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Tameside Metropolitan Borough

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HEALTH AND WELLBEING BOARD

Day: Thursday
Date: 21 September 2017
Time: 10.00 am
Place: Lesser Hall 2 - Dukinfield Town Hall

Item No.	AGENDA	Page No

GENERAL BUSINESS

1. **10.00AM APOLOGIES FOR ABSENCE**

2. **DECLARATIONS OF INTEREST**

To receive any declarations of interest from Members of the Health and Wellbeing Board.

3. **MINUTES** 1 - 8

The Minutes of the meeting of the Health and Wellbeing Board held on 29 June 2017 to be signed by the Chair as a correct record.

ITEM FOR CONSULTATION

4. **10.05AM INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP** 9 - 42

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

ITEMS FOR DISCUSSION / DECISION

5. **10.15AM TAMESIDE AND GLOSSOP CARE TOGETHER ECONOMY - FINANCIAL MONITORING**

a) **2017/18 FINANCIAL MONITORING REPORT AT 31 JULY 2017** 43 - 60

b) **2017/19 BETTER CARE FUND PLAN** 61 - 72

To consider the attached report of the First Deputy (Performance and Finance) / Executive Member (Adult Social Care & Wellbeing) / Executive Member (Healthy and Working) / Executive Member (Children and Families) / Director Of Finance – Single Commission.

6. **10.25AM CARE TOGETHER UPDATE** 73 - 82

To consider the attached report of the Programme Director (Care Together).

7. **10.30AM INFLUENZA UPDATE AND SYSTEM RESPONSE** 83 - 88

To consider the attached report of the Director of Population Health.

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.

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ITEMS FOR NOTING / INFORMATION

8. **10.35AM TAMESIDE HEALTH AND EMPLOYMENT** 89 - 108

To consider the attached report of the Head of Employment and Skills. The Board will also receive an accompanying presentation from Mat Ainsworth, Assistant Director – Employment (Policy, Strategy and Delivery), Greater Manchester Combined Authority.

9. **10.45AM MENTAL HEALTH AND WELLBEING** 109 - 124

To consider the attached report of the Director of Population Health.

10. **10.55AM VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE SECTOR**

a) **TAMESIDE STATE OF THE VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE SECTOR RESEARCH 2017** 125 - 198

To consider the attached report of the Deputy Chief Executive, Action Together.

b) **COMPACT: RELATIONSHIP WITH PEOPLE, COMMUNITIES AND THE VOLUNTARY, COMMUNITY, FAITH AND SOCIAL ENTERPRISE SECTOR** 199 - 202

To consider the attached report of the Director of Population Health / Chief Executive Officer, Action Together.

11. **11.05AM GREATER MANCHESTER CANCER PLAN**

a) **STOCKTAKE FOR TAMESIDE AND GLOSSOP** 203 - 234

To consider the attached report of the Director of Population Health.

b) **GREATER MANCHESTER TOBACCO STRATEGY** 235 - 250

To consider the attached report of the Director of Population Health.

12. **11.15AM HEALTH AND WELLBEING BOARD FORWARD PLAN 2017/18** 251 - 254

To receive the attached report of the Director of Population Health.

13. **URGENT ITEMS**

To consider any additional items the Chair is of the opinion shall be dealt with as a matter of urgency.

14. **DATE OF NEXT MEETING**

To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 25 January 2018.

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 HEALTH AND WELLBEING BOARD

29 June 2017

Commenced: 10.00 am **Terminated: 12.00 pm**

PRESENT: Councillor Brenda Warrington (in the Chair) – Executive Member (Adult Social Care & Wellbeing)
Councillor Peter Robinson – Executive Member (Children and Families)
Stephanie Butterworth – Director of Children's and Adults
Angela Hardman – Director of Population Health
Claire Ousey – Pennine Care NHS Foundation Trust
Steven Pleasant – Chief Executive, Tameside MBC, and Accountable Officer for Tameside and Glossop CC
Christina Greenhough – Clinical Vice Chair & Lead for Mental Health, CCG
Dean Howard, Divisional Commander, Greater Manchester Police
Paul Starling – Borough Commander, GM Fire and Rescue Service
Mark Tweedie – Chief Executive, Tameside Sports Trust
Clare Watson – Director of Commissioning
Giles Wilmore – Tameside Hospital NHS Foundation Trust

IN ATTENDANCE: Kathy Roe – Director of Finance
Debbie Watson – Interim Assistant Director of Population Health
Jessica Williams – Programme Director (Care Together)
Jacqui Dorman – Public Health Intelligence Manager
Gideon Smith – Consultant in Public Health Medicine

APOLOGIES: Councillor K Quinn, Executive Leader, Tameside MBC
Alan Dow – Chair, Tameside and Glossop CCG
David Niven – Independent Chair, Tameside Safeguarding Children's Board
Tony Powell – Deputy Chief Executive, New Charter
Councillor Gerald P Cooney – Executive Member (Healthy and Working)
Julie Price – Department of Work and Pensions
Liz Windsor-Welsh – Action Together

1. DECLARATIONS OF INTEREST

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

2. MINUTES OF PREVIOUS MEETING

The Minutes of the Health and Wellbeing Board held on 9 March 2017 were approved as a correct record.

3. CARE TOGETHER 2016/17 CONSOLIDATED FINANCIAL MONITORING STATEMENT

The Director of Finance, Single Commission, presented a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the consolidated financial position of the economy for 2016/17. A summary of the Tameside and Glossop Integrated Care NHS Foundation Trust was also included within the report to ensure Members had an awareness of the overall financial position of the whole Care Together economy.

The report also provided details of the savings realised in 2016/17 together with the significant level of savings required in 2017/18 to ensure control totals were delivered and financial sustainability was achieved on a recurrent basis thereafter. It was acknowledged that the delivery

of additional savings beyond 2017/18 would also be required, the details of which would be reported to future meetings.

It was noted that all three constituent organisations had met financial controls in 2016/17 and in summary:

- The Clinical Commissioning Group had delivered a 1% surplus. The movement detailed in the position summary was in line with latest guidance on treatment of national system risk reserve and was explained in more detail in the report.
- The net deficit at outturn relating to the three Council services included with the Integrated Care Foundation Trust would be financed from Council reserves. The significant deficit primary arose within Children's Services and was due to exceptional additional demand during the year.
- The Integrated Care Foundation Trust had an authorised deficit of £17.3m for 2016/17. The actual normalised deficit was £13.3m so exceeding the target by almost £4m.

The Director of Finance emphasised that whilst the financial controls had been met across the economy, this had only been possible because of non-recurrent actions. On a recurrent basis there remained an underlying deficit across the economy which increased risk in future years.

In conclusion, the Director of Finance made reference to the Better Care Fund where the total spend had been in line with budgets and was reported to NHS England via the Health and Wellbeing Board and the monitoring statement was attached at Appendix A.

RESOLVED

(i) That the financial 2016/17 consolidated financial position of the economy be noted.

(ii) That the significant level of savings delivered in 2016/17 and required during 2017/18, as detailed in section 4 of the report, to achieve confirmed control totals and the financial sustainability of the economy on a recurrent basis thereafter, be acknowledged.

(iii) That the significant amount of financial risk associated with the achievement of financial control totals during this period be acknowledged.

(iv) That the 2016/17 quarter 4 Better Care Fund monitoring statement be noted.

4. IMPLEMENTING CARE TOGETHER: KEY PROPOSED DELIVERABLES OVER NEXT 12-18 MONTHS

Consideration was given to a report of the Programme Director (Care Together) providing the Board with an update on progress on the implementation of the Care Together Programme and included developments since the last presentation in March 2017.

It was explained that of the full £23.226m transformational funding award, £7.9m had been allocated within 2017/18. Transformational programmes were now being implemented at pace across the economy and expenditure profiles were being examined to understand the potential benefits in year. It was noted that the transformational funding award did not include any capital for IM&T and Estates. The Programme Management Office was continuing to liaise with the Greater Manchester Health and Social Care Partnership and NHS Improvement to understand the potential for funding bids.

Reference was made to operational progress and the implementation of a new senior management structure identifying the direction from operational commissioning to strategic, place based public sector commissioning and correlation with the life course, as outlined and approved in the Health and Wellbeing Board strategy. The next steps to achieve strategic commissioning included the alignment of clinical leadership to the life course, review of commissioning governance structures, identifying the process to develop a longer term outcomes based contract with the Integrated Care Foundation Trust and the development of high level milestones to ensure delivery of progress.

Updated and comprehensive governance structures would be presented at the next Health and Wellbeing Board following discussion and, where appropriate, decision by the statutory bodies.

Work continued to determine the full remit for the Integrated Care Foundation Trust and to align services accordingly. As well as the transformation and transaction of Integrated Neighbourhoods, discussions regarding mental health, how to optimise working with a variety of voluntary, community and faith sector groups and potentially, the alignment of primary care, were being discussed.

The Programme Director also provided an update on the recruitment process to move to a substantive Programme Management Office which had not happened as quickly as envisaged. In order to maintain focus and maintenance of the project management functions, a contract extension with Pricewaterhouse Coopers, who had created the Programme Management Office governance and assurance system, had been approved by the Single Commissioning Board in May 2017, in order to continue impetus and mitigate any risk of slippage in financial savings targets.

In addition, the Board received an accompanying presentation from the Programme Director (Care Together) and the Director of Strategy (Integrated Care Foundation Trust) outlining the high level deliverables of the programme within 2017/18 and into 2018/19 including the strategic and operation aspects and the approach and implementation plan for social prescribing across Tameside and Glossop.

RESOLVED

(i) That the recent developments of the Care Together Programme, including the move from design to implementation phase of the programme, be noted.

(ii) That the high level deliverables of the programme within 2017/18 and into 2018/19, including the strategic and operational aspects, be noted.

(iii) That the approach and implementation plan for social prescribing across Tameside and Glossop be noted.

(iv) That a further update be submitted to a future meeting.

5. TRENDS IN LIFE EXPECTANCY AND MORTALITY RATES - UPDATE

Consideration was given to a report and accompanying presentation of the Director of Population Health analysing the most recent mortality data, outlining changes in the calculation of Healthy Life Expectancy. At the Health and Wellbeing Board meeting in January 2017, members agreed that while the priorities of the Health and Wellbeing Strategy were upheld, that a refresh and alignment with the recently developed Locality Plan into a Population Health Implementation Plan for Tameside would be developed. The findings in the report aimed to inform the refresh.

Premature mortality and life expectancy were significant indicators of the health of the population and generally areas with higher life expectancy and lower rates of premature mortality contained populations that were both socially and economically advantaged. For Tameside and Glossop, residents here experienced some of the worst health and mortality outcomes in England and currently ranked 137 out of 150 local authorities for premature death.

Changes in the calculation of life expectancy meant that the current Tameside and Glossop Locality Plan ambition would need to be reviewed. Current projections of Healthy Life Expectancy based on the new method for calculation suggested that the Locality Plan ambition to reach North West average by 2020 would not be achieved, nor reaching the England average by 2025. These projections were based on mortality since 2009.

The key issues from the review were outlined as follows:

- New methodology for calculating Healthy Life Expectancy meant that the current Tameside and Glossop locality plan ambition would need to be revised.
- Recent mortality trends highlighted the importance of tackling premature mortality for cardiovascular disease, respiratory and liver disease.
- The Tameside and Glossop RightCare Programme highlighted the importance of tackling cardiovascular disease and respiratory conditions.
- Current Tameside Health and Wellbeing Board 'Turning the Curve' priorities on smoking, physical activity and blood pressure would impact on cardiovascular and respiratory disease.
- The updated Tameside Alcohol Strategy would contribute to reducing alcohol harm, cardiovascular and liver disease.

The challenges for improving life expectancy were highlighted and discussed as follows:

- Reducing deaths in people aged 15 years to 64 years; this would mean a reduction in male deaths of at least 51 each year and 21 less deaths for females.
- Targeting females in particular around lifestyle issues.
- Finding the missing thousands from the disease register. People with a condition would then get the appropriate care and interventions that would help them live longer and manage their condition better.
- Using risk stratification data to ensure that people in the risk groups 20% to 69% had access to the relevant services and interventions that would allow them to improve their outcomes.
- A focus on the wider determinants of health, housing, strengthening communities, health and work, mental health and wellbeing.

Care Together continued to be the key vehicle for realisation of the Locality Plan ambition to increase healthy life expectancy at pace. Reference was made to the local challenges and responses for improving life expectancy highlighted in the review were summarised in the report.

RESOLVED

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

(ii) That the recommendations for future action be agreed.

(iii) That a refresh of the Locality Plan to ensure a local Population Health Implementation Plan be endorsed and presented to a future meeting of the Health and Wellbeing Board.

6. GREATER MANCHESTER POPULATION HEALTH PLAN – STOCKTAKE FOR TAMESIDE

Consideration was given to a report of the Executive Member (Healthy and Working) and the Director of Population Health providing the Board with a local stocktake against the 20 strategic objectives in the Greater Manchester Population Plan outlining local initiatives to deliver on the ambitions in the plan together with local challenges. The report also gave an update on the review of the current public health system across Greater Manchester.

The Greater Manchester Population Health Plan was intended to enable residents to 'start well, live well and age well' and the lead happier and healthier lives. It covered the most crucial area for health and social care reform and put strong focus on prevention and how better health and wellbeing helped with work prospects and economy. The Plan would complement the individual work in the ten localities in the city region and highlighted where issues could be tackled more effectively by working together from a Greater Manchester stance. A Tameside stocktake against the 20 priorities list in the Greater Manchester Population Health Plan, together with challenges, was attached at Appendix 1 to the report.

A review of the current public health system had been underway since November 2016 with the aim of developing a set of propositions for creating a unified population health system for Greater Manchester. Directors of Public Health, local authority Chief Executives, Treasurers, Commissioners and other key stakeholders across the system had been actively involved in this process. The Greater Manchester Health and Social Care Partnership had used the findings from the review and the understanding of local system changes to inform the development of the proposals towards a unified health system for Greater Manchester. The summary findings from the review and outline proposals were attached at Appendix 2 to the report.

In terms of the implications for Tameside, population health place based leadership in Tameside and Glossop would be about ensuring the development of a culture of 'population health is everyone's business'. This would create opportunities for Health and Wellbeing Board members to champion and influence the health and wellbeing of their populations.

The population health transformation work would be integrated into the wider governance arrangements overseeing the delivery of the Locality Plan under Taking Charge Together. The overall stewardship of local population health would continue to sit with the Tameside Health and Wellbeing Board, and the Director of Population Health, in their statutory role, would continue to have overall accountability for public health leadership. This would ensure that the overarching principles of subsidiarity was applied and continued to enable and support local decision making on priority setting and public sector reform.

In conclusion, it was noted that the proposals had recently gone through Greater Manchester's internal governance with the intention of aligning the commissioning proposals with the outcomes of the current commissioning review taking place across Greater Manchester. A detailed delivery and transition plan would be developed, alongside an engagement and communications plan to support the transition. The Greater Manchester Health and Social Care Partnership would work with colleagues across the system and from the various sectors to co-design the approach to delivery.

RESOLVED

(i) That the attached stocktake against the strategic objectives in the Greater Manchester Population Plan be noted.

(ii) That the update on the review of the current public health system across Greater Manchester be noted.

(iii) That actions needed to implement the Greater Manchester Population Health Plan be included in the refresh of the Locality / Population Implementation Plan to be presented at a future meeting of the Health and Wellbeing Board.

7. SYSTEMS OUTCOME FRAMEWORK

Consideration was given to a report of the Director of Public Health and accompanying presentation detailing a System Outcomes Framework concentrating on high level outcomes to be achieved across the whole system. The main objective was to increase healthy life expectancy and reducing inequalities in the local population. Rather than focusing on progress targets, the Tameside and Glossop Systems Outcomes Framework would set the context for the whole system concentrating on high level outcomes covering the full spectrum from housing to health. It would be the principle / umbrella intelligence tool and would be used in the wider context along with other national and local intelligence to build a picture of health and wellbeing outcomes across Tameside and Glossop and would:

- Provide a consistent approach for both commissioning and service provision;
- Support the refocusing of resources to achieve the ambition for the local population and support new and innovative ways of working
- Ensure accountability across the system;
- Provide guidance and direction; and

- Pull together relevant information from a range of sources.

The Board discussed the proposed framework outlined in the report including three system outcomes and seven system themes and provided their initial thoughts on the framework. The indicators included were being developed and partners were asked to provide their comments to assist in refining the framework to ensure the system had the best outcome descriptors to drive transformation for population health improvement.

RESOLVED

(i) That the Systems Outcomes Framework be adopted as the principle intelligence tool for measuring economy progress towards improving healthy life expectancy.

(ii) That partners provide any further comments to assist in refining the framework with a definitive version being presented to a future meeting of the Health and Wellbeing Board.

8. STRATEGIC APPROACH TO SUBSTANCE MISUSE

Consideration was given to a report of the Director of Public Health proposing a reporting relationship to the Health and Wellbeing Board for the Tameside Strategic Alcohol and Drugs Group and adoption of a new Tameside Alcohol Strategy – 'Rethinking Drinking'.

To provide local system leadership and enable a collaborative approach to meeting the challenges of substance misuse, members of the Tameside Strategic Alcohol and Drugs Group had worked together for the past year. It was initially thought that the Group would best report to the Healthy Lives Model of Care work stream of Care Together, but with the move to an implementation phase for the Integrated Care Foundation Trust it was proposed that its system wide strategic remit was most appropriately located with the Health and Wellbeing Board. The draft Terms of Reference were attached to the report at Appendix 1.

The Tameside Strategic Alcohol and Drugs Group had drafted and consulted on a new strategy document: 'Rethinking Drinking' – A Strategy for Tameside attached to the report at Appendix 4. The Strategy emphasised that the level of alcohol related harm in Tameside was significant and considerably worse than the national average, that this harm was felt across all areas of the public sector and impacted on all sections of society. The Strategy outlined the local impact, how the Strategic Alcohol and Drugs Group would work to reduce alcohol related harm in Tameside and key focuses and priorities.

In addition, the Strategic Drugs and Alcohol Group prepared an annual Action Plan to guide its work to reduce the local impact of substance misuse. The Action Plan for 2016/17 had a strong emphasis on service transformation to reflect the establishment of a new service provider. The Action Plan for 2017/18, attached to the report at Appendix 3, was developed through a stakeholder workshop held in November 2016 and reflected four strategic priorities.

In conclusion, it was explained that at its meeting in May 2017 the Tameside and Glossop Single Commissioning Board adopted a recommendation to transfer the contract for the local Drug and Alcohol Recovery Service from Lifeline to CGL (Change, Grow, Live) from 1 June 2017. This was prompted by a request from Lifeline and CGL based on an agreement that had been reached between them following changes in the circumstances of Lifeline. In view of concerns raised by members of the Single Commissioning Board, the comments of the Section 151 Officer, the short notice of the change, the limited knowledge of the new provider and the absence of a tender process, an enhanced financial and performance monitoring framework was requested to support assurance and consideration of whether a re-tender was necessary.

In order to be assured of the capability and competence of CGL as an organisation and their ability to achieve and deliver the contractual obligations, a full organisational questionnaire was submitted by CGL, identical to the document provided by tendering organisations during the original service

tender in 2015. CGL passed all sections of the document including element on organisational information, financial details, insurance, equal opportunities, health and safety, clinical safety and governance, business contingency and safeguarding. The terms of the novated contract were the same as that agreed with Lifeline in 2015, and would run until July 2025.

RESOLVED

(i) That the Terms of Reference for the Tameside Strategic Alcohol and Drugs Group be adopted.

(ii) That the 'Rethinking Drinking' – Tameside Alcohol Strategy be adopted.

(iii) That the Tameside Strategic Alcohol and Drugs Group Action Plan 2017/18 be noted.

(iv) That the contract novation for the substance misuse service from Lifeline to CGL (Change, Grow, Live) be noted.

9. HEALTH AND WELLBEING BOARD FORWARD PLAN 2017/18

Consideration was given to report of the Director of Public Health, Business Intelligence and Performance outlining the forward plan 2017/18 designed to cover both the statutory responsibilities of the Health and Wellbeing Board and the key projects identified as priorities.

RESOLVED

That the content of the forward plan 2017/18 be noted.

10. URGENT ITEMS

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

11. DATE OF NEXT MEETING

To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 21 September 2017 commencing at 10.00 am.

CHAIR

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 September 2017
Executive Member / Reporting Officer:	Alison Lewin, Deputy Director of Commissioning
Subject:	**INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP**
Report Summary:	The vision for intermediate care in Tameside & Glossop is for the support to be delivered at home wherever possible. The model should include an element of bed-based care, have clear links with the Integrated Neighbourhoods (including the Extensivists), a robust model for hospital discharge planning, and be able to offer a response to urgent care requests. The outcomes expected from a model of intermediate care are: • Maximising independence; • Preventing unnecessary hospital admissions; • Preventing unnecessary admissions to long term residential care; • Following hospital admissions, optimising discharges to usual place of residence. This report sets out the work undertaken to date, a proposed model for Intermediate Care for Tameside and Glossop, and details of the consultation process approved by the Single Commissioning Board on 22nd August. Also attached to this report are copies of the consultation documents.
Recommendations:	Health and Wellbeing Board are asked to note the decision taken by the Single Commissioning Board on 22nd August 2017 to approve the model outlined in the attached report, and agree to consult with option 2 as the preferred option for the Single Commission and Integrated Care Foundation Trust. The consultation process commenced on 23rd August and will run for 12 weeks until 15th November 2017.
Links to Health and Wellbeing Strategy:	The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.
Policy Implications:	This report outlines a clear intention to include a programme of engagement and formal consultation to ensure the patient and public implications are understood and taken into account. The report includes a full Equality Impact Assessment. The Care Together programme is focused on the transformation of the health and social care economy to improve healthy life expectancy, reduce health inequalities and deliver financial sustainability. This work is a critical part of the programme

Financial Implications:

(Authorised by the Borough Treasurer)

Finance officer support was confirmed for the proposals presented to Single Commissioning Board on 22 August 2017.

Budget Allocation (if Investment Decision)	£ 1.983 million (via GM Transformation Funding)
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Expected savings to be realised of £ 0.453 million in 2017/18 (part year effect) and £ 0.686 million on a recurrent basis from 2018/19.
Additional Comments The flexible bed base proposal has been subject to a stringent business case and has been supported by the Project Management Office gateway review process (Stage 2 complete). It is essential that appropriate legal advice is sought in respect of the public consultation prior to inclusion of the report at the next Single Commissioning Board meeting.	

Legal Implications:
(Authorised by the Borough Solicitor)

An open and transparent consultation process is required to attract maximum public engagement in order to ensure the public sector equality duty has been complied with. This should be reflected in the Equality Impact Assessment, which decision makers must have due regard to before making any decision. What needs to be considered is that Option 1 is unlikely to be a viable option as it is not affordable. Therefore is unlikely to be legal. By including in the consultation it will be responded to as a viable option so there needs to be clear communication as to why it is not.

Risk Management :

This programme will be managed via the Care Together Programme Management Office and therefore the risks will be reported and monitored via this process

Access to Information :

The background papers relating to this report can be inspected by contacting Alison Lewin, by:

 Telephone: 07979 713019

 e-mail: alison.lewin@nhs.net

1. BACKGROUND AND INTRODUCTION

1.1 The development of a system wide strategy for Intermediate Care for Tameside and Glossop is required to enhance the delivery of intermediate care in the locality.

1.2 The vision is for the support to be delivered at home wherever possible. The model should include an element of bed-based care, have clear links with the Integrated Neighbourhoods (including the Extensivists), a robust model for hospital discharge planning, and be able to offer a response to urgent care requests.

1.3 The outcomes expected from a model of intermediate care are:

- Maximising independence
- Preventing unnecessary hospital admissions
- Preventing unnecessary admissions to long term residential care
- Following hospital admissions, optimising discharges to usual place of residence

1.4 This report sets out the work undertaken to date, a proposed model for Intermediate Care for Tameside and Glossop, and details of the recommended consultation process.

2. PROPOSED TIMESCALE AND MILESTONES

2.1 Attached to this report at **Appendix 1** is the proposed timeline for the project, including the consultation, resulting in the presentation of a final model to the Single Commissioning Board in December 2017.

2.2 The Single Commission will engage and consult on the proposed Intermediate Care model described in section 6 of this report. The outcome of the consultation will inform the model presented to the Single Commissioning Board in December.

3 DEFINITION OF INTERMEDIATE CARE

3.1 The definition of Intermediate Care included in the National Audit of Intermediate Care 2017 (developed with the assistance of the Plain English Campaign) is set out below. This is the definition which will be used in any communication, engagement and consultation work referred to in this report and associated strategy documents. [1]

What is intermediate care?
Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system –community services, hospitals, GPs and social care.

What are the aims of intermediate care?
There are three main aims of intermediate care and they are to:

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

Where is intermediate care delivered?
Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

[1] http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/NAIC%202017/NAIC2017overview.pdf

How is intermediate care delivered?
A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

4. CASE FOR CHANGE

4.1 A number of factors and service reviews have led to the identification of Intermediate Care as a priority for the Tameside and Glossop locality and the development of the model outlined in this report.

4.2 **Intermediate Care – Halfway Home:** The Department of Health's 2009 intermediate care guidance, *Halfway Home*[2] defined intermediate care as follows: *Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.* The initial guidance set out definitions of intermediate care, service models, responsibilities for provision and charges and planning. The definition included services that met the following criteria:

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

The local intermediate care offer described in this report embraces the philosophy of the Halfway Home guidance, with a focus on delivering care and the required wrap-around support to maximise independence.

4.3 **National Audit for Intermediate Care 2015:** The results of the National Audit for Intermediate Care from 2015 (based on 2013-14 data from providers and commissioners across the locality) identified the following in relation to the Tameside & Glossop intermediate care model (summary / selection of key indicators):

- An above average investment in intermediate care per 100,000 weighted population (4th highest of the 47 localities which participated);
- Above average beds commissioned per 100,000 weighted population (12th highest);
- Above average investment in bed based care compared with national average (£3.9m against a national average of £2.3m);
- A positive response was provided to 6 of the 13 quality standards;
- A negative response to the commissioning of integrated home and bed based intermediate care services.

The analysis of this report led to the early identification of Intermediate Care as a priority for the developing Care Together programme. A number of developments have taken place,

2 http://webarchive.nationalarchives.gov.uk/20130124050747/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

informed in part by this review, which are included in the current model of intermediate care. The National Audit for Intermediate Care is taking place in 2017. The Single Commission and Integrated Care Foundation Trust are participating in the audit to support the ongoing review of the locality's intermediate care system.

4.4 **Tameside & Glossop NHS Foundation Trust Contingency Planning Team (CPT) Final Report September 2015[3]:** Price Waterhouse Cooper were appointed by Monitor to carry out a review of the Tameside and Glossop locality and produced a report which states that improving the way services are currently delivered, through an innovative, more joined-up approach across Tameside and Glossop, will improve the care patients receive and put Tameside NHS Foundation Trust back on to a sound clinical and financial footing. The Contingency Planning Team worked with a range of stakeholders across the locality to develop proposals for a model of care which included a new Urgent Integrated Care Service. Intermediate Care is described as a key element of the Urgent Integrated Care Service (now developed and implemented as IUCT and Home First). One of the features included in the Contingency Planning Team report is that the Urgent Integrated Care Service would be increasingly delivered in people's own homes.

4.5 A report presented to the Single Commissioning Board in August 2017 included a range of other reports and analyses which support the case for change and the development of the model outlined in this paper.

5. STRATEGY DEVELOPMENT AND ENGAGEMENT

5.1 An Intermediate Care strategy was developed, outlining national guidance, local expectations of intermediate care, and the action taken over the past 2 years as part of the Care Together programme to refine the Tameside and Glossop locality model. This document outlined the expectations from the Single Commission for the delivery of intermediate care at home wherever possible, therefore requiring a clear model of community based care and an appropriate level of bed based intermediate care.

5.2 The Single Commission reviewed the outputs from previous consultation and engagement on intermediate care and the wider Care Together model to inform the model of Intermediate Care. This includes information extracted from the engagement events facilitated by Action Together and the Glossop Volunteer Centre, and information from Care Together engagement events facilitated by the NHS Benchmark Consulting team during 2014/15.

5.3 The Commissioning Directorate supported a range of pre-consultation engagement events in early summer 2017 to inform the final proposal for a model of intermediate care for Tameside and Glossop.

5.4 Details of the engagement activities referred to in this report are included in the paper presented to the Single Commissioning Board in August 2017.

6. PROPOSED MODEL FOR INTERMEDIATE CARE IN TAMESIDE & GLOSSOP

6.1 The proposals for Intermediate Care set out in this report have been prepared jointly by Tameside and Glossop Integrated Care NHS Foundation Trust and the Single Commission and have been designed to support delivery of the Commissioning Strategy for Intermediate care services. The strategy document describes the aim to support rehabilitation and recuperation, maximising people's ability to function independently, and enabling them to continue living at home in all but most challenging cases. With a requirement for:

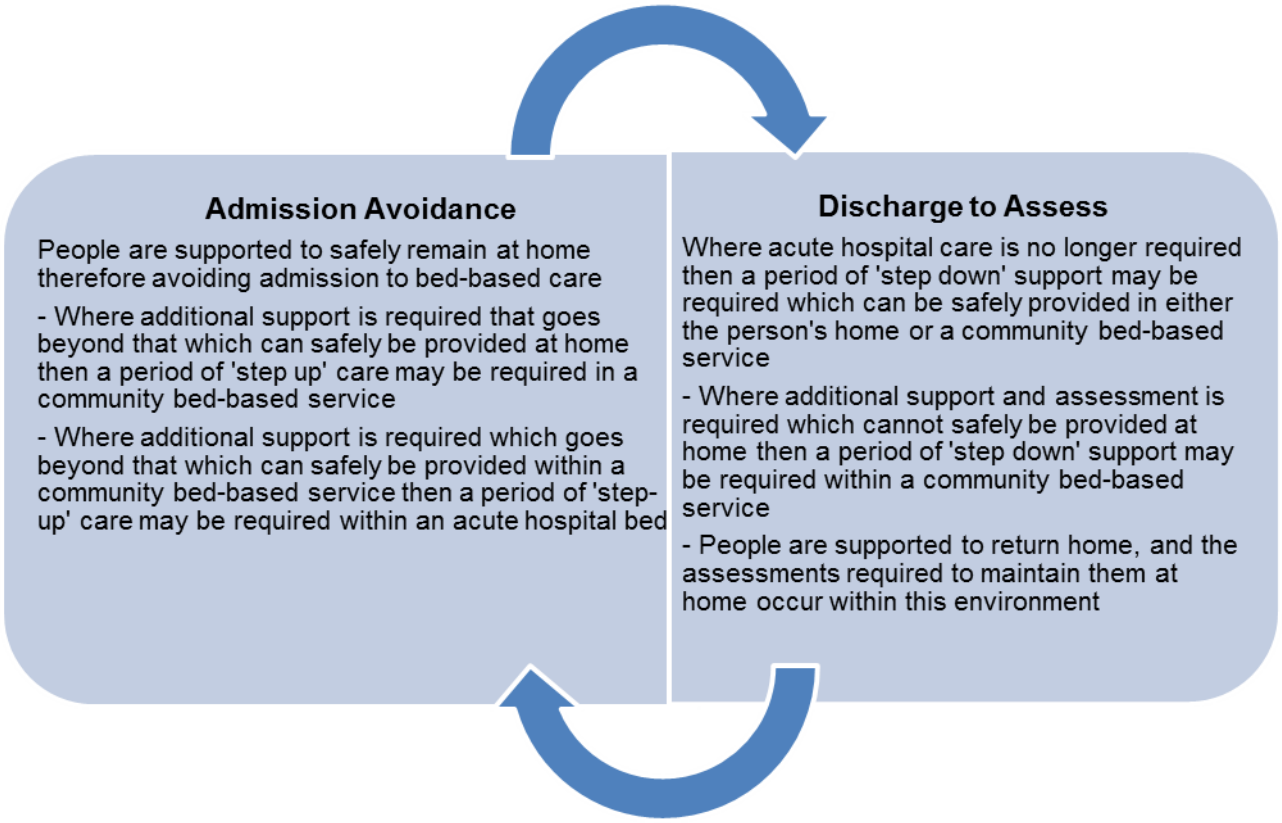
3 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461261/Final_CPT_report.pdf

- Home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) provided by an integrated team providing both health and social care input based on individual need.
- Community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.
- An ability to care for clients with all levels of dementia, in an appropriate setting.

6.2 **Home First:** One of the key principles within the Tameside and Glossop Care Together approach to integrated care is that wherever it is possible for a person to have their care requirements met within their own place of residence, the system will be responsive to meeting this need in a timely manner. This principle is embodied in this proposal for an intermediate care model. In order to be responsive to people's needs and deliver against this principle Tameside and Glossop Integrated Care Foundation Trust has implemented the "Home First" service model. This model will provide a response to meet an urgent/crisis health and/or social care need. Home first is fundamental to the intermediate care offer and is a key interface between the Integrated Neighbourhoods, community services and the acute setting, ensuring people are supported in the environment that is suited to their own care needs and most likely to achieve positive outcomes. This supports the intermediate care aims of:

- Helping people avoid going into hospital unnecessarily;
- Helping people be as independent as possible after a stay in hospital; and
- Preventing people from having to move into a residential home until they really need to.

The Home first model comprises of two key elements:



6.3 The Home First offer will ensure that people are supported through the most appropriate pathway with "home" always being the default position. However, it is recognised that not all individuals' intermediate care needs can be managed safely in their own home. In some cases there is a need for an alternative community based bed, for a short period of time, to

enable the appropriate interventions to be undertaken with the individual to enable them to return home, whether this be following an admission to the Hospital or to avoid the need for an admission in the first place.

6.4 Tameside and Glossop Integrated Care Foundation Trust has identified four core interfaces where services are provided to patients which make up the Intermediate Care model:

- **Integrated Neighbourhood services;**
- **Intermediate / Specialist Community Based Services;**
- **Community Bed Setting;**
- **Acute Hospital Setting.**

6.5 **Integrated Neighbourhood Services:** The Integrated Care Foundation Trust and the Commissioners are working collaboratively through the Care Together programme to develop five Integrated Neighbourhood Teams, which will be Multi-disciplinary teams comprising Primary care (including GP services and pharmacists), community services such as district nursing and therapy services, social care, Mental Health services and the voluntary/community sector. The vision of these Neighbourhood Teams is to provide place based care to support neighbourhoods to deliver high quality and connected services which look after the whole neighbourhood population, to support self-care in order to improve outcomes, prosperity and wellbeing. The services will aim to:

- Optimise self-care and family/carers support;
- Help people live as independently as possible;
- Improve condition management;
- Co-ordinate delivery of services from all providers;
- Provide seamless support during periods of crisis and the transition to / from hospital based care;
- Ensure a multi-disciplinary case management approach;
- Use risk stratification data to identify those who may benefit from care co-ordination and put this into place;
- Reduce the need for crisis interventions.

In respect of intermediate care model the Integrated Neighbourhoods through the GP, social care services and community teams will provide a co-ordinated care and support service to people who live in their neighbourhood area who have intermediate care needs, long-term conditions, other ongoing care and support needs, or who are most at risk of unplanned admissions to hospital. The multi-disciplinary team will also link with the intermediate tier/specialist and urgent care services to provide additional care input where required, to step-up services to avoid a hospital admission or social care placement, or support people returning to their place of residence following an acute admission, with the aim of supporting people to be as independent as possible.

The Integrated Neighbourhood Teams will also include social prescribing navigators to help patients and carers to identify non-medical, voluntary and community services that will benefit their overall health and well-being, these might include social or physical services/clubs to encourage social inclusion and physical independence.

6.6 **Intermediate / Specialist Community Based Services:** The Integrated Care Foundation Trust has identified a range of more specialist community based services that are available which provide a link between acute services and the Integrated Neighbourhood Teams. These form a core element of the out of hospital intermediate care offer. The Intermediate Tier services will provide short term intensive interventions to people who require higher intensity or more specialist care than is available within the Neighbourhood services, and provide care to meet the specific aims of the intermediate care strategy of:

- Helping people avoid going into hospital unnecessarily;
- Helping people be as independent as possible after a stay in hospital.

Intermediate Tier services will be provided following a referral from a Neighbourhood service or from the acute setting, to support early discharge from hospital care, or to enable people to remain in their own home for treatment. Risk stratification data will in some cases identify those who may benefit from additional care input based on individual needs. The Intermediate Tier will take a proactive approach to care for people who have ongoing health and care needs, or are at a high risk of experiencing worsening health or unplanned admissions, and will in some circumstances accept self-referrals. The Intermediate Tier services which will provide services for the intermediate care offer include:

- A new Extensivist service has commenced to work with those individuals living with complex ongoing health and care needs, to improve their health and wellbeing and reduce demand on services by ensuring that their care is managed more effectively. This will offer a fundamentally different way of organising care around an individual's needs, including medical, social, psychological, functional, pharmaceutical and self-care. This will be staffed by specialist Extensivist consultants or GPs, who will work with a cohort of high risk patients identified through risk stratification.
- 7 day Community IV therapy service to provide IV therapy in the home setting.
- Digital Health Service – a new innovative service which provides Care Homes and the Community Response Service with access via SKYPE to an Advanced Nurse Practitioner for clinical consultation and advice.
- Reablement which is a social care service which provides time limited care to intermediate care patients.
- Community Therapy services
- Integrated Urgent Care Team made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team works between the hospital and the community, supporting people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team will have a key role in responding to people with urgent care needs. Ongoing support will then be provided for up to 72 hours to allow for close working with the Neighbourhood Teams, who will manage their ongoing care and support needs where possible.
- Community Social Care services provided by Tameside Metropolitan Borough Council and Derbyshire County Council that will assess and provide care to patients to ensure they are able to remain independent for as long as possible and to delay placements into long term residential care. Social care is a fundamental part of the Integrated Care model in Tameside and Glossop. Progress is being made with proposals for Tameside MBC social care staff to transfer to the Integrated Care Foundation Trust in due course. Closer alignment of services is also planned with Derbyshire County Council for Glossop residents.

The intermediate tier services will focus on ensuring that people have access to specialised care in the community, to avoid unnecessary admissions, and will have a key role in helping coordinate care around an individual's needs, to allow them to return to their normal place of residence as quickly and easily as possible.

6.7 **Community Bed Setting - Overview:** The health and social care economy is currently commissioning community based beds from a range of sources from across the local economy. This includes intermediate care beds, spot beds and an arrangement for discharge to assess beds. In order to improve the community bed offer locally a revised model is being proposed in this report. The key principle of the flexible community bed base model is that support will be delivered through location-based community beds providing general nursing whilst encouraging independence and reablement, alongside in-reach from specialist teams such as therapy services, primary care and mental health. This will ensure individual centred management plans based on care needs that support people's transition

back home effectively and ensure a smooth transfer of care, when necessary, to the Integrated Neighbourhood. A flexible community bed-base is key to effective intermediate care as it supports an individual's needs that cannot be met through home based intermediate care. By providing an enabling environment for further assessment, rehabilitation, completion of treatment and/or recuperation, it will prevent unnecessary admissions to hospital (through step up) or into long term care, and facilitate timely discharge to assess for those people not able to be assessed at home but do not require acute hospital based care. When home is not an option for the provision of care for an individual, the flexible community beds base will offer:

- Step down capacity for discharge to assess (including complex assessments);
- Step up capacity to avoid acute admission;
- Intermediate Care Capacity;
- Recuperation beds that offer an opportunity to re-stabilise prior to undertaking rehabilitation;
- Specialist assessment and rehabilitation for people with dementia.

The model will provide community beds for individuals with dementia who are at risk of being admitted to hospital or remaining in a hospital bed because they are awaiting assessments. At present there is no local provision to meet this requirement outside of the acute settings meaning that these individuals remain in hospital for longer than is necessary.

The Integrated Care Foundation Trust is the provider of all intermediate care beds for Tameside and Glossop as of 1 July 2017, and currently provides community beds from two locations: 64 beds in the Stamford Unit at Darnton House[4], which is a 3-floor 96 bedded purpose-built nursing home adjacent to the Tameside Hospital site (the Trust currently uses two floors, one for intermediate care and one for discharge to assess) and 36 intermediate care beds in Shire Hill Hospital located in Glossop.

6.8 **Acute Hospital Setting**: The Acute element of the Intermediate Care model forms part of the "Home First" service that responds the urgent/crisis health and/or social care need for patients. The Home First model is described in detail above, through the Integrated Urgent Care Team and the discharge to assess team, which ensures patients are supported through the most appropriate pathway with "home" always being the goal.

6.9 **Community Bed Model – the proposal:** All intermediate care models recognise the need for a bed-based offer. The National Audit of Intermediate Care 2014 showed that whilst locally we spend more than the national average on intermediate care, (beds and community based service) the balance is weighted toward beds with 79% more intermediate care beds than the national average. The Integrated Care Foundation Trust believes that the intermediate care model proposed in this paper redresses the balance to align more closely to the national average and restates the focus of intermediate care away from a purely bed based offer with the embedding of the 'home first' principles.

If Tameside and Glossop intermediate care beds were in line with the national average for our population we assessed that we would need 65 beds.

[4] Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1st July 2016 with the CQC the location of The Stamford Unit at Darnton House. This was to provide a community in-patient facility as part its intermediate care services. Services in the Stamford Unit at Darnton House are accessed via agreed Trust patient pathways and it operates as community wards for medically stable patients who are having their discharge planned and enabled. They form part of services provided by the Trust as a provider of commissioned Acute and Community services for the population of Tameside and Glossop within the Integrated Care Foundation Trust.

The Integrated Care Foundation Trust is the provider of all intermediate care beds for Tameside and Glossop as of 1 July 2017, and currently provides community beds from two locations: 64 beds in the Stamford Unit at Darnton House and 36 intermediate care beds in Shire Hill Hospital located in Glossop. Therefore a total of 100 community beds in the system, 68 of which are currently 'intermediate care' beds.

Alongside the ongoing development and delivery of the Integrated Neighbourhoods and intermediate tier services, and the implementation of the Home First model (which ensures delivery of robust intermediate care services in the home setting) this paper proposes that all the community beds should be located in a single location in order to utilise the resource flexibly to meet the needs of people in Tameside and Glossop, and fully deliver the service model for intermediate care beds. Offering these services from a single site provides the opportunity for a more holistic, flexible and skilled workforce. Staffing resource would be focussed on one site so able to work across and with a wide range of conditions, providing resilience and responsiveness.

6.10 **Options for delivery of bed based intermediate care:** In order to deliver the proposed model, a number of options have been considered. The Single Commission and Integrated Care Foundation Trust identified 3 options for the delivery of a flexible community bed base. All options should be considered alongside the ongoing development and delivery of the Home Frist model, Integrated Neighbourhoods, the Intermediate / Specialist Community Based Services, and acute hospital based elements of intermediate care.

Option 1: **Maintain current arrangements**
Delivery of bed based intermediate care from the Stamford Unit at Darnton House (32 beds) and Shire Hill in Glossop (36 beds).

The view of the Single Commission and Integrated Care Foundation Trust is that this is not a sustainable model going forwards. As described in the report, the economy is not functioning to its optimum: people are in acute beds that do not need to be, they are in these beds for longer than they need to be, and they are unable to access the services they require at the time they need them. The current arrangements are fragmented – beds are delivered across 2 sites – Shire Hill and the Stamford Unit at Darnton House. At present staff are working from a number of bases, with the expectation that community and neighbourhood staff travel across the locality, diluting the capacity and time that could be inputted with individuals to maximise the potential for returning home promptly. This option does not deliver the vision of a single location for bed based intermediate care.

Option 2: Use of available 96 bedded unit
Transfer of all bed-based intermediate care to a single location in the Stamford Unit at Darnton House. This is the preferred option from the assessment carried out by the Single Commission and Integrated Care Foundation Trust for the following reasons:

- Whilst the aim of the home first model is to use the community beds flexibly to meet the demand at any point in time, the notional intermediate care bed figure proposed is 64 beds.
- Patient Environment - The Stamford Unit is 100% en-suite single room accommodation with significant communal space on each of the three wards which has been demonstrated to encourage social interaction and independence. Additionally one floor of the Stamford Unit in the Darnton Building has been designed as dementia friendly with access to outside space and wandering routes, which will enable the Trust to provide community beds for patients with Dementia.
- Accessibility – the Stamford Unit is located in a central location and is co-located close to the Tameside Hospital site and therefore has strong public transport links, ample parking and is easily accessible for patients and relatives. Additionally easy access and short journey times for health care professionals and support services into Darnton Building will enable development of in-reach into the unit as proposed in the model.

- Recruitment and Retention – recruitment and retention of nursing and support staff at the Shire Hill hospital site is an ongoing risk due to the remote location at the edge of the conurbation and lack of public transport access.
- Single location – option 2 supports the delivery of bed based intermediate care from a single location to enable the flexible use of community beds to support the Home First model and enable the approaches to Discharge to Assess and Intermediate Care to be flexed depending on the demands in the system at any point in time.
- Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1 July 2016 with the Care Quality Commission the location of The Stamford Unit at Darnton House.
- This option meets the national definition of 'intermediate care' from a combination of home and bed-based services and is in line with the recommendations of the Contingency Planning Team report from 2015 (referred to in section 4).

Option 3: Stimulation of the Local Market to Develop Single / Multi Site
Engagement with local providers to develop capacity within existing care homes, or the development of capacity in new homes is an option. Whilst the benefits of a larger scheme would not be realised, it is possible that in the longer term, once the Integrated Neighbourhoods and Home First models have fully embedded, that there could be a benefit to developing capacity at a neighbourhood level. The maturity of the wider economy may mean that fewer community beds are required, and that services could be developed at a neighbourhood level to meet need.

This option relies on their being the engagement from providers to invest locally in increasing capacity. Should this be available there would be a lead in time to any new building, which would again require a short term solution until additional bed capacity is developed. There are a number of providers who have indicated their interest in working on developments with the Single Commission so this is something that is possible to negotiate. While the current capacity has been estimated, it is difficult to commit at this time to the capacity that may be required in the economy in 2-3 years' time, which is the information a provider would need in order for providers to invest in new capacity.

6.11 **Proposal**: The proposal is that the Single Commission with the Integrated Care Foundation Trust enter into a formal consultation programme, based on the 3 options outlined above, stating the case for the current preferred option as **Option 2**.

7. FINANCIAL MODEL

7.1 The Care Together Project Management Office are supporting the locality's 'Savings Assurance' programme by ensuring a consistent approach is applied to all projects, using a gateway approach to scope and approve projects via the Finance Economy Workstream and Locality Executive Group.

7.2 **Financial Summary of Current Position:** The recurrent funding available for the provision of intermediate care inpatient services within Tameside and Glossop equated to c £8.7m per annum, with a total spend if we "did nothing" of £9.75m due to overspends on agency spend due to recruitment pressures. Spot beds were funded in 2016/17 non-recurrently, this equated to £0.75m.

7.3 **Financial Summary of Proposal – Flexible Community Beds:** The proposal requires funding for £8.26m for the provision of 96 flexible community beds at Darnton house. This delivers a saving on a recurrent basis of **£0.69m** against recurrent budget from 1 April 2018.

8. CONSULTATION

8.1 The proposals included in section 6 include the intention to bring together a community bed provision on a single site that can be flexed and responsive to meet clinical demands, whilst supporting the principles of 'home first'. This is a level of change to service delivery which requires a period of formal consultation.

8.2 The consultation offers local people the opportunity to comment on the proposals and options which have been developed and considered by the Single Commission and the Integrated Care Foundation Trust. The options for consultation, the details of which can be seen in section 6.11, are:

- **Option 1:** Maintain current status.
- **Option 2:** Use of available 96 bed facility and co-location of all intermediate and community beds as 'flexible bed base' model (Stamford Unit, Darnton House).
- **Option 3:** Stimulation of the market to develop a single / multi-location base.

8.3 The consultation is in the form of a standard questionnaire with an introduction to explain the reason for the changes followed by a series of questions. There are free format text boxes to allow people to provide any comments, views and suggestions they wish to be taken into account.

8.4 The consultation is available on the CCG website at:
http://www.tamesideandglossopccg.org/get-involved/intermediate-care-consultation

8.5 In order to encourage as many people as possible to express their views contact has been made with a range of organisations with a request to make their service users, groups and members aware. Due to the identification of an impact on certain Protected Characteristic Groups, this work will include some focused discussions with representatives from stakeholder groups representing over 65s, those with dementia, carers, and people with disabilities. The link to the on-line consultation along with a word document version for printing in paper format will be provided.

8.6 Staff in the Integrated Care Foundation Trust, Tameside MBC and Derbyshire CC will be made fully aware of the consultation and will be encouraged to complete the survey so that their perspective can be included in the evaluation.

8.7 A programme of consultation will commence on 23 August, and will run for 12 weeks until 15 November 2017.

9. ALIGNMENT WITH REVIEW OF ESTATES

9.1 The Single Commission and Integrated Care Foundation Trust are working together, via the Strategic Estates Group, on a review of the 'Neighbourhood Assets' to ensure alignment between any proposals arising from the intermediate care strategy and the plans for the estate in the locality.

10. QUALITY AND EQUALITY IMPACT ASSESSMENTS

10.1 Detailed Quality and Equality Impact Assessments have been undertaken to support the proposals included in this document, which will be used to support the consultation process. These can be seen in the Single Commissioning Board paper via the Clinical Commissioning Group website.

11. RECOMMENDATION

11.1 As set out on the front of the report

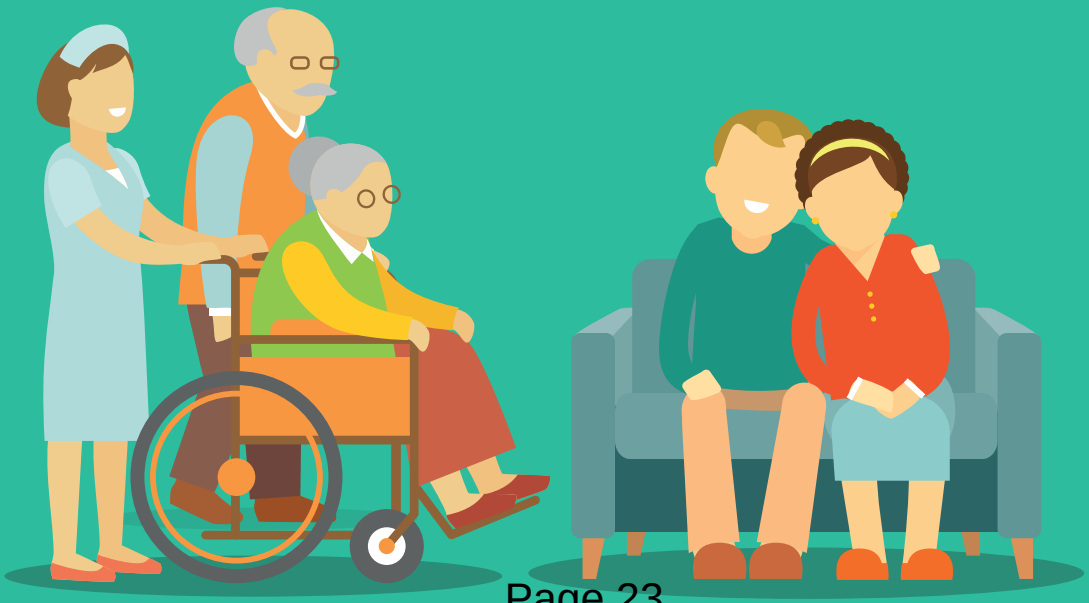
Appendix 1

Timetable for Intermediate Care Model Development & Consultation

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Draft initial strategy										
Ongoing development of strategy & model										
Pre-consultation engagement										
Paper to PRG & SCB - draft strategy & plan										
Produce consultation documents/model										
Consultation and engagement										
Produce final proposal										
Final proposal to SCB										

Review of Intermediate Care provision in Tameside and Glossop

(OPTIONS FOR THE DELIVERY OF BED BASED INTERMEDIATE CARE)



NHS
Tameside and Glossop
Clinical Commissioning Group

TAMESIDE AND GLOSSOP
Caretogether
SINGLE COMMISSIONING FUNCTION

INTRODUCTION

NHS Tameside and Glossop Clinical Commissioning Group (CCG) is committed to ensuring the best possible health care is provided for residents in Tameside and Glossop. However we face significant challenges in providing quality services that meet the needs of a growing older population and the increasing number of people with long-term health conditions that need care. In order to meet the health care needs of our population for the future and within the budgets available, the CCG and its partners have reviewed ways to deliver our services. This consultation focuses on how we continue providing a high quality, responsive and accessible Intermediate Care service in Tameside and Glossop in light of increased demand.

WHAT IS INTERMEDIATE CARE?

Intermediate Care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system – community services, hospitals, GPs and social care.

The main aims of Intermediate Care are to:

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

HOW AND WHERE IS INTERMEDIATE CARE DELIVERED?

Intermediate Care can be provided to people in different places, for example:

- in a community hospital,
- residential home; or
- in people's own homes. We have invested heavily in this in recent years.

We've also introduced the following services as part of our Intermediate Care offer:

- Digital Health Service providing Care Homes and the Community Response Service with rapid access to an Advanced Nurse practitioner for advice via SKYPE.
- An Extensive Care Service (including additional doctors called Extensivists) to work with individuals living with complex ongoing health and care needs.
- Intravenous Therapy service now provided in the home.

A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing care will depend on the individual's needs at that time.

HOW HAVE WE DEVELOPED THE PROPOSALS?

Engagement on developing a new model for Intermediate Care began in 2014 with specific focus groups involving members of the public and patients. These sessions identified key issues that need addressing.

- There is no 'step up' into Intermediate Care bed based services which means patients are often admitted direct to hospital when care could be provided in a community setting.
- Patients stay in hospital longer than necessary whilst they are being assessed to identify their ongoing needs – which is not ideal for the hospital OR for the patient

Further engagement events have taken place more recently with patient groups from across the community to help us understand views on the current system of Intermediate Care and people's expectations for future provision. The key findings from these discussions were:

- The importance of supporting people to live independent lives but also remain safe.
- Recognition that a community based bed offer is needed but where possible individuals should be cared for at home.
- The 'step-up' offer which avoids direct admission to hospital needs to be expanded; this can be achieved through care at home or in a community based setting.
- Intermediate Care needs to focus on the physical needs of the individual but also take into consideration and be able to support their wider emotional needs, including people with mental health needs.
- The environment in which Intermediate Care is delivered needs to enable individuals to interact with others and provide physical space to help them regain their independence.

OUR APPROACH TO INTERMEDIATE CARE

Care Together is our plan in Tameside and Glossop to bring health and social care services together to improve quality and access to the services you need.

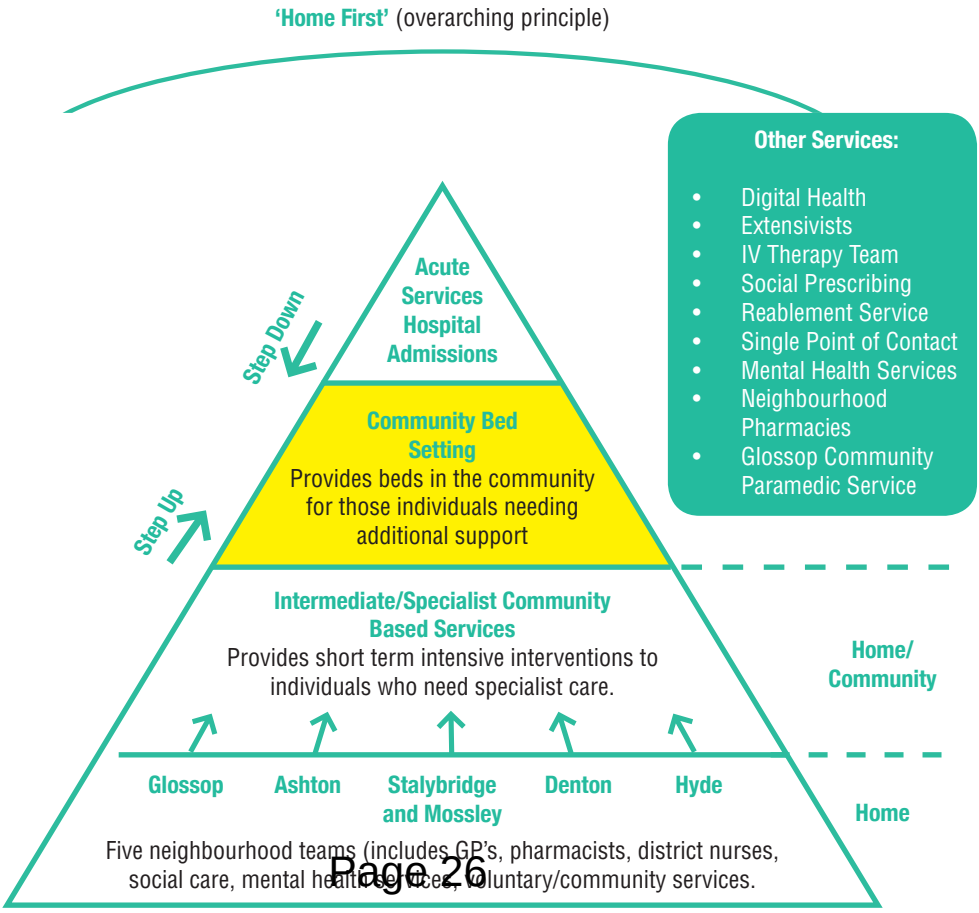
A key priority of our Care Together Programme is:

- to support people at home, wherever possible and safe to do so, or in a community bed where home is not appropriate; and
- to avoid unnecessary hospital attendances, admission and to ensure prompt and safe discharges back into the community or home.

To enable us to achieve this ambition in regards to Intermediate Care, we have implemented the 'Home First' model which comprises of two key elements: avoiding hospital admissions where unnecessary and ensuring individuals can leave hospital as soon as they are well enough to.

Our overall approach to Intermediate Care is shown below in Figure 1.1.

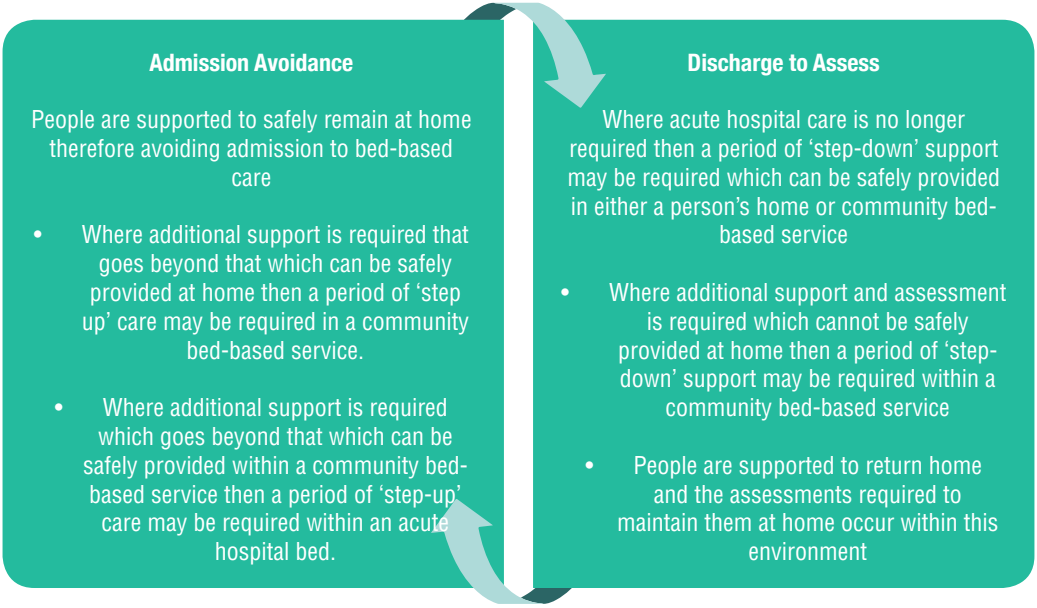
FIGURE 1.1: INTERMEDIATE CARE MODEL



The 'Home First' model ensures that people are supported through the most appropriate pathway with care provided in the home always being the preferred option. However, it is recognised that not all individuals' Intermediate Care needs can be managed safely in their own home. In some cases there is a need for a community based bed, for a short period of time, to enable the appropriate interventions to be undertaken with the individual to enable them to return home without going into hospital (Admission Avoidance) or as soon as they are medically fit (Discharge to Assess).

This 'Home First' model of care, explained in the diagram below, is a key component of our overall Intermediate Care offer.

FIGURE 1.2: HOME FIRST MODEL OF CARE



In addition to Home First model, Integrated Neighbourhood Teams have been established across five localities including Glossop. This is an integrated team comprising of primary care (including GP services and pharmacists), community services such as district nursing and therapy services, social care, mental health services and the voluntary/community sector.

These Neighbourhood Teams will deliver high quality, core health and care services, tailored to the neighbourhood population in order to best meet the specific needs of the population and to improve outcomes. In respect of the intermediate care model, the Integrated Neighbourhoods through the GP, social care services and community teams will provide a co-ordinated care and support service to people who live in their neighbourhood area who have intermediate care needs. The team will also link with the intermediate tier/ specialist and urgent care services to provide additional care input where required.

If the preferred option is implemented with intermediate care provided in one central location in the Stamford Unit, these Integrated neighbourhood and specialist services will provide Glossop with a community based offer of care in addition to the service provided from the Stamford Unit. This includes a care offer from community clinic locations including the Glossop Primary Care centre, GP practices, care homes, community beds or in patients own homes. These services will enable more Glossop patients to be safely provided with intermediate care more locally instead of needing to have an inpatient stay in a community bed, based on clinical assessment.

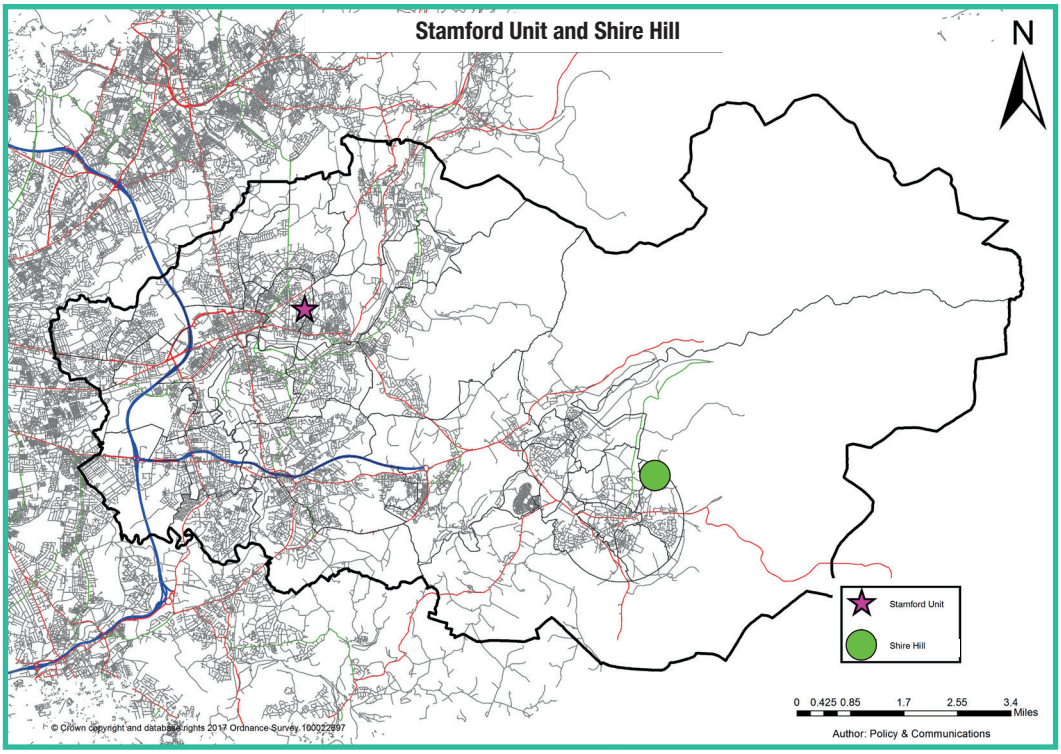
THE OPTIONS FOR PROVIDING BED BASED INTERMEDIATE CARE SERVICES

This consultation seeks your views on three options for providing the bed based Intermediate Care services (highlighted in yellow in the model in Figure 1.1).

Currently we provide 68 bed based Intermediate Care in two locations:

- 32 beds in the Stamford Unit in Ashton on the site of and run by Tameside Hospital (Tameside and Glossop Integrated Care NHS Foundation Trust).
- 36 Intermediate Care beds in Shire Hill in Glossop also run by Tameside Hospital.

FIGURE 1.3 CURRENT LOCATION OF COMMUNITY BASED BEDS



OPTION 1: MAINTAIN CURRENT ARRANGEMENTS

This option maintains the number of beds provided at the Stamford Unit (32) within the Tameside Hospital site and maintains the current community beds provided at Shire Hill in Glossop (36 beds). There is also access to 32 'discharge to assess' beds at the Stamford Unit.

- The facilities available at each of the two locations are different and provide differing levels of care, due in part to the location of and facilities available in the buildings.
- This option requires staff to work from a number of locations, with the expectation that community and neighbourhood staff travel across the area reducing the amount of time that can be spent with individuals to help them return home quickly.
- It is our view that this is not a sustainable model for the future.
- Between April 2015 and May 2017; 847 service users stayed at Shire Hill only 40% of them lived within 5 miles of it. 84% of them lived within 5 miles of Stamford Unit.
- Between March 2015 and May 2017; 1,279 service users stayed at Stamford Unit and 96% of them lived with 5 miles of it.
- In the off-peak period, during weekdays, 80% of residents in Tameside and Glossop can reach the Stamford Unit by public transport within 45 minutes compared to 24% travelling to Shire Hill.

