff skills and knowledge to align with priorities. Benefit of gaining skilled and experienced staff via TUPE. Having a varied combination of skills and professional backgrounds within the core public health workforce will also increase the recruitment pool and allow for movement across the wider system. As posts become vacant there is opportunity for service	Capacity – the service has a lead manager, but an element of capacity from the existing senior team will be required to oversee the service. This can be offset to an extent by the time spent commissioning the service and contract monitoring.

redesign and recruitment of roles via Council T&Cs. Provides an element of stability to existing staff rather than the uncertainty of a new external provider.	
Control – greater control over decision making and aligning the service to Council and local priorities. Enables more rapid change should local, regional or national policy or drivers change.	Recruitment – if staff leave or additional staff are required, cost and time for recruitment will be required, which would otherwise be an external providers responsibility. There is also a risk that posts could lie vacant if recruitment is unsuccessful.
Integration – can allow for a more joined-up delivery and integration with other services, increasing efficacy and efficiency and reducing duplication. This includes at a local level but also potential on a regional footprint as well. Delivery of a holistic solution with other council services including vulnerable groups, supporting public health, children/ adult services and social care outcomes and Corporate Plan strategic objectives	Time and resource – will be required to transfer the service in-house. Support from population health, HR, legal for example will be required to lead the due diligence exercise.
Communication – enables direct communication with staff, preventing risks of miscommunication via an intermediary, such as dealing with a manager of a commissioned external service.	

5.9 Advice has been gained from Legal Services, Human Resources, Finance, Adults commissioning and STAR procurement to assess the feasibility, risks and benefits of each option. It is the groups view that **option 2 is the preferred option for the authority to take**, following a detailed due diligence exercise. The Council has experience of leading a similar, although more complex, due diligence process following the TUPE transfer of public health staff and novation of public health contracts and services into the Council in 13/14.

5.10 Should option 2 be chosen, a project working group will be established to oversee the process and to draft a timetable for change:

- Sept 2021: Initiation of detailed due diligence to cover HR, Finance, Asset management, accommodation, Data/IG
- End Sept 2021: Consultation with existing health improvement team staff over TUPE process, terms & conditions
- Nov 2021: Report to ECG for TUPE process
- April 2022: Service & staff transfer to TMBC

5.11 The provisional budget requirement for an in-house Health Improvement team, inclusive of Oral Health, is set out below. Because the vast majority of the costs would arise from NHS staff transferring under TUPE, the position is uncertain until the contractual situation can be definitively determined. However, on the estimate below this option would achieve the 22/23 savings target, and save a further £117k to cover overheads or be offered up as an additional saving.

Health Improvement Team	**£000s**
Health Improvement Gross Budget	1,152
22/23 Base Savings Target	(186)
Net Budget	**966**
Staffing including oncosts (including Oral Health)	809
Additional operating costs	40
In-house Health Improvement- Total Costs	**849**
Additional saving	(117)

5.12 Staffing costs are based on information provided from Pennine Care and with contractual matters such as pension, redundancy, and sick pay still under review. The estimate has been formulated on the basis of:

Health Improvement Team- cost estimate after TUPE	
Salary Costs (assumes 3% 21/22 pay award)	£626,280
Employers National Insurance (13.8% above secondary threshold)	£53,489
Pension Contribution (contribution rate 20.68%)	£129,515
Additional operating expenses (mileage, office costs, Oral Health materials)	£40,000
Total	**£849,283**

6. EQUALITIES

6.1 Screening for equality impacts has been undertaken in order to help ensure that potential changes to delivery models do not result in any discrimination against individuals or groups who share the protected characteristics. It is not anticipated that there are any negative impacts on equality and diversity as a result of this proposal, although some positive impacts are anticipated. An equality impact assessment has been developed. This is a live document that will be updated as required, see **Appendix 2**.

7. RISKS

7.1 The following risks have been identified and will be managed as part of the project plan and mobilisation.

Risk	Risk Description	Mitigation
Mobilisation – failure to meet key deadlines.	The new model is not delivered on time to dovetail with the expiry of the existing contract which results in service disruption and reputational damage for the Council	Project plan with milestones is in place supported by commissioning team. The Population Health team will oversee the implementation of transfer of the service in-house. An updated project plan and more detailed programme of due diligence will be undertaken to ensure key milestones are met.
Financial – affordability of new model	The change in model result in costs being greater than working budget	The cost of delivering the service within the financial envelope are affordable. Further detailed due diligence will be carried out to confirm the available budget and possible savings. All costs to be identified including accommodation, currently provided via CCG. If the service is re-commissioned, Officers will follow Tameside's procurement procedures, such as the Contract Standing Orders (CSOs), which are designed to ensure that the Council achieves best value and continued improvement for all commissioned services.
Staffing and culture – insufficient capacity within the	The organisation's capability and capacity to accommodate an expanded Population Health team with the	The Health Improvement team will align to the Health Improvement team within the Population Health team. Through detailed project

organisation.	associated infrastructure, management and staffing requirements. Through detailed project planning the organisational capacity required will be identified and detailed in the preferred in house model and will impact on a number of other directorate functions.	planning, the organisational capacity required will be identified. Due diligence to include review of subcontracting arrangements within the current contract. A risk assessment on the status of fixed term workers (as defined by the current provider) to ascertain whether these individuals are casual or permanent employees.
Reputational – failure to deliver on council commitments and service standards	The preferred option does not deliver the additional benefits to the community.	The Health Improvement service model has been informed by extensive resident and customer engagement over the past 18 months. The current specification reflects this and will form the basis of the team plan, aligned with the population health service plan. Continued evaluation of the delivery model will aim to identify service benefits to the community and future service improvements.
COVID-19 recovery - ongoing uncertainly of the pandemic	Demand for services have changed and this may affect referrals into the service and the way the service is delivered.	Flexibility will need to be built into the service delivery plan and monitoring of demand/ pathways to ensure residents can easily access support
Legal and regulatory – health and safety responsibility	Increased risk and exposure for the Council as it will take on health and safety and other associated responsibilities previously held by the current provider.	Ensuring that the health and safety management of the health improvement service is sufficiently resourced.

