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Tameside & Glossop Care Together

SINGLE COMMISSIONING BOARD

Day: Tuesday
Date: 11 April 2017
Time: 3.00 pm
Place: Lesser Hall 2 - Dukinfield Town Hall

Item No.	AGENDA	Page No
1.	**WELCOME AND APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST**	
	To receive any declarations of interest from members of the Single Commissioning Board.	
3.	**MINUTES OF THE PREVIOUS MEETING**	1 - 6
	To receive the Minutes of the previous meeting held on 14 March 2017.	
4.	**CARE QUALITY COMMISSION - INSPECTION RESULTS**	7 - 30
	To receive a presentation from Karen James, Chief Executive, Tameside and Glossop Integrated Care Foundation Trust.	
5.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND**	31 - 52
	To consider the attached report of the Director of Finance, Single Commission.	
b)	**INTEGRATED COMMISSIONING FUND - SINGLE FINANCE AGREEMENT FROM 1 APRIL 2017**	53 - 78
	To consider the attached report of the Director of Finance, Single Commission.	
6.	**QUALITY CONTEXT**	
a)	**PERFORMANCE REPORT**	79 - 114
	To consider the attached report of the Director of Public Health and Performance.	
7.	**COMMISSIONING FOR REFORM**	
a)	**PRIMARY CARE QUALITY SCHEME**	115 - 192
	To consider the attached report of the Director of Commissioning.	
b)	**LEARNING DISABILITY DAY SERVICES REVIEW**	193 - 220
	To consider the attached report of the Executive Member (Adult Social Care and Wellbeing / Executive Director (People).	

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

Item No.	AGENDA	Page No

8. URGENT ITEMS

To consider any items which the Chair is of the opinion shall be considered as a matter of urgency in accordance with legal provisions as set out in the Local Government Act 1972 (as amended).

9. DATE OF NEXT MEETING

To note that the next meeting of the Single Commissioning Board will take place on Thursday 25 May 2017 commencing at 11.00 am in the Rutherford Suite, Hyde Town Hall.

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

**TAMESIDE AND GLOSSOP
SINGLE COMMISSIONING BOARD**

14 MARCH 2017

Commenced: 3.00 pm **Terminated: 4.20 pm**

PRESENT: Alan Dow (Chair) – Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Councillor Peter Robinson – Tameside MBC
Councillor Gerald Cooney – Tameside MBC
Graham Curtis – Tameside and Glossop CCG
Christina Greenhough – Tameside and Glossop CCG
Alison Lea – Tameside and Glossop CCG

IN ATTENDANCE: Sandra Stewart – Director of Governance
Kathy Roe – Director of Finance
Clare Watson – Director of Commissioning
Stephanie Butterworth – Director of People
Angela Hardman – Director of Public Health
Anna Moloney – Public Health
Ali Rehman – Public Health
Sandra Whitehead – Assistant Executive Director of Adults

APOLOGIES: Steven Pleasant – Chief Executive, Tameside MBC, and Accountable Officer, Tameside and Glossop CCG
Jamie Douglas – Tameside and Glossop CCG

137. DECLARATIONS OF INTEREST

Members	Subject Matter	Type of Interest	Nature of Interest
Christina Greenhough	Item 4(a) – A&E Streaming at the Front Door	Prejudicial	Director – GotoDoc

* Dr Greenhough left the room during consideration of this item and took no part in the decision thereon.

138. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 14 February 2017 were approved as a correct record

139. A&E STREAMING AT THE FRONT DOOR

The Director of Commissioning presented a report proposing the introduction of A&E Streaming at the Integrated Care Foundation Trust within 2017/18. This service was in response to the national and Greater Manchester mandate for A&E Streaming services but built on this to ensure locally commissioned outcomes were also achieved. The A&E Streaming service would complement the development of Integrated Neighbourhoods, the Extensivist service and also start the transformation process for a new Urgent Primary Care system across Tameside and Glossop.

Tameside and Glossop had not previously commissioned or provided a Primary Care Streaming service at A&E due to a variety of alternative primary care services and access points. However, it was fully accepted by the economy that a pre-A&E streaming service with appropriate treatment and diversion services could help manage demand and flow at Tameside and Glossop Integrated Care Foundation Trust A&E, improve the quality of services for those requiring more serious urgent care and contribute towards achieving a financially sustainable economy.

Tameside and Glossop needed a comprehensive primary care strategy to ensure a high quality, well managed and sustainable primary care system which achieved national, Greater Manchester and locally commissioned outcomes and was aligned to the place based public sector system. The primary care strategy would need to address how Tameside and Glossop responded to the General Practice Forward View, Greater Manchester Primary Care Quality Standards, national requirements for extended/7 day access, Out of Hours, the prevention agenda and achieved improved health and social care outcomes for the whole population. In addition, the strategy would need to understand the impact of the contract for the current Walk-in-Centre expiring on 31 August 2017.

It was reported that officers of the Integrated Care Foundation Trust had been made aware of the content of the report and would be requested to respond in June 2017 with a proposed model to achieve the desired outcomes. The model would need to be flexible to accommodate differing activity levels, be cognisant of the significant financial pressures in Year 1 (2017/18) and identify what, if any, capital was required to ensure the model is operational by winter. The Single Commissioning Board would expect the proposed model to have support from the Tameside and Glossop A&E Delivery Board and the Integrated Neighbourhood clinical leads.

Board Members noted that the contract for the current Walk-in Centre element of the APMS contract expires on 31 August 2017. There is also a need to ensure economy wide compliance with Primary Care Extended Access, the General Practice Forward View and implement and embed the local priority of integrated neighbourhood teams. These initiatives together provide an opportunity to discuss with residents of Tameside and Glossop options for the redesign of primary care services in line with the vision of accessible, high quality and financially sustainable services.

The Single Commissioning Board requested that a Primary Care Strategy be submitted for discussion in June 2017. This would include how the economy would ensure national, GM and local commissioning objectives were delivered as well as identifying the development of options for Urgent Primary Care and an Equality Impact Assessment. Subject to the content of this, the Single Commissioning Board would determine whether a public consultation was required, provisionally to take place summer / autumn 2017.

Due to wishing to explore options with the public and the timescales involved, the Board requested that discussions be facilitated with Go-To-Doc regarding an extension to the Walk-in-Centre aspect of the APMS current contract, continuing to offer a safe and affordable service, to commission for a time limited period, no longer than 31 December 2017, to enable effective consultation.

RESOLVED

(i) That the approval be given to the acceleration of the process of redesigning Urgent Primary Care by commissioning from the Integrated Care Foundation Trust, and A&E Streaming service ideally to be in place by 1 October 2017.

(ii) That the ICFT be requested to respond in June 2017 with the proposed model to achieve the desired outcomes.

(iii) That the contract for the current Walk-in-Centre element of the Alternative Provider Medical Services contract expiring on 31 August 2017 be noted.

(iv) That a Primary Care Strategy be presented to the Single Commissioning Board in June 2017.

(v) That discussions be facilitated with Go-T-Doc regarding an extension to the Walk-in-Centre aspect of the APMS current contract to continue to offer a safe and affordable

service for a time limited period, no longer than 31 December 2017, to enable effective consultation.

140. TRANSFORMING MENTAL HEALTH SERVICES: MEETING POPULATION NEEDS AND DELIVERING NATIONAL REQUIREMENTS

Consideration was given to a report of the Director of Commissioning advising that the pressures in mental health services were unprecedented due to an increase in demand, an increase in acuity and an increase in expectations laid out in the national Mental Health Standards. It was acknowledged that investment in mental health services was required and the Clinical Commissioning Groups had investment targets over a number of years. Previously called Parity of Esteem and now called Mental Health Investment Target, it was expected that the Clinical Commissioning Group would uplift mental health investment by £1m in 2017/18. To achieve this and meet the needs of the population, mental health investment needs to be prioritised within the Care Together Transformation Fund, the Greater Manchester Transformation Fund as well as within the Single Commission.

The report sought approval for ongoing funding for two services funded until March 2017:

1) Mental Health Crisis Provision – update on developments and proposal to maintain investment at the current level until Greater Manchester developments were known;
2) Specialist service for adults with Attention Deficit Hyperactivity Disorder – proposal to expand and extend the pilot for a further 12 months; and
3) A decision on a request for a contribution to a GM Enhanced Street Triage Pilot.

This was the first report focused on two elements of service provision that required decisions regarding ongoing funding and the Single Commissioning Board would receive further reports relating to Mental Health Transformation, Healthy Lives, Early Intervention in Psychosis, Adult Autistic Spectrum Disorders and Parent Infant Mental Health.

Members of the Board commented that mental health should be an area of focus and the continued importance of engaging Pennine Care NHS Trust in current and future plans was highlighted.

RESOLVED

(i) That the high priority of mental health nationally and in Greater Manchester be noted.
(ii) That the reduction in the use of A&E, aligning to local priorities and contributing to the Parity of Esteem 2% growth required in 2017/18 be supported.
(iii) That the proposed investment in mental health crisis care be approved as follows:
  a. extension of £146,000 funding for 12 months;
  b. investment of £32,690 in the Greater Manchester Enhanced Street Triage Pilot for 2 years.
(iv) That the expansion and extension of the Adult Attention Deficit Hyperactivity Disorder to meet the needs of the population by committing £60,780 for a further year be supported.

141. HOME CARE, CARE HOMES, SUPPORTED ACCOMMODATION PROVISION AND DAY TIME ACTIVITIES – REVISED FEES AND CHARGES

Consideration was given to a report of the Director of Commissioning outlining proposals in relation to revised prices to meet the increasing cost of providing home care, care home beds, supported accommodation and day time activities for vulnerable adults. It also outlined proposals in relation to a schedule of revised charges to vulnerable adults for the services they received for 2017/18. Reference was also made to an addendum to the substantive report containing an additional recommendation to approve the revised fees for Shared Lives Service as detailed in Section 6, and

amended tables in the executive summary, section 5.29 (Direct Payments) and section 6.3 (Residential Fees).

It was explained that the health and social care economy had seen unprecedented reductions in funding over the past five years. As a result of these reductions all services had been subject of review to establish where efficiencies could be achieved and / or where services could be provided differently. This included consideration of services where there were statutory and non-statutory duties and responsibilities.

The demand to meet savings targets had progressed at a time when providers had in the main been facing increased operating costs. The most significant increase in costs had been those recently experienced specifically in relation to the introduction of the National Living Wage to a sector that had for many years been operating on wage levels at, or close to, minimum wage levels, but also in relation to increased pension contributions.

Work had been progressing over the past three months to work with providers to reflect these additional costs in realistic prices that could continue the delivery of what were essential services for the vulnerable adults concerned. The methodology adopted had included revising costs of care framework that reflected local factors, whilst in the case of the supported accommodation had adopted open book accounting methodology to establish the impact on costs of these additional requirements. The report set out proposals for costs that would constitute the minimum requirements to meet the specific cost pressures imposed on providers following consultation with the provider sector.

RESOLVED

(i) That approval be given to the revised home care costing framework and proposed new rate of £14.20 per hour, sleep-in rate of £98.91 per night and £131.85 per night for waking nights, with the revised rates being applicable from 1 April 2017.

(ii) That in accepting the new fees the Board also acknowledged the revised charges set out in Section 5 of the report already agreed by the Council for 2017-18 and approved the increase of 3.7% in charges for home care in line with the fees uplift for this service.

(iii) That approval be given to the revised home care fees highlighted in Section 5 of the report from 1 April 2017.

(iv) That approval be given to the revised supported accommodation contract prices as detailed in Section 5 of the report from 1 April 2017.

(v) That approval be given to the revised contract prices for the Dementia Day Service as detailed in Section 5 of the report.

(vi) That approval be given to the revised fees for the Shared Lives Service as detailed in Section 6 of the report.

142. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

The Director of Finance, Single Commission, presented a jointly prepared report of the Tameside and Glossop Care together constituent organisations on the revenue financial position of the economy. It provided a 2016/17 financial year update on the month 10 financial position at 31 January 2017 and the projected outturn at 31 March 2017. There needed to be careful management of the pressures faced by the each of the Tameside and Glossop Care Together constituent organisations.

It was explained that the overall positon of the Care Together Economy had improved by around £3m month on month, reducing t whole economy projected year end deficit to £1.85m as at the 31 January 2017. This remaining deficit comprised values at Tameside MBC and the Integrated Care Foundation Trust as the Clinical Commissioning Group had now fully met its Quality, Innovation, Productivity and Prevention Programme target of £13.5m in 2016/17. It was this combined with an improvement in the Integrated Care Foundation Trust positon of £1.8m that had resulted in the

£3m improvement in the financial positon since last month. It was important to note that although the CCG Quality, Innovation, Productivity and Prevention programme target had been met in 2016/17, only £1.7m was delivered recurrently and £11.6m was as a result of non-recurrent funding, which created additional pressures for 2017/18 and 2018/19 target of £23.9m.

The diligent efforts commenced in 2016-17 as part of the CCG Recovery Plan would continue at pace and scale to transform services, manage demand and facilitate the delivery of financial efficiencies. Work continued to deliver and identify further savings as part of the Tameside MBC Quality, Innovation, Productivity and Prevention programme. The final year settlement which was in the process of being agreed with the Integrated Care Foundation Trust would mitigate any risk for the rest of the year including the risk regarding winter pressures.

Prescribing costs was an area requiring continued intense scrutiny and future pressure on the position could be mitigated by sustained efforts to reduce volumes and control spend.

Members of the Board discussed the announcement in the Chancellor's Spring Budget of an additional £2bn to social care over the next three years, with £1bn available in 2017/18. Tameside's allocation was expected to be £5.3m and consideration was being given to how this could be used to address the pressures in the Tameside and Glossop health economy, noting that it was a one-off payment only.

RESOLVED

(i) That the 2016/17 financial year update on the month 10 financial position at 31 January 2017 and the projected outturn at 31 March 2017 be noted.

(ii) That the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget be acknowledged.

(iii) That the significant amount of financial risk in relation to achieving an economy balanced budget across this period be acknowledged.

143. PERFORMANCE REPORT

Consideration was given to a report of the Director of Public Health and Performance providing an update on quality and performance data. Assurance was provided for the NHS Constitutional Indicators. In addition, Clinical Commissioning Group information on a range of other indicators were included to capture the local health economy position. This was based on the latest published data to end of December 2016.

The format of the report also included elements on quality from the Nursing and Quality Directorate and a selection of Adult Social Care indicators.

In addition, included in the report was a summary of the Greater Manchester Health and Social Care Partnership commissioned report from the Institute of Excellence, Greater Manchester Baselining and Best Practice review. As a result of the Greater Manchester review, four business areas were being prioritised for focus within the analysis, relating to Care at Home, Residential and Nursing Care, Carers and Learning Disability. The evolving report would align with the other Greater Manchester and Social Care Partnership and national dashboard reports.

- Diagnostic standard improving but still failing the standard;
- A&E standards were failed at Tameside Hospital Foundation Trust;
- Cancer 62 day upgrades;
- Ambulance response times were not met at a local or at a North West level;
- Improving Access to Psychological Therapies performance for Access and Recovery remain a challenge;
- 111 Performance against Key Performance Indicators; and
- MRSA.

Also attached for information was the Draft Greater Manchester Partnership dashboard and the latest NHS England Improvement and Assessment Framework.

In particular, reference was made to the summary of past / current performance for the North West Ambulance Service and 111 which was disappointing. The Chair commented that Greater Manchester, in common with many other parts of the country, was experiencing significant performance issues and the Greater Manchester Health and Social Care Partnership was currently considering a revised commissioning model for North West Ambulance Service and 111.

RESOLVED
That the contents for the performance and quality report and revised format be noted.

144. URGENT ITEMS

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

145. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 11 April 2017 commencing at 3.00 pm at Dukinfield Town Hall.

CHAIR

Tameside and Glossop Integrated Care NHS Foundation Trust

CQC Inspection Results

Date of Inspection: 8th – 11th August 2016

Feedback Quality Summit: 10th February 2017

Everyone Matters

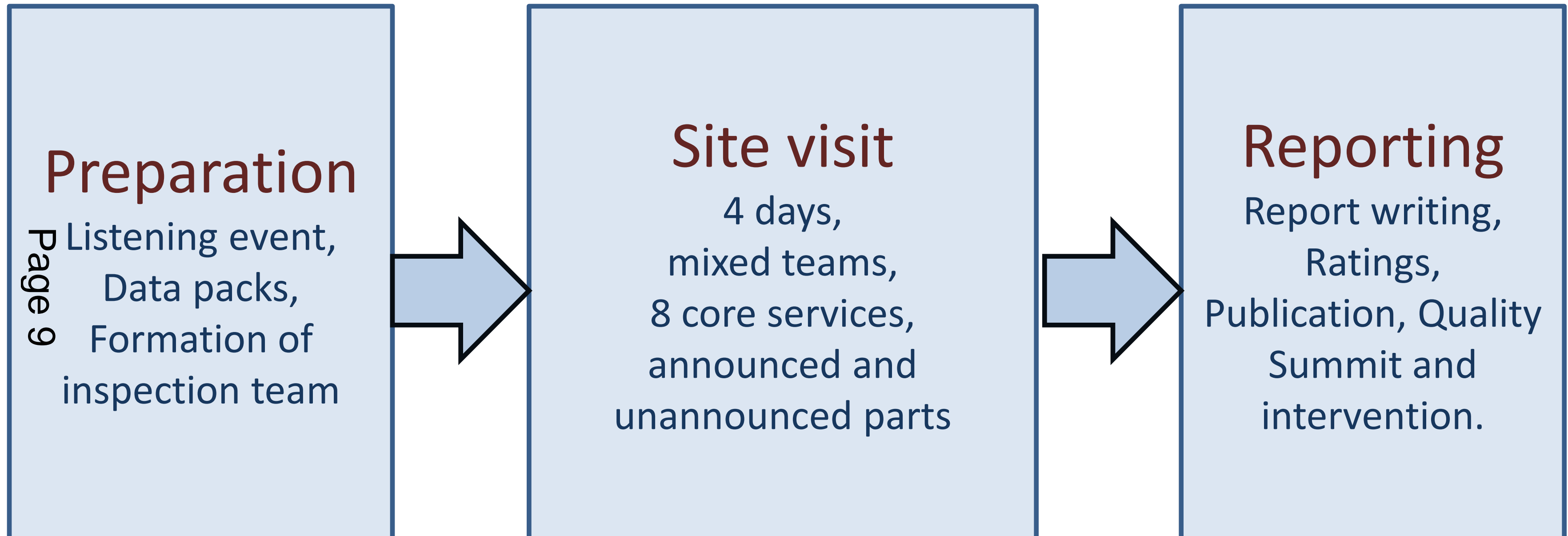
CQC's Approach

CQC as these questions of all services:

- Is it safe?
- Is it effective?
- Is it responsive?
- Is it caring?
- Is it well–led?

CQC's Approach

Tameside and Glossop Integrated Care
NHS Foundation Trust



Everyone Matters

CQC Inspection 8th – 11th August 2016

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

CQC inspected eight core services of the Tameside and Glossop Integrated Care NHS Trust across two sites:

Tameside General Hospital

- Urgent and emergency care;
- Medical care (including older people's care);
- Surgery;
- Critical Care;
- Maternity
- Children and Young People
- End of life care;
- Outpatients and diagnostic imaging.

Stamford Unit

- Medical care (including older people's care) (To early to rate)

Everyone
Matters

Ratings

Tameside and Glossop Integrated Care NHS Foundation Trust

CQC's ratings for Tameside General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Good	Good

Everyone Matters

Staff Survey Results 2016

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

2016 results were really positive. For 29 of the 32 key indicators the Trust was better than the national average and the best in Greater Manchester

Overall

Trust Score 2015	Trust Score 2016	National Average for Combined Acute and Community Trusts
3.94	3.95	3.80

This puts us ***Above better than average***

Everyone
Matters

Staff Survey Results 2016

Tameside and Glossop Integrated Care
NHS Foundation Trust

TOP FIVE RANKING SCORES	Trust Score 2016	National Average for Combined Acute and Community Trusts
KF8. Staff satisfaction with level of responsibility and involvement (Higher score the better)	4.08	3.92
KF9. Effective team working (Higher score the better)	3.94	3.78
KF31. Staff confidence and security in reporting unsafe clinical practice (Higher score the better)	3.87	3.68
KF24. Percentage of staff / colleagues reporting most recent experience of violence (Higher score the better)	83%	67%
KF4. Staff motivation at work (Higher score the better)	4.06	3.94

Everyone Matters

Key Findings of the Inspection

Tameside and Glossop Integrated Care
NHS Foundation Trust

Vision Leadership and Culture

- Visible and accessible executive team.
- Senior team focused on service quality and positive patient experience.
- Values and behaviours were based on safety, care, respect, communication and learning.
- Values and behaviours were well understood and adopted by all staff groups.
- A very positive culture throughout the trust.
- Staff of all grades were committed to the continuous improvement regarding the quality of care and treatment delivered to patients.
- Staff felt comfortable and confident in respect of raising matters of concern.

Everyone Matters

Key Findings of the Inspection

Tameside and Glossop Integrated Care NHS Foundation Trust

Governance risk management and Mortality rates

- Robust governance arrangements, with each division reporting to the board through a committee structure.
- Mechanisms were in place so that performance was challenged and understood.
- Robust challenge and scrutiny by non-executive directors in respect of quality and risk.
- Staff had access to management information to support good performance and identify poor performance
- **Mortality rates**
- All deaths were reviewed and key learning points cascaded to staff.
- Monitoring at board level ensured learning and improvement

Key Challenges and Risks

Tameside and Glossop Integrated Care
NHS Foundation Trust

Nurse staffing

- Nurse staffing levels, although improved remained a challenge in a number of areas particularly in the medical directorate.
- Availability of a nurse on duty on the children's ward who were up to date in Advanced Paediatric Life Support. (Two new starters had yet to attend the appropriate training, although Trust Doctor cover was available)

Medical Staffing

- The number of consultants was below the England average (37% compared with England average 42%) also the number of registrars was below the England (27% against England average 36%)
- A&E was better than average
- Improvement in numbers from last year

Access and Flow

- Patient being seen within 4 hours of arrival in ED not being met consistently
- Patients waiting 4 to 12 hours to be admitted once seen in ED over England average. Patients leaving ED before being seen over the England average. Relatively high number of medical outliers .
- Delays in the rapid discharge of end of life care patients to their preferred place of care

Everyone Matters

Key Challenges and Risks

Tameside and Glossop Integrated Care NHS Foundation Trust

Individual Plan of Care (IPOC).

- Low up take of IPOC for patients on the end of life pathway

Equipment and Environment

- Equipment used to provide care for children's care and treatment not always properly maintained (maintenance dates on some pieces of equipment had lapsed)
- Further work to continue on ward 27 to ensure infection control and prevention standards met. (This related to bedside tables and chairs etc not conforming to infection prevention standards)

Everyone Matters

CQC regulatory requirements arising from the August 2016 Inspection

Tameside and Glossop Integrated Care
NHS Foundation Trust

Regulation 12: Safe care and treatment:

- Care and treatment was not always provided in a safe way in that the risks to the health and safety of patients was not always assessed and mitigated. This is because patient flow throughout the hospital was an ongoing challenge, particularly in A&E and medical care. Due to continual bed pressures there were occasions when patients had been transferred from the Acute Medical Unit during the night and medical outliers were still common place. This meant that some patients were not placed in the area best suited to their needs. There were also long delays in A&E.

Everyone Matters

Tameside and Glossop Integrated Care
NHS Foundation Trust

In response to this we are implementing the best practice guidance from NHS Improvement and NHS England and working with partners using a whole systems model to address patient flow

- Embed 'home first: discharge to assess' ways of working
- Embed 'trusted assessor' ways of working
- Implement policy on supporting patients' choices to avoid long hospital stays (if existing policy not in use)
- Reduce the number of NHS CHC screenings and full assessments taking place in an acute location
- Working with the LA to reduce the number of DTOC
- Increase proportion of patients receiving RRR (rehabilitation, recovery and reablement) care in home or community settings
- Focus on simple discharge. Expediting routine (simple) discharges can be more effective in releasing beds than only concentrating on complex discharges
- Transforming community services and integrated working

Everyone Matters

CQC Assurance Plan in response to “Must do” recommendations arising from the August 2016 Inspection - Tameside Hospital

Tameside and Glossop Integrated Care
NHS Foundation Trust

ID	Primary area identified	Requirement	Action	Divisional / Director Lead	Operational lead(s)	Group to which assurance and monitoring is assigned	Assurance Review frequency
TGH M16.1	Urgent care	Ensure that patients can access emergency care in a timely way.	Continue to implement the plans and actions agreed via the health economy A&E delivery board; Continue to fully engage with GM wide initiatives intended to improve access and flow.	Divisional Director of Operations Clinical Director	Directorate Manager	Daily Bed meetings Executive Management Team Directorate Meetings, Divisional Operations Group, Trust Operations Group, Service Quality Operational Governance Group	Daily Weekly Monthly Bi Monthly Quarterly
TGH M16.2	Urgent care	Ensure all staff receive mandatory training at the required level and within the appropriate time frame.	Continue to deliver local implementation plans in place across the directorate. These continue to be monitored at Directorate and Divisional Level in order to achieve the Trust trajectory.	Divisional Director of Operations Clinical Director	Directorate Manager	Directorate Meeting Executive Management Team Divisional Operations group Trust Operations Group Service Quality Operational Governance Group	Monthly Bi Monthly Quarterly
TGH M16.3	Urgent care	Ensure that fridges used to store medications are kept at the required temperatures and checks are completed on these fridges as per the trusts own policy.	Revised Fridge temperature monitoring system implemented. Continue to implement Trust wide the Medicines Safety Improvement plan across all services with audit and systematic monitoring of practice.	Directors of Operations Chief Nurse Medical Director	Chief Pharmacist, Assistant Chief Nurses and Clinical Directors	Medicines safety Group , Patient Safety Programme Service Quality Operational Governance Group	Monthly Bi Monthly Quarterly
TGH M16.4	Medical Services Including Older People	Ensure there are appropriate numbers of nursing staff deployed to meet the needs of patients	Trust wide and local recruitment plans are in place. These continue to be enacted and progressed with the support of Senior Nursing and HR colleagues. Workforce planning and transformational working	Divisional Director of Operations Assistant Chief Nurse	Directorate Manager Matron	Daily Bed meetings Executive Management Team Directorate Meetings Divisional Operations Group Trust Operations Group Service Quality Operational Governance Group Trust Board	Daily Weekly Monthly Quarterly
TGH M16.5	Children and Young People	Ensure all equipment used to provide care or treatment to a service user is properly maintained.	Medical Equipment Service Dept. (MESD) have carried out a sweep of all equipment in Maternity and NNU to check it is registered, and has been serviced/ tested/ checked as appropriate. MESD have revised their equipment assurance programme and are developing an annual report to be shared with local managers Ongoing checks being carried out by ward/unit managers and Directorate/ Divisional management teams	Divisional Director of Operations	MESD Manager Directorate Managers	Paediatric Governance Divisional Quality and Safety Group Service Quality and Operational Group	Monthly Monthly Quarterly
TGH M16.6	Children and Young People	Ensure that there is one nurse on duty on the children's ward trained and up to date in Advanced Paediatric Life Support on each shift.	The remaining 4 sisters are booked on APLS training in April 17 at which point the ward will achieve100% compliance. Until training completed, shifts which do not have an APLS trained nurse on duty are flagged to the Consultant on call for the ward to mitigate this. Plans in place to train all band 5 nurses in APLS to reduce reliance on sisters.	Divisional Director of Operations Assistant Chief Nurse	Matron	Paediatric Governance Divisional Quality and Safety Group Service Quality and Operational Group	Monthly Monthly Quarterly

CQC Assurance Plan in response to the "Should do" recommendations arising from the August 2016 Inspection - Tameside Hospital -1

Tameside and Glossop Integrated Care
NHS Foundation Trust

ID	Primary area identified	Requirement	Action	Divisional / Director Lead	Operational lead	Committee to which assurance and monitoring of the action is assigned	Assurance Review frequency
TGH S16.1	Urgent care	Ensure that staff receive their annual appraisal.	Continue to deliver local implementation plans in place across the directorate. These continue to be monitored at Directorate and Divisional Level in order to achieve the Trust trajectory.	Divisional Director of Operations Clinical Director	Directorate Manager	Directorate Meeting Executive Management Team Divisional Operations group Trust Operations Group Service Quality Operational Governance Group	Monthly Bi Monthly Quarterly
TGH S16.2	Medical services including Older people	Ensure children's safeguarding training across all professions within the medical directorate is up to date.	Continue to deliver local implementation plans in place across the directorate. These continue to be monitored at Directorate and Divisional Level in order to achieve the Trust trajectory.	Divisional Director of Operations Clinical Director	Directorate Manager	Directorate Meeting Executive Management Team Divisional Operations group Trust Operations Group Service Quality Operational Governance Group	Daily Weekly Monthly
TGH S16.3	Medical services including Older people	Look to reduce the number of medical patients being cared for on surgical wards.	Trust wide programme of work in place to improve flow and reduce requirement to care for patients outside specialty beds. This work is fully supported by external partners with whom the ICFT works in collaboration.	Divisional Director of Operations Clinical Director Assistant Chief Nurse	Directorate Managers	Directorate Meetings Divisional Operations Group Service Improvement Group	Monthly Bi Monthly Quarterly
TGH S16.4	Medical services including Older people	Continue to monitor staffing arrangements on wards.	Trust wide and local recruitment plans are in place for medical and nursing staff. These continue to be enacted and progressed with the support of Senior Nursing and HR colleagues.	Divisional Director of Operations Clinical Director Assistant Chief Nurse	Directorate Managers	Bed meeting Executive Management Team Directorate Meetings, Divisional Operations group, Service Quality Operational Governance Group Trust Board	Daily Weekly Monthly
TGH S16.5	Children and Young People	Ensure recording of fridge checks include the maximum and minimum temperatures in accordance with national guidance.	Revised Fridge temperature monitoring system implemented. Continue to implement Trust wide the Medicines Safety Improvement plan across all services with audit and systematic monitoring of practice.	Directors of Operations Chief Nurse Medical Director	Chief Pharmacist, Assistant Chief Nurses and Clinical Directors	Medicines Safety Group Patient Safety Programme Group Service Quality Operational Governance Group	Monthly Bi Monthly
TGH S16.6	Children and Young People	Ensure dates of cleaning and safety checks are legible on equipment.	Equipment cleaning checks are recorded using appropriate disposable labels. Estates department reviewing electrical safety check labelling with the subcontractor. MESD have introduced new service/ test/ check labels with transparent protective cover for dates. Routinely monitored through divisional walk rounds.	Divisional Director of Operations	Estates manager Directorate Managers	Paediatric Governance Divisional Quality and Safety Group Service Quality Operational Governance Group	Monthly Monthly Quarterly

CQC Assurance Plan in response to the “Should do” recommendations arising from the August 2016 Inspection - Tameside Hospital -2

Tameside and Glossop Integrated Care
NHS Foundation Trust

ID	Primary area identified	Requirement	Action	Divisional / Director Lead	Operational lead	Committee to which assurance and monitoring of the action is assigned	Assurance Review frequency
TGH S16.7	Children and Young People	Review documentation for infants when intervention is reduced to high dependency or special care.	Use of Neonatal Intensive Care Chart for all level babies was introduced last year. Chart offers flexibility to record the details of each baby's individualised care plan Ongoing review of this chart in place.	Divisional Director of Operations	Lead clinicians Matron	Paediatric Governance Divisional Quality and Safety Group Service Quality and Operational Group	Monthly Monthly
TGH S16.8	Children and Young People	Ensure the security and confidentiality of medical records in the paediatric outpatients department.	Revised system and processes implemented - During clinics, medical records for upcoming patients are placed inside the clinic room. Routinely monitored through divisional walk rounds.	Divisional Director of Operations	Matron	Paediatric Governance Divisional Quality and Safety Group Service Quality and Operational Group	Monthly Monthly Quarterly
TGH S16.9	Children and Young People	Ensure PEWS documentation is completed and audited to improve compliance.	New combined ED/Children's Unit PEWS introduced in Nov. 2016. Audit planned for completion in March 2017	Chief nurse supported by Director of Operations	Matron	Divisional Operations Group through to Operational Group Patient Safety Group to SQOGG	Monthly Quarterly
TGH S16.10	Children and Young People	Ensure the neonatal unit consistently collect patient feedback using the NHS Friends and Family Test.	Feedback system reviewed additional electronic capture device procured to improve feedback rates. Until this is available staff are actively promoting the use of FFT postcard feedback in interim. Routinely monitored through divisional walk rounds and in reports to divisional forums	Divisional Director of Operations	Matron	Paediatric Governance Divisional Quality and Safety group	Monthly Quarterly
TGH S16.11	Children and Young People	Ensure inpatient discharge summaries and outpatient clinic letters are sent in a timely way.	Review of current process by consultant group Revised SOP to planned for February Paediatric Clinical Governance meeting for approval. Ongoing compliance to be monitored through governance forum.	Divisional Director of Operations	Lead clinicians Directorate manager	Paediatric Governance Divisional Quality and Safety group	Monthly Quarterly
TGH S16.12	Children and Young People	Ensure regular staff meetings take place on the neonatal unit.	Identified as a key objective for the interim and new NNU manager who are being actively supported by the Matron who will be regularly attending, Monitoring through Specialty Governance group	Divisional Director of Operations	Matron	Paediatric Governance Divisional Quality and Safety group	Monthly Quarterly
TGH S16.13	Surgical Services	Take appropriate actions to improve mandatory training compliance rates.	Continue to deliver local implementation plans in place across the directorate. These continue to be monitored at Directorate and Divisional Level in order to achieve the Trust trajectory.	Divisional Director of Operations Clinical Director	Directorate Manager	Directorate Meeting Executive Management Team Divisional Operations group Trust Operations Group Service Quality Operational Governance Group	Monthly Quarterly
TGH S16.14	Surgical Services	Take appropriate actions to reduce the number of cancelled elective operations.	Continue to implement the Service improvement work being implemented and progressed through Theatre Service Improvement Group and Pre-Op Improvement Group	Divisional Director of Operations	Directorate managers	Divisional Operational Group Service Improvement Group	Monthly Quarterly

CQC Assurance Plan in response to the "Should do" recommendations arising from the August 2016 Inspection - Tameside Hospital -3

Tameside and Glossop Integrated Care
NHS Foundation Trust

ID	Primary area identified	Requirement	Action	Divisional / Director Lead	Operational lead	Committee to which assurance and monitoring of the action is assigned	Assurance Review frequency
TGH S16.15	Maternity and gynaecology	Ensure the improvements in the infection prevention and control measures and the environment on ward 27 should continue.	Assertive workplan implemented and progressed. Actions from infection prevention audit completed and remedial estates work being progressed. Ongoing local monitoring by maternity & Divisional management teams	Divisional Director of Operations	Matron	O&G Governance Divisional Quality and Safety group Service Quality Operational Governance Group	Monthly Quarterly
TGH S16.16	Maternity and gynaecology	Emergency medicines should be safely stored in the obstetric theatre in line with trust's policy for the safe use of emergency medicines.	Specific policy developed for the storage and use of emergency medications with pre-filled syringes now readily available. Chief Pharmacist to include in the Trust Wide Policy Assurance being provided through routine monitoring and audit to assure consistent implementation.	Divisional Director of Operations	Directorate manager	Anaesthetic Directorate O&G Governance Divisional Quality and Safety group Service Quality Operational Governance Group	Monthly Quarterly
TGH S16.17	Maternity and gynaecology	Records should be securely stored in the ward areas.	Review of ward records storage undertaken. Revised process implemented and remedial work planned where required. Health Records manager undertakes spot audits and ongoing local monitoring by Maternity & Divisional management teams.	Divisional Director of Operations	Directorate manager Head of Midwifery	O&G Governance Divisional Quality and Safety meeting	Monthly Quarterly
TGH S16.18	Maternity and gynaecology	Appropriate actions should be taken to improve the mandatory training compliance rates including the safeguarding training.	Continue to deliver local implementation plans in place across the directorate. These continue to be monitored at Directorate and Divisional Level in order to achieve the Trust trajectory.	Divisional Director of Operations Clinical Director	Directorate Manager	Directorate Meeting Executive Management Team Divisional Operations group Trust Operations Group Service Quality Operational Governance Group	Monthly Quarterly
TGH S16.19	Maternity and gynaecology	Ensure that a deteriorating patient's care was managed in line with the trust's policy.	Revised MEWS chart developed. Guideline due to be ratified at February O&G Governance meeting. Ongoing regular audit of MEWS charts on maternity ward to ensure compliance	Divisional Director of Operations	Head of Midwifery	O&G Governance Patient Safety Programme Divisional Quality and Safety meeting	Monthly Bi monthly Quarterly
TGH S16.20	Maternity and gynaecology	Continue to make improvements in the completion of the safer surgery checklists.	WHO Checklist is completed by the whole Theatre Team Maternity processes reviewed to ensure they are consistent with other Theatres. Agreed in January 17. Use of Out of Theatre (OOT) checklist in Sept 2016 audited and presented at LOCSIPPs forum. Maternity staff reminded of requirement for OOT checklist for fetal blood sampling OOT checklist usage to be re-audited Feb 2017	Divisional Director of Operations	Directorate manager Head of Midwifery	Divisional Quality and Safety meeting Service Quality and Operation Governance group	Monthly Quarterly

CQC Assurance Plan in response to the "Should do" recommendations arising from the August 2016 Inspection - Tameside Hospital -4

Tameside and Glossop Integrated Care NHS Foundation Trust

ID	Primary area identified	Requirement	Action	Divisional / Director Lead	Operational lead	Committee to which assurance and monitoring of the action is assigned	Assurance Review frequency
TGH S16.21	Maternity and gynaecology	Develop a system to ensure patients received required home visits by the community midwives.	Processes reviewed and revised management team in place Draft SOP in place, for ratification at February O&G governance meeting Ongoing monitoring of incidents to ensure downward trend of missed visits continues	Divisional Director of Operations	Matron	O&G Governance Divisional Quality and Safety meeting Service Quality and Operation Governance group	Monthly Quarterly
TGH S16.22	End of life care	Consider how it can increase uptake of the use of the individual care plan for end of life care patients.	Continuous reinforcement of Trust wide and Local communications regarding individual care plans for end of life care patients.	Medical Director Chief Nurse	Clinical Directors Assistant Chief Nurse	End of Life Service Group Meetings Mortality Meetings	Monthly Quarterly
TGH S16.23	End of life care	Consider how it can encourage improvement in the accuracy and completeness of DNACPR forms, including the undertaking and recording of mental capacity act assessments, the recording of best interest's decisions, and discussions with patients and their relatives.	Continue implementation with Trust programme of education and audit in relation to use of DNACPR forms.	Medical Director Chief Nurse	Clinical Directors Assistant Chief Nurse	Patient Safety Programme Service Quality Operational Governance Group	Bi monthly Quarterly
TGH S16.24	End of life care	Consider reviewing information held within the palliative rapid discharge link nurse files held in wards and units across the trust to ensure the information held is accurate, up to date, and in line with prescribing and dosage guidelines for anticipatory medicines.	Full review of discharge services underway, to include review of palliative rapid discharge (including associated documentation at ward level). An improvement plan will be developed following review.	Divisional Director of Operations	Head of Patient flow	Divisional Operations Group Service Improvement Group	Monthly
TGH S16.25	End of life care	Consider what actions it could take to further increase the proportion of end of life care patients dying in their preferred place of care.	Full review of discharge services being undertaken. Improvements anticipated ensuring appropriate preferred place of care offered and facilitated for patients receiving end of life care.	Divisional Director of Operations	Head of Patient flow	Divisional Operations Group Service Improvement Group End of Life service group meetings	Monthly
TGH S16.26	End of life care	Consider what actions it can take, within its control and where requested, to increase the percentage of end of life care patients discharged within the timescales of the rapid and fast discharge process.	Full review of discharge services being undertaken. Improvements anticipated in ensuring appropriate preferred place of care offered and facilitated for patients receiving end of life care.	Divisional Director of Operations	Head of Patient flow	Divisional Operations group Service Improvement group End of Life service group meetings	Monthly
TGH S16.27	Outpatients and Diagnostics	Continue the active recruitment of Radiologists to meet actual WTE requirements and maintain safe staffing levels.	Continue with current recruitment plan (Nationally and Internationally with a view to substantive recruitment. Intermediate measures for service continuity in place, including Greater Manchester wide support	Clinical Director	Directorate Manager	Directorate Meeting Divisional Operations Group Trust Operations Group Service Quality Operational Governance Group	Monthly

CQC Assurance Plan in response to the "Should do" recommendations arising from the August 2016 Inspection - Tameside Hospital -5

Tameside and Glossop Integrated Care NHS Foundation Trust

ID	Primary area identified	Requirement	Action	Divisional / Director Lead	Operational lead	Committee to which assurance and monitoring of the action is assigned	Assurance Review frequency
TGH S16.28	Outpatients and Diagnostics	Resolve the issue of Allied Health Professionals being unable to accurately record mandatory training levels.	Local manual recording arrangements now in place to ensure accurate records are available to facilitate appropriate monitoring of compliance.	Clinical Director	Directorate Manager	Directorate Meeting Divisional Operations Group	Monthly
TGH S16.29	Outpatients and Diagnostics	Carry out an infection control risk review of positioning aids foam pads in Radiology, to ensure that the risk of infection is minimised.	Local risk review undertaken and monitoring process in place. Monthly audit performed by Modality leads to ensure compliance. Any damaged pads immediately removed from use.	Assistant Chief Nurse	Directorate Manager	Radiology Quality Group Directorate Governance Meeting Divisional Quality and Safety Meeting	Monthly
TGH S16.30	Outpatients and Diagnostics	Ensure that all entries on patient notes are signed and dated.	Trust Policy to be reinforced to ensure compliance in relation to documentation both electronic and handwritten. Local monitoring will now take place in conjunction with Chaperone audit. Trust wide record keeping audit is part of the annual Audit programme	Clinical Director	Directorate Manager	Directorate Governance Meeting Divisional Quality and Safety Meeting Service Quality and Operational Governance group	Monthly
TGH S16.31	Outpatients and Diagnostics	Continue to increase the numbers of staff who have undertaken Child Safeguarding training to meet trust targets.	Continue to deliver local implementation plans in place across the directorate. These continue to be monitored at Directorate and Divisional Level in order to achieve the Trust trajectory.	Divisional Director of Operations Clinical Director	Directorate Manager	Directorate Meeting Executive Management Team Divisional Operations group Trust Operations Group Service Quality Operational Governance Group	Monthly
TGH S16.32	Outpatients and Diagnostics	Review version controls on Local Rules for Radiation Protection and ensure that all staff have signed them to indicate that they have read and understood them.	Review of current local rules being progressed with Radiation Protection Advisor. Staff will be required to read and sign to confirm acknowledgement and understanding of these rules. Documentary evidence will be available for audit purposes.	Divisional Director of Operations Clinical Director	Directorate Manager Assistant Chief Nurse	Directorate Meeting Executive Management Team Divisional Operations Group Trust Operations Group	Monthly
TGH S16.33	Outpatients and Diagnostics	Continue to seek a solution to the lack of an electronic system that interfaces with local GP surgeries.	Implementation of the Trust IM&T strategy will enable this. The Trust is deploying EMIS into community which is the same product suite as GP EMIS and working with other providers to enable this as part of the Transformation work being undertaken.	Director of Performance & Information	Chief Information Officer	Executive management team IM&T group Health Records Group	Monthly
TGH S16.34	Outpatients and Diagnostics	Continue to seek viable solutions to reduce "Did Not Attend" (DNA) rates.	Continue with Outpatient Service Improvement workstream plans which includes initiatives to support attendance at clinic/OPD appointments, e.g. text reminder service Routine monitoring through systematic reporting processes	Divisional Directors of Operations Clinical Directors	Directorate Managers (Diagnostics & outpatients)	Directorate meeting Reporting Service Improvement Group OPD Business Meeting	Monthly

CQC Assurance Plan in response to the "Should do" recommendations arising from the August 2016 Inspection - Tameside Hospital -6

Tameside and Glossop Integrated Care NHS Foundation Trust

ID	Primary area identified	Requirement	Action	Divisional / Director Lead	Operational lead	Committee to which assurance and monitoring of the action is assigned	Assurance Review frequency
TGH S16.35	Outpatients and Diagnostics	Continue to seek solutions to improve "Referral to Treatment" (RTT) times so that all clinical pathways met national standards.	Continue to monitor waiting times across all modalities / specialties and develop/enact action plans to mitigate. Early and proactive escalation for Executive level support if/where required. Routine monitoring through systematic reporting processes	Clinical Directors	Directorate Managers	Directorate meeting Divisional Operations group Referral to Treatment meeting Waiting List Steering group	Monthly / weekly (WLSG)
TGH S16.36	Outpatients and Diagnostics	Review the consultation room in Clinic 9 where the door opens outwards to improve privacy and dignity for patients.	A review of the consultation room has been undertaken and modifications made to ensure maintenance of Patient Privacy and dignity.	Clinical Director	Directorate Manager	Directorate meeting Divisional Quality and Safety Group Service Quality and Operational Governance group	Monthly
TGH S16.37	Outpatients and Diagnostics	Review the children's play area in outpatients clinics 6-9 to see whether this could be better located or children observed and kept safer.	Review of service provision being undertaken in conjunction with planned redesign of Outpatient suite.	Divisional Director of Operations	Directorate Managers	Directorate meetings Divisional Quality and Safety Group Service Quality and Operational Governance group	Monthly
TGH S16.38	Outpatients and Diagnostics	Improve patient knowledge of how to access PALS should they need to do so.	Review of all OPD areas to ensure PALS leaflets and posters in plain sight for patients Monitoring through routine reviews and walkrounds	Divisional Director of Operations	Directorate Managers and Matrons	OPD Governance Divisional Quality and Safety Group Service Quality and Operational Governance group	Monthly

Tameside and Glossop Integrated Care
NHS Foundation Trust

CQC ratings 2014

Inadequate

	Safe	Effective	Caring	Responsive	Well-led		Overall
Urgent and emergency services	Requires Improvement	Not Rated	Good	Good	Good		Good
Medical care (including older people's care)	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement
Critical care	Inadequate	Requires Improvement	Good	Inadequate	Inadequate		Inadequate
Maternity and gynaecology	Requires Improvement	Good	Good	Good	Good		Good
Services for children and young people	Requires Improvement	Good	Good	Good	Good		Good
End of life care	Requires Improvement	Requires Improvement	Good	Good	Good		Requires Improvement
Outpatients and diagnostic imaging	Requires Improvement	Not Rated	Good	Inadequate	Requires Improvement		Requires Improvement
Overall	Inadequate	Requires improvement	Good	Inadequate	Requires Improvement		Inadequate

Everyone Matters

Tameside and Glossop Integrated Care
NHS Foundation Trust

CQC ratings 2015

Requires improvement

	Safe	Effective	Caring	Responsive	Well-led		Overall
Urgent and emergency services	Good	Requires Improvement	Good	Requires Improvement	Good		Requires Improvement
Medical care (including older people's care)	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement
Surgery	Good	Good	Good	Requires Improvement	Good		Good
Critical care	Good	Good	Good	Requires Improvement	Good		Good
Maternity and gynaecology	Requires Improvement	Good	Good	Good	Good		Good
Services for children and young people	Requires Improvement	Good	Good	Good	Good		Good
End of life care	Requires Improvement	Requires Improvement	Good	Good	Good		Requires Improvement
Outpatients and diagnostic imaging	Good	Not Rated	Good	Good	Good		Good
Overall	Requires Improvement	Requires improvement	Good	Requires Improvement	Good		Requires Improvement

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Tameside and Glossop Integrated Care
NHS Foundation Trust

CQC ratings 2016

Good

	Safe	Effective	Caring	Responsive	Well-led		Overall
Urgent and emergency services	Good	Good	Good	Requires Improvement	Good		Good
Medical care (including older people's care)	Requires Improvement	Requires Improvement	Good	Good	Good		Requires Improvement
Surgery	Good	Good	Good	Good	Good		Good
Critical care	Good	Good	Good	Good	Good		Good
Maternity and gynaecology	Requires Improvement	Good	Good	Good	Good		Good
Services for children and young people	Good	Good	Good	Good	Good		Good
End of life care	Good	Requires Improvement	Good	Good	Good		Good
Outpatients and diagnostic imaging	Good	Not Rated	Good	Good	Good		Good
Overall	Requires Improvement	Requires improvement	Good	Good	Good		Good

Everyone Matters

Tameside and Glossop
Integrated Care
NHS Foundation Trust

Any Questions?

Everyone
Matters

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	11 April 2017
Officer of Single Commissioning Board	Kathy Roe – Director Of Finance – Single Commissioning Team Ian Duncan - Assistant Executive Director – Tameside Metropolitan Borough Council Finance Claire Yarwood – Director Of Finance – Tameside and Glossop Integrated Care NHS Foundation Trust
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2016/17 CONSOLIDATED FINANCIAL MONITORING STATEMENT AT 28 FEBRUARY 2017 AND PROJECTED OUTTURN TO 31 MARCH 2017**
Report Summary:	This is a jointly prepared report of the Tameside & Glossop Care Together constituent organisations on the consolidated financial position of the Economy. The report provides a 2016/2017 financial year update on the month 11 financial position (at 28 February 2017) and the projected outturn (at 31 March 2017). The Tameside & Glossop Care Together Single Commissioning Board are required to manage all resources within the Integrated Commissioning Fund. The CCG and the Council are also required to comply with their constituent organisations' statutory functions. A summary of the Tameside and Glossop Integrated Care NHS Foundation Trust financial position is also included within the report. This is to ensure members have an awareness of the overall financial position of the whole Care Together economy and to highlight the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the financial gap next year and through to 2020/21.
Recommendations:	Single Commissioning Board Members are recommended to note and acknowledge: 1) The 2016/2017 financial year update on the month 11 financial position (at 28 February 2017) and the projected outturn (at 31 March 2017). 2) The significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget. 3) The significant amount of financial risk in relation to achieving an economy balanced budget across this period.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	This report provides the consolidated financial position statement of the 2016/17 Care Together Economy for the period ending 28 February 2017 (Month 11 – 2016/17) together with a projection to 31 March 2017 for each of the three partner organisations. The report explains that there is a clear urgency to implement associated strategies to ensure the projected funding gap is addressed and closed on a recurrent basis across the whole economy.

	Each constituent organisation will be responsible for the financing of their resulting deficit at 31 March 2017. It should be noted that the Integrated Commissioning Fund for the partner Commissioner organisations will be bound by the terms within the existing Section 75 agreement and associated Financial Framework agreement which has been duly approved by both the Council and CCG.
Legal Implications: **(Authorised by the Borough Solicitor)**	Given the implications for each of the constituent organisations this report will be required to be presented to the decision making body of each one to ensure good governance.
How do proposals align with Health & Wellbeing Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Health and Wellbeing Strategy
How do proposals align with Locality Plan?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Locality Plan
How do proposals align with the Commissioning Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Single Commissioning Strategy
Recommendations / views of the Professional Reference Group:	A summary of this report is presented to the Professional Reference Group for reference.
Public and Patient Implications:	Service reconfiguration and transformation has the patient at the forefront of any service re-design. The overarching objective of Care Together is to improve outcomes for all of our citizens whilst creating a high quality, clinically safe and financially sustainable health and social care system. The comments and views of our public and patients are incorporated into all services provided.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	The reconfiguration and reform of services within Health and Social Care of the Tameside and Glossop economy will be delivered within the available resource allocations. Improved outcomes for the public and patients should reduce health inequalities across the economy.
What are the Equality and Diversity implications?	Equality and Diversity considerations are included in the re-design and transformation of all services
What are the safeguarding implications?	Safeguarding considerations are included in the re-design and transformation of all services
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report and therefore a privacy impact assessment has not been carried out.
Risk Management:	Associated details are specified within the presentation

Access to Information :

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

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TAMESIDE AND GLOSSOP

Care together

Tameside and Glossop Integrated Financial Position

2016/17 Revenue & Capital Monitoring Statements

Period Ending 28 February 2017 (Month 11) & Projected outturn to 31 March 2017

11 April 2017

Kathy Roe
Claire Yarwood
Ian Duncan

Section 1

Care Together Economy

Revenue Financial Position

Care Together Economy Revenue Financial Position

Organisation	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Tameside & Glossop CCG	347,863	347,863	-	384,899	384,899	-	-	-
Tameside MBC	61,425	65,039	(3,614)	69,272	73,283	(4,011)	(3,650)	(361)
Total Single Commissioner	**409,288**	**412,902**	**(3,614)**	**454,171**	**458,182**	**(4,011)**	**(3,650)**	**(361)**
ICFT Deficit	(15,712)	(14,838)	874	(17,300)	(14,500)	2,800	-	1,000
Total Whole Economy			**(2,740)**			**(1,211)**	**(3,650)**	**639**

The overall financial position of the Care Together Economy has improved by c £0.6m month on month, reducing the whole economy projected year end deficit to £1.21m as at 28 February 2017. This remaining deficit comprises an improvement of £2.8m for the ICFT and a deficit of £4.0m at TMBC. The CCG has now fully met its QIPP target of £13.5m in 2016-17 but this has mainly been as a result of non recurrent means as highlighted last month..

Key Risks in Year End Forecast

- The outcome of difficult negotiations with local Care Home Providers relating to Funded Nursing Care tariff increases.
- That the current level of Delayed Transfers of Care adversely impacts on the delivery of the Winter Plan with associated financial consequences

Planned Mitigations to Identified Risks

- The Winter Plan reflects an integrated approach across the economy which is essential in managing delayed transfers of care (DTOCs) with implementation of the Home First transformation project critical to managing the level of DTOCs.

The CCG figure quoted in table 1 differs from that reported to NHS England in the Non ISFE return, due to the treatment of QIPP and timing of the recovery plan. This is to ensure consistency of reporting across the Integrated Commissioning Fund, for both CCG and Local Authority. This is presentational only and does not affect the underlying position. It has been agreed at Single Commissioning Board, that all financial gaps (including QIPP) should be treated as a deficit until the savings have been achieved (i.e., reported as green in QIPP/recovery plans). Please note that accruals are included within the year end projections for the Council and not within the year to date totals. The CCG projections include accruals with in both year to date and year end projection total.

The outstanding commissioner gap for 2016-17 is £4.011m which is in respect of TMBC services. It is important to note that although the CCG QIPP target has been met in 2016-17, only £1.7m was delivered recurrently and £11.6m was as a result of non recurrent funding which creates additional pressures for 2017-18 and a 2017-18 QIPP target of £23.9m.

Mitigations to adverse variances contained in Year to Date Position

- The diligent efforts commenced in 2016-17 as part of the CCG Recovery Plan will continue at pace and scale to transform services, manage demand and facilitate the delivery of financial efficiencies.
- Continued work to deliver and identify further savings as part of the TMBC QIPP.
- The final year end settlement which is in the process of being agreed with the ICFT will mitigate any risk for the rest of the year including the risk regarding winter pressures.

Tameside & Glossop CCG

Description	Year to Date Budget £'000s	Year to Date Actual £'000s	Year to Date Variance £'000s	Year End Forecast Budget £'000s	Year End Forecast Actual £'000s	Year End Forecast Variance £'000s	Movement Previous Month £'000s	Movement Movement in Month £'000s
Acute	180,486	180,929	(443)	197,310	197,836	(526)	(125)	(401)
Mental Health	26,533	26,475	58	28,993	28,894	99	2	97
Primary Care	74,968	74,804	164	81,655	82,387	(732)	(899)	167
Continuing Care	11,081	11,415	(334)	12,251	12,628	(377)	(396)	19
Community	25,187	25,195	(8)	27,493	27,544	(51)	(51)	0
Other	25,615	25,039	576	32,019	31,097	922	836	86
QIPP					0	0	0	0
CCG Running Costs	3,993	4,006	(13)	5,178	4,513	665	633	32
CCG Total	**347,863**	**347,863**	**-**	**384,899**	**384,899**	**0**	**0**	**0**

At the end of month 11, there has been an improvement to the CCG's projected year end financial position and the 2016-17 QIPP target of £13.5m has been met albeit mainly as a result of non recurrent funding. Work is on-going at pace and scale to deliver savings to contribute to the 2017-18 QIPP target .

Changes in the outturn position by directorate:

- **Acute** : Details provided on a separate slide.
- **Prescribing** : A detailed report on the current prescribing position is provided later in this report.
- **Community :** There is a pressure of £25k on the forecast as a result of 2 patients placed in St Ann's Hospice as they required specialist care which could not be provided locally. The duration of the individual placements is under continual review by the Nursing & Quality Directorate and these patients will be repatriated to local services as soon as it is clinically safe to do so.
  There is also a further increase in the overspend on Community IT by £9k.
- **Other :** The £5.2m allocation in respect of the Transformation Funding for 2016-17 has been received to support the implementation of service transformation and facilitate the delivery of recurrent savings. This is being closely monitored to ensure the funding is spent in line with plans.

- The CCG has met the £13.5m QIPP target in 2016-17 but as the majority has been met non-recurrently, this creates additional pressure in 2017-18.
- Diligent efforts continue at pace and scale to transform services and deliver recurrent financial benefits.
- A year end settlement is in the process of being finalised with the ICFT to mitigate any risk for the remainder of the year including any caused by winter pressures.

CCG planning to :

- Deliver 1% surplus in 2016/17
- Keep 1% of allocation uncommitted
- Maintain Mental Health Investment Target (formerly parity of esteem)
- Remain within running cost allocation

Recommendations

- Note the updated M11 YTD position and the diligent efforts undertaken to meet the 2016-17 QIPP target.
- Acknowledge the significant recurrent savings required to close the long term financial gap.

The CCG figure quoted in table 1 differs from that reported to NHS England in the Non ISFE return, due to the treatment of QIPP and timing of the recovery plan. This is to ensure consistency of reporting across the Integrated Commissioning Fund, for both CCG and Local Authority. This is presentational only and does not affect the underlying position. It has been agreed at Single Commissioning Board, that all financial gaps (including QIPP) should be treated as a deficit until the savings have been achieved (i.e., reported as green in QIPP/recovery plans)

CCG Key Movements & Narrative

Acute Provider Drilldown – Notable movements :

- **Central Manchester**: Adverse movement of the full year forecast (£215k) driven by 2 high cost patients (£160k) and Rehab (£55k).
- **Stockport:** Improvement in year to date forecast of £22k due to an underspend in stroke activity. This is partially offset by an increase in Elective (£31k) for Trauma & Orthopaedics and Non elective (£32k) for Urology.
- **UHSM:** Adverse movement of year to date position (£86k) due to Critical care services.
- **SRFT:** Improvement in the year to date position of £8k due to a trend of underspending in stroke activity.
- **Pennine Acute:** Adverse movement of the full year position (£66k) driven by Elective Ophthalmology (£23k)
- **ICFT:** An agreed end of year settlement is being finalised which will mitigate against any overspend on budget.

Description	Year to Date			Year End Forecast		
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s
ICFT	115,863	115,863	0	126,575	126,575	0
Central Manchester	20,404	21,481	(1,077)	22,280	23,444	(1,164)
Stockport	10,917	10,174	743	11,968	11,113	855
South Manchester	5,932	6,327	(395)	6,568	6,907	(339)
Pennine Acute	3,675	3,603	72	4,029	3,921	108
Salford	2,945	3,074	(129)	3,226	3,452	(226)
WWL	1,276	1,146	130	1,409	1,245	164
Bolton	73	72	1	80	72	8
CCG Total	**161,085**	**161,740**	**(655)**	**176,135**	**176,729**	**(594)**

Acute Referrals Analysis

- ICFT GP Referrals are down by 8.9% compared to the same period last year (April – Jan), whereas Other referrals have increased by 0.6%.
- The main areas of reduction in GP referrals are shown in the table below

GP Referrals to Tameside & Glossop ICFT				
Specialty	2015/16	2016/17 FOT	% Change	Reduction in number of referrals
NEUROSURGERY	159	100	-37%	-59
VASCULAR SURGERY	1,043	708	-32%	-335
ENT	4,215	3,036	-28%	-1,179
GENERAL SURGERY	1,568	1,196	-24%	-372
NEPHROLOGY	274	218	-20%	-56
RHEUMATOLOGY	1,145	930	-19%	-215
TRAUMA & ORTHOPAEDICS	4,798	4,009	-16%	-789
OPHTHALMOLOGY	2,807	2,393	-15%	-414
UROLOGY	2,681	2,368	-12%	-313

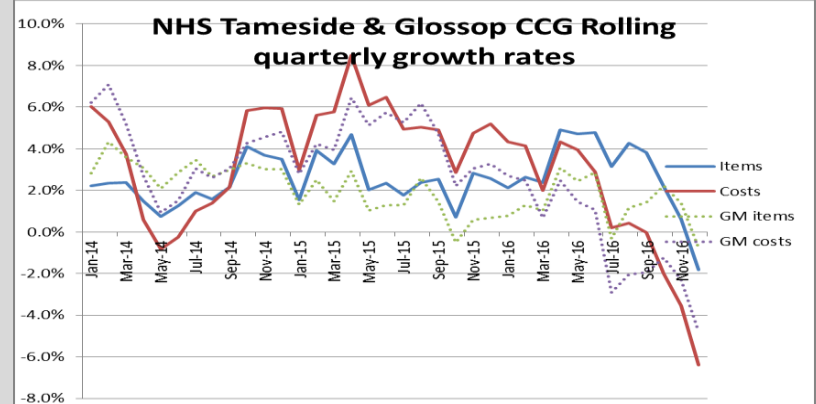
- The main areas where Other referrals have increased are shown in the table below :

Other Referrals to Tameside & Glossop ICFT				
Specialty	2015/16	2016/17 FOT	% Change	Increase in number of referrals
OPHTHALMOLOGY	638	804	26%	166
RESPIRATORY MEDICINE	855	1,067	25%	212
TRAUMA & ORTHOPAEDICS	3,514	3,995	14%	481
RHEUMATOLOGY	135	152	13%	17
GERIATRIC MEDICINE	142	160	12%	18
DERMATOLOGY	264	282	7%	18

CCG Key Movements & Narrative

Prescribing

- As reported previously a detailed review of prescribing costs identified an additional pressure on the budget of £757k which, along with a cross-year pressure identified earlier in the year, created a total pressure of £1m. Savings have previously been reported relating to the costs of Scriptswitch licences and higher than expected rebates being received.
- There has been a further reduction this month of £180k in the outturn position caused primarily by a lower than anticipated prescribing cost in December, which appears to be as a result of the increase usually seen at this time of year not materialising. A degree of caution must still be noted as it may be that the usual annual pressure has been delayed into later months this year.
- The initiatives implemented by the Medicines Management Team are showing positive signs of success as shown in the chart opposite. However it is still uncertain whether the improved performance will continue and this is crucial as the QIPP target for Quarter 4 is £50k per month higher than plans in the third quarter. It is critical that the improved performance is replicated every month to ensure no additional pressure is created in later months.
- It has been identified that where a reduction in usage of certain drugs has been achieved, there is often an increase applied in the prices meaning little impact is seen in overall costs for those drugs. This is indicative of prescribing being difficult to forecast as it is subject to so much volatility.
- Any future pressure on the position will be mitigated by sustained efforts to reduce volume prescribing where Tameside and Glossop are identified as being a significant outlier.
- Prescribing is an area that has been subject to a high level of focus and stringent monitoring throughout 2016-17 and this will continue in 2017-18.



