Tameside Metropolitan Borough

ASHTON-UNDER-LYNE · AUDENSHAW · DENTON · DROYLSDEN · DUKINFIELD · HYDE · LONGDENDALE · MOSSLEY · STALYBRIDGE

HEALTH AND WELLBEING BOARD

Day: Thursday
Date: 1 October 2015
Time: 9.30 am
Place: Lesser Hall 2 - Dukinfield Town Hall

Item No.	AGENDA	Page No
1.	**APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from Members of the Health and Wellbeing Board.	
3.	**MINUTES** To receive the minutes of the previous meeting of the Health and Wellbeing Board held on 18 June 2015.	1 - 6
4.	**HEALTH PROTECTION GROUP MINUTES** To note the minutes of the meeting of the Health Protection Group held on 13 July 2015.	7 - 12
5.	**CARE TOGETHER PROGRAMME: INTEGRATION UPDATE** To receive the attached report and accompanying presentation from the Executive Member (Adult Social Care and Wellbeing) / Programme Director.	13 - 76
6.	**PUBLIC HEALTH ANNUAL REPORT 2014/15** To receive the attached report of the Director of Public Health.	77 - 120
7.	**OUTCOMES OF HEALTH AND WELLBEING BOARD DEVELOPMENT SESSION** To receive the attached report of the Executive Member (Health and Neighbourhoods) / Director of Public Health.	121 - 126
8.	**TAMESIDE ADULT SAFEGUARDING PARTNERSHIP BOARD - ANNUAL REPORT 2014/15** To receive the attached report of the Executive Member (Adult Social Care and Wellbeing) / Chair of Tameside Adult Safeguarding Partnership Board.	127 - 148

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

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9. HEALTH AND WELLBEING BOARD FORWARD PLAN 149 - 150

To receive the attached report of the Executive Member (Health and Neighbourhoods) / Director of Public Health.

10. URGENT ITEMS

To consider any items which the Chair is of the opinion shall be considered as a matter of urgency.

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

ITEM NO: 3

TAMESIDE HEALTH AND WELLBEING BOARD

18 June 2015

Commenced: 10.00 am **Terminated: 11:15 am**

PRESENT:
Councillor Kieran Quinn (Chair) – Tameside MBC
Councillor Allison Gwynne – Tameside MBC
Councillor Brenda Warrington – Tameside MBC
Steve Allinson – Clinical Commissioning Group
Jane Ankrett – Stockport NHS Foundation Trust
Graham Curtis – Clinical Commissioning Group
Ben Gilchrist – CVAT
Angela Hardman – Tameside MBC
Karen James – Tameside Hospital NHS Foundation Trust
Steven Pleasant – Tameside MBC
Richard Spearing – Pennine Care Foundation Trust
Dominic Tumelty – Tameside MBC

IN ATTENDANCE:
Sandra Stewart – Tameside MBC
Ben Jay – Tameside MBC
Robin Monk – Tameside MBC
Debbie Watson – Tameside MBC
Alan Ford – Clinical Commissioning Group
Chris Leese – Clinical Commissioning Group
Stewart Tod – Tameside MBC

APOLOGIES:
Councillor Lynn Travis – Tameside MBC
Stephanie Butterworth – Tameside MBC
Alan Dow – Clinical Commissioning Group
David Niven – Tameside Safeguarding Children's Board
Andy Searle –Tameside Safeguarding Adults Board

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 1 April 2015 were approved as a correct record.

3. MINUTES OF THE GM HEALTH AND WELLBEING INTERIM BOARD

The minutes of the GM Health and Wellbeing Interim Board held on 22 May 2015 were noted.

4. GREATER MANCHESTER HEALTH AND SOCIAL CARE DEVOLUTION LOCALITY PLAN

The Board gave consideration to a report which provided an update on Devolution Manchester and addressed what was being asked of Tameside, the challenges over the next six months and how

the Health and Wellbeing Board and other organisations could contribute and the benefits from the Devolution Agreement.

Devolution would bring in a wide range of powers on health and social care with the goal to improve health and wellbeing. Four work streams had been agreed at Greater Manchester level which included:

- Strategic Plan;
- Leadership, Governance and Accountability;
- Devolving Responsibilities and Resource; and
- Early Implementation Priorities.

The Strategic Plan would be built from the 10 Locality Place Based Plans which incorporated those objectives along with GM level activities. The framework for the development plans had been received. The scope of the local plan was a place-based ambition and the framework included Strategic Direction; Locality Transformation Proposals; and Financial Plan and Enablers. The timelines for the development of the Locality Plan were outlined in the report with the first draft of the GM Strategic Plan to be handed to the Treasury by the end of August 2015.

RESOLVED
That the content of the presentation be noted.

5. CARE TOGETHER PROGRAMME: INTEGRATION UPDATE

Consideration was given to a report of the Executive Member (Adult Social Care and Wellbeing) and the Programme Director (Care Together Programme) providing an overview of developments and future changes to the Care Together Programme since the last meeting. The programme was moving from transition to implementation on a number of aspects.

Efforts were focusing on the launch of the Governance Framework and meeting structure that would support the operational delivery of the Care Together Programme. Robust governance was essential and building on the existing platform would be the appointment of an Independent Chair of a Programme Board together with a full time Director for Implementation. This would ensure the economy was progressing at a pace and that the programme's strategic direction complemented and underpinned the wider strategic changes taking place across the Greater Manchester conurbation. Details of the revised governance framework would be the subject of a separate report to the Board.

The new model of care was detailed, based on the engagement and involvement of professionals and patient representatives brought together as part of the Care Design Group and building on the concept of the economy developing a new health and wellbeing offer to citizens based on the assets of the whole community.

In terms of operational progress, as of 1 April 2015 the commissioners had formally entered into a 'pooled budget' arrangement which had commenced with the Better Care Fund monies and Tameside MBC was acting as the host organisation for this arrangement. The second Commissioning for Outcomes workshop had taken place in May building on the previous event and explored actions, behaviours and approaches to outcome based commissioning.

The nine outline business cases had now completed their design phase and were currently being assessed by the Transformation and Finance Directorates together with colleagues from the Council.

During June, the final details of the operational delivery plan would be completed to form the basis of the next report to the Health and Wellbeing Board in October.

RESOLVED

(i) That the proposed changes to the governance arrangements of the Care Together Programme be noted.

(ii) That the appointment of an Independent Chair and full time Programme Director for implementation be noted.

(iii) That the Board receive a further update at its meeting in October including attendance of the Independent Chair and new Programme Director.

6. HEALTH AND WELLBEING STRATEGY BUSINESS PLAN 2015/16 – UPDATE ON TURNING THE CURVE EVENT

The Director of Public Health reminded the Board that at its last meeting it had agreed an approach to update the Joint Health and Wellbeing Strategy with a complementary action plan focusing on a smaller number of actions that would have the biggest impact on sustained health outcomes whilst reducing the inequalities that persisted in the community, namely, reducing and controlling high blood pressure; tackling tobacco and increasing physical activity.

She outlined the aims of the 'Turning the Curve' events and the very positive tobacco and hypertension events had recently taken place.

In relation to e-cigarettes, it was commented that while there was a lack of reliable research into their safety, there was evidence of take-up by people who were not currently smokers and the danger that their use normalised smoking particularly amongst young people. Consideration would be given to further publicity on prohibiting the use of e-cigarettes in partner organisations.

RESOLVED

That the content of the presentation be noted.

7. CHILDREN AND YOUNG PEOPLE EMOTIONAL WELLBEING AND MENTAL HEALTH PROGRAMME BOARD

Alan Ford, Commissioning Business Manager, NHS Tameside and Glossop CCG, presented a report informing and updating the Board on the remit and work of the Children and Young Peoples Emotional Wellbeing and Mental Health Programme Board national pilot.

He explained that delivering better coordinated care and support centred around the child or young person was difficult and there were barriers at national and local level. The complex fragmented nature of current child and adolescent mental health services (CAMHS) commissioning arrangements, and lack of coordination between agencies gave potential for children and young people to fall though the net, which had been highlighted in several recent national reports and serious case reviews.

As a result the Government established the Children and Young People's Mental Health and Wellbeing Taskforce in September 2014. Under the remit of the Taskforce the Department of Health and NHS England invited proposals from CCGs to become national pilot sites in leading the changes required and accelerate co-commissioning arrangements for CAMHS. Tameside and Glossop CCG with its partners was selected in November 2014 as 1 of the 8 national pilots sites tasked with considering what changes and improvements were needed in the current system and identify innovative and effective solutions for achieving progress; feeding into the work of the Taskforce.

The Children and Young People Emotional Wellbeing and Mental Health Programme Board was formed in February 2015 with a new approach that would review and strengthen referral pathways to make them more effective. It would deliver and clear offer through partnership service delivery requiring the development of pathways across an array of services including school support

services, health, social care and the third sector. The Programme Board's Terms of Reference was appended to the report.

Progress to date was outlined and it was the Programme Board's intention that core CAMHS specialist service would deliver Tier 3 treatment. Agreed partnership approaches would focus on early intervention at Tier 1 and 2. Front line staff would be equipped to be able to identify and respond to mental health issues within an agreed framework for intervention providing clear pathways and access supported by consultation, advice and guidance model.

RESOLVED

(i) That the work and remit of the Children and Young People Emotional Wellbeing and Mental Health Programme Board be supported.

(ii) That update reports be submitted to future meetings of the Board.

8. TAMESIDE AND GLOSSOP CLINICAL COMMISSIONING GROUP: CO-COMMISSIONING STRATEGY

Consideration was given to a report of the Director of Transformation explaining that Tameside and Glossop Clinical Commissioning Group had been given approval on 1 April 2015 to move forward with Level 2 Joint Commissioning of Primary Care. The CCG was now jointly responsible for commissioning of core General Practice services across Tameside and Glossop and a structure had been put in place to support the delivery of this as required as part of the approval process.

A Joint Committee representing the CCG and NHS England was meeting monthly to discuss relevant commissioning and contracting issues and Tameside MBC Public Health was also in attendance. The Terms of Reference, appended to the report, had been agreed and signed off nationally ensuring Conflict Of Interest was managed appropriately. A Memorandum of Understanding had also been signed between the CCG and NHS England. To support this work and the growing Primary Care Development agenda, the CCG had appointed a Head Of Primary Care Development, Practice Liaison Post and Primary Care Quality Manager.

Future discussion may take place this year to move to Level 3 at some point in the future (delegated commissioning of Primary Care General Practice from NHS England to the CCG). However, more work to understand the implications would need to take place to ascertain how this would impact on capacity and resources.

RESOLVED

That the content of the report be noted and the Board receives regular updates as work progressed.

9. TAMESIDE AND GLOSSOP CLINICAL COMMISSIONING GROUP: OPERATIONAL PLAN 2015/16

Consideration was given to a report of the Chief Operating Officer, which explained that each year CCGs were required to complete an Operational Plan setting out the work programme for the coming year to enable CCGs to meet their statutory duties and make progress towards their strategic aims.

NHS Tameside and Glossop CCG had submitted a refresh of the second year of the 2014/16 plan building the foundations for progressing the Five Year Forward View and describing programmes and detail of work that had been achieved since the last submission and designed to provide a platform for a new and improved model of care for the people of Tameside and Glossop.

RESOLVED

That the NHS Tameside and Glossop CCG Operational Plan 2015/16 be noted.

10. HEALTHWATCH REPORT: ENTER AND VIEW

Ben Gilchrist, Healthwatch Tameside, presented a report which explained that the purpose of the Enter and View visits was to help Healthwatch form a view about how the improvement plans at Tameside Hospital had affected patients' experiences of their care. The visits had been undertaken with the full support and co-operation of Tameside Hospital and other partners by trained Healthwatch staff and volunteers during the period of a week in December 2014. Standard questions and observations were used by all staff and volunteers and the records of these were analysed and interpreted by staff.

The report incorporated the output from 96 interviews with patients and / or their families as well as observations made in seven wards / areas in the hospital. These Enter and View visits were designed to answer a few key questions which were outlined. The report's executive summary provided an overview in terms of each of these questions. In summary, Healthwatch Tameside:

- Recognised that improvements had been made in several areas where historically Tameside LINk had expressed concerns. These areas were based on concerns raised by the local population in 2010.
- Felt that further improvements could be made to build on the progress that had been made over the past two years.
- Recognised the hard work of front line care staff. They also noted that many patients said that nursing staff looked very busy.
- Welcomed the openness, transparency and willingness to be challenged which had resulted from changes in the hospital's leadership.
- Made seven recommendations and received positive responses to these from both the hospital and the CCG.
- Noted that future changes to health and care services will require the hospital to consider its position within the evolving services and for partners to work together.

The report had been shared with NHS England, the Care Quality Commission and Monitor who have all given positive feedback about its content.

RESOLVED
That the contents of the report be noted and thanks extended to Healthwatch Tameside volunteers and staff for their work on behalf of the local population.

11. JOINT STRATEGIC NEEDS ASSESSMENT – SIGN OFF

Consideration was given to a report of the Executive Member (Health and Neighbourhoods) and Director of Public Health containing a summary of the Joint Strategic Needs Assessment (JSNA) process. The full JSNA document, a comprehensive description of the current health and wellbeing of the population of Tameside and recommendations for actions that would lead to improvements, had been circulated to the Board separately prior to the meeting.

RESOLVED
That the approval be given to Joint Strategic Needs Assessment being signed off and released into the public domain.

12. HEALTH AND WELLBEING BOARD FORWARD PLAN 2015/16

Consideration was given to an outline forward plan covering key issues associated with the Board's duties and terms of reference.

RESOLVED
That the Forward Plan be approved.

13. TAMESIDE HEALTH AND WELLBEING BOARD SUMMER DEVELOPMENT SESSION – 29 JULY 2015

Details and objectives of the Board's first development session arranged for 29 July 2015 commencing at 11.00 am at Dukinfield Town Hall were provided.

14. URGENT ITEMS

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

CHAIR

ITEM NO. 4

Tameside Health Protection Group

3.00 pm Monday, 13 July 2015
Rainbow Room, Ashton Primary Care Centre

Action notes

1. Welcome and apologies

Present:

Anna Moloney (Chair)	Consultant in Public Health, TMBC	AM
Debbie Pritchard	Clinical Lead, Infection Prevention, THFT	DP
Gary Mongan	Environmental Services Manager, TMBC	GMo
Khush Ahmed	Environmental Services Manager, TMBC	KA
Graham Munslow	Screening/Immunisation Team, GMPHE	GMu
Laura Birch	Pennine Care Foundation Trust	LB
David Armitage	Public Health Manager, TMBC	DA
Tim Wilde	Team Manager, TMBC	TW
Andrea Welch (Notes)	Senior Secretary, TMBC	AW

Apologies:

Jamie Douglas	General Practitioner, T&G CCG
Ian Saxon	AED, Environmental Services, TMBC
Andrea Morris	Head of Integrated Governance, PCFT
Lindsay Stewart	Interim Deputy Director of Nursing, THFT
Lorraine Lighton	Consultant in Communicable Disease Control, GMPHE
Brian Dillon	Resilience Manager, GMCSU
Andrea Morris	Head of Integrated Governance, PCFT
Peter Howarth	Head of Medicines Management, T&G CCG
John Goodenough	Director of Nursing, Infection Prevention and Control, THFT
Pauline Patton	AGMA Civil Contingencies and Resilience Unit
Gill Gibson	Director of Nursing and Quality, T&G CCG
John Goodenough	Director of Nursing, Infection Prevention and Control, THFT

2. Notes from previous meeting and further actions

AM welcomed everyone attending and introductions were made. LB is representing Andrea Morris, who gave apologies for today.
AM stated that the main item for discussion with be Item 10 on the Agenda regarding Sector Led Improvement (SLI) Outbreak Planning. AM is participating in a forthcoming SLI on Outbreak Planning being organised by Greater Manchester Public Health Network (GMPHN) on 10 and 11 August 2015 and would welcome any comments on the template.

The notes from the last meeting were read and the following amendments are to be made: **Item 2 - AM to contact Pauline Patton (PP) regarding reference and guidance list in respect of outbreaks.** **Item 8 – delete "DP will attend" at the end of paragraph 4.** Following these amendments, the notes were agreed. Exercise Cygnus regarding pandemic flu will not be taking place until at the earliest April 2016, DP advised. AM provided an explanation of what this Exercise was and said that Tom Walley, Civil Contingencies and Resilience Unit (CCRU) would be organising this.	**AM** **AW**
3. GMSIT – Update GMu gave a brief explanation of how the routine immunisation data is compiled. Data was provided on the following immunisation programmes: • HPV – target exceeded (Tameside highest achiever) AM mentioned a national concern where in 1 GM area (not Tameside) there had been concerns over newspaper reports on alleged adverse reaction to the vaccine. AM has briefed Cllr Clooney on this issue but there were no reports of any issues with the vaccine in Tameside. PHE have issued a statement. • 0-5 primary dose – target exceeded • MMR 1st dose – just under target GMu advised that there is an issue across all areas but this can now be resolved because of access to GP data. • DTap/IPV booster – slightly under target GMu quoted an organisation issue where PHE have liaised with Tameside and Glossop Clinical Commissioning Group (T&G CCG) to resolve. An improvement should be seen by the November HPG meeting. • MMR pre-school booster – target exceeded. GMu shared good practice from another GM area. • Flu over 65 year olds – above target including national AM extended congratulations to everyone involved and advised that flu telephone conferences for 2015/16 have been organised. The pharmacy pilot is continuing and GMu provided information on target groups stating eventually that all under 17s will be able to receive the vaccine. This has the advantage of reducing the amount of older people contracting flu. • Flu at risk groups – under target • Flu pregnant women – under target but an increase compared to 2014/15 • PPV – given routinely when 65 years old, no national target but increase on uptake from last year. • Shingles – slightly under target 2013 programme to target 70 and 79 year olds. GMu provided background information on age difference. Discussion followed regarding uptake. • Pre natal pertussis – new programme introduced and GMu provided	

background information. Good uptake to date. • Men B – new programme commencing 1 September 2015 to include 3 doses and short catch-up programme. • Meningococcal ACWY vaccination programme commencing on 1 August 2015 targetting 14-17 year olds and 1st year university students up to 25 because of increase in number of fatalities recently in Manchester. Outbreak should be under control within 1-2 years. GP practices starting immunisation from 1 August 2015 and year groups 9 and 10 over the next 2 years. A promotional campaign is planned and a letter to universities has been sent out advising them on the action for student health and how this should be dealt with during "Freshers" week.	
4. HCAI Whole Health Economy Overview AM commented on the attached report produced by Martin Kent, CCG re: April and May figures. On plan for close of May. DP has the June data but this has not yet been signed off. DP provided a breakdown of the report in respect of Clostridium Difficile which is currently still in breach of target. As regards Root Cause Analysis (RCA) this is almost complete and will shortly commence on outstanding cases. DP explained the situation regarding risk factors involved. AM confirmed that antibiotic prescribing was a critical causative factor. AM said that there was not much change in the figures from last year and DP commented that there had been an increase in community cases but a decrease in hospital cases compensating for economy. A Service Level Agreement for RCAs is being processed. AM with the CCG is treating this as a matter of urgency. Post infection reviews completed and submitted to PHE and termed unavoidable. DP updated meeting on the process involved, clarifying the situation regarding arbitration. TW asked if it was worth reporting on unavoidables and DP explained that this was routine practice and that it was a mandatory report for PHE. **AM is to arrange an appointment with CCG to discuss HCAI performance.**	**AM**
5. Public Protection GMo spoke about deaths due to air quality, where PHE and DEFRA are involved. A draft quality action plan is to be issued shortly. The plans to clean up a former chemical site locally have been slightly delayed and GMo provided updated information stating that the work is now due to commence in Feb/March 2016. **When the full plans are received PHE will be involved and it was agreed that GMo will contact Lorraine Lighton, PHE to inform her of the situation.** **KA will provide information on food outlets to future HPG meetings.**	**GMo** **KA**
6. Sexual Health DA advised that the national Chlamydia data has been released and Tameside have the second highest results this year which is positive news. DA provided an explanation of the data. There are 2 areas of high prevalence in GM and DA	

explained the difficulties being experienced and a discussion has been entered into around sharing costs. The HIV late diagnosis rate is being addressed and should significantly improve shortly.	
7. PHE Health Protection This item was deferred until the next meeting.	**LL**
8. Medicine Management **AM is to speak to Peter Howarth, CCG.**	**AM**
9. PHOF – Health Protection Document provided for members information and attention.	
10. Report from the SLI Flu Support Panel AM provided background information on the SLI programme and the forthcoming Outbreak Planning SLI. There will be a panel consisting of health protection specialists and lay men who will interview the local authority representatives. AM expressed her thanks to Monica Chapman, Environmental Health, TMBC who contributed to the completion of the template. KA will be attending the SLI Panel with AM and AM would like a representative from CCG to attend also. **AM will contact CCG regarding a representative to attend SLI on 11 August 2015. Once a CCG representative is identified, a telephone conference with AM, KA and CCG representative will be arranged prior to 11 August.** AM went through the self-assessment template for members and asked for comments. The score was provided from AM's personal perception. LL provided feedback on Intelligence from the PHE perspective and this is an opportunity to highlight future development**. It was agreed that a discussion is required and the Salford document is being worked on by PP and AM**. The MoU also needs to be completed. AM provided an overview of the key challenges. SLI Flu Support Workshop – AM attended this workshop on behalf of TMBC and explained the reasons and methodology behind it. TMBC had systems of good practice such as: changes to care home contracts and reminders of their employer obligations; Flu voucher scheme for TMBC staff considered to be high risk with an increased uptake last year, in collaboration with Mark Whitehead, TMBC; TGH staff had a very high uptake of flu vaccinations. A discussion followed regarding the voucher scheme and staff uptake rate. AM asked for ideas for future promotion of this scheme and DP suggested roving clinics which were used in hospital, for use in care homes. **Different ways of engaging staff were discussed and AM asked for any further ideas to be communicated to her.** AM mentioned the local Flu debrief meeting held in May where the actions from last year had been evaluated and forward planning for this year discussed. Future telephone conferences for 2015/16 are arranged.	**AM** **AM/PP** **All**

11. Community CPE Toolkit **This item is deferred to the next meeting as Lorraine Lighton, PHE was unable to attend today**. Documents provided for information purposes and AM advised that Tameside and Glossop is not an area of concern at this time compared to other GM areas.	**LL**
12. Tuberculosis in Greater Manchester: Annual Review (2013 data) AM explained that this report provided useful background information, in particular page 27 contained a table in respect of the completed treatment rate. Tameside has a low incidence rate, but this could be improved. TB is a matter which will be brought to the attention of the Health and Wellbeing Board (HWBB) in the future. **AM asked DP to bring this item to John Goodenough's attention.**	**DP**
13. Health and Social Care Act Code of Practice AM advised that she had received this letter regarding a consultation that was to take place and had ended in March 2015. AM asked DP for any information following the end of the consultation period. DP explained that no information had yet been received and explained the process involved, informing the meeting that there would be a probable implementation date of 1 April 2016.	
14. Any Other Business Infection Prevention and Control Collaborative meeting held Thursday, 9 July 2015 – unfortunately neither AM, DP or NF had been able to attend this meeting. DP has never attended this meeting to date. **AM is to check with NF regarding attendance as it would be beneficial to** feedback **information from this meeting into the HPG.**	**AM**
15. Date and Time of Next Meeting **Monday, 21 September 2015 at 3.00 pm – 5.00 pm in Rainbow Room, Ashton Primary Care Centre, 193 Old Street, Ashton under Lyne, OL6 7SR**	

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ITEM NO: 5

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	1 October 2015
Executive Member / Reporting Officer:	Councillor Brenda Warrington – Executive Member (Adult Social Care and Wellbeing) Jessica Williams, Programme Director for Integration, Tameside and Glossop CCG / Tameside MBC
Subject:	**MAKING PROGRESS ON THE INTEGRATED CARE SYSTEM ACROSS TAMESIDE AND GLOSSOP**
Report Summary:	Monitor, the regulator for health services in England, published a report on the 17.09.15 outlining options for the future of Health and Social Care in Tameside and Glossop endorsing our current work, known as '*Care Together'*, which has been taking place locally to develop better health and care services for local people. This now gives us a mandate to take forward nationally significant plans. These plans will place Tameside at the forefront of a new era in health and social care. We will be the first in the country to deliver health and social care services via an Integrated Care Organisation (ICO) bringing together services from Tameside Council, Tameside and Glossop Clinical Commissioning Group (CCG) and Tameside Hospital. We know that the future of health care services in Tameside needs to look very different, particularly given our reducing budgets. Integrating preventative and proactive care, GP's, Social Care and the services provided in the hospital will deliver better service for local people. Those in need of support will receive it in a more co-ordinated way, without having to work their way through a complex system of multiple organisations and teams, as anyone who has care of an elderly relative will know. Care will, wherever possible, be provided closer to home (preferably in their own homes) and we will do all that we can to keep people out of hospital especially where early support can prevent a unnecessary stay in hospital. Although a lot of the detail of how the ICO will work is yet to be decided and will be shaped as the programme progresses, staff will be at the forefront of this as we co-design the new services and ways of working going forward. The ICO will provide new opportunities for our workforce and their experience, knowledge and skills will play a vital part in ensuring we have a future care organisation that is fit for purpose and holds the needs of the person central to the health and care it provides. Staff will receive briefings throughout this process. The attached report sets out the initial commitments of all the parties to make progress on delivering the new ICO.
Recommendations:	This Health and Wellbeing Board is asked to note the contents of this report.

Links to Community Strategy:	Meets all objectives.
Policy Implications:	In line with Council policy.
Financial Implications: **(Authorised by the Section 151 Officer)**	The report of PwC confirms previous estimates made of the future funding gap in the local health economy and calculates this gap to be c£69m (see page 26 of appendix e to this report). The anticipated improvement to this position that can be made by creating the Integrated Care Organisation is c£28m. This is a significant level of cost reduction and represents a vital component of achieving financial sustainability in the local health economy. In due course it will also provide a significant contribution to the financial sustainability of the Council. Further work is in hand to address the residual gap of c£42m (also set out in appendix e to this report). No direct financial implications arise from this report. Further decisions will be taken which will enable the steps required to deliver the ICO and secure the anticipated spending reductions.
Legal Implications : **(Authorised by the Borough Solicitor)**	There are some significant financial, organisational and legal risks to be addressed throughout this process and kept under review. However, those risks and the benefits outweigh the significant consequences of doing nothing both in terms of care, impact on the local economy and the Council's budget. There would appear to be no other options or alternatives and this has been endorsed by PWC who drafted the report and undertook the CPT with Monitor over some 9 months.
Risk Management :	These are set out in the CPT report but a proper risk register will be required for this programme.
Access to Information :	**Appendix A** – Board to Board report. **Appendix B** - Joint key stakeholder briefing from the three parent organisations summarising the CPT report. **Appendix C** - Joint press statement from the three parent organisations in response to the CPT report. **Appendix D** - Tameside Hospital NHS Foundation Trust contingency planning team: an overview. **Appendix E** - The Contingency Planning Report as published by Monitor on 17 September 2015. The background papers relating to this report can be inspected by contacting Jessica Williams, Programme Director by: Telephone:0161 304 5342 e-mail: jessicawilliams1@nhs.net

	ITEM NO: 2
REPORT TO:	**JOINT BOARD MEETING OF THE TAMESIDE AND GLOSSOP CLINICAL COMMISSIONING GROUP ('THE CCG'), TAMESIDE METROPOLITAN BOROUGH COUNCIL ('TMBC') AND TAMESIDE HOSPITAL FOUNDATION TRUST ('THFT')**
DATE:	23 September 2015
REPORT OF:	Karen James, Chief Executive - Tameside Hospital Foundation Trust Steve Allinson – Chief Operating Officer - Tameside and Glossop Clinical Commissioning Group Steven Pleasant – Chief Executive - Tameside Metropolitan Borough Council Chris Mellor – Independent Chair Jess Williams – Programme Director for Integration
SUBJECT MATTER:	**INTEGRATED CARE SYSTEM ACROSS TAMESIDE AND GLOSSOP**
REPORT SUMMARY:	Following the publication by Monitor of the Contingency Planning Team (CPT) report on 17 September 2015, the three "parent" organisational Boards are meeting collectively on 23 September 2015 to formally accept the CPT report and to determine how they wish to work together to deliver the anticipated benefits for the people of Tameside and Glossop. This report sets out recommendations which each organisations needs to sign up to and adopt in order to deliver the benefits of an integrated care system across Tameside and Glossop. Appendices to this report for information are: • The Contingency Planning Report as published by Monitor on 17 September 2015 (**Appendix A**) • Tameside Hospital NHS Foundation Trust contingency planning team: an overview (**Appendix B**) • Joint press statement from the three parent organisations in response to the CPT report (**Appendix C**) • Joint key stakeholder briefing from the three parent organisations summarising the CPT report (**Appendix D**).
RECOMMENDATIONS:	Tameside and Glossop Clinical Commissioning Group ('the CCG'), Tameside Metropolitan Borough Council ('TMBC') and Tameside Hospital Foundation Trust ('THFT') agree the following and to ensure that any organisation governance process will be

undertaken to give effect to the following:

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

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

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

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

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

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

   a) The objective of providing governance arrangements which aim to provide streamlined decision making; excellent co-ordination of services for the residents of Tameside & Glossop; mutual co-operation; partnering arrangements, and added value in the provision of shared services.

   b) an acknowledgement that the arrangement does not affect the sovereignty of any party and the exercise and accountability for their statutory functions.

   c) A commitment to open and transparent working and

	proper scrutiny and challenge of the work of the Programme Board and any party to the joint working arrangements. d) A commitment to ensure that any decisions, proposals, actions whether agreed or considered at the Programme Board carry with them an obligation for the representative at the Programme Board to report these to their own constituent bodies. 7. Each organization will effect the necessary authority to its representatives at the programme Board to implement the recommendations of the CPT report, which will be binding on the organization. 8. We agree to develop a Memorandum of Understanding, the Programme Board Terms of Reference, and a detailed Scheme of Delegation for consideration and ratification at a future meeting. 9. To provide mutual assurance to the constituent bodies, we agree that there will be regular reports from the Programme Board to the Boards of the constituent bodies. 10. We agree to the formation of a Programme Management Office to manage the implementation of the new Model of Care and will jointly look to resource this as appropriate. 11. The Commissioners agree to deliver a joint commissioning function, to be in place by 1 January 2016. 12. We agree that the governance arrangements will be kept under regular review and be revised from time to time to reflect the changing status of the integrated care delivery vehicle. 13. That any decision affecting the statutory duties of an organisation will be referred through that organisation's governing processes.
ACCESS TO INFORMATION	**NON-CONFIDENTIAL** This report does not contain information which warrants its consideration in the absence of the Press or members of the public
REFERENCE DOCUMENTS:	The background papers relating to this report can be inspected by contacting by: Jessica Williams, Programme Director, Tameside and Glossop Integrated Care: Landline: 0161 304 5342 Email:jessicawilliams1@nhs.net

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Briefing on the publication of the Monitor Contingency Planning Team Report

In November 2014, Monitor appointed PwC as a Contingency Planning Team (CPT) to assess the sustainability of the Foundation Trust following a number of critical reports. The Contingency Planning Team report is to be published by Monitor on the 17th September. NHS Tameside and Glossop Clinical Commissioning Group, Tameside Metropolitan Borough Council and Tameside Hospital NHS Foundation Trust have worked closely with the CPT on developing a model of integrated care, the principles of which were already well established.

Key Points

- The publication of this report from Monitor feeds directly into our work around developing integrated health and social care in Tameside and Glossop.
- Monitor has tied the release of the report into the decision to remove the Hospital from special measures, although the two are not directly related.
- This represents the next stage in our journey and gives us access to levers of national significance in terms of creating an integrated care organisation. Tameside and Glossop have an opportunity to be at the forefront of the national drive to integrate health and social care, allowing us to collectively deliver better outcomes for our residents. The plan could see Tameside and Glossop deliver a national first.
- The CPT report concludes that Tameside Hospital NHS Foundation Trust (THFT) could become the delivery vehicle for the integrated health and social care system. Local organisations need to consider this recommendation in more detail and we are clear that if this were the case, THFT would need to be a very different organisation in the future.
- The CPT estimate that the proposed model could save £28 million a year across health and social care, but will still leave a deficit of around £42 million.
- We do know that in the future health care services in Tameside and Glossop are likely to look very different. Integrating preventative and pro-active care, GPs, social care and the services provided in the hospital will deliver better health and social care service for local people. Those in need of support will receive it in a more co-ordinated way, without having to work their way through a complex system of multiple organisations and teams. Care will, wherever possible, be provided closer to home (or even in people's homes) and we will do all we can to keep people out of hospital where effective, early support could have prevented a stay in hospital.

- The CPT report proposes a model of care in four parts: preventative and proactive care; urgent care; elective care; and specialist input. All of which have been designed through Care Design Groups (CDGs) which involved input from clinical and management staff, patient representation and the public.

- The CPT propose the creation of Locality Community Care Teams (LCCTs) in each of the five localities. We support this and believe that they will be a really important element of the new local approach, bringing together delivery across primary care (GPs), mental health, community care, social care, secondary care and the 3rd sector. They will coordinate care through individual care plans and the sharing of expertise. The locations of these community care teams will be:

    - Ashton
    - Denton, Droylsden, Audenshaw
    - Hyde, Hollingworth and Longdendale
    - Stalybridge, Dukinfield, Mossley
    - Glossop

- Tameside could also benefit from a new best practice Urgent Integrated Care Service ('UICS'). The UICS will have unequivocal responsibility for looking after local people who are in social crisis, or who are seriously unwell. There is a range of services sitting under the UICS including A&E, rapid response team, discharge team and intermediate care.

- The report proposes Tameside Hospital as an elective surgical centre with an A&E (as part of the UICS), maternity services and a reduction in medical beds and overall activity by c18%.

- The report also introduces the possibility of using 12 extensivists. Extensivists are hospital-based specialists who would focus on a cohort of high-risk patients. Extensivists are trained and experienced in looking after patients with complex medical conditions.

- The report represents a significant step forward but does not provide us with all of the answers. The report is supportive of maternity services locally but does not provide a recommendation on this issue, referring to the need to wait for the output from the Cumberledge Report.

- Currently the proposals are unfunded (and are modelled to be around £48 million of one-off costs) and discussions are taking place around how funding could be brought to Tameside and Glossop to deliver this ambitious programme.

- Local organisations are working up a fuller response to the publication of the report and face to face briefings with interested parties will be arranged.

- Staff briefings for all affected workforce are taking place following the publication of the report.

Contingency Planning Team (CPT) Locality Press Release

NHS Tameside and Glossop Clinical Commissioning Group (CCG), Tameside Metropolitan Borough Council and Tameside Hospital NHS Foundation Trust welcome the publication of the Contingency Planning Team (CPT) report from Monitor, the sector regulator for health services in England, outlining options for the future of health and social care in Tameside and Glossop.

Monitor's report builds on the exciting work which has been going on to develop better health and care services for local people and gives us a mandate to take forward nationally significant plans. These plans put Tameside and Glossop at the forefront of a new era in health and social care as we will be the first area in the country to deliver health and social care services via an integrated care organisation (ICO). This will be an organisation designed to deliver integrated health and social care enabling the provision of seamless health and social care services for the people of Tameside and Glossop.

This new way of working will place a greater emphasis on prevention rather than cure and keeping people as healthy and independent as possible. It will also mean that when people do need hospital treatment or to receive care services, these are provided safely, promptly and efficiently. As they work together in one organisation. Health and care staff will have the ability to share information to reduce duplication and work around the individual's needs in an effective way.

