Report to: HEALTH AND WELLBEING BOARD

Date: 9 October 2014

Reporting Officer: Clare Watson – Director of Transformation, Tameside and Glossop Clinical Commissioning Group

Subject: OPERATIONAL RESILIENCE PLAN

Report Summary: Every Clinical Commissioning Group is required to submit an Operational Resilience Plan that will ensure the local health and social care economy can operate as effectively as possible in delivering year-round services to patients.

The plan covers both urgent and planned care and reflects the good practice, wider context and governance requirements set out in the national guidance ‘Operational resilience and capacity planning for 2014/15’ jointly produced by Monitor, NHS England, the NHS Trust Development Authority and ADASS.

The Tameside and Glossop plan has been collaboratively developed by local provider, commissioner and social care organisations and signed-off by all System Resilience Group member organisations. It was submitted on 16 September 2014. It shows how we are building on 2013/14 work and developing the use of primary care, community and mental health services as well as social services to support patients with urgent care needs or to help avoid such urgent episodes altogether. It is aligned with Care Together and Better Care Fund plans and will support early integration.

It sets out how the funding available from NHS England will be used and the processes used to monitor both performance and the use of the funding.

<table>
<thead>
<tr>
<th>Use of Central Allocation</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Communication</td>
<td>50,000</td>
</tr>
<tr>
<td>Primary Care services</td>
<td>250,000</td>
</tr>
<tr>
<td>Services supporting patients in their own home to avoid the need for admission to hospital</td>
<td>150,000</td>
</tr>
<tr>
<td>Services to support effective discharge from A&amp;E, MAU and wards.</td>
<td>600,000</td>
</tr>
<tr>
<td>Services to ensure prompt treatment in hospital</td>
<td>450,000</td>
</tr>
<tr>
<td>Cross GM Acute Trust support</td>
<td>180,888</td>
</tr>
<tr>
<td>Contingency</td>
<td>6,746</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of RTT Allocation</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validation</td>
<td>189,000</td>
</tr>
<tr>
<td>Additional Activity</td>
<td>1,279,406</td>
</tr>
</tbody>
</table>
Release of the Non elective funding (£1,687,634) is dependent on assurance of our plans by the tripartite above.

**Recommendations:**
That the submitted plans be received and noted.

**Links to Health and Wellbeing Strategy:**
The plan covers all priorities within the Health and Wellbeing Strategy.

**Policy Implications:**
The Plan is aligned with the better care fund. The Better Care Fund has been initiated by government to ensure that a greater level of cooperation, joint planning and integrated delivery of health and social care begins to take place.

**Financial Implications:**
The CCG’s Operational Resilience and Capacity plan identifies the Council as a key stakeholder involved in the development and implementation of this, as part of Central Government's drive to provide improved local efficiencies across services and a more co-ordinated experience of care for patients. A national £3.8 billion Better Care Fund (BCF) allocation has been made available in 2015/16 to support the integration of health and social care services at a local level.

The services are an integral part of the drive towards an increase in community based care which will result in cost reductions in acute and residential based services. In addition to this a number of reforms proposed by the Care Bill will place further financial pressure on key social care services.

**Legal Implications:**
It is a legal requirement that any plan complies with the NHS Constitution as well as the Council's.

**Risk Management:**
As set out in the Plan.

**Access to Information:**
The background papers relating to this report can be inspected by contacting Clare Watson/Elaine Richardson by:
- **Telephone:** 0161 304 5332
- **Email:** clarewatson2@nhs.net/elaine.richardson@nhs.net
Tameside and Glossop Health and Social Care Economy

Operational Resilience and Capacity Plan

2014/2015

1. Purpose

This document sets out how we will ensure that we are able to provide a high quality and responsive health and social care service in Tameside and Glossop throughout 2014/15 and beyond. It encompasses the Operational Resilience and Capacity planning requirements for 2014/15 and describes what services will be in place to meet expected demand and the agreed processes when the demand on the system is greater than anticipated.

The plan has been developed following

- A local lessons learned review of 2013-14 plans
- The GM event on Planning for Urgent Care in 2014/15
- An analytical review of non-elective and elective activity at Tameside Hospital Foundation Trust
- An ECIST review of Tameside Hospital Foundation Trust
- Evaluation of key new services e.g. Alternative to Transfer and Integrated Rapid Intervention Service to support out of hospital care

It seeks to ensure that:

- Organisations are prepared for the anticipated demand in 2014/15;
- Potential risks have been identified and contingencies have been put in place;
- The local escalation process is understood and has defined escalation levels and triggers;
- The impact of pressures on the levels of service, national targets and finance are managed;
- A process is in place to meet the reporting requirements of our governing bodies;

Each provider and the CCG will have their own Resilience Plans and Business Continuity Plans and this document should be considered alongside those plans.

This plan is the starting point for the winter plan which is being reviewed and the escalation process further refined. The final version of this plan will be available early October.

This document and plan are subject to continuous improvement and evaluation and as such is a ‘working document’. The Operational Resilience and Capacity Planning templates (appendix A) reflect the key schemes that had been identified at June and July Emergency Care Network (ECN) and were further refined through individual organisations and the ECN tactical subgroup. The plans had been reviewed and developed by the System Resilience Group.
This plan will be developed further following feedback from NHS England GM and as the Care Together programme develops.

2. Introduction

Local Health and Social Care providers and commissioners have been working closely together for the last two years to plan an integrated approach to development and delivery of services to local people. The financial and quality challenges faced in Health and Social Care are fully recognised and our plans look both to the immediate and longer term future taking into account the changes to social care described in the Care Act, the Better Care Fund and local system changes across Greater Manchester.

The CCG 14/16 Operational Plan, Commissioning Strategy 2014-2019 and the Tameside Better Care Fund all describe our local vision of an Integrated Care organisation that reduces demand on more intensive health and social care services by focussing on community based prevention and early intervention initiatives. The programme that will deliver that vision is known as ‘Care Together’.

In 2013/14 several integrated services were developed to enable urgent care to be more effectively planned for vulnerable people and to increase opportunities to manage people out of hospital. In 2014/15, building on our previous work, we have embarked on our Care Together programme. This builds on existing good practice and will enable us to make an impact on non-elective and elective activity in 2014/15 which will accelerate from April 2015.

The key stakeholders involved in the development and implementation of this Operational Resilience and Capacity Plan include:

- Derbyshire County Council
- Go to Doc
- GM Local Area Team Primary Care Commissioning
- Meridian Healthcare
- NHS Tameside & Glossop CCG
- North West Ambulance Service (NWAS)
- Pennine Care NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside Metropolitan Borough Council (TMBC)
- Tameside Hospital NHS Foundation Trust (THFT)

The implementation of the plan and the resulting performance within the system will be monitored by the SRG along with any recovery plans required to bring the system back to an acceptable performance level. This does not replace the monitoring systems in individual organisations; however, it incorporates the Urgent Care System performance monitoring undertaken by NHS Tameside and Glossop CCG.

3. Governance

The governance arrangements reflect the fact that our plans are being developed in partnership but partners still retain their individual statutory responsibilities.
The local Health and Social Care economy recognised the achievement of the ECN in developing a culture of shared responsibility around Urgent Care and decided to retain the ECN as the committee focusing on the development of an integrated urgent care approach. The elective planning element will continue to take place through the partnership arrangements Tameside and Glossop CCG have with the key local providers in particular Performance and Quality meetings. Where activity is being undertaken by trusts other than THFT CSU will provide insight into progress and achievement and raise any concerns the SRG has through the lead commissioner.

The System Resilience Group therefore sits above these arrangements and ensures non-elective and elective planning work in harmony to deliver effective, high quality accessible services which are good value for taxpayers.