8. CONCLUSION

8.1 The Council has a wide range of strategic outcomes which will change over time and have been affected by the impact of the COVID-19 pandemic and the inequalities experienced by our residents. There are also sub-sets of objectives and priorities that are reflected within the Corporate Plan, education plans, adults and children services, early help plans, and social care plans. These requirements can be documented within contracts and specifications; however, to build these relationships with external providers can often be difficult for Council departments to deliver. Changes can be difficult to put in place, given there is normally a financial and contracting implication to be considered and approved. This can often be seen as providing a less flexible approach to the constant changes to the Council's own outcomes, demand and needs.

8.2 As outlined above and in a previous commissioning intentions paper that was approved by SCB, many aspects of the current offer are working well. Reconsidering how the service is delivered will, however, give us the opportunity to make changes to optimise the efficiency and outcomes of the service, and to bring the offer in line with recent changes to local health needs and the evidence-base.

8.3 The consultation provides important information to note when considering the re-design but does not preclude the option to make the proposed changes to the service, providing a mix of group and individual sessions, maintaining a digital/telephone offer alongside face-to-face, targeting groups that are more likely to experience inequalities and working with communities.

8.4 In conclusion, it is felt that on balance, the option to transfer the service in-house is preferable. This is because it provides additional financial savings and allows a greater flexibility around continued provision of the service to meet priorities and service demand. Whilst there are risks associated with both options, the risks associated with bringing the service in-house are considered more acceptable and manageable.

9. RECOMMENDATIONS

9.1 As set out at the front of the report.

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APPENDIX 1

Tameside Metropolitan Borough

Health Improvement Consultation

1. Introduction

Be Well is Tameside's current wellbeing service, supporting people in Tameside to improve their health and prevent illness. Be Well currently offers:

- A wellbeing service covering stopping smoking, weight management, diet, sleep and stress management;
- NHS Health Checks in the community;
- Encouraging and helping people to live their lives in a healthy way through Public Health campaigns;
- Training other professionals so that they can give health improvement advice;
- Work with settings to help improve oral health in children and older adults.

2. Service delivery

Be Well has continued to work with Tameside residents throughout the COVID-19 pandemic, and has been working in different ways to make sure people have access to the service while staying safe. This has meant that face-to-face services have been replaced with telephone and virtual appointments for some periods.

The Health Improvement contract is due to end next year. Services will be recommissioned and there is a need to ensure there is a focus on the right things for Tameside. In November 2020, the Health Improvement Service was one of a number of services identified by the council's spending review for savings. For the Health Improvement service this is a budget reduction of £185,800 per year.

3. Future of service

We are planning to have three new services: Oral Health (which will remain largely the same), Smoking Cessation and Community Wellness, which will focus on healthy weight and community NHS Health Checks. These services will also help people to find support from other services for things like sleep and stress, to avoid duplication and to make sure people get to the right place for help.

The new services will have some similarities and some differences compared to Be Well.

3.1. Smoking Cessation Service:

- Ensure that everybody in Tameside who wants to stop smoking gets help from a specialist, high-quality service.
- People who are most in need of help are able to reach it.
- Increase different ways of seeing people, including telephone appointments and other virtual ways of providing support, as well as keeping some face to face appointments where needed
- Likely that the new service won't be able to do as much community engagement for stopping smoking.

3.2. Community Wellness Service:

- Performs NHS health checks in the community; helps local residents to have a healthy diet and healthy weight.

- This new service is likely to look very different to the current offer. Planning to work with the service and with local people to develop a high-quality offer for the residents of Tameside.
- To make the biggest difference to as many people as possible, planning to offer fewer one-to-one services for healthy eating and healthy weight. New service will work closely with communities, organisations and small groups of people to encourage healthy behaviours in the whole community.
- The new service will work with new and existing local groups and communities to encourage and support healthy eating across Tameside.
- Ensure that this service is something that everyone can benefit from and use, but that it works especially with those communities in greatest need, working with local residents to help them make positive changes in their lives.

4. Consultation

A consultation process was conducted to seek views on what the new service should look like to ensure that the new proposal would fit with the needs of the public. The consultation ran for a period of 12 weeks from 18th February, 2021 to 13th May 2021. The content of the survey is included in Appendix 1.

An online survey was created and promoted widely through as many channels as possible, including attendance at community groups to explain and publicise it. In addition to the online survey, 6 focus groups/workshops were held with 4 different community organisations with an aim to maximise opportunity to feedback. The results of these groups are summarised below in Section 5.

4.1. Demographics

Of the total respondents, 50% or fewer answered the questions on their demographics so this data may not be fully representative but gives some picture of the respondents:

- 74% were female, which is a higher proportion than the wider local population.
- 97% responded that their gender identity was the same as the gender they were assigned at birth, with no respondents openly identifying as transgender.
- Most respondents (85%) were aged 35-65, with the highest proportion (22%) being 50-54 years. There were no respondents over 80 or under 25 years.
- 88% identified as White British with the remaining 12% being from a variety of ethnic minority groups. The percentages were roughly representative of the ethnicity of the wider population in Tameside but it is worth noting that 57% did not report their ethnicity.
- Christianity was the most common religion/belief reported (58%), followed by ‘no religion’ (31%) and then Muslim (5%).
- 94% of respondents stated they were heterosexual, with almost all others preferring not to say and 2% identifying as LGBTQ+.
- Most respondents (59%) did not feel their day-to-day activities were limited by a long-term disability or health problem, with 22% feeling they were limited a little and 19% feeling they were limited at lot.
- 16% cared for another person(s) 1-19hours a week with 10% caring for more hours and 75% not caring for anyone else.
- 3% were a member or ex-member of the armed forces.
- The highest proportion were married or in a civil partnership (50%), 19% single, 14% co-habiting, 10% divorced and 6% widowed.
- Almost no respondents (98%) were pregnant, on maternity leave or returning from leave.

- Only 7.7% smoked, vaped or took another form of tobacco, with most of these smoking cigarettes. Of that small number, 60% were actively trying to give up, with most using a service for support and another 20% having recently quit smoking.
- More detailed data on responses is available in Appendix 2.

4.2. How respondents used the service

The consultation reported the following findings about the respondents:

- The vast majority (63%) of respondents completed the survey from their perspective as Tameside residents, with the second highest proportion being healthcare professionals (16%).
- Over half of the respondents had used or were using the Be Well service (52%) and 41% had used the service as a professional, either working for the service or referring into it.
- Of the 65% of respondents who answered the question about when they last used the service: 39% were currently using it; 14% had used it in the last 1-2 months; 29% had used it in the previous 3-18months and 18% had used it more than 18months previously.
- The vast majority who reported using the service had used the integrated Be Well service (82%), with 28% using the Health Checks service and a smaller proportion using other elements (selection of multiple services was permitted).
- More detailed data on responses is available in Appendix 2.