Chris Mellor, the Independent Chair of the Care Together Programme in Tameside and Glossop, said: *"I welcome the publication of this report. Partners locally can now work hard to implement our plans to improve health and social care services for people in Tameside and Glossop.*

"I look forward to establishing the first truly integrated care organisation in the country. The news that the hospital trust has been taken out of special measures is also great news for local people and gives us an excellent platform to move forward."

Health and social care services will be provided through five local community care teams (LCCTs). These will support residents in choosing healthy lifestyles, encouraging them to take more control and responsibility for their own health. They will also enable care to be given in the community, and where possible in residents' homes and people will get a named staff member to co-ordinate their support.

These plans, alongside the Greater Manchester wide Healthier Together programme and Greater Manchester Health and Social Care Devolution will ensure that local people have access to some of the best health and social care services available.

For more information on the Monitor CPT report, please contact;

kirk.millis-ward@monitor.gov.uk

Note: Care Together is the name of the Tameside and Glossop integrated care programme. GPs, health and social care providers, hospital clinicians, the community and voluntary sector are coming together to deliver much more joined up health and social care services for people in Tameside and Glossop.

By improving how these different services work together we believe we will optimise the quality of care, empower power and improve their experiences.

Monitor
Making the health sector work for patients

Improving joined-up care for patients puts Tameside Hospital NHS Foundation Trust back on a sound clinical and financial footing

Monitor, the health sector regulator, has accepted the findings and recommendations of an independent report into Tameside Hospital NHS Foundation Trust. The report confirms that an innovative, more joined-up approach to delivering health and social care across Tameside and Glossop will improve the care patients receive. The report states that improving the way services are currently delivered, in line with its recommendations, will put Tameside NHS Foundation Trust back on a sound clinical and financial footing and protect services for the long term. The recommendations require action by commissioners, the trust and the local authority.

In November 2014 Monitor brought in a Contingency Planning Team (CPT), a team of experts from PwC, to review and develop further a joint plan by Tameside Metropolitan Borough Council and NHS Tameside and Glossop Clinical Commissioning Group to better join up health and social care across the area. The CPT was employed to find out if the integrated care solution would solve the long-standing problems at the trust, and either find an alternative or create a plan for taking it forward.

The CPT report suggests the new care model could close the trust's annual cash shortfall of £23 million a year, within five years, if their recommendations are accepted, leaving the trust with no deficit. However, this is not the end of the story as this new care model is based on the wider health and social care system, where financial problems would still remain and need to be tackled.

At the same time as the CPT report is being published, Monitor has brought the trust out of special measures following a recommendation from the Care Quality Commission noting significant improvements. Monitor has agreed with the trust a set of actions it must continue to pursue based on the findings and recommendations of the CPT.

Local health and care partners have already said that the current system often doesn't make life easy for many patients, keeping some stuck in hospital when they could be at home and with patients having to repeat their story multiple times to different services.

The proposed new model of health and social care in Tameside and Glossop has been developed jointly by the CPT and the local health and care system, including doctors, nurses, patients, social care professionals, the voluntary sector and others. It would mean a radically new way of health and care professionals working together for the patient and a single care professional who would co-ordinate patient care.

It should not be underestimated how new and radical this approach is and the local partners in Tameside and Glossop would be leading the way. The report suggests a number of innovations, such as the development of new care professionals called 'extensivists'. Extensivists are specialists who focus on the patients most likely to require NHS services. In addition to specific training they will have extensive experience in looking after patients with complex medical conditions which will

complement GP expertise. They will, however, work alongside GPs to support existing primary care activities.

There are five key elements of the new care model, designed to deliver high quality care and experience for patients. These formed the basis of workshops held with patients and staff to create the new model and will be used to inform its implementation if the CPT recommendations (below) are fully adopted by the local health and care system:

- **Preventative and proactive care**: keeping people well and independent for as long as possible. Setting this goal allows the development of services that help people to stay well and manage their illness better. It will be delivered through five locality community care teams (LCCTs) that bring together GPs, mental health, community care, social care, hospital doctors and the voluntary sector.

- **Integrated urgent care service**: the development of a single service to deal with people who are in social crisis or seriously unwell. It will create a single point of access for patients and mean that the service has unequivocal responsibility for each patient using it. This approach strives to get the patient well and into the most appropriate care setting as quickly as possible.

- **Planned care**: making sure community and hospital services are more joined up. This is done through sharing budgets and having a single management team. It means that responsibility for the wellbeing of the patient is shared by a single team, from home to hospital and back home again.

- **Maternity care**: the report recognises the national work being done by the Cumberlege Review of maternity services and notes the high quality of local mother and baby services. It suggests local partners take another look at the service in light of the Review when it is published.

- **Hospital specification**: a view of what the hospital will look like in the new care model. In the new model every resource, including the hospital, is brought together around the four elements of care above. The hospital will be a key resource in keeping people well and not just treating them when they get sick.

The CPT estimates the proposed changes will contribute £28 million in total to the local health and care system each year, but there would still be an overall deficit of £42 million – reduced from the forecast deficit of around £70 million. There would also be one-off costs for implementing the changes of around £48 million, so more work needs to be done by the local partners together and with national organisations

to address these challenges. Commissioners will also need to decide how services are delivered and by whom.

Monitor has shared the CPT report with the local partners and tried to ensure that the new care model is compatible with the Healthier Together programme, part of Greater Manchester devolution. However the CPT report states, “The programme will need to be well-planned and well-led, and it will only succeed if several major risks are managed effectively”. To that end the CPT worked closely with the local chief executives and their teams to develop an implementation plan. Where appropriate, this work is moving forward.

Tameside Hospital NHS Foundation Trust CPT Final report

28 July 2015

pwc

Monitor
Wellington House
133 – 155 Waterloo Road
London
SE1 8UG

Dear Sirs

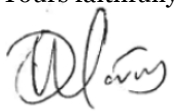
This report has been prepared for you, Monitor, in respect of Tameside Hospital NHS Foundation Trust (the "Trust") in accordance with the terms of our agreement dated 10 November 2014 (the "agreement") and the variation letter and solely for the purpose and on the terms agreed with you. We accept no liability (including for negligence) to anyone else in connection with this report.

This report contains information obtained or derived from a variety of third party sources as indicated within the document. We have not sought to establish the reliability of those sources or verified the information so provided.

We understand that you may wish to publish this report on your website, and in doing so we would draw to your, and any other person who may access and read this report, attention to the following:

1. The report is provided to Monitor, in accordance with Monitor's instructions, as a summary of the work carried out by PwC under the agreement and variation letter, which was performed exclusively for Monitor's benefit and use.
2. The report may therefore not include all matters relevant to the reader.
3. The report does not constitute professional advice to any third party.
4. The information contained in this report should not be acted on by any other party without first obtaining specific professional advice.
5. PwC accepts no liability (including for negligence) to any party, other than Monitor, in connection with this document.

This is our final report.
Yours faithfully



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If you are familiar with the context and previous work of the CPT, go straight to page 7 for the headlines of our work.

Report overview

Report section	Page number	Description	Structure within report
Context and previous work of the CPT	5	• Overview of the different phases of work the CPT has undertaken.	• Provides background and context to this report.
At a glance	7	• Provides a high level overview of the key points and headlines of the CPT in developing and recommending an integrated care model.	• Allows the reader to quickly see the headlines and key points.
Model of care	10	• Sets out what the model of integrated care will look like and how it drives better outcomes for patients delivered through a single provider. • Includes how urgent care will be dealt with and the expected hospital configuration.	• Follows the approach of the CPT to focus on the patient and services in the design of the model of care.
Clinical sustainability	23	• Illustrates why the model of care is clinically sustainable.	• Follows the model of care to support the assessment of clinical sustainability.
Financial sustainability	26	• Describes the financial challenge, how the financial impact has been modelled and sets out the financial benefits from an integrated model of care over 5 years. • Assesses the financial sustainability after the benefits from the model of care.	• Follows the model of care to support the assessment of financial sustainability.
Engagement	33	• Describes whether public consultation is needed and the CPT's approach to showing public consultation in the implementation plan. • Demonstrates the CPT's local engagement and ownership in the model of care and other aspects of the CPT's work.	• Consideration of consultation approach within the implementation plan.
Implementation	37	• Overview of the implementation plan and the governance of the programme.	• At the end of the report to support next steps.
Glossary	43	• Sets out definitions of key terms and acronyms used throughout this report.	• For reference.

Context and previous work of the CPT

This section sets out the background to the CPT's work in previous phases.

Monitor took action to put the Trust in Special Measures. It also appointed a CPT to focus on the Trust becoming an Integrated Care Organisation as a solution to its financial problems.

❶ Overview of the Tameside and Glossop health and care economy

- The Tameside and Glossop health economy is part of the Greater Manchester area and serves a population of approximately 250,000 residents.
- There are 2 main commissioners within the economy – Tameside and Glossop CCG and Tameside Metropolitan Borough Council.
- There is a single acute provider, Tameside Hospital NHS Foundation Trust (the Trust). Community services and mental health services are provided by organisations based out of the area. There are 41 GP practices grouped into 4 localities in Tameside and one locality in Glossop, Derbyshire. The social services in the Glossop locality are commissioned by Derbyshire County Council.
- The health and care economy has estimated it's combined income in FY20 to be c£433m with a combined deficit of c£69m pa.

❷ In Summer 2013, Monitor took action to address unacceptable standards of care and the Trust being financially unsustainable

- In July 2013, the Trust was placed in Special Measures following findings from the Keogh Review. In early 2014, the Trust was deemed clinically and financially unsustainable.
- Partly in response to these concerns, the CCG initiated the development of a programme called Care Together, that had integrated care at its heart.
- In September 2014, Monitor took further action and announced the appointment of a CPT; *'...the first time the NHS will try to create a full Integrated Care Organisation (ICO) at a foundation trust...lead to long term benefits for patients....the team will build on the work already done...'.*
- The CPT's work has been in 4 phases:
  - Phase 1 – review of the current preferred solution;
  - Phase 2 – determine the viability of the ICO;
  - Phase 3 – test and confirm sustainability; and
  - Phase 4 – implementation plan.

❸ In Phase 1, we reported that there was a recognised need for change but very little consensus over a model of care

- Our Phase 1 review identified that some areas within Care Together were strong, others needed substantial further work. Key findings included:
  - There was a collective recognition of the need for change amongst local leaders and a willingness to pursue a move towards integrated care;
  - Whilst there was a high level strategy and some emerging business cases (e.g. dermatology), there was no overall model of care that described the services that would bring the full benefits of integrated care to local people;
  - There was significant difference of opinion between the CCG and Trust regarding the acute footprint at Tameside Hospital; and
  - The estimates of the financial benefits of the strategy were not owned by the various stakeholders in the economy and were in some places unrealistic.

Context and previous work of the CPT

The CPT was appointed by Monitor to consider a financially and clinically sustainable solution for Tameside Hospital NHS Foundation Trust within the context of the Tameside local health economy. The recommendations set out in the report have been shared with the local health economy which will consider the recommendations and their implications for the local health economy.

❹ In Phase 2, we worked closely with local stakeholders to build on existing thinking to design and develop a pioneering new model of care. We identified substantial patient benefits and estimated a financial benefit of £20m - £34m pa

- In developing our Phase 2 findings, we worked with patient groups, care professionals, local leaders and others to design the new model of care that would drive significant benefits to local residents, who would be healthier and need less care.
- We also found there to be substantial financial benefits driven by the model of care of between £20m - £34m pa although there would be significant one-off implementation costs.
- We reported that in our view the combined deficit in the health and care economy would be reduced but not fully addressed.

❺ In this document we report at the end of Phases 3 and 4 of our work on an exciting way forward for the Trust and system

- This report comes at the end of an intense 6 months of activity by the CPT.
- What is proposed and planned here really is the first in the UK - a fully integrated care organisation with a capitated contract, which has not yet been achieved in the UK.

At a glance

PwC view:

- *What emerges from 6 months of work by the CPT and Monitor is a first of its type in the UK.*
- *On implementation, the patients and population served by the local health economy will be able to easily access high quality healthcare.*
- *The financial benefits from this work are significant and equate to a c£28m pa reduction against existing running costs.*
- *Providing the new model of care requires a delivery vehicle that could be the Trust. This would be the first trust in the UK to provide a fully integrated range of services.*
- *The system has a growing financial deficit driven largely by the underfunding of social care costs.*

❶ This is an executive report at the end of the Tameside Hospital NHS Foundation Trust CPT

This report has been written for Monitor at the end of the CPT.

- During the CPT, we have worked closely with Monitor's Enforcement Team, the Trust, CCG and TMBC and others and received helpful input.
- The CPT's brief was to develop an integrated care model and its implementation plans to create a clinically and financially sustainable Trust. Full details of the CPT's brief are set out in the service order.

❷ We have worked with the local health and care economy to develop and optimise the integrated model of care

- The CPT has developed a new and exciting model of care, that integrates care across the Tameside and Glossop area. Key aspects of the model of care are:
  - Locality Community Care Teams ('LCCTs') in each of the 5 localities;
  - A new Urgent Integrated Care Service ('UICS'); and
  - Tameside Hospital as an elective surgical centre with an A&E (as part of the UICS), maternity services and a reduction in medical beds and overall activity by c18%.
- We have engaged with primary care GPs on a number of occasions and in a number of ways. The GPs shared a range of views and are broadly supportive of the proposed way forward.
- The CPT has engaged widely in the development of the model of care and worked daily with the CCG, Council and Trust, who support this new model of care. More details of this engagement can be found from page 34.

❸ The model of care drives financial benefits of c£28m pa

- The model of care drives significant financial benefits over and above 'normal' efficiencies in the system (CIPs and QIPP) reducing the cost to the tax payer and helping to relieve the financial burden in the system.
- The redesign of services has been done in a way that balances financial benefits for the system and the need for a clinically sustainable model. In doing so, consideration has been given to the Trust's existing PFI obligations, the skills and experience of existing staff across the economy and importantly the needs of the population.
- We believe that our acute configuration is clinically sustainable and the most affordable.
- The model of care is complementary with Healthier Together, the Greater Manchester health and social care reform programme.

❹ We have put forward a rationale that indicates that the current Foundation Trust should transition into the first fully integrated care provider in the UK

- We have put forward a case indicating why the integrated care provider should be grown out of the Trust. It is now for the CCG to consider how to take this forward.
- Assuming the Trust transitions into a new integrated care provider, it would be a pioneering delivery vehicle. This would mean the way in which services are delivered locally would go much further than those models outlined in the 5 Year Forward View.
- The Trust, in its new form, will need to develop in many ways to effectively deliver a broader and larger range of services and look and feel like an integrated care provider and not like the existing acute Trust.
- The Trust would need to develop its leadership capacity and capability to be able to take forward the delivery of such different and broader services, on a larger scale. This is likely to mean increasing clinical and operational leadership capability to provide the model of care.

At a glance

PwC view:

- *Even with benefits from the model of care of c£28m pa, the residual health and care economy deficit is c£42m pa. We have apportioned this deficit between the commissioners and have provided a rationale for this on page 30.*
- *As a result, the Trust would be financially sustainable.*
- *The combined forecast deficit of c£216m over the next 5 years and implementation costs of c£48m will need addressing. Without the benefit and implementation costs, the combined deficit for addressing is estimated at c£299m.*
- *Beyond year 5, the system would provide better care and be more affordable.*

❺ There is a substantial financial benefit from the model of care but a health and care economy deficit remains. This is forecast at c£42m pa

- Before the benefits of the model of care but after normal efficiencies, the system forecast deficit of c£69m in 5 years is comprised of the Trust c£23m, TMBC of c£46m and the CCG is breakeven. The benefit from the model of care is c£28m leaving a residual deficit of c£42m pa (figures are rounded to the nearest £m).
- The CEOs of the Trust, CCG and Council consider the residual deficit as a shared issue and this is consistent with TMBC and the CCG's co-commissioning where they are pooling budgets.
- However, on the basis that the model of care costs what the CPT has estimated and it is the model the commissioners wish to commission, we believe the deficit should rest with the commissioners. This is supported locally although not yet fully ratified.
- As a result, the Trust would be financially sustainable with income and costs of c£414m annually. However, with a long term capitated contract, the Trust would bear the downside risk if the cost of provision was greater than the level of the contract.

❻ One-off implementation costs of c£48m and c£216m for deficits over 5 years across the NHS and local government will need addressing

- There are one-off implementation costs that are needed within the next 2-3 years including for capital, estates and people (training, role change etc.) related costs.
- We estimate these to be in the region of c£48m.
- The combined deficit and implementation costs will also need addressing but we note that the 5 year forecast shortfall is lower after the benefits of integrated care and one-off implementation costs.
- Also, from year 5 onward, better care would be provided to local residents and the system would be c£28m pa more affordable.

❼ The local health and care economy will need support to deliver a change of this magnitude

- Significant change will be needed to existing services to deliver the benefits from this new model.
- Our experience of working with local leadership is that they will need additional capacity and capability to deliver change of this scale and to the pace shown by the implementation plans. Change of this scale will need to be implemented as well as the 'day job'.
- Local leadership recognise the need to improve their capacity and capability and are taking steps to address the issue. This includes a jointly appointed Independent Chair, Programme Director and PMO to support the delivery of the programme.

At a glance

PwC view:

- *We have sought to maximise local ownership of the implementation plans, with local Executives or Directors leading each component of the plan.*
- *Implementation risks will need careful management.*
- *With these matters considered, we recommend the model of care should be implemented.*

❽ There is strong local support to the model of care, but there are implementation risks that will need careful management

- We have worked with local leaders to develop the implementation plans to deliver the model of care.
- We have engaged extensively in the local health and care economy throughout the CPT and taken key interim and final findings to the Trust's Board, CCG's Governing Body and TMBC's Cabinet.
- Key risks for implementation have been discussed and provided to Monitor and local leaders and will require careful management.

❾ Next steps

- Some steps towards implementation have occurred already:
  - The Independent Chair of the new system wide Programme Board and the Programme Director have been appointed;
  - The CCG has been considering if it is comfortable the Trust becomes the provider of the model of care in line with relevant regulations;
  - The CCG included the model of care within its locality plans that have gone into the Greater Manchester Devolution; and
  - The first Programme Board has taken place.
- In the next 30 days:
  - Monitor to consider this report;
  - NHS England to clarify their local assurance process (previously the gateway process);
  - The next Programme Board meeting; and
  - Further consideration of the additional capability and capacity the stakeholders and the local economy should build.
- Beyond this, other key milestones are:
  - The CCG developing its commissioning intentions for the model of care and consulting with the scrutiny panels in Tameside and Derbyshire on whether public consultation is needed;
  - Addressing the implementation costs, linked with the Greater Manchester Devolution funding position;
  - Transferring services into the Trust; and
  - Changing services at the care provider level i.e. the roles of each individual, training and changing the model of service delivery.

Model of care

Integration of care provides an opportunity to improve both outcomes and affordability.

However, these benefits require care to be delivered in a fundamentally different way – through a new 'model of care'.

The CPT has co-developed a model of care that provides the best opportunity for a viable and affordable provider.

The model of care described in this chapter is supported by implementation plans.

Introduction to the model of care

CPT key points:

- *The model of care co-developed by the CPT and local system provides a coherent description of how care could be delivered by the Trust.*
- *The model of care is informed by service specifications which include bottom up costed workforce models.*
- *There is local buy in for the model of care which has been aligned with the Care Together Programme.*
- *While primary care has been engaged and alignment increases with the CCG's primary care strategy, further work will need to be undertaken by the CCG on contract arrangements.*

Why develop a model of care?

- There is little robust evidence in the UK (or elsewhere) that simply combining teams or merging organisations delivers significantly better value care.
- International examples of successful Integrated Care Organisations (ICOs) that manage population demand risk have developed their own models of care over time in response to commercial pressures. These have significantly improved the financial and clinical value associated with services.
- In Tameside and Glossop, we have developed the model of care as part of the CPT process, in order to:
  - Calculate and demonstrate the potential benefits of how integrated care could improve value;
  - Help articulate to the local population and care professionals how care will be provided;
  - Create an evidence base to drive decisions on provider organisation form and commissioning; and
  - Assess clinical and financial sustainability.

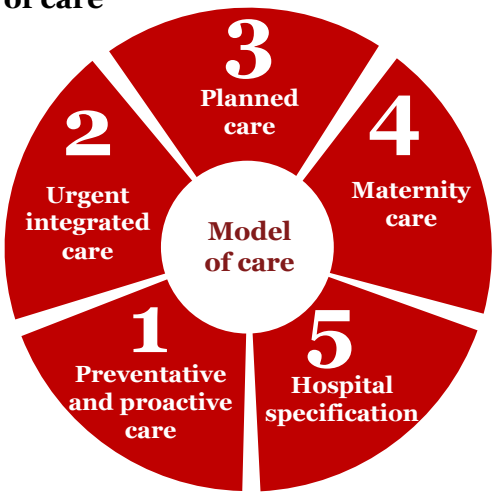
How the model of care was developed

- The model of care was jointly developed with care professionals, patient representatives and the CPT:
  - The model of care was developed taking into account national and international best practice which was used to inform a cost and activity model which details the benefits of the new model of care;
  - The CPT has run workshops on patient scenarios and the role of mental health in the new model of care;
  - An evening event was held with GPs and the CPT has attended primary care locality meetings; and
  - The Primary care strategy developed by the CCG is aligned with the incentives of the model of care.

The key elements of the model of care

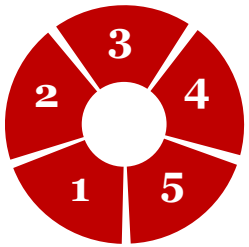
- The CPT undertook design work around the key elements of the model of care – as patients and citizens experience and interact with them. The 5 areas where specific design work was focussed are noted below and elaborated on over the next few pages.
- Planned care, urgent care, maternity and preventative and proactive care where designed through Care Design Groups ('CDGs').

The key elements of the newly designed model of care



- The structuring of the services into the key elements allowed local professionals to engage in how they could best work together.
- The key elements are also driving the development of detailed service specifications as part of the implementation governance. This will be used to inform the design and commissioning of services going forward.

Introduction to the model of care



CPT key points:

- *The patient centred model of care combines the currently disparate services into an integrated model of providing the health and social care for the population of Tameside and Glossop.*

The model of care has been designed with the person / patient being at the centre and aims to deliver better patient outcomes for the population of Tameside and Glossop within an affordable financial envelope.

The model of care focuses on four key areas:

- Preventative and proactive care;
- Urgent care;
- Elective care; and
- Specialist input.

The key features of these areas are described below.

Preventative and proactive care

- The whole system has a responsibility to keep people well and independent as long as possible with care being delivered in the lowest cost setting while maximising patient outcomes.
- A key principle in this emerging model of care is that community resources are developed and optimised so that there is a clear understanding of how they can help the individual.
- People and patients have a responsibility to maintain their own health and take an active role in managing their care.
- A key mechanism for delivering the proactive care approach is through LCCTs.
- The LCCTs bring together delivery across primary care, mental health, community care, social care, secondary care and the 3rd sector.
- The LCCTs coordinate care through actively managed care plans and share expertise across the teams.
- Risk stratification and early identification of potential issues are an important role of the LCCTs and GPs.
- The LCCTs can work with any individual but tailors services depending on level of need.

Urgent care

- In the event that there is a crisis, this is managed by one cross Tameside and Glossop Urgent Integrated Care Service (UICS).
- The UICS will have unequivocal responsibility for looking after local people who are in social crisis, or who are seriously unwell.
- The UICS acts as a single point of access and can mobilise all relevant assets and resources across the health and care system to help get the patient well and back in the lowest cost and most appropriate care setting as quickly as possible. There is clear accountability between the LCCTs and the UICS.
- There is a range of services sitting under the UICS including A&E, rapid response team, discharge team and intermediate care.

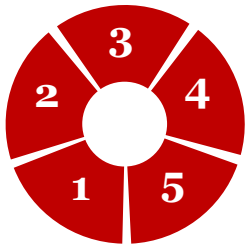
Elective care

Elective care is delivered in the most efficient way possible, with non-surgical interventions being considered where appropriate and timely interventions made to keep levels of acuity as low as possible.

Specialist input

- Access to specialist input is managed at a T&G level rather than specialists being allocated to individual LCCTs.
- Specialist input needs to feature early in care pathways, rather than only “at the end”.

Key elements of the model of care



CPT key points:

- *The structuring of the services into the key elements allowed local professionals to engage in how they could best work together.*
- *Through the new governance structure, the CDGs' workstreams will work together to determine relationships and links between the 5 interrelated elements of the model of care. This will be used to inform the design and commissioning of services going forward.*
- *Specific efficiencies from the model of care were identified through CDGs in which care professionals and local public and patient representatives gave their views on how care could be improved.*

The key elements of the model of care

- As described previously, the CPT undertook design work around 5 key elements of the model of care – as patients and citizens experience and interact with them.
- The table below describes some of the features of the 5 key elements of the model of care.
- Further detail on these is provided on the following pages.

Key element	Features of this element of the model of care	Benefits
1 Preventative & proactive care	• Currently, responsibility for the proactive and preventative care is diffused, and most care provided is reactive (responding to crisis or urgent need, rather than managing a condition to obviate or minimise crises or urgent need). • In the new model, 5 fully integrated LCCTs will have clear and unequivocal responsibility for the long term outcomes of the populations they serve. This multi-disciplinary team will proactively engage with patients with long term conditions, to help them manage their conditions in their own homes.	• Proactively managed health for at risk parts of the population. • Earlier interventions reducing downstream crises and costs.
2 Urgent integrated care	• All of the urgent care resources will be managed as a single operational unit – including A&E, out of hours primary care and the aspects of community healthcare, mental healthcare and social care that need to be able to respond to a crisis (Urgent Integrated Care Services). • Response will be co-ordinated and increasingly in people's own homes. • Care professionals able to access key care services – e.g. A&E and CCU doctors able to "admit" patients to an urgent social care home package.	• Simplified services – reducing complexity and duplication in expensive 24/7 services. • Unnecessary hospital stays avoided.
3 Planned care	• Alignment of community and hospital services, as well as appropriate referral management, through single management and capitated budgets • Networked provision – with access to greater specialist expertise and critical mass.	• Access to improved networked services. • More defined and efficient portfolio.
4 Maternity care	• Maintain the excellent ante-natal services provided for mothers in deprived areas in T&G. • Maintain obstetrics-led maternity pending The Cumberlege Review findings.	• Local services protected.
5 Hospital specification	• In the model of care every resource, including the hospital, is brought together around the elements of care above. We consider the following factors: 1. Key services have significant fixed and stepped costs (such as the need to have 24/7 consultant cover, PFI estates and diagnostic services); and 2. Critical mass is required to deliver services safely and affordably. 3. Tameside Hospital as an elective surgical centre with an A&E (as part of the UICS), maternity services and a reduction in medical beds and overall activity by c18%.	• Efficient use of healthcare assets. • Local hospital services.

Benefits of the model of care

CPT key points:

- *This model of care is not a "soft" aspiration or intention – it represents a radical restructuring of how all of the resources and assets in the system are deployed.*

Benefits for the population

- We believe that there are a number of benefits within this model of care, including:
  - Less fragmented care, with fewer handovers and greater continuity whether in hospital, at home or in the community.
  - Services structured to be able to look after people with multiple physical and mental health, and social care needs.
  - A far greater focus on preventing ill health, and proactively keeping people as healthy and well as possible.
  - A provider structured and incentivised to promote and protect their long term health and social outcomes.

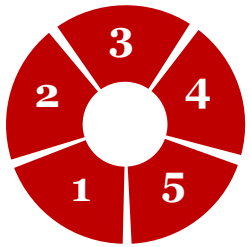
Benefits for the Trust

- The Trust would have control over a sufficiently broad range of resources to be able to plan end-to-end care, prioritise resources and ultimately be best placed to accept population demand risk.
- The model of care is compatible with Healthier Together and Manchester Devolution.
- The organisation will have a clear sustainable model for the future and will improve the ability to retain and attract staff.

System benefit

- The impact of the model of care through better preventative and proactive care, a more efficient and joined up approach to dealing with crises, a networked approach to planned care and effective use of system resources will deliver a range of benefits outlined below:
  - Based on the KH03 quarterly collection of beds available/occupied, the Trust has 449 general and acute beds, 41 day case beds and 29 maternity beds.
- Over the period, the CPT is forecasting a 'do nothing' need for 92 additional general and acute beds, 3 additional day case beds and 4 additional maternity beds.
- The impact of the changes (net of the demand increase) is a 246 bed reduction in general and acute beds and 30 bed increase in day case beds (no change in maternity beds). This bed reduction represents a significant part of the financial savings associated with this model of care.
- Therefore the hospital will reduce in size to 203 general and acute beds, 71 day case beds and 33 maternity beds.

Model of care: Primary care involvement



CPT key points:

- *The continued engagement of primary care in the new model of care is crucial to its delivery.*
- *GPs have been engaged throughout the CPT and the CCG has developed its Primary Care Strategy that aligns incentives with the model of care.*
- *Use of Extensivist roles to manage the needs of high-risk cohort of patients can help to ensure the benefits of general practice inclusion.*

Primary care involvement

- The newly designed model of care will require substantial doctor time to be focussed on the 5% highest risk patients in the region (c10,000 adults in T&G).
- This would require working with 35-40 doctor WTEs to be dedicated to this role which would equate to 2 sessions per week focused on these high risk patients.
- Some GP practices already employ GPs whose time is dedicated on working with high risk patients such as those in nursing homes.
- Moving to this new way of working for GPs would require a new approach.
- The CCG has developed the new primary care strategy which from 2016/17 will incentivise GPs to deliver the new model of care. This means GPs would be working in ways that align with the model of care and as such all benefits would be delivered.
- After 2016/17 GPs may join the Trust as salaried staff with further increase in organisational and operational alignment.

Extensivist model

- The CPT considered the employment of Extensivists and has designed a way forward as it believes it to be innovative. Extensivists are hospital-based specialists who would focus on a cohort of high-risk patients. Extensivists would be trained and experienced in looking after patients with complex medical conditions which may exceed GP's expertise.
- CPT analysis indicates that managing c10,000 high-risk patient cohort would require 40 WTEs Extensivists.
- This would by far exceed the supply of suitable doctors (currently the Trust employs 6 consultant general physicians and geriatricians) and would cost c£3m.
- Therefore, an Extensivist model alone is not deemed sustainable and the CPT proposes a combination of GPs and hospital physicians (Extensivists) to cover the needs of the high-risk patient cohort.
- This will comprise of 12 WTE Extensivists in addition to the GP staffing in the model of care. This would allow Extensivists to review the cohort of c10,000 patients once every quarter for half an hour, supplementing and supporting existing primary care activities.
- The extensivist model would be subject to availability of personnel in the market as well as suitable working arrangements being put in place with GPs.

Model of care: Preventative and proactive care

CPT key points:

- *In order to reduce complexity and ensure clear responsibility, the CPT has developed a model of preventative and proactive care based on geographic populations (rather than a disease specific or population sub-set approach).*
- *The LCCTs draw in both core primary care and resources such as diagnostics and consultant skills that are currently focused on Tameside Hospital.*
- *Clinical accountability will reside with either the GP or consultant. Bringing all providers together under one structure will tighten clinical accountability.*

The current model of preventative and proactive care

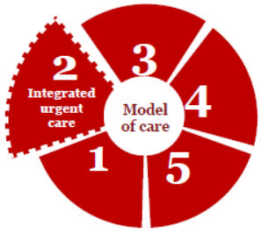
- Currently, responsibility for the proactive and preventative care is diffused amongst a range of different organisations between TMBC, the CCG, the Trust and other care providers.
- The overwhelming majority of care provided, including primary care, is reactive – responding to crisis or urgent need, rather than managing a condition to obviate or minimise crises or urgent need, and the services provided are complex, duplicated and unevenly distributed.

We recommend 5 Locality Community Care Teams (LCCTs)

- The 5 LCCTs will be responsible for:
  - Identifying people who would most benefit from preventative and proactive care (risk stratification);
  - Using multi-disciplinary teams to develop care plans, share these across the system and maintain them so they reflect current status; and
  - Assigning care co-ordinators.
- With primary care at the very centre, these teams will empower citizens and patients to better manage their own care and remove the boundaries between services and care professionals.
- Geographically, the localities are coterminous with the TMBC localities and Glossop, which will be supported by Derbyshire County Council from a social care perspective.
- The 5 localities have differing populations with different needs. Consistency and simplicity in LCCT structures are also key – so LCCTs will have the same operating model – however, the level of resourcing in different specialist roles will vary in response to different population needs.

- The LCCTs will draw together all of the care resources that support preventative and proactive care – including primary care, community nurses, drug and alcohol teams, mental health practitioners and others – into single operational units across each LCCT area.
- LCCTs will have clear and unequivocal responsibility for the long term outcomes of the defined populations they serve. In order to achieve this they will have:
  - Control over all of the health and care resources so they can be directly deployed, co-ordinated and focussed on those who would most benefit; and
  - Shared risk and incentives across every constituent part of the LCCT.
- Our modelling indicates that the LCCTs will be staffed by 478 WTE (in comparison to the current establishment of 477 WTE). This includes:
  - New locality management roles;
  - New care coordinator roles; and
  - A restructured and retained workforce based in localities and focused around multidisciplinary ways of working.

Model of care: Urgent Integrated Care



CPT key points:

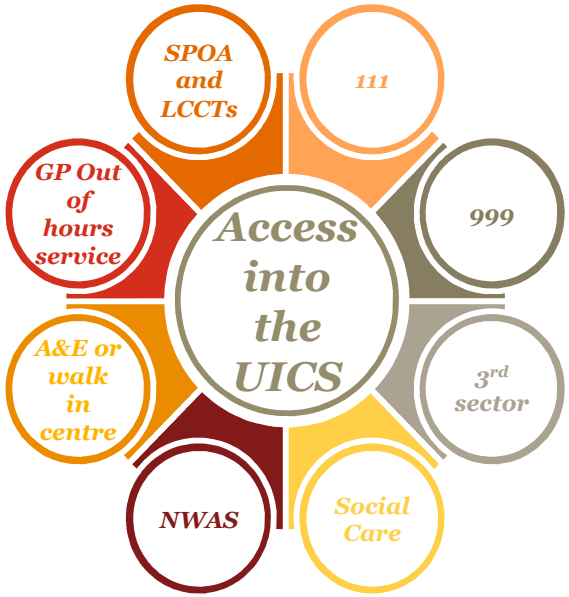
- *In the event that there is an unplanned decline in a person's health it will be managed by a single T&G UICS.*
- *The UICS will have unequivocal responsibility for looking after local people who are in social crisis, or who are acutely unwell.*
- *The UICS acts as a single point of access and can mobilise all relevant assets and resources across the health and care system to help get the patient well and back in the lowest cost and most appropriate care setting as quickly as possible.*
- *There is clear accountability between the LCCTs and the UICS.*

The current model of urgent care provision

- Various different services are run separately, with A&E, out of hours primary care and other key elements of urgent care response run by different organisations.

The new UICS

- The proposed UICS will draw together all of the resources that need to be able to respond to urgent needs under a single operational management – including A&E, MAU, urgent primary care as well as some key mental health, social care and other support that needs to be deployed rapidly. These services are noted in the diagram below.
- The UICS will have unequivocal responsibility for looking after local people who experience a crisis (whether medical or social). They will look after people from the moment they report their difficulties, until they have undergone diagnosis, treatment, support and rehabilitation in order to be able to live independently or with the help of the LCCT.