OPTION 2: ALL BED-BASED INTERMEDIATE CARE IN A SINGLE LOCATION AT THE STAMFORD UNIT. (OUR PREFERRED OPTION)

All bed-based Intermediate Care would be provided at a single location in the Stamford Unit run by Tameside Hospital on their site in Ashton. The hospital is rated Good by the Care Quality Commission (CQC). The provision of Intermediate Care beds at Shire Hill in Glossop would cease.

- This option provides 64 Intermediate Care beds in the Stamford Unit, Ashton
- If we located all the Intermediate Care beds along with the 'discharge to assess' beds in the Stamford Unit, we would have a dedicated building of 96 beds which could be used flexibly to accommodate daily patient need.
- 27% of patients from Shire Hill were readmitted back to the hospital as their condition required greater clinical support which cannot be provided at Shire Hill, but is more accessible from the Stamford site. One central location will reduce transfers which fragments the care pathway and creates a poor experience for the patient themselves and their families.
- The Stamford Unit is able to provide single room accommodation, each with their own en-suite facilities along with significant communal space on each of the three wards. This encourages social interaction and independence and provides space to support rehabilitation and patients' excercises.
- One floor of the Stamford Unit has been designed to be dementia friendly with access to outside space and wandering routes, which will enable us to provide intermediate care and 'discharge to assess' beds in a unit which is able to support patients with dementia.
- The Stamford Unit is located in a central location in Ashton within the Tameside Hospital site. The site has good public transport links, parking facilities, is well known and is easily accessible for patients and relatives.
- Additionally easy access and short journey times for health care professionals and support staff between the Stamford Unit and main hospital will reduce staff travelling time, increase specialist support to all Intermediate Care beds and enable the development of services in the unit.

OPTION 3: DEVELOP A SCHEME OF BED BASED INTERMEDIATE CARE WITHIN LOCAL PRIVATE CARE HOMES

This option would require us to work with private care home providers to develop capacity within existing care homes or invest locally in increasing capacity to host bed based Intermediate Care. This option would mean that Intermediate Care beds are not located in one single location but spread out across the area where capacity can be found. This option requires care home providers to be willing to invest in increasing bed spaces and if new care homes were required, a short term solution would be required whilst capacity in the system is built.

TABLE 1.1: SUMMARY OF OPTIONS

	Stamford Unit, Ashton	Shire Hill, Glossop	Private Care Home Provider
Current Provision	32	36	0
Option 1	32	36	0
Option 2	64	0	0
Option 3	32	0	Up to 32

HAVE YOUR SAY ON THE PROPOSALS

We are keen to hear your views on the three options set-out above. You can provide your views by:

Completing the online survey at: **www.tamesideandglossopccg.org/intermediatecare**
You can pick up a paper copy at local GP's across Tameside and Glossop.
Write to us at: NHS Tameside and Glossop Clinical Commissioning Group, Dukinfield Town Hall, King Street, Dukinfield. SK16 4LA or email us at: **tgccg.communications@nhs.net**

HOW WILL WE USE YOUR COMMENTS?

The consultation will run for 12 weeks from 23 August 2017 until 15 November 2017. Once the consultation closes, the CCG will analyse all the responses received by the closing date. This feedback from residents, along with a range of other factors including legal and financial considerations, will be taken into account when preparing a final proposal on which option should be implemented. It is proposed that a report will be taken to Single Commissioning Board with our recommendations in December 2017. This report will be available on the CCG's website: **www.tamesideandglossopccg.org**

WHERE CAN I GET MORE INFORMATION ABOUT THIS CONSULTATION?

More information, including the detailed reports presented to the Tameside & Glossop Single Commissioning Board, are available via the CCG website at: **www.tamesideandglossopccg.org**

NHS Tameside and Glossop Clinical Commissioning Group

TAMESIDE AND GLOSSOP Caretogether SINGLE COMMISSIONING FUNCTION

Review of Intermediate Care provision in Tameside & Glossop
(Options for the delivery of bed based Intermediate Care)

NHS Tameside and Glossop Clinical Commissioning Group (CCG) are committed to ensuring the best possible health care is provided for residents in Tameside and Glossop. However we face significant challenges in providing quality services that meet the needs of a growing older population and the increasing number of people with long-term health conditions that need care. In order to meet the health care needs of our population for the future and within the budgets available, the CCG and its partners have reviewed ways to deliver our services. This consultation focuses on how we continue providing a high quality, responsive and accessible Intermediate Care service in Tameside and Glossop in light of increased demand

1. Have you ever used Intermediate Care services in Tameside & Glossop? (Please tick one box only)

☐ Yes (Go to Q2) ☐ No (Go to Q4)

2. When did you last use Intermediate Care services in Tameside & Glossop? (Please tick one box only)

☐ Within the last month

☐ Within the last six months

☐ Within the last year

☐ Within the last two years

☐ More than two years ago

3. Which Intermediate Care facility / services have you previously used? (Please tick all that apply)

☐ Shire Hill

☐ Stamford Unit (on the site of Tameside Hospital)

☐ Grange View

☐ Community services / Reablement e.g. you received treatment from a nurse / physiotherapist etc in your own home

☐ Other (please state)

4. Intermediate Care helps people avoid going into hospital unnecessarily and supports people to come out of hospital as quickly as possible. It helps people stay in their own homes and to keep their independence for as long as possible. The Intermediate Care offer across Tameside & Glossop will include a home-based service, which will give a more intensive amount of care in people's own home. This will be provided by a joint team of social care (carers and social workers) and health professionals (nurses and therapists).

What are your thoughts on a home based Intermediate Care service being provided across Tameside & Glossop? (Please write your comments in the box below)

5. There are three options in our model for how bed based Intermediate Care services could be delivered across Tameside & Glossop in the future. Please tell us what each of these options would mean for you if they were implemented? (Please write your comments in the box below each option)

You can access further information about the Intermediate Care service and each option in our information document available at
www.tamesideandglossopccg.org/intermediatecare

Option 1: Maintain current arrangements

This option maintains the number of beds provided at the Stamford Unit (32) within the Tameside Hospital site and maintains the current community beds provided at Shire Hill in Glossop (36 beds). There is also access to 32 'discharge to assess' beds at the Stamford Unit.

- The facilities available at each of the two locations are different and provide differing levels of care, due in part to the location of and facilities available in the buildings.
- This option requires staff to work from a number of locations, with the expectation that community and neighbourhood staff travel across the area reducing the amount of time that can be spent with individuals to help them return home quickly.
- It is our view that this is not a sustainable model for the future.
- Between April 2015 and May 2017; 847 service users stayed at Shire Hill only 40% of them lived within 5 miles of it. 84% of them lived within 5 miles of Stamford Unit.
- Between March 2015 and May 2017; 1,279 service users stayed at Stamford Unit and 96% of them lived with 5 miles of it.

- In the off-peak period, during weekdays, 80% of residents in Tameside and Glossop can reach the Stamford Unit by public transport within 45 minutes, compared to 24% travelling to Shire Hill.

Option 2: All bed-based intermediate care in a single location at the Stamford Unit.

This is our preferred option. All bed-based Intermediate Care would be provided at a single location in the Stamford Unit run by Tameside Hospital on their site in Ashton. The hospital is rated Good by the Care Quality Commission (CQC). The provision of Intermediate Care beds at Shire Hill in Glossop would cease.

- This option provides 64 Intermediate Care beds in the Stamford Unit, Ashton
- If we located all the Intermediate Care beds along with the 'discharge to assess' beds in the Stamford Unit, we would have a dedicated building of 96 beds which could be used flexibly to accommodate daily patient need.
- 27% of patients from Shire Hill were readmitted back to the hospital as their condition required greater clinical support which cannot be provided at Shire Hill, but is more accessible from the Stamford site. One central location will reduce transfers which fragments the care pathway and creates a poor experience for the patient themselves and their families.
- The Stamford Unit is able to provide single room accommodation, each with their own en-suite facilities along with significant communal space on each of the three wards. This encourages social interaction and independence and provides space to support rehabilitation and patients' exercises.
- One floor of the Stamford Unit has been designed to be dementia friendly with access to outside space and wandering routes, which will enable us to provide intermediate care and 'discharge to assess' beds in a unit which is able to support patients with dementia.
- The Stamford Unit is located in a central location in Ashton close to Tameside Hospital. The site has good public transport links, parking facilities, is well known and is easily accessible for patients and relatives.
- Additionally easy access and short journey times for health care professionals and support staff between the Stamford Unit and main hospital will reduce staff travelling time, increase specialist support to all intermediate care beds and enable the development of services in the unit.

Option 3: Develop a scheme of bed based Intermediate Care within local private care homes

This option would require us to work with private care home providers to develop capacity within existing care homes or invest locally in increasing capacity to host bed based Intermediate Care. This option would mean that Intermediate Care beds are not located in one single location but spread out across the area where capacity can be found. This option requires care home providers to be willing to invest in increasing bed spaces and if new care homes were required, a short term solution would be required whilst capacity in the system is built.

6. If you have an alternative option on how the Intermediate Care service could be delivered across Tameside & Glossop in the future please tell us in the box below, Please explain the benefits this alternative option will bring and any financial considerations.

7. Do you have any other comments you would like to make about Intermediate Care services in Tameside & Glossop? (Please write in the box below)

About You

8. Please tick the box that best describes your interest in this issue? (Please tick one box only)

- ☐ A user or previous user of Intermediate Care services in Tameside & Glossop
- ☐ A family member or carer of someone who has used or is using Intermediate Care services in Tameside & Glossop
- ☐ A member of the public
- ☐ An employee of Tameside Council
- ☐ An employee of NHS Tameside & Glossop Clinical Commissioning Group
- ☐ An employee of Tameside & Glossop Integrated Care NHS Foundation Trust
- ☐ An employee of Derbyshire County Council or High Peak Borough Council
- ☐ A community or voluntary group
- ☐ A partner organisation
- ☐ A business / private organisation
- ☐ Other (please specify)

9. What is your home postcode? (Please state)

10. What best describes your gender? (Please tick one box only)

- ☐ Female
- ☐ Male
- ☐ Prefer to self-describe
- ☐ Prefer not to say

11. What is your age? (Please state)

12. Which ethnic group do you consider yourself to belong to? (Please tick one box only)

White

- ☐ English / Welsh / Scottish / Northern Irish / British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other White background (Please specify)

Mixed / Multiple Ethnic Groups

- ☐ White and Black Caribbean
- ☐ White and Asian
- ☐ White and Black African
- ☐ Any other Mixed / Multiple ethnic background (Please specify)

Black / African / Caribbean / Black British

- ☐ African
- ☐ Caribbean
- ☐ Any other Black / African / Caribbean background (Please specify)

Asian / Asian British

- ☐ Indian
- ☐ Bangladeshi
- ☐ Pakistani
- ☐ Chinese
- ☐ Any other Asian background (Please specify)

Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group (Please specify)

13. What is your religion? (Please tick one box only)

- ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ No religion
- ☐ Any other religion, please state

14. What is your sexual orientation? (Please tick one box only)

- ☐ Heterosexual / Straight
- ☐ Gay man
- ☐ Gay woman / lesbian
- ☐ Prefer not to say
- ☐ Prefer to self-describe

15. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age. (Please tick one box only)

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No

16. Do you look after, or give any help or support to family members, friends, neighbours or others because of either, long-term physical or mental ill-health / disability or problems due to old age? (Please tick one box only)

- ☐ Yes, 1-19 hours a week
- ☐ Yes, 20-49 hours a week
- ☐ Yes, 50+ hours a week
- ☐ No

17. Are you a member or ex-member of the armed forces? (Please tick one box only)

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

18. What is your marital status? (Please tick one box only)

- ☐ Single
- ☐ Married / Civil Partnership
- ☐ Divorced
- ☐ Widowed
- ☐ Prefer not to say

FACT SHEET

REVIEW OF INTERMEDIATE CARE PROVISION IN TAMESIDE AND GLOSSOP

(OPTIONS FOR THE DELIVERY OF BED BASED INTERMEDIATE CARE)

1. Intermediate Care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of health and social care – community services, hospitals, GPs and social care.

2. Intermediate Care helps people avoid going into hospital unnecessarily, helps people be as independent as possible after a stay in hospital, and prevents people from having to move into a residential home until they really need to.

3. Intermediate Care services are provided by a variety of different professionals, from nurses and therapists to social workers. The person or team providing care will depend on the individual's needs at that time.

4. We deliver Intermediate Care in two main ways. Home First – a range of services which support people in their own home or at a location in their local community. Intermediate Care beds – beds for people coming out of hospital requiring a package of care which cannot be provided at home, or for people who need a short stay away from home for extra support to prevent them needing admission to hospital.

5. In Tameside and Glossop we have invested heavily in recent years in Home First services. We now need to look at the Intermediate Care beds to ensure they are fit for purpose, provide quality care and are affordable. Our plans for Intermediate Care beds are the focus of this consultation.

TAMESIDE AND GLOSSOP Caretogether SINGLE COMMISSIONING FUNCTION

NHS Tameside and Glossop Clinical Commissioning Group

FIND OUT MORE AND HAVE YOUR SAY ON THE PROPOSALS AT WWW.TAMESIDEANDGLOSSOPCCG.ORG/INTERMEDIATECARE

6 When developing our plans we have listened to the public and patients. Over the last two years we've sought your views on how Intermediate Care should be provided.

- **You said** – care should be provided at home first and then via Intermediate Care beds if needed
- **You said** – intermediate care beds should be used to avoid admittance to hospital where appropriate, as well as being used following discharge from hospital.

7 We currently provide 68 Intermediate Care beds across two sites – the Stamford Unit in Ashton next to Tameside Hospital and Shire Hill in Glossop. Both are managed by Tameside Hospital, now called Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT).

8 Our preferred option is to provide all Intermediate Care beds in one central location at the Stamford Unit in Ashton run by the ICFT, which is rated as Good by the Care Quality Commission (CQC).

9 Our preferred option is to provide 64 beds with the flexibility to use further beds in the Stamford Unit if required, depending on the daily requirement for beds.

10 We're continuing to grow and develop our Home First services which will reduce the need for Intermediate Care beds and avoid unnecessary admissions to hospital, supporting more people to stay at or return to their home.

11 847 people have stayed in Intermediate Care beds at Shire Hill in Glossop over the last two years. 40% of them lived within 5 miles of it. 84% of them lived within 5 miles of the Stamford Unit in Ashton.

12 80% of residents in Tameside and Glossop can reach the Stamford Unit in 45 minutes by public transport compared to only 24% travelling to Shire Hill (weekdays, off-peak)

13 The Stamford Unit offers single room en-suite accommodation, communal space for social interaction, is close to wider services at Tameside Hospital and is modern and up-to-date.

14 One floor of the Stamford Unit has been designed to be dementia friendly with access to outside space and wandering routes, which will enable us to provide Intermediate Care beds for patients with dementia.

15 Have your say on the options for delivering bed based Intermediate Care by completing the online survey at **www.tamesideandglossopccg.org/get-involved/intermediatecare.** You can pick up a paper copy from your local GP or email **TGCCG.communications@nhs.net.**

16 27% of patients from Shire Hill were readmitted back to the hospital as their condition required greater clinical support which cannot be provided at Shire Hill, but is more accessible from the Stamford site. One central location will reduce transfers which fragments the care pathway and creates a poor experience for the patient themselves and their families.

FIND OUT MORE AND HAVE YOUR SAY ON THE PROPOSALS AT WWW.TAMESIDEANDGLOSSOPCCG.ORG/INTERMEDIATECARE

FREQUENTLY ASKED QUESTIONS

REVIEW OF INTERMEDIATE CARE PROVISION IN TAMESIDE AND GLOSSOP

(OPTIONS FOR THE DELIVERY OF BED BASED INTERMEDIATE CARE)

Q Will your decision result in a reduction in the number of Intermediate Care beds across Tameside & Glossop?

A The following table outlines the number of beds currently provided and the number of beds under each option:

	Stamford Unit, Ashton	Shire Hill, Glossop	Private Care Home Providers
Current Provision	32	36	0
Option 1	32	36	0
Option 2	64	0	0
Option 3	32	0	Up to 32

Q Why is your preferred option to have all bed-based intermediate care in a single location at Stamford Unit?

A The Stamford Unit is located in a central location in Ashton on the Tameside Hospital site. The site has good public transport links, parking facilities, is well known and is easily accessible for patients and relatives. Additionally it will provide easy access and short journey times for health care professionals and support services between the Stamford Unit and main hospital increasing staff contact time with patients, reducing staff travelling time, increasing specialist support if required which ultimately could reduce the need for any patients to be readmitted into a hospital bed.

The Stamford Unit is able to provide single room accommodation, each with their own en-suite facilities along with significant communal space. This encourages social interaction and independence.

One floor of the Stamford Unit has been designed to be dementia friendly with access to outside space and wandering routes, which will enable us to provide intermediate care and 'discharge to assess' beds in a unit which is able to support patients with dementia. If we located all the intermediate Care beds along with 'discharge to assess' beds in the Stamford Unit, we would have a dedicated building of 96 beds which could be used flexibly to accomodate patient needs.

27% of patients from Shire Hill were readmitted back to the hospital as their condition required greater clinical support which cannot be provided at Shire Hill, but is more accessible from the Stamford site. One central location will reduce transfers which fragments the care pathway and creates a poor experience for the patient themselves and their families.

Q If 64 of the 96 beds at Stamford Unit are expected to be used for Intermediate Care, what will the other 32 beds be used for?

A The additional 32 beds at the Stamford Unit will primarily be used as discharge to assess beds. However, we have the flexibility to use some of these beds for Intermediate Care if the need arises, due to changes in demand.

Q If Intermediate Care beds are transferred to a single location in the Stamford Unit (as per Option 2 of the consultation), what will happen to patients currently based at Shire Hill?

A Intermediate Care services from bed based facilities are usually only delivered for a maximum of 6 weeks. This is not a 'long stay' option. If the location for delivery of bed based services should change as a result of this consultation, the process will be managed very carefully to minimise the number of people who have to be transferred / moved.

Q What will happen to the Shire Hill building if Option 2 of the consultation is implemented? Are there any other services provided from here in addition to intermediate care?

A If following the consultation process a decision is made to close the Intermediate Care bed service at Shire Hill, further work would be undertaken to determine future viability of the Shire Hill site. There is a group already working on the review of buildings across the whole of Tameside & Glossop who are aware of this proposal and will provide support on the future use of Shire Hill should the decision be made to relocate the bed based Intermediate Care service to the Stamford Unit.

Q Who will be providing the care for patients?

A Under Options 1 and 2 all care will be provided by staff from Tameside Hospital (Tameside & Glossop Integrated Care NHS Foundation Trust). Under Option 3, some care could be provided by the staff employed by the care home in in which the beds are based, but the specialist Intermediate Care will be delivered by staff from Tameside & Glossop Integrated Care NHS Foundation Trust (ICFT), who would travel to the appropriate site (care home) to do so.

Q If you relocate the bed based Intermediate Care service as per Option 2 of the consultation, some people may have to travel further to the Stamford Unit site. How can I get there?

A Stamford Unit is situated on the ICFT site (Tameside Hospital) and is accessible via various modes of transport including public transport. A full assessment of public transport and drive time accessibility has been undertaken as part of the Equality Impact Assessment.

Analysis shows that:

- 847 people have stayed in intermediate care beds at Shire Hill in Glossop over the last two years. 40% of them lived within 5 miles of it. 84% of them lived within 5 miles of the Stamford Unit in Ashton.
- 80% of residents in Tameside and Glossop can reach the Stamford Unit in 45 minutes by public transport compared to only 24% travelling to Shire Hill (weekdays, off-peak)

Q I believe there have previously been concerns about the quality of services provided at Darnton House (the site on which Stamford Unit now sits). Is this still the case?

A No, since July 2016 the Stamford Unit has been run by the ICFT (Tameside Hospital) which is rated 'Good' by the Care Quality Commission (CQC).

Q Is this just about closing services?

A No, we are looking to balance affordability of services with quality and accessibility. We believe our preferred option provides the best care in a modern and patient friendly environment in an accessible, central location.

Q Will I get the same level of service that I do now?

A Under our preferred option we believe the level of service will improve.

The Stamford Unit is able to provide single room accommodation, each with their own en-suite facilities along with significant communal space. This encourages social interaction and independence.

One floor of the Stamford Unit has been designed to be dementia friendly with access to outside space and wandering routes, which will enable us to provide intermediate care and 'discharge to assess' beds in a unit which is able to support patients with dementia.

The Stamford Unit is located in a central location in Ashton on the Tameside Hospital site. The site has good public transport links, parking facilities, is well known and is easily accessible for patients and relatives. Additionally it will provide easy access and short journey times for health care professionals and support services between the Stamford Unit and the main hospital as required.

A full Quality Impact Assessment has been completed as part of this process.

Q Why can't you leave things as they are?

A Tameside and Glossop Clinical Commissioning Group (CCG) are committed to ensuring the best possible health care is provided for residents in Tameside and Glossop. However we face significant challenges in providing quality services that meet the needs of a growing older population and the increasing number of people with long-term health conditions that need care. In order to meet the health care needs of our population for the future and within the budgets available, the CCG and its partners have reviewed ways to deliver our services. We believe that there is a better way of delivering the Intermediate Care service, which is more affordable and will result in better service for patients. We feel that maintaining services as they are currently does not provide this.

Q How will my views to the consultation help you make a decision?

A Your views are very important to us in making a decision on how Intermediate Care services will be delivered across Tameside & Glossop in future. The consultation will run for 12 weeks from 23 August 2017 until 15 November 2017. Once the consultation closes, the CCG will analyse all the responses received by the closing date. This feedback from residents, along with a range of other factors including legal and financial considerations, will be taken into account when preparing a final proposal on which option should be implemented.

Q How have you calculated how long it takes for people to travel to the locations where Intermediate Care is provided in Tameside & Glossop (i.e. Shire Hill and Stamford Unit on the site of Tameside hospital)?

A A Basemap's TRACC software was used to calculate travel times to both Shire Hill and Stamford Unit on the site of Tameside hospital (Tameside and Glossop Integrated Care NHS Foundation Trust) using public transport at both peak and off peak time periods. This covers all major public transport options across Tameside and Glossop including bus, train and tram.

TRACC was also used to calculate drive times at both peak and off peak time periods, and walk times.

Full details of this public transport, drive time and walk time analysis (including maps) is included in the Equality Impact Assessment.

Q When will the final decision be made?

A It is proposed that a report will be taken to Single Commissioning Board with our recommendations in December 2017. This report will be available on the CCG's website at **www.tamesideandglossopccg.org**

TAMESIDE AND GLOSSOP Caretogether SINGLE COMMISSIONING FUNCTION

NHS Tameside and Glossop Clinical Commissioning Group

Have YOUR say

FIND OUT MORE AND HAVE YOUR SAY ON THE PROPOSALS AT WWW.TAMESIDEANDGLOSSOPCCG.ORG/INTERMEDIATECARE

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 September 2017
Executive Member / Reporting Officer:	Councillor Jim Fitzpatrick – First Deputy (Performance and Finance) Councillor Brenda Warrington – Executive Member (Adult Social Care & Wellbeing) Councillor Gerald P. Cooney – Executive Member (Healthy & Working) Councillor Peter Robinson – Executive Member (Children & Families) Kathy Roe – Director Of Finance – Single Commission
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2017/18 CONSOLIDATED FINANCIAL MONITORING STATEMENT AT 31 JULY 2017 AND PROJECTED OUTTURN TO 31 MARCH 2018** **TAMESIDE HEALTH AND WELLBEING BOARD 2017-19 BETTER CARE FUND PLAN**
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 2017/2018 financial year update on the month 4 financial position (at 31 July 2017) and the projected outturn (at 31 March 2018). 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. The report also provides details of the Tameside Health and Wellbeing Board Better Care Fund Plan submission for the period 2017-19. It should be acknowledged that the associated Better Care Fund resources are included within the Integrated Commissioning Fund of the economy which is reported on a monthly basis to the Single Commissioning Board.
Recommendations:	Health and Wellbeing Board Members are recommended : 1. To note the 2017/2018 consolidated financial position of the economy at 31 July 2017 and the projected outturn position at 31 March 2018. 2. To acknowledge the significant level of savings required during 2017/2018 to achieve confirmed control totals and the financial sustainability of the economy on a recurrent basis thereafter.

3. To acknowledge the significant amount of financial risk associated with the achievement of financial control totals during this period.

4. To approve the 2017-19 Better Care Fund Plan Submission **(Appendix A)**

Links to Community Strategy: The Sustainable Community Strategy and Local Area Agreement are key documents outlining the aims of the Council and its partners to improve the borough of Tameside (agreed in consultation with local residents). Within health the CCG's Commissioning Strategy and Primary Care Strategy are similarly aligned to these principles and objectives.

Policy Implications: The Care Together resource allocations detailed within this report supports the strategic plan to integrate health and social care services across the Tameside and Glossop economy.

Financial Implications:

(Authorised by the Section 151 Officer))

This report provides the consolidated financial position statement of the 2017/18 Care Together Economy for the period ending 31 July 2017 (Month 4 – 2017/18) together with a projection to 31 March 2018 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.

A risk share arrangement is in place between the Council and CCG relating to the residual balance of net expenditure compared to the budget allocation at 31 March 2018, the details of which are provided within the report.

It should be noted that the Integrated Commissioning Fund for the partner Commissioner organisations will be bound by the terms within the Section 75 agreement and associated Financial Framework agreement which has been duly approved by both the Council and CCG.

Health and Wellbeing members should also note that the Better Care Fund allocations within **Appendix A** are included within the Section 75 funding allocation of the Integrated Commissioning Fund as this is a revenue funding allocation**.** The Disabled Facilities Grant allocation however is excluded as it is a capital funding allocation.

Legal Implications:

(Authorised by the Borough Solicitor)

There is a need to deliver a balanced budget. Consequently, there are significant changes required to achieve this and reduce the current levels of spend which previously have been bailed out. This requires new models of working and relentless focus on budgets without compromising patient care and safety. Many of the new models are intended to achieve this rather than simply look to cut out waste.

Access to Information :

Any background papers relating to this report can be inspected by contacting :

Stephen Wilde, Finance Business Partner, Tameside Metropolitan Borough Council

Telephone:0161 342 3726

e-mail: stephen.wilde@tameside.gov.uk

Tracey Simpson, Deputy Chief Finance Officer, Tameside and Glossop Clinical Commissioning Group

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David Warhurst, Associate Director Of Finance, Tameside Hospital NHS Foundation Trust

Telephone:0161 922 4624

e-mail: David.Warhurst@tgh.nhs.uk

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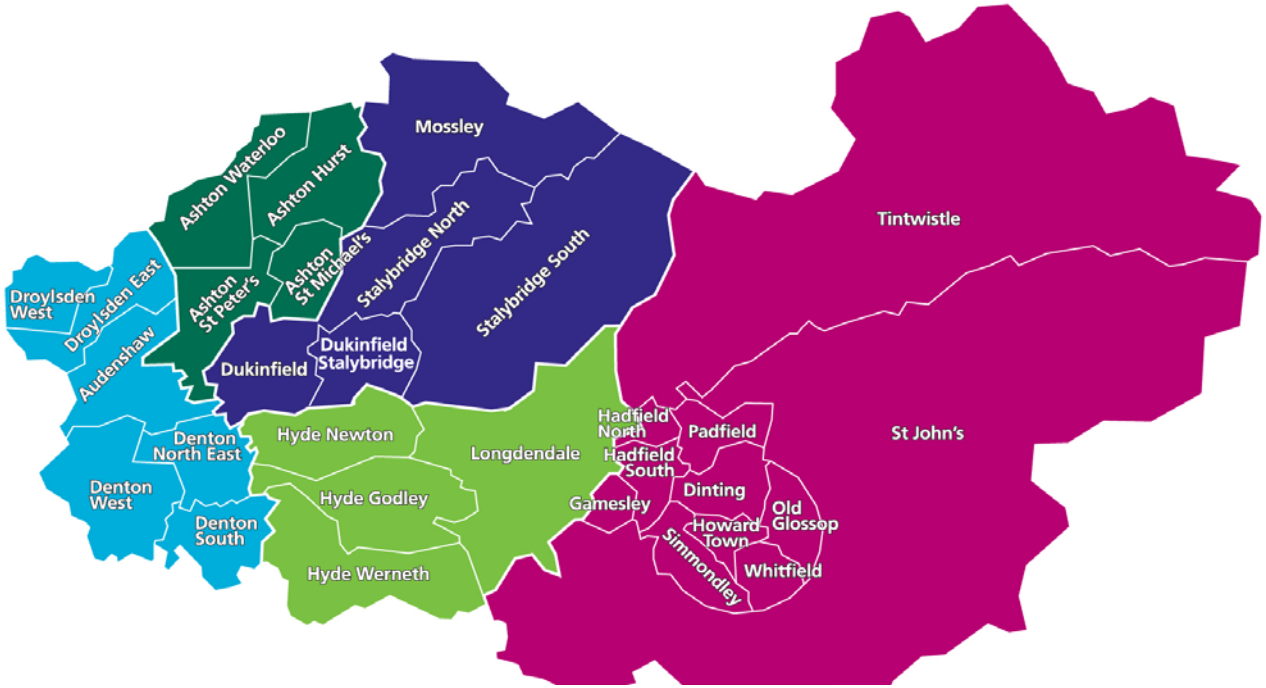
TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position

Financial Monitoring Statements

Period Ending 31st July 2017 [Month 4]

Kathy Roe
Ian Duncan
Claire Yarwood



Contents

Care Together Economy Revenue Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

Organisation	YTD Position			Forecast Position			Forecast Position	
	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Single Commission	164,050	165,892	-1,842	486,227	497,597	-11,370	-10,949	-421
ICFT	-8,827	-9,115	-288	-24,506	-24,506	0	14	-14
Total Economy	155,223	156,777	-2,130	461,675	473,045	-11,370	**-10,935**	**-435**
Integrated Commissioning Fund	164,050	165,892	-1,842	486,227	497,597	-11,370		
A: Section 75 Services	93,686	94,545	-858	266,514	270,838	-4,324		
B: Aligned Services	59,179	60,466	-1,286	185,854	192,537	-6,684		
C: In Collaboration Services	11,184	10,881	303	33,860	34,222	-363		

Key Headlines:

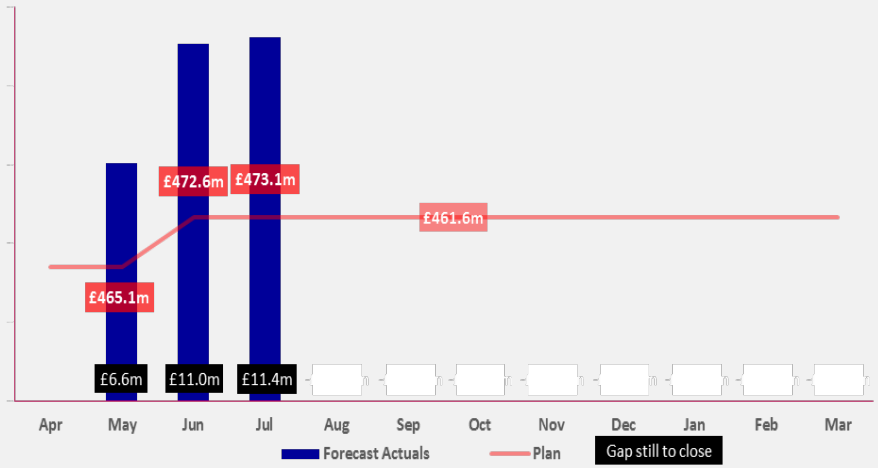
- YTD Position across the economy is currently: **£2,130k Deficit**
- 2017/18 Projected year end position across the economy is currently: **£11,370k Deficit**
- Movement in forecast year end position is: **£435k Adverse**

Single Commission - Risk Share	£'000
TMBC - Non Recurrent Contribution	-5,000
CCG	-1,000
TMBC	-5,370
Total	-11,370

- Non Rec repayable contributions between CCG/TMBC across 4 year period
- 80:20 Risk share arrangement between CCG/ TMBC as per contributions to ICF
- £500k upper threshold on CCG contribution to TMBC & £2m cap on TMBC contribution to CCG

Revenue Forecast Position

Forecast detail - £m's



Financial Summary – Forecast Position

- The CCG are reporting that all financial control totals will be met, however there is significant risk attached to the QIPP programme which is forecast £5.6m shortfall to plan
- The ICFT are still working to a deficit of £24.5m for 2017/18. This is yet to be agreed by NHSI. Trust efficiencies of £10.4m are required in order to meet this control total.
- Under terms of the Integrated Commissioning Fund financial framework, a non-recurrent contribution of c£5m can be accessed from council reserves towards the finance position of the CCG in 17/18. This would need to be repaid within a 4 year period.

Tameside & Glossop CCG Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

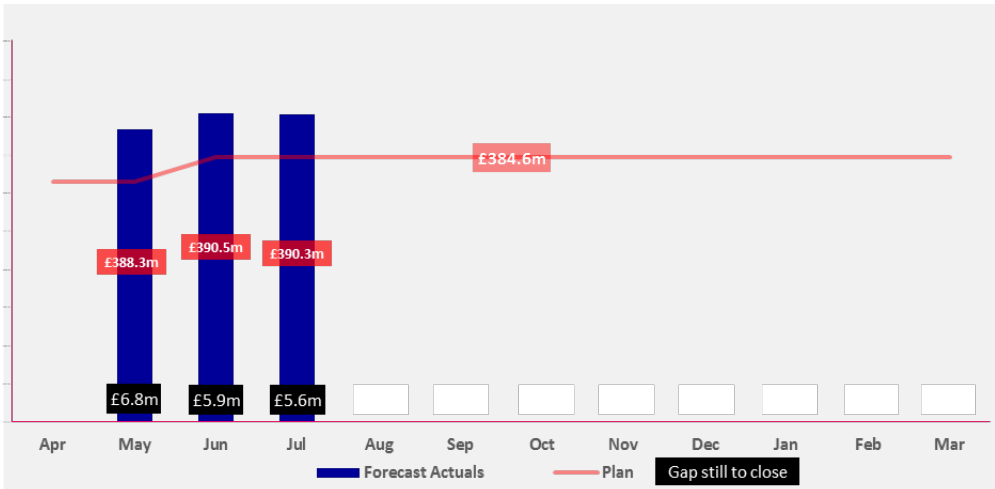
Organisation	YTD Position Budget	YTD Position Actual	YTD Position Variance	Forecast Position Budget	Forecast Position Actual	Forecast Position Variance	Forecast Position Previous Month	Forecast Position Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Acute	66,408	66,372	35	203,014	202,983	31	- 457	488
Mental Health	9,843	9,997	- 154	29,483	30,398	- 914	- 978	64
Primary Care	27,892	27,184	708	85,150	85,135	15	57	- 42
Continuing Care	4,556	6,421	- 1,864	13,671	17,206	- 3,534	- 3,217	- 318
Community	9,146	9,005	141	27,455	27,548	- 93	- 161	68
Other	10,170	9,141	1,030	20,684	16,188	4,496	4,756	- 260
QIPP			-		5,605	- 5,605	- 5,860	255
CCG Running Costs	2,017	1,833	184	5,197	5,197	-	-	-
CCG Expenditure	**130,032**	**129,953**	**80**	**384,655**	**390,260**	**- 5,605**	**- 5,860**	**255**
CCG Surplus	4,261	4,261	-	7,174	7,174	-	- 5,860	255

Key Headlines:

- 2017/18 Projected year end position across the economy is currently: **£5.605m Deficit** (i.e. QIPP savings still to be delivered to meet financial control totals)
- Movement in forecast year end position is: **£255k Favourable**
- YTD Position across the CCG is currently: **£80k Favourable.** Monthly profile of budgets is currently under review

Revenue Forecast Position

Forecast detail - £m's



Financial Summary – Forecast Position

- £3.5m projected overspend on continuing care causing significant pressures
- Impact of all cross year benefits/pressures included in M4 position
- Reporting that financial control totals will be met, but significant risk attached to this:
  - Deliver a surplus of 1% against opening allocation (£3,496k), plus carry forward of £3,678k from 16/17
  - Achieve a £23,900k QIPP target.
  - Keep 0.5% of allocation uncommitted to fund a national system risk reserve
  - Demonstrate growth in Mental Health spend of 2%
  - Remain within the running costs allocation

Tameside & Glossop CCG Financial Position

Overall Risk Rating - Medium

Theme	Highlights	Key Risks
Acute	• Overspend at Christies, Salford & South Manchester, offset by underspend at Central Manchester, Stockport & Pennine • £200k released to QIPP at M4 relating to reduced elective activity	• Increasing C&V spend in independent sector (diagnostics & MSK) caused by shift in activity from ICFT • Change in charging arrangement for stroke • Profile of plans may understate pressures
Mental Health	• £914k overspend relates to OOA ,managed by individualised commissioning and within scope of CHC recovery plan • Meeting MHIS with 3.15% increase in spend (2% target)	• Work ongoing to look at investment required in order to meet commitments around the five year forward view for mental health
Primary Care	• £170k QIPP realised in YTD position - Repeat Prescribing, COPD Pathway, DNP/Grey/Red list items • £56k cross year benefit reflected in position	• Paul Bauman letter – benefit of unplanned drug price reductions to be held centrally • NCSO pressure of £680k - Quetiapine and Olanzapine
Continuing Care	• Underlying forecast stable since significant pressures at M3 • Adverse movement of £313k relates to cross year pressure • Recovery Plan progressing and new system being procured	• Transforming Care – movement from specialist to CCG's • Fast track patients • Forecast assumes 7% growth. 16/17 growth was 14%
Community	• Contract variation with ICFT for flexible community beds following termination of Grange View contract. • £68k cross year benefit from non-medical prescribing	• Awaiting outcome of VAT reclaim on wheelchairs
Other	• Variance figures relate to treatment of reserves • Negative reserve of £1m to clear over and above the outstanding QIPP still to be delivered	• Nothing in position for additional critical care costs associated with Healthier Together • Estates schedules from Propco still outstanding
QIPP	• £10.3m (43%) of targeted savings banked at M4 • £1m reduction in planned savings since M3 (red schemes) • Expected savings stable due to increase in banked schemes	• Still need to deliver further £5.6m savings (plus clear the negative reserve) • Only 55% of expected savings delivered on recurrent basis
CCG Running Costs	• QIPP savings of £526k released at M4 • On track to remain within running cost allocation	• YTD Underspend relates to vacancies – conversation needed with budget holders about releasing to QIPP

TMBC Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

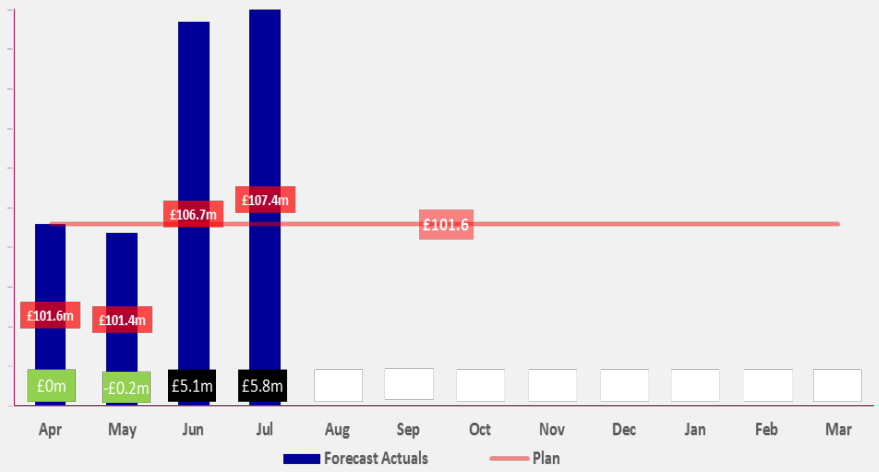
Organisation	YTD Position			Forecast Position			Forecast Position	
	Budget	Actual	Variance	Budget	Actual	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Adult Services	14,475	14,431	44	49,672	49,541	131	107	24
Children's Services	10,293	12,258	- 1,965	35,192	41,088	- 5,896	- 5,196	- 700
Public Health	9,250	9,250	-	16,708	16,708	-	-	-
Total Net Expenditure	34,017	35,939	- 1,922	101,572	107,337	- 5,765	- 5,089	- 676

Key Headlines:

- YTD Position is currently: **£1,922k Deficit**
- 2017/18 Projected year end position : **£5,765k Deficit**
- Movement to Forecast year end position is: **£676k Adverse**

Revenue Forecast Position

Forecast detail - £m's



Financial Summary – Forecast Position

Children's Services remains a high risk area . The majority of the projected additional net expenditure relates to placements within independent sector provision of £5.0m. It is currently estimated that on average there will be an additional 68 children in need of external placement provision above the number of placements estimated when the 2017/18 budget was approved by the Council in February 2017.

In addition the average cost of some external placements have increased since the budget was approved. This equates to a projected increase of £0.6m in the current financial year.

ICFT Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

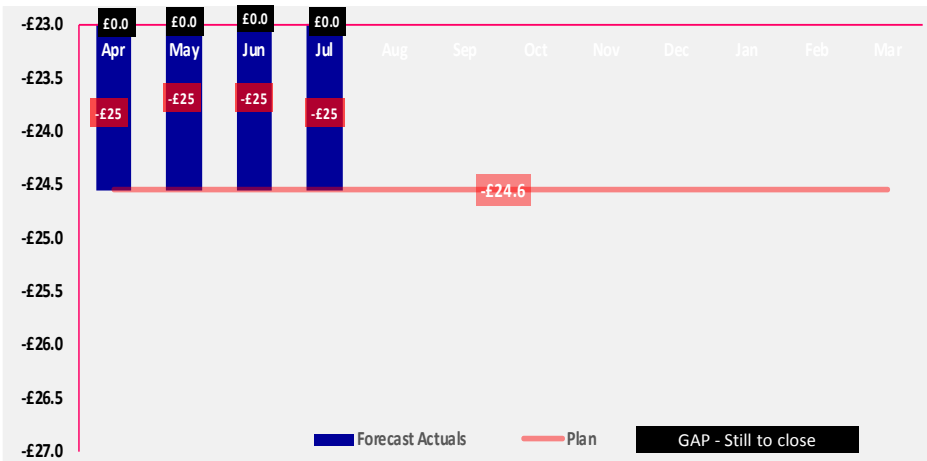
Organisation	YTD Position			Forecast Position		
	Budget	Actual	Variance	Budget	Forecast	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Income	68,072	68,867	- 796	204,701	204,701	-
Expenditure	73,887	74,862	- 975	219,916	219,916	-
EBITDA	- 5,815	- 5,995	180	- 15,215	- 15,215	-
Financing	2,957	3,064	- 107	9,129	9,129	-
Normalised Surplus/ (Deficit)	- 8,772	- 9,059	287	- 24,344	- 24,344	-
Exceptional Items	55	56	- 1	162	162	-
Net Deficit after Exceptional Costs	- 8,827	- 9,115	288	- 24,506	- 24,506	-

Key Headlines:

- YTD Position the ICFT is currently: **£288k overspent**
- The Trust has still to agree a control total with its regulator, NHSI.
- The Trust has agreed with NHSI, due to the volatility of risk that a detailed forecast will be presented at Month 6.
- The Trust is developing an action plan to mitigate risk of delivery.

Revenue Forecast Position

Forecast detail - £m's



Financial Summary – Key Risks

- The Trust is paying escalated rates to clinical staff due to gaps in medical rotas and a change in tax regulation. Consequently this is putting significant pressure on the Trusts financial position.
- The Trust has a number of escalated beds that are unfunded. Closing these beds will be difficult whilst the Trusts bed occupancy continues to be high.
- Income on smaller clinical contracts is falling and there is a focus on ensuring costs fall in relation to the loss of income.
- The Trusts efficiency programme is currently forecasting to underachieve, which will result in a financial pressure.

Health Economy Efficiency Position

Overall Risk Rating - Medium

Health Economy Position - At a glance

	YTD			2017/18 FORECAST BREAKDOWN £000'S									
	Target	Delivered	Variance	Delivered	Low	Medium	High	Hopper	Forecast Savings	Forecast Savings Excl High Risk	Target	Variance	Status
ICFT	2,599	2,300	(299)	4,440	2,619	1,906	2,118	0	11,083	8,965	10,397	(1,432)	
T&G CCG	9,823	10,296	474	10,296	7,999	3,123	6,800	0	28,218	21,418	23,900	(2,482)	
LOCAL AUTHORITY	258	258	0	258	284	231	0	0	773	773	773	0	
TOTAL	12,680	12,854	175	14,994	10,901	5,261	8,917	0	40,074	31,156	35,070	(3,913)	

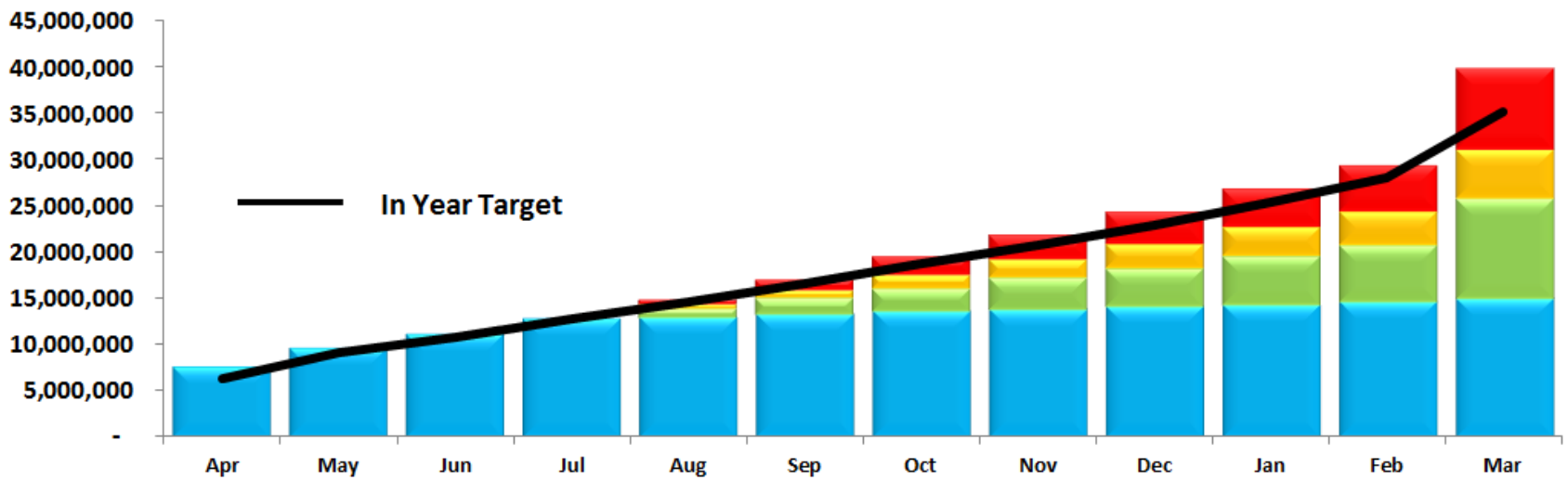
In Month/YTD Position

- 17/18 YTD Delivery across the economy is currently: **£12,854k**
- This is an overachievement against plan of **£175k**

Forecast Position

- 2017/18 Projected Economy saving forecast: **£3,913k Shortfall to plan**
- 2018/19 Projected Economy saving forecast: **£8,416k Shortfall to plan**

Phasing of Forecast - Cumulative



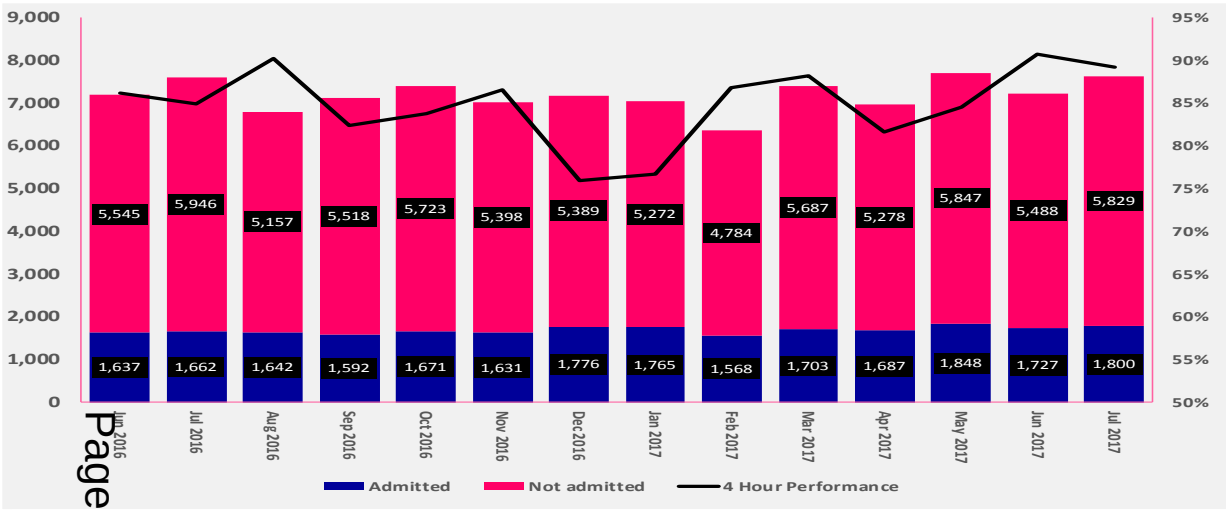
NB: Red Schemes are not included within the forecast savings figures due to high risk of non-financial delivery

Performance data– Emergency Attendances

Overall Risk Rating - Red

Emergency Department Performance – Tameside ICFT

Rolling 12 months ED performance:

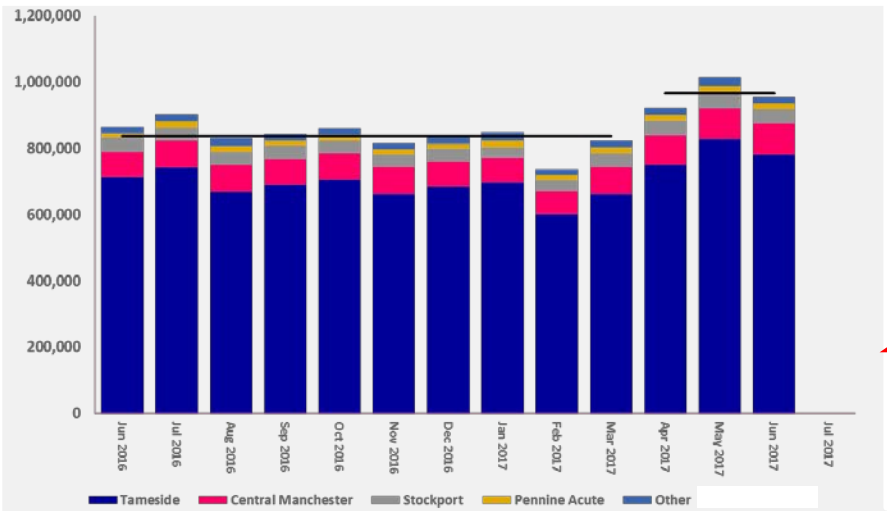


Q1 2016/17 v Q1 2017/18:

- A&E attendances up **1.6%** (359 attendances)
- Admissions up **8.2%** (406 admissions)
- 4 Hour up **0.5%** (88.1% - 87.6%)
- July ED performance **89.2%** of patients treated within 4 hours

Accident & Emergency Performance – Tameside Health Economy

Rolling 12 months PbR cost of A&E attendances:

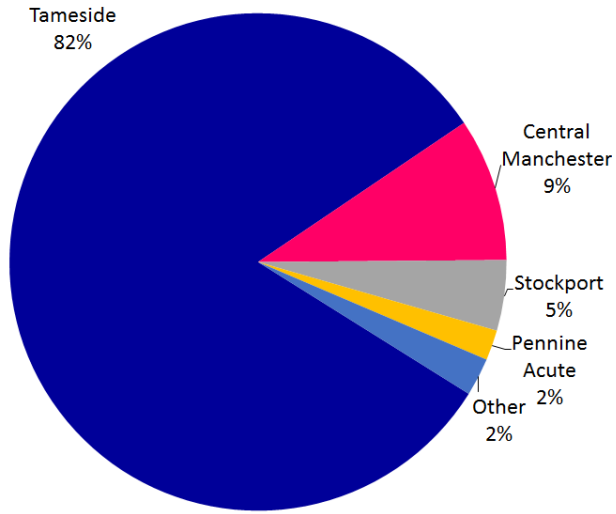


2016/17 v 2017/18:

- Average monthly PbR indicative spend in 16/17 **£837k**
- Average monthly PbR indicative spend in 17/18 **£966k**

An increase of **15.4%** (mainly driven by increase in tariff value)

Split of A&E spend by provider:

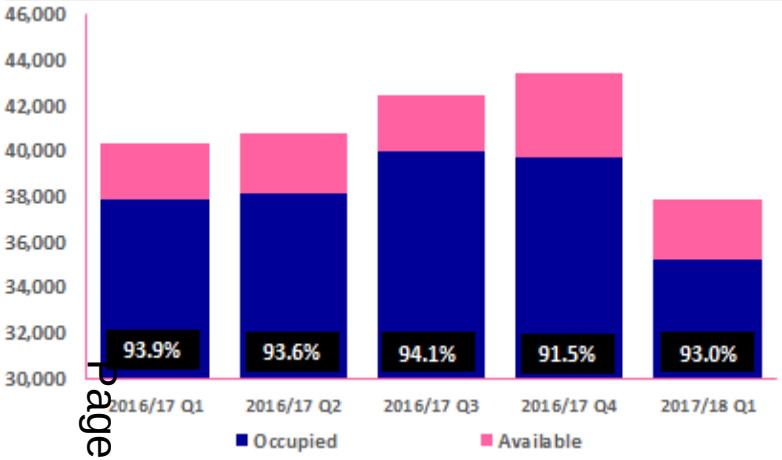


Performance data– Admissions

Overall Risk Rating - Red

Other key data - ICFT

Bed Occupancy:

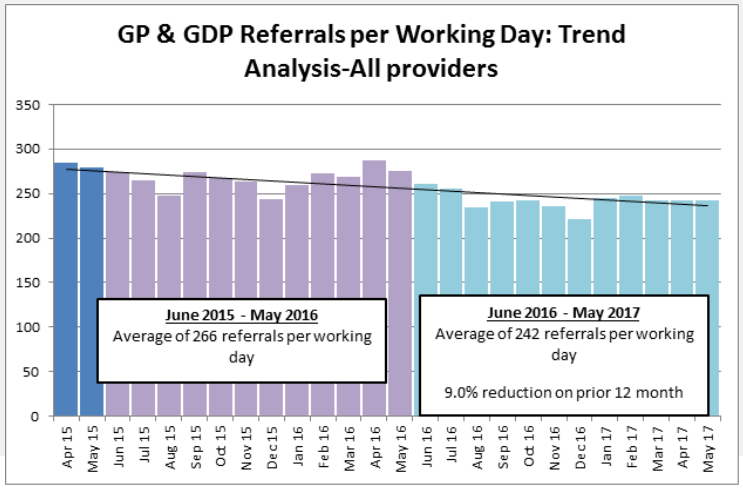


Finance:

- Whilst the Trust has a full establishment of Consultants (9 in total of which 7 are locums) – there is 6 vacancies at a speciality doctor level that are causing significant financial pressures.
  - As an example, speciality grade doctors on Agency are costing **£95ph** – Premium c. **£70k** per year per post.
  - Consultants having to step down, meaning we pay consultant rates+ for speciality level roles.
  - IR35 has been a significant pressure in ED, potentially above £300k.

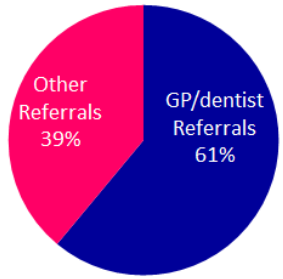
Other key data – Health Economy

Referrals:



- GP/dentist referrals have seen a significant reduction over the last year
- Other referrals, most notably consultant to consultant, at providers other than the ICFT have increased in the same period . Offsetting some of the benefit of the reduction in GP referrals.

	Apr & May 16/17	Apr & May 17/18	Variance	% Var
ICFT: GP Referrals	8,059	6,716	-1,343	-16.7%
ICFT: Other Referrals	3,068	3,155	87	2.8%
Other Providers: GP Referrals	3,453	2,740	-713	-20.6%
Other Providers: Other Referrals	2,584	2,880	296	11.5%
All Referrals	17,164	15,491	-1,673	-9.7%



Key/Emerging Risks

Children's services

Cost of Children's placements

Estates

Lack of fully developed plans in the estates strategy

TAMESIDE AND GLOSSOP
Caretogether

Transformation timeframes

GP Extensivists – Particularly Prescribing.

Areas of concern

Medical Staffing

Failure to recruit/IR35

CHC

Increased cost of CHC and social care assessments

Due Diligence

Complexities & timelines of due diligence to support transfer of services

Appendix 1 - ICFT Efficiency Position

Overall Risk Rating - Medium

ICFT Position - At a glance

	YTD			FORECAST BREAKDOWN £000'S								RECURRENT					
Theme	Target	Delivered	Variance	Delivered FYE	Low	Medium	High	Total Savings	Total Savings Excluding Red	Target	Variance	Status	Recurrent Target	Forecast	High	Total Savings Excluding Red	Variance	Status
Technical Target	414	628	214	752	765	0	0	1,517	1,517	1,243	274	Grn	43	235	0	235	193	Grn
Pharmacy	91	254	162	406	168	0	53	626	573	392	182	Grn	282	391	142	250	(32)	Amb
Divisional Target - Surgery	198	148	(50)	457	156	27	0	640	640	640	0	Grn	560	560	0	560	0	Grn
Estates	95	50	(45)	138	243	94	7	482	475	557	(82)	Amb	557	364	6	358	(199)	Amb
Divisional Target - Corporate	323	320	(3)	399	235	320	28	983	955	1,020	(65)	Amb	465	515	92	423	(42)	Amb
Medical Staffing	170	97	(74)	354	168	117	105	744	639	716	(77)	Amb	661	806	225	581	(80)	Amb
Workforce Efficiency	40	0	(40)	0	0	58	0	58	58	121	(63)	Amb	121	0	0	0	(121)	Red
Paperlite	42	0	(42)	0	21	9	86	116	30	125	(95)	Red	125	160	0	160	35	Grn
Nursing	300	242	(59)	255	0	506	224	985	760	975	(215)	Amb	375	556	175	381	6	Grn
Divisional Target - Medicine	268	224	(44)	589	132	0	379	1,100	721	803	(82)	Amb	803	820	445	375	(428)	Amb
Procurement	162	62	(100)	195	255	358	265	1,073	808	1,073	(266)	Amb	1,073	1,334	0	1,334	260	Grn
Demand Management	494	275	(219)	895	23	418	395	1,732	1,336	1,732	(395)	Amb	1,682	1,682	371	1,310	(371)	Amb
Transformation Schemes	0	0	0	0	453	0	574	1,028	453	1,000	(547)	Amb	1,000	2,223	1,537	686	(314)	Amb
TOTAL ICFT - TEP	2,599	2,300	(299)	4,440	2,619	1,906	2,118	11,083	8,965	10,397	(1,432)	Amb	7,747	9,646	2,993	6,653	(1,094)	Amb

Performance to date and forecast:

- Slightly behind the YTD target **c.£300k**, although for the third consecutive month the Trust has over delivered against its in month target,
- **42%** of the Target is actually delivered although the forecast is for the Trust to fail the Full Year target by **£1,432k**.
- Transformation has the biggest gap **£573k** and this is manly in relation to the Trust being unable to close beds.

Key issues and recovery:

- The trust is continuing to push themes in the Trust efficiency group.
- The Chief Executive has asked for more schemes to be escalated to both the Executive Committee and Finance and Performance Committee.
- Themes have been challenged to speed the development of hopper ideas into fully fledged schemes.