4.3. Free text responses

Four questions in the consultation invited a free text response. The answers to these have been analysed and common themes collated.

Question 6 related to how the proposed changes to the smoking cessation service would affect the respondent or other users of the service. The majority of respondents did not answer this question (58%) and a further 13% said the question was not applicable to them. Of the remaining 29% who provided an answer, the following points were covered:

- There was concern that the proposals would deter or prevent people from seeking support to stop smoking or have a negative impact on their ability to quit.
- Concerns often related to a lack of one-to-one support or that the service would be more difficult to access, particularly for those who are not digitally enabled.
- Positive feedback related to the fact that the service was felt to have had a positive impact for many, with a number saying that they felt they would not have been successful in stopping smoking without the service.
- There were no respondents who indicated that they felt the service wasn't needed, all wanted the service to continue and a number felt that it should be part of the wider wellbeing service, not stand-alone.

Question 7 related to how the proposed changes to the community wellness service would affect the respondent or other users of the service. As with the previous question, the majority (59%) did not answer or said they did not know (4%). Of those that did respond, the following points were highlighted:

- There was general concern that the changes may make it more difficult to access support and/or that the service should be maintained.
- Many gave positive feedback about the service they had used and highlighted the value of it.
- A considerable proportion raised concerns specifically about the loss of one-to-one services or that a group session approach may not be appropriate for all, although few were positive about the group session approach in particular.

- A small number of people raised concerns about the location of clinics and digital exclusion.
- A small number of others felt there would be no impact from the proposed changes.
- Having a joined up approach to services rather than keeping them separate was raised by some.

Question 8 asked for any further points for consideration regarding the health improvement service. The majority of respondents (65%) left this section blank. Of those that did respond the key themes included:

- Concerns that the service should continue to offer one-to-one support and that group sessions would not be appropriate for all.
- There was feedback that the service has a positive impact, particularly through its integrated approach to wellbeing.
- There were concerns that the service might become less accessible and suggestions to work more closely with the community and improve communications/publicity in order to prevent this. Some respondents highlighted a need to target communities at higher risk or experiencing inequalities.
- A few mentioned it was good that the service had continued to deliver support during the pandemic but also suggested the service may be more important as a result of the impacts of the pandemic (short and long term).
- A number supported the service focusing on prevention and enabling people to improve or maintain their own health, including providing education on certain long-term conditions and healthy lifestyles.

The final question asked for any other feedback. As with the other free text answers, a large proportion (70%) chose to leave this blank. The comments that were made offered much along the same themes as the previous questions:

- There was positive feedback about the service and people's experience of it.
- Many said they did not think the service should change and should be given equivalent or increased funding in order to continue and/or expand. There was concern from some that a reduction in funding would lead to greater expenditure elsewhere through lost opportunities for intervention and health improvement.
- Others recognised that if changes needed to be made, this seemed to be an acceptable compromise with the caveats covered by the above responses, such as keeping an element of one-to-one support, ensuring continued access, keeping an integrated approach to wellbeing and not excluding those who were not digitally or financially enabled.
- There were a number of comments that mentioned the service branding and reputation and that this should not be lost as it has taken time to build up and develop.

5. Focus groups, workshops and other feedback

5.1. Groups consulted

As part of the consultation process, a series of focus groups and workshops were also completed to gather further feedback. The following groups were consulted:

- Community Champions
- Public Engagement Network
- Integrated Care and Wellbeing Overview and Scrutiny Panel
- Independent Advisory Group

5.2. Summary of group feedback

Similar themes were elicited from the groups as was via the survey. The main points covered were:

- A desire to maintain one-to-one support but also recognition of the value of group sessions, as long as both options remain available.
- Maintaining and continuing to develop a community-based service, integrating with other providers, including the voluntary sector and building on community cohesion and existing assets.
- Making the most of existing connections and reputation that has been established but consider enhanced publicity so that more people are aware of the service.
- Providing training and education on healthy lifestyles, particularly to families.
- Outreach into communities was considered important, particularly following the pandemic restrictions.
- Keep messages positive and motivational.
- Access should be a consideration, including time/days of sessions for working age population, targeting groups that experience inequalities, and a recognition that telephone/digital options are welcomed by many but not suitable for all.
- Focus on prevention rather than intervention to turn around, for example working with young people and educational settings.
- Consider co-production with the public to develop the service and different ways to engage communities.

5.3. Additional feedback from Be Well service

The current provider also gave feedback from the results of an internal staff consultation, based on the public consultation questions. The session was split by way of the service being discussed.

On the smoking cessation service, a summary of the feedback was as follows:

- Similar positive and negative feelings about the move to a primarily digital service, recognising the benefits of improved access for some and potential for greater work-life balance but also the drawbacks, not just to those who are less digitally enabled but also to the cohesion and motivation of the staff.
- There were considerations for the future of the service, including how adaptations could be made in the future to offer a mixed service (digital and face-to-face), ongoing promotion, how administrative functions would work and whether service users could be triaged in advance of appointments.
- There was also recognition of the need to re-assess balance in the service around awareness raising, smoking cessation and harm reduction, incorporating an acknowledgement that as smoking rates reduce, quit rates may be harder to achieve because remaining smokers may be less willing and able to do so.

On the community wellness / weight management service the following feedback was captured:

- As with other aspects of the consultation, there was acknowledgement that group sessions and digital access were positive for many but that individual and face-to-face sessions were still required for others.
- There was a feeling that splitting the service into more focused separate areas rather than a broader wellness offer could offer a more targeted support that would be beneficial to some, whereas others would gain more from the wider programme and a more targeted approach would have a negative impact. There was also concern that this could make the service more confusing, both for users and referrers.
- There was a concern that training and skills could be lost as a result of changes to the service and could make the service more expensive to run.

- There was also a worry that community engagement and promotion could be lost/reduced and this would be detrimental to the service.