The Care Together programme has its own governance structure with the Tameside and Glossop Commissioning Executive ensuring the programme remains consistent with the strategic needs of the population. The Integration Board oversees the implementation and system reform and the Clinical and Professional Reference Group provides clinical and professional insight to the programme and ensures engagement with frontline staff.

The terms of reference for the SRG, ECN and Performance and Quality meetings can be found in appendix B.

The SRG has met once formally to discuss the plans and the final sign off has been through email. Future meetings and teleconferences have been scheduled monthly to enable effective monitoring of progress and the impact of the plans.

Monthly reports will focus on achievement of Operational Standards for A&E and RTT, progress on service developments and performance against the outcomes of:

- Reduced Emergency Admissions
- Reduced Length of Stay
- Reduced Delayed Discharges
- Reduce Cancellation of Elective Operations

They will also capture key risks and issues and recovery plans. A draft report can be found in appendix C. This will be finalised once we are clearer what the national template will include.

4. Activity Patterns

Our capacity planning builds on the whole system approach, which acknowledges the usual peaks in demand over the Christmas and New Year period, plus unusual peaks in demand for other reasons, e.g. as a result of adverse weather conditions. Our commitment is to ensure that we have an adequate 'system wide' resilience plan, to respond to operational difficulties in parts of the system.

It is an inherent understanding that organisations will work to manage variations in demand internally but that no action should be undertaken by one service, which may undermine the ability of other parts of the system to manage their core business, without prior consultation/discussion.
Historical data (2008/09 to 2012/13) suggest there is a strong seasonal component to pressures indicating they are in part predictable. Although there is some variation between the years there are reoccurring patterns and the main periods of pressure are:

- At the start of October
- From the start to mid December.
- A ‘pressure’ lull before re-emerging in January, typically as elective activity resumes following the Christmas and New Year lull.
- March

ED attendance numbers are generally typical or ‘expected’ during these periods suggesting that numbers per se are not the driver for pressure.

Periods of pressure manifest after periods of variation in activity, i.e. decreased discharges (at weekends and Bank Holidays) and electives during holiday periods such as the half-term and especially the Christmas and New Year period. Discharges display substantially more variation than admissions which can lead to bed availability issues across days of the week. The low numbers at the weekend compared to admissions are likely to lead to bed availability issues on Mondays. The timing of discharges is fundamental in balancing the flow of activity through the hospital.

Elective admissions display considerable variation across the days of the week from 0 to 22, the daily average being nine.

The level of demand in 2013/14 remained within predictable levels with the exception of a few days in March. There were only two days when A&E attendances were above the upper control limit of 236 and three days when below 197. On only one day were ambulance arrivals higher than 81 but the pattern of arrivals has resulted in some stacking and long arrival to transfer times.

The level of A&E attendances, ambulance arrivals and emergency admissions at THFT in October 13 to March 14 were lower than in 13/14 and in all cases the decrease was greater than GM average change.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>THFT Average Activity</th>
<th>Greater Manchester</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11/12</td>
<td>12/13</td>
</tr>
<tr>
<td>Attendances</td>
<td>204.79</td>
<td>214.87</td>
</tr>
<tr>
<td>Emergency admissions via A&amp;E</td>
<td>53.72</td>
<td>57.96</td>
</tr>
<tr>
<td>Direct Admissions</td>
<td>14.21</td>
<td>13.24</td>
</tr>
<tr>
<td>Emergency admissions total</td>
<td>67.93</td>
<td>71.20</td>
</tr>
<tr>
<td>Ambulance Arrivals</td>
<td>70.92</td>
<td>77.62</td>
</tr>
</tbody>
</table>

Detailed analysis can be found in appendix D
We believe that our out of hospital support has contributed to the decreases. Our Alternative to Transport (ATT) Scheme prevented 155 avoidable attendances in its first 5 months and 76 subsequent admissions to hospital (based on a conversion rate of 49%). Our Integrated Rapid Intervention Service (IRIS) receives around 300 referrals a month one third of which are one hour responses. Generally it is felt these one hour referrals would attend A&E and 53.1% would result in an emergency admission. On average 84% of referrals are for people over 65 and referrals comes from a range of health and social care professional as well as patients and carers/families.

Although signs of pressure were lower, when they did occur they were at similar times to previous years confirming the predictable nature of much of the variation seen. Whilst we have always seen daily variation in A&E attendances a notable increase has been seen in Monday attendances.

A&E Activity in 2014/15 has changed and we have seen around 150 more people a week compared with 13/14. The case mix this year is showing around 40% of attendances has been minors. The change in case mix may reflect the increased range of urgent out of hospital support for patients. All GPs have capacity to review patients with urgent care needs and whilst no systematic analysis has been undertaken for 13/14 we are aware some practices have unused slots and patients who could have been seen in the practice are attending A&E. We are undertaking further analysis to understand how all of our schemes influence A&E attendance and where further improvements can be made.

On average just over 1 in 4 people attending A&E are admitted and bed pressures have impacted on the number of direct admissions with some GP admissions being managed through A&E. The schemes that keep people supported in their own homes will mean that those people who are admitted are likely to be more poorly and initial analysis of average Length of Stay indicates that could be the case. Further analysis will enable us to understand the interactions and how the increase in Ambulatory Care and Day Case surgery affect Length of Stay. Tameside FT is slightly above the NW average for 1 day LoS suggesting there may be some delays in the assessment pathway that offer potential for improvement.

Bed availability and process issues rather than activity appear to be a key issue locally. Average bed occupancy was marginally lower in 2013/14 than 2012/13 but there have been some occasions when electives were cancelled due to bed pressures.

Discharges of Emergency Admissions show a high degree of variability and this adds to capacity variation. Improved/earlier discharge planning and support may smooth patient flow.

Mental Health support through the ED RAID and Older People’s RAID is providing effective and referrals are high at around 100 a month so capacity is stretched. Increasing capacity to enable RAID to work with MAU would improve access to psychiatric assessments and enable more effective discharge of vulnerable patients.

Reablement services support around 116 new referrals a month and on average 42 % of people leave the service and do not need an ongoing package of care.
The majority of patients registered with NHS Tameside and Glossop attend THFT.

For non-elective care our patients make up around 90% of THFT’s Urgent Care Contract. However, local patients also make up 5.3% of Central Manchester FT’s Urgent Care Contract.

<table>
<thead>
<tr>
<th>Bolton FT</th>
<th>CMFT</th>
<th>Pennine Acute</th>
<th>Salford Royal FT</th>
<th>Stockport FT</th>
<th>Tameside FT</th>
<th>UHSM</th>
<th>WWL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tameside and Glossop CCG</td>
<td>0.1%</td>
<td>5.3%</td>
<td>0.4%</td>
<td>0.9%</td>
<td>4.1%</td>
<td>89.8%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

The majority of our hospital based elective care takes place at THFT (76% of FAOP, 58% of daycase and 41% or elective admissions) with CMMC delivering 13% of FAOP, 20% of daycases and 19% of elective admissions and Stockport, 3% of FAOP, 8% of daycases and 14% of elective admissions. Whilst we only have a small % of our activity in Independent hospitals through AQP contracts it varies by Speciality. Our Greater Manchester ISCATS contract is relatively well utilised currently (June) showing 87% utilisation and we have a range of activity with other independent providers.

Electives increased in 2013/14 and aggregate Referral to Treatment times were achieved for completed pathways at 91.9% for admitted and 96.2% for non admitted. Incompletes achieved 93.7%.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>THFT Average Activity</th>
<th>Greater Manchester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Inpatients</td>
<td>9.07</td>
<td>8.65</td>
</tr>
</tbody>
</table>

CMFT, Salford FT and Stockport FT have all identified NHS T&G long waiters for elective activity and along with THFT are undertaking additional elective activity to clear their backlogs.