Appendix 2 - Single Commission Efficiency Position

Overall Risk Rating - Red

Single Commission Position - At a glance

	YTD			FORECAST BREAKDOWN £000'S								RECURRENT					
Theme	TARGET	Delivered	Variance	Delivered FYE	Low	Medium	High	Total Savings	Total Savings Excluding Red	Target	Variance	Status	Recurrent Target	Forecast	High	Total Savings Excluding Red	Variance	Status
Technical Target	1,635	3,197	1,562	3,197	3,844	120	120	7,280	7,160	1,875	5,285	Grn	455	455	0	455	0	Grn
Neighbourhoods	781	781	0	781	0	0	0	781	781	781	0	Grn	781	781	0	781	0	Grn
Primary Care	1,625	2,000	375	2,000	0	47	75	2,123	2,047	1,748	300	Grn	1,123	1,185	107	1,079	(44)	Amb
Single Commissioning	346	527	181	527	-35	323	323	1,137	814	1,137	(323)	Amb	1,137	1,246	386	861	(277)	Amb
Mental Health	294	296	2	296	0	300	300	896	596	994	(398)	Amb	994	1,007	630	377	(617)	Red
Effective Use of Resources	500	252	(248)	252	503	373	373	1,500	1,128	1,500	(373)	Amb	1,500	1,500	750	750	(750)	Amb
Acute Services - Elective	586	557	(29)	557	29	0	0	586	586	1,116	(530)	Amb	1,116	1,086	450	636	(480)	Amb
Other	724	724	0	724	0	60	540	1,324	784	1,324	(540)	Amb	724	724	0	724	0	Grn
Back Office Functions and Enabling Schemes	175	0	(175)	0	524	100	900	1,524	624	2,024	(1,400)	Red	2,024	1,524	700	824	(1,200)	Amb
GP Prescribing	713	171	(542)	171	678	381	1,287	2,516	1,229	2,516	(1,287)	Amb	2,516	3,054	2,191	863	(1,654)	Red
Demand Management	2,444	1,792	(652)	1,792	2,456	1,420	2,882	8,550	5,668	8,885	(3,217)	Amb	7,057	9,513	4,757	4,757	(2,300)	Amb
Sub Total CCG PP	9,823	10,296	474	10,296	7,999	3,123	6,800	28,218	21,418	23,900	(2,482)	Amb	19,427	22,075	9,970	12,105	(7,322)	Amb
Adult Social Care	112	112	0	112	40	184	0	336	336	336	0	Grn	336	336	0	336	0	Grn
Public Health	146	146	0	146	244	47	0	437	437	437	0	Grn	437	437	0	437	0	Grn
Sub Total Local Authority	258	258	0	258	284	231	0	773	773	773	0	Grn	773	773	0	773	0	Grn
Total Single Commission	10,080	10,554	474	10,554	8,283	3,355	6,800	28,991	22,191	24,673	(2,482)	Amb	20,200	22,848	9,970	12,878	(7,322)	Amb

Performance to date and forecast:

- Slightly ahead of schedule overall – this relates to non recurrent savings achieved as a result of budget management
- Only 2 months of data available for prescribing. This limits the savings available to bank in M4 data above
- M3 data available for associates, which again limits the value banked for demand management

Key issues and recovery:

- More work required to bring forward new schemes addressing the short fall

Appendix 3 – Practice Budget Statements

Overall Risk Rating - Medium

CCG Monthly Summary Report Month 2(May) 2017/18	Unified Position (Including Prescribing & Delegated Co-Commissioning)								Prescribing PMD Values					
	Budget				Actual	Actual	Actual	Actual	Variance	Budget		Actual	Variance	YTD	Prior month
	M1 Fixed Initial Budget	Annual Budget (May)	Y-T-D (May)	HC Patient Y-T-D (May)	HC Patient Y-T-D (May)	Y-T-D (May)	Y-T-D Variance (May)	%	%	Annual Budget	Y-T-D (May) Budget	Y-T-D (May)	Y-T-D (May)	%	%
P89003 ALBION MEDICAL PRACTICE	15,437,882	15,438,101	2,532,957	(10,962)	(40,050)	2,765,004	(232,046)	(9)%	0%	1,795,821	282,589	286,756	(4,167)	(1)%	0%
P89008 BEDFORD HOUSE MEDICAL CENTRE	11,206,031	11,206,191	1,838,620	(7,957)	0	2,039,092	(200,472)	(11)%	0%	1,303,549	205,125	202,821	2,304	1%	0%
P89011 GORDON STREET MEDICAL CENTRE	7,039,799	7,039,899	1,155,049	(4,999)	0	1,236,235	(81,186)	(7)%	0%	818,909	128,863	132,200	(3,337)	(3)%	0%
P89017 CHAPEL STREET MEDICAL CENTRE	8,214,891	8,215,007	1,347,851	(5,833)	0	1,504,377	(156,525)	(12)%	0%	955,602	150,373	166,686	(16,313)	(11)%	0%
P89020 HT PRACTICE	12,483,774	12,483,952	2,048,265	(8,865)	0	2,021,112	27,152	1%	0%	1,452,183	228,514	221,134	7,380	3%	0%
P89030 WEST END MEDICAL CENTRE	7,228,805	7,228,908	1,186,060	(5,133)	0	1,245,264	(59,204)	(5)%	0%	840,895	132,323	132,751	(428)	(0)%	0%
P89033 TAME VALLEY MEDICAL CENTRE	10,164,485	10,164,630	1,667,729	(7,218)	0	1,675,588	(7,858)	(0)%	0%	1,182,390	186,060	181,831	4,229	2%	0%
P89609 STAMFORD HOUSE	6,450,370	6,450,462	1,058,339	(4,580)	0	1,030,283	28,056	3%	0%	750,343	118,073	120,002	(1,929)	(2)%	0%
P89613 WATERLOO MEDICAL CENTRE	4,054,029	4,054,087	665,161	(2,879)	0	670,253	(5,092)	(1)%	0%	471,587	74,209	73,542	667	1%	0%
Y02586 ASHTON GP SERVICE	4,887,386	4,887,455	801,894	(3,470)	0	826,145	(24,252)	(3)%	0%	568,528	89,463	85,355	4,108	5%	0%
Ashton	**87,167,453**	**87,168,691**	**14,301,926**	**(61,897)**	**(40,050)**	**15,013,353**	**(711,427)**	(5)%	(2)%	**10,139,809**	**1,595,593**	**1,603,078**	**(7,485)**	(0)%	0%
P89010 MEDLOCK VALE MEDICAL PRACTICE	11,097,784	11,097,941	1,820,859	(7,880)	0	1,962,247	(141,388)	(8)%	0%	1,290,957	203,144	217,623	(14,479)	(7)%	0%
P89015 WINDMILL MEDICAL PRACTICE	18,416,743	18,417,005	3,021,712	(13,078)	(101,706)	3,794,235	(772,523)	(26)%	0%	2,142,339	337,117	469,093	(131,976)	(39)%	0%
P89018 DENTON MEDICAL PRACTICE	10,600,605	10,600,755	1,739,285	(7,527)	0	1,866,858	(127,573)	(7)%	0%	1,233,122	194,043	188,782	5,261	3%	0%
P89019 CHURCHGATE SURGERY	11,775,834	11,776,001	1,932,110	(8,362)	0	1,672,188	259,922	13%	0%	1,369,831	215,556	100,967	114,589	53%	0%
P89029 MARKET STREET MEDICAL PRACTICE	8,776,444	8,776,569	1,439,988	(6,232)	0	1,623,771	(183,783)	(13)%	0%	1,020,925	160,652	153,722	6,930	4%	0%
P82663 DROYLSDEN MEDICAL PRACTICE	4,765,269	4,765,337	781,857	(3,384)	0	902,662	(120,804)	(15)%	0%	554,323	87,228	99,802	(12,574)	(14)%	0%
P82713 GUIDE BRIDGE MEDICAL PRACTICE	4,835,009	4,835,078	793,300	(3,433)	0	850,455	(57,155)	(7)%	0%	562,436	88,504	79,471	9,033	10%	0%
P89616 ASHTON ROAD (BUTLER)	0	0	0	0	0	0	0	0%	0%	0	0	0		0%	0%
Denton	**70,267,688**	**70,268,686**	**11,529,112**	**(49,896)**	**(101,706)**	**12,672,416**	**(1,143,305)**	(10)%	(6)%	**8,173,933**	**1,286,244**	**1,309,460**	**(23,216)**	(2)%	0%
C81077 HOWARD MEDICAL PRACTICE	4,624,398	4,624,463	758,744	(3,284)	0	753,650	5,094	1%	0%	537,936	84,649	84,636	13	0%	0%
C81081 MANOR HOUSE SURGERY	16,659,485	16,659,722	2,733,391	(11,830)	0	3,061,581	(328,190)	(12)%	0%	1,937,925	304,950	350,752	(45,802)	(15)%	0%
C81106 LAMBGATES HEALTH CENTRE	7,703,847	7,703,957	1,264,002	(5,470)	0	1,370,073	(106,071)	(8)%	0%	896,155	141,018	145,919	(4,901)	(3)%	0%
C81615 COTTAGE LANE SURGERY	3,098,473	3,098,517	508,379	(2,200)	0	470,632	37,748	7%	0%	360,432	56,717	56,362	355	1%	0%
C81640 SIMMONDLEY MEDICAL PRACTICE	3,643,107	3,643,159	597,740	(2,587)	0	732,137	(134,397)	(22)%	0%	423,787	66,687	81,568	(14,881)	(22)%	0%
C81660 HADFIELD MEDICAL CENTRE	3,835,224	3,835,278	629,261	(2,723)	0	627,997	1,264	0%	0%	446,135	70,203	34,198	36,005	51%	0%
Glossop	**39,564,534**	**39,565,096**	**6,491,518**	**(28,094)**	**0**	**7,016,069**	**(524,552)**	(8)%	0%	**4,602,370**	**724,225**	**753,435**	**(29,210)**	(4)%	0%
P89002 THE BROOKE SURGERY	14,105,865	14,106,066	2,314,408	(10,016)	0	2,556,279	(241,871)	(10)%	0%	1,640,874	258,207	294,545	(36,338)	(14)%	0%
P89004 AWBURN HOUSE MEDICAL PRACTICE	9,292,546	9,292,678	1,524,667	(6,599)	0	1,656,871	(132,204)	(9)%	2%	1,080,961	170,099	192,969	(22,870)	(13)%	0%
P89012 CLARENDON MEDICAL CENTRE	12,044,291	12,044,462	1,976,157	(8,553)	(18,938)	2,123,207	(147,050)	(7)%	0%	1,401,060	220,470	261,733	(41,263)	(19)%	0%
P89013 HATTERSLEY GROUP PRACTICE	9,764,977	9,765,115	1,602,180	(6,934)	0	1,554,604	47,576	3%	0%	1,135,917	178,747	154,067	24,680	14%	0%
P89014 HAUGHTON THORNLEY MEDICAL CENTRE	17,711,762	17,712,014	2,906,042	(12,577)	(48,626)	3,109,400	(203,358)	(7)%	0%	2,060,332	324,212	348,789	(24,577)	(8)%	0%
P89016 DONNEYBROOK MEDICAL CENTRE	14,704,322	14,704,531	2,412,599	(10,441)	0	2,658,626	(246,027)	(10)%	0%	1,710,490	269,161	283,848	(14,687)	(5)%	0%
P89021 DUKINFIELD MEDICAL CENTRE	15,868,573	15,868,798	2,603,623	(11,268)	0	2,712,537	(108,914)	(4)%	0%	1,845,922	290,473	290,193	280	0%	0%
P89602 THE SMITHY SURGERY	5,478,203	5,478,281	898,832	(3,890)	0	912,745	(13,914)	(2)%	0%	637,255	100,278	108,287	(8,009)	(8)%	0%
Hyde	**98,970,539**	**98,971,944**	**16,238,508**	**(70,278)**	**(67,564)**	**17,284,270**	**(1,045,762)**	(6)%	0%	**11,512,811**	**1,811,647**	**1,934,431**	**(122,784)**	(7)%	0%
P89005 LOCKSIDE MEDICAL CENTRE	10,208,603	10,208,748	1,674,968	(7,249)	(16,976)	1,760,560	(85,592)	(5)%	0%	1,187,522	186,868	164,744	22,124	12%	0%
P89007 STAVELEIGH MEDICAL CENTRE	9,905,525	9,905,666	1,625,241	(7,034)	0	1,766,785	(141,545)	(9)%	0%	1,152,266	181,320	173,556	7,764	4%	0%
P89022 KING STREET MEDICAL CENTRE	5,461,197	5,461,274	896,041	(3,878)	0	973,114	(77,073)	(9)%	0%	635,277	99,967	97,460	2,507	3%	0%
P89023 ST ANDREWS HOUSE	7,729,781	7,729,891	1,268,257	(5,489)	0	1,355,386	(87,129)	(7)%	0%	899,172	141,493	145,572	(4,079)	(3)%	0%
P89025 TOWN HALL SURGERY	4,772,636	4,772,703	783,066	(3,389)	(21,272)	875,329	(92,263)	(12)%	0%	555,180	87,363	72,558	14,805	17%	0%
P89026 GROSVENOR MEDICAL CENTRE	8,721,501	8,721,625	1,430,973	(6,193)	0	1,454,953	(23,980)	(2)%	0%	1,014,534	159,646	155,346	4,300	3%	0%
P89612 MOSSLEY MEDICAL PRACTICE	2,718,936	2,718,975	446,107	(1,931)	0	488,547	(42,440)	(10)%	0%	316,282	49,770	40,262	9,508	19%	0%
P89618 PIKE MEDICAL CENTRE	2,752,759	2,752,798	451,657	(1,955)	0	472,898	(21,241)	(5)%	0%	320,216	50,389	47,973	2,416	5%	0%
Y02936 MILLBROOK MEDICAL PRACTICE	3,826,847	3,826,902	627,887	(2,717)	0	637,917	(10,030)	(2)%	0%	445,160	70,050	57,311	12,739	18%	0%
Stalybridge	**56,097,786**	**56,098,583**	**9,204,197**	**(39,834)**	**(38,248)**	**9,785,489**	**(581,292)**	(6)%	0%	**6,525,610**	**1,026,865**	**954,782**	**72,083**	7%	0%
Total	**352,068,000**	**352,073,000**	**57,765,260**	**(250,000)**	**(247,569)**	**61,771,598**	**(4,006,339)**	(7)%	0%	**40,954,533**	**6,444,575**	**6,555,186**	**(110,611)**	(2)%	0%

Planning Template v.14.6b for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: 1. Cover Sheet

<< Link to the Guidance tab

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Who signed off the report on behalf of the Health and Well Being Board:	Councillor Brenda Warrington, Executive Member, Adult Social Care and Wellbeing

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***Only those identified will be addressed in official correspondence**

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete Template

	No. of questions answered
1. Cover	6
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5. National Conditions	12

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 2. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Tameside

Data Submission Period:

2017-19

2. HWB Funding Sources

[<< Link to the Guidance tab]

Local Authority Contributions exc iBCF		
Disabled Facilities Grant (DFG)	2017/18 Gross Contribution	2018/19 Gross Contribution
Tameside	£2,152,698	£2,327,193
Lower Tier DFG Breakdown (for applicable two tier authorities)		
Total Minimum LA Contribution exc iBCF	**£2,152,698**	**£2,327,193**

Are any additional LA Contributions being made in 2017/18 or 2018/19? If yes please detail below	No	No

Local Authority Additional Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution	**£2,152,698**	**£2,327,193**

Comments - please use this box clarify any specific uses or sources of funding

iBCF Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Tameside	£6,343,181	£8,775,818
Total iBCF Contribution	**£6,343,181**	**£8,775,818**

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Tameside and Glossop CCG	£15,597,033	£15,893,377
Total Minimum CCG Contribution	**£15,597,033**	**£15,893,377**

Are any additional CCG Contributions being made in 2017/18 or 2018/19? If yes please detail below	No	No

Additional CCG Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Additional CCG Contribution	**£0**	**£0**

Comments - please use this box clarify any specific uses or sources of funding

	2017/18	2018/19
Total BCF pooled budget	**£24,092,912**	**£26,996,388**

Funding Contributions Narrative
Allocations assumed in line with current national circulars, all of the funding contributions are included within a larger local Section 75 agreement between Tameside MBC and Tameside & Glossop CCG

Specific funding requirements for 2017-19	Response	Response	If the selected response for either year is 'No', please detail in the comments box
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes	
2. In areas with two tiers of local government:			
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?			

ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.			
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes	
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes	
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes	
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes	

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 3. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Tameside

Data Submission Period:
2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	2017/18	2018/19
BCF Pooled Total balance	£1	
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance		
Additional CCG Contribution balance	£0	£0
iBCF	£0	
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£9,629,033	£9,842,377
Ringfenced NHS Commissioned OOH spend	£4,622,160	£4,696,080

Expenditure

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	%NHS (if Joint Commissioner)	%LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure Question	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
	LD Employment Services	16. Other		Employment Support	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£29,000	£29,000	Existing
	Through the Night Service	6. Domiciliary care at home	1. Dom care packages		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£112,000	£115,000	Existing
	Sensory Services	16. Other		Sensory support service	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£16,060	£40,200	Existing
	Contract uplifts / demographic pressures	14. Residential placements	1. Supported living		Social Care		Local Authority			Private Sector	Improved Better Care Fund	Both 2017/18 and 2018/19	£362,000	£394,000	Existing
	Quality Assurance Team	16. Other		[illegible]	[illegible]		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£213,567	[illegible]	New
	Mental Health Recovery Service	15. Wellbeing centres			Mental Health		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£30,500	£40,000	Existing
	Additional Assessment Capacity	2. Care navigation / coordination	1. Care coordination		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£81,500	£127,920	Existing
	Approved Mental Health Practitioner	2. Care navigation / coordination	1. Care coordination		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£207,000	£207,000	Existing
	Court of Protection - clear backlog	16. Other		COP clearance of backlog / DOLs authorisation	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£123,500	£123,000	Existing
	Additional Occupational Therapists	6. Domiciliary care at home	1. Dom care packages		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£34,000	£34,000	Existing
	Direct Payment Capacity	16. Other		Promoting the move towards Direct Payments in line with	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£54,000	£54,000	Existing
	Grafton Model rollout	15. Wellbeing centres			Social Care		Local Authority			Charity / Voluntary Sector	Improved Better Care Fund	2017/18 Only	£160,000		New
	Care Home Contracts	14. Residential placements	4. Care home		Social Care		Local Authority			Local Authority	Improved Better Care Fund	2017/18 Only	£46,000		Existing
	Third Sector capacity	16. Other		Contributions to Age UK and Tameside Sight charities	Social Care		Local Authority			Charity / Voluntary Sector	Improved Better Care Fund	2017/18 Only	£137,900		Existing
	PMO Costs	7. Enablers for integration	3. Programme management		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£50,800	£101,000	New
	CRS Project lead	1. Assistive Technologies	1. Telecare		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£20,500	£20,500	Existing
	Reablement Service Review Capacity	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£10,500	£10,500	Existing
	Shared Lives project lead	14. Residential placements	2. Learning disability		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£20,500	£20,500	Existing
	Carers Project lead	3. Carers services	1. Carer advice and support		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£20,500	£20,500	Existing
	Autism co-ordinator	2. Care navigation / coordination	1. Care coordination		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	[illegible]	£41,000	Existing
	Further capacity to reduce DTOC's	14. Residential placements	5. Nursing home		Social Care		Local Authority			Private Sector	Improved Better Care Fund	Both 2017/18 and 2018/19	£250,000	£1,000,000	New
	Transformation schemes in development	16. Other		Schemes under development	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£3,393,506	£590,362	New
	DFG Adaptations	4. DFG - Adaptations			Social Care		Local Authority			Private Sector	Local Authority Contribution	Both 2017/18 and 2018/19	£2,152,098	£2,327,199	Existing
	Growth in nursing care home market to increase capacity and support reduction in DTOC's	14. Residential placements	5. Nursing home		Social Care		Local Authority			Private Sector	Improved Better Care Fund	Both 2017/18 and 2018/19	£978,547	£5,478,950	Existing
	Telecare/Telehealth	1. Assistive Technologies	1. Telecare		Social Care		Joint	32.0%	68.0%	Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£983,000	£989,000	Existing
	ICES (Joint Loan Store)	1. Assistive Technologies	4. Other	Joint equipment store to support people to remain independent	Community Health		Joint	65.0%	35.0%	Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,268,000	£1,294,000	Existing
	Reablement Services	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,145,000	£2,146,000	Existing
	Wheelchairs	16. Other			Community Health		CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£615,000	£625,000	Existing
	Parkinson's Nurse	16. Other			Community Health		[illegible]			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£45,000	£46,000	Existing
	Integrated Care	10. Integrated care planning	4. Other		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,200,000	£1,224,000	Existing
	Carer Breaks (Adults)	3. Carers services	4. Other		Social Care		[illegible]			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£133,000	£136,000	Existing
	Integrated Urgent Care Team	10. Integrated care planning	1. Care planning		Other	Joint Social Care and Health team	Joint	30.0%	70.0%	NHS Acute Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,928,000	£1,940,000	Existing
	Early Supported Discharge Team	10. Integrated care planning	1. Care planning		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£288,000	£288,000	Existing
	Community Occupational Therapists	6. Domiciliary care at home	1. Dom care packages		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£751,000	£761,000	Existing
	Home based IC services (including crisis response)	16. Other		Home based services - step down	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,012,000	£1,032,000	Existing
	Mental health Services	16. Other		Range of MH social work and wellbeing services	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,450,000	£2,450,000	Existing
	Adult Social Care - Community based Services (inc care Homes)	16. Other		Range of community based services to support	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,349,033	[illegible]	Existing
	Impact of New Care Act Duties	2. Care navigation / coordination	1. Care coordination		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	[illegible]	£529,000	Existing

Selected Health and Well Being Board:

Tameside

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	2017/18	2018/19
BCF Pooled Total balance	£1	
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	
Additional CCG Contribution balance	£0	£0
iBCF	£0	
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£9,629,033	£9,842,377
Ringfenced NHS Commissioned OOH spend	£4,622,160	£4,896,080

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme

Expenditure

Scheme Type	Description	Sub Types
1. Assistive Technologies	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	1. Telecare 2. Wellness services 3. Digital participation services 4. Other
2. Care navigation / coordination	A service to help people find their way to appropriate services and support and thus also support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. This is often as part of a multi-agency team which can be on line or use face to face care navigators for frail elderly, or dementia navigators etc. . This includes approaches like Single Point of Access (SPoA) and linking people to community assets.	1. Care coordination 2. Single Point of Access 3. Other
3. Carers services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	1. Carer advice and support 2. Implementation of Care Act 3. Respite services 4. Other
4. DFG - Adaptations	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	
5. DFG - Other Housing	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	
6. Domiciliary care at home	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	1. Dom care packages 2. Dom care workforce development 3. Other
7. Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning.	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Other
8. Healthcare services to Care Homes	Improve the availability and quality of primary and community health services delivered to care home residents. Support the Care Home workers to improve the delivery of non-essential healthcare skills. This includes provider led interventions in care homes and commissioning activities eg. joint commissioning/quality assurance for residential and nursing homes.	1. Other - Mental health / wellbeing 2. Other - Physical health / wellbeing 3. Other
9. High Impact Change Model for Managing Transfer of Care	The 8 changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system.	1. Early Discharge Planning 2. Systems to Monitor Patient Flow 3. Multi-Disciplinary/Multi-Agency Discharge Teams 4. Home First/Discharge to Access 5. Seven-Day Services 6. Trusted Assessors 7. Focus on Choice 8. Enhancing Health in Care Homes 9. Other
10. Integrated care planning	A co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	1. Care planning 2. Integrated care packages 3. Review teams (reviewing placements/packages) 4. Other
11. Intermediate care services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and delivered by a combination of professional groups. Services could include Step up/down, Reablement (restorative of self-care), Rapid response or crisis response including that for falls.	1. Step down 2. Step up 3. Rapid/Crisis Response 4. Reablement/Rehabilitation services 5. Other
12. Personalised healthcare at home	Schemes specifically designed to ensure that a person can continue to live at home through the provision of health related support at home. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term and end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in the Personalised Healthcare at Home scheme type.	1. Other - Mental health /wellbeing 2. Other - Physical health/wellbeing 3. Other
13. Primary prevention / Early intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	1. Social Prescribing 2. Other - Mental health /wellbeing 3. Other - Physical health/wellbeing 4. Other
14. Residential placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	1. Supported living 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Other
15. Wellbeing centres	Wellbeing centres provide a space to offer a range of support and activities that promote holistic wellbeing or to help people to access them elsewhere in the community or local area. They can typically be commissioned jointly and provided by the third sector.	
16. Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 4. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Tameside

Data Submission Period:
2017-19

4. HWB Metrics

<< Link to the Guidance tab

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
HWB Non-Elective Admission Plan* Totals	6,996	7,066	7,104	6,963	6,852	6,916	6,952	6,815	28,130	27,535

Are you planning on any additional quarterly reductions?	No

Please only record reductions where these are over and above existing or future CCG plans. HWBs are not required to attempt to align to changing CCG plans by recording reductions.

If yes, please complete HWB Quarterly Additional Reduction Figures

HWB Quarterly Additional Reduction										
HWB NEA Plan (after reduction)										
HWB Quarterly Plan Reduction %										

Are you putting in place a local contingency fund agreement on NEA?	No

	2017/18	2018/19
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/contingency fund **	£4,432,234	£4,516,447

Cost of NEA as used during 16/17***	£1,506	Please add the reason, for any adjustments to the cost of NEA for 17/18 or 18/19 in the cells below
Cost of NEA for 17/18 ***		
Cost of NEA for 18/19 ***		

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Total 17/18
Additional NEA reduction delivered through BCF (2017/18)						
		Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 18/19
Additional NEA reduction delivered through BCF (2018/19)						
HWB Plan Reduction % (2017/18)						
HWB Plan Reduction % (2018/19)						

The CCG Total Non-Elective Admission Plans are taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 10/07/2017

* This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

** Within the sum subject to the condition on NHS out of hospital commissioned services/contingency fund, for any local area putting in place a contingency fund for 2017/18 or 2018/19 as part of its BCF

*** Please use the following document and amend the cost if necessary: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf

4.2 Residential Admissions

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing	Annual rate	633.8	622.9	608.3	597.9	Performance in this area remains comparatively good with Greater Manachester and North West authorities. Given the rising aging demographic, the aim is to maintain current performance. Additional work is underway within the integration programme to build a more
	Numerator	243	243	241	241	

care homes, per 100,000 population	Denominator	38,343	39,013	39,619	40,307	resilient community and extra care housing resource that will allow people to remain in their own homes for longer.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a Residential Admissions rate for these two Health and Well-Being Boards.

4.3 Reablement

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	86.4%	78.0%	81.5%	81.5%	Performance in this area remains comparatively good with Greater Manchester and North West authorities. Following a review of the Reablement Service and with the development of a more robust Urgent Care Team it is anticipated that services will in the future be more efficiently targeted to ensure that the correct people are receiving services at the right point. 81.5% level is set from the actual 4th quarter outturn for 16-17.
	Numerator	274	425	371	371	
	Denominator	317	545	455	455	

4.4 Delayed Transfers of Care

		16-17 Actuals				17-18 plans				18-19 plans				
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	2005.9	2409.7	2733.1	2208.5	1382.8	1341.5	1155.8	1094.0	1094.0	1094.0	1094.0	1090.9	The local trajectory has been developed in line with the GM target of 3.3% for Q4 17/18. Local analysis suggests that to reduce furthor would require significant care home market stimulation for EMI needs and so the ambitions is to maintain 3.3%. We acknowledge despite expected demographic growth in our older population that we will not increase the level of DToC's.
	Numerator (total)	3,473	4,172	4,732	3,838	2,403	2,331	2,009	1,906	1,906	1,906	1,906	1,906	
	Denominator	173,136	173,136	173,136	173,782	173,782	173,782	173,782	174,231	174,231	174,231	174,231	174,714	

Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a DTOC rate for these two Health and Well-Being Boards.

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 5. National Conditions

Selected Health and Well Being Board:

Tameside

Data Submission Period:

2017-19

5. National Conditions

<< Link to the Guidance tab

National Conditions For The Better Care Fund 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?	If the selected response for either year is 'No', please detail in the comments box issues and/or actions that are being taken to meet the condition.
1) Plans to be jointly agreed	Yes	Yes	
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes	
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes	
4) Managing transfers of care	Yes	Yes	

CCG to Health and Well-Being Board Mapping for 2017-19

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E08000008	Tameside	14L	NHS Manchester CCG	2.3%	5.9%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.8%
E08000008	Tameside	01W	NHS Stockport CCG	1.7%	2.2%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.1%	88.1%

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 September 2017
Executive Member / Reporting Officer:	Councillor Brenda Warrington, Executive Member (Adult Social Care and Wellbeing) Jessica Williams, Programme Director, Tameside and Glossop Care Together
Subject:	**INTEGRATION REPORT – UPDATE**
Report Summary:	This report provides Tameside Health and Wellbeing Board with progress on the implementation of the Care Together Programme and includes developments since the last presentation in June 2017.
Recommendations:	The Health and Wellbeing Board is asked: 1. To note the updates as outlined within this report. 2. To note the proposed changes within the Clinical Commissioning Group governance and clinical leadership structures. 3. To receive a further update at the next meeting.
Links to Health and Wellbeing Strategy:	Integration has been identified as one of the six principles agreed locally to achieve the priorities identified in the Health and Wellbeing Board Strategy
Policy Implications:	One of the main functions of the Health and Wellbeing Board is to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.
Financial Implications: **(Authorised by the Section 151 Officer)**	The Tameside and Glossop health and social care economy has a projected £70 million financial gap by 2020/21, the delivery of which will be supported by the Care Together Programme. It is important to note that the locality financial gap will be subject to revision, the details of which will be reported to a future Health and Wellbeing Board meeting. It should also be noted that the approved Greater Manchester Health and Social Care Partnership funding of £23.2 million should be monitored and expended in accordance with the investment agreement and that recurrent efficiency savings are subsequently realised across the economy as a result of this investment.
Legal Implications: **(Authorised by the Borough Solicitor)**	It is important to recognise that the Integration agenda, under the auspices of the 'Care Together' banner, is a set of projects delivered within each organisation's governance model and delivered jointly under the Single Commissioning Board together with the Integrated Care Foundation Trust. However, the programme itself requires clear lines of accountability and decision making due to the joint financial and clinical implications of the proposals. It is important as well as effective decision making processes that there are the means and resources to deliver the necessary work. This is to provide confidence and oversight of delivery. We

need to ensure any recommendations of the Care Together Programme Board are considered / approved by the constituent bodies to ensure that the necessary transparent governance is in place.

Risk Management :

The Care Together Programme has an agreed governance structure with a shared approach to risk, supported through a project support office

Access to Information :

The background papers relating to this report can be inspected by contacting Jessica Williams, Programme Director, Tameside and Glossop Care Together

 Telephone: 0161 304 5389

 e-mail: jessicawilliams1@nhs.net

1. INTRODUCTION

1.1 This report provides Tameside Health and Wellbeing Board with an outline of the developments within the Care Together Programme since the last presentation in June 2017.

1.2 The report covers:

- Greater Manchester Health and Social Care Partnership;
- Programme Management Office;
- Operational Progress;
- Recommendations.

2. GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP (GM HSCP)

2.1 Of the full £23.226m transformational funding award, £7.9m has been allocated within 2017/18. Transformational programmes are now being implemented at pace across the economy and expenditure profiles are being examined to understand the potential benefits in year.

2.2 Monitoring of the Investment Agreement within the locality takes place on a fortnightly basis at the Finance Economy Workstream and at the quarterly Care Together Programme Board. In addition, Greater Manchester Health and Social Care Partnership require quarterly returns and a self-assessment process is being undertaken.

2.3 The Greater Manchester Health and Social Care Partnership have requested applications for the Greater Manchester Digital Fund. Tameside and Glossop has submitted a bid for £4.77m as this is the capital required to deliver our IM&T ambitions. However, as the Greater Manchester Digital Fund is constrained and bids are likely to far exceed the allocation available, we have also broken the £4.77m into phases to ensure that as a minimum, we receive sufficient funding to continue the current drive to improve connectivity. If our Digital Fund submission is not successful, we will submit a further application to the Greater Manchester Transformation Fund.

2.4 The Greater Manchester Health and Social Care Partnership have unfortunately not yet confirmed the £995k programme management support which we submitted on 23 March. We continue to press for this funding.

2.5 Our Programme Management Office is well represented throughout the governance and operational structures at the Greater Manchester Health and Social Care Partnership. We continue to ensure we remain aligned with the Greater Manchester Health and Social Care Partnership vision and direction of travel, learn from best practice opportunities elsewhere and where appropriate, support the development of central and other locality plans.

3. PROGRAMME MANAGEMENT

3.1 As reported at the last meeting, the governance processes implemented in our Programme Management Office have been commended by Greater Manchester Health and Social Care Partnership. Over the summer, we have supported the Greater Manchester Health and Social Care Partnership Programme Management Office team and they have confirmed that they will be adopting our system more widely.

3.2 The Programme Management Office has successfully recruited to all 4 positions and will be fully established from beginning of October.

4. OPERATIONAL PROGRESS

Single Commissioning Function

3.1 At its meeting on 26 July 2017 the Clinical Commissioning Group's Governing Body considered a report proposing revisions to its governance. The main driver for the review was the recognition that the governance arrangements for the Single Commission are maturing and there is a need to ensure duplication is minimised. Governing Body considered whether existing structures continue to be fit for purpose, if the leadership is correct for each constituent part, and if it is delivering value for taxpayers' money.

3.2 The Governing Body agreed the following key proposals:

- Introduction of a Stakeholder/Partners Strategic Engagement Forum, to be held quarterly and chaired by the Elected Member for Health and Social Care.
- Monthly meetings of the Single Commissioning Board, Finance Committee, Primary Care Committee, and Health and Care Advisory Group (previously known as Professional Reference Group).
- Introduction of a new Quality, Performance, and Assurance Group to meet bi-monthly and to be chaired by the Clinical Commissioning Group's Governing Body Nurse.
- Audit Committee moves to five times a year and the Governing Body to quarterly. The Remuneration and Terms of Service Committee to meet at least annually.

3.3 Proposed new Chair arrangements for the majority of committees were also agreed.

3.4 The Governing Body agreed the following proposals in relation to the clinical leadership:

- Chair of the Single Commissioning Board/Clinical Commissioning Group Governing Body to continue the leadership role within the Greater Manchester Health and Social Care Partnership Primary Care Reform programme or other programme as appropriate, as well as within Tameside and Glossop.
- Four new leadership GP roles are created with explicit responsibilities to support the Chair, provide clinical input into strategic commissioning decisions, and bring wider GP perspectives to place based public services.
- Three of these GP leadership roles will drive commissioning of the Starting, Living, and Ageing Well public sector agenda. They will be accountable to the Chair of the Single Commissioning Board and be expected to work across organisational boundaries to support delivery of new models of care. For example, the Living Well agenda could be developed and led by a lead GP, with a senior commissioning manager, employment specialist, public health consultant, finance manager, and business intelligence lead collectively working to identify population outcomes which support a new method of commissioning mental health services, employment support, Active Tameside etc.
- The fourth GP leadership role will provide clinical support for General Practice and Primary Care.
- One of the posts will need to be elected by the Governing Body membership as Clinical Vice-chair.
- An additional clinical role is created as a Post-CCT Fellowship to cement Tameside and Glossop as an innovative place for training and development and also to aid succession planning within the strategic clinical commissioning leadership. The specific responsibilities for the post will be agreed with the successful candidate and according to their interests.
- The role of Chair of the Single Commissioning Board/Clinical Commissioning Group Governing Body moves to 6 sessions per week.
- Four GP clinical leadership posts at three sessions per week with the Fellowship currently costed as two days per week.
- Each of the leadership clinicians will need to take specific commissioning responsibility for a Neighbourhood and link to the corresponding Integrated Care Foundation Trust Neighbourhood Leads.

- An advert to be drafted to recruit three Governing Body GPs (from 1 April 2018) and to be employed by the Clinical Commissioning Group subject to clarification of the Employment Status of the Governing Body GPs.
- The Chair ensures clarity on the deliverables required in each leadership area on an annual basis.
- Each lead will be a formal attendee of the Single Commissioning Board and of the Clinical Commissioning Group Governing Body. Other statutory committees will not require representation from all and, collectively, the GP clinical leads will allocate responsibilities and determine best coverage and use of time
- The previous five Clinical Commissioning Group Neighbourhood Leads posts transferred to the Integrated Care Foundation Trust on 1 April 2017. This arrangement needs to be formalised to provide the Integrated Care Foundation Trust with £228,150 to support these sessions. Should the Integrated Care Foundation Trust wish to increase the number of sessions, the additional funding will be a matter for the Trust.
- The Named GP for Children's Safeguarding remains with one session per week to ensure the continued focus in this area.
- The Chief Finance Officer, Lay Members, and Governing Body Nurse costs all remain as agreed in the opening budget for 2017/18.
- All other posts within the commissioning clinical leadership structures will be reviewed to determine future need for these roles and, if clear objectives remain, whether it is more appropriately a Single Commission or Integrated Care Foundation Trust role.

3.5 The Governing Body was of the opinion that these recommendations strengthen the clinical leadership within the Strategic Commission and Clinical Commissioning Group, reduce some capacity back into the system through a reduction in the frequency of some meetings, and represent good value for the public purse. It is noted that the introduction of the post-CCT Fellowship Governing Body role is highly innovative and will help to evidence how Tameside and Glossop is a dynamic place in which to work as a GP.

3.6 In line with the Clinical Commissioning Group's Constitution these recommendations were put to the wider GP membership of Tameside and Glossop by an email from Dr Alan Dow on 7 August 2017. The feedback received by the stated deadline of 31 August 2017 was overwhelmingly positive.

3.7 The key next steps taking place during September 2017 are as follows:

- The five GP Neighbourhood Groups are minuting from their September meetings that they have reviewed and supported the recommendations. This will provide useful evidence of the Clinical Commissioning Group's membership support when applying to NHS England for the Constitution changes.
- Dr Alan Dow has been invited to the 11 September meeting of the Local Medical Committee to explain the proposals to this GP representative group.
- At its meeting on 27 September the Governing Body meeting will receive a report summarising the membership responses and seeking formal support to approach NHS England in order to make the formal changes to the Constitution.
- From October 2017 work will be undertaken in preparation for the anticipated approval from NHS England.

3.8 The new Governance Structure is attached at **Appendix A** and the new Clinical Leadership Structure at **Appendix B**.

3.9 The Single Commission has launched a consultation on proposals for Intermediate Care. This will be explored in detail under a separate agenda item.

Integrated Care Foundation Trust

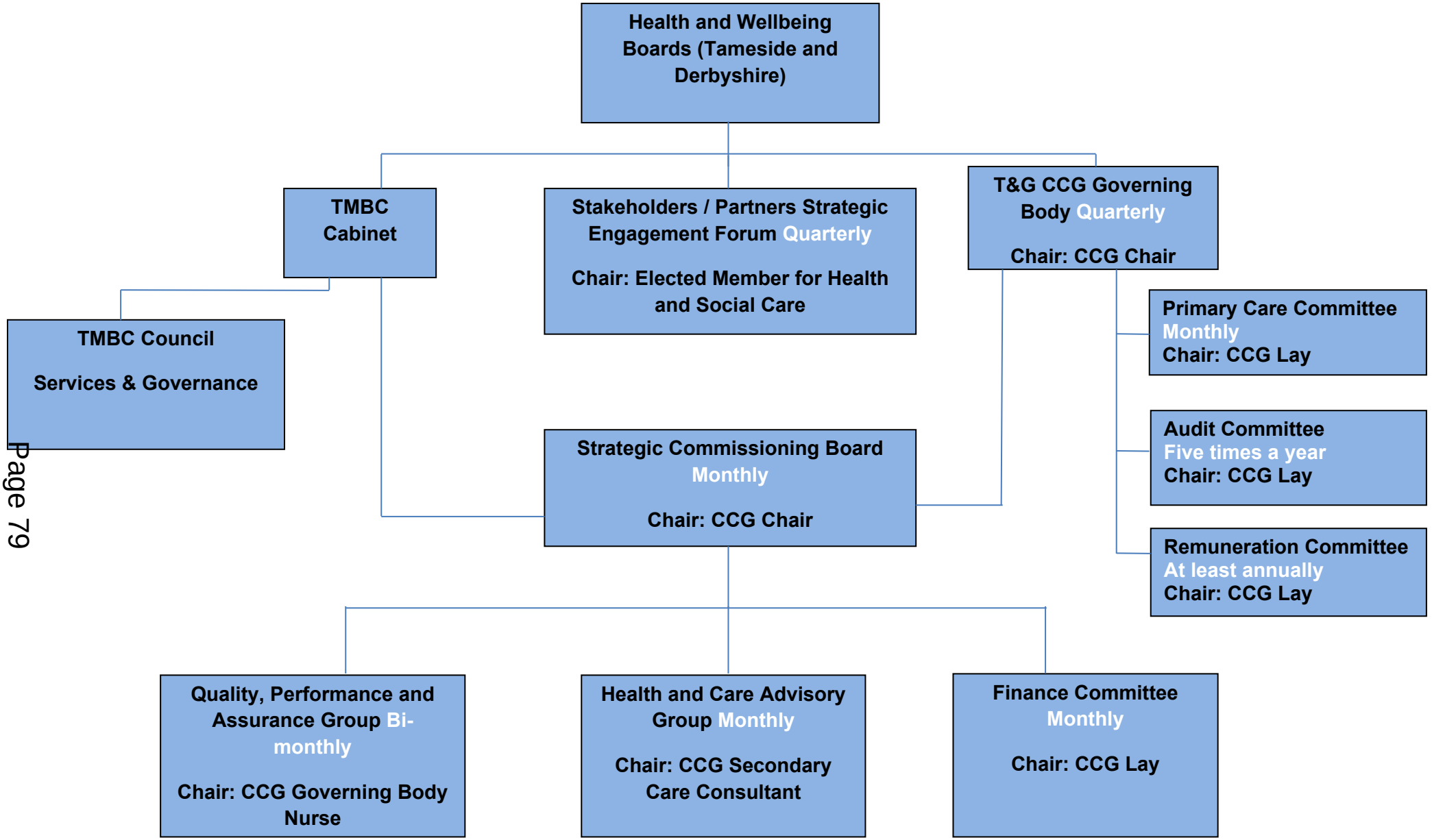
3.10 Work continues to determine the full remit for the Integrated Care Foundation Trust and to align services accordingly. As well as the transformation and transaction of Integrated

Neighbourhoods, discussions regarding mental health, how to optimise working with a variety of voluntary, community and faith sector groups and potentially, the alignment of primary care are being discussed.

3.11 Key in the development of the Integrated Care Foundation Trust is the transformation and management of Adult Social Care. The agreed timetable for the Adult Social Care transaction process will be brought to the next Health and Wellbeing Board.

4. RECOMMENDATIONS

4.1 As stated on the front of the report.


Health and Wellbeing Boards (Tameside and Derbyshire)
TMBC Cabinet
Stakeholders / Partners Strategic Engagement Forum Quarterly
Chair: Elected Member for Health and Social Care
T&G CCG Governing Body Quarterly
Chair: CCG Chair
TMBC Council
Services & Governance
Primary Care Committee
Monthly
Chair: CCG Lay
Audit Committee
Five times a year
Chair: CCG Lay
Strategic Commissioning Board
Monthly
Chair: CCG Chair
Remuneration Committee
At least annually
Chair: CCG Lay
Quality, Performance and Assurance Group Bi-monthly
Chair: CCG Governing Body Nurse
Health and Care Advisory Group Monthly
Chair: CCG Secondary Care Consultant
Finance Committee
Monthly
Chair: CCG Lay

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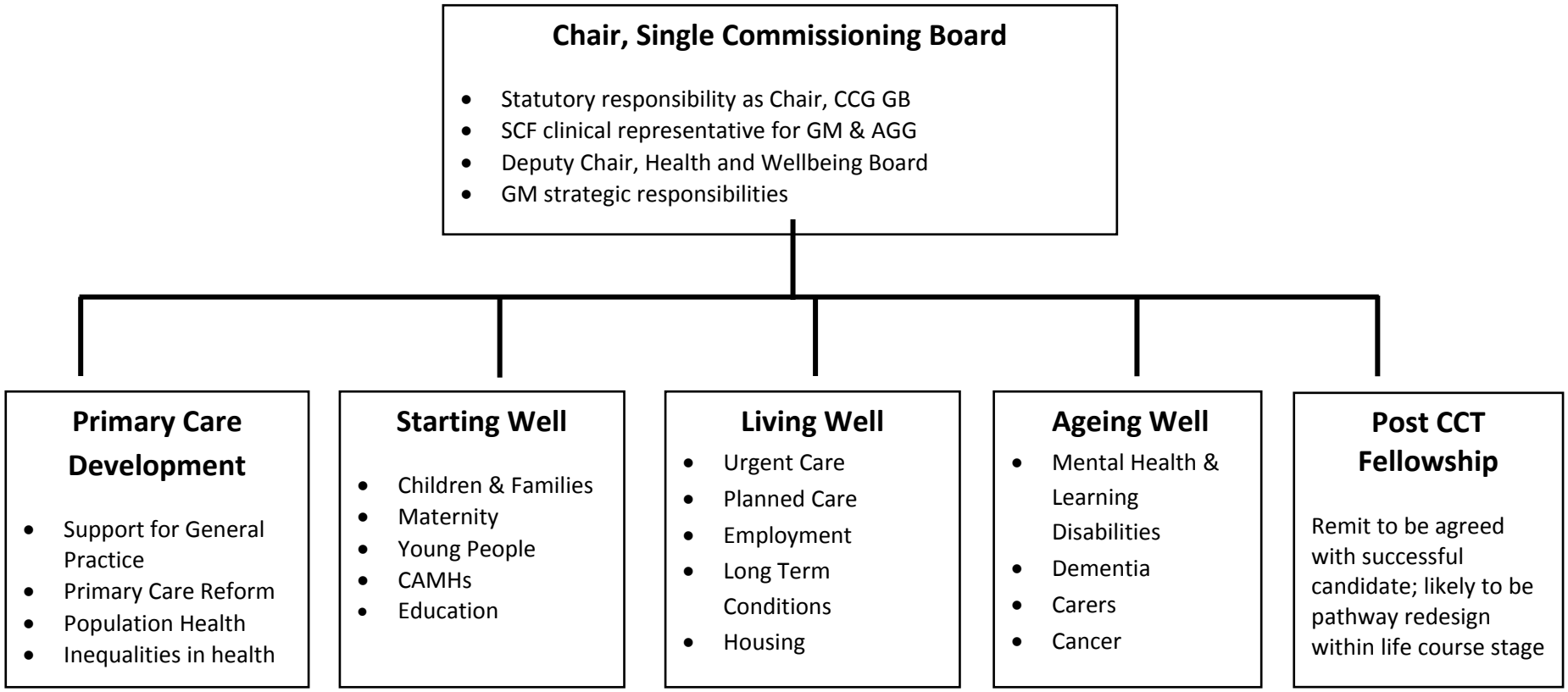
Strategic Commissioning Function: Clinical Leadership Roles



To note;
All are members of the Strategic Commissioning Board.
All are 3 sessions per week with the exception of Chair at 6.
Each Clinical Lead (except for post CCT Fellowship) to take commissioning leadership responsibility for one of the Neighbourhoods.

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Report to :	**TAMESIDE HEALTH AND WELLBEING BOARD**
Date :	21 September 2017
Executive Member / Reporting Officer:	Angela Hardman, Director of Population Health Anna Moloney, Consultant Public Health
Subject :	**SEASONAL FLU IMMUNISATION PROGRAMME**
Report Summary :	National Guidance for the seasonal flu campaign 2017/18 has been issued. The success of the seasonal flu programme is dependent on the collaboration of many stakeholders across the Greater Manchester and local health and social care system. The role of targeted communications is pivotal to the success of the flu campaign. The Tameside and Glossop Clinical Commissioning Group performance for the 2016/17 seasonal flu performance is summarised. The main conclusions from the annual seasonal flu debrief are highlighted with the ambition of increasing flu vaccination uptake during the 2017/18 programme.
Recommendations :	Health and Wellbeing Board to note local performance for the 2016/17 seasonal flu programme plus the arrangements for the 2017/18 flu immunisation programme ; and the relationship between programme success and winter preparedness planning.
Links to HWB Strategy :	Health protection is a core foundation programme of the strategy. Seasonal flu immunisation is a national targeted immunisation programme. It makes an important contribution to the health of older and vulnerable groups including those with long term conditions and those living in residential care.
Policy Implications :	It is a national programme commissioned by NHS England. The Local Authority has an oversight role in assuring the delivery of a high quality effective flu immunisation programme and in doing so will have due regard to principles 3 and 5 of the NHS constitution: Principle 3: The NHS aspires to the highest standards of excellence and professionalism Principle 5: The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
Financial Implications: (Authorised by the Section 151 Officer)	The business case for flu vaccinations is fully supported and while there is no impact on the local authority or on the integrated commissioning fund, the cost of immunisation does impact on delegated primary care budgets which are jointly managed between the Clinical Commissioning Group and NHS England, although the cost of this is insignificant when compared to the potential cost of flu, both in primary care and for hospital admissions.

Legal Implications: (Authorised by the Borough Solicitor)	Local authorities have a statutory duty to have regard to the NHS Constitution (patients charter) when exercising their public health functions under the NHS Act 2006: https://www.gov.uk/government/publications/the-nhs-constitution-for-england In particular, this means that when making a decision relating to public health functions, a local authority must properly consider the Constitution and how it can be applied, in so far as it is relevant to the issue in question. The report author confirms compliance with the NHS constitution in undertaking this programme.
Risk Management :	National programme commissioned by NHS England.
Access to Information :	The background papers relating to this report can be inspected by contacting Dr Anna Moloney by: Telephone:0161 342 2189 e-mail anna.moloney@tameside.gov.uk

1. OUTLINE

1.1 In April 2013 responsibility for commissioning of immunisation programmes transferred to National Health Service England (NHSE). The Greater Manchester National Health Service England (GMNHSE) Area Team has planned and initiated arrangements for this year's Seasonal Flu Immunisation Programme in response to national guidance with the aim of maximising uptake in the targeted populations. Flu is one of the factors that is considered as part of NHS winter preparedness plans.

2. PARTNERS' ROLES AND RESPONSIBILITIES

2.1 The successful implementation of the national flu plan is dependent on a range of organisations fulfilling their roles. These responsibilities are summarised below:

2.2 Department of Health - Flu policy decisions and oversight of the supply of antiviral vaccines. Hold NHS England and Public Health England to account.

2.3 Public Health England - Planning and implementation of the national approach. Surveillance of flu activity and vaccine uptake. Oversight of vaccine supply. Advise NHS England on the commissioning of the flu vaccination programme. Support Directors of Public Health with surveillance data and expert input. Within the Greater Manchester Area Team the Greater Manchester Screening and Immunisation Team have a key role in leadership and co-ordination of the flu plan. Each borough has a named link officer from this team that supports local implementation. The Screening and Immunisation Co-ordinator is a member of the Tameside Health Protection Group, which has a role in coordinating the borough level multi agency flu plan.

2.4 NHS England - Commissioning the flu vaccination programme. Assuring that the NHS is prepared for seasonal flu. Working with Directors of Public Health to ensure local population needs are addressed by providers.

2.5 Local Authorities – Directors of Public Health to provide oversight, advocacy to ensure good access to flu vaccination. Independent scrutiny to the arrangements of NHS England, Public Health England and employers of front line social care staff and other providers of health and social care. Provide leadership with partners if required to respond to flu outbreaks.

2.6 Clinical Commissioning Groups - Quality assurance and improvement of primary care services delivering the flu plan. Commissioning of flu immunisation for pregnant women via is via the Greater Manchester maternity services specification.

2.7 GP Practices - Vaccine ordering for eligible practice population. Issuing patient invitations. Prescribing antiviral medication according to Department of Health policy. Facilitate flu vaccination of their own staff.

2.8 Pharmacists can choose to deliver the national flu vaccination specification where all eligible at risk adults can choose to receive their vaccination by a participating pharmacist.

2.9 NHS and Social Care Employers - Management of flu vaccination for frontline staff.

2.10 Within the Greater Manchester Area Team the Greater Manchester Screening and Immunisation Team have a key role in leadership and co-ordination of the flu plan. Each borough has a named link officer from this team that supports local implementation. The Screening and Immunisation Co-ordinator is a member of the Tameside Health Protection Group, which has a role in coordinating the borough level multi agency flu plan.

3. NATIONAL GUIDANCE

3.1 National guidance was issued in March 2017 for the 2017/18 flu immunisation programme. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/600532/annual_flu_plan_2017to2018.pdf

3.2 Groups eligible for the 2017/18 programme are:

- Those aged 65 year or over (delivered by GP practices, pharmacists);
- Those aged under 65 in a clinical at risk group (delivered by GP practices, pharmacists);
- Pregnant women (delivered by midwives, GP practices, pharmacists);
- All 2 and 3 year olds (delivered by GP practice);
- Children in reception class and Year 1, 2 ,3 and 4.(delivered by Intrahealth);
- Frontline health and social care workers (delivered by employer);
- People living in long stay residential care homes or other long stay facilities (delivered by GPs);
- Carers (delivered by GPs, pharmacists).

3.3 Flu vaccination of preschool and school aged cohorts is important for their own protection and also to reduce the risk of transmission in communities.

3.4 Compared to the 2016/2017 season the 2017/18 programme now includes reception (4 to 5 year olds), school year 4 (8 to 9 year olds) and morbidly obese people with a BMI of 40 or more.

4. RISKS

4.1 Flu is one of the factors that the health and social care system considers as part of winter preparedness. Risks to programme success are mainly related to vaccine effectiveness, disruption to supply networks or a change in the predicted circulating flu strains. Risk mitigation plans are prepared by Public Health England, NHS England and the Department of Health. Local surge and outbreaks plans would need to be activated if there were extra cases placing pressure on care locally.

5. MONITORING

5.1 Monitoring will involve immunisers recording activity on the national IMMform system from 1 September until early February 2018. In addition the Single Commissioning Function also monitors this data from October to assess uptake in Tameside and Glossop Practices. Practices are notified of any flu vaccinations administered by third parties such as local pharmacists, midwives and Intrahealth, the school programme provider.

6. COMMUNICATIONS AND PROMOTION

6.1 Flu campaign material and training resources can be accessed on; https://www.gov.uk/government/collections/annual-flu-programme

6.2 In addition Public Health England's, collaboration with the NHS England and the Department of Health on the Stay Well This Winter integrated campaign will involve this year's seasonal flu marketing campaign which will run from 9 October to 17 December 2017 in two stages:

Phase 1 – Flu vaccination campaign will run from 9 October to 29 October 2017 aiming to:

1) Support reported flu vaccination uptake amongst key target groups (pregnant women, children, and those with long term health conditions);
2) Improve awareness of the nasal spray among parents of 2–3 year olds;
3) Continue to promote reasons to get the flu vaccine to pregnant women.

Phase 2 – Winter (First Signs) will run from 6 November to 17 December 2017, looking to:
1) Maintain high levels of awareness of the winter campaign among at-risk groups (Adults aged 65+, LTC and Carers)

National evaluation of the 2016/17 of Stay Well This Winter saw the flu campaign recognition reaching 79% among pregnant women and 71% among parents. 70% of the audience knew that nasal spray is the vaccination method for children, while 78% agreed that "flu is a serious and debilitating illness". Flu vaccination levels in pregnant women and Long Term Conditions have increased, but the correlation between marketing activity and the increase in uptake remains the subject of further analysis.

6.3 Throughout the flu season PH England will publish a weekly flu report detailing levels of circulating flu strains.

6.4 Locally planned communications will need to be coordinated with the Clinical Commissioning Group Communications Lead Officer. The Primary Care Commissioning Team is seeking a Practice Flu lead for every General practice in line with national recommendations.

7. PERFORMANCE

7.1 Table 1 shows that overall Tameside and Glossop Clinical Commissioning Group has attained a very good position within national Clinical Commissioning Group rankings for adult flu vaccination. Locally there has been an increase in uptake in clinical at risk groups under 65 and pregnant women. The picture is less favourable for the pre-school cohort and this picture is seen across the Greater Manchester area. There is considerable practice variation in performance which is most stark in the pre-school cohort.

Table 1: Comparative National / Greater Manchester ranking and flu vaccination uptake for 2015/16 and 2016/17

Ranking

	2015/16	2016/17	Target/Ambition	2016/17 % uptake (practice variation)
For those aged 65 or over				
National Rank*	13	18	75%	74.4% ↓0.6%
GM Rank	4	4		(85.6%-65.7%)
Clinical at risk groups aged 6 months to 65 yrs				
National Rank	5	11	55%	55.8% ↑3%
GM Rank	3	4		(71.1%-43.3%)
Pregnant Women				
National Rank	6	11	55%	54.4% ↑2.1%
GM Rank	2	2		(77.3%-38.3%)
2 year olds				
National Rank	61	144	40% -65%	38.5% ↓1.5%
GM Rank	3	6		(91.3%-8%)
3 year olds				
National Rank	61	92	40%-65%	43.7% ↑1.3%
GM Rank	3	6		(73.1%-10.6%)
4 year olds				
National Rank	82	148	40%-65%	29% ↓3.1%
GM Rank	6	8		(65.7%-4.3%)

• National ranking is out of 211 CCGs (practice variation

7.2 **Tameside Schools Flu Programme Performance (Ambition 40%-65%)**
Tameside's local performance for the school based programme compares favourably to the GM average and also approaches the national England average, as shown in Table 2.

Table 2: Tameside schools performance 2015/16 and local, Greater Manchester and national performance for 2016/17

	Tameside 15/16	Tameside 16/17	GM average 16/17	Eng Average 16/17
Year 1	57.5%	56.6%	51.9%	57.6%
Year 2	54.6%	54.1%	50.2%	55.4%
Year 3	N/A	50%	47.5%	53.3%

Glossop schools uptake is reported with Derbyshire data.

7.3 **Carers' uptake**.
The uptake for Carers was 51.8% in 2016/17 which represents a welcome 8.3% increase in uptake from 2015/16.

7.4 **Frontline HealthCare Workers**
The Integrated Care Foundation Trust reported 65.5% which represents a 4% increase but fell short of the 75% Commissioning for Quality and Innovation (CQUIN) target. NHS England has published a 2 year CQUIN covering 2017/18 and 2018/19 which includes an indicator to improve the uptake of flu vaccinations for frontline healthcare staff within providers. The previous 2016/17 CQUIN target was 75%, however within the revised CQUIN it is now 70% rising to 75% in the second year.

Locally of the 12 general practices reporting staff uptake data, 73.7% of practice staff received a flu vaccine.

7.5 **Performance improvement**
An annual flu debrief occurs at the conclusion of the season when Public Health England performance reports are released to localities. The essence of action for all stakeholders involved is effective continuous communication to promote awareness of the vaccination among at risk groups, their carers and frontline health and social care staff. Primary care colleagues have received information on performance at a practice, neighbourhood and locality level. A key strategy is to reduce the variation seen among practices and promote continuous improvement in stakeholder forums. The national change to include children in reception class within the schools programme has been welcomed and it is anticipated this will significantly improve uptake in 4 and 5 year olds

8. GOVERNANCE

8.1 The Tameside Health Protection Group oversees the co-ordination of the local seasonal flu campaign. In addition a local monthly teleconference is held with a wider range of stakeholders, including Public Health England to update on performance, national and local communications and agree key actions as the season unfolds.

9. RECOMMENDATIONS

9.1 As set out on the front of the report.

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 September 2017
Executive Member / Reporting Officer:	David Berry, Head of Employment and Skills
Subject:	**TAMESIDE HEALTH AND EMPLOYMENT**
Report Summary:	Devolution has presented Greater Manchester with the opportunity and ability to deliver improved health outcomes by supporting people to contribute and connect to growth. This report provides the Health and Wellbeing Board with an update following last year's report outlining the major employment initiatives in Tameside and the current success, progress and opportunities to integrate with health services.
Recommendations:	The Health and Wellbeing Board are requested to: 1. Note the employment initiatives taking place in Greater Manchester and Tameside recognising the work that has taken place to date to integrate work, skills and health services. 2. Consider the Health and Employment Implementation Plan. 3. Actively promote and support the development and delivery of the Health and Employment Implementation Plan and Pilots, Programmes and approaches detailed in the report to deliver work, skills and health integration in Tameside developed alongside Greater Manchester Models. 4. Consider how the Health and Wellbeing Board could support the identification of funding for a scaled up model following full evaluation of the Healthy Hattersley Pilot.
Links to Health and Wellbeing Strategy:	This report delivers specifically to the working well strand of the strategy.
Policy Implications:	This work has implications for the longer term health and work system economies in reducing demand through improved levels of health. This work is also designed to provide improved patient experience and access.
Financial Implications: **(Authorised by the Section 151 Officer)**	The report provides and update on the employment initiatives across Greater Manchester and the Tameside locality. Any associated financial benefits realised within the Healthy Hattersley Pilot (as explained in section 3.4 of the report) will be considered within the evaluation of the scheme. The details of any benefits realised will be included within a business case which will consider opportunities to potentially scale up the model to work in combination with the Self Care and Health Integrated Neighbourhood Teams. It is essential that any investment required to scale up the model is also identified within the business case together with the source of the associated investment.

Legal Implications: **(Authorised by the Borough Solicitor)**	The successful integration of work, skills and health services is essential to achieving the Greater Manchester Growth Strategy and reform of Health and Social Care. Effective integration will improve services for residents and reduce public spend on high demand provision therefore reducing longer term risk of affordable and quality services.
Risk Management:	There are no risks associated with this report.
Access to Information:	The background papers relating to this report can be inspected by contacting – David Berry Head of Employment and Skills Tameside Council  Telephone:0161 342 2246  e-mail: david.berry@tameside.gov.uk

1.0 INTRODUCTION

1.1 This report sets out the progress and success made in the last 12 months to integrate Health, Employment and Skills in Tameside within the context of a new 12 month implementation plan. This update is set within the context of work by the Greater Manchester Combined Authority and Health and Social Care Partnership.

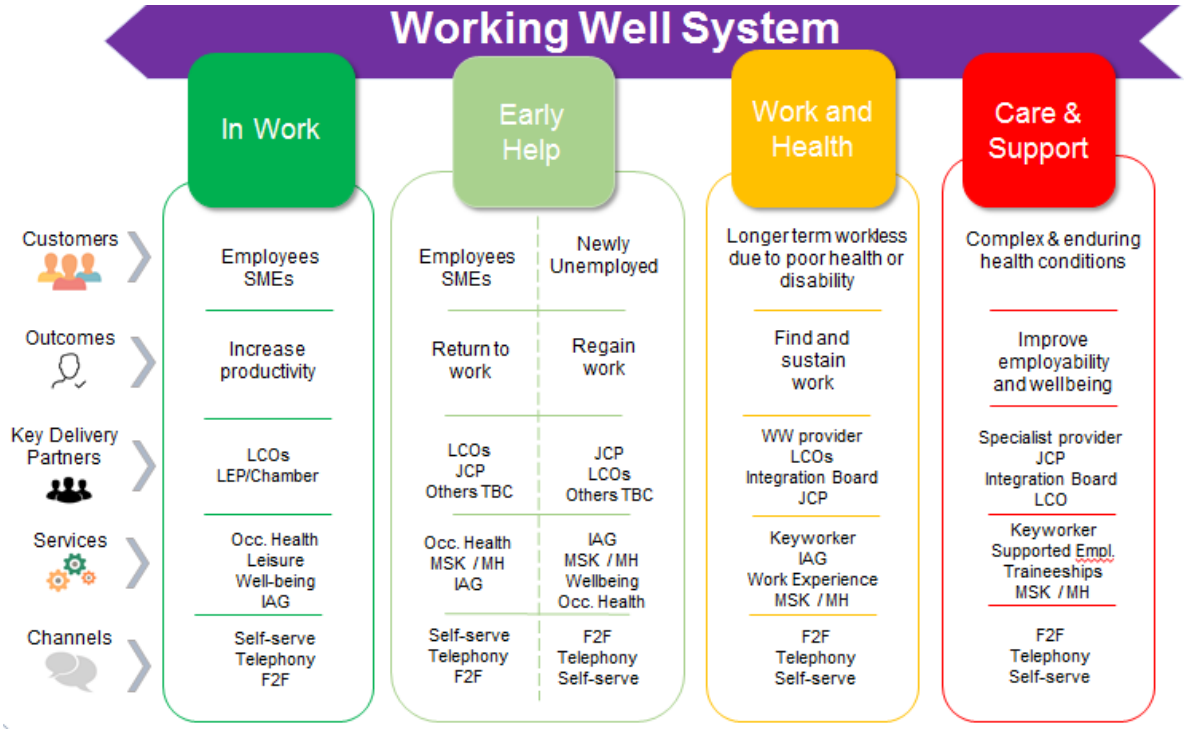
1.2 The Health and Employment implementation plan aims to shape existing and future service models and commissioning strategies and is set out for the consideration of the Health and Wellbeing Board at section 3.2 of this report. Our work supports the delivery of the GM Population Health Plan Live Well objective: *To build and test an approach to work and health that improves the integration and alignment of health, employment and other services*.

1.3 The Health and Wellbeing Board is asked to note the progress achieved to date and consider the plans and opportunities to deliver further integrated work and health services.

2.0 GREATER MANCHESTER LEVEL

2.1 In the last 12 months a clear programme of work has developed from Greater Manchester endorsed and driven by the Greater Manchester Combined Authority and Greater Manchester Health and Social Care Partnership.

2.2 This work is set out in the diagram below with the intention of putting a co-ordinated Greater Manchester offer in place across the entire system:



2.3 Activity is currently focused on two elements of the Working Well System:

- Working Well Work and Health Programme – this is currently out for tender (contract value £52m) with a start date of February 2018 providing a service to 22,600 Greater Manchester residents up to 2024. The service will provide 15 months of tailored key worker support followed by 6 months of in work support. The programme will compliment and integrate with existing Working Well Pilot and Expansion provision.

Tameside Council's Employment and Skills team have been involved in the design, development and procurement of the programme.

- Working Well Early Help – this is currently in design with GPs and Small Medium Enterprises (SMEs) to provide a wrap-around service to support employees who seek a Fit Note from their GP to be positively supported to stay in work with access to occupational health support. The service is estimated to work with around 11,000 GM residents with a contract value of £8m. Tameside Council is engaged in the design of this service and has brokered the engagement of Hyde Neighbourhood GPs to deliver the initiative in Tameside.

3.0 HEALTH AND EMPLOYMENT ACTIVITY IN TAMESIDE

3.1 Following the report to the Health and Wellbeing Board in September 2016 the following activity has taken place to improve service delivery and outcomes for health and employment.

3.2 **Establishment of a Health and Employment Strategy Group** - The Tameside Health and Employment Strategy Group has been set up to develop our approach and produce an implementation plan at its first meeting on the 29 June 2017. The core purpose of the group is set out below:

- Provide direct strategic leadership and promotion of health and employment at a senior officer level to support the aims and approach agreed by Health and Wellbeing Board.
- Agree, support and co-ordinate Tameside's engagement in Greater Manchester initiatives such as the Greater Manchester Health and Employment Programme and where appropriate extend work or share learning into Glossop.
- Produce, co-ordinate and support the delivery of a 12 month Tameside implementation plan directed by the Health and Wellbeing Board.
- Provide a forum to discuss emerging health and employment projects to ensure co-ordination and develop new officer networks to support integration.
- Identify and remove system blockages to integrating our health and employment approach.
- Consider opportunities to deliver the wider Public Service Reform agenda through Place Based Initiatives, workforce development and other work as appropriate.

Membership of the group includes:

- Clare Watson, Director of Commissioning, Tameside and Glossop Single Commissioning Function (Joint Senior Responsible Officer)
- Damien Bourke, Assistant Executive Director Investment and Development (Joint Senior Responsible Officer)
- Angela Hardman, Director of Population Health
- Anna Maloney, Consultant Public Health Medicine
- David Berry, Head of Employment and Skills
- Chris Easton, Integrated Care Foundation Trust
- Jenny Osborne, Strategic Lead, Health and Employment Greater Manchester Health & Social Care Partnership & Manchester City Council
- Viv Robinson, JCP Partnership Manager Tameside and Oldham
- Pennine Care NHS (to be confirmed)

3.2 The implementation plan is set out below. This plan sets a SMART approach for delivery over the next 12 months and will develop as appropriate to external factors and resource and capacity available. The plan includes our commitment to support the development of a Greater Manchester Early Help offer and successful implementation of the Work and Health Programme locally.

Ref	Item	Lead(s)	Sponsor	Outcome	Status	Deadline
1	Develop state of readiness document for GM Working Well Early Help Project - and review the wider Tameside and Glossop and infrastructure	David Berry	Director of Commissioning	Understand our strengths, areas for improvement, assets and capacity	Complete	Jun-17
2	Deliver the Healthy Hattersley Pilot and produce end evaluation and utilise existing learning	David Berry	Damien Bourke	Proof of concept pilot delivered integrating health and work services	In progress	Aug-18
3	Formally engage in the GM Working Well Early Help Project design and procurement to deliver in 2018	David Berry Anna Moloney	Angela Hardman	Influenced design of service and strengthened local infrastructure to deliver H&E	In progress	Jun-18
4	Review the Tameside Ask and Offer Work and Health Programme and continually consider improvements	David Berry	Director of Commissioning	Enhance existing delivery of Working Well provision and future WHP	In progress	Feb-18
5	Review how we can influence the commissioning of future contracts to support the integration of health and employment and setting in place a timetable and process to implement our ambitions around commissioning. Review upcoming single commissioning contracts and consider how employment and skills can be integrated into delivery and outcomes	Trevor Tench Ian Bromilow Alison Lewin	Director of Commissioning	Drive a systemic approach to integrating H&E	In progress	Apr-18
6	Influence and engage in the design and implementation of the System Wide Self Care approach and Health Integrated Neighbourhood Teams to integrate H&E	David Berry Kate Benson Debbie Watson	Angela Hardman	Build integration with employment and skills into the universal model	In progress	Feb-18
7	Update on progress and gain system wide support via report to September Health and Wellbeing Board	David Berry Anna Moloney	Angela Hardman	Achieve system wide buy-in for our plans, remove identified	In progress	Sep-17
8	Develop approach to Tameside and Glossop health footprint where GM or Tameside employment offers restrict delivery	Dave Berry Elaine Richardson	Director of Commissioning	Clear approach to how we can utilise our work across the full health footprint	In progress	Dec-17

3.3 The views of the Health and Wellbeing Board are welcome in setting the direction and focus of our work. The plan is intended to be flexible adapting to opportunities to access resource and provide both a strategic and operational mix of activity.