Accessing the UICS

- Access into the UICS could be through different routes as shown in the diagram below.
- Specific details of how 111 and 999 will link in with the UICS will build on existing local plans and include:
  - Pilots are in place with NWAS to identify "alternatives to transport"; and
  - Community Risk Intervention Teams (CRIT) led by Greater Manchester Fire and Rescue Service respond to low-priority calls from NWAS to falls in the home, where they can help people to stay in their own homes rather than going to hospital. They will also attend calls from Greater Manchester Police involving low level mental health crises.
- Mental health crises are dealt with in the UICS through a range of services including the access and crisis team, RAID, street triage, the home intervention team and the home treatment team. Access is as shown in the diagram opposite although some patients may directly access the LCCT (i.e 999 / 111 to LCCT rather than UICS if most appropriate).
- The UICS would be staffed by 326 WTE (in comparison to the current establishment of 378 WTE). This includes:
  - Urgent care village / triage;
  - Urgent Assessment Response Team; and
  - Delivery of intermediate care.

Model of care: Urgent Integrated Care

CPT key points:

- *The CPT model of care retains an A&E as part of the UICS.*
- *The retention of local A&E services – in addition to being no more expensive than sending A&E activity out of area – provides key resources and expertise to support urgent care response throughout the community as an integrated part of the UICS. It also smooths discharge routes as well as avoiding additional travel for patients.*
- *Key urgent care services that require scale to be effective and efficient – such as emergency surgery and complex medical patients – will be centralised at larger A&Es outside of T&G.*

Urgent care within Tameside Hospital

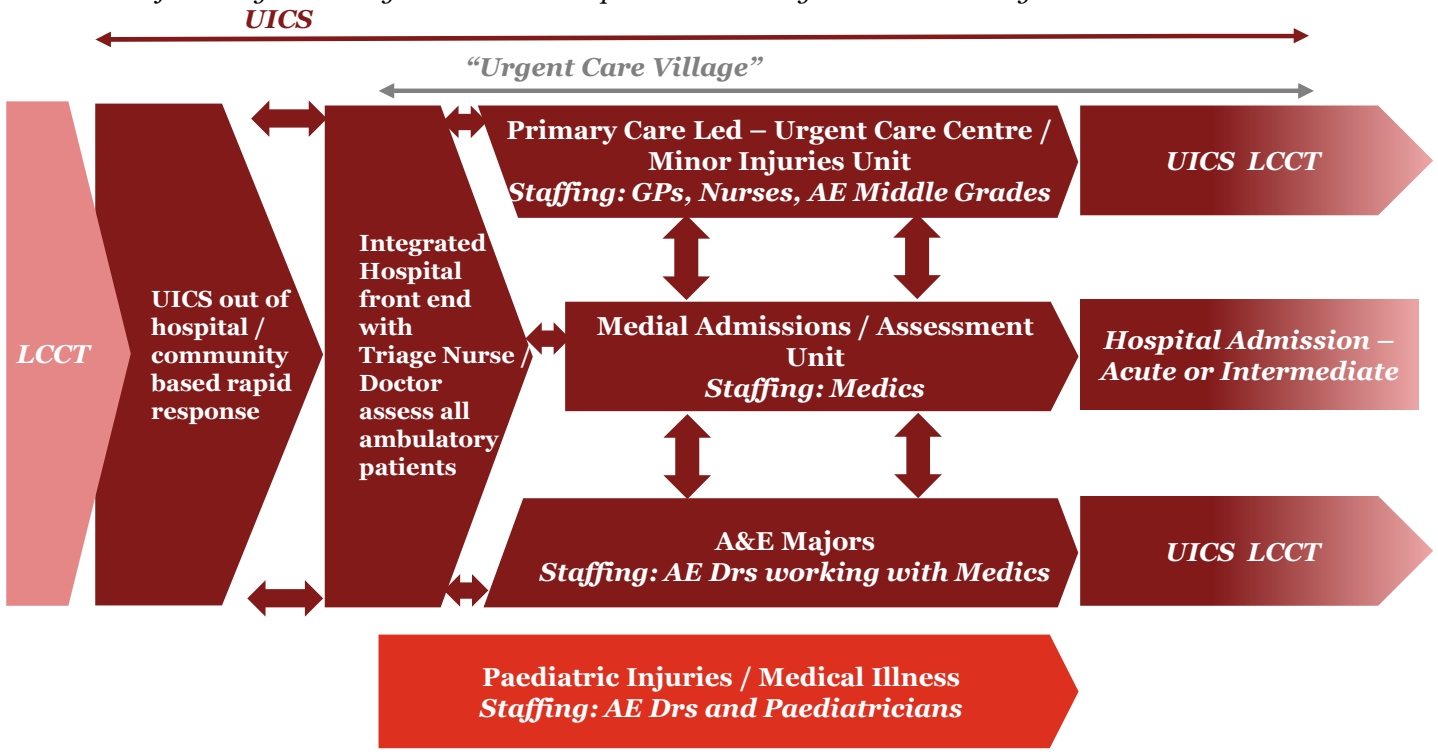
- Unlike the 5 LCCTs, the high cost and variable demand mean that a single service UICS model will be available for all of T&G.
- Wherever possible, the UICS will respond to urgent needs in community settings.
- Within the Tameside Hospital site, all physical urgent care services (A&E, Walk-In Centre, emergency primary care, etc.) will be co-located as an "Urgent Care Village".

Flow of patients into and out of hospital

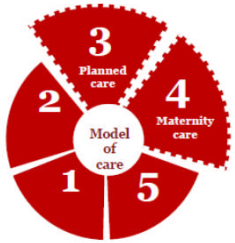
- The model will support the effective flow of patients through the health and social care system.
- With access to alternative care options within direct control, individuals are only admitted to hospital when absolutely required.
- The discharge team as part of the UICS would take an integrated team approach to supporting discharge from bed based care back to the person's home.

Components of the integrated "Urgent Care Village" within Tameside Hospital

A combined A&E and GP-led urgent care centre – with a single front door and working as a single team to provide resilience and flexibility – working under the same operational management as other urgent care resources

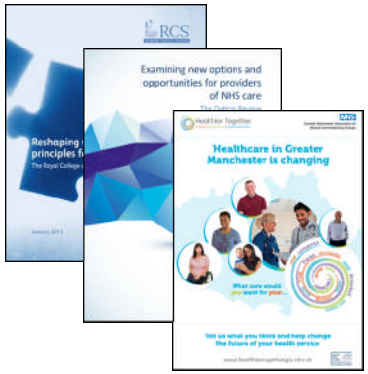


Model of care: Planned and maternity care



CPT key points:

- *Retention of key services is contingent upon agreement of networking with other providers (although many such agreements are already in place and operating).*
- *Decisions on maternity services will need to be reviewed once The Cumberlege Review report is published.*



Planned care

There is building evidence of the need for scale in planned care, including:

- The **Royal College of Surgeons** recent analysis showed centres which undertake higher numbers of complex and emergency surgery, have better mortality and morbidity rates improving quality of care for patients;
- The **Dalton Review** suggested networked models of care between high performing larger organisations and smaller organisations to improve quality of care; and
- **Healthier Together** review for Greater Manchester has already suggested a networked model of care for surgical services with central hubs for complex surgery.

As part of Healthier Together, all planned care services will be delivered as part of wider clinical networks. The Trust already delivers a significant proportion of planned care through networks.

Building on the structured review of Location Specific Services performed by T&G CCG, the CPT applied criteria to assess the clinical sustainability and operational efficiency of delivering different planned care services at Tameside Hospital.

CPT recommendation for planned care

The portfolio of planned care surgery recommended in the model of care to be delivered at Tameside Hospital includes:

- Daycase surgery for simple cases for the population of T&G;
- Simple overnight surgery (e.g. joint replacements) where overnight cover can be provided by medical staff, rather than requiring dedicated overnight surgical support; and
- Daycase surgery for patients from outside of T&G as part of the Healthier Together review of hospital portfolios pending commissioning decisions such that providers can share access to assets and infrastructure.

Maternity care

The Trust currently provides an obstetrician-led maternity service at Tameside Hospital. This service incurs very high CNST (insurance) premium charges – primarily due to historical claims.

With approximately 2,500 births per year, and with complex births being transferred to other hospitals, the CPT looked closely at the quality, sustainability and economic viability of the service.

There is significant support for the ante-natal care provided in the community – particularly for mothers from deprived backgrounds. However, the link between the quality of this service and the location of the birth could not be firmly established.

Quality of outcomes and patient experience have improved. A range of options for the service has been considered.

CPT recommendation for maternity services

The CPT has determined that the financial savings of closing the unit – even without costs of building additional capacity elsewhere – are marginal.

Given the national review, it would seem inappropriate to make a decision to close the unit pending their findings which are likely to materially impact upon this decision.

Model of care: Hospital specification

CPT key points:

Under the CPT model of care, more local services are retained at Tameside Hospital than under the CCG's previous ICO plans. This reflects:

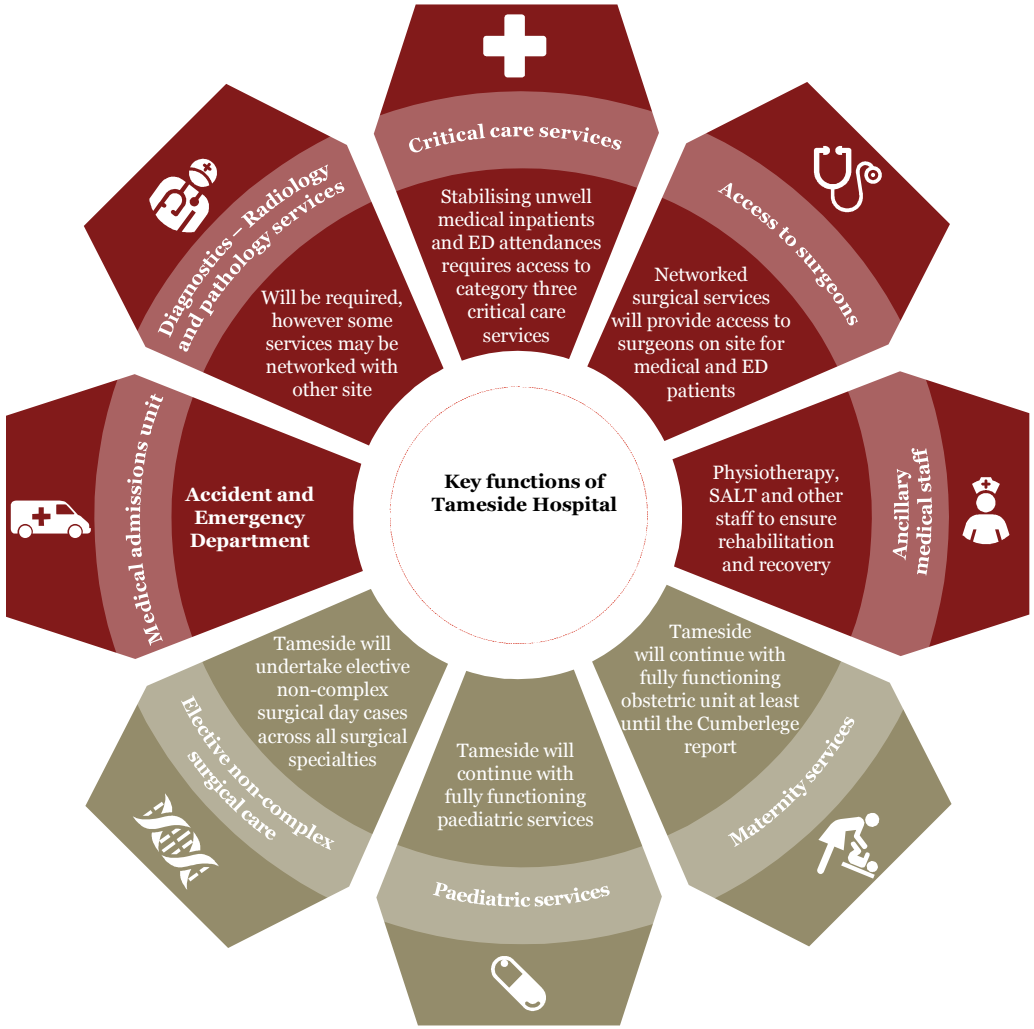
- *The benefits of integrated care rely upon having sufficient expertise focussed on the local population and working closely alongside local GPs and other community-based care professionals.*
- *The financial benefit of moving activity elsewhere is marginal or negative if local stranded costs and the cost of providing that care elsewhere are included.*

Description of Tameside Hospital

- The Trust will use Tameside Hospital site as a core inpatient medical unit with focus on acute medicine, non-interventional cardiology, respiratory, gastroenterology, geriatrics and stroke rehabilitation with associated required specialties.

Key functions of Tameside Hospital

- The diagram to the right shows the key functions that will be provided at Tameside Hospital.
- These functions have significant clinical and resource inter-dependencies.
- The hospital will be an asset to the community, with LCCTs, UICS both benefitting from access to local specialist expertise and diagnostic capabilities from Tameside Hospital.
- High acuity inpatient medical services will form the core function of the hospital.
- Surgical services consist of elective non-complex day case and simple overnight surgery where overnight cover can be provided by medical staff.
- Maternity services will continue at least until The Cumberlege Review reports.
- Paediatric services continue to be delivered in an integrated fashion.
- Critical care and diagnostic services are required for a safe functioning inpatient medical unit.
- Acute surgical services including; general surgery, gynaecology and orthopaedic trauma will be networked with other local services.
- This portfolio of services is clinically sustainable, and optimises the balance between localism and scale.



Model of care: Hospital specification

CPT key points:

- *6 core medical specialties will form the main function of the hospital. Other medical specialties will be provided by visiting consultants.*
- *All complex and emergency surgery will be networked across other acute providers.*
- *Maternity services will be maintained but should be re-assessed after the national review.*

Core elements of the Hospital Specification

Building on the overall specification on the previous page, the boxes below provide further detail on the function of Tameside Hospital.

Medicine

The majority of patients currently admitted as medical inpatients are in six core specialties: *non-interventional cardiology, respiratory medicine, gastroenterology, geriatrics, neurology (stroke) and acute medicine.* As part of the ICO, this will form the core medical services of the hospital albeit with a reduced number of medical inpatient beds.
For a clinically sustainable delivery of inpatient medical services – there is a requirement for access to diagnostics (radiology and pathology) and critical care access at level 3 for all patients across the hospital.
Supporting the entry of medical patients will be an integrated A&E function with Urgent Care and medical administrators working in an integrated 'urgent care village'.
Hospital doctors will work in a much more integrated fashion with community colleagues in MDTs and ensure specialist expertise is available much more readily.

	Current	'Do nothing'	'Model of care'
Inpatient episodes	28,099	34,332	18,627
Inpatient bed requirement[1]	340	415	196

Emergency surgery and Gynaecology

In line with regional and national trends, complex and emergency surgical services will soon be centralised across Greater Manchester. The vast majority of all current activity at Tameside is non-complex day case for general surgery and gynae with relatively small numbers of emergency activity for both specialties. Running emergency theatres for small number of non-complex emergency patients would not be cost-effective.
Tameside would cease to undertake all emergency and longer stay complex general surgery. However, it has 11 theatres which would become an elective non-complex day case centre for all surgical specialties to increase operational efficiencies and reduce specific unit costs.
All surgical specialties would be networked with hospitals and surgical opinions available for all inpatients twice daily.

	Current	'Do nothing'	'Model of care'
Inpatient episodes	5,615	6,952	-
Inpatient bed requirement[1]	80	97	-
Theatre requirement[2]	2	2	-

Maternity and Paediatrics

Tameside currently runs a good quality maternity service as assessed by CQC, but due to historic claims, it pays high negligence indemnity costs impacting profitability. There is currently a national review of maternity services being undertaken by Baroness Cumberlege. However, removing all maternity services from Tameside will have minimal financial impact to the whole health economy.
In the interim, whilst the national review is ongoing, we suggest to continue with an obstetrics led maternity unit. Coupled with this, Tameside will continue to provide an integrated paediatric unit which will further integrate with children's social and community care.

	Current	'Do nothing'	'Model of care'
Deliveries	2,628	2,902	2,902
Other obstetrics episodes	6,087	6,749	6,757
Paediatric episodes	4,069	4,390	3,646
Inpatient bed requirement[1]	52	57	52

Planned care

As with general and gynae surgery – all sub-specialty services in both medicine and surgery will be provided on a networked basis as a single service specialty model across other hospitals. Specialties which are more currently conducted on an outpatient basis such as dermatology, rheumatology, breast surgery, ENT and ophthalmology will all be provided on a networking visiting basis from other organisations. For both inpatient opinions and outpatient clinics. All sub-specialty inpatient admissions will be at other organisations due to the small volume of patients and specialist requirements.

	Current	'Do nothing'	'Model of care'
Medical inpatient episodes	407	436	462
Surgical inpatient episodes	3,102	2,865	1,012
Medical day cases	5,368	6,178	5,216
Surgical day cases	11,123	11,325	20,563
Inpatient bed requirement	84	86	96
Theatre requirement	5	7	7

[1] Assumes continuation of current occupancy rates
[2] Assumes maintaining current theatre throughput, with similar weighting for inpatients and daycases in theatre times
[3] 11 theatres with 6 in the PFI

Model of care: Provider considerations

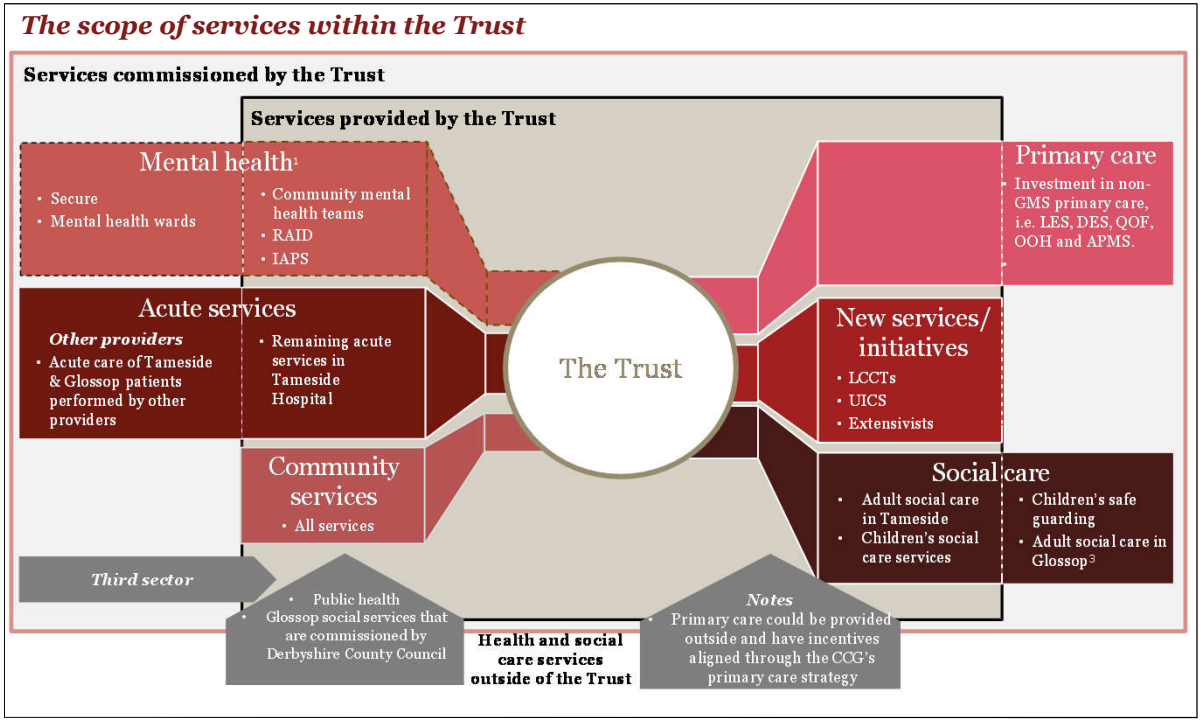
CPT key points:

- *In our view in order for the model of care to truly integrate services it requires single operational management, shared incentives and long term accountability for health outcomes. This is most simply delivered through a single provider where possible.*
- *Primary care will be incentivised through the new Primary Care Strategy which will influence GP involvement.*
- *The CPT's recommendation is that the main provider and prime contractor should be the Trust.*
- *A long term capitated contract would be an appropriate type of contract for the Trust.*

Provider scope and shape

- The model of care describes how the resources in Tameside and Glossop will be optimised by working as integrated functions.
- Currently these resources are held within multiple different organisations. The CPT recommends a single provider form with the scope laid out in the diagram below.
- The rationale follow these 3 criteria:
  - ***Simplicity***: Minimising the need for complex alliance contracting or sub-contracting where possible;
  - ***Single operational management:*** a single provider with operational management of staff etc can ensure services are fully integrated and deployed in the most effective way overall.
  - ***Ability to implement:*** This form and scope recognises that it is easier to implement the changes as one organisation but implementing some options – such as employing all GPs directly – is more difficult.
- The diagram below sets out the CPT recommendations for the scope and shape of the integrated care provider.

The scope of services within the Trust



Organisational form

The CPT has concluded that the Trust would be an appropriate vehicle to be the new integrated care organisation. There is strong (but not universal) informal support for this locally in Tameside and Glossop, but it is for the CCG to determine whether it wishes to select the Trust as the 'delivery vehicle' or integrated care organisation. If the Trust were to take on this role, its leadership and management would need to have significant additional skills and capacity to enable the effective provision of services the Trust does not currently provide, such as community and social services across Tameside.

Clinical sustainability

We have assessed the clinical sustainability of the model of care. The reason for undertaking this assessment is to show that the services in the model of care are clinically sustainable. Without this, the services could not be provided safely. The proposed service changes should improve clinical sustainability.

Assessment by the implementation workstreams and the overall governance arrangements will need to continue through the implementation process.

Clinical sustainability

CPT key points:

- *We have assessed the clinical sustainability of the model of care assuming it is provided by the Trust as the future ICO.*
- *Our view is that the model of care is clinically sustainable.*
- *The proposed model of care improves almost all dimensions of clinical sustainability. Only travel times for patients with surgical emergencies and elective inpatient procedures could suffer due to larger distances. A recent review has found travel distances for such services acceptable, by not classifying them as Location Specific Services to Tameside Hospital.*
- *The report of the 2015 CQC inspection is pending and it remains to be confirmed that all issues raised in the 2014 report have been resolved.*

Clinical sustainability

- The CPT has assessed the clinical sustainability of the model of care, assuming that the Trust would provide these services as the future Integrated Care Organisation. Given that the Trust was rated inadequate in the 2014 CQC inspection, clinical sustainability has to be ensured beyond addressing the shortcomings in the CQC inspection.

Approach

The Trust was reviewed again by the CQC in April 2015 after a new senior management team had focussed on addressing the concerns in the 2014 report. The 2015 CQC report has not yet been published by the time of this report, however we have assumed that shortfalls identified in 2014 have been addressed.

Clinical sustainability has been the major consideration underpinning the entire process of designing the new model of care. Indeed, many specific features of the model of care have been shaped through iterations driven mainly by considerations of clinical sustainability. Our assessment focuses on clinical sustainability of the new model of care and the changes it would bring to clinical services. Our approach to the design and development of the model of care has had extensive clinical involvement and has included:

- Engagement with clinicians and patient representatives in Care Design workshops and other sessions;
- Discussions with a range of local and national clinicians including Monitor's Medical Director and clinicians in the Enforcement Team, clinicians in the CCG's Governing Body, GPs in all 5 localities, the Trust's Medical Director and Nursing Director and other Clinicians in the Trust;
- Reference to relevant national guidance such as from the Royal Colleges;
- Reference to the regional Clinical Senate who will review implementation plans for clinical services; and
- Clinicians in the CPT have undertaken the assessment.

Assessment and conclusion

We have concluded that the model of care is clinically sustainable. In reaching our conclusion, we note:

- **Safety, outcomes and patient experience (Quality)** will be improved compared to current services beyond addressing concerns of the 2014 CQC inspection (details on next page);
- **Workforce** challenges would reduce by networking hospital clinical teams with other providers to ensure adequate activity levels across provider sites for maintaining clinical skills, for training purposes, and to maintain on-call rotas; and
- **Clinical governance** will be improved by bringing currently diverse and fragmented provider teams under one integrated governance arrangement.

It is important that the CCG and implementation work streams continue to assess the clinical impact of all proposed changes during the implementation process.

Risks to manage post implementation

We have noted the key risks to manage post implementation;

- **Travel times** could be adversely impacted when patients for emergency surgery or elective inpatient procedures need to be treated at other hospitals. Some patients may arrive directly at the Trust's A&E and require transfer. After surgery, patients may be repatriated back to the Trust if further post-operative hospital care is required, leading to another transfer. Additionally, while inpatient at another provider, it would be less convenient for visitors to reach those patients.
- **Maternity workforce** would become unsustainable if the Royal College of Obstetricians and Gynaecologists ("RCOG") were to recommend on birth units being covered by 168 hours weekly consultant obstetrician presence. Such a rota only becomes sustainable at centres with at least 6,000 births. It is expected that the RCOG publishes new guidelines within the next 1-2 years.

Clinical sustainability

CPT key points:

- *Clinical sustainability improves significantly in the new model of care.*

	Improvements	Challenges and risks
Safety	• The entire model of care was designed with safety concerns at the centre during the design phase. • Sub-scale services (e.g. emergency surgery) are diverted to larger providers, or networked (e.g. elective surgery). • Integration of care across care settings improves communications and care monitoring.	• Diverting surgical emergencies to other providers adds travel time. However a recent analysis by the CCG has found that travel times for emergency surgery are acceptable.
Outcomes	• Consolidating surgical activity in larger units (also when networked) improves outcomes. • Integrated care model with early expert clinician input early in care pathways leads to better outcomes.	• N/A
Patient experience	• More services will be provided closer to home, which is a key driver of better patient experience. • Care professionals act as one integrated team providing one cohesive service.	• Diversion of emergency and inpatient elective surgery to other providers makes access less convenient for patients and their visitors.
Workforce	• Networked services ensure sufficient activity to maintain skills, achieve better training and sustain on-call rotas. • "One team" approach has been shown to lead to greater staff satisfaction, which should help with local recruitment and retention. • New model of care does not require material numbers of additional staff.	• Maternity: If RCOG insists on 168 hours per week of obstetrician presence, the service may become unviable. • Many members of current staff would require additional support and retraining to new roles andways of working.
Clinical governance	• Bringing governance from multiple separate teams together into one governance arrangement. This reduces risk of governance boundaries with gaps and conflicts.	• New governance arrangements have to be designed and implemented.

Financial sustainability

In this section we have considered the financial sustainability of the Trust within the Tameside and Glossop health and care system. To achieve this, we have looked at the system's financial challenge, the benefits of the model of care, the residual deficit and then, how this could be apportioned to the Trust and its commissioners. This allows us to undertake a financial sustainability assessment on the Trust.

Summary of financial sustainability assessment

We have modelled the financial impact of the model of care with the Trust as the provider.

CPT key points:

- *There is a system deficit before the benefit of model of care in FY20 of c£69m pa.*
- *The financial benefit of the model of care is c£28m pa.*
- *The residual deficit is c£42m pa.*
- *The residual gap has been allocated to the commissioners, so the Trust is breakeven.*
- *We believe the Trust is financially sustainable.*

Financial sustainability assessment

The CPT has modelled the activity and financial impact of the new model of care. This includes:

- Reductions in in-patient demand from proactive and preventative care;
- The costs related to the new out of hospital model of care including the LCCTs, UICS; and
- Costing of the different options for maternity services.

Financial modelling

We have performed a financial modelling exercise, to estimate the financial impact of 2 scenarios:

1. **The 'do nothing' scenario** is used as a comparison against integrated care. This scenario maintains the current structure of delivering health and social care across Tameside and Glossop and is forecast up to FY20.
2. **Integrated care scenario** reflects the impact on activity levels and the cost of provision from the new model of care described elsewhere in this document.

The table below describes some of the features of the financial analysis undertaken by the CPT. Further details on these are provided on the following pages.

	Financial analysis	Summary of findings
1	**The affordability challenge if the system does nothing**	• We have modelled a 'do nothing' scenario, which maintains the status quo of separate organisations delivering care, along with 'normal' efficiencies. • This results in a forecast deficit of c£69m pa in FY20.
2	**What is the impact of the model of care?**	• We have modelled the financial impact of the model of care across the health and care system. • The benefit of the model of care reduces the system wide deficit by c£28m. • The (c£69m) deficit in the do nothing scenario in FY20 improves but leaves a system deficit of (c£42m).
3	**There remains a residual deficit. We have considered how it should be allocated**	• There are a range of ways that the residual deficit can be attributed set out in this part of the report. • On the basis that the model of care costs what the CPT has estimated and it is what the commissioners wish to commission, the deficit should rest with the commissioners.
4	**The financial sustainability of the Trust**	• The Trust would be financially sustainable.
5	**The investment required to implement the model of care**	• The implementation of the model of care will need an element of transition costs, we identify the type and likely amount. • The combined deficit will also need addressing but we note that the need would have been c£299m in 5 years before integrated care and c£216m in 5 years after the model of care.

The affordability challenge if the system does nothing

The affordability gap is based on the assumptions and plans from the Trust, CCG and TMBC.

CPT key points:

- *The system has a growing financial deficit driven largely by rising demand, cost inflation and the underfunding of social care costs.*
- *The combined system deficit in 5 years is c£69m, after 'normal' efficiencies of c3% pa, comprising of the Trust c£23m and TMBC c£46m.*

Approach to financial modelling and the financial impact of the model of care

Our financial analysis has taken forward the work undertaken by the CCG, Trust and TMBC:

- We have applied financial planning and demand assumptions to update the deficit for the whole system, split by organisation;
- We have built an activity and finance model, to show the cost of providing existing services and then the impact of the model of care and linked this with income, demand and other assumptions;
- Our approach is organisation agnostic when we consider how the cost of provision changes with the impact of the model of care (changing demand, acute configuration, LCCTs etc.) as it looks at system costs; and
- With the Trust as the provider of the model of care, we have then considered the cost of the provision in the Trust and a contractual basis for receiving income.

1 The affordability gap in a do nothing scenario

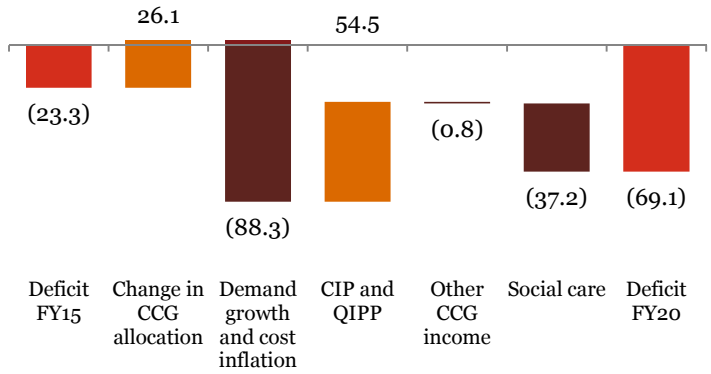
In FY15, the Trust finished the year with a c£15m deficit. Adding to this a small CCG surplus and a c£8m social care deficit of allocation against actual cost, gives a c£23m deficit for the health and care economy.

The key drivers of from the current deficit to the forecast deficit in 5 years are shown in the diagram opposite and include:

- Demographic demand growth;
- Non-demographic demand growth and cost inflation; and
- Benefits associated with QIPPs and CIPs of c3%.

Do nothing scenario £'m	FY15	FY20
System income		
T&G CCG allocation	332	358
Trust income from other CCGs	23	24
Other Trust income	13	11
Social care allocation	66	41
Total income	**433**	**434**
Cost of provision		
Trust expenditure	-173	-185
Commissioning of other services	-210	-231
Social care expenditure	-74	-87
Total expenditure	**-456**	**-503**
System deficit	**-23**	**-69**

Do nothing deficit (£m)



What is the impact of the model of care?

We have modelled the financial impact of the model of care with the Trust as the provider.

CPT key points:

- *The financial benefit of the model of care is c£28m pa.*
- *This drives a significant reduction of the system affordability gap of £69m, but a system wide deficit of c£42m remains.*
- *The Trust, as the provider of integrated care, would have costs of c£414m pa, more than double the current costs.*

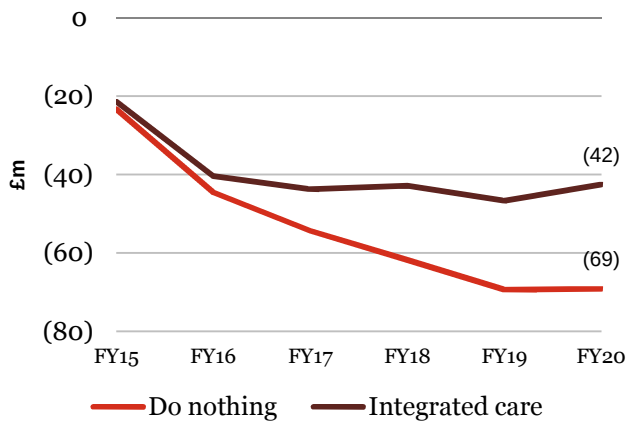
2 The model of care significantly improves the affordability gap within health and social care in Tameside and Glossop

The graph below shows our estimate of the 5 year deficit within the health and social care economy of a c£69m deficit. It also shows the benefit of integrated care in Tameside and Glossop, which reduces the deficit by c£28m, to c£42m. The table opposite details the split between income and costs.

The reasons why benefits for the model of care are greater in FY20 are:

- The model of care takes time to implement; and
- Once implemented, the benefits from preventative and pro-active care do not occur immediately.

System-wide affordability challenge



We have considered the phasing of the benefits of the model of care shown in the diagram opposite in line with the implementation plans described later in this document.

£'m	Do nothing FY15	Do nothing FY20	IC FY20
System income			
T&G CCG allocation	332	358	358
Trust income from other CCGs	23	24	20
Other Trust income	13	11	11
Social care income	66	41	41
Total income	**433**	**434**	**430**
Cost of provision			
Trust expenditure	-173	-185	-414
Commissioning of other services	-210	-231	-58
Social care expenditure (moves into Trust expenditure in the model of care)	-74	-87	-
Total expenditure	**-456**	**-503**	**-472**
System deficit	**-23**	**-69**	**-42**

The financial benefits from the model of care come mainly from the following:

- A reduction in demand for relatively expensive in-patient services;
- A resulting reduction in estate use at the Trust; and
- Managing the demand increase with the same financial envelope of community, social care and mental health services that operate in a new integrated model.

Contracting basis

We have considered the most appropriate contracting basis for the Trust as the provider of the model of care. Following workshops on this topic and discussions in the local OFG, there is a common view that this is the most appropriate contracting basis.

- Key features of the contract and its phased introduction are:
- A long term capitated contract with outcome based measures;
- Operating the contract in shadow form in FY17 following development and discussion of the outcome based elements between the commissioners and Trust in FY16;
- FY18 as the first year when the contract is in effect; and
- The commissioners and Trust may want to increase the impact that the outcome based measures have beyond FY18.

There remains a residual deficit. We have considered how it should be allocated.

CPT key points:

- *We have considered different bases for allocating the deficit and recommend an approach we believe is most appropriate.*
- *On the basis that the model of care costs what the CPT has estimated and it is what the commissioners wish to commission, our recommendation is that the deficit should rest with the commissioners.*
- *Whilst we have suggested ways that the deficit could be allocated, the system leaders are set on maintaining this residual gap as a system wide issue for resolving as a system.*

3 Allocating the residual deficit

In order to assess the financial sustainability of the Trust, the CPT has had to allocate the system's residual deficit at an organisation level.

We have set out in the table below 4 ways in which the deficit could be allocated.

The CPT recommended basis for allocating the deficit

We have considered the 4 options below.

On the basis that the model of care costs what the CPT has estimated and it is what the commissioners wish to commission, it is our view that the deficit should rest with the commissioners. As a result, we are assuming that the cost of provision is covered by income and the Trust breaks even.

However, with a long term capitated contract, the Trust would bear the downside risk if the cost of provision was greater than the level of the contract.