As at May 14/15 THFT ranked 8th out of 12 CCGs for Admitted performance at 91.41% and 7th out of 12 for Non-Admitted at 96.76%. The median waits are 8.79 weeks for Admitted and 4.89 weeks for Non-Admitted. There was no significant increase in GP referrals in 2013/14 with a rate of 224.88 per 1000 of weighted CCG Population which put the CCG above average.

5. Lessons Learned from 2013/14

Several new services came into force during 2013/14 that were designed to reduce the need for emergency hospital admissions by providing rapid assessment in the home and a timely intervention. These appear to have had a positive impact on activity as shown above. The staff within the integrated teams are still employed by separate organisations and this sometimes makes it harder to flex capacity and skill mix quickly to meet demand.
Other services increased capacity, changed skill mix or improved processes to make transfers of patients more efficient.

In-reach into A&E by RAID, IRIS, Manual Handling had enabled more patients to be discharged into the care of community services directly from A&E. However, in the past we have not always insured the community capacity is ready to take the patient straight from A&E so closer planning would help avoid the need to transfer staff from planned work to enable the rapid escalation.

There have been changes in the cohort of patients supported by services e.g. Community Mental Health teams had seen a change in their case mix and are now focussed on patients with a mental Health crisis as IRIS were treating other patients that may previously been picked up by the teams.

The shift towards a more integrated culture was seen as very positive however, it was recognised that some services did not always think about whether other services could manage patients. To overcome this more co location of services and multiservice reviews have been taking place particularly within bed bases e.g. Intermediate Care Units and the Hospital.

Whilst multi service reviews have a positive impact in discharging people from beds one disadvantage is those staff involved are not available to support direct care. The need to deliver services within a decreasing financial envelope means we need to explore more efficient ways of achieving effective discharges without increasing staff capacity.

Ambulatory Emergency Care (AEC) worked well especially when A&E and MAU patients were proactively identified. However, it became necessary to prevent AEC being used for escalation beds by fitting a bollard to restrict bed access. Opportunities to maximise AEC are being explored and this may increase usage to a level that impacts on the location of AEC with MAU.

Communication flows across services had greatly improved and services work more effectively together to support patient flows and reduce admissions and increase discharges. The enhanced cross services communication has resulted in the establishment of cross organisational boundary working groups and meetings enabling participants to work together on pulling patients through the system and formulating actions and strategies. The separation of services still means patients are ‘handed over’ and the different process and assessments used by services can delay things even when working within agreed performance standards. Increased integration should help reduce this.

The reporting system has supported a system wide view with capacity challenges being shared with a five day perspective. This has enabled services to plan in advance as well as to proactively approach others to discuss ways of managing individual cases when required. Services requested the continuation of the daily reporting throughout the year as it was felt to be beneficial both within organisations and across the system. Weekly conference calls were requested to protect time for a review of how things were going and to plan prior to bank holidays. The conversations on calls are very constructive with supportive challenge and good practice sharing.
It was not possible to deliver to the 95% A&E 4hr operating standard seven days a week. However, the system worked together to ensure that we recovered quickly from escalation and recovered A&E 4 hour standards quickly. Increasing the range of services that operate across seven days will help smooth some of this flow as there appears to be nervousness about discharging home around weekends.

The Flu planning arrangements enabled organisations to meet the expected targets and the intention will be to encourage staff to take up the opportunities for vaccination as early as possible. Extending flu vaccines to care home staff is being explored and all providers of services inc voluntary organisations will be encouraged and supported in effective flu planning. 2013/14 saw conflict of interests between NHS England and CCG member Practices because of the promotion of pharmacy flu vaccinations when practices had pre-purchased flu vaccinations for their patients. A more coordinated approach would help increase uptake without confusion.

Our communications campaign was later started than hoped and there were delays in receiving information from other parties i.e. Pharmacy dates from NHS LAT. There was a lower level of involvement from all partners to ensure a single-message campaign and it was felt the NHS England campaign in January 2014 was confusing the public.

Whilst there was no formal evaluation social media monitoring tools showed the following but this is only for part of the time the campaign was running

- Campaign Reach: 36K
- Highest Individual Tweet Reach: 9.8K
- Total Links Clicked: 206
- Highest Links Clicked per day: 26
- Highest Link Click per individual tweet: 22

Anecdotal evidence was received from a number of sources, including the CCG 360 survey, which commented that people were aware of the campaign but were still going to A&E when perhaps another service was more appropriate.

Details of the Lessons Learned from Winter 2013/14 for Urgent Care can be found in appendix E.

In 2013/14 a key elective care change was the implementation of our community based integrated approach to the management of diabetes. This provides a holistic service and has enabled 577 patients (43% of total reviewed) to be discharged from hospital and managed in primary care. There has also been a reduction in GP referrals. This model will be replicated for other LTCs through Care Together i.e. Respiratory and Cardiology.

Reviews of the levels of Follow Up Outpatient appointments has highlighted opportunities for patients who can be effectively managed in Primary Care being discharged back to their GP. Cardiology, Diabetes, Respiratory Medicine, Pain Management, Rheumatology and Anticoagulation Clinics are all areas where GPs are looking to see if patients are being called back for Hospital Follow Up when they could be discharged to Primary Care.
6. 2014/15 Capacity Planning

Our capacity planning as an integrated system is still in its infancy. All services and organisations undertake separate capacity planning and have in place systems for flexing capacity and these support this system operational resilience plan. Information is currently shared to predict demand along pathways and we are building on this in October and November, developing a pathway approach to capacity planning that ensures effective patient flow.

As we develop more out of hospital alternatives we want to move away from using A&E to quantify the demand pressures, so we are developing how we capture quantifiable demand from General practice and our Community alternatives to admissions. This will enable us to get a better picture of the demand on urgent care and the cohorts or people/conditions that make up that wider demand. This is particularly important in our planning around skill mix as we aim to manage more patients out of hospital before they develop an urgent care need and to be able to respond promptly when a need arises.

We are seeing increased acuity which has an impact on both the acute sector and community based services.

We recognise that a focus on the demand in the hospital can distract from the level of service needed for people in the community, support which prevents admissions. We are therefore planning resources to ensure that we have sufficient capacity to maintain people on the existing caseload whilst accepting new people directly from the community and from the hospital e.g. Reablement capacity will increase to enable 120 cases to be supported with the ability to flex to 160 quickly should the need arise.

We are also looking to deliver support that works both in the hospital and community and enables patients to be assessed in A&E/MAU by the professional who can support them in the community either until they are able to be discharged or until their care can be transferred to the community service e.g. manual handling.

We are increasing capacity in a range of services to ensure patients can be accessed quickly when they attend hospital e.g. consultant led rapid assessment, acute physician support for medical intake and RAID

Ambulatory capacity is protected and suitable patients are directed to AEC. Hot clinics and a surgical assessment unit will reduce flow through A&E.

Our current acute based information (below) shows we have fluctuations across the days and recently we have seen increased activity over weekends. As we have more services delivering seven day a week services we will monitor how variation across the week changes. We balance our capacity around the average and the upper control limit activity levels as the former is likely to lead to ‘failure’ in managing on around 50% of the days as half the activity is above the average and the later is comparatively costly and has the inherent problem of under-utilisation of resources. Resourcing between the average and the upper control limit of activity should support more proactive management of the ‘flow'.