3.4 **Delivery of the Healthy Hattersley Pilot** – The Healthy Hattersley Pilot ran from 31 October 2016 to 31 August 2017. The Pilot was funded by the Hattersley Land Board (£59,999) and aimed to test the value of GP patient referrals into work and skills services. Adullam Housing delivered the direct Healthy Hattersley Service using a key worker model to provide personalised support. The Pilot also linked with the Working Well Expansion increasing capacity and opportunities for patients. A full evaluation of the pilot is being prepared following the conclusion of the Pilot on the 31 August 2017. Overall the Pilot has been a success with 5 patients starting employment (above contract target based on engagements) and GP surgeries effectively referring patients alongside a self-referral

process connected to the practices. Patients reported positive changes in their understanding and management of conditions. 98 patients were referred into the pilot with 23 accessing the Healthy Hattersley service and 23 referred onto Working Well. 3 GP practices (Hattersley Group Practice, Awburn House and Donneybrook) participated in the Pilot. The key learning from the Pilot is set out below.

- GP and Practice Managers found the service to be easy to use with documentation and the referral process non-bureaucratic. In particular patients fed back positive experiences of the service.
- 94% of patients rated the service Good or Excellent.
- Patients can be supported into work 5 of 23 (21%) secured employment through the Healthy Hattersley direct provision, with improvements in patients management and understanding of their conditions. 20% of the patients referred onto Working Well provision can also be expected to start work over the course of the 2 years of support they receive.
- The GP referral route is effective and should be scaled up with the understanding that it requires quality relationship management with the practice and referrals will not be high in volume until embedded.
- Establishing a sustainable and quality referral route is dependent on identifying and supporting individual GPs rather than expecting a consistent, volume flow across all GPs within a practice.
- The pilot approach enabled us to test and learn alongside and taking advantage of the Working Well service. Utilising the additional capacity to refer into the Working Well Expansion was an effective use of resources, however this brought additional complexities to the referral route and future commissioned work should focus on streamlining provision.
- GPs welcomed the ability to provide an option for their patients to move into a service that would support their wider needs (that sit outside a GPs control – GPs sometimes feel like Citizens Advice) and specifically employability.
- Patients entered the pilot with significant support needs include substance misuse, confidence, wellbeing, housing and homelessness and low skills.

3.5 The next step is to complete a full evaluation, prepare a costed business case and identify and consider opportunities to scale up the model to work in combination with the Self Care and Health Integrated Neighbourhood Teams.

3.6 **Agreement to design and implement the GM Working Well Early Help programme with Hyde Neighbourhood GPs** – As a legacy of the Healthy Hattersley Pilot we have agreed to design and deliver the Greater Manchester Working Well Early Help service with GPs in the Hyde Neighbourhood area. Dr Gutteridge and Dr Harvey will act as GP leads as our locality contributes to the design of this £8m Greater Manchester programme. This programme brings in additional services to Tameside at no cost to our locality. The Greater Manchester Working Well - Early Help programme will design and test an early intervention service to people with health conditions, who are at risk of falling out of employment, or are newly unemployed. Greater Manchester recognises that there is a co-dependent relationship between health and work: good quality work supports good health, and economic growth relies on a healthy, productive workforce. To this end the Greater Manchester Combined Authority and Greater Manchester Health and Social Care Partnership leadership have agreed to develop this joint programme to provide:

- An effective early intervention system available to all Greater Manchester residents in work who become ill and risk falling out of the labour market, or are newly unemployed due to health issues.
- Better support for the diverse range of people who are long-term economically inactive to prepare for, find and keep work.

- Development to enable Greater Manchester employers to provide 'good work', and for people to stay healthy and productive in work.

3.7 The rationale for the service is set out below:

- Currently no effective or systematic early intervention pathway to prevent people with health conditions falling out of work.
- 98% of Greater Manchester Employers are small or medium sized enterprises or self-employed, covering over 50% of the working Greater Manchester population. They have little or no access to occupational health/ Employee Health and Wellbeing support.
- The NHS struggles to respond rapidly to the needs of those in work, and the Fit note system can be ineffective from both GP and employer perspective.
- Increasing number of people living with long-term conditions and raising of retirement age.
- National Fit For Work Service not effectively meeting local need – Greater Manchester can do this better locally.

3.8 The proposed objectives are provided below:

- Reduce the number of days lost to sickness absence for those in employment;
- Prevent GM residents with health conditions from leaving the labour market;
- Support businesses to retain employees and better manage health in the workplace;
- Reduce time spent by clinicians on non-clinical work in primary care;
- Support newly unemployed people with health conditions to access an enhanced health support offer to facilitate an early return to work.

3.9 The outline timeframes for the programme are:

• Detailed service design; evaluation development	Jul-Oct '17
• Joint Investment bids and procurement options appraisal	Nov '17
• Procurement/funding	Jan '17
• Mobilisation	July-Oct 18
• Service commences to 2021/2	Nov '18

3.10 **Development of employment pathways within the Self Care approach and Health Integrated Neighbourhood Teams** – Employment must be embedded within our local models to appropriately support residents with health conditions. The Employment and Skills team are actively engaged in the development of the self-care and social prescribing offer as part of the Oversight Group for System Wide Self Care. Enabling an effective pathway into existing (as set out in **Appendix 1**) or future employment and skills provision will provide an enhanced offer for patients to manage their conditions. It is important that employment and skills provision is part of the core social prescribing offer and not a secondary element. Further work is ongoing to develop our approach and realise our ambitions.

3.11 **Integration of core programmes** – In the September 2016 report to the Health and Wellbeing Board a clear approach was set out to integrating core employment programmes within Tameside (see **Appendix 1 and 2**). This approach has been successful delivering improved outcomes for residents with some key examples of our efforts set out below:

- Motiv8 (Building Better Opportunities) is operating well in Tameside and has successfully developed alongside existing work and skills provision (this has not been the case across all Greater Manchester areas). Motiv8 is incorporated into the Tameside Working Well Steering Group to enable effective integration and reduce duplication.
- Tameside has the best integration in Greater Manchester between the Working Well Expansion and Skills for Employment contracts. 39% of referrals to Skills for Employment in Tameside come from Working Well (compared to 10% in Stockport and 16% in Wigan), we also have the best conversation of job starts from the Working Well

client group 32% (compared to Bolton 3%). These measures of integration reveal that our approach through the Working Well Steering Group enables us to create the right environment and conditions to integrate services.

- Tameside has the second highest GM referral rate into Talking Therapies provision 23% (highest Bury 32%, lowest Rochdale 7%). Talking Therapies was commissioned by Greater Manchester alongside the Working Well Expansion to provide additional mental health provision (Cognitive Behavioural Therapy) for Working Well clients.
- Working Well continues to perform strongly in Tameside in relation to referrals, attachment of clients to receive the service and job starts. The vast majority of clients on Working Well have a physical or mental health barrier to employment:
    - Referrals and attachments – Tameside has contributed 1893 (9%) of referrals and attachments across the Pilot and Expansion;
    - Tameside has contributed 157 (9%) of job starts across the Pilot and Expansion, this puts us on target compared to our cohort size (for comparison purposes Oldham has contributed 136 job starts).

3.12 **Preparing for the Work and Health Programme External Local Signposting Organisation (ELSO) pathway** – building on the experience of the GP referral route into the Working Well Expansion the Work and Health Programme will enable 5% of all referrals from an area to originate outside of Jobcentre Plus (JCP) – for example this could be a Registered Social Landlord or NHS services. In Tameside this will equate to around 100 residents. We have proposed that the Hyde Neighbourhood GPs provide the referrals into the Work and Health Programme building on the legacy of the Healthy Hattersley Pilot and further strengthening our service infrastructure between health and employment. Although the figure of 100 residents appears low it should be noted that our experience from the Healthy Hattersley Pilot is that the GP referral route should not be operated at volume, but as a quality pathway that is supported by excellent relationship management.

3.13 The Tameside External Local Signposting Organisation route will be developed with the successful provider once selected and Hyde GP practices, we welcome the support of the Health and Wellbeing Board in supporting our efforts to realise this work. This work will be developed alongside consideration for a scaled up Healthy Hattersley model across our locality.

4.0 PROGRAMMES/POLICY CHANGES

4.1 The Work, Health and Disability Green Paper released in early 2017 has provided impetus for the development of new approaches in relation to Jobcentre Plus detailed below:

- Community Business Partners – This new Greater Manchester based resource will enable Jobcentre Plus to engage and support development of community based provision for claimants with health conditions. The recruitment of the Business Partners is ongoing, Tameside is working with the lead Business Partner on behalf of Greater Manchester to support development of their business plan through the Universal Support Greater Manchester Programme.
- Disability Employment Advisors – The upscaling of Disability Employment Advisors within Jobcentre Plus across Greater Manchester will support Work Coaches to develop their knowledge and understanding of supporting clients with health conditions.
- Small Employer Advisors – This new Jobcentre Plus resource will work with Small Employers across Greater Manchester to develop a disability confident approach.

4.2 Full rollout of Universal Credit to all claimants will begin in Tameside in March 2018. Tameside was a pathfinder for Universal Credit in 2013 testing a limited type and complexity of claim, the rollout will see the full complexity of claim in Tameside. Based on insight from other Greater Manchester areas that have already experienced full rollout of Universal Credit we should expect additional levels of need and support for residents who

struggle on their Universal Credit customer journey. Tameside has high levels of claimants with a health conditions receiving Employment Support Allowance benefit. The issues we should be aware of and prepare for as a partnership which may impact on claimants health conditions and employability include:

- Claimants may be impacted by the requirement to claim online if they do not possess literacy or digital skills or can access appropriate technology.
- Claimants may be impacted by the requirement to wait several weeks for their first payment and then receive monthly payments thereafter into a bank account.
- Increased sanctioning rates as claimants fail to meet their agreed claimant commitment.
- Increased need for access to services to support claimants negatively impacted by the rollout including but not limited to homelessness, personal budgeting, employability, benefit advice, literacy and digital skills.

4.3 The Health and Wellbeing Board should be aware that we continue to work with Jobcentre Plus on the issues set out above continually trying to improve our partnership approach to develop our response including effective management and processing of benefit claims to providing the best possible wrap-around support for the individual (an example of this is our including within the Work and Health Programme Tameside Ask and Offer document that the provider puts in place effective services to support the implementation of Universal Credit).

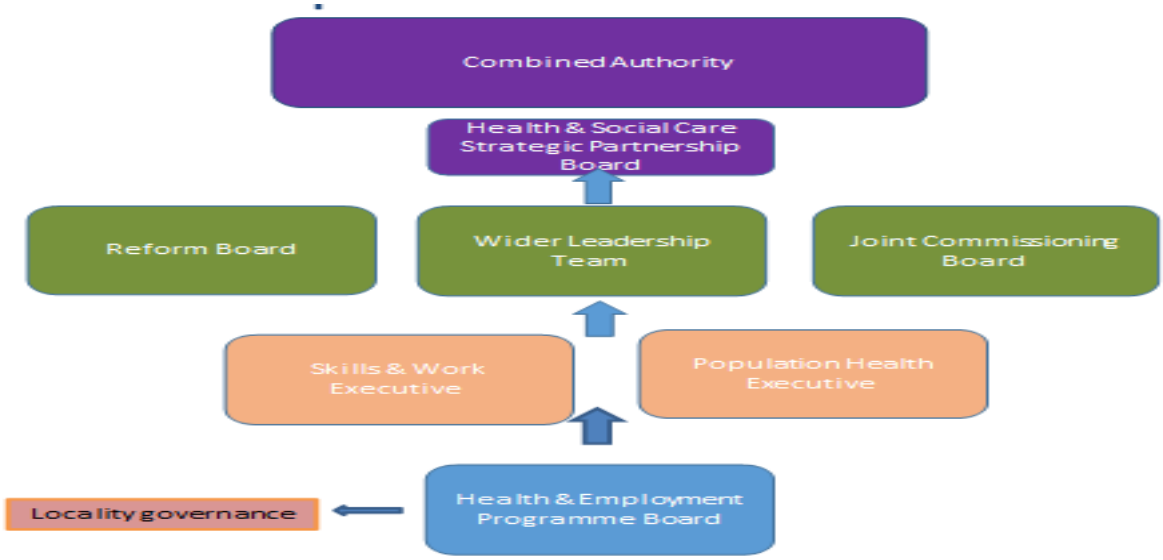
5.0 GOVERNANCE

5.1 The development of Tameside health and employment integration will be strategically and operationally taken forward in the following governance groups.

Strategic
- Health and Wellbeing Board
- Prosperous Board

Operational
- Health and Employment Strategy Group
- Working Well Steering Group
- System Wide Self Care Oversight Group

5.2 A Greater Manchester Health and Employment Programme Board has been developed to take forward this work which reports into Greater Manchester Combined Authority structures and ultimately the Health and Social Care Partnership Board (see structure below).



6.0 NEXT STEPS AND RECOMMENDATIONS

6.1 This report updates on our approach and activity to realise our Health and Employment integration ambitions. The implementation plan sets out our work in the next 12 months. We would welcome the support of the Health and Wellbeing Board in delivering the key activity summarised below:

- Managing the delivery of the Tameside Health and Employment Implementation Plan through the Strategy Group including the review of contracts and developing an integrated approach with Health Integrated Neighbourhood Teams and Self Care model
- Preparing for the delivery of the Working Well Early Help programme with GPs in the Hyde Neighbourhood for implementation in November 2018.
- Implementing the External Local Signposting Organisation referral route for the Working Well Work and Health Programme with GPs in the Hyde Neighbourhood for implementation in February 2018.
- Implementing the Working Well Work and Health Programme from February 2018

7.0 RECOMMENDATIONS

7.1 As set out on the front of the report.

APPENDIX 1

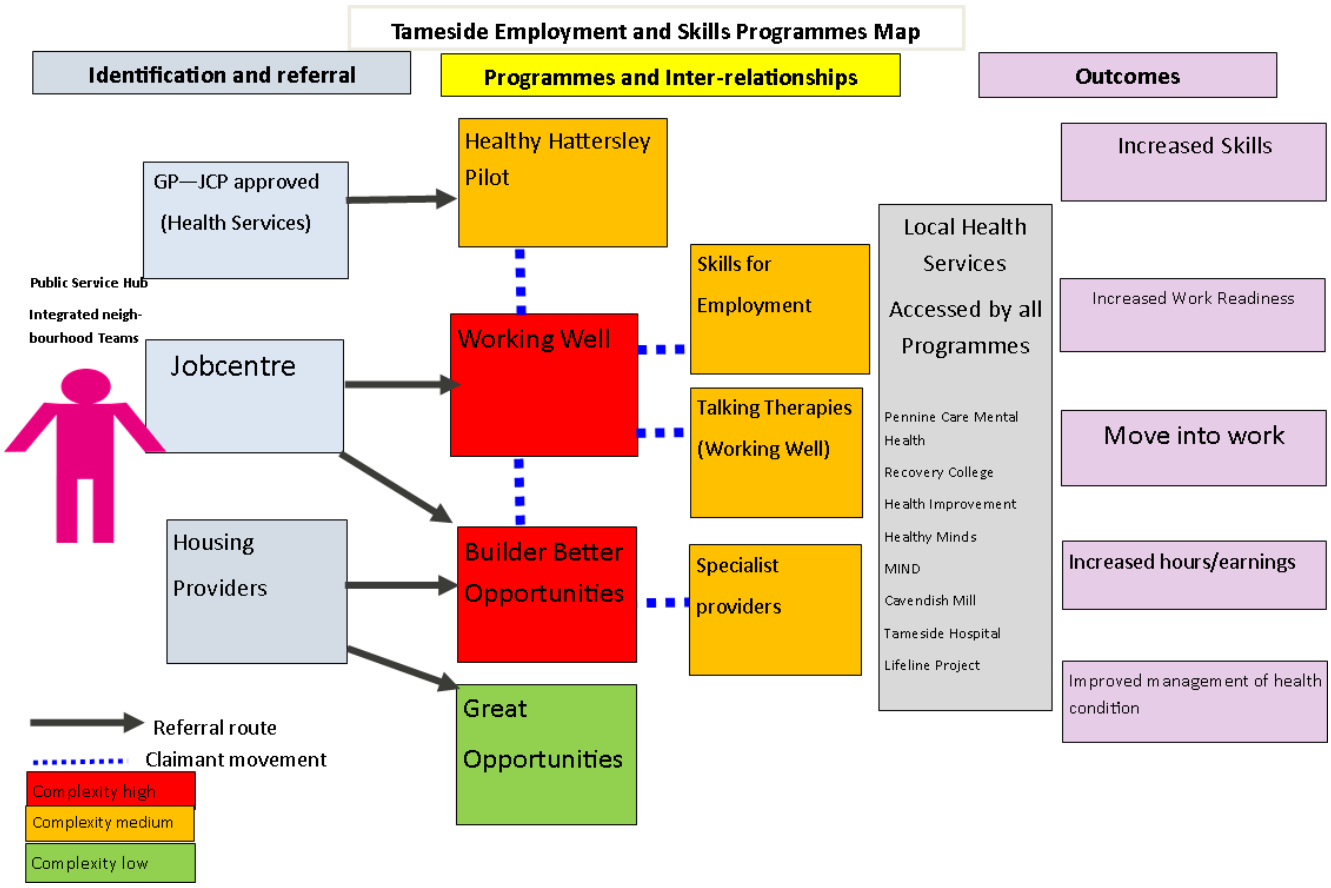
Key Employment and Skills Provision in Tameside

Employment Initiative	Description	Volume Tameside Residents (GM in brackets)	Integration with health	Commissioner	Provider (Tameside)	Delivery timescale
Working Well Pilot	2 year tailored key worker support for residents on ill health benefit (ESA). Referred from Jobcentre	441 (4,985)	All participants have a health condition (67% physical, 64% mental - or multiple), integration has been area led (GM Health Protocol agreed by HWBB 2014)	DWP and GMCA (Salford MBC)	Ingeus	2014-2019
Working Well Expansion (including GP referral route and Talking Therapies Service)	2 year tailored key worker support for residents on various benefit groups (JSA, ESA, UC, LPIS) Referred from Jobcentre and selected GPs	1,452 (15,000)	Majority of participants have health condition, some integration is established within the model (Talking Therapies/GP pilot referral), local areas required to lead on whole system integration	DWP and GMCA (Trafford MBC)	Ingeus	2016-2020
Motiv8 - Building Better Opportunities	3 year tailored key worker support for residents who are most excluded from the job market. Identified by Registered Social Landlords	Estimated 390 (3,990)	High number of participants likely to have a health condition	Big Lottery and European Social Fund	New Charter	2016-19
Work and Health Programme	Maximum 21 months tailored key worker support for • People who have a disability on a **voluntary** basis; • Early access	EST. 2000 (22,600)	In design – intention to focus support on residents with health conditions.	DWP and GMCA	Procurement ongoing	February 2018-2024

	disadvantaged groups on a **voluntary** basis; and • Long-term Unemployed on a **mandatory** basis.					
Healthy Hattersley Pilot	GP Referral pilot to support Hattersley residents with health conditions	Upto 145	Pilot to provide evidence base for further integration of GP and work and skill services	Tameside MBC on behalf of Hattersley Land Board	Adullam	2016-17
Skills for Employment	Tailored key worker skills support (Working Well Expansion and Pilot participants have priority access)	575 to date (6,000)	Majority of Working Well Participants have a health condition.	Skills Funding Agency	The Growth Company (Prime) Inspire to Independence (Sub contractor)	2016-2019
Great Opportunities	Work Club provision to support residents into work, education and training	435	Lifeline (substance misuse) project is an integrated partner	New Charter	New Charter	Ongoing
Troubled Families	Support programme for families (some members of the family may be out of work)	600-1000	The Troubled Families approach is rooted within the Public Service Hub with wrap around support from health agencies.	Department for Communities and Local Government	Tameside Council (Commissioner and Provider) and New Charter (Provider)	Ongoing

APPENDIX 2

Extract from Health and Wellbeing Board report September 2016 – Programmes to integrate these have been successfully integrated in the past 12 months).



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Working Well

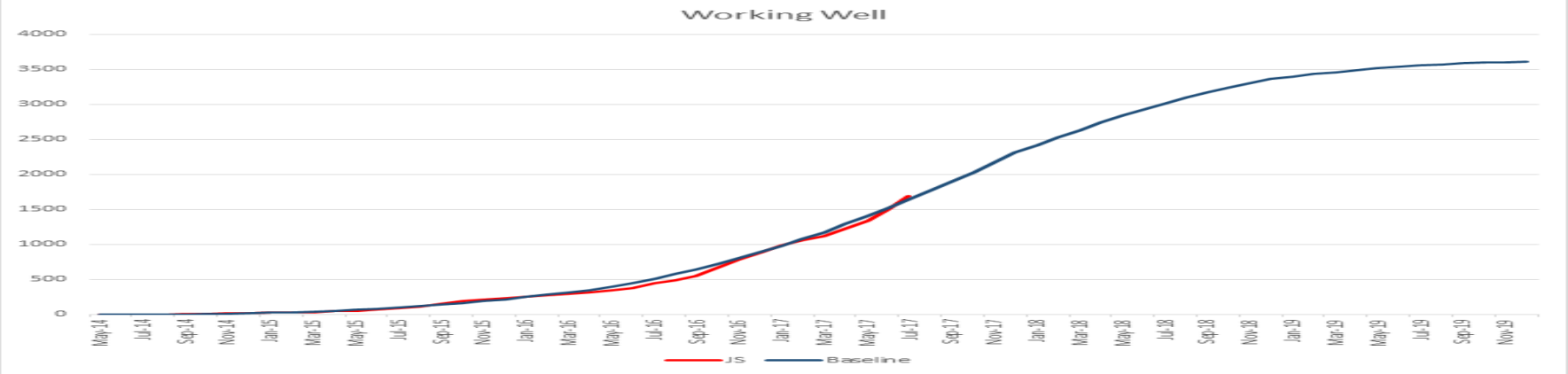
Mat Ainsworth
Assistant Director - GMCA

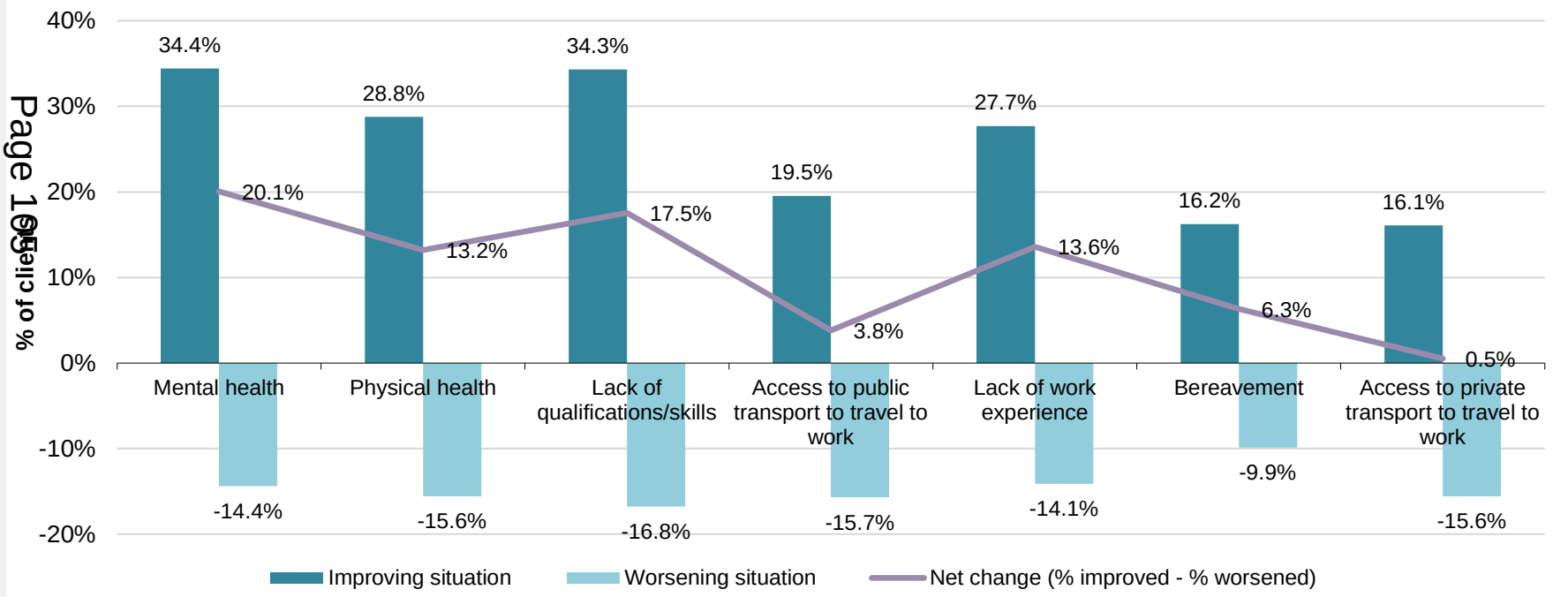
Thursday 21st September 2017

Complex barriers to work to address……

…… Keyworkers and integration boards providing challenge, support and co-ordination

Impact greater than employment…..





..improvements in health, skills, work experience and more

Important messaging through the health system

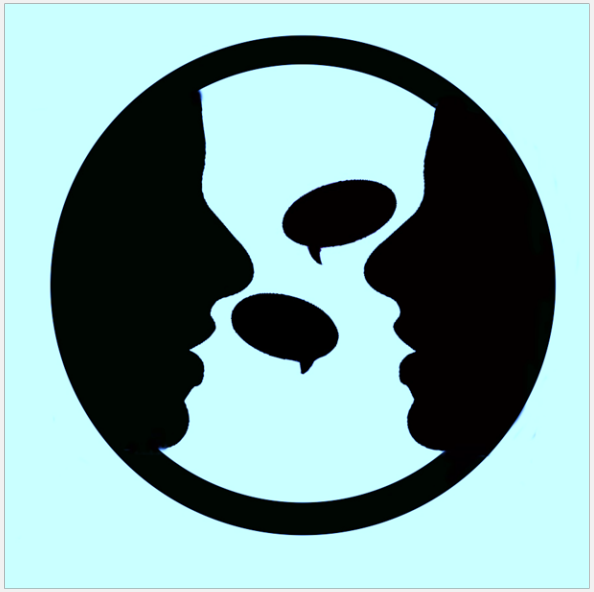
Around 60%* of people referred by Jobcentre Plus decide to take up Working Well Support.

This increases to 77%* for those who have been signposted by their GP.

Most patients not in contact with mainstream

More complex cases – flexed eligibility

Little or no waiting times



Joint working with Keyworker

High referrals entering treatment

positive recovery & reliable improvement

Commissioned talking therapies to support those with a mental health barrier to work. Early signs are positive.

* As reported to SQW: February 2017

A whole population approach to work and health

Care & Support	Work & Health Programme	Early Help	In Work
Complex and enduring health conditions or disability. Support for employability, meaningful activity, volunteering, wellbeing	Support for longer term workless with health conditions or disability to find and sustain work	Employees with health issues at risk of falling out of labour market Newly unemployed with health issues	SME's & Self Employed Larger Employers Public Service Leadership Social Value Effective Employee Assistance/OH
Development needed	Programme in place: Working Well	Development needed	Development needed

creating a ***Working Well*** system

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 September 2017
Executive Member / Reporting Officer:	Clare Watson, Director Commissioning, Tameside and Glossop Single Commission Angela Hardman – Director of Population Health Pat McKelvey, Head of Mental Health and Learning Disabilities, Tameside and Glossop Single Commission Anna Moloney, Consultant Public Health
Subject:	**MENTAL HEALTH AND WELLBEING**
Report Summary:	This report provides the Health and Wellbeing Board with an update on mental health commissioning highlighting the key strategic national and regional drivers; and how this has impacts on local mental health service delivery. This report covers the following areas: • Adult mental health; • Children and young people transformation; • Public Mental Health.
Recommendations:	The Health and Wellbeing Board are requested to note the strategic drivers for mental health service development and the progress that has been made locally in prevention and early intervention, treatment and recovery delivery models.
Links to Health and Wellbeing Strategy:	This report is relevant across the life course, and supports the Strategy underpinning principles of: no health without mental health, focussing on prevention and early help, and working together to tackle inequalities.
Policy Implications:	There are no direct policy implications in relation to mandated functions or services.
Financial Implications: **(Authorised by the Section 151 Officer)**	The mental health investment standard mandates that we invest 2% more on mental health during 2017/18 that we did in 2016/17. In addition to this there is some money available at Greater Manchester level to support the 5 year forward view in mental health. A financial plan which supports the strategic ambition of this paper is in the process of being refined and developed.
Legal Implications: **(Authorised by the Borough Solicitor)**	It is a necessary requirement that funding is spent to achieve agreed priorities in accordance with an agreed business case that is fit for purpose, there are systems in place to monitor compliance and refresh when required, and demonstrate rational, consistent and up to date approach based on best practice.
Risk Management:	There are no risks associated with this report.

Access to Information:

The background papers relating to this report can be inspected by contacting Pat McKelvey, Head of Mental Health and Learning Disabilities:

 Telephone:0161 342 5500

 e-mail: pat.mckelvey@nhs.net

1. NATIONAL IMPACT OF MENTAL ILL HEALTH[1]

1.1 Mental illness is the largest single cause of disability and represents 23% of the national disease burden in the UK. It is the leading cause of sickness absence in the UK, accounting for 70 million sick days in 2013. However, there is a very significant overall treatment gap in mental healthcare in England, with about 75% of people with mental illness receiving no treatment at all.

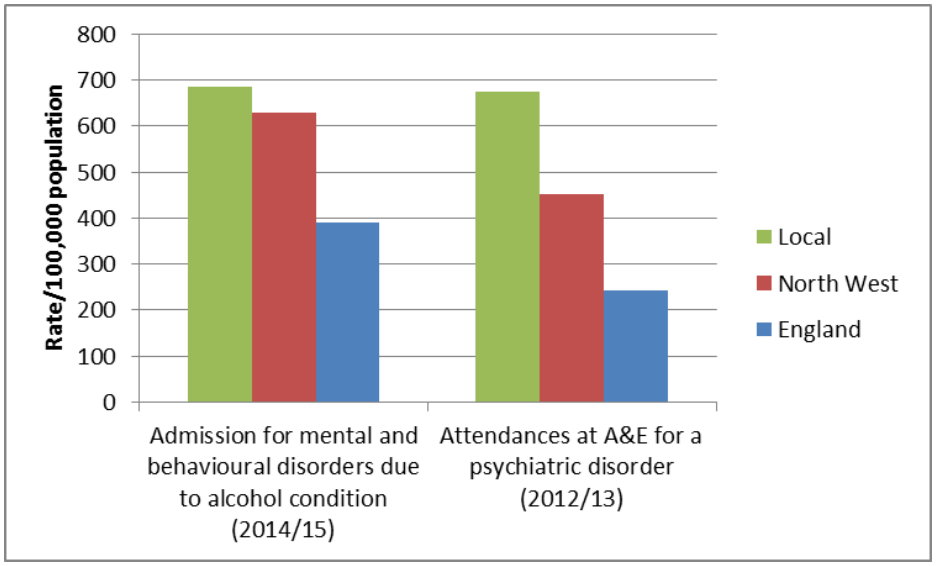
1.2 There is an unacceptably large 'premature mortality gap', as people with mental illness die on average 15–20 years earlier than those without, often from avoidable causes.

1.3 The economic cost of a completed suicide for someone of working age in the UK exceeds £1.6 million.

2. LOCAL IMPACT OF MENTAL ILL HEALTH

2.1 The data set out in Figure 1 below give a brief indication of the level of need and outcomes associated with mental health in Tameside. Attendances at A&E and admissions for mental health conditions are higher locally compared to the North West and England averages.

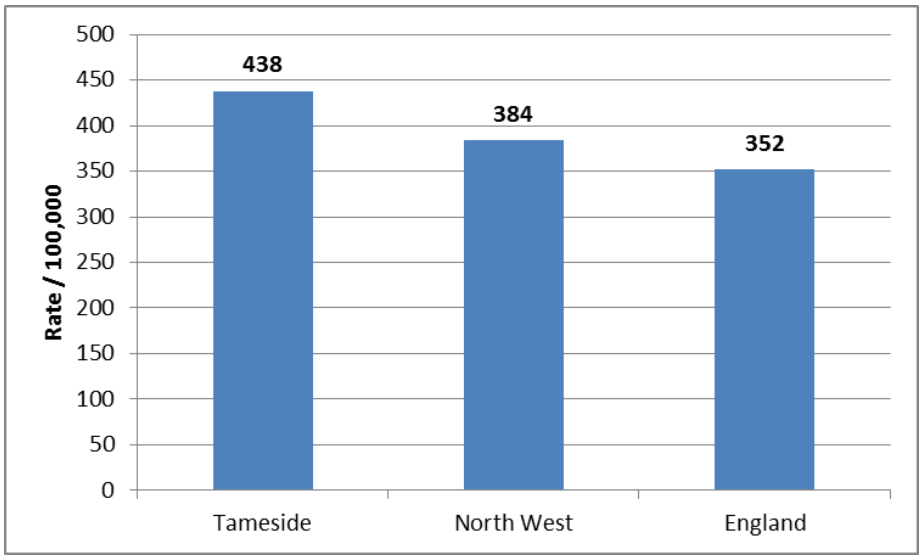
2.2 Figure 1: Admissions and attendances for specific mental health conditions



Note: Local data collection: Tameside borough for admissions and Tameside and Glossop for A&E attendance. Source: Public Health England Crisis Care profile and Community Mental Health profile.

2.3 The following data in figure 2 demonstrates the inequality that exists between people with mental ill health and the general population. If people with mental ill-health experienced the same mortality rates as the general population, there would be zero excess deaths.

Figure 2: Excess under 75 mortality rate in adults with serious mental illness, 2013/14.



Source: HSCIC data in the Public Health Outcome Framework.

2.4 In summary, there is a greater need for mental health support in Tameside as described by the lower levels of self-reported wellbeing and high hospital admissions and attendances. There is also great inequality experienced by people with mental ill health. In addition, suicide rates, particularly amongst men, have been rising in recent years but are comparable to those seen over a longer period of time.

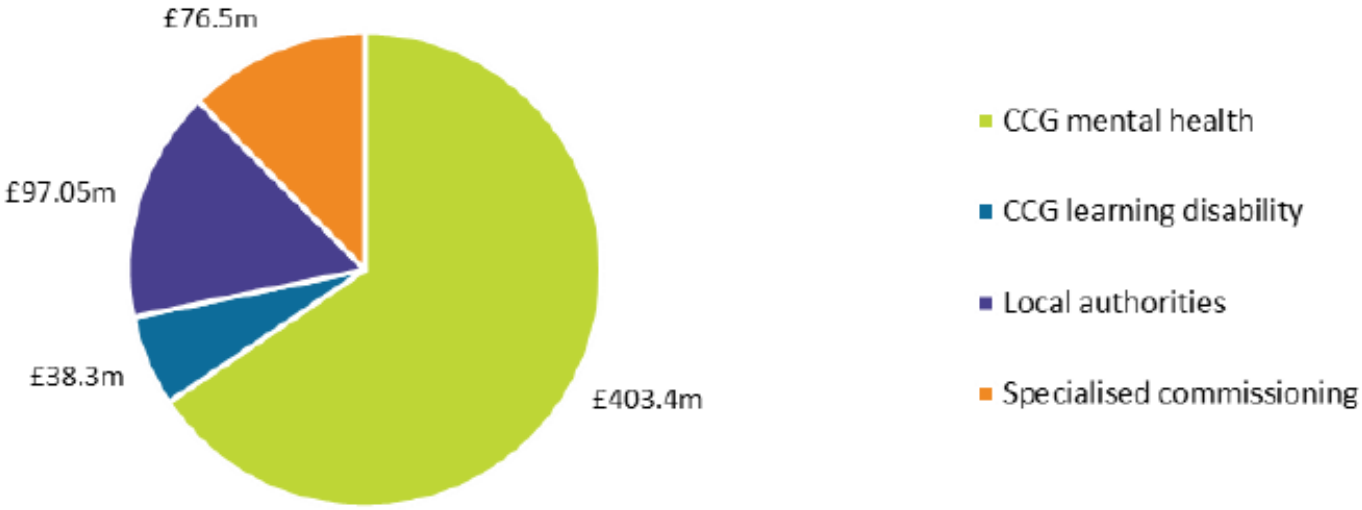
3. LOCAL SPEND ON MENTAL HEALTH

3.1 Spend on mental health comes from local authorities as well as Clinical Commissioning Groups. Significantly more is spent on mental health across Greater Manchester than the majority of UK cities. Figures 3 and 4 show the Greater Manchester wide direct costs of mental health in 2014/15 and the cost of Clinical Commissioning Group funded mental health services in Greater Manchester, per capita.

In 2014/15, the Greater Manchester total spend was calculated as £615.3 million, with a wide variance across localities:

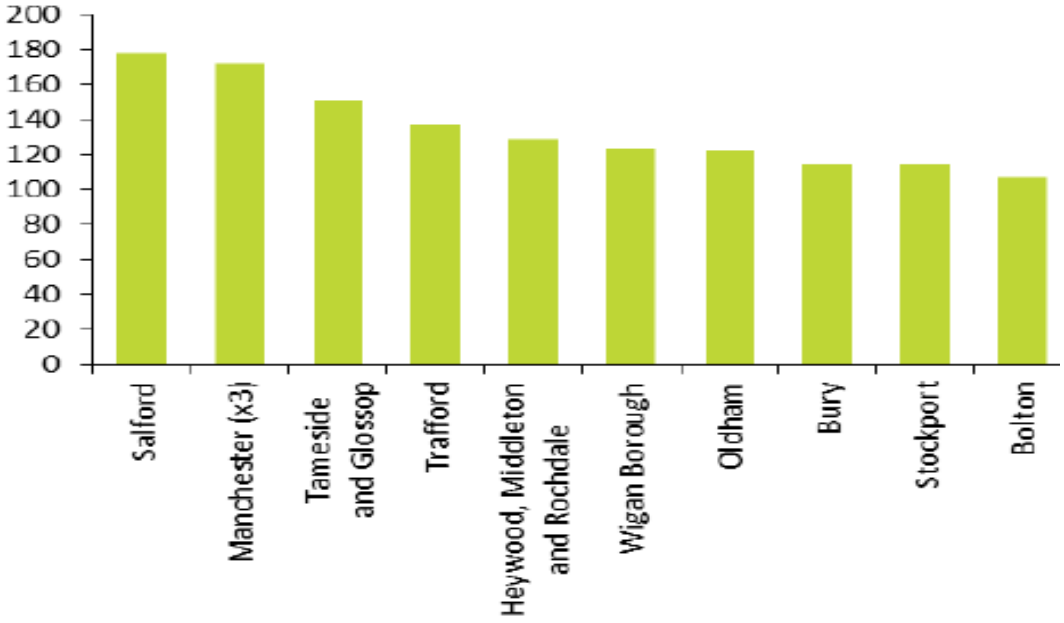
- Local authority spend (£97.05m);
- Clinical Commissioning Group Learning Disability spend (£38.3m)
- Clinical Commissioning Group Mental Health Specialist Commissioning (£76.5m) (which includes specialist units);
- Clinical Commissioning Group Mental Health Spend (£403.4m) - Approximately £30.1m of this is spent on out-of-area inpatient treatment (7.27% total Clinical Commissioning Group spend) including acute admissions due to capacity shortfalls and longer terms placements with complex needs

Figure 3: GM Wide Direct Costs of Mental Health, 2014/15.



Source: GM Mental Health Strategy[2]

Figure 4: Cost of CCG funded Mental Health services in GM, per capita.



Source: GM Mental Health Strategy

3.2 Latest information shows that NHS Tameside & Glossop forecast a spend of £37.8m on mental health during 2017/18, and Tameside MBC expect to spend just under £4.5m.

4. NATIONAL DRIVERS

4.1 The Five Year Forward View for Mental Health (2016) lays out 58 recommendations to improve standards of care for people with mental health needs against the following key themes:-

[1]Greater Manchester Mental Health and Wellbeing Strategy (v 23rd February 2016).

- Genuine Parity of Esteem between Physical and Mental Health;
- Prevention;
- Improved Waiting Times & New Commissioning Approaches to Transform Services;
- Integration of Physical and Mental Health Care;
- High Quality 7-day Services for People in Crisis;
- Provision Close to Home for those with Acute Intensive Needs, particularly Young People;
- Focus on Targeting Inequalities.

4.2 The strategy includes a commitment of an additional £1bn NHS Investment by 2020/21 to help an extra one million people of all ages.

4.3 The 'Must Do' priorities are as follows:

a. **Improving Access to Psychological Therapies (IAPT)**
   - Waiting time targets
   - Access – increase access for up to 25% of eligible population
   - Integrated (Long-term conditions / employment)
   - Recovery rate target

b. **Severe Mental Health Illness**
   - Early intervention in psychosis waiting times and NICE treatment compliant
   - Serious Mental Illness IAPT
   - Individual placement and support
   - Physical health care – smoking / obesity

c. **Dementia United**
   - Diagnosis (rate and waiting times)
   - Post-diagnostic support
   - Carers

d. **Armed Forces**

e. **Children and Young People (CAMHS)**
   - Waiting times
   - Community Eating Disorder services
   - Crisis care support & acute mental health liaison
   - Inpatient Care (Tier 4 collaborative)
   - Early intervention and prevention – iThrive+
   - Perinatal and Infant Mental Health – Specialist and early help
   - Transforming Care (learning disabilities)

f. **Crisis care**
   - A&E Psychiatric liaison – core 24 / RAID
   - All-age acute care pathway redesign (including Crisis Resolution Home Treatment and Primary Care MH)
   - Crisis care triage / support
   - Custody / liaison and diversion

g. **Suicide prevention**

h. **Secure care pathways**

5. GREATER MANCHESTER

5.1 The overarching Greater Manchester ambition for Mental Health is described within the Greater Manchester Mental Health and Wellbeing Strategy[3], and the governance framework for development and implementation of Greater Manchester Mental Health strategies is set out in **Appendix 4**.

[3] Greater Manchester Mental Health and Wellbeing Strategy (v 23rd February 2016)

5.2 The Greater Manchester Mental Health Strategy Vision is to:-

- Improve child and adult mental health, narrowing their gap in life expectancy, and ensuring parity of esteem with physical health is fundamental to unlocking the power and potential of Greater Manchester communities.
- Shift the focus of care to prevention, early intervention and resilience and delivering a sustainable mental health system in Greater Manchester requires simplified and strengthened leadership and accountability across the whole system.
- Enable resilient communities, engaging inclusive employers and working in partnership with the third sector will transform the mental health and well-being of Greater Manchester residents.

5.3 The strategy articulates four strategic principles for improved mental health and wellbeing:

- Prevention: Place based and person centred life course approach improving outcomes, population health and health inequalities through initiatives such as health and work.
- Access: Responsive and clear access arrangements connecting people to the support they need at the right time.
- Integration: Parity of mental health and physical illness through collaborative and mature cross-sector working across public sector bodies and voluntary organisations.
- Sustainability: Ensure the best spend of the Greater Manchester funding through improving financial and clinical sustainability by changing contracts, incentives, integrating and improving IT and investing in new workforce roles.

5.4 Further extracts from the strategy such as the plan on a page, financial impact of proposed interventions, and economic impact of metal ill health can be seen in **Appendices 1, 2 and 3.**

5.5 There is also a Greater Manchester Suicide Prevention strategy[4] that complements the vision of the Greater Manchester Mental Health strategy and focuses on preventing suicide across the life course. It reflects the six priorities set out in the national suicide prevention strategy. It is led by the Greater Manchester Suicide Prevention Executive Committee, which in turn reports to the Greater Manchester Mental Health Implementation Board.

6. LOCAL APPROACH TO MENTAL HEALTH

6.1 The Locality Plan[5] sets out the ambition for transforming local services. The Plan recognises that poor mental health and wellbeing has a significant impact on individuals, families and communities and that low mental wellbeing is associated with employment status, poor general health and a higher prevalence of diagnosed medical conditions.

6.2 More specifically, mental health is prioritised within the early intervention and prevention work stream using a life course approach: starting and developing well, living and working well and ageing and dying well. However, mental health also forms a crucial part of locality based services and the development of neighbourhood delivery models and multidisciplinary teams.

6.3 The Single Commissioning Board and the Locality Executive Group have agreed the Integrated Commissioning to Improve Mental Health Outcomes Proposal. This ensures that all additional investment is aligned to support transformation and meet the Five Year Forward View targets. The additional investment is as follows:

[4] Greater Manchester Suicide Prevention Strategy (2016-2021)
[5] A Place-Based Approach to Better Prosperity, Health and Wellbeing, Tameside and Glossop Locality Plan, November 2015, v 10.

Source	Investment	Status
Clinical Commissioning Groupd Mental Health Investment Standard uplift	£1,3m	Recurrent
Adult Social Care Transformation	TBC	Non-recurrent
Care Together	£280,000	Non-recurrent
Greater Manchester Mental Health Transformation - Locality developments	TBC Potentially £66k in 2017/8 rising to £415k in 2020/21	Potentially Recurrent
Greater Manchester Mental Health Transformation – Greater Manchester developments	n/a	Non-recurrent

6.4 Business cases are currently being developed in line with the Integrated Commissioning Strategy as follows

i. **Self-Management Education College**

- Effective local model for all health needs is being developed, building on existing good practice

ii. Neighbourhood Mental Health offer

- Integrated IAPT Plus – establishing a single service to include Healthy Minds and Voluntary and Community Sector pilot embedded within the Neighbourhoods;
- Neighbourhood MH development - Identify existing resources and develop a model embedded within the Neighbourhoods with phased investment plan;
- Neighbourhood Dementia development including Alzheimer's Society Pilot.

iii. Mental Health Crisis Care

- Mental Health Crisis Care – identifying existing resources and designing a new model of mental health crisis support;
- Greater Manchester Core 24 Mental Health Liaison Transformation development - connect with Greater Manchester developments re Healthier Together sites.

iv. Recovery Peer Support

- Identify existing resources and models of good practice to propose local model taking account Social Prescribing / ABCD developments.

v. Autism Support

- Expansion of autism support – integrated model.

vi. Secondary Care Mental Helath Services

- Early Intervention in Psychosis expansion of capacity;
- Approved Mental Health Practitioner expansion;
- Pennine Care Foundation Trust Mental Health Strategy;
- Pressures in Acute Mental Health Services;
- Secondary care Mental Health new models of care;
- Perinatal and Infant Mental Health – revise integrated care pathway in line with Greater Manchester Specialist Community Perinatal and Infant Mental Health team.

6.5 The local approach has also been aligned to the life course and complements the priorities and actions of the various Greater Manchester strategies. Nevertheless, the majority of the system wide resource available is applied to the 'treatment and recovery' portion of the model, which is mostly provided by Pennine Care NHS Foundation Trust. Their 2016-2021 Strategic Plan, shared in December 2016, is working towards the delivery of whole person, place-based care so that all of their patients, carers and families to receive care that meets all of their mental, physical and social needs. The Plan's standard operating model includes

services offers across Community resilience, Primary care, Intermediate care and Urgent and acute care.

7. LOCAL APPROACH – CHILDREN AND YOUNG PEOPLE

7.1 The substantial Children and Young People's Mental Health and Emotional Wellbeing Transformation Programme supported with funding from NHS England has previously been described to Board. As part of this programme the public health offer includes counselling services to young people aged 10 to 25 years old living in Tameside. The service provides a flexible service in partnership with a wide range of partners, including; Public Service HUB, GPs, Schools, Healthy Young Minds (CAMHS), The Phoenix Team, The Probation Service and the wider voluntary sector. The offer to young people itself includes non-appointment drop in sessions and series of 1-2-1 counselling sessions. More recently their offer has expanded to include online messaging board, online (skype) counselling and downloadable affirmations.

7.2 The Emotional Health and Wellbeing Resilience Programme is a universal offer to all secondary and primary (including special) schools and includes a package of interventions:

- Mental health and emotional wellbeing assemblies appropriately targeted at transition year pupils in order to provide a universal approach for relevant information and support through signposting.
- Resilience workshops for pupils, either targeted groups of young people with emerging emotional issues or whole year groups to encourage positive coping strategies and educate on good emotional wellbeing, positive self-esteem & self-confidence and challenging negative coping mechanisms.
- Staff training sessions to educate on how to support young people with maintaining emotional wellbeing and resilience. This will enable staff to become assets within the school setting and to drive sustainable prevention and early intervention.
- Parent training sessions to educate on how to support their child's emotional wellbeing outside of school setting in order to provide young people with a whole community support approach to their emotional wellbeing. This will not only enable assets within the family setting buy the community setting too.

7.3 **Emotional Health and Wellbeing Consultancy Programme (15 school pilot).** This intervention builds and sustains the previous programme as well as enhancing the emotional health and wellbeing assets of a school and encouraging schools to take ownership of their whole school community. The proposed outcomes are:

- Staff, parents and pupils within selected schools will have improved understanding, knowledge and skills to feel enabled to sustain positive mental health and emotional wellbeing throughout the whole school community.
- Staff will feel confident they can maintain a model of positive emotional wellbeing and mental health within their school for the benefit of staff, parents and pupils but engaging in an asset-based learning model where staff will be encouraged to build on their strengths and develop their current good practice. This will be developed through skills training provided by TOG Mind.

7.4 The Teens and Toddlers Programme targets young people (aged 14-15) who are identified as 'at risk' of becoming NEET (not in employment, training or education) and to deliver a programme across several weeks designed to help support these vulnerable young people. Teens and Toddlers aims to raise the young people's aspirations, self-esteem, resilience and sense of responsibility, so they can make informed positive decisions about their education, their health and their future. As the programme involves pairing up a young person with a small child, it also benefits the smaller child as the young person supports the learning of the

younger child with specific skills in order to improve their cognitive and emotional development, resulting in the smaller child's readiness for school.

8. LOCAL APPROACH – ADULTS

8.1 The focus amongst adults has been the promotion of resilience and positive mental wellbeing, i.e. mental health promotion.

8.2 In association with local partners, several key national campaigns have been promoted annually, such as "Time to Change"[6]. This national campaign is a growing movement of people aiming to change how we all think and act about mental health problems. It is led by Mind and Rethink Mental Illness, and is funded by the Department of Health, Comic Relief and the Big Lottery Fund. There is a range of resources available to promote the issue; and the accumulation of activities focus on the annual February 'Time to Talk Day', which aims to get people talking openly about mental health and their mental health experiences. In February 2016, Tameside MBC committed to sign the employer pledge, which is a commitment to change how we think and act about mental health within the workplace and has an action plan aiming at improving people's experience.

8.3 The national '5 ways to Wellbeing'[7] (Connect, Be Active, Take notice, Keep Learning, Give) promotion continues to be used to underpin many of our and our partners' interventions.

8.4 **Community resilience.** Tameside & Glossop Mind has been commissioned to continue their previous project that aimed to promote and enable community resilience in relation to mental wellbeing. The programme has been refreshed and the main objectives are to build resilience and promote self-care; to ensure people have information about how to help themselves and where to go for the right help when they need it, rather than immediately accessing more complex emotional wellbeing support services.

9. LOCAL APPROACH - OLDER PEOPLE

9.1 Dementia has not been included in this portion of the report. It is often associated with discussions about mental health, however, it is more appropriate to be included in discussions about ageing well in general.

9.2 Loneliness and social isolation are therefore the most widely recognised significant and entrenched mental health issues facing our ageing society. Around 10 per cent of people over 65 experience chronic loneliness at any given time. We also know that lonely individuals are more prone to depression[8]; loneliness and low social interaction are predictive of suicide in older age[9] and that loneliness puts individuals at greater risk of cognitive decline[10]. One study also concluded that lonely people have a 64% increased chance of developing clinical dementia[11].

9.3 The local aim is to enable partners to tackle loneliness and social isolation by enabling community projects and social activities that support people to remain connected to their communities, and to develop and maintain connections to friends and family. Commissioned programmes include:

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[6] http://www.time-to-change.org.uk/
[7] http://neweconomics.org/search/?_sft_project=five-ways-to-wellbeing
[8] (Cacioppo et al, 2006) (Green et al, 1992)
[9] (O'Connell et al, 2004)
[10] (James et al, 2011).
[11] (Holwerda et al, 2012)

i. **Manchester Camerata** to develop a music and drama model building on the lessons learnt through Asset Based Community Development (ABCD) work to reduce the sense of loneliness by allowing older members (and their carers) of the community to take the lead in shaping their own health care. The model 'A Tameside Opera Phase 1 and 2' highlighted the profound impact that music and drama can have on several types of mental health, and its ability to decrease medication use and decrease the need to access health services.

ii. **The Storybox Project** is a unique participatory story making project that uses creativity and imagination to enliven, engage and empower people living with dementia, alongside the people that support them. The Storybox project delivers the participatory story making project in a Library setting, and also through bespoke training sessions with care home staff to enable them to deliver similar sessions.

9.4 A local network of partners have signed up to the National Campaign to End Loneliness[12] with the aim of working in collaboration to tackle the huge issues of Social Isolation and Loneliness. A WOW (What's on Where) Guide in electronic and hard formats has been developed. The guide provides information about well-established community groups and support services.

10. LOCAL APPROACH – SUICIDE

10.1 The Tameside Self Harm and Suicide Prevention Group ago is chaired by Tameside MBC's Public Health and Greater Manchester Police. The aim is for partners to work together better to ensure people of all ages in Tameside and their families get the help they need when they need it and the right support at times of crisis, with the hope of reducing self-harm, suicide attempts and suicide.

10.2 The Group reports to the local 'Mental Health Crisis Care Concordat', which is a national agreement between services and agencies involved in the care and support of people in crisis. In Tameside, the Crisis Care Concordat provides a framework for agencies to work together and share information to ensure people suffering a mental health crisis get the right care when they need it.

10.3 The Tameside Self Harm and Suicide Prevention Action Plan is a live document which is regularly updated. It focuses on six key points that echo the six priority areas that have been set out in the National Suicide Prevention Strategy and the Greater Manchester Suicide Prevention Strategy:

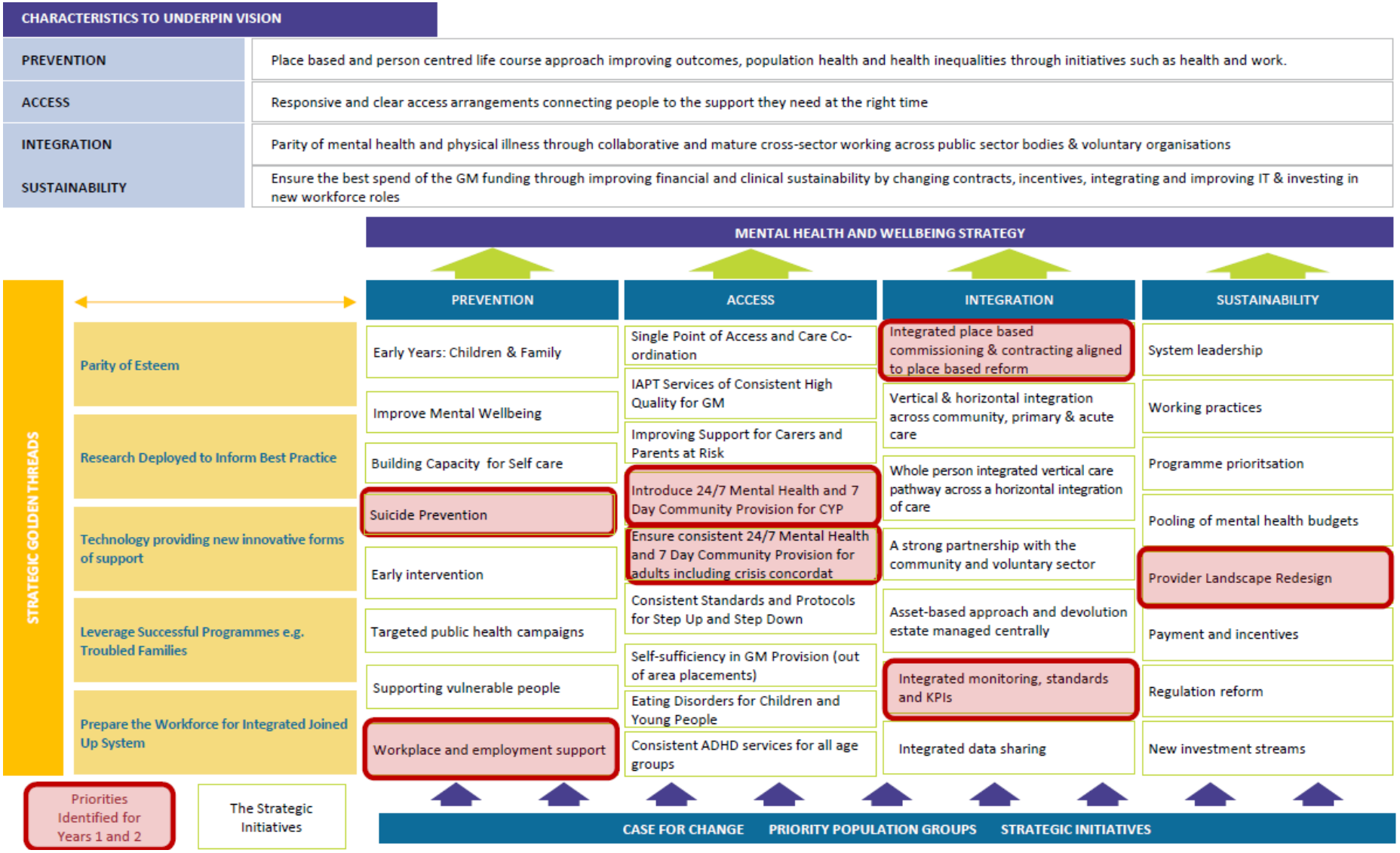
1) Reduce the risk of suicide in high-risk groups;
2) Tailor approaches to improve mental health in specific groups;
3) Reduce access to the means of suicide;
4) Provide better information and support to those bereaved or affected by suicide;
5) Communications, Media and Campaigns for Suicide and Self Harm;
6) Support research, data collection and monitoring.

11. RECOMMENDATIONS

11.1 As set out on the front of the report.

[12] http://www.campaigntoendloneliness.org

Appendix 1: Greater Manchester Mental Health and Wellbeing Strategy (v 23rd February 2016): Strategic Plan on a Page.



Appendix 2: Economic case – wider cost of MH across GM; Source: Greater Manchester Mental Health and Wellbeing Strategy.

Cohort	Volume/Impact on GM economy	Cost (£)
GM Population Unemployed with Mental health conditions	• **144,000** Individuals on Employment Support Analysis/Incapacity benefit across GM. Up to **80%** of benefits claimants have a mental health condition.[1]	**£1.05 bn** Based on £9,091 fiscal cost per claimant per year.
Children with conduct disorder	• **5.8%** of children (~2200 in each GM year group cohort) estimated to have conduct disorders. [2]	**£330m public sector costs** Based on £150,000 over the lifetime of each child (including NHS, social services, education and criminal justice). [2]
Alcohol misuse	• **504,263** Alcohol-related hospital admissions and attendances across GM (2013) (1,155 deaths directly attributable to alcohol).	**£167m** [3] (hospital admissions, A & E attendances). **£1.2bn** in wider costs due to lost productivity, crime, health and social care costs
Substance misuse	• **2,994** Estimated OCU (Opiate or Crack) Users not in treatment in GM in 2014/15. [4] • **86%** of Troubled Families with mental health issues also have issues with substance misuse	**£78m cost of crime** (this is a conservative estimate and does not include other drugs such as Amphetamines, Cannabis, prescription drugs and legal highs) [4] Based on cost of crime for those not in treatment of £2924 per person.
Mental Health bed based-inpatients	• **44%** of total CCG MH spend on bed-based inpatients. [5] • On average, **10,495** occupied bed days for MH inpatients in GM per 100, 000 population (higher than the 7,199 national average).	**£176m** CCG spend on bed based-inpatients. [5] (£21m uncategorised by CCGs).
Suicides	• **277** suicides registered in Greater Manchester (2014). [6]	**£2.9m** in direct costs to the NHS and policing **£442.7m** wider costs due to lost waged and non-waged output, as well as intangible human costs . Based on total cost per suicide of £1.6m [6]
Homelessness	• **25-35%** of all those accessing homelessness services present with mental health as their main need.	**£2.8m** cost to Local Authorities Based on total GM spend on homelessness of £9.45m per year[7]

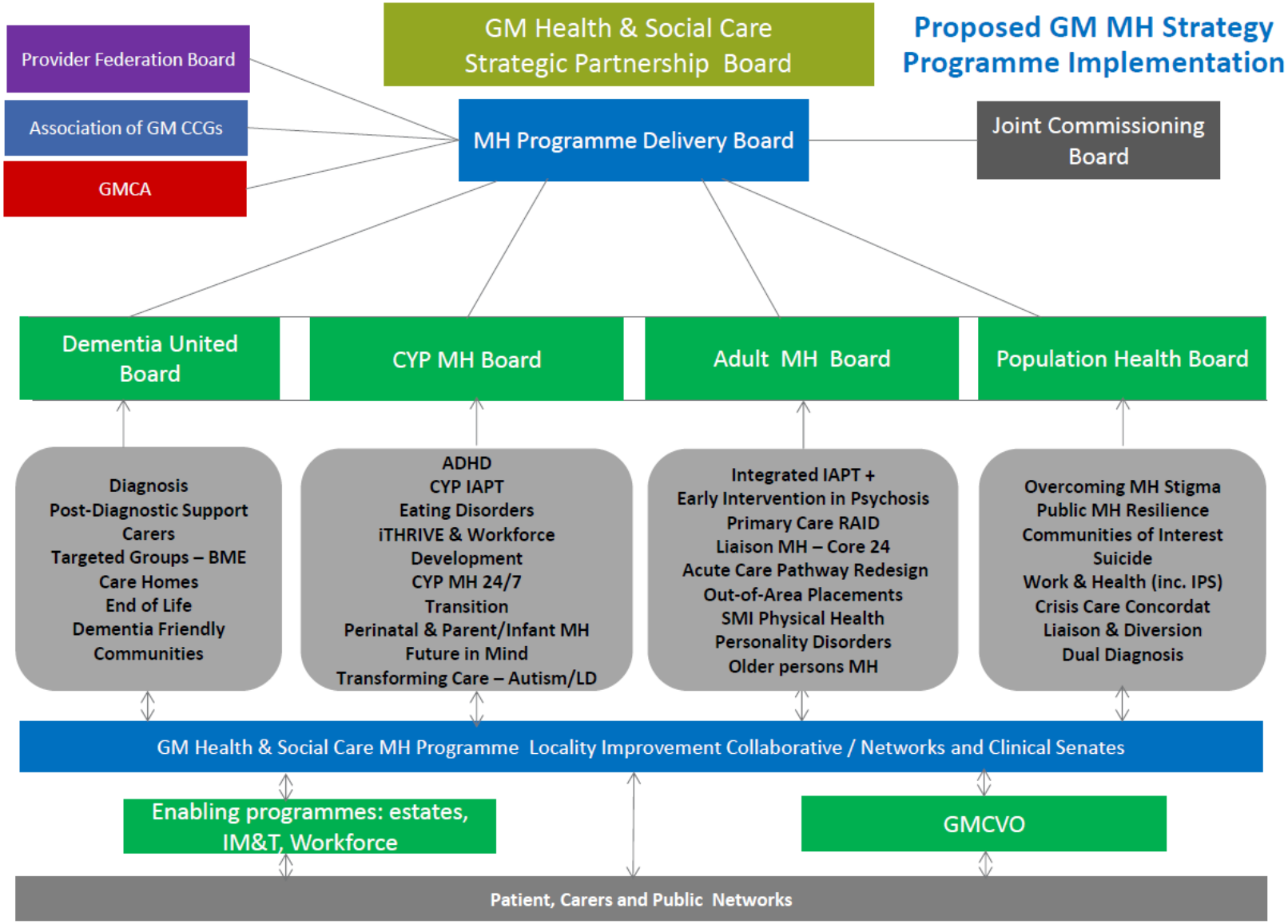
Source: (1) GMCA Mat Ainsworth Working Well: Supporting long term ESA claimants into sustained employment. http://stats.cesi.org.uk/events_presentations/SeminarSeries2014/TacklingEmployment/MatAinsworth.pdf
(2) a) http://www.hscic.gov.uk/catalogue/PUB05116; b) http://www.nice.org.uk/guidance/qs59/documents/qs59-antisocial-behaviour-and-conduct-disorders-in-children-and-young-people-support-for-commissioning2
(3) http://www.alcoholconcern.org.uk/training/alcohol-harm-map/
(4) a) 'ITEM 6 - Substance Misuse in Greater Manchester', GMCA; b) http://www.nta.nhs.uk/uploads/whyinvest2final.pdf
(5) a) CCG programme budget returns; b) Mental Health Benchmarking 2012to13 vs 2013to14 v4.
(6) a) ONS, Suicides in England and Wales by local authority, 2016; b) Scottish Executive, Evaluation of Choose Life, 2006
(7) Local authority outturn returns 2014/15

Appendix 3: GM Mental Health & Wellbeing Strategy: Investment Case and the Potential Benefits

Scheme	Cost	Fiscal Benefits[1]	Additional Public Value Benefits[2]
Early years	£15.1m	£15.8m	£28.1m
Education: School based social and emotional learning	£5.8m	£44.4m	Unknown
Troubled families	£22.8m	£33.4m	£75.2m
Alcohol Misuse: Screening and brief early intervention	£1.3m	£5.9m	Unknown
Suicide Prevention: Suicide awareness training and intervention	£0.4m	£0.3m	£48.0m
Working well	£3.0m	£5.1m	£13.0m
Workplace screening for depression and anxiety	£1.2m	£0.7m	£2.2m
Promoting wellbeing in the workplace	£0.04m	£0.0m	£0.5m
Housing step down support facility	£0.5m	£5.2m	Unknown
RAID - Psychiatric Liaison	£1.5m	£2.4m	£0.2m
Intermediate Care for patients with delirium	£9.6m	£12.7m	Unknown
Crisis prevention through IAPT	£6.9m	£11.6m	Unknown
Assertive Outreach for individuals with complex dependency	£1.0m	£1.5m	£1.4m
Total of above schemes	**£69.3m**	**£139.0m**	**£168.4m**

[1] the financial or 'fiscal' impacts to government agencies
[2] the overall public value created by a project including economic benefits to individuals and society; and wider social welfare/wellbeing benefits

Appendix 4: **Governance framework for implementation of the GM Mental Health Strategy for Greater Manchester.**

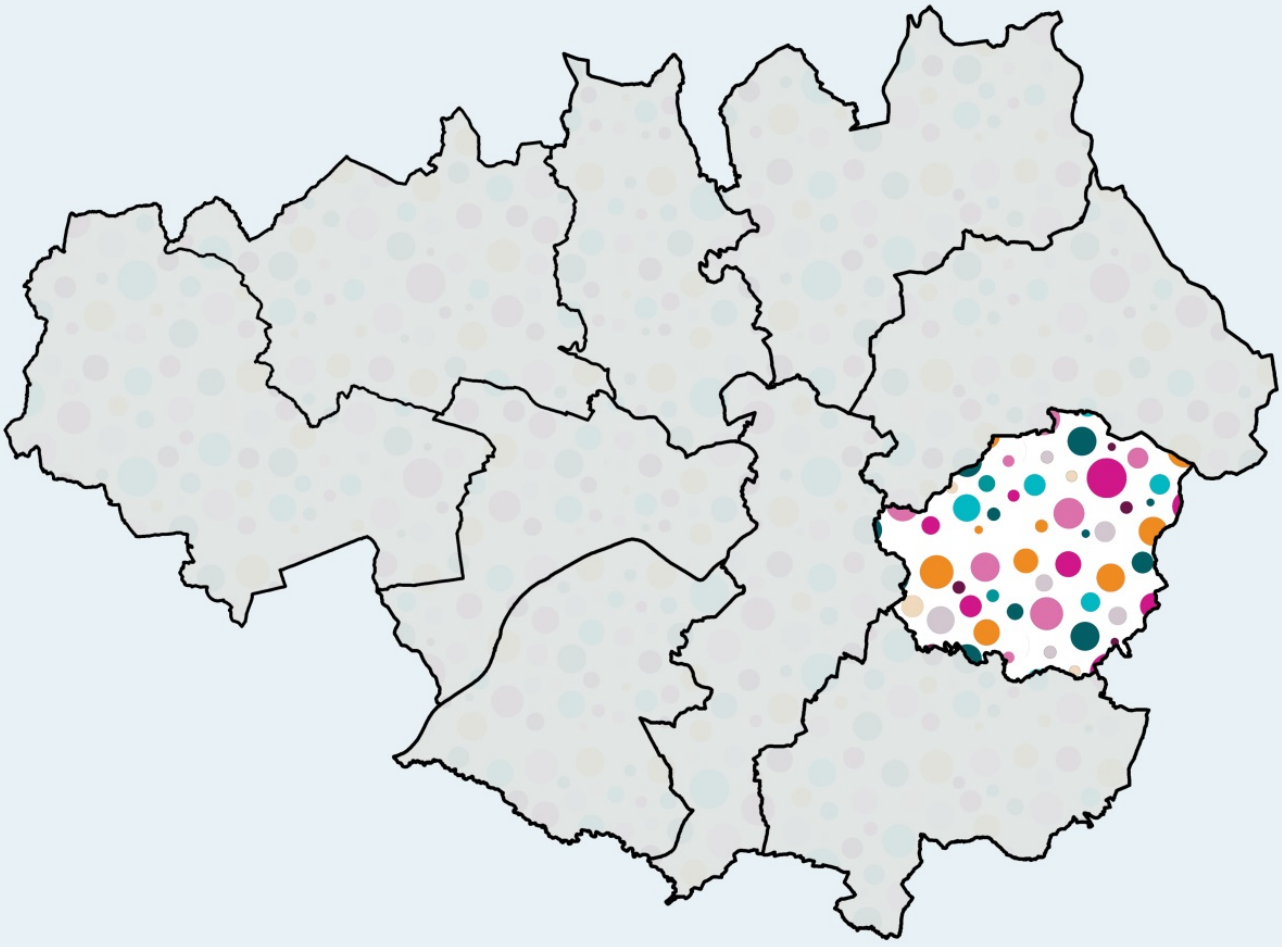


Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 September 2017
Executive Member / Reporting Officer:	Ben Gilchrist, Deputy Chief Executive, Action Together
Subject:	**TAMESIDE STATE OF THE VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE SECTOR RESEARCH 2017**
Report Summary:	This report provides the main findings of research aimed at improving the understanding of the social and economic impact of the voluntary, community and social enterprise (VCSE) sector in Tameside. The key objective of the research was to provide a comprehensive overview of the sector in Tameside at the start of 2017.
Recommendations:	It is recommended that the Health and Wellbeing Board take note of the research findings and: 1. Share these materials with other leaders and professionals to raise awareness about the voluntary, community and social enterprise sector. Action Together can support further presentations. 2. Provide sustained and coordinated leadership to ensure continued support for, and partnership with, Tameside's voluntary, community and social enterprise sector. 3. Recognise and celebrate this evidence of Tameside's active and vibrant communities and strong base for community action. For example 46 per cent of the voluntary, community and social enterprise sector work to improve health and wellbeing (including mental health) and 33 per cent provide practical community development help to build and strengthen communities and reduce isolation. 4. Consider how to invest both short and long term in the voluntary, community and social enterprise sector's sustainability given the significant and increasing number of groups and organisations using their reserves to ensure that services run, that people are supported and that change happens in communities.
Links to Health and Wellbeing Strategy:	This work has cross cutting relevance to the Health and Wellbeing strategy but in particular the focus on asset based community development, voluntary, community and social enterprise sector involvement and support for person- and community-centred approaches.
Policy Implications:	This evidence should contribute to the development of: - The Health and Wellbeing Strategy; - Health and Wellbeing Board priorities; - Commissioning strategies and plans; - Care Together implementation.

Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications arising from the report at this stage.
Legal Implications: **(Authorised by the Borough Solicitor)**	Any decisions relating to the future level of investment within the Tameside locality voluntary, community and social enterprise sector will be subject to the associated governance arrangements in place within the locality partner organisations.
Risk Management :	N/A
Access to Information :	The background papers relating to this report can be inspected by contacting Ben Gilchrist, by  Telephone: 0161 339 2345  e-mail: ben.gilchrist@actiontogether.org.uk

Tameside State of the Voluntary, Community and Social Enterprise Sector 2017

A report on social and economic impact



Sheffield Hallam University | Centre for Regional Economic and Social Research

Tameside State of the Voluntary, Community and Social Enterprise Sector 2017

Centre for Regional Economic and Social Research

Sheffield Hallam University

Chris Damm

Ioannis Prinos

Elizabeth Sanderson

DOI: 10.7190/cresr.2017.6488868973

June 2017

Acknowledgements

This research has been commissioned by Action Together as part of 10GM[1] with GMCVO and undertaken by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University. This Tameside report forms part of a wider collection of reports: there is a Greater Manchester wide report and a report for each of the other local authority areas participating in the study[2]. The full collection of reports can be downloaded from the CRESR website (http://www.shu.ac.uk/research/cresr/reports) and the websites of the project partners.

In completing the report we are particularly grateful to members of the Research Steering Group[3] and the Action Together in Oldham and Tameside team for their support in developing and administering the survey and for their input into earlier drafts of the report. We are also grateful to the many employees and volunteers from across the voluntary, community and social enterprise sector who took the time to complete a questionnaire or participate in a focus group.

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[1] 10GM is a joint venture by the Greater Manchester Voluntary Sector Infrastructure Organisations (Action Together in Oldham and Tameside, Bolton CVS, CVS Rochdale, Macc, Salford CVS, VCAT, Wigan & Leigh CVS)
[2] The other areas are: Bolton, Manchester, Oldham, Rochdale, Stockport, Salford and Wigan.
[3] The following organisations were represented on the Research Steering Group: CRESR, Salford CVS (lead partner), Greater Manchester Centre for Voluntary Organisation (GMCVO), Bolton CVS, Macc, Action Together in Oldham and Tameside and CVS Rochdale.

Definitions

This report is about the 'state of the voluntary, community and social enterprise sector in Tameside'. At various times the voluntary sector has been known as the 'voluntary and community sector' or the 'third sector' whilst the current Government talks a lot about 'civil society'. In this report, when we talk about the voluntary sector in Tameside, we mean **voluntary organisations**, **community groups**, the **community work of faith groups,** and **those social enterprises** where there is a wider accountability to the public via a board of trustees or a membership and all profits will be reinvested in their social purpose.

Foreword

Action Together strives to build dynamic and strong communities in Tameside. We are in a time of immense political, system and structural change with increasing inequalities and levels of poverty. From this it is clear that the need for our work and that of the voluntary, community and social enterprise (VCSE) sector is as critical as ever. That's why we commissioned this independent research with Sheffield Hallam to gather insight into how VCSE activity in Tameside is changing and what that means for the support we need to provide and the external factors that will affect the sector's sustainability.

At Action Together we believe local people have the power to improve lives and communities particularly through collective action. It's evident from this research that Tameside has active and vibrant communities and a strong base for community action with 1,167 VCSE groups. These provide 1.5 million interventions of support to local people every year and an established culture of volunteering with 34,000 people giving their time to benefit others.

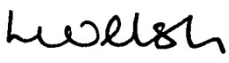
As a team, we are frequently inspired by the real-life stories that underpin the statistics in this report and the difference each and every 'intervention' makes. What is sometimes easier to miss is the direct correlation between the work that the VCSE sector does and the key strategic priorities for Tameside. 46 per cent work to improve health and wellbeing (including mental health) and 33 per cent provide practical community development help to build and strengthen communities and reduce isolation.

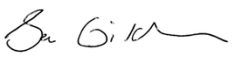
Of significant concern and a call to action for Action Together is the fact that sustainability for many groups and organisations continues to be a major challenge. More groups and organisations are using their reserves to ensure that services run, that people are supported and that change happens in communities.

Tameside has a long history of partnership working, so it's good to see that this report highlights the strength of these local partnerships. Action Together makes connections and brokers new relationships right across the breadth of public services and in recent years has developed new initiatives such as Tameside4Good that provides grant funding but also fosters new relationships with local businesses. So, it's particularly pleasing to see an 11 per cent increase (since 2013) in community groups reporting that local business has a positive impact on their organisations success.

Finally, we'd like to say a big thank you to everyone that completed the survey and all those involved in supporting us and the VCSE sector in Tameside. We hope you enjoy reading this report and get in touch to see what more we can do by working together.

Best wishes





Liz Windsor Welsh
Action Together, Chief Executive

Ben Gilchrist
Action Together, Deputy Chief Executive

Contents

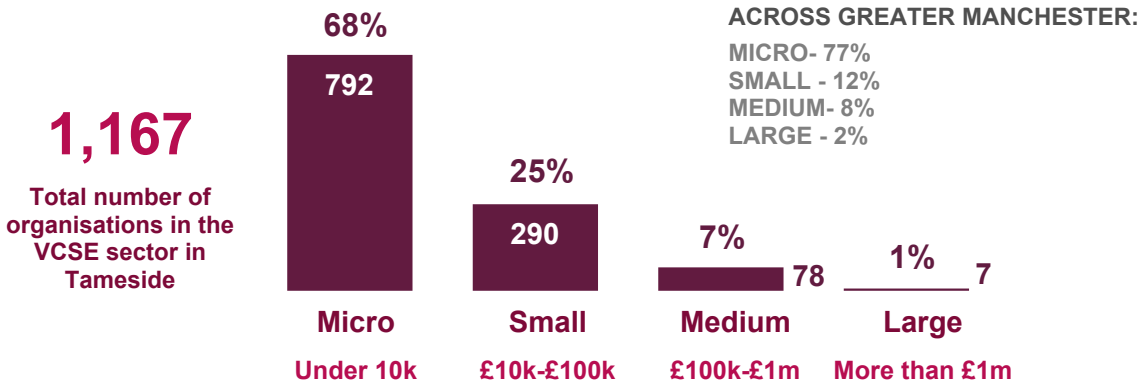
Executive Summary

This report provides the main findings of research aimed at improving the understanding of the social and economic impact of the voluntary, community and social enterprise (VCSE) sector in Tameside. The key objective of the research was to provide a comprehensive overview of the sector in Tameside at the start of 2017.

In this summary we answer eleven key questions about the sector and its role across Tameside.

Q1. How many organisations are there?

There are an estimated **1,167 organisations** working in the VCSE sector in Tameside and the vast majority of organisations are micro or small (93 per cent with income less than £100,000):

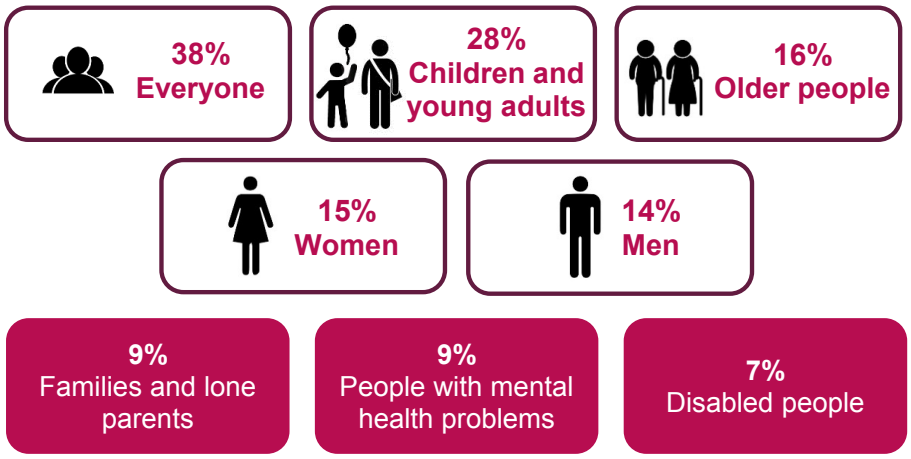


ACROSS GREATER MANCHESTER:

MICRO- 77%
SMALL - 12%
MEDIUM- 8%
LARGE - 2%

Q2. Who benefits from their work?

The client groups served by the largest proportions of organisations can be broadly characterised as being demographic. Almost two-fifths of organisations surveyed identified 'everyone' as their main clients, users or beneficiaries.



MAIN CLIENT GROUPS IN 2012/13:

WOMEN - 32%
EVERYONE- 31%
CHILDREN - 30%
OLDER PEOPLE - 30%
MEN - 28%
YOUNG PEOPLE - 25%

MAIN CLIENT GROUPS ACROSS GREATER MANCHESTER:

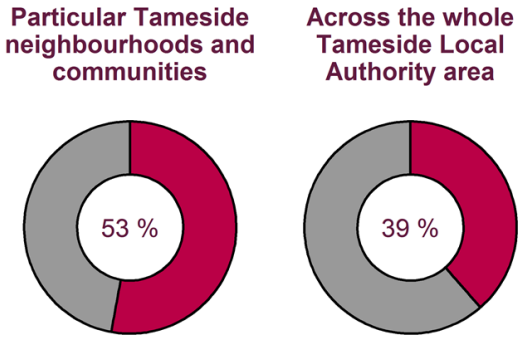
EVERYONE - 33%
CHILDREN & YOUNG ADULTS- 23%
OLDER PEOPLE - 17%
WOMEN - 15%
MEN - 12%

It is estimated that the VCSE sector in Tameside made:

1.5 million interventions

with clients, users or beneficiaries in the past year

The VCSE sector works at a range of different geographical levels both across and beyond Tameside. The local authority area, and specific communities and neighbourhoods within it, are the main focus for a majority of organisations:



Q3. What does the VCSE sector in Tameside do?

The areas with the greatest proportion of organisations working in them are:

MAIN AREAS IN 2012/13:

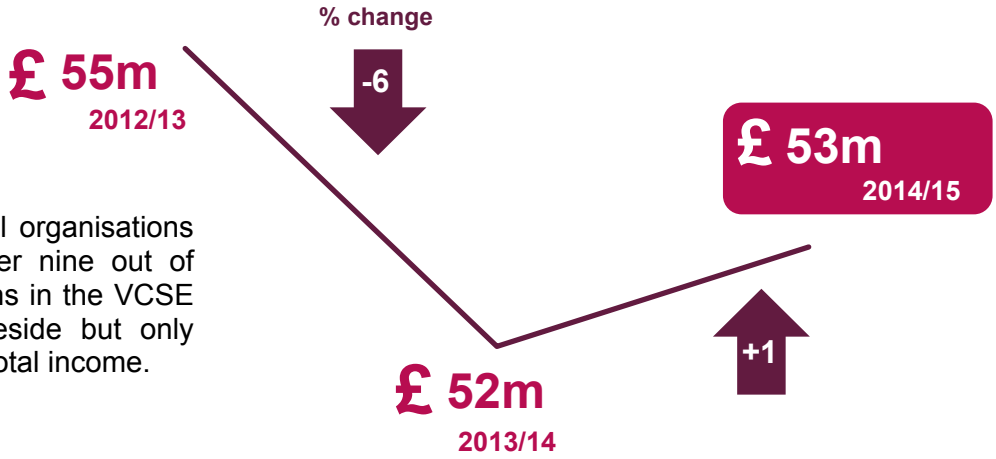
COMMUNITY DEVELOPMENT - 33%
HEALTH & WELLBEING - 32%
SPORT & LEISURE - 32%
EDUCATION, TRAINING & RESEARCH - 26%

MAIN AREAS ACROSS GREATER MANCHESTER:

HEALTH & WELLBEING - 46%
COMMUNITY DEVELOPMENT - 39%
EDUCATION, TRAINING & RESEARCH - 26%
SPORT & LEISURE - 25%

Q4. What is the income of the VCSE sector in Tameside?

Total income in 2014/15 is estimated to be **£53m**, an increase of one per cent compared to 2013/14.



Micro and small organisations account for over nine out of ten organisations in the VCSE sector in Tameside but only one quarter of total income.

Across Greater Manchester **micro and small organisations** experienced **year on year reductions** in total income between 2012/13 and 2014/15.

By contrast medium and **large organisations** saw a reduction in total income between 2012/13 and 2013/14 but then **an increase** between 2013/14 and 2014/15. But income is still below 2012/13 levels.

Q5. Where does the VCSE sector in Tameside receive its funding from?

81% have at least one source of **non-public** sector funds

63% IN 2012/13

84% ACROSS GREATER MANCHESTER

INCLUDING:

Fundraising (received by 55 per cent of respondents)

Grants from charitable trusts and foundations (38 per cent)

Membership fees and subscriptions (29 per cent)

MAIN SOURCES OF FUNDING IN 2012/13:

FUNDRAISING - 41%
GRANTS FROM CHARITABLE TRUSTS & FOUNDATIONS - 24%
MEMBERSHIPS FEES & SUBSCRIPTIONS- 24%

56% have at least one source of **public** sector funds

50% IN 2012/13

68% ACROSS GREATER MANCHESTER

INCLUDING:

Grant funding administered by Action Together on behalf of a public sector body (received by 22 per cent of respondents)

Tameside Council (22 per cent)

MAIN SOURCES OF FUNDING IN 2012/13:

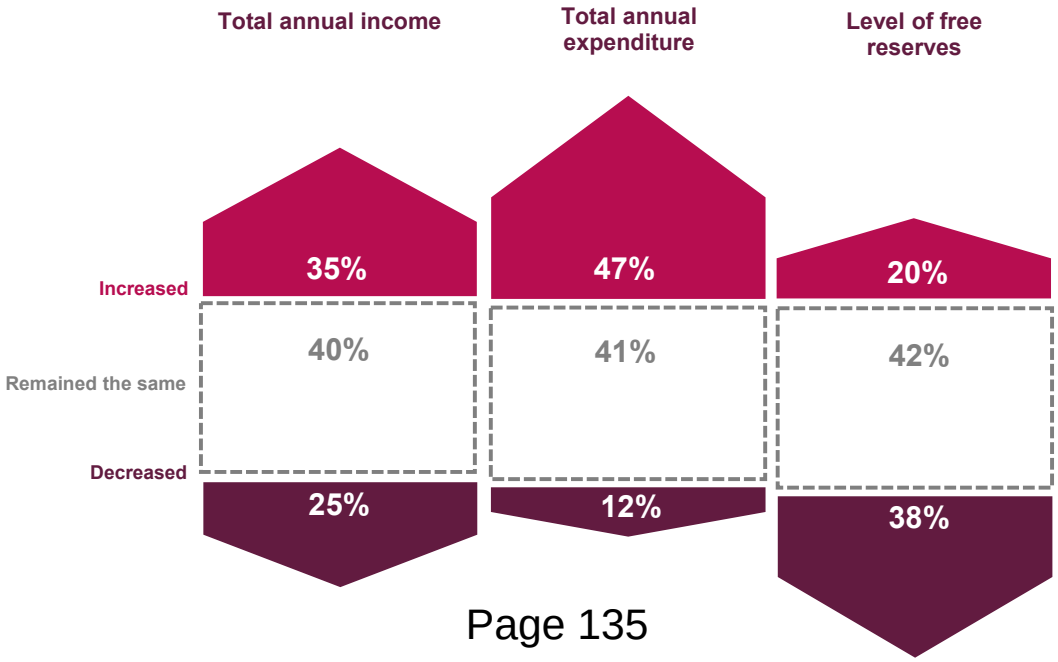
TAMESIDE COUNCIL - 35%
FUNDING ADMINISTERED BY TS3C OR VOLUNTEER CENTRE - 24%

Q6. How sustainable is the VCSE sector in Tameside?

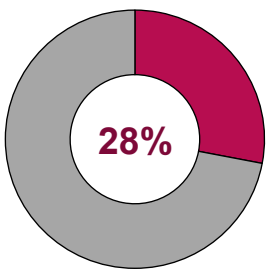
The survey highlights some areas for concern:

- **47 per cent** of respondents reported increasing their expenditure but only **35 per cent** had experienced an increase in income
- **25 per cent** of respondents reported a decrease in income but only **12 per cent** reduced their expenditure
- **38 per cent** reported a reduction in their financial reserves compared to **20 per cent** reporting an increase.

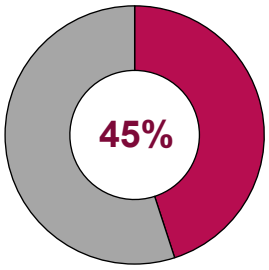
30 per cent of respondents provided an expenditure figure for 2014/15 that was greater than their income. **This means that there were a sizeable number of organisations that spent more money than they received in the past 12 months**. This was, however, lower than the 2012/13 figure of 36 per cent but greater than across Greater Manchester overall (23 per cent).



The precarious financial situation of some organisations is further emphasised by the state of their reserves:



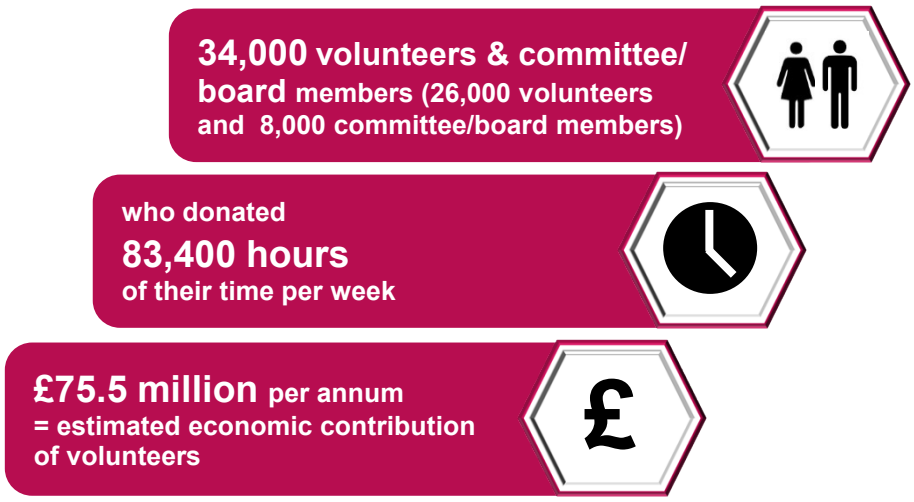
Proportion of organisations with reserves less than one month's expenditure



Proportion of organisations with reserves less than 25 per cent of annual expenditure

Q7. Who works and volunteers in the VCSE sector?

The sector is supported by:



The VCSE sector is also a significant employer. There are an estimated:

1,300 FTE[4] paid staff
employed in the VCSE sector in Tameside

£39.9 million per annum
contributed to the economy by paid employees of Tameside VCSE sector organisations

[4] FTE = Full-time equivalent

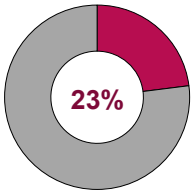
Q8. How good are relationships with public sector bodies?

Survey respondents had dealings with a range of local public sector bodies, the highest responses being in relation to:

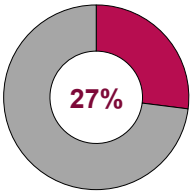
74% **had some dealings with Tameside Council (69% in 2012/13)**

48% **had some dealings with Greater Manchester Police (44% in 2012/13)**

38% **had some dealings with Pennine Care (not asked in 2012/13)**



…**23 per cent** of VCSE organisations are satisfied with their ability to influence Tameside Council, **identical** to the proportion in 2012/13; but more respondents (34 per cent) are satisfied with their ability to influence their most frequent other public sector contact

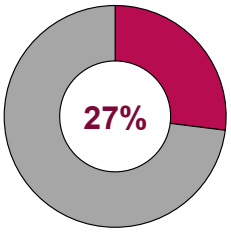


…**27 per cent** of VCSE organisations felt Tameside Council is a positive influence on their success, **similar to** the proportion in 2012/13 (29 per cent) but more respondents (56 per cent) felt their most frequent other public sector contact was a positive influence on their success

Q9. How well does the VCSE sector work with private businesses?

57% **had some dealings with local private businesses (46% in 2012/13)**

… **27 per cent** of respondents felt that the private business community in Tameside was a positive influence on their organisation's success - this is **an increase of 11 percentage points since 2012/13**



Agree private businesses a positive influence

1% **are members of a private sector-led consortium**

Q10. How well does the VCSE sector work together?

53% had a 'great' or 'fair amount' of contact with **other VCSE organisations** in Tameside (31 per cent with VCSE organisations in Greater Manchester)

41% **...satisfied with opportunities to network with other VCSEs**

33% **...satisfied with opportunities to work together to deliver services**

42% IN 2012/13

35% **...satisfied with opportunities to work together to influence decisions**

40% IN 2012/13

13% **are members of a formal VCSE consortium**

Q11. What are the key issues facing the VCSE sector in the future?

Respondents were asked about the strategies they are actively pursuing or planning to pursue. Almost half of respondents or more were already doing or planning to do the following:

57% **increase earned income**

53% **work more closely with another voluntary/not-for-profit organisation**

48% **increase individual donations**

Respondents were also asked to consider the factors they anticipated assisting or constraining their organisation over the next 12 months:

Anticipate assisting the organisation in next 12 months

TOP FACTORS:

Ability to employ staff with sufficient skills (47 per cent assisting or greatly assisting)

Engagement with other VCSE organisations (43 per cent)

Engagement with public sector bodies (42 per cent)

Anticipate constraining the organisation in next 12 months

TOP FACTORS:

Ability to recruit volunteers with sufficient skills (36 per cent constraining or seriously constraining)

The local economy (34 per cent)

1 Introduction

This report provides the main findings of research aimed at improving the understanding of the social and economic impact of the voluntary, community and social enterprise (VCSE) sector in Tameside. The research was commissioned by Action Together as part of 10GM[5] with GMCVO and undertaken by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University.

The key objective of the research was to provide a comprehensive overview of the sector in Tameside at the start of 2017.

The research involved a web-based survey of organisations supporting the people and communities of Tameside and focus groups with VCSE organisations. The research took place between September 2016 and January 2017.

Appendix 1 provides further detail on the research methodology.

[5] 10GM is a joint venture by the Greater Manchester Voluntary Sector Infrastructure Organisations including Salford CVS (lead partner on this research), Action Together in Oldham and Tameside, Bolton CVS, CVS Rochdale, Macc and Wigan and Leigh CVS.

Context for the Research

2

This research comes during both a period of slow economic recovery following the recent long-term economic downturn and a rapidly changing political backdrop as the UK prepares to exit the European Union and the devolution agenda gains pace.

NCVO report that between 2012/13 and 2013/14 the income and spending of the voluntary and community sector in the UK increased, the first notable net growth since the peaks of 2007/08 and 2009/10 respectively.[6] Total income has increased by just over £2.4bn to £43.8bn and now exceeds the 'peak income' seen in 2007/08 (£43.2bn). NCVO also report that following a decrease in income from government after 2009/10, income from government increased between 2012/13 and 2013/14 by around £0.5bn, although this remains below 2009/10 levels. The majority of this increase was in the largest charities which means the impact might not be felt as keenly at a local level. Income from individuals has also increased by just over £1bn between 2012/13 and 2013/14 and is now at its highest ever level.

While these figures provide reasons to be optimistic there is still need for caution. With the election of the Conservative Government in May 2015, austerity measures are set to continue for the foreseeable future and VCSE organisations are likely to feel the impact of these measures. In particular, the Government's commitment to a continuing programme of welfare reform is likely to result in increasing demand for some services as benefits are restricted or withdrawn. The total anticipated reduction by 2020/21, from both pre and post-2015 welfare reforms in Tameside, is predicted to be £121m per year or equivalent to £860 per working age adult per year.[7][8] These reforms are likely to continue to put pressure on VCSE organisations both in terms of their financial health and the need to meet greater levels of need from existing and new beneficiaries.

Locally, the reductions in public expenditure have been felt acutely in Tameside. As part of the Coalition Government's plan to reduce the deficit, it reduced funding for local government in England. Local authorities across Greater Manchester have experienced, and are continuing to experience, a decline in Government funding.

[6] UK Civil Society Almanac (2016) NCVO.
[7] Beatty and Fothergill (2016) *The Uneven Impact of Welfare Reform: The financial losses to places and people.*
[8] Note: These figures are based on HMRC Budgets and Autumn Statements from between 2010 and 2015. In the 2016 Autumn statement the Pay-to-stay measure was scrapped and so this has been taken account of in the figures. The estimate of cuts due to the LHA Cap in social housing was increased by a further £160m p.a. which is not taken account of in the figures. The Universal Credit Taper was also increased by 2p in the pound, an increase in funding of £570m p.a., which is not included in the figures presented here.

In 2015, Tameside was ranked the 41st most deprived area out of 326 local authorities, with eight LSOAs[9] in the worst five per cent nationally for deprivation. 16 of Tameside's LSOAs are among the 10 per cent most deprived for education, skills and training in the country and the borough has 27 LSOAs in the worst 10 per cent for adult skills.

Unemployment is higher than average in Tameside with 5.8 per cent of the total population being unemployed between October 2015 and September 2016 compared to 5.1 per cent in the North West and 4.9 per cent nationally.

Against this background this research provides in depth data about the 'state of the VCSE sector' in Tameside at the start of 2017. The research provides a comprehensive overview of the sector in Tameside for partners to draw upon and further strengthen and support the considerable contribution of the sector.

[9] A Lower Layer Super Output Area (LSOA) is a geographic area. Lower Layer Super Output Areas are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales

3 What the Voluntary Community and Social Enterprise Sector in Tameside does

This chapter develops a picture of the core features of the voluntary, community and social enterprise (VCSE) sector in Tameside. It focuses on a series of general questions in which respondents were asked about their group or organisation: what it is and what it does.

3.1. How many VCSE organisations are there in Tameside?

Estimating the number of organisations represents a major challenge. This is because a large proportion of organisations are small, local and **not formally constituted** as charities, limited companies or other recognised forms which require registration (e.g. industrial and provident societies). As a result they do not appear on formal central records such as those held by the Charity Commission or Companies House so are considered **'below the radar' (BTR).** Any estimate of the total number of organisations in an area therefore requires information on the numbers of registered and unregistered (i.e. BTR) organisations.

In estimating the total number of organisations in Tameside we drew on information from the following sources:

- The Register of Charities in England and Wales, which indicated **270** registered charities with postcodes in Tameside.
- The ratio of charities to non-charities provided in the 'National Survey of Charities and Social Enterprises' (NSCSE), undertaken by Ipsos MORI for the Cabinet Office in 2010. This was used to gross the estimate upwards to a total of **355** registered organisations, to take account of non-charitable social enterprises.
- Research by NCVO and the University of Southampton[10] which found that on average there are 3.66 BTR organisations per 1,000 population. If this figure is applied to Tameside[11], it can be estimated that there are **811** BTR organisations in the borough. [12]

[10] Mohan, J et al. (2010). *Beyond 'flat-earth' maps of the third sector: enhancing our understanding of the contribution of 'below-the-radar' organisations*. Northern Rock Foundation Briefing Paper
[11] Based on Office for National Statistics 2015 population estimates
[12] It is important to note that the BTR figure is an estimate based on an average across 46 local authorities. The BTR research found significant variability, with some local authorities reaching over seven BTR organisations per 1,000 population, and in one case exceeding ten.

Summing the estimated numbers for both registered and BTR organisations produces an estimated figure of:

1,167 organisations *in total operating in the VCSE sector in Tameside.*

This figure is in line with Action Together's estimation of the number of VCSE organisations in the sector in Tameside, which draws on their database of groups which is comprised mostly of BTR groups.

This is higher than the estimate produced for the 2013 report (1,068). Whilst this may reflect a genuine increase in the number of voluntary organisations between the two surveys this could also in part be due to unavoidable differences in the estimation methodology.

For the 2013 report, the sampling frame for the NSCSE was used to provide the estimates for the number of formally registered organisations. Unfortunately this survey was subsequently cancelled. As such, only the ratio of charities to non-charities was taken from this data source and combined with the number of charities from the charity register.

3.2. What size are organisations in Tameside?

The size of organisations is traditionally measured using their annual income[13]. When the distribution of organisations across Tameside was explored by size category based on income for 2014/15, it showed that **the majority of organisations were either micro or small**. But the survey was under-representative of BTR organisations (only 38 per cent of survey respondents were identified as BTR), so this did not present an accurate picture of the actual distribution. The figures were therefore adjusted based on the assumption that the estimated 357 organisations not included in the survey sample were BTR and micro in size[14].

Exploring the distribution by size category based on income for 2014/15 across Greater Manchester also showed some inconsistency with the distribution found in 2013. Therefore, in order to provide the most robust estimate of the distribution of organisations in the VCSE sector by size, data from both waves of the survey have been used to calculate the proportion of organisations estimated to be in each size category.

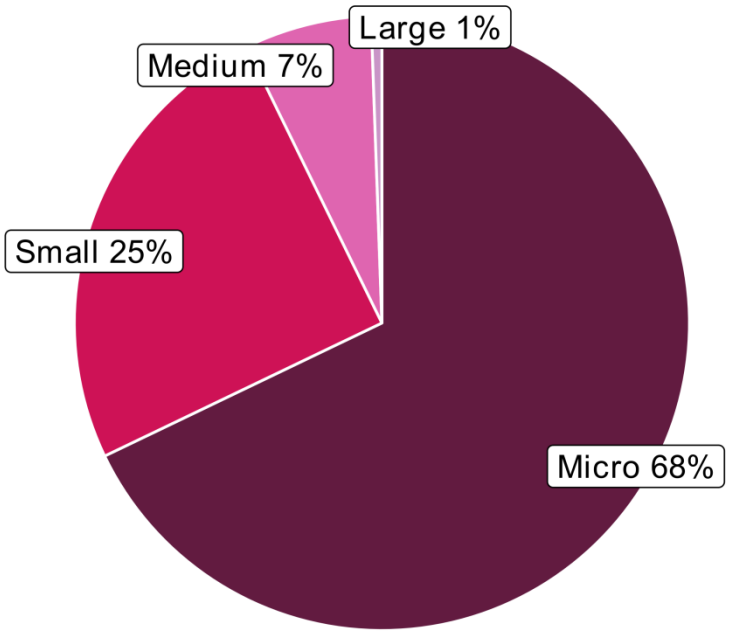
The outcome of this process is shown in figure 3.1, which demonstrates that an estimated 68 per cent of the VCSE sector (792 organisations) are micro in size, 25 per cent are small (290 organisations), seven per cent are medium (78 organisations), and one per cent are large (seven organisations).

Introducing the BTR figure produces a much higher estimate for the number and proportion of micro organisations and emphasises the finding that a large proportion of organisations in the VCSE sector in Tameside are very small (93 per cent micro or small). This is similar, but even more pronounced, to the national picture: NCVO[15] estimate that 83 per cent of the VCSE sector is made up of micro or small organisations, 14 per cent are medium, and three per cent are large. Results are

[13] In exploring organisation size we used the categories developed by NCVO for use in their Almanac series (see e.g. Clark, J *et al*., 2010)
[14] The basis for these assumptions is discussed in more detail in the methodological annex
[15] UK Civil Society Almanac (2016) NCVO.

also consistent with the pattern across Greater Manchester as whole, where 90 per cent of organisations are micro or small, eight per cent are medium and two per cent are large.

Figure 3.1: Proportion of Tameside VCSE organisations by size (estimated)



Source: Tameside State of the VCSE sector survey 2016/17
Base: 95

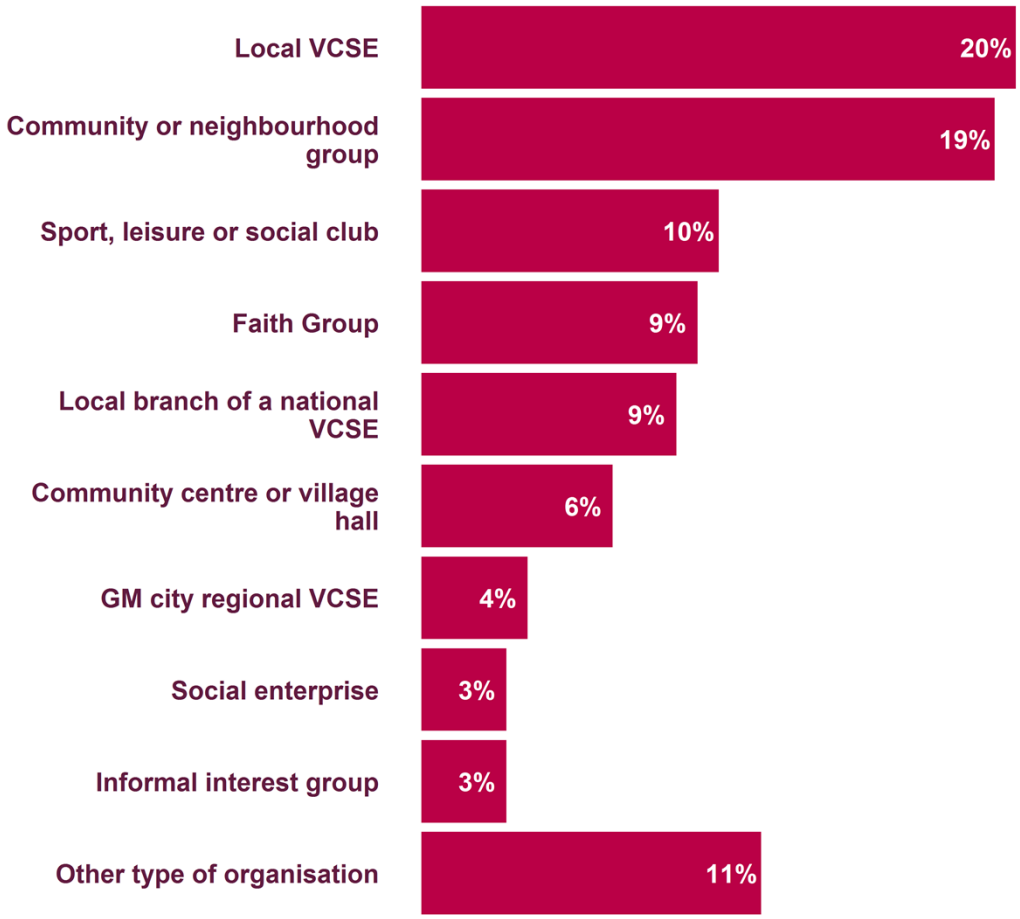
3.3. What types of organisations operate in the VCSE sector in Tameside?

Respondents to the questionnaire were asked to identify which category from a list of 'organisation types' best described their organisation. The results indicate that many organisations in the VCSE sector are likely to have a local focus. Figure 3.2 shows that the largest proportion, **20 per cent, identified their organisation as being a local voluntary organisation**. The second most common category was 'community or neighbourhood group', with which 19 per cent of organisations identified. Ten per cent identified as a 'sport, leisure or social club' and nine per cent as 'faith group'. Nine per cent also identified as local branches of a national organisation, noticeably lower than the proportion of local VCSEs. No respondents identified as just a 'national organisation'.

This breakdown of organisations by type followed a similar pattern to that in the 2012/13 survey. The four largest categories were the same: community or neighbourhood group (21 per cent), local voluntary organisation (17 per cent) and faith group (16 per cent) and sport, leisure or social club (13 per cent).

The analysis across Greater Manchester found a similar picture with local voluntary organisations (22 per cent) and community or neighbourhood groups (15 per cent) accounting for 38 per cent of respondents. Only 13 per cent of respondents stated they were either a national voluntary organisation (two per cent), a branch of a national voluntary organisation (six per cent) or an affiliated member of a national voluntary organisation (four per cent).

Figure 3.2: Type of organisations[16]



Source: Tameside State of the VCSE sector survey 2016/17
Base: 140

3.4. How long have organisations in the VCSE sector been operating?

The questionnaire asked respondents to indicate when their organisation was formed. Assessment of organisations by the year in which they were formed provides an indication of how established the VCSE sector was in Tameside.

The responses received build a picture of a VCSE sector that has a fairly well established core. However, the VCSE sector in Tameside has also seen the formation of many new organisations since 2001. Figure 3.3 shows that 56 per cent of organisations responding to the survey had been formed since 2001, including 46 per cent in the past 10 years (i.e. since 2006). Furthermore, an additional 10 per cent were formed between 1991 and 2000; this means **two-thirds (66 per cent) of organisations were formed in the last 25 years.** At the other end of the spectrum 23 per cent of organisations had been formed before 1971, including nine per cent formed in 1910 or before.

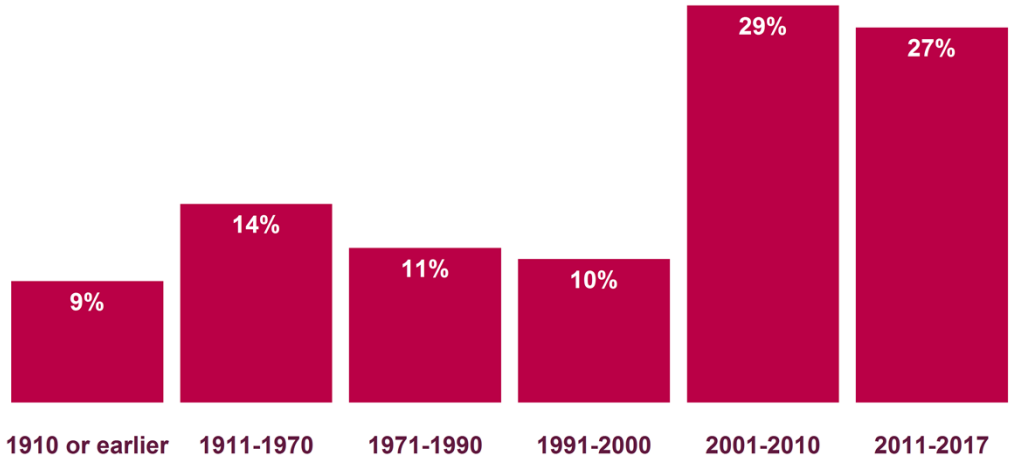
In the 2012/13 survey, 57 per cent of organisations were formed since 1991, including 38 per cent, which had been formed in the past 10 years. 15 per cent of

[16] A range of responses were received under 'other type of organisation'. These included: arts and cultural organisation, social rehabilitation skills centre, coaching and camera club.

organisations in 2012/13 had been formed in 1910 or before, compared with just nine per cent in the 2016/17 survey.

The pattern for organisations responding to all of the Greater Manchester surveys was broadly similar. 43 per cent of respondents had been formed in the past 10 years and six per cent of Greater Manchester organisations had been formed before 1911.

Figure 3.3: Year in which organisations were formed



Source: Tameside State of the VCSE sector survey 2016/17
Base: 126

It is important to conclude this section by drawing a significant qualification. Although the results suggest that it is likely that the VCSE sector in Tameside has experienced growth in the number of organisations established in the last 20 years or so, it may not be as dramatic as the figures suggest. By definition, the survey is of organisations still operating in Tameside in 2016/17, not those which have closed down or ceased operations. Of the organisations which have survived through to 2016/17, the results suggest that a high proportion were established in the last 20 years. But some of the organisations established before, and since, may have subsequently closed down. Because we do not know the rate of closure over time we cannot be certain that the aggregate number of organisations being established or surviving is increasing.

3.5. What does the VCSE sector in Tameside do?

To elicit a picture of what the VCSE sector in Tameside does, the survey asked respondents to identify up to three main areas in which their organisation operates. Figure 3.4 presents the top ten main areas selected and confirms the message that the VCSE sector in Tameside works in a diverse range of thematic service areas. However, the proportion of responding organisations working in each area varies. This is most likely dependent on need and funding opportunities.

Figure 3.4 shows:

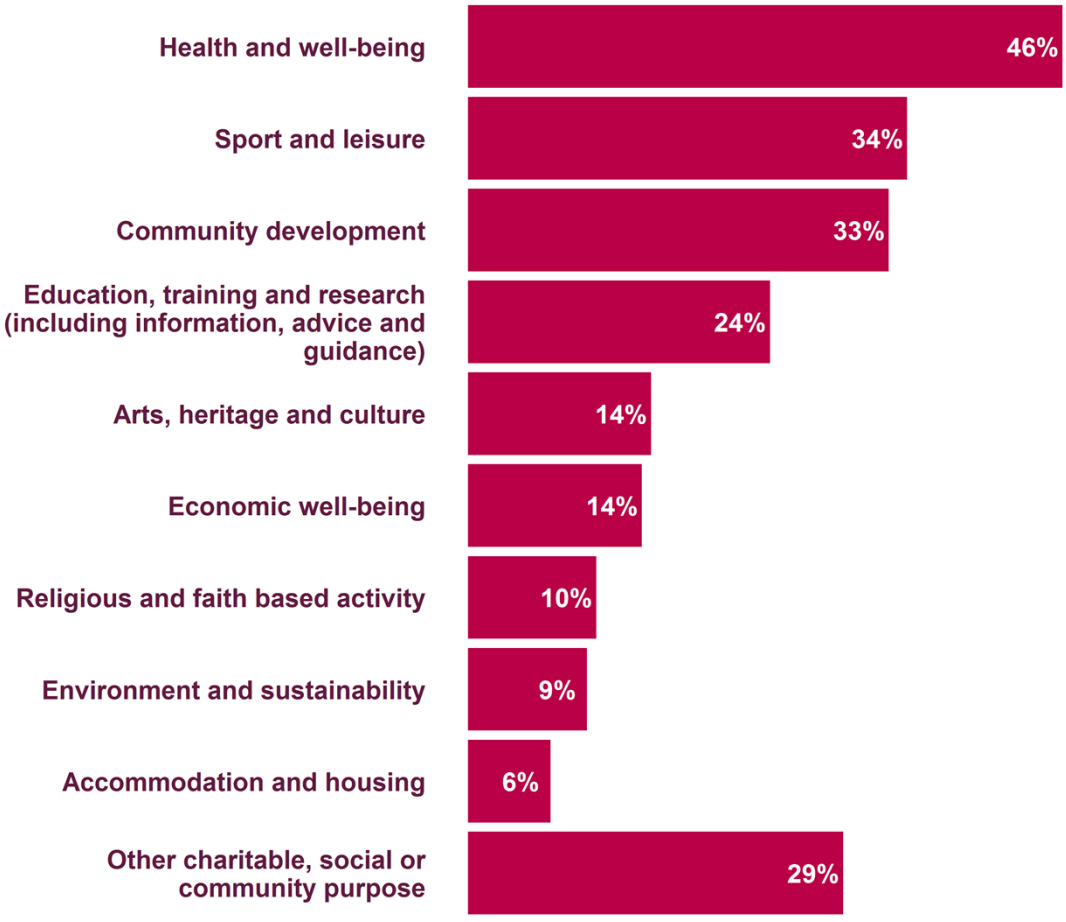
- **46 per cent of organisations worked in the area of health and well-being, the most common area**; in 2012/13 this area was the second most common main area (32 per cent)

- 34 per cent also worked in sport and leisure (32 per cent in 2012/13) and 33 per cent work in community development (33 per cent in 2012/13, the most common category)
- 24 per cent worked in education, training and research (26 per cent in 2012/13).

Across Greater Manchester as a whole the same four areas of work were reported as being the most common to work within:

- health and well-being (46 per cent)
- community development (39 per cent)
- sport and leisure (25 per cent)
- education, training and research (26 per cent).

Figure 3.4: Top 10 main areas in which organisations work[17]



Source: Tameside State of the VCSE sector survey 2016/17
Base: 140

Respondents who indicated they worked in the area of health and well-being were asked to specify the specific areas in which they operate. The majority (82 per cent) stated they worked in health and well-being in general. **Around half (49 per cent)**

[17] A range of responses were received under 'other charitable, social or community purpose'. These included: food hamper scheme, digital inclusion, family and parent support and not for profit advice.

indicated they worked in mental health. Other common areas were healthy living (food & lifestyle, sexual health) (28 per cent), support for carers (26 per cent), and disability or sensory impairment (18 per cent). Responses were similar at the Greater Manchester level, **though the proportion working in the area of dementia is higher (24 per cent versus 13 per cent in Tameside).**

In a similar vein, respondents who identified education, training and research as a main area of work were asked to specify the areas they worked within this theme. Of the 32 respondents who answered this question, 23 (72 per cent) worked in information, advice and guidance, 18 (56 per cent) worked in the area of employability skills, and 16 (50 per cent) worked in education generally.

4

Who the Voluntary Community and Social Enterprise Sector in Tameside works with

This chapter focuses on who the VCSE sector in Tameside works with and where.

4.1. Who are the clients, users or beneficiaries of the VCSE sector in Tameside?

The questionnaire asked respondents to provide the total number of individual clients, users or beneficiaries that their organisation had supported in the last year, both overall and within Tameside. Analysis of responses to this question by size and type of organisation revealed that in many cases organisations had provided the number of 'interventions' or 'contacts' that they had had with clients, users or beneficiaries. So, for example, an individual who visited a community centre once a week would have been counted 52 times within the year. Whilst some organisations will have provided the number of unique clients, users or beneficiaries, so as not to overestimate, in our analysis we have assumed the number provided represents the total number of interventions.

Summing across the 115 organisations that responded gives a total of 188,000 interventions overall (i.e. with individuals both within Tameside and beyond). Doing the same for the 121 organisations who provided a figure for Tameside specifically gives a total of 184,000 interventions in Tameside. The responses received can be extrapolated for the estimated 1,167 organisations thought to be operating in the VCSE sector in Tameside to provide an estimate of the total number of interventions by Tameside organisations. Working through the calculation it is estimated that Tameside organisations had:

1.5 million interventions ***with clients, users or beneficiaries in the past year overall***

1.3 million interventions ***with clients, users or beneficiaries in the past year in Tameside***

The 2012/13 study estimated that Tameside organisations made 1.4 million interventions with clients, users or beneficiaries overall (i.e. with individuals both within Tameside and beyond).

The questionnaire also asked respondents to identify up to three groups that make up the main clients, users or beneficiaries of their organisation.

Figure 4.1 shows that, as might be expected, the VCSE sector in Tameside serves a diverse and wide ranging population. In many cases, client groups are served by relatively small numbers of organisations: 10 per cent of organisations or fewer served 17 of the client groups listed.

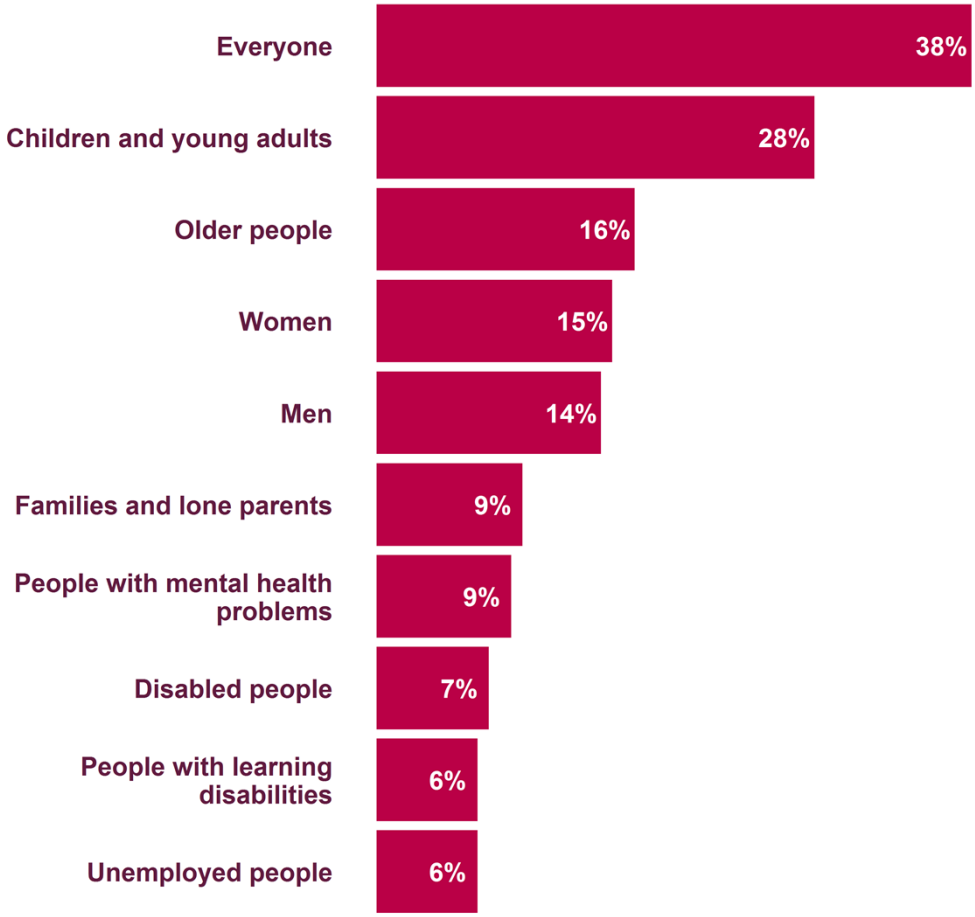
Figure 4.1 shows that the client groups served by the largest proportions of organisations can be broadly characterised as being demographic: gender - women (15 per cent) and men (14 per cent) - and age - older people (16 per cent) and children and young adults (28 per cent). Over a third (38 per cent) of organisations identify 'everyone' as their main clients, users or beneficiaries.

General and demographic client groups were also the most common groups identified in the 2012/13 survey, although the ordering was different. In 2012/13 the most common client groups were women (32 per cent), children (30 per cent), older people (30 per cent), men (28 per cent) and young people (25 per cent).

Analysis of responses to the Greater Manchester survey found a broadly similar pattern with general and demographic client groups also being the most common beneficiary groups identified:

- everyone: 33 per cent
- children and young adults: 23 per cent
- older people: 17 per cent
- women: 15 per cent
- men: 12 per cent.

Figure 4.1: Top 10 main client groups of Tameside organisations

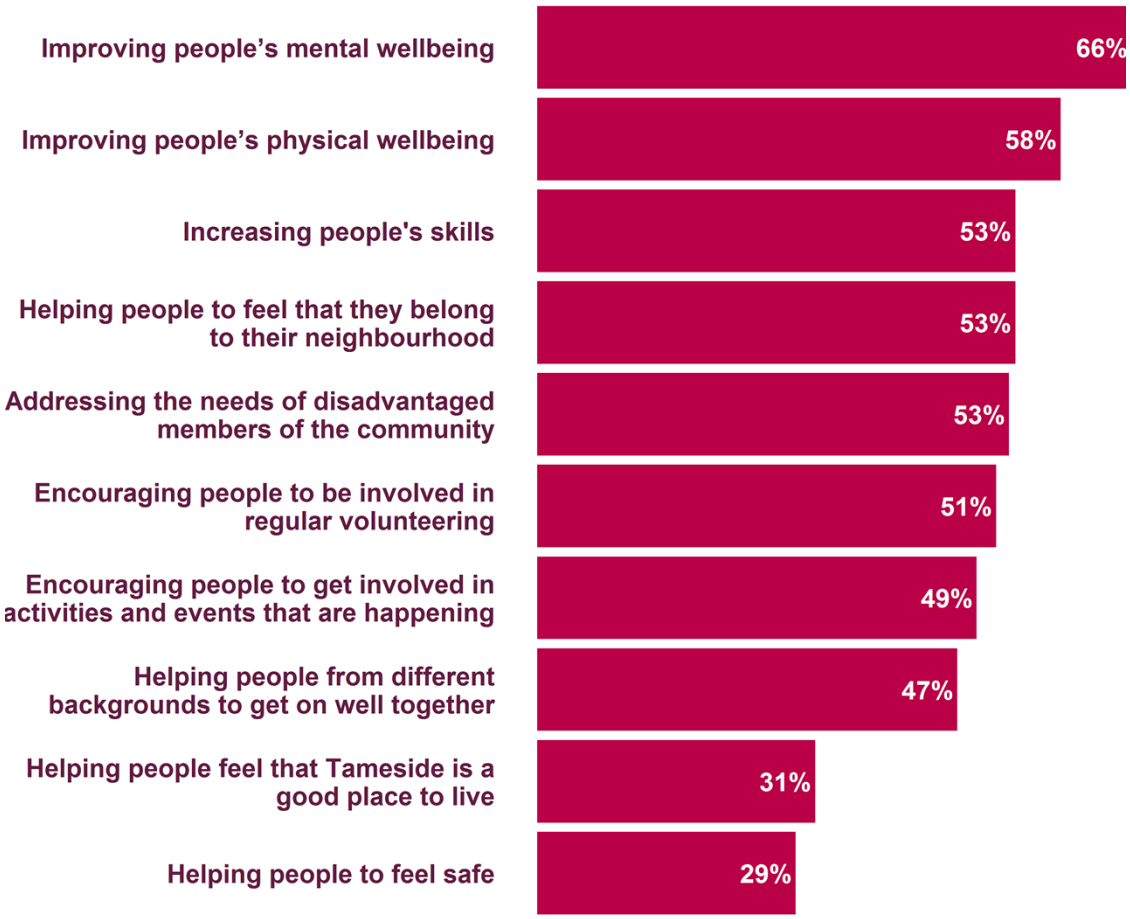


Source: Tameside State of the VCSE sector survey 2016/17
Base: 140

Respondents to the survey were asked to identify the ways in which their organisation makes a difference for its service users/client group(s). **This question demonstrates the key role that the VCSE sector has in fostering strong and cohesive communities within Tameside and highlights the importance of the VCSE sector as an essential part of the social fabric of the borough.**

As figure 4.2 shows, **two-thirds felt they were improving people's mental wellbeing** (66 per cent; 68 per cent across Greater Manchester) and **58 per cent** claimed **they were improving people's physical wellbeing** (56 per cent across Greater Manchester). An equal proportion of respondents claimed to be increasing people's skills, helping people to feel that they belong to their neighbourhood, and addressing the needs of disadvantaged members of the community (all 53 per cent).

Figure 4.2: Top 10 ways in which organisations make a difference



Source: Tameside State of the VCSE sector survey 2016/17
Base: 139

4.2. What geographical levels does the VCSE sector operate at?

The survey asked respondents to identify the main geographical levels at which they operate – this ranged from the neighbourhood level, to those operating across England, the UK or overseas[18]. In this question respondents were asked to pick out up to three main geographic levels, the results of which are presented in figure 4.3. This shows that the **local area is a main focus for a majority of organisations**:

- over half (53 per cent) identified particular Tameside neighbourhoods or communities as a main focus; slightly lower than the proportion of organisations in the 2012/13 survey (63 per cent)
- a further 39 per cent identified the whole of the Tameside local authority area as a main focus of their work; similar to the proportion of organisations in the 2012/13 survey (36 per cent).

A relatively low proportion of organisations cited that a main geographic area at which they work is either national (seven per cent) or international (five per cent). In

[18] This question was asked slightly differently in the latest survey compared to 2012/13. Two additional options ('Across more than one Greater Manchester Local Authority area' and 'Across the whole of Greater Manchester') were included.

many cases those organisations that work internationally will reflect their main clients, users and beneficiaries.

The picture for Greater Manchester organisations shows a relatively high proportion also identified particular neighbourhoods and communities as a main geographic focus (44 per cent). The percentage of organisations who said they work nationally and internationally was similar within Tameside and Greater Manchester.

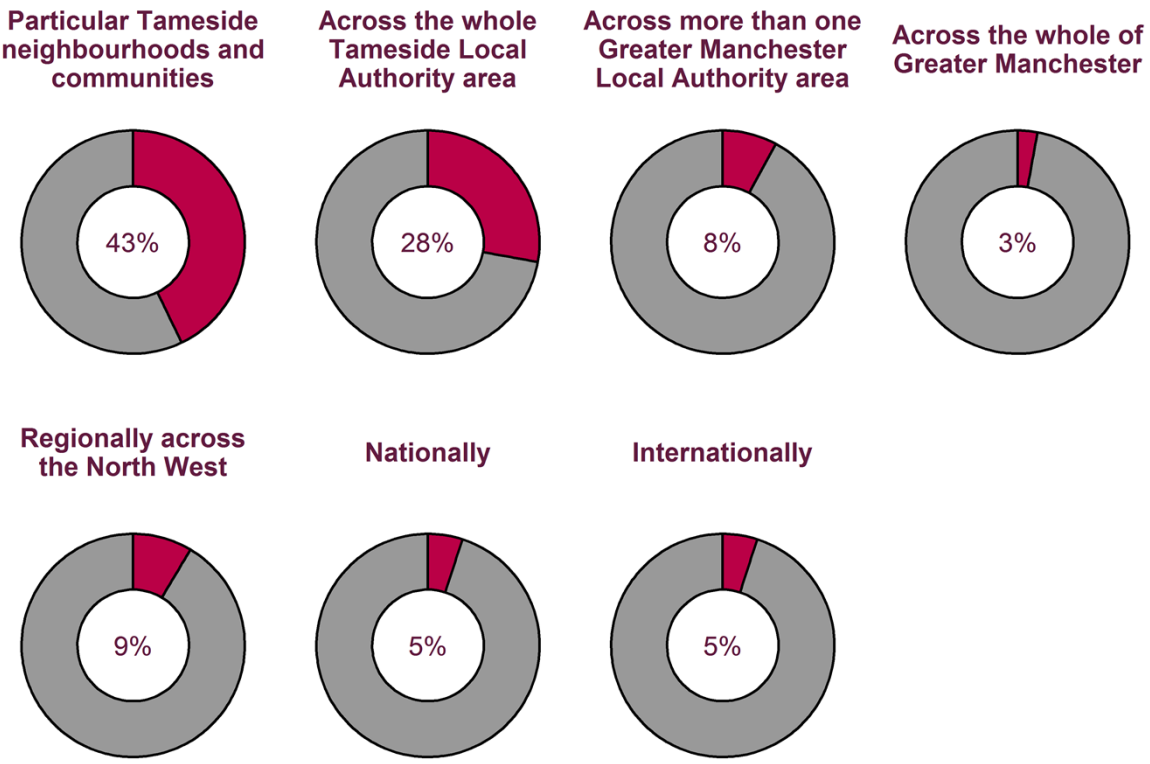
Figure 4.3: Main geographic focus

Source: Tameside State of the VCSE sector survey 2016/17
Base: 140

Using the responses to this question it is also possible to identify the highest main geographic area that an organisation carries out its activities (see figure 4.4 below). The highest geographic area that could be identified was internationally.