Ongoing work

Other areas of important work currently underway comprise:-

- Annual Report and Accounts. Timelines have been agreed, and work is underway to ensure we meet all deadlines.
- 2016/17 Commissioning Improvement Scheme. In the process of informing practices of indications of potential savings achieved, and performance targets.
- Primary care benchmarking exercise. We are leading on this work across GM. A report will be presented to the next meeting.
- Continued efforts to support phase 2 QIPP schemes. A further update of the CCG recovery plan must be submitted to GM by 31st March 2017.
- CHC and FNC forecast and planning. This area of expenditure is a particular high risk for both the CCG and the Local Authority. Working with the CHC team, to ensure databases are robust for financial forecasting. Fluctuations regarding potential price increases in this area have made planning more difficult and it is imperative that an accurate baseline to assess any potential pressures or savings is established.

Tameside MBC

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Adult Social Care & Early Intervention	37,782	38,850	(1,068)	41,995	43,160	(1,165)	(1,237)	72
Childrens Services, Strategy & Early Intervention	23,543	26,089	(2,547)	25,877	28,723	(2,846)	(2,413)	(433)
Public Health	100	100	-	1,400	1,400	0	-	-
TMBC Total	**61,425**	**65,039**	**(3,614)**	**69,272**	**73,283**	**(4,011)**	**(3,650)**	**(361)**

Overall the TMBC year end forecast position has deteriorated by £0.361m since period 10 increasing the projected year end variance to c.£4.01m, 6.5% on the current year's net budget. An explanation of the movements and other background is provided below:

Children's Social Care

- There have been further increases in the cost of Looked After Children Placements and agency staff recruitment which has led to a deterioration in the financial position of £0.361m since the previous reporting period.

Public Health

- The above figures include provision for a borrowing repayment of £0.186m. This is offset by incidental savings across Public Health contracts and associated overheads.

Adult Social Care

- The improved position at period 11 is due to a reduction in Direct Payment costs due to an increased forecast clawback from service users.

Recommendations

- Note the updated M11 YTD position and projected outturn
- Acknowledge the risk in relation to achieving balanced 2016/17 financial position

Tameside and Glossop ICFT

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Income	185,225	189,971	4,746	202,785	210,439	7,654	209,181	1,258
Expenditure	192,864	196,816	(3,952)	210,707	216,186	(5,479)	215,981	(2,232)
Earnings before interest, taxes, depreciation and amortisation	(7,639)	(6,845)	794	(7,922)	(5,747)	2,175	(6,800)	(974)
Net Deficit after Exceptional Costs	**(15,712)**	**(14,838)**	**874**	**(17,300)**	**(14,500)**	**2,800**	**(15,500)**	**1,000**

Financial Position

- For the 11 months to February 2017, the ICFT is delivering a deficit of £14.8m, £0.9m better than plan.
- The year end forecast is for the planned £14.5m deficit, which is a £2.8m improvement on the plan. This is driven by;
  - Delivery of the £7.8m Efficiency savings target
  - Successful appeal for Q3 and Q4 STF associated with the A&E trajectory.
  - Matched STF for delivery of an improved deficit against plan.
  - Delivery of the Tameside and Glossop CCG block contract
  - Small over performance on all associate PbR contracts
  - Delivery of agency expenditure within the NHSI cap.

Key Risks to the Financial Position

- Increased expenditure on agency staffing.
- Performance targets requiring unplanned expenditure to use the independent sector.

Key Information

- The Trust has successfully appealed the reduction of STF funding relating to delivery of the A&E trajectory for Q3, and is forecasting the Q4 appeal will be successful.
- Due to the timing of the receipt of any additional cash, a short term uncommitted loan has been agreed to fund the deficit.

The Financial Gap

Establishing the Financial Gap

- The current financial gap outlined below across the health and social care economy in Tameside & Glossop is estimated to be £70.2m by 2020/21.
- In 2016/17 the opening gap was £45.7m which consists of £13.5m CCG, £8m council and £24.2m ICO. Progress towards closing these gaps has been made throughout the year.
- The provider gap represents the non-recurrent financial position for the ICFT. The Trust is forecasting receipt of £ 8.3m of sustainability and transformation funding in 2016/17 resulting in a forecast year end deficit of £14.5m.
- A detailed savings tracker is currently being developed to include an economy wide position of progress made in bridging the financial gap. This will comprise a variety of informative dashboards which will be used to track progress and highlight any areas of concern and risk. This will be presented to the next meeting.

T&G Projected Financial Gap	2016/17 £'000s	2017/18 £'000s	2018/19 £'000s	2019/20 £'000s	2020/21 £'000s
Tameside MBC	4,011	22,114	22,601	21,752	25,837
Tameside & Glossop CCG	-	22,485	22,083	22,209	18,547
ICFT (after CIP)	14,500	24,380	24,686	25,049	25,786
Economy Wide Gap	**18,511**	**68,979**	**69,370**	**69,010**	**70,170**

Closing the Financial Gap - CCG

- The CCG recovery plan submitted to NHS England demonstrated initiatives which would allow the CCG to close the £13.5m 2016/17 gap and deliver the required surplus.

Summary of QIPP £'000s	2016/17				2017/18			
	R	A	G	Total	R	A	G	Total
PRIORITY 1 - Prescribing	0	0	0	**0**	1,123	1,393	0	**2,516**
PRIORITY 2 - Effective Use of Resources / Prior	0	0	0	**0**	0	745	755	**1,500**
PRIORITY 3 - Demand Management	0	0	500	**500**	828	1,634	3,684	**6,146**
PRIORITY 4 - Single Commissioning Function	0	0	553	**553**	0	542	467	**1,009**
PRIORITY 5 - Back Office Functions and Enabling	0	0	200	**200**	500	1,000	0	**1,500**
PRIORITY 6 - Governance	0	0	0	**0**	0	100	0	**100**
Other Schemes in progress/achieved:	R	A	G	Total	R	A	G	Total
Neighbourhoods	0	0	459	**459**	0	74	681	**755**
Primary Care	0	0	698	**698**	0	312	1,000	**1,312**
Mental Health	0	0	232	**232**	500	0	232	**732**
Acute Services - Elective	0	0	500	**500**	500	59	500	**1,059**
Enabling Schemes to facilitate QIPP	0	0	0	**0**	0	1,682	0	**1,682**
Technical Finance & Reserves	0	0	6,167	**6,167**	0	0	4,382	**4,382**
Other efficiencies	0	0	4,191	**4,191**	3,688	0	1,340	**5,028**
Grand Total:	0	0	13,500	**13,500**	**7,139**	**7,540**	**13,041**	**27,720**
Including adjustment for Optimism Bias:	-	-	13,500	**13,500**	714	3,770	13,041	**17,525**
10% of red rated schemes will be realised								
50% of amber rated schemes will be realised								
100% of green rated schemes will be realised								
QIPP Target				**13,500**				**23,900**
Savings still to find assuming application of optimism bias:				0				6,375
Outstanding QIPP at close of 2016-17:				**0**				

- Since last month all schemes are now showing as green and the gap for 2016/17 is nil.
- A number of QIPP schemes for 2016/17 are non-recurrent so work continues to identify schemes for 2017/18.

Recurrent v Non Recurrent	2016/17 £'000s	2017/18 £'000s
Recurrent Savings	1,744	21,770
Red	-	6,311
Amber	-	7,300
Green	1,744	8,159
Non Recurrent Savings	11,756	5,950
Red	-	828
Amber	-	240
Green	11,756	4,882
Total	**13,500**	**27,720**

Closing the Financial Gap - TMBC

Service	Savings Area	Detail	2016/17			
			R	A	G	Total
Public Health	Savings found	Planned Reduction to annual management fee payable to Active Tameside and other incidental savings			659	659
		Reduction in Community Services contract value - agreed with ICO			169	169
	Additional resource (projected cost pressures)				49	49
	Reduction in estimated capital financing repayments	Reduction in capital financing costs in 2016/17 due to rephasing of works to reconfigure Active Tameside estate			456	456
	Negotiated reduction in Public Health Network subscription				48	48
	sub total Public Health		**-**	**-**	**1,381**	**1,381**
Adult Social Care	Additional resource (projected cost pressures)				3,908	3,908
	Savings found	Reduction in Dowrie costs			101	101
	Savings still to be found	The Council is currently in the process of identifying further options to address the projected financial gap that is expected to arise during 2016/17. Updates will be reported within future monitoring reports.	896			896
	sub total Adult Social Care		**896**	**-**	**4,009**	**4,905**
Childrens Social Care	Savings found	Reduction to inflationary increases that were projected to materialise during 2016/17.			120	120
	Additional resource (projected cost pressures				1,215	1,215
	Savings still to be found	The Council is currently in the process of identifying further options to address the projected financial gap that is expected to arise during 2016/17. Updates will be reported within future monitoring reports.	379			379
	sub total Childrens Social Care		**379**	**-**	**1,335**	**1,714**
TOTAL			**1,275**	**-**	**6,725**	**8,000**
Including adjustment for Optimism Bias			128	-	6,725	**6,853**
	10% of red rated schemes will be realised					
	50% of amber rated schemes will be realised					
	100% of green rated schemes will be realised					
QIPP Target						**8,000**
Savings still to be found after accounting for optimism bias						**1,148**

Integrated Commissioning Fund 2016/17

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Acute	180,486	180,929	(443)	197,310	197,836	(526)	(125)	(401)
Mental Health	26,533	26,475	58	28,993	28,894	99	2	97
Primary Care	74,968	74,804	164	81,655	82,387	(732)	(899)	167
Continuing Care	11,081	11,415	(334)	12,251	12,628	(377)	(396)	19
Community	25,187	25,195	(8)	27,493	27,544	(51)	(51)	-
Other	25,615	25,039	576	32,019	31,097	922	836	86
QIPP	0	0		-	-	0	-	-
CCG Running Costs	3,993	4,006	(13)	5,178	4,513	665	633	32
CCG sub-total	**347,863**	**347,863**	**-**	**384,899**	**384,899**	**-**	**0**	**-**
Adult Social Care & Early Intervention	37,782	38,850	(1,068)	41,995	43,160	(1,165)	(1,237)	72
Childrens Services, Strategy & Early Intervention	23,543	26,089	(2,547)	25,877	28,723	(2,846)	(2,413)	(433)
Public Health	100	100	0	1,400	1,400	0	-	-
TMBC sub-total	**61,425**	**65,039**	**(3,614)**	**69,272**	**73,283**	**(4,011)**	**(3,650)**	**(361)**
Grand Total	**409,288**	**412,902**	**(3,614)**	**454,171**	**458,182**	**(4,011)**	**(3,650)**	**(361)**
A: Section 75 Services	**211,481**	**213,674**	**(2,193)**	**234,790**	**237,223**	**(2,433)**		
CCG	174,221	174,221	(0)	192,770	192,770	-		
TMBC	37,260	39,452	(2,192)	42,020	44,453	(2,433)		
B: Aligned Services	**168,543**	**169,965**	**(1,422)**	**187,002**	**188,580**	**(1,578)**		
CCG	144,378	144,378	0	159,750	159,750	-		
TMBC	24,165	25,587	(1,422)	27,252	28,830	(1,578)		
C: In Collaboration Services	**29,263**	**29,263**	**(0)**	**32,379**	**32,379**	**0**		
CCG	29,263	29,263	(0)	32,379	32,379	-		
TMBC	-	-	-	-		-		

Better Care Fund

Tameside Better Care Fund

- Tameside Better Care Fund plan for 2016/17 was approved by NHS England on 1 September 2016.
- The plan meets all requirements and funding has been released in accordance with the final approved plan.
- All expenditure is monitored through the ICF.
- 2017-18 guidance for BCF has not yet been received.

Scheme name	2016-17 budgets (£000's) CCG	TMBC	Total
Urgent Integrated Care Service	**578**	**2,374**	**2,952**
IRIS	578	1,338	1,916
Early Supported Discharge Team		286	286
Community Occupational Therapists		750	1,974
Localities	**412**	**3,265**	**3,677**
Telecare/Telehealth	174	667	841
ICES (Joint Loan Store)	238	450	688
Reablement Services		2,148	2,148
Carers Support (in line with National Conditions of Care act related funding)	**412**	**-**	**412**
Carer Breaks (Adults)	412	-	412
Primary Care (£5 per head for over 75's)	**1,070**	**-**	**1,070**
Existing Grant - Disabled Facilities Grant	**-**	**1,978**	**1,978**
Impact of New Care Act Duties	**-**	**529**	**529**
Integration Pump Primimg	**982**	**-**	**982**
Maintaining Services	**-**	**4,801**	**4,801**
Mental health Services		2,450	2,450
Adult Social Care - Community based Services (Inc care Homes)		2,351	2,351
Contingency	**900**	**-**	**900**
Total	4,354	12,947	17,301
	Funded by (£000's)		
NHS Tameside & Glossop CCG			15,323
Central Funded Grants			1,978
Total BCF Fund			17,301

Derbyshire Better Care Fund

- Derbyshire Better Care Fund for 16/17 has also been approved by NHS England.
- Plan meets all requirements and funding has been released subject to spend being consistent with final approved plan.

Scheme name	CCG	Hosted by DCC/Other CCGs	Total
	£000's		
Community Home & Hospital Enhanced care team	**-**	**23,138**	**23,138**
Reablement Services / Community services		18,287	18,287
CDM & Discharge Ward		2,877	2,877
Mental Health		1,974	1,974
Primary Care	**164**	**1,529**	**1,693**
Intergration Pump priming		**8,051**	**8,051**
Maintaining Services	**284**	**24,801**	**25,085**
Maintaining Eligibilty Criteria			-
LCCTS	284		284
Adult Social care		24,801	24,801
Demographic pressures			-
Total	448	57,519	57,967
	Funded by (£000's)		
NHS Tameside & Glossop CCG			2,212
Other CCGs and Central			55,755
Total BCF Fund			57,967

Risk and Other Issues

- The main 2016-17 financial risks within the Integrated Commissioning Fund are listed below.
- Detailed registers including further information on risk and mitigating actions are regularly reviewed by the Audit Committee. Copies are available on request.
- IR35 – With effect from 6 April 2017, the legislation associated with employing 'off payroll' workers will change. This has a potential financial risk due to a reduction in the availability of 'off payroll' workers which could lead then to higher related costs if they are subsequently employed by the Economy.

Transformation Funding

- Transformation funding of £23.2m has been approved by Greater Manchester Health & Social Care Partnership. The Investment Agreement that will support the release of the funding been developed and was signed on 16 December 2016. The year 1 funding of £5.2m has now been made available to the economy and it is expected that this money will be fully accounted for in 2016-17.

Extracts From the Corporate Risk Registers	Probability	Impact	Risk	RAG
Not spending transformation money in a way which delivers required change	2	4	8	A
Over spend against GP prescribing budgets	4	4	16	R
Over spend against Continuing Health Care budgets	2	3	6	A
Operational risk between joint working.	1	5	5	A
CCG Fail to maintain expenditure within the revenue resource limit and achieve a 1% surplus.	1	4	4	G
In year cuts to Council Grant Funding	2	3	6	A
Care Home placement costs are dependent on the current cohort of people in the system and can fluctuate throughout the year	4	4	16	R
Looked After Children placement costs are volatile and can fluctuate throughout the year	3	4	12	A
Unaccompanied Asylum Seekers	4	3	12	A
Care Home Provider Market Failure	3	5	15	R
Funded Nursing Care – impact of national changes to contribution rates and potential legal challenge	4	3	12	A
IR35 – the potential impact of reduced availability of 'off payroll' workers from 6 April 2017 and the increased cost impact if they are subsequently employed by the Economy.	4	3	12	A

Section 2

Care Together Economy

Capital Financial Position

Tameside MBC

Scheme	Approved Capital Programme Total £'000s	Approved 2016/2017 Allocation £'000s	Expenditure to Month 11 £'000s	Projected Expenditure to 31 March 2017 £'000s	2016/2017 Projected Outturn Variation £'000s	Comments
Childrens Services - In Borough Residential Properties	912	912	741	800	112	Purchase of 2 additional in-borough properties including associated property adaptations. An Edge of Care establishment is yet to be purchased
Public Health - Leisure Estate Reconfiguration	20,268	5,203	3,315	3,879	1,324	Active Dukinfield - The scheme is on budget and the new facility opened on 28th January 2017. Active Longendale (Total Adrenaline) - The scheme is on budget and opened on 19th November 2016. Active Hyde – Work commenced on site on February/March 2017 with completion scheduled for November/ December 2017. Denton Wellness Centre – Layout plans and development agreement being established. Facility to be completed late 2018. The programme total of all schemes includes the sum of £ 2.650 million which will be wholly financed by Active Tameside.
Adult Services - Disabled Facilities Grant - Adaptations	1,978	1,978	1,089	1,300	678	One of the three surveyors left the Council in Nov 2015, under voluntary severance thus in effect eliminating his post, prior to the unexpected national increase in DFG funds. This reduced capacity in the team by one-third. Capacity in the team is in the process of being increased.
Total	**23,158**	**8,093**	**5,145**	**5,979**	**2,114**	

Section 3

GM Transformation Fund

Progress Update

GM Transformation Funded Schemes

Scheme Description	Progress
Home First	Underway – delivering reduced length of stay
Digital Health	Underway – pilot commenced in March 2017
Neighbourhoods	Recruitment to some posts completed. Caseload reviews planned for April 2017
System Wide Self Care	Delivery commencing 1 April 2017 in Glossop. Tender to be launched 31 March 2017 for Tameside
Flexible Community Beds	Beds opened in November 2016
Home Care	In Development
Organisational Development	Underway
Estates	Underway

Report to: SINGLE COMMISSIONING BOARD

Date: 11 April 2017

Officer of Single Commissioning Board

Kathy Roe – Director Of Finance – Single Commissioning Team

Ian Duncan - Assistant Executive Director – Tameside Metropolitan Borough Council Finance

Subject: **TAMESIDE COUNCIL AND TAMESIDE & GLOSSOP CLINICAL COMMISSIONING GROUP – INTEGRATED COMMISSIONING FUND – SINGLE FINANCE AGREEMENT FROM 1 APRIL 2017**

Report Summary:

This report has been prepared jointly by officers of Tameside Council and Tameside and Glossop Clinical Commissioning Group as part of the Care Together Programme in Tameside. It sets out the key principles of the single fund (Integrated Commissioning Fund) between the Council and the CCG managed by the Single Commissioning Board.

The report provides an update on progress made during 2016/2017 together with the 2017/2018 value of the Integrated Commissioning Fund. The same report was approved by the Tameside Council Executive Cabinet on 22 March 2017 and the Tameside and Glossop Clinical Commissioning Group Governing Body on 29 March 2017.

Recommendations:

Single Commissioning Board Members are recommended :

1. To note that this report has been previously approved by the Tameside Council Executive Cabinet on 22 March 2017 and the Tameside and Glossop Clinical Commissioning Group Governing Body on 29 March 2017.

2. To note that at the meetings stated in recommendation 1, the Tameside Council Executive Cabinet and the Tameside and Glossop Clinical Commissioning Group Governing Body delegated authorisation to the Executive Director for Governance, Resources and Pensions of Tameside Council to ensure that the terms of the financial framework which governs the Integrated Commissioning Fund are updated for the 2017/2018 financial year as necessary.

3. To note the Integrated Commissioning Fund 2017/2018 budget allocations as stated in **Appendix 1.**

4. To note the management of the associated share of financial risk during 2017/2018 as stated within section 13 of the report.

5. To note that Tameside Council will continue to be the host organisation for the Section 75 pooled fund agreement.

Financial Implications:

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

This report explains the Integrated Commissioning Fund (ICF) arrangements from 1 April 2017.

It should be noted that the ICF will be bound by the terms within the existing Section 75 agreement and associated Financial Framework agreement which will be duly updated as necessary.

	It should also be noted that the Council agrees to increase the value of Council resources within the ICF by a maximum sum of £5.0 million in both 2017/2018 and 2018/2019, should this be necessary, on the condition that T&G CCG agrees a reciprocal arrangement in 2019/20 and 2020/21. A key section of the Financial Framework agreement is the revised risk sharing arrangements. The associated variance to the total net budget allocation at the end of each financial year will be financed in proportion to the percentage of the net budget contribution of each organisation to the ICF. However, the variance will be initially adjusted to exclude any CCG net expenditure associated with residents of Glossop as the Council has no legal powers to contribute to such expenditure. Details of the risk sharing arrangements are provided within section 13 of the report and the values are additional to the £5.0 million contributions explained in the previous paragraph. Single Commissioning Board Members should also note that the Council Service budgets within the ICF exclude related overheads and the additional funding for Adult Social Care announced by the Government on 8 March 2017.
Legal Implications: **(Authorised by the Borough Solicitor)**	Section 75 partnership agreements provided by the National Health Service Act 2006 allow budgets to be pooled between local health and social care organisations and authorities. Resources and management structures can be integrated and functions can be reallocated between partners. The legal mechanisms allowing budgets to be pooled under the section 75 partnership agreement enable greater integration between health and social care and more locally tailored services. This facilitates a strategic and more efficient approach to commissioning local services across organisations and a basis to form new organisational structures that integrate health and social care. The associated Financial Framework Agreement makes provision for governance and accountability of the ICF, the authorities and responsibilities delegated from the partners, financial planning and management responsibilities, budgeting and budgetary control, including forecasting and identifies the responsibilities of each partner organisation.
How do proposals align with Health & Wellbeing Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Health and Wellbeing Strategy
How do proposals align with Locality Plan?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Locality Plan
How do proposals align with the Commissioning Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Single Commissioning Strategy
Recommendations / views of the Professional Reference Group:	A summary of this report is presented to the Professional Reference Group for reference.
Public and Patient Implications:	Service reconfiguration and transformation has the patient at the forefront of any service re-design. The overarching objective of Care Together is to improve outcomes for all of our citizens whilst creating a high quality, clinically safe and financially sustainable health and social care system. The comments and views of our

public and patients are incorporated into all services provided.

Quality Implications:

As above.

How do the proposals help to reduce health inequalities?

The reconfiguration and reform of services within Health and Social Care of the Tameside and Glossop economy will be delivered within the available resource allocations. Improved outcomes for the public and patients should reduce health inequalities across the economy.

What are the Equality and Diversity implications?

Equality and Diversity considerations are included in the re-design and transformation of all services

What are the safeguarding implications?

Safeguarding considerations are included in the re-design and transformation of all services

What are the Information Governance implications? Has a privacy impact assessment been conducted?

There are no information governance implications within this report and therefore a privacy impact assessment has not been carried out.

Risk Management:

Associated details are provided within section 13 of the report.

Access to Information :

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

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1. INTRODUCTION

1.1. This report has been prepared jointly by officers of the Council and Tameside and Glossop CCG as part of the Care Together Programme in the Tameside area. The same report was approved by the Tameside Council Executive Cabinet on 22 March 2017 and the Tameside and Glossop Clinical Commissioning Group Governing Body on 29 March 2017.

1.2. This report seeks to continue the existing Integrated Commissioning Fund in place which was previously approved by the Executive Cabinet (24 March 2016) and the CCG Governing Body (23 March 2016).

1.3. Members should note that the associated Integrated Commissioning Fund reporting arrangements have evolved during the current financial year with a single Health and Social Care economy wide monthly monitoring report presented to the Single Commissioning Board. The monthly report includes the financial details of respective Council services, the Tameside and Glossop CCG (detailed in **Appendix 1**), together with the Tameside and Glossop Integrated Care NHS Foundation Trust.

1.4. Non-recurrent funds were identified by both organisations in 2015/2016 financial plans to serve as an investment/contingency fund to facilitate the delivery of Care Together. Details of the non recurrent fund is provided within section 12 of this report.

1.5. Single Commissioning Board members should note that the Tameside Council Executive Cabinet and the Tameside and Glossop Clinical Commissioning Group Governing Body have delegated authorisation to the Executive Director for Governance, Resources and Pensions of Tameside Council to ensure that the terms of the financial framework which governs the Integrated Commissioning Fund are updated for the 2017/2018 financial year as necessary. Delegated authorisation was approved within the report referred to in section 1.1.

2. BACKGROUND

2.1 Single Commissioning Board Members are reminded that the Care Together Programme over recent years has focused on designing and testing models for improving health and social care services across Tameside and Glossop. This work culminated in the hospital regulator, Monitor, approving a plan for an Integrated Care Organisation (ICO) in September 2015 to bring together health and social care services to improve how these work collectively for the benefit of our population.

2.2 At a joint Board meeting between Tameside Hospital Foundation Trust, NHS Tameside and Glossop Clinical Commissioning Group (CCG) and Tameside Metropolitan Borough Council on 23 September 2015, all parties unanimously agreed to work together within the Care Together programme structure to implement the plan and agreed the principles set out below:

i. *We agree that an integrated system of health and social care is the best way to ensure optimum health and care outcomes for our population and to ensure collective financial sustainability.*

ii. *We welcome the Contingency Planning Team's ('CPT') final report of 28 July 2015 and the assurances it provides as to the new model of care that the Tameside and Glossop Clinical Commissioning Group ('the CCG'), Tameside Metropolitan Borough Council ('TMBC') and Tameside Hospital Foundation Trust ('THFT') have jointly agreed to develop and operate to create a new integrated system of health and social care in Tameside and Glossop.*

iii. *We acknowledge that creating an ICO will not resolve the significant budget challenges facing all organisations but it goes someway to reducing it and it will be necessary to continue to work closely together with all stakeholders to manage the deficit set out in the CPT report.*

iv. *We agree that a Tameside & Glossop Locality Plan setting out our vision to work together to reform health and social care services to improve the health outcomes of our residents and reduce health inequalities as quickly as possible, be considered and approved in due course at the statutory Health and Wellbeing Board, and that the model of care, which is as outlined in the CPT creating a new integrated system of health and social care in Tameside and Glossop report is a key component of that Plan.*

v. *We agree that THFT represents the best legal delivery vehicle for the integrated care system subject to an amended foundation trust licence and constitution to enable a new legal entity of an Integrated Care Foundation Trust to be constituted by the 1 April 2017. Such an organisation will need to be appropriately representative of all three bodies and other stakeholders including primary care and the voluntary sector, which will be reflected in its constitution. We agree to work together to support the THFT in this transformation with a view to be in the ICFT shadow form from the 1 April 2016.*

vi. *We agree that in working together to reform health and social care services to improve health outcomes for residents as quickly as possible and enable system wide change to take place transparently and clearly, robust and inclusive governance structures need to be developed and agreed. The key principles of any governance arrangements include:*

vii. *The objective of providing governance arrangements which aim to provide streamlined decision making; excellent co-ordination of services for the residents of Tameside & Glossop; mutual co-operation; partnering arrangements, and added value in the provision of shared services.*
   - *an acknowledgement that the arrangement does not affect the sovereignty of any party and the exercise and accountability for their statutory functions.*
   - *A commitment to open and transparent working and proper scrutiny and challenge of the work of the Programme Board and any party to the joint working arrangements.*
   - *A commitment to ensure that any decisions, proposals, actions whether agreed or considered at the Programme Board carry with them an obligation for the representative at the Programme Board to report these to their own constituent bodies.*

viii. *We agree to delegating our decision making power, regarding the implementation of the recommendations of the CPT report, to the Programme Board.*

ix. *We agree to develop a Memorandum of Understanding, the Programme Board Terms of Reference, and a detailed Scheme of Delegation for consideration and ratification at a future meeting.*

x. *To provide mutual assurance to the constituent bodies, we agree that there will be regular reports from the Programme Board to the Boards of the constituent bodies.*

xi. *We agree to the formation of a Programme Management Office to manage the implementation of the new Model of Care and will jointly look to resource this as appropriate.*

xii. *The Commissioners agree to deliver a joint commissioning function, to be in place by 1 January 2016.*

xiii. *We agree that the governance arrangements will be kept under regular review and be revised from time to time to reflect the changing status of the integrated care delivery vehicle.*

2.3 An important initial step in the development of an Integrated Care Organisation was the transfer of the Tameside and Glossop community staff previously employed by Stockport Foundation Trust into Tameside and Glossop Integrated Care NHS Foundation Trust. This process was completed on 1 April 2016.

2.4 During 2016 Greater Manchester (GM) Devolution submitted a five year comprehensive Strategic Sustainability Plan for health and social care in partnership with NHS England and other national partners. Each of the GM areas was required to submit a Locality Plan to provide a "bottom up" approach to the development of the GM Plan. The GM Strategic Sustainability Plan included objectives to:

a. improve health and wellbeing of all residents of Greater Manchester, with a focus on prevention and public health, and providing care closer to home;
b. make fast progress on addressing health inequalities;
c. promote integration of health and social care as a key component of public sector reform;
d. contribute to growth, in particular through support employment and early years services;
e. build partnerships between health, social care, universities, science and knowledge sectors for the benefit of the population.

2.5 As such, the Tameside and Glossop Locality Plan addressed how the locality will meet these objectives and on the 12 November 2015, the Health and Wellbeing Board endorsed the Tameside and Glossop Locality Plan.

2.6 The Tameside and Glossop Locality Plan is based on the following objectives to:

- ✓ improve health and wellbeing of residents with a focus on prevention and public health, and providing care closer to home;
- ✓ make fast progress on addressing health inequalities;
- ✓ promote integration of health and social care as a key component of public sector reform;
- ✓ contribute to growth, in particular through support employment and early years services;
- ✓ build partnerships between health, social care, and knowledge sectors for the benefit of the population.

2.7 On 18 December 2015, updated governance proposals were considered and approved by the Joint Meeting of The Greater Manchester Combined Authority and AGMA Executive Board.

2.8 At the local level, full Council approved arrangements on the 21 January 2016 for local governance arrangements to ensure that we have the right leadership for the pace of change required to deliver health and social care integration including the joint committee known as the Tameside & Glossop Care Together Single Commissioning Board.

2.9 The purpose of the governance was to:

- ✓ Ensure a strong clinical voice is secured in the governance arrangements
- ✓ Ensure commissioner/provider engagement
- ✓ Alignment to the pooled budget arrangements

- ✓ Securing appropriate primary care engagement within the governance structure, acknowledging the breadth and range of primary care including pharmacies, general practice, dental and optometry practices. Locally good engagement is developing across the wider primary care partners who are keen to play a full role in this transforming agenda.

3. FINANCIAL CONTEXT FOR THE COUNCIL

Background

3.1 The overall Council budget is set in the context of reductions in Government funding to all councils. This will be the eighth year of reductions in funding with at least another two years to follow.

3.2 The Council budget brings together the Council's many service plans and delivery strategies and sets out an overall plan in financial terms. The budget also ensures that the Council uses resources to deliver services to local people in line with the agreed priorities of the Council and its partners. Some of the key messages are:

- By the end of 2016/17 the Council will have had to make efficiency savings of £144.5 million, due to a combination of reductions in funding and an increase in the cost of providing services.
- The Council has managed this difficult challenge by taking tough decisions, early, and will continue to do this.
- The Council is committed to growing Tameside as outlined in the Corporate Plan – to building houses, attracting businesses, creating jobs and promoting better health, skills and education for our communities. By doing so the Council will seek to tackle the causes of service demand, and so continue to reduce the overall cost of Council services.
- The Council budget for 2017/18 has been prepared following an intense review of the resources required to support and deliver the services of the Council. It takes account of the pressures that services are facing as well as increasing demographic demands to enable the Council to achieve its desired outcomes.
- The Council continues to find new ways to deliver services that are sustainable and even more efficient.
- There will be step up in the partnership working with the NHS which will require a change in risk sharing in order to see transformational changes in service delivery in Health and Social Care. Funding of £23.2 million has been approved from the GM Health and Social Care Partnership to assist with implementing some of these changes. The associated investment agreement was signed on 16 December 2016.

3.3 It is essential to note that the Integrated Commissioning Fund **(Appendix 1)** does not include all Council service budget allocations. The services included are Adult Social Care, Childrens Services and Public Health. These service budget allocations currently exclude related overhead budgets and the additional funding for Adult Social Care announced by the Government on 8 March 2017.

3.4 Single Commissioning Board Members should also note that that the Council has agreed to increase the value of Council resources within the ICF by a maximum sum of £ 5.0 million in both 2017/2018 and 2018/2019 on the condition that the T&G CCG agrees a reciprocal arrangement in 2019/20 and 2020/21 should this be necessary

Forward planning and key challenges facing the Council

3.5 There are a number of key challenges facing the Council in 2017/18 and future years, these include:

a) Continuing to review the delivery of sustainable services to local people from a much reduced level of resources; delivering the necessary further reduction in the overall size of the Council in the subsequent years and securing ongoing cost reductions in a timely manner.

b) The increasing number of people that need to access adult social care services. The Council welcomes the fact that people are living longer, and indeed, it is the Council's ambition for this improvement in health to continue. However, an increasing number of people living longer will mean the Council is exposed to additional financial demands on its constrained resources. Furthermore, the cost of care is increasing, in part as a result of the introduction of the New Living Wage, which adds to the pressure on the budget.

c) There is increasing recognition nationally that the solution to many of the difficulties confronted by the NHS is to invest more in social care. So far this has not resulted in any significant additional resources from the Government, although it is permitting some costs to be passed on to local council tax payers. The response in Tameside has been to create a partnership approach operating under the banner of Care Together.

d) Under Care Together, the three organisations will, for the first time, be taking shared financial risks which are seen as essential for the initiative to succeed. This will mean the Single Commission being exposed to a greater degree of risk than it is currently.

e) Demands on services are not restricted to Adults' Services. The Council is experiencing a surge in the number of children being referred to Children's services. The Council is responding to this demand by increasing significantly the budget for Children's care services so that vulnerable children are not put at risk.

f) Business Rates are set nationally by the Government but collected locally by the Council. It is only since April 2013 that councils have been able to share in any growth in business rates and whilst the Council supports this move, it has meant at the same time that councils have had to share responsibility for losses in business rates. Tameside Council, like many others, has experienced losses arising from successful appeals against rateable values placed on properties. From April 2017 a completely new valuation list comes into force and the reaction of businesses is likely to be the start of a fresh round of appeals. This brings uncertainty into the Council's financial planning and is likely to exist for a number of years.

g) The Council has a significant capital investment programme over the medium term which can have a direct impact on residents, businesses and visitors to the borough. In recent years spending performance has been disappointing and therefore improvements are needed in effective delivery of capital and infrastructure investment e.g. Vision Tameside.

The Grant Settlement

3.6 Whilst the current Government has eased back on the pace by which public expenditure has to come into balance with available resources it is still adopting a policy of spending constraints, no more so than in the support given to local government.

3.7 Last year the Government gave an offer of a fixed four year settlement on condition each Council published an efficiency plan for the period 2016-20. The Council's efficiency plan was published in October 2016. The Council is now guaranteed the main financial

settlement through to, and including, 2019-20. Altogether 97% of local councils took up the offer of a fixed settlement and whilst it gives some certainty to assist financial planning, it is still nevertheless a reduction in central government support.

3.8 Greater Manchester is to participate in a pilot scheme to retain 100% of business rates, ahead of a national rollout of the scheme in 2020. Under the arrangement the 10 district councils in GM will no longer receive any revenue support grant or public health grant. This will be adjusted through the amount received in respect of business rates grants and therefore the financial settlement for the Council has been restated in **table 1** as follows:

Table 1

Restated Settlement	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000
Revenue Support Grant	34,493	0	0	0
Business Rates Baseline	27,481	47,701	49,285	51,094
Business Rates Top-up Grant	24,043	43,635	37,267	30,865
Total Settlement Funding Assessment	**86,016**	**91,336**	**86,552**	**81,959**
Section 31 Grant	1,960	3,960	3,960	3,960
Public Health Grant	15,699	0	0	0
Total SFA and Public Health	**103,675**	**95,296**	**90,512**	**85,919**
Reduction in Year		**(8,379) 8.1%**	**(4,784) 5.0%**	**(4,593) 5.1%**
Cumulative Reduction				**(17,756) 17.1%**

3.9 Another aspect of the grant settlement was the introduction of a new grant for adult social care worth £241 million across England. The grant will last for one year only and the Council share of this grant is £1.159 million. However, to pay for this the Government has reduced the amount paid to local authorities in New Homes Bonus (NHB). Tameside will lose £1.165 million in NHB and as a result is marginally worse off and therefore does not receive any benefit from this change.

3.10 There were other changes relating to New Homes Bonus. The grant was introduced in 20211 and a bonus (grant) is paid for six years for every newly built home, conversion and long term empty property brought back into use. Following a consultation, this mechanism will be amended as follows:

- A move to 5 year payments for both existing and future Bonus allocations in 2017/18 and then to 4 years from 2018/19; and

- The introduction of a national baseline of 0.4% for 2017/18, below which allocations will not be made.

3.11 The Government will continue to pay the funding as an un-ringfenced grant and also retains the option of making adjustments to the baseline in future years to reflect significant and

unexpected housing growth. It will also revisit the case for withholding New Homes Bonus from 2018-19 from local authorities that are not planning effectively, making positive decisions on planning applications and delivering housing growth. To encourage more effective local planning the Government will also consider withholding payments for homes that are built following an appeal.

Council Tax

3.12 As part of the finance settlement an announcement was also made about council tax, including options concerning the adult social care precept.

3.13 When the grant settlement was announced in December 2016 the Secretary of State set out his guidelines on Council Tax. He announced it would be permissible for the adult social care precept to be increased above the 2016/17 level of 2% (of the Council's tax level) as follows:

2017/18: maximum increase of 3%;

2018/19: maximum increase of 3%;

2019/20: maximum increase of 2%;

Over the three year period the maximum combined increase is 6%.

For general increases in Council Tax, the trigger point for a referendum to be called is 2% or more.

3.14 On 28 February 2017 the Council agreed to increase council tax by 4.99%. **Table 2** below illustrates the effect of increases in Council Tax on the affordability of the Council's medium term plan. The budget for 2017/18 has been balanced but there remains a shortfall in future years even after a tax increase.

Table 2

	2017/18 £000	2018/19 £000	2019/20 £000
<u>Resources</u>			
Revenue Support Grant	0	0	0
Business Rates Baseline	(47,701)	(49,285)	(51,094)
Business Rates Top-up Grant	(43,635)	(37,267)	(30,865)
Collection Fund Surplus	(1,000)	(1,000)	(1,000)
Amount to be funded from Council Tax	(74,333)	(74,333)	(74,333)
Use of Reserves and Balances	(2,600)	(1,600)	(300)
Total Resources	**(169,269)**	**(163,485)**	**(157,592)**
<u>Spending Plans</u>			
Director of People	83,117	80,998	79,343
Public Health	16,707	16,740	16,548
Director of Places	58,595	59,783	60,079
Director of Governance and Resources	9,652	9,725	9,824
Corporate Costs	9,325	15,472	19,249
Total Spending	**177,396**	**182,718**	**185,043**
<u>Council Tax Increases</u>			
Council Tax Increase - 4.99% (1.99% in 2019/20)	**(3,824)**	**(7,871)**	**(9,597)**
Revised Tax Base & Collection Rate	**(2,303)**	**(2,612)**	**(2,922)**
Additional Collection Fund Surplus	**(2,000)**	**(500)**	**(500)**
Remaining Gap to be addressed	**0**	**8,250**	**14,432**

Key assumptions

3.15 In line with these key principles, the following specific assumptions have been made in the development of the 2017/18 MTFS:

- Government support in accordance with the four year fixed funding agreement
- Pay awards - 1%;
- Employer's pension contribution rate increase of 1.3% in 2017/18 and maintained thereafter;
- Inflation on running expenses - 2% per annum. Increased allowance for adult services contract costs due to New Living Wage;
- Fees and charges - average increase of 2.5% unless costs are not being recovered or market conditions require a higher or lower level;

- Allowance for demographic change in children and adults' service;

- Average investment return on cash deposits of 0.5%;

- The Council will remain in an under-borrowed position. A limited amount of new borrowing to take place at an average interest rate of 2.70%;

- Increase in levies per guidance issue by GM Combined Authority and GM Waste Disposal Authority;

- Provision of loss on business rates of £0.5 million per annum.

Increased Demand for Council Services

3.16 Each year the Council anticipates increased demand for services, particularly for Children and Adults' care services. In 2016/17 the Council has seen an unprecedented increase in the number of children coming into care services. This is clearly illustrated in **Table 3**

Table 3

Caseloads	Apr 2014	Apr 2015	Apr 2016	Jul 2016	Sep 2016	Dec 2016
Children In Need	888	840	732	681	971	1,224
Children Looked After	423	417	435	437	446	479
Child Protection Plans	167	212	223	261	259	344
Total	**1,478**	**1,469**	**1,390**	**1,379**	**1,676**	**2,047**

3.17 Such demand results in costs in two main ways. One is for the additional staffing costs, mainly social workers, to deal with increased caseload whilst also keeping children safe. The second is the cost in providing care that each child has been assessed as needing. This can vary widely depending whether at one end of the range the child can be cared for safely in a home environment which may involve only modest or no cost or needs, to the extreme of a child needing a secure permanently staffed external placement external placement.

3.18 The Council is already addressing the situation and is facing increased costs in 2016/17 which will be managed within the overall budget envelope. For 2017/18 a recurrent budget provision of £ 6 million is being made to cope with this demand. In addition a non-recurrent sum is included in the children's services budget as outlined in paragraph 3.19. Spending at this level is not sustainable in the context of declining resources and therefore managers will need to identify over the medium term how expenditure can be brought within available resources. The impact of this increased demand in terms of outcomes for children and also financial sustainability will be monitored by an independently chaired Improvement Board and also by a panel of elected Members.

3.19 For Adults' services, the number of people coming into the service should be easier to predict and consequently have less volatility in this budget. Having said that the Council is having to care for an increased number of people with a learning disability and there can be a wide range of costs depending on what their assessed needs are; for elderly people there are more with dementia who need more support. Caseload details are provided in tables 4 and 5:

Table 4

					Projected		
Caseloads	**Apr 16**	**Jul 16**	**Sep 16**	**Dec 16**	**2017-18**	**2018-19**	**2019-20**
People in Care Home placements	793	789	800	800	807	820	832
Homecare hours provided p/w	9,543	9,283	8,982	9,467	9,459	9,600	9,744
Homecare - number of clients	948	945	916	960	956	971	985
Extract of Number of people helped to live at home;							
Day Care	439	446	462	462	459	466	473
Supported Accommodation (incl Extra Care Housing)	400	399	411	411	411	417	424
Shared Lives	150	141	140	141	145	147	150

N.B.

Please note that the above growth projections are based on POPPI & PANSI demographic growth assumptions the numbers do not include the impacts of activity deflections from Acute services into community based settings arising from implementation of new models of care through Care Together. The prevalence rates for Dementia are also increasing, the extract below demonstrates the projected local trend

Table 5

Dementia - all people	**2016**	**2017**	**2018**	**2019**	**2020**
People aged 65-69 predicted to have dementia	161	153	147	141	136
People aged 70-74 predicted to have dementia	266	293	310	328	347
People aged 75-79 predicted to have dementia	428	433	445	457	470
People aged 80-84 predicted to have dementia	597	610	657	708	762
People aged 85-89 predicted to have dementia	583	622	622	622	622
People aged 90 and over predicted to have dementia	508	508	536	566	597
Total Tameside population aged 65 and over predicted to have dementia	**2,543**	**2,619**	**2,717**	**2,822**	**2,934**

3.20 Alongside the increased service demand within Childrens Services, there will also be additional investment required within the service for 2017/18 of £ 2.6 million funded from reserves. This is for the current demand faced by children's services which is anticipated to decline over the medium term plus a non-recurrent sum to facilitate service improvement initiatives following the recent Ofsted inspection. These improvements include a review of service provision pathways and the associated business processes and system infrastructure together with additional capacity to improve the development of the service workforce.

Savings and Efficiencies

3.21 Over the past seven years of austerity the Council has removed substantial sums from both back office and service costs. Costs are kept under review and new initiatives for savings are constantly sought. For 2017/18 services have again identified measures to make further savings:

People Directorate (£ 0.336 million)

3.22 There have been a number of services reviews within Adult Social Care which will achieve a £0.336m recurrent saving from 2017-18 onwards. Areas reviewed include Sensory Services, Learning Disabilities Day Services and Respite Provision. Further work is ongoing to ascertain the suitability of the Reablement service and invest to save proposals are currently being evaluated to expand the community based model for people with sub-threshold needs to enable them to live independently.

Public Health (£ 0.436 million)

3.23 The Directorate has reviewed and recommissioned a number of contracts to deliver recurrent savings of £0.436 million from 1 April 2017. Contracts where savings will be delivered include the provision of support for residents with issues associated with drugs and alcohol and sexual health needs. Savings will also be realised within the contract for the provision of 0-19 public health services.

3.24 It should be noted that there are also further savings initiatives within the Governance and Resources and Place directorates of the Council which total £ 1.581 million.

4. COUNCIL RISKS

4.1 A critical element of the Medium Term Financial Strategy and budget is to ensure that the financial consequences of risk are adequately reflected in the Council's finances.

4.2 A risk-based assessment of issues which could have a major impact on the Council's finances provides a flexible and responsive approach that reflects the continuously changing environment within which local government has to work. A risk assessment of the overall 2017/18 budget has been undertaken covering the following areas:

- Performance against the current year's budget.
- Realistic income targets.
- 'At risk' external funding.
- Reasonable estimates of cost pressures.
- One-off cost pressures identified.
- Robust arrangements for monitoring and reporting performance.
- Reasonable provision to cover the financial risks faced by the Council.

The risk-based approach takes into account relevant external factors such as changes in Government policy, the state of the local economy and the impact of this on the demand for Council services, and any potential changes to the underlying financial assumptions within the period.

5. CCG FINANCIAL PLANS

5.1 The NHS Operational and Contracting Planning Guidance 2017-2019 was published on the 27 September 2016 by NHS England (NHSE) and NHS Improvement (NHSI) for use by NHS commissioners and NHS providers. The guidance explains how the NHS operational planning and contracting processes will now change to support Sustainability and Transformation Plans (STPs) and the 'financial reset'. It reaffirms national priorities and sets out the financial and business rules for both 2017/18 and 2018/19.

5.2 The key objectives underpinning all 2017-2019 healthcare planning are to implement the Five Year Forward View to drive improvements in health and care, restore and maintain financial balance and deliver core access and quality standards.

5.3 The 2017-2019 operational planning and contracting round is built out from STPs. Two-year contracts will reflect two-year activity, workforce and performance assumptions that are agreed and affordable within each local STP. NHSE and NHSI issued a two-year tariff for consultation and two-year CQUIN and CCG quality premium schemes. A joint NHSE and NHSI oversight process will provide a unified interface with local organisations to ensure alignment of CCG and provider plans. The timetable was brought forward by three months for agreeing contracts and all 2017-19 contracts were required to be signed by 23 December 2016. NHS Tameside and Glossop CCG achieved this timeline. Furthermore, the Single Commission agreed a block contract with Tameside and Glossop Integrated Care NHS Foundation Trust as a means of mitigating risk across the economy.

6. CCG ALLOCATION

6.1 In October 2016, the CCG received confirmation of its allocation adjustments for 2017-2019 and these show a net reduction to T&G's allocation of £1.340 million and £1.361million respectively for 2017/2018 and 2018/2019. This net reduction is a result of adjustments for information rules on specialist commissioning and tariff. These values had been derived from national modelling undertaken by NHSE and NHSI.

6.2 The reduced allocation was challenged as this implied the CCG would incur reduced costs for secondary care and specialist commissioned services and local modelling demonstrated a £ 2.1 million pressure to the CCG. As a result of the challenge, the CCG was granted an additional allocation of £1.192 million which has been shared between the CCG and ICFT to off-set some of the risk associated with the tariff changes in secondary care.

Financial Plans submitted to GM Health and Social Care Partnership and NHS England

6.3 A high level summary of the CCG financial plans submitted to NHSE on 24 February 2017 is shown in Table 6 below. This demonstrates how the CCG total allocation of £381.491 million for 2017/2018 and £389.212 million for 2018/2019 is planned to be spent over the next two years. The 2016/2017 values are shown for comparative and illustrative purposes:

Table 6

Revenue Resource Limit

	2016/17 £'000	2017/18 £'000	2018/19 £'000
Recurrent	373,734	381,628	389,414
Non-Recurrent	11,615	(137)	(202)
Total In-Year allocation	**385,349**	**381,491**	**389,212**
Income and Expenditure			
Acute	197,418	196,448	196,448
Mental Health	28,991	29,645	30,234
Community	27,544	27,724	27,724
Continuing Care	12,647	13,247	13,611
Primary Care	50,572	49,409	50,796
Other Programme	32,705	27,104	31,488
Primary Care Co-Commissioning	30,926	31,988	32,954
Total Programme Costs	**380,803**	**375,565**	**383,255**
Running Costs	4,545	4,018	4,010
Contingency	0	1,908	1,947
Total Costs	**385,348**	**381,491**	**389,212**

6.4 **Assumptions underpinning the Financial Plan**

The CCG has statutory responsibilities referred to as the business rules with which it must comply. These comprise:

- Maintain expenditure within the revenue resource limit and make an underlying recurrent surplus of 1%
- Maintain expenditure within the allocated cash limit;
- Maintain capital expenditure within delegated limits;
- Ensure that 1% of recurrent funds are spent non-recurrently in line with the 2016-17 uncommitted 1% fund. However, for 2017-18 0.5% is available to spend immediately on transformational schemes and 0.5% to be held uncommitted in a risk reserve;
- Ensure a minimum 0.5% contingency is held;
- Ensure running costs do not exceed the allocation of £5.155 million;
- Ensure compliance with the Better Payment Practice Code whereby the CCG ensures it pays all NHS creditors within 30 days of receipt of a valid invoice.

These are incorporated in the plans above together with the following assumptions outlined in table 7 below taken from the planning guidance:

Table 7

2017/18	Gross Provider Efficiency %	Inflation %	Net tariff inflation %	Activity Growth (Demog) %	Activity Growth (Non-Demog) %	Total %
Mental Health	-2.00	2.10	0.10	1.00	0.90	2.00
Acute	-2.00	2.10	0.10	1.00	0.70	1.80
Primary Care - CCG	-2.00	2.10	0.10	1.00	1.65	2.75
Primary Care - Delegated	0.00	0.00	0.00	0.00	3.73	3.73
Continuing Care	-2.00	2.10	0.10	1.00	1.65	2.75
Community Health Services	-2.00	2.10	0.10	1.00	0.70	1.80
Other	-2.00	2.10	0.10	1.00	0.90	2.00
Corporate	0.00	0.00	0.00	0.00	-0.14	-0.14
2018/19	**Gross Provider Efficiency %**	**Inflation %**	**Net tariff inflation %**	**Activity Growth (Demog) %**	**Activity Growth (Non-Demog) %**	**Total %**
Mental Health	-2.00	2.10	0.10	1.00	0.89	1.99
Acute	-2.00	2.10	0.10	1.00	0.70	1.80
Primary Care - CCG	-2.00	2.10	0.10	1.00	1.65	2.75
Primary Care - Delegated	0.00	0.00	0.00	0.00	3.01	3.01
Continuing Care	-2.00	2.10	0.10	1.00	1.65	2.75
Community Health Services	-2.00	2.10	0.10	1.00	0.70	1.80
Other	-2.00	2.10	0.10	1.00	0.89	1.99
Corporate	0.00	0.00	0.00	0.00	-0.16	-0.16

6.5 Incorporated within the above plans is the intention that the CCG will meet the Mental Health Investment Standard, formerly known as the Parity of Esteem. This comprises investment growth of 2.5% in 2017-18 giving a total investment in mental health of £37.611 million and 2.0% growth in 2018-19 giving a total mental health investment of £38.359 million. This includes all mental health services including those aligned to learning disabilities and dementia.

7. CCG RECOVERY PLAN

7.1 The CCG has made good progress on realising savings as part of its Financial Recovery Plan in 2016/2017. The CCG has met the 2016/2017 Quality Innovation Productivity and Prevention (QIPP) target of £13.5 million in full and although a significant proportion was a result of non-recurrent means, many of the schemes started in 2016-17 will continue to be developed delivering increasingly more savings recurrently in 2017-18 and beyond. The CCG has a QIPP target of £ 23.9 million in 2017/2018 but planned recurrent savings from work started in 2016/2017 and negotiated within 2017/2018 contracts are shown in Table 8.

Table 8

CCG Recovery Plan Schemes:	2017-18 £		2018-19 £
Tameside ICFT	4,438,659	Consistent with agreed contract.	4,438,659
Other Associate Providers	2,752,729	Savings built into signed associate contracts. Increased risk of overperformance, but if we are able to prevent referrals and admissions, it is not unreasonable to realise the savings.	2,755,456
Other Acute	2,321,286	Within the gift of the CCG to reduce Independent Sector referrals which would deliver this saving.	1,323,164
GP Prescribing	2,516,350	Targeted schemes directed at reducing demand and stopping growth. T&G are an outlier at 4.28% prescribing volume growth against a national average of 2.08%.	2,514,846
CCG Commissioned Primary Care	2,787,825	Plans at an advanced stage of implementation on these areas including over 75s and Primary Care Quality Schemes.	797,599
Delegated Primary Care	587,500	Part year effect of Equitable Access Services.	587,500
Community Health Services	1,583,217	Re-procurement of certain community services including the Wheelchair contract.	756,681
Continuing Care	934,552	High risk area but work on-going to better understand care home spend across the economy.	331,843
Mental Health	1,285,062	Some savings incorporated into the Pennine Care contract but we must ensure the Mental Health Investment Target is met.	1,283,191
Corporate	1,137,000	Includes various efficiencies as a result of forming a Single Commissioning function.	1,137,000
Other	2,405,711	This primarily includes the Estates and IM&T strategies and considered high risks at this stage.	2,517,863
Reserves	4,970,860	Technical accounting savings in accordance with statutory guidance.	4,970,000
Grand Total	**27,720,751**		**23,413,802**

7.2 Planned QIPP savings have been categorised across 2 broad categories: Phase 1 and Phase 2 QIPP. Phase 1 QIPP comprise schemes where decisions have been made, but where there may be some implementation risk. Phase 2 QIPP is where potentially decisions are still required, for example, to de-commission/stop services but where savings can be realised in 2017/2018 once a decision is made. Phase 2 QIPP can be highly emotive and contentious requiring some very difficult and unpalatable decisions.

7.3 The QIPP plans detailed in table 9 comprise both Phase 1 and Phase 2 QIPP schemes. The CCG has applied a RAG rated weighting to each of the schemes to reflect optimism bias and provide a clearer understanding of the level of risk of delivery. The outcome of this further analysis for 2017/2018 QIPP reduces the planned savings outlined in table 8 by £10.421 million to £17.300 million. The composition of this analysis is shown in table 9 below:

Table 9

Total QIPP savings	Phase 1 £'000	Phase 2 £'000	Total £'000	Expected Saving £'000
RED	1,123	6,016	7,139	714
AMBER	7,991	0	7,991	3,995
GREEN	11,867	724	12,591	12,591
Total	**20,981**	**6,740**	**27,721**	**17,300**

7.4 As table 9 clearly demonstrates, it is crucial that momentum continues and the pace and scale of CCG schemes and economy wide transformation is accelerated to ensure the

planned savings are delivered and reduce financial risk across the wider health and social care economy.

8. GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP

8.1 Single Commissioning Board Members are reminded there was a direct allocation of £ 450 million revenue resources to Greater Manchester from NHS England representing its 'fair share' of available transformation budgets over a five year period. The GM Strategic Partnership Board will oversee the deployment of funding to deliver the major change programme set out in the GM Strategic Plan.

8.2 The transformation funds will enable the delivery of the Tameside and Glossop Locality Plan. This will ensure more effective and efficient service provision and in the longer term, will significantly improve the health and wellbeing of the Tameside and Glossop community.

8.3 On 30 September 2016, the Partnership Strategic Partnership Board ratified the full transformational funding award of £23.226 million to Tameside and Glossop economy over a four financial year period.

8.4 Work commenced with the Greater Manchester Health and Social Care Partnership (GMHCP) thereafter to develop our investment agreement. Inclusion in this was implementation and delivery milestones to measure progress against the national "must do's" and our transformation priorities as outlined in the Cost Benefit Analysis submission.

8.5 The full suite of documentation for the Investment Agreement was submitted, reviewed and refined over three weeks, with final submission taking place on 2 December 2016.

8.6 The Investment Agreement was formally signed on 16 December 2016 by:

- Councillor Kieran Quinn - Executive Leader – TMBC
- Karen James - Chief Executive – Tameside and Glossop Integrated Care Foundation
- Trust)
- Lord Peter Smith - Chair – Greater Manchester Health and Social Care Strategic
- Partnership Board)
- Dr Alan Dow - Chair – Tameside and Glossop Single Commissioning Board
- Steven Pleasant - Chief Executive – Tameside MBC and Accountable Officer of
- Tameside and Glossop CCG.

8.7 Monitoring of the Investment Agreement within the locality will take place on a monthly basis, with progress updates provided to Greater Manchester on a quarterly basis.

8.8 The transformational funding award unfortunately does not include any capital for IM&T and Estates. Liaison continues with Greater Manchester Health and Social Care Partnership and NHS Improvement to understand the potential for funding bids and progress will be continually provided to the Members.

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9 CARE TOGETHER OPERATIONAL PROGRESS

Programme Management

9.1 The new Care Together (CT) programme structure was implemented from January 2017 and will see the CT Programme Board move to quarterly meetings instead of monthly.

9.2 Priority programmes of work, such as the potential transfer of Adult Social Care services into the Integrated Care Organisation Foundation Trust (ICFT) require dedicated resources,

and as such, resources from the Care Together Programme have been deployed to work on this.

9.3 In addition, as the programme moves towards implementation phase, the Care Together Programme Support Office will need to be enhanced to provide the necessary system assurance. External management consultancy support has been procured to set up the necessary systems to inspire confidence and provide the appropriate reassurance across the system.

Adult Social Care Transaction

9.4 The Adult Social Care Transaction Board continues to meet monthly, a full business case and due diligence process is being developed to ensure organisational and regulatory approval for the transfer of the service to the Integrated Care NHS Foundation Trust.

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9.5 Associated workstreams were agreed and established during January 2017.

Healthy Neighbourhoods

9.6 Three Neighbourhood managers have now been appointed. This is a significant milestone towards achieving our vision for the neighbourhoods, overseeing multidisciplinary teams working jointly across health and social care to ensure the best possible outcomes for our local people.

Savings Assurance

9.7 In November 2016, the Locality Executive Group (LEG) discussed the importance of aligning the financial work across the locality to provide a holistic view of progress against the projected financial gap.

9.8 To facilitate the in-depth support and challenge required, it was agreed to set up half day sessions in January to test the robustness of action plans in each scheme.

These sessions:

- Confirmed the Senior Responsible Officer and accountability for each scheme, key team leads and savings target for 2017/2018 to 2020/2021;
- Reviewed the action plans of each scheme;
- Agreed the level of savings achievable in 2017/2018;
- Confirmed if any additional support is required to ensure delivery of targets.

10. CARE TOGETHER ORGANISATIONAL UPDATE

Single Commissioning Function

10.1 As part of the drive to improve efficiency and reduce the costs of commissioning, New Century House was vacated during the spring of 2016/2017. Officers were relocated to existing Council locations.

Integrated Care Organisation

10.2 The governance of the models of care is currently being reviewed and revised within the Integrated Care NHS Foundation Trust to take into account a move towards implementation phase.

10.3 As such, a new Joint Management Team has been established in Tameside and Glossop Integrated Care NHS Foundation Trust to lead the implementation work, standing down the Models of Care Steering Group. It met for the first time on 21 December 2016. Chaired by the Trust's Chief Executive, Karen James, it will bring together the Trust's executive team and clinical directors with the clinical GP leads for the five neighbourhoods and the lead directors for public health and social services.

Next Stages

10.4 The notable next stages are as follows:

- Monitoring and reporting of the GM Transformation Fund Investment Agreement;
- Agree financial sustainability plan for the economy;
- Procurement of additional Programme Support
- Development and sign off of the business case for the transaction of adult social care into the Integrated Care Organisation;
- Continued discussions to determine options for aligning primary care outcomes alongside those of the Integrated Care Organisation and therefore for the whole population;
- Continue the review of the Mental Health Contract for the locality, to be completed by the end of 2016/2017;
- Developing and implementing a measurement framework which accurately ensures our planned transformational schemes are improving the healthy life expectancy of the Tameside and Glossop population.

11. CAPITAL INVESTMENT

11.1 In addition to the revenue funding detailed in **Appendix 1**, the Council is proposing capital investment within the Tameside Care Together economy. The associated details are included in table 10 below.

Table 10

COUNCIL CAPITAL PROGRAMME	16/17	17/18	18/19	TOTAL
	£'m	£'m	£'m	£'m
Children's Services - In Borough Residential Properties	0.812	0.100	0.000	0.912
Active Tameside - Leisure Estate Reconfiguration	3.814	9.930	6.524	20.268
Adult Services - Disabled Facilities Grant - Adaptations	1.300	0.678	0.000	1.978
Total	**5.926**	**10.708**	**6.524**	**23.158**

11.2 It is important to note that the estimated additional annual revenue expenditure associated with the repayment and interest for the prudential borrowing (unsupported) required to finance the Childrens Services and Active Tameside estate investment in table 10 will be an associated cost against the Integrated Commissioning Fund in the respective financial year.

12. NON RECURRENT INVESTMENT FUND

12.1 Members are reminded that the Council and the CCG approved a non-recurrent investment budget totalling £ 6.38 million. This sum is additional to the revenue budgets stated in **Appendix 1** and the capital investment in section 11.

The contributions from each organisation are stated in table 11 below:

Table 11

Organisation	£ m
CCG	3.00
Tameside MBC	3.38
Total	**6.38**

12.2 The 'investment fund' finances specific non-recurrent or capital investments required to support service reconfiguration and in particular for the pump priming of schemes and double running costs. This fund may also be called upon to support investment in infrastructure to secure greater overall efficiency (e.g. IT investment). All such bids supported with a robust business case are subject to approval by the Care Together Programme Board.

12.3 It should be noted that there will be an estimated residual balance of £ 2.58 million on 1 April 2017.

13. ICF RISK SHARE

13.1 The arrangement agreed for 2016/2017 was that, whilst working as a single commissioning function, the Council and CCG would retain full responsibility for their own financial risks. After a year of formally working together the current financial arrangements feel out of step with the concept of a single commissioner.