Table 1: Upper Control Limits for expected activity by day of week

<table>
<thead>
<tr>
<th>Day</th>
<th>ED Attendances</th>
<th>Emergency admissions via ED</th>
<th>Direct admissions</th>
<th>Emergency admission total</th>
<th>Elective Inpatient</th>
<th>Ambulance arrivals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average</td>
<td>Upper Control Limit</td>
<td>Average</td>
<td>Upper Control Limit</td>
<td>Average</td>
<td>Upper Control Limit</td>
</tr>
<tr>
<td>Mon</td>
<td>233</td>
<td>291</td>
<td>61</td>
<td>87</td>
<td>16</td>
<td>38</td>
</tr>
<tr>
<td>Tue</td>
<td>223</td>
<td>273</td>
<td>60</td>
<td>86</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Wed</td>
<td>214</td>
<td>276</td>
<td>57</td>
<td>82</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>Thu</td>
<td>217</td>
<td>256</td>
<td>60</td>
<td>83</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>Fri</td>
<td>200</td>
<td>261</td>
<td>59</td>
<td>80</td>
<td>16</td>
<td>29</td>
</tr>
<tr>
<td>Sat</td>
<td>206</td>
<td>257</td>
<td>56</td>
<td>82</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>Sun</td>
<td>213</td>
<td>265</td>
<td>53</td>
<td>73</td>
<td>7</td>
<td>17</td>
</tr>
</tbody>
</table>

NB Emergency admissions and direct admissions will not sum to the total due to: variation within the two admission streams limits and the figures displayed are the upper control of the two admission streams.

The additional elective activity that is taking place will reduce the risk of patients waiting over 18 weeks. We will look to plan elective admissions considering the expected demand of emergency admissions to reduce the risk of bed capacity issues and cancelled operations. Where possible daycase activity and enhanced recovery programmes are used to reduce length of stay and ensure effective patient flow.

7. Services for 14/15 and 15/16

From 2014/15 onwards we will see several of our services becoming more integrated as Care Together progresses. Care Together keeps the individual at the centre of their care organising services around them according on need.
By 15/16 we expect to be piloting increased integration in all four levels of Care Together, as we have recognised that to have the level of impact needed to secure high quality cost effective care over the next five years we need to deliver whole system change.

Whilst we already have several integrated services within our Urgent Care system there are many services that are not integrated. The level of awareness and communication between many of the services are good and close working exists but patients are still handed over and the level of flexibility for cross cover and support is limited. To improve patient flows and reduce capacity risks we are moving away from the separate services working cooperatively towards integrated levels of care that take a holistic approach to care planning and service delivery.

Our Healthy daily Living Support is designed to avoid the need for specialist care either through a non-elective or elective pathway. The services focus on risk assessment and interventions that support people to remain healthy and independent. Our plans include:

- Close working arrangements with care homes including the CHEW protocol (care home early warning scores) to help care home nurses to clinically assess clients if unwell and guide them to making appropriate referrals
- GP commitment to admissions avoidance. We have 100% uptake of Avoidable Admission DES and innovative plans to support our over 75s.
- Our Health and Wellbeing service will encourage referrals from other services to provide support and advice to our residents
- Telehealth and telecare are used to support patients in their own homes
- Our health and social care professions provide advice and support for the physical and mental health needs of our population
- Integrated Locality Based Teams to identify who is most vulnerable, ‘At Risk’, undertake care planning and care coordination
Our Urgent Care Community Support is designed to provide rapid intervention when an individual's need increases to keep people at home and support prompt discharge from hospital. Our plans include:

- Integrated Response Intervention Service (IRIS)
• Community Bed based Step Up
• Alternative to Transport (ATT) an Urgent GP based support model when an ambulance does not feel a transfer to hospital is desirable
• Responsive seven day a week access by community teams including LTC, DN, Community Mental Health, Social Care
• Walk in centre - covering 365 days a year 8.00am - 8.00pm and OoH appointments
• 24/7 GP access including same day appointments for urgent needs
• GP home visits that enable any hospital admissions by 16:00
• In-reach into Hospital by out of hospital services is avoiding admissions and facilitating discharge
• RAID - two teams ED and Older People to support prompt MH assessment and discharge to community
• Integrated Transfer Team - to manage prompt and effective discharge
• Intermediate Care home based service (CARA) who support step down through a combined health and social care assessment and deliver care for up to X weeks managing individuals in their own home
• Marie Curie liaison - to facilitate fast track discharge of EoL patients
• Learning Disability Hospital Liaison Nurse – to ensure prompt discharge and facilitate planning for elective admissions
• Reablement - supporting rehabilitation at home
• Intermediate Care Inpatients - who support step down
• Discharge team working in MAU
• Pharmacy discharge support
• Community Home & Hospital Enhanced Care Team to increase out of hospital management
• Hospital to Home and Discharge transport

Our hospital based services are designed to assess and treat people promptly and discharge them home unless clinically necessary to admit. Our plans include:

• Acute based Ambulatory Care for UTI, CAP, DVT, Cellulitis, PE, Chest Pain, TIA
• Hot Clinics for direct access rapid diagnosis and assessment
• Consultant-led Rapid Assessment and Treatment
• Acute physician support for medical intake
• Prompt access to diagnostics
• Paediatric A&E and 24 hour Children’s Observation and Assessment Unit
• Development of Surgical Assessment Unit

Our communications work will support the effective use of services and promote self care and the aim is to use a variety of media and build on existing relationships people have with health and social care to encourage a partnership approach to responsible use of services.

Our elective services are also being arranged around the four levels of Care Together with particular emphasis on Specialist pathways that provide short term support and advice and/or long term care depending on an individual’s needs. Specialist teams will ensure
the most appropriate professional assesses what somebody needs and makes sure they get treatment as conveniently as possible. Specialists teams will, where it is safe, provide hospital type care at home or in the community. Our plans include:

- Developing pathways where routine diagnostic tests are reported for the First OP appointment
- Maximising Day Case surgery
- Using Enhanced Recovery pathways
- Discharging to GPs when ongoing management can be provided in Primary Care
- Developing Primary Care services for elective activity where safe and clinically appropriate

A Whole System Urgent and Emergency Care Flow model can be found in appendix F

8. Monitoring

The majority of services have existing KPIs and operating standards that are monitored through contractual arrangements. These will be used as the basis for the development of agreed smart KPIs that reflect the increased integrated way of working.

The ECN have discussed the setting of aspiration targets for Urgent Care such as:

- 95% patients in A&E treated or discharged within 3 hours
- Medically Fit List below 35
- Increased patients with Urgent Care need supported at home

The willingness to adopt these and the time frame for achievement will be discussed with the SRG.

The reporting of KPIs has in the past sometimes distracted from the delivery of care and caused services to be in conflict when working to different timeframes. The focus for the SRG monitoring (appendix C) will be on the KPIs that will give assurance around the delivery of operating standards. These are aligned with the Better Care Fund targets.

The outcome leads will be expected to ensure that standards and precise measures are agreed for pathway milestones that demonstrate effective patient management. The update reports they complete will include achievement against these milestones.

Each organisation will be expected to continue to use their internal monitoring arrangements such as weekly Patient Tracking meetings, case load monitoring.

The implementation of Lorenzo will continue to make accurate weekly monitoring of incomplete pathways difficult, however, through validation and proxy measures it is hoped that THFT will be able to reassure the system that the risk of missing the operational standards is minimal.

9. Escalation

The arrangements for 2013/14 were felt to have worked well and increased ownership at a service level and promoted a whole system responsibility. The process has therefore
fundamentally remained the same as the ability to recover performance through it has been tried and tested in real time not just through a desk top exercise.

There are minor adjustments on the reporting and refreshed escalation criteria and responses which are shown in appendix G.

The process is designed to ensure that all services work together to improve patient flow both during normal levels of demands and at times of pressure.

A test of the resilience plans will be undertaken as part of the GMwide test in October.

The organisational resilience plans across the Health and Social Care economy have been tested through Operation Mallard which also linked to Stockport and Trafford economies.