This analysis finds that for over two-fifths (43 per cent) their highest main geographic focus was particular Tameside neighbourhoods or communities; similar to the proportion in 2012/13 (48 per cent). **This is higher than Greater Manchester as a whole where 34 per cent of organisations indicated their highest main geographic focus was particular neighbourhoods and communities.**

Figure 4.4: Highest geographic focus



Source: Tameside State of the VCSE sector survey 2016/17
Base: 140

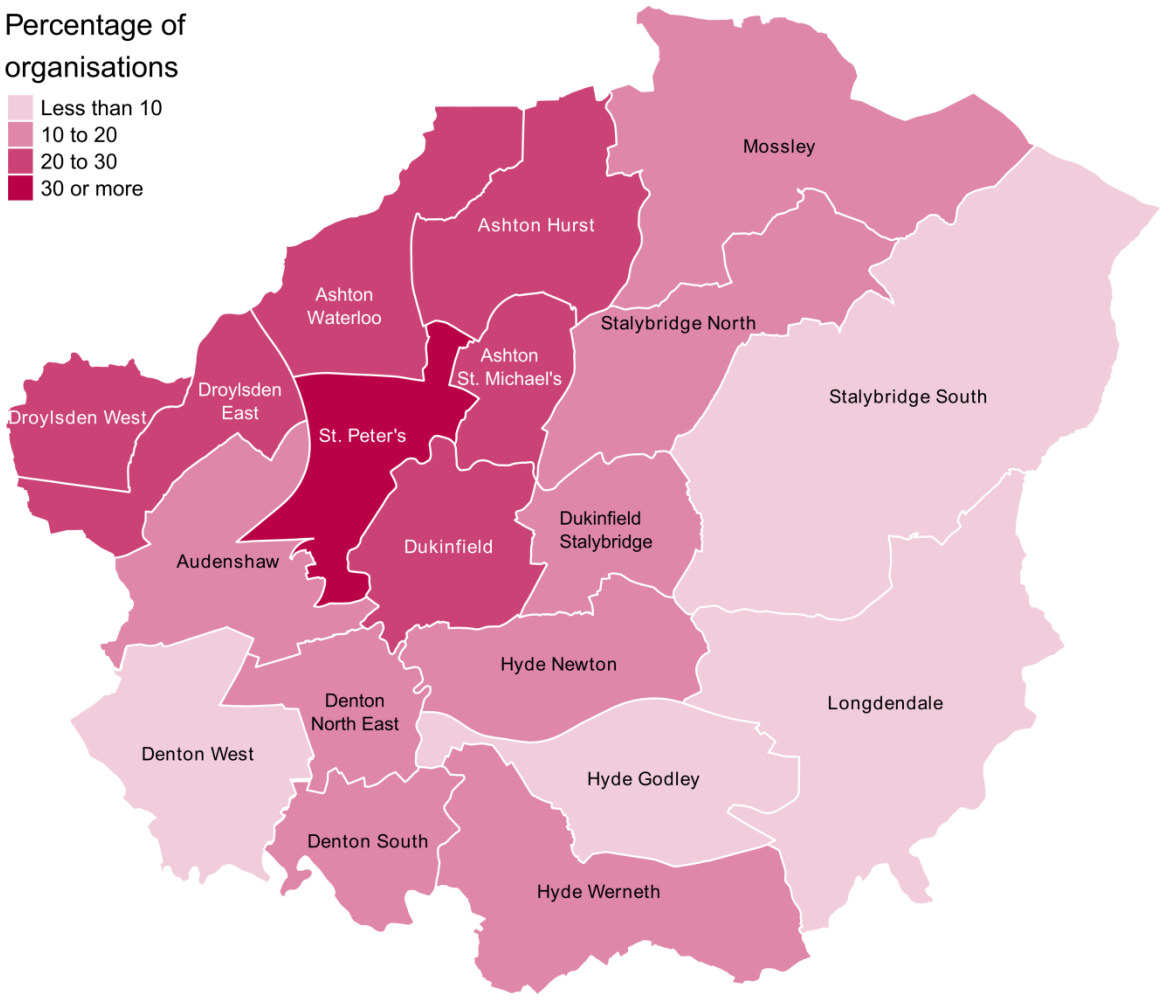
Respondents who reported that the whole Tameside local authority area or particular Tameside neighbourhoods or communities were the main geographic focus of their organisation, were asked to identify in which wards their work focused on. Map 4.1 shows the percentage of all organisations that identified each of Tameside's wards as a main focus of their work.

35 per cent identified Ashton St Peter's as a main focus of their work. The next two most common wards were Ashton St. Michael's (28 per cent) and Ashton Hurst (25 per cent).

The four wards which were a main focus for the lowest proportions of Tameside organisations were:

- Denton West (ten per cent)
- Stalybridge South (ten per cent)
- Hyde Godley (eight per cent)
- Longdendale (seven per cent).

Map 4.1: Percentage of organisations that identify Tameside's wards as a main focus of their work



Source: Tameside State of the VCSE sector survey 2016/17
Base: 72

5 Finances and Income

This chapter provides an overview of the finances and income of the VCSE sector in Tameside. It includes estimates of the overall income received by the sector between 2012/13 and 2014/15, analysis of the different sources of income received (public sector and non-public sector) and their relative contribution, and an assessment of the financial sustainability of the VCSE sector.

Where possible this chapter compares results from the latest survey and the 2012/13 study. Revisions to the questionnaire and methodology between these studies, however, mean that comparisons are not always possible or appropriate and that caution should be applied when comparing across the two waves (see Appendix 1 for more detail).

5.1. Income

Based on the average (mean) income of respondents to the survey across Greater Manchester, and drawing on the assumptions used to estimate the total number of organisations in Tameside, the following is estimated -[19]

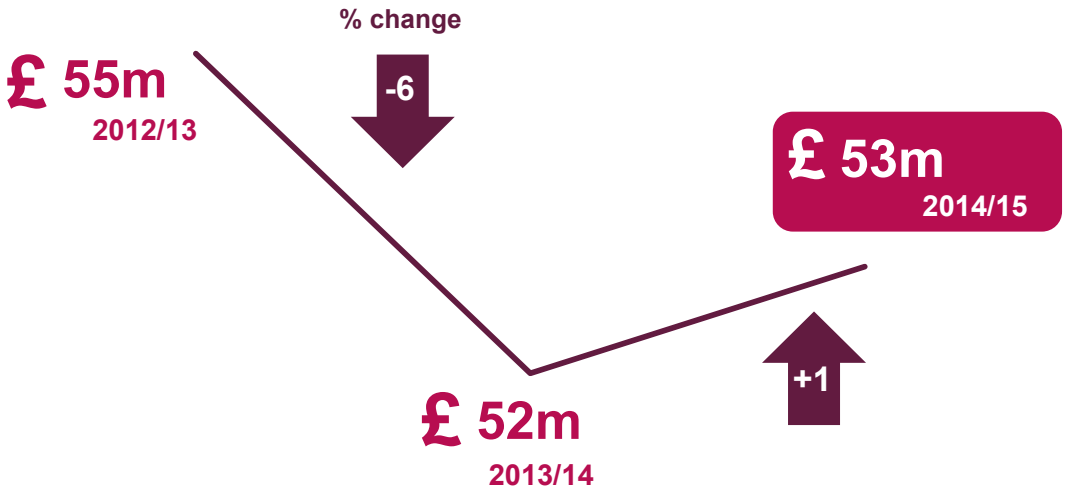
£53 million ***the total income of the VCSE sector in Tameside in 2014/15***

This total income estimate is higher than the figure of £47 million estimated for the sector in 2011/12 from the 2012/13 survey. It also represents an increase of one per cent compared to 2013/14 when the total income of the VCSE sector was an estimated £52 million. This follows a reduction between 2012/13 and 2013/14 of an estimated six per cent in the total income of the sector.

This data is outlined in more detail in figure 5.1.

[19] This figure is based on a weighted average (mean) for each size category for respondents from across Greater Manchester. The methodology is explained in more detail in the methodological appendix.

Figure 5.1: Estimated annual income of the VCSE sector in Tameside (2012/13-2014/15)



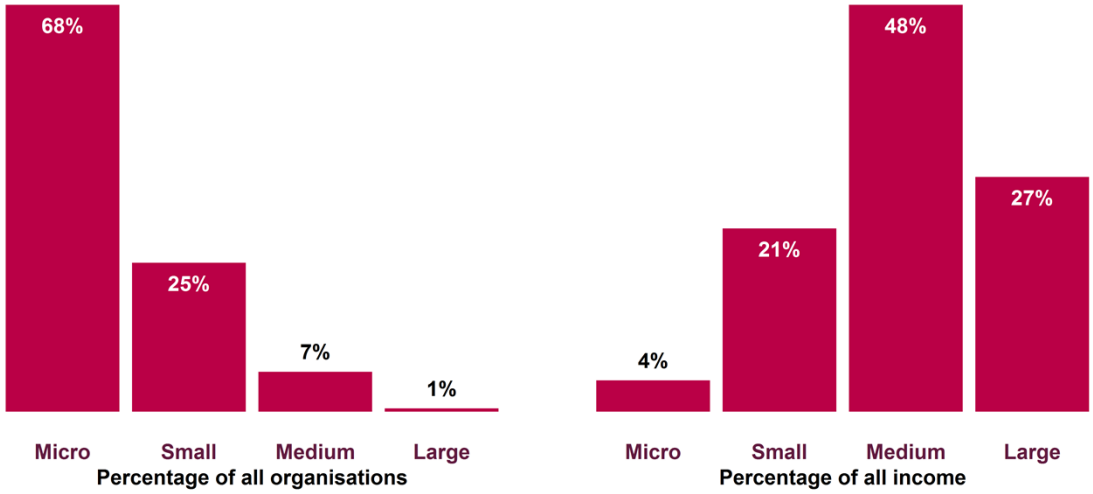
Source: Tameside State of the VCSE sector survey 2016/17
Base: 95 All figures are in 2014/15 prices

This change in income should be viewed in the wider national context discussed in Chapter two. The picture is somewhat more positive than in the previous 2012/13 study. Between 2012/13 and 2013/14 the income and spending of the VCSE sector in the UK increased, representing the first notable net growth since the peaks of 2007/08 and 2009/10 respectively. While the data above shows a decrease in Tameside between these two years, results indicate a more recent upturn in the local area. However, with austerity measures set to continue for the foreseeable future and public sector funding for the sector continuing to be squeezed, there is still need for caution.

When the VCSE sector's income is explored in more detail it shows notable variations according to organisation size[20]. In 2014/15, the majority of income was concentrated in large and medium sized organisations even though the majority of organisations were micro or small. This is outlined in more detail in figure 5.2.

[20] In exploring organisation size we used the categories developed by NCVO for use in their Almanac series (see e.g. Clark *et al*., 2010)

Figure 5.2: Proportion of organisations and proportion of income by organisation size (2014/15)



Source: Tameside State of the VCSE sector survey 2016/17
Base: 95

This shows that **micro and small organisations account for over nine out of ten organisations in the VCSE sector but only a quarter of total income** in Tameside. By contrast medium and large organisations account for just seven per cent of the VCSE sector's organisations but receive 75 per cent of its income.

Analysis of income data from survey respondents across Greater Manchester[21] identified further variations according to organisation size when we explored how income levels had changed between 2012/13 and 2014/15. These are summarised in table 5.1.

Table 5.1: Estimated change in annual income by organisation size (all Greater Manchester organisations: 2012/13-2014/15)

	Micro (under £10k)		Small (£10k-£100k)		Medium (£100k-£1m)		Large (more than £1m)	
	Income	*% change*	*Income*	*% change*	*Income*	*% change*	*Income*	*% change*
2012/13	£32.3m		£84.9m		£413.9m		£829.2m	
2013/14	£31.0m	-4	£82.4m	-3	£382.8m	-8	£785.1m	-5
2014/15	£30.0m	-3	£77.0m	-7	£391.5m	2	£822.6m	5

Source: Greater Manchester State of the VCSE sector survey 2016/17
Base: 720 All figures are in 2014/15 prices

This shows that across Greater Manchester the micro and small organisation categories experienced year on year reductions in total income between 2012/13 and 2014/15. For micro organisations this is a continuation of a trend identified in the 2012/13 survey where these organisations experienced a reduction of more than 10 per cent between 2010/11 and 2011/12. In contrast the 2012/13 survey identified a small increase in income between 2010/11 and 2011/12 for small organisations.

[21] It was not possible to undertake sufficiently robust analysis of these trends at a local authority level

By contrast medium and large organisations saw a reduction in total income between 2012/13 and 2013/14 but then an increase between 2013/14 and 2014/15. For medium organisations this could indicate the start of a reversal in a trend identified in both the 2010 and 2012/13 surveys where year-on-year reductions in income were identified. This income volatility is a significant challenge in the operating context for medium and large organisations.

5.2. Sources of Income

5.2.1. Public sector income

Survey respondents were asked to identify the public sector bodies from which they received funding in their most recent financial year. Overall, **56 per cent of respondents reported having at least one source of public sector funds**. This is similar to the 50 per cent who reported having public sector funds in the 2012/13 survey **but lower than the figure for Greater Manchester as a whole (68 per cent).**

Grant funding administered by Action Together on behalf of a public sector body, and funding from Tameside Council, were the joint most common sources of public sector funding (22 per cent for both). The former was a new category for the 2016/17 survey, but a similar category referring to grant funding administered by TS3C or Volunteer Centre Tameside was recorded by 24 per cent in 2012/13. Tameside Council was reported as a funder more frequently in 2012/13 (35 per cent).

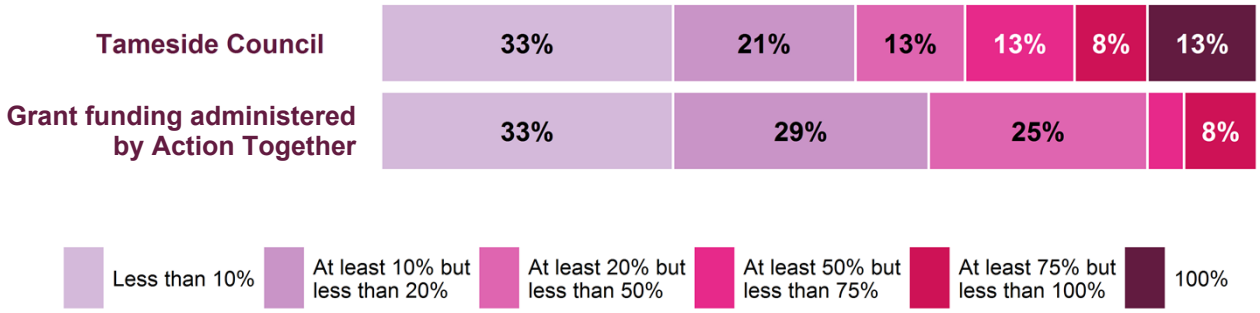
The other potential sources of funding were identified much less frequently. The next most common was Tameside and Glossop Clinical Commissioning Group, identified by only three respondents (three per cent).

Respondents were also asked to estimate the proportion of their group or organisation's total income that each source of public sector income represented. Figure 5.3 shows the two most common sources of public sector funding received and the estimated proportion of total income this represents.

This shows that of those receiving funding from Tameside Council, 67 per cent reported it accounted for less than half their income. For grant funding administered by Action Together the comparable figure was considerably higher at 88 per cent.

The survey also asked respondents with public sector income whether they had received a formal funding agreement for each source. Of the two most frequently identified sources, 92 per cent of funding from Tameside Council and 94 per cent of grant funding administered by Action Together was made with a formal agreement.

Figure 5.3: Public sector funds received by Tameside respondents (2014/15)

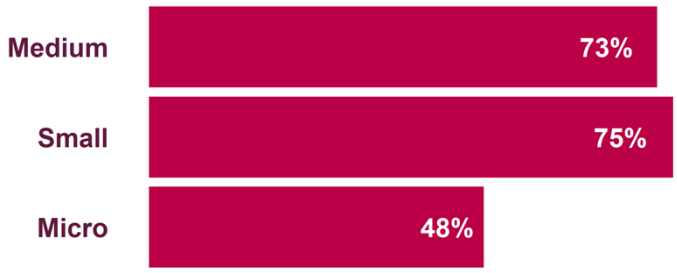


Source: Tameside State of the VCSE sector survey 2016/17
Base: 24

The survey also revealed notable variations in public sector income received by organisations of different sizes. Micro organisations were less likely than small or medium organisations to have at least one source of public sector income (no large organisations responded to this question). This is outlined in more detail in figure 5.4.

This shows that only 48 per cent of micro organisations that responded to the survey received public sector funding (the same as in 2012/13) compared to 75 per cent of small organisations (up from 64 per cent in 2012/13) and 73 per cent of medium organisations.

Figure 5.4: Proportion of Tameside organisations in receipt of public sector funds by organisation size (2014/15)



Source: Tameside State of the VCSE sector survey 2016/17
Base: 91

5.2.2. Other sources of income

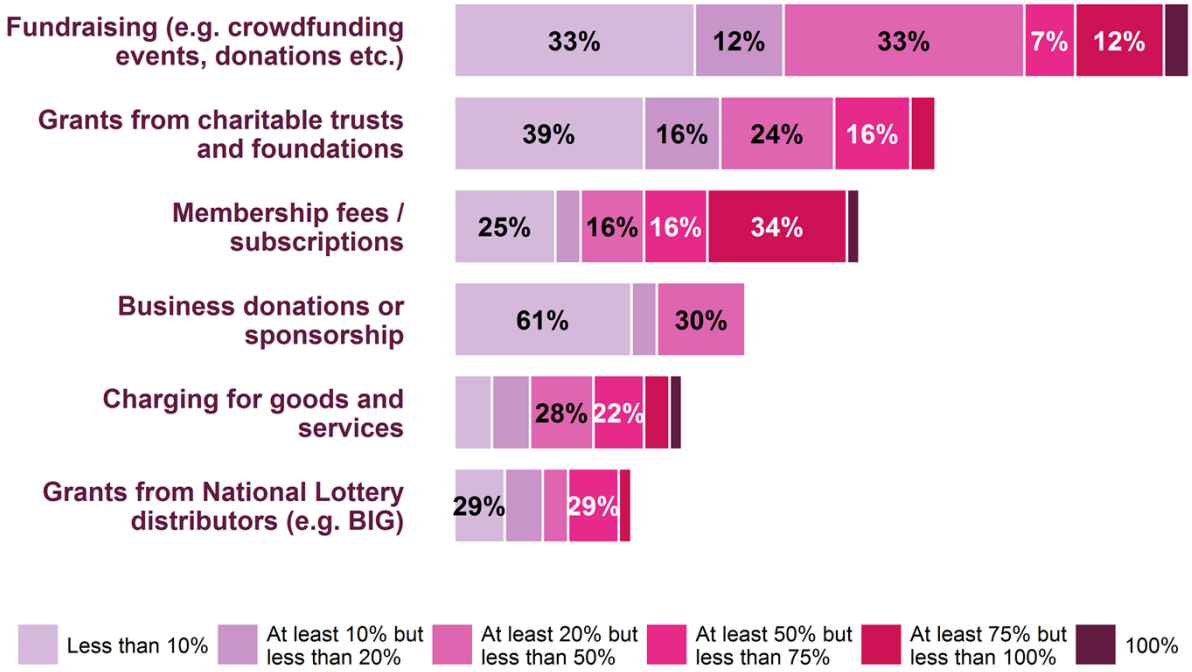
Survey respondents were also asked to identify any other sources of income (i.e. non-public sector) they received in 2014/15. Overall, **81 per cent of respondents received funds from at least one non-public sector source**. This is a noticeable increase from the figure of 63 per cent in 2012/13. Across Greater Manchester 84 per cent of respondents received non-public sector income.

Fundraising was the most frequently identified source of other funds (55 per cent of respondents) followed by grants from charitable trusts and foundations (38 per cent) and membership fees and subscriptions (29 per cent). Fundraising was also the most common type of other funding received across Greater Manchester as a whole, (50 per cent), as well as in 2012/13 (41 per cent).

Respondents were also asked to estimate the proportion of their group or organisation's total income received from each of the non-public sector funding sources. Figure 5.5 shows the most prominent sources of non-public sector funding received and the estimated proportion of total income this represents.

Figure 5.5 shows that for a third (33 per cent) of those receiving income from fundraising, this funding represented less than 10 per cent of their total income. At the other end of the spectrum, for 22 per cent of organisations this represented at least 50 per cent of their total income. The figures are similar for the second most common source, grants from charitable trusts and foundations. 39 per cent relied on this funding for less than 10 per cent of their income and 21 per cent for 50 or more per cent.

Figure 5.5: Other funds received by Tameside respondents (2014/15)



Source: Tameside State of the VCSE sector survey 2016/17
Base: 14-58

Micro organisations were less likely than small, and medium organisations to have income from non-public sector sources (77 per cent, up from 61 per cent in 2012/13) (again there were no responses from large organisations). This is demonstrated by figure 5.6. A majority (around three-quarters or more) of each size of organisation had income from non-public sector sources.

Across Greater Manchester the pattern was similar. Three-quarters (75 per cent) of micro organisations were in receipt of non-public sector funds, lower than the proportion of small organisations (92 per cent) and medium organisations (95 per cent).

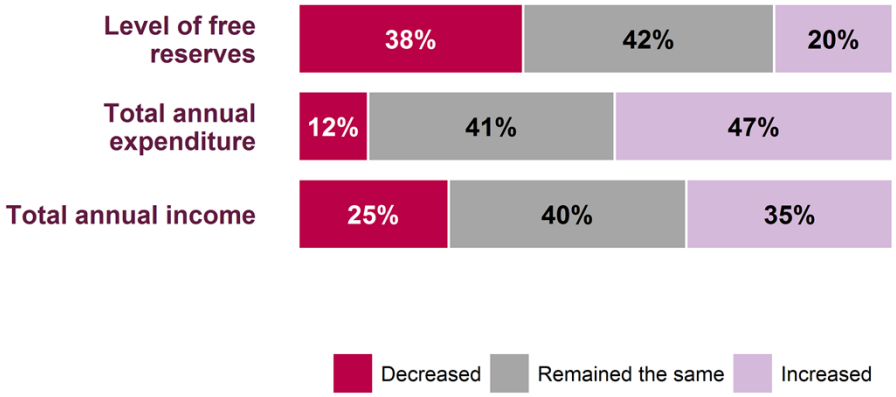
Figure 5.6: Proportion of organisations in receipt of non-public sector funds by organisation size (2014/15)

Source: Tameside State of the VCSE sector survey 2016/17
Base: 92

5.3. Financial Sustainability

The survey asked respondents about how their organisation's financial situation had changed in the past 12 months (i.e. during the current financial year). The results are outlined in figure 5.7.

Figure 5.7: Change in financial circumstances in the last 12 months



Source: Tameside State of the VCSE sector survey 2016/17
Base: 95 (income), 94 (expenditure), 90 (free reserves)
Note: 'cannot say' response has been excluded from the analysis

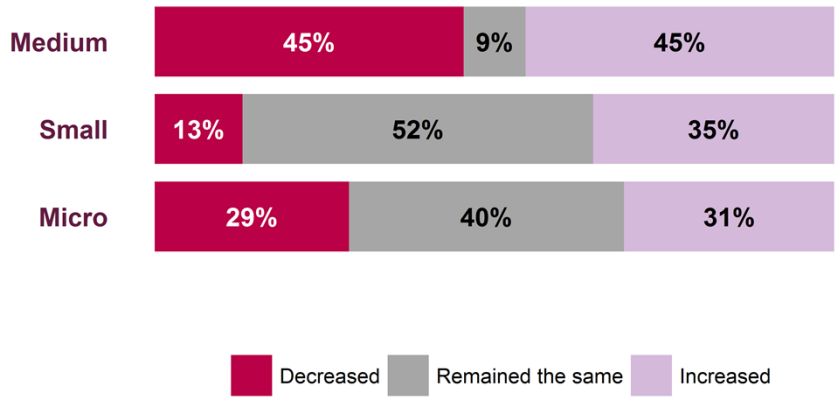
This raises some concerns: 47 per cent of respondents reported increasing their expenditure but only 35 per cent had experienced an increase in income and only 20 per cent reported an increase in reserves. In addition, 25 per cent of respondents reported a decrease in income but only 12 per cent reduced their expenditure.

30 per cent of respondents provided an expenditure figure for 2014/15 that was greater than their income. **This means that there were a notable number of organisations that spent more money than they received in the past 12 months**. This is slightly down from 36 per cent in 2012/2013, but nevertheless it still appears that the sustainability of a significant number of organisations could be under threat.

Explored by organisation size, collectively, the data indicates that the sustainability of medium sized organisations is of particular concern: 45 per cent of medium organisations reported increasing their income in the past 12 months but 73 per cent

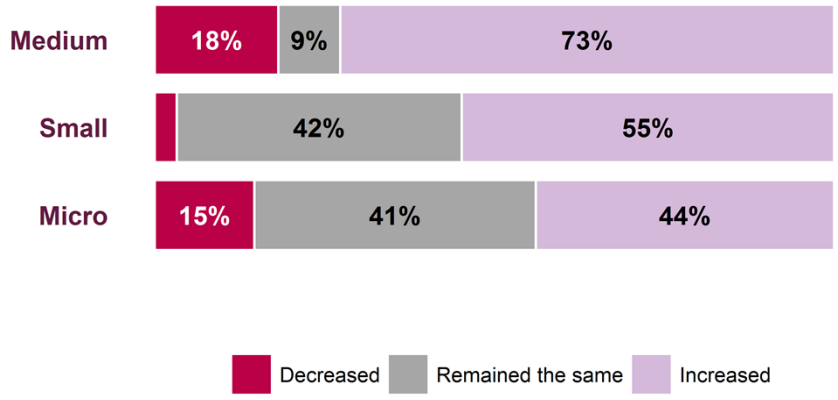
increased their expenditure. For small organisations 35 per cent increased their income compared to 55 per cent that increased their expenditure. For micro organisations the figures are 31 per cent for income and 44 per cent for expenditure. This is outlined in more detail for all sizes of responding organisations in figures 5.8a and 5.8b below.

Figure 5.8a: Change in income in the last 12 months by organisation size



Source: Tameside State of the VCSE sector survey 2016/17
Base: 84
Note: 'cannot say' response has been excluded from the analysis

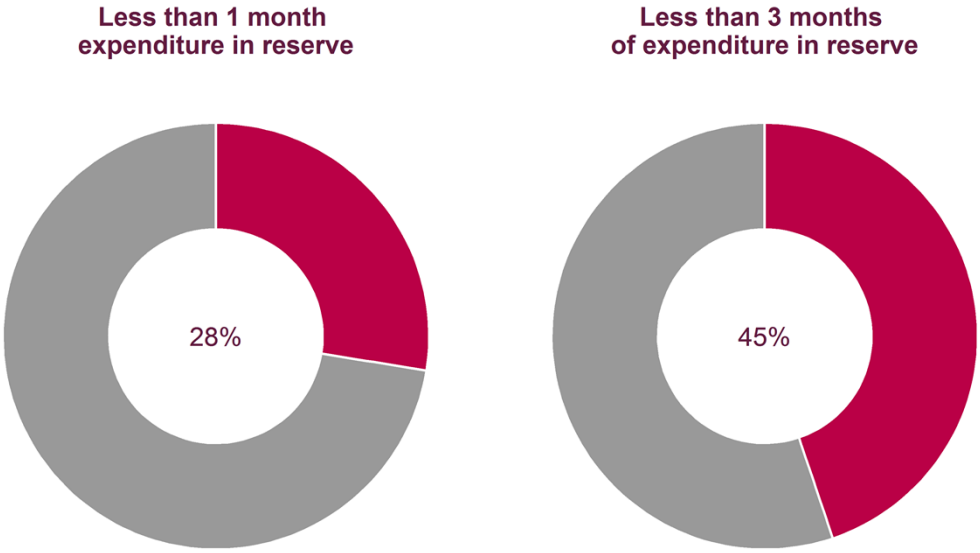
Figure 5.8b: Change in expenditure in the last 12 months by organisation size



Source: Tameside State of the VCSE sector survey 2016/17
Base: 83
Note: 'cannot say' response has been excluded from the analysis

Further analysis of the financial reserve levels reported by respondent organisations provides an additional insight in to the financial health of the VCSE sector. Reserves are important as they provide organisations with funds to fall back on in the short term should other sources of funding reduce or be withdrawn. They also provide organisations with the flexibility to develop new and innovative activity that might not have attracted external funding from the outset. Organisations with low reserves relative to expenditure are therefore more likely to be restricted in their ability to adapt if key external funding is lost. In order to explore this issue in more detail reserves (2014/15) were calculated as a proportion of expenditure (2014/15) for each respondent. The results are shown in figure 5.9.

Figure 5.9: Financial vulnerability of organisations in Tameside

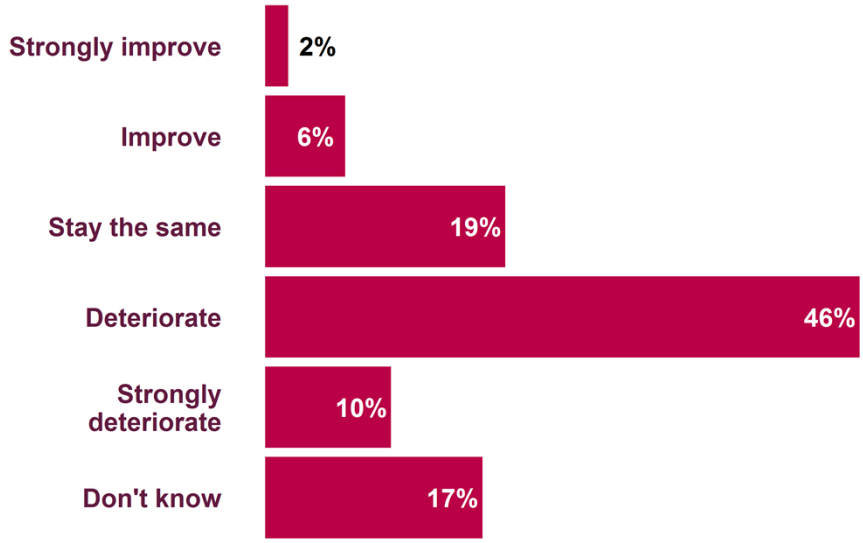


Source: Tameside State of the VCSE sector survey 2016/17
Base: 87

This shows that **28 per cent had reserve levels of less than one month's expenditure**, and a further 17 per cent had reserves that covered less than three month's expenditure. **This suggests that over two-fifths of all organisations in the VCSE sector could be vulnerable should their funds be severely reduced or withdrawn.** In the 2012/13 survey a similar proportion reported less than three months of reserves (42 per cent), but the number reporting less than one was much lower (just 13 per cent). The figures for the Greater Manchester as a whole are similar to those for Tameside.

Survey respondents were also asked how they thought the environment for funding/income for the VCSE sector will change over the next year. Figure 5.10 shows the responses received to this question. This shows that over half (56 per cent) of organisations in Tameside thought the environment will deteriorate compared to just eight per cent who felt the environment is set to improve. One fifth saw the environment for funding/income staying the same. These results were similar across Greater Manchester as a whole where 56 per cent thought the environment will deteriorate and just seven per cent saw the environment improving.

Figure 5.10: Change in the environment for funding/income in the next year



Source: Tameside State of the VCSE sector survey 2016/17
Base: 112

6 Paid Employees

This chapter looks at the paid workforce of the VCSE sector in Tameside.

6.1. How many FTE (Full-time equivalent) paid staff are employed in the VCSE sector in Tameside?

Based on the average number of FTE paid staff employed by organisations responding to the survey across Greater Manchester, and drawing on the assumptions used to estimate the total number of organisations in Tameside, it is estimated that:

1,300 FTE paid staff ***were employed in the VCSE sector in Tameside in 2016/17***

This represents **2,000 employees.**

This was four per cent of the estimated total number of FTE paid staff working within the VCSE sector in Greater Manchester. This is a higher figure than the 1,200 FTE paid staff estimated to work in the sector in the 2013 study.

Gross Value Added (GVA), the value of goods and services produced, is a key measure of the economic contribution of organisations or sectors. It can be estimated for paid employees working in Tameside organisations by multiplying the number of FTE paid staff by the estimated gross value added (GVA) per FTE employee[22]. From this calculation it is estimated:

£39.9m ***contributed to the economy per annum by paid employees of Tameside VCSE sector organisations***

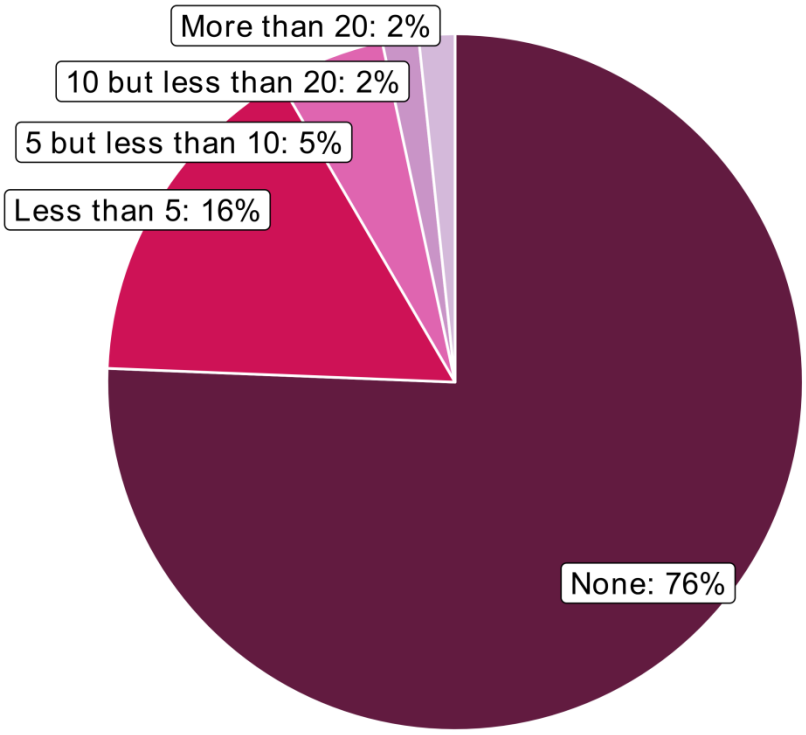
Medium size organisations employed the largest proportion of FTE staff (43 per cent) in Tameside. Small and micro organisations employed 35 per cent of FTE between them, and large organisations, of which there are relatively few in Tameside, accounted for 22 per cent. Staff appear to be generally less concentrated in medium and large organisations in Tameside compared to other areas in Greater Manchester. This also contrasts to the 2012/13 study, when 43 per cent of employees came from large organisations.

[22] This study used Greater Manchester GVA per employee averaged across the following two VCSE sectors: education and human health and social work activities.

Figure 6.1 presents a breakdown of responding organisations by the number of FTE paid staff they employed. Just over nine out of ten (92 per cent) organisations employed less than five FTE paid staff members. Included in this figure were 76 per cent of organisations that did not employ any paid staff. Further analysis reveals that the majority of these were micro organisations with income of less than £10,000. At the other end of the spectrum two per cent of organisations employed 20 or more FTE paid members of staff, and two per cent employed 10 to 20. This pattern is broadly equivalent to that identified in the 2012/13 survey, though the proportion with between five and ten staff was previously lower (one per cent), and the proportion with no FTE staff slightly higher (81 per cent).

Compared with the Greater Manchester sample as a whole, a lower proportion of organisations within Tameside appeared to have FTE paid staff: 24 per cent in Tameside compared with 49 per cent in Greater Manchester.

Figure 6.1: Organisations by numbers of FTE paid staff



Source: Tameside State of the VCSE sector survey 2016/17
Base: 119

6.2. How has the VCSE sector's workforce changed in the last 12 months?

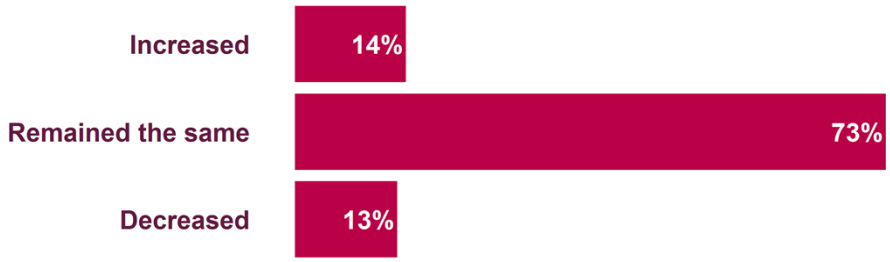
The survey asked respondents whether the number of staff in their organisation's workforce had ‘increased’, ‘remained the same’ or ‘decreased’ this year compared to the previous year. Figure 6.2 presents the results to this question, the key findings of which are:

Paid employees:

- 73 per cent of organisations employed a similar number of paid employees to a year ago
- 14 per cent of organisations reported an increase in paid staff, a similar percentage to the percentage that reported a decrease (13 per cent)

- very similar percentages reported an increase or decrease in paid employees in 2012/13 (13 per cent for both categories)
- across Greater Manchester there was slightly more of a discrepancy; 22 per cent of organisations reported an increase in their number of paid employees; while 16 per cent reported a decrease.

Figure 6.2: Change in aspects of the workforce (paid staff) in the last 12 months



Source: Tameside State of the VCSE sector survey 2016/17
Base: 93
Note: 'cannot say' response has been excluded from the analysis

7 Volunteers

This chapter looks at the volunteers within the VCSE sector in Tameside.

7.1. How many volunteers are part of the VCSE sector workforce in Tameside and what is their economic contribution?

Based on responses to the survey across Greater Manchester on questions exploring the numbers of volunteers and committee/board members and the hours which they contribute, and drawing on the assumptions used to estimate the total number of organisations in Tameside, it is estimated there are:

34,000 volunteers or committee/board members ***in the VCSE sector's workforce in Tameside in 2016/17***[23]

This includes:

26,000 volunteers ***in the VCSE sector's workforce in Tameside in 2016/17***

8,000 committee/board members ***in the VCSE sector's workforce in Tameside in 2016/17***

This figure for volunteers represents 12 per cent of Tameside's total population (221,700) and seven per cent of the estimated total for all Greater Manchester organisations.

It is also estimated that:

83,400 hours ***of their time provided by these volunteers and committee/board members per week***

This represents eight per cent of the estimated number of volunteer and committee/board member hours for all Greater Manchester organisations.

[23] It is possible in cases where a person is volunteering for more than one organisation they could have been counted more than once; additionally, there will be residents from outside of Tameside volunteering within Tameside; and conversely there will be Tameside residents volunteering for organisations outside of Tameside

The 2012/13 study estimated there were 26,200 volunteers in Tameside who provided 73,900 hours per week. The previous study did not ask for volunteers and committee/board members to be recorded separately so caution should be applied when making comparisons.

There are two broad approaches to valuing the contribution of volunteers. One method, and this study's preferred approach, is to value the output that they produce. In effect this is the value to society of the goods and services that volunteers produce. This can be estimated by multiplying the number of FTE volunteers by the estimated gross value added (GVA) per FTE employee.[24] From this calculation:

£75.5 million per annum *estimated as the economic contribution of volunteers and committee/ board members in Tameside organisations*

The use of estimated GVA per FTE employee to measure the value of the output produced by volunteers assumes that paid employees would not be used in the absence of volunteers to produce the same level of goods and services. In such a situation the value of output is the value of the labour input (wages and benefits) plus the value of the capital input (for example office space and computers). If paid employees were to be used to produce the same level of goods and services then the value of capital input would be borne whether or not volunteers were used. Therefore the value of the output from volunteers would be just the value of the labour input. This value would be roughly equivalent to the value estimated from the input method of valuation which is outlined in the next paragraph.

In the second method, the value of the input of volunteers is used to value the contribution of volunteers[25]. This is the amount that it would cost to pay employees to do the work carried out by volunteers. As such, this can be considered to be the benefit to organisations[26]. However, this benefit might also be passed onto society via lower prices for goods and services due to lower costs of production. The input value of volunteers can be calculated by multiplying the number of hours that volunteers give per week by an estimate of how much it would cost to employ someone to do that work. There are a number of widely accepted hourly rates that could be used to estimate this value; these include: the national minimum wage or national living wage, the local median wage, the local mean wage and the reservation wage. The preference in this study has been to provide a range using the national living wage (low estimate) and the local median wage (high estimate). In reality the true value of the input provided by volunteers will lie between the two estimates. It is estimated that:

- assuming the national living wage for adults[27] it would cost **£31.2 million annually to employ staff to do the work provided by volunteers in Tameside organisations**
- assuming the median gross hourly wage for full time employees in Greater Manchester[28] it would cost **£55.8 million annually to employ staff to do the work provided by volunteers in Tameside organisations.**

[24] This study used Greater Manchester GVA per employee averaged across the following two VCSE sectors: education and human health and social work activities.
[25] This is the approach recommended by Volunteering England
[26] This assumes that there are no additional costs faced by organisations in using volunteers: for example extra management costs
[27] £7.20 for 25 years and older in 2016
[28] £12.86 for 2016

Figure 7.1 presents a breakdown of responding organisations by the number of volunteers that they use. Just two per cent of respondents indicated they had no volunteers, while 17 per cent had 50 or more. This pattern was largely representative of the picture for organisations across Greater Manchester as a whole. In the previous 2012/13 survey a slightly lower proportion of respondents had 50 or more volunteers (14 per cent), and no respondents had zero volunteers.

Figure 7.1: Organisations by numbers of volunteers

Source: Tameside State of the VCSE sector survey 2016/17
Base: 132

7.2. How has the VCSE sector's workforce changed in the last 12 months?

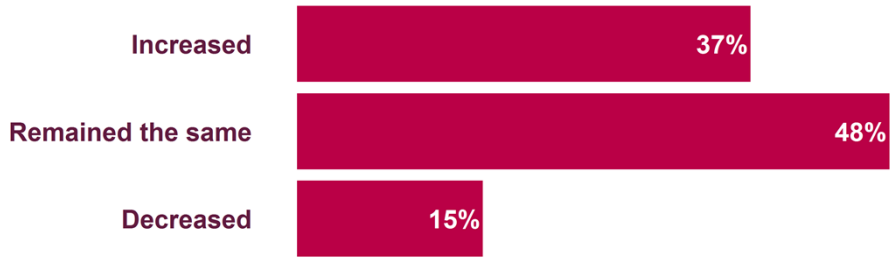
The survey asked respondents whether the number of volunteers in their organisation's workforce had 'increased', 'remained the same' or 'decreased' this year compared to the previous year. Figure 7.2 presents the results to this question, the key findings of which are:

- 37 per cent of respondents reported increased numbers of volunteers now compared to a year ago
- in comparison 15 per cent of organisations reported a decrease in volunteer numbers
- just over two fifths (42 per cent) of Greater Manchester organisations reported an increase in their number of volunteers over the previous year, compared with 13 per cent who reported a decrease, a reasonably similar picture to Tameside.

The 2012/13 survey found similar results, but with a larger proportion reporting no change:

- 32 per cent of respondents reported increased volunteer numbers
- three-fifths (61 per cent) reported that volunteer numbers remained the same
- seven per cent reported that numbers of volunteers decreased.

Figure 7.2: Change in aspects of the workforce (volunteers) in the last 12 months



Source: Tameside State of the VCSE sector survey 2016/17
Base: 125
Note: 'cannot say' response has been excluded from the analysis

7.3. Qualitative responses on volunteering

Focus group participants from registered charities and small VCSE organisations were asked to discuss changes and challenges associated with volunteering in recent years. Participants argued that volunteering is essential for what they do and in general were very positive with regards to volunteering.

> *"We rely heavily on volunteers. Our output is around 15 hours a week. The vast majority of our volunteering comes from internal recruiting, from people in the church. Our faith encourages putting back into the community…There has been a slight increase in that pot in the last 2 years, although it still remains quite small."*

However, participants did identify one recent development which was affecting the way they worked with volunteers. This was when volunteers are referred to the organisation from other voluntary groups or public bodies as part of an employment programme or as a condition of benefits. Participants argued that sometimes these potential volunteers got involved in activities without really wanting to, which could undermine VCSE organisations' ability to function effectively.

> *"When you have volunteers referred here, there can be an ethical thing for us, where you have to volunteer to keep your benefits, but our organisation wants to make sure that you are not being forced to volunteer. Another scenario, is that sometimes referrals come to volunteer as a route back to work, and then you need a really competent volunteer to manage the less competent volunteer, which in turn makes it harder to function as an organisation."*

Linked to this was the ongoing challenge of recruiting and retaining skilled and committed volunteers for the long term, which was something most participants said their organisation struggled with.

8 Partnership Working: the Public Sector

This chapter considers the relationship between the VCSE sector and the public sector, exploring organisations experiences of partnership working with Tameside Council and other public sector bodies.

8.1. Dealings with local public sector bodies

Survey respondents were asked about the extent of their dealings with each of the main public sector bodies covering the borough of Tameside. An overview of their responses is provided in figure 8.1, along with the local authority figure for Greater Manchester combined.

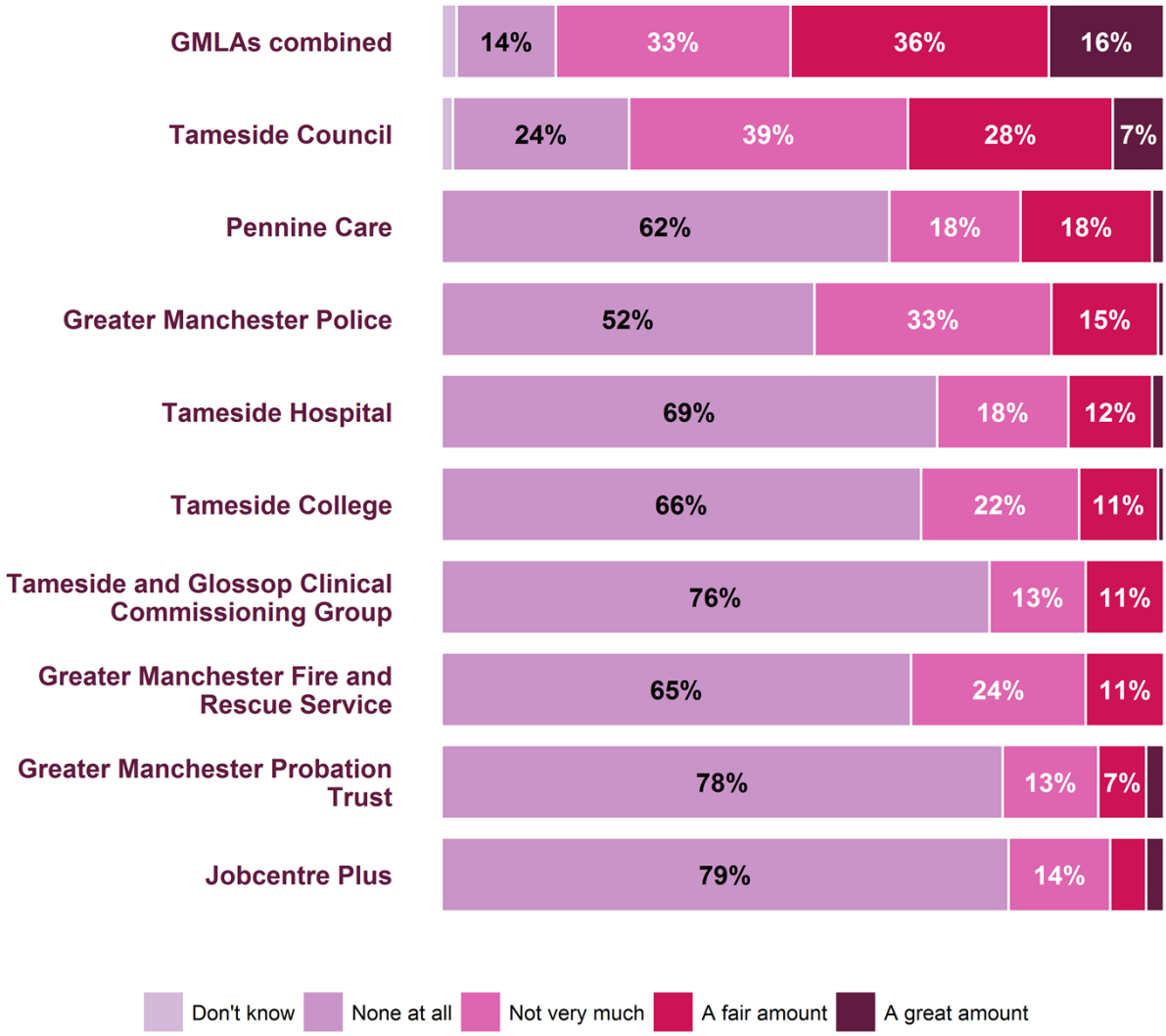
This shows that survey respondents had dealings with a range of local public sector bodies. The three most prominent were Tameside Council, Pennine Care and Greater Manchester Police:

- **Tameside Council:** 74 per cent had some dealings with the Council; including seven per cent who had a 'great amount' of dealings and 28 per cent who had a 'fair amount' of dealings
- **Greater Manchester Police:** 48 per cent had some dealings with Greater Manchester Police; including one per cent who had a 'great amount' of dealings and 15 per cent who had a 'fair amount' of dealings
- **Pennine Care:** 38 per cent had some dealings with Pennine Care; including two per cent who had a 'great amount' of dealings and 18 per cent who had a 'fair amount' of dealings.

Tameside Council was also the organisation respondents had the most dealings with in the 2012/13 survey (69 per cent had some dealings). Greater Manchester Police was also commonly identified in the previous survey (44 per cent).

Local authorities consistently emerged as the most prominent public sector contact for respondents to this study across Greater Manchester. Overall, 16 per cent of respondents said they had a 'great amount' of dealings with their local authority and 36 per cent said they had a 'fair amount'.

Figure 8.1: Dealings with local public sector bodies[29]

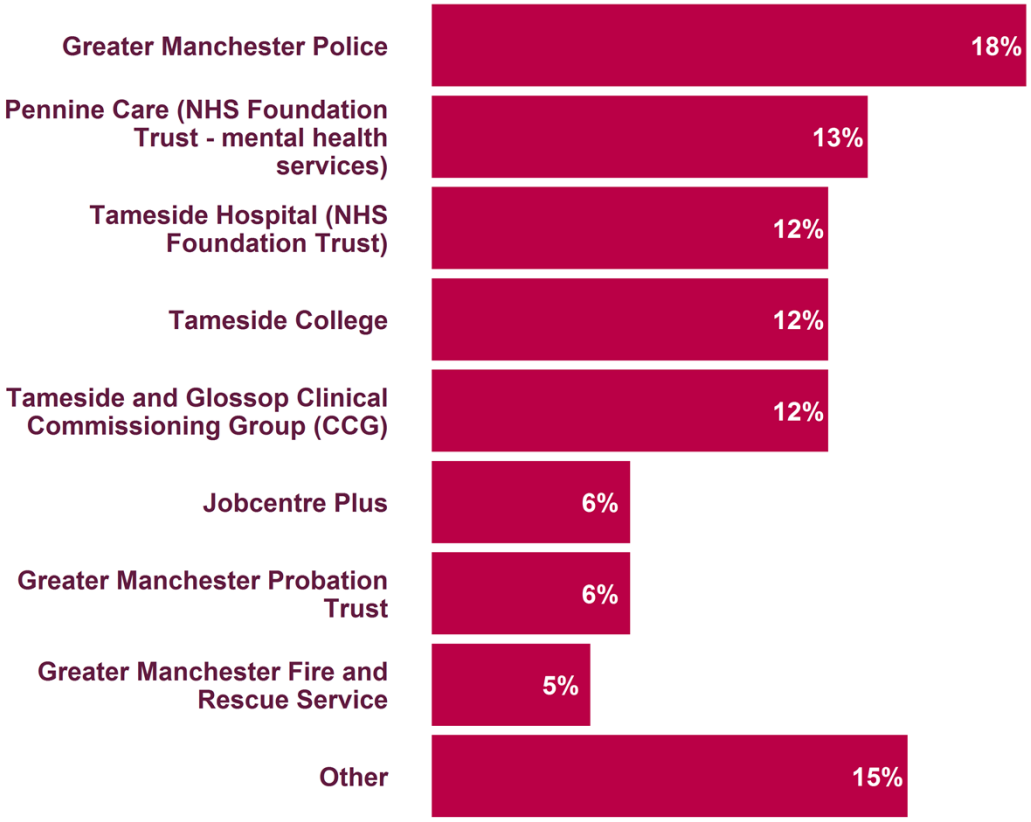


Source: Tameside / Greater Manchester State of the VCSE sector survey 2016/17
Base: 119-127 (Tameside), 1,080 (Greater Manchester)

Survey respondents were asked to indicate their most frequent public sector contact other than their local authority. Figure 8.2 shows the responses received to this question with Greater Manchester Police the most commonly cited (18 per cent) followed by, Pennine Care (13 per cent), reflecting the picture from figure 8.1.

[29] GMLAs combined = Greater Manchester local authorities' combined.

Figure 8.2: Most frequent public sector contact other than local authority

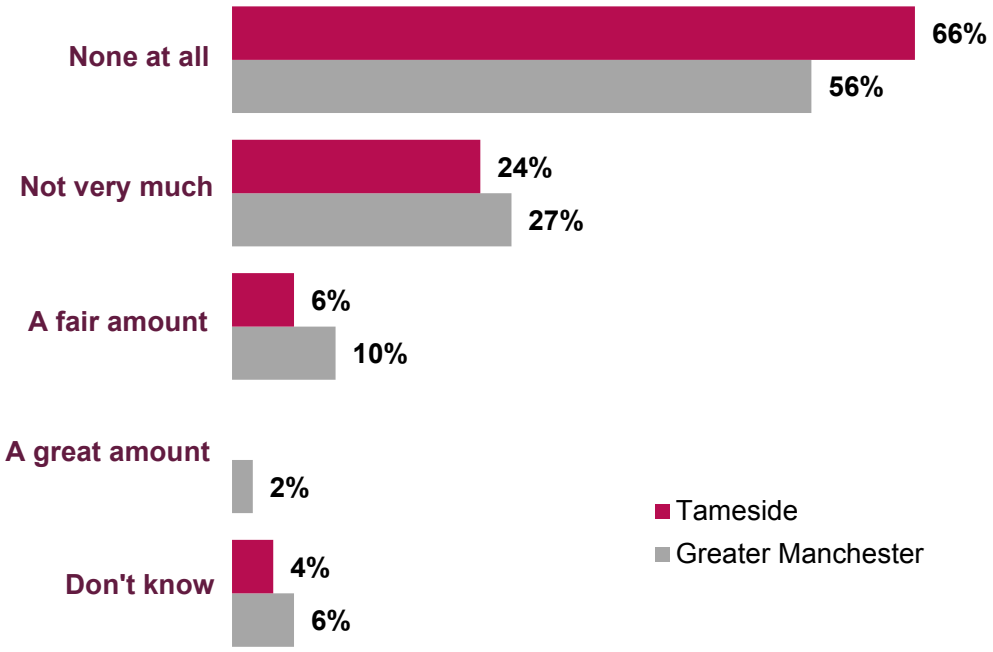


Source: Tameside State of the VCSE sector survey 2016/17
Base: 82

Respondents were also asked to consider the extent to which their organisation has direct dealings with any emerging Greater Manchester structures (e.g. Greater Manchester Combined Authority, The Office of the Police and Crime Commissioner, The Health and Social Care Devolution Team etc.). Figure 8.3 presents the results to this question.

No respondents reported a 'great amount' of dealings with these structures, though six per cent reported 'a fair amount' and a further 24 per cent reported 'not very much'. **The results were higher across Greater Manchester where 38 per cent had some dealings, including two per cent who had a 'great amount' of dealings and 10 per cent who had a 'fair amount' of dealings.**

Figure 8.3: Dealings with emerging Greater Manchester structures



Source: Greater Manchester / Tameside State of the VCSE sector survey 2016/17
Base: 124 (Tameside); 977 (Greater Manchester)

8.2. Relationships with local public sector bodies

Survey respondents were also asked two further questions about the extent to which their organisations were satisfied with their ability to influence public sector decisions of relevance to their organisation and the extent to which they thought local statutory bodies influenced their success[30]. The results of these questions are summarised in figure 8.4. A comparison with the Greater Manchester average is also provided.

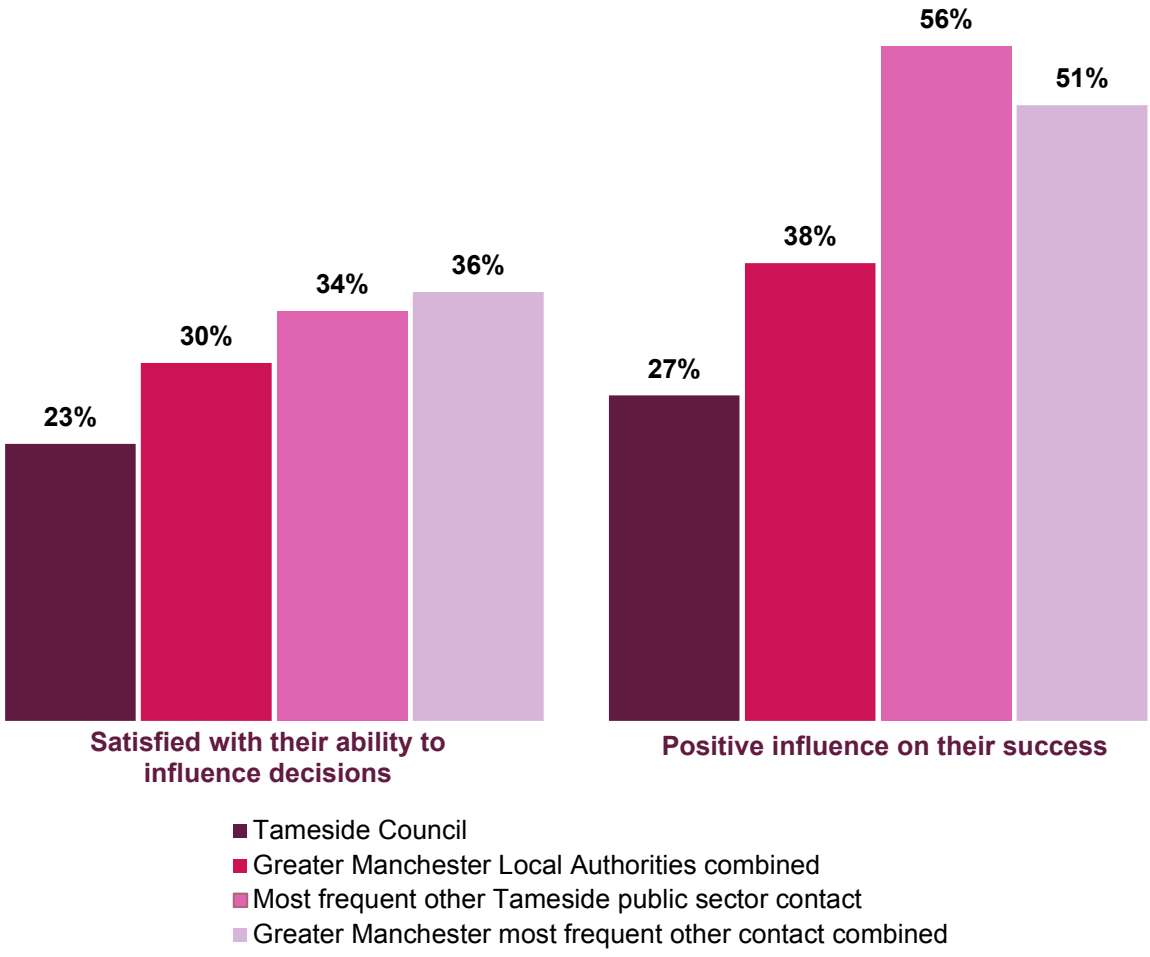
Figure 8.4 shows that 23 per cent of respondents were satisfied with their ability to influence Tameside Council decisions of relevance to their organisation and 27 per cent said that the council had a positive influence on their organisation's success. Results are similar to the Greater Manchester combined figures (30 per cent were satisfied with ability to influence their local authority and 38 per cent agreed their local authority has a positive influence on their success).

Results are very similar to 2012/13, when 23 per cent of respondents were satisfied with their ability to influence Tameside Council decisions of relevance to their organisation and 29 per cent said that the council had a positive influence on their organisation's success.

In addition, 34 per cent of respondents said they were satisfied with their ability to influence the key decisions of their most frequent other public sector contact and 56 per cent said this contact had a positive influence on their success. These are similar to the Greater Manchester combined figures (36 per cent and 51 per cent respectively).

[30] This latter measure was used in 2008 and 2010 to provide evidence of local authority performance against 'National indicator 7: the environment for a thriving third sector'.

Figure 8.4: Proportion of organisations who said they were satisfied with their ability to influence public sector decisions of relevance to their organisation and who said local public sector bodies influence their organisation's success



Source: Tameside / Greater Manchester State of the VCSE sector survey 2016/17
Base: Tameside: 98/59 (ability to influence), 100/63 (positive influence); Greater Manchester: 897/570 (ability to influence), 889/605 (positive influence)

8.3. Funding from local public sector bodies

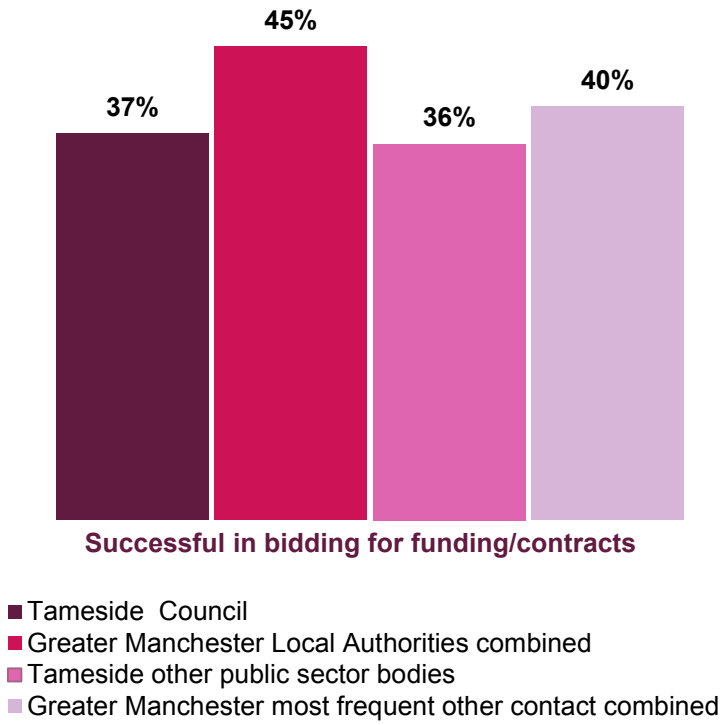
Respondents were also asked to reflect on their experiences of public sector funding in terms of how successful they had been, how satisfied they were with bidding arrangements, and how satisfied they were with the level of opportunity to bid for long-term funding.

Figure 8.5 shows responses to the question which asked organisations to consider how successful they had been in applying for funding or bidding for contracts. Results are split between perceptions of Tameside Council and of other public sector bodies. A comparison with the Greater Manchester average is also provided.

This shows that 37 per cent of respondents were successful in bidding for funding or contracts with Tameside Council compared to a 36 per cent success-rate with other public sector bodies. At the Greater Manchester level, a slightly higher proportion (45 per cent) had been successful in bidding for funding or contracts from their local authority and from other public sector bodies (40 per cent).

In 2012/13 a higher proportion indicated they had been successful in bidding for funding or contracts from Tameside Council (48 per cent) but the figure for other public sector bodies was lower (32 per cent).

Figure 8.5: Success bidding for funding and contracts



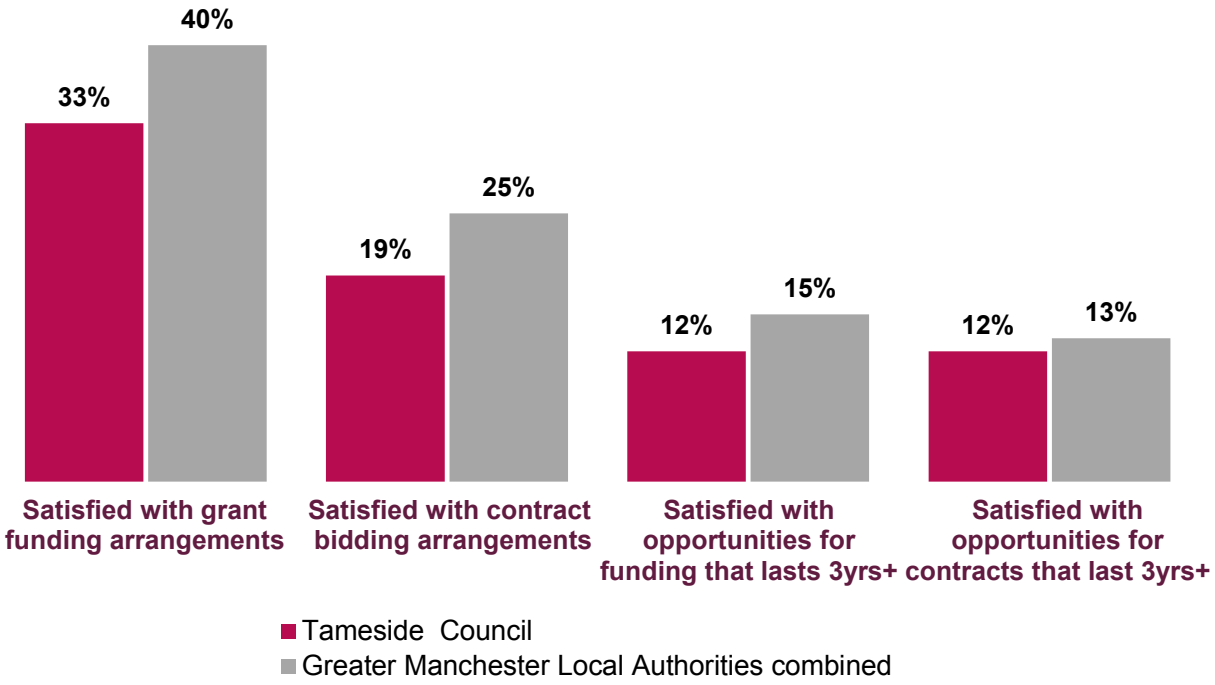
Source: Tameside / Greater Manchester State of the VCSE sector survey 2016/17
Base: Tameside: 126/124; Greater Manchester: 1,060/1,036

Respondents were asked specifically about Tameside Council and how satisfied they were with their grant funding and contract bidding arrangements and opportunities for funding and contracts lasting three years or longer. The responses are illustrated in figure 8.6. A comparison with the Greater Manchester local authority average is also provided.

One third (33 per cent) were satisfied with grant funding arrangements. Satisfaction with contract bidding arrangements was lower at 19 per cent. Satisfaction with opportunities for both funding and contracts lasting three years or longer was lower still (both 12 per cent). The pattern was similar among the Greater Manchester combined figures, though in all cases a slightly higher proportion were satisfied.