The CEOs of the Trust, CCG and Council consider the residual deficit as a shared issue and this is consistent with TMBC and the CCG's co-commission where they are pooling budgets. The Greater Manchester Devolution likely position will be to pool budgets across social care and health care as well. Nevertheless, the CPT's recommended basis is supported locally but not yet fully ratified.

Further addressing the residual gap

The CPT has been asked to take a high level review of the likely opportunities for further reducing the gap. We have considered these through the Ops and Finance Group, compared the opportunities to the potential CIP opportunities at the Trust and across the system and our experience of the type of efficiencies from system wide change programmes. Outside of productivity and efficiency opportunities, which we have assumed will be part of the normal CIPs for the organisations, there are several further potential areas for reducing the residual gap identified by the system including:

- Estates reconfiguration – c£5m. The system believes that there are further opportunities to rationalise the estate and make revenue savings on estate running costs;
- Back office function consolidation. Joint commissioning and integration of services provides further efficiency opportunity – c£5m;
- A culture of continuous financial and operational improvement. Whilst difficult to quantify, lessons learnt from other economies overseas indicates this culture to be the single biggest contributor to improved financial and clinical performance; and
- Procedures of lower clinical value– limited opportunity in reviewing referral criteria for services.

Potential basis of allocating deficit (£m)	Trust	CCG	TMBC	Total
1 All to commissioners	-	Combined deficit of 42		42
2 All to TMBC	-	-	42	42
3 Pro-rata the benefits in proportion to the deficits in the do nothing scenario.	14	-	28	42
4 Shared equally	14	14	14	42

The financial sustainability of the Trust

We have undertaken the financial sustainability assessment assuming the Trust provided the model of care at a capitated payment set at a level at the cost of provision.

CPT key points:

- *It is our view that the Trust (as the primary provider of services under the new model of care) would be financially sustainable against the definitions described opposite.*
- *However, the capitated payment means that the financial risk for delivering the model of care on or under the level of the capitated contract rests with the Trust.*

Financial sustainability assessment

The tests for financial sustainability commonly used by Monitor are as follows:

- Ability of the Trust to pay its debts when due;
- Ability of the Trust to generate cash; and
- Ability to make a surplus.

The forecast system deficit comprises TMBC c£46m, the Trust c£23m and the CCG breakeven.

Applying basis 1 for allocating the deficit described on the previous page, the deficit is moved to the commissioners and the Trust is breakeven.

The Trust is therefore on the margin of being financially sustainable, however, we believe it will generate cash and pay its debts when due.

The Trust

The new model of care will see the size of the Trust grow as it takes on new services but the income from acute activity will reduce by 18%. The Trust transitions to a model where the majority of its income (62%) and costs (67%) relate to non-acute health and social care activities.

Our financial modelling of the Trust's future position assumes that all of the system wide deficit lies with the Commissioners. The deficit is driven almost entirely by the difference between the allocation for social care from TMBC £41m and the cost of provision of social care services £87m.

An alternative method of assessing financial sustainability

If only the NHS aspect of the forecast deficit in FY20 of £23m is compared against the benefit of the model of care of c£28m, there would be a surplus in the NHS of c£5m.

On the basis the capitated contract is set at breakeven for the Trust, the surplus would move to the CCG.

Whilst we do not believe that this alternative method is more appropriate, it does help to illustrate the impact that the size of TMBC's deficit has on the system.

Trust position	Do nothing		IC
£'m	FY15	FY20	FY20
Trust income			
Income from T&G joint commissioners (TMBC and CCG)	121	127	383
Income from other CCGs	23	24	20
Other Trust income	13	11	11
Total income	**157**	**162**	**414**
Cost of provision			
Trust acute costs	-154	-169	-122
Trust community care costs	-	-	-24
Trust mental health costs	-	-	-25
Trust social care costs	-	-	-87
Trust commissioning of other care services	-	-	-139
Trust other costs	-18	-16	-16
Total expenditure	**-173**	**-185**	**-414**
Trust deficit	**-16**	**-23**	**0**

Investment monies required to implement the model of care

CPT key points:

- *Implementation costs have been considered through the Operations and Finance Group as well as identified individually in the implementation plans.*
- *We believe the one-off implementation costs will be c£48m.*
- *The majority of the implementation costs will be incurred in the first 2 years of implementation.*
- *We also think that there could be further investment beyond the implementation stage to drive further benefits of integrated care, such as alignment of IT systems and further technological solutions.*
- *Ways to address and sources of funding need to be explored and agreed as soon as possible.*

The type of costs needed to implement integrated care in Tameside and Glossop have been identified through the development of the implementation plans, via workstreams owned by clinical and executive leads in Tameside and Glossop.

We believe the implementation costs will be c£48m.

The majority of these costs are expected to be incurred in the first 2 years of implementation.

Following discussions with the Ops and Finance Group, further costs have been added as follows:

- Provision for legal fees has increased to £0.5m;
- Provision for investment in IT – the implementation plans incorporate the costs that would be needed to get to day 1 of an integrated provider. In the future, it may be possible to drive further benefits from integrated care with more investment in common systems across all points of care that can be accessed remotely, create paperless working, and link to each other (e.g. EPR, SLAM, SUS, PLICS, ESR). This would mean further capital costs but a potential reduction in the cost of provision;
- Contract terminations – no provision has been made in the implementation plans for existing contracts that may need to be terminated, amended or transferred; and
- Contingency – given the level of uncertainty and risk associated with the programme of work a higher provision would be appropriate, estimated at a total of £8m.

Ways to address the gap and sources of funding will be needed. In discussions with the Tameside Ops and Finance Group, several potential sources of funding have been identified, including:

- NHS funding routes, such as PDC, and DH lending; and
- Greater Manchester Devolution funding.

Area	Description	Costs per workstream plans £m	Additional cost to drive full benefits of integrated care £m
Estate reconfiguration costs	Reconfiguration of the Trust's estate – assessment, planning and design of the new estates, moving services within the estate, development of new LIFT buildings for LCCTs, relocating services currently provided outside hospital, building work around the new front end of the hospital, and demolition costs associated with Charlesworth building.	6.5	
Workforce costs	Requirements for changes to workforce regarding: training, re-deployment costs, redundancy, recruitment and contractual/pay-scale changes between social care and healthcare.	5.8	
Implementation management and professional costs	External/temporary support for: – Implementation support, programme management, communications/engagement and contracting; and – Due diligence, actuarial advice, legal advice and other transaction costs.	4.9	0.6
Double running costs	Where services are to be replaced with services in alternative settings, or where facilities are closed to new patients but need to retain staffing for a period while existing bedded patients are cared for until discharge/transfer, there will be some need for overlap of services.	1.2	
Organisational / leadership development	Cultural change support within ICO organisations and development of ICO leadership team.	0.5	
Investment in integrated IT and comms systems	Set up cost and capital investment in new IT including community migration, equipment to support community diagnostics, gap modelling, and infrastructure investment.	5.5	14.0
Contract terminations	Transfers of services between organisations or changes to where and how services are delivered may mean that some support contracts need to be terminated, modified or transferred. There could be financial costs and penalties associated.		1.2
Contingency		1.9	6.1
Total		**26.2**	**21.9**

Engagement

This section outlines our work on communications and engagement as part of developing the model of care. We have also considered if public consultation will be needed and recommended how this is addressed in the implementation plans.

Engagement

CPT key points:

- *We have created a strong spirit of collaboration between communications and engagement leads from partner organisations through the formation of the local Communications Working Group (CWG).*
- *We recommend the Tameside and Derbyshire scrutiny panels consider whether a public consultation is needed.*
- *We have included public consultation in the implementation plans.*

Summary of communications and engagement in Phase 3 and 4

Throughout the CPT process we have engaged with a broad range of stakeholders across the health and care economy to:

- Involve the people delivering services on the ground in the design process;
- Build support for the proposed changes; and
- Establish a clear and consistent understanding of a best-practice approach to public consultation.

Through these interactions we have developed a view of the local health economy from a communications perspective.

Examples of local engagement

- Running Care Design Groups across the 4 care areas as referenced in the model of care section of this report:
  1. Preventative and proactive;
  2. Urgent Integrated Care;
  3. Planned care; and
  4. Maternity care.
- This helped design the model of care with a range of local clinical, patient and management input;
- The CPT attended over 400 local meetings;
- Working closely with local leadership with over 25 CEO meetings and over 50 attendances at 'Exec' meetings across the Trust, CCG and TMBC;
- Meeting a range of local stakeholder groups from Trust staff groups, CVAT (represents the third sector in part of T&G), leaders from nearby providers etc.;
- Chairing and supporting the local Communications and Working Group;
- Running dozens of workshops on a range of CPT related topics; and
- Running sessions with local GPs from an all GP session to meeting GPs in each locality.

Building a strong foundation

The Communications Working Group (CWG) will need to be well resourced and well supported to ensure that the ongoing engagement and consultation period maintains public and media support for the proposed changes.

During the CPT we focused on planning and preparing for pre-consultation engagement and consultation - building the knowledge and capability of the local organisations to deliver it effectively. Throughout the process we have made sure that there was a transfer of knowledge to the CCG and partners so that they are well prepared to continue the work going forward through a CCG led CWG.

Consideration of public consultation

With the latest model of care and advice the CPT has received, public consultation may be needed due to the extent of service change and proposing such significant change in the 'provider'.

We recommend that to help the CCG determine whether public consultation is needed, the local scrutiny panels for Tameside and Glossop should be consulted. This has been built into the implementation plans.

Whilst our implementation plans reflect public consultation, in the event that public consultation is not required the overall length of the implementation plans could be reduced by up to 3 months.

Engagement

CPT key points:

- *Under CCG leadership, the CWG should look to bring in additional resource to deliver the plan.*

Stakeholder status

The CPT has worked in the local system extensively in the development of the model of care, implementation plans etc. and set out below our understanding of the status of each stakeholder. In summarising the status, we have sought to take the overall position from each group but note that individuals within each group may have different views. Also, some groups represent a large number of individuals that again, may have different views.

Overall, the CPT's experience engaging with local stakeholders has been encouraging.

CEOs and board level leaders: The CEOs and board level leaders of the Trust, CCG and TMBC have been closely involved throughout the CPT and are supportive of the proposed model of care. Each organisation has been involved with the development of implementation plans and the new governance arrangements (see page 36). Maintaining this support will be critical in the next few years. A series of meetings has been held with senior councillors and officers of Derbyshire County Council, who are supportive of the direction of travel and wish to have extensive operational engagement in the new model, but without transferring staff or budgets into the ICO.

GPs: There are a number of GPs that have been engaged on developing the model of care and there is a common view that more integrated care would be beneficial to patients. The role of primary care and GPs in particular within an ICO will need continued engagement in coming months and years.

Clinicians: Clinicians from several providers have actively participated in the development of the mode of care. Clinicians from the Trust and CCG's Governing Body have also been involved with the development of the Hospital Specification. We note that there will be many individual clinicians in the Trust who we did not meet and the Trust will need to engage further with their clinicians in the short term.

Trust staff: During the CPT, representatives of the CPT attended a number of internal meetings for staff at the hospital and there were updates the Trust communicated as well. We believe that awareness of the CPT was high but details of the Hospital Specification set out in this report will be low, as this was finalised towards the end of the CPT. Also relevant to Trust staff, will be how their roles will change (i.e. in an LCCT) and the co-working arrangements with staff that are currently employed by other organisations.

Trade Unions: The CPT met Trade Union and staff representatives at the Trust several times. Awareness and understanding of the CPT was high but they are not aware of the details of the new model of care (as Trust staff above).

MPs/Councillors: Generally the engagement with Tameside MPs was undertaken by leaders of the Trust, CCG and TMBC, although the CPT did have one meeting. The CPT worked with or presented to councillors within several groups, such as Tameside's Scrutiny Panel, within TMBC's Cabinet or in Derbyshire County Council in meetings with some senior leaders and councillors. There is a good understanding of the model of care and many of the councillors will have a critical role in considering whether public consultation is undertaken. The CPT has not engaged directly with the High Peak MP.

Public, patients and voluntary sector: Public and patient representatives (including Tameside Healthwatch and voluntary sector organisations) were involved in designing the model of care. Continued public and patient engagement is planned by the CCG (even if no public consultation is required) and the public and patients have not been notified of the model of care or other aspects of the CPT's recommendations, such as on the form and identify of the provider of the model of care. The CPT met and briefed the CEO of Healthwatch Derbyshire.

Healthier Together and neighbouring trusts: The CPT has engaged with senior officers of Healthier Together and neighbouring trusts, including Stockport FT, Pennine Care FT, Pennine Acute Hospitals, CMUH and UHSM. NWAS, PCFT and SFT clinical and managerial staff were involved in the CDGs.

Engagement

CPT key points:

- *Under CCG leadership, the CWG should look to bring in additional resource to deliver the plan.*

Next steps: Immediate priorities

- Public rules prohibiting stakeholder engagement by public bodies during purdah meant that no public and patient engagement has taken place around options development in Phase 3 and 4 so this needs to be driven forward at pace by the CCG with the tools we have provided.
- The responses received from planned engagement work (CVAT/CVS) need to be fed into the design workstream, and a 'You Said' report published.
- The pre-consultation and consultation strategy and implementation plan will need to be ratified by the Programme Board and appropriate resourcing will need to be agreed.
- The CWG will need to work together to implement the detailed communications and engagement plan.
- An Equalities Impact Assessment should be commissioned.
- Care Together ambassadors must be identified and briefed to front messages before and during consultation.
- A dedicated plan for staff engagement and subsequent consultation should be developed for each of the 3 organisations and tailored according to impact.
- Staff and trade unions will need to be engaged/consulted on any potential changes to roles or services as employees of the organisations, but also encouraged to respond as residents and service users to the consultation itself.
- Advance briefings should be planned key stakeholders.

Implementation

The CPT believes that the proposed model of care can be delivered successfully in Tameside and Glossop, but this will require an implementation programme which is large, complex and pioneering.

The programme will need to be well-planned and well-led, and it will only succeed if several major risks are managed effectively.

To this end, the CPT has worked closely with the local CEOs and their teams to develop a summary implementation plan and 11 supporting workstream plans, to devise and introduce a tight programme governance structure. This is 'owned' locally, with key roles already filled.

Implementation

The CPT has worked closely with the CEOs and their teams to develop a summary implementation plan and supporting governance structure to deliver the integrated care solution.

CPT key points:

- *This plan conservatively assumes full Public Consultation. If this is not required, launch of new models can be accelerated by up to 3 months.*
- *The plan assumes that the Trust is the delivery vehicle (integrated care organisation). More details on this can be found on page 39.*
- *Enabling workstreams (notably Workforce and IM&T) are critical to launch dates.*
- *We believe new services could be launched in summer and autumn of 2016.*
- *c£48m is estimated to be required to implement this programme. This needs be found urgently or the programme will be delayed.*

Implementation - summary

The CPT has worked closely with the CEOs and their teams to develop an implementation plan and underpinned by 11 supporting workstream plans, to devise and introduce an effective programme governance structure to drive implementation, and to identify key risks to delivery (with mitigations). These are outlined over the next 4 pages.

Governance and delivery

Establishing the right governance structures will introduce the drive and accountability necessary to implement the service reconfiguration, something which the CPT has noted has been lacking to date. This is now well advanced (see overleaf).

The plan assumes that the Trust is the 'delivery vehicle' (see overleaf) and that a procurement is not required.

Consultation

The summary plan assumes full Public Consultation will be required for all service changes.

However, the plan also assumes that Public Consultation will not be required either for formal agreement on the proposed 'delivery vehicle' (the future provider or 'integrated care organisation') or the proposed transfer of services and staff from other NHS organisations to the delivery vehicle, because neither involves service change.

Launch of new services

The core elements of integrated care (LCCTs and UICS) can be launched safely between July and November 2016.

If full Public Consultation is not required, the new services can be launched earlier, between April and September 2016.

Some 'early wins' and some new services (e.g. drug and alcohol) may be introduced earlier.

Elective and surgical changes commence post-Consultation with introduction in late 2016 or 2017.

No plans are being made for changes in maternity services. Any consideration of this will follow the national review.

Resources

Partner organisations acknowledge that substantial additional resource capacity and capability will be needed. This requirement is estimated to be £48 million. A business case is being prepared locally for this.

Enabling workstreams

The implementation of a new service model is dependent upon a number of enabling projects including workforce, estates, IM&T and transport. The outputs of these workstreams need to be in place to enable the model of care to be launched safely and sustainably.

Implementation plans have been produced for each enabling workstream. These plans identify key activities,, with milestones, accountabilities, risks, mitigations, resource requirements.

These plans have then been reconciled against the 4 model of care workstreams to ensure that the appropriate infrastructure will be in place in time for the launch of key elements of the model of care.

Work across a number of these enablers has already begun including, identification of new models for outcome based commissioning, identification of the IM&T systems necessary to enable cross-network working across a number of service areas, identification of the estate requirements for the new service and modelling of the workforce needed to put LCCTs and the UICS in place.

The new model of care will involve the transfer of services and staff from other organisations. A dedicated workstream will be created to engage with staff and manage this complex process.

Risks to delivery

A programme as pioneering, large and complex as this carries several critical delivery risks.

Implementation

New programme governance arrangements have been designed by the CPT, and agreed and introduced by the CEOs to provide backbone, accountability and drive to implementation of Care Together.

CPT key points:

- *A tight Programme Board with delegated authority will drive implementation, under the leadership of an independent chair.*
- *Monitor, NHS England and DCC will have observer seats on the Programme Board.*
- *Liaison with 'DevoManc' and Healthier Together is essential.*
- *Delivery will be driven and integrated with 'daily business' by 'backfilled' workstream director leads who hold substantive posts in the CCG, TMBC and the Trust.*
- *The CPT recommends that the Trust becomes the 'delivery vehicle'. A decision on this must be made by the CCG urgently.*

New implementation structure

The CPT supported the CCG, TMBC and the Trust to devise and introduce a new implementation (programme) governance structure for Care Together. This was built on simple principles of accountability and effective decision-making, whilst reflecting the complexity and inter-agency nature of the overall programme. Senior appointments have been made to this new structure. This structure is explained in detail in the CPT's Working Papers.

Programme Board

The Programme Board will comprise 7 local leaders led by an independent chair.

Workstream Director Leads

A newly appointed Programme Director will be supported by 11 workstream director leads, each with clear accountability for delivering their workstream.
These director leads have all been appointed from director posts in the CCG, TMBC or the Trust, and will be 'backfilled' to enable them to fulfil their 'day job' and their workstream role effectively.

National oversight and Greater Manchester

Monitor and NHS England will have Observer seats on Programme Board. Liaison with 'DevoManc' and Healthier Together will be tight.

Derbyshire County Council

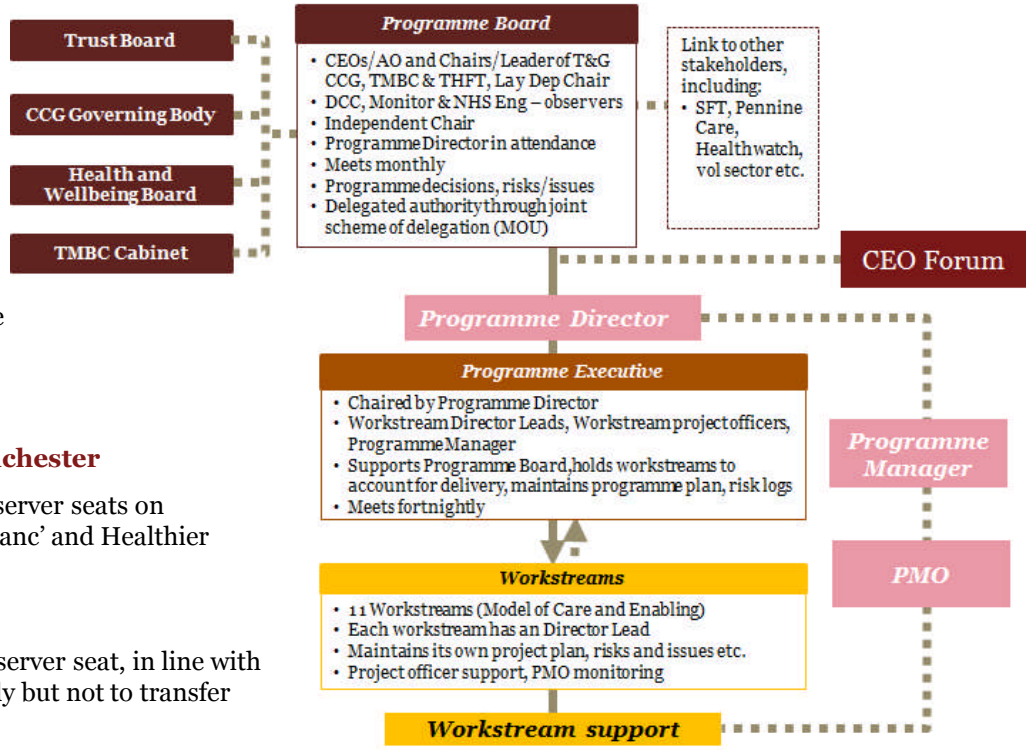
Derbyshire County Council will have Observer seat, in line with its agreement to collaborate operationally but not to transfer staff of budget into the new model.

Delivery vehicle

The programme is designed by commissioners but delivery and operation will need to be by a single 'integrated care organisation' or 'delivery vehicle'.

The CPT recommends that the Trust becomes this 'delivery vehicle'.

Decision on this is the prerogative of the CCG, which needs urgently to determine whether or not this will be the case. If it is not, a procurement exercise may be required, which may delay implementation by up to 12 months.



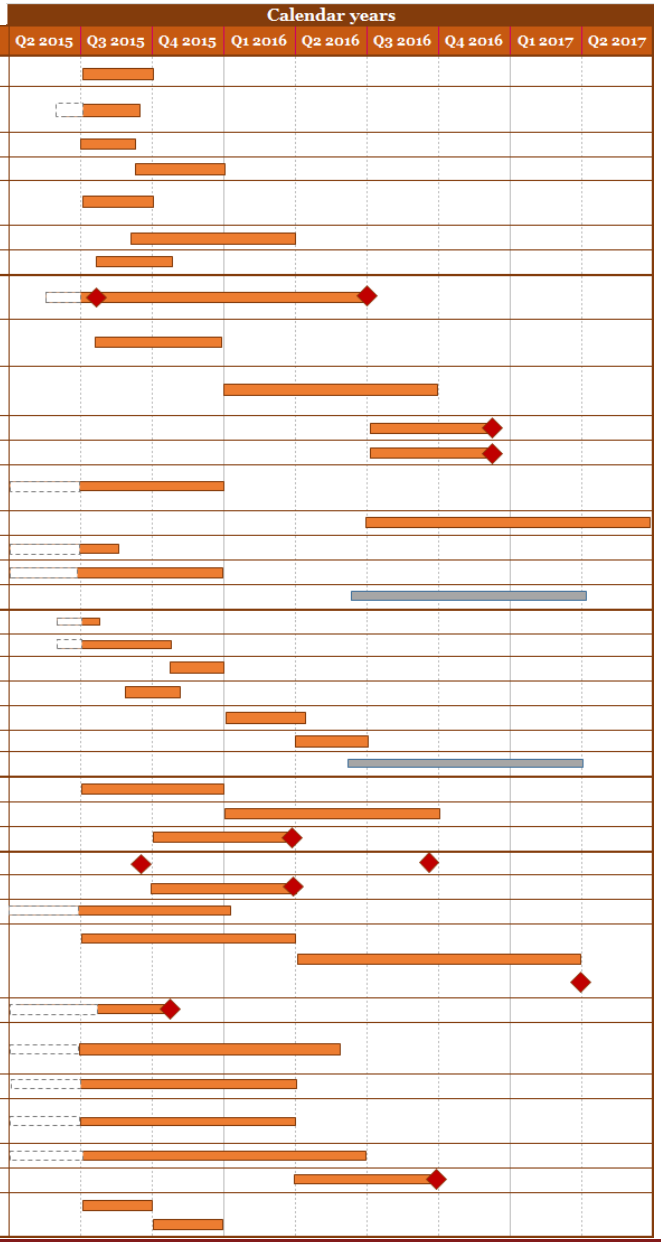
Implementation

This summary implementation plan captures the key activities and identifies how the delivery timelines interact in delivering the new model of care.

CPT key points:

- *This plan assumes Public Consultation. If this is not needed, timelines could shorten by up to 3 months.*
- *Launch of the main new services (LCCTs and UICS) commences after Consultation in late summer and autumn 2016.*
- *Some 'early wins' and some new services (e.g. drug and alcohol) may be introduced earlier.*
- *Elective and surgical changes commence post-Consultation and with introduction in late 2016 or 2017.*
- *This plan involves multiple inter-dependencies and substantial enabling activity (e.g. Workforce).*

Workstream	Key milestone description
Implementation Governance & Organisational Form	Second wave key appointments (Project Manager, PMO, Project Officers)
	MOU, Scheme of Delegation and escalation routes drafted and agreed by Gov Body, Cabinet, Board
	CCG option appraisal and recommendation about Delivery Vehicle
	Enhanced capability/structure for Delivery Vehicle designed and agreed
	Formal agreement, by CCG and Board of nominated organisation, on Delivery Vehicle
	New appointments/restructuring of Delivery Vehicle
	Business case development
Model of Care	Interim agreement on model of care, with final agreement reached after consultation
	Detailed planning of new teams and pathways (policies, staffing, enabling requirements, GP input)
	Pre-operational mobilisation of new teams and pathways (staff appointments, patient profiling, communications)
	LCCTs go live (phased)
	UICS goes live
	Wellness offer, drugs and alcohol and primary care extended access procured
	Implementation of elective and surgical changes
	Agree mental health relationship to ICO
	GP and extensivist model planning within the ICO
	CCG and HT, post Cumberlege, review of Maternity options
Comms & Engagement	Agree budget, plan and resources
	Undertake pre consultation engagement (PCE) activities and quality
	Evaluate PCE activities and decide on consultation
	Clinical Senate review and assurance
	Full Public Consultation on service changes
	Post consultation and decision
	Agree need for consultation around Maternity options
Workforce & OD	Planning phase (OD, TUPE, role mapping, workforce design)
	OD, new appointments, new teams formed
	Staff consultation and TUPE of staff
Other enabling workstreams	Publication of CCG commissioning intentions
	Stockport services and staff transfer planned and executed
	Identify and resolve issues around joint commissioning
	Development of capitation and outcome based commissioning
	Operation and testing of shadow commissioning model
	Go live with new commissioning model
	Formal decision around application for transition funding
	IM&T solutions (Accordant, community clinical IT and secondcare systems) tested and implemented
	Go live with shared intelligence database
	All patient, visitor, staff & goods transport arrangements in place and tested
	Community estate plan agreed and estate in place (phased)
	UICS estate building and opening
	Identification of potential quick wins
	Implementation of identified quick wins



Glossary of key terms

Term	Definition
'Care Together'	The programme of work aimed at delivering an integrated care solution for T&G.
'Cost and activity model'	The model for the service specification and the hospital specification that shows the cost and activity in the health economy. This includes the operational assumptions that convert the service specification and hospital configuration into assumptions that can be modelled.
'CPT'	Contingency Planning Team.
'CVAT'	Community Voluntary Action Tameside
'CVS'	Community Voluntary Support
'Delivery vehicle'	The organisation responsible for delivering the new model of care.
'Extensivist'	Hospital-based specialists who would focus on cohort of high-risk patients.
'Health economy'	The health economy of Tameside and Glossop.
'Hospital Specification or configuration'	The part of the model of care and service specification that covers the proposed configuration of services at TH, flowing from many factors including the impact of integrated care.
'ICO / integrated care organisation'	The proposed model of integrated care in Tameside and Glossop.
'IC'	Integrated care.
'LCCTs / Locality Community Care Teams'	5 multidisciplinary, local community care teams focused on keeping people well and out of hospital.
'LIFT'	Local Improvement Finance Trust
'LSS'	Location Specific Services
'MDT / Multi Disciplinary Team"	A team composed of members from different healthcare professions with specialised skills and expertise working collaboratively to make treatment recommendations that facilitate quality patient care..
'Model of care'	The way the health economy works, that spans health and social care and covers what is to be provided within an ICO and the services outside an ICO.
'NWAS'	North West Ambulance Service,

Glossary of key terms

Term	Definition
'OFG'	• Operations and Finance Group.
'PACS / Primary and Acute Care System'	• A whole system integration of hospital, community, social and primary care within a single outcomes-based capitation contract.
'SPOA'	• Single Point of Access.
'Service specification'	• What is being delivered, where and by whom. This describes the model of care.
'TH'	• Tameside Hospital.
'the Trust'	• Tameside Hospital NHS Foundation Trust.
'T&G / Tameside and Glossop'	• The geography of Tameside and Glossop.
'CDG / Care Design Group'	• Model of care design sessions bringing together inputs from health and care professionals, third sector patient and public representation.
'UICS / Urgent Integrated Care Service'	• Multi disciplinary team responsible for dealing with urgent care patient needs under a single operational management structure.

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Care Together Programme Update

1st October 2015

Tameside and Glossop Case for Change

250,000 people live in Tameside & Glossop

By 2018, funding to the local health and social care system will fall short of the demands to be placed upon it by approximately £75m annually

We have some of the worst health indicators and inequalities in the country:

- 64% of our electoral wards are in the highest 10% in terms of economic and social deprivation, which has a direct correlation with the health of local people.
- Both women and men die c.2 years younger than the national averages
- Circulatory diseases including heart disease are the commonest cause of early death and rates are 55% higher than the national average
- Premature death through lung cancer is 54% higher than the national average
- Healthy Life expectancy is 57 years

Complex Health and Social Care System

- Public Health and social care services are provided by two different Councils; Tameside and Derbyshire
- Responsibility for funding, organising and managing GP services is split between the CCG and NHS England, a national organisation.
- Pharmacy, Dental and Optometry Services are all funded by NHS England
- The community services operating across Tameside and Glossop are currently managed by Stockport Hospital
- Our local mental health services are managed by a specialist Mental Health Foundation Trust
- Hospital services are delivered by Tameside Hospital Foundation Trust
- Some specialist services are provided to our residents by hospitals located in Stockport, Oldham and Central Manchester
- <u>BUT</u> significant opportunities through our previous work , geography and Devolution

Developing the concept

All parties recognised 'doing nothing' was not an option

We need to bring together social, primary, community and hospital services to provide an integrated care system which provides;

- A focus on wellness and preventing illness
- Supporting people to manage their own health and make healthy choices
- Support people as far as possible in their own homes and communities
- Accessible, high quality general practice
- Ensure a safe, effective local hospital which works in partnership with neighbouring hospitals to ensure consistent, optimum health care for all in need

Wide recognition that we need to focus on the wider public health system if we are going to close the gap

Current position

Contingency Planning Team Report (CPT) published which outlines proposed new model of integrated care;

- Local community care teams who co-ordinate all care being provided to residents and therefore ensuring high quality, responsive services
- New Urgent Care Service which brings together all intensive support services e.g.; A&E, rapid response teams, step up/step down intermediate care
- Tameside Hospital remains with an A&E, maternity and elective services although a reduction in medical beds due to improved prevention of illness and the shift of care into localities

Tameside Hospital Foundation Trust formally out of Special Measures; really positive and significant step.

Timeline for progress

Boards of all 3 “parent” organisations agreed on 23rd September 2015;

- Formally welcomed and accepted recommendations within CPT
- Agreed an integrated system of health and social care is the best way to ensure improved health and social care outcomes
- Decided THFT will transform into a new organisation able to deliver this
- Agreed how we will work together to ensure we collectively make this happen (our strategic principles)

Key milestones;

1st January 2016;	Start of Joint Commissioning function
1st April 2016;	Shadow Integrated Care Organisation
1st April 2017;	Legal Integrated Care Organisation

ITEM NO: 6

Report to :	**HEALTH AND WELLBEING BOARD**
Date :	1 October 2015
Executive Member / Reporting Officer:	Angela Hardman, Director of Public Health
Subject :	**PUBLIC HEALTH ANNUAL REPORT 2014-15**
Report Summary :	The Director of Public Health's Annual Report 2014-15 is themed around the health and wellbeing of children and young people. It describes through the life course approach the challenges Tameside children and families face from pre-conception through to transition to adulthood. The report shares recommendations for public health action, with a call to all partners and communities to contribute. There are examples in the document of how many of our communities and services are responding to these challenges together.
Recommendations :	This report is for information only.
Links to Sustainable Community Strategy :	This Public Health Annual Report is relevant to all aspects of the Community strategy, but health most specifically. Although an independent report, it also contributes to the delivery of the corporate vision: The Council, as a representative body, exists to maximise the wellbeing of the people of the borough.
Policy Implications :	The report does not have any policy implications, however, it presents a challenge to the council and partners to embed principles within their policies that promote health and reduce inequalities.
Financial Implications: **(Authorised by the Section 151 Officer)**	The annual report is part of the accountability arrangements for the grant, providing an explanation to residents, the department of Health and other stakeholders on how £12.6m of s31 Public Health grant was spent within Tameside (part of £2.8bn nationally).
Legal Implications: **(Authorised by the Borough Solicitor)**	The publication of this report fulfils a statutory requirement of Tameside's Director of Public Health.
Risk Management :	The annual report of the Director of Public Health is being presented to Board for their information.
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

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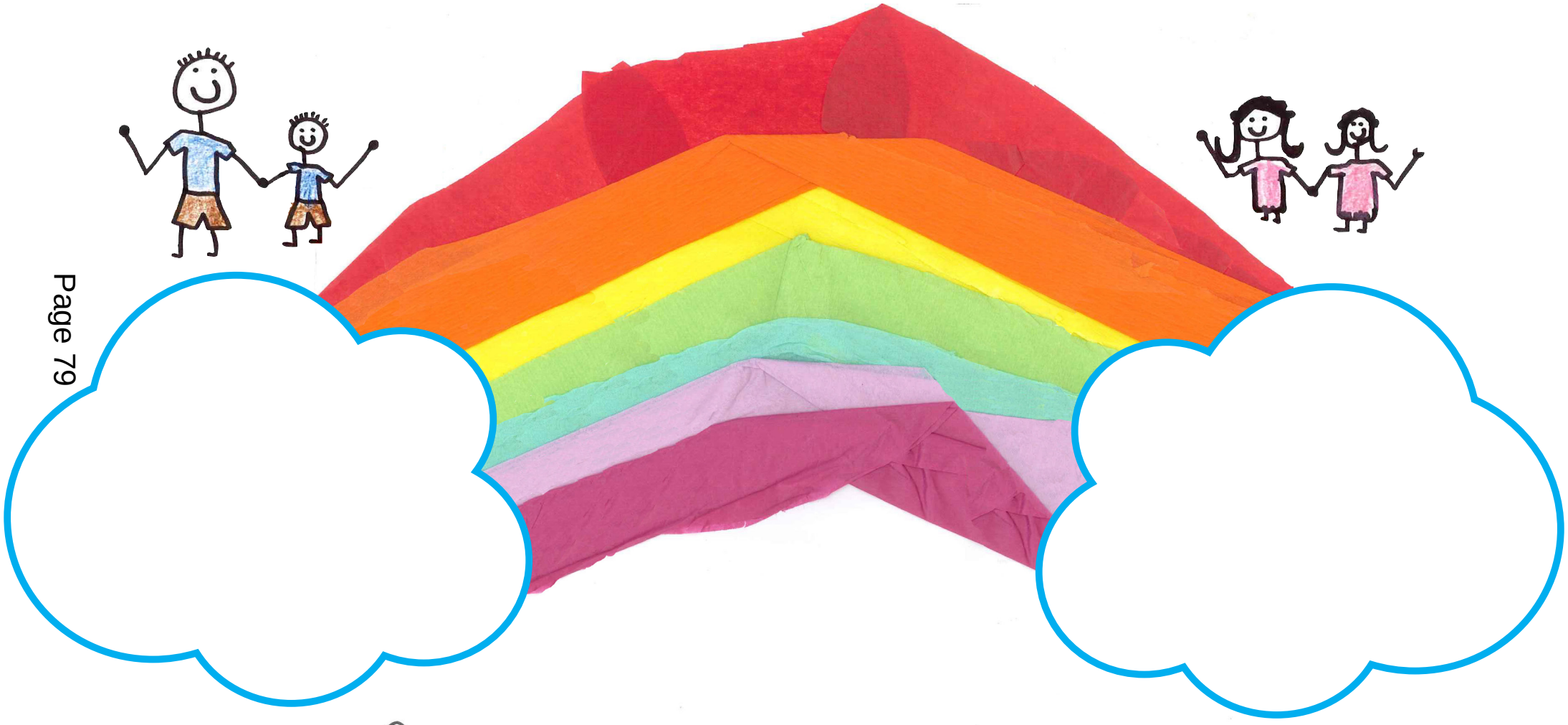
Tameside Public Health
Annual Report 2014/15



Tameside Metropolitan Borough

Contents

Welcome

Welcome to my Public Health annual report 2014-15. Last year my report focussed on the importance of good mental health and wellbeing in tackling life's ups and downs. I made a commitment to focussing on ways to help the people in our borough to build their personal resilience. We chose the 5 Ways to Wellbeing as a solid foundation, and took part in some excellent work. A summary of this can be found on page 39. I'm pleased to say that with further funding invested as part of the Council's 2015-16 business plan, progress will continue to be made.