6. Summary of key themes

The consultation covered a wide range of respondents through a number of different methods. Throughout all aspects of the consultation the following themes were recurring:

- A need to maintain both a digital and face-to-face offer, as well as group and individual sessions to make the service more accessible to all. This included ensuring access to groups that experience inequalities.
- A general feeling that the integrated, broader wellness offer was beneficial and that whilst a more targeted offer had some benefits, it would be a shame to lose the former entirely.
- Community outreach and engagement and working with partners was considered a key benefit of the service and should not be lost.
- There was a great deal of positive feedback about the way the current service was run and people were grateful for the input they had received. A number of people stated that they would not have lost weight or managed to quit smoking if they had not had access to the service.
- Training and education sessions were felt to be important and there was a recognition that there should be at least an element of the service focusing on prevention.
- There was a general feeling that the service was well recognised and respected by the community and other professionals, but that work would need to be done to maintain relationships and promote the service more widely.

Tameside Metropolitan Borough

Appendix 1

Consultation survey content:

1. **What is your main interest in completing this survey? (Please tick one box only)**

   ❑ I am a Tameside resident
   ❑ I represent a community of voluntary group
   ❑ I am a Tameside Council or Tameside & Glossop CCG employee
   ❑ I am a health professional/other frontline professional using Be Well for my patients/service users
   ❑ I represent a business/private organisation
   ❑ I represent a partner organisation
   ❑ Other (please specify)

2. **Are you currently, or have you in the past, used Tameside's Be Well health improvement service? (Please tick one box only)**

   ❑ Yes (Please go to Q4)
   ❑ No (Please go to Q3)

3. **Are you currently, or have you in the past used Tameside's Be Well health improvement service as a professional, either working for/with the service or referring service users to them? (Please tick one box only)**

   ❑ Yes
   ❑ No

4. **When did you last use the Be Well health improvement service? (Please tick one box only)**

   ❑ I am a current user of the service
   ❑ I used this service within the last 1-2 months
   ❑ I used this service within the last 3-6 months
   ❑ I used this service within the last 7-12 months
   ❑ I used this service within the last 13-18 months
   ❑ I used this service more than 18 months ago

5. **Which aspects of the Be Well health improvement service did you use? (Please select all that apply)**

   ❑ Health checks in the community
   ❑ The integrated Be Well service covering stopping smoking, weight management, diet, sleep and stress management
   ❑ Community engagement
   ❑ Health improvement campaigns
   ❑ Workforce development and training on how to give health improvement advice

6. **Please explain in the box below how the proposed changes to the Smoking Cessation Service may impact you or other users of the service?**

[Free text answer]

7. **Please explain in the box below how the proposed changes to the Community Wellness service may impact your or other users of the service?**

[Free text answer]

8. **Thinking about the proposed changes to the service, is there anything else you think we need to consider regarding the Be Well health improvement service? Please write your thoughts in the box below.**

[Free text answer]

9. **Please state in the box below any other views and comments you have on the proposed changes to the Be Well health improvement service.**

[Free text answer]

ABOUT YOU

We would like to ask some questions about you. This information will help the Council to improve its services. The information you provide will be kept entirely confidential, will be used for statistical and research purposes only and will be stored securely. If there are any questions you do not wish to answer, please move on to the next question.

10. Are you: (Please tick one box only)

❑ Female
❑ Male
❑ Other (Please state below)
❑ Prefer not to say

11. Is your gender identity the same as the sex you were assigned at birth?
❑ Yes
❑ No
❑ Prefer not to say

12. What is your age? (Please state)

[Free text answer]

13. What is your postcode? (Please state)

[Free text answer]

Tameside Metropolitan Borough

14. What is your ethnic group? (Please tick one box only)

White
❑ English / Welsh / Scottish / Northern Irish / British
❑ Irish
❑ Gypsy or Irish Traveller
❑ Any other White background (please specify)

Mixed / Multiple Ethnic Groups
❑ White and Black Caribbean
❑ White and Black African
❑ White and Asian
❑ Any other Mixed / Multiple ethnic background (please specify)

Black / African / Caribbean / Black British
❑ African
❑ Caribbean
❑ Any other Black / African / Caribbean background (please specify)
❑ Any other Black / African / Caribbean background (please specify)

Asian / Asian British
❑ Indian
❑ Pakistani
❑ Bangladeshi
❑ Chinese
❑ Any other Asian background (please specify)

Other ethnic group
❑ Arab
❑ Any other ethnic group (please specify)

15. What is your religion or belief? (Please tick one box only)
❑ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
❑ Buddhist
❑ Jewish
❑ Sikh
❑ Hindu
❑ Muslim
❑ No religion
❑ Any other religion (please specify)

16. What is your sexual orientation? (Please tick one box only)
❑ Heterosexual / straight
❑ Gay or lesbian
❑ Bisexual
❑ Prefer not to say
❑ Prefer to self-describe
❑ Other sexual orientation (Please state below)

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

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

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

- ❑ No
- ❑ Yes, 1-19 hours a week
- ❑ Yes, 20-49 hours a week
- ❑ Yes, 50 or more a week

19. Are you a member or ex-member of the armed forces? (Please tick one box only)

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

20. What is your marital status? (Please tick one box only)

- ❑ Single
- ❑ Married
- ❑ Civil Partnership
- ❑ Divorced
- ❑ Widowed
- ❑ Prefer not to say

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

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

22. If yes, are you:

- ❑ Pregnant
- ❑ On maternity leave
- ❑ Returning from maternity leave

23. Do you smoke/take any of the following? (Please tick all that apply)

- ❑ Cigarettes
- ❑ E-cigarettes/vape
- ❑ Other forms of tobacco
- ❑ I do not smoke, vape or use tobacco in other ways

24. Are you actively trying to/thinking about trying to quit? (Please tick one box only)

- ❑ Yes – actively trying and using a specialist service
- ❑ Yes – actively trying on my own
- ❑ Yes – thinking about trying
- ❑ No
- ❑ Prefer not to say

Tameside Metropolitan Borough

❑ Other (please specify)

APPENDIX 1

Tameside Metropolitan Borough

Appendix 2

Data from online survey multiple-choice answers. Free-text answer data (including age and postcode) has been redacted to keep the information anonymous.