In 2012/13 respondents were not asked separately about grant funding and contracts. Just over one third (35 per cent) of respondents were satisfied with Tameside Council's funding/bidding arrangements in 2012/13 and 15 per cent were satisfied with their opportunities for funding/contracts which lasted three years or longer.

Figure 8.6: Experiences of bidding for funding and contracts with local authorities

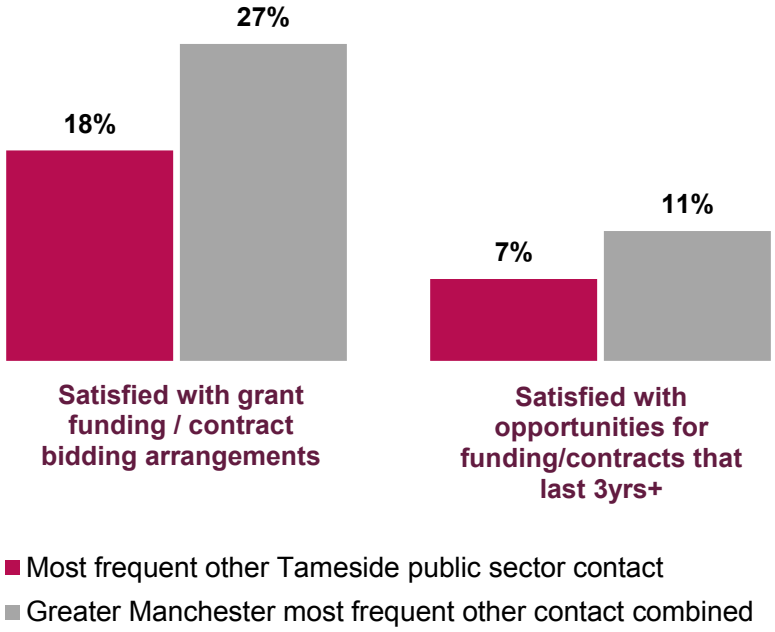


Source: Tameside / Greater Manchester State of the VCSE sector survey 2016/17
Base: Tameside: 88 (grant funding arrangements), 52 (contract bidding arrangements), 73 (opportunities for funding), 50 (opportunities for contracts); Greater Manchester: 808 (grant funding arrangements), 631 (contract bidding arrangements), 703 (opportunities for funding), 605 (opportunities for contracts)

Survey respondents were asked to consider how satisfied they were with the grant funding and contract bidding arrangements of their most frequent other public sector contact. As figure 8.7 shows, 18 per cent indicated they were satisfied, lower than across Greater Manchester as a whole (27 per cent).

They were also asked about their satisfaction with opportunities for funding and contracts longer than three years. Just seven per cent were satisfied, lower again than the Greater Manchester combined figure (11 per cent).

Figure 8.7: Experiences of bidding for funding and contracts with other public sector bodies



Source: Tameside / Greater Manchester State of the VCSE sector survey 2016/17
Base: Tameside: 77 (funding/bidding arrangements), 76 (opportunities for funding/contracts); Greater Manchester: 705 (funding/bidding arrangements), 687 (opportunities for funding/contracts)

8.4. Qualitative responses on relationships between the VCSE sector and local public sector bodies

The focus groups discussed participants' views about and experiences of working with public sector bodies in Tameside. Two key issues dominated these discussions: the prospects of devolution for VCSE organisations, and issues associated with developing effective relationships with the local public sector.

There was a general feeling amongst participants that they didn't really know what to make of devolution, but also a tendency to be sceptical about it, in particular its implications for smaller voluntary organisations. Most VCSE organisations reported good links with certain parts of the public sector, although there was an overriding sense of frustration about not getting enough support and information from the key public bodies.

> *"The voluntary sector in Tameside is doing a great job, because there are so many gaps in health for example. But they have taken all the money from social services and they expect us to fill the gap without support; without information or consistent liaising and liaising with the community which are the people who need the services. How will this work?"*

Participants recognised the challenges facing the public sector as a result of enforced spending cuts, but felt that it was vitally important for the two sectors to have a dialogue so that they could be more efficient in coordinating efforts to deal with problems in the area.

> *"I think everybody is working very hard in worse conditions; both the voluntary sector and public bodies feel so stretched and so stressed. Everybody at grassroots level knows that the overall figure of investment is now less and so the output is less and people get angry and frustrated with agencies."*

9

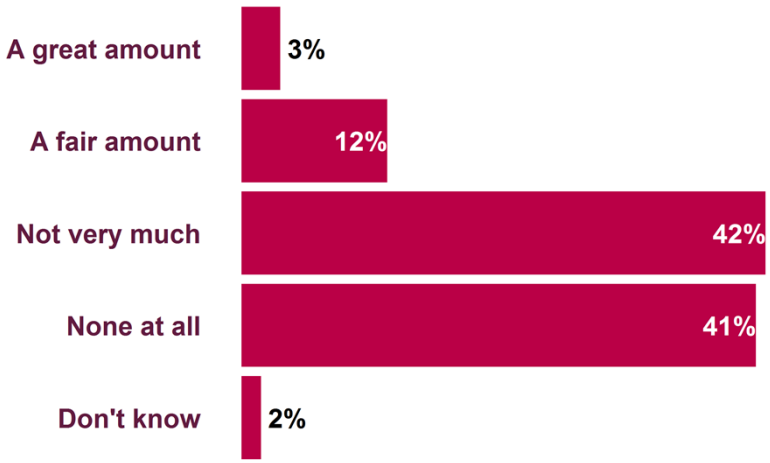
Partnership Working: the Private Sector

The previous chapter explored respondents' experiences of partnership working with public sector bodies. This chapter moves on to explore their experiences of working with private sector organisations. Only 21 per cent of survey respondents received any income through business donations. While this is an increase since the 2012/13 survey when just 17 per cent received this type of income, this area still appears to be new territory for many VCSE organisations. Survey respondents were asked about their direct dealings and experiences of working with private businesses in Tameside.

9.1. Working with private businesses

Survey respondents were asked to indicate the extent to which they had direct dealings with private businesses in Tameside. 57 per cent reported that they had some direct dealings, with 15 per cent having a 'great' or 'fair' amount of contact (figure 9.1). This is slightly lower than the average for Greater Manchester as a whole (21 per cent 'great' or 'fair' amount of contact). The picture has changed from the 2012/13 survey where a lower 46 per cent of respondents reported some direct dealings, including 13 per cent having a 'great' or 'fair' amount of contact.

Figure 9.1: Extent of direct dealings with private businesses

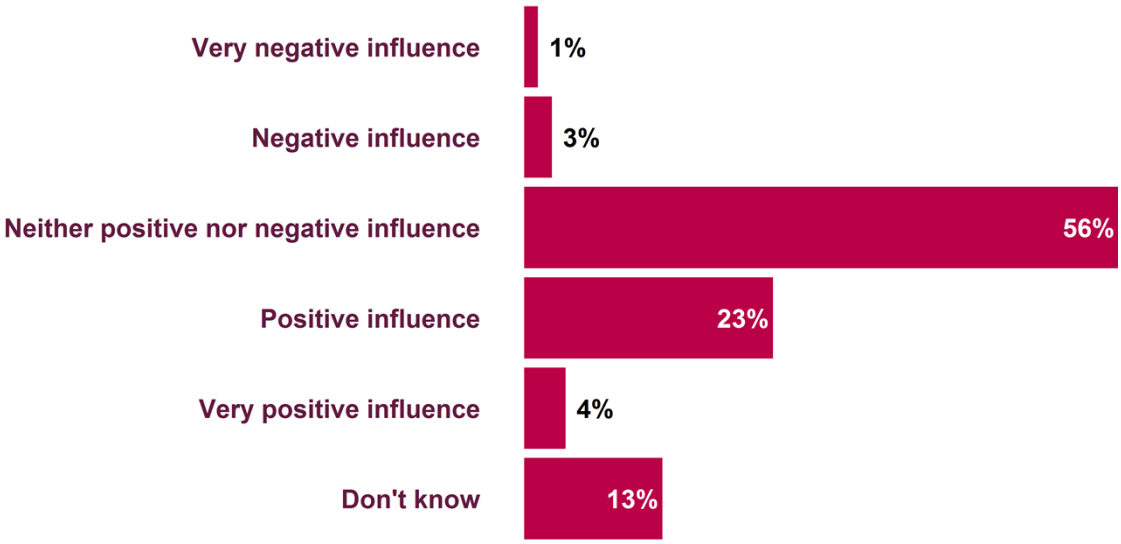


Source: Tameside State of the VCSE sector survey 2016/17
Base: 128

Just one respondent indicated they are members of a formal private sector-led consortium out of a total of 21 across Greater Manchester. Five per cent (six respondents) of respondents said their organisation is in formal partnership with private sector organisation(s), slightly lower than the seven per cent of organisations across Greater Manchester.

Respondents were asked to comment on the influence private businesses have on their organisation's success. As figure 9.2 shows, taking all things into account, 27 per cent of survey respondents felt that the private business community in Tameside was a positive influence on their organisation's success. This is similar to the proportion for Greater Manchester as a whole (31 per cent) and **an increase since the 2012/13 survey when just 16 per cent of survey respondents felt that the private business community in Tameside was a positive influence on their organisation's success.**

Figure 9.2: Private business community's influence on VCSE sector organisations' success



Source: Tameside State of the VCSE sector survey 2016/17
Base: 77

9.2. Qualitative responses on working with private sector businesses

Focus group participants discussed their views about and experiences of working with private businesses. Overall, their experiences of and relationships with private businesses was mixed. A number of participants reported long-standing relationships with local business while others received only occasional donations and not any sort of formal partnership.

A key advantage of working with the private sector was that they could move things more efficiently, in either one-off or longer collaborations, compared to working with the public sector. However, concerns were expressed about the different aims and culture of private business, which centre on the generation of profit, and that this is not always a natural fit with the social aims of most VCSEs. **However, participants argued that when businesses are truly motivated by philanthropy and a genuine intent to do some good in the community, working with the private sector can be mutually beneficial.**

"A business is designed to make money and what we've found, is that sometimes businesses want to be real generous… It all sounds really generous and it does benefit us for what we are doing, but, invariably there would be a photographer there. Also, I know that they would pay money to have these things removed so we are basically removing their waste and they are getting the publicity of being generous. We always take it because we need it of course, but you know it's not so ethical. On other occasions, we find a genuine philanthropic attitude; so I've had a mixed bag with businesses so far."

"*You have to be very pragmatic with these people. If you do find a business which is genuinely generous, then they are very pragmatic, they eschew the paperwork when they trust you and they can be very efficient, and we can be more efficient in what we do."*

"We work with businesses for fundraisers and they are really matter of fact in their attitude. We also have an arrangement with a business to receive building materials, not money really."

10

Partnership Working: Voluntary Community and Social Enterprise Organisations

The previous two chapters have explored respondents' experiences of working with organisations from the public and private sectors. This chapter discusses survey respondents' views on their work with other VCSE sector organisations.

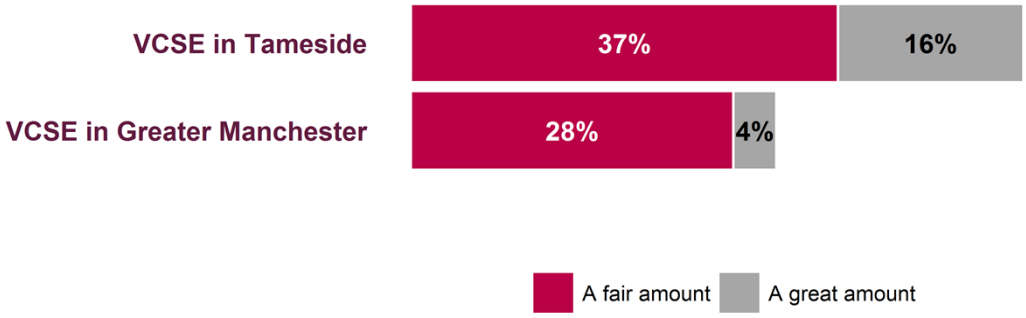
10.1. Working with other VCSE organisations

Survey respondents were asked about the extent to which they had direct dealings with other VCSE sector organisations in both Tameside and Greater Manchester.

The vast majority (91 per cent) had some direct dealings with other VCSE sector organisations in Tameside, and as figure 10.1 illustrates, 53 per cent had a 'great' or 'fair amount' of contact. A very similar proportion of organisations across Greater Manchester had some direct dealings with other VCSE sector organisations in their local area (90 per cent), **but a slightly higher proportion had a 'great' or 'fair amount' of contact (67 per cent). A lower proportion had direct dealings in the 2012/13 survey (78 per cent)** and a lower proportion had a 'great' or 'fair amount' of contact (51 per cent).

The proportion of respondents reporting they had direct dealings with other VCSE sector organisations in Greater Manchester was lower (65 per cent), along with the proportion who had a 'great' or 'fair amount' of contact (31 per cent). Results were similar at the Greater Manchester level (70 per cent direct dealings and 37 per cent with a 'great' or 'fair amount' of contact). Survey respondents were only asked about their dealings with other VCSE organisations across Greater Manchester in 2016/17.

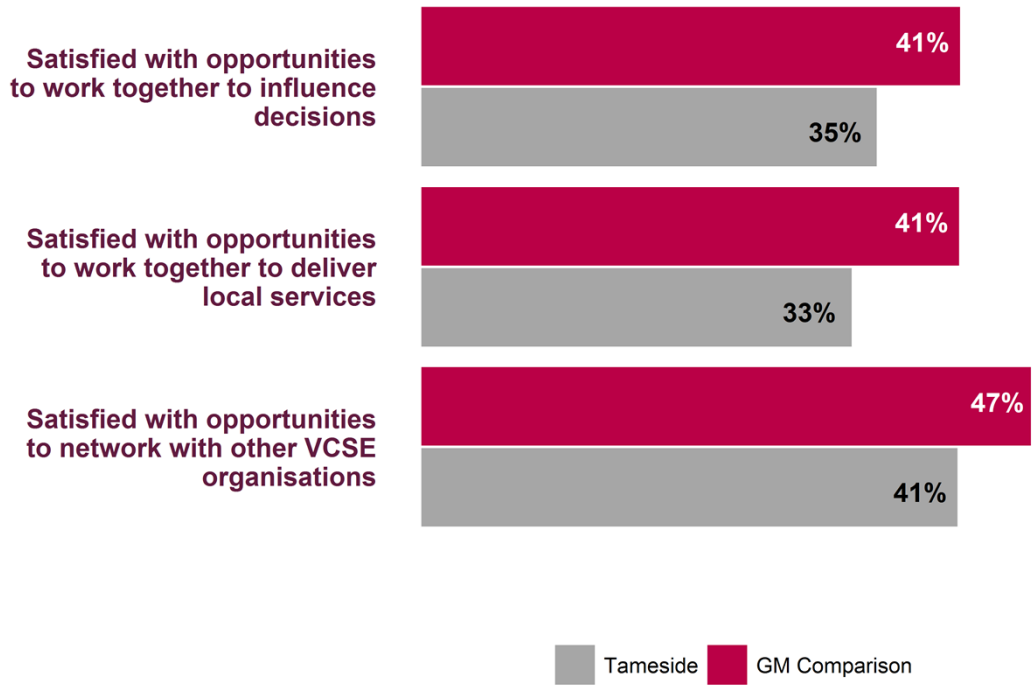
Figure 10.1: Extent of direct dealings with VCSE organisations



Source: Tameside State of the VCSE sector survey 2016/17
Base: 125 (Tameside) / 108 (Greater Manchester)

Respondents were asked to reflect on the opportunities they had to work with other VCSE sector organisations in terms of influencing local decisions, delivering local services and networking. Figure 10.2 summarises the responses.

Figure 10.2: Satisfaction with opportunities to work with VCSE organisations



Source: Tameside State of the VCSE sector survey 2016/17
Base: 123 (influence decisions) / 121 (delivering services) / 124 (networking)

This shows that 35 per cent of respondents were satisfied with the availability of opportunities to influence local decisions (40 per cent in 2012/13) and that 33 per cent were satisfied with the availability of opportunities to work together to deliver local services (42 per cent in 2012/13). A higher proportion of organisations across Greater Manchester were satisfied with opportunities to influence local decisions (41 per cent), and with opportunities to work together to deliver local services (also 41 per cent). 41 per cent of respondents were also satisfied with opportunities to network with other VCSE organisations (47 per cent across Greater Manchester as a whole).

13 per cent of respondents said their organisation is a member of a formal VCSE sector consortium, lower than the 22 per cent of organisations across Greater Manchester.

Only five per cent indicated their organisation is in another type of formal partnership with other VCSE organisations to deliver specific services (13 per cent across Greater Manchester). A wide range of responses were received when organisations were asked to specify which partnership they were members of, with a range of services covered by partnerships.

10.2. Qualitative reflections on working with other VCSE organisations

The focus groups discussed participants' views about and experiences of working in partnership with other VCSE organisations in Tameside and more widely. All participants reported good relationships with other VCSEs but were rarely involved in formal partnerships.

> *"We do work with other VCSEs, it's been very helpful; we have our ties in the sector and try to use them."*

> *"We have a lot of small connections, nothing which is really regular, or big, or contractual. Basically just organising events in Christmas, day-trips with youth groups, things like that."*

Most contact with other VCSEs took place informally at a local level through in the form of mutual help and support, for example working together to co-organise events, and the occasional sharing of resources.

The Future

11

This chapter details the responses received to questions about the future in the survey of organisations.

11.1. Factors assisting or constraining delivery

Respondents were asked to consider the factors they anticipated assisting or constraining their organisation over the next 12 months. Figure 11.1 illustrates that over two-fifths of respondents thought the following factors would assist their organisation over the next year:

- **ability to employ staff with sufficient skills:** 47 per cent anticipated this factor assisting their organisation; including 19 per cent who saw this as 'greatly assisting' and 28 per cent 'assisting'
- **engagement with other VCSE organisations:** 43 per cent anticipated this factor assisting their organisation; including six per cent who saw this as 'greatly assisting' and 37 per cent 'assisting'
- **engagement with public sector bodies:** 42 per cent anticipated this factor assisting their organisation; including six per cent who saw this as 'greatly assisting' and 36 per cent 'assisting'.

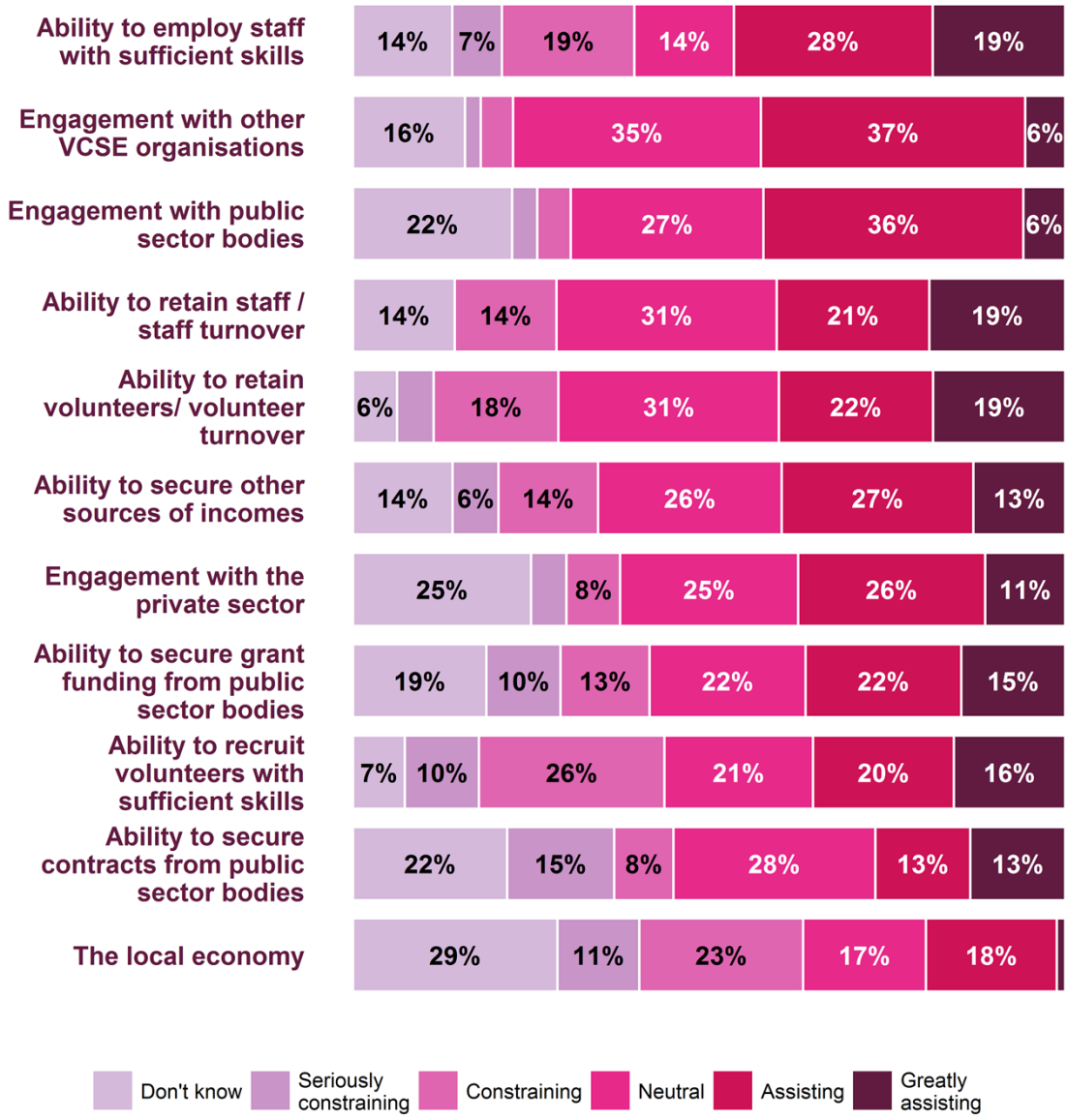
Engagement with other VCSE organisations was the most common factor selected across Greater Manchester, with 50 per cent of organisations envisaging this factor assisting their organisation over the next 12 months.

In contrast over one third saw the following factors as constraining their organisation over the next 12 months:

- **ability to recruit volunteers with sufficient skills:** 36 per cent anticipated this factor constraining their organisation; including 10 per cent who saw this as 'seriously constraining' and 26% per cent 'constraining'
- **the local economy:** 34 per cent anticipated this factor constraining their organisation; including 11 per cent who saw this as 'seriously constraining' and 23 per cent 'constraining'.

The local economy was the most common factor selected across Greater Manchester as a whole, with 38 per cent anticipating this factor constraining their organisation over the following year.

Figure 11.1: Factors anticipated as assisting or constraining organisations over the next 12 months



Source: Tameside State of the VCSE sector survey 2016/17
Base: 42-97

Following on from quantitative questions regarding the factors that organisations anticipated assisting or constraining their organisation over the next year, respondents were also asked to provide further qualitative (i.e. written) information about these factors.

Unsurprisingly some organisations were concerned with accessing public sector funding or resources:

"There is little or no money available for which we can apply, since we cannot specify that we are assisting one particular sector of the community"

"Lack of funding and inability to pay for a team of staff is a constant worry"

The most common concern, however, was with volunteer recruitment and retention:

"Ongoing difficulties with recruiting new and retaining existing volunteers"

"Experienced and dedicated volunteers are hard to recruit"

"We have difficulty in finding volunteers with the necessary skills"

"We really struggle to get any volunteers to come and stay long enough to be trained and effective"

Some also stressed the importance of local economic conditions to their future success:

"We are dependent financially on our social enterprise which is affected by the local economy"

"Local and national economics impacts the most on voluntary sector ability to deliver services"

Not all comments on these issues were negative, however. There was some optimism from organisations on their future prospects:

"We are increasingly confident that we will be able to secure funding from public sector bodies that will enable us to deliver services"

"We have sufficient dedicated volunteers to carry out the aims of the Charity"

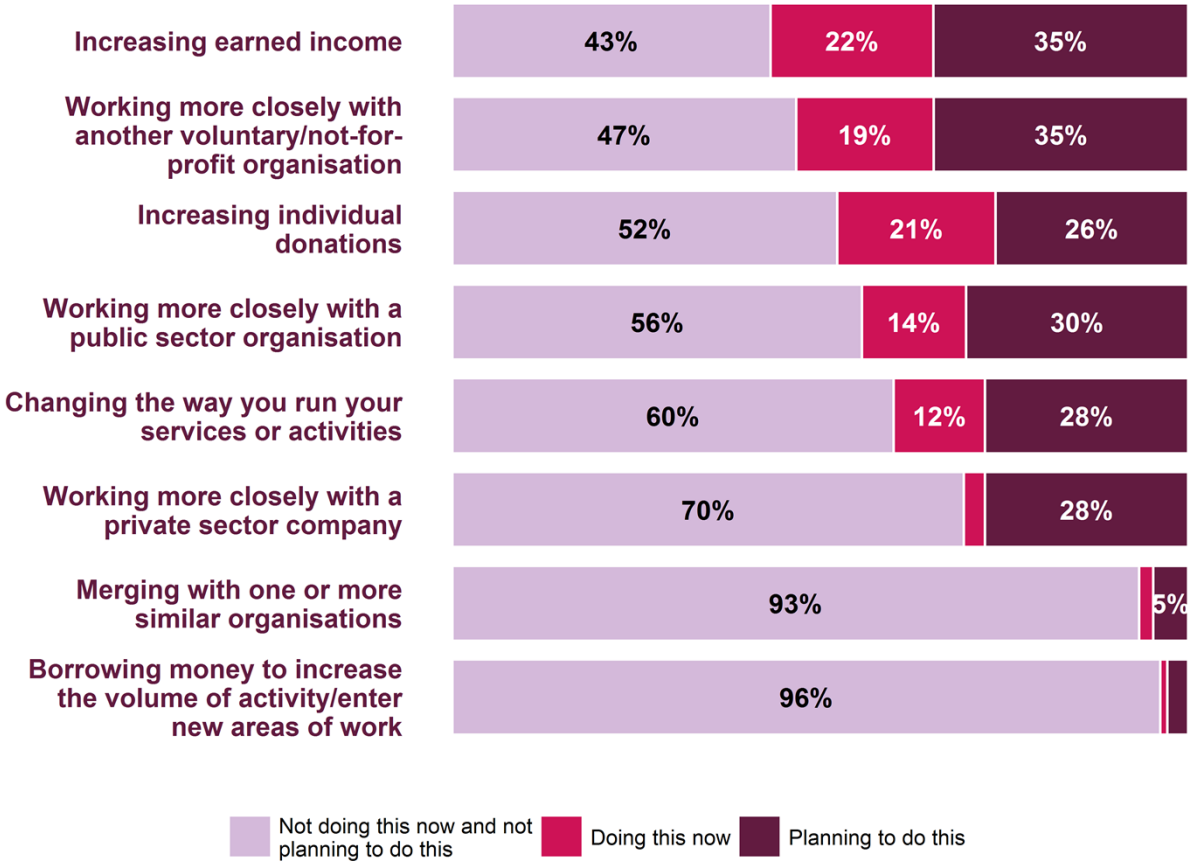
11.2. Current and future strategies

Survey respondents were asked what strategies they are actively pursuing or planning to pursue. Figure 11.2 summarises the responses received and shows that almost half or more of respondents were already doing or planning to do the following:

- **increasing earned income:** 57 per cent were already pursuing or planning to pursue this strategy; including 22 per cent who are doing this now and 35 per cent who are planning to do this
- **working more closely with another voluntary/not-for-profit organisation:** 53 per cent were already pursuing or planning to work more closely with other VCSE organisations; including 19 per cent who are doing this now and 35 per cent who are planning to do this in the future
- **increasing individual donations:** 48 per cent were already pursuing or planning to increase individual donations; including 21 per cent who are doing this now and 26 per cent who are planning to do so.

Results across Greater Manchester followed a broadly similar pattern, but organisations were in general more likely to be currently pursuing each of the listed strategies or planning to do so.

Figure 11.2: Strategies being planned or pursued



Source: Tameside State of the VCSE sector survey 2016/17
Base: 104-107

12 Conclusions

1. The VCSE sector in Tameside continues to occupy an important strategic position between policy development, service provision and everyday life.

There are an estimated 1,167 organisations working in the VCSE sector in Tameside who are involved in many areas of activity.

As in the 2013 study, the local area is a main focus for the majority of organisations; 43 per cent identified particular neighbourhoods or communities in Tameside as their highest main geographic focus, and a further 28 per cent identified the whole of the Tameside local authority area as their highest main geographic focus.

The thematic areas with the greatest proportion of organisations working in them are: health and wellbeing; sport and leisure; community development; and education, training and research (which includes information, advice and guidance); the same four areas selected most frequently in 2012/13.

The VCSE sector plays a key role in fostering strong and cohesive communities within Tameside and is an essential part of the social fabric of the borough. Two-thirds of respondents felt they were improving people's mental wellbeing (66 per cent) and 58 per cent claimed they were improving people's physical wellbeing.

2. The sector in Tameside remains an important economic player, contributing significantly to GVA[31], but patterns in income, expenditure and the level of reserves suggest that, as in 2013, the sustainability of many organisations may be under threat.

Valuing the contribution of both paid employees and volunteers and committee/board members to Tameside organisations by the expected value of the output that they produced gives an estimated contribution overall of £115.4 million.

Total income of the VCSE sector in 2014/15 is estimated to be £53 million. This represents an increase of one per cent compared to 2013/14 when the total income of the VCSE sector was an estimated £52 million. The majority of organisations are micro or small although the majority of income is concentrated in large and medium-sized organisations.

The picture is more positive overall than in the previous 2013 study which identified year-on-year reductions in income. However analysis of income data across Greater

[31] Gross Value Added (GVA), the value of goods and services produced, is a key measure of the economic contribution of organisations or sectors.

Manchester by organisation size revealed micro and small organisations experienced year on year reductions in total income between 2012/13 and 2014/15. By contrast medium and large organisations saw a reduction in total income between 2012/13 and 2013/14 but then an increase between 2013/14 and 2014/15.

Almost half (47 per cent) of respondents reported increasing their expenditure but only 35 per cent had experienced an increase in income and only 20 per cent report an increase in reserves.

In addition, 25 per cent of respondents reported a decrease in income but only 12 per cent reduced their expenditure.

30 per cent of respondents provided an expenditure figure for 2014/15 that was greater than their income. These results indicate a sizeable number of organisations spent more money than they received in the last 12 months and that a considerable number of organisations are using their reserves to supplement their income, potentially leaving them in a fragile financial position.

3. The VCSE sector in Tameside continues to provide significant social value.

It is estimated that the VCSE sector in Tameside made 1.5 million interventions with clients, users or beneficiaries in the previous year.

VCSE organisations work with a range of different people, especially children and young people and older people, but also people from vulnerable groups (for example those with health problems).

4. The VCSE sector continues to be a significant employer.

In 2016/17 there were an estimated 1,300 FTE paid staff. In addition the sector was supported by 26,000 volunteers and 8,000 committee/board members who combined donated 83,400 hours per week.

Valuing the contribution of paid employees to Tameside organisations by the expected value of the output that they produced gives an estimated annual contribution of £39.9 million. Doing the same for volunteers and committee/board members gives an estimated contribution of £75.5 million.

5. Volunteering is essential to what VCSE organisations do however there are challenges associated with volunteering across the borough.

Almost two-fifths (37 per cent) of organisations responding to the survey reported increased numbers of volunteers compared to the previous year, while just 15 per cent of organisations reported a decrease in volunteer numbers.

Focus group participants argued that volunteering is essential for what they do and in general were very positive with regards to volunteering. However, participants did identify one recent development which was affecting the way they worked with volunteers. This was when volunteers are referred to the organisation from other voluntary groups or public bodies as part of an employment programme or as a condition of benefits. Participants argued that sometimes these potential volunteers got involved in activities without really wanting to, which could undermine VCSE organisations' ability to function effectively.

Linked to this was the ongoing challenge of recruiting and retaining skilled and committed volunteers for the long term, which was something most participants said their organisation struggled with.

6. There is a mixed picture in Tameside regarding relationships between the VCSE sector and public sector bodies.

Overall, 74 per cent of respondents in Tameside had some dealings with Tameside Council (69 per cent in 2012/13): seven per cent had a great amount of dealings with the Council and 28 per cent had a fair amount of dealings.

Around one quarter (23 per cent) of respondents were satisfied with their ability to influence Tameside Council decisions of relevance to their organisation while 27 per cent said Tameside Council had a positive influence on their organisation's success. Results are very similar to those in 2012/13.

Most focus group participants reported good links with certain parts of the public sector, but there was an overriding sense of frustration about not getting enough support and information from the key public bodies.

There was also a general feeling amongst participants that they didn't really know what to make of devolution, but also a tendency to be sceptical about it, in particular its implications for smaller voluntary organisations.

7. Engagement with private businesses remains relatively low but perceptions of the private business sector appear to have improved.

57 per cent of organisations had some direct dealings with private businesses, with 15 per cent having a 'great' or 'fair' amount of contact. This is a change from 2012/13 when 46 per cent reported some direct dealings and 13 per cent had a 'great' or 'fair' amount of contact.

Over one quarter (27 per cent) felt that the private business community in Tameside was a positive influence on their organisation's success. This is an increase since 2012/13 when just 16 per cent agreed private businesses were a positive influence.

Overall, focus group participants had mixed experiences of and relationships with private businesses. A number of participants reported long-standing relationships with local business while others received only the occasional donation and no formal partnership.

8. The VCSE sector in Tameside continues to be well connected internally although most contact appears to be informal.

As in the 2013 study, the majority of organisations had some direct dealings with other VCSE sector organisations in their local area, including 53 per cent who had a 'great' or 'fair amount' of contact.

Just 13 per cent of respondents said their organisation is a member of a formal VCSE sector consortium.

All focus group participants reported good relationships with other VCSEs but were rarely involved in formal partnerships.

9. The sector still faces an uncertain future.

With austerity measures set to continue for the foreseeable future and public sector funding for the sector continuing to be squeezed, there are still reasons for caution within the sector.

Respondents appear to recognise this uncertainty and are pursuing a range of strategies to ensure their sustainability, in particular, generating earned income from other sources, partnership working and organisational change.

Appendix 1

A1

Methodology

Survey of organisations

At least partial responses were received from 65 of the 735 organisations that were sent a survey questionnaire: this represents a response rate of nine per cent. Another web-based version of the survey was also distributed by Action Together in Oldham and Tameside, reaching organisations also included in the original sample and beyond. Action Together played a key role in boosting the response rate to the survey by utilising their relationships with the sector to encourage organisations to complete a questionnaire. In addition GMCVO distributed a version of the survey via their networks. A further 75 responses were collected via these methods, meaning a total of **140 responses were collected overall** during September 2016 - January 2017, giving a higher overall response rate.

The survey was undertaken as part of a wider study in six other Greater Manchester boroughs: Bolton, the City of Manchester, Oldham, Rochdale, Stockport and Salford.

The questionnaire was based on the one originally developed for the 'State of the Voluntary Sector Survey' undertaken in Salford in 2010. The questionnaire was revised for the 'Greater Manchester State of the Voluntary Sector' research undertaken in 2012/13 and again for this wave of the survey following input from the Research Steering Group. The Greater Manchester Chief Officers Group also provided additional oversight regarding the survey design and implementation.

The questionnaire provided data on various aspects of the VCSE sector including:

- **the scale and scope of its activity**, including the roles organisations undertake, the people they support, and the areas they benefit
- **the economic impact of its work**, including income and expenditure, sources of funding, the role of paid staff and volunteers, and financial sustainability
- **relationships with the public sector**, including Tameside Council, public sector health bodies, and a range of other local statutory bodies
- **relationships with other local organisations**, including VCSE organisations and private businesses.

Where possible the report compares results from the latest survey and the 2012/13 study. Revisions to the questionnaire mean that comparisons are not always possible or appropriate. It is also worth noting that in 2012/13 a large postal survey was the main method of data collection which was supplemented with a web based survey. This is different to the latest study when a web based survey was the primary method of data collection.

When reading the report it is important to acknowledge two key points. First, the results reported are based on the survey responses received. Therefore it is possible that if a different sample of organisations had taken part in the survey different results may have emerged. It is estimated that the results reported are within +/- 7.8 percentage points of the true value.

Secondly, on a number of occasions the analysis in this report has used extrapolations from the survey responses to provide estimates of totals for all organisations that work in the VCSE sector including:

- the number of clients, users and beneficiaries of the sector
- the total income of the sector
- and the number of FTE paid staff and the number of volunteers and committee/board members that are part of the sector's workforce; including the hours per week that volunteers contribute.

In each case the same three stage method has been used for calculating the sector wide totals:

- **stage one:** calculate the Greater Manchester averages for each of the four size bands of organisations: 'micro', 'small', 'medium' and 'large': column (a) in table A1
- **stage two:** multiply the average for each size band (column (a) in table A1) by the estimated number of organisations within that size band (column (b) in table A1) to give the total for each size band of organisations (column (c) in table A1)
- **stage three:** sum the estimates from stage two (column (c) in table A1) to give a sector wide total estimate (cell (d) in table A1).

This was necessary to take account of noticeable differences in the response rates by organisation size. A failure to do this would lead to upwardly biased estimates: a small number of mainly 'large' organisations create a high mean value that is not representative of the majority of organisations. This is an important point given that we estimate that a large proportion of the sector is made up of 'micro' organisations which tend to have far lower values and not taking into account difference by size of organisations would produce estimates that are much higher.

Table A1: Extrapolations: a worked example (total annual income)

	Average income by size (a)	Estimated number of organisations (b)	Total income (thousands) (c)
Micro (under £10k)	£2,438	792	£1,930,426
Small (£10k to £100k)	£38,844	290	£11,271,991
Medium (£100k to £1m)	£320,581	78	£25,010,280
Large (over £1m)	£2,201,023	7	£14,436,849
Total			**(b) £52,649,546**

Please note it has been assumed here that the estimated averages for Greater Manchester organisations are representative for organisations within Tameside. So, for example, it is has been assumed that the estimated average income of approximately £320,600 for medium sized organisations across Greater Manchester is representative of the income for medium sized organisations within Tameside.

Using the Greater Manchester averages improves the reliability of the estimates.

Focus groups

A focus group was conducted to provide a further depth of understanding to some of the themes covered in the State of the Sector Survey. The group was held midway through the survey administration and undertaken by Action Together who recruited local organisations to participate in the groups.

A topic guide was devised to help guide discussions and ensure a standardised approach across all local authority areas conducting focus groups. The topic guide was created in partnership between CRESR and the Research Steering Group with CRESR providing advice and guidance on best practice in undertaking this type of research.

The focus group lasted approximately 1 hour - 1 hour 30 minutes and was digitally recorded with consent obtained from all participants. The recording was then provided to CRESR who analysed the discussion. Analysis of the discussion is included in the relevant chapters of this report.

The topics discussed in the focus group concentrated on four key themes: volunteering, working with the public sector, working with other VCSE organisations and working with the private business sector.

The focus group took place with small VCSE groups/registered charities.

Legal status of responding organisations

Respondents to the questionnaire were asked to identify the legal status of their organisation. For this question it was possible for organisations to select registered charity in addition to identifying their legal form. Figure A1 below shows that 34 per cent were a group with a constitution, but not registered charities and 18 per cent of organisations were a company limited by guarantee and that separate to identifying their legal status half of respondents, 49 per cent, identified that their organisation was a registered charity.

These results are slightly different to those in the 2012/13 survey when:

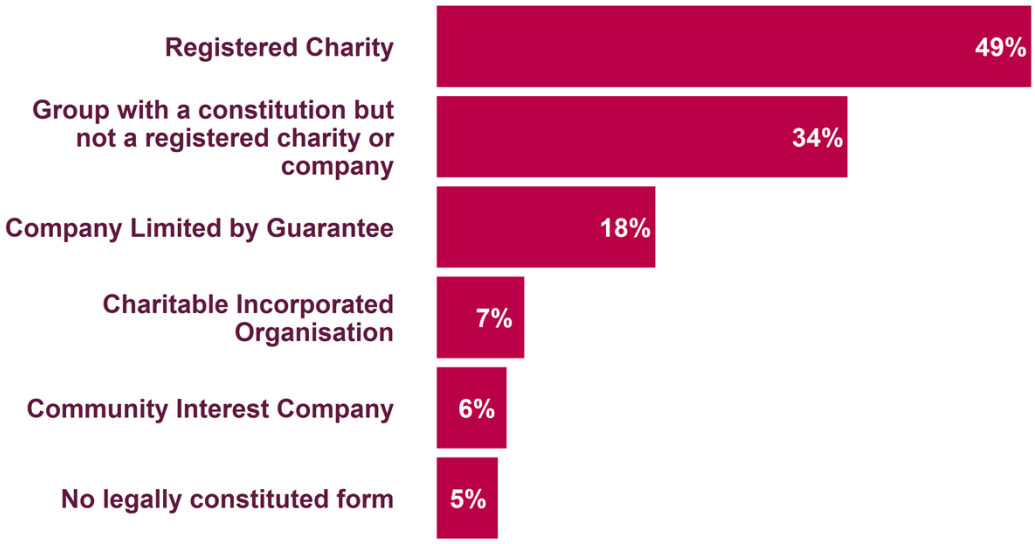
- 45 per cent of organisations were a group with a constitution, but not registered charities (noticeably higher than the latest survey)
- 13 per cent were companies limited by guarantee
- four per cent of organisations had no legally constituted form
- 43 per cent of respondents identified that their organisation was a registered charity.

In the latest survey, however, six per cent of respondents indicated their organisation was a Community Interest Company; double the proportion in 2012/13 (three per cent).

Across Greater Manchester:

- 30 per cent of organisations were a group with a constitution - but not a registered charity
- 28 per cent were a company limited by guarantee
- four per cent of organisations had no legally constituted form
- 49 per cent of organisations were registered charities.

Figure A1: The legal status of responding organisations



Source: Tameside State of the VCSE sector survey 2016/17
Base: 138

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 September 2017
Executive Member / Reporting Officer:	Angela Hardman, Director of Public Health Liz Windsor-Welsh, Chief Executive Officer, Tameside Action Together
Subject:	**COMPACT: RELATIONSHIP WITH PEOPLE, COMMUNITIES AND THE VOLUNTARY, COMMUNITY, FAITH AND SOCIAL ENTERPRISE SECTOR (VCFSE).**
Report Summary:	This report introduces new work that is about to commence to establish a new, and progressive way of working between statutory organisations and the voluntary, community, faith and social enterprise sector. This is key to the success of our ambitions for both health and social care reform and wider public sector reform.
Recommendations:	It is recommended that the Health and Wellbeing Board take note of the work and: • Endorses the ambitions of the work. • Agrees for the relevant senior personnel from their organisation will participate in the development of the 'Principles' that will detail our commitments. • Ensure there is a commitment from senior personnel across key agencies to join the Leadership Group to ensure progress is made and system blockers identified and resolved.
Links to Health and Wellbeing Strategy:	This work has cross cutting relevance to the Health and Wellbeing strategy and in particular the implementation of Care Together and its ambitions for increased Self Care. This also links to emerging work with regard to Public Sector Reform, 'Forward Five' and the re-development of the Early Help Strategy.
Policy Implications:	None immediately but will have significant relevance to the following once the commitments are developed, particularly in relation to; - Citizen and patient engagement - Commissioning strategies and plans - Care Together implementation
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications arising from the report at this stage.
Legal Implications: **(Authorised by the Borough Solicitor)**	Achieving this 'new relationship' will require clear leadership, governance and accountability. It would be helpful to set out expectations in a MOU.

Risk Management :	There are no risks associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Anna Moloney  Telephone: 0161 342 2189  e-mail: anna.moloney@tameside.gov.uk

1.0 INTRODUCTION

1.1 At a meeting on 22nd March 2017, there was a joint commitment from the Single Commissioning Function (SCF), Integrated Care Foundation Trust (ICFT) and representatives of Action Together to establishing a new, and progressive way of working between statutory organisations and the voluntary, community, faith and social enterprise sector (VCFSE). This is key to the success of our ambitions for both health and social care reform and wider public sector reform.

1.2 Subsequently, senior leadership from these organisations have proposed the development of a 'Compact' to underpin a new and progressive relationship with the VCSFE. Historically 'Compacts' have often been viewed as passive agreements between the state and the VCFSE. We have agreed that this agreement should detail our shared ambitions and agree how we will actualise this new relationship in our joint work together by identifying joint priorities where change is required and key workstreams to begin to implement these changes.

1.3 It is also important to note that a number of the transformation programmes associated with Care Together rely heavily on the VCFSE (e.g. social prescribing, asset based approaches) and as such their success will be enabled by a consistent set of principles, values and ultimately actions that traverse the approach taken by all agencies in Tameside and Glossop.

2.0 DEVELOPING A PROGRESSIVE RELATIONSHIP BETWEEN STATUTORY AGENCIES AND THE VCFSE

2.1 The development of a Compact with the VCFSE will enshrine a set of key principles that all organisations should adhere to. This process will require collaborative leadership and accountability to ensure that all partners are aware of it; its principles and how it should influence the way we work.

2.2 We should be clear what success looks like and identify a set of metrics that are indicative of working differently with the VCFSE, people and communities and assure ourselves of progress against them. Therefore the Single Commission and Tameside and Glossop Integrated Care Foundation Trust are to work with Action Together, The Bureau Glossop and High Peak CVS and their members to develop and publish a new Compact with the VCFSE. It will embed awareness and understanding of the way we do things as any Compact has to be on the basis of equal partnership and co-leadership. It is not a document that outlines how statutory agencies will engage with the VCFSE.

2.3 The Compact should be orientated around a set of key principles and underpinned by an expectation of partnership and collaboration, these principles could be:

- Respect – with statutory and VCFSE organisations both being accountable in different ways. Relationships need to be underpinned by integrity and transparency, built on a mutual understanding of the differences between partners;
- Honesty – successful relationships must be underpinned by honest, full and frank conversation;
- Independence – many VCFSE organisations will have a remit to represent the views of a population – their independence must be maintained and protected, irrespective of whatever other relationship exists;
- Diversity – partners involved in the Compact must demonstrably value a thriving civil society that brings a multitude of voices to the fore;
- Citizen Empowerment – working together, the statutory sector and the VCFSE can deliver change that is built around people and communities, meeting their needs and reflecting their choices;

- Volunteering – The significant role played by volunteers for the benefit of the public and a vibrant society should be recognised, appreciated and built upon.

3.0 LEADERSHIP AND GOVERNANCE

3.1 Achieving this 'new relationship' will require clear leadership, governance and accountability. In order to do this we will establish a Leadership group that will be cross sectoral and made up of senior representatives from across a wide range of public sector agencies and VCFSE organisations. This should be jointly chaired by a representative from the VCFSE and a representative from the statutory sector. The group will drive forward work relating to the ambitions and agreed principles and seek to uncover and resolves blockers in this new way of working. Where appropriate groups don't already exist, workstreams should be established to ensure we address key areas including (but not exclusively):

- The commissioning relationship with the VCFSE;
- The role of the VCFSE as strategic influencers;
- The role of the VCFSE in supporting public engagement and co-production;
- The VCFSE as a route to support a new relationship with people and communities;

3.2 This work should feed appropriately in to the governance of the local health and care economy, Tameside's Voluntary Influencing Group and critically including the Health and Wellbeing Board.

4.0 NEXT STEPS AND KEY MILESTONES

4.1 The following key actions and milestones will ensure this work progresses and achieves stated aims;

- Establish the Leadership Group and agree Terms Of Reference, scope and activity milestones (October 2017);
- Facilitate engagement from across public agencies and the VCFSE (Tameside and Glossop) to establish the shared ambitions and agree principles (by December 2017);
- Agree workstreams and begin work in practice to address priority areas (January 2018);
- Leadership Group meets bi-monthly to review progress, identify and resolve system blockers;
- Report back progress to identified governance forums including Health and Wellbeing Board.

4.2 The two accountable officers for this work are; Angela Hardman, Director of Population Health, and Liz Windsor-Welsh (Chief Executive Officer, Action Together, also on behalf of High Peak CVS and The Bureau).

5. RECOMMENDATIONS

5.1 As stated on the front of the report.

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 September 2017
Executive Member / Reporting Officer:	Angela Hardman, Director of Population Health Gideon Smith, Consultant in Public Health Medicine
Subject:	**GREATER MANCHESTER CANCER PLAN – TAMESIDE AND GLOSSOP STOCKTAKE**
Report Summary:	The Greater Manchester Cancer Plan was received by the Health and Wellbeing Board in March 2017. The Tameside and Glossop Cancer Board, which is led by Tameside and Glossop Integrated Care Foundation Trust with membership from the Single Commission, have developed a comprehensive implementation plan. A detailed working action plan has been developed by the project manager to support the work of the local working group, and progress is reported to Tameside and Glossop Cancer Board. **Appendix 1 and 2** provide an update on the current local position and next steps required to deliver the contributions required in the locality specific plan.
Recommendations:	The Health and Wellbeing Board is asked to : 1. Note the progress to date with local implementation of the Greater Manchester Cancer Plan; 2. Endorse the local action summaries outlined in **Appendix 1 and 2**. 3. Receive further progress reports.
Links to Health and Wellbeing Strategy:	Cancer is the most common cause of death in Tameside for males and females, and there are significantly more deaths than there should be given the population age and gender profile, so improving cancer outcomes delivers against all life course priorities of the Health and Wellbeing Strategy.
Policy Implications:	The Greater Manchester Health and Social Care Strategic Partnership Board approved the Greater Manchester Cancer Plan for implementation on 24 February 2017. This paper summarises the local actions required to realise the ambitions of the Greater Manchester Cancer Plan.
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications arising from the report at this stage. However, the financial implications within further update reports on the associated plan will be considered and reported accordingly to Health and Wellbeing Board members.
Legal Implications: **(Authorised by the Borough Solicitor)**	It is important that decisions regarding resources are made on an evidence based approach. This report sets out the evidence of the challenges and how we tackle improving cancer outcomes.

Risk Management :

The Greater Manchester Cancer Plan contains a substantial amount of work, much of which requires contributions from all parts of the cancer system. The proposed accountable cancer network model as part of cancer vanguard programme requires further substantial Greater Manchester system debate and engagement. Transformation funding will be sought to deliver some of the signature proposals in the plan, including lung health check (if pilot successful) and delivery of the recovery package.

The actions detailed in this local stocktake are extensive, but within the scope of existing service and clinical development and improvement expectations.

Access to Information :

The background papers relating to this report can be inspected by contacting Gideon Smith, Consultant, Public Health Medicine, by:

 Telephone: 0161 342 4251

 Gideon.smith@tameside.gov.uk

1.0 INTRODUCTION

1.1 The Greater Manchester Cancer Plan was received by Tameside Health and Wellbeing Board on the 9 March 2017. The Tameside and Glossop Cancer Board, which is led by Tameside and Glossop Integrated Care Foundation Trust with membership from the Single Commission, had develop a comprehensive implementation plan.

1.2 The Greater Manchester Plan sets out the ambitions for Greater Manchester Cancer, the cancer programme of the Greater Manchester Health and Social Care Partnership. It is set out in eight domains reflecting a combination of the five key areas for change set out in Taking Charge and the six key workstreams of the national cancer strategy.

1.3 Much of the work set out in the plan will be delivered by the current and proposed Greater Manchester Cancer infrastructure. A substantial part of the plan in 2016/17 and 2017/18 is part of the vanguard innovation programme and funded by NHS England's New Care Models Team.

1.4 Greater Manchester Transformation funding will be sought to deliver other key parts of the programme and, if appropriate, to roll out successful pilots from the vanguard innovation programme beyond 2017/18.

2.0 GREATER MANCHESTER CANCER PLAN: "ACHIEVING WORLD-CLASS CANCER OUTCOMES: TAKING CHARGE IN GREATER MANCHESTER 2017-2021"

2.1 Vision and key objectives:

1) We will reduce adult smoking rates to 13% by 2020;
2) We will increase one-year survival to more than 75% by 2020;
3) We will prevent 1,300 avoidable cancer deaths before 2021;
4) We will offer class-leading patient experience, consistently achieving an average overall rating of 9/10 in the national survey from 2018;
5) We will consistently exceed the national standard for starting treatment within 62 days of urgent cancer referral;
6) We will ensure that the Recovery Package is available to all patients reaching completion of treatment by 2019.

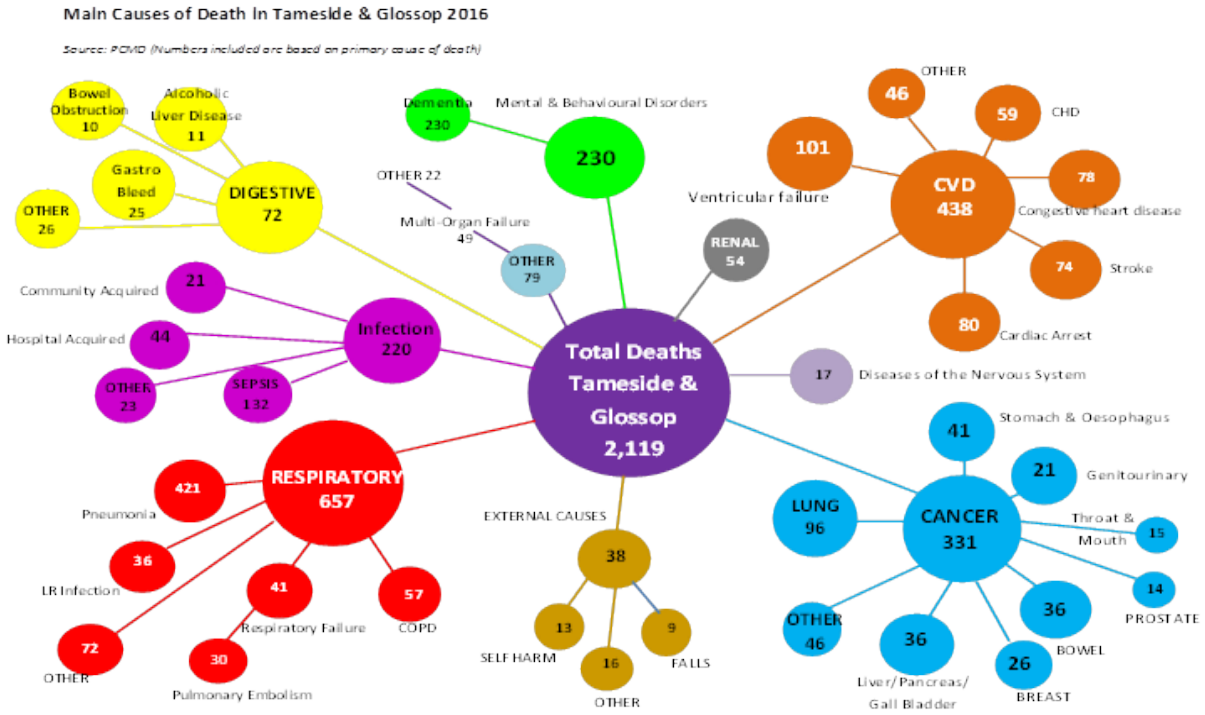
2.2 Domains:

There are eight domains within the Greater Manchester plan**;** reflecting a combination of the five key areas for change set out in '**Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-2021'** and the six key work streams of the National Cancer Strategy.

3.0 CANCER IN TAMESIDE AND GLOSSOP

3.1 A detailed summary of local cancer experience received by T&G Single Commissioning Board in June 2017 is included as appended.

3.2 In 2016 Cancer was the main cause of death in 15.6% of the population in Tameside and Glossop Clinical Commissioning Group (331 out of 2,119 total deaths).



3.3 In Tameside and Glossop Clinical Commissioning Group all of the following were higher than the NHSE average:

- incidence of cancer;
- mortality rates;
- under 75 years of age mortality;
- number of deaths from cancers considered preventable;
- adult smoking rates.

3.4 The majority of the time we are achieving the operational waiting times standards (93% within 2 week waits, 96% within 31 days and 85% within 62 days).

3.5 NHS Right Care data highlights areas for improvement where we were worse than our average 10 Clinical Commissioning Group equivalents including:

- Screening uptake;
- Smoking;
- Spend on primary care prescribing;
- Waiting times for endoscopy;
- Liver disease.

3.6 The report to Single Commissioning Board concludes that the following areas need to be considered as part of an ongoing improvement process and incorporated into the local response to cancer:

- What else can we do to detect Cancer earlier and raise public awareness through national and local campaigns?

- How do we reduce emergency presentations (impact on non-elective admissions)?
- Role of Primary Care e.g. Use of e-referrals and EMIS templates.
- Improve access e.g. Straight to Test Colonoscopy, new lung pathway, bowel prep issued within primary care .
- Ensure access to services is equitable.
- Planning, demand and Capacity.
    - Impact of Locum staff e.g. new rules IR35.
    - How do we reduce the number of DNAs?
    - Learning from breach analysis.
    - Support within the community.
    - Data shows Length of Stay in hospital is greater than comparative CCGs.
    - Care planning, data shows we only prepare 32.5% of after care plans
    - How do we improve patient experience?

4.0 TAMESIDE AND GLOSSOP RESPONSE

4.1 Vision and key objectives

GM Cancer Plan key objective	Tameside and Glossop current position
1. We will reduce adult smoking rates to 13% by 2020	Current downward trend of up to 2% per year. 22.1% in 2016.
2. We will increase one-year survival to more than 75% by 2020	One year survival from cancer is improving year on year but is lower that the NHSE average (70.2%) at 67.6% in 2013. When comparing to 10 similar CCGS two were lower than T&G CCG.
3. We will prevent 1,300 avoidable cancer deaths before 2021	331 cancer deaths in T&G in 2016. Aim to avoid 130 deaths in T&G by 2021.
4. We will offer class-leading patient experience, consistently achieving an average overall rating of 9/10 in the national survey from 2018	Cancer patient experience rating 8.9 for T&GICFT and 8.8 for T&GCCG for 2016 (England 8.7).
5. We will consistently exceed the national standard for starting treatment within 62 days of urgent cancer referral	Better than the NHSE average (82.2%) for GP referral to first definitive treatment within 62 days in Q1 16/17. When comparing to 10 similar CCGS all were lower.
6. We will ensure that the Recovery Package is available to all patients reaching completion of treatment by 2019	T&G ICFT made a successful bid to Macmillan for 2 year funding for a 3 member team to support local implementation of the Recovery Package.

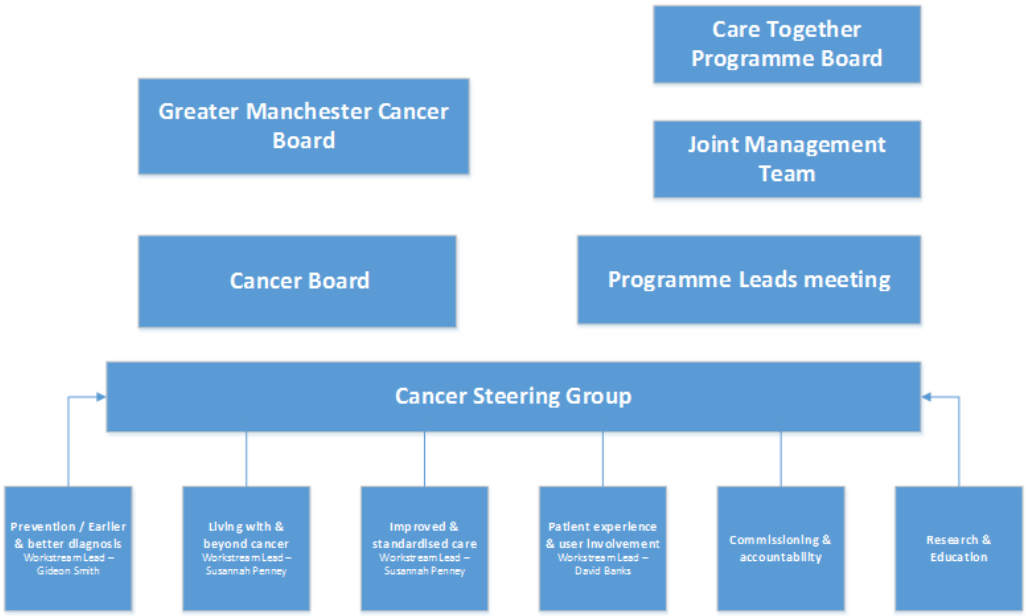
4.2 To date the Tameside and Glossop Cancer Board has:

- audited local working position and outlined actions required to meet the Locality Specific actions;
- Agreed terms of reference and membership of Greater Manchester Cancer Plan local working group to further progress the plan that will meet on a monthly basis;

- assigned a Care Together Project Manager who started to develop a project plan;
- progressed the development of the Locality specific plan;
- established Task and Finish Groups for each of the work streams identified within the plan to oversee the implementation of Locality Specific actions with these work streams:
    - Prevention and Earlier & Better Diagnosis (lead - Gideon Smith)
    - Living With and Beyond Cancer (lead - Carol Diver)
    - Improved & Standardised Care (lead – Susi Penney)
    - Patient Experience & User Involvement (lead - David Banks)
    - Commissioning & Accountability (lead - Alison Lewin)
    - Research & Education – (lead Tameside and Glossop Cancer Board)

4.2 Going forward the Tameside and Glossop Cancer Board will be kept informed of progress by the Steering Group with any areas of concern escalated as appropriate.

4.3 Greater Manchester and Tameside and Glossop governance for Greater Manchester Cancer Plan implementation:



3.3 A detailed working action plan has been developed by the project manager to support the work of the local working group, and progress is reported to T&G Cancer Board.

3.4 Appendix 1 and 2 provide an update on the current local position and next steps required to deliver the contributions required in the Locality specific plan.

4.0 LOCAL HIGHLIGHTS

4.1 Prevention and Earlier and Better Diagnosis

4.2 ***Tobacco Control****:* Smoking is a significant challenge locally, but good progress is being made with year on year reductions for adults, young people and pregnant women. And the Tameside Tobacco Alliance is an effective partnership driving the HWBB Turning the Curve ambition to reduce local smoking prevalence.

4.3 ***Cancer Champions Social Movement:*** The GM lead for this programme is Ben Gilchrist, Deputy Chief Executive of Action Together in Tameside and a HWBB member, and this connection provides additional impetus to local activity. Action Together and Be Well Tameside have previously worked together on a Macmillan funded project to recruit and support community volunteers, and there is strong local expertise and commitment to enable this vision.

4.4 ***Promoting Screening:*** the Bowel Cancer Screening Programme for Tameside, Stockport & Trafford includes a shared Health Improvement Practitioner for Tameside and Glossop who leads and coordinates the local promotion of bowel cancer screening. T&G Primary Care Delivery and Improvement Group have an Quality Improvement Initiative for cancer screening.

4.5 ***T&G Cancer Early Detection Network:*** This group links local stakeholders including: Public Health, Be Well Tameside, Bowel Cancer Screening Team, Cancer Research UK, workplace health, Macmillan GP, CCG commissioner, Tameside Macmillan Centre and Action Together. It enables coordination and joint working, and its members will be key to the development of the social movement, symptom awareness and improving screening uptake.

4.6 ***Cancer Waiting Times:*** Local good performance is built on sustained concerted effort of clinical teams to continuously improve pathways and protocols. Plans for further developments to reduce waits for complex and high volume pathways in step with GM pathway work is in hand locally.

4.7 Living With and Beyond Cancer

4.8 ***Recovery Package:*** T&G ICFT made a successful bid to Macmillan for 2 year funding for a 3 member team to support local implementation of the Recovery Package.

4.9 Improved and Standardised Care

4.10 ***Lymphoedema service***: T&G has had an award winning service in place for several years, and is very well placed to extend this in line with GM aspiration.

4.11 ***GM Clinical Pathways:*** T&G cancer patients receive much of their care from a range of providers across GM, and efficient pathways are critical for good outcomes. Local clinicians are actively involved in the development and local implementation of these pathways.

4.12 Patient Experience and User Involvement

4.13 ***T&G Macmillan Unit:*** This recently opened facility at Tameside Hospital includes a dedicated team member with a remit for user and community engagement, as well as an information centre. The Unit is very well placed to support the development of the Recovery Package, patient engagement and Cancer Champion recruitment and support.

5.0 LOOKING FORWARD TO 2021

5.1 By 2021 in Tameside and Glossop, in line with the GM vision we will have:

- reduced smoking in adults, young people and pregnant women
- increased one year survival

- reduced the number of preventable deaths from cancer
- improved patient experience
- improved waiting times
- introduced the Recovery Package

5.2 In addition the Tameside and Glossop Cancer Board will have overseen and coordinated a programme of developments and transformation that addresses the actions for CCGs and Provider Trust prioritised in the GM Cancer Plan, including:

- growth of a GM Cancer Champions Social Movement
- increased uptake of screening
- expanded lympoedema service
- adoption of standard GM system-wide pathways
- optimised multi -disciplinary team processes
- adoption of optimal GM tumour specific service specifications
- 7 day specialist palliative care advice and assessment
- choice in end of life care
- shared digital palliative and end of life care records
- patient self-referral
- stratified follow pathways of care
- service user involvement in continuous development of services
- access to clinical nurse specialists
- integrated acute oncology service
- primary care education platform

6.0 RECOMMENDATIONS

6.1 As detailed on the front of this report.

APPENDIX 1

TAMESIDE AND GLOSSOP COMMISSIONING INTENTIONS AND ACTION PAPER

The table below provides an update on the contributions required from Clinical Commissioning Groups to meet the level of ambition across Greater Manchester; these will be developed further and incorporated into the Locality specific plan.