13.2 The proposal is that from 1 April 2017 each organisation will begin to share financial risk in proportion to the respective contributions they make into the Integrated Commissioning Fund. This would result in a sharing arrangement of 80 % for T&G CCG and 20 % for the Council as calculated in table 12.

Table 12 – Net Budgets Per Appendix 1

Commissioner	17/18 Total Net Budget	ICF Contributions
	£'000	%
T&G CCG	381,491	80
Tameside MBC	96,438	20
Total	**477,929**	**100**

13.3 This would be a significant step for both organisations given the current financial climate and the scale of the savings that must be delivered in the short term and the risks that the local health and social care economy face currently.

The variance to the total net budget allocation at the end of each financial year will be financed in proportion to the percentage of the net budget contribution of each organisation to the ICF (per table 12). However, the variance will be initially adjusted to exclude any CCG net expenditure associated with residents of Glossop (13% of the total CCG variance) as the Council has no legal powers to contribute to such expenditure. The associated adjusted total variance of both the CCG and the Council would then be financed in proportion to the % contributions as stated in table 12.

13.4 In addition it is also proposed that a stepped approach is taken to risk sharing and that a cap is placed on the shared financial exposure that each organisation would be expected to meet. For 2017/2018 it is proposed that :

- a cap of £ 2.0 million is placed on CCG related risks that the Council will contribute to;
- a cap of £ 0.5 million is placed on Council related risks that the CCG will contribute to.

13.5 The differential cap is recognises that it would be difficult for the CCG to assume responsibility for 80% of the Council's risks at a time when it is facing the highest QIPP target across Greater Manchester.

13.6 For clarity, the risk sharing arrangement applies to the Section 75 pooled fund, the aligned fund and the 'in collaboration' budget as set out in **Appendix 1**. It should be noted that the Council's cap of £ 2.0 million (per section 13.3) is over and above the non-recurrent contribution to the ICF of up to £ 5.0 million in both 2017/18 and 2018/19 (on the condition that the T&G CCG agrees a reciprocal arrangement in 2019/20 and 2020/21 should this be necessary – per section 3.4).

14 RECOMMENDATIONS

14.1 As detailed on the report cover.

APPENDIX 1

Service	2017/2018											
	Section 75			Aligned			In Collaboration			Total		
	Gross Expenditure	Gross Income	Net Expenditure	Gross Expenditure	Gross Income	Net Expenditure	Gross Expenditure	Gross Income	Net Expenditure	Gross Expenditure	Gross Income	Net Expenditure
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ICO CONTRACT	88,242	0	88,242	66,003	0	66,003	430	0	430	154,675	0	154,675
ACUTE	33,982	0	33,982	32,062	0	32,062	0	0	0	66,044	0	66,044
MENTAL HEALTH	29,596	0	29,596	0	0	0	0	0	0	29,596	0	29,596
PRIMARY CARE	9,722	0	9,722	41,148	0	41,148	31,988	0	31,988	82,857	0	82,857
CONTINUING CARE	13,247	0	13,247	0	0	0	0	0	0	13,247	0	13,247
COMMUNITY HEALTH SERVICES	3,639	0	3,639	0	0	0	0	0	0	3,639	0	3,639
CORPORATE	4,018	0	4,018	0	0	0	0	0	0	4,018	0	4,018
OTHER	18,810	0	18,810	7,870	0	7,870	734	0	734	27,414	0	27,414
ADULT SOCIAL CARE	73,506	(30,047)	43,459	1,161	(80)	1,081	0	0	0	74,667	(30,127)	44,540
CHILDRENS SERVICES	672	(487)	185	37,723	(2,717)	35,006	0	0	0	38,395	(3,204)	35,191
PUBLIC HEALTH	16,804	(97)	16,707	0	0	0	0	0	0	16,804	(97)	16,707
Grand Total	**292,239**	**(30,631)**	**261,608**	**185,966**	**(2,797)**	**183,169**	**33,151**	**0**	**33,151**	**511,357**	**(33,428)**	**477,929**

Savings which are incorporated into and assumed delivered in the above	
CCG	23,900
ADULT SOCIAL CARE	336
PUBLIC HEALTH	436
TOTAL	**24,672**

N.B.

Council Service budgets (Adult Social Care, Childrens Services and Public Health) exclude :

- Related Overheads
- The additional funding for Adult Social Care announced by the Government on 8 March 2017

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	11 April 2017
Reporting Member / Officer of Single Commissioning Board	Angela Hardman, Executive Director, Public Health and Performance Anna Moloney, Consultant in Public Health
Subject:	**DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – GOVERNING BODY PERFORMANCE UPDATE**
Report Summary:	This report provides the Single Commissioning Board with a quality and performance report for comment. Assurance is provided for the NHS Constitutional indicators. In addition Clinical Commissioning Group information on a range of other indicators are included to capture the local health economy position. This is based on the latest published data (at the time of preparing the report). This is as at the end of January 2017. The format of this report will include elements on quality from the Nursing and Quality directorate as this report evolves. This report also includes Adult Social Care indicators. This evolving report will align with the other Greater Manchester Health and Social Care Partnership and national dashboard reports. The following have been highlighted as exceptions: • Diagnostic standard improving but still failing the standard; • A&E Standards were failed at Tameside Hospital NHS Foundation Trust; • Ambulance response times were not met at a local or at North West level; • Improving Access To Psychological Therapies (IAPT) performance for Aceess and Recovery remain a challenge; • 111 Performance against Key Performance Indicators; • MRSA; • 62 day Cancer upgrade. Attached for information is the Draft Greater Manchester Partnership dashboard and the latest NHS England Improvement And Assessment Framework (IAF) Dashboard.
Recommendations:	The Single Commissioning Board is asked to note the contents of the performance and quality report, and comment on the revised format.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The updated performance information in this report is presented for information and as such does not have any direct and immediate financial implications. However it must be noted that performance against the data reported here could potentially impact upon achievement of CQUIN and

	QPP targets, which would indirectly impact upon the financial position. It will be important that whole system delivers and performs within the allocated reducing budgets. Monitoring performance and obtaining system assurance particularly around budgets will be key to ensuring aggregate financial balance.
Legal Implications: **(Authorised by the Borough Solicitor)**	As the system restructures and the constituent parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all parts to account and understanding best where to focus resources and oversight. This report and framework continues to be developed to achieve this.
How do proposals align with Health & Wellbeing Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
How do proposals align with Locality Plan?	Should provide check & balance and assurances as to whether meeting plan.
How do proposals align with the Commissioning Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
Recommendations / views of the Professional Reference Group:	This section is not applicable as this report is not received by the professional reference group.
Public and Patient Implications:	Patients' views are not specifically sought as part of this monthly report, but it is recognised that many of these targets such as waiting times are a priority for patients. The performance is monitored to ensure there is no impact relating to patient care.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	This will help us to understand the impact we are making to reduce health inequalities. This report will be further developed to help us understand the impact.
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None reported related to the performance as described in report.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no Information Governance implications. No privacy impact assessment has been conducted.
Risk Management:	Delivery of NHS Tameside and Glossop's Operating Framework commitments 2016/17
Access to Information :	The background papers relating to this report can be inspected by contacting Ali Rehman, Public Health, by: Telephone: 01613663207 e-mail: alirehman@nhs.net

1. **INTRODUCTION**

1.1 The purpose of this iterative report is to provide the Board with a quality and performance report for comment. The quality and performance report format aims to provide a dashboard view of indicators and provide exception reporting as appropriate. This evolving report will align with the other Greater Manchester Health and Social Care Partnership and national dashboard reports.

1.2 The format of this report will include further elements on quality from the Nursing and Quality Directorate as this report evolves.

1.3 It should be noted that providers can refresh their data in accordance with national guidelines and this may result in changes to the historic data in this report.

2. **CONTENTS – QUALITY AND PERFORMANCE REPORT**

2.1 NHS Tameside & Glossop Clinical Commissioning Group: NHS Constitution Indicators (January 2017).

2.2 Adult Social services indicators. (Quarter 3 16/17) - these will be further expanded on in future iterations of this report.

2.3 Exception Report - the following have been highlighted as exceptions:

- Diagnostic standard improving but still failing the standard;
- A&E Standards were failed at Tameside Hospital Foundation Trust;
- Ambulance response times were not met at a local or at North West level;
- Improving Access To Psychological Therapies (IAPT) performance for Access and Recovery remain a challenge;
- 111 Performance against Key Performance Indicators;
- MRSA Bacteraemia;
- Cancer 62 day upgrades.

The exception reports in future reports will evolve as clarity is provided on the comparators.

2.4 Greater Manchester Combined Authority (GMCA) / NHS Greater Manchester (NHSGM) Performance Report:

- Better Health;
- Better Care;
- Sustainability;
- Well Led.

2.5 NHS England Improvement and Assessment Framework (IAF) dashboard.

2.6 There are a number of indicators where the Clinical Commissioning Group is deemed to be in the lowest performance quartile nationally. These indicators have been highlighted in light orange on the dashboard and are as follows:

2.7 **Better Health**
- Maternal Smoking at delivery;
- People with diabetes diagnosed less than a year who attend a structured education course;
- Utilisation of the NHS e-referral service to enable choice at first routine elective referral;
- People with a long-term condition feeling supported to manage their condition(s);

- Inequality in emergency admissions for urgent care sensitive conditions;
- Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions;
- Quality of life of carers.

2.8 **Better Care**

- One-year survival from all cancers;
- Proportion of people with a learning disability on the GP register receiving an annual health check;
- Choices in maternity services;
- Emergency admissions for urgent care sensitive conditions;
- Delayed transfers of care per 100,000 population;
- Population use of hospital beds following emergency admission;
- Management of long term conditions.

2.9 **Sustainability**

- Digital interactions between primary and secondary care.

3. KEY HEADLINES - HEALTH

3.1 Below are the key headlines from the quality and performance dashboard.

Referrals

3.2 GP referrals have increased this month compared to last month however they have continued to decrease overall and have decreased compared to the same period last year. Other referrals have increased compared to last month and have increased compared to the same period last year. Year to date GP referrals have decreased by 8.9% compared to the same period last year and other referrals have increased by 0.6% compared to the same period last year for referrals at Tameside and Glossop Integrated Care Foundation Trust. Referrals to all providers have decreased by 5.3% compared to the same period last year and other referrals have decreased by 2.7%.

18 Weeks Referral to Treatment Incomplete Pathways

3.3 Performance continues to be above the national standard of 92%, currently achieving 93.0% during January. The specialties failing are Urology 90.11%, Trauma and Orthopaedics 89.16%, Neurology 90.00%, and Plastic Surgery 71.81%. There were no patients waiting longer than 52 weeks during January.

Diagnostics 6+ week waiters

3.4 This month the Clinical Commissioning Group failed to achieve the 1% standard with a 1.85% performance. Of the 86 breaches, 37 occurred at Central Manchester (echocardiography, flexi sigmoidoscopy, gastroscopy and MRI). 33 at Tameside and Glossop Integrated Care Foundation Trust (audiology assessments, colonoscopy, CT scans, gastroscopy and NOUS), 9 at Care UK (CT, MRI AND NOUS), 3 at Pennine Acute (Cystoscopy, Gastroscopy and Neurophysiology), 2 at Salford Trust (MRI and NOUS), 1 at Pioneer Healthcare (Neurophysiology) and 1 at South Manchester (Respiratory physiology). Central Manchester performance is due to an ongoing issue with endoscopy which Greater Manchester are aware of. Tameside and Glossop Integrated Care Foundation Trust performance is primarily due to audiology struggling with capacity.

A&E waits Total Time with 4 Hours at Tameside and Glossop Integrated Care Foundation Trust

3.5 The A&E performance for January was 76.22% which is below the target of 95% nationally and below the local target of 90%. The key issue is medical bed capacity which not only cause breaches due to waiting for beds but the congestion in A&E then delays first assessment. There is still medical cover and specialty delays when teams are in Theatres.

The trust reports acuity is high which can lead to people needing more than 4 hours for a decision to be reached on their care need.

Ambulance Response Times Across North West Ambulance Service area

3.6 In January the North West position (which we are measured against) was not achieved against the standards. Locally we also did not achieve any of the standards. Increases in activity have placed a lot of pressure on North West Ambulance Service and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

3.7 **111**

The North West NHS 111 service is performance managed against a range of Key Performance Indicators reported as follows for January:

- Calls Answered (95% in 60 seconds) = 77.5%;
- Calls abandoned (<5%) = 7.1%;
- Warm transfer (75%) = 32.9%;
- -Call back in 10 minutes (75%) = 38.4%.

3.8 The benchmarking data shows that the North West NHS 111 service was ranked 42nd out 42 for calls answered in 60 seconds (78%). This is compared to East London City which is the highest ranked for calls answered in 60 seconds (97%).

3.9 Looking at the dispositions we are also ranked 41st out of 42 for % recommended to dental/pharmacy (2%) compared to the highest ranked provider York and Humber (11%). Percentage recommended home care (3%) we are ranked 42nd out 42 compared to the highest ranked provider, East London and City (8%).

3.10 In January the North West NHS 111 service experienced a number of issues which lead to poor performance in the month against the four Key Performance Indicators. Performance was particularly difficult to achieve over the weekend periods.

3.11 All of the cancer indicators achieved the standard during January apart from the 62 day Cancer upgrades which was at 75.0% for January against the 85% standard. There were 4 breaches mostly due to late referrals and complex issues.

Improving Access to Psychological Therapies

3.12 Performance continues to be above the Quarterly Standard for the Improving Access to Psychological Therapies (IAPT) access rate (75%) achieving 3.92% during Quarter 2. However, the Quarter 2 performance for IAPT recovery rate remains below the standard at 46.00%. In terms of IAPT waiting times the Quarter 2 performance is above the standard against the 18 week standard (95%) which was reported as 98.6%. The Quarter 2 performance for the 6 week wait standard (75%) was reported as 73.4%.

Healthcare Associated Infections

3.13 Clostridium Difficile: The number of reported cases during January was below plan. Tameside & Glossop Clinical Commissioning Group had a total of 5 reported cases of clostridium difficile against a monthly plan of 7 cases. For the month of January this places Tameside and Glossop Clinical Commissioning Group 2 under plan. Of the 5 reported cases, 2 were apportioned to the acute (1 at Tameside Hospital Foundation Trust and 1 at Stockport Foundation Trust) and 3 to the non-acute. To date (April to January 2017) Tameside and Glossop Clinical Commissioning Group had a total of 68 cases of clostridium difficile against a year to date plan of 82 cases. This places Tameside and Glossop Clinical Commissioning Group 14 cases under plan. Of the 68 reported cases, 36 were apportioned to the acute (27 at Tameside Hospital Foundation Trust, 4 at Central Manchester Foundation Trust, 2 at Christie Hospital Foundation Trust, 1 at The Royal Orthopaedic Hospital Foundation Trust, 2 at Stockport Foundation Trust) and 32 to the non-

acute. In regards to the 2016/17 financial year, Tameside and Glossop Clinical Commissioning Group have reported 68 cases of clostridium difficile against an annual plan of 97 cases. This currently places the Clinical Commissioning Group 29 cases under plan with 2 months of the financial year remaining.

3.13 MRSA: In January 2017 Tameside and Glossop Clinical Commissioning Group have reported 2 cases of MRSA against a plan of zero tolerance. To date (April 2016 to January 2017) Tameside and Glossop Clinical Commissioning Group have reported 8 cases of MRSA against a plan of zero tolerance. Breakdown includes 5 acute cases (1 at Tameside Hospital Foundation Trust, 3 at Central Manchester, 1 at South Manchester Foundation Trust) and 3 non acute cases.

Mixed Sex Accommodation

3.14 This month there were 2 breaches reported against the Mixed Sex Accommodation standard of zero breaches for Tameside and Glossop Clinical Commissioning Group patients.

Dementia

3.15 We continue to perform well against the estimated diagnosis rate for people aged 65+ for January which was 74.8% against the 66.7% standard.

4. ADULT SOCIAL CARE INDICATORS

Introduction

4.1 Performance in Adult Social Care is supported by the Adult Social Care Outcomes Framework. The framework contains nationally published qualitative and quantitative indicators. The qualitative indicators are informed by the completion of an annual national survey of a selection of service users and a biannual survey of a selection of Carers- both surveys are administered locally.

4.2 It is widely recognised that the quantitative indicators in the Adult Social Care Outcomes Framework do not adequately represent the service delivery of Adult Social Care. Therefore in response, data sets have been developed regionally and locally in order to provide performance data that supports service planning and decision making for Adult Social Care in Tameside.

Proportion of People Using Social Care Who Receive Direct Payments
Performance Summary

4.3 This measure supports the drive towards personalisation outlined in the Vision for adult social care and Think Local, Act Personal, by demonstrating the success of councils in providing personal budgets and direct payments to individuals using services.

4.4 Performance in Tameside in 2015/2016 was 15.43% compared to 23.5% regionally and 28.1% nationally.

4.5 Tameside performance as at Quarter 3 2016/2017 is showing 13.62%, which is a reduction of 23 people since 2015/2016.

4.6 **Actions**

- Review the Direct Payments offer and how this is promoted by front line staff;
- Review the capacity of Direct Payment Officers;
- Gain views from Service Users as to why Direct Payments may not be considered.

People With Learning Disabilities In Employment
Performance Summary

4.7 The measure is intended to improve the employment outcomes for adults with learning disabilities reducing the risk of social exclusion. There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing and financial benefits.

4.8 Performance in Tameside in 2015/2016 was 2% compared to 4.1% regionally and 5.8% nationally. 6 Greater Manchester authorities have less than 3% of People with Learning Disabilities in Employment, with only Trafford, Stockport and Rochdale achieving above 4%.

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

4.10 Tameside performance at Quarter 3 2016/2017 is showing 1.89%, although the number of people in employment has actually remained the same, the number of people known to social care has increased which has affected the performance out turn.

4.11 If Tameside were to be at the National average of 6%, this would mean an additional 20 People with Learning Difficulties into Employment.

4.12 If Tameside were to be at the same level as Trafford 14%, this would mean an additional 58 People with Learning Difficulties into Employment. Performance in this area has been a concern for some time and has been impacted upon the reduction of the Learning Difficulties Employment Support Team due to financial restraints.

4.13 **Actions**

- Make Contact with Trafford to share best Practice.
- We have moved the remaining Employment staff into the Employment and Skills corporate team to ensure a more focused approach to employment and access to wider resource and knowledge base.
- The development of a new scheme focused on supporting people with pre-employment training and supporting people into paid employment including expansion of the Supported Internship Programme for 16-24 year olds.

Considerations of the Quality and Performance Assurance Group

4.15 The Quality and Performance group recommended a systematic review of quality & performance reporting. This is essential to clarify reporting requirements and expectations across the Single Commissioning Board, Clinical Commissioning Group Governing Body and Council Board governance, with a view to minimising duplication and providing assurance at the most appropriate system level.

5. RECOMMENDATIONS

5.1 As set out on the front of the report.

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Key Messages

Positive trends

18 Weeks RTT Incomplete Pathways: Performance continues to be above the national standard of 92%, currently achieving 93.0% during January.
18 Weeks RTT 52+ Week Waits: There were no patients waiting longer than 52 weeks during January.
Cancer: All of the cancer indicators achieved standard during January except 62 day Cancer upgrades.
IAPT Access Rate: Performance continues to be above the Quarterly standard (3.75%) achieving 3.92% during Quarter 2.
IAPT Waiting Times: Quarter 2 performance is above standard for 18 week waiting times and 18 week waits is reported as 98.6% (Standard 95%)
Healthcare Associated Infections Clostridium Difficile: The number of reported cases during January (5) was below plan.
Dementia: Estimated diagnosis rate for people aged 65+ for January was 74.8% against the 66.7% standard.
Referrals: GP referrals have increased this month compared to last month however they have continued to decrease overall and have decreased compared to the same period last year. Other referrals have increased compared to last month and have increased compared to the same period last year.

Challenges

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

A&E Waits Total Time Within 4 Hours At T&G ICFT: January performance at Tameside And Glossop Integrated Care NHS FT (T&GICFT) is below the 95% target, at 76.7%. A total of 7,037 patients attended A&E in the month, of which 1638 did not leave the department within 4 hours.
Diagnostics 6+ Week Waiters: Performance was higher (worse than) the national standard of 1.00%, currently achieving 1.88% during January.
Cancer: Performance was below the threshold (85%) for 62 day cancer upgrades for January.
Ambulance Response Times Across NWAS Area: Performance against all three response times across the North West Ambulance Service (NWAS) area are worse than the national standards in January. Responses to Red1 and Red2 calls within 8 minutes were below the 75% standard, at 61.8% and 58.8%, respectively. Responses to all Red calls within 19 minutes were also below the 95% standard, at 85.7%.
Healthcare Associated Infections MRSA: There have been 8 reported cases of MRSA during the year. 2 further cases reported in the month of January.
111: The North West NHS 111 service is performance managed against a range of KPIs reported as follows for Jan:- Calls Answered (95% in 60 seconds) = 77.52%- Calls abandoned (<5%) = 7.08%- Warm transfer (75%) = 32.89%Call back in 10 minutes (75%) = 38.4%
IAPT Recovery Rate: Quarter 2 performance was below the standard (50%) achieving 46.00%.
IAPT Waiting Times: Quarter 2 performance is below the standard for 6 week waiting times. IAPT 6 week waits is reported as 73.4% (standard 75%).

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

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

Better Health

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Exceptions	GM	England	Trend
	Utilisation of the NHS e-referral service to enable choice at first routine elective referral	M	T&G CCG	H							11.8%	11.6%	11.2%	11.1%	11.6%	10.4%	10.7%	10.0%	10.1%				51.1% (Sept)	
	Number of women Smoking at Delivery.	Q	T&G CCG	L	England	14.4%		16.1%		15.8%		13.6%			16.9%			15.3%				11.9% (Q1)	10.40%	
	Personal health budgets	Q	T&G CCG	H				4.0				4.0			4.1							11 (Q1)	18.7 (Q2)	
	Percentage of deaths which take place in hospital	Q	T&G CCG	<>				50.7%				47.6%			49.0%							50% (Q4 15/16)	47.1% (Q1 16/17)	
	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q	T&G CCG	L				1475															929	
	Inequality in emergency admissions for urgent care sensitive conditions	Q	T&G CCG	L				3269															2168	
	Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Q	T&G CCG	<>										1.1									1.1	
	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	Q	T&G CCG	<>											7.8%								9.10%	
	Injuries from falls in people aged 65 and over	A	T&G CCG	L					2116				2159										1985	

Description	Indicator		Level	Better is...	Threshold	09/10	10/11	11/12	12/13	13/14	14/15	15/16			Exceptions	GM	England	Trend
	Percentage of children aged 10-11 classified as overweight or obese	A	T&G CCG	L						33.3%	34.1%					34.6% FY 14/15	33.2% FY 14/15	
	Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	A	T&G CCG	H							46.8%					41.8% FY 14/15	39.8% FY 14/15	
	People with diabetes diagnosed less than a year who attend a structured education course	A	T&G CCG	H							0.0%					1.9% FY 14/15	5.7% FY 14/15	
	People with a long-term condition feeling supported to manage their condition(s)	A	T&G CCG	H				66.6%	63.9%	62.9%	62.4%	61.4%					64.30%	
	Quality of life of carers	A	T&G CCG	H				80.4%	80.7%	77.70%	80.00%	77.5%				90.5% (2015)	80.0% (2016)	

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

Better Care

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Exceptions	GM	England	Trend
Cancer 2 Week Wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	M	T&G CCG	H	93%	97.5%	97.4%	97.7%	96.3%	96.4%	95.8%	97.1%	96.1%	94.3%	94.6%	95.4%	96.5%	97.5%	98.1%	94.4%		96.90%	94.00%	
	Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	M	T&G CCG	H	93%	98.4%	96.1%	98.2%	98.9%	93.0%	93.9%	98.0%	95.8%	94.0%	96.7%	97.3%	100.0%	100.0%	98.8%	100.0%		96.30%	93.80%	
Cancer 31 Day Wait	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	M	T&G CCG	H	96%	100.0%	100.0%	100.0%	100%	99.1%	100.0%	98.9%	100.0%	100.0%	98.8%	98.9%	98.0%	98.2%	100.0%	98.9%		97.80%	96.50%	
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	M	T&G CCG	H	94%	100.0%	100.0%	100.0%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%	100.0%		96.60%	94.20%	
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	M	T&G CCG	H	98%	100.0%	96.2%	100.0%	100%	99.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Breach due to deferred treatment in Jan-16.	99.60%	98.90%	
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	M	T&G CCG	H	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	100.0%		100%	96.00%	
Cancer 62 Day Wait	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	M	T&G CCG	H	85%	88.2%	96.1%	93.3%	93.8%	89.9%	89.7%	88.6%	91.5%	89.6%	91.3%	74.4%	91.1%	90.4%	88.0%	89.1%	There were 10 breaches out of a total of 39 seen in Sept 16.	88.30%	79.50%	
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	M	T&G CCG	H	90%	100.0%	100.0%	100.0%	100.0%	95.3%	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%		90.00%	90.60%	
	Maximum 62 day wait for first treatment following a consultants decision to upgrade the priority of the patients (all cancer)	M	T&G CCG	H	85%	85.7%	100.0%	92.3%	88.2%	88.9%	83.3%	86.7%	94.4%	82.4%	100.0%	53.8%	78.3%	94.4%	78.6%	75.0%	For Jan 17 20 patients treated with 4 being treated over the target. For Dec 16 14 patients treated with 3 being treated over the target. For Sept 16 there were 13 patients treated with 6 being treated over the target	86.50%	87.00%	
18 Weeks RTT	Patients on incomplete non emergency pathways (yet to start treatment)	M	T&G CCG	H	92%	91.8%	91.8%	92.1%	91.9%	91.6%	92.4%	92.5%	92.4%	92.4%	92.1%	92.1%	92.1%	92.7%	92.6%	93.0%	CCG target (92%) achieved. Failing specialties are Urology (90.11%), Trauma & Orthopaedics (89.16%), Ear, Plastic Surgery (71.81%), Neurology (90.00%).	92.30%	89.90%	
	Patients waiting 52+ weeks on an incomplete pathway	M	T&G CCG	L	Zero Tolerance	1	0	2	0	12	1	0	1	1	1	0	1	0	0	0	In Oct-16 there was 1 patient waiting over 52 weeks for treatment on an incomplete pathway. This patients is waiting under the speciality plastic surgery and has now been seen.			
Diagnostics < 6 Weeks	Patients waiting for diagnostic tests should have been waiting less that 6 weeks from referral	M	T&G CCG	L	1%	2.5%	2.68%	1.83%	2.88%	2.17%	2.55%	1.55%	2.36%	1.70%	1.20%	1.24%	1.34%	1.29%	1.85%	1.88%	CCG target not achieved, 86 breaches. Failing for CCG are Central Manchester with 37 breaches for Cardiology - echocardiography, Colonoscopy, Computed Tomography, Flexi sigmoidoscopy, Gastroscopy, Magnetic Resonance Imaging. PAHT with 3 breaches for Cystoscopy, Gastroscopy, Neurophysiology - peripheral neurophysiology. Salford with 2 breaches for Magnetic Resonance Imaging, Non-obstetric ultrasound. THFT with 33 breaches,for Audiology Assessments, Cardiology - echocardiography, Colonoscopy, Computed Tomography, Gastroscopy, Non-obstetric ultrasound. Care Uk with 9 breaches for Computed Tomography, Magnetic Resonance Imaging, Non-obstetric ultrasound. South Manc with 1 breach for Respiratory physiology.	1.50%	1.70%	
Dementia	Estimated diagnosis rate for people aged 65+	M	CCG	H	66.70%	68.90%	70.30%	71.60%	71.10%		69.60%	69.80%	70.50%	70.3%	71.3%	72.8%	75.3%	74.4%	74.9%	74.8%		77.50%	68.00%	
A&E < 4 Hours	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department - THFT	M	THFT	H	95%	73.0%	73.4%	76.0%	93.1%	84.9%	92.5%	92.2%	86.5%	85.0%	90.5%	82.7%	84.1%	86.6%	76.2%	76.7%	2015-16 performance shows that 12,737 patients waited more than 4 hours (denominator 84,303). Breached by 8,522 patients. June 2016 performance is 86.54% breached by 967 patients. July 2016 performance is 84.98% breached by 1143 patients. August 2016 performance is 90.5% breached by 646 patients. September performance is 82.7% breached by 1224 patients. October performance is 84.1% breached by 1,176 patients. November performance is 86.6% breached by 943 patients. December performance is 76.2% breached by 1703 patients. January performance is 76.7% breached by 1638 patients.	86.00%	77.60%	
	Delayed transfers of care per 100,000 population	M	T&G CCG	L											21.2			24				16.3	15	

	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	M		H			0.0%	11.1%	33.3% 45.5%	62.1% 65.4%						78.0%	77.20%	
	Achievement of milestones in the delivery of an integrated urgent care service	M		H							4							
IAPT-Improving Access to psychological services	Access	Q	T&G CCG	H	3.75%	4.30%	4.41%	4.3%	3.95%		3.92%						4.00%	
IAPT-Improving Access to psychological services	Recovery	Q	T&G CCG	H	50%	44.00%	40.14%	40.0%	45.75%		46.00%					47.50%	48.40%	
IAPT-Improving Access to psychological services	Waiting times less than 6 weeks	Q	T&G CCG	H	75%	52.60%	60.14%	56.3%	62.75%		73.40%					79.30%	84.82%	
IAPT-Improving Access to psychological services	Waiting times less than 18 weeks	Q	T&G CCG	H	95%	89.61%	90.54%	90.4%	91.50%		98.60%					95.40%	97.47%	
	Reliance on specialist inpatient care for people with a learning disability and/or autism	Q		L			65		62							62 (Q1)	58 (Q1)	
	Emergency admissions for urgent care sensitive conditions	Q		L			3269										2359	
	Population use of hospital beds following emergency admission	Q		L			1.3		1.2								1.0	
	Management of long term conditions	Q		L			1276										795 Q4 15/16	
	People eligible for standard NHS Continuing Healthcare	Q		H					63.9		62.7					53.5	46.2	

Description	Indicator		Level	Better is...	Threshold	2009	2010	2011	2012	2013	2014	2015			Exceptions	GM	England	Trend
	Cancers diagnosed at early stage	A	T&G CCG	H					44.1	43.7	44.2					48.90%	50.70%	
	One-year survival from all cancers	A	T&G CCG	H		64.9	65.7	66.6	67.6	67.6						69.50%	70.20%	
	Cancer patient experience	A	T&G CCG	H							9.1	8.7				9 (2014)	8.9 (2014)	
	Women's experience of maternity services	A	T&G CCG	H								77.6					79.7	
	Choices in maternity services	A	T&G CCG	H								61.4%						
Description	**Indicator**		**Level**	**Better is...**	**Threshold**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**			**Exceptions**	**GM**	**England**	**Trend**
	Neonatal mortality and stillbirths	A	T&G CCG	L			5.9	5.1	6.4	7.8	7.8					8.0 fy 14/15	7.1 FY 14/15	
	Dementia Care Planning and Post-Diagnostic Support	A	T&G CCG	H							79.4%					79.6% FY 14/15	77.0% FY 14/15	
	Patient experience of GP services	A	T&G CCG	H				85.6%	85.7%	83.4%	81.2%	83.2%				85.40%	83.20%	
	Proportion of people with a learning disability on the GP register receiving an annual health check	A	T&G CCG	H						44.6%	34.0%					47.5% FY 13/14	37.1% FY 15/16	
Description	**Indicator**		**Level**	**Better is...**	**Threshold**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**			**Exceptions**	**GM**	**England**	**Trend**
	Primary care workforce	A	T&G CCG	H							0.9	1.0					1.0	

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

Better Care - Adult Social Care

Description	Indicator	F	Level	Better is...	Threshold	3rd Quarter 2015-16	4th Quarter 2015-16 Out-turn	1st Quarter 2016-17	2nd Quarter 2016-17	3rd Quarter 2016-17	Exceptions	GM	England *	Trend
						Nov-15 Dec-15	Jan-16 Feb-16 Mar-16	Apr-16 May-16 Jun-16	Jul-16 Aug-16 Sep-16	Oct-16 Nov-16 Dec-16		GM	England *	Trend
ASCOF 1C - Proportion of people using social care who receive self-directed support, and those receiving direct payments.	**Part 1a - % of service users who receive self directed support**	Q	LA	H	86.9	97.80%	97.77%	97.59%	97.51%	96.63%	Cumulative year to date performance reported	-	86.9	
	Part 1b - % of carers who receive self directed support	Q	LA	H	77.7	92.89%	91.10%	99.57%	99.79%	100.00%	Cumulative year to date performance reported	-	77.7	
	Part 2a - % of service users who are in receipt of direct payments	Q	LA	H	28.1	16.38%	15.43%	14.91%	14.74%	13.62%	Cumulative year to date performance reported	-	28.1	
	Part 2b - % of carers who are in receipt of direct payments	Q	LA	H	67.4	91.38%	74.63%	77.87%	73.43%	75.93%	Cumulative year to date performance reported	-	67.4	
ASCOF 1E - Proportion of adults with learning disabilities in paid employment.	**Total number of Learning Disability service users in paid employment**	Q	LA	H	5.8	2.20%	2.00%	1.99%	1.92%	1.89%	Cumulative year to date performance reported	-	5.8	
ASCOF 1G - Proportion of adults with learning disabilities who live in their own home or with their family.	**Total number of Learning Disability service users in settled accomodation.**	Q	LA	H	75.4	94.29%	93.79%	94.69%	93.80%	93.90%	Cumulative year to date performance reported	-	75.4	
ASCOF 2A - Permanent admissions to residential and nursing care homes, per 100,000 population.	**Total number of permanent admissions to residential and nursing care homes per 100,000 aged 18-64**	Q	LA	L	13.3	9.69 (13 Admissions)	11.92 (16 Admissions)	1.49 (2 Admissions)	2.98 (4 Admissions)	7.44 (10 Admissions)	Cumulative year to date performance reported	-	13.3	
	Total number of permanent admissions to residential and nursing care homes per 100,000 aged 65+	Q	LA	L	628.2	481.61 (182 Admissions)	643.03 (243 Admissions)	153.87 (59 Admissions)	307.75 (118 Admissions)	453.8 (174 Admissions)	Cumulative year to date performance reported	-	628.2	
	Total number of permanent admissions to residential and nursing care homes aged 18+	Q	LA	H	-	195	259	61	122	184	Cumulative year to date performance reported	-	-	
ASCOF 2B - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/ rehabilitation services.	**Proportion of older people (65 and over) who were still at home 91 days after discharge from Hospital**	Q	LA	H	82.7	-	86.44	-	-	-	Based on a sample period of discharges from hospital between October - December each year.	-	82.7	
	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital compared against the HES data (hospital episode stats)	Q	LA	H	2.9	-	4.02	-	-	-	Based on a sample period of discharges from hospital between October - December each year.	-	2.9	
Early Help	**Number of people supported outside the Social Care System with prevention based services.**	Q	LA	H	-	8609	8503	8406	8308	8180	Cumulative year to date performance reported	-	-	
Helped To Live At Home	**Number of people helped to live at home and remain independent with support from Adult Services in community based services**	Q	LA	H	-	2945	2971	3027	3000	3008	Cumulative year to date performance reported	-	-	
Early Help - Re-ablement Services	**% of people completing re-ablement who leave with either no package or a reduced package of care.**	Q	LA	H	-	90.29%	90.40%	85.98%	87.76%	87.94%	Cumulative year to date performance reported	-	-	
REVIEWS D40 - Proportion of service users with a completed review in the financial year	**Service users needs change and frequent reviews ensure that they receive services which are suitable for their needs, and that LA's can utilise resources in the most efficient and appropriate way.**	Q	LA	H	-	60.07%	72.78%	22.39%	41.09%	62.78%	Cumulative year to date performance reported	-	-	

* Rag ratings are based on thresholds where appropriate otherwise based quarter on quarter and year on year comparisons. England data is 15/16.

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

Sustainability

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Exceptions	GM	England	Trend
Referrals	GP Referrals-Total	M	T&G CCG	L		5116	5180	5723	5636	67180	6018	5494	5724	5359	5142	5310	5086	5192	4421	5132	Variance from Monthly plan			
	Other referrals- Total	M	T&G CCG	L		2694	2670	2871	2837	34656	2904	2748	2730	2751	2853	2786	3060	3085	2434	2822	Variance from Monthly plan			
	GP referrals- T&G ICFT	M	T&G CCG	L		3804	3817	4242	4129	48782	4088	3971	4053	3766	3452	3611	3566	3673	3142	3615	Variance from previous year			
	Other referrals - T&G ICFT	M	T&G CCG	L		1418	1419	1639	1540	19274	1640	1428	1521	1637	1670	1612	1836	1854	1431	1626	Variance from previous year			
Activity	Outpatient Fist Attend	M	T&G CCG	L	Plan	6561	6591	6698	6554	80783	6852	7137	7441	6755	6903	7205	7265	7606	6394	6620	Variance from Monthly plan			
	Elective Inpatients	M	T&G CCG	L	Plan	2642	2799	2898	2717	34015	2799	2890	3022	2871	2876	2915	2956	3201	2624	2278	Variance from Monthly Plan			
	Non-Elective Admissions	M	T&G CCG	L	Plan	2562	2407	2372	2636	28906	2361	2409	2314	2267	2336	2244	2337	2431	2444	2470	Variance from Monthly Plan			
	In-year financial performance	Q		H																				
	Outcomes in areas with identified scope for improvement	Q		H																			58.30%	
	Digital interactions between primary and secondary care	Q		H											52.6									
	Local strategic estates plan (SEP) in place	A		H							Yes													
	Financial plan	A		H							AMBER													

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

Well Led

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Exceptions	GM	England	Trend
	Quality of CCG leadership	Q		H																				

Description	Indicator	F	Level	Better is...	Threshold	2009	2010	2011	2012	2013	2014	2015			Exceptions	GM	England	Trend
	Staff engagement index	A		H								3.9					3.8	
	Progress against workforce race equality standard	A		L								0.3					0.2	

Description	Indicator	F	Level	Better is...	Threshold	09/10	10/11	11/12	12/13	13/14	14/15	15/16			Exceptions	GM	England	Trend
	Effectiveness of working relationships in the local system	A		H								66.9						

Indicates the lowest performance quartile nationally.

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

Other Indicators

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Exceptions	GM	England	Trend
Mixed Sex Accommodation	MSA Breach Rate	M	T&G CCG	L	0	0	0	0	0	0	0	0	0.1	0.2	0	0	0	0.1	0	0.3	Total of 1 breach in June 16, 2 breaches in July 16, 1 breach in Nov 16 and 2 breaches in Jan17 for T&G CCG. This is an unjustified mixing in relation to sleeping accommodation. Data shows the breach rate per 1,000 finished consultant episodes.		0.65	
Cancelled Operations (Elective)	The number of last minute cancelled elective operations in the quarter for non-clinical reasons where patients have not been treated within 28 days of last minute elective cancellation	Q	THFT	L	0	4		2		12		2			0			0			Number of last minute cancellations at THFT; 15-16 Q1 = 63, Q2 = 54, Q3 = 86, Q4 = 96 16-17 Q1 = 85, Q2 = 60, Q3 = 78		1229	
Care Programme Approach (CPA)	The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	Q	T&G CCG	H	95%	96.3%		100%		96.7%		94.5%			96.7%			100.0%			16-17 Q1 52 patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care out of a total of 55 patients = 94.5%		96.70%	

Other Indicators

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Exceptions	GM	England	Trend
Other Indicators	Avoidable admissions- People		T&G CCG	L		-14.25%	14.22%	14.95%	29.21%															
	Avoidable admissions-Cost		T&G CCG	L		41.00%	12.51%	15.90%	-2.92%															
	Re admissions		T&G CCG	L																				
	Average LOS	M	T&G CCG	L								5.38	5.22	5.00	4.20									
	DTOCS (Patients)	M	LA	L		19	43	42	37		38	49	37	47	42	47	71	52	61	55				
	DTOCS (Patients)	M	Trust	L		16	43	36	25		26	38	25	32	29	38	61	45	50	42				

Other Indicators-111

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Exceptions	GM	England	Trend
111 KPIs	Calls answered (60 Seconds)	M	NW	H	95.00%	55.00%	56.00%	58.00%	49.00%		80.00%	85.00%	90.00%	83.0%	90.0%	89.0%	71.4%	67.5%	64.7%	77.5%			90.60%	
	Calls abandoned	M	NW	L	<5%	15.00%	16.00%	15.00%	23.00%		6.00%	4.00%	2.00%	4.0%	2.0%	2.0%	6.4%	6.9%	10.8%	7.1%			2.30%	
	Warm Transfer	M	NW	H	75%	38.0%	39.0%	38.0%	31.0%		35.0%	33.0%	32.0%	33.0%	35.0%	36.0%	33.2%	35.0%	31.3%	32.9%			50.10%	
	Call back in 20 mins	M	NW	H	75%	36.00%	32.00%	34.00%	32.00%		39.00%	41.00%	40.00%	38.0%	39.0%	34.0%	34.7%	36.0%	33.5%	38.4%			43.40%	

Ambulance

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Exceptions	GM	England	Trend
Ambulance	Red 1 < 8 Minutes (75% Target)	M	T&G CCG	H	75.00%	76.60%	54.50%	67.00%	73.20%		81.50%	71.10%	69.50%	75.6%	66.7%	65.9%	68.3%	60.4%	61.3%	59.4%	High levels of demand and lengthening turn around times.	63.00%	66.70%	
	Red 2 < 8 Minutes (75% Target)	M	T&G CCG	H	75%	65.30%	60.90%	55.80%	68.30%		64.90%	58.00%	63.10%	58.60%	65.80%	60.00%	60.48%	54.76%	53.50%	54.50%	High levels of demand and lengthening turn around times.	57.10%	58.50%	
	All Reds <19 Minutes (95% Target)	M	T&G CCG	H	95%	91.2%	89.1%	87.9%	92.3%		90.7%	89.9%	91.1%	89.9%	91.0%	89.1%	86.4%	83.1%	82.9%	83.3%	High levels of demand and lengthening turn around times.		87.60%	
	Red 1 < 8 Minutes (75% Target)	M	NWAS	H	75%	78.5%	69.3%	70.5%	74.8%		76.5%	74.3%	73.1%	70.5%	72.6%	69.5%	64.6%	62.8%	61.6%	61.8%	High levels of demand and lengthening turn around times.	63.00%	66.70%	
	Red 2 < 8 Minutes (75% Target)	M	NWAS	H	75%	69.5%	63.5%	61.1%	70.4%		67.5%	66.3%	66.2%	62.7%	65.3%	61.8%	63.0%	60.4%	57.3%	58.8%	High levels of demand and lengthening turn around times.	57.10%	58.50%	
	All Reds <19 Minutes (95% Target)	M	NWAS	H	95%	92.70%	89.90%	88.10%	92.60%		92.00%	91.50%	91.50%	89.8%	91.1%	89.0%	88.2%	86.8%	85.4%	85.7%	High levels of demand and lengthening turn around times.		87.60%	

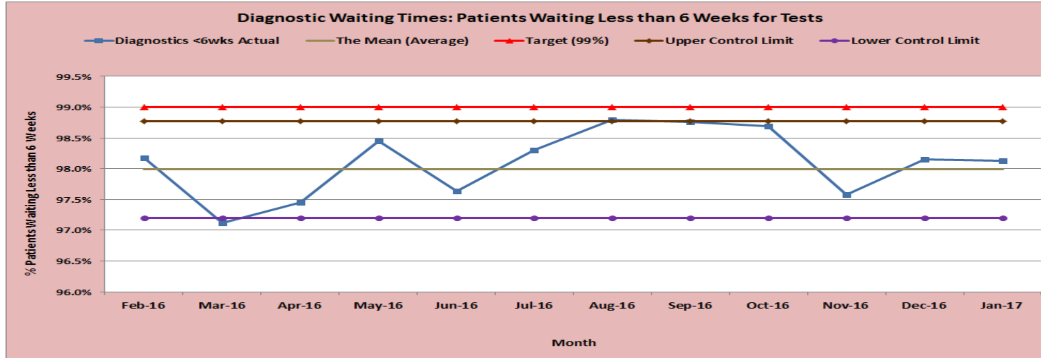
Quality

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Exceptions	GM	England	Trend
Quality	Clostridium Difficile-Whole Health Economy	M		L	Plan	1	4	5	3	71	4	7	3	9	10	5	13	6	6	5			1004	
	Clostridium Difficile-Acute	M		L	Plan	0	1	4	0	29	2	2	2	4	5	2	8	5	4	2			410	
	Clostridium Difficile-Non-Acute	M		L	Plan	1	3	1	3	42	2	5	1	5	5	3	5	1	2	3			594	
	MRSA-Whole Health Economy	M		L	0	2	0	0	1	8	0	0	2	1	3	0	0	0	0	2		4	92	
	MRSA-Acute	M		L	0	1	0	0	0	3	0	0	2	0	2	0	0	0	0	1			39	
	MRSA-Non Acute	M		L	0	1	0	0	1	5	0	0	0	1	1	0	0	0	0	1			53	

Exception Report

Tameside & Glossop CCG- April

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



Key Risks and Issues:

As a CCG

This month the CCG failed to achieve the 1% standard with a 1.88% performance.

Of the 86 breaches. 37 occurred at Central Manchester (echocardiography, colonoscopy, flexi sigmoidoscopy, gastroscopy and MRI). 33 at T&G ICFT (audiology assessments, colonoscopy, CT scans, gastroscopy and NOUS). 9 at Care UK (CT, MRI, NOUS). 3 at Pennine Acute (cystoscopy, gastroscopy and neurophysiology), 2 at Slford Trust (MRI and NOUS), 1 at Pioneer Healthcare (Neurophysiology) and 1 at Souch manchester (respirotory physiology).

Central Manchester performance is due to increased demand and issues around decontamination have impacted endoscopy performance which GM are aware of. Performance in 2017/18 is expected to be impacted when work is undertaken to ensure they achieve the JAG rating as 6 week waits may build up again.

T&G ICFT performance is primarily due to audiology struggling with capacity.

As lead Commissioner.

T&G ICFT as a provider are achieving the standard.

Actions:

CMFT reported to their Board they hope to get back on track by the end of February 2017 or by the end of March at the latest.

T&G ICFT Information Team are working with the Audiology business manager to understand what action is needed to resolve the audiology waits.

Practices are being encouraged to book NWCATS Direct Access MRI through E-referral which would reduce booking delays.

Potential monbile provider details shared with ICFT and GM HSCP

Operational and Financial implications:

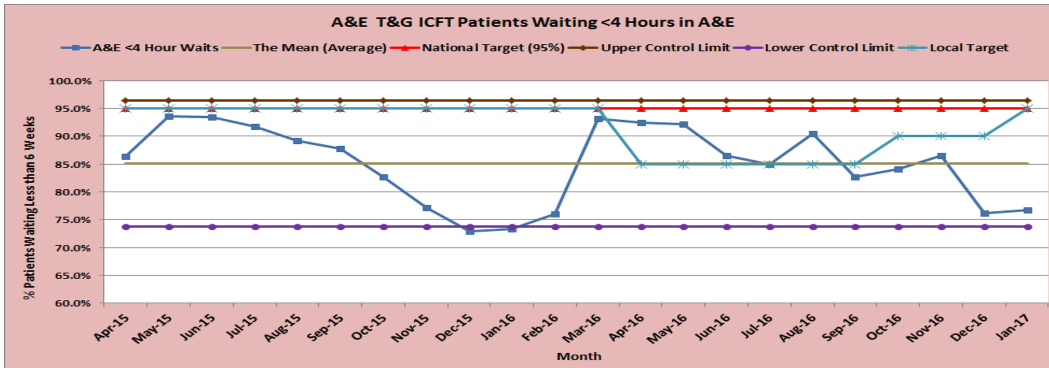
Failure of the standard will negatively impact on the CCG assurance rating. The CCG can Levey penalties through contract with those providers who fail the target.

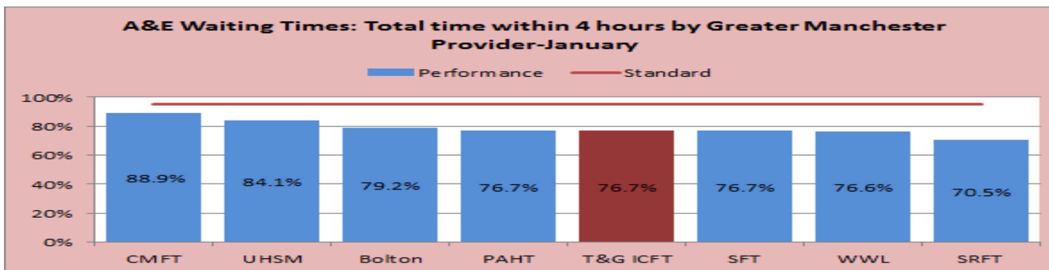
Diagnostics Waiting Times Patients Waiting > 6 Weeks by GM CCG

	Jan-17			
CCG	**Waiting > 6 Weeks**	**Total Waiting List**	**Performance**	**Standard**
NHS Central Manchester CCG	166	2800	5.9%	1%
NHS North Manchester CCG	69	3047	2.3%	1%
NHS Tameside and Glossop CCG	86	4583	1.9%	1%
NHS Bury CCG	59	3279	1.8%	1%
NHS Oldham	58	3701	1.6%	1%
NHS South Manchester CCG	41	2677	1.5%	1%
NHS Trafford CCG	69	5055	1.4%	1%
NHS Heywood Middleton & Rochdale CCG	52	3928	1.3%	1%
NHS Bolton CCG	46	3558	1.3%	1%
NHS Salford CCG	49	4169	1.2%	1%
NHS Stockport CCG	61	5265	1.2%	1%
NHS Wigan Borough CCG	53	4938	1.1%	1%

Unvalidated -Next month FORECAST

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





January Performance: 76.22%

15/16 ytd: 84.85%

16/17 ytd: 85.31%

Key Risks and Issues:
The A&E performance for January was 76.22% which is below the target of 95%. The key issue is medical bed capacity which not only cause breaches due to waiting for beds but the congestion in A&E then delays first assessment. There are still medical cover and specialty delays when teams are in Theatres . Acuity is high which can lead to people needing more than 4 hours for a decision to be reached on their care need. IAU and AEC are used as escalation capacity at times of pressure and this then increases traffic through A&E as the capacity to accept direct admissions are reduced.

The level of acute beds occupied by people who should have been discharged is higher than it should be which reduces Medical bed capacity.

Overall the system has little resilience and so increased demand or reduced capacity in any one of the component Health and Social Care services can quickly reduce the A&E performance.

Actions:
Actions include:
- Weekly urgent Care Exec focus on the Delayed Discharges to address capacity issues and prioritising discharges. Additional staffing in IUCT will support the wider roll out of Discharge to Assess building on the excellence seen in discharging people home for assessment. Additional capacity has been funded in the Community bed base.
- T&G ICFT internal Silver Command model operational when required
- Ward Liaison Officers operational to support effective patient flow
- Escalation beds are closed as quickly as possible to release IAU and AEC capacity and the old Critical care area is being opened to deliver the Ambulatory Care service.
- Using Fracture Clinic at peak times to assist with managing the minors work stream. the trust are also working with Salford ED to identify improved model for minors
- Staffing capacity is being flexed to support times of peak activity

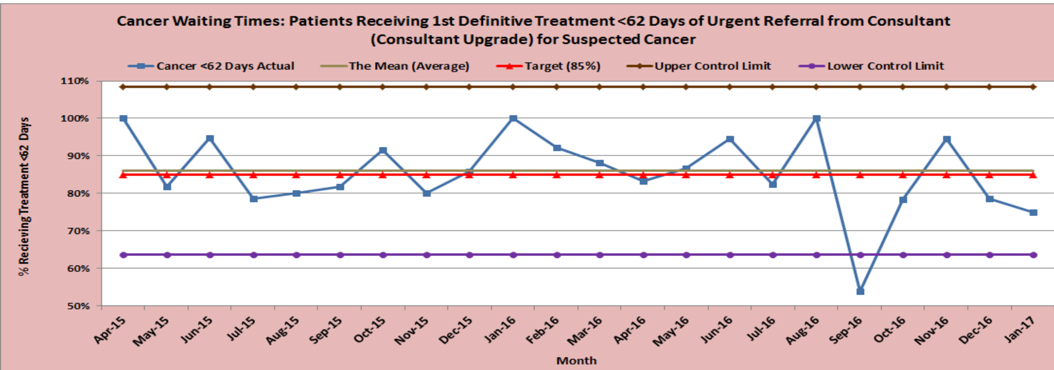
Operational and Financial implications:
Failure of the standard will negatively impact on the CCG assurance rating. However regular contact is maintained with GMHSCP and the local work being undertaken is recognised.

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

Next month FORECAST

* Please note that Tameside Trust local trajectory for 16/17 is Q1 85%, Q2 85% Q3 90% And Q4 95%.

Cancer 62 Days Upgrade- **Lead Officer: Alison Lewin** **Lead Director:** Clare Watson **Governance: Contracts meeting**



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Cancer Waiting Times: Patients Receiving 1st Definitive Treatment <62 Days of Urgent Referral from Consultant (Consultant Upgrade) for Suspected Cancer by GM CCG	Jan-17			
CCG	<62 Days	Total	Performance	Standard
NHS South Manchester CCG	15	15	100.0%	85%
NHS Central Manchester CCG	6	6	100.0%	85%
NHS Trafford CCG	13	14	92.9%	85%
NHS Wigan Borough CCG	50	56	89.3%	85%
England	1733	1993	87.0%	85%
NHS Stockport CCG	12	14	85.7%	85%
NHS Bolton CCG	17	20	85.0%	85%
NHS Salford CCG	16	19	84.2%	85%
NHS Bury CCG	7	9	77.8%	85%
NHS Tameside and Glossop CCG	12	16	75.0%	85%
NHS North Manchester CCG	4	6	66.7%	85%
NHS Heywood Middleton & Rochdale CCG	8	12	66.7%	85%
NHS Oldham	5	8	62.5%	85%

Key Risks and Issues:

The 62 day upgrade standard was not met in Jan with performance at 75.0% against the 85% threshold. 5 breaches mostly due to late referrals and patient cancellation.
Small numbers make larger impact on performance.

Actions:

Tameside & Glossop ICNHSFT have introduced an internal policy to manage the 'consultant upgrade' process. To date there have been issues with consultants upgrading patients to 2ww pathways when referring them for further diagnostics, thus putting additional pressure on the radiology and endoscopy departments. Due to the recognised challenges created by the national lack of diagnostic resources, the ICFT recognise that both the Radiology and Endoscopy departments must be able to manage the priority demand for this cohort of patients. Both departments have in place a system that identifies the patients as those with a suspected or confirmed cancer. To allow this identification to take place it is the responsibility of the clinical team referring the patient for the test to appropriately mark the request as a Suspected Cancer Patient (SCP) or Cancer Patient (CP). This allows for the patient identified to be prioritised effectively. The revised Standard Operating Procedure was approved at the Cancer Board meeting on 30th Nov
ember 2016.

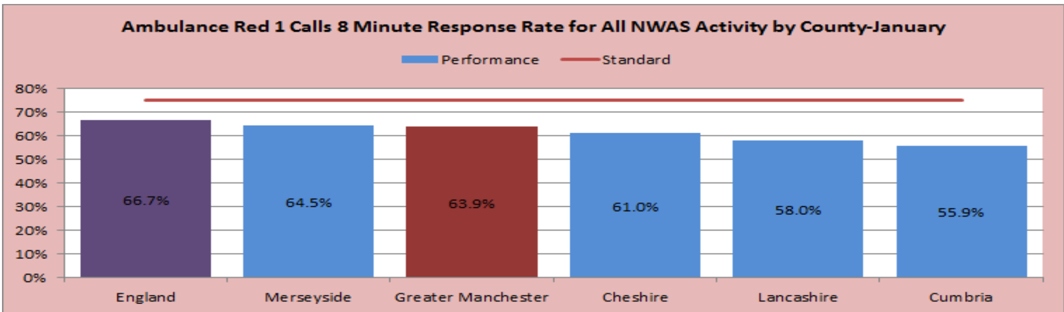
A deep dive will be conducted into all cancer performance targets for the next board meeting.

Operational and Financial implications:

Failure of this standard could negatively impact on the patients experience. Patients having to wait longer than the standard for first definitive treatment.

FORECAST

Ambulance performance- **Lead Officer: Elaine Richardson** **Lead Director:** Clare Watson **Governance: A&E Delivery Board**



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

CCG	Jan-17 <8 Mins	Total	Performance	Standard
NHS Central Manchester CCG	53	69	76.5%	75%
NHS South Manchester CCG	46	62	74.2%	75%
NHS North Manchester CCG	79	110	71.8%	75%
NHS Heywood Middleton & Rochdale CCG	67	94	71.3%	75%
NHS Salford CCG	75	112	67.0%	75%
NHS Wigan Borough CCG	88	139	63.2%	75%
NHS Oldham	56	91	61.8%	75%
NHS Stockport CCG	61	99	61.2%	75%
NHS Tameside and Glossop CCG	61	102	59.4%	75%
NHS Bolton CCG	70	119	58.8%	75%
NHS Bury CCG	37	72	50.7%	75%
NHS Trafford CCG	30	61	49.2%	75%

January Performance: 61.79%

15/16 ytd: 76.10%

16/17 ytd: 68.29%

Key Risks and Issues:

In January the north west position (which we are measured against) was 61.79% however locally we only achieved 59.41% Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

Actions:

Blackpool CCG have agreed to support NWAS in implementation of its remedial action plan.

NWAS have agreed the following actions including :

Working with Health Care Professionals to ensure ambulances are dispatched appropriate to priority of need e.g. non urgent used when suitable.
Working with identified care homes that are high users of 999.
Working with acute trusts with handover delays to identify opportunities to reduce them.
An additional 700 hours added to the Urgent Care Desk to support decision making process and reduce activity to ED.
Additional areas of support are also being identified including working more closely with 111.

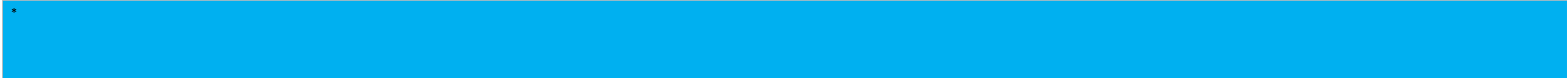
The Contracting and Strategic Partnership Board will maintain scrutiny on NWAS to ensure agreed actions are implemented.

Locally a hospital ambulance liaison officer and a community specialist paramedic are in place to support effective use and turnaround of ambulances.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating.
The failure of this target will impact on the CCGs ability to obtain the money attached to this target for the Quality Premium Payment (QPP).

Unvalidated next month FORECAST



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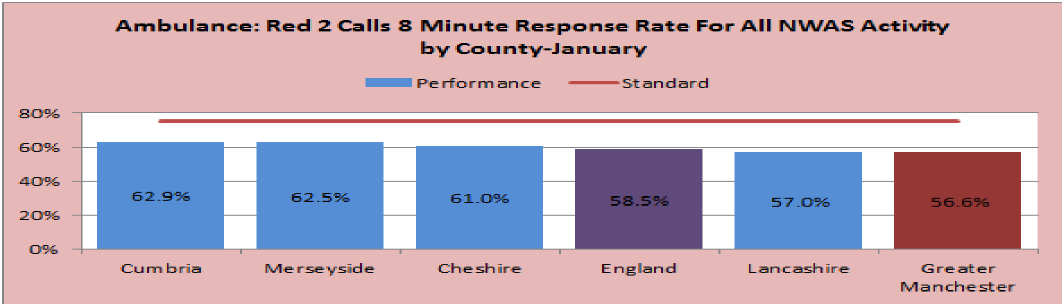
Ambulance performance- **Lead Officer: Elaine Richardson** **Lead Director:** Clare Watson **Governance: A&E Delivery Board**



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

CCG	Jan-17 <8 Mins	Total	Performance	Standard
NHS South Manchester CCG	845	1213	69.6%	75%
NHS North Manchester CCG	938	1506	62.3%	75%
NHS Central Manchester CCG	635	1032	61.5%	75%
NHS Heywood Middleton & Rochdale CCG	829	1470	56.4%	75%
NHS Wigan Borough CCG	1036	1872	55.3%	75%
NHS Bury CCG	666	1217	54.8%	75%
NHS Tameside and Glossop CCG	957	1757	54.5%	75%
NHS Salford CCG	867	1595	54.4%	75%
NHS Stockport CCG	924	1709	54.1%	75%
NHS Oldham	792	1468	53.9%	75%
NHS Bolton CCG	901	1681	53.6%	75%
NHS Trafford CCG	606	1133	53.5%	75%

January Performance: 58.78%

15/16 ytd: 72.70%

16/17 ytd: 62.76%

Key Risks and Issues:

In Januarythe north west position (which we are measured against) was 58.78% however locally we only achieved 54.48% Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

Actions:

Blackpool CCG have agreed to support NWAS in implementation of its remedial action plan.

NWAS have agreed the following actions including :

Working with Health Care Professionals to ensure ambulances are dispatched appropriate to priority of need e.g. non urgent used when suitable.
Working with identified care homes that are high users of 999.
Working with acute trusts with handover delays to identify opportunities to reduce them.
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Additional areas of support are also being identified including working more closely with 111.

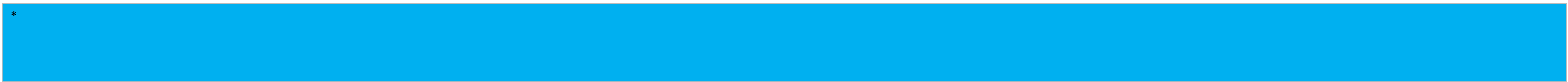
The Contracting and Strategic Partnership Board will maintain scrutiny on NWAS to ensure agreed actions are implemented.

Locally a hospital ambulance liaison officer and a community specialist paramedic are in place to support effective use and turnaround of ambulances.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating. Contract penalties applied by lead commissioner (Blackpool CCG).