140521 Health Improvement Consu

Tameside Metropolitan Borough

Tameside and Glossop Clinical Commissioning Group

Tameside & Glossop Strategic Commission
Equality Impact Assessment (EIA) Form

Subject / Title	Health Improvement Offer

Team	**Department**	**Directorate**
Health Improvement	Population Health	Population Health

Start Date	**Completion Date**
25 July 2019	Ongoing Last Reviewed 29.03.2021

Project Lead Officer	Anne Whittington
Contract / Commissioning Manager	Linsey Bell
Assistant Director/ Director	Debbie Watson

EIA Group (lead contact first)	**Job title**	**Service**
Anne Whittington	Acting Consultant in Public Health	Population Health
Linsey Bell	Commissioning and Contracts Officer	Adults
Liz Harris	Programme Manager	Population Health
Debbie Watson	Assistant Director of Population Health	Population Health

PART 1 – INITIAL SCREENING

An Equality Impact Assessment (EIA) is required for all formal decisions that involve changes to service delivery and/or provision. Note: all other changes – whether a formal decision or not – require consideration for an EIA.

The Initial screening is a quick and easy process which aims to identify:

- *those projects, proposals and service or contract changes which require a full EIA by looking at the potential impact on, or relevance to, any of the equality groups*
- *prioritise if and when a full EIA should be completed*
- *explain and record the reasons why it is deemed a full EIA is not required*

A full EIA should always be undertaken if the project, proposal and service / contract change is likely to have an impact upon, or relevance to, people with a protected characteristic. This should be undertaken irrespective of whether the impact or relevancy is major or minor, or on a large or small group of people. If the initial screening concludes a full EIA is not required, please fully explain the reasons for this at 1e and ensure this form is signed off by the relevant Contract / Commissioning Manager and the Assistant Director / Director.

Tameside & Glossop Strategic Commission
Equality Impact Assessment (EIA) Form

1a.	**What is the project, proposal or service / contract change?**	The proposal is for the transformation and commissioning intentions of the Health Improvement service offer currently delivered across 3 areas: oral health; smoking cessation; community wellness. The current Health Improvement offer for Tameside residents is universal, but targeted to those with the greatest health needs. It is delivered through a holistic, integrated service. The offer provides: • 1:1 lifestyle advice and support (including smoking cessation and weight management) • Oral health promotion to schools, nurseries, care homes, and others • Community NHS Health Checks • Community development • Training and development in brief advice and intervention to health and social care staff • Support to health improvement campaigns The new service will continue with a holistic offer including smoking cessation, weight management, NHS Health Checks and general wellbeing support. It will offer a mixed digital and face-to-face offer, as well as group consultations alongside one-to-one support where required. The new service will place stronger emphasis on smoking cessation to increase system capacity. Community engagement and development will be an important element of the service, and will increase community readiness to engage with health improvement messages, particularly within communities with the strongest health inequalities and the least access to healthcare. This will have the dual effect of generating demand for and activity in the service, and changing attitudes, knowledge and understanding on a population level. If re-commissioned, the contract period will be for up to 5 years commencing 1 April 2022. An alternative option being proposed is to bring the service in-house. It is proposed that a new model is designed to meet the local population health needs, based on the evidence available and changes in demand.

Tameside & Glossop Strategic Commission
Equality Impact Assessment (EIA) Form

1b.	What are the main aims of the project, proposal or service / contract change?	The main changes to the service are: • To meet population need and the increased demand on smoking cessation services which will be generated by local innovations, by increasing the smoking cessation capacity in the system. There may also be a need to flex the service to respond to demand as required. • To contribute towards a whole system approach to tackling obesity. • To scale up the impact of weight management intervention by taking a population health approach. • To shift towards a community asset-based approach. • To reduce duplication by improving alignment with other services, groups and facilities in Tameside. • To increase community readiness for change through engagement, health campaigns and community action. The new services will be delivered with a cost saving of £185,800 compared to the current budget. This means that some reduction in activity is highly likely. Bringing the service in-house should also allow maximum use of the budget for the service through reduction in on-costs and will permit greater flexibility and control over the service to meet changing demand and population needs. The preferred option is to bring the service in-house rather than re-commissioning but the service delivered will utilise the same service design.

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

Protected Characteristic	Direct Impact / Relevance	Indirect Impact/Relevance	Little / No Impact/ Relevance	Explanation
Age			✓	The service is for all persons 12+ (smoking cessation) and 16+ (community wellness). There will be no change to the age the service is directed toward and therefore this group is not anticipated to be heavily impacted by the proposed changes.
Disability	✓			The service is open to all and the new service providers are expected to make provision for disabilities. However, there will likely be a change in the service and therefore possible relevance to people with disabilities. Consultation respondents included those who identified as having a long-term health condition or disability who commented that they had benefitted from the service. The consultation also highlighted that the evolution of digital consultations

				could have positive impacts on access but would not be suitable for all.
Ethnicity	✓			There may be a change to the weight management offer as the current service does have a targeted approach to support ethnic communities. However we aim to maintain this and work with more community assets. Consultation respondents included those from minority ethnic groups who commented that they had benefitted from the service.
Sex			✓	The future service is for all adults, but aims to target harder to reach groups and therefore this group is not anticipated to be impacted by the proposed changes.
Religion or Belief			✓	The new service will be open to adults of any or no religion and therefore this group is not anticipated to be impacted by the proposed changes.
Sexual Orientation	✓			The future service is for all adults, but aims to target harder to reach groups and the new service intends to increase accessibility for the LGBT+ community through working with other organisations and the community.
Gender Reassignment	✓			The future service is for all adults, but aims to target harder to reach groups and the new service intends to increase accessibility for the LGBT+ community through working with other organisations and the community.
Pregnancy & Maternity			✓	The service is for all adults. There is also a separate smoking cessation service for Pregnancy and Maternity, which will remain unchanged and therefore this group is not anticipated to be impacted by the proposed changes.
Marriage & Civil Partnership			✓	The future service is for all adults, regardless of partnership status and therefore this group is not anticipated to be heavily impacted by the proposed changes.
Other protected groups determined locally by Tameside and Glossop Strategic Commission?				
Group (*please state*)	**Direct Impact/Relevance**	**Indirect Impact/ Relevance**	**Little / No Impact/ Relevance**	**Explanation**
Carers	✓			The future service is for all adults, but aims to target harder to reach groups and have a direct positive impact. Consultation respondents included those who identified as carers who commented that they had benefitted from the service.
Military			✓	The future service is for all adults, but aims to

Veterans				target harder to reach groups and therefore this group is not anticipated to be impacted by the proposed changes.
Breast Feeding			✓	The future service is for all adults, and the new provider is expected to be welcoming and non-judgemental, including for those breast-feeding.
Are there any other groups who you feel may be impacted by the project, proposal or service/contract change or which it may have relevance to? (*e.g. vulnerable residents, isolated residents, low income households, those who are homeless)*				
Group (*please state)*	**Direct Impact/Relevance**	**Indirect Impact/ Relevance**	**Little / No Impact/ Relevance**	**Explanation**
Socio economic deprivation and areas of high deprivation	✓			The future service is for all adults, but aims to target harder to reach groups and have a direct positive impact. Smoking rates are higher amongst those in routine and manual jobs and therefore a higher proportion of those on lower income are more likely to benefit from the smoking cessation element of the service.