	What do we need to do? - Update on the local position and next steps required.	**When**
Prevention, Earlier and better diagnosis		
1	Strengthen existing tobacco controls and smoking cessation services, in line with **reducing smoking prevalence** to below 13% nationally • Implement locality requirements outlined in the Greater Manchester tobacco control plan (expected April 2017). • Ensure effective and accessible locality based smoking cessation services are in place. **Local Actions required** • Raise awareness of lifestyle risk factors and change behaviour. • Help people to understand their individual risk of cancer. • Deliver lifestyle-based secondary prevention. **Local Current Position** • Be Well Tameside provides a person-centred, holistic service which is flexible and responsive to the needs of local people. The service operates on 3 levels. o Support for multiple lifestyle issues (e.g. improving the quality of diet and nutrition, stopping smoking, reducing alcohol intake, increasing physical activity). o Community Liaison, outreach and capacity building. The service works with residents, groups and organisations to promote Health and Wellbeing and encourage greater access to Be Well Tameside services. o Training and Learning and Development. Be Well Tameside offers a health and wellbeing training programme to enhance and develop the competencies and skills of the wider public health workforce across organisations and the community. The training programme this year will include, Making Every Contact Count, Brief Advice/Intervention, Stop Smoking, Weight Management, Oral Health and other health related subjects. • Glossop has a newly commissioned Smoking Cessation service run by Derbyshire County Council/ Public Health. • Tameside are in their first year of a 3 year contract with Be Well (Pennine Care) who provides smoking cessation services for Tameside. **Next Steps** • Delivery model of lifestyle-based secondary prevention developed as part of new aftercare pathways by April 2018 • Identify areas for Improvement. • Social care assessments for all age groups (lifestyle interventions that would impact positively on a family/individual) Youth and young	By March 2020

	adults 16+ (12 years + for smoking support) • Consider innovative ideas to use Apps, software and website design for an interactive experience. • Greater Manchester population health plan produced by January 2017 • Greater Manchester tobacco control plan produced by April 2017 • Online tool for the assessment of individual risk of cancer available to people in Greater Manchester by September 2017.	
Prevention, Earlier and better diagnosis		
2	Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to test a GM wide **social movement focused on cancer prevention** **Local Actions required** • Create a citizen-led social movement **Local Current Position** • The local Cancer Early Detection Network links local stakeholders including: public health, Be Well, Bowel Cancer Screening Team, Cancer Research UK, workplace health, Macmillan GP, CCG commissioner, Tameside Macmillan Centre. • Be Well Tameside provide a training package on cancer symptom awareness for staff and volunteers in Tameside. Be Well are also recruiting and supporting volunteers, including some who are trained in cancer symptom awareness. • The Be Well service is a legacy from the Macmillan funded Community Cancer Awareness Project. **Next Steps** • Early Detection Network to oversee implementation plan.	By March 2019
Prevention, Earlier and better diagnosis		
3	Oversee roll out **primary care prescribing of drugs to prevent breast cancer**, subject to GM business case agreement **Local Actions required** • Prescribe drugs that are effective in preventing cancers. **Local Current Position** • Medicines Management Committee has had oversight of prescribing to date and this role will be picked up by the new Joint Medicines Optimisation Committee. **Next Steps** • Tameside and Glossop Clinical Commissioning Group Joint Medicines Optimisation Committee carry out Assessment of evidence of effectiveness of drugs to prevent breast cancer and business cases agreed by May 2017.	By May 2017
Prevention, Earlier and better diagnosis		
4	Improve access to, and uptake of, three national **cancer screening programmes** (bowel, breast, and cervical) and ensure a locality contribution to the overall GM targets of:	

	• Achieve bowel cancer screening uptake (FIT and scope) of 75% • Increase cervical screening coverage to 80% • Increase breast screening coverage by 10% to 75% **Local Actions required** • Enhance cancer screening • Increase public awareness of screening, and cancer signs and symptoms • Make the Manchester Cancer Improvement Programme lung health check available to all if successful • Pilot patient self-referral. **Local Current Position** • The local Cancer Early Detection Network links local stakeholders including: public health, Be Well, Bowel Cancer Screening Team, Cancer Research UK, workplace health, Macmillan GP, CCG commissioner, Tameside Macmillan Centre. • Be Well Tameside provide a training package on cancer symptom awareness for staff and volunteers in Tameside. Be Well also recruit and support volunteers, including some who are trained in cancer symptom awareness. • The Be Well service is a legacy from the Macmillan funded Community Cancer Awareness Project. • Pilot for Lung Cancer screening programme within Manchester Macmillan Cancer Improvement Partnership provided by University Hospital of South Manchester. **Next Steps** • FIT in use in bowel screening programme by April 2018 • HPV testing in cervical screening programme implemented by April 2018 • Bowel scope programme for 55 year old in place by April 2020 • Breast screening improvement trial reports findings in May 2017 • Bowel and cervical screening improvement trials report findings in October 2017 • Health equity profiles to identify areas of low screening uptake produced by July 2017 • Be Clear on Cancer branded campaign to promote bowel screening, January-March 2017 • Decision on implementation of MCIP lung health check across Greater Manchester by May 2017.	By March 2020 By March 2021
Prevention, Earlier and better diagnosis, Improved and standardised Care, Commissioning, provision and accountability and Patient experience and user involvement.		
5	**Improve one-year survival rates** to achieve 75%. • Deliver a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two – o Agree data collection trajectories with providers to ensure robust and timely staging data collection o Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to raise awareness of the signs and symptoms of cancer and encourage earlier	By March 2020 April 2017 onwards By March 2020

	presentation and advice seeking
	
	• Reduce the proportion of cancers diagnosed following an emergency admission
	  o Contribute towards a GM reduction in the proportion of cancers that are diagnosed as an emergency to below 18%
	  o Implement strategies for all patients diagnosed as an emergency to have their cases looked at through a Significant Event Audit
		By December 2017
		
		By March 2018

6	Drive earlier diagnosis by:
	• **Implementing NICE** referral guidelines
	  o Ensuring primary care adherence to use of updated standardised suspected cancer referral process and forms
	  o Support a GM approach to training and education for primary care professionals on cancer symptoms and referral processes
	• Ensuring local provision of **GP direct access** to key investigative tests for suspected cancer
	
	Local Actions required
	• Greater Manchester Cancer Volunteers – Raising awareness and Changing Behaviour
	• Implement the NICE suspected cancer referral guidelines
	• Improve adherence to NICE suspected cancer referral guidelines
	• Support pathway-specific efforts to deliver earlier and better diagnosis
	• Encourage Serious Event Audits (SEA)
	• Develop rapid cancer investigation units
	• Pilot patient self-referral
	• Reduce diagnostic waiting times
	• Contribute to regional improvements in diagnostic services
	• Agree data collection strategies to ensure robust and timely staging data collection.
	
	Local Current Position
	• GP TARGET sessions held in 2016 and 2017 .
	• Support available to Practices to reduce any variation
	• New GM wide referral proformas developed by ST & Macmillan GP colleagues in collaboration with MC pathway board clinical leads.
	• New e-referral templates installed on practice systems.
	• SEA of all emergency presentations to identify any key themes
	• ACE wave 2 Pilot of one-stop-diagnostic clinic for patients with non-specific symptoms at UHSM and PAHT from Jan 2017.
	
	Next Steps
	• GP use of updated standardised suspected cancer referral process and forms audited by June 2017 (Brain and sarcomas to follow)
	• Use of standardised suspected cancer referral process extended to other referrers by January 2018
	• Study into the impact of feedback on GP referral behaviour reports findings by September 2017	

	• Regional haematological malignancy diagnostic service in place by January 2018 • Regional jaundice pathway for pancreatic cancer in place by January 2018 • Regional optimal lung cancer pathway implemented by January 2018 • Standardised approach to prostate cancer diagnosis agreed and implemented by January 2018 • Standardised approach to one-stop unexplained vaginal bleeding clinics by August 2018 • Pilot of straight-to-test pathway for colorectal cancer by October 2017 • Sector MDT model in colorectal cancer fully implemented by September 2017 • Pilot of streamlined oesophago-gastric cancer diagnostic pathway by January 2018 • Current provision of breast one-stop triple assessment clinics audited and plan developed by September 2017 • Non-specific but concerning symptoms clinic pilots start March 2017 • Faster pathways in Bolton for lung, colorectal and oesophago-gastric cancers by May 2017 • Share learning on faster pathways locally and nationally by December 2017 • Workshop to commence regional radiology development programme by March 2017 • Proposal for regional cellular pathology development programme produced by September 2017.	
Prevention, Earlier and better diagnosis, Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
7	Work with providers, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree a co-produced cancer **patient access charter**	By June 2107
Prevention, Earlier and better diagnosis, Improved and standardised Care, Commissioning and provision and accountability.		
8	Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day **cancer waiting time standard.** Work towards achievement of the 28-day faster diagnosis standard. Ensure sufficient capacity for timed pathways for lung and HPB to deliver a • 50-day standard • 42-day standard **Local Actions required** • Reduce diagnostic waiting times • Contribute to regional improvements in diagnostic services • Speed up pathways to treatment **Local Current Position** • Consistently achieving the 62 day standard.	By March 2018 By March 2019 December 2017 December 2018

	Next Steps • Faster pathways in Bolton for lung, colorectal and oesophago-gastric cancers by May 2017 • Share learning on faster pathways locally and nationally by December 2017 • Workshop to commence regional radiology development programme by March 2017 • Proposal for regional cellular pathology development programme produced by September 2017 • 50-day pathway in place in identified tumour types by December 2017 • 42-day pathway in place in identified tumour types by December 2018 • System in place to report average and range of waiting times for all pathways by April 2017 • Identify priority pathways by April 2017	
Improved and standardised Care and Commissioning, provision and accountability.		
9	Work collaboratively to develop a commissioning plan for an **integrated acute oncology service** for implementation in 2018 **Local Actions required** • Deliver an integrated acute oncology service • Lead oncology patient safety translational research **Next Steps** • Commissioning plan for integrated acute oncology service by October 2017 • Agreed model for integrated acute oncology service implemented by October 2018	By October 2017
Improved and standardised Care and, Commissioning, provision and accountability.		
10	Work collaboratively to develop and commission comprehensive **lymphoedema** services **Local Actions required** • Commission a comprehensive lymphoedema service **Local Current Position** • T&G ICFT lymphoedema service available **Next Steps** • Sustainable lymphoedema service by March 2020	By March 2020
Prevention, Earlier and better diagnosis, Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
11	Work with clinical pathway boards, hospital providers, people affected by cancer and other stakeholders to develop and agree an **optimal Greater Manchester specification** for each tumour type. GM Led approach.	To a timetable to be set by Greater Manchester Cancer

	Local Current Position • Living With and Beyond Cancer group and End Of Life Strategy Group progressing. • Annual Dying Matters events organised. **Local Actions required** • Ensure access to seven-day specialist palliative care advice and assessment • Deliver choice in end of life care • Ensure that shared digital palliative and end of life care records are rolled out **Next Steps** • A detailed map of specialist palliative care provision against national standards and competencies by March 2018 • An innovative economic modelling proposal for the delivery of a seven-day specialist palliative care advice and assessment by March 2018 • Qualitative and quantitative evaluation tools to measure the impact of seven-day specialist palliative care advice and assessment services agreed by March 2018 • Dying Matters Coalition events across Greater Manchester by May 2018	
Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
12	Lead the **implementation of the Recovery Package** through: A. A contribution to the development of a standard Greater Manchester approach, and B. Building the delivery of each of the Recovery Packages elements into commissioning specifications GM led approach Ensure all parts of the Recovery package are available to patients including: A. Holistic Needs Assessment and Care Plan at diagnosis and end of treatment B. Treatment Summary is sent to GP at end of treatment C. Cancer Care Review completed by GP within 6 months of cancer diagnosis **Local Actions required** • Commission the Recovery Package • Develop new aftercare pathways • Explore supported patient decision-making in progressing disease • Improve access to psychological support • Support people with long-term consequences of treatment • Earlier integration of supportive care into cancer care **Local Current Position** • Actively support Greater Manchester Recovery Package Implementation Group to agree standardised approach within	To a timetable to be set by Greater Manchester Cancer

	region by August 2017 • Facilitate a scoping exercise to understand what treatments are provided locally • Explore the introduction of an electronic holistic needs assessment. **Next Steps** • Standardised Greater Manchester approach to the Recovery Package agreed by August 2017 • Full Recovery Package available to all patients reaching completion of treatment by March 2019 • All patients receive a care plan at the point of diagnosis and treatment decision, and at the end of their treatment, based on holistic needs assessments, by December 2017 • Health and wellbeing events in place for all breast, colorectal and prostate cancer patients to support new aftercare pathways by March 2018, with models for other pathways developed by March 2019 • All patients receive a care plan at the point of diagnosis and treatment decision, and at the end of their treatment, based on holistic needs assessments, by December 2017 • Health and wellbeing events in place for all breast, colorectal and prostate cancer patients to support new aftercare pathways by March 2018, with models for other pathways developed by March 2019 • Full Recovery Package available to all patients reaching completion of treatment by March 2019 • New aftercare pathways defined and implemented for all breast, colorectal and prostate patients by March 2018 • New aftercare pathways pilots begin in further tumour types by March 2019 • Goals of Care tool tested in appropriate clinics at The Christie from March 2017 • Goals of Care tool pilot extended to other sites by March 2018 • Role of regional psychological support clinical group formalised by June 2017 • Psychological support clinical group to produce plan for improved access to psychological support by October 2017 • Potential consequences of treatment mapped by pathway by June 2017 • Assessment of current consequences of treatment expertise in Greater Manchester by June 2017 • Action plan to address any gap in support for consequences of treatment by September 2017 • Enhanced supportive care outpatient clinic piloted at the Christie centre at the Royal Oldham by April 2018.	
Prevention, Earlier and better diagnosis, Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
13	Ensure patients have access to Greater Manchester Cancer agreed **stratified follow up pathways** of care for o Breast cancer o Prostate and Colorectal cancer	By March 2018

	Next Steps • Current provision of breast one-stop triple assessment clinics audited and plan developed by September 2017 • Health and wellbeing events in place for all breast, colorectal and prostate cancer patients to support new aftercare pathways by March 2018, with models for other pathways developed by March 2019 • New aftercare pathways defined and implemented for all breast, colorectal and prostate patients by March 2018 • New aftercare pathways pilots begin in further tumour types by March 2019 • Goals of Care tool tested in appropriate clinics at The Christie from March 2017	By March 2019
Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
14	Work with providers, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree system-wide **follow-up protocols** and create a timetable for offering stratified follow up arrangements dependent on risk. Greater Manchester approach. Refer to point 12 above.	By September 2017
Improved and standardised Care, Living with and beyond cancer, and supportive care, Commissioning, provision and accountability and Patient experience and user involvement.		
15	Ensure all patients have access to a **clinical nurse specialist** or other key worker Local Cancer Nurse specialists working across all Tumour pathways.	By December 2017

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APPENDIX 2

TAMESIDE AND GLOSSOP INTEGRATED CARE ORGANISATION INTENTIONS AND ACTION PAPER

The table below provides an update on the contributions required by provider trust (T&G ICO) to meet the level of ambition across Greater Manchester; these will be developed further and have been incorporated into the Local Delivery Plan.

	What do we need to do? - Update on the local position and next steps required.	**When**
1	**Deliver a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two –** • **Work with commissioners to agree data collection trajectories to ensure robust and timely staging data collection** **Local Actions Required** • Greater Manchester Cancer Volunteers – Raising awareness and Changing Behaviour • Implement the NICE suspected cancer referral guidelines • Improve adherence to NICE suspected cancer referral guidelines • Support pathway-specific efforts to deliver earlier and better diagnosis • Encourage Serious Event Audits (SEA) • Develop rapid cancer investigation units • Pilot patient self-referral • Reduce diagnostic waiting times • Contribute to regional improvements in diagnostic services • Agree data collection strategies to ensure robust and timely staging data collection. **Local Current Position** • Work in progress within the Trust to improve access times and introduction of straight to test referral pathways • Local Be Clear on Cancer roadshows promoted within T&G • In additional to existing performance management mechanisms within the Trust, a dashboard has been developed to track and monitor performance against 6 KPIs of the GM Cancer Plan • New straight to test pathway in place for Lung Cancer – SOP being tested and refined **Next Steps** • Refine new straight to test lung pathway and incorporate lessons learnt • Introduce more straight to test pathways into endoscopy • Implement straight to test for breast cancer pathway **Reduce the proportion of cancers diagnosed following an emergency admission** • **Support primary care implementation strategies for all patients diagnosed as an emergency to have their cases looked at through a Significant Event**	By June 2017 By December 2017

	Local Actions Required • Audit of patients diagnosed with CA following an emergency presentation, including data from across the whole clinical pathway. • Analysis of the data provided from the Diagnosed with CA following Emergency presentation audit, assess the key reasons for the late presentation in to the specialist services. • Establishment of cross care working group to develop an Action Plan and implement. • Encourage the use of the Gateway C programme throughout the ICO FT. • In cooperation with local community and religious leaders develop a stagey for highlighting of the cancer agenda to the harder to reach communities, including symptom awareness. **Local Current Position** • Information has been gathered to allow for the audit of patients diagnosed with CA following Emergency presentation • Gateway C has been developed and is being fed out through GP forums. **Next Steps** • Full Audit to take place of the patients diagnosed with CA following Emergency presentation • Establishment of a cross care working group. • Identification of the local and religious leaders and establishment of the cross cutting group.	
2	**Enable the delivery of the system-wide pathways to diagnosis and treatment set by clinical pathway boards, with a focus on streamlining the patient journey.** **Local Actions Required** • Adoption of the timed tumour site specific pathways provided by the GM Cancer Pathway Boards. • Introduce direct access for relevant pathways i.e. Breast lumps. • Introduce Straight to diagnostics where clinically appropriate. • Introduce 'One Stop' models where clinically appropriate. • Develop a capacity and demand model for all events in a cancer pathway to ensure that diagnostics can be performed and reported within the time frames expected. **Local Current Position** • Development work started on direct access to the Breast Service. • Straight to test colonoscopies are in place for patients referred with a suspicion of colon cancer. • Straight to test is in place for patients referred with a suspicion of lung cancer. • One stop model is in place for patients referred with a suspicion of breast cancer. **Next Steps** • Develop working groups for each tumour site where STT or one stop model in not in place to assess the appropriateness of introducing one or the other.	By December 2017

	• Development of a capacity and demand tool for all events in each cancer pathway.	
3	**Support pathway board efforts to review the pathway MDT processes and standardise the approach to streamline the MDT discussions in routine cases and create more time for complex case discussion. Explore sector based and GM based MDT approaches.** **Local Actions Required** • Identify the Tumour site specific MDT's that would benefit from a sector/ specialist MDT model. • Develop working relationships with other Providers to establish what links are required for sector/ specialist MDT's. • Develop and implement a model for 'Paperlite' MDT's with the use of electronic systems for all information required for discussions. **Local Current Position** • Number of MDT's are linked to specialist MDT's i.e. UGI, HPB and Lung • Work underway to link LGI to Stepping Hill in line with the Healthier together programme. **Next Steps** • Development of the plans for 'Paperlite' MDT's with clinical teams and exploration of the electronic solutions to provide relevant data. • Review of all local MDT's to assess for opportunities to join specialist MDT's where possible.	By December 2017
4	**Ensure 85% of patients continue to meet the 62-day cancer waiting time standard.** **Work towards achievement of the 28-day faster diagnosis standard.** **Ensure sufficient capacity for timed pathways for lung and HPB to deliver a** • **50-day standard** • **42-day standard** **Local Actions Required** • Reduce diagnostic waiting times • Contribute to regional improvements in diagnostic services • Speed up pathways to treatment **Local Current Position** • Trust consistently achieves the 62 day standard of 85% (91.3% for Qtr 1 of 16/17) • New Lung cancer pathway introduced in June 2017 – performance data to be validated **Next Steps** • Working with relevant stakeholders from across the health economy consider pathway redesign work to meet new standards for speedier	By March 2018 By March 2019 December 2017 December 2018

	diagnosis and pathway delivery	
5	**Work with commissioners, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree an optimal Greater Manchester specification for each tumour type.** GM led approach - awaiting progress and update prior to further local actions **Local Actions Required** • Living With and Beyond Cancer group and End Of Life Strategy Group progressing. • Annual Dying Matters events organised. **Local Current Position** • Ensure access to seven-day specialist palliative care advice and assessment • Deliver choice in end of life care • Ensure that shared digital palliative and end of life care records are rolled out **Next Steps** • A detailed map of specialist palliative care provision against national standards and competencies by March 2018 • An innovative economic modelling proposal for the delivery of a seven-day specialist palliative care advice and assessment by March 2018 • Qualitative and quantitative evaluation tools to measure the impact of seven-day specialist palliative care advice and assessment services agreed by March 2018 • Dying Matters Coalition events across Greater Manchester by May 2018	To a timetable to be set by Greater Manchester Cancer
6	**Support the implementation of the Recovery Package through:** • **A contribution to the development of a standard Greater Manchester approach, and** • **Enabling all clinical teams to deliver each of its elements** **Local Actions Required** • Consolidate current local practises in order to be ready for full implementation of the Recovery Package: written care plans based on holistic needs assessment; treatment summaries; cancer review in primary care and offer of health and wellbeing events. **Local Current Position** • Successful bid for Macmillan funding secured to recruit transformation team to steer, drive and deliver Recovery Package by GM timetable (yet to be agreed) • Active engagement in GM Recovery Package Implementation Group with two representatives from the Trust • Await agreed standardised GM approach to inform local implementation (standards expected by August 2017) • Data sharing and hosting agreement signed for the implementation of eHNAs based on the Macmillan model	To a timetable to be set by Greater Manchester Cancer

	Next Steps • Recruitment process initiated to recruit living with and beyond cancer transformation team. Forecast for 3 team members to be in post by December 2017 • Implementation of eHNAs within the Trust • Meeting with clinical nurse specialists planned for early Sept to assess readiness and enablers required to support the full roll out of eHNAs • Once Tramformation Manager in post a detailed project plan will be developed to drive full implementation • Continue to support GM's Recovery Package Implementation Group	
7	**Ensure Greater Manchester Cancer agreed stratified follow up pathways of care are in place for** • **Breast cancer** • **Prostate and Colorectal cancer** **Local Actions Required** • Stratified breast cancer pathway • Stratified prostate and colorectal cancer pathway **Next Steps** • Current provision of breast one-stop triple assessment clinics audited and plan developed by September 2017 • Health and wellbeing events in place for all breast, colorectal and prostate cancer patients to support new aftercare pathways by March 2018, with models for other pathways developed by March 2019 • New aftercare pathways defined and implemented for all breast, colorectal and prostate patients by March 2018 • New aftercare pathways pilots begin in further tumour types by March 2019 • Goals of Care tool tested in appropriate clinics at The Christie from March 2017	By March 2018 By March 2019
Improved and standardised Care and Commissioning, provision and accountability.		
8	**Work with commissioners, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree system-wide follow-up protocols and create a timetable for offering stratified follow up arrangements dependent on risk.** GM led approach **Local Actions Required** • See point (6) above **Next Steps** • See point (6) above	By September 2017
9	**Work with commissioners, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree a co-produced cancer patient access charter** **Local Actions Required**	By June 2107

	• Co-produced cancer patient access charter in place **Local Current Position** • Work on this action is behind schedule - draft patient access charter to be developed and shared with stakeholder by September 2017 **Next Steps** • Draft cancer patient access charter for discussion with service users in September 2017 • Draft cancer patient access charter to be ratified by Cancer Steering Group and Cancer Board October 2017	

10	**Ensure access to a CNS or other key worker for all cancer patients through identifying gaps in access by pathway and developing access improvement plans**
	
	Local Actions Required
	• Ensure all cancer patients have access to a CNS or other key worker
	
	Local Current Position
	• 2016 Patient Survey results:-
	  • Patient given the name of the CNS who would support them through their treatment – 97%
	  • Patient found it easy to contact their CNS 91%
	  • Get understandable answers to important questions all or most of the time – 93%
	• CNS present at diagnosis – 45% in 2016 against 34% in the same year for Greater Manchester
	
	Next Steps
	• Audit current position to inform potential improvement work
		By December 2017

11	**Maintain oversight and facilitate recruitment to the 100,000 Genome Project in appropriate eligible pathways.** **Local Actions Required** • Development and implementation of local protocols for patient recruitment • Engagement with GM development **Local Current Position** • New initiative requiring engagement with GM development process **Next Steps** • GM development workshop scheduled	By March 2017

APPENDIX 3

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	28 June 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning Angela Hardman, Director, Public Health
Subject:	**CANCER UPDATE**
Report Summary:	The purpose of this report is to inform the Board about a review of cancer data to help inform the development of locality specific actions to ensure we contribute to the ambitions set out within the plan for Greater Manchester.
Recommendations:	The Single Commissioning Board are asked to note the contents of the report

Financial Implications:

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

Budget Allocation (if Investment Decision)	No direct budget implications in paper
CCG or TMBC Budget Allocation	N/A
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	N/A
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	N/A
Additional Comments We note the data contained within this report. There are no immediate direct financial implications in the report. But over the longer term if we are able to improve outcomes for patients without significant additional investment, there would be clear alignment to the aspirations and goals of the Care Together programme.	

Legal Implications: **(Authorised by the Borough Solicitor)**	The purpose of this report is to ensure that the Board has sufficient data and performance information to ensure that it is allocating resources appropriately.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with Starting Well, Developing Well, Living Well, Working Well, Aging Well and Dying Well.
How do proposals align with Locality Plan?	The proposals are consistent with Healthy Lives (early intervention and prevention), Community development, Enabling

	self-care, Locality based services, Urgent Integrated Care Services and Planned care services strands of the Locality plan.
How do proposals align with the Commissioning Strategy?	The work contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	In light of the information within this report the Board are asked to endorse the approach taken in ensuring better outcomes for our patients in terms of contributing to the level of ambition set for preventing avoidable deaths, reducing variation and improving experience.
Public and Patient Implications:	The implications for Public and Patients are to aim to develop a local plan that aims to prevent avoidable deaths, reduce variation and improve experience.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	This report will help us to understand the impact we are making to reduce health inequalities to incorporate into the local plan.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristics groups within the Equality Act.
What are the safeguarding implications?	Safeguarding will be central to the review /plan.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications as part of the review. No privacy impact assessment has been conducted.
Risk Management:	No current risks identified
Access to Information :	The background papers relating to this report can be inspected by contacting Louise Roberts Telephone: 07342056005 e-mail: Louise.roberts@nhs.net

1. BACKGROUND

1.1 NHS Tameside and Glossop Clinical Commissioning Group in partnership with Tameside and Glossop Integrated Care Foundation Trust are developing locality specific actions to ensure we contribute to the ambitions set out within the plan for the Greater Manchester Cancer Board and the cancer programme of the Greater Manchester Health and Social Care Partnership Strategic Partnership Board.

1.2 There are eight domains within the Greater Manchester plan**;** reflecting a combination of the five key areas for change set out in '**Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-2021'** (each part of the system will be expected to contribute and will be held to account) and the six key work streams of the National Cancer Strategy.

1.3 A substantial part of the plan in 2016/17 and 2017/18 is part of the vanguard innovation programme and funded by NHS England's New Care Models Team; this may be funded by Transformation funding going forward. At a Greater Manchester and local level, work is ongoing to meet the level of ambition with the aim of preventing avoidable deaths, reducing variation and improving experience. Refer to **Appendix 1** for the level of contribution required from Provider Trusts and **Appendix 2** for Clinical Commissioning Groups).

1.4 This report uses National, Greater Manchester and Local data to inform areas for improvement which can be incorporated into the locality-specific actions that are currently being developed within NHS Tameside and Glossop Clinical Commissioning Group.

1.5 The Greater Manchester Cancer Plan was received by Tameside Health and Wellbeing Board on the 09 March 2017. The Tameside and Glossop Cancer Board, which is led by T&G ICFT with membership from SCF, are currently developing a comprehensive implementation plan. The contributions of the SCF to the plan are outlined in the timeline at 5.1 below.

1.6 Reporting into Board currently includes the Better Care Measures:

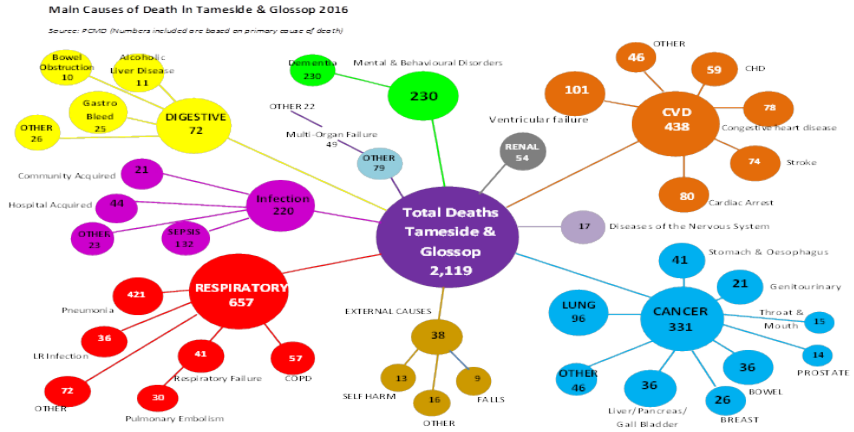
- One-year survival from all cancers;
- Proportion of people with Cancer diagnosed at an early stage;
- Cancer Patient experience;
- Cancer 2 week wait (2ww), Cancer 31 day wait and Cancer 62 day wait.

1.7 These need to be considered alongside measures that prevent incidence of cancer (e.g. reducing smoking prevalence, lifestyle and activity), cancer screening programmes and access to diagnostics along the pathway for patients.

1.8 Patients often have co-morbidities and we need to consider how we work across pathways in partnerships; for example Right Care data shows that of 187 patients admitted for Cancer, 54 patients were admitted for Gastro Intestinal conditions, 48 for Respiratory Conditions, 39 Genito Urinary, 43 Poisoning and adverse effects and 31 for circulation.

2. OVERVIEW

2.7 In 2016 Cancer was the main cause of death in 15.6% of the population in Tameside and Glossop Clinical Commissioning Group (331 out of 2,119 total deaths).



2.8 In 2012/14 1,756 children in England were newly diagnosed with Cancer (less than 1% of all cancers were in children) of these 257 died, 82% surviving five years and 91% one year. The commonest childhood cancer is leukaemia. Other than age and genetics, there is very little good evidence on risk factors that contribute to cancer in childhood. Statistics for childhood cancers are not routinely published for Greater Manchester, the North West or Tameside. Local data will be requested from the North West Local Cancer Intelligence Network and an analysis of data will be incorporated into the developing plan.

2.9 In Tameside and Glossop Clinical Commissioning Group all of the following were higher than the NHSE average:

- incidence of cancer;
- mortality rates;
- under 75 years of age mortality;
- number of deaths from cancers considered preventable;
- adult smoking rates.

2.10 The majority of the time we are achieving the operational waiting times standards (93% within 2ww, 96% within 31 days and 85% within 62 days).

Better Care

Description	Indicator	F	Level	Better is...	Threshold	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	Exceptions
Cancer 2Week Wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	M	T&GCCG	H	93%	95.3%	97.1%	94.1%	94.3%	94.6%	95.4%	94.5%	97.5%	96.3%	94.4%	95.6%	95.3%	95.9%	
	Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	M	T&GCCG	H	93%	93.3%	98.0%	91.8%	94.0%	94.7%	97.3%	100.0%	100.0%	96.8%	100.0%	91.4%	98.3%	91.6%	
Cancer 31 Day Wait	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	M	T&GCCG	H	96%	100.0%	98.9%	100.0%	100.0%	96.8%	98.9%	96.0%	98.2%	100.0%	98.9%	100.0%	97.7%	100.0%	
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	M	T&GCCG	H	94%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	M	T&GCCG	H	98%	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%	Breach due to deferred treatment in Jan-16.
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	M	T&GCCG	H	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	100.0%	100.0%	100.0%	100.0%	
Cancer 62Day Wait	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	M	T&GCCG	H	85%	89.7%	88.6%	91.3%	89.6%	91.1%	78.6%	91.7%	90.6%	88.0%	89.1%	87.3%	82.6%	91.4%	There were 10 breaches out of a total of 70 seen in Sept 16.
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	M	T&GCCG	H	90%	100.0%	100.0%	66.0%	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Maximum 62 day wait for first treatment following a consultant's decision to upgrade the priority of the patients (all cancer)	M	T&GCCG	H	85%	81.1%	85.7%	94.4%	92.4%	100.0%	56.8%	71.7%	94.6%	73.4%	75.0%	87.5%	85.2%	91.7%	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

2.11 We have a higher than average number of 2ww referrals than the NHS average for suspected cancers per 100,000 of the population.

2.12 The conversion rate into diagnosed cancer is lower than the NHSE average but 2015/16 data shows that we are starting to reduce the gap.

2.13 While survival rates from cancer are increasing we have a relatively high number of cancers detected late, with 20% of all cancers identified through emergency presentation (slightly higher than NHSE average), and consequently reduced survival rates, compared to the England average and other CCGs across Greater Manchester.

2.14 Therefore it is important to focus on prevention and early diagnosis of cancer and offer support to reduce any variation across Tameside and Glossop CCG, for example screening uptake within Tameside is lower than High Peak for Breast and we are outliers across Greater Manchester for cancer screening for people with Learning disabilities.

3. HOW DO WE COMPARE?

3.1 NHS England Clinical Commissioning Group Improvement and Assessment Framework:

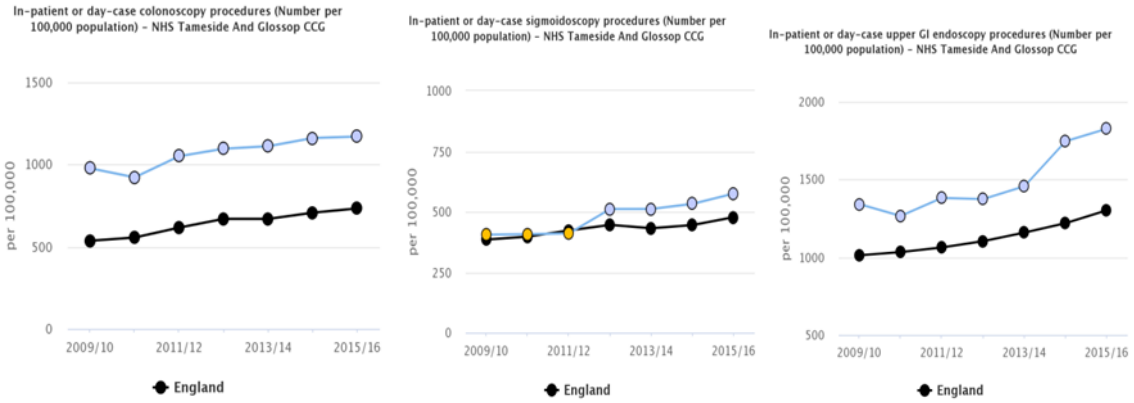
- One year survival from cancer is improving year on year but is lower that the NHSE average (70.2%) at 67.6% in 2013. When comparing to 10 similar CCGS two were lower than T&G CCG.
- Fewer cancers (45.2%) are detected at an early stage compared NHSE Average 50.7% in 2014. When comparing to 10 similar CCGS one was lower.
- Better than the NHSE average (82.2%) for GP referral to first definitive treatment within 62 days in Q1 16/17. When comparing to 10 similar CCGS all were lower.
- Cancer patient experience is slightly lower than the National average in 2015.

3.2 Public Health NHSE Dashboard and trends :

- Higher Incidence rate of cancers per 100,000 in 2014 at 647.82 compared to NHSE 608.3.
- 20.7% of Cancers are diagnosed through an emergency presentation (higher than average and a good proxy measure).
- Achieve the operational performance standards (2ww, 31 days and 62 days standard) and better than the NHSE average; however our average 2ww for breast, lower GI and lung is higher than the NHSE average.
- Worse than the NHSE Average (608.3) for Cancer Incidence and Mortality at 647.82 per 100,000, < 75 mortality, from cancers considered preventable and adult smoking rates (21.7% 2015).

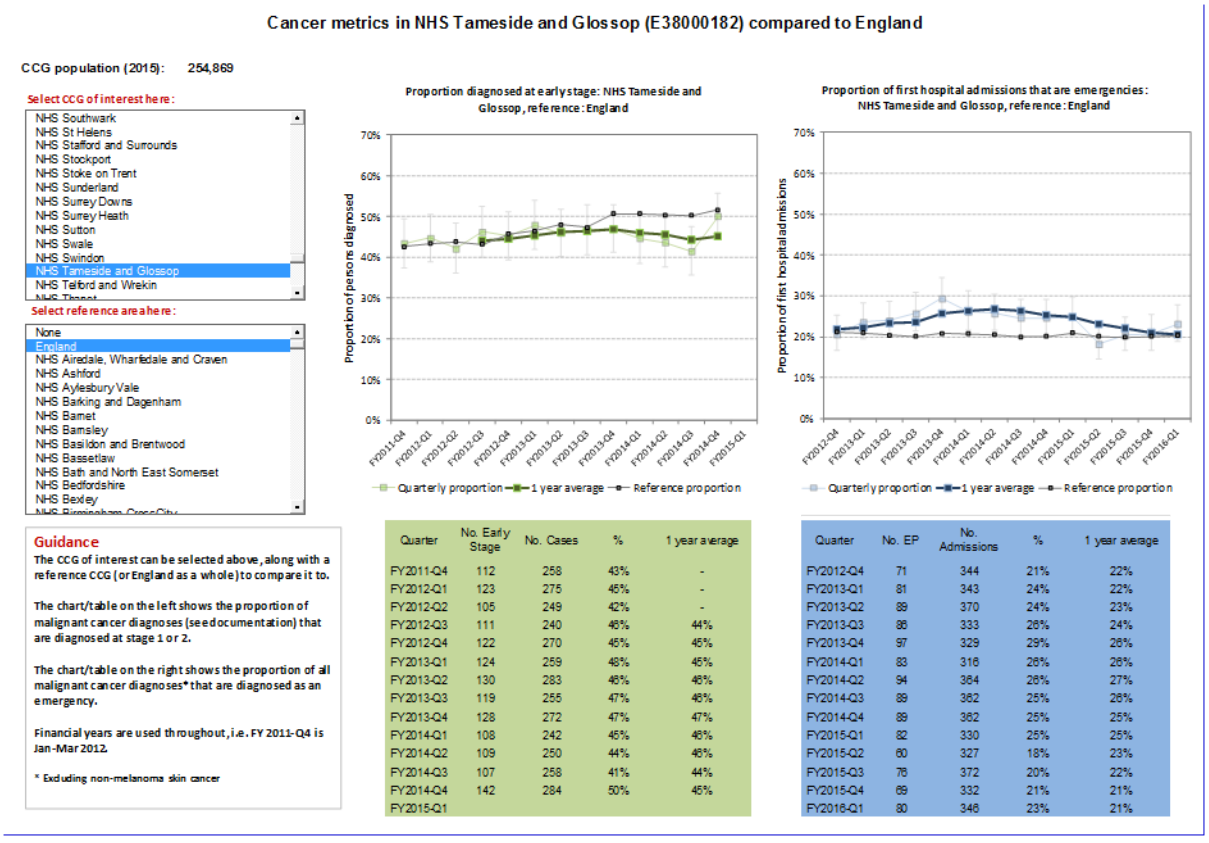
	Breast	**Bowel**	**Lung**
Incidence rate per 100,000 – 2014 (CCG)	NHSE 173.38 Tameside 148.52	NHSE 70.43 Tameside 78.43	NHSE 78.34 Tameside 121.8
Incidence rate per 100,000 – <75 Mortality, 2014 (CCG)	NHSE 21.21 Tameside 25.35	NHSE 11.9 Tameside 13.03	NHSE 33.26 Tameside 46.82
Screening uptake 2015 (LA) %	NHSE 75.4 Tameside 68.4 High Peak 77.4	NHSE 57.1 Tameside 52 High Peak 60.02	X

- Alignment to Local Authority level shows variation across tumour sites.
- Clinical Headline Data is also available by provider for Breast, Colorectal and Cervix.
- Higher than the NHS and GM average for In patient day case colonoscopy, upper GI endoscopy and sigmoidoscopy.



Key: Light blue – Higher then NHSE and GM and Dark Blue – Lower than NHSE and GM

3.3 Cancer Outcomes: Stage at Diagnosis and Emergency Presentations



Quarter	No. Early Stage	No. Cases	%	1 year average
FY2011-Q4	112	258	43%	-
FY2012-Q1	123	275	45%	-
FY2012-Q2	105	249	42%	-
FY2012-Q3	111	240	46%	44%
FY2012-Q4	122	270	45%	45%
FY2013-Q1	124	259	48%	45%
FY2013-Q2	130	283	46%	46%
FY2013-Q3	119	255	47%	46%
FY2013-Q4	128	272	47%	47%
FY2014-Q1	108	242	45%	46%
FY2014-Q2	109	250	44%	46%
FY2014-Q3	107	258	41%	44%
FY2014-Q4	142	284	50%	45%
FY2015-Q1				

Quarter	No. EP	No. Admissions	%	1 year average
FY2012-Q4	71	344	21%	22%
FY2013-Q1	81	343	24%	22%
FY2013-Q2	89	370	24%	23%
FY2013-Q3	86	333	26%	24%
FY2013-Q4	97	329	29%	26%
FY2014-Q1	83	316	26%	26%
FY2014-Q2	94	364	26%	27%
FY2014-Q3	89	362	25%	26%
FY2014-Q4	89	362	25%	25%
FY2015-Q1	82	330	25%	25%
FY2015-Q2	60	327	18%	23%
FY2015-Q3	76	372	20%	22%
FY2015-Q4	69	332	21%	21%
FY2016-Q1	80	346	23%	21%

3.4 Health and care of people with learning disabilities:

- Data shows the number of eligible adults with Learning disabilities screened for cancer is poor in Tameside and Glossop CCG compared to those with no Learning Disability and we are outliers across Greater Manchester. Cervical 25%, Breast 33% and Bowel 48%.

3.5 NHS Right Care data highlights the following areas for improvement as we were worse than our average 10 CCG equivalents in the following

- Breast cancer screening, emergency presentation of breast cancer and <75 Mortality from breast cancer.
- Bowel cancer screening, < 75 mortality from colorectal cancers and cases of C.diff.

- Number of successful 16+ quitters, Non elective spend on lung cancer, detection of lung cancer at an early stage, lung detected at an early stage and <75 mortality from lung cancer.
- Spend on Primary Care Prescribing.
- Lower GI - 6 week waits for colonoscopy and rate of emergency colonoscopies.
- Upper GI - 6 week waits for Gastroscopy and number of alcohol related hospital admissions.
- Liver Disease Pathway – Alcohol specific hospital admissions, non-elective spend on liver disease, alcoholic liver disease - emergency admissions, Liver cancer incidence and <75 mortality from liver disease.
- The Right Care Focus data pack published in May 2016 suggested the additional improvements areas: Cervical screening, LOS, Detecting bowel cancers at an early stage, diagnostic and surgical procedures and Information provided following discharge.
- The Cancer focus pack was updated in April 2017 to include further possible improvement areas: spend on non-elective admissions, total spend on Cancer, detecting breast cancer at an early stage, rate of bed days and average number of days spent in hospital as a result of an emergency admission for patients in their last year of life.

3.6 Tameside and Glossop Integrated Care Foundation Trust presents a cancer performance report to the Cancer Board. The report provides assurances that standards are being met, includes exception reporting of any breaches, highlights any area of concerns and how they will mitigate these. Information is available by tumour site and directorate pathways. The December 2016 / January 2017 Board report showed 38 breaches year to date on the 62 day pathway, 24 were due to complex cases with co morbidities; 5 patient dis engagement, 4 Internal diagnostics, 2 multiple MDTs and treatment delays. The Trust will continue to review capacity and demand.

4. CONSIDERATIONS

4.1 The development of locality-specific actions, currently being developed within NHS Tameside and Glossop Clinical Commissioning Group will support achievement of all the measures identified in within 'Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-2021' and the six key work streams of the National Cancer Strategy. The following areas need to be considered as part of an ongoing improvement process and incorporated into the plan:

- What else can we do to detect Cancer earlier and raise Public awareness through National and Local Campaigns?
- How do we reduce emergency presentations (impact on non-elective admissions)?
- Role of Primary Care e.g. Use of E Referrals and EMIS templates.
- Improve access e.g. STT Colonoscopy, New Lung pathway, Bowel prep issued within Primary care etc.
- Ensure access to services are equitable.
- Planning, demand and Capacity.
    - Impact of Locum staff e.g. new rules IR35.
    - How do we reduce the number of DNAs?
    - Learning from breach analysis.
    - Support within the Community.
    - Data shows LOS in hospital is greater than comparative CCGS.
    - Care planning, data shows we only prepare 32.5% of after care plans
    - How do we improve Patient experience?

5. TIMELINE

5.1 The following Timeline details the development of the locality specific action plan.

DATE	PROGRESS OR ACTIONS REQUIRED
Early 2017	Greater Manchester (GM) Plan ratified on 24 February 2017.
March 2017	Introduction to GM plan to Health and Wellbeing Board on the 09 March 2017.
March 2017	Outcomes from local Cancer Board discussions on 29 March 2017: • Ongoing development of locality specific actions • Audit of Local working position and develop actions required to meet the Locality Specific actions • Identified membership of GM Cancer Plan local working group to further progress the plan.
March 2017	On 07 March 2017 established a GM Cancer Plan local working group that will meet on a monthly basis.
April 2017	Review of Cancer data to highlight areas for consideration for inclusion within the plan.
May 2017	GM Cancer Plan local working group: • agreed Terms of Reference and governance process agreed by Cancer Board on 19 May 2017 • assigned a Care Together Project Manager who started to develop a project plan • progressed the development of the Locality specific plan • Established Task and Finish Groups for each of the work streams identified within the plan to oversee the implementation of Locality Specific actions. • The work streams are: o Prevention and Earlier & Better Diagnosis (lead - Gideon Smith) o Living With and Beyond Cancer (lead - Carol Diver) o Improved & Standardised Care (lead – Susi Penney o Patient Experience & User Involvement (lead - David Banks) o Commissioning & Accountability (lead - Alison Lewin) o Research & Education – (lead Tameside and Glossop Cancer Board) • **Appendix 3** provides an update on the current local position and next steps required to deliver the contributions required in the Locality specific plan.
June 2017	Present update at Chairs Brief on 13 June 2017 and 28 June 2017
July 2017	Present update at Single Commissioning Board on 11 July 2017
July 2017 to March 2021	GM Cancer Plan local working group Board will be kept informed of progress with any areas of concern escalated as appropriate.

6. RECOMMENDATIONS

5.1 As set out at the front of the report.

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 September 2017
Executive Member / Reporting Officer:	Debbie Watson, Interim Assistant Director of Population Health
Subject:	**TOBACCO FREE GREATER MANCHESTER STRATEGY**
Report Summary:	The Tobacco Free Greater Manchester Strategy sets out our ambition to reduce smoking in our population by one third by 2021. This will result in 115,000 fewer smokers, supporting a tobacco free generation and ultimately helping to make smoking history. Ambitions within the strategy take account of targets within the newly published Towards a smoke-free generation: tobacco control plan for England. This will allow us to close the gap with smoking prevalence in England, reducing inequalities and saving thousands of lives and millions of pounds.
Recommendations:	The Health and Wellbeing Board is asked to endorse the Tobacco Free Greater Manchester strategy.
Links to Health and Wellbeing Strategy:	Tobacco Control links to all priority areas in the Health and Wellbeing Strategy, in particular Living Well.
Policy Implications:	Tobacco is the leading preventable cause of cancer worldwide. It is important to prioritise policy to ensure that the Greater Manchester tobacco control implementation plan is implemented in the Tameside.
Financial Implications: **(Authorised by the Borough Treasurer)**	The Public Health resource envelope within the Council supports existing investment of £0.483m per annum in a range of smoking cessation services. Any additional costs arising from the implementation of the Tobacco Free strategy will also be financed via this existing resource envelope. The cost of Non-Elective Admissions for respiratory related illness is £2.2m per year in Tameside. A significant proportion of this cost is linked to smoking related disease. It is essential that the Tobacco Free Strategy is stringently monitored to ensure cost reductions materialise as these will also contribute towards the reduction of the existing and projected financial gap across the local health and social care economy.
Legal Implications: **(Authorised by the Borough Solicitor)**	The Council has a statutory duty in respect of public health and to deliver any services which are value for money in line with the NHS Constitution. It is important that any interventions are evidence based and performance monitored in order that resources can be fixed and directed to priorities. It will be key that all agencies, including the Council, update and review existing policies to ensure fit for purpose and provide consistent approach.

Risk Management : There are no risks at this stage.

Access to Information : The background papers relating to this report can be inspected by contacting Debbie Watson

Telephone:0161 342 3358

e-mail: debbie.watson@tameside.gov.uk

1.0 BACKGROUND

1.1 The development of the strategy has been led by the Population Health Transformation team of the Greater Manchester Health and Social Care Partnership on behalf of the Greater Manchester Cancer Board, and has been co-produced with input from a wide range of partners across Greater Manchester localities and many system and subject matter experts. This follows on from work undertaken with the Greater Manchester Tobacco Control Leaders' Network, starting in December 2015, led by Steven Pleasant.

1.2 The strategy has been informed by the best international and as well as local evidence and has been subject to an extensive consultation and engagement period running from November 2016 to March 2017, including an expert stakeholder development group and a key leaders workshop.

1.3 The following groups and bodies have been involved in its development or are part of its sign off: Action on Smoking and Health; Association Governing Group of Clinical Commissioning Groups; Cancer Education Manchester; Cancer Research UK; Directors of Public Health Group; Greater Manchester Health and Social Care Partnership; Greater Manchester Combined Authority Executive; Greater Manchester Population Health Programme Board; Greater Manchester Cancer VCSE Advisory Group; Greater Manchester VCSE Devolution Reference Group; Greater Manchester LGBT Foundation; Greater Manchester Fire and Rescue Service; Greater Manchester Tobacco Control Commissioners Group; Fresh Smokefree North East; HMRC; Healthier Futures CIC; Public Health England; Trading Standards North West; Wider Leadership Team.

2.0 GREATER MANCHESTER APPROACH

2.1 The changes underway under Taking Charge create a golden opportunity for a new and focussed approach to tackling tobacco harms across Greater Manchester. The tobacco control strategy graphically illustrates the human and financial costs incurred by a product which kills more than 1 in 2 long-term users and debilitates many more. Greater Manchester will reduce smoking at a pace and scale faster than any other major global city with an ambition to reduce smoking by around a third to 13% by 2021, closing the gap with England, saving thousands of lives and millions of pounds.

2.2 A new tobacco control programme supports the aims of the wider Population Health Plan and the Greater Manchester Cancer Plan, as well as contributing to the far wider public service reform agendas. A transformative programme of work delivered in collaboration across the system will include a range of innovative and evidence based interventions as outlined below.

3.0 NEXT STEPS

3.1. To turn this strategy into action, a delivery plan for the potential initiatives outlined in section 4.1 to 4.7 of the strategy will be developed in sufficient detail to enable a stakeholder supported and implementable programme of work. The partnerships are learning from what's working well in Greater Manchester, the UK and globally to bring the very best evidence and innovation to our delivery. Further stakeholder consultation and engagement is being undertaken to facilitate this during May-September 2017. A transformation funding proposal will also be developed including full cost benefit analysis and matched/alternative funding proposals. This phase of work will be completed by September 2017.

4.0 RECOMMENDATIONS

4.1 As set out on the front of the report.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester
Health and Social Care Partnership

Making Smoking History

A Tobacco Free Greater Manchester

Taking charge in Greater Manchester

2017-2021

Contents

Taking charge

in Greater Manchester

2017-2021

Making smoking history in Greater Manchester

This is a summary of our plan to reduce smoking prevalence in Greater Manchester by a third by the end of 2021. It is an unprecedented ambition and at a pace and scale greater than any other major global city. If we achieve it, there will be 115,000 fewer smokers in Greater Manchester, a key part of delivering our commitment to achieving the greatest and fastest improvement to the health, wealth and wellbeing of the population. We'll also be on our way to delivering a tobacco free generation.

We need to do things differently because each year there are still 4,500 deaths caused by smoking in Greater Manchester and it is estimated that every hour, one child starts to smoke. That's a whole classroom of smokers every day! The plan looks at seven key ways in which we are going to tackle smoking, both by ensuring young people don't start smoking and encouraging more people than ever to quit.

Lots of people and organisations – including hospitals, local councils, GPs, charities, housing providers and Greater Manchester Fire and Rescue Service, have been involved in developing our tobacco control plan to make sure our targets are achievable and that we have included everything to make it successful.

What we need to do

Our vision is simple. We want fewer people to smoke in Greater Manchester, which will lead to fundamental improvements to the health, wealth and wellbeing of some of the poorest residents, as well as save Greater Manchester an average of £1,800 a year per smoker that quits. To achieve this we will focus on MPOWER, a system recognised worldwide to help reduce tobacco use, and add in our own 'G' to reflect that we want to involve as many people as possible in helping to achieve our ambitions.

G row a social movement for a Tobacco Free Greater Manchester

M onitor tobacco use and prevention policies

P rotect people from tobacco smoke

O ffer help to quit

W arn about the dangers of tobacco

E nforce tobacco regulation

R aise the real price of tobacco

Grow a social movement for a Tobacco Free Greater Manchester

To achieve our ambition we need everyone in Greater Manchester to get behind our plans and support them. This is when social movements can happen:

> "Social movements happen when people come together to fight for their rights, solve problems, shift how people think, support each other and demand what they need."

We've already got some great examples where the community have got involved with health improvement campaigns in Greater Manchester such as 'The Wigan Deal' and 'People Powered Health' in Stockport. We are also recruiting 20,000 cancer champions who will use their experience, knowledge and passion to support those at risk of developing cancer and those recently diagnosed with the disease.

With this experience plus help from local charities, and partners such as Cancer Research UK, Action on Smoking and Health and Macmillan Cancer Support, we are confident we can grow a new social movement to help people quit smoking and take a stand against the tobacco industry to ensure young people never start smoking in Greater Manchester. The tobacco industry needs to recruit new smokers to replace the more than 1 in 2 who die early from smoking related disease. Most start smoking as teenagers so smoking is an addiction of childhood, not an adult choice.

How will we do it

- Straight away we are going to start working with the cancer champions social movement programme to kick-start citizen-led involvement in and support for our plan.
- We will work with the Greater Manchester Mayor, Andy Burnham to start a conversation with people across the city region to engage everyone in the health and wellbeing of their communities and families and to tackle smoking.
- We will use lots of different ways to communicate our messages so everyone will be able to support us and find out how important it is to quit smoking or never start.

Monitor tobacco use and prevention policies

We will use experts to help us keep an eye on how many people are quitting, who they are and where they are from. This enables us to make decisions about how and when we spend money on tobacco control to make sure the work we are doing is as effective as it can be. We will look at everything from how many adults and children are smoking to how many people use e-cigarettes and other measures such as how many people have successfully quit and how much people spend on tobacco including illegal tobacco.

How will we do it

- Develop and maintain a robust data set on smoking prevalence, attitudes and behaviours
- Commission a boosted sample for the Smoking Toolkit Study to track Greater Manchester smoking prevalence and quitting behaviours

Protect people from tobacco smoke

Second hand smoke is harmful for everyone and being exposed to tobacco smoke can cause death, disability and disease. New-born babies are more likely to be born prematurely and have a low birth weight if their mum smokes and children are more likely to have breathing difficulties and development problems.

We want to consider extending the smokefree laws in Greater Manchester by introducing smokefree parks, entrances to public buildings and family friendly spaces to help make everyone healthier. Hospitals will be stricter in enforcing no smoking rules in their grounds and we will work with housing providers and their tenants to increase the number of smokefree homes.

We believe e-cigarettes have the potential to help people to quit smoking completely without encouraging children or non-smokers to start smoking and we will work with Public Health England guidelines to develop policies around vaping.

Young people can be powerful ambassadors and we want to equip them with the confidence to address smoking in their family, social circles and beyond through healthy schools programmes.

Smoking related fires also cost the Greater Manchester tax-payer an average of £20m per year and cause 40% of accidental fire deaths. We will work with the fire service to promote positive quit and smokefree messages across Greater Manchester during home and workplace safety checks.

How will we do it

- Straight away the NHS in Greater Manchester will start delivering a fully 'smokefree NHS'.
- We will work with housing providers to identify opportunities to make their estates and homes smokefree in partnership with residents, as well as offering support to quit.
- We will look at delivering a smokefree homes campaign to protect children and families.
- We will support prisoners and prison staff to quit and implement smokefree prison estates.
- We will create more smokefree spaces with the help of the Mayor.
- We will ensure the council and the police have enough resources to ensure people adhere to the smokefree laws, including in cars.
- We will work with Transport for Greater Manchester and the Fire and Rescue Service to promote smokefree spaces and smokefree homes.
- We will work with Public Health England to promote the benefits of vaping over continuing to smoke, recognising that people need to stop smoking completely.
- We will deliver a more consistent approach to involving young people in smokefree initiatives.

Offer help to quit

Smoking costs the NHS a lot of money so we will continue to invest in stop smoking services. When smokers are told about how much smoking harms their health and those around them, the vast majority want to quit. Not everyone wants face-to-face support though so new ways of digital and self-support need to be developed that can be accessed 24/7.

Patients, including pregnant women, people with mental health challenges, smokers with long term health conditions and people recovering from drug and alcohol misuse should also have stop smoking treatments incorporated into their healthcare so that it becomes a routine part of their treatment, wherever that is happening.

E-cigarettes could be suggested as alternatives to those who are unwilling or unable to completely quit their nicotine habit immediately as current evidence shows it is far less harmful than smoking.

Workplaces can also better promote stopping smoking by offering incentives to staff for reductions in sickness absences.

How will we do it

- We will develop an e-cigarette friendly plan that will offer a range of stop smoking services including self-support options and digital support that will be accessible to all smokers.
- NHS providers in Greater Manchester will work out whether it is financially viable to provide hospital stop smoking services and will make it compulsory to know the smoking status of patients.
- We will work with experts to improve 'Very Brief Advice', maximising opportunities for professionals to offer the right advice to people at the right moment.
- We will explore ways to work with employers to promote the benefits of quitting and understand how incentives can play a role.

Warn about the dangers of tobacco

Evidence has found that mass marketing campaigns are one of the best ways to educate the public around the dangers of smoking tobacco, motivate quit attempts and signpost people to stop smoking support.

There are lots of ways to make sure the right messages reach the right people at the right time. This includes adapting campaigns to reach different sections of the population such as LGBT (lesbian, gay, bisexual and transgender) and BME (black, minority, ethnic) populations.

How will we do it

- We will implement a mass media and social marketing campaign that will carry through until 2021 to increase the number of people quitting and further change how people think and feel about tobacco use.
- We will support national campaigns such as Stoptober and New Year Quit to further raise awareness.
- We will learn about the needs of specific groups and communities from specialist research to find out the best way to support them to quit smoking.
- We will tackle shisha and other niche products to educate and inform smokers and make sure businesses that sell them are better regulated and managed.
- Other public services will work with us to sign up to a new GM Declaration on Tobacco Control.
- Schools and colleges will work with us to reduce the uptake of smoking and support young smokers to quit.

Enforce tobacco regulation

Despite killing 1 in 2 consumers tobacco products can be sold by anyone in England. Currently, a very low percentage of retailers are ever convicted for selling tobacco products to young people despite 44% of young smokers saying they get cigarettes from shops. There is now growing public support for a licensing scheme that would make shopkeepers have a licence to sell tobacco products making it cheaper and easier to enforce the law if they are found to be breaking it.

Each year, the tobacco industry internationally spends billions of pounds to market its products using sophisticated and covert forms of tobacco advertising, promotion and sponsorship (TAPS). It is subtly promoted on TV, films, music videos, video games, the internet, at concerts, sporting events and even at Manchester Pride. Evidence has proven that the more children and young people see smoking on screens, in music videos or in online games they play, the more likely they are to take the habit up.

How will we do it

- We will work towards a licensing scheme for tobacco retailers that may allow Greater Manchester to raise the age of sale for tobacco from 18 to 21.
- We will be a lot stricter with shopkeepers that sell tobacco, making sure their sales and age restrictions are constantly enforced.
- We will look for ways to further reduce point of sale displays in shops and options for fewer outlets selling tobacco.
- We will consult on ways to introduce anti-smoking adverts to be shown in Greater Manchester cinemas before films that have smoking in them.
- We will also consider whether to ban real cigarettes during theatrical productions, but allow fake products in case of dramatic necessity.

Raise the real price of tobacco

Increasing the tax on tobacco is proven to be the single and most effective way of reducing smoking. People who have less money are more likely to be affected by price rises and if they don't quit are more likely to suffer ill health in the long term so it is important that they are offered stop smoking support at the same time.

Nationally, more people are smoking hand rolled tobacco because it's cheaper than normal cigarettes. People with less money are also more likely to turn to illegal tobacco which is cheaper, more accessible to children and young people and linked to organised crime and anti-social behaviour.

How will we do it

- We will work to tackle the supply and demand for illicit tobacco in Greater Manchester with new targets and campaigns that will reduce demand by focussing on harm to children and links to crime.
- We will talk to the Government about increasing the price of tobacco through duty and making sure cigarette and hand rolled tobacco rates are the same. We will also talk to them about introducing a charge on tobacco industry profits which will raise money to help people quit. In the meantime, we will investigate to see if we are able to do this in Greater Manchester.

What happens next

- To make our plan a reality needs contributions from everyone in Greater Manchester. We need the public to become advocates of our work to help friends, families and everyone in our communities quit smoking. We also need organisations such as councils, educational establishments, the NHS, Transport for Greater Manchester and Greater Manchester Fire and Rescue Service to work with us and make our plans become a reality.
- We've got a specialist team to start working on the plan straight away and to implement it we will be enlisting the help of a lot more community champions, professionals and experts in the field to deliver our ambitious target of reducing smoking prevalence by a third in Greater Manchester by 2021.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

For more information contact:

Email: **gm.hscinfo@nhs.net**

Tweet: **@GM_HSC**

Call: **0161 625 7791** (during office hours)

Address: **4th Floor, 3 Piccadilly Place, Manchester, M1 3BN**

Website: **gmhsc.org.uk**

If you need this document in an alternative version please contact us via one of the channels above.

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 September 2017
Executive Member / Reporting Officer:	Angela Hardman – Director of Population Health Debbie Watson – Interim Assistant Director of Population Health
Subject:	**HEALTH AND WELLBEING FORWARD PLAN 2017/18**
Report Summary:	This report provides an outline forward plan for consideration by the Board
Recommendations:	The Board is asked to agree the draft forward plan for 2017/18.
Links to Health and Wellbeing Strategy:	The Health and Wellbeing Strategy to address needs, which commissioners will need to have regard of in developing commissioning plans for health care, social care and public health. The Forward Plan ensures coverage of key issues associated with the Board's duties to deliver improved outcomes through the strategy
Policy Implications:	The Forward Plan has been designed to cover both the statutory responsibilities of the Health and Wellbeing Board and the key projects that have been identified as priorities by the Board.
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications for the Council relating to this report
Legal Implications: **(Authorised by the Borough Solicitor)**	Local Authorities are obliged to publish a forward plan setting out the key decisions and matters they will consider over a rolling 4 months.
Risk Management :	There are no risks associated with this report**.**
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson, Head of Health and Wellbeing by: Telephone:0161 342 3358 e-mail: debbie.watson@tameside.gov.uk

TAMESIDE HEALTH AND WELLBEING BOARD FORWARD PLAN 2017/18

	Strategy / policy and Board process	Priorities and performance	Integration	Other

21 September 2017	• Intermediate Care in Tameside and Glossop
	• Tameside and Glossop Care Together Economy - Financial Monitoring
		• Mental Health and Wellbeing
		• Health and Working Well
		• Greater Manchester Cancer Plan
		  ○ stocktake for Tameside & Glossop
		  ○ GM Tobacco Strategy
		• Influenza Update and system response
			• Care Together Update	• Forward Plan
				• GM State of the VCSE Sector 2017 and Compact

16 November 2017	Health and Wellbeing Board Development Session • Refresh of the Locality plan / Health and Wellbeing Strategy • System wide approach to tackling inequalities			

25 January 2018	• Tameside Safeguarding Children Annual Report
	• Tameside Adult Safeguarding Partnership Annual Report
	• Pharmaceutical Needs Assessment – review and sign off
	• Physical Activity Strategy
	  ○ Live Well Active Tameside
	  ○ Tour of Tameside
		• System Wide Self Care programme update / Strengthening Communities
		• Public Health Annual Report
		• Locality Plan / HWB Strategy Action Plan sign off
			• Care Together Update	• Forward Plan

8 March 2018	• Tameside & Glossop System Wide Outcomes Framework		• Care Together Update	• Forward Plan

	Strategy / policy and Board process	Priorities and performance	Integration	Other
NOTE: AGENDA ITEMS ARE SUBJECT TO CHANGE				
	Items to include: • JHWS – approval, alignment with other strategies • JSNA – updates and approval of arrangements • GM HWB and other strategy updates • National policy updates • Updates from linked governance processes – eg Health Protection Forum, Healthwatch.	Items to include: • JHWS Performance monitoring (outcomes) • JSNA updates • PH annual report • HWB performance	Items to include: • Regular public service reform updates • Integrated Commissioning Programme – Care Together • Partner member business planning updates (including CCG operating plan)	Items to include: • Forward Plan • Consultation on key issues and developments

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