Unvalidated next month FORECAST



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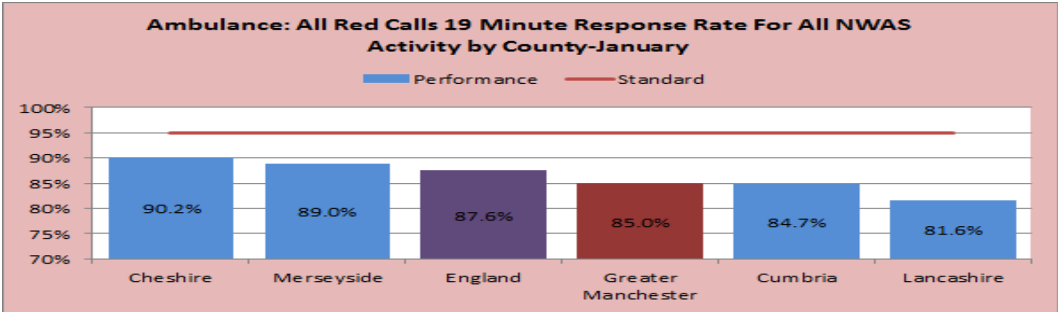
Ambulance performance- **Lead Officer: Elaine Richardson** **Lead Director:** Clare Watson **Governance: A&E Delivery Board**



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

	Jan-17			
CCG	**<19 Mins**	**Total**	**Performance**	**Standard**
NHS South Manchester CCG	1149	1275	90.1%	95%
NHS Central Manchester CCG	968	1101	87.9%	95%
NHS Stockport CCG	1584	1808	87.6%	95%
NHS North Manchester CCG	1407	1616	87.1%	95%
NHS Salford CCG	1460	1707	85.5%	95%
NHS Trafford CCG	1010	1194	84.6%	95%
NHS Oldham	1317	1559	84.5%	95%
NHS Wigan Borough CCG	1681	2011	83.6%	95%
NHS Tameside and Glossop CCG	1549	1859	83.3%	95%
NHS Bolton CCG	1496	1800	83.1%	95%
NHS Heywood Middleton & Rochdale CCG	1298	1564	83.0%	95%
NHS Bury CCG	1039	1289	80.6%	95%

January Performance: 85.74%

15/16 ytd: 93.70%

16/17 ytd: 88.99%

Key Risks and Issues:

In January the north west position (which we are measured against) was 85.74% however locally we only achieved 83.32% Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

Actions:

Blackpool CCG have agreed to support NWAS in implementation of its remedial action plan.

NWAS have agreed the following actions including :

Working with Health Care Professionals to ensure ambulances are dispatched appropriate to priority of need e.g. non urgent used when suitable.
Working with identified care homes that are high users of 999.
Working with acute trusts with handover delays to identify opportunities to reduce them.
An additional 700 hours added to the Urgent Care Desk to support decision making process and reduce activity to ED.
Additional areas of support are also being identified including working more closely with 111.

The Contracting and Strategic Partnership Board will maintain scrutiny on NWAS to ensure agreed actions are implemented.

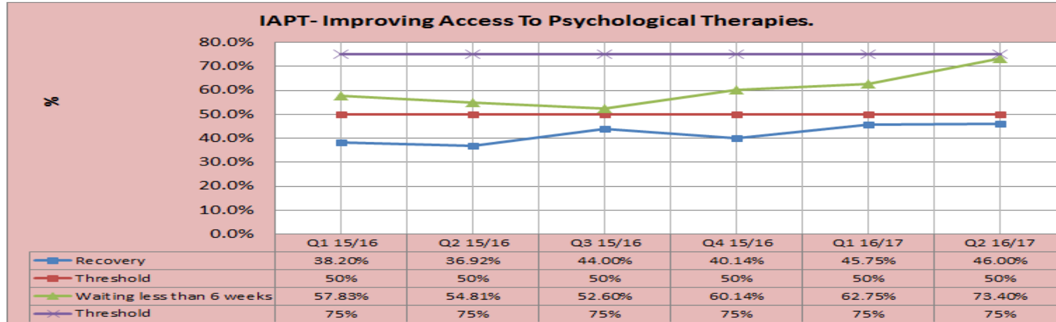
Locally a hospital ambulance liaison officer and a community specialist paramedic are in place to support effective use and turnaround of ambulances.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating.
Contract penalties applied by lead commissioner (Blackpool CCG).

Unvalidated next month FORECAST

Improving Access To Psychological Therapies (IAPT)- **Lead Officer: Pat McKelvey** **Lead Director:** Clare Watson **Governance: Contracts**



Key Risks and Issues:
Recovery.
Higher than expected waiting times compounded by high complexity levels.
Poor outcomes relating to depression and Post Traumatic Stress Disorder (PTSD).

Access.
Ongoing clearance of backlog from high referral rates. Currently in line with trajectory

Actions:
Recovery.
In line with action plan 1) increasing use of anxiety disorder measures to 100% of relevant cases 2) Review of PTSD pathway and clinical interventions 3) Review of interventions for depression

Access
In line with current action plan 1) Promoting accurate data reporting 2) Reduction of time taken for initial triage 3) Increased roll-out of step 3 groups

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating. The achievement of the standards may need additional investment notably to achieve the expected expansion of the service by 2020.

	IAPT Recovery Rate	
Greater Manchester CCG	Rolling Quarter Ending Sep 2016	Plan (50%)
NHS TRAFFORD CCG	55.05%	50.00%
NHS WIGAN BOROUGH CCG	51.18%	50.00%
NHS BOLTON CCG	50.98%	50.00%
NHS BURY CCG	50.90%	50.00%
NHS STOCKPORT CCG	48.65%	50.00%
NHS TAMESIDE AND GLOSSOP CCG	46.04%	50.00%
NHS SALFORD CCG	44.67%	50.00%
NHS OLDHAM CCG	44.30%	50.00%
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	41.43%	50.00%
NHS SOUTH MANCHESTER CCG	41.10%	50.00%
NHS NORTH MANCHESTER CCG	33.75%	50.00%
NHS CENTRAL MANCHESTER CCG	31.71%	50.00%

	IAPT Completing Treatment <6 Weeks	
Greater Manchester CCG	Rolling Quarter Ending Sep 2016	Plan (75%)
NHS WIGAN BOROUGH CCG	100.00%	75.00%
NHS OLDHAM CCG	89.00%	75.00%
NHS TRAFFORD CCG	83.00%	75.00%
NHS BOLTON CCG	83.00%	75.00%
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	82.00%	75.00%
NHS SALFORD CCG	81.00%	75.00%
NHS TAMESIDE AND GLOSSOP CCG	78.00%	75.00%
NHS STOCKPORT CCG	78.00%	75.00%
NHS BURY CCG	77.00%	75.00%
NHS NORTH MANCHESTER CCG	57.00%	75.00%
NHS CENTRAL MANCHESTER CCG	46.00%	75.00%
NHS SOUTH MANCHESTER CCG	44.00%	75.00%

Unvalidated next QTR FORECAST

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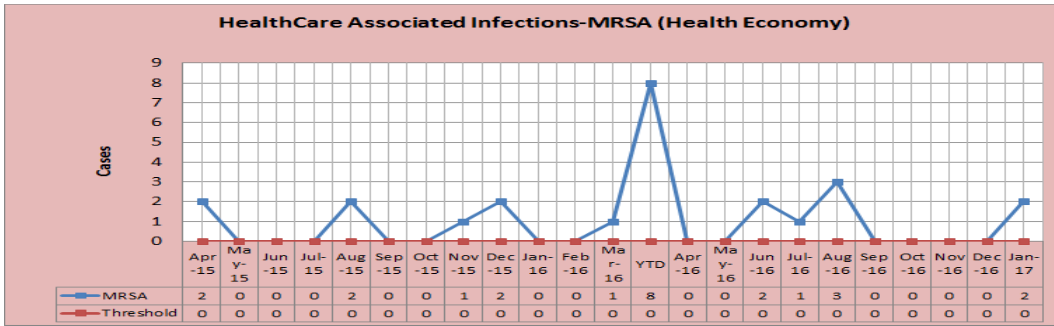
MRSA- | **Lead Officer: Lynn Jackson** | **Lead Director:** Michelle Walsh | **Governance: Contracts**



Greater Manchester CCGs MRSA

Organisation Name	Code	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Total
NHS BOLTON CCG	00T	0	1	0	2	3	1	3	1	1	3	15
NHS BURY CCG	00V	0	0	1	0	0	0	0	0	0	0	1
NHS CENTRAL MANCHESTER CCG	00W	0	0	0	0	0	0	0	1	1	1	3
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	01D	0	0	0	0	0	0	0	0	0	1	1
NHS NORTH MANCHESTER CCG	01M	1	2	0	0	0	1	0	2	0	0	6
NHS OLDHAM CCG	00Y	1	0	0	0	1	1	0	1	0	0	4
NHS SALFORD CCG	01G	1	0	0	2	0	0	1	0	0	0	4
NHS SOUTH MANCHESTER CCG	01N	1	0	0	0	0	0	0	0	1	0	2
NHS STOCKPORT CCG	01W	1	1	1	0	0	0	0	0	1	0	4
NHS TAMESIDE AND GLOSSOP CCG	01Y	0	0	2	1	3	0	0	0	0	2	8
NHS TRAFFORD CCG	02A	0	0	0	0	0	0	0	1	0	1	2
NHS WIGAN BOROUGH CCG	02H	0	0	0	0	0	0	0	1	1	1	3
Total		5	4	4	5	7	3	4	7	5	9	53

Key Risks and Issues:

There were 2 reported cases in December.
T&G CCG have reported 8 cases of MRSA; 4 acute cases (1 at T&G ICFT, 2 at Central Manchester, 1 at South Manchester FT) and 2 community cases, against a plan of zero tolerance.
The PIR (Post Incident Review) investigations, for the 3 cases that T&G CCG are responsible for, were reviewed by the HCAI WHE Quality Improvement Group and confirmed that all cases were unavoidable with no lapses in care identified.
1 x T&G IC FT - urethral trauma caused by urinary catheter
1 x Community - leg ulcer all appropriate care in place
1 x Community unavoidable - patient non-compliant with catheter care

Actions:
Investigations have been completed for the 4 cases that the CCG are responsible for; of these 3 have been reviewed by the HCAI WHE Quality Improvement Group and concluded that all cases were unavoidable with no lapses in care identified.
1 x T&G IC FT - urethral trauma caused by urinary catheter
1 x Community - leg ulcer all appropriate care in place
1 x Community unavoidable - patient non-compliant with catheter care

The MRSA case for T&G CCG was on the 25th Jan 2017. Early findings from the PIR investigation show no lapses in care identified; this will reviewed for assurance at the HCAI quality improvement group.
Learning from MRSA and CDIF investigations form the WHE HACI action plan which aims to achieve the WHE strategic objectives of 1) to improve antibiotic stewardship and 2) to improve infection prevention practice.

The CCG has also commissioned a 2 year quality initiative with T&G ICFT which aims to supporting residential and care homes with nursing to improve their infection prevention practice and reduce avoidable HCAIs.
The CCG also reviews monthly HCAI Quality Assurance Framework submitted by providers as part of the contracting process.

Operational and Financial implications:
The CCG can Levey penalties through contract with those providers who fail the target.

Next month FORECAST

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111-	Lead Officer: Elaine Richardson	Lead Director: Clare Watson	Governance: Contracts

Indicators - access & quality		NW inc. Blackpool	Scoring out of 42 Areas: NW inc. Blackpool	Highest		Lowest	
Calls per month per 1,000 people		26.1	22	Isle of Wight	46.9	East London and City	14.1
Calls per month via 111 per 1,000 people		26.1	20	Isle of Wight	46.8	East London and City	14.1
Of all calls offered, % abandoned after at least 30 seconds[1]		7%	1	NW inc. Blackpool	7%	South East Coast	0%
Of calls answered, % in 60 seconds		78%	42	East London and City	97%	NW inc. Blackpool	78%
Of calls answered, % triaged		88%	18	Luton	120%	Bedfordshire	66%
Of answered calls, % transferred to clinical advisor		22%	24	South East Coast	39%	Bedfordshire	14%
Of transferred calls, % live transferred		48%	12	Isle of Wight	95%	York & Humber	10%
Average NHS 111 live transfer time[1]		00:00:07					
Average warm transfer time		NCA					
Of calls answered, % passed for call back		11%	30	Devon	19%	Isle of Wight	1%
Of call backs, % within 10 minutes		38%	21	South East Coast	73%	North Central London	10%
Average episode length		00:14:35					
Of answered calls, % calls to a CAS clinician		22%	28	Lincolnshire	41%	Bedfordshire	14%

Dispositions as a proportion of all calls triaged	T&G CCG	NW inc. Blackpool	Scoring out of 42 Areas: NW inc. Blackpool	Highest		Lowest	
111 dispositions: % Ambulance dispatches	17%	15%	5	Cornwall	19%	York & Humber, Buckinghamshire, South East London, South Essex, North Essex	10%
111 dispositions: % Recommended to attend A&E	7%	8%	22	East London and City	13%	Leicestershire and Rutland	4%
Recommended to attend primary and community care	56%	58%	30	Berkshire	67%	North Central London	52%
Of which - % Recommended to contact primary and community care		43%	20	Banes & Wiltshire	47%	Nottinghamshire	36%
- % Recommended to speak to primary and community care		13%	16	Cambridge and Peterborough	19%	York & Humber, East London and City	9%
- % Recommended to dental / pharmacy		2%	41	York & Humber	11%	Devon	1%
111 dispositions: % Recommended to attend other service	2%	3%	25	Somerset	10%	Banes & Wiltshire	1%
111 dispositions: % Not recommended to attend other service	18%	17%	7	North Central London	20%	Oxfordshire, Mainland SHIP	8%
Of which - % Given health information		4%	1	NW inc. Blackpool	4%	Oxfordshire, Somerset, Staffordshire	0%
- % Recommended home care		3%	42	East London and City	8%	NW inc. Blackpool	3%
- % Recommended non clinical		9%	10	York & Humber	13%	Cambridge and Peterborough	2%

Key Risks and Issues:

The North West NHS 111 service is performance managed against a range of KPIs reported as follows for Jan:
- Calls Answered (95% in 60 seconds) = 77.52%
- Calls abandoned (<5%) = 7.08%
- Warm transfer (75%) = 32.89%
Call back in 10 minutes (75%) = 38.4%

In Januarythe NW NHS 111 service experienced a number of issues which lead to poor performance in the month against the four KPIs. Performance was particularly difficult to achieve over the weekend periods.

Actions:

NWAS has agreed a further remedial action plan with commissioners.
NWAS has continued to deploy all available staff, and is actively managing staff absence and attrition in order to best meet the service needs.
Recruitment and training has been carried out to deliver new staff into operations during December and January.
A range of process changes are being implemented this includes patients using telephone key pads to identify the most appropriate call handler e.g. call regarding children automatically go to a nurse and issues such as coughs and colds receive self care and advise.
Greater Manchester is working with NWAS and Out Of Hours providers to implement the clinical assessment service that will help ensure A&E and primary care dispositions are correct.

Operational and Financial implications:

Poor patient experience could impact on willingness to use the service and increase A&E and primary care presentations.
Contract penalties applied by lead commissioner (Blackpool CCG).

Unvalidated next month FORECAST

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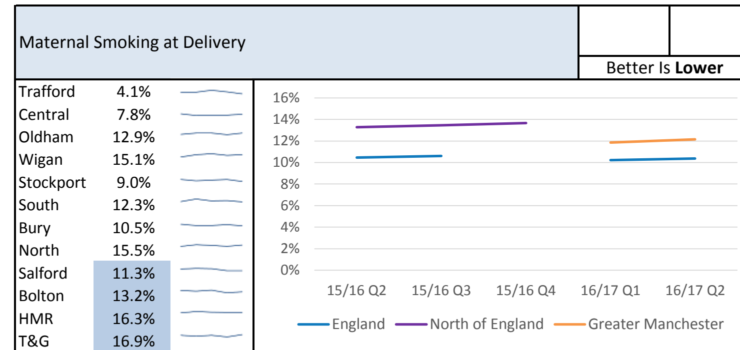
GMCA GREATER MANCHESTER COMBINED AUTHORITY
NHS Greater Manchester

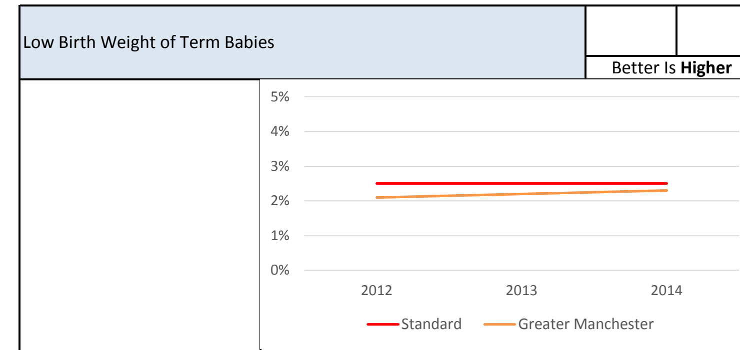
Better Health

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



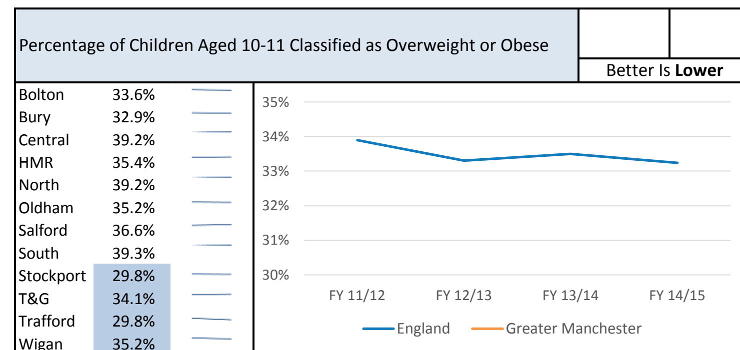
Maternal Smoking at Delivery — Better Is **Lower**

Area	Value
Trafford	4.1%
Central	7.8%
Oldham	12.9%
Wigan	15.1%
Stockport	9.0%
South	12.3%
Bury	10.5%
North	15.5%
Salford	11.3%
Bolton	13.2%
HMR	16.3%
T&G	16.9%



Low Birth Weight of Term Babies — Better Is **Higher**

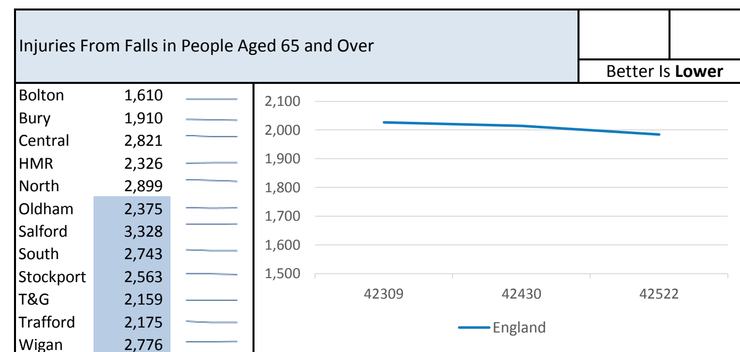
More GM Children Will Reach a Good Level of Development Cognitively, Socially & Emotionally



Percentage of Children Aged 10-11 Classified as Overweight or Obese — Better Is **Lower**

Area	Value
Bolton	33.6%
Bury	32.9%
Central	39.2%
HMR	35.4%
North	39.2%
Oldham	35.2%
Salford	36.6%
South	39.3%
Stockport	29.8%
T&G	34.1%
Trafford	29.8%
Wigan	35.2%

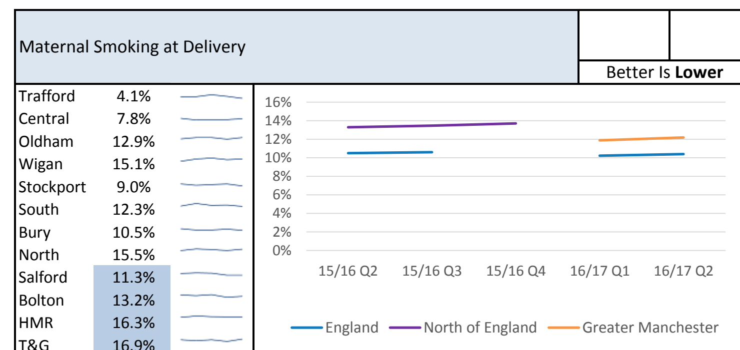
More People Will Be Supported To Stay Well and Live at Home for as Long as Possible



Injuries From Falls in People Aged 65 and Over — Better Is **Lower**

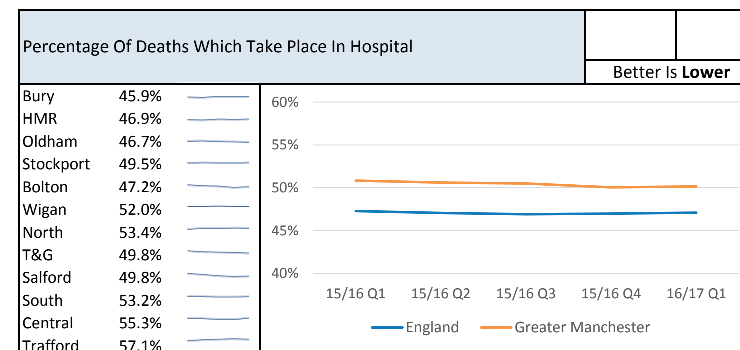
Area	Value
Bolton	1,610
Bury	1,910
Central	2,821
HMR	2,326
North	2,899
Oldham	2,375
Salford	3,328
South	2,743
Stockport	2,563
T&G	2,159
Trafford	2,175
Wigan	2,776

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



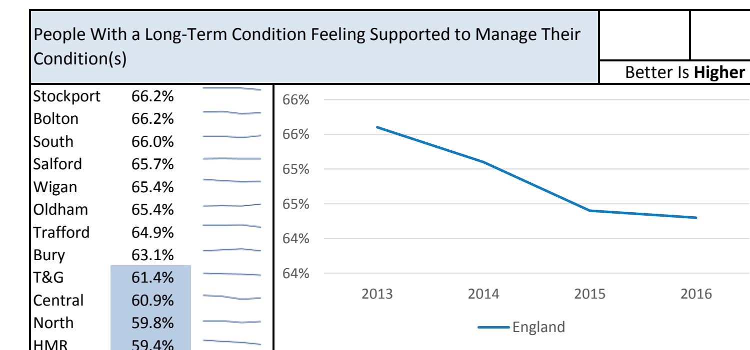
Maternal Smoking at Delivery — Better Is **Lower**

Area	Value
Trafford	4.1%
Central	7.8%
Oldham	12.9%
Wigan	15.1%
Stockport	9.0%
South	12.3%
Bury	10.5%
North	15.5%
Salford	11.3%
Bolton	13.2%
HMR	16.3%
T&G	16.9%



Percentage Of Deaths Which Take Place In Hospital — Better Is **Lower**

Area	Value
Bury	45.9%
HMR	46.9%
Oldham	46.7%
Stockport	49.5%
Bolton	47.2%
Wigan	52.0%
North	53.4%
T&G	49.8%
Salford	49.8%
South	53.2%
Central	55.3%
Trafford	57.1%



People With a Long-Term Condition Feeling Supported to Manage Their Condition(s) — Better Is **Higher**

Area	Value
Stockport	66.2%
Bolton	66.2%
South	66.0%
Salford	65.7%
Wigan	65.4%
Oldham	65.4%
Trafford	64.9%
Bury	63.1%
T&G	61.4%
Central	60.9%
North	59.8%
HMR	59.4%

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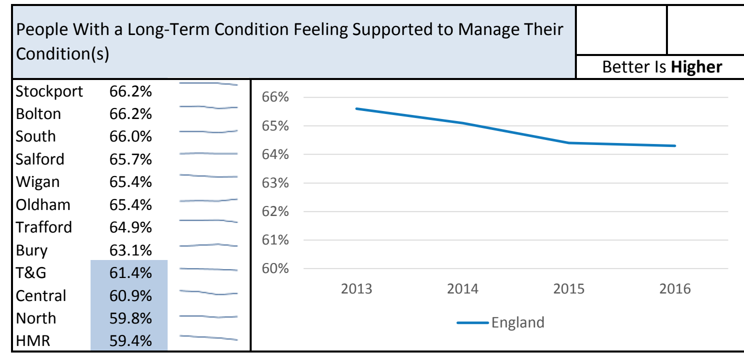
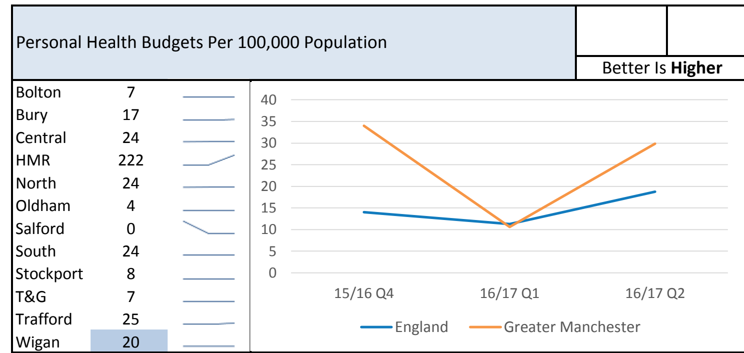
Improved Patient/Carer Experience Of Care And Increased Patient Empowerment



People With a Long-Term Condition Feeling Supported to Manage Their Condition(s) — Better Is **Higher**

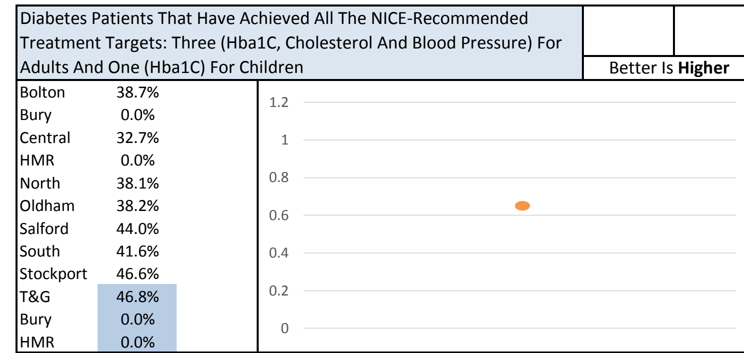
Area	Value
Stockport	66.2%
Bolton	66.2%
South	66.0%
Salford	65.7%
Wigan	65.4%
Oldham	65.4%
Trafford	64.9%
Bury	63.1%
T&G	61.4%
Central	60.9%
North	59.8%
HMR	59.4%

(Placeholder TBC)



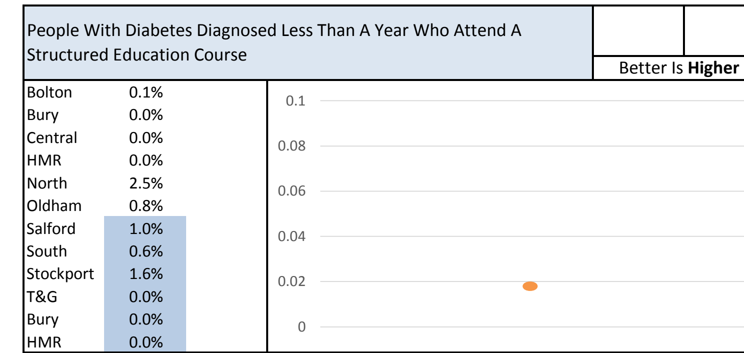
Personal Health Budgets Per 100,000 Population — Better Is **Higher**

Area	Value
Bolton	7
Bury	17
Central	24
HMR	222
North	24
Oldham	4
Salford	0
South	24
Stockport	8
T&G	7
Trafford	25
Wigan	20



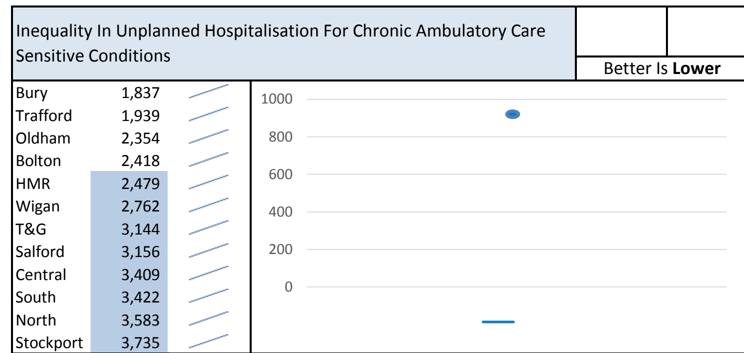
Diabetes Patients That Have Achieved All The NICE-Recommended Treatment Targets: Three (Hba1C, Cholesterol And Blood Pressure) For Adults And One (Hba1C) For Children — Better Is **Higher**

Area	Value
Bolton	38.7%
Bury	0.0%
Central	32.7%
HMR	0.0%
North	38.1%
Oldham	38.2%
Salford	44.0%
South	41.6%
Stockport	46.6%
T&G	46.8%
Bury	0.0%
HMR	0.0%



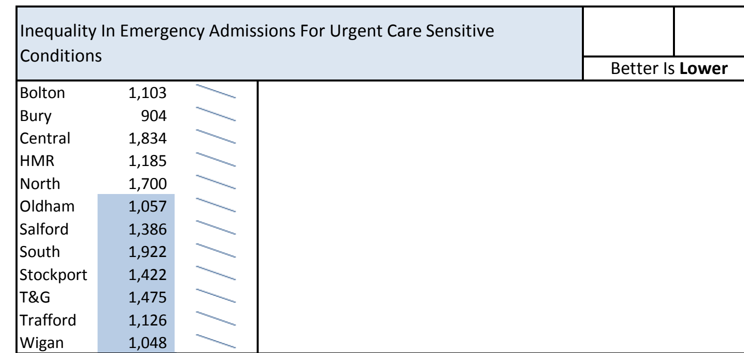
People With Diabetes Diagnosed Less Than A Year Who Attend A Structured Education Course — Better Is **Higher**

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



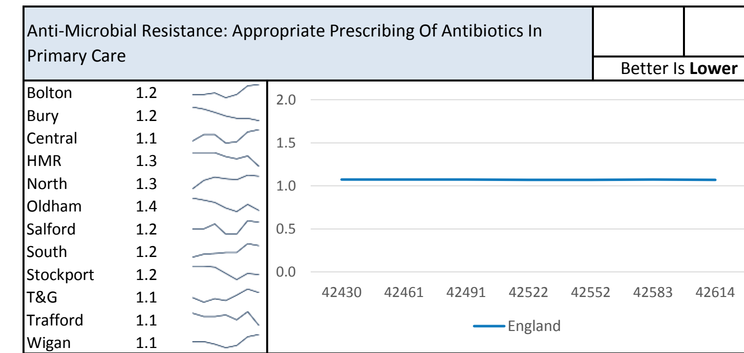
Inequality In Unplanned Hospitalisation For Chronic Ambulatory Care Sensitive Conditions — Better Is **Lower**

Area	Value
Bury	1,837
Trafford	1,939
Oldham	2,354
Bolton	2,418
HMR	2,479
Wigan	2,762
T&G	3,144
Salford	3,156
Central	3,409
South	3,422
North	3,583
Stockport	3,735



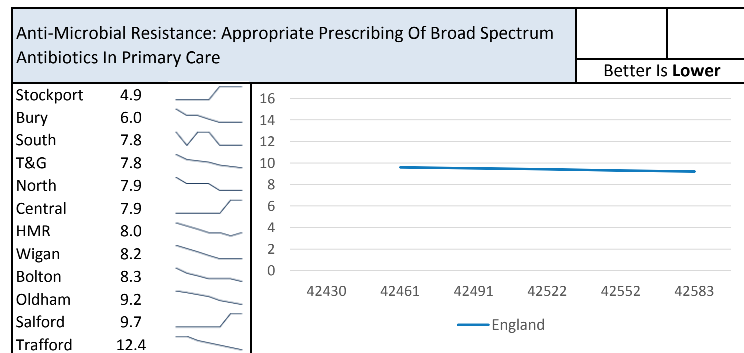
Inequality In Emergency Admissions For Urgent Care Sensitive Conditions — Better Is **Lower**

Area	Value
Bolton	1,103
Bury	904
Central	1,834
HMR	1,185
North	1,700
Oldham	1,057
Salford	1,386
South	1,922
Stockport	1,422
T&G	1,475
Trafford	1,126
Wigan	1,048



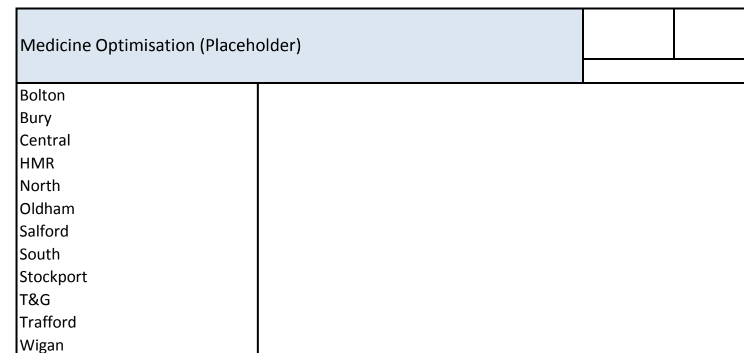
Anti-Microbial Resistance: Appropriate Prescribing Of Antibiotics In Primary Care — Better Is **Lower**

Area	Value
Bolton	1.2
Bury	1.2
Central	1.1
HMR	1.3
North	1.3
Oldham	1.4
Salford	1.2
South	1.2
Stockport	1.2
T&G	1.1
Trafford	1.1
Wigan	1.1



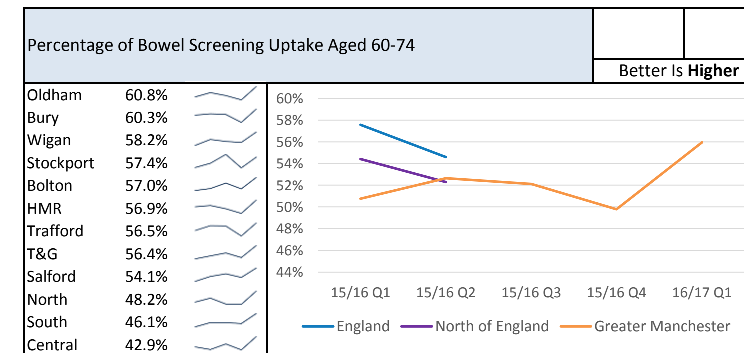
Anti-Microbial Resistance: Appropriate Prescribing Of Broad Spectrum Antibiotics In Primary Care — Better Is **Lower**

Area	Value
Stockport	4.9
Bury	6.0
South	7.8
T&G	7.8
North	7.9
Central	7.9
HMR	8.0
Wigan	8.2
Bolton	8.3
Oldham	9.2
Salford	9.7
Trafford	12.4



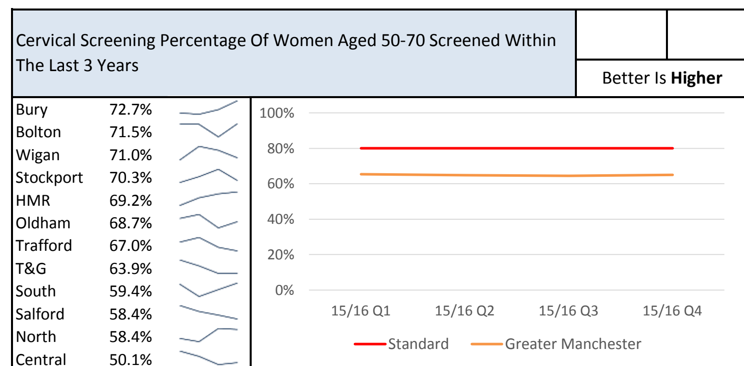
Medicine Optimisation (Placeholder)

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



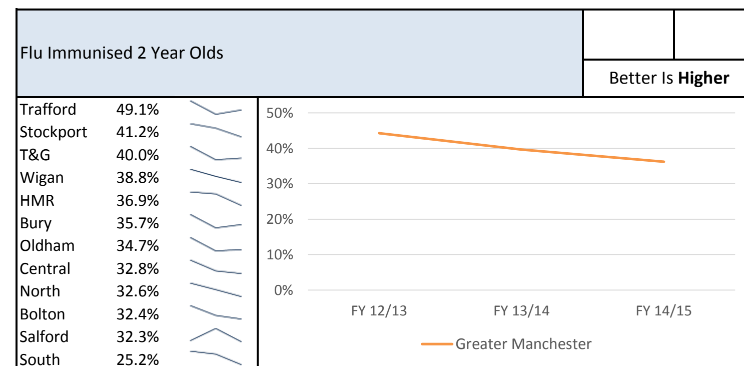
Percentage of Bowel Screening Uptake Aged 60-74 — Better Is **Higher**

Area	Value
Oldham	60.8%
Bury	60.3%
Wigan	58.2%
Stockport	57.4%
Bolton	57.0%
HMR	56.9%
Trafford	56.5%
T&G	56.4%
Salford	54.1%
North	48.2%
South	46.1%
Central	42.9%



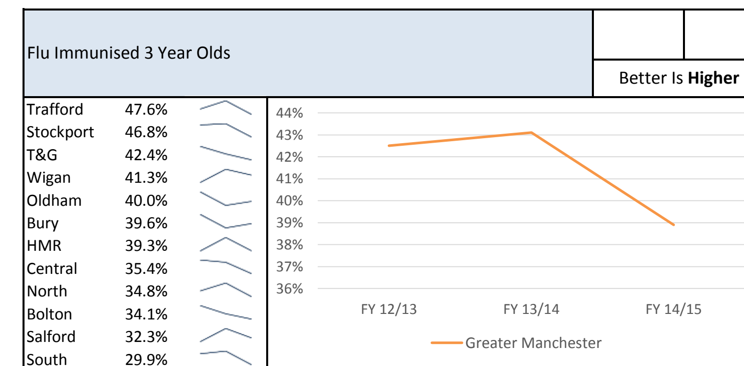
Cervical Screening Percentage Of Women Aged 50-70 Screened Within The Last 3 Years — Better Is **Higher**

Area	Value
Bury	72.7%
Bolton	71.5%
Wigan	71.0%
Stockport	70.3%
HMR	69.2%
Oldham	68.7%
Trafford	67.0%
T&G	63.9%
South	59.4%
Salford	58.4%
North	58.4%
Central	50.1%



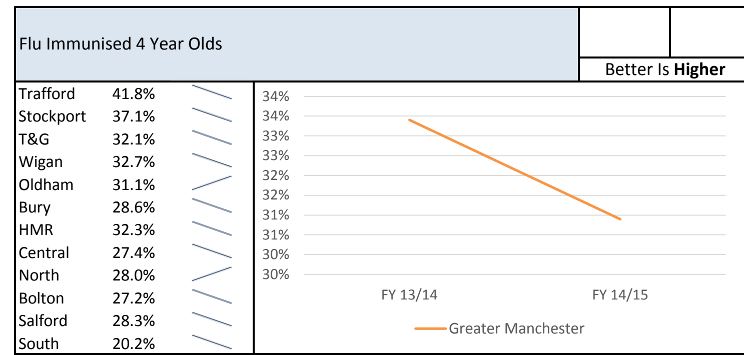
Flu Immunised 2 Year Olds — Better Is **Higher**

Area	Value
Trafford	49.1%
Stockport	41.2%
T&G	40.0%
Wigan	38.8%
HMR	36.9%
Bury	35.7%
Oldham	34.7%
Central	32.8%
North	32.6%
Bolton	32.4%
Salford	32.3%
South	25.2%

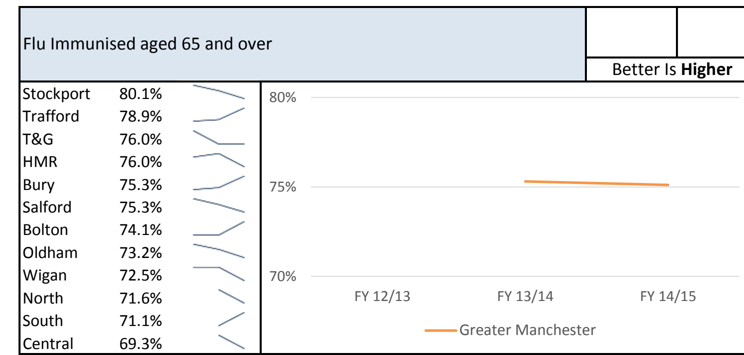


Flu Immunised 3 Year Olds — Better Is **Higher**

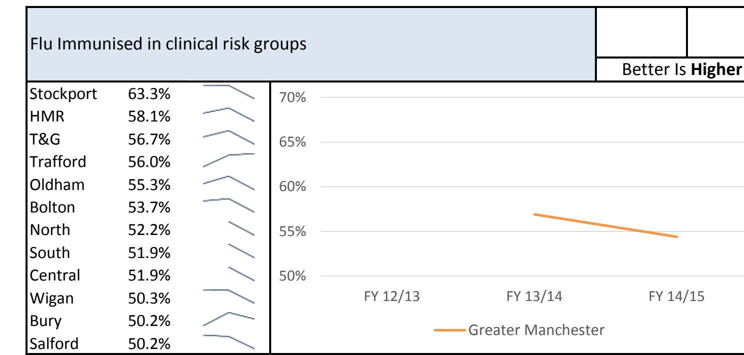
Area	Value
Trafford	47.6%
Stockport	46.8%
T&G	42.4%
Wigan	41.3%
Oldham	40.0%
Bury	39.6%
HMR	39.3%
Central	35.4%
North	34.8%
Bolton	34.1%
Salford	32.3%
South	29.9%



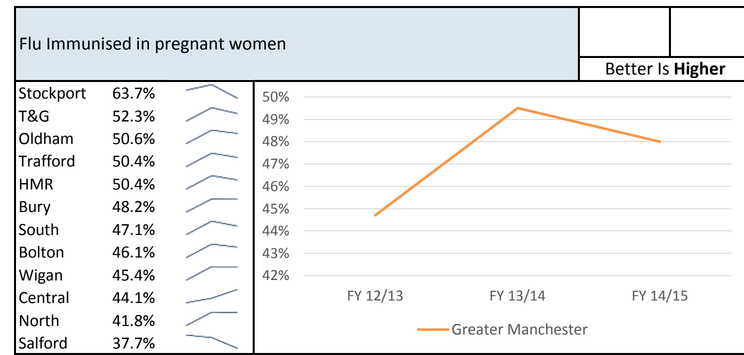
Flu Immunised 4 Year Olds
Better Is Higher
Trafford 41.8%
Stockport 37.1%
T&G 32.1%
Wigan 32.7%
Oldham 31.1%
Bury 28.6%
HMR 32.3%
Central 27.4%
North 28.0%
Bolton 27.2%
Salford 28.3%
South 20.2%
FY 13/14
FY 14/15
Greater Manchester



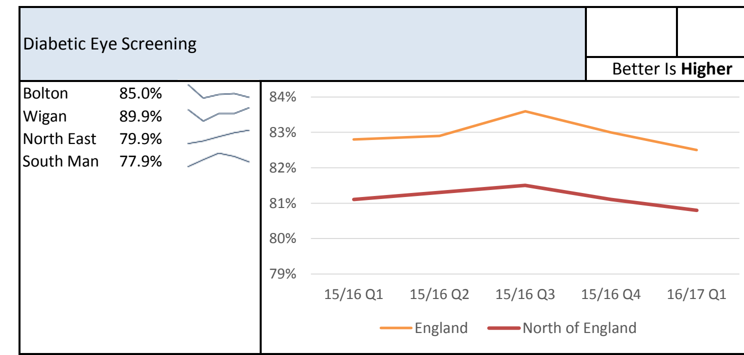
Flu Immunised aged 65 and over
Better Is Higher
Stockport 80.1%
Trafford 78.9%
T&G 76.0%
HMR 76.0%
Bury 75.3%
Salford 75.3%
Bolton 74.1%
Oldham 73.2%
Wigan 72.5%
North 71.6%
South 71.1%
Central 69.3%
80%
75%
70%
FY 12/13
FY 13/14
FY 14/15
Greater Manchester



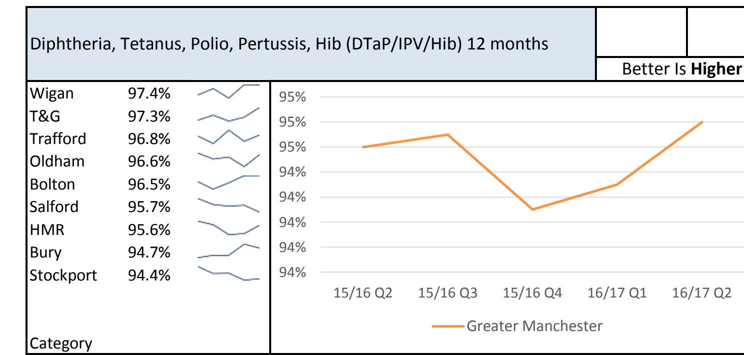
Flu Immunised in clinical risk groups
Better Is Higher
Stockport 63.3%
HMR 58.1%
T&G 56.7%
Trafford 56.0%
Oldham 55.3%
Bolton 53.7%
North 52.2%
South 51.9%
Central 51.9%
Wigan 50.3%
Bury 50.2%
Salford 50.2%
70%
65%
60%
55%
50%
FY 12/13
FY 13/14
FY 14/15
Greater Manchester



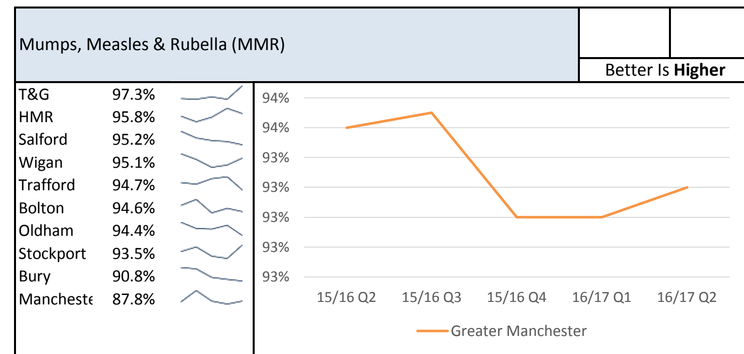
Flu Immunised in pregnant women
Better Is Higher
Stockport 63.7%
T&G 52.3%
Oldham 50.6%
Trafford 50.4%
HMR 50.4%
Bury 48.2%
South 47.1%
Bolton 46.1%
Wigan 45.4%
Central 44.1%
North 41.8%
Salford 37.7%
FY 12/13
FY 13/14
FY 14/15
Greater Manchester



Diabetic Eye Screening
Better Is Higher
Bolton 85.0%
Wigan 89.9%
North East 79.9%
South Man 77.9%
84%
83%
82%
81%
80%
79%
15/16 Q1
15/16 Q2
15/16 Q3
15/16 Q4
16/17 Q1
England
North of England



Diphtheria, Tetanus, Polio, Pertussis, Hib (DTaP/IPV/Hib) 12 months
Better Is Higher
Wigan 97.4%
T&G 97.3%
Trafford 96.8%
Oldham 96.6%
Bolton 96.5%
Salford 95.7%
HMR 95.6%
Bury 94.7%
Stockport 94.4%
Category
15/16 Q2
15/16 Q3
15/16 Q4
16/17 Q1
16/17 Q2
Greater Manchester

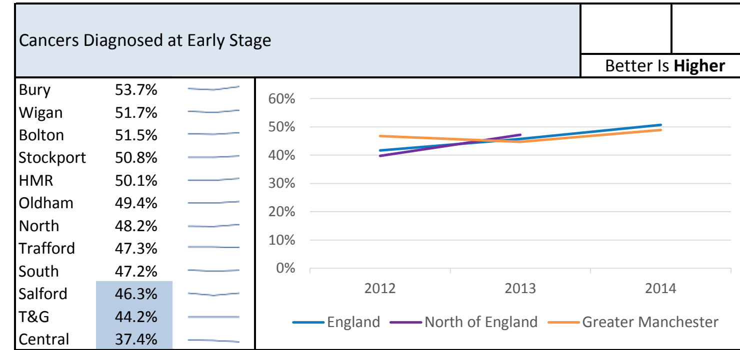


Mumps, Measles & Rubella (MMR)
Better Is Higher
T&G 97.3%
HMR 95.8%
Salford 95.2%
Wigan 95.1%
Trafford 94.7%
Bolton 94.6%
Oldham 94.4%
Stockport 93.5%
Bury 90.8%
Mancheste 87.8%
15/16 Q2
15/16 Q3
15/16 Q4
16/17 Q1
16/17 Q2
Greater Manchester

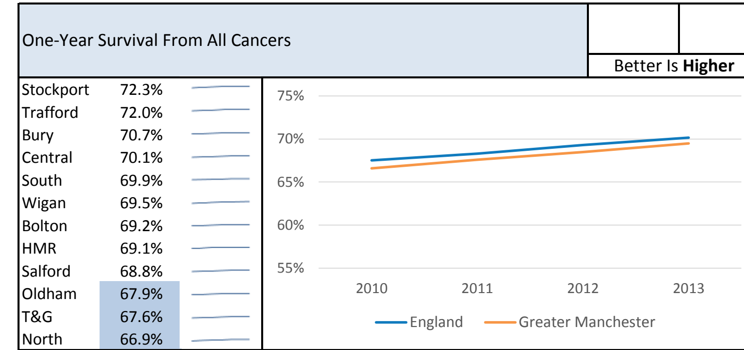
GMCA GREATER MANCHESTER COMBINED AUTHORITY
NHS Greater Manchester

Better Care

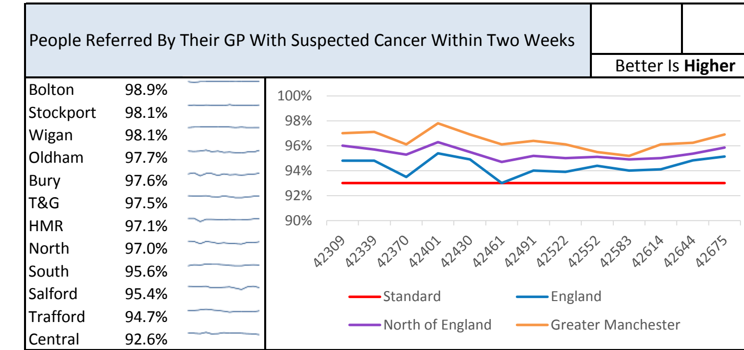
Fewer People Will Die Early From: Cardio-Vascular (CVD); Cancer; and Respiratory Disease



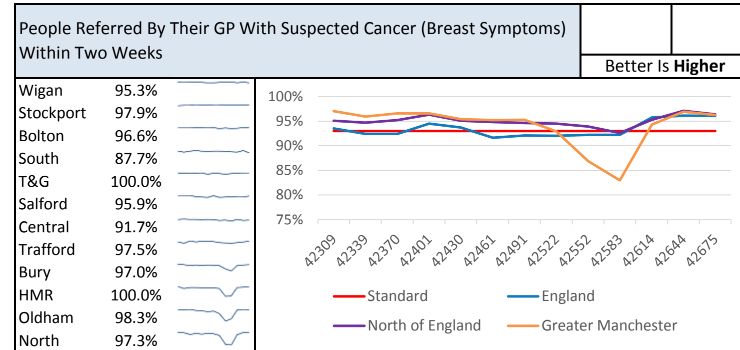
Cancers Diagnosed at Early Stage	Better Is Higher
Bury	53.7%
Wigan	51.7%
Bolton	51.5%
Stockport	50.8%
HMR	50.1%
Oldham	49.4%
North	48.2%
Trafford	47.3%
South	47.2%
Salford	46.3%
T&G	44.2%
Central	37.4%



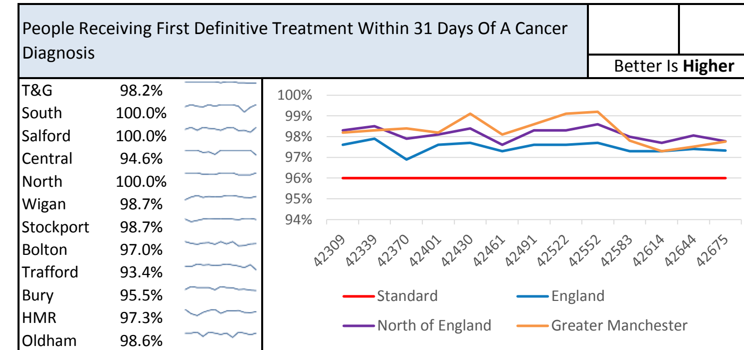
One-Year Survival From All Cancers	Better Is Higher
Stockport	72.3%
Trafford	72.0%
Bury	70.7%
Central	70.1%
South	69.9%
Wigan	69.5%
Bolton	69.2%
HMR	69.1%
Salford	68.8%
Oldham	67.9%
T&G	67.6%
North	66.9%



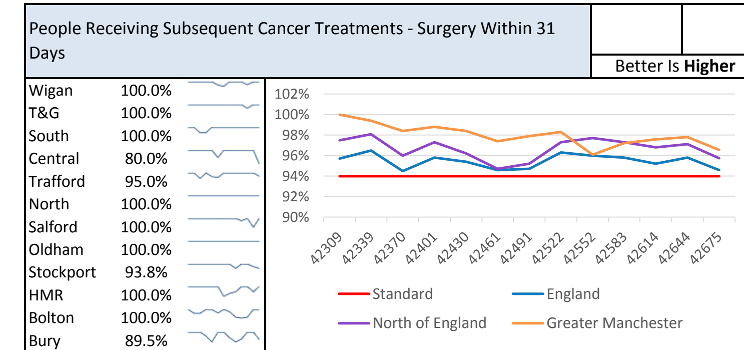
People Referred By Their GP With Suspected Cancer Within Two Weeks	Better Is Higher
Bolton	98.9%
Stockport	98.1%
Wigan	98.1%
Oldham	97.7%
Bury	97.6%
T&G	97.5%
HMR	97.1%
North	97.0%
South	95.6%
Salford	95.4%
Trafford	94.7%
Central	92.6%



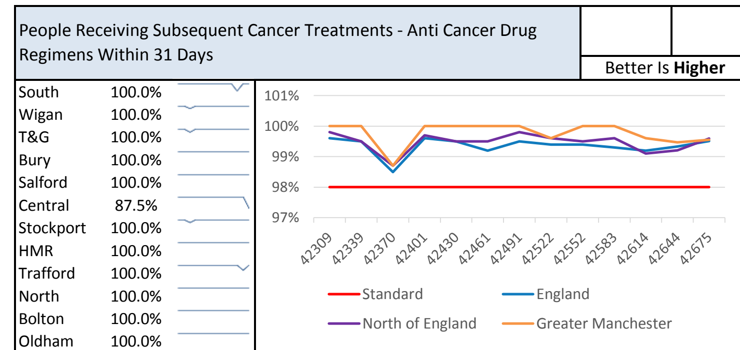
People Referred By Their GP With Suspected Cancer (Breast Symptoms) Within Two Weeks	Better Is Higher
Wigan	95.3%
Stockport	97.9%
Bolton	96.6%
South	87.7%
T&G	100.0%
Salford	95.9%
Central	91.7%
Trafford	97.5%
Bury	97.0%
HMR	100.0%
Oldham	98.3%
North	97.3%



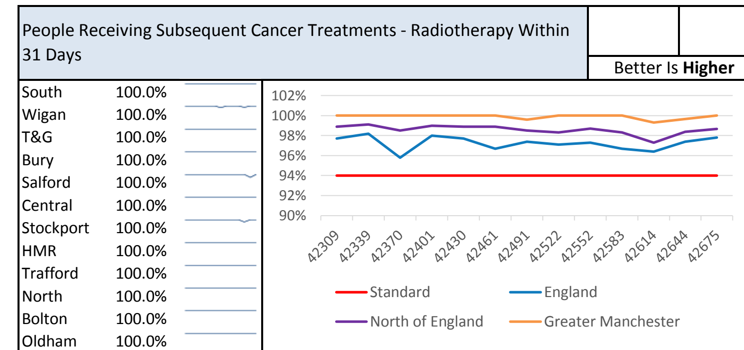
People Receiving First Definitive Treatment Within 31 Days Of A Cancer Diagnosis	Better Is Higher
T&G	98.2%
South	100.0%
Salford	100.0%
Central	94.6%
North	100.0%
Wigan	98.7%
Stockport	98.7%
Bolton	97.0%
Trafford	93.4%
Bury	95.5%
HMR	97.3%
Oldham	98.6%



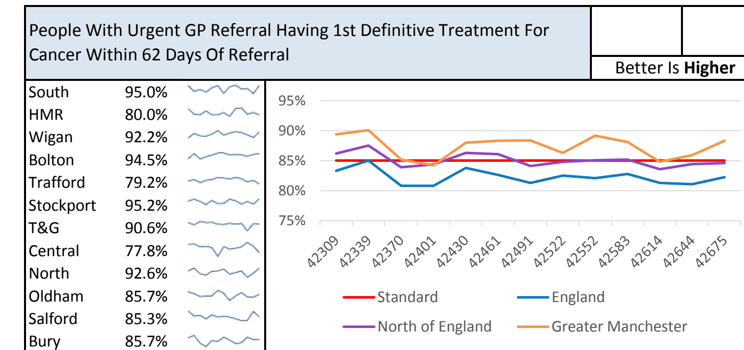
People Receiving Subsequent Cancer Treatments - Surgery Within 31 Days	Better Is Higher
Wigan	100.0%
T&G	100.0%
South	100.0%
Central	80.0%
Trafford	95.0%
North	100.0%
Salford	100.0%
Oldham	100.0%
Stockport	93.8%
HMR	100.0%
Bolton	100.0%
Bury	89.5%



People Receiving Subsequent Cancer Treatments - Anti Cancer Drug Regimens Within 31 Days	Better Is Higher
South	100.0%
Wigan	100.0%
T&G	100.0%
Bury	100.0%
Salford	100.0%
Central	87.5%
Stockport	100.0%
HMR	100.0%
Trafford	100.0%
North	100.0%
Bolton	100.0%
Oldham	100.0%

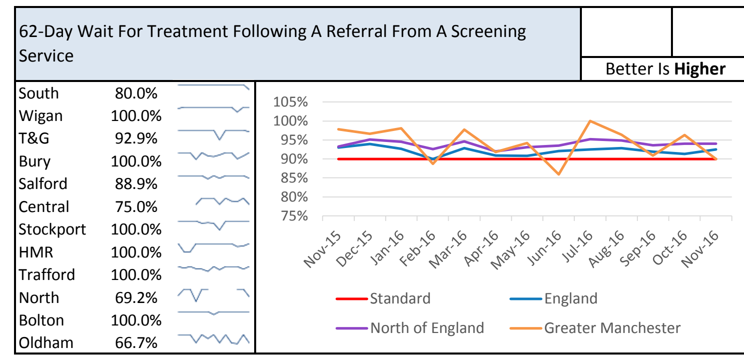


People Receiving Subsequent Cancer Treatments - Radiotherapy Within 31 Days	Better Is Higher
South	100.0%
Wigan	100.0%
T&G	100.0%
Bury	100.0%
Salford	100.0%
Central	100.0%
Stockport	100.0%
HMR	100.0%
Trafford	100.0%
North	100.0%
Bolton	100.0%
Oldham	100.0%



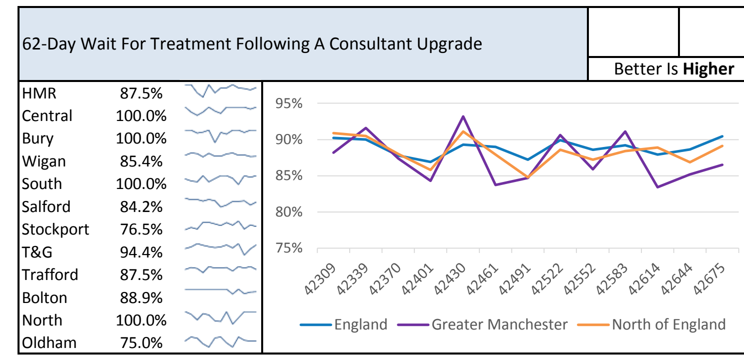
People With Urgent GP Referral Having 1st Definitive Treatment For Cancer Within 62 Days Of Referral	Better Is Higher
South	95.0%
HMR	80.0%
Wigan	92.2%
Bolton	94.5%
Trafford	79.2%
Stockport	95.2%
T&G	90.6%
Central	77.8%
North	92.6%
Oldham	85.7%
Salford	85.3%
Bury	85.7%

Decreased Variation In Quality Of Care Health Outcomes Across GM Localities



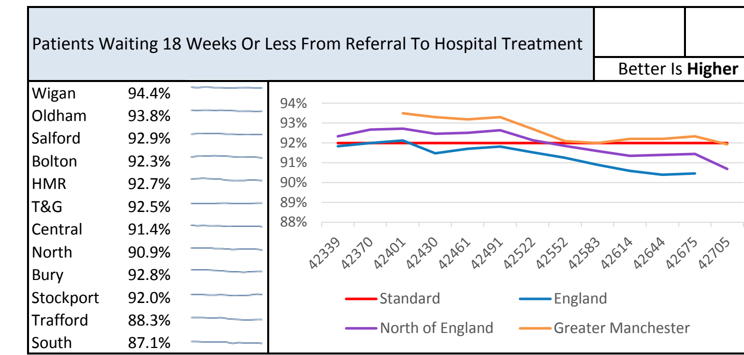
62-Day Wait For Treatment Following A Referral From A Screening Service — Better Is **Higher**

Locality	Value
South	80.0%
Wigan	100.0%
T&G	92.9%
Bury	100.0%
Salford	88.9%
Central	75.0%
Stockport	100.0%
HMR	100.0%
Trafford	100.0%
North	69.2%
Bolton	100.0%
Oldham	66.7%



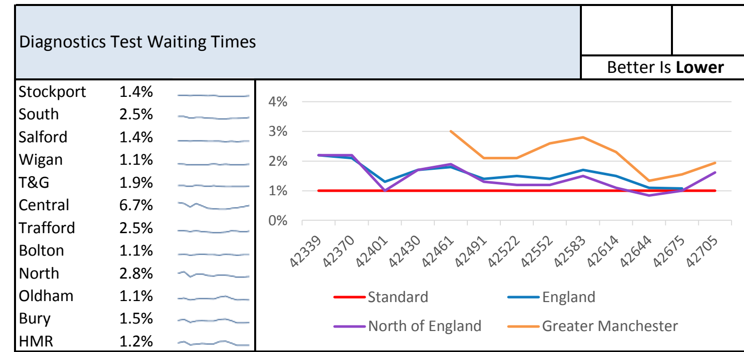
62-Day Wait For Treatment Following A Consultant Upgrade — Better Is **Higher**

Locality	Value
HMR	87.5%
Central	100.0%
Bury	100.0%
Wigan	85.4%
South	100.0%
Salford	84.2%
Stockport	76.5%
T&G	94.4%
Trafford	87.5%
Bolton	88.9%
North	100.0%
Oldham	75.0%



Patients Waiting 18 Weeks Or Less From Referral To Hospital Treatment — Better Is **Higher**