**10. Key Risks and Challenges**

The local system is subject to the key challenges below:

- Financial position of TMBC and THFT which could lead to service reductions.
- Demographics increased risk of older population requiring residential or nursing home care
- Significant rise in A&E attendances and changes in case mix
- Level of staffing at THFT

These may impact on the Operational Resilience and Capacity Plans however these challenges are closely monitored through the risk management arrangements within the Care Together Programme, Better Care Fund and in separate organisations.

The Systems Resilience Group will review the impact and mitigation of the above along with specific risks around the Operational Resilience and Capacity Plan on a monthly basis. The initial version of the System Resilience Risk and Issue log can be found in appendix H. The Log is held by the CCG and is updated when new risks are identified or RAG increases as well as being subject to a monthly review. The key areas of risk are summarised below.

<table>
<thead>
<tr>
<th>Area of Risk</th>
<th>Impact</th>
<th>Mitigation/Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>New ways of working not fully implemented in time</td>
<td>Increased pressure on existing services</td>
<td>Scheme Leads to ensure timely implementation Schemes fully aligned with Care Together and Better Care Fund</td>
</tr>
<tr>
<td>Seasonal holiday causing patients to present because they have not accessed timely care or are more vulnerable</td>
<td>Additional attendances at ED/WIC Increased demand for IRIS and mental health services</td>
<td>Focussed communication to encourage effective planning and advise patients where to get support Plans to support fast increase of capacity</td>
</tr>
</tbody>
</table>
Adverse weather resulting in rise in specific conditions and transport difficulties
- Additional attendances at ED/WIC
- Increased demand for IRIS
- Reduced staffing available in services
- Delays in attending patients
- Preventative case management from Primary Care and others
- Flexible workforce and transport arrangements

Increased acuity and complexity of patients within services
- Increased admissions
- Caseloads more difficult to manage
- Reduced patient flow
- Capacity planning and escalation arrangements take into account complexity

Patients waiting over 18 weeks increases
- RTT standards not achieved
- Effective PTL management and associated capacity planning

Staff sickness reducing capacity
- Delays in care for patients
- Robust locality sickness management/prevention strategy in place

Service Failures
- Patients requiring transfer to alternative services
- Robust service level resilience plans in place

### 11. Finance

The funding for the plans includes:

- Existing funding for the services that are already in place.
- Central allocation of £1,687,634
- RTT allocation of £1,468,406 – this cover THFT activity not CCG activity

The ongoing financial challenge across the health and social economy means that we are facing a gap of £74.1m over the next five years.

<table>
<thead>
<tr>
<th></th>
<th>2014-15 £m</th>
<th>2015-16 £m</th>
<th>2016-17 £m</th>
<th>2017-18 £m</th>
<th>2018-19 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td>5.1</td>
<td>7.9</td>
<td>9.8</td>
<td>10.0</td>
<td>9.9</td>
</tr>
<tr>
<td>Local Authority</td>
<td>4.5</td>
<td>16.8</td>
<td>27.0</td>
<td>36.0</td>
<td>44.2</td>
</tr>
<tr>
<td>TOTAL COMMISSIONING</td>
<td>9.6</td>
<td>24.7</td>
<td>36.8</td>
<td>46.0</td>
<td>54.1</td>
</tr>
<tr>
<td>Tameside FT</td>
<td>17.5</td>
<td>22.6</td>
<td>21.1</td>
<td>20.6</td>
<td>20.0</td>
</tr>
<tr>
<td>TOTAL ECONOMY GAP</td>
<td>27.1</td>
<td>47.3</td>
<td>57.9</td>
<td>66.6</td>
<td>74.1</td>
</tr>
</tbody>
</table>

The additional funding is non-recurrent and it has been agreed that a sustainable approach would be to allocate the funding to the three key areas of impact and use it to enable increased integration and pump prime some increased capacity for seven day working or to ensure patients who are discharged early are supported effectively at home.
The contingency fund is available for times of extreme system pressure. The communications allocation is expected to exceed the final costs and any under spend will be transferred to the contingency. Each area is also expected to identify a contingency to initially manage pressures within the area along with plans to utilise it should it not be required.

If the contingency fund is insufficient to manage demand pressures the SRG will submit a business case to the CCG who will look to identify funding from slippage in other budgets.

Whilst none of the central funding allocation has been specifically allocated to NWAS, the CCG is funding the Alternative to Transport service (£260,000) and supporting the CHEW protocol in Care Homes both these schemes have been shown to have had a positive impact on NWAS. The ATT has avoided 527 hospital attendances Oct 13 to August 14.

Services are expected to lever efficiencies and to show that the investment in prevention and out of hospital care is releasing funding to bridge our financial gap and enable us to continue to have high quality services that are clinically effective and safe now and in the future.
12. Appendix A – Operational Capacity and Resilience Template
13. Appendix B – Terms of Reference
15. Appendix D – Activity Analysis
16. Appendix E – Lessons Learned analysis
17. Appendix F – Whole System Urgent and Emergency Care Flow model
18. Appendix G – Daily Reporting and Escalation Process
19. Appendix H – Risk Log
Section 2: Narrative on local system configuration, key strengths and key challenges

Local Health and Social Care providers and commissioners have been working closely together for the last two years to plan an integrated approach to development and delivery of services to local people. In 2014/15 we embarked on our Care Together programme which aims to reduce demand for more intensive health and social care services by focussing on community based prevention and early intervention initiatives. The programme builds on existing good practice so we enable us to make an impact on activity in 2014/15 which will accelerate from April 2015. We anticipate a significant impact on non-elective care from October 2014.

System Configuration

Activity flows
In 2012/13 79% of our A&E activity went to THFT with 11% going to CMRC and 4% going to Stockport. 81% of emergency admissions were to THFT with 9% to CMRC and 4% to Stockport. 65% of our non emergency admissions were to Tameside with 16% at CMRC and 12% at Stockport.

Our 2014/15 A&E and Urgent Care Admissions contract values are 8.9% THFT, 0.1% Bolton FT, 5.2% CMRC, 0.4% Pereine Acute, 0.9% Salford Royal FT, 4.1% Stockport FT, 1.7% UHSM, 0.4% WPL.

ED Attendance trend increase of approximately 20% per year. Seasonal variation with generally higher attendance numbers in Quarters 1 and 2 than in Quarters 3 and 4.

ED % conversion rate - seasonally variable but on average just over 1 in 4 ED patients are admitted.

Trust is slightly above the NW average for 1 day LoS suggesting there may be some delays in the assessment pathway that offer potential for improvement.

see a decrease in the level of Direct Admissions to THFT in comparison to previous years with more patients supported in their homes. 2013/14 saw increased capacity to support patients in their own homes and Direct Admissions to THFT fell. Further assurance is needed to be sure this is not due to admissions being directed in advance of A&E. Discharges of Emergency Admissions show a high degree of variability and earlier discharge planning and support may smooth patient flow

Services

Several integrated services have been in place since 2013/14 (IMS, ATT, ATT) and these are being developed to increase our out of hospital capacity in 2014/15. Services to support urgent out of hospital care include:

* Integrated Response Intervention Service (IRIS) who undertake a rapid combined health and social care assessment and instigate a care plan for up to 6 weeks managing individuals in their own home to avoid an admission. Cohort includes LTC patients with crisis exacerbation, frail, elderly and Palliative care crises.
* Alternative to Transport (ATT) an Urgent GP based support model when an ambulance does not feel a transfer to hospital is desirable.
* Walk in centre - covering 162 days a year 8:00am - 8:00pm and Dali appointments.
* Acute based Ambulatory Care for UTI, CAP, DVT, Cellulitis, PE and Chest Pain, TIA
* Pandemic A&E and 24 hour Childrens Observation and Assessment Unit
* RAID - two teams ED and Older People to support prompt MRI assessment and discharge to community
* Integrated Transfer Team - to manage prompt and effective discharge
* Intermediate Care home based service (CARA) who support step down through a combined health and social care assessment and deliver care for up to 7 weeks managing individuals in their own home.
* Marie Cure liaison - to facilitate fast track discharge of EoL patients.
* Learning Disability Hospital Liaison Nurse - to ensure prompt discharge and facilitate planning for elective admissions.
* Telehealth and Telecare - supporting people at home
* Reablement - supporting rehabilitation at home
* Intermediate Care Inpatients - who support step down The above work closely with other Primary and Community services.