Wherever a direct or indirect impact or relevance has been identified you should consider undertaking a full EIA or be able to adequately explain your reasoning for not doing so. Where little / no impact or relevance is anticipated, this can be explored in more detail when undertaking a full EIA.

1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
		✓	
1e.	**What are your reasons for the decision made at 1d?**	The new service offer will extend access to more of the population across Tameside and aims to have a direct positive impact on the community, by targeting groups with inequalities in health outcomes. The aim is to maintain and extend current work with people in groups at higher risk of health inequalities, and to work with more community assets. The service is open to anyone who meets the criteria. However, with the planned cost saving of £185,800 per year, some reduction in activity is highly likely, with potentially greater impact if re-commissioned to an external provider.	

If a full EIA is required please progress to Part 2.

Tameside & Glossop Strategic Commission
Equality Impact Assessment (EIA) Form

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary

The contract for the Health Improvement Service, is currently held by Pennine Care, who have a commitment to Equality and therefore have policies, procedures and processes in place to ensure importance is given to equality, diversity and inclusion. The definitions for equality, diversity, and inclusion are as follows:

- **Equality** is making sure everyone is treated fairly and given an equitable chance to access opportunities. The notion of equality or equal opportunities is not about treating everyone the same, it's about levelling the playing field to address the different needs individuals may have, in order to achieve the same outcomes.
- **Diversity** is recognising and valuing individuals as well as group differences. It also means treating people as individuals, placing positive value on the diverse aspects they bring as a result of belonging to a certain personal cultural, linguistic religious, faith or background characteristic.
- **Inclusion** is seen as a universal human right. The aim of inclusion is to embrace all people irrespective of any of the protected characteristics giving equal access and opportunities and getting rid of discrimination and intolerance. This means removal of barriers.

The contract is either going out to tender or will be brought in house. It is expected that the new provider or the Council will continue to meet these high standards with an even stronger focus on having a direct positive impact by reaching out to individuals and groups who are at risk of/experience health inequalities. However, with the reduction in budget, it is likely that some reduction in activity will occur, particularly if re-commissioned externally. In addition, with the shift in focus away from one-to-one support for Healthy Weight and towards a Community Wellness model, there may be some people who would prefer a one-to-one service, but have to wait longer to access this.

2b. Issues to Consider

- Age
- Disability
- Ethnicity
- Sex
- Religion or belief
- Sexual orientation
- Gender reassignment
- Pregnancy and maternity
- Marriage and civil partnership
- Carers
- Military Veterans
- Breast feeding
- Socio-economic deprivation

2c. Impact/Relevance

Age

The service is committed to making sure that no one is discriminated against because of their age. The service is accessed on the basis of need, not age. The service is available to all adults (16+), and for children and young people from age 12 for smoking cessation (as this is the limit below which nicotine-replacement treatment is not licenced). For children below these ages, other

services are in place, and the new service provider will develop strong links with these services and refer to them when necessary.
Access will be maintained for all age groups currently served. The proactive approach to risk stratification should ensure the service is targeted towards those at risk of/with long term conditions. The service operates from a range of community based locations and this provides flexibility as where a service is located as this can act as a barrier to those accessing the service. It is also considered that older people find familiarity important. The new service will work in partnership will local communities.

Disability

This broad category includes people with physical and sensory impairments, mental health problems and long-term conditions (including learning disabilities). There is no need for a person to have a medically diagnosed cause for their impairment. The current service is committed to ensuring that the protections of the Disability Discrimination (Amendment) Act 2005. The service is not specifically defined as being for people with disabilities; however, the service gives support and makes reasonable adjustments. The new service will work proactively in partnership with the community assets and organisations to ensure those with physical and/or mental health disabilities are directly offered access to the service, and supported to access it. Offering the service in a range of locations and via different methods of delivery is thought to be beneficial for people with a disability. However, assessment of the location/method of delivery to the needs of the person is given consideration e.g. ramp access, toilet facilities, parking, noise levels, social distancing, digital access. It is also important to consider appointment times and length of the appointment.

This consideration is more important now than ever due to the ongoing COVID-19 pandemic. It is reasonable and likely that some individuals may have different needs now compared to before the pandemic, and these may require reasonable adjustments to be made for them to access services. For the Smoking Cessation offer, the new service is expected to build upon the knowledge and experience developed throughout the past year, and make more use of virtual offers, which may be of use to people who would prefer to remain socially distanced from others. The Community Wellness offer is expected to develop a range of approaches for a diverse range of Tameside residents, and this includes those who are less able to travel and/or meet face to face with others.

Ethnicity

It is important to consider both the concepts of race and ethnicity. Race describes physical characteristics, while ethnicity encompasses cultural traditions such as language and religion, playing pivotal and socially significant roles in individual's lives. These aspects of our identity inform how we see ourselves and the world, how others see us, and how we relate to each other.
In the current provision there is an objective to engage with groups who are at higher risk of health inequalities, including those from BME communities. In the 12 months to March 2021 the Be Well service saw 82% of its clients from White British Backgrounds, and 11% of clients from BAME backgrounds, the largest group of which being Pakistani/ Pakistani British (2.5%). This is broadly in keeping with the latest demographic data from Tameside as a whole.
The new services will also have a focus on meeting the needs of individuals and communities who traditionally have lower access to services. An example of this would be providing specialist help and support for addiction to tobacco in different forms e.g. chewing smokeless tobacco, such as paan. The service also provides accessible support for residents whose first language is not English.
The current provider has a sub-contract with Diversity Matters North West to improve their reach into certain ethnic communities. The new service will need to ensure access for these communities is not impacted by changes to the service.

