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Tameside Metropolitan Borough

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# HEALTH AND WELLBEING BOARD

**Day:** Thursday
**Date:** 12 November 2015
**Time:** 10.00 am
**Place:** Lesser Hall 2 - Dukinfield Town Hall

| Item No. | AGENDA | Page No |
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| 1. | **APOLOGIES FOR ABSENCE**<br>To receive any apologies for the meeting from Members of the Board. | |
| 2. | **DECLARATIONS OF INTEREST**<br>To receive any declarations of interest from Members of the Board. | |
| 3. | **MINUTES**<br>To receive the Minutes of the previous meeting of the Health and Wellbeing Board held on 1 October 2015. | 1 - 4 |
| 4. | **CARE TOGETHER PROGRAMME** | |
| a) | **PROGRAMME UPDATE**<br>To receive the attached report from the Chair of the Care Together Progamme Board / Programme Director. | 5 - 8 |
| b) | **TAMESIDE AND GLOSSOP LOCALITY PLAN**<br>To receive the attached report from the Chief Executive, Tameside MBC / Chief Operating Officer, Tameside and Glossop Clinical Commissioning Group. | 9 - 42 |
| 5. | **WORKING WELL UPDATE**<br>To receive the attached report of the Assistant Executive Director (Development, Growth and Investment). | 43 - 52 |
| 6. | **ADVISORY COMMITTEE ON RESOURCE ALLOCATION CONSULTATION 2016/17 ON PUBLIC HEALTH GRANT**<br>To receive the attached report of the Executive Member (Health and Neighbourhoods) / Director of Public Health. | 53 - 66 |

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker, on 0161 342 2798 or by emailing linda.walker@tameside.gov.uk to whom any apologies for absence should be notified.

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| **7.** | **0-5 TRANSITION OF HEALTHY CHILD PROGRAMME UPDATE** | 67 - 90 |
| | To receive a presentation and attached report of the Executive Member (Children and Families) / Director of Public Health and Executive Director (People). | |
| **8.** | **CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES - TRANSFORMATION PLAN** | 91 - 160 |
| | To receive the attached report of the Commissioning Business Manager for Children, Young People and Families, Tameside and Glossop Clinical Commissioning Group. | |
| **9.** | **TAMESIDE SAFEGUARDING CHILDREN'S BOARD ANNUAL REPORT** | 161 - 196 |
| | To receive the attached report of the Executive Member (Children and Families) / Chair of Tameside Safeguarding Children's Board. | |
| **10.** | **HEALTHWATCH TAMESIDE** | |
| **a)** | **ANNUAL REPORT 2014/15** | 197 - 218 |
| | To receive the attached report of the Executive Member (Health and Neighbourhoods) / Chief Executive, Healthwatch Tameside. | |
| **b)** | **ANNUAL INTELLIGENCE REPORT 2014/15** | 219 - 288 |
| | To receive the attached report of the Executive Member (Health and Neighbourhoods) / Chief Executive, Healthwatch Tameside. | |
| **11.** | **PUBLIC HEALTH OUTCOMES FRAMEWORK SCORECARD** | 289 - 306 |
| | To receive the attached report of the Executive Member (Health and Neighbourhoods) / Director of Public Health. | |
| **12.** | **URGENT ITEMS** | |
| | To consider any items which the Chair is of the opinion shall be considered as a matter of urgency. | |
| **13.** | **DATE OF NEXT MEETING** | |
| | To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 21 January 2016. | |

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker, on 0161 342 2798 or by emailing linda.walker@tameside.gov.uk to whom any apologies for absence should be notified.

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**HEALTH AND WELLBEING BOARD**

**1 October 2015**

**Lesser Hall 2 - Dukinfield Town Hall**

**Commenced:** 9.30 am **Finished:** 10.30 am

**Present:**
Councillor Kieran Quinn (Chair) – Tameside MBC
Councillor Allison Gwynne – Tameside MBC
Councillor Lynn Travis – Tameside MBC
Councillor Brenda Warrington – Tameside MBC
Steve Allinson – Clinical Commissioning Group
Stephanie Butterworth – Tameside MBC
Karen Kromolicki – Stockport NHS Foundation Trust
Graham Curtis – Clinical Commissioning Group
Alan Dow – Clinical Commissioning Group
Ben Gilchrist – Healthwatch Tameside
Angela Hardman – Tameside MBC
Andy Searle – Tameside Safeguarding Adults Board
Richard Spearing – Pennine Care Foundation Trust
Giles Wilmore – Tameside Hospital NHS Foundation Trust

**In Attendance:**
Sandra Stewart – Tameside MBC
Ben Jay – Tameside MBC
Clare Watson – Clinical Commissioning Group
Debbie Watson – Tameside MBC

**Apologies for Absence:**
Steven Pleasant – Tameside MBC
Tony Powell – New Charter Housing Trust
Robin Monk – Executive Director (Place)
Dominic Tomelty – Tameside MBC

## 15 DECLARATIONS OF INTEREST

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

## 16 MINUTES

The Minutes of the Health and Wellbeing Board held on 18 June 2015 were approved as a correct record.

## 17 HEALTH PROTECTION GROUP MINUTES

The action notes of the Health Protection Group held on 13 July 2015 were noted.

## 18 CARE TOGETHER PROGRAMME: INTEGRATION UPDATE

The Chair welcomed Jessica Williams, recently appointed Programme Director, who outlined the content of a report and accompanying presentation explaining that Monitor, the regulator for health services in England, had published a report on 17 September outlining options for the future of Health and Social Care in Tameside and Glossop endorsing current work being undertaken locally to develop better health and care services for local people. This now provided a mandate to take forward nationally significant plans which would place Tameside at the forefront of a new era in health and social care. An Integrated Care Organisation (ICO), bringing together services from Tameside Council, Tameside and Glossop Clinical Commissioning Group and Tameside Hospital.

Following publication by Monitor of the Contingency Planning Team (CPT), the three organisation Boards met collectively on 23 September 2015 and determined:

- Formally welcomed and accepted recommendations within the CPT;
- Agreed an integrated system of health and social care was the best way to ensure improved health and social care outcomes;
- Decided Tameside Hospital Foundation Trust would transform into a new organisation able to deliver this; and
- Agreed how the organisations would work together to ensure collectively this would happen (strategic priorities).

Reference was made to the report which had been considered at the Board to Board meeting of all three bodies held on 23 September 2015 setting out in detail the recommendations that each organisation had signed up to for adoption in order to deliver the benefits of an integrated care system across Tameside.

The Chair stated that the detail of how the ICO would work had yet to be decided and would be shaped as the programme progressed, staff would be at the forefront of this as the new services were co-designed and ways of working going forward. The ICO would provide new opportunities for the workforce and their experience, knowledge and skills would play a vital part in ensuring the future care organisation was fit for purpose and the needs of the person was central to the health and care it provided. Staff would receive briefings throughout this process.

**RESOLVED**
**That the update report be noted.**

## 19 PUBLIC HEALTH ANNUAL REPORT 2014/15

The Director of Public Health submitted her Annual Report 2014/15 themed around the health and wellbeing of children and young people. It described through the life course approach the challenges Tameside children and families faced from pre-conception through to transition to adulthood. The report shared recommendations for public health action, with a call to all partners and communities to contribute. There were examples of how many communities and services were responding to these challenges together.

**RESOLVED**
**That the Director of Public Health's Annual Report 2014/15 be noted.**

## 20 OUTCOMES OF HEALTH AND WELLBEING BOARD DEVELOPMENT SESSION

Consideration was given to a report outlining the key themes that emerged from the development session with regard to the Board's priorities regarding focus, purpose and function. This information would be used by the Director of Public Health to present a revised offer of the Board going forward. This would allow the Board to focus on providing system-leadership to the network of organisations and arrangements making up the local 'system', by addressing a smaller number of agenda items specifically relating to adding value to efforts across the system against the Borough's key health challenges.

**RESOLVED**
**That the outcomes of the development session be noted.**

## 21 TAMESIDE ADULT SAFEGUARDING PARTNERSHIP BOARD - ANNUAL REPORT 2014/15

Consideration was given to a report of the Executive Member (Adult Social Care and Wellbeing) was pleased to introduce the Annual Report of the Tameside Adult Safeguarding Partnership Board Annual Report for 2014/15. The Independent Chair of the Partnership Board who explained that the main purpose of the report was to focus on the previous 12 months providing an insight as to how the Partnership had tackled the issues surrounding adult safeguarding.

He stated that the Board had a responsibility to assure itself that there was in place a joined up approach to these issues and that a strong partnership existed where individual partner agencies were as committed singularly as jointly. The past year had seen continued challenges for public bodies linked to financial pressures and restructuring and the Board would be ensuring that the impact of future financial challenges on provisions, services and support was minimised as much as possible.

He continued that the Board was well positioned for the introduction of the Care Act and in fact many of the requirements had been in place for several years within the Borough and policies and procedures had been adapted to ensure compliance with the Act.

The Chair thanked the members of the Partnership Board and members of the Safeguarding Adults Team within the Council for their efforts in preventing, reducing or supporting individuals affected by abuse and neglect.

**RESOLVED**
**That the content of the report be noted.**

## 22 HEALTH AND WELLBEING BOARD FORWARD PLAN

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

**RESOLVED**

**(i) That the Forward Plan be approved.**

**(ii) That due to time constraints, delegated authority by given to the Chair of the Health and Wellbeing Board, the Executive Member (Health and Neighbourhoods), the Director of Public Health and the Executive Director (People) to meet on 12 October 2015 to approve the Children and Adolescent Mental Health Services Transformation Plan.**

## 23 URGENT ITEMS

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

**CHAIR**

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| **Report to :** | **HEALTH AND WELLBEING BOARD** |
| **Date :** | 12 November 2015 |
| **Executive Member / Reporting Officer:** | Chris Mellor, Chair, Care Together Programme Board<br>Jessica Williams, Programme Director for Integration |
| **Subject :** | **CARE TOGETHER PROGRAMME: UPDATE** |
| **Report Summary :** | The report gives a summary of progress and key milestones for the Tameside and Glossop Care Together Programme. |
| **Recommendations :** | The Health and Wellbeing Board are asked to receive and note the information provided in the update. |
| **Links to Health and Wellbeing Strategy :** | Integration has been identified as one of the six principles that have been agreed locally that will help to achieve the priorities identified in the Health and Wellbeing Strategy. |
| **Policy Implications :** | One of the main functions of the Health and Wellbeing Board is to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate. This meets the requirements of the NHS Constitution. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | It is estimated that, based on current patterns of activity, operating costs will exceed the resources available in the local health economy by £69million in five years time.<br>The Care Together Programme is an important part of how that funding gap will be bridged, transforming how care is delivered to ensure sustainable care and health improvement can be achieved.<br>To enable this transformation to take place, some of which is discussed in this report, significant one-off investment will be required. This source and application of this investment is the subject of ongoing work. Estimated requirements are £53 million transition funding (revenue £27m and capital £26m), phased over five years. This is being sought from the Greater Manchester Devolution programme.<br>In addition the Tameside Hospital Foundation Trust will require continuation of current Public Dividend Capital loan funding (received from Department of Health) across the period to ensure its financial viability. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | It is important to recognise that the Integration agenda, under the auspices of the 'Care Together' banner, is a set of projects delivered within each organisation's governance model. However, the programme itself requires clear lines of accountability and decision making due to the joint financial and clinical implications of the proposals. It is important as well as effective decision making processes that there are the means and resources to deliver the necessary work. |
| **Risk Management:** | Risks will be managed via the Care Together Programme Board and the Programme Support Office. |

**Access to Information:**

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

Telephone: 0161 304 5342

e-mail: jessicawilliams1@nhs.net

## 1. INTRODUCTION

1.1 The Care Together Programme (the Programme) over the past couple of years has focussed on designing and testing models for improving health and social care services across Tameside and Glossop. This work culminated in the hospital regulator, Monitor, approving a plan for an Integrated Care Organisation (ICO) in September 2015 to bring together health and social care services to improve how these work collectively for the benefit of our population.

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

1.3 Consequently, the Programme now needs to move from a conceptual/development phase into a detailed planning and implementation phase to drive the changes across health and social care. This is the first report to the Health and Wellbeing Board from the Independent Chair and Programme Director of the Care Together Programme which will summarise our work and the proposed direction of travel. Our focus is on overall strategy, developing and managing the overarching programme plan and providing progress reports against key activities.

## 2. PROGRAMME DEVELOPMENT

2.1 As the Programme moves into a different phase, the structure of the Programme has been realigned to ensure appropriate engagement in the detailed design work as well as delivery. The new structure identifies the three main working parties focussing on Single Commissioning, the Model of Care and the plans to deliver an ICO Foundation Trust. The architecture to support these groups is currently being determined and will be reported at the next meeting.

2.2 A governance structure, Risk Log and an interim budget has been developed to enable the work to be progressed at scale and pace. A high level plan to demonstrate the milestones for the Programme is being finalised and will be reported at the next meeting.

## 3. TRANSFER OF COMMUNITY SERVICES

3.1 An important initial step in the development of an integrated care organisation is the transfer of the Tameside and Glossop community staff who are currently hosted by Stockport Foundation Trust into Tameside Hospital Foundation Trust. This process is now underway and will be completed on 1 April 2016.

3.2 The governance arrangements for this transaction focus on a fortnightly Project Board, now well attended by representatives from THFT, CCG and TMBC and Stockport Foundation Trust (SFT). A number of work streams have also been established to manage the detail and be accountable for progress.

## 4. FORWARD PLAN

- **Communications and Engagement**

An overall plan to ensure effective engagement with our population and staff is being developed to ensure optimum development of our services. This will identify key milestones and will be produced in conjunction with our key stakeholders.

- **Single Commissioning**

To ensure rapid progress in this area, additional capacity to develop the commissioning strategy and an initial outcomes based contract will be required. On behalf of TMBC and the CCG, this will be secured by and placed within the Care Together programme

- **Greater Manchester Devolution (Devolution)**

The Programme is working closely with Devolution to ensure the plans for Tameside and Glossop remain in line with those for the wider conurbation. Where appropriate, Tameside and Glossop will offer to pilot different health and care delivery mechanisms. We look forward to continuing to build on possibilities afforded by Devolution.

- **Primary Care**

A key aspect for the Model of Care development is how Primary Care is aligned to the ICO. Detailed discussions are underway across Tameside and Glossop about how to achieve this most effectively.