For this year's report I turn the spotlight on the health of children and young people. The conditions in which children are born, grow, live, work and age can lead to health inequalities – the unfair and avoidable differences in health status. I set out my response as the Director of Public Health to the health challenges children and young people in our borough face. This report shares my recommendations for public health action, with a call to all partners and communities to contribute. Improving the health and wellbeing of children and families requires a collaborative effort and response through our existing strong partnerships in Tameside, led by our Health and Wellbeing Board.

The traditional African proverb, "It takes a village to raise a child", has been widely quoted when looking at the approach needed to support children into adulthood. Our 'village', made up of individuals, families and communities, is becoming ever more important as technology places the world at children's fingertips 24 hours a day. Our children and young people are faced with multiple challenges and opportunities. The immediate challenge for us is how to bring our efforts and resources together to improve the outcomes that really make a difference. Most children in our borough grow up healthy and happy but for some there are challenges. Childhood poverty is a very real issue for many families in our borough – poverty damages childhoods and it damages life chances. Improving health offers economic benefit to the borough and its residents, and can help break this damaging cycle of poverty.

I'm pleased to say that recognition of the need to improve the lives of our children and young people is increasing. The call to create an upward spiral of improved health, personal development, and economic opportunity for our young people is gathering momentum, especially here, in Greater Manchester.

No report on this topic would be complete without the voice of children and young people being heard. We are committed to being active partners, to support and prepare our children and young people for the future, and that means providing opportunities for them to be involved. Look out for comments from children, parents, and professionals throughout this report. Youth Engagement and Participation activity in Tameside is also outlined.

Finally, I wish to thank Megan, aged 11, for the beautiful design of our front cover. I hope you enjoy reading my report.

Whilst the public health annual report provides an overview of some of the health data of our local population, more detailed and regularly updated information is available from the Joint Strategic Needs Assessment (JSNA). This can be found on Tameside Council website Public Health pages. I encourage everyone to take a look.

CLICK HERE

Angela Hardman
Director of Public Health

CLICK HERE
for Summary
Recomentations

Introduction and Future Opportunities

Around 3000 babies are born in Tameside each year. Even before these children are conceived social, economic and environmental factors are at work to determine their health in adulthood.

Their mother's experiences and lifestyle choices in pregnancy, their home environment in early years, where and how they play as children, and the relationships they build through adolescence all contribute towards their health and wellbeing as adults.

A healthy life begins with healthy parents pre-pregnancy, and good antenatal care, so mum has a healthy pregnancy and baby is born at a healthy weight. It continues with support for babies and toddlers to meet important milestones in their development; ensuring they arrive at school fit, well and ready to learn. These early building blocks lay the foundations for our children to grow physically, emotionally and mentally, opening doors to better opportunities and creating a lifestyle in which being healthy is an attainable reality.

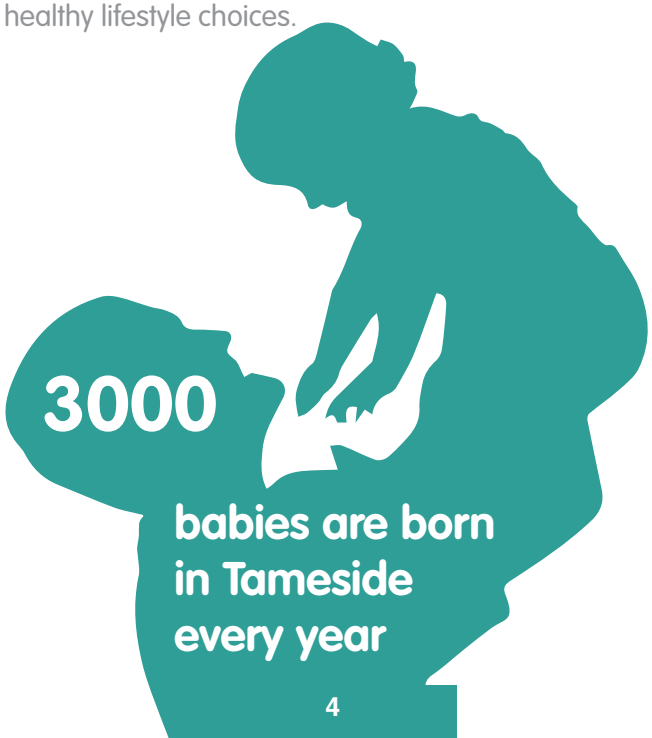
We are committed to supporting families of children from pre-birth through to five years, when we can have the greatest impact on the future health and wellbeing of children.

Maintaining healthy development for older children and adolescents ensures that they are able to achieve their full potential through learning, education and later employment.

The period we call 'transition', when a child makes the move between being classed as a child to being classed as an adult, is a notoriously difficult time for young people, and indeed for professionals from different services. Varying age thresholds between services can make for a 'bumpy ride' for young people, who are already going through big changes. Creating a seamless transition is naturally an ambition for the future.

For vulnerable children, such as looked after children or those with additional or complex needs arising from a disability, support through this period is particularly important. Decisions made at this time may be more complicated and can include important choices around care provision, living arrangements and financial independence.

They may need help and advice to understand the full range of options available to them to ensure they have the best chance to develop well, and make healthy lifestyle choices.



The foundations for virtually every aspect of human development – physical, intellectual and emotional are laid in early childhood. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and well-being from obesity, heart disease and emotional health to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences and ensure that we give every child the best start in life.

(Fair Society, Healthy Lives the Marmot Review, 2010)

Listening to...
our children and engaging our young people

Young people in Tameside can and should be involved in the decisions that affect them. We actively invite them to shape their development by interacting with the people and opportunities made available in their environment.

What are the benefits of youth engagement?

Youth engagement is a win-win proposition.

- **Young people** benefit by gaining skills, knowledge, self-esteem, and connectedness
- **Adults** benefit by enhancing their own competencies, learning to better understand and value youth, and increasing their commitment and energy to their organizations
- **Organisations** benefit by improving their programmes, gaining community recognition, and attracting funders
- **Communities** benefit by improving quality of life, coordinating youth services, and authentically embracing diversity by representing young people.

http://www.actforyouth.net/adolescence/

How do we listen to young children?

For younger children, a fun and visual feedback tool called 'Tops and Pants' is used in Children's Centres; 'Tops' to feedback on things they enjoyed and 'Pants' if they didn't. This is an opportunity for parents of young children to say what they and their child did or didn't like about a session, and is posted alongside a response from the team, often with ways they intend to improve, change or tailor a session going forward. Children's centres also facilitate parent forums to allow discussion and share ideas. A compliments/ complaints box is available at each reception to encourage parents have their say.

An annual consultation also takes place with parents around their experiences. This is used by the centre to inform future delivery. Each Children's Centre also has a Facebook page where comments/ suggestions/ideas can be posted.

How do we listen to older children and adolescents?

From a political point of view, youth engagement is important because young people deserve the right to represent their own interests. Youth civic engagement is also critically important to prepare young people to be active citizens in a democracy.

Tameside Youth Forum is currently in transition to become Tameside Youth Council. Members are recruited from schools, colleges and youth voluntary groups, with a democratically elected member appointed to represent them.

The members of the Youth Council are involved in national 'Youthforia' workshops, and have the opportunity to share and debate on issues that affect them. They will also be consulted and have input in campaigns, for example 'Make your Mark', a campaign to encourage entrepreneurialism amongst young people.

Pledges for young people

The Executive Leader of the Council, Councillor Kieran Quinn, has made a set of 15 pledges to deliver during 2015. Several of these relate to children and young people and increasing their chances of good health, development and opportunity.

These include free swimming events for the under 16s, and a programme of family activities that were delivered during the school holidays. See opposite for just one way Public Health and Cultural Services are making the most of Tameside's summer events.

The pledges also include bringing children and young people closer to the the democratic process by creating a Youth Council, whom we can regularly engage on matters of health.

It also includes a youth jobs pledge, promising paid employment for any young person who is not employed, in education or in training. In addition to the jobs pledge, Tameside Enterprise Scheme supports small businesses to mentor young people, helping nurture opportunity and personal development.

During 2015 Public Health joined with Cultural Services and Tobacco Free Futures to promote a 'Smoke Free Summer'.

The new initiative ran across Greater Manchester over the Summer holidays. It saw a series of family-friendly events in the area becoming smoke free to protect children by reducing their exposure to smoking. In Tameside, our Theatre in the Park programme was the first to 'fly the smoke free flag'. This move was welcomed by the majority of respondents on a survey of park users, with 76% of people agreeing that smoking outdoors in front of children sets a bad example.

Life Stage: Pre-Conception and Pregnancy

The health and wellbeing of a mother before and during her pregnancy has a direct effect on the health of her baby. To maximise child health, we start before birth - even before conception when possible. This means Tameside is a good place to have a baby. Having an underweight baby is less common here than in the North West or England as a whole. This has improved since 2010. Baby deaths in the first month are also less common here.

It is important that women are supported to maximise their health before and during pregnancy. Women especially need to be encouraged to maintain a healthy diet and avoid smoking. The health benefits to those living in more deprived communities will particularly important.

Women living in deprived communities are most at risk of having a poor outcome of their pregnancy. Access to high quality pre-conception and pregnancy care is therefore paramount. Pregnancy is a time when women are more motivated to make healthy choices, and the majority are in contact with services. This makes for an ideal opportunity to make changes that make a difference to mother, child and family.

Tameside NHS Foundation Trust provides maternity services for the majority of our local mothers. The trust provides support for pregnant women and their families through antenatal, delivery and postnatal care. The best maternity care is delivered through high quality, family focused services with a seamless approach both locally and in the wider community.

Teenage Pregnancy

Most pregnancies are planned, but when we narrow the focus to teenagers, evidence tells us that around 75% of pregnancies are unplanned, with about half of these ending with abortion. During 2014 there were 140 births to women under the age of 20 in Tameside, with 29 of those being to women under 18 years.

Being a young parent can be challenging. Whilst young people can be good parents, research shows that having children at a young age can lead to reduced employment and education opportunities, increase the risk of living in poverty and increase the chance of poor maternal physical and mental health.

This year sees a new Family Nurse Partnership (FNP) programme for young parents starting in Tameside. The Family Nurse Partnership is a preventive programme aimed at first time mums aged 20 and under, and has the potential to transform the life chances of the most disadvantaged children and families in our communities. Specially trained Family Nurses will visit and support the whole family regularly from early pregnancy through to when the child is two, helping and enabling them to become a good parent. They help to support a healthy pregnancy, parenting and wider issues such as housing, finances, employment and training.

Tameside's under-18s conception rate has halved over the past five years. Our strategy has been to ensure there is good provision of accessible, young people-centred contraception and sexual health services to enable increased access and use of contraception.

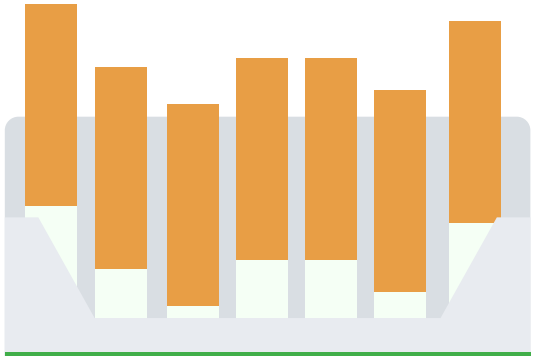
The continued delivery of comprehensive Sex and Relationship Education (SRE) programmes in schools will be key to ensuring our rates continue to fall.

The Youth service deliver the YOUthink prevention programme, consisting of Family Planning Agency trained youth workers delivering sexual health awareness in all schools. They provide targeted support for vulnerable or high risk young people. There is a multi-agency training programme available for front line staff members who work with children and young people, to improve skills and grow confidence to discuss sex, relationships and sexual health with young people.

75% of teenage pregnancies are unplanned, with about half of these ending with abortion. During 2014 there were 140 births to women under the age of 20 in Tameside, with 29 of those being to women under 18 years.

Smoking During Pregnancy

Tobacco use remains the greatest, single preventable cause of ill health, disability and death in Tameside and England as a whole. Babies born to women who smoke during pregnancy are, on average, significantly smaller than those born to women who don't smoke. Low birth weight is one of the main causes of illness and disability in babies, and also increases the risk of a baby being stillborn.



Smoking in pregnancy increases the risk of sudden infant death syndrome (SIDS), also known as cot death, by four times if you have between one and nine cigarettes a day. This risk doubles if you smoke 20 cigarettes or more a day.

In Tameside, one in five women smoke through pregnancy. This is higher than the average for the North West and England. Whilst we have seen a reduction in smoking rates since 2010-11 there is much more to be done to reach the government's target in the Tobacco Control Plan for Englan (2011).

This sets out a national ambition to reduce smoking as recorded at the time of delivery to 11% or less by the end of 2015. If rates continue to fall at levels seen over the last three years in Tameside, this ambition will not be achieved.

We offer a variety of non-judgemental support for women who are smokers and pregnant. The NHS Stop Smoking Service has specialist pregnancy advisors who are skilled and experienced in providing support to women at this important time. All midwives are able to refer women to this free service. Support is also available from Health Visitors, GPs and Pharmacists to help women stay smoke free after pregnancy.

Following the birth of the baby, the biggest benefit for both mother and child is to remain smoke free. However, some women who manage to give up smoking during pregnancy find this really hard.

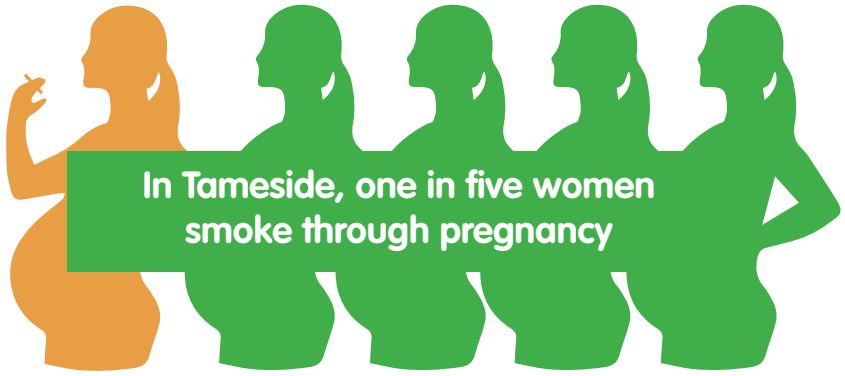
For families who feel unable to give up smoking, we recommend that they keep children and other family members safe by adopting the 'Take 7 Steps Out' approach. This ensures that the home is kept free from harmful second hand smoke.'

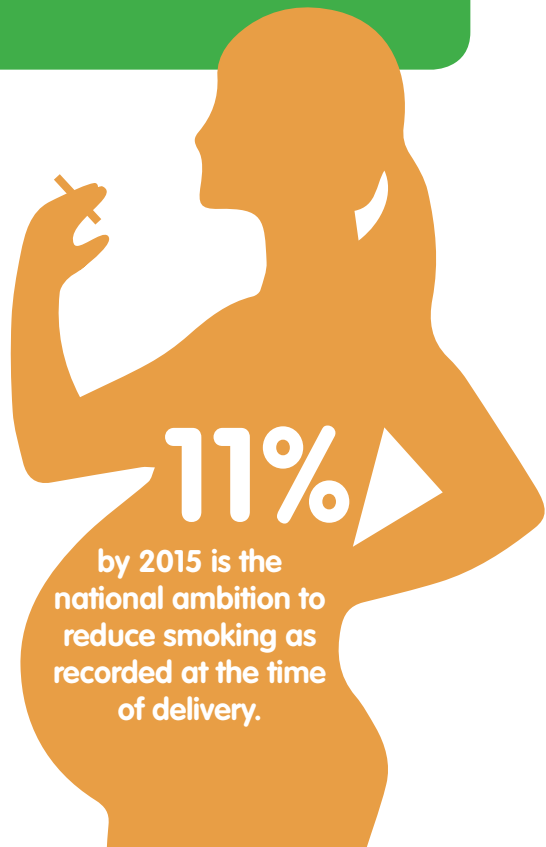
Case Study: Rima

Rima* lives at home with her mother Shobna*. Rima was pregnant for the first time. Shobna was also pregnant with her third child. Rima, Shobna and Shobna's partner all smoked. After discussing the risks to both unborn children in the house, and to the children when they were born, both mums agreed to quit with help from the Midwife Led Stop Smoking Service. Shobna's partner wasn't ready to quit and usually smoked in the house.

Both women began nicotine replacement therapy. With support Rima managed to quit within a couple of weeks, and Shobna cut back to the occasional few. Shobna's partner reduced the number of cigarettes smoked regularly, and began 'Taking 7 Steps Out', smoking outside the house. Both women remained smoke free for the duration of their pregnancies and delivered healthy babies.

*Name changed

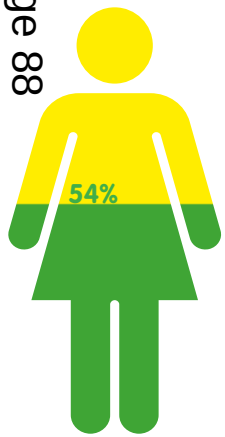




Vaccination Programme for pregnant women

Seasonal flu

There is good evidence that pregnant women have a higher chance of developing complications if they get flu, particularly in the later stages of pregnancy. In some cases it can even cause premature birth. Evidence has shown that the flu vaccine is safe for mother and child. It will protect the mother during pregnancy, but also passes to the unborn child. This means they are protected when they are born, and will continue to be protected for the first few months of life.



Just over half of all pregnant women in Tameside are vaccinated against flu at 54%.

The flu vaccine is made available to pregnant women free of charge; therefore it is recommended that all pregnant women take advantage of it. At the moment, just over half of all pregnant women in Tameside are vaccinated against flu.

Whooping Cough

Whooping cough in babies under a year old can result in hospitalisation, as the infection can lead to severe complications such as pneumonia, seizures, and dehydration affecting kidney function.

If coughing causes the flow of oxygen to the brain to be interrupted, brain damage can occur. Although this is rare, it is important that babies are protected against the bacteria. Evidence shows that vaccination is a safe and reliable option.

Babies cannot be immunised until they are two months old, therefore pregnant women are offered a whooping cough vaccine, ideally between 28-32 weeks, to protect their child in their first few weeks of life. The vaccine crosses the placenta and enters the unborn child's system, protecting them from whooping cough until they are able to be vaccinated themselves.

Recommendations

- Offer high quality advice and support through pre-conception and pregnancy to ensure both physical and mental health is optimised for every mother in Tameside
- Ensure tailored support for disadvantaged groups of pregnant women, and young mums under 20 is available by delivering innovative approaches to health promotion. Support is to be built around the needs of the mother, her partner and their wider family
- Deliver and promote partnership and multi-faceted approaches supporting our young mothers to ensure the best outcomes for mother and child.

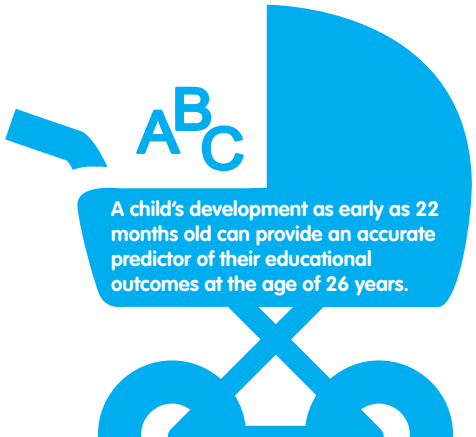
Life Stage: Early Years

Every child deserves the best possible start. This positive start is crucial for later success - not only for academic achievement but also for a happy and healthy life.

Many important milestones in a child's development take place between ages 0 and 5. Some can be seen clearly like starting to feed themselves, taking first steps, first words, but many are made long before that in ways that are not as obvious. Reaching a developmental milestone is a product of a number of experiences. Meeting them shows us that the child is taking in language, is honing movement, and understands how to connect with the world around them at an appropriate pace. A child's brain takes in information at an amazing rate. This is never more so than during first 1001 days of life, when billions of brain cells meet to form networks that will later become hard wired thoughts and behaviours.

This ultimately shapes who the child becomes. If their experiences at this time aren't positive and varied, and if the connections with people around them are not warm and loving, the thought patterns and behaviours they develop may not produce a positive outcome for the child and family. For some children their development may be impaired due to disability. It is important that the services we provide understand their additional needs and support their parents in helping them reach their potential.

To have an impact on health inequalities, investment and action in early years needs to be based on real evidence, be cost effective, and proportionate to needs of that family and their circumstances. When good foundations are lacking, later interventions are considerably less effective. Evidence shows that for every £1 spent in early years, we would need to spend £7 in adolescence to achieve the same effect, so it makes financial sense to intervene before problems set in. The Marmot review (Fair Society, Healthy Lives; The Marmot Review 2010) recognised that disadvantage starts before birth and accumulates throughout life. Marmot recommends that action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes be broken. This is why making a difference in the early years in Tameside is one of our highest priorities.

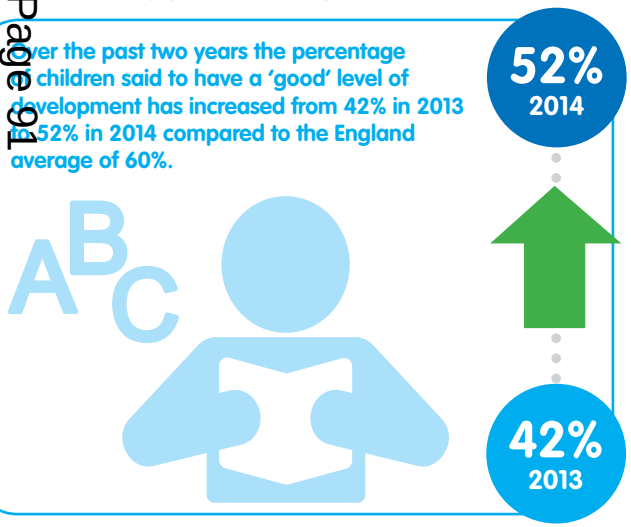


Early Years Development and School Readiness

School readiness is an indicator of early years development and a child's ability to learn on entry to primary school. It can be used as an indicator of a child's long term likelihood to achieve academically, to develop strong relationships, and to become self-sufficient in adulthood. It brings together physical, social and emotional development, the child's approach to learning, level of language, cognition and general knowledge.

All local authorities in Greater Manchester are working together on a new way of improving children's early years development.

Over the past two years the percentage of children said to have a 'good' level of development has increased from 42% in 2013 to 52% in 2014 compared to the England average of 60%.



This is known as the 'Early Years New Delivery Model'. This seeks to ensure families' needs are identified and supported. Additional support can comprise courses in parenting, communication and language, early attachment, and physical development. Early access to this support can prevent difficulties from escalating. It acts as a gateway to more intensive or specialist support for those who need it. When we deliver these types of courses, or carry out any activity that aims to help a child catch back up to the appropriate level of development for their age, we call it an 'intervention'. All interventions have been tried and tested and are known to work if followed properly by parents, professionals and children. This is what we mean when we talk about 'evidence based interventions'. The model also aims to increase access to high quality day care for some children. See an example of an intervention in Claire's case study.

The Health Visiting Service delivers the full Healthy Child Programme (HCP) to every child (0 to 5 years) and their family in Tameside. The HCP is the early intervention and prevention public health programme that lies at the heart of our universal service (services that are open to all) for children and families. At a crucial stage of life, the HCP's universal reach provides an invaluable opportunity to identify families that are in need of additional support, and children who are at risk of poor outcomes.

The Government intends to transfer the commissioning responsibility of children's public health services from pregnancy to age five to local authorities in October 2015. Tameside Council is working with key partners to make sure the transfer and integration of the services is safe and effective.

A national programme came into effect in September 2014 to offer eligible families a free nursery place for their 2 year old. This gives 15 hours childcare per week. The aim of this programme is to support children's learning and development, and give parents who are economically disadvantaged access to childcare. For children with additional needs arising from a disability it is particularly important for them to have access to provision that promotes their development.

Case Study: Claire

Claire* came to the Children's Centre when her son Rhys* was first born. She attended baby weigh in and would sometimes come to the baby group. Earlier this year her son was referred to a Health Visitor as he wasn't really talking and was very shy and clingy. She advised Claire to bring Rhys to Toddler Talk.

Claire said she had reservations about coming back to the centre and wasn't sure how Rhys would be in a group. The Early Years Worker telephoned to put her mind at ease, and she reported feeling more enthusiastic about the session.

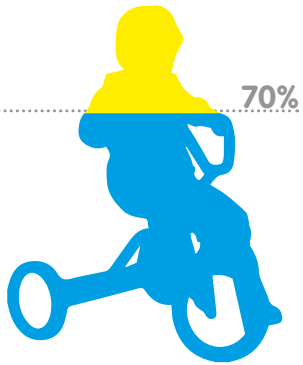
Claire found the first week quite scary for both herself and her son. Whilst she got a lot from it she was concerned about Rhys as he didn't leave her knee through the whole group. Despite this she came back the second week. Claire noticed a marked different in her son. He became more outgoing and playful, and took part in singing. In the following weeks he didn't want to leave. Claire decided to try out a stay and play session, and take part in some of the holiday activities at the Children's Centre.

https://www.youtube.com/watch?v=DZo0EFKRZ5E

*name changed

Claire*; "We have really enjoyed attending Ridge Hill Children's Centre it is so friendly and welcoming and we love the staff."

70% of targeted two year olds eligible places are taken up in Tameside



Early Attachment

Being pregnant and having a baby is a special time in a parent's life, but it can be a hard time too. Healthy first relationships are vital for a baby's wellbeing and development, but difficult emotions, experiences and expectations can affect how closely parents bond with their baby, especially in the early days. The quality of this 'early attachment' has an impact on the baby's future. When a baby doesn't feel securely bonded with a primary caregiver it can lead to poorer outcomes in later life.

Tameside's Early Attachment Service provides intensive help to parents and their babies in the critical first 3 years of life, when bonding has been difficult. They help parents to build a strong relationship with their baby, so that their baby feels safe, secure and happy. They provide information for all new and expectant parents in the form of a booklet and DVD 'Getting it Right from the Start', available from midwives or health visitors. Support is also available through the specialists in the service, maternity, health visiting and the wider early years workforce, including trained volunteers within Homestart.

In 2015 Tameside established a 'Babies Can't Wait' agreement which means that all pregnant women or those with children under the age of two years and their partners can access the adult Healthy Minds service directly following referral, avoiding any wait. This has meant it is possible for parents to receive support for their own mental health.

Parenting courses for families with children aged 0-5 are focused on relationship building between parent/carer and child. We utilise the Solihull Approach and Solihull Parenting course to meet the needs of our families. A further parenting course called Mellow Parenting is now being introduced specifically to support parents and children with a higher level of need.

Health Visitor;
"We need to reach out with different skills to appeal to parents. It's not about our agenda; it's got to be about the family's too"

On the Solihull Parenting Programme - Parent:
"I didn't want the course to finish; it's been the lifeline of my week
Over the last 10 weeks I have learnt how to be more patient and calmer. I understand that my behaviour and attitude impacts on how my children feel and act"

Case Study: Jade

Jade* started experiencing difficulties after the birth of her second child. Her family was experiencing significant stress which came out through domestic abuse, substance misuse, mental health needs and financial difficulties. These, joined with isolation and lack of support networks began to affect the children's development and attachment. Jade was reluctant to work with social care and support services due to her own childhood experiences, so for a short time the children were taken into care. Different organisations came together in partnership with Jade and her family to work through their issues. They made sure the children were at the centre of the picture.

A Family Intervention Worker from Jade's local children's centre supported the family to manage debt and access benefits. Jade was supported to allow her older child to access a free 2 year old place and speech and language therapy at a local nursery. She built good relationships with the Health Visitor and Early Attachment Specialist who supported Jade with parenting, and enabled the family to get back on track.

Both parents accepted the help and support they needed to make changes and the children were returned to the family.

They continue to make significant progress. Jade's very proud of her children and is keen that they have a positive childhood experience. Jade no longer needs a Family Intervention Worker but often pops into the children's centre to attend the groups where she has built confidence and made new friends.

*name changed

Breastfeeding

Breastfeeding supports babies to get the best start in life. It offers amazing opportunities for mothers to bond with their babies, which is vital for the baby's emotional and social development. For the child, breastfeeding reduces the risk of chest and ear infections, eczema, constipation, diarrhoea and vomiting, and for the mother it reduces the chance of developing certain cancers.

2 in every three babies in Tameside start life with breast milk

1 in three are still breastfed 6-8 weeks later

Mum;

"It's what she wants to do as soon as she's born so I didn't want to deny her that, and I love doing it. It gives me peace of mind to know she's benefitting from my immunities passed on through the breast milk"

A network of partners and organisations in Tameside are working hard to support new and expecting mother to initiate breastfeeding, and to keep it up for as long as possible. This also includes working with Tameside businesses to create a culture that welcomes breastfeeding.

Some examples of this work include:

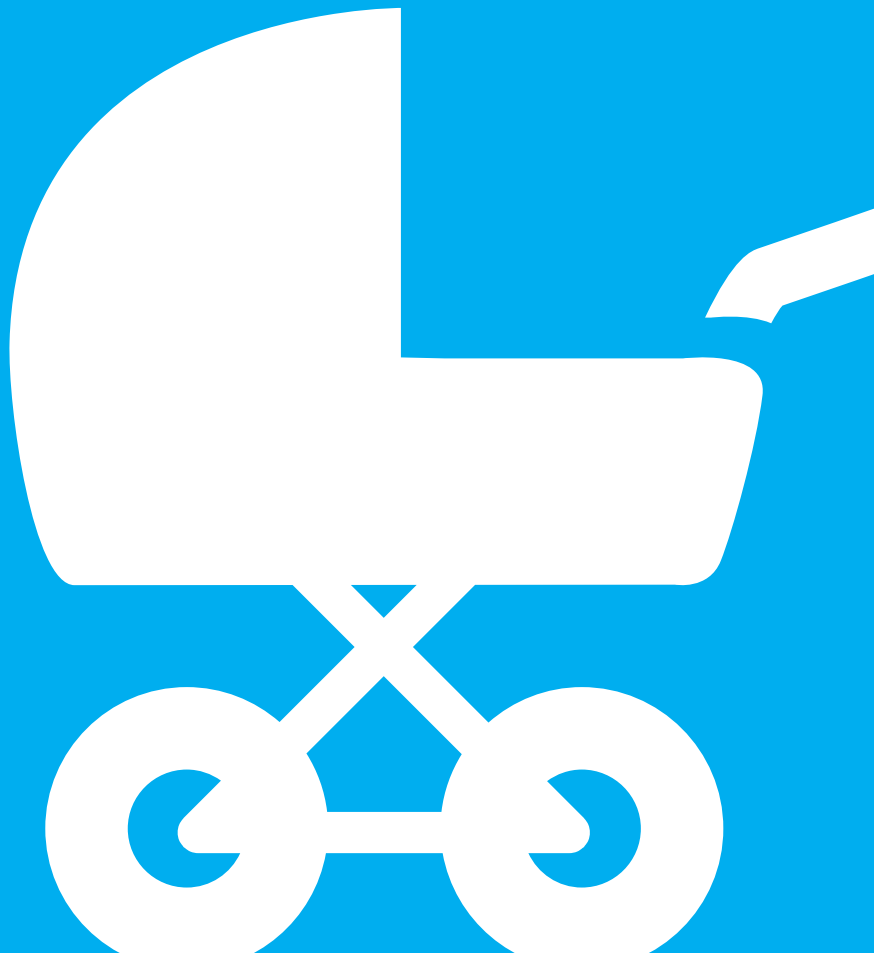
- Promotion of a social marketing campaign 'Breast Milk, it's Amazing'. This also included a website www.amazingbreastmilk.nhs.uk and the BreastStart App, where mums and mums-to-be can gain help and advice
- Supporting local businesses and community venues to sign up to a 'Baby Welcome' award scheme. This work included promoting all venues that welcome breastfeeding mothers, and advising them on how to provide a comfortable environment for them to feed their babies
- Tameside Hospital, Community Health Visiting, Children's Centres and Breastfeeding Community Co-ordinators successfully awarded with the UNICEF Baby Friendly stage 3 accreditation.
- Homestart offer breastfeeding support to every breastfeeding mum in Tameside through bedside support at Tameside Hospital, advice and home visits and support groups.

"I want mums to feel confident and comfortable breastfeeding and to really enjoy it as a chance to bond with their baby"

breast milk
...it's amazing!

Recommendations

- Increase the proportion of children in Tameside who are 'school ready' enabling parents to give them the best possible start in life using an integrated approach across our partnerships and services in the borough
- To develop integrated, flexible services to ensure learning and childcare for all children and families, and improve family economic wellbeing
- To promote breastfeeding and early attachment to ensure parents build a strong relationship with their baby.



Life Stage: School Years Primary

Parents are undoubtedly the most important teachers a child has throughout their life. The responsibility for developing our children is not a baton that is passed from parent to teacher on starting school, but is a job for which the team grows bigger with the child. As children in Tameside enter the education system, responsibility for their healthy development expands to include teachers, school staff and health professionals. All parties contribute towards children being healthy, safe, and cared for. As children progress through school years it is important that we help parents continue to provide opportunities for their children to develop and grow in the home environment, in particular those families who live in poverty or difficult circumstances.

The vast majority of children in Tameside will enter a school setting aged 5. This gives us an opportunity to collaborate with schools to work with children directly. By supporting schools to deliver a strong health and wellbeing programme for children and young people, we can increase children's own understanding of health, and shape better habits that lead to wiser choices as they get older. For some children with special educational needs and disability an Education, Health & Care Plan will ensure that holistic support is available to them.

Healthy Weight

The rates of childhood obesity in Tameside are in line with England averages and don't appear to be increasing or decreasing. However, one child in ten in reception year, and one in five in year six children is obese. For these children the health risks in childhood, and likelihood of developing problems as a result in adulthood, are unacceptably high.

The diets of children are largely shaped by their family's habits. The National Diet and Nutrition Survey (Years 1-4) found that as a whole, the population is consuming more saturated fat, sugar and salt than is recommended for good health. They take in less oily fish and fruit and veg than recommended.

There are also risks of vitamin and mineral deficiencies, especially vitamin D and iron; which are vital for a child's developing body.