Key Strengths

Integrated Health and Social Care approach in both delivery and planning.

Inreach into Hospital by out of hospital services is avoiding admissions and facilitating discharge

Integrated Health and Social Care approach in both delivery and planning.

Key Challenges

Demographics increased risk of older population requiring residential or nursing home care

Significant rise in A&E attendances and changes in case mix

The work closely with other Primary and Community services.

Section 2: Minimum plan requirements. Please note that development of a sufficient plan to deliver all of these elements is a pre-requisite to qualify for any central funding in response to the challenge issued in 2014/15. More detail on these plan requirements can be found on page 8 of the operational resilience and capacity planning document.

### Key Plan Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Activities</th>
<th>Timescale</th>
<th>Responsible</th>
<th>Funding Allocated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Developing and more accurate capacity modelling and scenario planning across the system</td>
<td>Improve modelling accuracy and capacity planning using data from all sectors.</td>
<td>Mar-15</td>
<td>Trainer Lead</td>
<td>Funding already accounted for</td>
</tr>
<tr>
<td>2. Working with NHS 111 to identify the service that is best able to meet patients’ urgent care needs</td>
<td>Improve capacity to refer to 111 for ED has been increased. For clarity, partner arrangements mean that no specific provision of 111 is in place.</td>
<td>Mar-15</td>
<td>Trainer Lead</td>
<td>Funding already accounted for</td>
</tr>
<tr>
<td>3. Additional capacity for primary care</td>
<td>Strengthen the Admissions Avoidance and Primary Care support fund, ensuring there are opportunities for system wide improvement</td>
<td>Mar-15</td>
<td>Trainer Lead</td>
<td>Funding already accounted for</td>
</tr>
<tr>
<td>4. Support and Patient Services</td>
<td>Ensure support is provided to the full extent of the needs identified</td>
<td>Mar-15</td>
<td>Trainer Lead</td>
<td>Funding already accounted for</td>
</tr>
<tr>
<td>5. System-wide improvements</td>
<td>Ensure support is provided to the full extent of the needs identified</td>
<td>Mar-15</td>
<td>Trainer Lead</td>
<td>Funding already accounted for</td>
</tr>
</tbody>
</table>
1. SRGs should serve to link Better Care Fund (BCF) principles in with the wider planning agenda

- Better Care Fund (BCF)
- Estimated Costs in 2014/15
- Funding already accounted for in Care Together

2. Seven day working arrangements

- Seven day working arrangements
- Support from local providers and evacuation of critical care
- Equipment and infrastructure upgrades
- Staff training and development
- Increase in staffing levels

3. Clearing the way for patient and public involvement

- Clearing the way for patient and public involvement
- Engagement of patients, carers and the public
- Joint working with local authorities
- Development of patient and public involvement initiatives

4. Supporting patients to find their way to hospital

- Supporting patients to find their way to hospital
- Identification of patients at risk
- Early intervention and support
- Referral to appropriate services

5. Seven day working arrangements

- Seven day working arrangements
- Support from local providers and evacuation of critical care
- Equipment and infrastructure upgrades
- Staff training and development
- Increase in staffing levels

6. Clearing the way for patient and public involvement

- Clearing the way for patient and public involvement
- Engagement of patients, carers and the public
- Joint working with local authorities
- Development of patient and public involvement initiatives

7. Supporting patients to find their way to hospital

- Supporting patients to find their way to hospital
- Identification of patients at risk
- Early intervention and support
- Referral to appropriate services

8. Seven day working arrangements

- Seven day working arrangements
- Support from local providers and evacuation of critical care
- Equipment and infrastructure upgrades
- Staff training and development
- Increase in staffing levels

9. Clearing the way for patient and public involvement

- Clearing the way for patient and public involvement
- Engagement of patients, carers and the public
- Joint working with local authorities
- Development of patient and public involvement initiatives

10. Supporting patients to find their way to hospital

- Supporting patients to find their way to hospital
- Identification of patients at risk
- Early intervention and support
- Referral to appropriate services

11. Seven day working arrangements

- Seven day working arrangements
- Support from local providers and evacuation of critical care
- Equipment and infrastructure upgrades
- Staff training and development
- Increase in staffing levels

12. Clearing the way for patient and public involvement

- Clearing the way for patient and public involvement
- Engagement of patients, carers and the public
- Joint working with local authorities
- Development of patient and public involvement initiatives

Section 3: Local Plans for Innovation. Plans over and above the minimum requirements to meet local patient needs. If there is any funding gap between the total emergency care funding and the total cost of the minimum plan requirements, SRGs must present plans to close such gaps such that the minimum requirements are deliverable.
Section 4: Local Stakeholder Engagement. Please describe how you have considered each of the elements listed below and how you have included them in your resilience plans (as appropriate)

A. Independent sector non-acute bed capacity (intermediate care, nursing homes, etc.)

All providers have been invited to be involved in Care Together programme.

B. Other independent sector capacity (e.g. healthcare at home etc.)

Some organisations are existing providers e.g. Macmillan and Marie Curie, St Johns ambulance.

C. Volunteers & active participation of patients

Voluntary Sector  have been involved in the development of Care Together plans

D. Improvement in access to psychiatric liaison service teams in A&E

Seven day working arrangements are designed to avoid unnecessary delays in commencement of new care packages.

E. Collaboration with and development of Children's services

Care Together programme has included patient representatives through the CCG Consumer Advisory Panel and Public & patient Impact Committee.

F. Engagement with patient representative groups

Voluntary sector  have been involved in the development of Care Together plans

Section 5: Key Partner Organisation Sign-Off. By signing this document you are stating both that you have been fully involved in developing this plan and that you will commit to attending all SRS meetings (or sending an appropriate deputy when unavailable).

Section 6: CCGs and Trust Finance Directors sign off that the plans are affordable, and will delivered whilst maintaining or improving their financial position
# Non-elective care costings template 2014/15

## Section 1: Minimum Plan Requirements

All services are looking to lower efficiencies before confirming additional capacity requirements as the aim is to bring about sustainable change that can be mainatained with reduced recurrent funding.