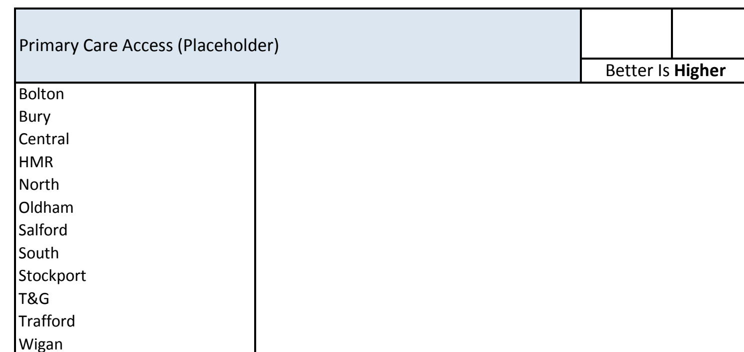
Locality	Value
Wigan	94.4%
Oldham	93.8%
Salford	92.9%
Bolton	92.3%
HMR	92.7%
T&G	92.5%
Central	91.4%
North	90.9%
Bury	92.8%
Stockport	92.0%
Trafford	88.3%
South	87.1%



Diagnostics Test Waiting Times — Better Is **Lower**

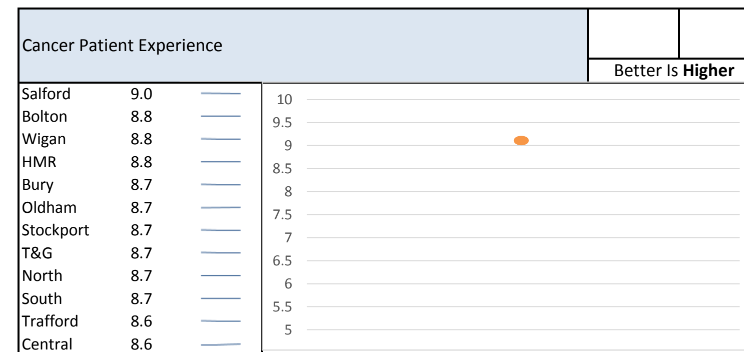
Locality	Value
Stockport	1.4%
South	2.5%
Salford	1.4%
Wigan	1.1%
T&G	1.9%
Central	6.7%
Trafford	2.5%
Bolton	1.1%
North	2.8%
Oldham	1.1%
Bury	1.5%
HMR	1.2%

Improved Patient/Carer Experience Of Care And Increased Patient Empowerment



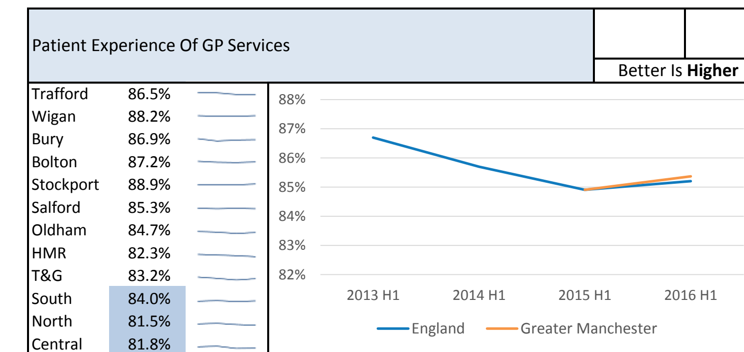
Primary Care Access (Placeholder) — Better Is **Higher**

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



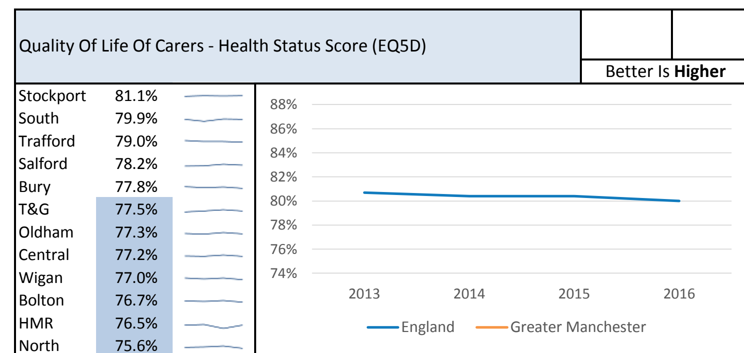
Cancer Patient Experience — Better Is **Higher**

Locality	Value
Salford	9.0
Bolton	8.8
Wigan	8.8
HMR	8.8
Bury	8.7
Oldham	8.7
Stockport	8.7
T&G	8.7
North	8.7
South	8.7
Trafford	8.6
Central	8.6



Patient Experience Of GP Services — Better Is **Higher**

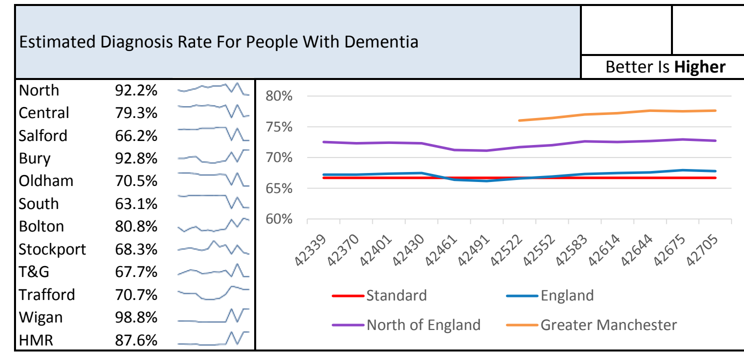
Locality	Value
Trafford	86.5%
Wigan	88.2%
Bury	86.9%
Bolton	87.2%
Stockport	88.9%
Salford	85.3%
Oldham	84.7%
HMR	82.3%
T&G	83.2%
South	84.0%
North	81.5%
Central	81.8%



Quality Of Life Of Carers - Health Status Score (EQ5D) — Better Is **Higher**

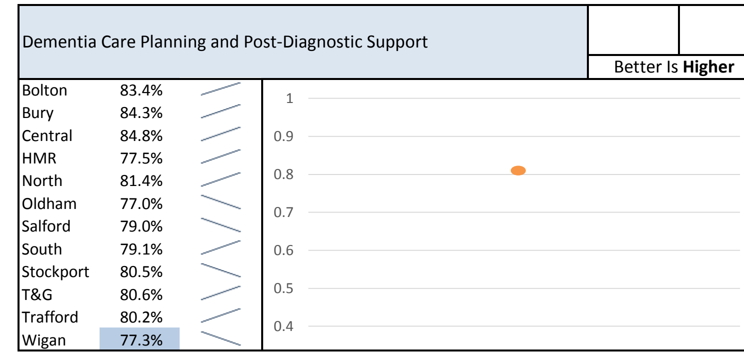
Locality	Value
Stockport	81.1%
South	79.9%
Trafford	79.0%
Salford	78.2%
Bury	77.8%
T&G	77.5%
Oldham	77.3%
Central	77.2%
Wigan	77.0%
Bolton	76.7%
HMR	76.5%
North	75.6%

Improved Outcomes For People With Learning Disabilities/Mental Health Needs



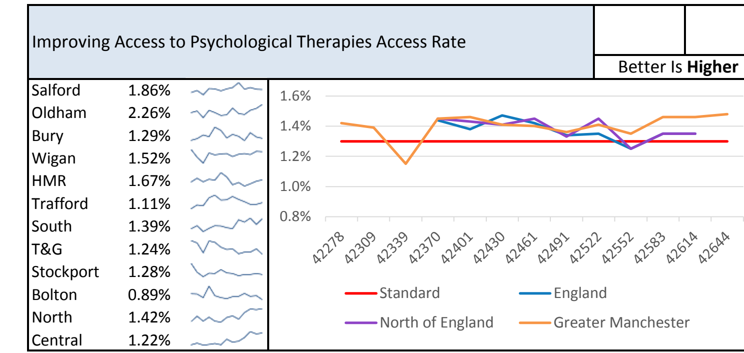
Estimated Diagnosis Rate For People With Dementia — Better Is Higher

Area	Value
North	92.2%
Central	79.3%
Salford	66.2%
Bury	92.8%
Oldham	70.5%
South	63.1%
Bolton	80.8%
Stockport	68.3%
T&G	67.7%
Trafford	70.7%
Wigan	98.8%
HMR	87.6%



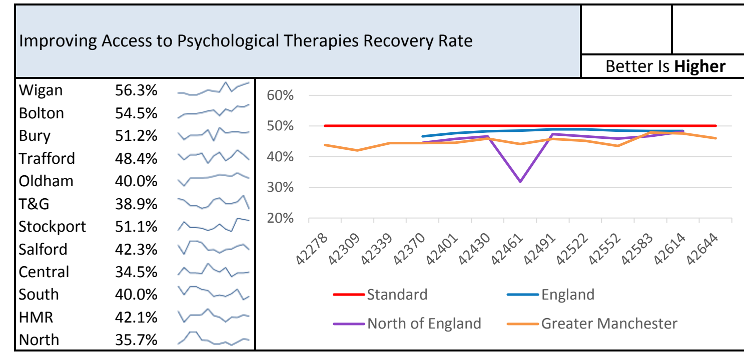
Dementia Care Planning and Post-Diagnostic Support — Better Is Higher

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



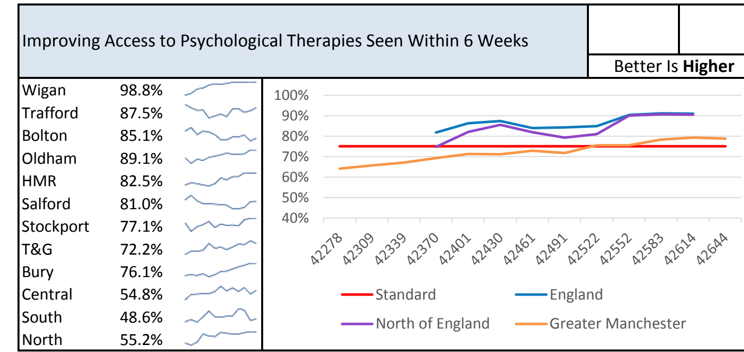
Improving Access to Psychological Therapies Access Rate — Better Is Higher

Area	Value
Salford	1.86%
Oldham	2.26%
Bury	1.29%
Wigan	1.52%
HMR	1.67%
Trafford	1.11%
South	1.39%
T&G	1.24%
Stockport	1.28%
Bolton	0.89%
North	1.42%
Central	1.22%



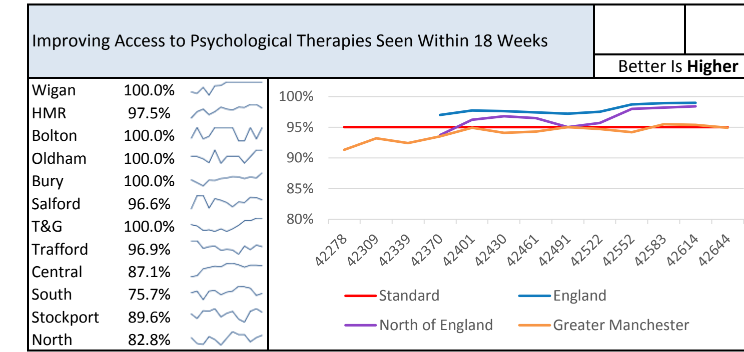
Improving Access to Psychological Therapies Recovery Rate — Better Is Higher

Area	Value
Wigan	56.3%
Bolton	54.5%
Bury	51.2%
Trafford	48.4%
Oldham	40.0%
T&G	38.9%
Stockport	51.1%
Salford	42.3%
Central	34.5%
South	40.0%
HMR	42.1%
North	35.7%



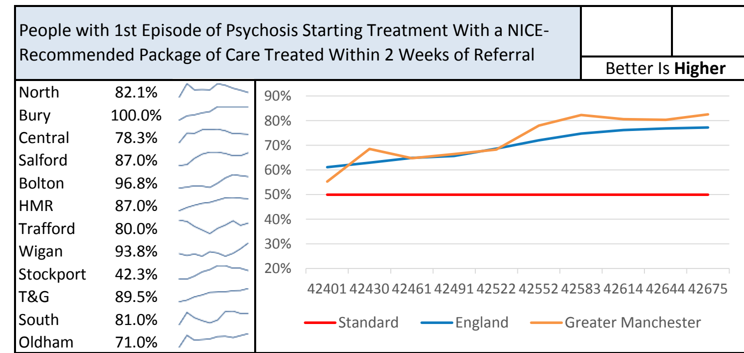
Improving Access to Psychological Therapies Seen Within 6 Weeks — Better Is Higher

Area	Value
Wigan	98.8%
Trafford	87.5%
Bolton	85.1%
Oldham	89.1%
HMR	82.5%
Salford	81.0%
Stockport	77.1%
T&G	72.2%
Bury	76.1%
Central	54.8%
South	48.6%
North	55.2%



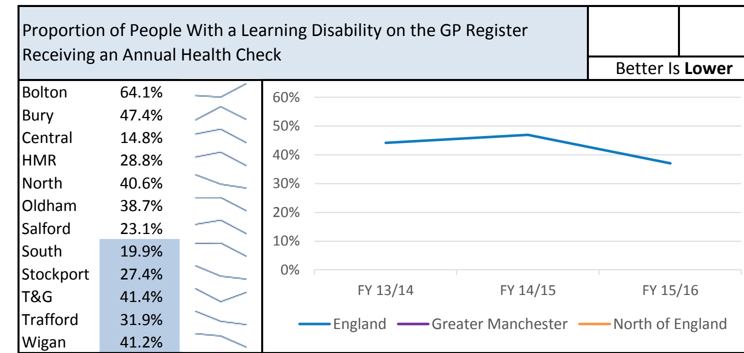
Improving Access to Psychological Therapies Seen Within 18 Weeks — Better Is Higher

Area	Value
Wigan	100.0%
HMR	97.5%
Bolton	100.0%
Oldham	100.0%
Bury	100.0%
Salford	96.6%
T&G	100.0%
Trafford	96.9%
Central	87.1%
South	75.7%
Stockport	89.6%
North	82.8%



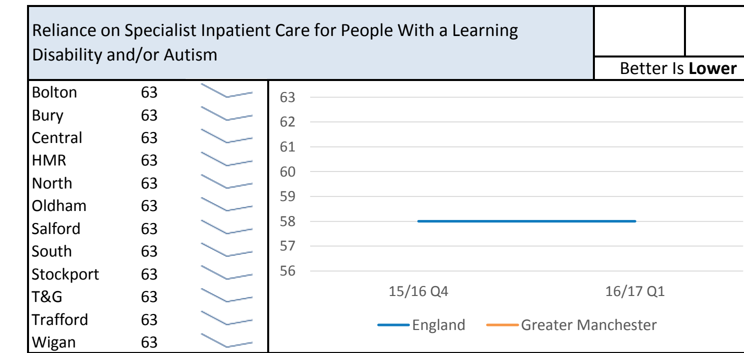
People with 1st Episode of Psychosis Starting Treatment With a NICE-Recommended Package of Care Treated Within 2 Weeks of Referral — Better Is Higher

Area	Value
North	82.1%
Bury	100.0%
Central	78.3%
Salford	87.0%
Bolton	96.8%
HMR	87.0%
Trafford	80.0%
Wigan	93.8%
Stockport	42.3%
T&G	89.5%
South	81.0%
Oldham	71.0%



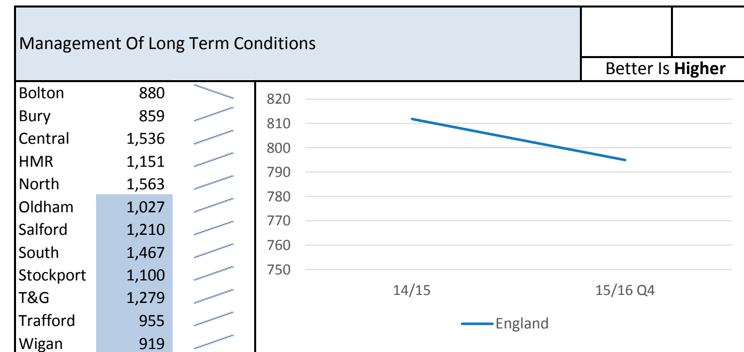
Proportion of People With a Learning Disability on the GP Register Receiving an Annual Health Check — Better Is Lower

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



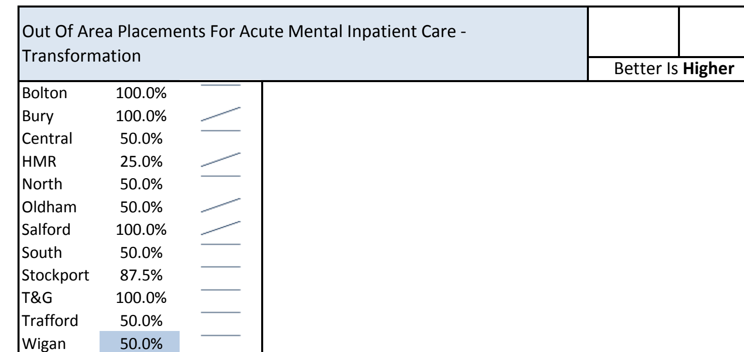
Reliance on Specialist Inpatient Care for People With a Learning Disability and/or Autism — Better Is Lower

Area	Value
Bolton	63
Bury	63
Central	63
HMR	63
North	63
Oldham	63
Salford	63
South	63
Stockport	63
T&G	63
Trafford	63
Wigan	63



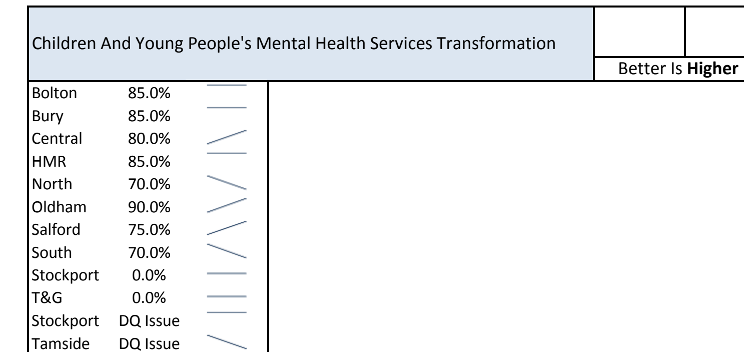
Management Of Long Term Conditions — Better Is Higher

Area	Value
Bolton	880
Bury	859
Central	1,536
HMR	1,151
North	1,563
Oldham	1,027
Salford	1,210
South	1,467
Stockport	1,100
T&G	1,279
Trafford	955
Wigan	919



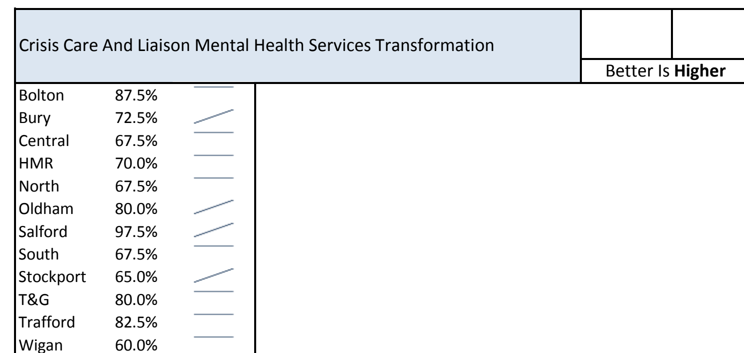
Out Of Area Placements For Acute Mental Inpatient Care - Transformation — Better Is Higher

Area	Value
Bolton	100.0%
Bury	100.0%
Central	50.0%
HMR	25.0%
North	50.0%
Oldham	50.0%
Salford	100.0%
South	50.0%
Stockport	87.5%
T&G	100.0%
Trafford	50.0%
Wigan	50.0%



Children And Young People's Mental Health Services Transformation — Better Is Higher

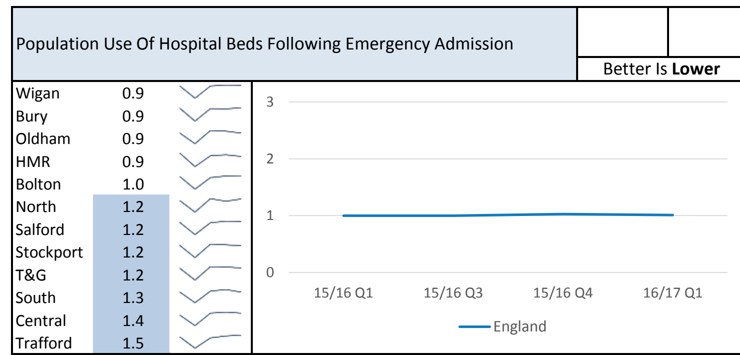
Area	Value
Bolton	85.0%
Bury	85.0%
Central	80.0%
HMR	85.0%
North	70.0%
Oldham	90.0%
Salford	75.0%
South	70.0%
Stockport	0.0%
T&G	0.0%
Stockport	DQ Issue
Tamside	DQ Issue



Crisis Care And Liaison Mental Health Services Transformation — Better Is Higher

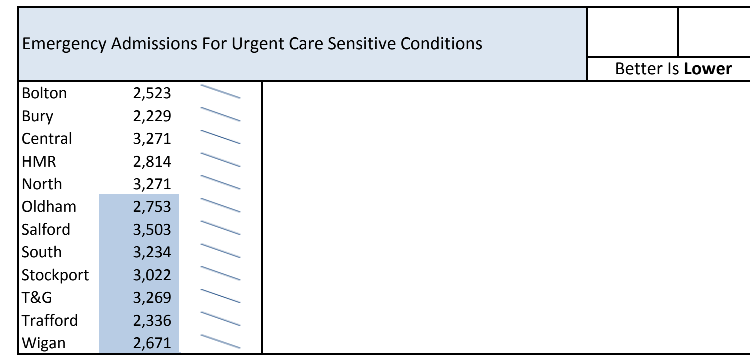
Area	Value
Bolton	87.5%
Bury	72.5%
Central	67.5%
HMR	70.0%
North	67.5%
Oldham	80.0%
Salford	97.5%
South	67.5%
Stockport	65.0%
T&G	80.0%
Trafford	82.5%
Wigan	60.0%

Decreased Need For Hospital Services With More Community Support



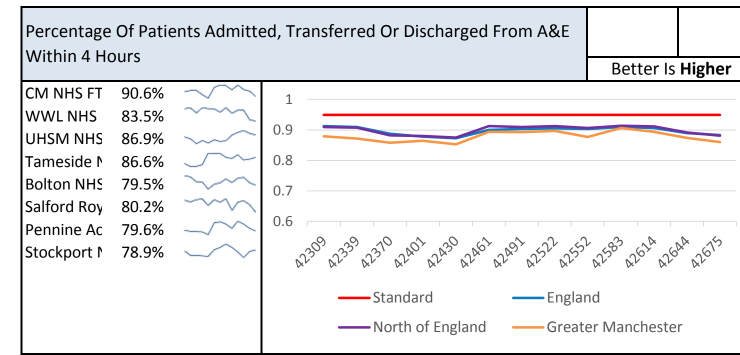
Population Use Of Hospital Beds Following Emergency Admission — Better Is **Lower**

Area	Value
Wigan	0.9
Bury	0.9
Oldham	0.9
HMR	0.9
Bolton	1.0
North	1.2
Salford	1.2
Stockport	1.2
T&G	1.2
South	1.3
Central	1.4
Trafford	1.5



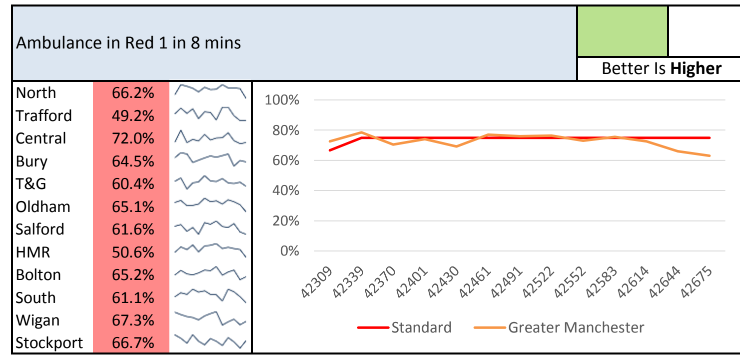
Emergency Admissions For Urgent Care Sensitive Conditions — Better Is **Lower**

Area	Value
Bolton	2,523
Bury	2,229
Central	3,271
HMR	2,814
North	3,271
Oldham	2,753
Salford	3,503
South	3,234
Stockport	3,022
T&G	3,269
Trafford	2,336
Wigan	2,671



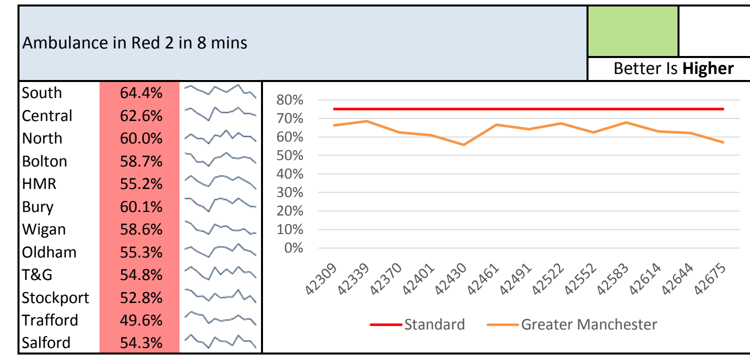
Percentage Of Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours — Better Is **Higher**

Trust	Value
CM NHS FT	90.6%
WWL NHS	83.5%
UHSM NHS	86.9%
Tameside N	86.6%
Bolton NHS	79.5%
Salford Roy	80.2%
Pennine Ac	79.6%
Stockport N	78.9%



Ambulance in Red 1 in 8 mins — Better Is **Higher**

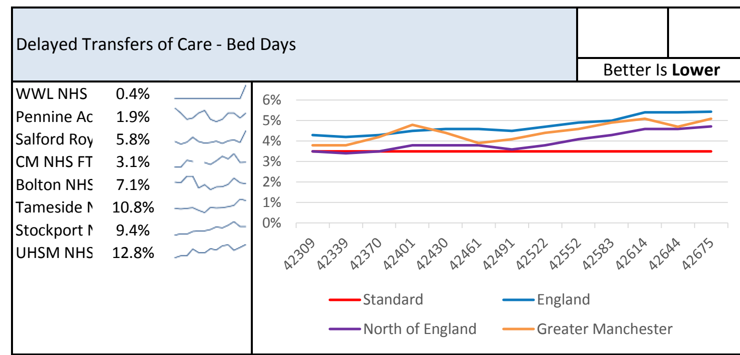
Area	Value
North	66.2%
Trafford	49.2%
Central	72.0%
Bury	64.5%
T&G	60.4%
Oldham	65.1%
Salford	61.6%
HMR	50.6%
Bolton	65.2%
South	61.1%
Wigan	67.3%
Stockport	66.7%



Ambulance in Red 2 in 8 mins — Better Is **Higher**

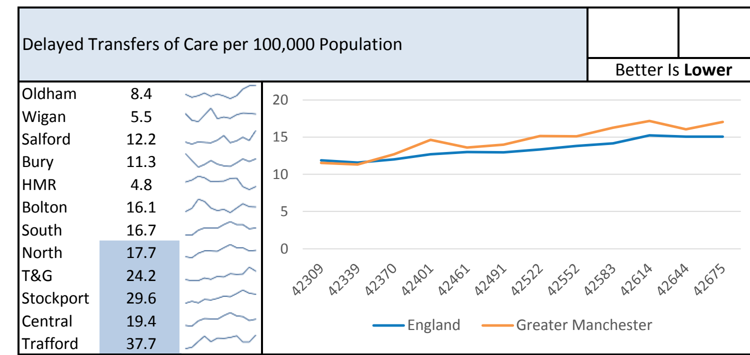
Area	Value
South	64.4%
Central	62.6%
North	60.0%
Bolton	58.7%
HMR	55.2%
Bury	60.1%
Wigan	58.6%
Oldham	55.3%
T&G	54.8%
Stockport	52.8%
Trafford	49.6%
Salford	54.3%

Improved Transition Of Care Across Health And Social Care



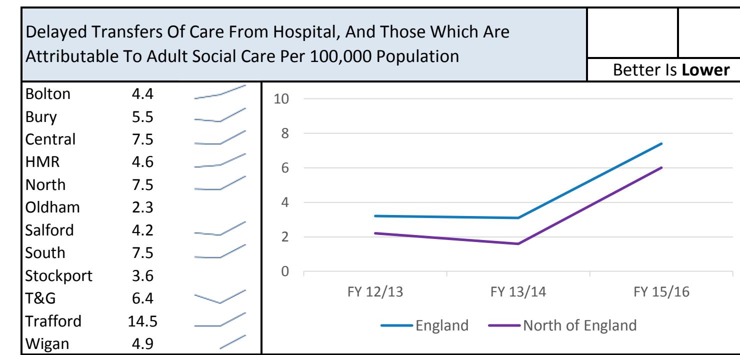
Delayed Transfers of Care - Bed Days — Better Is **Lower**

Trust	Value
WWL NHS	0.4%
Pennine Ac	1.9%
Salford Roy	5.8%
CM NHS FT	3.1%
Bolton NHS	7.1%
Tameside N	10.8%
Stockport N	9.4%
UHSM NHS	12.8%



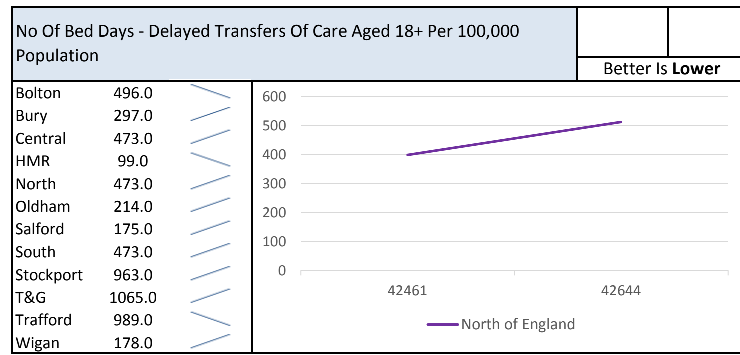
Delayed Transfers of Care per 100,000 Population — Better Is **Lower**

Area	Value
Oldham	8.4
Wigan	5.5
Salford	12.2
Bury	11.3
HMR	4.8
Bolton	16.1
South	16.7
North	17.7
T&G	24.2
Stockport	29.6
Central	19.4
Trafford	37.7



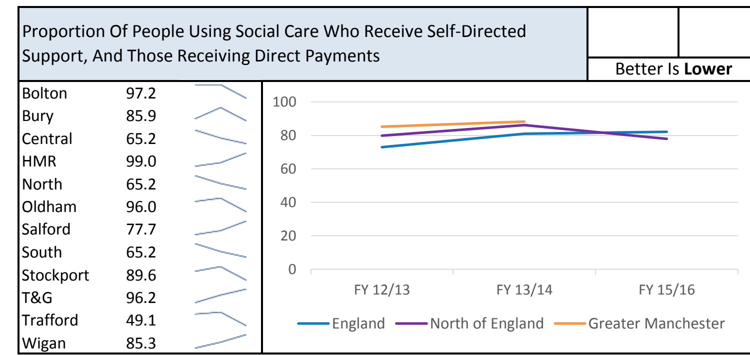
Delayed Transfers Of Care From Hospital, And Those Which Are Attributable To Adult Social Care Per 100,000 Population — Better Is **Lower**

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



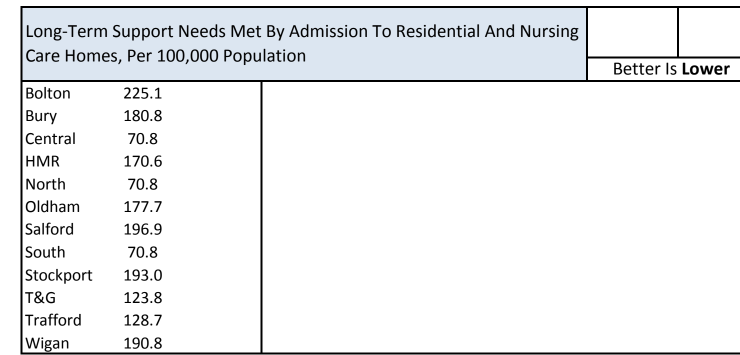
No Of Bed Days - Delayed Transfers Of Care Aged 18+ Per 100,000 Population — Better Is **Lower**

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



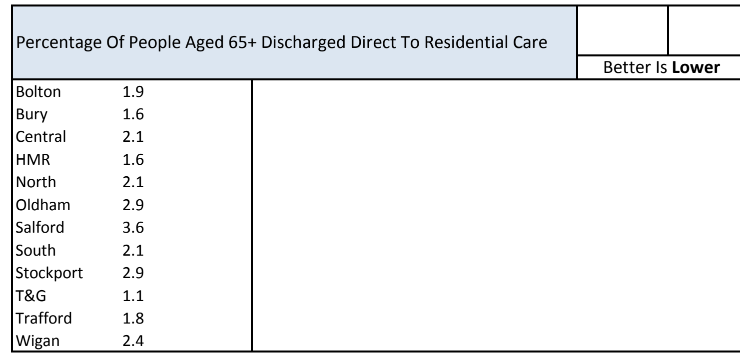
Proportion Of People Using Social Care Who Receive Self-Directed Support, And Those Receiving Direct Payments — Better Is **Lower**

Area	Value
Bolton	97.2
Bury	85.9
Central	65.2
HMR	99.0
North	65.2
Oldham	96.0
Salford	77.7
South	65.2
Stockport	89.6
T&G	96.2
Trafford	49.1
Wigan	85.3



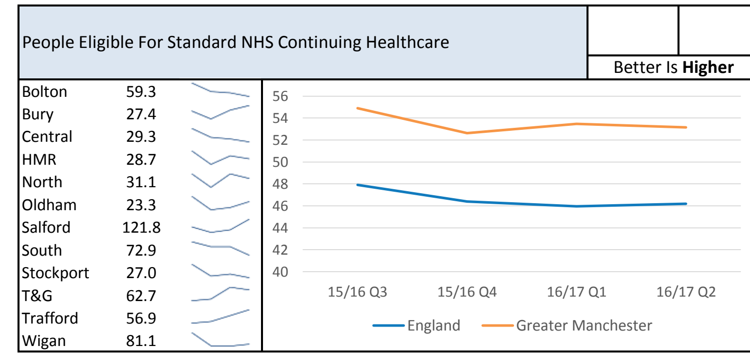
Long-Term Support Needs Met By Admission To Residential And Nursing Care Homes, Per 100,000 Population — Better Is **Lower**

Area	Value
Bolton	225.1
Bury	180.8
Central	70.8
HMR	170.6
North	70.8
Oldham	177.7
Salford	196.9
South	70.8
Stockport	193.0
T&G	123.8
Trafford	128.7
Wigan	190.8



Percentage Of People Aged 65+ Discharged Direct To Residential Care — Better Is **Lower**

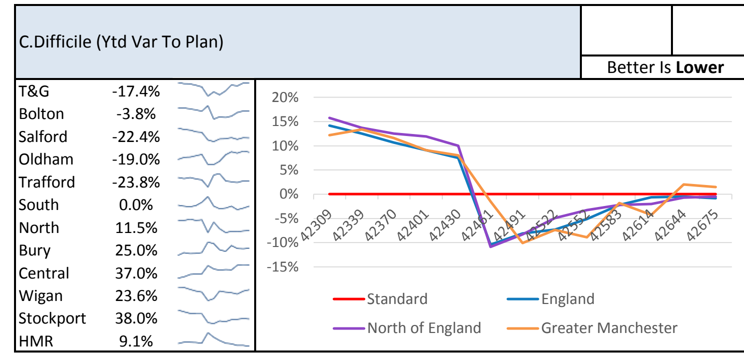
Area	Value
Bolton	1.9
Bury	1.6
Central	2.1
HMR	1.6
North	2.1
Oldham	2.9
Salford	3.6
South	2.1
Stockport	2.9
T&G	1.1
Trafford	1.8
Wigan	2.4



People Eligible For Standard NHS Continuing Healthcare — Better Is **Higher**

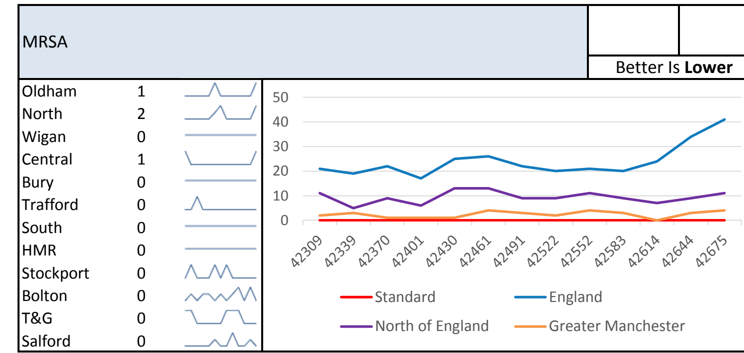
Area	Value
Bolton	59.3
Bury	27.4
Central	29.3
HMR	28.7
North	31.1
Oldham	23.3
Salford	121.8
South	72.9
Stockport	27.0
T&G	62.7
Trafford	56.9
Wigan	81.1

Placeholder TBC



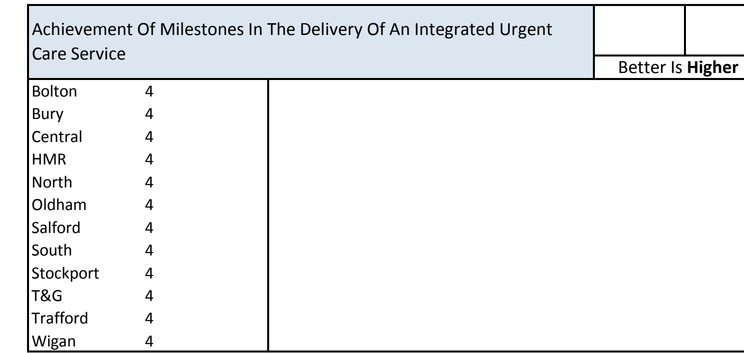
C.Difficile (Ytd Var To Plan) — Better Is **Lower**

Area	Value
T&G	-17.4%
Bolton	-3.8%
Salford	-22.4%
Oldham	-19.0%
Trafford	-23.8%
South	0.0%
North	11.5%
Bury	25.0%
Central	37.0%
Wigan	23.6%
Stockport	38.0%
HMR	9.1%



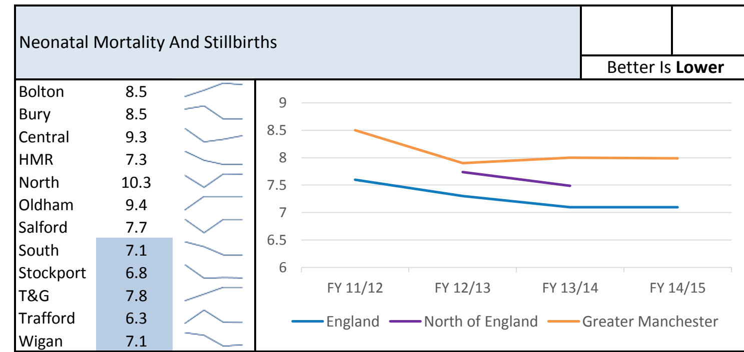
MRSA — Better Is **Lower**

Area	Value
Oldham	1
North	2
Wigan	0
Central	1
Bury	0
Trafford	0
South	0
HMR	0
Stockport	0
Bolton	0
T&G	0
Salford	0



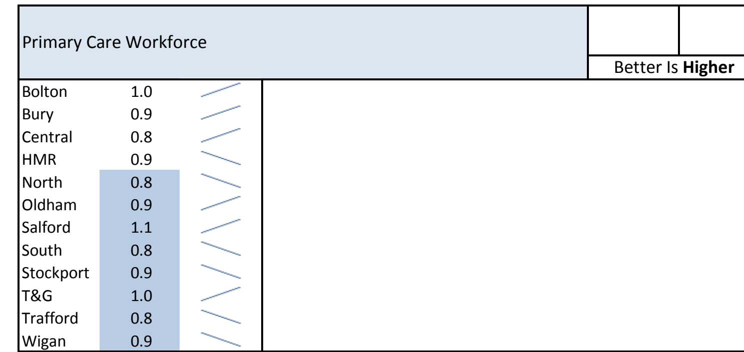
Achievement Of Milestones In The Delivery Of An Integrated Urgent Care Service — Better Is **Higher**

Area	Value
Bolton	4
Bury	4
Central	4
HMR	4
North	4
Oldham	4
Salford	4
South	4
Stockport	4
T&G	4
Trafford	4
Wigan	4



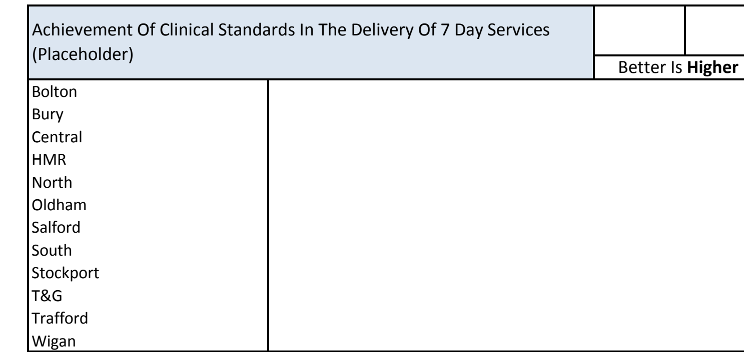
Neonatal Mortality And Stillbirths — Better Is **Lower**

Area	Value
Bolton	8.5
Bury	8.5
Central	9.3
HMR	7.3
North	10.3
Oldham	9.4
Salford	7.7
South	7.1
Stockport	6.8
T&G	7.8
Trafford	6.3
Wigan	7.1



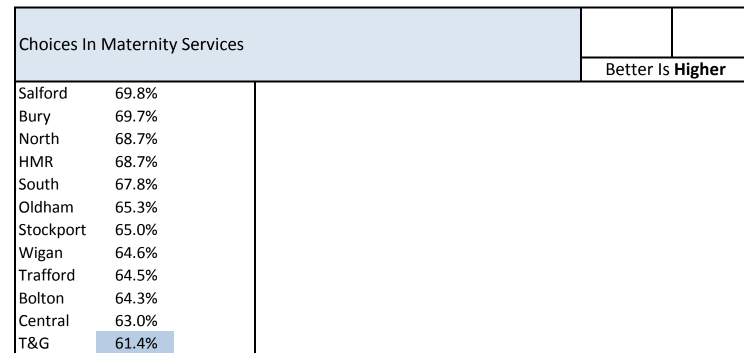
Primary Care Workforce — Better Is **Higher**

Area	Value
Bolton	1.0
Bury	0.9
Central	0.8
HMR	0.9
North	0.8
Oldham	0.9
Salford	1.1
South	0.8
Stockport	0.9
T&G	1.0
Trafford	0.8
Wigan	0.9



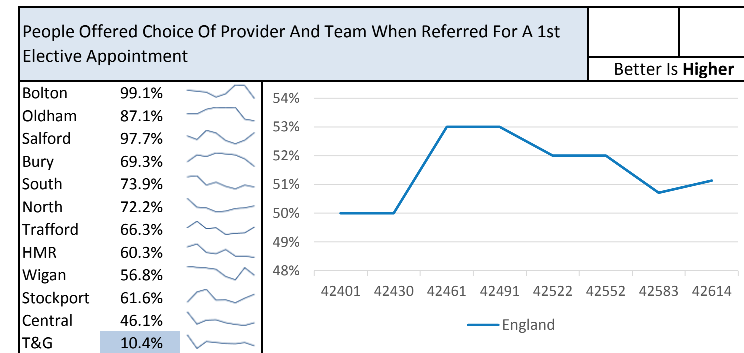
Achievement Of Clinical Standards In The Delivery Of 7 Day Services (Placeholder) — Better Is **Higher**

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



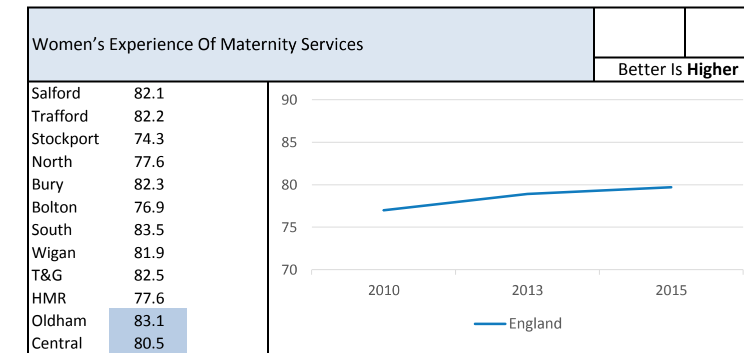
Choices In Maternity Services — Better Is **Higher**

Area	Value
Salford	69.8%
Bury	69.7%
North	68.7%
HMR	68.7%
South	67.8%
Oldham	65.3%
Stockport	65.0%
Wigan	64.6%
Trafford	64.5%
Bolton	64.3%
Central	63.0%
T&G	61.4%



People Offered Choice Of Provider And Team When Referred For A 1st Elective Appointment — Better Is **Higher**

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



Women's Experience Of Maternity Services — Better Is **Higher**

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

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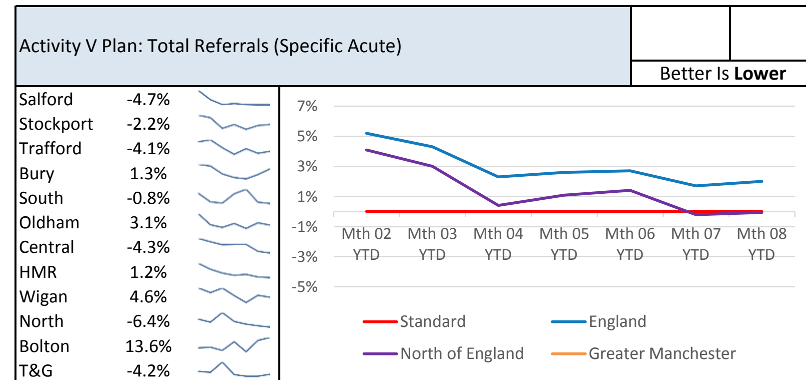
GMCA GREATER MANCHESTER COMBINED AUTHORITY

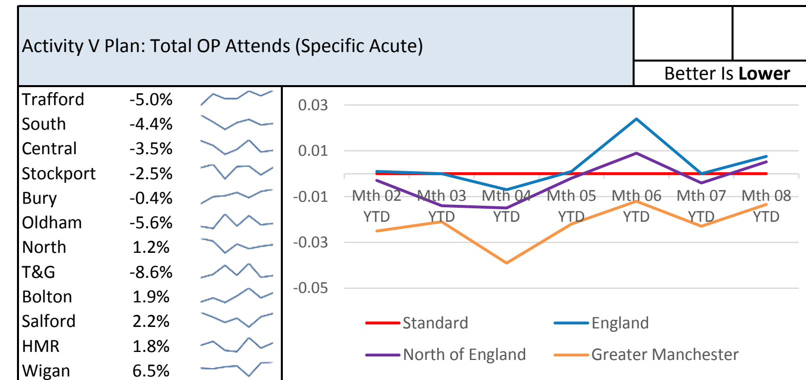
NHS Greater Manchester

Sustainability

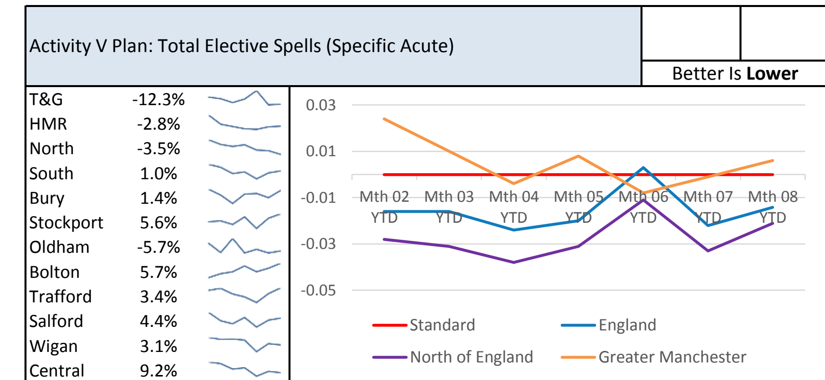
Reduced Demand for Reactive Health and Social Care Services and a Shift in Spend to Proactive Provision



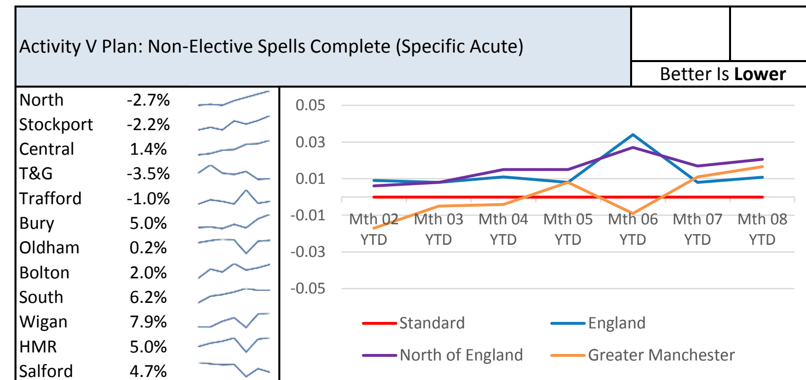
Activity V Plan: Total Referrals (Specific Acute)		Better Is Lower
Salford	-4.7%	
Stockport	-2.2%	
Trafford	-4.1%	
Bury	1.3%	
South	-0.8%	
Oldham	3.1%	
Central	-4.3%	
HMR	1.2%	
Wigan	4.6%	
North	-6.4%	
Bolton	13.6%	
T&G	-4.2%	



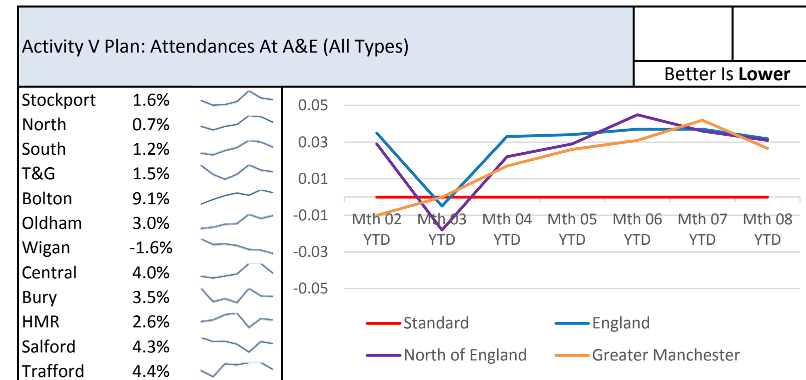
Activity V Plan: Total OP Attends (Specific Acute)		Better Is Lower
Trafford	-5.0%	
South	-4.4%	
Central	-3.5%	
Stockport	-2.5%	
Bury	-0.4%	
Oldham	-5.6%	
North	1.2%	
T&G	-8.6%	
Bolton	1.9%	
Salford	2.2%	
HMR	1.8%	
Wigan	6.5%	



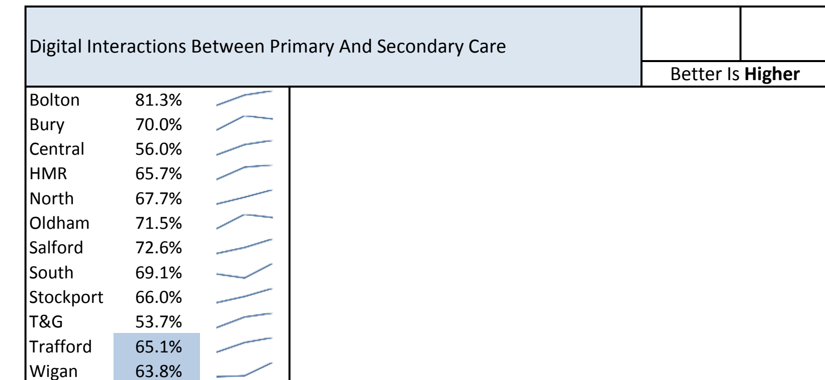
Activity V Plan: Total Elective Spells (Specific Acute)		Better Is Lower
T&G	-12.3%	
HMR	-2.8%	
North	-3.5%	
South	1.0%	
Bury	1.4%	
Stockport	5.6%	
Oldham	-5.7%	
Bolton	5.7%	
Trafford	3.4%	
Salford	4.4%	
Wigan	3.1%	
Central	9.2%	



Activity V Plan: Non-Elective Spells Complete (Specific Acute)		Better Is Lower
North	-2.7%	
Stockport	-2.2%	
Central	1.4%	
T&G	-3.5%	
Trafford	-1.0%	
Bury	5.0%	
Oldham	0.2%	
Bolton	2.0%	
South	6.2%	
Wigan	7.9%	
HMR	5.0%	
Salford	4.7%	



Activity V Plan: Attendances At A&E (All Types)		Better Is Lower
Stockport	1.6%	
North	0.7%	
South	1.2%	
T&G	1.5%	
Bolton	9.1%	
Oldham	3.0%	
Wigan	-1.6%	
Central	4.0%	
Bury	3.5%	
HMR	2.6%	
Salford	4.3%	
Trafford	4.4%	



Digital Interactions Between Primary And Secondary Care		Better Is Higher
Bolton	81.3%	
Bury	70.0%	
Central	56.0%	
HMR	65.7%	
North	67.7%	
Oldham	71.5%	
Salford	72.6%	
South	69.1%	
Stockport	66.0%	
T&G	53.7%	
Trafford	65.1%	
Wigan	63.8%	

Financial Plan 16/17		In-Year Financial Performance 16/17 Q1	In-Year Financial Performance 16/17 Q2	- Better Is Green
Bolton	#REF!	Green	Green	◀▶
Bury	#REF!	Amber	Amber	◀▶
Central	#REF!	Green	Green	◀▶
HMR	#REF!	Green	Green	◀▶
North	#REF!	Green	Green	◀▶
Oldham	#REF!	Green	Green	◀▶
Salford	#REF!	Green	Green	◀▶
South	#REF!	Green	Green	◀▶
Stockport	#REF!	Red	Amber	▲
T&G	#REF!	Red	Amber	▲
Trafford	#REF!	Amber	Amber	◀▶
Wigan	#REF!	Amber	Amber	◀▶

Local Strategic Estates Plan (SEP) In Place		-	- Better Is Yes
Bolton	#REF!		
Bury	#REF!		
Central	#REF!		
HMR	#REF!		
North	#REF!		
Oldham	#REF!		
Salford	#REF!		
South	#REF!		
Stockport	#REF!		
T&G	#REF!		
Trafford	#REF!		
Wigan	#REF!		

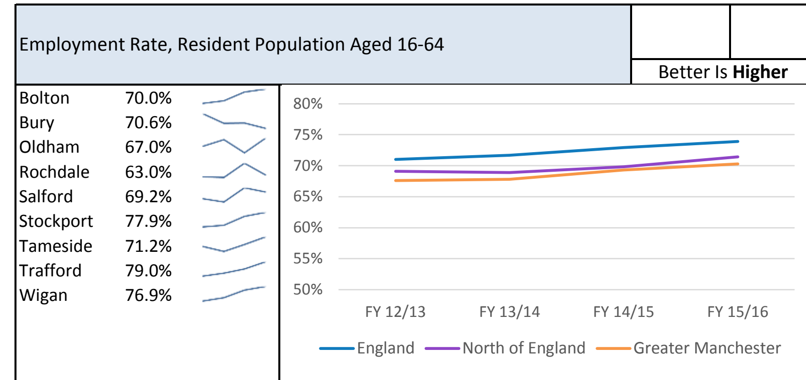
Adoption Of New Models Of Care (Placeholder)	Better Is Higher
Bolton	
Bury	
Central	
HMR	
North	
Oldham	
Salford	
South	
Stockport	
T&G	
Trafford	
Wigan	

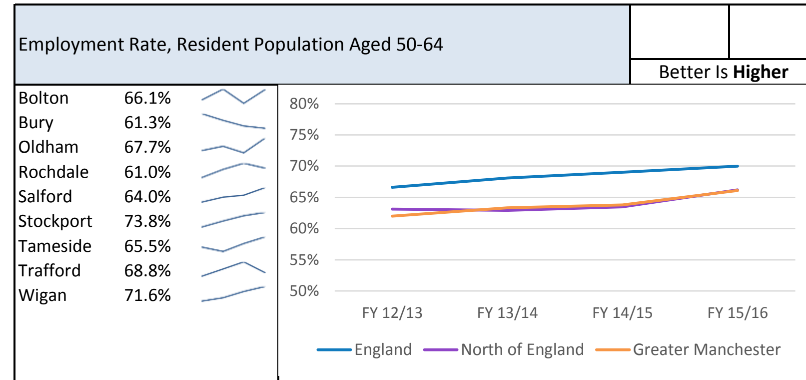
Local Digital Roadmap In Place (Placeholder)	Better Is Higher
Bolton	
Bury	
Central	
HMR	
North	
Oldham	
Salford	
South	
Stockport	
T&G	
Trafford	
Wigan	

Expenditure In Areas With Identified Score For Improvement (Placeholder)	
Bolton	
Bury	
Central	
HMR	
North	
Oldham	
Salford	
South	
Stockport	
T&G	
Trafford	
Wigan	

Outcomes In Areas With Identified Scope For Improvement (Placeholder)	Better Is Higher
Bolton	
Bury	
Central	
HMR	
North	
Oldham	
Salford	
South	
Stockport	
T&G	
Trafford	
Wigan	

More People Will Be In Employment, With An Increasing Proportion In 'Good Work' And Able To Stay In Work For Longer





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GMCA GREATER MANCHESTER COMBINED AUTHORITY
NHS Greater Manchester

Well Led

Placeholder TBC

Staff Engagement Index		Better Is Higher
Wigan	4.0	
T&G	3.9	
Bolton	3.9	
Central	3.9	
Trafford	3.8	
Salford	3.8	
Stockport	3.8	
South	3.8	
North	3.8	
Bury	3.7	
Oldham	3.7	
HMR	3.7	

Progress Against Workforce Race Equality Standard		Better Is Lower
Wigan	0.6	
Bolton	0.5	
T&G	0.3	
Stockport	0.3	
Bury	0.3	
HMR	0.2	
Oldham	0.2	
Salford	0.2	
North	0.2	
South	0.1	
Trafford	0.1	
Central	0.0	

Effectiveness Of Working Relationships In The Local System		Better Is Higher
Bolton	74.4	
Bury	67.1	
Central	71.0	
HMR	71.5	
North	66.0	
Oldham	74.3	
Salford	74.2	
South	69.8	
Stockport	68.8	
T&G	66.9	
Trafford	69.9	
Wigan	69.8	

Quality Of CCG Leadership	-	- Better Is Green Star
Salford	Green Star	
Bolton	Green	
Bury	Green	
Central	Green	
HMR	Green	
North	Green	
Oldham	Green	
South	Green	
Stockport	Green	
T&G	Green	
Trafford	Green	
Wigan	Green	

Sustainability And Transformation Plan (Placeholder)
Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Probity And Corporate Governance (Placeholder)
Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Select a CCG

1. North — Select a region
2. STP — Select STP or DCO
3. — Select an STP or DCO
4. — Select a CCG
5. — Select an indicator

Print Current CCG to PDF
(This will print rows 57 - 116 only)

NHS Tameside and Glossop CCG

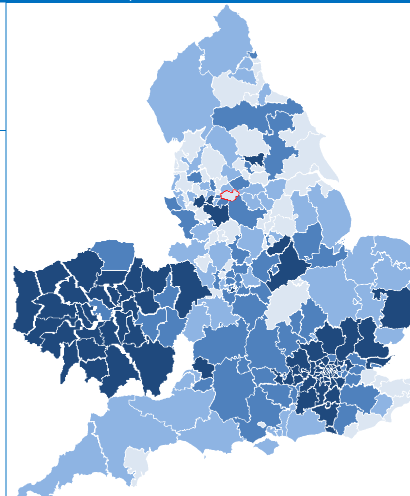
The 10 closest CCGs to NHS Tameside and Glossop CCG

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

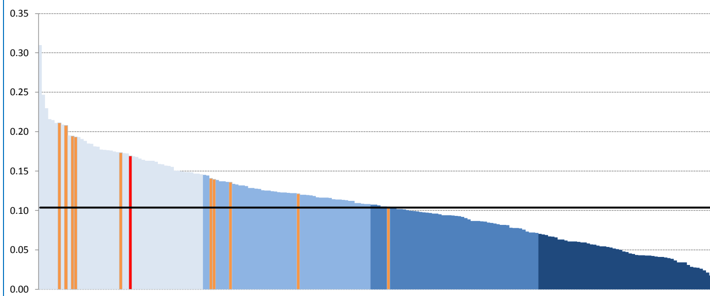
What you need to know...

- CCG and national values for each IAF indicator are presented in the table.
- Sparklines show the scores for each indicator over time.
- The spine chart shows how the CCG value compares other CCGs. A key is displayed over the chart to help with interpretation.

Performance Map



National distribution of CCG values for 101a: Maternal smoking at delivery



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

If indicator is highlighted in BLUE, this value is in the lowest performance quartile nationally.