Our Children's Nutrition Team has a key role in providing prevention and weight management services for children, young people and families in Tameside. The team offers support to improve diet, have good oral health and be physically active; all of which will promote healthy weight and improve long term health.

Courses are provided for children and families of different age groups. All of which promote a healthy lifestyle. Sessions include healthy eating, physical activity and the importance of good self-esteem. 'Ready Steady Cook' courses in primary schools are also held to increase children and families' cookery confidence and nutritional knowledge, and to promote healthy choices.

The Food4Life award scheme supports and recognises schools for their whole school approach to providing a healthy food environment leading to improved nutrition for children.

The Nutrition and Oral Health awards for carers of under fives aim to ensure that childcare providers meet local and national guidelines on nutrition and oral health. A varied programme of food and nutrition training is offered to staff or volunteers working with children, young people and families; this includes accredited training, and healthy weight brief intervention and training to promote the Healthy Start Scheme.

A total of 215 staff/volunteers working with children, young people and families received food and nutrition training in 2014/15. This enabled a further 295 children to improve their knowledge and confidence to make healthier food choices, maintain a healthier weight and contributed towards avoiding health problems related with too much weight in later life.

For example

As a result of working towards improving healthy weight in pupils, Fairfield Road Primary School implemented a new snack time policy. They consulted with parents to allow only fruit or vegetables and water or milk to be brought into school for snacks. They also altered their policy on birthdays; instead of parents sending in sugary treats, a child is now allowed to wear non-uniform on their birthday as a treat.

Dad;
"I want my child to enjoy their food and be healthy"

Case Study: Miah

Eight year old Miah* attended a 10 week Jumps 7-13 course with her mum Karen*. Karen brought sugary fizzy drinks to drink whilst she was on the course with her daughter. She stopped bringing these after a few weeks and at the end of the course Karen said that it had had a significant impact on the family's eating habits and activity levels. The sessions had also made her realise the impact of her own eating habits on her daughter's habits.

She reported that her daughter and family were now eating fruit daily, eating smaller quantities of chocolates and sweets, had reduced portion sizes at mealtimes, and were drinking more water. They were walking regularly as a family and had started going swimming every week. Her daughter's weight had reduced during the course and a range of healthier habits were developed.

*name changed

Oral Health

Around a third of children under the age of 5 in Tameside lose a tooth to decay. Whilst this is below the average for England for decay/cavities, there is more work to be done.

Thorough brushing of baby teeth and creating good oral hygiene habits in early childhood is very important in protecting the health of children's teeth and gums. Baby teeth that are in a good condition when they fall out help create a healthy mouth for adult teeth to grow in.

At 6 and 12 months all Tameside children receive an oral health pack containing information on how to access NHS dental services, a baby toothbrush, a tube of family fluoride toothpaste, and a list of venues where parents and carers can purchase more affordable oral health items for all the family.

Training and resources are offered to all early years settings including pre-school, childminders, reception classes in schools and general dental practitioners by our Oral Health Team. More targeted programmes include a fluoride varnish scheme in Hyde where additional support is given to the Bangladeshi communities, where 70% of children have some decay with an average of nearly four teeth affected.

Physical Activity

Physical activity is important for children of all ages, yet less than a quarter of children in England and Tameside do enough to meet the recommended guidelines.

Fun and games provide invaluable brain and body stimulation for the developing child, fine tuning motor skills and fuelling the imagination, as well as creating opportunities to learn about sportsmanship, camaraderie and team skills with playmates. Throughout this time physical activity lays the foundations of a healthy body through exercising muscles and joints, making them stronger for life.

From birth to age 5 play and exploration are crucial in teaching a child how to interact with the people and world around them.

We wish to help families to spot the opportunities for physical activity in their wider environment and day to day life. Walking or riding a bike to school, climbing trees or making dens in our local parks, and exploring our greenspaces and local environment are all ways we intend to encourage families to move more.

Riding a bike to school

Our communities are also home to a multitude of sports clubs for children and young people, and we have good provision of recreation and sports facilities across the borough.

Parent;
"I haven't got much time in between other things so it needs to be something cheap and easy. I don't want them glued to the TV or a tablet."

Tameside Greenspaces have also worked with the Football Association to provide age specific pitches in our parks, with over 300 children playing football at King George V playing field every week during the season.

The Greenspace team also currently maintain 34 play areas in the Borough as well maintaining and parks and countryside to a high standard to give Children and Young People the chance for informal play that is so important to their development.

Young Person with Disability;
"I love coming to the club every week - I can see my friends, have time away from my Mum and Dad as well as being with others who understand me."

The Council has been working with the School Sports Partnership to support schools to deliver a high standard of physical education and activity.

Family Health Mentor;
"I want families to recognise the benefits of their children being a healthy weight and to feel confident in providing a balanced diet and active lifestyle"

This includes extending the 'Make a Difference' programme (MAD). We are also in the early stages of working with partners to develop an Active4Life award for schools, encouraging them to provide the most active school environment they can.

Living Streets currently work with 51 Primary Schools and 8 Secondary Schools encouraging children to walk more. They have given out over 10,330 badges in Tameside as part of the Walk Once a Week scheme.

Case Study:
Programme participant

I have been doing this programme called Make a Difference. We do different activities like basketball, hockey and going to the gym. It has made me feel really positive about myself. Not only that, I have lost 25lbs in about 10 weeks of MAD.

In 2014/15 Active Tameside, our local sports and recreation centre provider, delivered or supported swimming lessons for children in Tameside, which resulted in 70% achieving the National Curriculum standard. A further 4000 children took part in private swimming lessons. They also provided 'Coaches in Schools', which supported 7000 young people to get physically active every week.

ACTIVE TAMESIDE

Active Tameside have recently developed Active Juniors, which focuses on encouraging young people to take part in physical activity. Characters have been created for children to identify with, including Elegant Ella the gymnast, who will appeal to the 900 young people who took part in gymnastics classes this year.

There's also Adventure Ava, who represents Active's new climbing and high ropes centre, the first of its kind in Tameside.

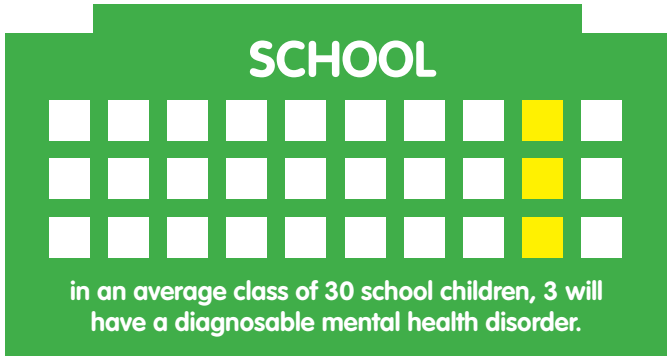
Sports Coach in Schools;
"I want families to enjoy fun active stuff together, and for kids to grow up with physical activity being something that is a normal part of everyday life"

Emotional Health and Wellbeing

Nearly 10% of children aged 5-16 in this country have a clinically diagnosable mental health condition, but it's estimated that just one in four children and young people with mental health problems receive any support or treatment.

As a result, mental health difficulties such as anxiety, low mood, depression, severe behavioural problems, and eating disorders can stop some young people achieving what they want in life or making a full contribution to society.

This means in an average class of 30 school children, three will suffer from a diagnosable mental health disorder, with the most common being severe behavioural problems, anxiety, depression and hyperkinetic disorders (disorders that are characterised by problems with lack of attention, excessive energy or impulsive behaviour) . There is also emerging evidence of a rising need in certain groups, for example the rate of young women with emotional problems is increasing, as is the number of young people presenting with self-harm.



Young Minds mental health and wellbeing awareness Project:

Tameside, Oldham and Glossop Mind (TOG Mind) has developed and implemented an early intervention programme with schools and young people including:

- **Assemblies and workshops at Tameside Secondary Schools** - Schools are offered a week of assemblies covering all pupils and 2 student drop-in sessions or targeted workshops (depending on the needs of the school).

- **Follow on and development work requested by existing schools** - TOG Mind has received requests from schools in the first stage of the programme to follow up with the new intake of year 7s and provide additional sessions.

- **Development of a primary school model in conjunction with local schools** - There is a need for emotional resilience and wellbeing sessions for primary children, in particular year 6 during the transition period to secondary school. TOG Mind is consulting with local primary schools to develop material that could be rolled out during the summer and autumn terms of 2015 (secondary school transition period)

An example of local work:

Teens and Toddlers

This programme sees young people paired with a toddler in a nursery or primary school setting, whom they mentor and act as a positive role model. This experience is supported by young people working towards an Entry Level 3 in Personal and Social Education.

Teens and Toddlers works with young people aged 13-16 who are in need of extra support to help them;

- Raise their aspirations
- Develop healthy relationships
- Improve their emotional health and well being
- Realise their potential

Case Study: Natasha, Teens and Toddlers Programme

Natasha* was placed into care following a family breakdown, but her younger siblings had stayed in the family home. She was given a place on the Teens and Toddlers project where she started to build a meaningful relationship with her own toddler and other children who wanted her attention. She enjoyed the nursery time, reporting to one of the Teens and Toddlers staff that she missed her little brother but playing with her toddler made her feel closer to him.

Natasha had a difficult time with her peers, and had been bullied, but she was able to use classroom time to share how she felt with the group which increased their respect for her. Natasha's class and folder work were of a very high standard. She understood the material we were teaching and said how much she enjoyed the nursery time and learning how babies and toddlers developed emotionally and psychologically.

During the programme Natasha decided she wanted to work with toddlers, and was supported to explore available courses to qualify to become a childcare worker. This helped her understand the level of commitment required, which gave her a real focus.

Her individual learning plan showed attention to detail, and a progressive route within a clear time frame. This supported Natasha to focus on her goal.

Natasha took her GCSE's in May 2014. She secured 5 good grades and enrolled on a college course to become a nursery assistant/teacher. The positive connection she had received during her time on the project enabled her to embark upon a meaningful career helping young children.

*name changed

Recommendations

- Deliver a variety of approaches to make health choices around diet, oral health and physical activity fun and sustainable through our healthy weight strategy
- To ensure the smooth transition of children from early years into primary school providing a health and wellbeing offer, including emotional wellbeing throughout these vital school years.

Life Stage: School Years/Adolescence

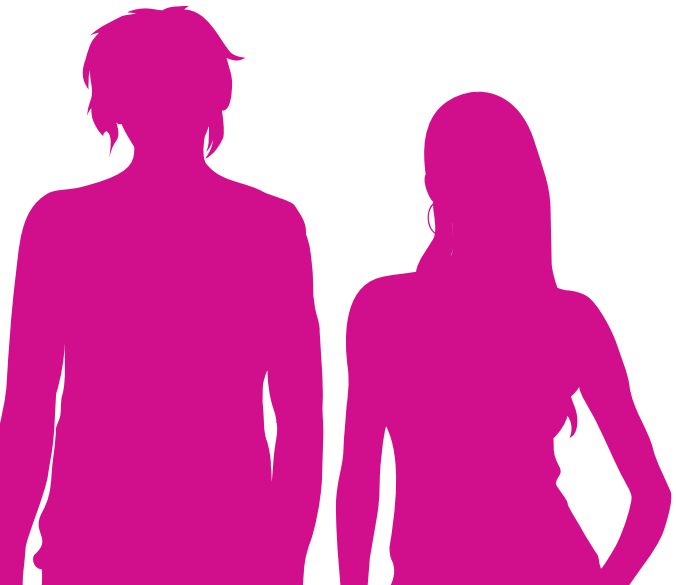
Secondary school is a hugely important period in a young person's life. There are biological, cognitive and emotional changes, but for many the change to secondary school marks social upheaval too. It can be a stressful time for young people, who may look for ways to cope or fit in with peers that could negatively impact their health. Children learn most from friends and families, and the habits these people have will influence their behaviour.

Young people at this stage are prone to risk taking and experimentation with things like tobacco and alcohol as they learn to manage changing levels of responsibility and freedom.

Young people aged 10-19 years are assumed to be low users of health services. This can sometimes make young people almost invisible in a health service that focuses on the very young, middle aged and the old. As adolescence is a key period of rapid and extensive physiological and biological growth, second only to early childhood, there needs to be a greater focus on supporting this age group in Tameside.

Children with additional needs arising from their disability can find accessing social opportunities away from their families difficult at this time, for example such as meeting friends outside of school.

It is also a challenging time for parents who are anxious about the growing independence of their child. Many voluntary groups provide vital support to both young people and their parents at this time.



Sexual Health Promotion

Young people today are having sex at an earlier age than previous generations (average age is now 16).

Chlamydia is one of the most common sexually transmitted infections in the UK. It is symptomless; so many people carry it without knowing. This means it can spread undetected, and is especially common amongst younger people. Those under 25 are the most at risk of contracting chlamydia through unprotected sex.

Left untreated, in both women and men Chlamydia can reduce fertility. It can also increase the risk of ectopic pregnancy in women, so screening is needed to identify and treat the infection. A third of all young people aged 15-24 in Tameside come forward for Chlamydia screening each year. Of the 9,860 who requested a test in 2014, over 8% were found to have the infection.

Our aim is to increase the number of sexually active young people who request a test. In addition to facilitating testing and treatment, we also wish to support sex education and services that appeal to young people through appropriate media.

Young people told us they want rapid access to confidential, open access sexual and reproductive health services in a range of settings, accessible at convenient times. The local sexual health service in Tameside offers a 'no appointment necessary' drop in. Young people can also access a Chlamydia test on request via their GP, by post from:

www.ruclear.co.uk

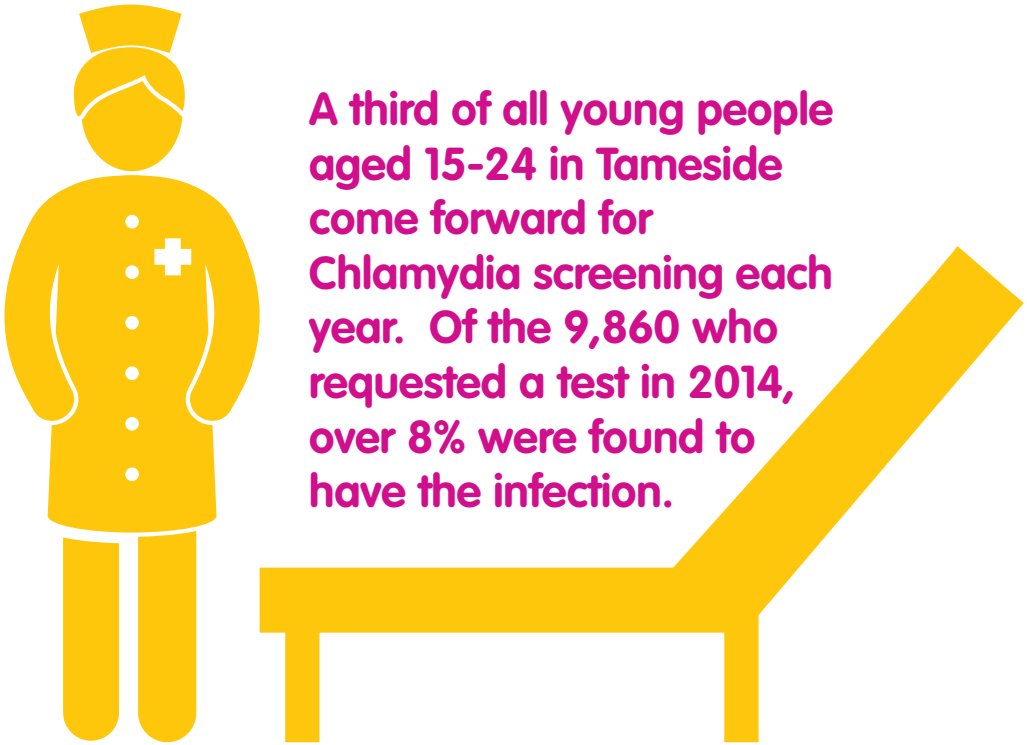
or from the Orange Rooms sexual health service.

www.theorangerooms.co.uk

The sexual health service has recently been working through the Young People's Quality kite mark 'You're Welcome', and has developed a smart phone friendly website as a result:

www.theorangerooms.co.uk

Tameside sexual health is working with partners across Greater Manchester to ensure future services meet the needs of our younger residents.



A third of all young people aged 15-24 in Tameside come forward for Chlamydia screening each year. Of the 9,860 who requested a test in 2014, over 8% were found to have the infection.

Personal Social and Health Education (PSHE) and Sex and Relationships Education (SRE) for all

According to the below select committee report, PHSE requires improvement in 40% of schools. The situation appears to have worsened over time, with young people consistently reporting that the sex and relationships education (SRE) they receive is inadequate. This situation would not be tolerated in other subjects, and yet the Government's strategy for improving PSHE is weak. There is a mismatch between the priority that the Government claims it gives to PSHE, and the steps it has taken to improve the quality of teaching in the subject.

http://www.publications.parliament.uk/pa/cm201415/cmselect/cmeduc/145/145.pdf

Tameside Council is helping support better sex and relationship education via outreach from the You Think team **www.tgsafe.co.uk**

This website is for any young person who is having, or planning to have sex. It offers advice on contraception, sexually transmitted infections and avoiding unwanted pregnancy.

The page also offers a directory of local pharmacies that offer emergency contraception, and the locations of sexual health clinics across Tameside.

In addition it has a series of short educational films made with young people for young people dealing with the consequences of having unprotected sex.

What is needed:

- A statuary requirement for, and higher quality of PSHE and SRE in schools
- More clarity on the status of the subject
- PSHE Education being Statuary and Ofsted must clarify how schools provision of SRE relates to its safeguarding judgements and pupils spiritual, moral social and cultural development
- Regular parent, family and carer involvement
- Participation of young people in design and plan of SRE and PSHE Services
- Good teacher training and staff development in PSHE/SRE

We understand that young people have different experiences of learning about sexual health and contraception:

Young Person;
"They do not teach us about sexual health only about puberty and contraception in Year Seven."

Young Person;
"I really wanted to learn about it and I always ask teachers if we can but we never do, although I would really like a lesson about it."

Tobacco

Whilst the proportion of young people using tobacco in Tameside is thankfully in decline. Evidence shows that the younger an individual starts to smoke, the more likely they are to be an adult smoker, the heavier they are likely to smoke during adulthood, and the more likely they are to fall ill and die as a result of smoking. Whilst the proportion of young people using tobacco in Tameside is thankfully in decline, for those who do take up the habit, half will lose their lives to smoking related disease.

70% Approximately of smokers start under the age of 18.

As nicotine is a highly addictive substance it is much better to support young people to choose to stay smoke free rather than help them give up when they are adults. Because of this, we are working to 'Make Smoking History for Children' in Tameside. This is how;

- We offer a stop smoking service that provides free, non-judgmental support to adults and teenagers to become smoke free
- For those who haven't yet succeeded or do not wish to quit, we promote the 'Take 7 Steps Out' campaign. This seeks to protect children from second hand smoke by keeping homes smoke free
- Children are less likely to smoke if they don't see adults around them smoking. All Council owned parks playgrounds in Tameside operate a voluntary ban on smoking, with 34 sites across the borough displaying smoke free playground signage

- Some of Tameside's young people took part in Greater Manchester project 'Smoke and Mirrors'. Understanding more about the industry to empower them to make more informed decisions about where they spend their money.

The use of e-cigs by young people in Tameside is an emerging trend. Whilst there is no guarantee of safety, there is a body of opinion that e-cigarettes are significantly less harmful than tobacco. Despite this, we still wish to protect children and young people from any form of addiction. Since e-cigs include nicotine, we see this as a public health concern.

The Council's Trading Standards team plays an integral role in protecting children from tobacco. In 2014/15 33 test purchases were made for underage tobacco sales, with only one resulting in a child successfully purchasing tobacco. This was swiftly dealt with. They also tackle the suppliers of illicit and illegal tobacco. They remain particularly vigilant of businesses targeting young people, and are currently seeking to prosecute an ice cream van, which parked outside a school selling illegal tobacco products to children.

Supporting adults who want to quit, promoting smoke free homes, and encouraging young people to choose to remain smoke free all contribute to making smoking history for children.

Professional'; *"I want to see a Tameside where young people feel being smoke free is the norm, and who see smoking as uncool"*

Parent;
"I don't want to see my child get ill from smoking"

Alcohol and Drugs

Alcohol affects children directly and indirectly through their parent's use. In a survey people were asked whether they knew of a child who had been neglected or not well looked after because of someone else's drinking. 8% of people said yes. That equates to around 728 children in Tameside each year.

19% of people who access alcohol treatment have dependent children, and for 17% of children on a child protection plan, parental alcohol misuse was a contributing factor.

The number of children aged 14-17 binge drinking in Tameside is showing a downward trend, dropping 13% between 2011 and 2013. Alcohol related hospital admissions in the under 18s has been steadily falling since 2006 dropping from 190 to just 81 admissions in 2014/15. Whilst this is a vast improvement, there is clearly further room to move alcohol use to less damaging levels.

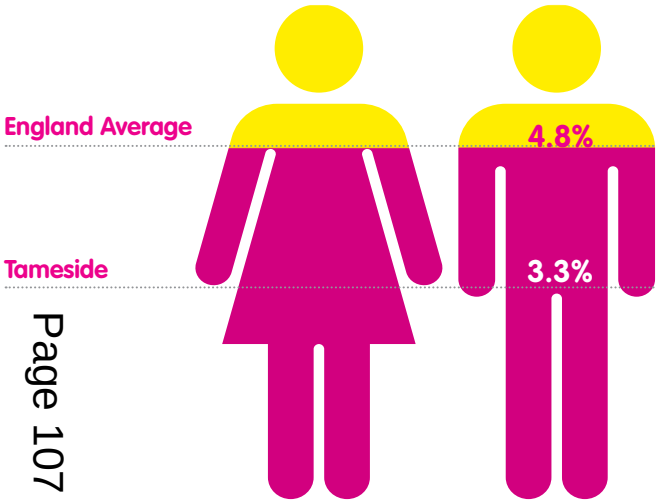
There has been an overall decline of drug use by children in the last decade. Cannabis is the most widely used. There has, however, been an increase in the use of legal highs, which are increasingly being revealed to cause immediate and long term harm.

Although the decrease in cannabis use is positive, there are still too many children using the drug in Tameside. As with smoking we need to prevent young people from starting to use the drug in the first place, and offer support to those already using the drug to quit.

It is estimated that 0.4% of 9-17 year olds will seek help for drugs and alcohol issues. In Tameside, this accounts for around 97 children and young people. For those who do, Lifeline is our local provider of drug and alcohol support. Lifeline work with individuals, families and communities both to prevent and reduce harm, to promote recovery, and to challenge the inequalities linked to alcohol and drug misuse. Lifeline currently provides a diverse range of services including recovery and peer mentoring, harm minimization, day programmes, prescribing and shared care, community detoxification services, criminal justice and prison initiatives, family work and services for young people. See more at:

www.lifeline.org.uk/about/#sthash.JahPkIz9.dpuf

Young People Not in Education, Employment or Training (NEETS)



There are fewer young people who are NEET in Tameside than the England average. At just 3.3% of the young population compared to 4.8% nationally, the steps both we and our young people are taking to further skills and increase employability are evident.

Evidence shows that being out of work can be detrimental to health, with immediate consequences including increased risk of depression and suicide. Being unemployed for extended periods whilst young can have an impact on long term employment chances. Those who are out of work for six months or more become less likely to develop a good career. If the situation remains unchanged to the age of 21, it can result in a lack of training, a criminal record, and poor physical health.

The reasons for ill health linked to unemployment relate to a number of causes, including reductions in income, increased social exclusion, isolation and a lack of social support. There is also potential for increases in unhealthy behaviours such as drinking and smoking.

Positive participation and youth unemployment are high on the national agenda and a local priority in Tameside where there are a number of support programmes available.

Talent Match is a mentoring scheme to help young people overcome barriers to employment. The purpose of the Youth Contract programme for 16 and 17year-olds is to engage young people who are hardest to reach and support them into education, training or a job with training. Other local Tameside initiatives include grants for employers taking on new apprentices and grants for young people entering a career in hands on trades such as plumbing, joinery and roofing to name but a few.

Support for those who are NEET is managed locally in Tameside by Positive Steps. Positive Steps provide a range of targeted and integrated services for young people designed to get them on the right track and fulfil their potential. In addition they also work in several of Tameside's schools providing careers advice to pupils.

Case Study: Sam

Sam has learning difficulties and had a history of exclusions, poor attendance and threatening behaviour towards peers and teachers, he was also NEET. Following an incident of domestic violence aimed at his mother he was put on to a referral order with Tameside Youth Offending Team.

Sam worked with his Career Adviser and was assessed for educational needs. It was agreed that he would benefit from accessing a local Study Programme. With support he chose local provider Rathbone. He was still prone to displaying behavioural difficulties and had some attendance issues, but his Careers Advisor maintained contact with him throughout and worked closely with the staff there to ensure he received intensive 1 to 1 support. She also facilitated a referral to the Young People's Mental Health Service to effectively manage his anger

Sam's educational attainment improved markedly. From Pre-Entry Level 1 he has now attained Entry Level 3 for his literacy and numeracy. Rathbone staff feel confident that achieving a Level 1 qualification and starting a full time college course by September 2016 is achievable.

Recommendations

- Develop and implement our public health strategies and interventions for young people which have a balanced focus on early childhood, school years and adolescence, with particular focus on improving sexual health, reducing substance misuse and improving emotional health and wellbeing
- To work in partnership with parents/carers and outside agencies towards an embedded PSHE/SRE curriculum that builds upon previous knowledge, and takes into account what children and young people know and want to know
- To drive the PHSE/SRE Agenda forward across the borough through the Tameside CYP Health and Wellbeing Partnership Forum and SRE special interest group
- Implement a strategic focus on locally based activities and programmes to improve employment prospects and opportunities for youth education and employment
- Work with partners to ensure poor health is not a barrier to employment for young people. We will offer practical support for young people to be healthy, so they can achieve and access opportunities.

Life Stage: Vulnerable Children

The period between leaving school and becoming an adult is a critical time for young people. On leaving the structure and formality of school life through which they have been channelled for many years, the majority will find the choices before them exciting and liberating.

Some children are more vulnerable than others, meaning they are exposed to greater risks, or are at a disadvantage in comparison to other children their age. We have a responsibility to ensure they are kept safe, above all else, but also to give them an equal chance of becoming happy, healthy and independent adults. For those whose childhood experiences have been difficult, this can be a daunting time. With the right support where it is needed, we can help them set off on a path that leads to good health in later life.

For some of our children, in the absence of consistent parenting, and with different expectations of family life, situations and relationships may develop that bring risks. For others, like young carers, their choices may feel restricted as they look for ways to develop themselves whilst juggling their caring commitments. For children with additional needs arising from a disability their choices will be far more complex, and they may need additional support to make sure they fully understand what their options are. The challenge is to strike a balance between guiding young people in the right direction, nurturing independence, and respecting personal choice.

Transition to Adulthood

The transition from adolescence to adulthood is an important time for families of children with additional needs. During this period services are split between those aimed at children and young people, and those aimed at adults. Oversight is needed in order that they experience a seamless journey from one set of services to another. This is now assisted by a Transition Social Worker (TSW), who liaises with different organisations, the young person, and their family, to ensure their aspirations can be planned for and supported.

Around 30 young people aged 15-18 in Tameside work with a TSW. TSWs work with young people with complex needs that mean reaching their potential may require additional help. TSWs work alongside families to identify the young person's aspirations, and assist them in planning how they may work towards them. This role was introduced in 2014 and has, to date, been an invaluable resource for young people, families and professionals.

Young Carers Project;
"We want to support these children so they can still enjoy a childhood. It's important they don't miss out on opportunities to build their own future."

Parents;
"We want our child to gain independence but letting go makes us anxious. We need to feel he's still supported when he moves into the adult world"

Child;
"I know I need some help to do it, but I want to be able to work and have a flat, go out with friends and do the things other people my age do"

Around 30 young people aged 15-18 in Tameside work with a Transition Social Worker (TSW).

Case Study: Jane

Jane is now 18 and living independently but with tailored support. She was a looked after child and has autism. Her formal "transition" started at age 16. Her Social Worker, placement, school and the Transition Social Worker all worked together with her to identify her aspirations. She was able to identify what she was good at and what she needed help with.

This formulated her person centred plan. An early referral to adult services was made to make sure that new services would have an understanding of her needs. By knowing where she wanted to be services were put in place to help her achieve her goals. This meant that she was working to independence at her own pace with the security of support to help her manage new situations. She was able to make a positive move towards independence.

Young Carers

A Young Carer is a child or young adult with a responsibility for looking after the needs of someone close to them. Children in these circumstances may need support to balance school and home life, and to access opportunities to enjoy childhood as much their peers.

There are believed to be around 600 children under the age of 15 caring for someone else in Tameside, and a further 1,500 aged 15-24. We wish to ensure all young carers are supported with their responsibilities, but are also given the opportunity to meet others in a similar situation, to make friends, get advice, and to ensure that their own aspirations don't fall by the wayside.

Tameside Young Carers Project has 419 children aged 8-18 on its register. The project supports young carers with regular after school clubs for different age groups. These help to develop their social skills and friendships, and provide arts, crafts and sports activities, as well as practical sessions such as first aid. The groups are accessed by 150 children and young people in a year. At present the project runs one weekly group for over 13's, and four fortnightly groups for Primary, years 7/8, years 9/10/11, as well as a separate girls' group. Older young carers are offered a 'Time for me' course to help look at their confidence and planning for the future.

The Young Carers Manager and support staff provide one to one work on different issues identified in assessments for young carers. This includes anger management, talking about their feelings, and open discussion about the illness in their families

The Young Carers Manager also supports a network of named staff in schools, and works with schools to support young carers with issues such as bullying.

Grants are also available for breaks and holidays as well as support with costs of school trips college courses, and attending national Citizenship Scheme or work placements.

Child;
"I don't want to feel guilty about leaving my mum on her own. If I know someone else is there to help I can go out and just be myself for a little while"

Parent;
"I want my child to have friends and time to play. I don't want them to be too tired for school or fall behind or miss out on things just because they are helping me"

Looked After Children

The number of Looked After Children in Tameside is in line with the average for the North West at 417. Looked After Children have the same health needs as their peers, but the extent of these needs is often greater because of their past experience.

Looked After Children tend to be more vulnerable to emotional and mental health issues which may have longer term implications. For some children who experience multiple placements, the presence of emotional upset and the absence of a single guardian with whom to form a steady attachment can mean the usual boundaries required by a young person are not consistently reinforced. This can lead to increased risk taking and experimentation when compared to children who live with parents. This can go on to become lifestyle choices that lead to ill health.

We must ensure children growing up in care have equitable access to health and life chances as their peers. It is important that all agencies and services fulfil their corporate parenting responsibilities

As a local authority we have a statutory responsibility to ensure all Looked After Children have a 'Review Health Assessment' in place. This assessment takes place to ensure no health conditions are overlooked, and enables an effective plan of action to be put in place to address identified health needs. The resulting health plans are quality assured.

A specialist 'Named Nurse' is designated for Looked after Children. This person is responsible for developing appropriate care for Looked After Children in conjunction with multi-disciplinary teams. The Named Nurse delivers a training programme to all health staff, which examines the health inequalities Looked After Children may face whilst in their care, and beyond into adulthood. A specialist qualified nurse also works with Children's Homes around protecting children who are at risk of child sexual exploitation.

Children Living with Domestic Abuse

Around one child in 20 in Tameside is thought to be living in a situation with domestic abuse. The impact of this on a child's life and their consequent development into adulthood is significant. It is important, where a child experiences abuse, that the appropriate safeguarding protocol is followed. There are additional ways in which we can support families at risk of becoming violent or abusive by addressing some of the underlying factors that lead to it.

Poverty and deprivation, mental health issues, and drug and alcohol abuse are all factors that are linked to domestic abuse. Supporting families to tackle these underlying problems, assisting them to build personal resilience, and finding appropriate outlets for frustration are ways we can see domestic abuse reduce over time.

Case Study: Off the Record

Jane was an 18 year old victim of domestic violence who sought help. She received counselling to support her whilst going through the court system in relation to the domestic abuse. She had a significant substance misuse problem and as a result of the abuse, she had become very isolated and suffered from agoraphobia. With the help of Branching Out, who work with children and young people who misuse substances, Jane was able to stabilise her substance misuse habit.

Jane started a new relationship and subsequently became pregnant. However, her new partner then became verbally abusive and controlling, and Jane became fearful of physical violence. With support, Jane was able to recognise the cycle of abuse starting again and knew that she had options. She was able to rebuild links with her immediate family and stopped her substance misuse. Her unborn baby gave her a new focus and she began looking after herself more. She has now started working again, and has recently completed a college course in Child Care and Education.

Children with Additional Needs arising from a Disability

Some children have complex health needs which can be related to a physical or mental disability, or a terminal or life limiting illness.

Extra support is available to achieve positive outcomed for children living in such circumstances. It is important that all services are inclusive and don't deny access to children with additional needs. For children who may require more formal arrangements, it is important that our Local Offer and Short Break Statements reflect the services and support available. These published details state what support is available locally, and the short breaks are available to children with additional needs. This can be seen on the Tameside Council website. This enables families understand and access provision that supports improved outcomes for their child.

http://www.tameside.gov.uk/disabilities/children/shortbreaks

There are currently around 65 members of staff within the Integrated Service for Children with Additional Needs (ISCAN). The service comprises therapists, nurses, dieticians, a behaviour team, social workers and portage workers who all work with children identified with additional needs from 0-19 years.

Whilst some children will not be known to Social Care, particularly the under 5's, they will receive a range of services from health staff. Health staff members work closely with Social Care and Education to provide a holistic approach to the children's needs.

A member of the team also acts as Lead Professional, a designated single point of contact for the family. They help to co-ordinate services for families, which includes a number of parent support groups.

Social Care Manager;
"These children's experiences should mirror those of peers who do not have additional needs. Life chances should be equitable with our support"

Case Study: Anna

Anna is 8 years old and lives with her mother in Tameside. Anna has Cerebral Palsy and needs lots of exercise to keep her supple and mobile. Anna and her mother receive support through the direct payments scheme, to access social and leisure activities and support in the home.

They employ a personal assistant through direct payments, who helped Anna to access swimming lessons and sessions at her local pool.

At her review Anna and her mother said that they would like more opportunities to access sporting and craft activities. Active Tameside and "Our Kids Eyes (OKE)" have worked together to ensure that Anna was able to access swimming.

Since working with "OKE", Anna and her mother no longer need a personal assistant. They attend a range of play sessions with other families, and are able to access many more mainstream opportunities.

Recommendations

- Work together to help Young Carers to care for their loved one, to help them build a support network, to connect with friends who understand their lives, and to reach their full potential
- Work with social care to provide additional help for vulnerable children to enjoy good mental health and self-esteem, and to build resilience and confidence to say no to risky behaviours
- Promote the integration of services to improve the young person's journey from childhood to adult.

2013/14 Public Health Annual Report Update

Mental health has been standing in the shadow of physical health for too long. Last year we aimed to bring it into the daylight by taking part in a range of programmes to build the emotional health and wellbeing of our residents. We chose the 5 ways to wellbeing (5WTWB) as a strong yet simple starting point; Connect, Be Active, Take Notice, Keep Learning and Give.

So what did we do?

- We invited a number of community groups to come forward for grant funding. With the help of Community and Voluntary Action Tameside (CVAT) we awarded 12 community grants to groups who could best deliver 5WTWB. These ranged from groups for new mums, to adults recovering from substance misuse, to a girls' football team.