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| **Report to :** | **HEALTH AND WELLBEING BOARD** |
| **Date :** | 12 November 2015 |
| **Executive Member / Reporting Officer:** | Steven Pleasant, Chief Executive Tameside Council<br>Steve Allinson, Chief Operating Officer Tameside and Glossop Clinical Commissioning Group |
| **Subject :** | **TAMESIDE AND GLOSSOP LOCALITY PLAN** |
| **Report Summary :** | In 2015/16, GM Devolution is submitting a five year comprehensive Strategic Sustainability Plan for health and social care in partnership with NHS England and other national partners. Each of the GM areas has been asked to submit a Locality Plan to provide a "bottom up" approach to the development of the GM Plan.<br>The GM Strategic Sustainability Plan will be based on the following objectives to:<br>• improve health and wellbeing of all residents of Greater Manchester, with a focus on prevention and public health, and providing care closer to home;<br>• make fast progress on addressing health inequalities;<br>• promote integration of health and social care as a key component of public sector reform;<br>• contribute to growth, in particular through support employment and early years services;<br>• build partnerships between health, social care, universities, science and knowledge sectors for the benefit of the population.<br>As such, the Tameside and Glossop Locality Plan addresses how we locally will meet these objectives. |
| **Recommendations :** | The Health and Wellbeing Board are asked to note and endorse the Tameside and Glossop Locality Plan. |
| **Links to Health and Wellbeing Strategy :** | Integration has been identified as one of the six principles that have been agreed locally that will help to achieve the priorities identified in the Health and Wellbeing Strategy. |
| **Policy Implications :** | One of the main functions of the Health and Wellbeing Board is to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate. This meets the requirements of the NHS Constitution. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | Section 5 of the Locality Plan provides details of the financial challenge to the Tameside Economy during the next five year period together with the associated proposals to finance the estimated £69 million gap.<br>It is recognised that there is an estimated sum of £53 million transition funding (revenue £27m and capital £26m) required (phased over the five year period) to support the implementation of a financially sustainable integrated health |

and social care provision within the borough.

A supporting business case to request the transition funding is currently in development in advance of submission to GM Devolution prior to the end of this calendar year. It is essential this sum is received over the timeline requested to ensure the projected financial gap is addressed.

In addition the Tameside Hospital Foundation Trust will require £71 million PDC funding over the five year period. This sum is being requested via the Department of Health.

**Legal Implications:**

**(Authorised by the Borough Solicitor)**

**Public Service Reform** (PSR) principles are at the heart of the Plan. The scale of public services will reduce over the next five years and current service provision will not be achievable. Making services, especially hospitals, more efficient will be insufficient without reducing or deflecting demand. The two actions must be considered together. It will be important to work on preventing demand and ensuring that the right intervention is made at the earliest possible stage. The public have a key role in taking more responsibility for their own health care, including more emphasis on prevention. PSR provides the backdrop to the changes by developing new approaches to investing and aligning priorities from a range of partners, and across a wide number of services. Increased use of evidence and evaluation underpins the move to reducing demand and focusing resources in the most effective interventions. The Locality Plan aims to connect health and social care transformation with the intention of reducing complex dependency and enhancing services to children and early years. **Devolution** provides the opportunity to remove barriers to reform. It allows Tameside & Glossop to be innovative in closing the financial gap and to be flexible in delivery. There are four key ways identified in the Locality Plan which devolution can make a difference

- Radical scaling up of shared priorities across the acute sector at a GM level
- Integrating primary, secondary, community and social services to take demand away from hospital/ residential care into care at or near people's homes
- Adoption of different payment methods and incentives so that resources can be moved around the system.
- Utilising the estate in a more effective way

A key role of the Locality Plan is to influence the CSR process and the impact on transforming health and social care in Tameside & Glossop and Greater Manchester.

**Risk Management:**

Continuing work will take place to strengthen the document and the financial plan. The aim is for the Tameside & Glossop Plan to be an independent document which accurately covers our ambitions and can effectively influence the CSR discussions. Identifying and agreeing the financial gap for the new arrangements will be essential. This will ensure that the best services are provided, key opportunities for revised commissioning and service provision are embraced and that the negotiations with Central Government clearly articulate the

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| | "ask" for Tameside & Glossop and Greater Manchester. Work is underway to assess reducing demand, creation of sustainable finance system and impact on activity. The Investment "ask" will be identified, together with those services to be decommissioned and where disinvestment can take place. |
| **Access to Information:** | The background papers relating to this report can be inspected by contacting Jessica Williams by:<br>  Telephone: 0161 304 5342<br>  e-mail: jessicawilliams1@nhs.net |

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# A Place-Based Approach to Better Prosperity, Health and Wellbeing

# Tameside and Glossop Locality Plan November 2015



Tameside Metropolitan Borough

Tameside Hospital NHS Foundation Trust

NHS Tameside and Glossop Clinical Commissioning Group

# CONTENTS

## 1. EXECUTIVE SUMMARY

We believe everyone living in Tameside and Glossop should be supported to live a long, healthy and fulfilling life. We are committed to changing the way we organise, provide and fund public services to ensure we achieve this aim.

It is a sad reality that people living in Tameside and Glossop have some of the worst health outcomes in the country. Not only does our population have a lower than average life expectancy, but the healthy life expectancy (HLE), the age at which one can expect to live healthily is also well below the England and North West average. For the period 2011-13, the England average for men was 63.3 years, the North West average was 61.2 years. Male Tameside residents on average have a healthy life expectancy of 57.9 years; the situation is similar in Glossop, a shocking statistic. Statistics for women also show healthy life expectancy as worse than the England and North West average. Obviously, this has a profoundly negative impact on the ability of residents to engage in work, support themselves and their families, and ultimately on the healthy and fulfilling lives they expect.

In Tameside and Glossop, we have set ourselves the bold ambition of raising healthy life years to the North West average by 2020. We then will continue to drive our ambition to ensure we achieve the England average over the next five years. This is a significant task especially considering we are a financially challenged economy, but it is an ambition behind which we can all unite.

This Locality Plan outlines how we will reorganise and energise our health and care services to contribute more effectively towards better prosperity, health and wellbeing. This starts by recognising and building on the strong voluntary, community and faith sector presence in our locality and ensures we continually hear the voice of our communities. We will strive to empower local residents, build community resilience by developing and delivering place based services and early intervention and prevention to keep people healthy and independent. When people do require health or social services, our single care provider which provides a fully integrated model of care, will ensure high quality locally based care including an enhanced integrated urgent care service. This aspect of our initiative was outlined in the recent Contingency Planning Team (CPT) report commissioned, published and endorsed by Monitor.

Tameside and Glossop have a significant financial challenge as evidenced by the estimated £69m gap in funding across the health and social care economy by 2020. Continuing with our current systems is not an option; we would run out of money long before the end of each financial year. Our proposals for a single health and care provider have been analysed and subjected to external financial scrutiny and once fully implemented, will reduce expenditure by £28m. Additionally, we have other key plans described within this Locality Plan to show how by leading together and pooling our resources, we can reach financial sustainability within five years. We require assistance to achieve this, both in terms of regulator support for the radical reform of our local health and social care system but also being able to access transitional funds to support a phased release of savings as we move from the present to new arrangements.

A clear vision and strong partnership in conjunction with the opportunities provided within Greater Manchester Devolution, provides us with the platform to drive forward our shared objectives. Working with local people across the statutory, private, voluntary, and community sectors will enable us all to achieve our ambition of prosperity, health and wellbeing for Tameside and Glossop into the future.

## 2. STRATEGIC CONTEXT

### 2.1 Tameside and Glossop

Tameside and Glossop have a residential population density of approximately 21 persons per hectare and covers 40 square miles with a mix of urban and rural landscape. The area includes historic market towns, a canal network and industrial heritage areas as well as modern fast transport links (rail, motorway and tram). It is bordered by the metropolitan boroughs of Stockport to the south, Oldham to the north, Manchester to the west and Derbyshire to the east. Some parts of our locality are sparsely populated whilst areas of the main towns are highly populated (e.g. Ashton, Droylsden and Hyde).

Tameside and Glossop's local economy is interconnected with that of Greater Manchester. The workforce is well placed, particularly in the west of the borough, to benefit from the geographic concentration of economic activity and newly improved transport links. 6.2% of all jobs in Greater Manchester are in Tameside and the Tameside and Glossop share of Greater Manchester working age (16-64) population is circa 8.5%, which means that there is a net outflow of workers to other areas including to the regional centre, Manchester, itself.

A number of key challenges over the next decade are likely to impact on the lives of our residents and our communities. These include some significant social issues including continuing high levels of relative deprivation as well as the impact of being a financially challenged economy. As described by this Locality Plan, we intend to take positive action in favour of both deprived places and deprived people and achieve a financially sustainable economy within five years.

Given that the prevalence of many diseases is age-sensitive, changes in the population and age distribution within Tameside and Glossop will have important implications for the burden of disease and the demand for health services. Compared to England as a whole, we have a slightly lower proportion of people aged 20-39 and a slightly higher proportion of people aged 40-69. In addition, an increasingly ageing population is likely to increase the overall prevalence of limiting long term illness or disability and increase demand for health services and social service interventions.

### 2.2 Population and Public Health

Statistics relating to our population are stark. Healthy Life Expectancy (HLE) is significantly lower than the North West and England average for both men and women, this is shown for Tameside in Table 1 below and Glossop broadly mirrors this.

**Table 1 - Healthy Life Expectancy in Tameside**

| | Men | Women |
|---|---|---|
| England | 63.3 | 63.9 |
| North West (NW) | 61.2 | 61.9 |
| Tameside | 57.9 | 58.6 |
| To achieve NW average need to increase HLE by (years) | 3.3 | 3.2 |
| To achieve England average need to increase HLE by (years) | 5.4 | 5.3 |
| | | |
| To get to the England average, Tameside need to prevent the following number of premature deaths each year | 105 | 71 |
| To get to the Northwest average, Tameside need to prevent the following premature deaths each year | 59 | 47 |

**Source; PHE 2011/13**
**Analysis; Tameside Public Health Intelligence**

From the Tameside and Derbyshire Joint Strategic Needs Assessments (JSNA), it is clear approximately two thirds of the life expectancy gap between our average and that of England as a whole is due to three broad causes of death; circulatory diseases, cancers and respiratory diseases. Data also shows that across the whole life course there are problematic rates of obesity, alcohol misuse and smoking related conditions.

Poor mental health and wellbeing also has a significant impact on individuals, families and communities. Low mental wellbeing is associated with employment status, poor general health and a higher prevalence of diagnosed medical conditions. A summary of key health challenges for Tameside can be found at **Appendix A** and Glossop (Derbyshire) at **Appendix B**. A full description of health needs can be found at:

Tameside JSNA
Derbyshire JSNA

### 2.3 Public Service Reform

The Greater Manchester Devolution Agreement (Devolution) brings opportunities, innovation and enthusiasm for changing current public sector policy and services for the rapid benefit of the Greater Manchester population. Tameside and Glossop is determined to work effectively within the Devolution construct to create the conditions for economic growth, connect more of our residents to the opportunities of that growth and create attractive places for people to live and work. We also will ensure this is underpinned by good quality, universal services including health and social care.

In line with the aspirations of Devolution, our public service reform principles are:

- using evidence-based interventions to improve outcomes
- integration and co-ordination of public services
- whole family / whole person approach to changing behaviour
- developing new approaches to investing and aligning resources from a range of partners on joint priorities
- robust evaluation of what works to reduce demand on public services

Devolution offers the opportunity to overcome many of the barriers to integrating public services, particularly for those residents and communities who will most benefit from an integrated response from public services.

### 2.4 Contingency Planning Team

In November 2014, Monitor appointed Price Waterhouse Cooper (PwC) as a Contingency Planning Team (CPT) to test the financial and clinical sustainability of Tameside Hospital NHS Foundation Trust (THFT) following a number of critical reports. The CPT report was supported and published by Monitor on the 17th September 2015 **(See Appendix C).**

The publication of the CPT report feeds directly into the work which has been on-going for the past two years to develop integrated health and social care across Tameside and Glossop. The CPT process provided considerable assurance on our plans for a new model of integrated care and gives us access to levers of national significance in terms of creating an Integrated Care Organisation (ICO). We 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 local residents.

The CPT report concluded that THFT should become the delivery vehicle for the integrated health and social care system. As a locality, we have agreed with this recommendation and will be supporting THFT as they transition into a representative integrated care organisation. The CPT estimates that by implementing the proposed model of care, we will save £28 million a year across health and social care by 2020. Although this is significant, it does not solve the whole financial gap. The detail of how we will meet this gap is contained within Chapter 5.

However, financial reasons are not the main reason why we believe health and social care services in Tameside and Glossop will need to look very different in the future. Integrating preventative and proactive 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 (preferably in people's homes) and we will do all we can to keep people out of hospital and where effective, provide early support to prevent a stay in hospital.

Two important aspects of the new model of care are the creation of Locality Community Care Teams (LCCTs) in five localities and the Urgent Integrated Care Service (UICS). The LCCTs will bring together health and social care delivery and dramatically improve coordination of care through individual care plans and the sharing of expertise. The UICS will have responsibility for looking after local people who are in social crisis, or who are seriously unwell. There will be a range of services sitting under the UICS including A&E, a rapid response team, a discharge team and intermediate care.

The CPT report proposes Tameside Hospital will continue to provide planned surgery and A&E care (as part of the UICS) but will have a reduction in beds for patients needing medical care of 18% due to the positive impact of integrated care providing services in the community.

The report represents a significant step forward but does not provide us with all of the answers. The proposals are unfunded and discussions are taking place around how the required transformation funds can be obtained in the economy to drive forward our plans for an integrated health and social care system at scale and pace. The CPT report is available at **Appendix C**.

## 3. OUR AMBITION

### 3.1 Our focus

Our ambition for the public sector across Tameside and Glossop is bold. We aim to raise healthy life expectancy to the North West average within five years. By 2020, a male in Tameside and Glossop can expect to have an additional 3.3 years of healthy life expectancy and women an additional 3.2 years. We then will continue to drive our ambition to achieve the England average within the subsequent five years.

We do not underestimate this challenge and the significant changes this will require in the planning and delivery of services across the public sector to deliver this. This Locality Plan describes how health and social care services will contribute towards our ambition by creating a fully integrated health and social care system which:

- creates resilient and empowered residents and communities as well
- improves health and wellbeing outcomes with a focus on early intervention and prevention
- provides high quality, safe, clinically effective and local services meeting NHS constitutional standards
- delivers long term financial sustainability.

### 3.2 Our principles and values

We will ensure that the way in which we take forward this Locality Plan is based on a number of important principles and values. We are committed to:

- ensuring the interests of the people of Tameside and Glossop are at the heart of everything we do
- valuing and building upon the skills and assets we already have in our local communities
- tackling inequality in our community wherever we can, particularly if this means some people get a better health and social care service than others
- creating a person-centred culture where the care delivery system is designed around the individual and not the system
- ensuring that local people and staff working in our organisations have the opportunity to participate as equal partners in taking forward this plan
- promoting social value in all our work, meaning we will look to invest in local businesses, not for profit businesses and community organisations to provide the services we need
- providing the best quality care that we can, within the available resources
- supporting healthy behaviours across our communities both through a focus on high risk behaviour and longer term lifestyle changes
- supporting people with long term conditions or on-going care needs, and their carers, to self-care more effectively and engage proactively in their own health and care
- providing an integrated health and social care service that is based on supporting people to live healthy, independent lives in their own homes wherever possible, with the support they need close at hand. Where people need to travel for more specialised care or treatment we will ensure that services are in the most appropriate location to deliver good quality care.
- develop strong working relationships with Devolution to ensure our plans compliment the work for the wider conurbation and that Tameside and Glossop residents benefit from the wider work across Greater Manchester.

### 3.3 Our determinants of success

By 2020, the people of Tameside & Glossop will be living longer, healthier and more fulfilled lives. Healthy life expectancy will be increasing, health and social care will be delivering services in a different way including a significant shift towards prevention of illness and a focus on wellness, and the economy will have a robust financial platform.