Sex

The new service will continue to provide support regardless of sex. It will be expected to provide a broader range of options improving accessibility to all. An example of access being improved is

offering the service in more community venues benefiting men as they are more likely to access services in non-medical settings.

Religion or belief
The new service will provide support regardless of religion or belief. There is no anticipated change to this. To improve accessibility for people from all religions, some communities may need gender-sensitive support, for example, providing women-only sessions or groups. Promotion of the service and health advice could be delivered in settings such as religious organisations to improve accessibility.

Sexual orientation
It is estimated that between 5 and 10 percent of the UK population define themselves as gay or lesbian. It is recognised that people who are lesbian, gay or bisexual may experience prejudice, discrimination and disadvantage as a result of their sexual orientation. Research shows that sexual orientation and gender identity play an important role in health inequalities, resulting in poor experience in the provision, and take up of health services by the LGBT+ community. Research also shows that due to fear of discrimination, homophobia and ignorance; older gay, lesbian and bisexual people are five times less likely to access services than the general older population. People from LGBT+ groups are more likely to smoke than the rest of the population. The current service recorded only 3.6% of those service users who disclosed a sexuality as being from an LGBT+ group. However, as a further 25% of all service users did not disclose a sexuality, it is difficult to interpret these data.
The new service has a recognised duty to work with the LGBT+ community to make the service accessible and implementation of an improved specialist smoking cessation service will increase support and access that would be beneficial. The new service will work with organisations such as the LGBT Foundation to ensure the service is meeting the needs of the local population.

Gender reassignment
Data relating to gender identities is not well understood. The Equality Act 2010 provides a legal framework to protect the rights of individuals with 'protected characteristics' and advance equality of opportunity for all. To be protected, there is no need to have undergone treatment or surgery and the person can be at any stage in the transition process – proposing to, or undergoing a process to reassign your gender, or have completed it. The new service will be accessible to people of all gender identities. It will be respectful when using pronouns to ensure they are consistent with how the person identifies.
As above, the new service has a recognised duty to work with the LGBT+ community to make the service accessible and implementation of an improved specialist smoking cessation service will increase support and access that would be beneficial. The new service will work with organisations such as the LGBT Foundation to ensure the service is meeting the needs of the local population.

Pregnancy and maternity
There is a specialist smoking cessation service for pregnant women outside this contract. However, the new service may see women who are referred for ongoing support following their pregnancy and it also may see the family members of pregnant women to support their stop smoking effort during pregnancy, to help the pregnant woman to quit. The Service may also see people in or around pregnancy for advice on healthy diet and being active. There are no anticipated negative impacts as a result of the change of service.

Marriage and civil partnership
The new service will see everyone, regardless of marital or civil partner status. There are no anticipated negative impacts as a result of the change of service.

Carers
Being a carer can be rewarding and fulfilling. However, it can also be physically and emotionally

exhausting and can lead to negative health consequences, as well as social isolation. Being a carer may also make accessing services more difficult, as it may be harder to commit to activities and sessions. The new services are expected to continue to see carers and further develop links with other services and work in partnership, e.g. with Tameside Carers' Centre. In addition, the new services are expected to provide support at various times and days, and to do more work on remote/virtual ways of providing support. There may therefore be a positive impact on this population.

Military Veterans
The new service will see everyone, including military veterans. Specific groups of veterans may also have different health needs. For example, there is evidence that: older veterans (those born before 1960) appear to be at higher risk of smoking-related cancers and cardiovascular diseases; and veterans who left service early appear to be at higher risk of a range of poor outcomes, including mental illness, alcohol and substance misuse, homelessness, and unemployment. The new service will align to the principles of the Tameside Armed Forces Covenant and the new service will make stronger links and work in partnership with Tameside Armed Forces Community (TASC) to ensure it is meeting the needs of this group.

Breast feeding
The new service will see everyone, including those who are breastfeeding. There are no anticipated negative impacts as a result of the change of service. The service will have an awareness of where it is delivering sessions, and will support people to breast feed.

Socio-economic deprivation
Deprivation is a key determinant of health. Socioeconomic deprivation can lead to low mental and physical wellbeing, in addition to a higher risk of engaging in unhealthy behaviours such as smoking, excess alcohol consumption and poor diets, which has further negative impacts on mental and physical health. In Tameside, 37% of people are in the lowest 20% socio-economic status nationally. For Health Checks, in the year 2019/21, Be Well saw 24% of clients from this socioeconomic group. The new services will be expected to be proactive in targeting services to areas of deprivation, improving access for people from these areas. An example of this will be the new specialist smoking cessation targeting people in routine and manual work, who are more likely to be smokers.

Tameside & Glossop Strategic Commission
Equality Impact Assessment (EIA) Form

2d. Mitigations *(Where you have identified an impact/relevance, what can be done to reduce or mitigate it?)*	
Assess providers ability to give fair and equitable access	As a core component of the new service will be its ability to engage with people at high risk of health inequalities, this will be rigorously assessed through the re-commissioning process or process to bring in-house, including assessment of any provider's ability to give fair and equitable access to people with protected characteristics. This will review how they would identify and remove barriers in order to be inclusive; and how they will reach out to those at risk/of experience health inequalities.
Ensuring equitable access to services	The Equality Impact Assessment is an ongoing process that will be reviewed regularly at Contract Performance meetings or throughout in-house service delivery. Due to the reduction in the contract value, it is likely that some reduction in activity will occur across both the Smoking Cessation and the Community Wellness services. To mitigate this, the service will place strong emphasis on upskilling front-line workers in other job roles and organisations to increase the system's capacity for brief advice and interventions and to create a community of healthy behaviour change. In addition, due to the move away from one-to-one services for healthy weight and towards the Community Wellness offer, this may impact more on some people who prefer the one-to-one approach. To mitigate this, the service will be expected to support a range of community and direct options to ensure a diverse range of offers is available to people in Tameside, and that services are delivered in a non-judgemental and welcoming way.
Ensuring positive outcomes are maintained	Any positive impacts that are identified will be recorded, and monitored.
Any negative equalities impacts are continuously identified throughout the procurement and contract period	Any negative impacts that are identified will be recorded, and appropriate action is taken to address these