KEY
H = Higher
L = Lower
<> = N/A

KEY: Nat Average, Org Value, Worst, Best, 25th, Percentile, 75th

Improvement and Assessment Indicators	Latest Period	CCG	England	Trend	Better is...	Range
Better Health						
Maternal smoking at delivery	Q2 16/17	16.9%	10.4%		L	
Percentage of children aged 10-11 classified as overweight or obese	2014-15	34.1%	33.2%		L	
Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) fo	2014-15	46.8%	39.8%		H	
People with diabetes diagnosed less than a year who attend a structured education course	2014-15	0.0%	5.7%		H	
Injuries from falls in people aged 65 and over	Jun-16	2,159	1,985		L	
Utilisation of the NHS e-referral service to enable choice at first routine elective referral	Sep-16	10.4%	51.1%		H	
Personal health budgets	Q2 16/17	7.3	18.7		H	
Percentage of deaths which take place in hospital	Q1 16/17	49.8%	47.1%		<>	
People with a long-term condition feeling supported to manage their condition(s)	2016	61.4%	64.3%		H	
Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q4 15/16	1,475	929		L	
Inequality in emergency admissions for urgent care sensitive conditions	Q4 15/16	3,144	2,168		L	
Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Sep-16	1.1	1.1		<>	
Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	Sep-16	7.8%	9.1%		<>	
Quality of life of carers	2016	0.78	0.80		H	
Better Care						
Provision of high quality care	Q3 16/17	55.0			H	
Cancers diagnosed at early stage	2014	44.2%	50.7%		H	
People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Q2 16/17	86.6%	82.3%		H	
One-year survival from all cancers	2013	67.6%	70.2%		H	
Cancer patient experience	2015	8.7			H	
Improving Access to Psychological Therapies recovery rate	Sep-16	46.0%	48.4%		H	
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	Nov-16	89.5%	77.2%		H	
Children and young people's mental health services transformation	Q2 16/17	DQ Issue			H	
Crisis care and liaison mental health services transformation	Q2 16/17	80.0%			H	
Out of area placements for acute mental health inpatient care - transformation	Q2 16/17	100.0%			H	
Reliance on specialist inpatient care for people with a learning disability and/or autism	Q2 16/17	63			L	
Proportion of people with a learning disability on the GP register receiving an annual health check	2015/16	41.4%	37.1%		H	
Neonatal mortality and stillbirths	2014-15	7.8	7.1		L	
Women's experience of maternity services	2015	77.6			H	
Choices in maternity services	2015	61.4			H	
Estimated diagnosis rate for people with dementia	Nov-16	74.4%	68.0%		H	
Dementia care planning and post-diagnostic support	2015/16	80.6%			H	
Achievement of milestones in the delivery of an integrated urgent care service	August 2016	4			H	
Emergency admissions for urgent care sensitive conditions	Q4 15/16	3,269	2,359		L	
Percentage of patients admitted, transferred or discharged from A&E within 4 hours	Nov-16	86.8%	88.4%		H	
Delayed transfers of care per 100,000 population	Nov-16	24.2	15.0		L	
Population use of hospital beds following emergency admission	Q1 16/17	1.2	1.0		L	
Management of long term conditions	Q4 15/16	1,276	795		L	
Patient experience of GP services	H1 2016	83.2%	85.2%		H	
Primary care access	Q3 16/17	70.7%			H	
Primary care workforce	H1 2016	1.0	1.0		H	
Patients waiting 18 weeks or less from referral to hospital treatment	Nov-16	92.6%	90.6%		H	
People eligible for standard NHS Continuing Healthcare	Q2 16/17	62.7	46.2		<>	
Sustainability						
Financial plan	2016	Amber			<>	
In-year financial performance	Q2 16/17	Amber			<>	
Outcomes in areas with identified scope for improvement	Q2 16/17	CCG not inclu			H	
Expenditure in areas with identified scope for improvement	Q2 16/17	Not included			H	
Local digital roadmap in place	Q3 16/17	Yes			<>	
Digital interactions between primary and secondary care	Q3 16/17	53.7%			H	
Local strategic estates plan (SEP) in place	2016-17	Yes			<>	
Well Led						
Probity and corporate governance	Q2 16/17	Fully complia			H	
Staff engagement index	2015	3.9	3.8		H	
Progress against workforce race equality standard	2015	0.3	0.2		L	
Effectiveness of working relationships in the local system	2015-16	66.9			H	
Quality of CCG leadership	Q2 16/17	Green			<>	

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	11 April 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**2017-19 PRIMARY CARE QUALITY SCHEME PROPOSAL**
Report Summary:	This paper outlines the proposed redesign for our Primary Care Quality Scheme as a two year scheme for 2017/18 and 2018/19. This refresh recognises the national strategy around Primary Care, through the General Practice Forward View and also the NHS Operational Planning and Contracting Guidance for 2017-19 along with the Greater Manchester Primary Care Strategy and our local strategy and locality plan.
Recommendations:	The Single Commissioning Board is asked to approve the following recommendations: 1. Support of the Primary Care Quality Scheme taking into account the financial recommendations. 2. Make the mid-year payment in March 2018.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The expenditure proposed in this report is within the Section 75 and Aligned budgets of the Integrated Commissioning Fund. This proposal is supported but it is important that this is aligned to the locality plan and its aims and objectives as closely as possible to ensure value for money is achieved. The proposals and decisions need to be taken with consideration of the neighbourhood proposals as there must not be any duplication of investment or benefit delivery. Consideration should also be given to the proposals in section 4.3 with payments being made in line with actual delivery against plan such that if 20% of the plan is delivered 20% of the payment is received rather than the fixed 50% currently proposed. This way performance is rewarded more equitably in that if 70% of plan were delivered 70% of the payment would be received. It is recommended that a maximum of £1.50 per head is paid in financial year ending March 18 and a maximum of £1.50 per head is paid in financial year 2018-19 upon satisfactory delivery of agreed actions and achieved metrics. This is felt to be an appropriate split of the £3 per head payment over two years as it could be a reputational risk if the CCG is perceived to be deferring a quality payment against a national target. Furthermore, if quality is improved evidence suggests efficiencies will naturally emerge.
Legal Implications: **(Authorised by the Borough Solicitor)**	The Single Commissioning Board needs to be happy that the scheme is being / will be effectively monitored and understand how outcomes are to be assessed to ensure continuous improvement and value for money.
How do proposals align with Health & Wellbeing Strategy?	Improved care and outcomes, a focus on early intervention and prevention for all patients are priorities of the Health & Wellbeing Strategy.

How do proposals align with Locality Plan?	Strengthening and transforming general practice has a crucial role in the delivery of Sustainability and Transformation Plans and in integrating the aims and key local elements of the General Practice Forward View into the Locality Plan.
How do proposals align with the Commissioning Strategy?	The transformation of general practice is key to the Commissioning Strategy.
Recommendations / views of the Professional Reference Group:	The Professional Reference Group supported the proposal with a recommendation that the funding be split equally across the two years, with the mid scheme payment made in March. The Professional Reference Group recommended the number of practice projects be limited to a 'menu of choices' with alignment to workstreams, quality initiatives, Care Together workstreams, particularly self care and Integrated Neighbourhoods, to maximise impact, noting the balance between limiting the number of projects and addressing inequalities across practices and neighbourhoods.
Public and Patient Implications:	The drive to achieve improvements in health and care across primary care is intended to make the most of every opportunity to give people the right support close to where they live with the key principles of people powered change and care delivered by population based models.
Quality Implications:	This proposal supports the sustainability of general practice and the delivery of the ten high impact changes from the General Practice Forward View, which are both 'must dos' from the Operational Planning guidance and will deliver quality improvement in general practice and support this as continuous improvement by embedding the Quality Improvement principles.
How do the proposals help to reduce health inequalities?	The projects undertaken by each practices in the Primary Care Quality Schemes are to be co-selected based on practice specific data and therefore will address health inequalities within each practice population.
What are the Equality and Diversity implications?	This proposal addresses total practice population.
What are the safeguarding implications?	There are no safeguarding implications; the scheme identifies areas for Quality Improvement. Direct patient care as a result of the work within each project will be delivered through practices contracted route and therefore any safeguarding issues/implications be addressed under that process.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no IG implications; the scheme identifies areas for Quality Improvement through anonymous data. Direct patient care as a result of the work within each project will be delivered through practices contracted route and therefore any IG issues/implications be addressed under that process.
Risk Management:	Being managed as part of each measured deliverable.

Access to Information :

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

Tori O'Hare, Head of Primary Care

Telephone: 07920 086397

e-mail: tori.ohare@nhs.net

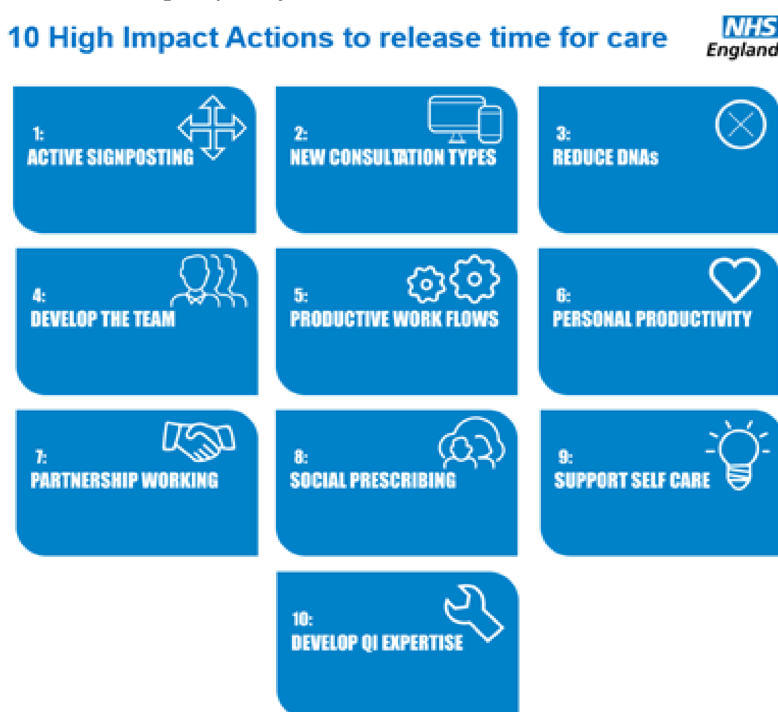
1. 2017-19 PRIMARY CARE QUALITY SCHEME

1.1 This report outlines the proposed redesign for our Primary Care Quality Scheme as a two year scheme for 2017/18 and 2018/19. This refresh recognises the national strategy around Primary Care, through the General Practice Forward View and also the NHS Operational Planning and Contracting Guidance for 2017-19 along with the Greater Manchester Primary Care Strategy and our local strategy and locality plan.

2. PURPOSE OF SCHEME

2.1 The operational planning guidance requires Clinical Commissioning Groups to identify resources for general practice transformational support; this scheme is designed to facilitate that support together with supporting the transformation agenda of Care Together.

2.2 The General Practice Forward View illustrates specific steps to improve general practice provision, both for patients and the workforce, and to address the pressures both in primary care and across the health system. These steps are summarised in the 10 High Impact Actions aimed at releasing capacity:



3. SCHEME OUTLINE

3.1 This scheme builds on high impact action 10 – develop Quality Improvement expertise - also supporting practices with projects which will address other of the 10 high impact actions. These will be determined by individual practices to best fit their requirements.

3.2 The proposal will support the development of Quality Improvement skills in GPs and their teams by applying them to real improvement projects embedding Quality Improvement as an underlying competence informing all of the work that practices undertake.

3.3 Each practice will receive a payment of £3 per head of their practice population spread over 2 years to deliver **three** Quality Improvement projects. There are six categories of improvement, and each practice, in conjunction with a subgroup of Primary Care Development and Improvement Group, will choose **two** projects from the **six** categories. In addition there will be **one** medicines management proposal that will be a mandatory

requirement for all practices; this will be the first project for all practices. By allocating this project first, this will ensure practices can start work on this area whilst the practice specific projects are being agreed, this will minimise the impact delay for 2017/18.

4. FINANCE

4.1 The NHS Operational Planning and Contracting Guidance for 2017-19 contains the following paragraph at Annex 6.1.2.1.

CCGs should also plan to spend approximately £3 per head (totalling £171m non-recurrently) in 2017/18 and 2018/19, from their existing allocations, for practice transformational support, as set out in the General Practice Forward View. This investment should commence in 2017/18 and can take place over two years as determined by the CCG, £3 in 17/18 or 18/19 or split over the two years. The investment is designed to be used to stimulate development of at scale providers for improved access, stimulate implementation of the 10 high impact actions to free up GP time and secure sustainability of general practice. CCGs will need to find this funding from within their NHSE allocations for CCG core services.

4.2 The scheme is built on the basis of that minimum investment recognising the financial pressure of the economy and also resources being invested in primary care transformation from non CCG core services allocation, ie the Transformation Fund and also resources which will be available from the Greater Manchester Transformation Monies, though the detail of the latter is being worked through by Greater Manchester Partnership and is to be confirmed in due course.

4.3 The proposed payment process is based on the following:

Engagement Payment (to be paid December 2017)	Initial payment on signing up to the scheme, agreeing practice projects and demonstrating approach and commencement of those projects	£0.50 per head of population
Mid scheme progress payment (to be paid March/April 2018)	Review of progress against agreed plan and achievement towards agreed data measures	£1.00 per head of population
Final achievement payment	Review of achievement against plan, either full payment if fully achieved or 50% payment if progressed but not fully delivered.	£1.50 per head of population Or £0.75 per head of population (subject to achievement)

This payment proposal has been drafted with consideration of QIPP and there a potential mechanism for delivering the £3 over the two years profiled in such a way as to give an option to minimise funding requirement in 2017/18 if the mid scheme payment is made in April 2018 rather than March 2017.

5. CHOICE OF QUALITY IMPROVEMENT PROJECTS

5.1 The choice of Quality Improvement projects will be agreed as a joint decision by the practice and Primary Care Delivery and Improvement Group and be determined by individual practice performance data. A range of data to be used is suggested in **Appendix 1**.

5.2 The project must follow established Quality Improvement methodology (for example LEAN, Model of Improvement), with outcomes monitored by on-going data collection. Quality

Improvement methodology suitable and acceptable for the scheme can be found in the Royal College of General Practitioners publication 'Quality Improvement for General Practice' at **Appendix 2**.

6. DISCRETIONARY CATEGORIES FOR IMPROVEMENT

6.1 The headings below detail the six project topics from which practices will be supported to choose two projects. Examples of potential projects are illustrated at **Appendix 3**.

Patient Access

6.2 This category will allow practices to explore their current performance data related to access to co-design their own improvement aims. Examples could include:

- an improvement in the waiting times for an appointment;
- a reduction in the number of times patients hang up as they can't get through on the phone;
- a reduction in the number of patients requesting care for self-limiting conditions;
- a reduction in the number of missed appointments;
- improving the continuity of care for patients;
- increasing the number of patients accessing their medical records.

The patient access project can be guided by the experiences of the Patient and Participation Group as well as by referring to other performance data, such as the National GP Survey (update to be published in July 2017), the friends and family test results and also access knowledge / patient feedback via other agencies, Healthwatch for example.

Patient Outcomes

6.3 This category allows practices to co-design a project based on a clinical area they think they might be able to improve. Examples could include:

- the number of patients who achieve blood pressure, lipid or HBA1c targets;
- reducing hospital admissions for conditions that might be managed in the community;
- changing prescribing habit in line with best evidence.

The choice of project will be guided by current performance when benchmarked with others (this could be drawn from RightCare data, Quality Outcomes Framework, national Diabetes audit, primary care web tool, openprescribing.net etc.)

Patient experience

6.4 This category allows practices to co-design a project with focus on an area where they know patients are less happy than they could be. This category could also include an aspect of access, if it relates to the patient experience and again should be guided by the PPG and practice results in the National GP survey or any other survey you may have conducted related to patient experience.

The category is broad enough to include more ambitious projects including how easy patients find accessing self-care information, though all projects are to be informed by data and have measurable outcomes.

Patient uptake of Public health interventions or improving disease prevalence

6.5 This category allows practices to co-design a project to support improving the health of their practice populations.

The choice of topic must be guided by data, and the Public Health England 'Fingertips' website, which provides useful data to help practices to choose their project. It can include:

- improving the uptake of screening programmes,
- improving the uptake of immunisation campaigns
- case-finding for long-term conditions where diagnosis is likely to improve outcomes.

Practice Systems and efficiency

6.6 This category allows practices to co-design a project to focus on their internal systems in order to reduce their overall work load. Examples of projects could include:

- the management of investigation results;
- managing the incoming mail;
- streamlining the repeat prescribing system;
- simplifying the medication review system;
- reducing the number of incoming phone calls to the practice;
- managing samples that are brought in to the practice unsolicited etc.

The whole practice team will need to be involved in choosing this project, and it may need some initial data collection in order to choose the priority area. This project may also be one which practices choose to undertake in collaboration aligned to integrated neighbourhoods and new models of care.

Practice Effective use of NHS Resources

6.7 This category will be co-agreed and be guided by the practice's neighbourhood support team, Clinical Lead, Commissioning Business Manager and Finance Lead also with Business Intelligence colleagues. It could include reducing the number or referrals to secondary care, reducing the number of A+E attendances by patients registered at the practice, reducing the number of referrals for procedures of low clinical value etc.

7. MANDATED CATEGORY FOR IMPROVEMENT

7.1 The CCG has been tasked with a number of improvement indicators, set by NHS England related to Gram negative sepsis and urinary tract infection treatment. If we succeed then the CCG can qualify, subject to overall achievement across all indicators, for extra funding, called a 'Quality Premium Payment'. It is with this in mind we have set the prescribing project aims. The criteria for the Quality Premium payment is that we reduce our trimethoprim prescribing and also increase the ratio of nitrofurantoin : trimethoprim prescribed. The rationale for the indicator is the high level of trimethoprim-resistant urinary tract infectioins in the UK. Both of these are a challenge for Tameside and Glossop for two reasons. We are already one of the lowest prescribing CCGs for trimethoprim in England. In addition to this practices often choose pivmecillinam or cefelexin in patients with reduced renal function or in pregnancy, and this affects the level of nitrofurantoin prescribing. However we have been set difficult challenges before, and have met them. Our local antibiotic support pharmacist believes there is still room for improvement. However we need to try to do this without causing harm to patients or working contrary to our local antibiotic guidelines.

7.2 The mandatory prescribing project is the Medicines Management Antibiotic Prescribing Project. The requirement for this indicator is that, from April 2017, each practice will run a monthly search on prescriptions for relevant medications and use run chart methodology to monitor performance on a monthly basis. If in any one month performance is outside anticipated levels then the practice will check all trimethoprim prescriptions against the local prescribing guidance for urinary tract infection (called a 'deep dive'), or known sensitivities to check prescribing was appropriate. The results will be fed back to the prescriber. Practices will be expected to submit their run chart to their medicines management technician monthly with the outcomes of any 'deep dive'.

8. SUPPORT FOR QI PROJECTS

8.1 Practices will be supported by the Primary Care Team, including CCG Quality Improvement Clinical Lead and Governing Body Clinical Lead for Primary Care with additional support delivered by the CCG Medicines Management Team and Neighbourhood Commissioning Support Teams. All projects will need to have prior approval based on:

1) Does it reflect the practice priorities as determined by data?
2) Does the project plan use good Quality Improvement methodology with measurable outcomes?
3) Is there a clear 'Quality Improvement Champion' leading the project?

9. ALIGNMENT

9.1 This scheme has been drafted within the framework of both the General Practice Forward View and the Greater Manchester Primary Care Strategy and to deliver the best value for the £3 per head investment to transform general practice required by the NHS Operational Planning Guidance. The scheme will sit alongside the refreshed Greater Manchester Medical Standards, with local mapping of services/provision in place against these being undertaken once the final document is published and the methods for ensuring delivery of each standard documented.

9.2 The scheme also offers alignment and support towards the delivery of Quality Premium indicators, particularly the reduction of inappropriate antibiotic prescribing for urinary tract infections in primary care element of the prescribing indicator however also, where access projects are selected the patient experience of making a GP appointment may also be supported.

10. RECOMMENDATIONS

10.1 As set out on the front of the report.

APPENDIX 1

Data Sources can be divided in to data sources external of individual practices and internal to individual practices, examples of each are listed below though these lists are not exhaustive and will include knowledge gained from practice visits, Healthwatch feedback and discussions at Primary Care Quality and Development Group.

External Data Sources
- GP Patient Survey
- Friends and Family Test
- Primary Care Web Tool
- Rightcare Data
- Public Health information – "Fingertips" website
- National Diabetes Audit
- Openprescribing.net
- ePact.net
- Quality Outcomes Framework
- Cancer Packs
- SLAM & SUS data

Internal Data Sources
- Practice clinical systems
- Individual practice Serious Event Analyses
- Practice surveys/Patient and Participation Group information and knowledge

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RCGP Royal College of General Practitioners

Quality improvement for General Practice

A guide for GPs and the whole practice team

Created with the busy primary care professional in mind, this guide details QI techniques that will see you and your team through a cycle of improvement time after time

CLINICAL INNOVATION AND RESEARCH CENTRE PILOT VERSION 1.0, SEPTEMBER 2015

The Royal College of General Practitioners was founded in 1952 with this object:

'To encourage, foster and maintain the highest possible standards in general practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same.'

Among its responsibilities under its Royal Charter the College is entitled to:

'Diffuse information on all matters affecting general practice and issue such publications as may assist the object of the College.'

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Acknowledgements

The work of the Quality Improvement Steering Group of the Clinical Innovation and Research Centre (CIRC), RCGP, has contributed greatly in the creation of this document. Members, past* and present: Dr Joanna Bircher, Chris Gush, Dr Matt Hoghton, Samina Ladhini*, Megan Lanigan*, Nicola O'Reilly, Sarah Pollet, Dr Imran Rafi, Ruchi Sivaganesh, Dr Bill Taylor.

The authors met with the following and received valuable advice from:

Professor Derek Bell. President Royal College of Physicians, Edinburgh. Director of NIHR CLAHRC for Northwest London and Professor in Acute Medicine, Imperial College, London.

Dr Helen Bevan. Chief Transformation Officer, NHS Improving Quality.

Professor Mike Crawford. Director of the Centre of Quality Improvement, Royal College of Psychiatrists. Professor of Mental Health Research, Imperial College, London.

Professor Amanda Howe. RCGP Vice Chair, Professional Development.

Professor Roger Jones. Editor, British Journal of General Practice.

Dr Terry Kemple. RCGP President-Elect.

Professor Simon De Lusignan. Chair in Health Care Management and Professor of Primary Care and Informatics, University of Surrey.

Professor Martin Marshall. Professor of Healthcare Improvement, University College London, and Lead for Improvement Science London.

Dr Kevin Stewart. Clinical Director, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians, London. Consultant Physician, Hampshire Hospitals.

Dr Robert Varnam. Head of General Practice Development, NHS England.

This guide was authored by Dr Bill Taylor, Clinical Lead for Quality Improvement, and Dr Joanna Bircher, Clinical Support Fellow for Quality Improvement, with the support of Sarah Pollet, Programme Officer at CIRC, RCGP.

Foreword

General practice is at the heart of the UK healthcare system. The scope, quality and innovation in UK primary care is recognised internationally. The challenge of improving the effectiveness and efficiency of the service we offer to our patients is continuous and ours to take up, to lead on and to achieve.

Improvement science as described by Martin Marshall *et al*[1] offers a systematic and evidence-based, health services approach to quality improvement. However, one of the many current challenges faced in primary care is having the time and commitment to evaluate initiatives in practice even if the potential exists for systematic improvement.

Our quality improvement experts in the Clinical Innovation and Research Centre at RCGP have highlighted these tools, produced in this guide, specifically to support primary care practitioners to plan, implement, evaluate, and embed new approaches more effectively and efficiently into practice.

Maureen Baker
Chair of RCGP Council

The tools demonstrated in this guide are accessible and workable at the practice level for interventions locally. The evidence it generates, through your work and shared experience, will provide support for improvements in general practice at scale. It also has the potential to influence upstream changes in the health system and in policy-making.

The potential improvements that could be made using this guide are a significant step towards implementing improvement science. It will help us to make the most of our systems, organisations and our talents and expertise to deliver better outcomes for patients.

Imran Rafi
Chair RCGP Clinical Innovation
and Research Centre

1. Marshall M, Baker M, Rafi I and Howe A. What can science contribute to quality improvement in general practice? *Br J Gen Pract* 2014 May; 64 (622): 254 -256

Introduction

As GPs, we strive to deliver the highest quality of care to our patients. There is a pressing need to harness this aim with 'evidence-informed' quality improvement (QI).

What is quality improvement?

The term 'quality improvement' describes a commitment to continuously improving the quality of healthcare, focusing on the preferences and needs of the people who use services. It encompasses a set of values (which include a commitment to self-reflection, shared learning, the use of theory, partnership working, leadership and an understanding of context); and a set of methods (which include measurement, understanding variation, cyclical change, benchmarking and a set of tools and techniques).

Why QI?

As members of primary care, we don't have the time or resources to spend on things that don't work, don't serve our patients, and that could be done either more efficiently or effectively. However, we need ways of identifying whether things work, how well they work, and the reasons why this is. What's more, these 'ways' need to be simple, straightforward and effective. The methodologies and techniques of quality improvement provide us with these skills and insights.

QI in practice

As members of primary care, we are already 'doing QI' in the form of clinical audit and significant event analysis. College members have been pivotal in the development and promotion of these instruments. In the face of the pressures on general practice, RCGP Council has agreed that members, and primary care generally, would benefit from advice, support and training in how to take advantage of what a wider approach to quality improvement has to offer us. A first step towards that goal is this Guide to quality improvement.

QI support

This guide provides the essential information about a select range of approaches and tools that we are likely to be able to use time and again to the benefit of our practice and patients. The tools are chosen for being simple and straightforward – even enjoyable, revelatory and rewarding – and, taken together, they will support you through the full circle of continuous improvement. They help to unravel the knottiest of system and process problems; to generate ideas for solving them; and they provide a methodology for testing those ideas, revealing the ones that merit further time investment, and those that should be dropped forthwith. They are drawn from 'evidence-based' materials from the emerging improvement science. We have devised a wheel to summarise the process. This guide will take you through it and the stages you will work through in your intervention.

Improving together

QI is a good place to direct team efforts. New models of working, such as federations or localities, will discover many benefits from engaging with QI work to share knowledge, skills and best practice.

We would appreciate hearing your improvement stories and case analyses so that we can learn from them and inspire others. Please send them to qualityimprovement@rcgp.org.uk

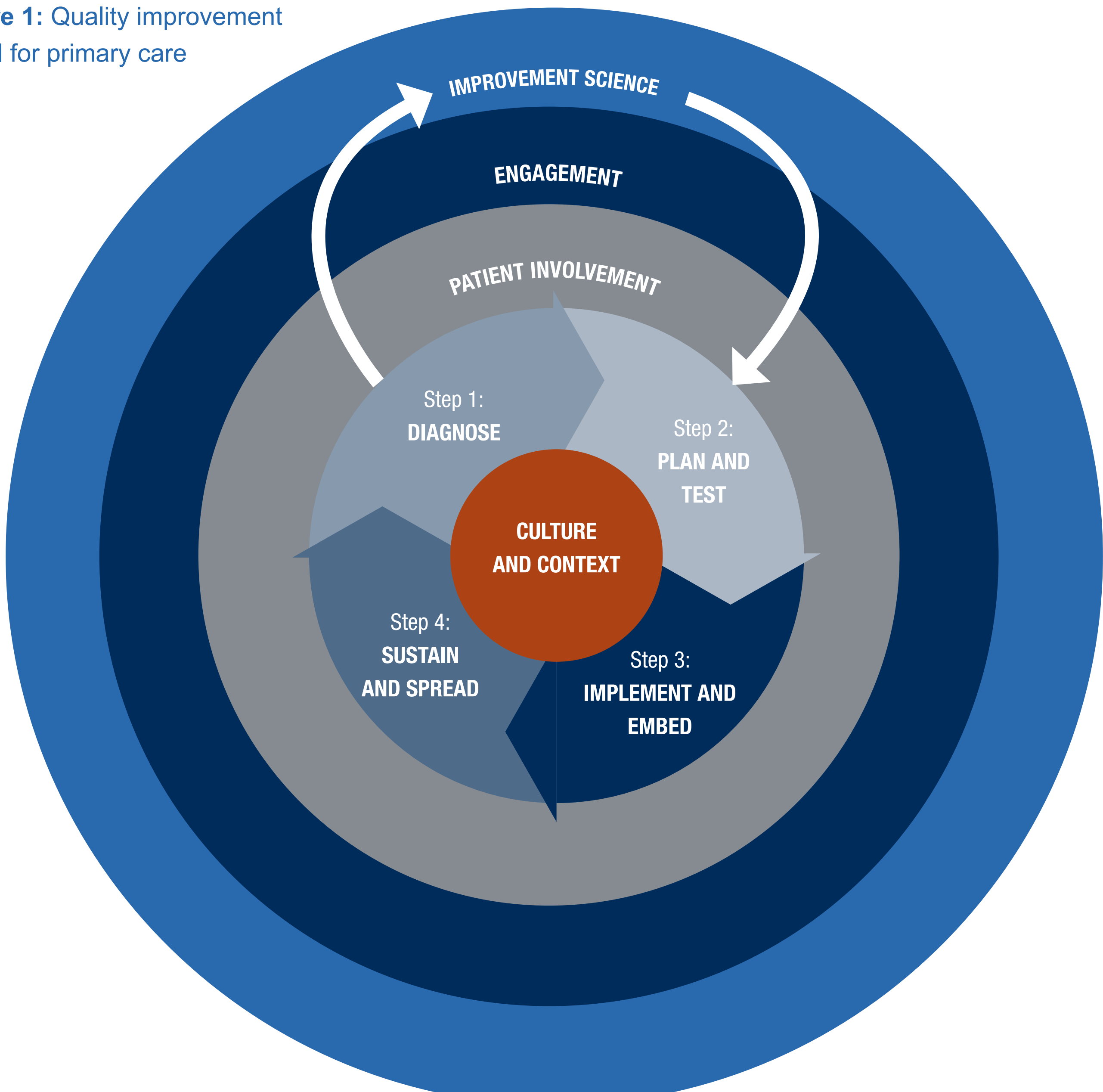
Bill Taylor and Joanna Bircher

Introducing the QI wheel for primary care

The aim of this guide is to make the principles and tools of quality improvement as accessible as possible for GPs and their practices teams.

We have created a simple visual representation of quality improvement for primary care to give you an overview of your quality improvement journey. It illustrates the main elements for you to consider in the design, delivery and evaluation of a QI project and acts as a guide to the stages you will work through during implementation.

Figure 1: Quality improvement wheel for primary care



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EXPLAINING THE QI WHEEL FOR PRIMARY CARE

The QI wheel is made up of five rings:

1. **Culture and context.** Helps you to create the right conditions for a successful project.
2. **QI cycle.** Guides you through project implementation
3. **Patient involvement.** It provides ideas on harnessing vital patient input for successful improvements
4. **Engagement.** It provides ideas on which stakeholders to engage and how to involve them.
5. **Improvement science.** Provides you with the big picture context that your QI work fits into.

THE HUB OF THE WHEEL: CONTEXT AND CULTURE

What is it? You can consider your culture and context to be the soil in which the intervention will germinate. The soil needs to be as favourable as possible to allow the intervention to be successful. Context is the local and national environment in which you operate. Culture covers your practice values, attitudes and ways of working. It includes your practice team, patients and stakeholders: how you involve them and interact together on a daily basis. Your patients and stakeholders are therefore included at the heart of this wheel.

Why is it there? We have placed 'Context and culture' at the centre of the wheel as without a culture and context that is keen to experiment, and supportive of trying something new, it will be hard for change to occur, or be sustained, regardless of what tools or methods you use.

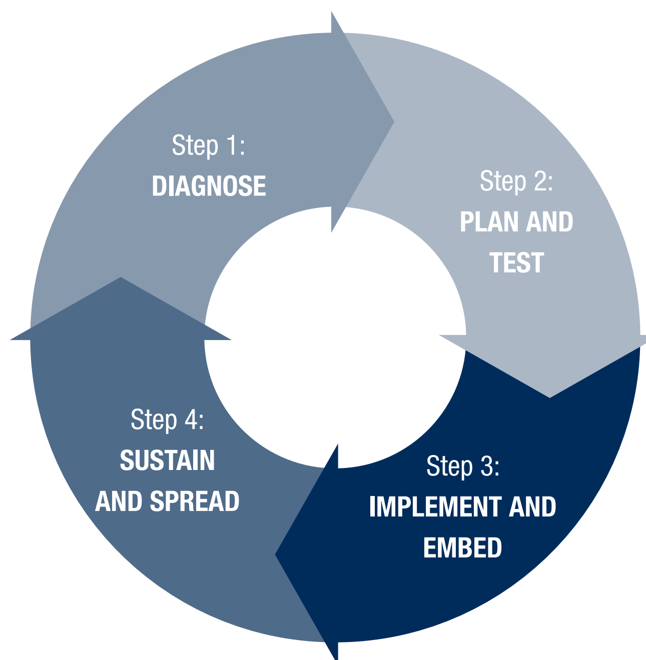
How do you use it? This section of the guide provides you with tools to analyse your own context and culture, which you can then use to find the best way to create a context that is supportive of the change(s) you wish to make.

THE INNER RIM OF THE WHEEL: THE QI CYCLE

What is it? These are the implementation steps for a cycle of quality improvement. We have broken it down into four steps.

Why is it there? These are the stages you will work through in any QI project.

Figure 2: QI cycle diagram



How do you use it?
This guide explains helpful tools for implementing each step:

- **Step 1:** Diagnose - assess the area of your practice or organisation that requires improvement, and generate some baseline data.
- **Step 2:** Plan and test – decide the aims, methods and monitoring of your change. You can also test your intervention in a graded fashion.
- **Step 3:** Implement and embed - make any successes part of your systems or processes.
- **Step 4:** Sustain and spread - consider how your aims or intervention can continue to be implemented on a larger scale, if appropriate, and how the conclusions can be made more widely available.

An overview of the QI tools is provided on page 20. Chapters 2 to 5 explain each tool.

THE ESSENTIAL SUPPORTING RIMS:

Patient involvement

What is it? Patients are part of your culture and context. Involving them in our QI work means we see our work through the eyes of the people who need our care.This helps us to design, implement and evaluate each individual quality improvement project.

Why is it there? The position of the patient involvement ring indicates it acts as scaffolding, to support any QI project.

How to use it? This section of the guide provides you with ideas on how to harness patient input into the design and delivery of your projects and their measures of success.

Engagement

What is it? Engagement represents all stakeholders relevant to your project. You will have internal stakeholders in your own practice and external stakeholders such as pharmacists, social care services, and health infrastructure bodies at the local and national level.

Why is it there? In a similar way to patients, your stakeholder involvement can support the different stages of your QI project.

How to use it? This section helps you to consider the who, when and how of involving your stakeholders.

Improvement science

What is it? Improvement science is research to identify and demonstrate the best and most appropriate methods for improvement in the quality and safety of health services.

Why is it there? Improvement science is the 'containing' ring because it is the big picture context for your QI work.

How to use it? Once you have made progress on your QI journey and have gained confidence using the approach explained in this guide, the Improvement science section signposts you to other improvement methodologies that you and your team may wish to explore.

HOW TO USE THIS GUIDE

This guide has been designed to get you started on your QI journey. You do not need to read it from cover to cover.

Be inspired. Read the example QI project described overleaf. It provides an overview of what a cycle of improvement in primary care might look like in practice.

Orientate yourself. Read chapter 3 to gain a broad overview of the QI approach we advocate.

Prepare your culture and context. Start at the hub and read chapter 1: analyse your own culture and context and make it as pro-change as possible.

Get started: try your first QI project. Follow the four steps in the QI cycle, starting with diagnosing an area for improvement. Page 20 provides a summary of the tools we recommend for each step. There is a menu to choose from. Pick the ones most relevant to your project. You will find that the tools can be re-used in later steps.

If you're reading the guide on screen, you can use the bookmark menu on the left to navigate to and from other sections.

QI in action: a practical example

What does a cycle of quality improvement in general practice look like? Here is an example from Dr Joanna Bircher which was undertaken in her practice in Tameside and Glossop, England.

Diagnosis of an area for improvement

The GPs at our practice attended a local GP education event where they heard a presentation from the local consultant in substance misuse. She presented compelling and disturbing data about the rise in prescribing of opiate medication and the challenge facing her service of helping people to come off these addictive prescription painkillers.

We had been aware of a general rise in prescribing within our own practice, and had also recognised we were sometimes reaching for the prescription pad when a multi-modality approach to chronic pain management might have been more appropriate. We made a plan to see if we could reduce our prescribing.

Plan and test

As described in this guide, we adopted the Institute for Healthcare Improvement's 'Model for Improvement' to steer our activity.

What are we trying to accomplish?

It was hard to set a clear aim, as we couldn't predict what would be an appropriate level of prescribing for our patients; but we hoped to reverse the upward trend in our prescribing. We therefore chose as our aim: a reduction in the number of prescriptions for strong opiate medication (drugs of the equivalent strength of codeine 30mg or above) issued per month.

What changes will result in an improvement?

We had two ideas to test.

The first was to write to all patients who receive a repeat prescription for these medications, excluding those coded as 'palliative' or 'end of life' care. One of the GPs would design the letter and test out the wording with the practice team and two patients on such a repeat prescription. The letter would explain the long-term problems that can be caused by the medication and the possible benefits of reducing or stopping the drugs, as well as the issue of withdrawal symptoms.

The second idea (implemented at the same time) was to reduce the quantity of medication issued the first time a prescription for a strong opiate for pain was prescribed to 50 tablets and attach a leaflet to that prescription explaining the value of the drug for acute pain as well its addictive potential and the issue of withdrawal symptoms following prolonged use. Again this leaflet would be drafted and shared with the practice team and a few patients to 'fine tune' the wording.

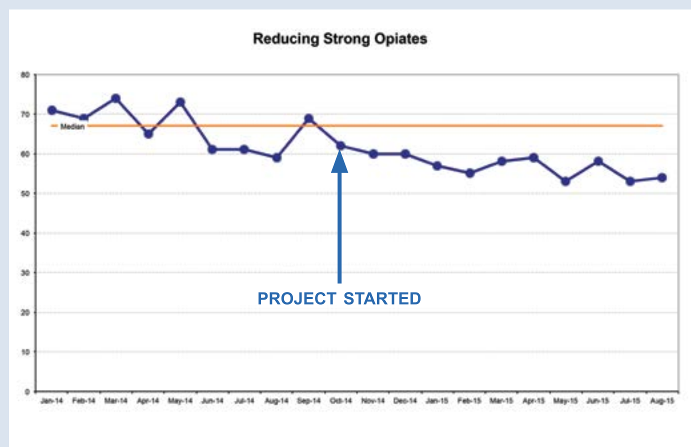
How will we know if a change is an improvement?

We would use a run chart to monitor our monthly data of the number of prescriptions of strong opiates issued. It was easy to gather retrospective data for the ten months prior to the project and provide ourselves with a baseline for comparison.

Implement and embed

We were delighted to see positive results with an overall reduction in the number of prescriptions issued for strong opiates.

Figure 3: Run chart for reducing strong opiates



Discussing the results in our practice meeting, it was felt the initial letter to patients on a repeat prescription had made the most difference because most of us had been forgetting to implement the second idea (prescribing smaller quantities when first issuing a prescription and to attach the leaflet to that prescription).

We had decided to gather any negative comments from patients about the project as our balance measure (which checks for negative impact of a project) and were surprised to find there were none. We wondered if this was because of patient involvement in the design of the letter.

We decided to repeat the first idea on an annual basis (letter). After our experience of the difficulties of implementing the second idea (leaflet), we will look for ways to make it easier for the doctors to remember and then see if it generates a further reduction.

Sustain and spread

We continue to run the search for the number of strong opiates issued per month and plot it on the run chart. This allows us to track if our change has been sustained. The chart is displayed on our practice 'Performance board': a visual display in our meeting room, where we all eat lunch. This helps to keep the goal in everyone's mind.

We try to spread the ideas by sharing our project with medical students and visitors to the practice.

PART I: The hub of the wheel

- CULTURE AND CONTEXT

Context and culture in quality improvement

Is the soil (context) fertile enough to allow the seeds of quality improvement to flourish?
(© Natural Resources Conservation Service)

Context can be defined as the 'environment' in which your quality improvement intervention is to be introduced. Variations in context influence the success or failure of your intervention, no matter how well planned it may be. Looking at your context at the very outset of your initiative will help it to thrive. Where you identify elements with the potential to be detrimental to your success, you will be able to devise strategies to accommodate or ameliorate them.

Breaking down 'context' into its component parts can help you to understand it. One way of doing this is to consider context as 'Inner' (related to the practice or organisation in which the intervention is introduced) and 'External' (related to factors in the world at large). Part of this analysis could include considering the behaviour and motivation of those involved. In order to give you multiple insights into your context we provide three tools for assessing it (see page 18): a checklist, forcefield analysis and SWOT analysis.

'INNER CONTEXT' FACTORS

The imposition of plans and ideas from above can create barriers to success. The following present an alternative to a top-down culture.

Culture

Success is more likely if all members of the practice or organisation:

- Support each other.
- Are satisfied with their work.
- Give high priority to quality and are prepared to recognise when things could be improved.
- Welcome patient feedback in all its forms – compliments, complaints and experiences – as an opportunity to see their service through the eyes of the users, and to learn from this.
- Operate a 'no blame' system when looking for root causes when things go wrong.
- Are happy to be involved in looking for solutions.
- Are prepared to experiment with new ideas.
- Believe it is worth investing time to improve.

Questionnaires administered within the practice can help assess the culture. Although most have been designed with safety in mind, they are still relevant for quality as a whole. Examples like the Manchester Patient Safety Framework and Safequest tool can be found on the RCGP Patient Safety Toolkit webpage.[2]

Leadership

Success is more likely if the leaders of the practice or organisation:

- Believe that involving staff and patients in planning improvements will create a better outcome.
- Have skills that allow for maximum participation and effective meetings.
- Inspire and motivate the team.
- Encourage members of the team to take the lead.
- Can support the team through challenging times that often accompany change.

Team working

Success is more likely if the practice or organisation:

- Recognises that good teamwork is essential and that each individual has a role to play.
- Invests time in developing the skills of the whole team.

Capacity

Success is more likely if the practice or organisation has:

- The financial and human resources needed to undertake the improvement. Costing of the change will include: the quantification of the costs of the intervention; the quantification of the outcomes; the differences between options; and the differences between costs and outcomes. Calculating costs can be difficult and rough estimates often have to be used.
- Methods of identifying those resources.
- Suitable equipment available.
- The time available for the programme to realistically achieve its goals. You may need to consider your time management.

'EXTERNAL CONTEXT' FACTORS

Evidence base

Success is more likely when:

- Planning the intervention has included looking for what has worked in other organisations. You may need to critically appraise such evidence, looking in particular at how a given context might differ from your own.
- Evidence-based guidelines are followed.

2. RCGP. *Patient Safety Toolkit for General Practice*. Available from: http://www.rcgp.org.uk/clinical-and-research/toolkits/patient-safety. [accessed 7 September 2015]

Using evidence-based quality improvement interventions is a developing field of research, see chapter 8: improvement science (page 53).

Political/regulatory

Success is more likely when:

- Your quality improvement intervention is compatible with the wider political priorities. Consider, for example, changes to contracts, performance measures, national frameworks and policies.
- Your intervention is compatible with the requirements of regulatory bodies, such as the Care Quality Commission (CQC), General Medical Council (GMC), and GP contract.

Technological

Success is more likely when:

- Effective IT and communication devices support your intervention, e.g. for data analysis and visual displays of progress.
- Wide use is made of all media systems to sustain and spread your learning.

Social/demographics

Success is more likely when:

- Your quality improvement intervention is appropriate for the demographics of age, gender, race, religion, and socio-economic status of the population affected.
- It follows a social trend. An example of this would be a general move towards 'patient-centred' care either from multiple organisations or from a wave of enthusiasm on social media for patient involvement in service design.
- Your quality improvement intervention is appropriate for the prevailing economic climate.

BEHAVIOUR CHANGE AND HUMAN MOTIVATION

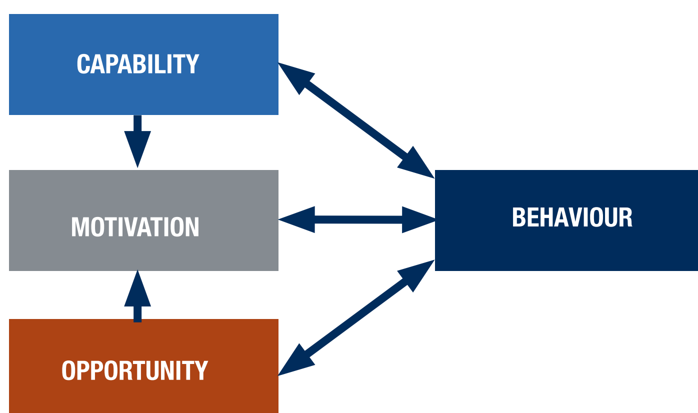
In addition to the 'Inner' and 'External' contextual factors, a good understanding of how to influence human behaviour is important for an effective quality improvement intervention.

There are many theories of behaviour change and human motivation. One way of thinking about it is that developed by Michie *et al*.[3] In their framework, capability, opportunity and motivation interact to create behaviour. 'Capability' is defined to include having the knowledge and skills needed to engage. 'Opportunity' refers to external factors that can influence the adoption of the intervention. 'Motivation' is creating the energy that will direct behaviour.

People are motivated by an array of factors. For some, improving the quality of care for their patients is enough, particularly if failure to take action will have dire consequences for their patients. For others, professionalism or interest in the subject matter might be key. Other possible levers include personal or organisational alignment with the goals of quality improvement; threat of coercion; or the offer of incentives (a gain in time, money or other resources). Identifying quick wins can motivate people in any of your projects.

3. Michie S, *et al*. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science* 2011; 6:42; DOI: 10.1186/1748-5908-6-42.

Figure 4: Behaviour change diagram[4]



Some of these elements you may be able to modify; for others you may have to change your approach to accommodate the context.

CONTEXT TOOLS

Here are three tools to help you consider and understand your context and culture. Choose the one(s) you feel will work for your situation.

CONTEXT CHECKLIST

The checklist (appendix one, page 56) breaks down context into eleven elements. Consider each in turn and decide whether they are applicable to your situation, and whether any action is required.

FORCEFIELD ANALYSIS

A forcefield analysis assesses which aspects of context are aiding or hindering the project. The chart is made up of two columns: one for driving forces and one for restraining forces. Brainstorm what the forces are and score the strength of each from 1 – 10. Then use the forcefield analysis to devise a strategy that accommodates or increases the driving forces and that either mitigates or decreases the strength of the restraining forces. A Word template is in appendix two, page 57.

SWOT ANALYSIS

In this analysis there are four headings:

- strengths
- weaknesses
- opportunities
- threats.

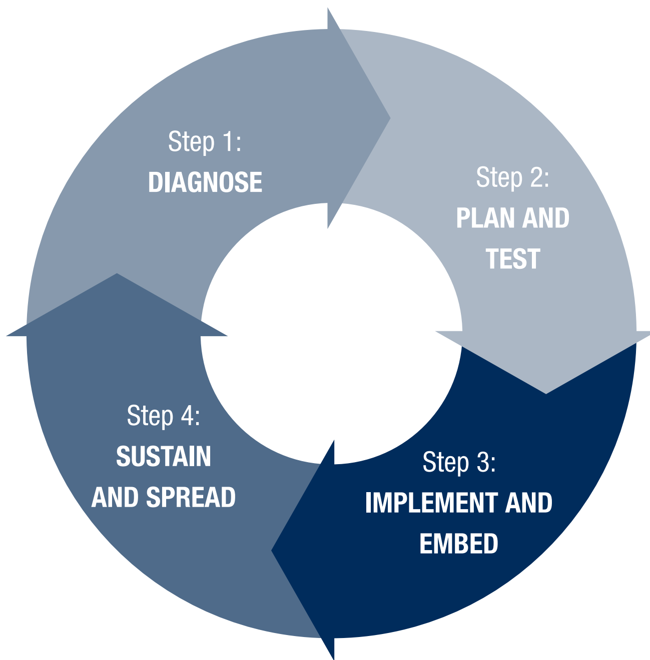
Consider which contextual elements fit under each heading. They may fit under more than one. You can then use the identified strengths and opportunities to your benefit; and you may also try to mitigate your weaknesses and avoid the threats.

4. Michie S, *et al*. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science* 2011; 6:42; DOI: 10.1186/1748-5908-6-42.

PART II:
The inner wheel

- QUALITY IMPROVEMENT TOOLS AND CYCLES

Figure 5: QI cycle and menu of tools



This diagram summarises the steps of a QI cycle and sets out a menu of tools that you can choose from for each step. You will find you will reuse some of the tools from earlier steps later in the cycle.

Step 1: DIAGNOSE

Examining a system or process
Process mapping: Visual representation of a process
Value stream mapping: More detailed than process mapping
Fishbone diagram: Diagram to identify the root cause of a problem
Clinical audit: Criterion and standard based study
Significant event analysis: Reflection and learning from a case
Enhanced significant event audit

Externally-sourced data
National audit: Use results obtained nationally
Benchmarking data: Data may illustrate variation in practice
CQC: Areas for improvement identified

Creating new sources of data
Gathering: Data can be used to identify a problem
Survey: Can identify needs of targeted group
Diagnostic analysis: Focus group(s) to identify areas for improvement
Appreciative inquiry: Improving processes that work well

Step 2: PLAN AND TEST

Model for improvement: defining purpose and measure of success
Driver diagrams: Used in planning a project
PDSA: Cyclical testing and implementing ideas in project
Run charts: Charts to analyse data and look at variation
Care bundle: Grouping of indicators measured collectively
Communication matrix: Identifying who and what to tell about project
Gantt chart: Action planner
Theory of constraints: Identifying constraints and eliminating them
Experience-based co-design: Patients and staff design services together

Step 3: IMPLEMENT AND EMBED

Run charts: Charts to analyse data and check if improvement
Visual display: Display to all involved

Step 4: SUSTAIN AND SPREAD

Evaluation: Elements required for evaluation
Networks: The 5C wheel to add value to networks
Communication strategy: Plan communication
Collaboratives: Grouping of practices and or disciplines
SPC charts: More sensitive run charts

Diagnosis

Having understood your culture and context, you can identify areas of practice that could be improved or would benefit from change. This section contains a variety of tools that enable you to do this. You can choose to use one tool or several together. We have grouped them into system or process analysis tools (below), externally-sourced data (pages 26) and creating new data sources (pages 27).

SYSTEM OR PROCESS ANALYSIS TOOLS

When you think of a process in your practice, you might be able to think of some 'solutions' off the top of your head. Tools, however, enable you to examine an area as a team and drill down to uncover useful pieces of information – such as false assumptions - that can help generate new solutions and provide the order in which to address them. They include tools you will already be familiar with, such as clinical audit and significant event analysis.

Figure 6: Photo of process map

PROCESS MAPPING

What is process mapping?

Process mapping creates a visual representation of all the steps in a process. It is best created by a group of people involved in the process. This can include patients or individuals from organisations that your practice works with. It can be used for any practice process that consists of multiple steps, e.g.:

- the repeat prescribing system
- dealing with results
- processing incoming and outgoing mail
- making a referral
- registering as a new patient
- registering as a patient for online services.

Why use process mapping?

The objective is to design a more efficient process, plan changes and free up time for other activities. The benefit of using process mapping for the practice team is that it can help everyone to:

- Understand each stage in the process, including those with which they are not directly involved.
- Quickly identify bottlenecks and steps that appear to be a waste of time.
- Engage in change, contribute to improvements and take ownership of the new or revised process, which will help with buy-in.

The steps in creating a process map

Before the session:

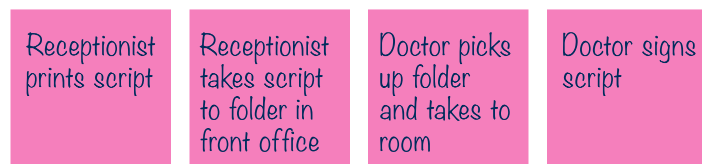
1. Decide which process is to be mapped and arrange a date to meet that all can make.
2. Choose a facilitator. This person needs to be able to explain the exercise to the rest of the team. They do not need to have a detailed understanding of the process that is to be mapped.
3. Collect the materials. You will need post-it pads of different colours and pens.

In the session:

The map can be constructed on a wall, on paper or on a table-top. A lot of horizontal space is required.

4. The facilitator explains process mapping to the participants, making it clear that each step needs to be broken down. The more detailed the better because this will identify waste.

Figure 7: Process map: sequential steps in a process



5. Define the start and end point of the process. For repeat prescribing, the start point could be the patient requesting a repeat prescription; the end point could be the patient collecting the prescription (fig. 7).
6. If one step can be done in several ways, this is added vertically. e.g. in the repeat prescribing process the patient may request a script in different ways (fig. 8).

Figure 8: Process map: how to display options in the process

7. Once the map is created, the facilitator asks the group where the problems arise. The participants then attach these to the map using a different coloured post-it note.
8. Participants are then asked to identify solutions. These are attached to the map using another different coloured post-it note. They are stuck over the problems that were identified.
9. This process will then have identified areas for improvement and generated new ideas to try out. The group should decide if they will try out the changes either one at a time or several together, and agree which measurements they will use to identify whether or not there is an improvement over time. The section on run charts (pages 34) offers you a method of measuring and tracking change that will help you to identify process improvement and show you which actions should be sustained.
10. A further process map is then created by the group to illustrate the agreed new process.

Depending on the complexity of the process to be mapped, the exercise can take as little as 20 minutes or up to 2 hours.

After the session: the outcome

By the end you will have created a visual display of an improvement to an existing process. On occasions there may be so many problems with the process that you need to start from scratch. At these times, creating a driver diagram (plan and test section, page 30) could be a useful starting point.

It might be a good idea to leave the map on display for a few weeks so that any issues that arise during implementation can be more easily discussed.

VALUE STREAM MAPPING

This is a visual map of a process or system from Lean methodology (improvement science, page 53). Its purpose is to identify waste to help streamline processes. It has similarities to process mapping, but is generally done in more detail. It is also similar to a flow diagram.

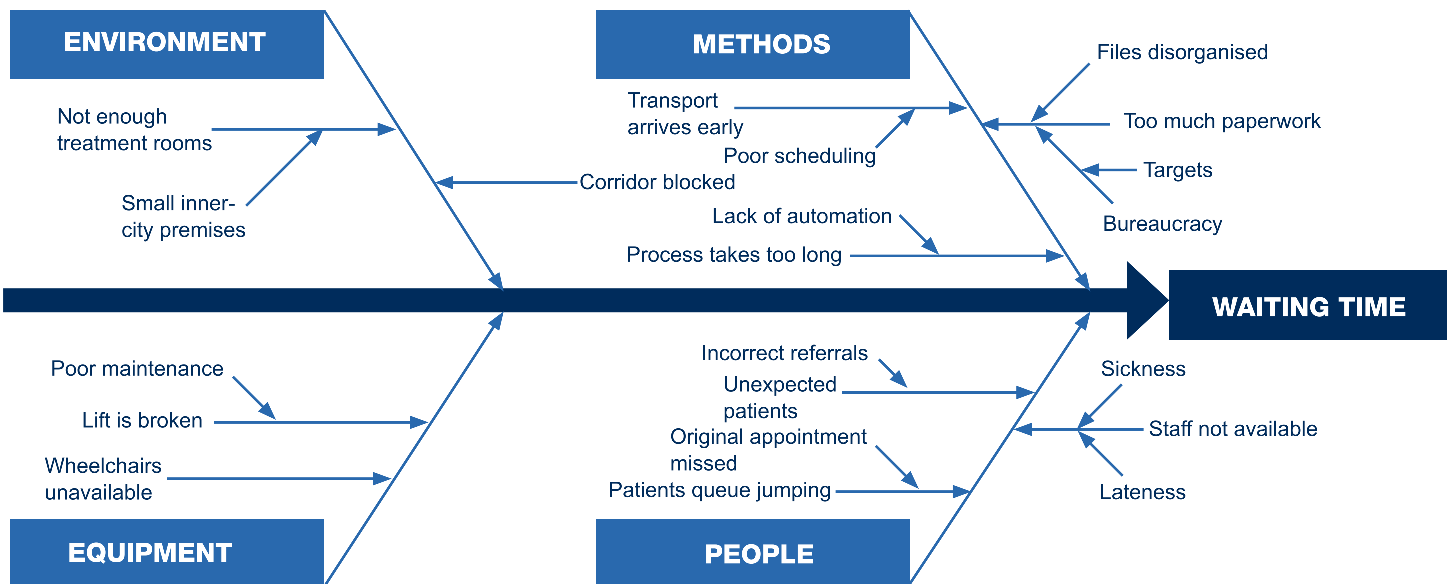
In value stream mapping, steps are divided into those that are value-added, value-enabling and non-value added. Value-enabling activities do not add direct value, but are necessary to the process. On this map, the time for each step is recorded together with the time taken between steps. The objective is to reduce or eliminate non-value added activities.

FISHBONE DIAGRAM

Fishbone diagrams (also called cause and effect analysis) look at identifying the root causes of a problem. They are useful when there are multiple causes of a problem and because of this may be complex. The example below, taken from the Institute for Innovation and Improvement, shows a diagram for the problem of waiting time[5].

The first stage is to identify the problem, which becomes the head of the fish.

Figure 9: Fishbone diagram for waiting time



5. Fishbone diagram: Adapted from TIN, now the East Midlands Improvement Network, and Dave Young. Cause and Effect (Fishbone). *The Handbook of Quality and Service Improvement Tools*. NHS Institute for Innovation and Improvement, 2008. http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_%20tools/cause_and_effect.html [accessed 28 May 2015].

Once your head is in place, you can brainstorm the major categories of the potential causes or use generic headings such as 'environment', 'people', 'equipment' and 'measurement'. These form the spines of the fish.

You can then discuss each major category, adding the ideas generated as sub-branches. Each sub-branch may be further broken down into its contributing factors.

For every spine and sub-branch identified, ask yourself 'Why does this happen?' and consider the question from different perspectives - such as patient, administrator, nurse, doctor, clinical commissioning group. This will produce the layers of causes that will help you to fully understand the root of the problem and its dependencies.

The exercise is best conducted in a group comprising everyone involved or affected by 'the problem'. Once you have your diagram, you can decide which cause is tackled first.

CLINICAL AUDIT

Undergraduates, postgraduates in training and those in long established practice have used clinical audit to meet their needs for summative and formative assessment as well as for the purposes of meeting professional obligations such as appraisal. Clinical audit can also be a means of diagnosing areas of practice that would benefit from improvement, but do bear in mind that it needs to be used in conjunction with other tools in the 'plan and test' phase of a quality improvement project. This is because a full cycle audit only measures two points in time, while effective quality improvement requires measurement to be 'little and often'. Frequent small-scale measurement will lead you to understand whether the variations in measurements can be attributed to the changes made through the QI interventions or whether they could be caused by something else instead (e.g. common cause variation due to natural or ordinary causes, see run charts on page 34).

Clinical audit differs from a survey because the data in a survey is not presented with reference to criteria or standards. The guidance below provides the standard headings for a clinical audit report and gives tips on how to define and fulfil each section. It attempts to keep the process simple and will satisfy the requirements of revalidation. Example audits are available on the RCGP website.[6]

1. Title

This will be the heading on your document.

2. Reason for the audit

Topics chosen can be identified from many sources. There may be a new guideline circulated and you may wish to see how your practice performs against new recommendations. A problem may have been identified from a complaint or significant event review and an audit would establish if there is a more widespread problem. You may be aware from your clinical work that there is scope for improvement in an area of care. The condition or treatment could be one that affects patients in a significant way or it may be one that affects many patients. What matters here is that in your opinion there is scope for improvement.

3. Criteria or criterion to be measured

You can help to keep your audit simple and effective by choosing just a small number of criteria. The criterion should pose an easy 'yes' or 'no' question so that you will know whether or not it has been met. Where possible, you will benefit from selecting your criterion from a well-evidenced guideline or piece of research, which you can then reference. It is better if it contains only one element so that it is clear which element is not being met. A criterion with two elements would be that "All patients with IHD are on aspirin and have had their blood pressure checked". For some quality improvement work you may wish to bundle elements together in one indicator to assess your care of patients with a clinical condition, for example, diabetes.

6 Example clinical audits: http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/clinical-audit.aspx

4. Standard(s) set

A 'standard' is the level of performance achieved and expressed as a percentage. It can be derived from external sources, such as audits that have been done elsewhere, or determined internally from discussion with clinicians in the practice. The standard should be realistic rather than idealistic and so you will usually wish to avoid a standard of 100%.

5. Preparation and planning

Planning your audit as a paper exercise prior to commencing data collection will help you to ensure that it is achievable and that it will answer the question you have set. You will want to decide how to identify your patients. This can often be done by a search on your database of patients. If you select this method, can you set up a search or do you need to talk to someone who can? Ask yourself, will the search criteria identify whom you want? Do you wish to include all the patients or a sample? This will obviously depend on the numbers involved. Most audit projects need not be as rigorous as a research project, so statistical methods of deciding sample size are not usually necessary. The number sampled needs to be practicable. Simple randomisation may suffice (e.g. choosing every second or third patient on a list). You can then decide how you will record your results, whether by using a software package or a simple paper checklist that records Yes/ No/ Not applicable. How might you inform members of the practice team that you are conducting an audit without this influencing the result?

6. Results and date of collection one

You will want to record the date. The collection could be one point in time, either retrospective or prospective. You might want to present your results in table format for ease of presentation (fig. 10).

The criterion may need to be abbreviated or numbered to fit in the table.

7. Description of change(s) implemented

From your results it will be easy to see whether or not your criterion or criteria have been met. Based on this, a decision can be taken on the changes to be made. This may be done once results have been presented to others to gain their opinion, especially if the change(s) will affect more than just you. It can be beneficial to share your audit results with the whole practice team since this will increase the likelihood of the change being sustained. A decision might then be taken as to when a further data collection is to be made. When setting a date, do allow sufficient time for the changes to have had an effect.

8. Results and date of data collection two

This can be presented in an extension of the previous table, with an additional column for the second data collection (fig. 11).

Figure 10: Template for clinical audit results (collection one)

Criterion	Number sampled	Achievement	Standard

Figure 11: Template for clinical audit results (collection two)

Criterion	Number sampled (Date one)	Data one achievement	Number sampled (Date two)	Data two achievement	Standard

9. Reflections

This is where you present the conclusions of your audit project. It would include any lessons learned; any further steps of change required; and you may wish to state when the audit will be repeated.

SIGNIFICANT EVENT ANALYSIS (SEA)

Another source for identifying areas for improvement can be significant event analyses. These are usually done when any event is thought to be significant in patient care or in the running of the practice. Whether clinical, administrative or organisational, the SEA process enables the following questions to be answered:

- What happened and why?
- What was the impact on those involved (patient, carer, family, GP, practice)?
- How could things have been different?
- What can we learn from what happened?
- What needs to change?

Further guidance can be found on the former National Patient Safety Agency webpages.[7]

ENHANCED SIGNIFICANT EVENT ANALYSIS (eSEA)

Enhanced significant event analysis is a further improvement to the existing SEA structure. A 'human factors' approach was taken in an NHS Education for Scotland (NES) pilot funded by the Health Foundation Shine programme. It considers contributory factors to an event and their interactions under headings of People factors, Activity factors and Environment factors. Human factors addresses problems by modifying the design of the system to better aid people: to understand and limit conditions in the system that predispose an individual to make an error and to reduce the risk of errors leading to harm. Further details on this study can be found on the NES website.[8]

EXTERNALLY-SOURCED DATA

Performance reports can be sources for identifying best practice and areas for improvement. They include national audits, benchmark reports and CQC data. We have created a list of data sources relevant to primary care, organised by UK country, which you may use to support your QI activity.[9] It is available to download from the RCGP website.

NATIONAL AUDIT

National audits exist in many clinical areas in England and Wales. Increasingly, data is being collected from primary care. This can be useful for highlighting areas for improvement. Primary care data is collected as part of the National Diabetes Audit.[10] RCGP contributes as a stakeholder to a number of other external audits such as COPD, continence care and dementia care.[11]

BENCHMARKING DATA

Data can be presented to enable comparisons between practices, between primary care organisations or between nations. If the variations are statistically significant then an opportunity for improvement may exist. Often this type of data is presented in a bar

7. Bowie P, Pringle M. *Significant event audit: guidance for primary care teams*. London: National Patient Safety Agency, 2008. http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61501 [accessed 31 Jul 2014].