The population of Tameside and Glossop will feel and understand the transformed system and will be engaging with services differently. This change will be described as:

- Tameside and Glossop being a place where people choose to live as it is safe, provides the opportunity to work, gives access to affordable housing and leisure and offers a wealth of opportunities to enjoy a good quality of life
- the lives people have, the employment they are in and the skills they have developed give them a real sense of purpose and the confidence and aspiration to achieve and believe in themselves
- regardless of age or ability, people feel they are making a positive contribution to their family and community, have a sense of belonging and take a pride in their community
- people are using information, advice and taking the opportunities to help them make the best choices about how they live their lives and stay fit for work and recreation
- people can see the benefit of being independent with less focus on public services but the knowledge that, when needed, they will be supported
- people understand what to expect from public services and are using them in a responsible way
- people have trust and confidence in the services provided, knowing that they are accessible and right for them and their families as they have been engaged by services and involved in their co-design
- their symptoms and problems are diagnosed early and they receive the best interventions from the right people, in the right place, at the right time
- children in the very earliest stages of their lives are getting off to a good start because their parents have the right skills, knowledge and support
- children and young people are making the most of opportunities that education, training and leisure offer them and are already adding value to their community with their skills and experience
- older people are treated with dignity and respect, are able to live safely and independently and continue to add value to their community with the skills and experience they have
- good mental health is valued equally as much as good physical health by our communities and by our services.

**Tameside and Glossop example of current best practice - Charmaine**

Charmaine is 14 years old. She had poor attendance at school and high levels of behavioural problems and incidents with staff and other young people. The school was very concerned about her declining academic performance and the impact of her risky social activities outside of school. She was putting herself in situations where she was at high risk of child sexual exploitation, including going missing from home.

Through mentoring support from a voluntary sector 'Achievement Coaching' programme, Charmaine was helped to improve her relationship with school, both physically and emotionally. She was also supported to access drugs and alcohol services and 'keeping safe work' was completed with her to improve her understanding of the risks she was putting herself in, and the potential consequences.

Charmaine engaged with the project for six months and in that time she progressed well during the programme. Her attendance improved and her behaviour incidents reduced by 70%. She submitted her course work on time, received a better grade then she was expecting and she plans to attend College. She has met several times with her Branching Out, drugs and alcohol worker (another voluntary sector provider) and her attitude towards risky behaviour has changed. Her assessments show that her knowledge on substance misuse has increased and her attitude towards legal highs is changing. School feels that she is less likely to be excluded due to the intervention.

Using the Troubled Families Cost Saving Calculator it has been calculated that an investment of £1000 for this intervention has saved the Public Sector £13256.

### 3.4 Partnership and participation

In line with our principles and values, we will ensure local people who use services and the staff who provide them are actively involved in further developing and delivering this plan. In order to ensure we design services that meet the needs and expectations of local people, we will invite people as individuals and part of community groups to be involved and help us shape our plans for how integrated health and care services will be delivered. In doing so, it will be important for us to hear the voice of all parts of our community so we develop services and community support networks that are attractive and accessible for all residents.

To help us take forward the co-design of this plan, and co-production of new care and support models and services, we will build strong working partnerships with a wide range of organisations that represent the interests of different parts of our local community, as well as those who provide support and services. We will develop the concept of relevant local organisations coming together to create community based consortiums to shape and deliver services. This will include organisations providing health and care services, but it will go much wider to include areas such as housing, education, transport, leisure facilities, employment and welfare. We also will develop our partnership approach to include local community organisations, charities, social enterprises, businesses and other parts of the public sector. We are committed to being open and clear in our communications, so that people know how and where they can get involved. We are not just looking to run a one-off exercise to take people's current views on integrated health and care, but to establish processes that will enable on-going participation and partnership working which stands the test of time.

**Tameside and Glossop example of current best practice - Engagement**

Community and Voluntary Action Tameside (CVAT) and their counterparts in Derbyshire, High Peak CVS and Glossop Volunteer Centre carried out engagement activities on behalf of the partners involved in developing the Care Together Programme.

Learning from previous engagement events, an asset based approach to engagement was developed. This meant working with existing 'assets,' in this case Voluntary, Community and Faith Sector (VCFS) groups already working with people from protected characteristic groups alongside traditional deliberative events. Through the in-reach, skills (e.g. interpretation support) and enthusiasm (in getting their member's voices heard) of these groups and the trust that they have from their members, it was possible to see additional opportunities to engage with over 220 local people, many of whom were from potentially marginalised communities. The approach has subsequently been used to engage with approximately 70 Children and young people around the re-design of Emotional Wellbeing services.

## 4. OUR APPROACH

The future health and social care system we are striving to develop for Tameside and Glossop is one where people are supported to be well, independent and connected to their communities. When people do need to access health and care services, they will be delivered locally in a joined up way with an emphasis on addressing the wider factors of the individual's health and wellbeing, including work, housing and access to leisure. We know this requires fundamental change in the way we work together and also in how services are delivered.

Delivering our ambition will be enabled through six priority transformation programme areas. Together these six areas will create a fully integrated, person-centered system of health and care support and treatment. The aim of each is to provide the care and support people need so they do not have to escalate to the next stage unless absolutely necessary. This chapter explains these six programme stages of the model of care in detail.

- **Healthy Lives (early intervention and prevention):** a focus on education, skills and support for people to avoid ill-health, including lifestyle factors but also employment, housing, education and income inequalities.
- **Community development:** this will strengthen and sustain community groups and voluntary sector organisations' work to provide the necessary support in the community.
- **Enabling self-care:** improving skills, knowledge and confidence of people with long-term conditions or with on-going support needs to self-care and self-manage.
- **Locality based services;** for people who need regular access to health and social services, these will be fully integrated in localities, offering services close to, or in, people's homes. They will be supported by multi-disciplinary teams (MDT) with a named care co-ordinator, based on a personalised care plan which focuses on the individual's life goals and aspirations, not just health and care needs. This will involve identifying upfront those people most in need of this care co-ordination.
- **Urgent integrated care services:** for people in crisis or who need urgent medical attention, other health or care support, and a single urgent care hub will align a range of urgent and out of hours care services around A&E to make it easier for people to access the most appropriate service.
- **Planned care services:** to ensure the provision of planned (elective) care in line with the Devolution and Healthier Together programmes.

### 4.1 Healthy Lives (early intervention and prevention)

Our ambition for our population is to be independent and in control of their lives. The Marmot Review into health inequalities "Fair Society, Healthy Lives" 2010 is very clear about how to improve health and wellbeing for all; employment, planning, transport, housing, education, leisure, social care are all interlinked and have an impact on physical and mental health. Further detail can be found via the link below:
http://www.local.gov.uk/health/-/journal_content/56/10180/3510094/ARTICLE

Delivery requires a greater focus on prevention, early intervention, shared decision making, supported self-management and self-care. Our Health and Wellbeing Strategy, which we are currently implementing, aims to deliver this as well as tackling unfair disadvantage and inequality through early intervention and prevention across the life course. This is described below.

#### 4.1.1 Starting & Developing Well

Encouraging healthy lifestyles and behaviour and thereby enabling all children and young people to maximize their capabilities is at the heart of our transformation work. We will achieve this through the continuing development of high quality services encouraging and promoting healthy habits. This includes preventing/reducing harmful alcohol consumption, substance misuse, obesity, physical inactivity, smoking and improving sexual health, so that individuals and communities are equipped and empowered to make healthy choices and live healthy lives.

Focusing healthy lifestyle messages on young people is likely to also have a long term effect on our Healthy Life Expectancy (HLE). A new generation can more easily break the unhealthy lifestyle choices that their family has traditionally made and thus reduce their risk of developing life limiting long term conditions later in life. There is also evidence that children can influence the behaviours of their parents, if they understand from an early age that they can encourage and support their parents to change their lifestyles.

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 to ensure every child is given the best start in life, is fit to learn and able to fully develop their potential, communication, language and literacy skills. A key priority is to increase the proportion of children who are 'school ready' by continuing the implementation of the Greater Manchester Early Years new delivery model to improve early intervention and prevention for children and families in need.

- **Healthy Schools Programme**

The Healthy Schools Programme ceased in 2011. Our aim going forward is to develop a Health and Well Being offer for Children and Young People (CYP) to improve health outcomes for children, young people and their families. This will be achieved by working in partnership with the School Health Service and others organisations to tackle health inequalities and contribute to key public health priorities for the 5-25 year old age range.

The core public health offer for school-aged children, which encompasses the Healthy Child Programme (5-19), includes:

- Health promotion and prevention by the multi-disciplinary team;
- Defined support for children with additional and complex health needs;
- Additional or targeted school nursing support as identified in the JSNA

We are taking a whole school approach i.e. one that goes beyond the learning and teaching in the classroom to pervade all aspects of the life of a school. Key to this will be to work collaboratively with schools to help their children and young people to grow healthily, safely and responsibly and to become active citizens who proactively contribute to society and the environment.

**Tameside and Glossop example of current best practice - Jade**

Jade started experiencing difficulties after the birth of her second child. Her family was experiencing significant stress which was linked to domestic abuse, substance misuse, mental health needs and financial difficulties. These, combined 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 is very proud of her children and is keen 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.

- **Child and Adolescent Mental Health Services (CAMHS)**

The early detection of mental health problems through all stages of a child's life is crucial. Intervention making a difference both for individuals and populations at this time can help avoid social and health problems in later years. The antenatal period and early years represent vital development stages when emotional wellbeing issues and problems with child development, speech and behaviour can arise. We are improving emotional and mental health services for children and their parents by delivering an integrated parent infant mental health pathway.

As one of only eight pilot sites nationally, NHS Tameside and Glossop Clinical Commissioning Group (CCG) is devising and implementing a transformational approach to CAMHS to better integrate care and support for our children and young people. The Children and Young People's Emotional and Mental Well-being Transformation Plan 2015-2020 sets out our partnership plans to improve prevention, early intervention and increase access to specialist CAMHs practitioners.

4.1.2 Living & Working Well

- **Stronger families**

Strengthening all generations of the family, leading to active residents with responsibility for their own health and wellbeing needs will be delivered by our Stronger Families programme, an integrated approach to working with families with complex needs. A central aim is to ensure we champion early intervention to prevent issues escalating downstream and later in the life course. In addition, this model ensures that we take a 'whole-family' approach when working with families rather than a simple single child, single adult response.

This model has proved to be one of the most successful nationally with some of the best outcomes for families ranging from reductions in anti-social behaviour, improvement in school attendance and some of the highest rates of moving adults into employment. As the model works closely with the multi-agency Public Service Hub, families and services have been able to pull on a range of agencies and voluntary sector provision to address the whole needs of the family, this has included better management of adult mental health and substance misuse, better coordination with Health Visiting teams and reductions in domestic violence.

Our plans include providing all children and adults with a learning disability with support from an integrated all age learning disability service, proactively managing a programme budget to meet the needs of those with complex needs, those within the Transforming Care cohort and those, including children and young people, at risk of requiring out of area packages of support.

- **Housing**

Using an approach that builds on existing community strengths, we aim to increase opportunities for residents in Tameside and Glossop to live in a safe and healthy home and community.

We know that the area where people live and the quality of their housing can have a major impact on their health and well-being and that poor housing and environment cause ill health. We welcome the mandate set out in the "Memorandum of Understanding to Support Joint Action on Improving Health Through the Home", December 2014 and will be working at pace and scale to create communities and neighbourhoods as well as the identification and management of housing related issues using the local community asset base. We will be training and developing our collective workforce to work in partnership to increase community resilience as well as provide a preventative approach in areas such as fuel poverty, accident prevention, financial resilience, homelessness, adaptations and assistive technology, to ensure residents have a home which promotes wellbeing.

- **Physical inactivity**

Investment in encouraging and enabling participation in physical activity is a cost effective method of increasing population health and reducing avoidable demand and expenditure. Physical inactivity is directly correlated to deprivation levels, meaning that it is a significant factor in maintaining health inequalities.

Increasing the level of physical activity amongst our local population is a fundamental aspect of our transformational work to improve overall health and wellbeing, enable economic growth, and to reducing demand for health and social care services.

- **Mental health and wellbeing**

Creating parity of esteem between mental and physical health is pivotal to our overall well-being. Within Tameside and Glossop, this concept is embedded across health, social care and wellbeing work streams such as health improvement, skills and employment, early help and substance misuse. Our strategic approach is being refreshed to maximise the new opportunities approaching with the NHS England Access and Waiting Times' standards, the Greater Manchester Mental Health Partnership and the forthcoming NHS England Task Force work.

Access, integration and recovery models underpin our transformational work. This work will ensure our mental health services are effective, efficient, based on 'best practice' and outcome focused to ensure services are sustainable and are provided as close to the users' community as possible. This will include integration with targeted and broader based voluntary, community and faith sector services to build on community assets.

- **Work and Health**

Improving the economic prosperity of local residents is another key driver for our reform work with specific outcomes focused on reducing worklessness, improving adult skills and improving household income. Our collaborative multi agency approach is tackling the multiple and complex barriers which can prevent people from accessing and progressing in work e.g.: mental and physical health, skills, addiction, housing, lack of affordable child care and debt. We are exploring a local "Fit to Work" pilot for out of work benefit claimants, which could establish GP referral routes into a work/health management service and increase activation of patients in self-management. Additionally, we will focus on prevention programmes to improve physical health and reduce our high rates of vascular dementia.

- **Transport and Health**

To sustain and improve our economy and enable our communities to flourish and prosper, good transport provision is crucial. This enables access to employment, healthcare, education and link with the benefits associated with tourism and leisure. Transport is a catalyst in underpinning investment opportunities in developing run down areas and improving housing provision in our local area.

Our public health approach to transport is to move away from cars and towards walking, cycling and public transport. This reduces the harms of the road transport system, enhances benefits to individuals, society and the environment by helping carbon reduction. To achieve this shift, our services will be restructured so that more of our population find, and are supported to see, the most convenient, pleasant and affordable option for short journey stages to be walking and cycling, and for longer journey stages to be cycling and public transport. We will be encouraging this via our plans to ensure people can easily access local services on foot or bicycle, and ensure new developments prioritise physically active lives, including walking and cycling.

4.1.3 Ageing & Dying Well

Our work to reduce loneliness and social isolation, particularly amongst older people, has been recognised nationally as best practice. Our approach aims to reduce chronic emotional loneliness which otherwise can lead to people leading lifestyles that result in poor health and premature death.

With a focus on promoting independence and by making Tameside and Glossop a good place to grow old, older people are helped to participate fully in community life. In our commitment to ensuring we provide high quality care to all that need it; we will ensure sources of support are joined up. We will build on the capacity of services and communities to know how to help and access this.

- **Increased Life Expectancy**

Improving the healthy life expectancy of our local population is key to improving the experiences of people in older age. Our whole sector proactive and preventative approach will connect people with their local communities, work with people to manage their health and will encourage and support people to access local community groups and resources. Along with the emotional impact on people and their families, dementia has a huge financial impact and reflects one of the biggest public health, NHS and social care challenges.

There are approximately 3,483 people with dementia living in Tameside and Glossop and the estimated total cost to the economy is £112m with long term institutional social care costs making up the majority of this. Our ambition locally is to ensure individuals and their carers have an early diagnosis of their dementia and quality post diagnostic support which meets their needs and is integrated within our Local Community Care Teams. As we have an above average rate of preventable dementia, caused predominantly by unhealthy lifestyle behaviours (the local rate of vascular dementia is 42%, more than double the national rate of 20%), we will build on keeping brains healthy within our Wellness Offer.