### Minimum Plan Requirements

**Itemised Net Costings**

<table>
<thead>
<tr>
<th>Minimum Plan Requirements</th>
<th>Itemised Net Costings</th>
<th>WTE Nurse increases</th>
<th>WTE Doctor increases</th>
<th>WTE other staff increases</th>
<th>Increases in bed capacity</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling better and more accurate capacity modelling and scenario planning across the system</td>
<td>Public Communications £50K</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs</td>
<td>GP costs (Based on £ per head of Population)</td>
<td>GP hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional capacity for primary care</td>
<td>Alternative to Transfer RAI, Manual Handling, Reablement Workers DN FNC Nurses</td>
<td>3 GP hours</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve services to provide more responsive and patient-centred delivery seven days a week</td>
<td>Ambulatory Care Radiologist &amp; Radiographs LTC DN IRIS CARA</td>
<td>2.8</td>
<td>1 WTE + 16 hours</td>
<td>8.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seven day working arrangements</td>
<td>React Team</td>
<td>4 consultant and specialty Drs x4</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expand, adapt and improve established pathways for highest intensity users within emergency departments. Organisations will want to review the pathways for the group(s) most relevant to them (e.g. frail/elderly pathways, minors pathways, and mental health crisis presentations) and there must be evidence of sign-up to local Mental Health Crisis Care Concordat arrangements.</td>
<td>Pharmacists; Medicines Optimisation Pharmacy Technicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand</td>
<td>Discharge vehicles Clinical Pharmacist ITT CARA DN LTC</td>
<td>0.31</td>
<td>0.5</td>
<td></td>
<td>1 pts/discharge vehicle</td>
<td></td>
</tr>
<tr>
<td>Processes to minimise delayed discharge and good practice on discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plans should aim to deliver a considerable reduction in permanent admissions of older people to residential and nursing care homes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross system patient risk stratification systems are in place, and being used effectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The use of real time system-wide data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sub Totals</strong></td>
<td></td>
<td>10.11</td>
<td>0</td>
<td>18.7</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

## Section 2: Local Plans for Innovation

- * add more rows as required

### Minimum Plan Requirements

**Itemised Net Costings**

<table>
<thead>
<tr>
<th>Minimum Plan Requirements</th>
<th>Itemised Net Costings</th>
<th>WTE Nurse increases</th>
<th>WTE Doctor increases</th>
<th>WTE other staff increases</th>
<th>Increases in bed capacity</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sub Totals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Total Capacity Increases*

- * needs to link to capacity plan
Section 1: Narrative on local system configuration, key strengths and key challenges

Introduction
Local Health and Social Care providers and commissioners have been working closely together for the last two years to plan an integrated approach to development and delivery of services to local people. In 2014/15 we embarked on our Care Together programme which aims to: reduce demand on more intensive health and social care services by focusing on community based prevention and early intervention initiatives. The programme, building on existing good practice such as Enhanced Recovery, Straight to Access and day surgery and case management on pathways was enhanced throughout 2015. Our work on vertical integration will ensure only those conditions that require intensive support take place in a hospital environment with the majority of care delivered within a patient’s own community. Healthy Together will also impact where elective activity takes place in the longer term.

System Configuration
The majority of our hospital-based elective care takes place at Tameside Hospital NHS Foundation Trust (70% of A&O; 58% of daycases and 45% of elective admissions) with CMAC delivering 13% of A&O; 25% of daycases and 70% of elective admissions. and Stockport 3% of A&O; 8% of daycases and 14% of elective admissions. We have seen a slight reduction in the number of incomplete pathways.

Across all our providers excluding THFT we had 335 people (6%) waiting 18 weeks and over on incomplete pathways at the end of June of these 16 were over 40 weeks and 63 over 28 weeks.

THFT implemented L o n e o v A u d i t i o n i n November 2010 and due to system faults the Trust have had to rely on manual validation to produce complete pathway returns. The focus for the validation has been to demonstrate RTT admittance and non-admitted aggregate standards have been achieved, however not all pathways have been fully validated so the standard reported is likely to be below the actual level of achievement. The Trust is currently using a supply chain data on incomplete pathways so whilst based on current performance no issues are expected the system is not fully assured that they will achieve the required 18 week standard. THFT has highlighted additional activity for July, August and September and additional pathways have been closed in July through the additional activity. THFT have requested funding to close an additional 459 Admitted pathways and 322 non-admitted pathways and to support additional validation.

CMFT, Stockport FT and Salford FT all highlighted the need to undertake additional activity for T&G patients to manage their workload.

Total electives from the MRR are 5% below plan with Day Cases 3% below and Elective Ordinary 13% below. However, currently (YTD June) GP referrals are around 12% higher than planned with referrals seen 10% above plan but variation has been seen month on month with June being significantly higher.

Key Strengths
Our community based integrated approach to the management of diabetes provides a holistic service and has enabled 577 patients (43% of total reviewed) to be discharged from hospital and managed in primary care. There has also been a reduction in referrals. This model will be replicated for other LTCs through Care Together i.e. Respiratory and Cardiology.

Our increased access to direct access diagnostics and Straight to Treatment pathways will reduce delays and avoid unnecessary appointments freeing up both patient and clinician time.

Our Care Together programme includes Respiratory, MSK and Ophthalmology in phase 1 and Rehabilitation in Phase 2 all of which are aiming to deliver increased community based activity and to deliver efficient and effective pathways.

Key Challenges
THFT implemented L o n e o v A u d i t i o n i n November 2010 and a number of system faults have been identified which are impacting on the accuracy and completeness of RTT pathway information. The timescales for the technical fixes is still unknown. The additional validation required to manage the number of incomplete pathways is considerable and ongoing until the fixes have been applied and the system is shown to be working correctly.

Our level of GP referrals appears to be increasing.

Our Care Together programme has identified the need for a community based MSK service that provides a holistic assessment, care plan and intervention to reduce the need for hospital based care. This will help address our level of GP referrals and allow us to invest in other non-MSK services.

Our Care Together programme includes Respiratory, MSK and Ophthalmology in phase 1 and Rehabilitation in Phase 2 all of which are aiming to deliver increased community based activity and to deliver efficient and effective pathways.

Section 2: Minimum plan requirements. Please note that development of a sufficient plan to deliver all of these elements is a pre-requisite to qualify for any central resilience funding in 2014/15. More detail on these plan requirements can be found on page 10 of the Operational resilience and capacity planning document.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Minimum Plan Requirements</th>
<th>Summary of plan to achieve requirement</th>
<th>Pathways for completion</th>
<th>Assurance Mechanisms</th>
<th>Estimated Costs in 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review and review the Trust’s patient access policy, and supporting operating procedures. The policy should include reference to cancer and other urgent patients, and should be made accessible to patients and their carers. An revised policy should be publicly available by September 2010</td>
<td>THFT’s policy has been reviewed by HTA and now meets clinical, operating and administrative requirements.</td>
<td>Sept-Dec 10</td>
<td>Internal policy</td>
<td>£1,468,406</td>
</tr>
<tr>
<td>2</td>
<td>Inset or implement a RTT training programme for all appropriate staff, focusing on roles and responsibilities. A record of training should be completed by all staff who have been trained during 2010/11.</td>
<td>RTT training programme developed for all appropriate staff based on Trust training policy.</td>
<td>June 13</td>
<td>Internal policy</td>
<td>£1,468,406</td>
</tr>
<tr>
<td>3</td>
<td>Build on any current analysis of capacity and demand for elective services at sub-specialty level, and keep under regular review and update as necessary. This should be done as part of evidence and capacity gaps and how updated in operating plans for 2011/12.</td>
<td>Use of IMS tool to be implemented and embedded across the Trust.</td>
<td>Mar 13</td>
<td>Internal policy</td>
<td>£1,468,406</td>
</tr>
<tr>
<td>4</td>
<td>Ensure that all specialties understand the elective pathway for common referral/referred treatment, and have an expected RTT ‘finder’ for each specialty. This should be in place by September 2010.</td>
<td>System for identifying waiting list management.</td>
<td>May 13</td>
<td>Internal policy</td>
<td>£1,468,406</td>
</tr>
<tr>
<td>5</td>
<td>Ensure that all specialties understand the elective pathway for common referral/referred treatment, and have an expected RTT ‘finder’ for each specialty. This should be in place by September 2010.</td>
<td>System for identifying waiting list management.</td>
<td>May 13</td>
<td>Internal policy</td>
<td>£1,468,406</td>
</tr>
<tr>
<td>6</td>
<td>Build on any current analysis of capacity and demand for elective services at sub-specialty level, and keep under regular review and update as necessary. This should be done as part of evidence and capacity gaps and how updated in operating plans for 2011/12.</td>
<td>Use of IMS tool to be implemented and embedded across the Trust.</td>
<td>Mar 13</td>
<td>Internal policy</td>
<td>£1,468,406</td>
</tr>
<tr>
<td>7</td>
<td>With immediate effect, review our local application of RTT rules against the national guidance, paying particular attention to how time clocks start and patient time.</td>
<td>Application of RTT rules reviewed in line with updating Access Policy and implementation of RTT training plan.</td>
<td>Oct 14</td>
<td>Internal policy</td>
<td>£1,468,406</td>
</tr>
<tr>
<td>8</td>
<td>Pay attention to RTT data quality. Carry out urgent root cause analysis of any non compliance. If not done in time so far, and schedule a data integrity management tool.</td>
<td>Application of RTT rules reviewed in line with updating Access Policy and implementation of RTT training plan.</td>
<td>Oct 14</td>
<td>Internal policy</td>
<td>£1,468,406</td>
</tr>
<tr>
<td>9</td>
<td>Put in place clear and robust performance management arrangements, based on our understanding of our current RTT PTL, and where clear in discussions across the local system.</td>
<td>RTT training programme implemented and embedded across the Trust.</td>
<td>Oct 14</td>
<td>Internal policy</td>
<td>£1,468,406</td>
</tr>
<tr>
<td>10</td>
<td>Ensure that patients waiting for 18 weeks on incomplete pathways (i.e. have not been discharged or discharged out of hospital) are reviewed and discharged.</td>
<td>Application of RTT rules reviewed in line with updating Access Policy and implementation of RTT training plan.</td>
<td>Oct 14</td>
<td>Internal policy</td>
<td>£1,468,406</td>
</tr>
</tbody>
</table>