8. NHS Education for Scotland (NES). *Enhanced significant event analysis*. Edinburgh: NES, Mar 2014. http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/patient-safety-and-clinical-skills/enhanced-significant-event-analysis.aspx [accessed 3 June 2015].

9. RCGP. *Data sources for undertaking quality improvement activity in primary care*. http://www.rcgp.org.uk/clinical-and-research/our-programmes/~/media/Files/CIRC/Quality-Improvement/RCGP-Data-sources-for-undertaking-QI.ashx [accessed 2 July 2015]

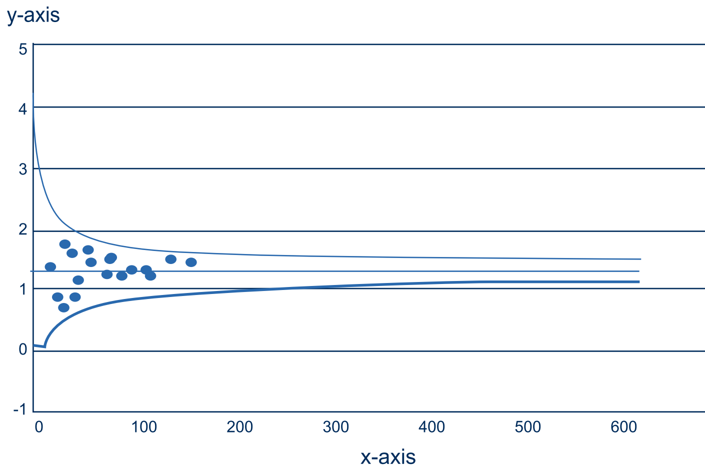
10. Health and Social Care Information Centre (HSCIC). *National Diabetes Audit*. Leeds: HSCIC. http://www.hscic.gov.uk/nda [accessed 12 August 2015].

11. RCGP. External audits. *Clinical audit*. http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/clinical-audit.aspx [accessed 12 August 2015].

chart, ranking the participants. Examples include the national GP survey and NHS England Primary Care Webtool and your practice QOF data. One criticism of this method is that it encourages mediocrity: being in the middle range is acceptable. Further, bar charts do not reflect differences in sample size from each practice or organisation. In bar charts, small changes in a small sample can therefore seem to show great variation in performance compared with organisations with large sample size. Funnel plots provide one statistical approach that can take account of the sample size or the prevalence of a condition being measured. Hence, before drawing conclusions from benchmarking data, do consider how the data is presented and how that is affecting the results. As with any data, check that it is complete and reliable.

Learning can also be made when the data reveals best practice. If your practice or organisation is above average, you could ask yourselves, 'How have we managed it?' 'Is it sustainable?' 'Could we use this method of success in a different area?'

Figure 12: Funnel plot diagram



CARE QUALITY COMMISSION (CQC)

In England, practices are being provided with and may review updated 'intelligent monitoring data' that incorporates some QOF data as well as prescribing data. Some practices may find the feedback report from the CQC visit useful in deciding improvement priorities.

CREATING NEW SOURCES OF DATA

The data you need may already be available from established sources and does not always need to be collected de novo. However, if you do want or need to generate new data, your options include conducting a survey, undertaking a diagnostic analysis or leading an appreciative inquiry.

DATA GATHERING

Before collecting any data, you will want to plan the data gathering exercise to ensure that the data to be collected will help you to measure and monitor the area you want to improve. You can collect the data over time so that any variation can be explored. The frequency and duration of data collection can then be decided. Do consider the resources of time, money and personnel when data collection is planned. Will there be any unintended consequences in collecting this data? How will you ensure participants are clear that the measurement is not being made to criticise their performance? Data collected for quality improvement can differ from that collected for accountability or research.

SURVEY

In quality improvement, surveys are frequently used to identify the needs of the target group. Considering the following will help you to produce a well-designed survey.

Ensure your objectives for conducting the survey are clear and are clearly stated on the questionnaire, together with instructions on how it is to be completed and by when.

Do keep the questionnaire as short as possible while also allowing enough information to be collected. Asking two or more questions about the same aspect can increase the reliability of the results, but you will want to balance this against creating too long a survey that no-one completes.

Try to ensure each question is clear, concise, covers only one idea, avoids jargon and is unbiased. You can ask open or closed questions. A closed question can be answered with either a single word or a short phrase. For example, you may wish to discover how the respondents rate their knowledge on a subject from ‘very knowledgeable’ through, say, five stages to ‘no knowledge’. If presenting a selection of answers, check that you have covered all possible answers or added an ‘Other’ option. An example of an open question would be to ask respondents to complete free text comments to a question. This can be a source of new information, but will take longer to analyse.

You might benefit from testing your survey with a few people before it is launched.

If a sample is used, check that it is large enough in size to allow meaningful analysis, and that its selection is bias-free.

You can employ free-to-use internet survey websites and their webpages provide further guidance on designing a questionnaire and on conducting a survey.

DIAGNOSTIC ANALYSIS

In this method, one or more focus groups are formed. A facilitator has a guide to prompt discussion, if needed. An audio recording of the discussion can be made or written notes taken instead. Common themes can be identified as important to your project and can be a source for identifying areas for change.

APPRECIATIVE INQUIRY

This is based on the idea that something in a system is done well, but can still be improved. The most common model consists of four elements:

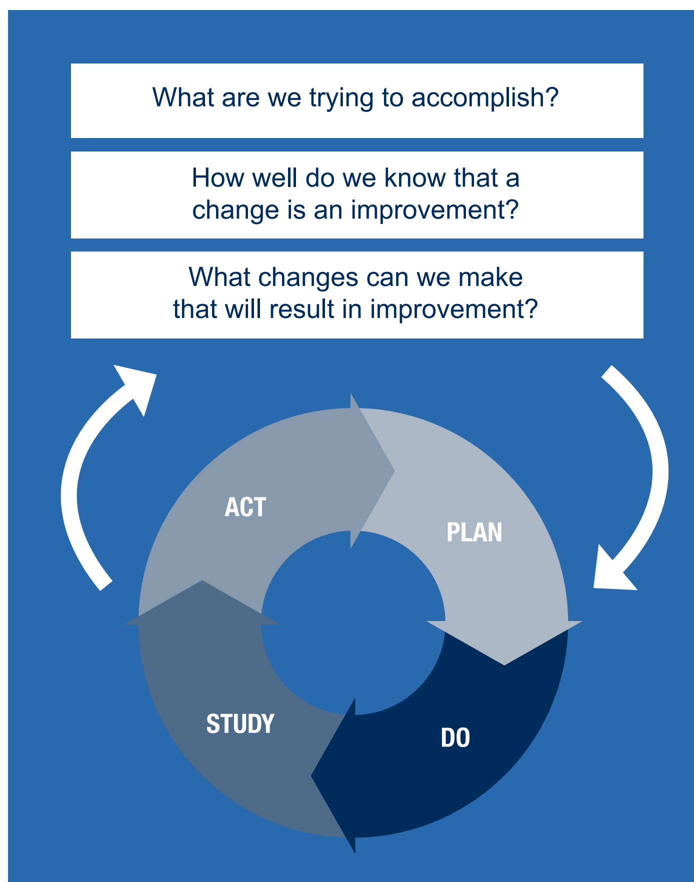
1. *Discover*. Identify what works well.
2. *Dream*. What could work better in the future?
3. *Design.* Prioritise processes that would work well.
4. *Deploy*. Implement design.

The identification of the processes can be done by interview or by forming a group of stakeholders. It is an approach that differs markedly from a problem-solving approach.

Plan and test

From the diagnosis phase of your project you will have identified areas to learn from that you already do well, and areas where there is scope for improvement. With some of the diagnostic techniques you will have also generated ideas for change and potential 'solutions'. You can now plan your changes and how they will be tested. This starts with identifying a clear purpose and measure of success (the Model for Improvement, below) and the actions that will deliver that purpose (driver diagrams, page 31). You will then plan out how each individual cycle of change will be implemented ('Plan-Do-Study-Act' approach, page 31) and measured (run charts, page 34) to identify which changes result in an improvement or not. Further planning tools that aid implementation are communication matrices (page 38) and Gantt charts (page 38). If you decide to measure multiple indicators at one time, this can be done as a care bundle (page 37).

Figure 13: Model for improvement diagram



MODEL FOR IMPROVEMENT

Before embarking on an intervention, ensure that you and the team are very clear and specific about what you want to improve and how you will know if you have been successful. The Model for Improvement gives you three questions to answer before you start testing changes.[12]

This section explains how to use the Model for Improvement approach to clarify your aim and measure of success by referring to a common GP issue - antibiotic prescribing.

Question 1: What are we trying to accomplish?

This needs to be specific and include 'by how much?' and 'by when?' For example: *"reduce the number of antibiotics we prescribe at the practice"* is not very specific.

12. Langley GL, *et al. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd Edition). San Francisco, CA: Jossey-Bass Publishers; 2009. ISBN: 978-0-470-19241-2 and is the source of the diagram on this page.

A more specific aim would be: *"reduce our antibiotic prescribing to be in line with the national average in 6 months' time"*

Question 2: How will we know if a change has been an improvement?

Decide what you are going to measure so that you know whether your ideas for change are working. Some organisations provide us with external data about our practice, and this can be very helpful in deciding on the overall success of a project; however, this data is often slow to arrive and may not be provided frequently enough for judging the success of a change.

Continuing the antibiotic example:

Data about antibiotic prescribing compared to national averages is being provided every three months by the local CCG Medicines Management Team and this will be used to assess the overall success of the project after six months.

However, this externally collected data is not useful for judging whether our small changes have been successful. Another data source is required to measure each of those individually.

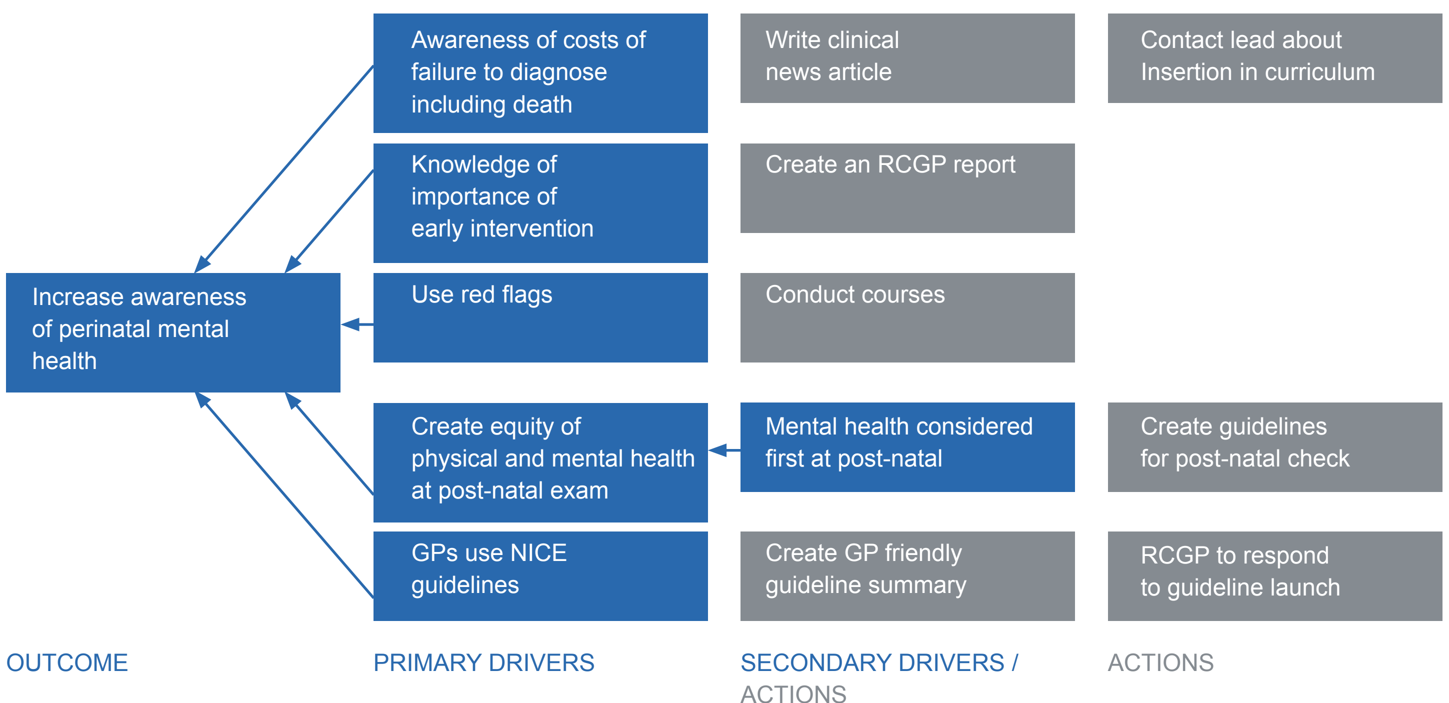
Question 3: What changes can we make that will result in improvement?

To answer this question, consider all of the ideas for change that were generated in both the diagnosis and the plan and test stages so that you can select those that you would like to test. In our example, the practice agrees to test three ideas:

- Put a poster in the waiting room explaining to patients why antibiotics are not useful for most coughs and colds.
- Benchmark the prescribing habits of the individual GPs in the practice – number of antibiotics prescribed per ten consultations.
- Provide all COPD patients with a leaflet explaining that most exacerbations should be treated with steroids first, and only use antibiotics if sputum becomes purulent.

These changes can be further considered using a driver diagram, a tool that is illustrated below and explained overleaf using the example of raising awareness of perinatal mental health.

Figure 14: Driver diagram



DRIVER DIAGRAMS

A driver diagram is a powerful mapping tool that helps you to translate a high-level improvement goal into a logical set of underpinning goals and projects: it identifies the actions that will achieve your aims. They are particularly useful when your aim has many components or subsidiary objectives. They can also serve to decide the direction of your practice or organisation following development of a vision or mission statement.

Driver diagrams consist of three columns: outcome, primary drivers and secondary drivers.

The outcome covers the aim(s) of your project or the impact you wish to make. It should be stated as simply as possible.

The primary drivers describe the set of high-level factors/areas that need to be addressed or influenced in order to achieve the outcome. They can often be derived from answering the first question in the Model for Improvement: 'What are we trying to accomplish?'

The secondary drivers contribute to at least one primary driver and cover areas in which to take action and plan for change.

Actions or specific projects that could generate the drivers can then be added.

Figure 14 is an example of a driver diagram for raising awareness in perinatal mental health.

It shows that the goal can be achieved in five different ways, either individually or concurrently. It identifies a means (an action/project) of achieving each driver. As a whole, the diagram provides a change strategy for 'increasing awareness' that can be shared and understood, and can provide the basis for planning the individual projects or interventions.

PLAN-DO-STUDY-ACT (PDSA)

Why use PDSA?

The 'Plan-Do-Study-Act' approach is part of the 'Model for Improvement'.[13]

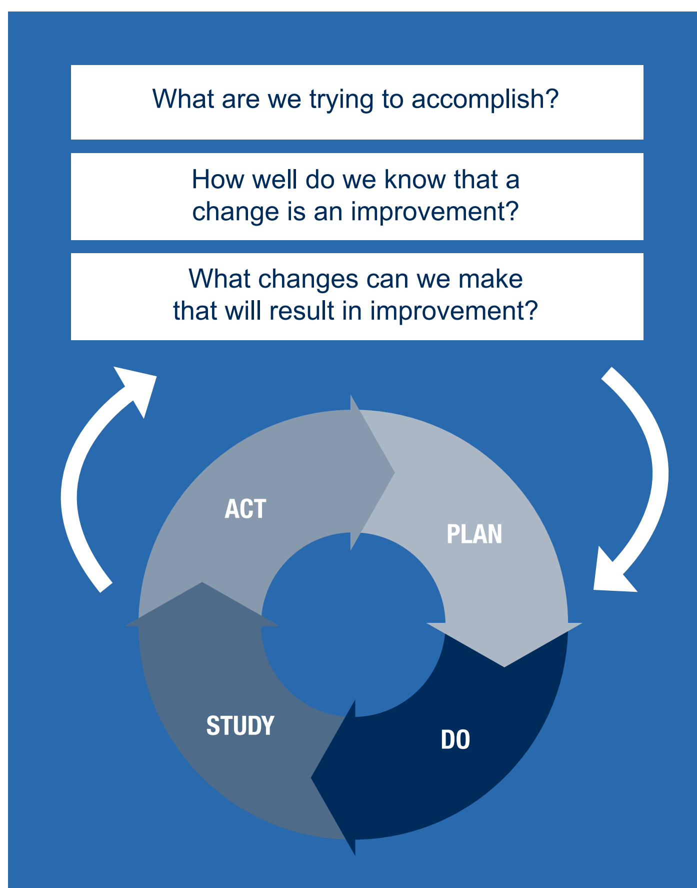
When we want to improve things in our practices, we often come up with a lot of ideas, but cannot be sure which will result in the change we want to see. Sometimes we try something different and we continue to do things the new way even if it does not actually result in improvement. It is easy to lose motivation and start to believe that we cannot make a difference.

The PDSA approach accepts the fact that not all of our ideas will work and allows us to test them out in a controlled way. We can then continue the ideas that work, and stop doing those that do not. It starts at small scale and so is a cost-effective approach.

Each change we identify from answering the third question of the Model for Improvement should enter a 'PDSA cycle' in turn.

We continue with the example of antibiotic prescribing to explain this approach.

13. Langley GL, *et al*. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd Edition). San Francisco, CA: Jossey-Bass Publishers; 2009. ISBN: 978-0-470-19241-2; and is the source of the diagram on page 32.



The PDSA cycle

Plan: In this stage you identify the change you wish to implement in order to bring about an improvement. For each idea or change you can use the three questions from the Model for Improvement and driver diagrams to clarify your aim and measure. Planning will also include identifying who will be responsible for the change; when it will be carried out; over what timescale; and how the measurement will be conducted. Involve all stakeholders in the process and do persuade any reluctant team members to participate. Consider how you might look out for the unexpected – for example, checking that a reduction in antibiotic prescribing does not cause an increase in COPD admissions. This is called a 'balance measure'.

In our example, the practice identified three changes it would test out: *a poster in the waiting room; benchmarking the GPs' prescribing habits; and a leaflet for COPD patients.*

Do: First collect your baseline data to monitor the existing state of play. You might do this as part of 'planning' or 'doing'. Ensure that all individuals who are conducting the measurements understand what data is being collected and how to collect it. After sufficient time, continue to collect the data but introduce the agreed change. If you are considering implementing several changes, you would usually introduce one change at a time so that the effect of each can be measured. By introducing only a small change you are likely to encounter less resistance, and, if unsuccessful, adaptions can be made more quickly. The scale at which you test your change should also be kept small at first. Any problems encountered, and any unexpected consequences, can be recorded as implementation progresses.

In our example: *For the second change, the practice decided to run a search every Friday at 17:00 to gather the number of antibiotic prescriptions issued that week.*

Study: The success or failure of the change is assessed at this stage, both quantitatively (by looking at the data collected) and qualitatively (by discussing how everyone experienced the change). Run charts (pages 34-37) could be used for numerical data. You should compare the results with the predictions you made and document any learning, including a record of the reasons for success or failure. Not all changes result in improvement, but learning can always be gleaned.

In our example: *The practice first tested having the poster in the waiting room and, once that PDSA cycle had completed, the practice tested benchmarking GP prescribing habits.*

Figure 15 shows the number of antibiotic prescriptions issued per week before and after the poster was displayed in the waiting room:

Figure 15: Run chart for reducing antibiotic prescribing (poster in waiting room)

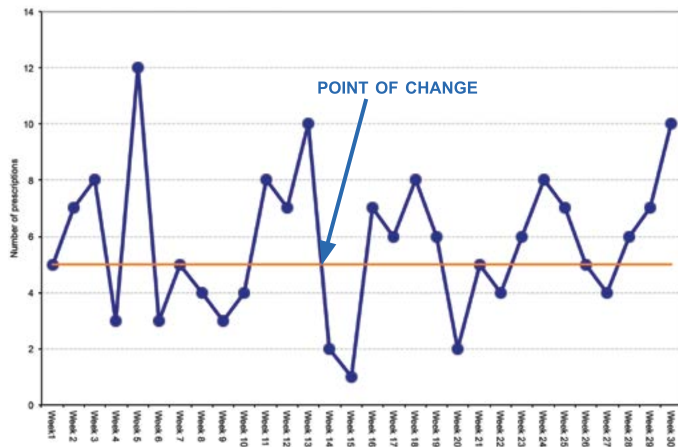
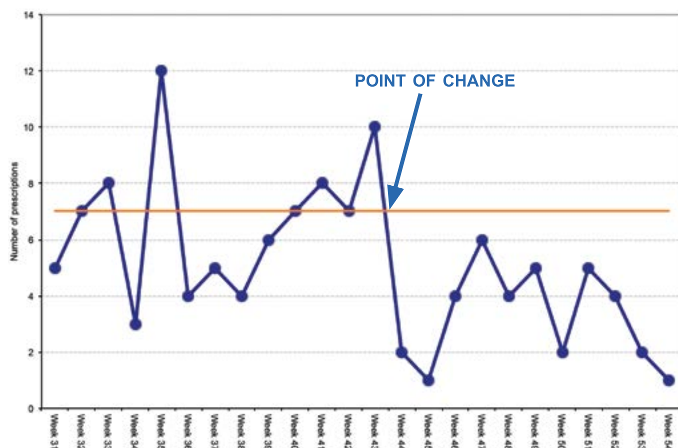


Figure 16 shows the number of antibiotic prescriptions issued per week before and after the GPs prescribing habits were benchmarked:

Figure 16: Run chart for reducing antibiotic prescribing (benchmarking GP habits)



From these charts the practice determined that the poster made no impact on the number of antibiotic prescriptions issued, but the benchmarking of GPs' prescribing habits did reduce the number issued.

The next section provides some simple rules for interpreting run charts like those above.

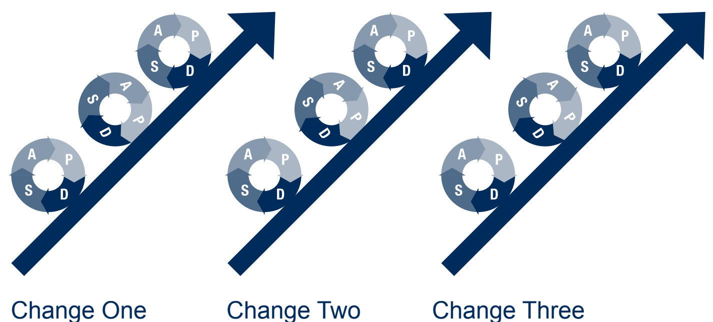
Act: In this stage, decide whether you just need to adapt what you have tried or whether you might try something completely new instead.

In our example*: The decision was made not to keep the poster in the waiting room, but to continue the benchmarking exercise every two months.*

Summary:

It is best to test small changes and then do multiple cycles. Learning from one cycle informs the next.[14]

Figure 17: Sequential PDSA cycles for learning and improvement



This method allows fairly rapid assessment of any intervention in a cost-effective manner.

MEASUREMENTS AND ANALYSIS

Data measured can be qualitative or quantitative. They can be an outcome measure (e.g. number of amputations in patients with diabetes), a process measure (e.g. blood pressure recorded), or a balancing measure (e.g. unintended consequences). Your measurements need to be able to assess the impact of your change. Common tools used for quantitative data are run charts (below) and statistical process control charts (SPC charts, pages 45). The latter are more advanced and are therefore discussed in sustain and spread (chapter 5), although both types of chart can be used for both the testing and sustaining phases of a project.

14. Multiple PDSA cycle diagram. Institute of Healthcare Improvement. Science of Improvement: Testing Multiple Changes. Cambridge, MA: IHI. http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingMultipleChanges.aspx [accessed 3 March 2015].

RUN CHARTS

Run charts help you to analyse any numerical data gathered to see whether a new initiative results in an improvement and whether the improvement is sustained over time.

There are many ways of analysing data. Run charts are useful when looking at data that varies from day-to-day (e.g. the number of days to the next routine appointment or the number of 'extra' patients seen each day). The charts enable you to study the variation and identify times when things appear to be 'out of the ordinary'.

The following fictional QI project shows how a run chart can be used to analyse the data.

Run chart example project – Reducing the number of 'extra' patients seen each day

Every practice has to deal with patients who need to be seen on the same day once all the routine and urgent appointments have been filled. For the purposes of this example these are called 'extras'.

Unpredicted peaks in the number of extras seen can cause stress for GPs and their staff, as well as leaving less time for other important work.
The example practice would like to study the number of extras. They want to understand the existing variation over time before they experiment with new ways of doing things.

Inputting the data into a spreadsheet to create a run chart

All that is needed to create a run chart is a basic knowledge of MS Excel and a look at the useful tips described below. However, to make this even easier, the Institute for Healthcare Improvement USA (IHI), has created an Excel template.[15] To access this template you will need to register with the IHI, but this is free and straightforward. It is best to gather at least 15 days of data before constructing your chart.

15. Scoville, R. Run Chart Excel Template. *Run Chart Tool*. Cambridge, MA: Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/Tools/RunChart.aspx [accessed 28 May 2015].

In our example, the lead receptionist gathers data about the number of extra patients seen over 20 working days. This is inputted into the IHI spreadsheet: dates in the left-hand column and the numbers seen in the 'value' column.

The IHI spreadsheet looks like this:

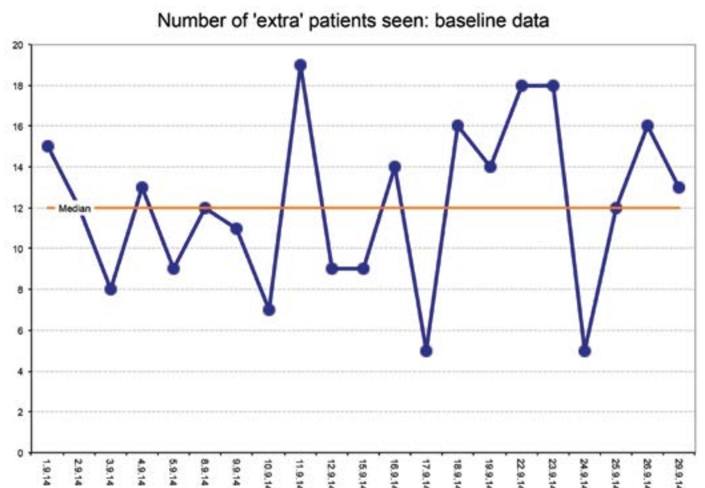
Figure 18: Data for 'extras seen' (baseline)

Vertical Axis Label: Number of extras seen
Graph Label: Number of 'extra' patients seen: baseline data

Date / Observation	Value	Median	Goal	End Median
1.9.14	15	12		
2.9.14	12	12		
3.9.14	8	12		
4.9.14	13	12		
5.9.14	9	12		
8.9.14	12	12		
9.9.14	11	12		
10.9.14	7	12		
11.9.14	19	12		
12.9.14	9	12		
15.9.14	9	12		
16.9.14	14	12		
17.9.14	5	12		
18.9.14	16	12		
19.9.14	14	12		
22.9.14	18	12		
23.9.14	18	12		
24.9.14	5	12		
25.9.14	12	12		
26.9.14	16	12		
29.9.14	13	12		

The IHI template automatically calculates the median number of extras and creates the chart:

Figure 19: Run chart for 'extras seen' (baseline)



The median line is drawn on the chart to help you check whether the data is random or not.

You will need to know that it is random variation so that you can make sense of any changes that happen when you experiment with a new way of doing things (your QI intervention).

How to tell if the data is random

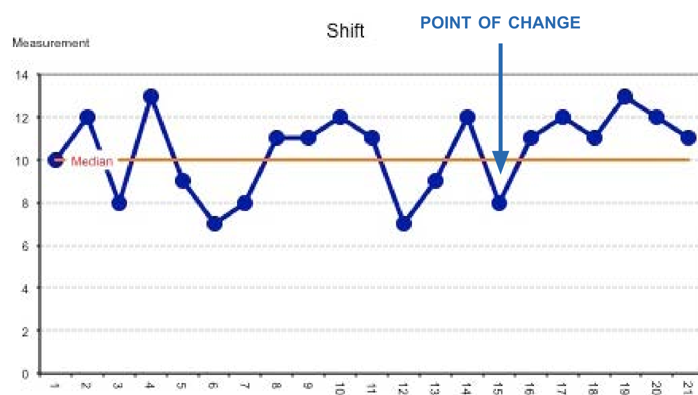
It is important to check that your baseline data shows random variation. If the variation is not random it may be that there are already things happening to change it (for example, a media campaign), and this will prevent you identifying whether changes you may see later are being caused by your intervention or by something else.

Here are some 'run chart rules' to help you make sense of your chart.
If your data is random:

- The graph line crosses the median line frequently.
- There are no 'trends' (five or more data points going up or down).
- There are no 'shifts' (six or more points in a row either above or below the median).
- The number of runs in a chart are within the expected lower and upper limits.

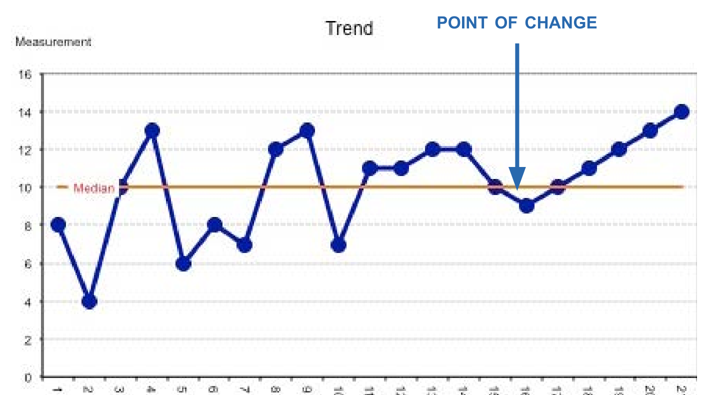
Figure 20: Run chart rules[16]

Rule 1



A shift has six or more data points above or below the median. For this rule, do not count a data point on the median line. In the example above the shift happens after the change is implemented.

Rule 2



A trend has five or more data points ascending or descending. The trend may cross the median and data points on either side of the median should be counted. For this rule, if two or more points are the same, only count as one. In the example above, there is a trend occurring just after the change.

Rule 3

Too many or too few runs. In the example left, there are 14 data points that are not on the median but only two runs, which are too few runs for the number of data points. This is explained in more detail in the next section. No 'change' is marked on this chart because it illustrates baseline data collected before any intervention has been trialled.

Counting runs

A run is a set of points that are on one side of the median. You can calculate the number of runs by counting the times the line crosses the median and adding one.

16. Scoville, R. Run Chart Excel Template. *Run Chart Tool*. Cambridge, MA: Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/Tools/RunChart.aspx [accessed 28 May 2015].

Expected number of runs

If your data is random, there is an expected lower and upper limit of runs you should see for the number of data points collected, illustrated by the expected number of runs table below. Too few or too many runs may mean your process is already changing. This will make it hard to know if your project is successful and will require investigation before you embark on your project.

Figure 21: Expected number of runs table [17]

Number of observations / data points not falling on the median	Lower limit for number of runs	Upper limit for number of runs	Number of observations / data points not falling on median	Lower limit for number of runs	Upper limit for number of runs
15	4	12	30	11	20
16	5	12	31	11	21
17	5	13	32	12	22
18	6	13	33	12	22
19	6	14	34	12	23
20	6	15	35	13	23
21	7	15	36	13	24
22	7	16	37	13	25
23	8	16	38	14	25
24	8	17	39	14	26
25	9	17	40	15	26
26	9	18	41	16	27
27	9	19	42	17	28
28	10	18	44	18	30
29	10	20	46	19	31

In our example, the number of data points will be the number of days surveyed, which was 20 days. If we look at the table, for 20 data points we should expect between six to 15 runs if the data is random. Our example has 11 runs with no shifts or trends and so it does seem to be random variation.

What next?

The practice has now gathered its baseline data and decided that the variation is random. They would like to reduce the number of extras seen in the surgery.

The first experiment is a GP telephone triage of all requests for same-day appointments. This involves significant change to the working day for the GPs and has the potential for fewer routine appointments to be made with them. However, it is seen by the practice as an experiment and they are confident that the run chart will help them to see if it makes a difference.

17. Scoville, R. Run Chart Excel Template. *Run Chart Tool*. Cambridge, MA: Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/Tools/RunChart.aspx [accessed 28 May 2015].

They continue to gather the data and input it into the spreadsheet:

Figure 22: Data for 'extras seen' (post-change)

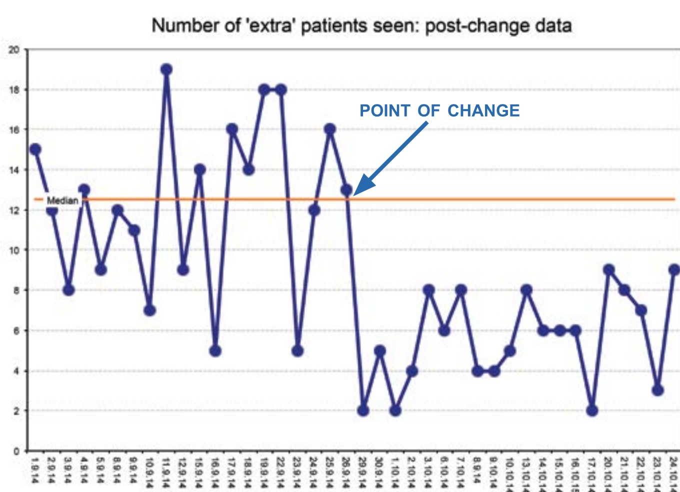
Vertical Axis Label	Number of extras seen			
Graph Label	Number of 'extra' patients seen: baseline data			
Date / Observation	**Value**	**Median**	**Goal**	**End Median**
1.9.14	15	12		
2.9.14	12	12		
3.9.14	8	12		
4.9.14	13	12		
5.9.14	9	12		
8.9.14	12	12		
9.9.14	11	12		
10.9.14	7	12		
11.9.14	19	12		
12.9.14	9	12		
15.9.14	9	12		
16.9.14	14	12		
17.9.14	5	12		
18.9.14	16	12		
19.9.14	14	12		
22.9.14	18	12		
23.9.14	18	12		
24.9.14	5	12		
25.9.14	12	12	x	
26.9.14	16	12		
29.9.14	13	12		

Mark with an 'X' the last number from the baseline data. This 'freezes' the median. Everything after this point came following the introduction of GP telephone triage for same-day appointment requests ('the intervention').

So what happened?

Here is the chart that was created by the IHI Excel template once the new data was inputted:

Figure 23: Run chart for 'extras seen' (post-change)



This graph shows that all the data points collected after the intervention fall on one side of the median. There is only one run after the intervention and there has been a definite shift (more than six points consecutively on one side of the median). As the shift coincided with the intervention, it suggests to the team that the intervention has generated a change.

Further information

If you are interested in finding out more, then the Health Service Executive (Ireland) provides useful guidance[18], which covers:

- how to check for 'special cause variation'
- how to use 'statistical control lines' to spot when something odd is happening
- the limitations of run charts.

CARE BUNDLES

An accepted method of measuring more than one indicator is known as a care bundle. The definition of a care bundle from the Institute for Healthcare Improvement is as follows: "A bundle is a structured way of improving the processes of care and patient outcomes. A small, straightforward set of evidence-based practices - generally three to five – that, when performed collectively and reliably, have been proven to improve patient outcomes."[19] Care bundles are applied to a defined patient population and care settings over a defined time period and it is important that they are not seen as simple checklists.

Care bundles are useful when you wish to implement a series of indicators that are all important in achieving the outcome. They provide an all or nothing measurement and the achievement should be

18. *Measurement and improvement: Guidance note on key concepts*. Produced for the Pressure Ulcers to Zero collaborative, Dublin North East region, part of the National Quality Improvement Programme, supported by the Health Service Executive, Ireland, and the Royal College of Physicians Ireland. http://www.hse.ie/eng/about/Who/qualityandpatientsafety/safepatientcare/Pressure_Ulcers/Pressure_Ulcer_Information/Measure_and_Improvement_Guidance_Document.pdf
19. Resar R, Griffin FA, Haraden C, Nolan TW. *Using Care Bundles to Improve Health Care Quality*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement, 2012. http://www.ihi.org/resources/pages/ihiwhitepapers/usingcarebundles.aspx [accessed 22 June 2015].

measured over time. Taking the example of diabetic indicators, all of the following would have to be achieved: BMI measurement, BP measurement, HbA1c measurement, cholesterol measurement, record of smoking status, foot examination, albumin: creatinine ratio, and serum creatinine measurement. Examples of care bundles used in healthcare include the National Diabetic Audit in England and Wales and some enhanced services in Scotland.

COMMUNICATION MATRIX

An essential part of planning for your intervention includes identifying who will be affected by your project and what they need to know about it to facilitate their participation and support. Using a simple communication matrix can help you to avoid sending out a blanket email and to generate both the targeted messages and instructions that will enhance adoption.

Along the top horizontal axis you write the groups or individuals who need to know about your project. Along the vertical axis you list the main themes that need to be known. Then, in each box you place specific details of what that group or individual needs to know about that theme. Below is an example for a project to reduce the number of dirty cups in a practice (fig. 24).

A detailed communication plan that considers the key messages for all your stakeholders at the different stages of the project is included in the sustain and spread section (page 43).

GANTT CHART

Determining a realistic timeframe is another part of planning the successful implementation of an intervention and a PDSA approach.

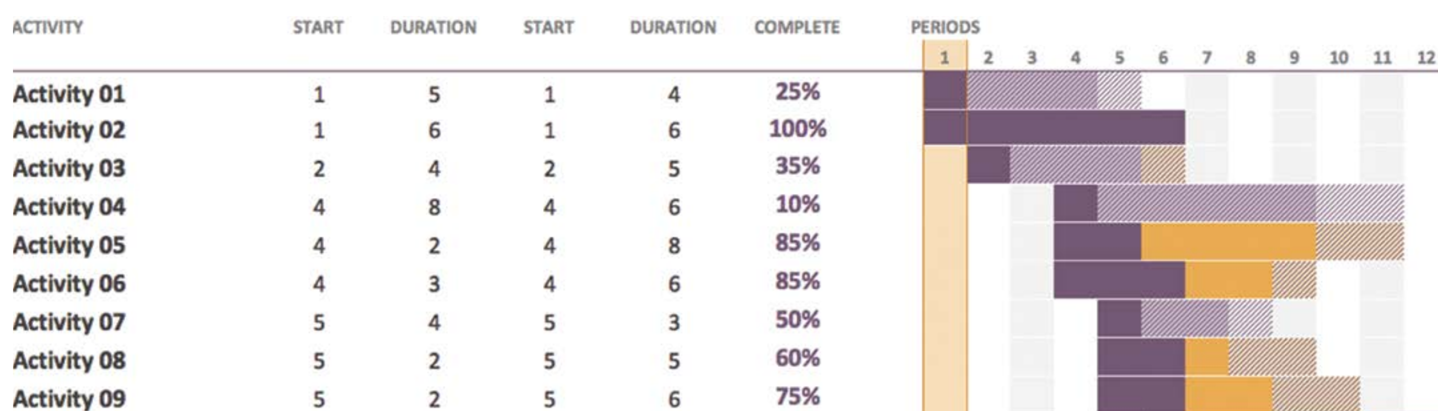
For this, think about all the milestones to be achieved for the project; the tasks involved in delivering each milestone; who will be responsible for each task; how long each will take; any problems the team might encounter in implementing them; and which tasks are contingent on another. A Gantt chart provides a visual representation of this information and helps you to establish whether the schedule is workable; how to make any necessary adjustments so that it does work; and later to review progress towards your milestones. Once your intervention is underway, it helps you to keep track of the next ‘to do’ that needs to be actioned (fig. 25).

Milestones and constituent actions (tasks) are listed on the vertical axis; and the time - in days, weeks or months – is given on the horizontal axis. The proposed start point is identified, and then a horizontal line is drawn from that point to the point

Figure 24: Communication matrix to reduce the number of dirty cups in a practice

Task / item	GP	Practice Nurse	Admin	Cleaner
Washing liquid	May need instruction in use	Reinforce not to be hand maiden	To order if need more	To check if need more
Rota for clean up	In GP rooms		Review in 1 month	
Penalty system	Where do profits go?			
Named cups	To decide name on cup			Leave dirty cups on shelf

Figure 25: Gantt chart



ACTIVITY	START	DURATION	START	DURATION	COMPLETE
Activity 01	1	5	1	4	25%
Activity 02	1	6	1	6	100%
Activity 03	2	4	2	5	35%
Activity 04	4	8	4	6	10%
Activity 05	4	2	4	8	85%
Activity 06	4	3	4	6	85%
Activity 07	5	4	5	3	50%
Activity 08	5	2	5	5	60%
Activity 09	5	2	5	6	75%

when the action is due to be completed. It can be created on Excel by customising a stacked bar chart. In Excel 2013 a template can be downloaded free from Microsoft.

The plan should be monitored and reviewed regularly.

THEORY OF CONSTRAINTS AND FLOW

The theory of constraints seeks to identify the weakest link in the chain and then to eliminate it. The theory provides a methodology for identifying the most significant limiting factor – the constraint – which stands in the way of the organisation's goal being met. The methodology then provides a way to systematically reduce the constraint until it is no longer the limiting factor. The constraint is commonly referred to as a 'bottleneck'.

Constraints are often categorised as:

- physical – lack of equipment, people or space
- policy – required and recommended ways of working
- paradigm – deeply engrained beliefs or ways of working
- market – production exceeds demand.

The Theory of Flow has developed from the Theory of Constraints. To promote Flow you:

- separate scheduled and unscheduled flows
- transform unscheduled work into scheduled
- eliminate artificial variation in scheduled work
- match skills and resources to meet needs.

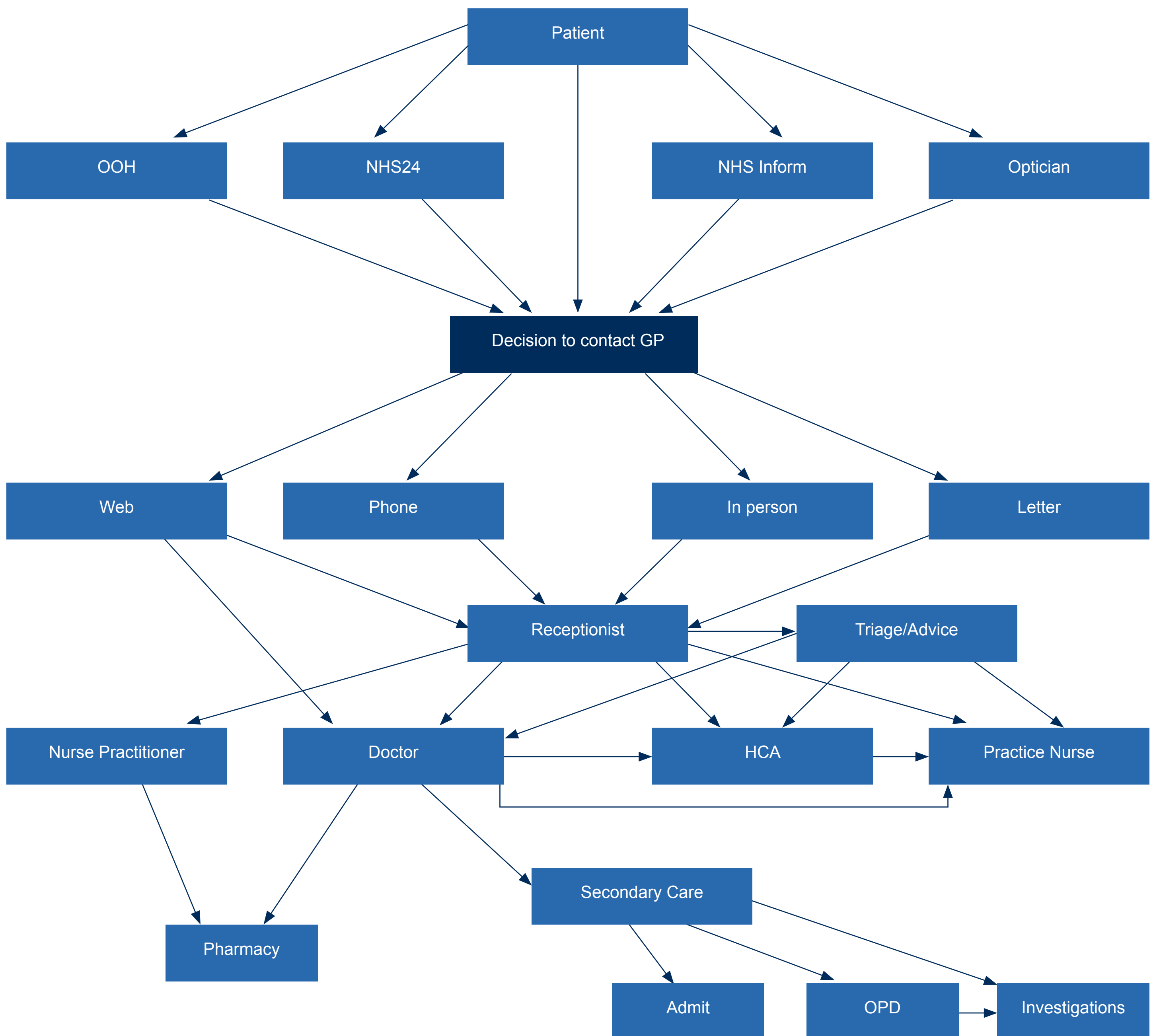
Examples of scheduled work in general practice would include chronic disease management clinics and advance-booked appointments. Examples of unscheduled work could include acute presentations of illness, such as respiratory tract infections.

In general practice it is possible to move some unscheduled work (acute presentations) to be scheduled. For example, a pathway can be designed for people who have depression.

Artificial variation is often created by the people involved in the systems and by those who design them. An example of system design failure would be dysfunctional timetabling.

Flow diagrams can be constructed to map or track a patient's journey through the system in order to identify bottlenecks and delays.

Figure 26: Flow diagram of a patient's journey through the system [20]



20. The Scottish Government. PPT flow diag. pptx [Embedded PowerPoint slides]. DC20140502 documentation [Embedded Word file]. Section 10: Appendix A: Supporting documentation for QS002(S). *Quality and Outcomes Framework (QOF): Guidance for NHS Boards and GP practices. Scottish Quality and Outcomes Framework guidance for GMS contract 2014/15.* The Scottish Government, 2014; 184. http://www.sehd.scot.nhs.uk/publications/DC20140502QOFguidance.pdf [accessed 10 June 2015].

EXPERIENCE-BASED CO-DESIGN (EBCD)

This is an approach that allows patients and staff to analyse and design services together. It involves in-depth interviews, observations and group discussions. The King's Fund has developed a toolkit for using this technique.[21] The toolkit identifies the following stages:

Figure 27: Stages of experience-based co-design

Project steering group meets at critical stages

1. Before the project starts
2. Before feedback events
3. After first co-design group
4. After celebration event

Further information can be obtained by clicking this link.

21. The King's Fund. Stages in experience-based co-design. *Experience-based co-design toolkit.* London: The King's Fund, 2013. http://www.kingsfund.org.uk/projects/ebcd/experience-based-co-design-description [accessed 3 June 2015].

Implement and embed

Having tested your change, you will know whether or not it has been successful; whether it needs modification; and whether or not it should be continued. If it was successful, you can demonstrate the success to your team and ensure that the change becomes part of your regular systems or processes.

RUN CHARTS

You can continue to use run charts once the improvement has been identified and once plans for its wider implementation have been made.

See the section on run charts in plan and test (pages 34).

VISUAL DISPLAY

Visual displays are powerful motivators. You might benefit from creating a dedicated space for collecting and displaying material you generate in the course of your quality improvement project. These displays are sometimes called ‘storyboards’. Storyboarding should commence as soon as the activity is started. It allows all staff and visitors to know what is going on; can become a talking point within the organisation; and can help build team ownership, engagement and motivation. The waiting room and staff room are good places. As illustrated below, simple run charts can form a powerful part of an engaging storyboard.

Figure 28: Display board in a practice

Sustain and spread

You will want to sustain any improvement within your practice or organisation. This can be supported by the same methods and measurements that you originally used to test the changes, as seen in the plan and test section of this guide (pages 29-41). If by now you feel confident with run charts, you might like to try using the more sophisticated SPC charts to measure your progress, which we describe below. It would be good if you could share any improvement stories with colleagues in primary care – whether this be locally, regionally or nationally – as their application could be of wider benefit. You could do this by devising a communications strategy (pages 44), producing an evaluation report (below) and by circulating your report or story via networks (page 44) and collaboratives (page 45) or presenting at meetings and in publications.

EVALUATION

You may have to present an evaluation to help spread the results of your quality improvement. If this needs to be formally presented, it is best to consider this at the outset of your project. In an evaluation you will describe your programme's aims, its background, the intervention(s) made, your implementation and monitoring methods, the data collected, the costing, and the outputs you achieved. Remember to consider the audience to which it will be delivered. There are various methods of conducting a formal evaluation, e.g. process evaluation or economic evaluation. You can use some of the quality improvement tools in the guide to help you. For example:

- **Aim**: Use driver diagram (page 31) and Model for Improvement (page 29)
- **Background**: From reviewing the context section (pages 15).
- **Intervention(s)**: Use actions from your driver diagram. The interventions need to be fully described: say whether or not they changed as your programme progressed; identify who your target audience was; demonstrate whether or not they engaged; and share their experience.
- **Methods**: Use tools of quality improvement (page 20) to implement and monitor.
- **Data**: Baseline data from diagnosis section and continued monitoring using, e.g. run charts.
- **Costings**: From reviewing context section and part of the description of the intervention(s).
- **Outputs**: Can use run charts (page 34), SPC charts (page 45) for quantitative data and also describe qualitative results. Also the third part of PDSA cycles (page 32), the study section, involves considering whether the change has brought about improvement or not.

An evaluation should explain what you planned to do; whether or not it worked; and why the actions taken were or were not successful. You also need to consider any side-effects or unintended consequences of your programme.

By sharing your work through the RCGP or the NHS system you can make recommendations for wider implementation.

NETWORKS

Networks can give you access to information; they can allow you to share representative duties; raise your profile; and can offer you good support. The Health Foundation has shared a "5C wheel"[22] model and this model enables a network to add value especially in quality improvement. The Cs are:

- **Common purpose.** The purpose needs to be clear and stated at the start.
- **Co-operative structure**. The style of leadership is important. It is often facilitative and can come from a respected figure. Members should be encouraged to get involved in the network's development.
- **Critical mass**. Membership can be encouraged by offering members something they would value. An engagement strategy needs to be in place and resourcing needs must be considered.
- **Collective intelligence**. There needs to be an easy way to share experiences and results within a safe environment. Feedback on any impact needs to be given.
- **Community building**. Personal contact should be encouraged and smaller sub-groups may need to be established.

A short film[23] from the Health Foundation explains the 5C model further.

COMMUNICATION STRATEGY

Once an improvement has been tried it is important to communicate this regardless of whether or not it has been successful. A short key message can be used to attract attention. You will want to use language which is accessible for the various target groups. Resources need to be identified to implement the strategy.

A strategy can include:

- **Objectives.** What is the aim of your communication?
- **Team involved.** Who needs to be involved in delivery?
- **Target audiences.** Who needs to know about the project?
- **Messages.** The message needs to be tailored to the audience.
- **Methods.** Which channels will you use?
- **Timescale**. When do you wish to achieve delivery of your message?
- **Evaluate**. Consider the effectiveness of your strategy.

A template of a plan to be included in the strategy is in appendix 3 (pages 58).

22. The Health Foundation. *Effective networks for improvement: Developing and managing effective networks to support quality improvement in healthcare*. London: The Health Foundation, March 2014. http://www.health.org.uk/publication/effective-networks-improvement [accessed 3 June 2015].
23. The Health Foundation. *Effective networks for healthcare improvement: explaining the 5C wheel*. [video file]. London: The Health Foundation, April 2014. http://www.health.org.uk/multimedia/video/effective-networks-for-healthcare-improvement-explaining-the-5c-wheel/

COLLABORATIVES

Practices can improve care by collaborating with each other. This can improve access to a greater number of experts and means that good practice can be exchanged between peers. Collaboratives usually involve a central learning event followed by local implementation using quality improvement tools, such as PDSA cycles. These are supported by regular communication between the expert(s) and the participants as well as through the sharing of results, feedback and learning. Greater success has been found where the learning events have been facilitated and where dedicated time has been given to all. Collaboratives are an ideal tool for Federations and general practices at scale to benefit from.

STATISTICAL PROCESS CONTROL CHARTS (SPC CHARTS)

Like run charts (pages 34), SPC charts are a technique for monitoring and assessing the impact of the changes that you implement. SPC charts are more complex to create than run charts and require an understanding of statistics.

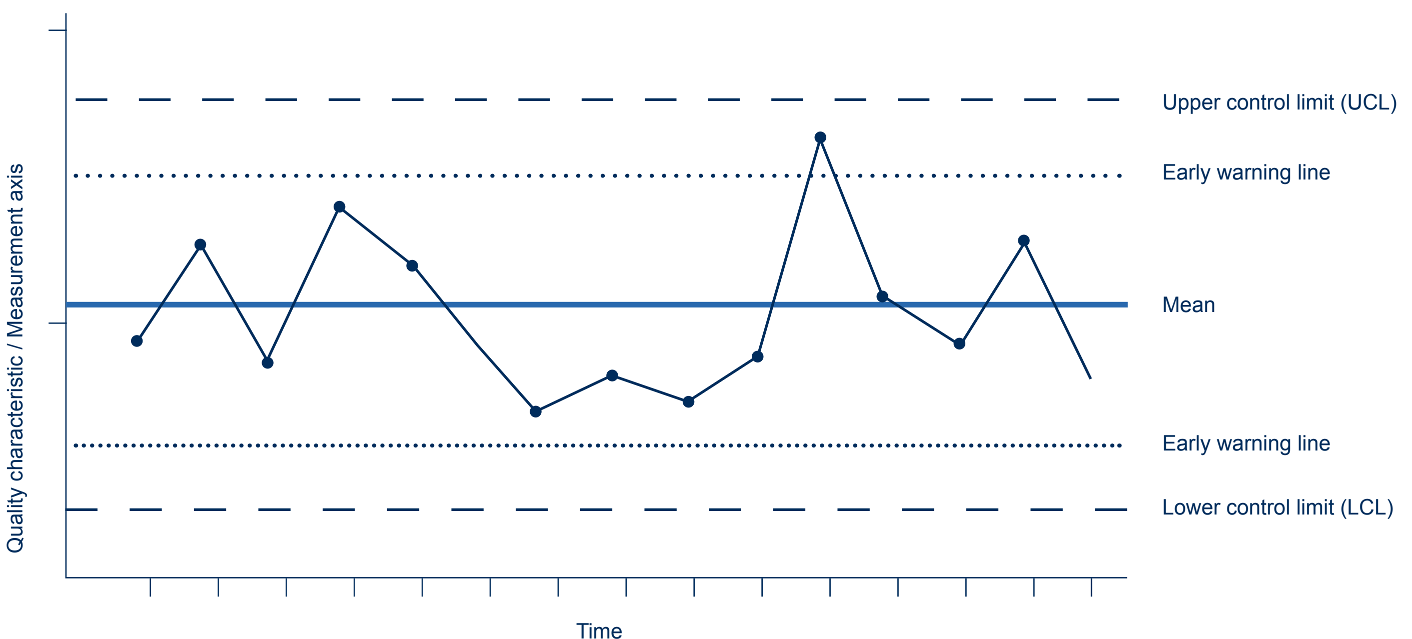
How do SPC charts differ from run charts?

Run charts are convenient, easy to understand, and can help you to identify whether your quality improvement intervention is leading to improvements. SPC charts are better than run charts for identifying 'freak' points that are far above or below the majority of the data points. This is because SPC charts use the mean for their centre line and using the mean makes freak points stand out, giving a clear signal that something unusual has happened. This is known as 'special cause variation'. It is harder to spot special cause variation in a run chart because it uses the median for its centre line. Instead it can look deceptively like normal variation. SPC charts include 'control lines' above and below the mean, which tell you when your process may be starting to perform in an unexpected way.

What are control lines?

Control lines are created by using the data you have gathered about your performance so far. The standard deviation (SD) of the data is calculated and the lines are drawn at values that would represent 3 SDs away from the mean, one line above (the 'upper control limit'), and one line below (the 'lower control limit'). This means that 99.73% of all future data would

Figure 29: An example of a SPC chart



be expected to fall between these two control lines. The inner dotted lines are plotted 2 SDs away from the mean and can be used as 'early warning' lines, indicating that something might be changing and may need further investigation. If a data point is outside of the upper or lower control limits (<99.73% likelihood that this has happened by chance), this is either a concern to be investigated, or a sign that your intervention is making a difference.

Different types of data (e.g. continuous or discrete) require different mathematical techniques to create the SPC chart, and statistical packages can be bought to help with this. Baseline© is an example of such software that is designed for use by novices and is recommended by NHS Improving Quality (NHS IQ).[24] It allows you to cut and paste in time-series data that it then converts into a chart. This gives you an image of how things are changing.

SPC charts vs run charts for quality improvement work in general practice

Most general practice quality improvements can be monitored using a simple run chart and the run chart rules as previously described. A greater understanding of statistics (e.g. calculation of standard deviations and understanding discrete and continuous data) is required to create an SPC chart.

Once you are happy with your improved performance, SPC charts can be useful for quality assurance purposes since you can use them to monitor for unexpected deterioration. The control lines allow you to make predictions about the range of values you might expect if there are no changes to the process. For example, using them to predict the number of visit requests per day might be useful in your practice's workforce planning.

24. SAASoft. Baseline©. http://www.saasoft.com/baseline/baseline.php [accessed 13 August 2015].

PART III:

The supporting rims of the wheel

- PATIENT INVOLVEMENT
- ENGAGEMENT
- IMPROVEMENT SCIENCE

Patient involvement

As patients will be impacted by your changes, it is important to include them at all stages of your programme from diagnosis through to sustain and spread; and then again in determining which interventions 'work' and are to be embedded.

UMBRELLA PATIENT GROUPS

The RCGP has the following patient groups and they have resources that can contribute to how patients can be involved:

- Patients and Carers Partnership Group (PCPG)
- Patient Partnership in Practice (P3), Scotland
- Patients in Practice (PiP), Northern Ireland
- Patient Partnership in Practice (PPiP), Wales.

Some resources can be found on the RCGP website.[25] You could also contact the National Association for Patient Participation (NAPP).[26]

WHO TO INVOLVE

Who you involve will depend on your objectives for patient involvement. You may have already established ways of involving patients and these could be utilised in your quality improvement intervention.

TYPES OF INVOLVEMENT

Ask yourself: How could you involve patients? How will you know if it 'works' for them? Could any of the following methods be useful?:

- patient participation groups
- focus groups
- surveys, including using data from the national patient GP survey
- patient shadowing
- patient stories / case studies
- patient interviews
- engagement with self-help groups
- patient journey maps.

25. RCGP: *Information for Patients*. London, RCGP. http://www.rcgp.org.uk/information-for-patients.aspx [accessed 12 August 2015].
26. NAPP website. http://www.napp.org.uk/ [accessed 12 August 2015].

QI and patient involvement: a practical example

Patients can help us to generate ideas for new quality improvement approaches. Joanna Bircher, RGCP Quality Improvement expert, talks about how practice teams and patients can and should work together to improve quality.

Together we can make a difference

One of the fundamentals of quality improvement methods used in industry is for companies to view their service or product through the eyes of their customers. We should do the same. It was with this in mind that I recently decided to explore how to do this with a group of practices and their Patient Participation Groups (PPGs) from my CCG area.

A number of important themes emerged, both about how patients can contribute to improving their practice and about some of the barriers to this happening effectively. The themes included how patients can work with practices to help us to:

- identify areas that need improving and uncover problems
- create a positive culture for quality improvement
- generate ideas for trying out new approaches and think outside the box.

Involving patients in identifying areas for improvement and uncovering problems

Feedback from our patients about what hasn't worked well for them can help us to redesign our systems and processes. However both giving and receiving feedback can be fraught with difficulties. Patients often feel they need courage to criticise, as they are concerned it might jeopardise their care in the future. Also, if we usually get things right, and they like us, they can be very forgiving of our inefficiencies and unresponsive systems. When they do give feedback it is often to our reception staff, who can feel very vulnerable. As a result the patients are often met with a leaflet on how to use the formal complaints process, when this isn't what they wanted to do at all. This could be a missed opportunity to capture valuable feedback and ideas.

Winston Churchill once said, "Courage is what it takes to stand up and speak. It is also what it takes to sit down and listen". Real listening is allowing yourself to be changed. Patients who are brave enough to tell us their stories when things didn't go well can provide us with gems of information that we may not get from any surveys or friends and family tests. We need to be genuinely curious about exactly what they experienced – it may uncover a flaw that we never realised existed.

One of the QI methods we have described in chapter 2 of this guide is process mapping. This involves creating a visual display of all the stages of a practice process, for example the repeat prescribing system or the managing of investigations and results. The map helps practices to identify wasted steps and problem areas to maximise efficiency, saving time and money. It encourages 'system thinking'. Giving patients easy and rewarding opportunities to share their experience is valuable to the practice.

At our recent session with patients and practice teams we 'process-mapped' the repeat prescribing system; we couldn't have done it as efficiently without the input of the patients and what went on 'behind the scenes' was a huge revelation to them. It's a great exercise for PPGs and is likely to lead to some real changes to current processes.

Patients can help to create a practice culture that promotes quality improvement

Your practice culture (i.e. your values, how you communicate, how you feel about your work, whether you are functioning as a team etc) is of vital importance in determining whether your quality improvement efforts will be successful. The more positive view the practice team has of the practice and the future, the more likely you are to be successful. The Greek writer and philosopher Nikos Kazantzakis (1883-1957) said, "In order to succeed we must first believe that we can". In this way the lovely things patients say about us can really boost our QI efforts. In our session the patient group recognised how positive feedback on NHS Choices and Friends and Family can make practices feel their efforts are worthwhile and means that future improvement work can have more impact.

Patients help us to try new approaches and think outside the box

Chapter 3 of this guide and the QI resource page on the RCGP website describe how we can use the 'Model for Improvement' as a tool to improve our practices. It describes the '3 questions and a wheel':

1. What are we trying to accomplish?
2. How will we know if there has been an improvement?
3. What changes can we make to drive an improvement?

The final question generates ideas that you can then test out using PDSA (Plan-Do-Study-Act) cycles. Patients have a valuable role to play in coming up with ideas for testing. In our joint session, the patients and practice staff worked together to generate ideas for reducing the number of patients who failed to show up for their appointments. The idea that works is not always the one you expect and patients help us to really think outside the box.