Our local strategy and action plan is ambitious. We want to ensure local people and their carers are able to live well with dementia, at home wherever possible, with resources available to support them throughout their journey, including in crisis situations. This supports the overarching aim of the Greater Manchester Strategic Plan for Dementia, which is to improve the lived experience for people living with dementia and their carers, whilst determining how to reduce dependence on health and care services. In line with this our local strategy will be refreshed against the five domains identified:-

- **Preventing Well:** reducing the risk of dementia in the local population, particularly vascular dementia
- **Diagnosing Well:** developing a robust seek and treat system that offers early, comprehensive, evidence based assessment for all
- **Living Well:** establishing dementia friendly communities, networks and support and ensuring that every person has access to tailored post diagnostic advice/support
- **Supporting Well:** regular access to health and social care services which reduce the number and duration of emergency admissions, re-admissions and care home placements. Ensuring care continuity, irrespective of the location of the individual.
- **Dying Well:** Focusing on understanding where people living with dementia are dying and striving to ensure the place of death is aligned with the person and family preference.

- **Housing**

Working with local partners – care homes, registered social landlords and private landlords, we will ensure that the quality of housing for older people is aspirational and supports good health. Assistive technology, telecare and telehealth are key factors in people remaining safely at home. Over 4,000 people are supported by our Community Response Service which offers a physical response within 20 minutes where necessary, in the majority of cases. Our Housing Strategy is being refreshed, with a greater emphasis on the needs of older people to ensure locally there is sufficient appropriate housing.

- **Urgent Integrated Care Services**

The vast majority of hospital attendances and admissions locally are older people. It is critical that we ensure we deliver a responsive community based integrated intervention that supports an individual to remain at home. Our ambition, as described in our Care Together programme, is to ensure we offer a professional response within one hour, where this is appropriate, with professional triage and support to offer a short term intervention to stabilize and refer on where required. Considerable benefits will be derived from this approach, not least that the individual remains in the comfort of their own home, wherever possible, and timely, appropriate interventions manage and minimize the acuity.

- **Palliative and End of Life Care Services**

The vision for palliative and end of life care services is to ensure the wishes of those in the final months of their life are met and also to improve the percentage of deaths occurring in the usual place of residence. Patients perceived to be in their last 12 months of life are already proactively monitored using the Gold Standards Framework and end of life care information is appropriately shared to improve co-ordination. We will be working through our locality teams to develop improved links with voluntary and community services and thereby further support patients and their families to self-care and prevent crises.

**Tameside and Glossop example of current best practice - Grace**

Grace is a recently retired French teacher who had surgery for bowel cancer five years ago. She is very private person, but after reading several newspaper articles and watching a documentary on-line, decided to be as open with family, friends and work colleagues as she could. She found many of them very supportive and encouraged by their response became a volunteer with a local cancer awareness programme and helped with community events encouraging people to take up screening for bowel cancer. She also gave several talks to patients at her GP practice about the importance of screening.

A year ago her cancer recurred, treatment was unsuccessful, and she started to find she had a lot less energy and lost weight. Her daughter who lives locally asked to stay with her as often as she could, and friends and family made sure that she had visitors every day. She continued to walk her dog three times a day and pick up her newspaper from the local shops.

Grace is currently in bed at home, receiving daily visits from the local Macmillan Community Palliative Care Team, District Nursing Team and overnight support from Marie Curie Cancer Care. She has indicated that she would like to spend her final days at home, and made a plan for her funeral with her sister. Her daughter and two of her friends visit every day. An Advanced Care Plan has been agreed, and her GP has visited three times in the past week.



### 4.2 Community Development

Our local communities have a vital role in delivering our ambitious plans as social connections and having a voice in local decisions are all factors that underpin good health. Understanding, building upon and utilising the rich and diverse assets within our community can provide a significant impact on health and wellbeing. This approach is known as Asset Based Community Development (ABCD) and has been summarised by Alex Fox, CEO of Shared Lives Plus in this way: “If all you look for in an individual, family or community, is need, that is all you will find and you will always conclude that an outside agency or expert is needed to fix them. It suggests that anyone offering support should always look first for what someone can or could do and should think about how to support them to maximize their capabilities and potential, drawing on their natural support networks.”

Our intention is to examine how local assets, including the community itself, can be used to meet identified needs and enable local residents to achieve and maintain a sense of wellbeing by leading healthy lifestyles, supported by resilient communities. Our approach is based on enabling the many strengths that already exist in our communities to thrive and as such will focus on supporting communities to develop and use their own assets to tackle the issues that affect their lives.

Tameside Council is currently developing and testing out approaches to working with local communities who want to contribute to the development of community asset based approaches. These pilot programmes will form the basis for developing future approaches and commissioning strategies and the focus has been to understand the specific facilities, activities and assets that are used and valued by communities and residents. This has involved working closely with our third sector support and development agency, Community and Voluntary Action Tameside (CVAT), to develop a strategic approach to ABCD and includes working with Manchester Metropolitan University to strengthen our understanding. The learning from this programme has formed the foundation of our Asset Based approach going forward.

A large part of this programme has been learning from and supporting our assets in terms of those already delivering community development work and providing opportunities for them to share learning and best practice, support one another and identify opportunities to work together. We created a 'Community Development Workers Network' for employees and volunteers from any organisation which has a community development aspect to their work. These bi-monthly network meetings include the key element of peer learning; Community Development workers have led sessions with their peers on several topics including monitoring and evaluation. We also have provided a three day practice based course on Appreciative Inquiry for frontline workers, some of whom are using this approach to facilitate community gatherings in their area.

The benefits of Asset Based Community Development include enhanced community and individual resilience, reduced isolation, and associated reductions in the demand for crisis care, such as for: dementia, falls, mental health crises, self-harm, substance misuse, CVD, cancer and end of life care. The type of approaches promoted through ABCD are usually based on social and community support for individuals who need it, and include approaches such as peer-to-peer support networks, befriending services, advocacy and sign-posting people to the most appropriate places for help. These approaches can include community based activities focusing on improving exercise, better diet, talking therapies for people suffering from depression or anxiety, social activities for people who are lonely or isolated, advice and support with understanding healthcare information and conditions, activities such as creative and performing arts which help build self-esteem and many more.

**Tameside and Glossop example of current best practice – Jill**

Jill is 79 and lives alone following the death of her husband, Harry 12 months ago. He was her main carer as Jill was diagnosed with vascular dementia whilst Harry was with her. Since his death Jill has been lonely and frightened, in spite of her daughter Ruth's help. She often calls her GP Surgery worried about her health.

The GP informed Jill and Ruth about "The Storybox Project". This provides participatory performing arts activities for older people with memory problems, providing opportunities for expression through alternative means of communication. The approach is participant-led, valuing each person's contribution equally, and fosters the development of personal relationships through engaging in a shared expressive activity. It has seen good outcomes, including improved relationships between participants and carers, who are invited along too. Jill's GP and Ruth have noticed an improvement in Jill's wellbeing since she started to attend Storybox. Jill loves it. She's sleeping better and is making new friends. She is realising that there is still much to enjoy in life and is talking with Ruth about attending a swimming session for people with memory problems and their carers too. Jill's GP has embraced an asset based approach to their practice and this is only one of many projects/schemes that they encourage their patients to enjoy and develop.

### 4.3 Enabling self care

We want to empower people to stay healthy. We also want to support those people with long term conditions to develop confidence, knowledge and skills to manage their condition and to make informed decisions and choices about their treatment and care. We will promote local self-care courses for anyone diagnosed with a long term condition to improve understanding on how their condition impacts on their life, job and relationships and thereby enable them to know more about and improve their health outcomes. This is an essential element of our plans if we are to reduce the demand for health and social care resources and thereby move to a financially sustainable position.

The internet and other technology improvements mean that people who have traditionally needed regular contact with health and care professionals are now in a much stronger position to manage long term conditions safely themselves. Tameside and Glossop has a long history of using assistive technology on social care provision and developing empowerment tools to enhance the skills and confidence of people to care for themselves. We also have one of the UK's leading GP practices in terms of empowering patients to access their own medical records and use this knowledge to research and manage their long term health conditions. In our GP practices, we have professionals keen to test out new ways of supporting patients where a face to face consultation is not necessary. We will build on the experiences and enthusiasm to develop new ways across our integrated care system to ensure people are empowered by information and can effectively judge when they can manage their own health and when they need a specific intervention or support.

As part of our work within Devolution, we will work in partnership to support the development of a social movement for change which promotes people making informed lifestyle choices and based on "bottom up" community leadership. This will create a fundamentally different relationship between public services, residents and local communities and support a shift towards people being empowered around responsibility for their own health, proactively supporting people to strengthen connections with their communities and enabling a focus on community and service user generated outcomes which shape local services. This will link to work on social value based commissioning and evaluation models and include targeted work on areas such as Social Impact Bonds.

### 4.4 Locality Based Services

Our vision for integrated health and social care services, and tested via the CPT process, is to provide an effective and efficient care system. To do this, we are developing a single integrated care provider, using the Foundation Trust delivery model to provide improved access to services, dramatically reduce artificial organisational boundaries, and greatly enhance the experience of using services.

The introduction of five Local Community Care Teams (LCCTs) 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, where possible in the persons' home and people will get a named staff member to co-ordinate their support. The LCCTs will have unequivocal responsibility for the health and wellbeing of the populations which they serve. This will be achieved through a co-ordinated approach with primary care, mental health including dementia services, social care services and voluntary, community and faith sector services. These teams will use the risk stratification tools currently available to identify those people most at risk of needing services in each locality with a view to using earlier intervention techniques to manage demand for longer term services. People with long term conditions will be supported by a named care coordinator.

We have invested in the core infrastructure and in primary care services to provide support and built additional capacity and capability into our practices to meet future challenges. We have co-designed and implemented a new local Quality and Performance Framework, complementary to the GM standards, which has standardised and stretched the contracted quality indicators. Practices are incentivised to achieve these outcomes and are supported through investment in a team of quality improvement and data quality experts to improve systems, processes and bring capacity into practice management and GPs.

We have already implemented coordinated CQUINS across our local community and acute providers to ensure quality and outcomes are aligned across clinical pathways. This includes general practice, primary care services, e.g. GP Out of Hours, Ashton Walk in Centre and extended access arrangements to ensure services are aligned and not operating as stand-alone providers. We are further developing this work to review how QoF (Quality Outcomes Framework) could be re-designed and negotiated into our local model of quality for primary care. We will include GPs in this via the 2016/17 contract negotiations as we continue to engage practices in the design of the future model of care.

The current funding and make-up of the GMS and PMS contractual models are being reviewed as Phase 3 of our GP investment plan. All GP commissioned services are being reviewed to ensure they remain relevant and contribute to the wider system challenges. We will ensure the GP budgetary allocation are place based and locally discretionary, including nationally commissioned services for GPs. We will listen to Healthwatch feedback from detailed local survey work to help design the specification to meet the needs of these populations and ensure we build on the assets in communities. We are also researching models used nationally and internationally to understand and develop the most effective ways of encouraging GPs to work in an aligned and ever increasingly integrated way with, and/or as part of, the future Integrated Care Organisation (ICO).

Primary Care based around the role of the GP service will be at the heart of the new LCCTs. Our new primary care strategy will invest in general practice to:

- strengthen Primary Care Infrastructure
- develop models of care that are meaningful to patients and practices, including access
- develop relevant and meaningful outcomes and quality indicators
- develop our membership and their relationship with the public.

We are looking at an outcomes based commissioning and contracting model to align incentives across pathways, contracts and providers. We will be working with Greater Manchester to ensure our plans complement those of Devolution. We are keen to test opportunities and be an early adopter of new models of primary care delivery and form. We also are keen to work with Devolution to develop transformational opportunities with pharmacies, dentists and optometrists.

### 4.5 Urgent Integrated Care Services

When people need support in the event of a crisis, this will be managed by one cross Tameside and Glossop wide urgent integrated care service (UICS). It will have clear responsibility for looking after local people who are in social crisis, or who are seriously unwell. The UICS will act as a single point of access and will be able to mobilize all relevant assets and resources across the health and care system to help get people well and back in the most appropriate care setting as quickly as possible. There will be clear accountability between the LCCTs and the UICS.

The UICS will provide one seamless service that supports people from the moment they have an urgent need, irrespective of whether this need is met in their home, by a short-term placement or in hospital to the point they are ready to resume independent living. We envisage the UCIS will comprise:

- a single point of access for people and their carers
- one single assessment process to ensure people only need to tell their story once
- care co-ordination
- an urgent response team

- co-ordination of all hospital discharges, including discharge planning to ensure no-one is discharged without the necessary community health and social care support in place, ensure no-one is in hospital longer than necessary and help improve the flow of individuals in and out of hospital
- bed and home-based intermediate care
- on-going support by a multi-disciplinary team until a person is stabilised and ready to return to independent living, or living with support from LCCTs.

Our integrated urgent care service will reduce demand for acute services and crisis care. We have already developed a new Urgent Integrated Care Service discharge and admission avoidance team which co-ordinates the intermediate tier of services in hospital, social and community health to manage patients home as quickly and safely as possibly. Our approach to urgent care is to ensure patients are not confined to a waiting room, chair or bed in an acute setting any longer than they need to be. People should get care in the most appropriate setting for their needs – often this will not be a hospital based urgent care service.

Attendances and admissions to hospital will reduce as individuals, and professionals access the right care, interventions and support at the right time, in the right place. This will also allow the hospital to operate effectively and safely. Where appropriate, the Urgent Integrated Care service will ensure discharge from hospital is safe and prompt, with an appropriate level of support to ensure recovery is maximised and the individual maintains their independence. This may involve community based intermediate care services which will aim to achieve maximum potential and recovery.

We will create an integrated urgent care front door/hub from where A&E is currently located. This will relocate the Walk in Centre, GP Out of Hours and the GP (registered list) from Ashton Primary Care Centre and provide wrap around advice and care from integrated acute, mental health, social and community health services all to be located at the urgent care hub. This will ensure the new discharge and admissions avoidance service and the acute/urgent support through the LCCTs is co-ordinated in one place.

### 4.6 Planned Care Services

Our ambition for planned care is for when people need pre-arranged treatment, they will have access to care that delivers the best health outcomes and returns them to independence as quickly as possible.

In line with the recent Healthier Together consultation and Greater Manchester Devolution plans, we will ensure our patients have access to the very best clinical support. This will be through ensuring our local hospital works with other hospitals to provide consistently high quality treatment and care which meets best practice standards and provides the best outcomes and experience for patients. We will share services across a number of hospitals and ensure concentrated expertise in clinical teams delivering the “once-in-a-lifetime” specialist care. This may mean that for some services, people will have to travel further for particular types of treatment but we will continue to develop opportunities for day case treatment by reducing overnight stays in hospital and increasing the amount of outpatient care in our communities.

## 5. DELIVERING OUR AMBITION

### 5.1 Leading the change

Tameside and Glossop health and social care leaders are determined to improve healthy life expectancy and also create an affordable health and social care system. Chapter 4 describes the detailed approach to our challenges and this chapter will focus on how we will achieve this.

The Care Together Programme is a joint programme between Tameside Metropolitan Borough Council (TMBC), Tameside Hospital NHS Foundation Trust (THFT) and NHS Tameside and Glossop Clinical Commissioning Group (CCG) and has a clear governance structure, led by an Independent Chair. The programme also has a Programme Director, a small Programme Support Office and a dedicated budget in 2015/16 to start our transformation plans. Transitional funding from 2016/17 needs to be secured to continue the process of transformation.