Total elective care support funding for 2014/15

£1,468,406
Section 3: Local Plans for innovation. Plans over and above the minimum requirements to meet local patient needs. If there is any funding gap between the total elective care support funding and the total costs of the minimum plan requirements, SRGs must present plans to close such gaps such that the minimum requirements are deliverable

<table>
<thead>
<tr>
<th>Plan Requirements</th>
<th>Minimum of plans to identify requirements</th>
<th>GAP</th>
<th>Action Plan</th>
<th>Achievable Action Plan</th>
<th>Estimated Costs in 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring and evaluation of fully co-ordinated services in primary care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early discharge from hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please add rows as appropriate

Section 4: Local Stakeholder Engagement. Please describe how you have considered each of the elements listed below and how you have included them in your resilience plans (as appropriate)

A Independent sector oversare local capacity (Intermediate care, nursing homes, etc.)
B Other independent sector capacity (e.g. hospices, etc.)
C Voluntary sector capacity and expertise
D Local voluntary sector organisations
E Data / information management
F Local community organisations
G Engagement with local decision makers and representatives of key stakeholders
H Engagement with partners and organisations
I Engagement with patient representation groups
J Engagement with patient representation groups

Section 5: Key Partner Organisation Sign-Off. By signing this document you are stating that you have been fully involved in developing this plan and are committed to its delivery

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Name</th>
<th>Title</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS (Chair)</td>
<td>Richard Mariner</td>
<td>Deputy COO</td>
<td></td>
</tr>
<tr>
<td>CCG</td>
<td>Jane Whitaker</td>
<td>Lead Commissioning</td>
<td></td>
</tr>
<tr>
<td>CCG</td>
<td>Dr Wilkinson and Dr Jha</td>
<td>Chief Executive</td>
<td></td>
</tr>
<tr>
<td>CCG</td>
<td>Kay Holland</td>
<td>Deputy Director Transformation</td>
<td></td>
</tr>
<tr>
<td>CCG</td>
<td>Dr Wilkinson and Dr Jha</td>
<td>Chief Executive</td>
<td></td>
</tr>
<tr>
<td>CCG</td>
<td>Nick Martin</td>
<td>Board Chair</td>
<td></td>
</tr>
<tr>
<td>CCG</td>
<td>Nick Martin</td>
<td>Chief Executive</td>
<td></td>
</tr>
</tbody>
</table>

*Caveat* Stockport Foundation Trust agree in principle that they are willing to work with partners to review the plans that were submitted with a view to ensuring the proposals and their implementation are as consistent as possible with the requirements of the local plan. The Trust will move forward with the proposals on a invest to save basis.

Section 6: CCGs and Trust Finance Directors sign off that the plans are affordable, and will deliver whilst maintaining or improving their financial position

<table>
<thead>
<tr>
<th>CCG</th>
<th>Name</th>
<th>Title</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td>Sandy Row</td>
<td>Finance Director</td>
<td></td>
</tr>
</tbody>
</table>

*Please add rows as appropriate
### Section 1: Minimum Plan Requirements

<table>
<thead>
<tr>
<th>Ref</th>
<th>Minimum Plan Requirements</th>
<th>Nominal Net Costings</th>
<th>WTE Nurse increases</th>
<th>WTE Doctor increases</th>
<th>WTE other staff increases</th>
<th>Additional Outpatient Appointments</th>
<th>Additional Inpatient/Daycase procedures</th>
<th>Additional Admitted Pathways closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review and revise the Trusts’ patient access policy, and supporting operating procedures. The policy should include reference to cancer and other urgent patients, and should be made accessible to patients and the public. A revised policy should be publicly available by September 2014</td>
<td>WTE Band 5 full time for 2 months</td>
<td>0.17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Develop and implement a RTT training programme for all appropriate staff, focusing on rules application, and local procedures, ensuring all staff have been trained during 2014/15</td>
<td>WTE Band 6 Trainer = £29,461</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Carry out an annual analysis of capacity and demand for elective services at sub-specialty level, and keep under regular review and update when necessary. This should be done as part of resilience and capacity plans and then updated in operating plans for 2015/16</td>
<td>WTE Band 6 Information Analyst = £29,461</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Build upon any capacity mapping that is currently already underway, and use the outputs from mapping exercises as an annex to resilience and capacity plans. This will avoid duplication and integrate capacity mapping into ‘business as usual’ arrangements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Ensure that all specialties understand the elective pathways for common referral reason/treatment plans, and have an expected RTT ‘timelines’ for each (e.g. DTA by week x). This should be in place by September in order to ensure that activity is maintained at a level where waiting lists are stable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>“Right size” outpatient, diagnostic and admitted waiting lists, in line with demand profile, and pathway timelines (see IMAS Capacity and demand tools)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>With immediate effect, review local application of RTT rules against the national guidance, paying particular attention to new clock starts and patient pauses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Pay attention to RTT data quality. Carry out an urgent ‘one off’ validation if necessary if not done in that last 12 months, and instigate a programme of regular data audits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Put in place clear and robust performance management arrangements, founded on use of an accurate RTT PTL, and use this in discussion across the local system</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Ensure that supporting KPIs are well established (size of waiting list, clearance time, weekly activity to meet demand, RoTT rate, etc) and are actively monitored</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Demonstrate how good practice in referral management is being followed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Demonstrate that patients receiving NHS funded elective care are made aware of and are supported to exercise choice of provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Provide assurance during Q2 2014/15 at Board level on implementation of the above</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sub Totals**: 2.17

---

### Section 2: Local Plans for Innovation

<table>
<thead>
<tr>
<th>Local plans for innovation</th>
<th>Nominal Net Costings</th>
<th>WTE Nurse increases</th>
<th>WTE Doctor increases</th>
<th>WTE other staff increases</th>
<th>Additional Outpatient Appointments</th>
<th>Additional Inpatient/Daycase procedures</th>
<th>Additional Admitted Pathways closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Encourage appropriate discharge back to care of GP</td>
<td>Review cost £20 per review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Add more rows as required*  

**Sub Totals**: -4000

**Total Capacity increases**: 0

---

* needs to link to capacity plan

* Add more rows as required