- We supported 'Time to Talk' day on 5th February 2015, encouraging people to break their own silence on mental health, and chip away at the stigma. We partnered local mental health charity Tameside, Oldham and Glossop Mind to create a double page spread for the local press. This included contributions from the Chief Executive of the Council, and of TOG Mind, as well as our Executive Member for Health and Neighbourhoods, and myself.

http://www.time-to-change.org.uk/

time to change
let's end mental health discrimination

- We continue to partner Tameside, Oldham and Glossop Mind which provides a number of interventions to improve mental health on our behalf. They have also been developing a network of community partners to build community resilience, and have developed a Mental First Aid model to take back into the community. So far 128 people have been trained and 92 have become community partners. They will provide emotional support and signpost to services to help with emotional and mental health problems when needed.

- We've refreshed our approach for positive mental health amongst children and young people. This includes workshops provided by Tameside, Oldham and Glossop Mind and Off the Record counselling services.

- We have supported interventions that reduce loneliness by connecting people, particularly older people for whom chronic loneliness can affect their health. Our 'Spread the Warmth Tea Party' on National Older People's Day in October 2014 kick started the programme with more than 100 older people in attendance. The then Mayor and Mayoress also joined as special guests.

'we said, we did' 2015

- We now support New Charter, a local social landlord, to provide transport that enables older people to be involved in activities that have been developed to reduce loneliness.

- We also supported the development of a bereavement service at Willow Wood Hospice.

- We delved deeper by asking our local Citizen's Panel about their mental wellbeing. Some of the initial results show us that women in Tameside have a higher wellbeing score than men, and it's the over 60s who scored highest compared to younger age groups. These results gave us some insight into further work that can be done.

- We provided mindfulness sessions for people working in local businesses through our workplace health improvement programme. Mindfulness is something that is gaining momentum as a technique to alleviate stress and anxiety.

- Keep your eye out for the 'Linking Tameside with the World' project at Portland Basin delivered by Tameside Council's Culture Team. It has the '5 Ways to Wellbeing' at the heart of its work, and encourages different generations to connect.

- New cycling and walking guides have been produced with interesting facts and points of interest about the local area. This will enable Portland Basin to become a hub of activity helping people to connect with others, take notice, and learn more about their local area.

- We supported the emotional health of babies, children, and their parents and families through our early attachment and parenting programmes. This enables parents to build strong bonds with their children which helps strengthen their child's emotional development and wellbeing.

As you can see we have taken steps in raising the profile of mental health, and building resilience with a wide variety of people in Tameside, but this is just a start of the journey. The destination is a place where mental health and physical health stand side by side in equal importance.

At the start of this report, I mentioned that further public health grant funding has been invested as part of the Council's 2015-16 business plan. With this, the commitment and enthusiasm of local communities and professionals, and the courage of individuals to keep sharing their own experiences day by day, we will continue to make good progress.

'we said, we did' 2015

Summary:
Recommendations and Priorities for Action

A LIFE COURSE APPROACH	
Pre-conception and Pregnancy	Offer high quality advice and support through pre-conception and pregnancy to ensure both physical and mental health is optimised for every mother in Tameside.
	Ensure tailored support for disadvantaged groups of pregnant women, and young mums under 20 is available by delivering innovative approached to health promotion. Support is to be built around the needs of the mother, her partner and their wider family.
	Deliver and promote partnership and multi-faceted approaches supporting our young mothers to ensure the best outcomes for mother and child.
Early Years	Increase the proportion of children in Tameside who are 'school ready' enabling parents to give them the best possible start in life using an integrated approach across our partnerships and services in the borough.
	To develop integrated, flexible services to ensure learning and childcare for all children and families, and improve family economic wellbeing.
	To promote breastfeeding and early attachment to ensure parents build a strong relationship with their baby.
School Years	Deliver a variety of approaches to make health choices around diet, oral health and physical activity fun and sustainable through our healthy weight strategy.
	To ensure the smooth transition of children from early years into primary school providing a health and wellbeing offer, including emotional wellbeing throughout these vital school years.

Adolescence	Develop and implement our public health strategies and interventions for young people which have a balanced focus on early childhood, school years and adolescence, with particular focus on improving sexual health, reducing substance misuse and improving emotional health and wellbeing.
	To work in partnership with parents/carers and outside agencies towards an embedded PSHE/SRE curriculum that builds upon previous knowledge, and takes into account what children and young people know and want to know.
	To drive the PHSE/SRE Agenda forward across the Borough through the Tameside CYP Health and Wellbeing Partnership Forum and SRE special interest group.
	Implement a strategic focus on locally based activities and programmes to improve employment prospects and opportunities for youth education and employment.
	Work with partners to ensure poor health is not a barrier to employment for young people. We will offer practical support for young people to be healthy, so they can achieve and access opportunities.
Vulnerable Children	Work together to help Young Carers to care for their loved one, to help them build a support network, to connect with friends who understand their lives, and to reach their full potential.
	Work with social care to provide additional help for vulnerable children to enjoy good mental health and self-esteem, and to build resilience and confidence to say no to risky behaviours.
	Promote the integration of services to improve the young person's journey from childhood to adult.

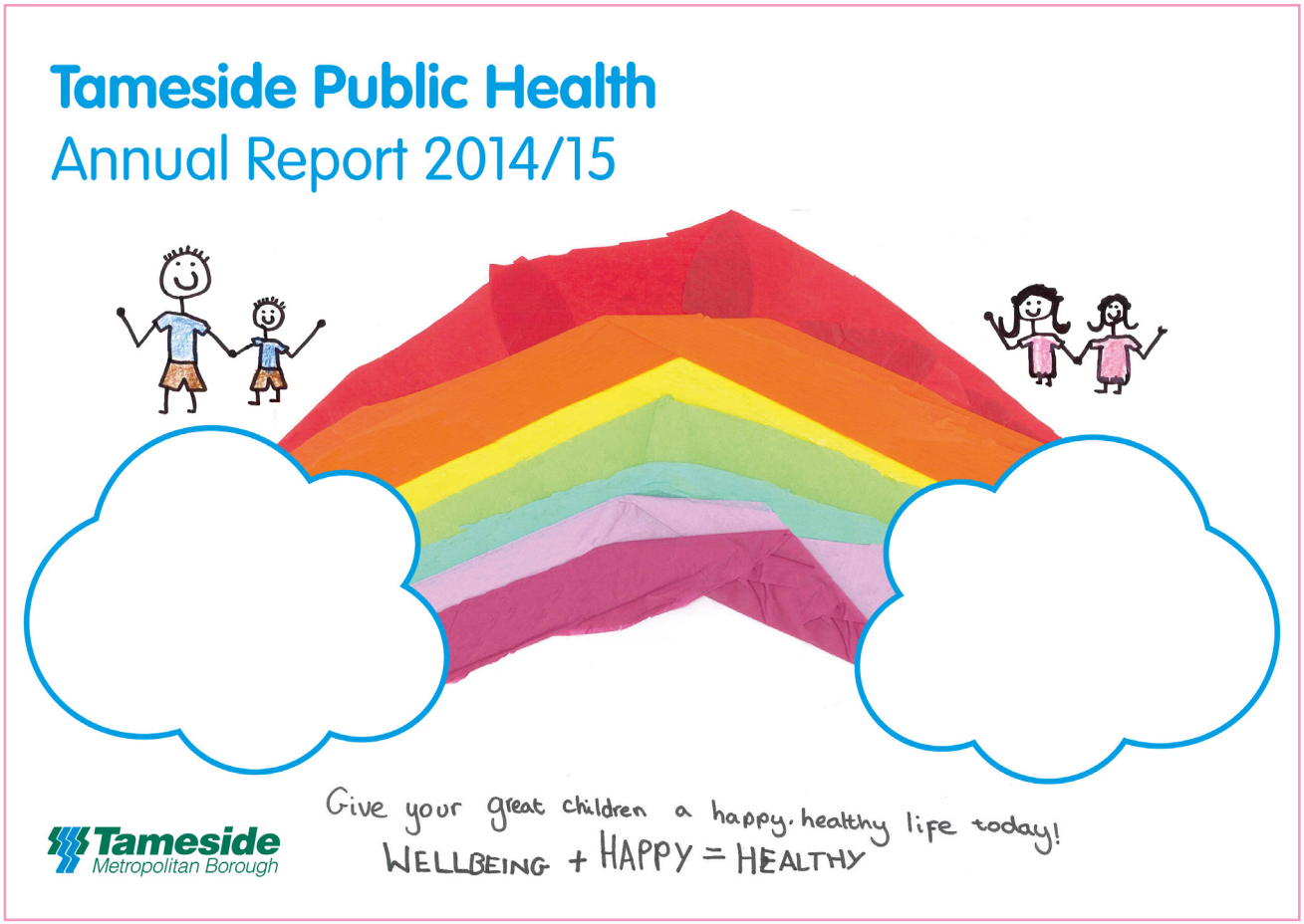
Acknowledgements and Thanks

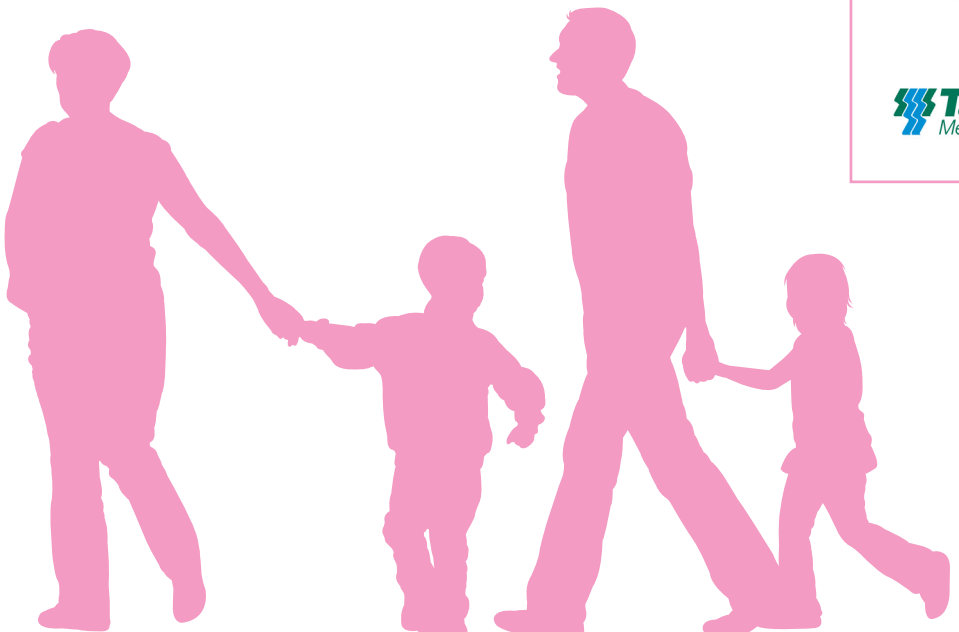
I would like to thank all those who have contributed contents to this report.

I am always happy to receive feedback. Should you wish to discuss the contents of this report please email me at publichealth.enquiries@tameside.gov.uk

Special thanks to the children of year 6, The Heys Primary School, for taking part in a competition to design the front cover of this report.

Winning design created by Megan Louise Walker, Aged 11.





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ITEM NO: 7

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	1 October 2015
Executive Member / Reporting Officer:	Councillor Lynn Travis Executive Member Health and Neighbourhoods Angela Hardman – Director of Public Health Ursula Humphreys – Programme Officer
Subject:	**OUTCOMES OF HEALTH AND WELLBEING BOARD DEVELOPMENT SESSION**
Report Summary:	The Health and Wellbeing Board held a development session to review its progress as a place-based system-leader. The report outlines the key themes that emerged from the session with regard to the Board's priorities regarding focus, purpose and function. This information will be used by the Director of Public Health to present a revised offer of the Board going forward.
Recommendations:	To allow the Board to focus on providing system-leadership to the network of organisations and arrangements that make up the local 'system', by addressing a smaller number of agenda items that specifically relate to adding value to efforts across the system against the borough's key health challenges. These map on to the Board's priority programmes for action, which were upheld by Members.
Links to Health and Wellbeing Strategy:	Ensuring the Board is able to deliver upon its key priority programmes for action.
Policy Implications:	The report does not have any policy implications.
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)**	In order to achieve good governance and effective decision making it is important to reflect on the leadership required and needed and review priority issues, purpose and function.
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 Ursula Humphreys – Programme Manager Telephone:0161 342 3508 e-mail: ursula.humphreys@tameside.gov.uk

1. INTRODUCTION

1.1 Tameside's Health and Wellbeing Board (HWBB) recently held a development session, to review its role to date regarding local systems and transformation leadership.

1.2 Participants were encouraged to undertake an honest appraisal of the Board's progress to date and reflect upon how the HWBB should proceed to provide effective leadership to both the local and Greater Manchester-wide integration programmes.

1.3 A number of key themes can be distilled from the discussions, which serve as the priorities for Board Members going forward, in relation to how the HWBB could function.

1.4 Using this information, a revised offer of the HWBB will be developed by the Director of Public Health.

2. THE CHALLENGE FOR TAMESIDE'S HEALTH & WELLBEING BOARD

2.1 The Tameside Health and Wellbeing Board (HWBB) has been in place since April 2013. Its statutory purpose is to provide system-wide leadership, offering constructive challenge, in order to:

- improve the health and wellbeing of the people in Tameside
- reduce health inequalities
- promote the integration of services.

2.2 The Local Government Association (LGA) and NHS Clinical Commissioners (NHSCC) have recently released a call to action for all HWBBs to review their role and consider how they can strengthen their position to:

- take a *place-based* preventative approach to health improvement and tackling health inequalities
- offer *system leadership*, as the basis for wider devolution of health and social care.

2.3 This is particularly important given the scale of the health and wellbeing challenge in Tameside and the nature of our health inequalities locally. The Board's role to provide leadership, across the system, is with a particular view to impact upon:

- increasing Tameside's healthy life expectancy above age 57
- reducing prevalence of diseases that both contribute to poor healthy life expectancy and our rates of premature death:
    - *cardiovascular disease* - Tameside's biggest killer, affecting 16,677 people
    - *cancer* - the greatest cause of premature death in Tameside, currently affecting 3,548 people
    - *respiratory disease* – 16,322 people in Tameside are living with this
    - *hypertension* – affecting 26,435 people
    - *diabetes* - affecting 10,113 people
- the lifestyle behaviours that lead to these health challenges, i.e.:
    - *smoking* - 38,531 Tameside residents smoke
    - *alcohol* – 1,781 people were admitted to hospital due to alcohol misuse last year
    - *physical inactivity*- 53,224 people are not moving their body for at least 30 minutes per day
    - *obesity* – 69% of Tameside residents, or 122,415 people – are overweight or obese.
- parity of esteem and promotion of mental health and wellbeing

2.4 These are the particular health challenges facing our population and therefore are the issues that underpin the Board's priorities for action, as detailed at **Appendix** 1.

3. DEFINING THE TERMS

3.1 **"Place-based" –** this is about having clarity about a common set of ideals focused on the needs and ambitions of a particular community[1]. Put differently, we must have a set of goals that are anchored in what is good for a geographical community[1].

3.2 In the context of our integration project to transform local services to meet the health challenges described above, this means balancing immediate priorities on integration with action on prevention and addressing the wider determinants of health[2]. This must all be in the context of local decision-making, specific to the needs and arrangements of our local health economy, in ways that are to directly address our key health challenges.

3.3 **"Systems leadership" –** this refers to leading across complex and interdependent systems of care, which is distinctly different to traditional leadership styles of care organisations.

3.4 The Kings Fund[1] refers to a *"discovery approach"* to leadership, which is required in order to successfully develop and implement integrated care. This recognises that within the complex and adaptive systems of a health economy seeking to integrate, there is much that is unknown: "uncertainty and ambiguity are the modus operandi for leaders."[1]

3.5 As such, curiosity, connectivity and coaching capability will be effective traits of leadership in a transformative context, *across* a network of organisations, as distinct to the styles of successful leadership required *within* organisations.[1]

3.6 Systems leaders are required at different levels of an integrative network:

- 'Micro level' – within teams and localities
- 'Meso level' – amongst services and patient pathways
- 'Macro level' – across whole systems.

3.7 At the macro level, there has traditionally been less opportunity for senior leaders to work, learn, explore and co-create with peers together. This is however part of the core-business of delivering integration[1], so investment in such *discovery* and *leadership learning* across systems is essential. It is at this macro level that Health and Wellbeing Boards must operate to provide effective leadership across a whole system. The members of Tameside's HWBB are therefore macro-level systems leaders.

4. SCOPE OF THE DEVELOPMENT SESSION

4.1 The recent development session sought to:

- explore the Board's strengths and opportunities and identify areas for discussion and self-improvement;

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[1] The King's Fund. (2014). *System Leadership: Lessons and learning from AQuA's Integrated Care Discovery Communities.* The King's Fund. See http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/system-leadership-october-2014.pdf

[2] LGA/NHSCC. (2015). *Making it better together: A call to action on the future of health and wellbeing boards.* Local Government Association. See http://www.local.gov.uk/documents/10180/6869714/L15-254+Making+it+better+together+-+A+call+to+action+on+the+future+of+health+and+wellbeing+boards/311885a4-5597-4007-8069-46bc2732d6a2

- inspire and develop the Board's ambition and approaches to leading the local system in transforming services and outcomes for local people; and
- understand the Health and Wellbeing Board's role in driving the GM Devolution Agreement.

4.2 To support this process, presentations were offered to reflect upon the refresh of the Tameside Health and Wellbeing Strategy; key health challenges; the Greater Manchester Devolution Agreement; and Locality Plan for Tameside and Glossop.

4.3 Participants were encouraged to undertake an honest appraisal of the Board's progress to date and reflect upon how the Board should proceed to provide effective leadership to both the local and Greater Manchester-wide integration programmes. A number of key themes can be distilled from the discussions, which are outlined below.

5. KEY THEMES FROM THE DEVELOPMENT SESSION

5.1 **Systems Leadership, Clarity of Purpose and Function –** this was the fundamental issue that arose from the session. Board Members felt that the primary role should be to provide macro-level system-leadership, across the network of organisations and arrangements that make up the local health economy –i.e. the local 'system'. A manageable number of issues should be explored, discussed and understood, for the purpose of the Board's time adding value to what happens in other parts of the system, rather than to duplicate the efforts of partner organisations.

5.1.1 Board members distinguished between scrutiny and oversight, considering that it was not the role of the Board to provide scrutiny or performance management, in the way that individual commissioning organisations might for specific service contracts; or as scrutiny panels would across a particular issue.

5.1.2 Whilst there are a number of decision-making structures across the system, the HWBB is the only forum that brings all of the economy's senior leaders together at one time; and the only space in which there is the opportunity for real discussion and ascertaining an in-depth understanding of issues for the Board's attention.

5.1.3 As such, the Board should function to protect this space and opportunity for the economy's leaders, in order to enable the Board to provide effective (macro-level) system-leadership. This should be the focus of the Board's function in order for it to make necessary decisions. The Board should not function as a scrutineer or performance manager of individual service areas.

5.2 **Self-assessment and development –** further development sessions are needed to review how effective the Board is being with regard to system-leadership and how it can further evolve as we move through the change programmes of both local and Greater-Manchester level integration.

5.3 **Priority Issues –** the priorities of the Joint Health and Wellbeing Strategy were upheld. It was considered that the efforts of the Board should be to determine where it can add value to impacting on these priorities via the collective partnership arrangement, and not include items on its agenda that may be duplicated elsewhere within the system.

5.4 **Structure of meetings –** the agenda should be much more focused on priority issues and, as such, be much smaller and more succinct, being disciplined in what issues are brought to the HWBB. The future development of the Board may wish to consider the frequency of meetings. Meetings however should be a discursive space, so that Members are able to provide the level of oversight and understanding they consider necessary to assure their decision-making processes.

5.5 **Governance -** there are a number of decision-making structures in place, such as those of Care Together and the Devolution Agreement. Each structure functions to make a range of decisions, different to those of the HWBB. The HWBB should have a role to inform and influence other governance structures with regard to their strategic direction in relation to health and wellbeing, not to duplicate them. It is for these reasons that clarity must be stipulated about how the HWBB relates to these external governance structures.

5.6 **Visibility –** increasing the visibility of the HWBB within the local economy would improve other partners' and the public's understanding of its value and purpose. The Plymouth model and its 'tagline' to describe the Board's overall goal was considered to be attractive, and that the Tameside HWBB could consider how it might communicate its purpose to the wider economy.

APPENDIX 1

HEALTH AND WELLBEING BOARD PRIORITY PROGRAMMES
(TAKEN FROM THE TAMESIDE JOINT HEALTH AND WELLBEING STRATEGY)

Priority Programme	This means	Tameside focus	So that
1. Starting well: Ensuring a positive start to life for children, young people & families.	We will intervene early where our children, young people and families need help and we will strengthen the support provided during pregnancy and the first five years of a child's life.	We will focus on early intervention and identification of vulnerable children and families.	Every child is given the best start in life and is fit to learn and able to fully develop their potential, communication, language and literacy skills.
2. Developing well: Encouraging healthy lifestyles and behaviours in all actions and activities.	We will develop high quality services to encourage healthy habits, prevent and reduce harmful alcohol consumption, substance misuse, obesity, physical inactivity, smoking and sexual health.	We will combine existing resources and expertise towards developing an integrated wellness service model.	Individuals and communities are equipped and empowered to live healthy lives.
3. Living well: Creating a safe environment to build strong communities, wellbeing and mental health.	We will implement early interventions and accessible and appropriate services for mental wellbeing.	We will create a safe environment and help to build strong communities, wellbeing and mental health.	People are helped to achieve positive mental wellbeing and can access support services when and where they need them.
4. Working well: Creating fair employment and good work for all.	We will improve access to work as this is critical to the health of communities, families and individuals, and better health will improve work opportunities.	We will focus on increasing employment and employability.	Increased employment will improve health, and improved health will improve economic prospects.
5. Ageing well: Promoting independence and working together to make Tameside a good place to grow older.	We will ensure that services work together to promote integrated support where needed in order to promote independence into old age.	We will focus on strengthening integrated working between health and social care providers and housing related support services.	Older people are helped to participate fully in community life and can choose to live in high quality accommodation appropriate to their needs.
6. Dying well: Ensuring high quality care to all who need it.	We will ensure careful joining up of all sources of support, and sensitivity to the vital importance of autonomy, choice and control during this usually vulnerable and dependent time.	We will focus on building the capacity of services and communities to know how best to help, and where to draw it from.	During the last year of life intensive support will be available from family, health and social care, community organisations and friends for those who need and want it.

ITEM NO: 8

Report to :	**HEALTH AND WELLBEING BOARD**
Date :	1 October 2015
Reporting Officer:	Councillor Brenda Warrington – Executive Member (Adult Social Care and Wellbeing) Andrew Searle – Independent Chair of Tameside Adult Safeguarding Partnership Board
Subject :	**TAMESIDE ADULT SAFEGUARDING PARTNERSHIP ANNUAL REPORT 2014/2015**
Report Summary :	This report sets out the activity and strategic work plan of the Safeguarding Board in Tameside and its partner organisations and agencies
Recommendations :	That the Health and Wellbeing Board receive the annual report of the Tameside Adult Safeguarding Partnership Board
Links to Health and Wellbeing Strategy :	Safeguarding vulnerable adults is a fundamentally important issue throughout of the Health and Wellbeing Strategy. Priority 3 – Living Well Priority 5 – Ageing Well
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications to this report. The annual contribution to Tameside Adult Safeguarding Partnership (TASP) is financed via the Adult Social Care revenue funding envelope.
Legal Implications: **(Authorised by the Borough Solicitor)**	'Safeguarding is everybody's business with communities playing a part in preventing, detecting and reporting neglect and abuse.' - Statement of Government Policy on Adult Safeguarding – DH May 2011. 'Abuse is the violation of an individual's human and civil rights by any other person or persons'. 'Safeguarding must be built on empowerment or listening to the person's voice. Without this, safeguarding is experienced as safety at the expense of other qualities of life, such as self-determination and the right to family life'. The Council along with other agencies have statutory duties in this regard and there are a number of regulatory bodies including the Human Rights Commission and Local Government Ombudsman in addition to the statutory regulatory bodies of each of the participating agencies.
Policy Implications :	The report highlights the strategic direction of the Safeguarding Board and its partners. It is in line with the duties and responsibilities set out in the Care Act 2014.
Risk Management :	The Safeguarding Board is required to produce an Annual Report and would be in breach of the legislative requirement if it failed to do so.

Access to Information :

The background papers relating to this report can be inspected by contacting Pam Gough, Safeguarding Adults Co-ordinator

Telephone:0161 342 5229

e-mail: pam.gough@tameside.gov.uk

SAFEGUARDING ADULTS ANNUAL REPORT 2014-2015

Tameside Adults Safeguarding Partnership Board

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Tameside Adults Safeguarding Partnership Board

Foreword

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As the Independent Chair of Tameside Adult Safeguarding Partnership Board TASPB I am pleased and privileged to introduce our Annual Report for 2014/15. Straight away please note our new name, as the Partnership officially becomes a statutory Board from April this year due to the introduction of the Care Act.

During this report you will see hints of what is to come under the new legislation post April 2015 however the main purpose of this report is to focus on the previous 12 months hopefully giving an insight as to how as a partnership we having tackled the issues surrounding adult safeguarding.

The Board has a responsibility to assure itself, there is in place a joined up approach to these issues and that a strong partnership exist and that within individual partner agencies are as committed singularly as jointly. All are encouraged to question and challenge each other in the belief that we need to understand safeguarding from all aspects yet at the heart of all we do is the individual - hence the adoption of the making safeguarding personal MSP which will be covered later.

The past year has seen continued challenges for Public bodies linked to financial pressures and restructuring, however, the closer working relationships between Health and Local Authority is I believe embedded in day to day activity. We have to brace ourselves for a further round of cost cuttings and I along with my colleagues on TASPB have to be the voice to ensure that the impact to provisions, services and support is minimised as much as possible. All partners statutory and none have to be imaginative as to how we can deliver a safe and swift response to all adult safeguarding matters.

TASPB continues to develop and we have a learning approach, we don't have all the answers and we borrow ideas from around the Country as they borrow from us. There are 12 Adult Safeguarding Boards across Greater Manchester and they work collectively when appropriate. I personally meet with fellow Independent Chairs locally and nationally. In Tameside we shared in a serious adult review (SAR) with colleagues in Rochdale further details can be found within the report but this is an example of sharing knowledge and learning together.

We are well positioned for the introduction of the Care Act, many of the requirements have been in place for several years within the Borough, our Policy and Procedures will have been adapted as this report is read to be compliant with the Act. There is always work to do.

The assurance I give you as the Independent Chair of TASPB is that there are individuals in Tameside who 'champion' adult safeguarding, they know the impact of adult abuse and neglect, they know it exists - it is our collective responsibility as Board members as partner agencies to ensure the profile of safeguarding is not just focussed on children but all ages. I thank them for their efforts in preventing, reducing or supporting the enquiries into abuse and neglect and the individual affected by abuse and neglect. In particular may I take this opportunity to publicly thank my fellow Board members and members of the Safeguarding Adult Team within the Council for their continued support and dedication.

Please remember

"***Adult Safeguarding needs to be everyone's responsibility"***.

A G Searle
Independent Chair

Introduction

This is the first Annual Report for Tameside Adult Safeguarding Partnership Board (TASPB), following the implementation of the Care Act 2014.

As defined in the Care Act, the Board has 3 Statutory Organisations at the Board:-

- Tameside MBC
- Tameside and Glossop Clinical Commissioning Group
- Greater Manchester Police

Partner organisations also represented at the Board are:-

- Stockport NHS Foundation Trust Community Healthcare Business Group
- Pennine Care NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- Greater Manchester Fire and Rescue Service
- Cheshire and Greater Manchester Community Rehabilitation Company
- North West Probation Service
- Healthwatch
- NHS England
- Victim Support

Elected Members of the Board are:-

- Councillor Brenda Warrington
- Councillor Lynn Travis

Tameside Adult Safeguarding Partnership evolved to a Board in response to the Care Act on 1st April 2015. The work that the Board had completed pre Care Act to respond to over 4,000 concerns of adult abuse since 2001 has provided the foundations to inform this seamless transition.

This report discusses the work of the Board during 2014/15, celebrates the successes and identifies the priorities of the Board going forward in 15/16.

STATEMENT OF PURPOSE

"It is everyone's responsibility to promote Safeguarding Adults. Tameside Adult Safeguarding Partnership Board is a multi-agency group whose ultimate aim is to safeguard adults. They facilitate a consistent approach for organisations to work in partnership to raise awareness and respond to adult abuse. They are committed to ensuring staff are trained to recognise and respond to adult abuse issues. Tameside Adult Safeguarding Partnership Board will continue to progress the Safeguarding Adults agenda and integrate the National Safeguarding Adults Standard Framework, responding to the Care Act 2014, to enable Tameside residents to live a life free from violence, harassment, humiliation and degradation".

Tameside Adult Safeguarding Partnership Board (TASPB)

The Board have continued to meet quarterly during 2014/15.

In addition meetings have been held to confirm progress to respond to the Care Act.

All these meetings have been well attended by partner organisations. However, TASPB have recognised that some Partner Organisations are not always represented and where appropriate the TASPB Chair and DASS have addressed this.

The Terms of Reference have been revised to respond to the Care Act and acknowledge the transition from a Partnership to a Board, with Statutory Organisations attending.

TASPB host an Annual Development Day for Board Members. The Board Members are Senior Officers representing individual organisations and have a lead responsibility for Safeguarding Adults. These TASPB Leads, make decisions regarding the delivery of the Safeguarding Adult Framework in Tameside. The Annual Development Day aids the Board Members in fulfilling their responsibilities. In addition, the day gives TASPB Leads the opportunity to explore specific areas in detail in relation to Safeguarding Adult Business and confirm the priorities for the following 12 month period.

TASPB Effectiveness Questionnaire was introduced at the Development Day in 2014. 50 % of TASPB Leads contributed to this work and agreed that the Board was effective. Objective recommendations were made that assisted the Board to develop during 14/15. These included recommendations, regarding the Board challenging and scrutinizing the breadth of the agenda, defining TASPB Lead roles in the context of specific agencies and for the Board to have an emphasis on the Safeguarding Adult strategic discussions.

Overall – invaluable forum for engaging partners, identifying overlaps in agendas and promoting working more closely together … (TASPB Lead response to the TASPB effectiveness questionnaire 2014)

In response to this the TASPB governance arrangements were reviewed to ensure there is a robust approach to Challenge the effectiveness of the Board. Consequently, it was agreed that the Annual Report will be presented to the Health and Well Being Board and the Personal and Health Services Scrutiny Panel.

TASPB Leads are encouraged to constantly review their role at TASPB and membership is reviewed annually. In particular TASPB have acknowledged the need to develop the role of the TASPB Lead for Housing Strategy, to ensure that the work with Registered Social Landlords (RSL's) to promote Safeguarding Adults is as effective as it can be. This work will continue to evolve during 15/16.

The TASPB Principle sub groups have focused on the operational work to respond to the TASPB strategy, ensuring the TASPB quarterly meetings have a strategic focus.

TASPB also recognise that the Care Act 2014, impacts on TASPB strategy 13-16. A key priority, therefore, for 15/16 is to refresh TASPB Strategy 13-16. .

Serious Adult Review (SAR)

TASPB have conducted one Serious Adult Review during 2014. This was a joint review with Rochdale Borough Adult Safeguarding Board. The Learning from this included recommendations for:-

•Planning and time to plan

•Identifying a Lead Person

•Regular review of care packages

•Documenting Actions

•Sharing Information

•Knowledge of organisations responsibilities

•Proportionate response to the level of risk

The TASPB Learning and Accountability Principle reviewed the learning from this and the Continual Improvement Principle will continue to progress how this learning is shared during 15/16.

As well as learning to be shared with practitioners regarding the outcome of this review, the work informed TASPB Learning Framework.

The Learning Framework is guidance for TASPB to apply when considering cases for a SAR. This is a Working Tool and is reviewed each time the guidance is applied and updated as appropriate.

TASPB Principle Updates

The Board has sub groups for the six key principles that underpin all adult safeguarding work and is the mechanism to progress TASPB strategy.

Empowerment *– People being supported and encouraged to make their own decisions and informed consent.*

"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

The work of the Empowerment Principle this year has focused on reviewing how and who to communicate the safeguarding adult agenda with. This work will inform the TASPB communication Strategy 2015-16

Prevention *– It is better to take action before harm occurs.*

"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

The priority for the work of this sub group during 14/15 has been to develop threshold guidance. This has been a successful piece of work. It has provided staff with a reference document with a focus on prevention and will aid further discussions during 15/16 to map the safeguarding adult arrangements in Tameside.

Self Neglect in the context of Safeguarding Adults has also been a focus for the Prevention Principle. The Principle, tasked the Multi-agency, Safeguarding Adult Managers Group with compiling guidance to support Practitioners in response to self neglect. This work remains in progress and is a priority for 15/16.

Proportionality *– The least intrusive response appropriate to the risk presented.*

"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

Protection – Support and representation for those in greatest need.

"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

The Protection and Proportionality Principle work during 14/15 has included Vulnerability Week in which there was a publicity drive to raise awareness of human trafficking, modern day slavery and illegal money lending and bogus officials. The results of this week, evidence the success of this event which included, an arrest for distraction burglaries and identifying properties which had been in breach of fire regulations.

This principle has also started work to explore the new definitions of abuse as defined in the Care Act 2014. This is to provide assurance to TASPB that organisations continue to have a consistent and proportionate approach to adult abuse. A workshop engaging practitioners from partner organisations in Summer 2015 will continue to inform this work.

Partnership *– Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.*

"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

The Leadership and Partnership Principle Lead is Andrew Searle, Chair of TASPB. A key piece of work for 14/15 in response to the TASPB strategy has been the review of the TASPB Information Protocol, All partner organisations contributed to this guidance, providing the Board with assurance that there is a consistent approach to Safeguarding Adults in Tameside and a commitment to share information regarding safeguarding adults.

Accountability *– Accountability and transparency in delivering safeguarding.*

"I understand the role of everyone involved in my life and so do they."

Learning and Accountability Principle Group priority has been writing the 7th edition of the Safeguarding Adult Procedures. The primary focus of this work was to update the guidance in response to the Care Act 2014 . In addition the revised edition, includes learning from Safeguarding Practice in Tameside and providing more clarity for practitioners. .

Continual Improvement Principle is also a sub group of TASPB. A significant piece of work for this group was to deliver Safeguarding Adult Care Act training to 170 staff across partner organisations. This was delivered over 2 sessions and provided opportunity for practitioners to discuss new categories of abuse, and the impact the Care Act has on existing Safeguarding adult practice in Tameside. Staff found the sessions and supporting briefing helpful indicating that they had received adequate information. TASPB have been instrumental in all levels of staff attending a wide range of Safeguarding Adult training with the support of the Continual Improvement Principle Group. The training has been refreshed to reflect the practice defined in the 7th Edition of the Safeguarding Adult Policy and Procedure. Training is ongoing to meet the demands of the Partner Organisations during 14/15.

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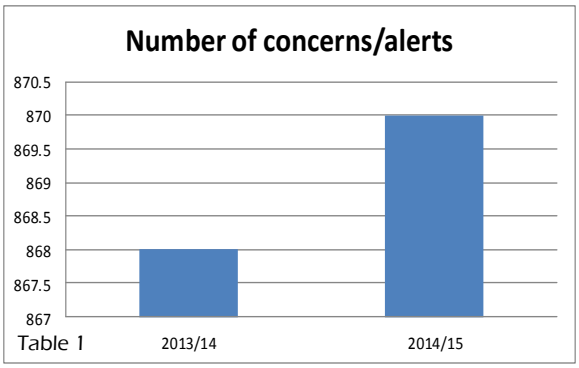
TASPB Leads have chaired the Principle Groups. This has been a challenge for TASPB Leads, given the varied commitments in their roles. Consequently, different models have been applied to respond to the action plans for this work. TASPB Leads have agreed to review this practice in Summer 2015 and will recommend an appropriate model as best practice to move this work forward in the future.