From the 1st January 2016, Tameside will have a single commissioning function operating under a single leadership and supported by one cohesive management team. The current pooled commissioning budget will be considerably expanded to provide a single pooled budget of circa £360m from 1st April 2016 which will include all health and social care expenditure. Once this is embedded and if desirable/appropriate, the remaining elements of public sector expenditure may also be incorporated. We are developing a single commissioning strategy to result in an outcomes based contract for implementation in April 2016.

Comprehensive engagement continues with Derbyshire County Council regarding how to ensure parity of service provision for Glossop residents. Although there are no plans to fully integrate social care and health services formally, discussions are on-going regarding how closer working can be achieved to ensure improved health outcomes and financial efficiencies where possible. Glossop will therefore continue current arrangements for the time being.

There will also be a single integrated provider progressively from 1st April 2016 delivered by the current THFT on its transition to becoming an Integrated Care Foundation Trust. As part of this journey, the Tameside and Glossop Community Services currently hosted by Stockport Foundation Trust will be transferred to THFT from 1st April 2016. The development of local primary and community care services will commence in earnest once the transaction is safely completed.

The Care Together programme expects to deliver the new legally constituted and representative Integrated Care Foundation Trust by 1st April 2017. The Care Together Programme Board will then cease as it hands over accountability for further development of the organisational culture and model of care to the ICO. There may, in time, be opportunities to identify further system wide benefits in Accountable Care Organisational models.

In order to achieve this ambition and to ensure that local people and staff working in our organisations have the opportunity to participate as equal partners in taking forward this plan, we will develop robust, consistent and effective channels for local people to inform and direct the services they receive through timely consultation, and meaningful engagement. We will do this by developing our existing best practice as individual organisations and committing to meaningful and timely engagement with system and organisation leaders, clinicians, staff, voluntary/community organisations and the public. This will be resourced and supported throughout our development to ensure that we meet our ambition of the interests of the people of Tameside and Glossop being at the heart of everything we do.

## 5.2 The financial challenge

Under a "Do Nothing" scenario, our financial gap is projected to be £69m across health and social care by 2020. Table 2 demonstrates the total deficit growing from £23m in FY15 to £69m by FY20.

**Table 2 - System-wide position in the "Do Nothing" scenario[1]**

***Source: PwC Contingency Planning Team Report: 28 July 2015***

| Health and social care system | Do nothing | | | | | |
|---|---|---|---|---|---|---|
| **£'m** | **FY15** | **FY16** | **FY17** | **FY18** | **FY19** | **FY20** |
| **System income** | | | | | | |
| T&G CCG allocation | 332 | 343 | 341 | 346 | 352 | 358 |
| Trust income from other CCGs | 23 | 23 | 23 | 23 | 24 | 24 |
| Other Trust income | 13 | 11 | 11 | 11 | 11 | 11 |
| Social care allocation | 66 | 60 | 52 | 47 | 41 | 41 |
| **Total income** | **433** | **436** | **427** | **427** | **427** | **434** |
| **Cost of provision** | | | | | | |
| Trust expenditure | -173 | -179 | -180 | -182 | -184 | -185 |
| Commissioning of other services | -210 | -223 | -219 | -223 | -227 | -231 |
| Social care expenditure | -74 | -79 | -82 | -84 | -87 | -87 |
| **Total expenditure** | **-456** | **-481** | **-481** | **-489** | **-497** | **-503** |
| **System deficit** | **-23** | **-45** | **-54** | **-62** | **-69** | **-69** |

Following two years of intense analysis, review and planning across the health and social care economy, we have identified the appropriate strategies to close the financial gap and deliver a balanced economy over the course of the next five years. However, there are four critical and fundamental conditions to achieving successful delivery of our plans. These conditions are:

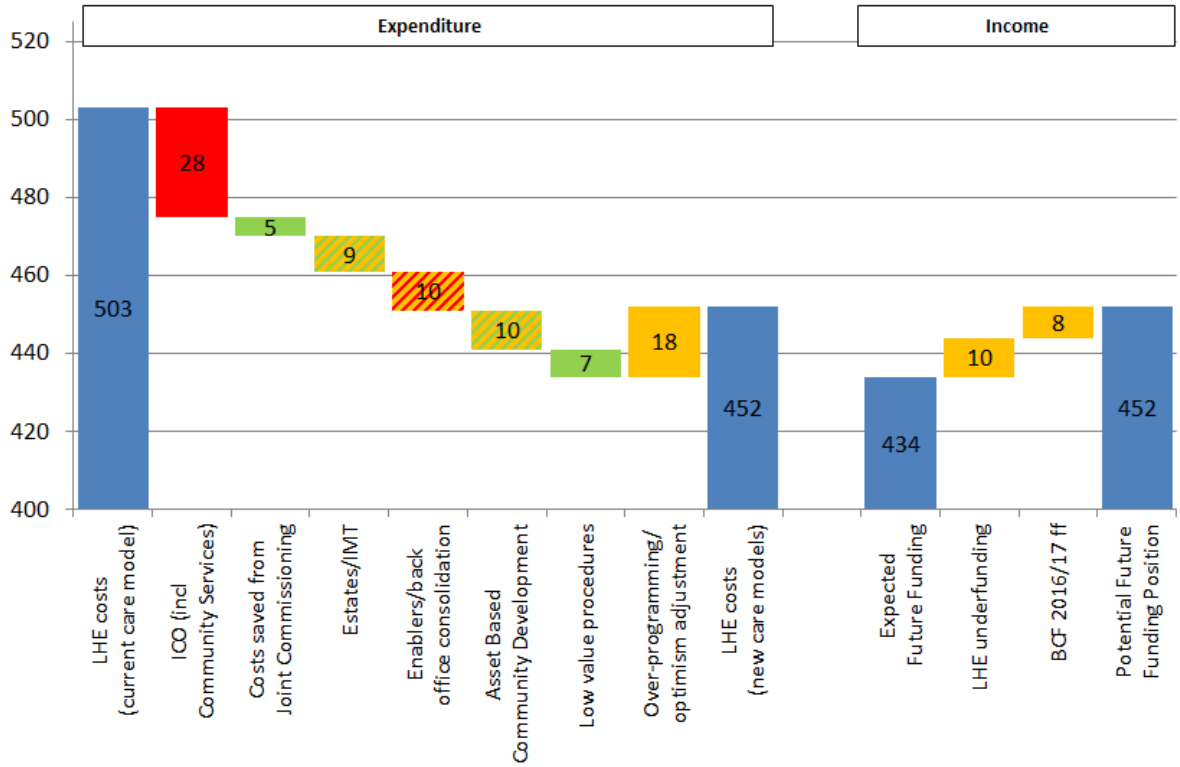
- The economy receives the required revenue and capital transitional funding to deliver the ambition. A robust coherent business case is currently being prepared outlining the request to Devolution
- Department of Health financial support (i.e. public dividend capital), for THFT continues to be received over the course of the next five years
- Social care funding is protected at 2015/16 levels to ensure stability and;
- The CCG is able to drawdown all its £6.746m cumulative carried forward surplus in 2016-17 from NHS England.

## 5.3 Closing the financial gap

Our plan to close the £69m financial gap is summarised in Table 3 below. The table shows the projected balanced economy in 2020 with the reduced level of expenditure and increased income across the different areas. Each of the components are risk rated to highlight those areas where transitional support is fundamental to delivery, (i.e. Red risk), to those areas where plans are already in an advanced stage of implementation using existing non-recurrent funding streams, therefore minimal risk (i.e. Green).

[1] The system deficit position in FY15 is being addressed through Public Dividend Capital (PDC) funding and therefore reporting a balanced cash position across the health and social care economy.

**Table 3 - Closing the financial gap by 2020**




The different components of the above table and the way in which they contribute to the balanced Local Health Economy (LHE) by 2020 are as follows:

5.3.1 Expenditure Components

**£503m – Cost of the local health and social care economy**
This represents the total value of the current cost of delivery of our health and social care model.

**£28m – Integrated Care Organisation (including Community Services)**
This is the reduction in annual costs identified by the CPT's recommendations for THFT through adopting a fully integrated model of care including the provision of community services. These cost reductions arise mainly from a reduction in demand for expensive inpatient services, a resulting reduction in estate use at Tameside Hospital and managing the demand increase with the same financial envelope of community care, social care and mental health services in a new integrated model.

The recommendations were published by Monitor in September 2015 and we are keen to drive through the implementation of these recommendations at pace and scale. The finance and activity modelling underpinning the CPT's recommendations is both sophisticated and thorough. The modelling uses granular level data to inform the proposals, correlate with activity projections within Healthier Together and also support the Locality Specific Services (LSS) analysis undertaken as part of the CPT's strategic review of a financially distressed FT.

The prevalence of various long term conditions have been considered and the numbers of hospital admissions these have historically caused. This has enabled an estimate of the impact of integrated care on a specialty and points of delivery basis which can be performance measured and provide critical success factors for delivery of our vision.

The modelling also demonstrates how general practice is at the heart of our plans for integrating care across primary, community, social and secondary care services for Tameside & Glossop. As described in Section 4.4 of this Locality Plan, general practice is the cornerstone of plans to reform local health services and improve health and outcomes for local people.

Our new models of care are focused on delivering as much care as is safe and appropriate in primary and community care and our aspiration for level 3 co-commissioning of primary care budgets from the 1st April 2016 is testimony to this. Benchmarking data suggests Tameside & Glossop are below average in investing funds in primary care and we recognise the urgent need to address this historic imbalance. We have already launched the first two phases of our Primary Care strategy by investing substantial recurrent and non-recurrent monies in primary care to get these programmes underway.

**£5m - Costs saved from joint commissioning**

As referenced previously, there will be one single commissioning function from 1st January 2016 by one cohesive management team. This will realise efficiencies and synergies which could not be achieved if operating as two independent commissioning teams. This fully integrated approach will ensure a cohesive function intent on securing the best possible outcomes for the residents of Tameside and Glossop. To this end, the pooled budget established in 2015-16 will be extended to include the full scope of health and social care expenditure and an aligned budget totalling circa £360m.

Further evidence of our vision is demonstrated within our commissioning intentions for 2016-17 contracts. We will work with partners to develop a model of contracting which reflects the changes in service provision and provides a methodology for funding to enable a long term development and a sustainable financial position. We are working towards a fully inclusive contract with our providers with pre-determined outcome based measures. We acknowledge a lead time is required in developing an outcome based contract model and therefore provider income will be relatively guaranteed in year 1 with minimal exposure to risk. However, this income guarantee will reduce incrementally year on year whilst exposure to risk will incrementally increase until such a time as a true outcomes based contract is in place which we would expect to be no later than 2020-21.

**£9m – Estates, Information Management and Technology (IM&T) and Shared Intelligence**

Estates: Rationalisation of the public sector estate in Tameside and Glossop will improve efficiency and reduce running costs. It is also hoped that, through Devolution, capital receipts can be retained within Greater Manchester to support the capital costs of transforming from the current health economy to one fit for the future, optimising running costs and securing transformation. We are also reviewing opportunities to increase business rates receipts to help contribute to closing the financial gap for social care.

IMT: We are developing an economy wide IM&T strategy and implementation plan to underpin the Shared Intelligence Service. Subject to receiving the required transitional funding, this work stream will achieve:

- One data set to move towards an outcome based contract
- Shared care record, ultimately to be owned and managed by the individual
- Procurement discounts due to increased purchasing volumes
- Improved efficiency as a result of the co-location of health and social care functions
- Reduced complexity of processes to increase quality and reduce costs
- Standardised desktop infrastructure, support and remote access, thereby improving quality and reducing costs and;
- Provide economies of scale in the application of IM&T.

**£10m - Enablers/back office consolidation**

Across our health and social care system, there are a number of services and functions required to support any type of organisation and economies of scale can become available by combining these services/ functions. We will be looking to consolidate these to maximise this opportunity whilst recognising there may be further opportunity by collaborating with other partners across Greater Manchester. We believe that shared services at scale provide the best opportunity to drive efficiencies and reduce corporate costs. The scope of transactional type services to be included has not yet been finalised but potentially include Procurement, Payroll, Finance, Transactional HR, IT and Estate Management.

Whilst we have agreed a £10m savings target across the economy, we will develop a gain share agreement to ensure all organisations benefit from the proposals and that quality of service is at least maintained. We recognise that automation of processes and reduction in transactions are what will drive the reduction in costs and will focus on these to achieve our savings.

**£10m - Asset Based Community Development**
As specified previously, we are committed to providing an integrated health and social care service based on supporting people to live healthy, independent lives in their own homes wherever possible, with the support they need close at hand. We value the skills and assets we already have in our local communities and will build on these. We want to build strong working partnerships with a wide range of organisations which represent the interests of different parts of our local community, as well as those who provide support and services. This will include organisations that provide health and care services, but it will go wider to include issues such as housing, education, transport, leisure facilities, employment and welfare. This extended collaboration will reduce costs and drive longer-term benefits by improving the health and wellbeing of our citizens.

A number of recent national pieces of work by leading experts have demonstrated the benefits of the kind of approach outlined in this initiative. Nesta's People Powered Health report and business case, published in 2013 estimated a national saving of £4.4billion could be achieved by taking community based "more than medicine" approaches. This would typically involve savings of 20% of spend for people with long-term conditions, who themselves account for 70% of the NHS budget – a saving of 14% of our total NHS spend. Earlier this year Public Health England and NHS England published a study by Professor Jane South of Leeds Metropolitan University, A Guide to Community Centred Approaches to Health and Wellbeing, which brought together all the key evidence of the effectiveness of community based approaches and mapped a "family of interventions" to demonstrate the range of approaches possible. The Kings Fund 2013 report Volunteering in Health and Care presents a compelling argument about the untapped potential in our communities and how that can work effectively with healthcare services. So, making greater use of the assets, skills and capabilities people in our communities already have will both save money and improve people's health and wellbeing. An efficiency saving of £10m for Tameside and Glossop by 2020 is a conservative estimate given the evidence presented in the research cited above.

**£7m - Low Clinical Value Procedures**
Low clinical value procedures are those deemed to be clinically ineffective, not cost effective or only meeting cosmetic rather than a clinical need. In line with our principle of using evidence-based interventions and not wasting tax payers' money, we will continue to review our "Effective Use of Resources" policies against national evidence to identify procedures which should not be carried out at all or only for the specific cohorts of patients who will derive sufficient clinical benefit. We will work with local residents, GPs and providers to ensure that only patients who meet the necessary criteria for these procedures receive them and others are supported in a more cost effective way.

**£18m - Over-programming/optimism adjustment**
Our plans are bold, show significant ambition but are also challenging. To mitigate the risk of any delays in delivery and/or additional costs from new emerging risks, we have incorporated an adjustment of circa 4% of the future expected funding which equates to £18m.

**£452m – Cost of the New Care Models**
This represents the £452m revised cost of providing the new care models, a reduction of £51m from the opening cost as a result of deploying the above strategies.