PPGs are developing their role over the whole country, and some CCGs are developing support structures for them. There are so many patients interested in making a positive contribution to the NHS – lets 'let them in' and allow them to make a real difference.

Engagement

All stakeholders need to be engaged, not just the patients. At the beginning of your project, identify the relevant stakeholders for your quality improvement and revisit this as necessary. For example, if you are aiming to improve continuity of care, involve all staff who book appointments for patients. If you are trying to improve the way tests are requested and handled, you are likely to benefit from involving a manager from your local pathology lab.

The Health Foundation's Overcoming Challenges to Improving Quality suggests the first stage is to convince people there is a problem.[27] A persuasive case can be built from hard data, patient stories and through peer-led discussion. If you also have a solution to propose, you may need to convince them it's the correct one. Clear facts and figures and involving respected figures will help with this.

IDENTIFY YOUR STAKEHOLDERS

A number of tools you have used (e.g. your communication strategy) and the scoping you have done for your project will help you to identify the relevant stakeholders for your quality improvement project. This should be done at the beginning of your project, but you may find that you will need to update this as your project progresses, for example as you build or link into new networks. You will need to consider both internal stakeholders - those inside your practice (e.g. all types of practice staff, patients); and external stakeholders – those outside of your practice (e.g. other practices, your CCG, your networks, RCGP).

WHEN TO ENGAGE YOUR STAKEHOLDERS

You will need to think about when to engage your stakeholders so that you get the maximum engagement from that group. Engaging practice staff at the beginning of their participation in the intervention is critical to its success. Your communication strategy (page 44) and your Gantt charts (page 38) can help you to identify the best time to engage a particular stakeholder.

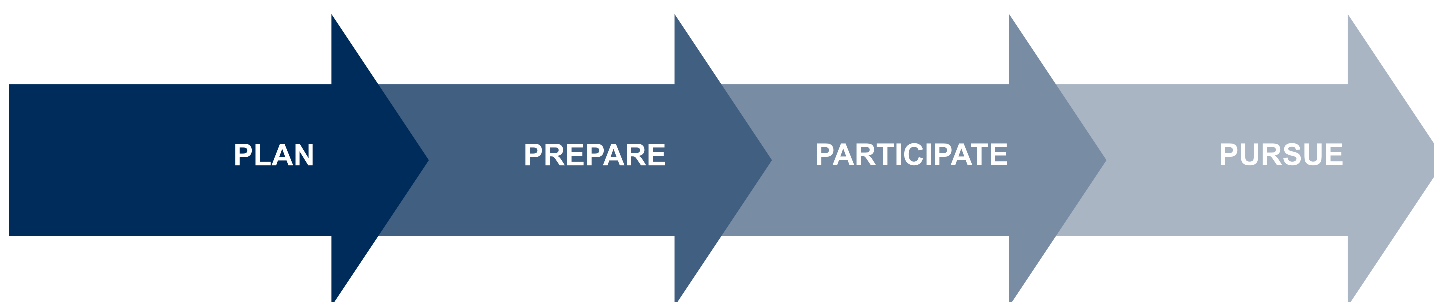
EFFECTIVE MEETINGS

In any quality improvement project there will be meetings, e.g. project team meetings. If held effectively they will improve engagement as well as aid the development of the project. The NHS Institute for Innovation and Improvement describes the 4Ps of an effective meeting.[28] The following is an adaptation of their work.

27. The Health Foundation. *Overcoming challenges to improving quality: Lessons from the Health Foundation's improvement programme evaluations and relevant literature*. London: The Health Foundation, April 2012. http://www.health.org.uk/publication/overcoming-challenges-improving-quality#sthash [accessed 12 August 2015].

28. NHS Institute for Innovation and Improvement. Meeting management. The Productive Leader. *The Productive Series*. 2013. http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_nhs_leader_ship_team_-_making_time_to_lead.html Retrieved from the Faculty of Allied Health Professions and Health Care Scientists https://www.heftfaculty.co.uk/content/meetings-management [accessed 3 June 2015]

Figure 30: The 4Ps of an effective meeting



PLAN.

The role of organiser:

- Consider whether meeting is necessary.
- Define objectives.
- Choose effective chair.
- Invite only those who need to be there.
- Ask for agenda items.
- Create agenda.
- Complete timings.
- Allocate owner of item.
- Circulate pre-meeting information.
- Appoint minute taker.
- Check venue appropriate.

PREPARE.

The role of all:

- Read material.
- Consider your contribution.
- Check actions assigned previously to you have been completed.

PARTICIPATE.

The role of all with chair facilitating:

- On time to start and keep to time.
- Stick to subject.
- Share your ideas.
- Listen to others.
- Chair to summarise clear actions and person attached to action.

PURSUE.

The role of all:

- Actions circulated as soon as possible.
- Action decisions promptly.

EXPERIENCE-BASED CO-DESIGN

See EBCD above (page 41). This tool is both an excellent mechanism for engaging stakeholders and a process that facilitates planning for an improvement.

PERSONALITY TYPING

When working in a team and delivering change together it can be beneficial to identify the different styles of the people involved. There are various ways of identifying these styles. The Merrill and Reid test identifies four personal styles: analyst, amiable, expressive and driver. The Belbin Inventory of Team Roles is used to score people on how strongly they express the behavioural traits from nine different team roles.[29] It is not a personality typing system since people often exhibit strong tendencies towards multiple roles. However, it is widely used and is a useful tool for gaining a better understanding of the strengths of your team and building on them.

29. Belbin Associates. Belbin® Team Roles. http://www.belbin.com/ [accessed 13 August 2015]

Improvement science

Improvement science is a relatively new academic field that aims to identify the best methods for improving the quality and safety of healthcare. It incorporates evidence from many academic disciplines and offers a systematic and evidence-based health services approach to quality improvement.

You can use published work from improvement science to provide you with ideas to try out. The majority of the tools described in this guide derive from various quality improvement approaches. A few of these are described below.

TOTAL QUALITY MANAGEMENT (TQM)

TQM is often used interchangeably with the term Continuous Quality Improvement (CQI). The principles of this approach include: strong leadership, continuous activity, attention to systems rather than individuals and Importance of measurement.

LEAN

'Lean' is a systematic approach to reducing waste through a process of continuous improvement. Any improvement must be made by those who are using the service. Waste is defined as non-value added activities or otherwise unnecessary activity. Many of the tools in this guide can form part of a Lean approach. Another tool is 5S (sort, set, shine, standardise, and sustain). Practices have used this tool for activities such as standardising the layout of consulting rooms. This approach has been adapted for use by the NHS Institute for Innovation and Improvement to create the Productive series, one of which is Productive General Practice.[30]

SIX SIGMA

The Six Sigma approach evaluates the needs of patients and identifies variations in meeting those needs. One of the methods it uses is DMAIC: Define, Measure, Analyse, Improve and Control.

MORE ON IMPROVEMENT SCIENCE

Further reading on improvement science includes work by Professor Martin Marshall, Lead in Improvement Science at University College London.[31] Professor Marshall advocates the need to ensure that health services research has an impact on quality improvement and calls for an evidence-informed approach to service improvement with better working relationships between academia and health services. A researcher-in-practice, working on a well-designed service improvement initiative, offers the potential for scientific rigour.

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30. For Scottish practices the link is http://www.qihub.scot.nhs.uk/quality-and-efficiency/outpatient-primary-and-community-care/productive-general-practice.aspx
For practices in other UK countries it is http://www.institute.nhs.uk/productive_general_practice/general/productive_general_practice_homepage.html
31. Marshall M. Bridging the ivory towers and the swampy lowlands; increasing the impact of health services research on quality improvement. *International Journal for Quality in Health Care* 2014; 26 (1): 1-5.

Conclusion

The concept of 'QI', or using a systematic approach to quality improvement, is quite new to general practice. It is an exciting development with the potential to improve the working lives of GPs and our teams, as well as improving patient care and how patients experience our services.

This guide is extensive and contains lots of tips, information and tools for you to start your own improvement journey. The guide will evolve over time and we welcome all feedback in making it as useful as it can possibly be to everyone working within UK general practice. You can contact us at qualityimprovement@rcgp.org.uk

We are continuing to add to the QI webpage of the RCGP website to link you to further resources.[32]

Taking a QI approach to changing practice often needs to start with a 'culture-shift' whereby all team members decide to work together to try doing something differently. It needs everyone to be prepared to experiment in a controlled way and with the appropriate measures in place. It requires all team members to open their minds to the possibilities of new ways of working; for us all to take more active steps to hear what our patients are saying about our services; and for us to use their thoughts to drive our improvements.

Our suggestion is not that you implement the whole guide, but rather that you use the information to get started, choosing which methods and tools suit your improvement priorities.

Healthcare is a complex area: it is often hard to know what will make a difference, and hard to know how to get started. We recommend you keep things simple at first and embrace the concept of 'small cycles of change'. You will become more confident at experimenting with new things as you see results. You will also get better at using the methodology until you find the whole team are motivated to embark on a new project.

Investing your time in QI can make general practice both a great place to work and a great place to access care. Good luck!

32. RCGP. *Quality Improvement.* http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement.aspx [Accessed 13 August 2015].

PART IV:

Appendices

BACK TO CONTENTS

SEE CONTEXT TOOLS — PAGE 18

Context checklist

Element	Applicable? If so, what aspect?	Action	Timescale
Culture			
Leadership			
Team Working			
Evidence base			
Political/Regulatory			
Technological			
Capacity			
Social/demographics			
Capability			
Opportunity			
Motivation			

SEE CONTEXT TOOLS – PAGE 18

Forcefield analysis

Driving forces	Score /10	Restraining forces	Score /10

SEE SUSTAIN AND SPREAD – PAGE 44

Communication strategy

Project Scope: ______________________
1. ....
2. ....
3. ....

Key Messages: ______________________

Initial stages (to be added to as the project progresses)

Messages for ______________________
- ....
- ....
- ....

Messages for ______________________
- ....
- ....
- ....
- ....

Messages for: ______________________
- ....
- ....
- ....
- ....

Messages for: ______________________
- ....
- ....

Communication Goals: ______________________
- ....
- ....

Team involved: ______________________

Target Audiences/Stakeholders: ______________________

Communication/media options: ______________________

Plan (detail who, what, when and how):

No	Message event	Comm-unication purpose	Target audience	Sender	Media planned	Content due date	Date planned	Date completed	Status

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Your notes

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APPENDIX 3

Project Illustrations

Example 1 – Patient Outcomes (COPD/Respiratory conditions)

- Practice A has been identified having a higher than expected number of admissions to hospital with respiratory conditions. This data has been provided by business intelligence and reviewed by the practice with the help of the CCG QI Clinical lead and their neighbourhood CBM.

- Over the preceding 12 months they have had 88 unplanned admissions to hospital for patients with respiratory conditions. This is a significantly higher admission rate per 1000 patients then their peer practices.

- This is chosen to be the focus of once of their PCQS QI Projects, and they use the model for improvement (IHI) to plan and test out their changes.

- Their overall aim is to reduce the number of admissions to hospital for respiratory conditions by 30% by the end of the scheme (April 2019).

- They will measure their monthly admission rate and plot it on a run chart.

- The practice will put together a project team to test out ideas for change, by referring to published evidence on what has worked well elsewhere, by drawing on the experience of their peer practices (neighbourhood working) and by asking the patients who have been admitted recently about what factors influenced the admission and how it might have been prevented.

- Change ideas for testing are likely to include: an increase in the number of patients with a winter action plan, and increase in the number who have had a practice nurse review with an FEV1 measure, improve information for patients on managing exacerbations at home, a pharmacists review of medication concordance. As each idea is implemented, the admission rate will be monitored monthly for improvement.

- If the project succeeds there will be a saving of approximately £70k in the use of non-elective services.

- The project is also in line with the CCG priority to use RightCare data to improve pathways for Respiratory Care and will support the achievement of our local Quality Premium payment for COPD generating, if achieved across the CCG, an additional £184k, subject to achievement of the NHS Constitution Requirements.

Example 2 – Prescribing (mandated component)

- Practice B has been identified by openprescribing.net data as prescribing significantly more trimethoprim per 1000 patients than their peers (6.41 items/1000 patients per month, compared to an average of 2.59 items/1000 patients per month)

- Due to high resistance rates of infections to trimethoprim prescribing in our CCG, patients may not be receiving optimum care

- Successful reduction in trimethoprim prescribing will generate a Quality Premium payment for the CCG

- The practice, with the support of the CCG QI lead and the medicines management team decide to use the model for improvement to plan and test out their changes.

- There overall aim is to reduce their prescribing to below 2.59 items/per 1000 patients per month by the end of March 2018. The practice has a list size of 6110 and so is aiming for a median number of trimethoprim prescriptions per month of less than 16.

- They will measure their number of prescriptions of trimethoprim monthly and plot this on a run chart.

- With support from the medicines management technicians they will test out ideas for change, based on best practice. These may include a review of patients who are using trimethoprim as a preventative therapy, a change in practice protocols for treatment, an increase in the use of the local antibiotic smartphone app and individual feedback to the prescribers.

- This project will support the achievement of the overall QP Premium indicator for use of antibiotics in UTIs which could generate £94k income for the CCG, again subject to achievement of NHS Constitution Indicators.

Example 3 – Patient Experience

- Practice C has been identified by the Primary Care webtool and the National GP Patient Survey as being a significant outlier in patients overall experience of making an appointment. 38% of patients score them as ‘Good’ or ‘Fairly good’ compared to a national average of 78%

- Their aim is to increase their score in the 2019 GP Survey to 50% or above (overall measure). However they need a ‘real time measure’ to monitor the success of their changes and so decide to increase their use of the Friends and Family test administered by text message and adding the additional option question ‘Score your overall experience of making an appointment’. They will gather this data monthly and plot it on a run chart to monitor their change.

- They put together a practice project group and with support from the Primary care team and the QI Clinical lead they come up with ideas for testing out. These ideas may include changing the number of reception staff answering the phone at busy times, offering a wider range of appointment options including telephone consultations, increasing their use of the Extended hours hub for working patients and increasing the number of patients able to book their appointments online. As

they implement their changes they will monitor for improvement using PDSA methodology.

- A positive outcome to the project will support the achievement of the CCG Quality Premium related to patient experience and generate a potential income of £208k if the target is achieved, again noting the potential reduction impact relating to the NHS Constitution indicators.

Example 4 – Patient Outcomes (early diagnosis of cancer)

- Practice D has been identified by the CCG MacMillan GP as having a significantly lower fast-track referral rate for suspected cancer than peer practices and a corresponding high level of cancers diagnosed as an 'emergency' during an unplanned admission

- As practice-level data does not exist for stage of diagnosis, they start their project by gathering their baseline data. This involves retrospectively looking at the last 20 cancer diagnosis the see how many were diagnosed at stage 1 or 2 and comparing this with national averages.

- They use the model for improvement and their aim is to bring their stage 1 and 2 diagnoses into line with national averages by the end of the project in March 2019. As cancer diagnoses are infrequent they will use a 12-month rolling graph, starting with their base line data to monitor for improvements, with the support of the QI Clinical lead. Every month the proportion diagnosed at stage 1 or 2 will be added to the graph.

- Their change ideas may include: easier access to the NICE guidance on when to refer, regular monitoring of their use of fast-track referrals, practice promotion of screening for bowel, breast and cervical cancer, improvements in their rate of screening. As this is a complex project, they will use a Driver Diagram to organise their change ideas.

- A positive outcome to the project will support the achievement of the QP Premium related to early diagnosis of cancer and generate a potential income of £208k if the target is achieved, again noting the potential reduction impact relating to the NHS Constitution indicators.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	11 April 2017
Reporting Member / Officer of Single Commissioning Board	Stephanie Butterworth – Executive Director (People) Mark Whitehead – Head of Service Operations
Subject:	**LEARNING DISABILITY / AUTISM DAY SERVICE REVIEW**
Report Summary:	Learning disability and autism internally provided day services have been significantly reduced since 2012 as a result of budget reductions. This review was undertaken in response to further savings being set against this area of operations. The report reviews current internal and external day service capacity and current and future demand and identifies that due to current lack of capacity to meet current and future predicted demand for day services that closure of any further day services would result in a lack of capacity to meet assessed need and would have a potential impact in terms of higher costs of provision having to be purchased from specialist providers out of area. The report proposes capital investment in a new disability centre at Oxford Park Ashton. This centre would increase current day service capacity as well as providing services for looked after children, children with disabilities and as an alternative post 16 further education site reducing out of area placements. The centre and site would be utilised to expand the internship programme assisting 16-24 year olds into employment and could be utilised for a range of other early intervention and prevention services focused on promoting good health. It is envisage that through collaborative working that significant financial and non-financial savings and benefits could be achieved across the sector.
Recommendations:	That the agreement is given in principle to progress the Oxford Park development subject to a bid against the Capital Programme to increase day service capacity, to improve collaborative working, improve a wide range of outcomes and achieve financial and non-financial benefits for a range of services including Children's, Education and Adult Services. That the existing internal day service's review individual users and move less complex individuals into independent provider services freeing capacity to reduce the waiting list for internally provided complex service provision.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The costs associated with provision of Learning Disability Day Services are in the Section 75 pooled budget. In 2016-17 these costs are estimated to be £1.8m with service user contributions of c£0.3m, resulting in a net cost of £1.5m. It is clear from the data available that demand will continue to grow in this area over the coming years and existing provision will be insufficient to cope with this demand. The proposal to create a new facility at Oxford Park will ensure that the Day Service offer is both appropriate to

	facilitate users with increasing levels of complex needs which will avoid higher costs in future years. It is important to note that the local economy gap calculation of £70m includes cost estimates associated with demographic growth for people with a Learning Disability of c£0.200m per annum, with further costs in addition as Children transition into Adulthood. The proposal outlined will reduce this cost pressure by offering provision at a reduced daily rate (see section 5.7), and will therefore contribute to closing the economy wide funding gap.
Legal Implications: **(Authorised by the Borough Solicitor)**	The Single Commissioning Board will need to be satisfied that the recommendations represent value for money and fit with the strategic objectives of the Board for Adult and wider social and health care services going forward.
How do proposals align with Health & Wellbeing Strategy?	The proposals and strategic direction are consistent and aligned.
How do proposals align with Locality Plan?	The proposals and strategic direction are consistent and aligned.
How do proposals align with the Commissioning Strategy?	The proposals and strategic direction are consistent and aligned.
Recommendations / views of the Professional Reference Group:	The Professional Reference Group supported the proposals and RECOMMENDED the report to the Single Commissioning Board for approval.
Public and Patient Implications:	None expected from this piece of work
Quality Implications:	None expected from this piece of work
How do the proposals help to reduce health inequalities?	Health inequalities faced by people with learning disabilities in the UK start early in life and result to an extent from barriers people face in accessing timely, appropriate and effective health care. People with learning disabilities have shorter life expectancy and increased risk of early death when compared to the general population. (Health Inequalities and People with Learning Disabilities 2010). Day services offer support to individuals with complex needs who often have associated long-term health conditions including the provision of support around eating, physiotherapy etc. Services also aim to provide low intensity exercise and activities to promote healthier lifestyles.
What are the Equality and Diversity implications?	None expected from this piece of work
What are the safeguarding implications?	None expected from this piece of work
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no known or unintended Information Governance implications.

Risk Management:

Failure to close a day service impacts on Adults budget savings targets for 2017/18, so may impact on identified targets. The provision of Oxford Park in collaboration with other service areas should achieve significant budget savings and efficiencies across Children's, Education and Adult Services.

The expansion of capacity is more a cost avoidance exercise and will reduce short and long-term costs in terms of having to procure services at greater cost to meet current and future predicted demand should we close services to meet savings targets.

Please see section 8 of the report for risk analysis. Failure to close a day service impacts on Adults budget savings targets for 2017/18, so may impact on identified targets. The provision of Oxford Park in collaboration with other service areas should achieve significant budget savings and efficiencies across Children's, Education and Adult Services.

The expansion of capacity is more a cost avoidance exercise and will reduce short and long-term costs in terms of having to procure services at greater cost to meet current and future predicted demand should we close services to meet savings targets.

Please see section 8 of the report for risk analysis.

Access to Information :

The background papers relating to this report can be inspected by contacting Mark Whitehead (Head of Strategic Operations, Adult Services).

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1. INTRODUCTION

1.1 This report follows the 5 August 2016 report which was seeking permission to consult with customers and their carers on the review of learning disability and Autistic Spectrum Disorder day service provision that is currently provided by Adult Services.

1.2 The review was initially driven by the need to review all service areas in response to Government cuts and rising demands for services. Day Services at the time had a £170,000 savings target against day services provision which would have meant closing one of the four remaining internally provided services to achieve the savings required.

1.3 This review is one of a number of reviews that have been undertaken across day services over the past six years. Since 2010 a number of day service pre-employment schemes have been closed to meet increasing funding reductions and in 2012 a substantial commissioning and market development / shaping exercise was completed with service users, carers and local providers. The aim was to develop more diverse day service options within the borough with a focus on offering more choice and control to individuals regarding the services on offer and a significant reduction in the daily unit cost of provision. This resulted in four internal day services closing and the re-provision of services by a range of providers including People First Tameside, Tameside Arts, Tameside Countryside Service and Active Tameside. This initiative achieved a reported £137.000 per annum saving.

1.4 The strategic vision was based on diversification of services being offered to facilitate greater choice and control, the introduction of a more diverse market to increase competition, drive up quality and reduce cost and to differentiate internally provided services to focus on the provision of higher cost specialist complex provision of day services to adults who have learning disabilities and / or Autistic Spectrum Disorder who have complex needs. This has been successful in that there is a more diverse range of service options on offer at a significantly reduced cost.

1.5 Internally provided day services are currently provided across four sites and include the provision of services to people who present challenging behaviours, have Autistic Spectrum Disorder and people with physical disabilities / complex health needs. This includes one centre that is assessed and accredited by the National Autistic Society for the provision of services to people on the autistic spectrum. Services are supported by community health teams in terms of Physiotherapy Services, Behavioural Services, Community Learning Disability Nursing and Speech and Language Therapy. Demand for these services is high with waiting lists being operated at several sites for access. Future predicted demand is high with forecasts indicating future rises in demand for complex service provision. 97% of people accessing day services live with families / carers with only 3% receiving other services. These services are essential in supporting families and carers and in the support of people to stay at home and prevent more costly supported accommodation / residential placements.

1.6 This report sets out the outcome of the review including extensive service user consultation, and proposes a number of options and recommendations for the future provision of services based on current and predicted demand. The review also considers demand and capacity in terms of children with disabilities and Looked After Children and the increasing demand for specific services for these groups as well as considering the provision of alternative services for children and young people with special educational needs post 16 in the borough as an alternative to out of borough placements in specialist education establishments. The focus being on improving outcomes for young people in terms of targeted education around the development of independent living skills, offering pre-employment and employment support and supporting more varied service options to improve choice and control while reducing costs of provision in the future.

2. POLICY CONTEXT

2.1 While day service provision does not form part of our statutory duty directly, if the provision is providing an identified service to meet an assessed eligible need within the Care Act (2014) it becomes the local authority's duty to meet that need. This fact, coupled with the benefits that day service activity offers in terms of providing day time support, an opportunity for people to keep in touch, meet people and develop relationships, respite to carers and in some cases essential care and therapeutic interventions, day services role and function, does become more fundamental in supporting individuals in the community while reducing the need for long term residential provision by supporting people to live at home.

2.2 Key legislation, guidance and statutory guidance in relation to day services and the recommendations proposed within this report include:

- Valuing People and Valuing People Now;
- Care Act (2014);
- The Children and Families Act - Special Educational Needs and Disability (SEND) (2014);
- Autism Act (2009);
- Autism Act Strategy *Fulfilling and Rewarding Lives (*2010);
- Autism Act Guidance *Think Autism (*2014);
- Statutory Guidance for Local Authorities and NHS Organisations to Support Implementation of the Adult Autism Strategy (2015);
- Transforming Care: A national response to Winterbourne View Hospital (2012);
- Greater Manchester Learning Disability and Autism Fast Track Programme;
- Putting People First (2007) and subsequently the Think Local Act Personal Programme.

2.3 Valuing People 2001, Valuing People Now 2009 and Putting People First 2008 all support the four key principles of rights, independence, choice and inclusion as being at the heart of change for people who have learning disabilities. People with learning disabilities should have the same opportunities to live an ordinary life, fully involved in the community alongside everyone else as equal citizens. Recent developments around day services within Tameside has meant that partnership working with other agencies has become essential both in terms of the provision of services but also in terms of more creative and efficient ways of providing and funding services, managing budgets and improving individual outcomes. Prevention, early intervention and personalisation are core elements of the Putting People First and Think Local Act Personal programme of work.

2.4 Fundamental elements of the Care Act (2014), the Children's and Families Act (2014) special educational needs and statutory guidance around the Autism Act (2009) places emphasis on good transition planning for children and young people moving from Children's to Adult Services. That the duty to undertake assessment of need and in planning of the provision of relevant services to meet identified need is essential for young people with disabilities and autism. Also recognised is the profound impact on the individual's ability to meet their full potential through access to further learning, training, employment and independent living is recognised as a fundamental element of the transition process and in preparing young people for adulthood.

2.5 Employment is promoted as a positive outcome for the majority of children and young people with autism and disabilities as it enables the individual to be less reliant on the state, be more independent, promotes health and wellbeing including good mental health and enables the individual to become an active citizen. This includes access to work through the Work Programme, Supported Employment or via the Supported Internship Programme which specifically focuses on young people in the 16-24 age group.

2.6 Care Act (2014), Autism Statutory Guidance (2015), Children and Families Act (2014) all emphasise the importance and need for co-operation between all services that support children and young people with special educational needs and their families and recognizes the need for local leadership in relation to the planning and provision of services to adults who have autism and disabilities.

3. DAY SERVICE REVIEW

Day Services

3.1 The current internally provided learning disability / autism day service provision consists of four bases that have 65 places per day and support 78 adults with varying packages of day support. The current mean unit cost per person per day is £71. Costs do vary depending on levels of need and some of the most complex individuals are supported by these services some of which require high staffing support ratios per person based on risk. The alternate providers of day services have a set payment per person per day of just under £32 per day. Although in a very small number of cases (four people currently) where needs require more intensive support this daily cost increases by approximately £10 per hour of additional 1:1 support thus increasing the daily cost. People who use day services are financially assessed and are required, where appropriate, to pay a contribution towards their care in line with the Care Act (2014).

3.2 The primary reason for this review is to meet financial savings targets. The savings target could be met through the closure of an existing base / service, reducing current provision from four day centres to three with estimated savings of £188,820, albeit that these services would have to be re-provided at a reduced cost reducing the actual savings, however we know that over the next two years 21 young people are coming through transition who have complex needs with 59 young people projected in total coming through transition over the next five years. As of February 2017 there are 8 individuals waiting for internal day services primarily at the centre that provides intensive support to people who present challenging behaviour and / or have autism.

3.3 Many of these individuals will require the complex service provision that is currently provided by internal services and many will also access existing services provided by partners through Children's Services. While closure of a day centre will contribute to the overall savings target, this is a short term solution to a budget pressure that will result in significant increased costs in the coming years as the young people with eligible needs transition into Adult Services and demand significantly exceeds service capacity which could realistically result in increases in high cost out of area placements. As a result of the known pressures this review has become a cost avoidance exercise rather than a savings exercise in terms of maintaining and possibly increasing current capacity to meet current and future demand.

Post 16 Education

3.4 In 2014 Adult Services created and funded a Transition Coordinator post to liaise between Adults, Children's, Education and Health and to develop the transition pathway for children and young people moving from Children's to Adults. As part of this work it became apparent that there was insufficient provision of post 16 educational placements available in Tameside. Post 16 placements have traditionally been provided by Tameside College's Dovestones Unit, and by placements in colleges outside the borough. These out of area placements can be at significant cost and they do not always meet the required outcomes identified with individuals. Due to capacity issues and syllabus changes at Dovestones their offer of a five day per week service has been reduced which has meant that more young people are being referred to Adult Services for day service provision, increasing pressure on existing services to provide day service provision.

3.5 Current figures provided indicate that we currently have 533 children and young people from Year 7 onwards who have an Education Health Care Plan or Statement. We currently have 53 young people post 16 who are placed out of area. These are primarily placed due to autism related needs however sixth form education ends at 19 and we have responsibilities under special educational needs until age 25. The question is could these young people access services in borough at a significantly reduced cost if we had a site and capacity to provide these services locally with the assistance of Tameside College for Education or other providers if not education based?

3.6 As part of this review and the requirements of the Children and Families Act (2014) special educational needs agenda the provision of effective transition, post 16 education, training and/or employment is a major issue for services going forward in terms of the 0-25 offer for young people with disabilities and/or autism and this is an area for development going forward, particularly in terms of the local offer under the special educational needs agenda.

Looked After Children

3.7 Adult Services are experiencing increasing referrals for young people coming through the care system who are vulnerable who may not meet Adult Services access criteria but who need support to learn skills for daily living and who may need additional support and training to support them into employment. Active Tameside are working with Children's services on a project focused on the training and skills development of Looked After Children to better prepare them for adult life. Currently 3 pupils are piloting this scheme.

3.8 There are currently 234 cases open in Leaving Care who are young people / young adults 16-25 years of age.

3.9 It is reasonable to assume that in addition to the Integrated Service to Children with Additional Needs (ISCAN) numbers, other Looked After Children who would be using the service would equate to approximately 23 (10% of leaving care open cases).

3.10 Approximately 10% of all open cases across the service are defined as having a disability, this equates to 105 children and young people who could be eligible for services.

3.11 In terms of Looked After Children a dedicated transitional support team has been established to proactively work with children in the most complex placements in order to ensure pace of change and ability to achieve independence is maximised. This will produce better outcomes for young people whilst also reducing spend in the longer term.

3.12 In addition the team will provide direct support to care leavers who are in semi-independent/independent living situations. This support will offer independent living skills, education support and interventions, health support and interventions and address readiness to work. The overall aim is to improve life chances, increase employability and reduce demand and dependency. The aim is to "break the cycle" of involvement or dependency with wider public services which leads to high cost on the public purse.

3.13 This team will work alongside key partners from Health, Education, New Charter Housing, Active Tameside and other local voluntary sector providers thereby utilising the full resource of the Corporate Parent.

3.14 Tameside has a profile inherited from previous years whereby over the coming 5 years plus, we have more teenagers who will need this service than would be expected. Failure to provide for them will make the cost unaffordable.

3.15 The work with this group of young people will follow the already well established Transition Pathway that is in place for young people with special educational needs. This model of working demonstrates improved outcomes for young people and a clear evidence base. The Oxford Park development will be a support to this process going forward.

Market Pressures

3.16 A number of day service providers are operating across Tameside providing day services to adults with learning disabilities and/or autism these include Tameside Arts, People First Tameside, Tameside Countryside Services and Active Tameside.

3.17 Active Tameside has proven to be a popular service offer with 115 people currently accessing the base at the Medlock Sports Centre. This is significantly more people than the planned capacity of the service and there are concerns that this scheme needs to expand capacity to meet current and possible future demand. The primary reasons for this growth is that the services offered are very popular and 70% of people who have commissioned services also pay privately to access services on days which are not commissioned. The scheme also provides a range of services to children and young people with disabilities at the same site. Active Tameside have been proactive in developing the supported internship programme with Education and during 2016 supported 13 out of 15 individuals into paid employment as a result of this programme. This has been supported by an independent provider who offers education and training opportunities to the young people on the programme.

Employment Review

3.18 As a result of funding reductions in Supported Employment capacity and service provision, performance in this area has dropped from above the Greater Manchester average several years ago to one of the poorest performers in GM, with only 2% of people with learning disabilities in paid employment. Routes to Work (Supported Employment) is another facet of this area of operations and is an area that there is significant interest in from the Department of Health, Care Quality Commission and Ofsted in terms the Special Educational Needs 0-25 agenda, transition in terms of people with disabilities and autism accessing education and employment and generally in terms of adults accessing employment. While this report refers to employment throughout because employment is one means of reducing day service demand and in meeting other positive outcomes for individual's employment is being looked at separately as part of the Supported Employment Review.

4. OXFORD PARK PROPOSAL

4.1 Oxford Park is a small park on the outskirts of Ashton which contains gardens, sports pitches and a small sports centre managed and run by Active Tameside. The site is owned by the Council. The collaborative proposal is that the Oxford Park site is developed through the provision of an extension to the existing building which will accommodate:

- Sensory Room;
- Several classrooms with access to internet;
- Teaching kitchen;
- Studio;
- Utilisation of outdoor areas including the pavilion and grounds.

Please see **Appendix 1** for the initial building plan.

4.2 The proposed development will provide a purpose built disability / community facility within Tameside that will host a wide range of services to children and adults. The proposed service will provide the following opportunities:

Opportunity	Outcome
Special education provision for young people excluded from college (alternative curriculum)	• Introduction to a structured programme focused on reducing levels of support required, introduction to Supported Internship Programme focused on employment and / or introduction to day services provision. • Delivery of Maths and English and various vocational skills including gaining qualifications. • Based on current pilot estimated savings of £25.000 per student per year as opposed to out of area placement based on current pilot with three young people. (Need to clarify figures).
Expand the supported internship programme. Support for 16-24 year olds with Special Educational Needs into paid employment. In 2016 13 young people were supported into paid employment.	• Increase current capacity to support young people 16-24 into paid employment. • Reduce reliance on the state, improve lives and support improved health and wellbeing. • Scheme is focused on supporting life skills, functional skills and vocational qualifications.
Holiday, community and respite provision to support families. Active Tameside provide 1056 places and 5000 hours respite on this scheme each year for holiday provision for children and young people with disabilities. Oxford Park will expand capacity to increase this provision significantly.	• Better support for families. Helping individuals to stay at home rather than being placed in residential or out of area care.
Support for hard to reach young people in conjunction with New Charter, Integrated Neighbourhoods, GM Police, Transport for Greater Manchester and other local community groups.	• Oxford Park will provide a base for this service in engaging these vulnerable young people. Increased engagement will result in potentially better outcomes and life chances for the youngsters involved.
Expansion of Learning Disability and Autism Day Service provision across the borough	• To meet current and projected increased demand. • Reduce higher cost provision spot purchased or provided out of area due to insufficient local capacity. • To provide a diverse service offer to increase choice and control. • To expand the employment offer to support adults with learning disabilities and autism into employment.
To provide support and training to LAC and to support transition into adulthood	• To build on the existing pilot assisting individuals to secure qualifications, work experience and employment. • To better prepare LAC for adulthood in terms of promoting independent living skills.
To work with Children with disability services in the provision of respite locally.	• To date 51 children and young people have moved from Direct Payments and external respite provision both in and out of borough with significant cost savings. Work is underway with a further 42 families.

To provide better facilities that are appropriate for the Pupil Referral Unit (PRU) in conjunction with White Bridge College	• To provide an inspiring environment for continued learning and routes to independence.
Expansion of 'Live Active' programme with local GP surgeries around low intensity support and clinical exercise sessions for people with long-term health conditions such as diabetes etc.	• Improve health and wellbeing of the population • Increased capacity to expand work programme • Healthier population. • Reduced demand on health providers • Offers proactive solutions for GP's to access for patients.
Work with the local BME population to reduce cardio vascular disease with the provision of culturally appropriate exercise programmes. Oxford Park development increases capacity for this work with particular emphasis on Asian women.	• Improved health and wellbeing. • Healthier population • Reduced demand on health providers.
The provision of alternative 16-25 SEN provision locally based on developing skills for daily living, improved employment opportunities and experience (see supported internship above).	• Reduction in out of area Sixth Form provision. • Significantly reduced cost of provision. • Greater choice and control for individuals and families

4.3 Services will be jointly commissioned / funded from Adult Services, Children's Services and Education to provide more economical and efficient provision that is more effective at meeting the outcomes of vulnerable children and adults within the borough.

4.4 The actual capital cost of the development is in the region of £425,000 and revenue will be based on invest to save initiatives / investment from different service areas and cost avoidance in terms of ensuring that there is adequate capacity to efficiently meet increasing demand now and in the future. The revenue for running the building will form part of the existing management fee. The range of services would generate a surplus income to offset additional utility costs. Boiler and heating for example would take the same terms as the current arrangements and would be included in the asset management plan.

4.5 We have explored the existing property portfolio in the borough to establish if this scheme could be provided in an existing building thus reducing capital investment costs, however no other buildings exist that could meet the requirements particularly in terms of the overall site that supports gardens and other facilities that will be utilized.

4.6 While the proposed scheme is led by Active Tameside we would expect other providers across the borough to be able to access and contribute towards service provision where appropriate to strengthen a more diverse and stronger market locally. An example is that Active Tameside work closely with Supported Employment and Pure Innovations to provide access to supported internship work and employment generally including validated educational programmes to support individual development and ability to secure employment. It is envisaged that other service provider's will be engaged to provide specific courses / activities. Active Tameside already have a good track record of working with partners including Tameside College, Action Together, Sport England, Tameside Arts, Green Space, Public Health, Tameside MBC and Denton Community College.

5. FINANCIAL PROVISION

5.1 This review has highlighted that current and future demand for day service provision exceeds current capacity and that over the next five years we expect to see increased demand for service provision for individuals with more complex needs. This review, while originally focused on savings, has become focused on future cost avoidance through the provision of more capacity within the sector and increasing greater specialisation of internally provided day service provision to better meet the needs of people with complex disabilities.

5.2 The cost of day services within Tameside are £1.8m per annum. People who use day services are financially assessed and are required, where appropriate, to pay a contribution towards their care in line with the Care Act (2014) and Tameside's Charging Policy 2015. Current income generated by day services is £300,000.

5.3 Actual predicted savings are difficult to project in relation to this review as demand will increase over coming years. The option to develop Oxford Park will require a predicted capital investment of £425,000 and revenue funding will be achieved via commissioned places by respective services that develop and/or utilize the services provided or developed at the site. This would create significant cost avoidance in coming years and would result in significant financial and non-financial benefits across a range of partners including sustainability of a market that is more diverse, offers choice and control to service recipients and improves outcomes.

5.4 Revenue funding in terms of the management and maintenance of the proposed structure will be captured in the existing management fee and high cost items such as boiler maintenance will form part of the current asset management plan.

5.5 When market shaping and development was undertaken in 2012 savings of £137,000 per annum based on a reduced daily cost of provision was achieved across adult learning disability services. This saving was primarily based on a reduced unit cost per person per day. In the sector additional payments are required in complex cases which varies but is based on a £10 per hour premium thus increasing the daily unit cost from £32 per day. Evidence suggests that this is only in four cases but reinforces the need for the more complex provision to be retained currently by the existing services in terms of negligible efficiencies, outcomes and risk.

5.6 It is proposed that this capital investment would be Department of Health capital spend which is ring-fenced to Adult Services. Education Services have also offered Special Educational Needs capital investment towards this development. An application for capital investment is currently being submitted to support this development.

5.7 Projected Return on Investment

Activity	Potential Saving
Increased learning disability and autism day service capacity and provision (Adults)	Based on current and predicted demand (36 people in 2 years) and an estimation of attendance identified in terms of need (3 days per week) the estimated cost avoidance in comparison to internal provision in two years is **£214,812 per annum** This excludes savings on transport costs and assumes a 3 day week level of provision. Over 5 years cost avoidance based on current predicted demand would be **£441,558 per annum.**

	This figure is based on predicted demand of 36 people over the next two years, and 74 people over the next 5 years. This includes current predicted demand plus current waiting lists. The figures are the differential between internally provided unit cost of £71 per day and the current non-complex rate of £32 per day within the existing market. This equates to a differential of £39 per day x 3 days estimated provision per person x 51 weeks provision per year: Two years: 36 people at £71 per day x 3 days per week x 51 weeks = £391,068 per annum. 36 people at £32 per day x 3 days per week x 51 weeks = £176,256 £391,068 - £176,526 = **£214,812** costs avoided per year after two years. The same rationale has been used in the calculation over the 5 year period, with predicted demand of 74 people over the next five years.

Based on these estimations we would have financial return on investment in terms of costs avoided within three years of the scheme opening. These figures are only based on the day service element of the proposal. These calculations are based on a number of assumptions:

- That the market daily rate remains at £32 per day.
- These figures are calculated on the differential between internal provision costs and the current market. Specialist provision both in borough and out of borough would be at a significantly higher cost thus increasing the actual cost avoidance estimation quoted above.
- Figures are based on the assumption that individuals' needs would be 3 days provision per week. If provision is higher (5 days assessed need per week) than the level of cost avoidance would increase.
- These figures are based on current and predicted demand known to us. Numbers could increase but we are unable to predict this. I have built in the possibility of an increase of 6 people into these figures.
- That if the needs are complex in the population then costs of provision would increase thus reducing current predicted cost avoidance and extending financial return timescale.
- These figures exclude transport costs. These costs would reduce significantly if utilising external provision at Oxford Park thus avoiding increased community transport costs increasing with demand / population increase.
- They are based on this point in time and any variables to the projections will impact positively and/or negatively on these projections

6. CONSULTATION

6.1 Consultation was undertaken towards the end of 2016 through to the beginning of 2017. The methodology used was varied to capture general public, family / carer, prospective future users of services and current users of the internally provided day services. This took the form of:

- The 'Big Conversation' - 30 responses
- Service User Questionnaire - 48 responses

- 'Planning Live' events and use of the 4+1 Question approach to co-production with existing users

6.2 Open and closed questions were used in the interests of ensuring qualitative responses could be captured. Questions primarily centred on the review of day services, people's perceptions and satisfaction of their current provision and the provision of open text for people to comment on services. Planning Live also looked at people's views on moving to other day services as alternatives to current provision.

Big Conversation

6.3 30 people responded on the Big Conversation. 83% of respondents were members of the public, 6% were carers, 4% were potential future users and 1% of respondents were current users of services. 57% of respondents would be interested in visiting day services to see what services are provided.

Service User Questionnaire

6.4 48 people responded to the questionnaire. Respondents were 69% carers, 21% current Users and 10% described as other. Satisfaction with current services was explored and respondents indicated that they were primarily satisfied with the current service offer:

- Very satisfied – 65%;
- Satisfied – 29%;
- Neither Satisfied or Not Satisfied – 4%;
- Very Dissatisfied – 0.

6.5 Reasons for attendance at day services were meeting health needs 43%, meeting complex needs 45%, activities 68%, respite for carers 43%, behavioural support 47% and other 26%. It should be noted that respondents may answer more than one question creating a disparity between reported percentages. 67% of respondents receive other services and only 3% of respondents actually live within services.

6.6 It is apparent that services being provided are effective in terms of meeting 94% satisfaction rating by service recipients and families/carers. All of the people who responded in open text and Planning Live stated that they would be reluctant to move to other service areas.

Open Text Responses

6.7 Comments generally reflect concerns on behalf of respondents that current services are going to be reduced or closed, and question the efficacy of the Council's approach to vulnerable people who have learning disabilities. Comments include reference to what is considered to be non-essential Council spend that should be redirected and invested in improving services.

6.8 Respondents feel that they have confidence within Council services to meet complex health, behavioural and autism needs and that staff have the skills and experience to support people with complex needs effectively. General feedback on current provision is very positive. Examples include:

"A very valuable service that needs more income to provide good to excellent care in the future, not less funding. People with learning disabilities are very vulnerable and we as a society should not be concerned with cost but with providing the very best."

"I have friends who use the service, the reduction in service provision has already affected them any more reductions may be even more detrimental."

"I love going to the day centre as I have lots of friends and do lots of activities, I don't like change."

"You have to resource the best you are able from the funds available and seriously examine other things non-essential, hanging baskets, car parking charging."

Planning Live / 4+1 Questions

6.9 Planning Live and 4+1 Questions are person centred approaches used to stimulate open and transparent dialogue with stakeholders. These approaches are used to co-produce plans for change or used to discuss problems or challenges facing services. These approaches are particularly effective when consulting with people who have learning disabilities and/or autism.

6.10 Copley Centre provides day support to 15 individuals who have complex needs. 13 individuals are supported by Physiotherapy programmes and health and wellbeing monitoring. 13 need wheelchair access, hoists and specialised support including peg feeding, specialised diets and snoezelen facilities. Individuals and families/carers all seem confident and happy with the services provided.

6.11 Hurst base is a specialised centre that supports individuals who present severe challenging behaviours and people who have autism. Hurst is a National Autistic Society validated centre for the provision of services to adults who have autism. Many of the individuals who attend Hurst require 1:1 support due to risks presented and staff require specialist physical intervention training. Due to the intensive nature of services provided at Hurst there is a waiting list for access to this centre. Through consultation most individuals, families/carers were satisfied with the services provided and would not wish to move to other services provided elsewhere.

6.12 Denton base and Ash Road Bases are more generic day centre bases supporting people with more mixed needs and requirements. Based on Planning Live it is apparent that individuals and family / carers want to stay using these existing services and would be unhappy if asked to move. We have established that while some individuals would be unhappy to move from these bases we have approximately 15 people who could move on if appropriate packages were commissioned.

6.13 Prior to progressing with any work we would fully engage all stakeholders in the process including the use of taster sessions with different providers to establish if this is something individuals and their families would wish to explore.

6.14 The consultation process was supported by Tameside's Policy Unit. Access to full documentary evidence can be obtained from the author of the report.

7. EQUALITIES

7.1 The Equality Act (2010) makes certain types of discrimination unlawful on the grounds of:

- Age;
- Gender;
- Race;
- Gender reassignment;
- Disability;
- Maternity;
- Sexual orientation;
- Religion or belief.

7.2 This decision relates to day services that are provided to vulnerable adults who have learning disabilities and/or autism. The primary objectives are to ensure that there is sufficient capacity to meet current and future predicted demand forecasts for services. This may mean further work around the differentiation of services, in that as internal services

progress to become more specialised in the provision of complex services, some people with less complex needs may need to be offered alternative service provision to free up current capacity within internal services.

7.3 A further addition to the offer is the development of a state of the art disability service at Oxford Park which will be able to accommodate some of the current demand capacity and also assist with building future capacity into services. This development will also be able to offer services to children with disabilities in terms of respite, Looked After Children, and as alternative service offer to the current post 16 further education offer. The scheme will also support the supported internship offer (16-24) in improving performance in terms of helping young people and adults to access paid employment.

7.4 In respect of section 149, of the Equality Act (2010), the Public Sector Equality Duty:

- The proposals are focused on meeting the needs of a range of protected groups including vulnerable children and adults.
- Encouragement of the groups accessing services to fully engage and participate within the community.
- To provide services that are designed to be accessible for particular disadvantaged groups including those with disabilities and autism.
- Provision of training and development of disabled people, people with autism and young vulnerable people to access employment and become active citizens.

7.5 The primary focus is on removing and minimising disadvantages experienced by disadvantaged groups through access to community facilities, community presence and support breaking down barriers and discrimination. To ensure vulnerable people are safeguarded from harassment within the community. We will ensure we have due regard to:

- Eliminating unlawful discrimination;
- Promoting equal opportunities between members of different equality groups;
- Foster good relations between members of different equality groups including by tackling prejudice and promoting understanding.

7.6 No protected groups should be disadvantaged by the proposed review. See **Appendix 2** for the Equality Impact Assessment.

8. RISK MANAGEMENT

Risk	**Consequence**	**Impact**	**Likelihood**	**Actions to Mitigate Risk**
Close day centre base to achieve current savings target	Reduced capacity in provision of identified need, Increased cost of out of area placements, challenges regarding meeting assessed need	High	High	To retain current levels of provision in terms of future cost avoidance. Establish efficiencies to meet some of the identified savings
Do not close day centre base	Savings targets will not be fully realised	Medium	Medium	Establish efficiencies to meet some of the identified savings Potential system wide and community

				efficiencies through the provision of lower cost service offers for Children, Education, and Adults through the provision of early intervention and prevention services such as employment access.
Failure to secure capital investment	Lack of capital will mean the Oxford Park development could not progress impacting on current and future day service capacity and on system wide offers and subsequent efficiencies that can be achieved.	Medium	High	Collaborative working across all stakeholders. Business case regarding benefits of the development both in terms of outcomes and efficiencies across all stakeholder agencies.
Failure to fully utilize the Oxford Park site	Lack of ROI in terms of savings across the system	Medium	Low	Full engagement from all stakeholder agencies. Current demand is high and predicted use will be high.

9. OPTIONS APPRAISAL

Option 1 - Closure of one existing internal day centre base to achieve £188.820 in savings

9.1 Actual provision as an assessed need would still need to be provided at a cost so the actual savings would be significantly lower than the stated £188.820 savings. This would reduce capacity by at least 15 places per day and would compound the existing waiting list as capacity is reduced. The impact based on future demand would mean that we would potentially have insufficient capacity to meet identified need and would have to purchase alternative services within borough or external to borough, some of which may have to be specialised. Previous benchmarking exercises have indicated that purchasing specialised services would be at a significantly increased cost than existing costs of provision. This is what led internal services to work on a model of differentiation in the market providing higher cost complex services to justify higher unit costs.

Option 2 - Retain existing day centre bases but review existing users of service and those with less complex needs move into current external provider sector. Invest capital into the development of Oxford Park to accommodate existing and future demand.

9.2 This would build capacity for more complex individuals on the waiting list and coming through transition to utilise existing vacancies left within internal day centre bases. While this would be unpopular with service users and families / carers this flexing capacity to meet demand would address current demand pressures This is if existing external providers have sufficient capacity to accommodate more people which is not currently the case.

9.3 Investment in the Oxford Park Development would provide a base to accommodate collaborative service provision across Children's, Education and Adults that will result in a wider more efficient and effective offer within the borough. The cost / benefit is wide ranging and has the potential to make a fundamental difference to the community in terms of health and wellbeing and early intervention and prevention across a wide range of vulnerable stakeholders.

Option 3 - Do nothing

9.4 This will result in pressures to meet demand and assessed need within the borough based on current and future demand and capacity. The Council would not achieve any efficiencies. This could result in more costly day service options being required and a lost opportunity to develop a service that has the potential to fundamentally transform the local offer to children and adults within Tameside.

Preferred Options

9.5 Option 2 is recommended from this review. The primary justification is that individuals with less complex needs who currently access internal day centre bases should be given the opportunity to transfer to the current range of independent day service provider options thus releasing capacity within internal services to accommodate people with more complex needs. This would assist in reducing the current waiting list for these services.

9.6 Through capital investment Oxford Park could be developed to provide a purpose designed disability centre that will provide a range of services to a range of vulnerable stakeholders. This would expand current Active Tameside capacity to meet current over-demand and would also assist in meeting future demand based on demand predictions.

9.7 Efficiencies while not fully determinable at this stage should be significant in both financial and non-financial benefits to partners including the provision of 5 day post 16 further education opportunities, services that support Looked After Children to become more independent and have improved access to employment opportunities and a wider offer based on supporting the community.

10. CONCLUSION

10.1 This review was initially triggered by the need to make savings across day services. Since 2012 over 50% of internal day service provision and 100% of pre-employment provision has closed and been re-provided by the independent sector including Tameside Countryside Service, Tameside Arts, Active Tameside and People First Tameside. This market shaping and development has been a success in terms of achieving significant savings and also in offering improved choice and control to people with learning disabilities and/or autism within Tameside.

10.2 Internal day service provision consists of four bases that primarily focus on the provision of services to individuals with highly complex needs, 97% of which live at home or with carers with only 3% of users actually living within 24 hour service provision. The services provide for assessed need support and work in conjunction with a range of health professionals to provide health interventions, including physical therapy and behavioural interventions. There is currently a waiting list in operation for internally provided services of 8 people. 94% of service users, families and carers have indicated high levels of satisfaction with the services currently being provided.

10.3 Active Tameside has proven to be a popular choice amongst people and the service based at Medlock is fundamentally over-subscribed with current provision to 115 individuals. This includes the Supported Internship programme supporting young people (16-24) into paid employment with 13 out of 15 young people securing paid employment in the past year. The programme also includes a pilot working with 3 Looked After Children which appears to

be a successful scheme for expansion in the future. A further recommendation of this report is that a review is undertaken of current supported employment opportunities with the sector to have a clear joined up strategy towards employment for vulnerable young people and adults.

10.4 As part of the special educational needs work it has been identified that there is also a gap in post 16 provision locally in terms of the 0-25 offer and demand exceeds current capacity with numbers of young people being placed out of area or being referred into Adult Services.

10.5 The report concludes that due to current and future predicted demand that it would be unwise to close a day centre base as this would result in possible increased cost in future to meet demand and assessed needs. The report highlights the developmental proposal of Oxford Park as a means of meeting current and future demand of children, young people and adults who have learning disabilities and autism as well as providing a base to assist with the provision of services to other vulnerable groups such as Looked After Children and hard to reach young people as well as providing a resource for post 16 further education and independent living opportunities. The scheme would also fit with the upcoming Employment Review and would link in this work with the Oxford Park offer and other provider offers to increase pre-employment training, qualifications and placements.

10.6 Following a review of the available options the recommendation is to secure capital investment to develop the Oxford Park site to become a disability centre and to review internal day service packages to establish if individuals currently in internal services could move into services provided by the sector releasing capacity for more complex individuals. Capital investment is predicted for £425,000 and revenue will be provided by partners who commission services from Active Tameside at Oxford Park. Both financial and non-financial efficiencies and benefits will be realized across partner agencies with cost avoidance return on investment being realized within three years of the scheme opening.

11. RECOMMENDATION

11.1 As stated at the front of the report.

Proposed Ground Floor Layout

Area Schedule

Name	Sq.m	Sq.ft
Kitchen	- 53	- 570
IT Suite	- 45	- 484
Classroom	- 110	- 1183
Sensory Room	- 22	- 236
Studio	- 16	- 172
Store	- 12	- 130
Internal Footprint	- 310	- 3336
External Footprint	- 323	- 3475

All levels and dimensions must be checked on site by contractor prior to commencement of works. Any variations must be reported to Millson Associates Ltd.

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B 23-11-16 Disabled Bathroom alts added

A 04-11-16 Revised scheme following client meeting 02.11.16

ACTiVE TAMESIDE Client

Date	Oct '16	Status	Approval
Drawn	NH	Checked	RB
Scale	1:50	Size	A1
Rev. B		Drawing Nr. 2225-SK.2.01	

Drawing Title
Proposed Ground Floor Plan
Sketch Scheme

Project Title
Proposed Extension and Alterations at:
Oxford Park Community Sports Centre
Ashton Under Lyne

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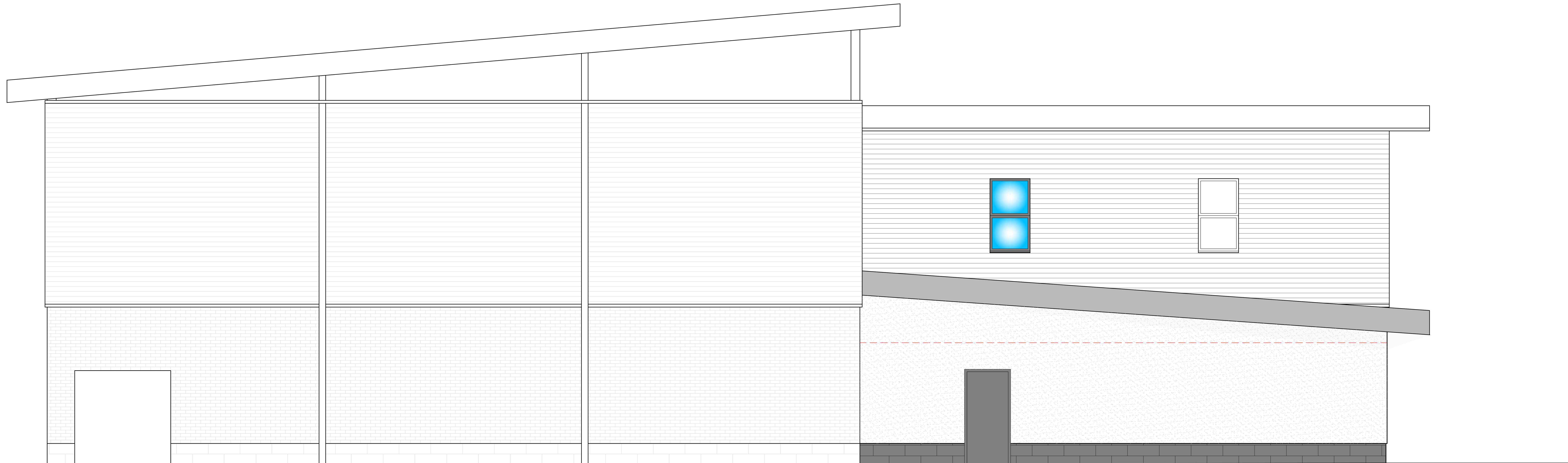
Proposed Front Elevation
Option 2



Proposed Side Elevation
Option 2

All levels and dimensions must be checked on site by contractor prior to commencement of works. Any variations must be reported to Millson Associates Ltd.

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ACTiVE TAMESIDE — Client

Date	Oct '16	Status	Approval
Drawn	NH	Checked	RB
Scale	1:50	Size	A1
Rev.		Drawing Nr.	2225-SK.3.01

Drawing Title
Proposed Front and Side Elevations
Option 2
Sketch Scheme

Project Title
Proposed Extension and Alterations at:
Oxford Park Community Centre,
Ashton Under Lyne

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Appendix 2

TAMESIDE COUNCIL EQUALITY IMPACT ASSESSMENT FORM

Subject / Title	Learning Disability / Autism Day Service Review

Service Unit	**Service Area**	**Directorate**
Provider Unit	Adult Service Operations	People

Start Date	**Completion Date**
February 2017	February 2017

Lead Officer	Mark Whitehead
Service Unit Manager	Alison White
Assistant Executive Director	Sandra Whitehead

EIA Group (lead contact first)	**Job title**	**Service**
Mark Whitehead	Head of Strategic Operations	Adults
Alison White	Service Unit Manager	Adult Services
Shaun Higgins	Active Tameside	Active Tameside
Sheena Wooding	Head of Service	Children's

PART 1 – INITIAL SCREENING

An Equality Impact Assessment (EIA) is required for all Key Decisions that involve changes to service delivery. All other changes, whether a Key Decision or not, require consideration for the necessity of an EIA.

The Initial Screening is a quick and easy process which aims to identify:

- *those projects, policies, and proposals which require a full EIA by looking at the potential impact on 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, policy or proposal is likely to have an impact upon people with a protected characteristic. This should be undertaken irrespective of whether the impact 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 Service Unit Manager and Assistant Executive Director.

1a.	What is the project, policy or proposal?	The review of learning disability / autism day services
1b.	What are the main aims of the project, policy or proposal?	Learning disability and autism internally based day services have been significantly reduced since 2012 as a result of budget reductions. This review was undertaken in response to further savings being set against this area of operations. The report reviews current internal and external day service capacity and current and future demand and identifies that due to current lack of capacity to meet current and future predicted demand that closure of any further day services would result in a lack of capacity to meet assessed need and the potential impact of higher costs due to reduced capacity in the long term as predicted demand. The report proposes capital investment in a new disability centre at Oxford Park Ashton. This centre would increase current day service capacity as well as providing services for LAC, children with disabilities and as an alternative post 16 further education site reducing out of area placements. The centre and site would be utilised to expand the internship programme assisting 16-24 year olds into employment and could be utilised for as range of other early intervention and prevention services focused on promoting good health.

1c. Will the project, policy or proposal have either a direct or indirect impact on any groups of people with protected equality characteristics?

Where a direct or indirect impact will occur as a result of the policy, project or proposal, please explain why and how that group of people will be affected.

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age	√			The Equality Act (2010) makes certain types of discrimination unlawful on the grounds of: • Age • Gender • Race • Gender reassignment

				- Disability - Maternity - Sexual orientation - Religion or belief This decision relates to day services that are provided to vulnerable adults who have learning disabilities and/or autism. The primary objectives are to ensure that there is sufficient capacity to meet current and future predicted demand forecasts for services. This may mean further work around the differentiation of services in that as internal services progress to become more specialised in the provision of complex services some people with less complex needs may need to be offered alternative service provision to free up current capacity within internal services. A further addition to the offer is the development of a state of the art disability service at Oxford Park which will be able to accommodate some of the current demand capacity and also assist with building future capacity into services. This development will also be able to offer services to children with disabilities in terms of respite, LAC, and as alternative service offer to the current post 16 further education offer. The scheme will also support the supported internship offer (16-24) in improving performance in terms of helping young people and adults to access paid employment. In respect of section 149, of the Equality Act (2010), the Public Sector Equality Duty (PSED): - The proposals are focused on meeting the needs of a range of protected groups including vulnerable children and adults - Encouragement of the groups accessing services to fully engage and

				participate within the community • To provide services that are designed to be accessible for particular disadvantaged groups including those with disabilities and autism • Provision of training and development of disabled people, people with autism and young vulnerable people to access employment and become active citizen's primary focus is on removing and minimising disadvantages experienced by disadvantaged groups through access to community facilities, community presence and support breaking down barriers and discrimination. To ensure vulnerable people are safeguarded from harassment within the community. We will ensure we have due regard to: • Eliminating unlawful discrimination; • Promoting equal opportunities between members of different equality groups; • Foster good relations between members of different equality groups including by tackling prejudice and promoting understanding. No protected groups should be disadvantaged by the proposed review.
Disability	√			AS ABOVE
Ethnicity	√			AS ABOVE
Sex / Gender	√			AS ABOVE
Religion or Belief	√			AS ABOVE
Sexual Orientation	√			AS ABOVE
Gender Reassignment	√			AS ABOVE
Pregnancy & Maternity	√			AS ABOVE
Marriage & Civil			√	AS ABOVE

Partnership				
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, policy or proposal? (*e.g. carers, vulnerable residents, isolated residents)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Children and adults who have disabilities, children with special educational needs & Looked After Children. Families and carers	√			The proposed review focuses on building capacity across existing services to meet identified needs. The development will improve the local offer to vulnerable children, young people and adults within the borough with a focus on better meeting individual outcomes more effectively.

Wherever a direct or indirect impact 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 is anticipated, this can be explored in more detail when undertaking a full EIA.

1d.	Does the project, policy or proposal require a full EIA?	Yes	No
			√
1e.	**What are your reasons for the decision made at 1d?**	That the review and proposed development does not disadvantage the protected groups. It focuses on enhancing the local offer to disadvantaged groups and their parents / carers.	

If a full EIA is required please progress to Part 2.

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary

2b. Issues to Consider

2c. Impact

2d. Mitigations *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
Impact1 (Describe)	*Consider options as to what we can do to reduce the impact*
Impact 2 (Describe)	*Consider options as to what we can do to reduce the impact*
Impact 3 (Describe)	*Consider options as to what we can do to reduce the impact*
Impact 4 (Describe)	*Consider options as to what we can do to reduce the impact*

2e. Evidence Sources

2f. Monitoring progress		
Issue / Action	**Lead officer**	**Timescale**
Required	*Required*	*Required*

Signature of Service Unit Manager	**Date**
Signature of Assistant Executive Director	**Date**