Safeguarding Adult Activity in Tameside

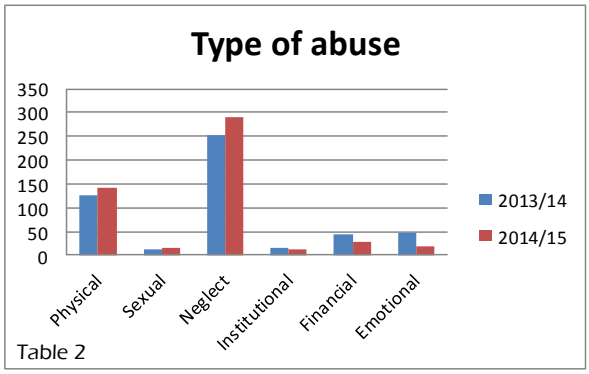


A total of 870 safeguarding adult concerns had been raised during this period. This is a minimal increase compared to last years total of 868.

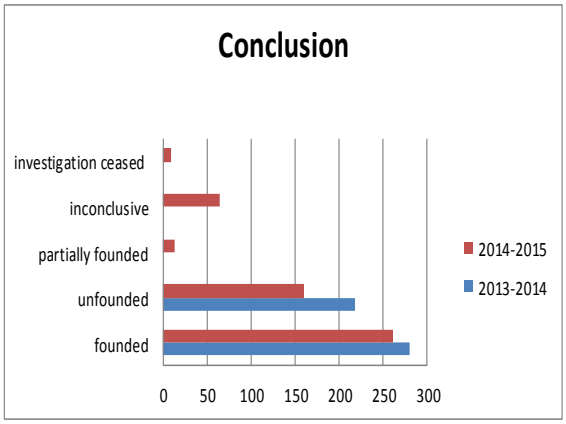
The Safeguarding Adult Return for 2014/2015 illustrated 563 Safeguarding Adult Investigations had been completed during the last financial year. This equated to 55 cases that had been raised in 13/14 being concluded this financial year and 508 cases raised 14/15 concluded this year.

It is acknowledged timescales of 8 days to conclude a safeguarding adult investigation cannot always be completed and reflective practice is encouraged to review reasons why delays for conclusion may have arisen and where appropriate to make recommendations for improvements in the future.

Reporting systems for the production of data for Safeguarding Adults is complex and presently being developed by the Safeguarding Adults Team in conjunction with Adult Social Care. Consequently as the data sets locally and nationally are not comparable, for the purpose of this report the focus is on the cases that have been raised this financial year. This ensures that TASPB have a greater understanding of activity at a local level, in turn informing the strategic plan and local operational arrangements.

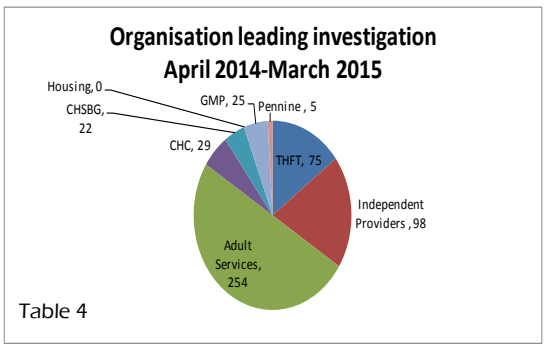


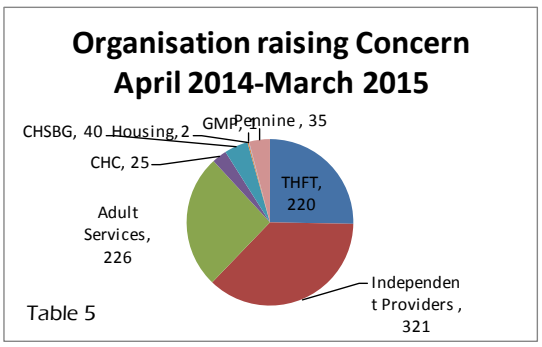
The types of abuse that have been reported during 2014/15 indicate a slight increase of 13% of investigations relating to physical abuse compared to 13/14. There is no particular trend where physical abuse appears more prevalent in a particular area or that specific people are being targeted. The rise in the reports may well be due to the increase in raising awareness with staff and the Community to recognise the signs and symptoms of physical abuse and how to report this. It is also evident that there has been an increase of 15% of investigations regarding neglect. This increase may be due to the number of concerns raised by Tameside Hospital Foundation Trust (THFT). A 95% increase is evident for 2014/15 regarding THFT raising safeguarding adult concerns. Many of these concerns are highlighted by Safeguarding Adult Managers at the Hospital regarding concern of neglect in the Community. Examples of these concerns relate to concerns how pressure sores have developed or the home environment is reported by the Ambulance service as appearing neglected. Many of these concerns are signposted for support from other Social and Health Care Services.



Last year TASPB reported unfounded and founded as conclusions for investigations. This financial year TASPB have included other options as prescribed by Health Social Care Information Centre for the Annual Safeguarding Adult Return to conclude the investigation as highlighted in table 3. The option to conclude an investigation as inconclusive has had a bearing on this years data regarding the decrease in founded and unfounded. However, this gives practitioners the opportunity to record a more reflective conclusion where there is insufficient evidence to allow a conclusion to be reached.

The Independent Providers Commissioned by Tameside Social Care and Tameside and Glossop Health economy reported the majority of the Safeguarding Adult Concerns in 14/15. This practice is encouraged and reflective of the requirements of the Care Act 2014. Consequently, this practice will have contributed to the number of Concerns raised by the Community based Health and Social Care Organisations decreasing during14/15. This is evidenced by Continuing Health Care (CHC) who have raised 31% less concerns than 13/14 and have continued to lead with investigations. The team have led on 90% more safeguarding adult investigations during 14/15. Adult Social Care also echo similar practice and continue to lead on the majority of investigations across Tameside.





Making safeguarding personal (MSP)

TASPB have focused on Making Safeguarding Personal to drive the Safeguarding Adult Agenda forward in Tameside.

The commitment to this agenda was evidenced with Partner Organisations involvement in a Making Safeguarding Programme led by the Local Government Association (LGA).

The Making Safeguarding Personal Programme provided an opportunity to support and enhance practitioner's approaches to enable adults at risk to feel in control. In addition the MSP programme assisted the need to move adult safeguarding from a process driven approach to one that is focused on improving outcomes and the experience of people who are referred for safeguarding.

The Adults involved in the Pilot stated what outcomes they wanted from the Safeguarding Adult Arrangements and this was a focus for staff throughout the Safeguarding Enquiry. There were numerous outcomes identified that included

- wanting 'to feel safe and comfortable',
- 'not wanting respite care,'
- 'wanting the radio tuned in'

40% of staff who participated in the programme felt that the making safeguarding personal approach improved outcomes for the Adults.

The outcome of this work promoted TASPB Safeguarding Adult Supervision Model as best practice.

TASPB have identified this as a priority area to develop for 15/16.

'Unless people lives are improved then all the safeguarding work, systems and procedures and partnerships are purposeless. Currently Directors and Safeguarding Adults Boards are faced with a plethora of input/output data but no way of telling from it if they really are making any impact. Directors must have a means of knowing what works and how they are making a difference to people'

Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services' ADASS; LGA, (March 2013)

Safeguarding adults in the community

TASPB acknowledge that there are various forums to Safeguard Adults in the community. The TASPB Multi – agency arrangement is just one option.

Work to promote partnership working and the use of existing forums in the community to Safeguard Adults in Tameside has continued to be promoted during the last 12 months.

This work has been assisted by the Safeguarding Adults Team, move to Ryecroft Hall in Audenshaw, in December 2014. This is also the base for West Neighbourhood Services. Both teams being based at the location has encouraged the conversations regarding vulnerable residents in Tameside and signposted adults who may be at risk of abuse to the relevant partner organisations for advice.

TASPB have also been instrumental in developing the Adult Social Care response to the Vulnerable Adult Referrals from Greater Manchester Police. Work to review this process and provide a timely response continues to be developed in the Public Service HUB.

Safeguarding Adult Managers remain integral to the Anti Social Behaviour Risk Assessment Conference (ASBRAC) . TASPB agreed in March 2015 that learning from this arrangement is to be shared with the Board annually.

Domestic Abuse

Tameside Domestic Abuse Strategy was presented to Board in March. It was agreed a joint protocol between the Domestic Abuse Group and TASPB is needed to respond to this strategy. This is work in progress and will enhance the partnership working in response to the safeguarding adult agenda in this context.

Safeguarding Adult Events

.**World Elder Abuse Awareness Day (WEAAD)**

World Elder Abuse Awareness Day 2014, involved all TASPB partner organisations, the Community, and the Voluntary and Independent Sector in Tameside. TASPB partner organisations worked together to raise the profile of Safeguarding Adults in Tameside holding various events involving both staff and residents in Tameside.

TASPB hosted an outreach stand in Ashton Indoor Market Hall and at Tameside Hospital NHS Foundation Trust and spoke to over 320 Tameside residents providing information and advice regarding keeping Safe in the Community.

Other events to promote Safeguarding Adults and WEAAD included facilitating an information stand at Peak Valley Housing Association and independent providers holding events such as purple themed coffee mornings.

Staff within TASPB partner organisations wore purple for the day to show support and raise awareness of safeguarding adults making safeguarding adults everybody's business!

To encourage Tameside residents to learn more about the signs and symptoms of abuse and how to report this, TASPB made sure as many people in Tameside were included encouraging organisations to use Safeguarding Adults screensavers, poster displays, activities and taking part in a Safeguarding Adults Quiz.

Working in Partnership to raise awareness 2014/15

People attending the ***Healthwatch AGM*** had the opportunity to gain a greater understanding of safeguarding adults and routes to report abuse, prior to the meeting at the safeguarding information stand in June 2014.

TASPB supported the ***Big Health Day*** event to raise awareness for Tameside residents with a learning disability. The Safeguarding Adults Team attended the event, sharing information regarding safeguarding adults and lots of promotional material.

In July 2014 the TASPB Safeguarding Adults Team attended the ***Deaf Club*** to give a short presentation followed by a question and answer session. The members were given the BSL version of the safeguarding adults leaflets on DVD and provided feedback to say they found these useful and will share with other hearing impaired residents of Tameside.

The TASPB Safeguarding Adults Team attended drop in sessions at the ***Stroke Awareness Group*** and ***Mental Health Group*** to speak to attendees about what to report and how to report, this was welcomed and triggered concerns to be raised.

TASPB were also involved in sharing information on ***World Mental Health day*** at an event in partnership with Pennine Foundation Trust.

In October 2014 TASPB worked in partnership with ***Health and Wellbeing*** continuing to raise the profile of the safeguarding adult abuse agendas in Tameside throughout Older Peoples week, attending the Grafton Centre and the Temple to give presentations and provide information for older people and the BME communities.

During ***Hate Crime Awareness Week*** in January 2015, the Board supported Diversity events throughout Tameside and the TASPB Safeguarding Adult Team hosted an information stand at Tameside Hospital Foundation Trust for both staff and patients raising the profile of safeguarding adults, links with hate crime and keeping safe.

Dignity in Care Observational Training is a role that TASPB safeguarding team continue to remain proactive in, contributing to observational visits during 14/15. These visits involve measuring outcomes regarding Dignity in Care for vulnerable adults to inform the daisy accreditation awards for the relevant establishments.

TASPB Partner Organisations Annual Update

TAMESIDE MBC ADULT SOCIAL CARE ANNUAL UPDATE 2015

Adult Social Care continue to demonstrate their commitment to TASPB and the Safeguarding Adult Agenda in Tameside.

The primary focus for 2014/15 has been the response to the Care Act 2014, to ensure that Adult Social Care was in a prime position to deliver their Safeguarding Adult Statutory responsibilities as defined in the Care Act.

The work to implement this was driven by the TASPB Continual Improvement Principle which concluded in the delivery of two successful Care Act Briefings attended by 170 staff from partner organisations. The emphasis was to share the Care Act guidance with practitioners and provide an opportunity to discuss the impact of this on the Safeguarding Adult Practice in Tameside.

Making Safeguarding Personal is a key driver for the development of the Safeguarding Adult Agenda. During 2014/15 Adult Social Care have been pro-active to inform this work. Practitioners from Localities have been involved in a Making Safeguarding Personal Pilot led by the Local Government Association (LGA). This has been a positive experience for staff and service users ensuring that the focus is on outcomes to Safeguard Adults.

There are 40 Safeguarding Adult Managers (SAMs) in Adult Social Care, this role is instrumental in ensuring that there is a consistent approach to Safeguarding Adults in Tameside. The SAM is the practitioner who decides to invoke the Safeguarding Adult Procedures and oversees this arrangement. 21 members of staff have attended investigators training during 14/15. Safeguarding Adults is integral to practitioners roles and the training provides support to staff when conducting safeguarding enquiries.

Partnership work is crucial to ensuring the Safeguarding Adults agenda is embedded in practice across Tameside. Earlier in the year, Adult Social Care initiated the discussions to review the process for receiving the Vulnerable Adult Referrals from Greater Manchester Police. This work also impacts on Community Health Services. The review was to assist a prompt, proportionate and appropriate response to these referrals. The Public Services Hub will progress this work in the future.

Adult Social Care are committed to ensuring that the Safeguarding Adult Agenda develops and ensuring Safeguarding Adults is everybody's business. As a TASPB Lead, my role is extended to Chair two TASPB Principle Sub Groups, Prevention and Continual Improvement. These Principle Groups are key to responding the TASPB strategy. During 14/15, emphasis of the Prevention Principle has been on developing threshold guidance and mapping safeguarding arrangements across Tameside. These continue to be work in progress, as a consequence will be a priority for 15/16. In addition Self Neglect guidance in the context of Safeguarding Adults has also been a key piece of work progressed by the Principle and will remain a priority for 15/16.

Paul Dulson

Head of Assessment and Care Management

Tameside Hospital NHS Foundation Trust

TASP Annual report 2014/15

Safeguarding Adults

The Trust has continued to make significant improvements to respond to and manage a range of structures that safeguard and protect adults in hospital. This work has been aligned to the wider Hospital Transformational Programme, and we have seen some tangible outcomes during 2014/15

Our key priority has been to create a safeguarding culture of openness and transparency, where Safeguarding Adult Framework(s) are embraced within daily business as a by-product of 'the way we do things' at Tameside Hospital.

To do this, the Trust held a range of promotional events during 2014/15. Of significant note was the launch of the Trust 's first Safeguarding Adults Managers' "Think Tank" in November 2014, where key partners joined the Trust to showcase local improvements , explore system and process barriers and blockages and to collectively plan for the new challenges and statutory responsibilities outlined within the then pending implementation of the Care Act (2014). This was followed up with an Integrated Hospital Safeguarding Awareness week (March 2015) for the public, patients and staff about the new domains listed within Care Act: over 120 people attended this.

In addition, the Trust is highly committed to empowering its workforce, to feel confident and to be more able to respond to complexities and concerns evident within safeguarding cases in real time using appropriate and proportionate actions. We continue the ethos of 'Everyone Matters' and have built on our responsibilities required by our regulators. Our new Safeguarding Adults Training Plan was launched in 2013 and is integrated within the Hospital Mandatory Training Programme/Structures to ensure everyone is aware of their statutory safeguarding responsibilities, with focussed sessions for both Consultants and new Medical staff. This work also responded to new and ongoing operational challenges, and included targeted training to meet our obligations and legal requirements for Mental Health Act, Mental Capacity Act / DoLS, and PREVENT.

We also successfully launched our new Divisional Supervision and Empowerment Model in alignment with the Care Act, the new professional responsibilities outlined with the revised NMC Code (March 2015) and Making Safeguarding Personal. This model provides clarity of responsibilities within the Divisions and introduces an additional layer of support and ownership from the Matrons assigned as Designated Safeguarding Adult Managers. This model centres its focus on the patient and not the process to ensure quick and timely responses are undertaken with the patients. We have seen a positive response to this model with SAM's responding within 24 hours to all new cases. This process has been supported by the launch of the Trust new Safeguarding checklist which ensures the correct standards are being followed and improves communication across the patient hospital journey whilst under a safeguarding investigation.

The Trust was also audited by Merseyside Internal Audit Agency for its' Safeguarding Adults Frameworks and processes in January 2015. We were pleased to receive "Significant Assurances" from the report which detailed the hospital improvements journey and transparency.

A significant amount of effort has been made to respond to the Cheshire West ruling, and consequently the Trust reported 102 DOLS cases applying the acid test criteria. The Trust has successfully achieved standard authorisation for 10 cases and developed close working relationship with both TMBC and DCC to support prioritisation of cases in view of their workload demands and delays.

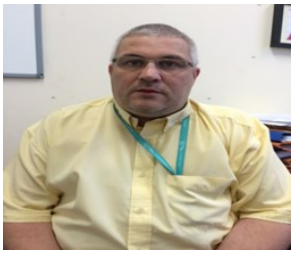
This work has placed us in a confident position to respond to and sensitively manage cases of lawful deprivation using least intrusive actions.

We have in addition successfully responded to the needs of our local Learning Disability users and have continued to capture their experiences in the hospital through our Annual Exit Survey. The interface and partnership working with the users of our Local Learning Disability (LD) Shadow Partnership Board has particularly beneficial with the Trust, and this has resulted in a range of new reasonable adjustments being introduced and a range of easy read material influence by the LD users.

Our partnership working with our Local Police and Victim Support teams has also continued throughout the year, resulting in positive outcomes.

Overall this has been a busy and active year for the Trust, the safeguarding adults activity continues to increase as more staff become vigilant and empowered to act. The Trust information dashboards prove to be useful in tracking and maintaining, affective intelligent monitoring through our Internal Safeguarding Board. We continue to be an active and committed member of the TASPB and its sub group structures.

Nasrin Khadim: Head of Adult Safeguarding & Prevent



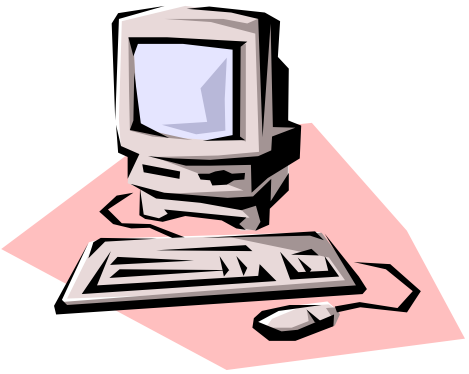
Peter Weller:Director of Quality & Governance

TASP Annual Report 2014/15

Greater Manchester Police – Tameside Division

Safeguarding vulnerable members of our communities continues to be a key priority for Tameside Division. The Senior Leadership Team conduct a daily review of all serious incidents involving vulnerability and ensure appropriate safeguarding measures are instigated, with partner agencies, to protect our vulnerable people.

The Public Protection Investigation Unit at Tameside continues as the professional lead for Safeguarding. Officers within the PPIU are trained to deal with Child Protection, Domestic Violence and Vulnerable Adults. This ensures we don't miss opportunities to link safeguarding across these areas, especially when dealing with complex cases.



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In April 2015 Tameside recorded 222 incidents identifying vulnerable adults. This highlights both the volume and critical work completed by the PPIU. Public Protection Officers will have taken the lead Safeguarding Adult Managers role in some of these cases which will have included complex investigations resulting in the arrest and conviction of perpetrators. Successful prosecutions have included a carer financially abusing a vulnerable adult out of £10,000; the offender received an 18 month custodial sentence.

We have been innovative in empowering our Response Officers and PCSO's to deal with standard risk Domestic Violence incidents. The officers were given additional training from PPIU and the Bridges service to ensure they had the necessary knowledge and skills. The impact of this scheme has seen more victims being referred to the Bridges services and freeing up PPIU officers to deal with incidents that required their expertise.

Over the past 12 months GMP has committed to training all front line supervisors with bespoke Vulnerability Training courses to improve their understanding of different types of abuse and the support available from partners. This has included inputs from Social Services, NHS and voluntary agencies such as the Samaritans. All our SAM officers have attended training courses for the Care Act and we have been actively involved with the Safeguarding Adult Mangers Group to assist with the implementation of the Act across Tameside.

Our annual report last year mentioned Tameside partners setting up a Public Service Hub. Through the hard work of all the partners the PSH is now working and comprises of a member of staff, including a police officer, from each agency being based at the Hub. The process allows for immediate sharing of information for complicated cases and a cross agency action plan.

Detective Sgt: Zed Ali: Vulnerable Adults: PPIU Tameside

Detective Inspector Anna Buchanan: Tameside Public Protection Division.

Stockport NHS Foundation Trust

TASP Annual Report 2014/5

Stockport NHS Foundation Trust continues to prioritise the safeguarding of Tameside adults within its Community Healthcare Business Group. This is evidenced by an increase in overall training compliance and the sustained increase in activity to support safeguarding. Frontline practitioners are increasingly aware of their responsibilities to recognise and respond to Adult Abuse and fifty seven Safeguarding concerns have been raised by our staff in the year.

A Core Group of 21 Safeguarding Adult Managers (SAMs) from frontline practice support staff and patients in the investigation of safeguarding issues. A rota system is co-ordinated by the Adult Safeguarding Specialist Nurse. This ensures that safeguarding incidents reported through the Business Group are acted on promptly and a SAM is allocated from the Business Group to take the initial lead with investigations in accordance with the Safeguarding Adults in Tameside Inter Agency Policy Procedures and Guidelines. In addition to the frontline SAMs, there are 20 other staff within the Business Group who have completed Safeguarding Adult Manager Training.

Community Healthcare Business Group Progress against the TASPB Priorities

Leadership:

The accountability for Safeguarding lies with the Director of Nursing and governance processes have been strengthened in 2014/5 with joint meetings taking place between the Director of Nursing, the Deputy Director of Nursing and the Trust Named Nurse for Adults and Trust Named Nurses for Children's Safeguarding in both Tameside and Glossop and Stockport.

The Named Nurse for Adults leads the Trust Safeguarding Adults Team and oversees the Trust Adult Safeguarding work primarily across Tameside and Stockport local Authority areas, benefiting from the opportunity to learn and to compare systems and processes. In addition, the Community Healthcare Business Group is supported by an Adult Safeguarding Specialist Nurse who sits in the locality of Tameside supporting frontline staff and ensuring that safeguarding is embedded within governance structures and all provider activity.

The Trust appointed a second full time Adult Safeguarding Specialist Nurse in 2014/5 to focus primarily on the Mental Capacity Act (MCA) and Deprivation of Liberties (DOLS) and the appointment of a Matron for Dementia will complete the Adult Safeguarding Team in 2015.

The Deputy Director of Nursing provides assurance with regard to the Trust's safeguarding compliance and practice in the quarterly meetings with the Clinical Commissioning Group Designated Safeguarding Nurses from Tameside and Glossop (and Stockport).

Empowerment:

The Community Healthcare Business Group is committed to putting patients at the heart of all their activities supporting and encouraging patients to make their own decisions and ensuring that safeguarding arrangements are carried out in partnership. In December 2015, District Nurses in Hyde and Hattersley took part in the Making Safeguarding Personal Project which promoted best practice in ensuring the patient's voice is heard throughout the safeguarding process and that outcomes are patient focused.

The Adult Safeguarding Specialist Nurse contributed to a communication workshop which was tasked with exploring options to raise awareness of safeguarding adults in an innovative and cost effective way. The work generated by the workshop will feed into the Empowerment Principal Sub Group.

Prevention/Continual Improvement:

Community Healthcare Business Group trains all staff in recognising the signs of adult abuse and how to report it. Compliance across the Business Group exceeded the target of 85% in Adult Safeguarding Training at all levels and concordance in MCA and DOLS training increased over the year to reach 78% with plans in place to meet the target of 85% early in 2015 / 16.

The Adult Safeguarding Training Strategy has been reviewed and rewritten and will be revalidated as a Training Policy by the appropriate committees in April / May 2015. The aim is to simplify the training by removing the levels and delivering a package of Adult Safeguarding and MCA / DOLS training that meets the needs of all clinical staff. A three hour session has been allocated as part of 'Essentials' training to deliver this and the training package has been revised in conjunction with commissioners to ensure this meets contract and assurance requirements.

Proportion and Protection:

The Community Healthcare Business Group Adult Safeguarding Specialist Nurse has worked with partners in the Local Authority and the Police and contributed to a workshop lead by the Principal Lead Greater Manchester Police Tameside Division. The Specialist Nurse ensures regular attendance at Multi Agency Safeguarding Adult Forums where work is undertaken to ensure that there is a consistent proportionate multiagency response to Adult Safeguarding.

Partnership:

There is a strong ethos in working in partnership within adult safeguarding and this commitment is demonstrated by representation at the Tameside Adult Safeguarding Board by the Director of the Business Group. The Named Nurse and Specialist Nurse attend and contribute to the work carried out in sub groups and workshops throughout the year and the Adult Safeguarding Specialist Nurse attends the Multi Agency Safeguarding Adult Managers Forum and the Safeguarding Operational Meetings led by Tameside Hospital Foundation Trust. Information from these meetings and forums are cascaded to front line SAMs across the Business Group at the Safeguarding Adult Manager's Forum.

Learning and Accountability:

The Trust is committed to learning from practice to safeguard adults at risk of abuse. The refreshed NHS England Serious Incident Framework published in March 2015 will require internal processes to be revised in 2015 /16 to strengthen our learning and the continual improvement of safety for our patients.

Wendy Stewart, Named Nurse for Adults

Tracey Hurst, Adult Safeguarding Specialist Nurse

Stockport NHS Foundation Trust

Tameside & Glossop CCG

Tameside & Glossop CCG became a statutory body of The NHS in April 2013 following the reorganisation of The NHS. The CCG is responsible for commissioning a variety of health services for the population of Tameside & Glossop in conjunction with NHS England and its Local Authority Partners.

The CCG puts patient safety, safeguarding and quality at the heart of all its business and is committed to promoting the welfare of adults at risk. The CCG ensures that adult safeguarding is embedded within the CCG governance structure and all our commissioning activity. As a CCG we have developed and embedded a safeguarding commissioning and quality framework which ensures we commission safe, effective services for our population. As part of our quality monitoring role we conduct an annual audit of all our providers around their safeguarding functions, which provides The CCG with assurance of safeguarding compliance and quality.

CCG Progress against TASP Strategic Priorities

Leadership:

The Director of Nursing, Quality and Safeguarding leads on safeguarding arrangements for The CCG. The post provides proactive leadership for The CCG in holding providers to account for their safeguarding arrangements. The Director is supported in this role by a deputy who is also the safeguarding children and adults lead for the organisation. As a CCG we have a safeguarding adults health economy governance Group which holds providers to account for safeguarding activity, but also acts as a vehicle to share best practice. This system is replicated for children and an additional GP Safeguarding Leads Group has been established which enables the CCG to drive up safeguarding quality in Primary Care.

Partnership:

The CCG has a strong ethos in working in partnership within adult safeguarding. Commitment to partnership working is demonstrated by The CCG's commitment to the work of TASP and its sub groups in driving forward the safeguarding adult strategy. The Deputy Director of Nursing chairs the TASP Learning and Accountability principle group and members of the CCG are represented on all TASP working groups. The CCG Continuing Health Care/Funded Nursing Care Service lead on many Safeguarding Adult investigations.

TASP is well represented by CCG staff, The Director of Nursing is The CCG member on The Partnership and The Deputy Director acts a safeguarding health advisor.

Empowerment:

Tameside & Glossop CCG actively promotes the NHS Constitution and aims to put patients at the heart of all its activities. The CCG is committed to two way communications with the public and patient's and actively listening to service users in order to improve the services it commissions.

The CCG has a strong ethos of quality improvement and engaging with the public, actively reaching out to people who are more vulnerable. The CCG equality impact assesses all its activities. The CCG actively monitor commissioned providers complaints and incidents , ensuring that it receives feedback on how lessons learned are embedded within organisations practice. In 2014 The CCG led a learning review into a failing in an individual's care journey. This review led to lessons learned for all agencies and The CCG has used the learning from this review to implement health economy improvement schemes (CQUINS) to ensure better patient journeys for vulnerable people.

Prevention

The CCG works with its partners to train all staff in recognising the signs of adult abuse and how to report where they have concerns. The CCG also monitors its providers on their safeguarding training and activity and ensure that whistleblowing policies for provider agencies are robust. The CCG also has a mechanism to monitor complaints and lower level concerns so that it can highlight at an early stage to any potential care failings.

Protection and Proportionality

The CCG has worked with its partners to ensure that the multi-agency safeguarding procedures are fit for purpose. The CCG is active in monitoring the timeliness of investigations and that outcomes for individuals are monitored.

Continual Improvement

The CCG ensures that Domestic abuse training is prioritised for all front line practitioners. The CCG also actively monitors its providers on implementing PREVENT training (protecting vulnerable people from radicalisation).

Learning and Accountability

The CCG have shared best practice guidance on safeguarding adult supervision with its commissioned providers to ensure reflective practice is embedded within adult safeguarding.

During the next year, The CCG is committed to working with its partners to ensure more integrated care is provided for its citizens. Ensuring collaboratively that all services are safe and effective and actively promote the needs of vulnerable people. The CCG remains committed to The Tameside Safeguarding Adult Partnership and its work in ensuring adults at risk receive the best possible service from all its partners.

Gill Gibson Deputy Director of Nursing, Safeguarding and Quality.

Summary

TASPB should celebrate the work to date regarding the Safeguarding Adult Agenda in Tameside. The approach to this work has contributed to TASPB transition to a Board in response to the Care Act.

In addition the response to the TASPB effectiveness questionnaire, review of the Terms of Reference and government arrangements demonstrates TASPB commitment to development of the Safeguarding Adult agenda and is evidence that effective links are made with related partnerships to maximise impact. This is particularly evident with the work to involve Registered Social Landlords (RSL's) and will be a priority area for the Partnership Principle to develop during 15/16. This work is also now enhanced by the implementation of the Care Act.

The challenges made to encourage partner organisations as appropriate to attend the Board is further evidence of the TASPB commitment to deliver a partnership approach to drive this work forward. The review of TASPB membership will continue to be ongoing to assure the Board that there is involvement from all partners as necessary to effectively carry out its duties.

In response to the Serious Adult Review (SAR) it is apparent the opportunity to promote effective learning and improvement action is embraced by TASPB. This working practice is further evidence of how well agencies are co-operating and collaborating.

TASPB approach to progress the work in response to the TASPB Strategy demonstrates the commitments of the individual representatives and partner organisations to develop the safeguarding adult agenda in Tameside. The six key principles apply to all safeguarding adult work and will particularly assist the work to ensure the adults well being is promoted. Furthermore, TASPB continue to move forward with this work and are committed to overcome any challenges to hinder this progress by presenting options for a best practice model to be adopted in the future. The approach will be integral and reflected in the refreshed TASPB Strategy 13/16. The refresh of this Strategy will be a priority for TASPB in the first quarter of the financial year. Consequently the priorities identified to respond to action plans for the delivery of TASPB strategy 13/16 should continue to be on target during 15/16.

The refresh of the strategy will also provide a mechanism for TASPB to seek assurance that there remains a consistent approach to respond to enquiries of adult abuse and in particular explore partner organisations collective response to self neglect. TASPB support the actions both the Prevention Principle and Protection and Proportionality Principle are taking to inform and develop best practice models in response to this work and acknowledge that this work is a priority for 15/16.

The continual improvement principle also supports TASPB to implement practice to prevent abuse or neglect. The TASPB training strategy provides TASPB with assurance that training takes place at all levels in organisations. This model ensures that practice is consistent and the evidence is reflected in the Safeguarding Activity recorded for the Annual Safeguarding Adult Return.

The impact of this work is evident as the number of concerns and investigations raised in 14/15 illustrates a minimal increase in comparison to 13/14 figures. This is positive as it indicates that there continues to be awareness of abuse of safeguarding adults and organisations recognise signs/symptoms and know how to report this. However, there is not significant increase of adult abuse in Tameside.

TASPB acknowledge the development of information systems is complex. However, the availability of the analysis of data is a priority to ensure TASPB remain up to date with safeguarding adult activity in Tameside, therefore, TASPB will highlight this work as a priority for 15/16 and monitor progress at quarterly meetings, supporting partners as appropriate.

Summary

The key priority for THFT *'to create a safeguarding culture of openness and transparency, where Safeguarding Adult Framework(s) are embraced within daily business as a by-product of 'the way we do things' at Tameside Hospital'*, is illustrated in 95% increase of concerns.

This also supports the evidence that the safeguarding adult procedures in practice are effective with partner organisations working together to raise and conclude safeguarding investigations. This practice responds to the Care Act, which confirms TASPB promote best practice to safeguard adults from abuse.

Making Safeguarding Personal (MSP) is also a key focus for TASPB and will continue to influence safeguarding adult practice in the future. The work to date provides TASPB with re-assurance that safeguarding adult practice is making an impact, is person led and outcome focused. The development of this work will remain a priority for TASPB 15/16.

Safeguarding adult arrangements are varied and TASPB are pro-active in their approach to this, utilising various forums to promote and respond to safeguarding adults. This approach is echoed in events to raise awareness in Tameside to reach all areas of the community. This work will be further enhanced in 15/16 with the Empowerment Principle priority, for completion of the refreshed TASPB communication strategy.

Since 2001 TASPB have made enquiries to protect over 4,000 adults from abuse and neglect in Tameside. The Board have reflected on this practice and used this knowledge to promote partnership working to protect an adults right to live in safety, free from abuse and neglect. Consequently, this work has placed TASPB in a prime position to respond to the implementation of the Care Act 2014. The Board has demonstrated, partnership working is key to the success of the Safeguarding Adult Agenda in Tameside and this approach ensures work to safeguard adults has an impact in Tameside. TASPB will conclude the TASPB Strategy 2013-16 over the next 12months with particular focus on the priorities for 2015/16:-

- Review of TASPB membership and effective links with organisations
- Refresh of TASPB strategy 2013-16
- Develop Self Neglect Guidance for Practitioners
- Mapping of Safeguarding Adult Arrangements in Tameside
- Development of Safeguarding Adult Information Systems
- Development of the MSP arrangements in Tameside
- Refresh of the TASPB Communication Strategy
- Assurance to TASPB that a consistent, proportionate response to adult abuse enquiries continues to be delivered

Tameside Adult Safeguarding Partnership Board will continue to embrace this work, respond to challenges and celebrate achievements to ensure that during 2015/16 and beyond partner organisations and the Community in Tameside acknowledge **'Safeguarding Adults is everybody's business'**

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ITEM NO: 9

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	1 October 2015
Executive Member / Reporting Officer:	Councillor Lynn Travis – Executive Member Health and Welling Angela Hardman – Director of Public Health Debbie Watson – Head of Health and Wellbeing
Subject:	**HEALTH AND WELLBEING FORWARD PLAN 2015/16**
Report Summary:	This paper provides an outline forward plan for consideration by the Board
Recommendations:	The Board is asked to agree the draft forward plan for 2015/16.
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 2015/16

	Strategy / policy and Board process	Priorities and performance	Integration	Other
01 October 2015	• Tameside Adult Safeguarding Partnership Annual Report • Outcomes of Board Development session	• Public Health Annual Report	• Care Together Update	• Health Protection minutes • Forward plan
12 November 2015	• 0-5 transition of Health Child Programme • Tameside Safeguarding Children's Board Annual Report • Healthwatch Annual Report • Healthwatch Intelligence Report • PHOF scorecard	• Turning the Curve Action Plan update • Working Well Update	• Care Together Update • Tameside and Glossop Locality Plan	• Health Protection minutes • Forward Plan • CAMHS Transition Plan
21 January 2016	TBC			
10 March 2016	TBC			
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