5.3.2 Income Components

**£434m - Expected Allocations**
As projected as at October 2015.

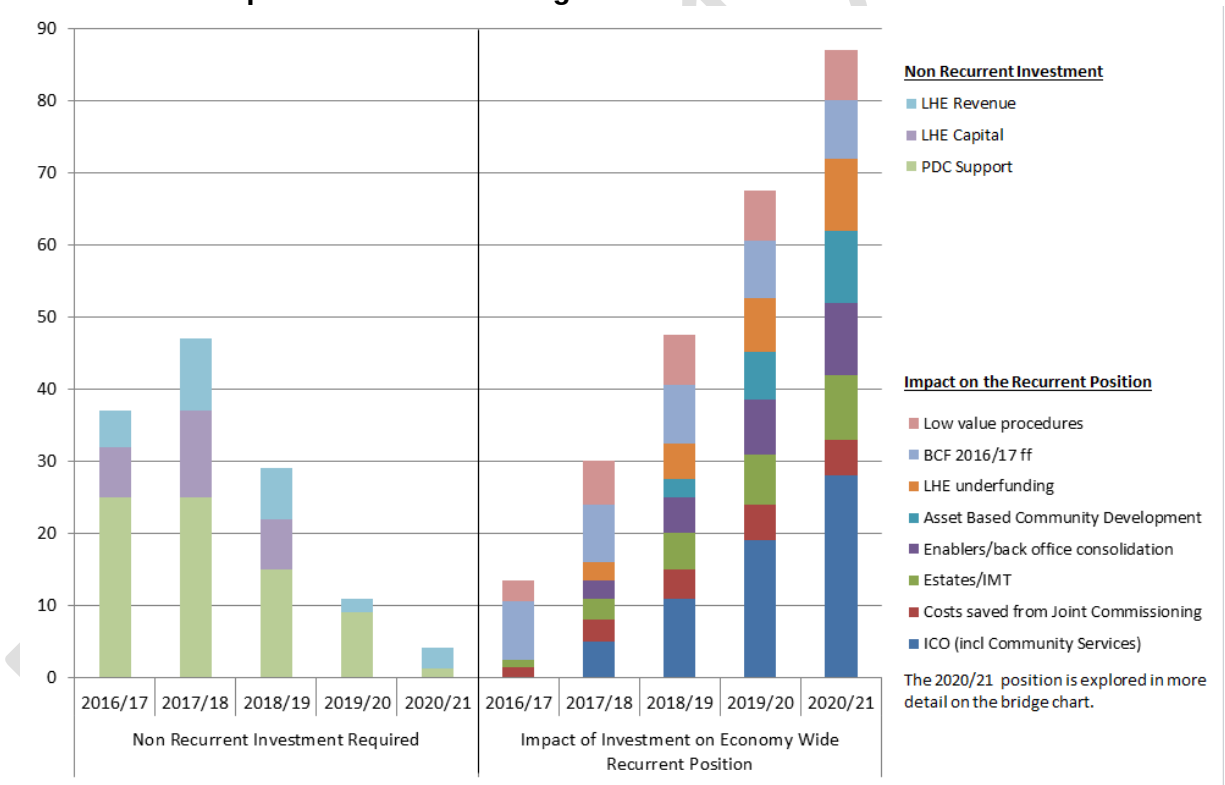
**£10m - LHE Underfunding**
Government data for CCG distance from target and Local Government financial settlement figures highlights that Tameside and Glossop is underfunded by approximately £14m. Therefore, if fair shares were applied, we should receive circa £14m more than we do currently. However, being conservative, we have assumed a material value of £10m which would reduce the overall financial gap requiring addressing in this Locality Plan.

**£8m - BCF 2016-17 funding**
This funding has now been confirmed nationally. This represents a financial benefit to the future economy closes the financial gap by matching income with expenditure.

## 5.4 Profile of Implementation

The implementation of the different strategies will be phased to ensure each of the actions are in line with the strategic vision of delivery being clinically safe, financially sustainable and integrated. The estimated phasing of the income and expenditure across the five year period until 2020 is shown in Table 4 below:

**Table 4 - Phased implementation of strategies to deliver a balanced LHE**




## 5.5 Costs of Implementation

The implementation/transition costs for delivering a financially balanced health and social care system are estimated to be in the region of £53m, combining capital and revenue requirements. These transition costs are vital to fund double running and pump priming of services whilst the transformation is being undertaken. There is also a requirement for continued public dividend capital to THFT to provide the essential working capital to run the hospital until efficiencies are released to fund the fully integrated, clinically safe and financially sustainable ICO. Although a significant level of transitional funding is necessary, the CPT report demonstrates that this would provide a good return on investment (Appendix C).

Implementation costs are summarised in Table 5. It is expected that the majority of these costs will be incurred in the first three years of implementation. It is imperative that external funding is made available to allow time for efficiencies to be released and facilitate the transition to the financially sustainable economy.

**Table 5 - Transition/Implementation Costs**

| Area | Description | Capital | Revenue | Implementation/ Transition |
|---|---|---|---|---|
| | | £ m | £ m | £ m |
| Public sector estate re-design | Reconfiguration of the Trust's estate as per the CPT's report comprising:<br>- assessment, planning and design of the new estates,<br>- moving services within the estate,<br>- development of premises for LCCTs,<br>- building work around the new front end of the hospital and demolition costs associated with the Charlesworth building. | 6.5 | | 6.5 |
| Workforce costs/organisational leadership development | Requirements for cultural and associated workforce changes to support the new ICO and the development of the ICO leadership team. | | 6.3 | 6.3 |
| Implementation management and professional costs | External/temporary support for:<br>- Implementation support, programme management, communications/engagement, contracting; and<br>- Due diligence, actuarial advice, legal advice and other transaction costs. | | 5.5 | 5.5 |
| 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. | | 4.3 | 4.3 |
| Investment in integrated IT and communication systems | Set up cost and capital investment in new IT including community migration, equipment to support community diagnostics, gap modelling, and infrastructure investment. | 19.5 | | 19.5 |
| 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 with this. | | 5.8 | 5.8 |
| Contingency | In developing a model which is a first of its type in the UK, it is important to ensure there is a contingency to mitigate risk. | | 5 | 5 |
| | | | | |
| | TOTAL TRANSITION/IMPLEMENTATION FUNDING REQUIRED: | 26 | 26.9 | 52.9 |

The above values are taken directly from the CPT report and are uplifted by 10% to cover contract termination costs which had not been adequately reflected. However, these values are being further reviewed and developed as part of the preparation of the business case and the composition is likely to change and the values revised downwards.

### 5.6 Profile of transition costs

The profile of the above transitional investment over the course of the next five years is shown in Table 6 below. These are currently being tested through the development of the robust and comprehensive business case for transitional funding and hence may change.

**Table 6 – Profile of transition costs[2]**

| Transitional investment: | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 | Total |
|---|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m | £m |
| Capital | 7 | 12 | 7 | 0 | 0 | 26 |
| Revenue | 5 | 10 | 7 | 2 | 2.9 | 26.9 |
| PDC support | 25 | 25 | 10 | 10 | 1 | 71 |

The majority of transitional funds are required to take forward change in the system at scale and pace. It should be noted that these figures do not include the full £6.746m cumulative carried forward surplus in 2016-17 from NHS England which we will be requesting in Year 1. Should these not be forthcoming, the revenue ask from Devolution will rise accordingly.

[2] The Department of Health have recently informed THFT that only £20m PDC support can be made available in 2016/17. The ramifications of this are currently being worked through.

### 5.7 Moving forwards

New financial pressures and risk will always emerge and financial plans will be continually reviewed and updated. We have therefore factored in some contingency for such items and recent examples worthy of consideration comprise:

- Transfer of specialist services back to CCGs will inevitably represent some financial risk to the economy
- The impact of the living wage following the Chancellor's 2015 budget statement, which will impact on the social care costs, and;
- The financial contributions required to support Greater Manchester wide early implementation priorities as outlined in the Programme approach to the Health and Social Care Devolution Programme.

We believe our plans are significantly advanced based on our vision for providing integrated health and social care at pace and scale to deliver our ambition of dramatically improving healthy life expectancy. Our plans have been scrutinised by external parties in depth and have now been endorsed by Monitor as being an absolute necessity for the future of Tameside Hospital and the population we serve, some of the most deprived in the country. We will ensure that wherever possible, the people of Tameside and Glossop receive the very best start in life with the best possible outcomes for health and care by investing funds wisely and ensuring effective stewardship of the public purse.

# APPENDIX A

**Summary of Tameside Health and Well Being**

Within Tameside there are significant inequalities in health outcomes. Whilst the wards of St. Peters, Ashton Hurst, Ashton St. Michael's and Hyde Godley have the worst outcomes in the Borough, the overall Tameside position for health and social care outcomes is poor.

## Key statistics (compared to the England average)

- Highest premature death rate for heart disease in England
- For premature deaths from heart disease and stroke, Tameside is ranked 148th out of 150 Local Authorities in England
- For overall premature deaths, Tameside is ranked 142nd out of 150 Local Authorities in England (<75 years)
- For premature deaths from cancer, Tameside is ranked 133rd out of 150 Local Authorities in England
- Life expectancy at birth for both males and females is lower than the England average (76.9 years males, 80.3 years females)
- Life expectancy locally is 8.7 years lower for men and 7.4 years lower for women in the most deprived areas of Tameside compared to the least deprived areas.
- Healthy life expectancy at birth is currently 57.9 years for males in Tameside and 58.6 years for females in Tameside. This is significantly lower than the England averages.
- In year 6, 33.3% of children are classified as being overweight or obese, under 18 alcohol specific hospital admissions, breast feeding initiation and at 6 to 8 weeks and smoking in pregnancy are all worse than the England average.
- In adults the recorded diabetes prevalence, excess weight and drug and alcohol misuse are significantly worse than the England average
- Rates of smoking related deaths and hospital admissions for alcohol harm are significantly higher than the England average and many of our statistical neighbours
- Life expectancy with Males in Tameside living 3 years less than the England average and nearly 7 years less than the England best.
- Females live on average just over 2 years less than the England average and 6 years less than the England best.
- Healthy life expectancy for women is nearly a year less than for men, and close to the worst in England.
- Premature mortality for women has not improved as fast as the NW and England.
- Circulatory diseases including heart disease are the commonest cause of early death and rates are 55% higher than the national average.
- Disability free life expectancy at 65 years is significantly worse than the England average (6.8 years compared to 10.2 years in England (males)) and 7.1 years compared to 10.9 years (females))
- Nearly 20% of Tameside residents are living in fuel poverty compared to the 16% England average
- Significantly higher emergency admissions for both males and females
- People returning to their own homes after a stroke is significantly worse than the England average, 28% less people return to their own homes after a stroke compared to the England average.

Source; Tameside JNSA 2015-16

# APPENDIX B

**Summary of Glossop Health and Well Being**

The High Peak is a Borough Council area in the North of Derbyshire. It has a population of about 91,000 distributed across 208 square miles. The largest town is Glossop (population 33,000) and the second largest is Buxton (population 25,000).

**Key statistics (compared to the England average)**

- Two lower super output areas (LSOA) in Glossop (Gamesley and Hadfield North) fall within the 10% most deprived in England and are the third and fourth most deprived LSOAs in Derbyshire ( IMD 2010)
- Male life expectancy in these areas is 69 and 73 compared with 78 for both Derbyshire and England (ONS). For females the figures are 72 and 78 respectively compared with 82 for both Derbyshire and England.
- The most recent ONS figures for Jobseekers allowance claimants (Nov 2013) show that Gamesley in Glossop has the highest level in Derbyshire with a rate of 6.6%. Whitfield ranked 15th worst (4.3%). The comparable figures for High Peak are 2.1% Derbyshire 2.1% and England 2.9%.
- In the High Peak, a higher percentage of Jobseekers allowance claimants are long term unemployed (over 12 months) compared to county or national rates (34.5% in High Peak equating to 430 people compared to 31.8% in Derbyshire and 31.2% England).
- Derbyshire had a significantly smaller proportion of children living in poverty.
- The rate of low birth weight births is significantly lower.
- Population vaccination coverage in childhood immunisations is significantly higher and, in the case of most vaccinations, rising.
- A smaller proportion of children are achieving a good level of development at the end of reception, and this is even lower in those entitled to free school meals.
- A smaller percentage of mothers are initiating breastfeeding of their babies and this appears to falling.
- By 6-8 weeks the percentage of breastfeeding mothers is even smaller and again appears to falling.
- A higher proportion of mothers are smoking at the time of delivery of their child.
- The percentage of young people who are not in education, employment or training is significantly lower and falling.
- The proportions of teenage girls conceiving, both under the age of 18 and under the age of 16, are significantly lower.
- The proportions of children recorded as carrying excess weight, in both reception (4-5 years) and Year 6 (10-11 years) are significantly lower.
- The rates of hospital admissions caused by unintentional and deliberate injuries in children, aged 0-4 years and aged 0-14 years, are significantly lower and falling.
- Cancer screening coverage – both breast and cervical – is significantly higher, though falling.
- The proportion of adults in Derbyshire who are overweight or obese is significantly higher.
- The percentage of people recorded as having diabetes is significantly higher and is increasing.
- The proportion of households living in fuel poverty is significantly higher, but falling.
- The hospital admission rate for injuries due to falls for 80+ year olds is significantly higher.
- Premature mortality from cardiovascular disease considered preventable is significantly higher.

# APPENDIX C

**Contingency Planning Report -**
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461261/Final_CPT_report.pdf

| | |
|---|---|
| **Report to :** | **HEALTH AND WELLBEING BOARD** |
| **Date :** | 12 November 2015 |
| **Executive Member / Reporting Officer:** | Damien Bourke, Assistant Executive Director (Development, Growth and Investment) |
| **Subject :** | **WORKING WELL UPDATE** |
| **Report Summary :** | The Working Well pilot has been live since March 2014 in Greater Manchester. This report provides an update of successful progress on the pilot and integration between work, skills and health. The report also sets out wider health and work initiatives and the expansion of Working Well in 2016. |
| **Recommendations :** | The Health and Wellbeing Board are recommended to:<br>1. Note the progress of Working Well so far;<br>2. Consider the opportunities for the expansion of Working Well in 2016 including supporting development of a health referral route. |
| **Links to HWB Strategy :** | The Working Well programme contributes to the Health and Wellbeing Strategy particularly through Priority 4 - *Working Well - Creating Fair Employment For All* and the Outcome – *Increased employment.* |
| **Policy Implications :** | Working Well is a key initiative for Greater Manchester as part of the public service reform programme. The successful delivery of the programme has been recognised through the Devolution Manchester Agreement and Working Well Expansion. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | There are no further contributions required from the Council for the Working Well expansion.<br>The total Council contribution towards the pilot scheme is £119,309. Funding has been identified and is included in the revenue budget for Development, Growth and Investment. A recently signed Partnership Agreement will commit the Council to indemnify the Lead Authority in the event of any losses it may incur for the pilot scheme, as a result of a third party claim, along with the other nine authorities. Should this occur funding would need to be identified. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | It is important that any interventions and programmes are evidence based and performance is monitored in order that resources are applied where they deliver the best outcomes and value for money. |
| **Risk Management:** | Greater Manchester has set a target of 15% of those exiting the work programme entering and sustaining employment for 12 months. Failure to deliver programmes will impact negatively on future investment models and programmes of this type being agreed and implemented at the Greater Manchester level. |

**Access to Information :**

The background papers relating to this report can be inspected by contacting David Berry, Project Lead, Employment and Skills by:

 Telephone:0161 342 2246

 e-mail: david.berry@tameside.gov.uk

## 1. INTRODUCTION

1.1 This report updates on progress on the current Working Well (WW) pilot and Phase 1 of the expansion from the existing 5,000 cohort to 15,000 across Greater Manchester (GM). Tameside Health and Wellbeing Board (and Implementation Group) received a report on Working Well in June 2014 and requested to be kept informed of progress annually. This report sets out opportunities in the expanded Working Well Programme that is scheduled to go live in February 2016.