2e. Evidence Sources
Food Consultation, 2019 Public consultation on the Health Improvement Service conducted over 12 weeks from 18th February 2021 to 13th May 2021. BHA for equality in health and social care. Tackling Inequalities in Health and Social Care. Available online at: http://1.thebha.org.uk/health-and-well-being/ Age UK. Transgender issues and later life. Available online at: https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs16_transgender_issues_and_later_life_fcs.pdf DH (2011). NO HEALTH WITHOUT MENTAL HEALTH: A cross-government mental health

outcomes strategy for people of all ages. Analysis of the Impact on Equality (AIE). Available online at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138255/dh_123989.pdf

Equality and Human Rights Commission. Gender reassignment discrimination. Available online at:
https://www.equalityhumanrights.com/en/advice-and-guidance/gender-reassignment-discrimination

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LGBT Foundation. Available online at: https://lgbt.foundation/

Pennine Care NHS Foundation Trust. Available online at:
https://www.penninecare.nhs.uk/protectedcharacteristics

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https://publichealthmatters.blog.gov.uk/category/priority2/health-inequalities-priority2/

Public Health England. Public Health Matters: What do PHE's latest inequality tools tell us about health inequalities in England? Available online at:
https://publichealthmatters.blog.gov.uk/2019/06/18/what-do-phes-latest-inequality-tools-tell-us-about-health-inequalities-in-england/

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https://www.tameside.gov.uk/TamesideMBC/media/EmploymentandSkills/TASC-GP-Recording-of-Military-Service-document-2019-V4_2.pdf

Tameside MBC. Tameside Carer's Centre. Available online at:
https://www.tameside.gov.uk/carers/centre

Thomson R. and Katikireddi S (2019) Improving the health of trans people: the need for good data. Lancet; 4(8)

Tameside & Glossop Strategic Commission
Equality Impact Assessment (EIA) Form

2f. Monitoring progress		
Issue / Action	**Lead officer**	**Timescale**
Ensuring equitable access to services	Anne Whittington, Liz Harris	Quarterly
Ensuring positive outcomes are maintained	Anne Whittington, Liz Harris	Quarterly
Any negative equalities impacts of the proposal are continuously identified throughout the procurement and contract period (or bringing in-house) – any negative impacts are identified and appropriate action is taken to address these	Anne Whittington, Liz Harris, Linsey Bell	Ongoing

Signature of Contract / Commissioning Manager	Date
Signature of Assistant Director / Director	**Date**

Report to : **STRATEGIC COMMISSIONING BOARD**

Date : 25 August 2021

Reporting Officers: Tracy Morris – Assistant Director Children's Services

Subject : **GRANT NO. 31/5110: LOCAL AUTHORITY EMERGENCY ASSISTANCE GRANT FOR FOOD AND ESSENTIAL SUPPLIES**

Report Summary : The report requests a variation to the allocations agreed in September 2020 by the Strategic Commissioning Board of the *'Local Authority Emergency Assistance Grant for Food and Essential Supplies'* fund provided by Defra (Grant No. 31/5110). The requested variation is for the £5,000 allocation to Caring & Sharing to be changed to Active Tameside. Despite support from the council Caring & Sharing have been unable to provide sufficient banking arrangements as per regulations for funding allocations. Active Tameside will use the £5,000 for the essentials supplies as follows to provide food within term time where families are in COVID hardship – gas and electric; sportswear / uniforms to support emotional well-being through physical activity. Through casework within the Early Help offer baby safety equipment, baby essentials (nappies, toys, milk, clothing etc.) and school uniform and where approved household equipment.

Recommendations : Agree the change of provider from Caring & Sharing to Active Tameside to the value of £5,000.

Links to Corporate Plan: A key aim of the Corporate Plan is to assist to those in the community in greatest need of support, both in the immediate term and in a sustainable way for the future. The proposals outlined in this report support that aim in the area of poverty and financial hardship.

Policy Implications : Complies with current policy.

Financial Implications :

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

This change will see no additional financial implications to the council, these funds have been set aside in a Covid earmarked reserve. The report requests an amendment to agree a change of provider of the allocation of £5,000 from the Local Authority Emergency Assistance grant for food and essential supplies from Caring and Sharing to Active Tameside.

Legal Implications :

(Authorised by the Borough Solicitor)

The legal implications in relation the grant generally are set out in the earlier report presented to Cabinet.

The project clearly needs to proceed at pace to ensure that the benefits of the grant are realised hence the proposed recommendation.

The project officers need to ensure that they take advise from STaR to ensure that Active Tameside it engaged compliantly.

Risk Management :

The approach and activity outlined in the report ensures that Tameside Council meets its obligations with regards to spending of Grant No. 31/5110.

Access to Information :

The background papers relating to this report can be inspected by contacting Lorraine Hopkins, Head of Early Help, Neighbourhoods and Early Years' Service.

Telephone:0161 342 5197

e-mail: lorraine.hopkins@tameside.gov.uk

1. BACKGROUND

1.1 The government announced an emergency fund of £63 million to be distributed to local authorities in England to help those who are struggling to afford food and other essentials due to Covid-19. *Grant No. 31/5110: Local Authority Emergency Assistance Grant for Food and Essential Supplies* was a one-off contribution and was made under Section 31 of the Local Government Act 2003. The allocation for Tameside Metropolitan Borough Council was £331,533.64.

1.2 At their meeting on 30 September 2020 the Strategic Commissioning received a report to agree how the grant would be distributed in Tameside and which organisations would receive funds from it as a local provider of assistance.

1.3 This report requests a variation of one of the providers from Caring & Sharing to Active Tameside. The variation is to the value of £5,000.

2. PROPOSAL FOR RE-ALLOCATION OF £5,000

2.1 Despite support from the council Caring & Sharing have been unable to provide sufficient banking arrangements as per regulations for funding allocations. Without the relevant banking details and for audit purposes we are unable to make the allocation to Caring and Sharing in relation to this funding for this grant.

2.2 Active Tameside will use the £5,000 for the essentials supplies as follows to provide food within term time where families are in COVID hardship – gas and electric; sportswear / uniforms to support emotional well-being through physical activity. Through casework within the Early Help offer baby safety equipment, baby essentials (nappies, toys, milk, clothing etc.) and school uniform and where approved household equipment.

3. RECOMMENDATIONS

3.1 As outlined on the front of the report.

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