1.2 The current Working Well pilot started in March 2014 to support Employment Support Allowance (ESA) Work Related Activity Group (WRAG) claimants who had spent two years unsuccessfully on the Work Programme into sustained employment. The scheme, which has been co-designed between GM and Government, has been built around a key worker model, giving providers the freedom to innovate and design services in the most effective and efficient way possible. By tackling the complex issues of the participants in a holistic way, it will benefit their employment, health and life chances, as well as helping to reduce the overall cost of key public service interventions. Demonstrating that this model can work is a key priority for GM as it has a direct impact on future decisions around commissioning the Work Programme or its successor. Integrating Working Well with health services has been challenging although many successes have been achieved to date. The Health and Wellbeing Board agreed a protocol in 2014 that has proved the basis of integration in the past year. The Working Well expansion provides a significant opportunity to develop integration at a faster pace on a larger scale.

1.3 Working Well has been successfully implemented and delivered so far in Tameside. The programme is being managed locally by a partnership Steering Group led by Damien Bourke (Assistant Executive Director Investment and Development). The role of the steering group is to understand progress and problem solve any blockages or barriers to the programme. The Steering Group includes representatives from Public Health, Clinical Commissioning Group and Pennine Care. At GM level the Working Well Pilot is led by Theresa Grant (Chief Executive Trafford Council). Two providers deliver the programme in GM Big Life (Salford, Trafford, Manchester) and Ingeus (Tameside and all other GM areas).

## 2. DELIVERY

2.1 The performance scorecard below sets out delivery in Tameside. Overall the programme is progressing well.

Table 1 (performance dashboard)

| Performance scorecard | Tameside | Greater Manchester |
|---|---|---|
| **Clients enlisted** | **335 (8%)** | **3945** |
| **Clients attached** | **280 (84%)** | **3414 (87%)** |
| **Baseline of how many clients should be in programme (+ is positive performance)** | **+22 (+7.11%)** | **-530 (-11.85%)** |
| **Job Starts (claimed)** | **10** | **152** |
| **Job Starts (claimed and unclaimed)** | **17** | **159** |
| **Clients attached within 30 days of referral** | **47%** | **47%** |

*Note: The providers Ingeus and Big Life have claimed and unclaimed job starts. It may take a period of time to secure contracted documentation from employers and employees to submit as evidence of a job start (claimed).*

2.2 The successes for the programme so far are set out in the bulleted list below:

- 17 clients in work in Tameside, this is in profile with the GM figure. Analysis shows that of the recorded job starts in GM the clients have taken on average 172 days from referral to employment.
- 3 clients in permitted work (permitted work enables the client to retain benefits and is a good marker for work readiness and progression).
- Overall 2 clients have taken up work experience placements with Tameside MBC improving their experience, skills and work readiness, both clients have secured employment with external organisations. This success can be built upon by all public sector organisations.
- Good performance in attaching clients within the 30 day target (47%).
- Acceptable performance in attaching clients compared to those enlisted – some clients are not engaging with the programme as they are awaiting a change of circumstances such as leaving the Work Related Activity Group to join the Support Group (meaning they will not be required to search for work as a condition of their benefit). Ingeus are currently in discussion with Jobcentre (Tameside) to co-locate in order to improve engagement with claimants who have not attended initial appointments.
- Continued positive engagement with housing providers in strengthening their operational involvement in the programme, including a specific named point of contact in every housing provider.
- Ingeus report that there are no current gaps in provision in Tameside, and continue to acknowledge the strong support provided by the Steering Group.
- Ingeus report good engagement with the following provision:
    - Tameside Psychological Well Being Service, Welfare Rights, Tameside Housing Advice, Cavendish Mill Women's Centre, St Anne's Learning Centre (adult skills).

2.3 The table below sets out information about employment barriers clients face when entering into the programme, bereavement has continued to be above the GM average.

| Barrier | Tameside % | GM % |
|---|---|---|
| Mental Health | 71% | 68% |
| Physical Health | 65% | 62% |
| Bereavement | 38% | 26% |
| Skills | 31% | 33% |
| Work experience | 28% | 27% |
| Debt/finance | 24% | 24% |

2.3 The short case study below illustrates how bereavement can act as a barrier to work. The Steering Group (including Pennine Care Mental Health) is reviewing how bereavement issues can be supported through existing or evolved services.

**Case Study 1 - Bereavement**

- Client (female, 50-60yrs) does not engage at appointments lethargic, uninterested and depressed.
- Family member (step) had died in a work related accident (over 10 years ago).
- Step family could not see the patient until they had passed leaving client feeling excluded.
- The client also suffered late term miscarriage.
- The client has had Cognitive Behavioural Therapy and counselling although feels that support can no longer help her and is not interested in anything else.
- Client has suffered from depression since childhood, has experienced domestic violence in previous relationships.
- Client has done permitted work (3hrs per week) for longer than the usual 52 weeks though struggles to attend as she needs to be accompanied leaving her home.
- Very disengaged and little interest in anything.

2.5 The Working Well cohort is complex and challenging due to the barriers experienced by the claimants. Recently the Tameside Steering Group has initiated bespoke pieces of work to address needs of the client base.

- Skills – 124 (47%) of our active cohort have no qualifications.
- Mental health – 159 (60%) of our active cohort have a mental health barrier (to work).
- Work readiness – 22 (8%) of our active clients have never worked while 61 (23%) have not worked in the last 11 years.

2.6 The Steering Group is continuing to design and deliver bespoke packages of support between Tameside College, Council Adult Community Education and Pennine Care for our clients. We are working with Ingeus to find innovative ways to engage this cohort to ensure they move closer to work readiness. An example of this are open days, group and one-to-one skills support at Learn at St Anne's, we are tailoring our offer to the client group to support engagement. Ingeus have also recently begun a small trial of the Big White Wall online resource to support people with mental health condition alongside existing services.

## 3. FOCUS ON HEALTH CONDITIONS

3.1 Based on GM the primary and secondary conditions for clients in the programme are set out below.

3.2 The primary health conditions of clients entering the programme (GM data) are:

- 25% Depression or low mood;
- 18% Anxiety disorders;
- 8% Problems with back;
- 6% Osteo – Arthritis;
- 5% Alcohol addiction.

3.3 The secondary health conditions of clients entering the programme (GM data) are:

- 21% Depression or low mood;
- 20% Anxiety disorders;
- 6% Problems with back;
- 4% Problems with legs;
- 3% Chest/breathing problems.

3.4 Only 38% of clients in the programme have confidence that they will be able to find and obtain work. Early indications show that being in the programme can have an impact on health management, whilst 25% of attached Working Well clients were not managing their health confidently on entry into the programme, this has now fallen to 22%. This provides

an early indication that the programme may be helping clients to become more confident about managing their health conditions. Also 16% of attached Working Well clients have seen some improvement in relation to mental health issues over the life of the programme.

3.5 The Working Well programme is supporting health management by patients. The case study below provides an example of a Tameside resident.

**Case Study 2 – Health Management**
**Background**

- Female, single, living alone.
- Started programme in July 2014.
- Presented with depression and anxiety and left last job because of her health condition;
- Had previously worked for many years as a charge hand/supervisor at local food company but left in 2006 as was unable to manage her depression in work.

**Action taken**

- Saw Ingeus' Senior Mental Health Advisor who recommended therapy and made a referral to IAPT (Improving Access to Psychological Therapies).
- The IAPT referral route was established through the Tameside Public Service Reform Hub and is an example of integration improving customer access to services.
- Appointment for Group CBT Therapy sessions called Managing Your Mood came through very quickly for client to attend weekly, local to her.
- Client was working intensively with Key Worker, Work and Wellbeing Coach and attending weekly CBT sessions and was coming on in leaps and bounds stating she felt better than she had for years and that she felt Ingeus really listened to her and were helping her.
- A new CV was produced and Work & Wellbeing coach was sourcing Voluntary opportunities.

**Outcome**

- Client attended a medical with ATOS in late August and was then put on to JSA as she had made such progress within such a short space of time – evidences an improvement to work readiness.
- The health improvement has supported the clients readiness for work.

3.6 The Working Well Annual Report set out progress of the pilot up to summer 2015 and included the quote below on the inter-relationship between work/skills and health. It is important that integration happens at multiple levels across the large scale reform work taking place. Tameside can continue to enact positive local changes and activity but will require larger scale change to support our overall ambitions.

*Our PSR work has acknowledged the failures of traditional practices of partial assessment, fragmented service response and late intervention which both generates new and different needs whilst often failing to address the root cause. The first year of the Working Well programme provided interesting examples of the success of simple, individual assessment alongside innovative cross sector working in identifying and addressing the root of a person's long term unemployment. In some cases the response has been as expected (mental health provision), in others less so (access to dental care). Our efforts to address long term unemployment therefore, as a single example, are quietly changing the way we think about health provision and, ultimately, reforming health services.*
*Warren Heppolette*
*Strategic Director – Health & Social Care Reform Greater Manchester*

## 4. HEALTH SECTOR ACTIVITY

4.1 The Tameside Steering Group has continued to place engagement and integration with the Health Sector as a main priority. We are continually exploring opportunities to specifically integrate Working Well into health services and also support the wider integration of health, work and skills services. The work below sets out some of the key activity to support our twin approach.

- Integration of Ingeus into the Public Service Reform Hub – Ingeus are working alongside health services like the Pennine Care Mental Health Team.
- Working Well Workshop for Health Providers July 2014 – this workshop was led by Public Health to raise awareness and develop integration with health providers.
- Presentation and Strategic discussion CCG PIQ February 2015 – This report set out the Working Well programme and supported the establishment of links with GPs.
- Presentation GP Target Group April 2015 – This presentation enabled a discussion with GPs about Working Well and wider health, work and skills issues. It has supported further integration and discussion around referrals, COPD and diabetes. The presentation also enabled key messages about the expansion of Working Well to be delivered. (As set out later in this report under the expanded Working Well programme there will be greater opportunity for health professionals to refer patients into Working Well – currently referrals are only taken from Jobcentre Plus.)
- Representation at the Primary Care Mental Health Liaison (GP) group – The Working Well Steering Group (including Ingeus) is a member of this meeting supporting long term integration and commissioning and discussions of immediate activity that can be undertaken to support Working Well clients.
- Bespoke activity regarding Mental Health – Ingeus are currently working with Pennine Care to continually develop the interventions and ongoing support that can be provided to Working Well clients with mental health barriers to work. Specifically the Steering Group is looking to develop opportunities around the Recovery College.
- Local fit for work pilot – The Steering Group is progressing an opportunity to develop a local fit to work pilot in Hattersley for out of work benefit claimants. The design of the pilot is currently being assessed. The main aim of the pilot would be to establish GP referral routes into a work/health management service that would support footfall in GP surgeries and increase activation of patients in self-management. Manchester City Council has undertaken a successful localised pilot. The pilot would support the next phase of Working Well expansion by designing and testing GP referral routes into 'work and skills' support services.

4.2 Alongside this local activity have been national and GM level work that should be noted.

- National Fit for Work service – This is a free Government service recently launched following pilots in Sheffield and Wales. The national service supports clients who are in work only. Fit for Work is designed to improve access to occupational health provision and help negate the almost 1 million employees nationally who go on long term sickness absence from work each year. The service aims to complement GP services by offering expert and impartial advice (telephone based). A Return to Work Plan will be produced for those who have been referred and will likely be absent from work for 4 weeks or more. The Government believes the Return to Work Plan could eventually replace the Fit Note. The Plan aims to be solution focused. GPs can refer into the national Fit for Work Service now.
- Work4health programme – A campaign in Wigan, Bolton and Oldham via GM Public Health Network to provide materials to support work discussions between patients and health practitioners. The campaign has supported learning across GM with the tools to support available publically. The work4health campaign will support longer term change by tackling the challenge of integrating work and health.

## 5. EXPANSION OF WORKING WELL PHASE 1

5.1 The success of the current Working Well Pilot supported the ground breaking Devolution agreement in November 2014. This agreement set out an expansion of Working Well to 50,000 GM residents. The expansion has now been developed in detail and will take place in 2 phases; the second phase will be formed around the re-commissioning of the Work Programme. The expansion of Working Well should be considered alongside the opportunities to influence health commissioning provided by the Integrated Care Organisation. Working Well is a 'work first' programme that can continue to progress the integration of work, skills and health services to provide effective holistic support for residents requiring support to access sustainable employment (and increased hours).

5.2 Phase 1 of the expansion will support 15,000 GM residents with referrals ending in March 2017. The procurement process began in July with a Pre-Qualification Questionnaire (PQQ) event for providers. The timetable for Phase 1 is set out below:

- July 2015 – December 2015 – Procurement phase;
- February 2016 – Referrals commence.

5.3 Phase 1 builds on the successes of the current pilot based on the principles below and the vision of setting out an integrated employment and skills eco-system:

- Personalised support;
- Integration;
- Market shaping;
- A new eco-system of work, skills and health;
- Evaluation.

5.4 Phase 1 is essentially a widening of the cohort from ESA WRAG claimants with improved referral mechanisms, it is expected that the cohort will have a variety of complexities including:

- In receipt of out-of-work benefits for 3 of the last 4 years;
- Ex-Offenders;
- Severe debt problems;
- Homelessness and housing problems e.g. threat of eviction;
- Addiction;
- Learning Disabilities and Difficulties;
- Severe literacy and numeracy problems;
- Mental health problems;
- Physical health problems;
- Family problems eg. domestic violence or relationship breakdown.

5.5 In Working Well Phase 1 referrals will now start from other providers as well as Jobcentre Plus (JCP). The clients identified by other providers such as GPs will be routed through the Jobcentre but crucially will not be limited to identification by JCP. All areas are currently updating their integration plans to enable successful delivery of Phase 1.

5.6 The contract has been divided into 2 lots (Lot 1 - Salford, Manchester, Trafford) and (Lot 2 the rest of GM). Providers will be able to bid for both lots or separately. The successful provider will be paid 30% (£900) on attachment, 30% (£900) on job start and 40% (£1,200) on sustained job start. The current Working Well Pilot pays 50% on attachment. Minimum performance is 20% entering and 15% sustaining work. Phase 1 is also aligned to Mental Health and Skills commissioned work, creating an eco-system of work, skills and health.

5.7 Phase 1 represents an important change in the welfare to work system in GM increased and widening of cohorts and enhanced integration should be viewed as key successes.

Working Well has so far supported change to public services with regards to work and skills. The further expansion will enable providers to become more operationally involved in holistically tackling work, skills and health by providing a referral route and increasing opportunities for co-case management.

5.8 In considering the opportunities of the expanded Working Well programme the Health and Wellbeing Board should consider how these opportunities could be realised through an updated Tameside Working Well Integration Plan. The Integration Plan will set out the opportunities and mechanism locally for Tameside agencies (including health services within a pilot of the expansion) to refer into Working Well. The Tameside Working Well Steering Group is continually developing our local integration plan with local agencies and providers (the Health and Wellbeing Implementation Group has been engaged in this process initially). The Steering Group would welcome the strategic support of the Health and Wellbeing Board in developing and establishing an effective operational Integration Plan that could support patients as part of a pilot within the Working Well expansion.

## 6. CONCLUSIONS AND RECOMMENDATIONS

6.1 Working Well is operating effectively in Tameside. Ingeus are integrated into our partnership structures and we have had an appropriate level of referrals, attachments and job starts. Engagement and integration between work/skills and health is progressing and will be strengthened further by the expansion of Working Well.

6.2 The Health and Wellbeing Board are asked to consider the recommendations set out on the front of the report.

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| **Report to :** | **HEALTH AND WELLBEING BOARD** |
| **Date :** | 12 November 2015 |
| **Executive Member / Reporting Officer:** | Cllr Lynn Travis, Executive Member Health and Neighbourhoods<br>Angela Hardman, Director of Public Health |
| **Subject :** | **CONSULTATION RESPONSE ON THE ADIVOSRY COMMITTEE ON RESOURCE ALLOCATION TARGET ALLOCATION FORMULA FOR 2016/17.** |
| **Report Summary :** | Advisory Committee on Resource Allocation (ACRA) has reviewed the formula for public health and has made a number of recommended changes for 2016-17 onwards.<br>The paper sets out ACRA's interim recommendations and implications for Tameside MBC. ACRA will make its final recommendations to Ministers this autumn. |
| **Recommendations :** | Health and Wellbeing Board are asked to:<br>• Note the launch of the funding formula consultation for 16/17, proposed changes and implications for Tameside;<br>• Endorse and discuss the consultation response;<br>• Agree to receive a further update following the autumn statement at the Health and Wellbeing Board on 21 January 2015. |
| **Links to Sustainable Community Strategy :** | Healthy Tameside<br>Prosperous Tameside |
| **Policy Implications :** | Local authorities have, since 1 April 2013, been responsible for improving the health of their local population and for public health services including most sexual health services and services aimed at reducing drug and alcohol misuse. The Secretary of State continues to have overall responsibility for improving health – with national public health functions delegated to Public Health England. |
| **Financial Implications :**<br>**(Authorised by the Section 151 Officer)** | The Council's grant allocation will reduce by £0.340m in 2016/17 following the outcome of this consultation. In addition it is expected that the confirmed 2015/16 in year grant allocation of £0.943m will be a recurrent reduction which will therefore lead to an estimated total grant reduction of £1.283m from 1 April 2016.<br>The Comprehensive Spending Review is due to be announced on 25 November 2015 when the value of grant reduction is expected to be confirmed. Associated proposals to deliver this level of funding reduction will require urgent implementation in advance of 2016/17 financial year on a recurrent basis |

| | |
|---|---|
| **Legal Implications :**<br>**(Authorised by the Borough Solicitor)** | There are significant risks to loss of funding and subsequent increases in health inequality and it is important the Council responds to the consultation. |
| **Risk Management :** | These are set out in the report.. |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting Debbie Watson<br>  Telephone:0161 342 3358<br>  e-mail: debbie.watson@tameside.gov.uk |

## 1. PURPOSE

1.1 To brief the Health and Wellbeing Board on:

- The ACRA Public health grant proposed target allocation formula for 2016/17 and how it has been developed.
- Implications on our local area.

## 2. BACKGROUND

2.1 The Advisory Committee on Resource Allocation (ACRA) developed a formula for public health grants for the first time in 2012 which was used to set target allocations for 2013-14 and 2014-15 for public health grants to Local Authorities.

2.2 Between 8 October and 6 November 2015 the Department of Health is consulting, on behalf of ACRA, on interim recommendations for a number of changes to the target formula for the public health grant for 2016-17 onwards.

2.3 The key steps in setting the Public Health allocations are:

- Setting the preferred relative distribution of resources,
- Setting the total resources available,
- Deciding how quickly to move organisations from their baseline position towards the level of resource implied by the preferred distribution (pace of change policy).

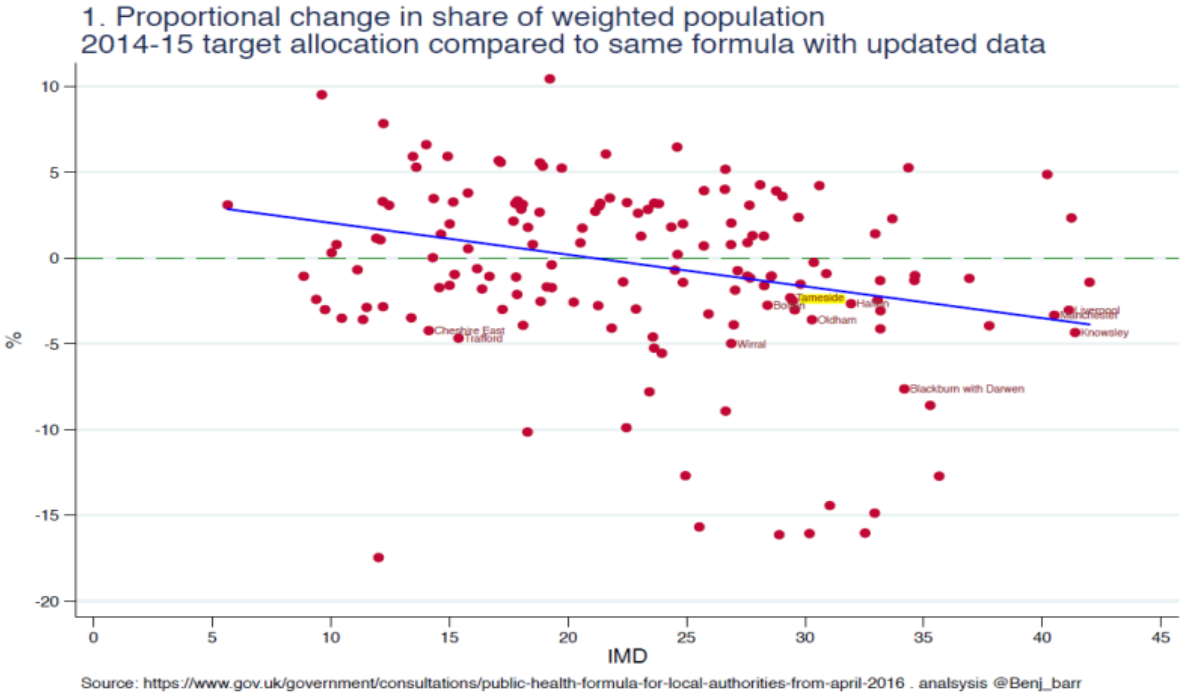
2.4 Pace-of-change is a decision reserved for ministers, as is the total resource available, which will not be known until the outcome of this year's spending review is published. Therefore, this consultation is focused solely on the target formula which determines the preferred relative distribution of resources.

## 3. KEY ISSUES

3.1 The existing public health grant formula is summarised in **Appendix 1**.

3.2 The proposed changes to the formula, and their impact on Tameside MBC target allocation are summarised below.

3.3 *Routine data updates*. Since the publication of the 2013-14 and 2014-15 allocations a number of the datasets have been updated, in particular the standardised mortality ratios (SMR) have been updated to use population estimates based on the 2011 as opposed to the 2001 census. Deprived areas have tended to see their SMR<75 estimate fall as the denominator (expected number of deaths based on the population size and age structure) rises. This effect is enhanced for the most deprived areas because of the exponential weighting used to weight the SMR<75 and shows the **no change** impact on Tameside target allocation in the graph below.




3.4 *Using a modelled rather than the actual standardised mortality ratio* has a number of benefits, particularly that it can continue to identify underlying drivers of poor health in a local authority that has been successful in meeting those challenges. For Tameside modelled standardised mortality ratios would be advantageous as work already completed re modelled prevalence of disease has shown that the current disease registers have lower rates of disease prevalence than expected.

3.5 However, ACRA's view is that the modelling is not yet robust enough for implementation so recommends the actual SMR<75 continues to be used, while work continues to develop the model. There are no implications for the proposed target allocation formula for 2016-17, but appears a **positive proposal**.

3.6 *Increasing the number of area groupings used for the standardised mortality ratio based component.* During the allocation period concerns were raised by independent analysts around the way small areas of similar mortality were grouped, in particular that this may mean the target was insufficiently sensitive to the most extreme deprivation. ACRA is proposing that finer grouping is used to offset this. The impact of this change is relatively small for the majority of Middle Super Output Areas (MSOAs). However, for the 5% of MSOAs with the worst SMR<75s there is a more marked increase, with some seeing their weighting double. On average, LAs with the most deprived populations benefit from this change. This factor does not change Tameside's share per 100,000 resident population by zero percentage points, so appears the **same.**

3.7 *A new formula component for substance misuse services.* The existing model for drugs misuse uses a combination of recent provision and recent success rates, in line with the approach used in the past for Pooled Treatment Budgets (PTBs). This formulation can be volatile and could be subject to perverse incentives, such as the incentive to treat more people rather than to invest in prevention. ACRA is therefore proposing a new formula, for both drugs and alcohol misuse, based on a utilisation dataset that can be linked to the user's place of residence and controlled for effects that may drive up utilisation, but are not connected to need. Most of the impact is to target more resources at the most deprived areas and this factor decreases Tameside's share per 100,000 resident population by 0.02 percentage points, so appears **negative.**

3.8 *A new formula component for sexual health treatment services*. The existing target formula uses the SMR<75 to indicate areas where deprivation and other factors may be creating a greater health challenge. Some stakeholders were concerned about the suitability of this approach for sexual health services, where the link between mortality and drivers of need for services may be particularly distant. As for substance misuse services, ACRA is now proposing a new formula based on a utilisation dataset that can be linked to a user's place of residence and controlled for effects that may increase utilisation, but are not linked to need.

3.9 Outside London the effect is predominantly to target more resources in more affluent areas and away from more deprived areas. This is consistent with the criticism of the existing approach: SMR<75 (which is highly correlated with deprivation) is not a good predictor of sexual health services utilisation, and so the most deprived areas tended to see their target share reduce as this is corrected. This factor reduces Tameside's share per 100,000 resident population by 0.04 percentage points, so appears **negative.**

3.10 In contrast, London is a net beneficiary of this change, with just two boroughs seeing a reduction of their target share, even when they are in the most deprived groups. This is consistent with the view of the London Boroughs in particular who felt the existing formula underestimates need for these services in their areas.

3.11 *A new component for children's 0-5 services* takes account of the transfer of resources from NHS England to LAs for responsibility for commissioning public health services for children aged under five years. From October 2015 to March 2016 the budgets are primarily on the basis of 'lift and shift.'

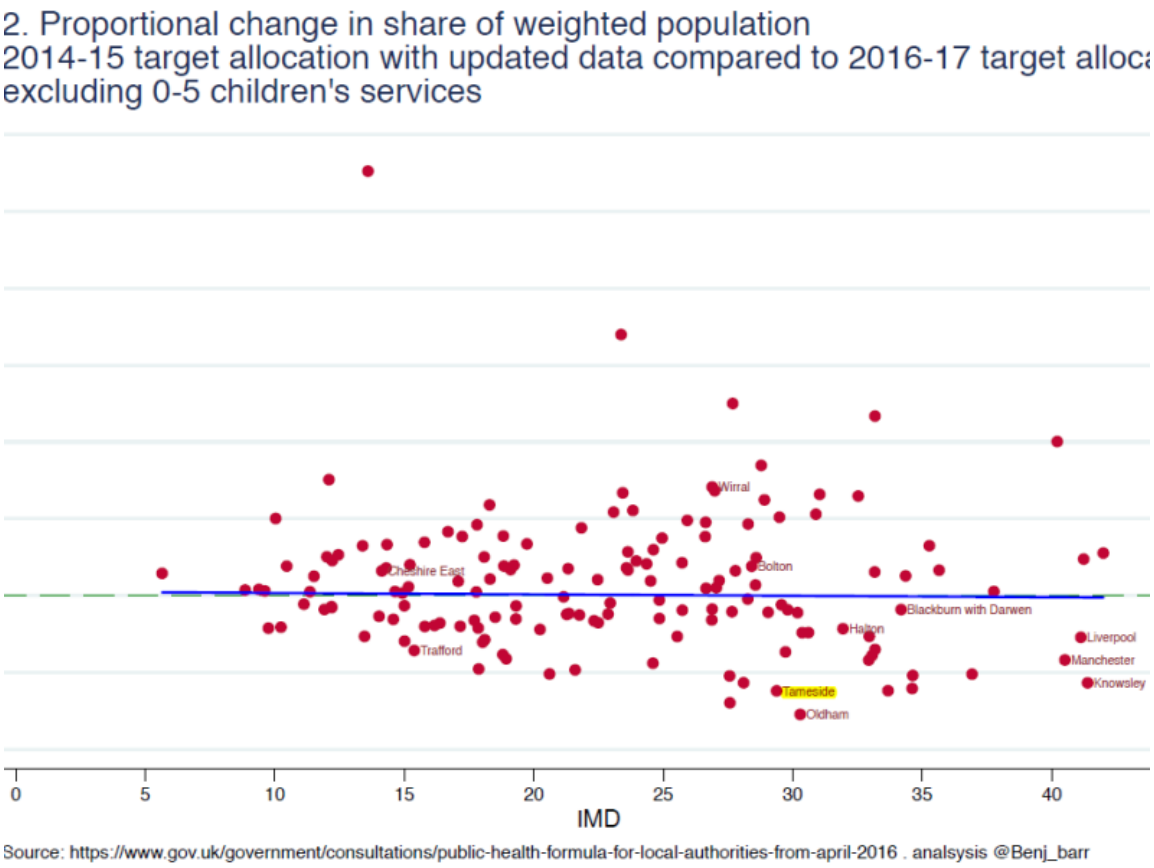
3.12 The formula proposed by ACRA has three elements:

- The under 5 years child population;
- An adjustment for relative need per head of the population base;
  - ACRA also considered the proportion of live births at term that are low birth weight and the number of births to women aged under 20 years. However, data on these were felt to be too volatile at LA level due to small numbers and not broad enough to capture all children with higher need.
  - The IMD2010 indices, which are based on data for around 2008, were felt to be too dated. The date of publication of the IMD2015 indices had not yet been finalised.
  - Children in need of support from social services and children in need of safeguarding and subject to a child protection plan were also considered, but not recommended due to concerns over the variability between LA in the interpretation of the definition of, and routes to identify, children in need and in need of a child protection plan.
  - ACRA favours, and has used in the proposed formula, the measure 'Children in Low Income Households'
  - The measure also needs to be scaled – how much higher should be the weight per head for children in poverty compared with children not in poverty. ACRA has found little evidence to support a particular weighting and an element of judgement is required, so are proposing a ratio of 4:1 as reflecting a central position given the advice they have received.
  - Sparsity; may create unavoidable differences in the costs of providing some 0-5 children's public health services between LAs, in particular where health visitors travel for home visits. A model has been developed which suggests that health visitors in the most sparsely populated areas require 4% more resources than the least sparsely populated.

3.13 With these three elements combined, the new component for children's 0-5 services tends to benefit areas with higher birth rates. It also has a tendency to reduce the target share for more deprived areas. Although counter intuitive at first sight, this is because core health

visiting is a universal service and so, the net effect of the weighting for deprivation in this part of the formula is less than for other parts of the formula.

3.14 **Tameside's share per 100,000 resident population reduces by 0.04 percentage points, so appears negative.**

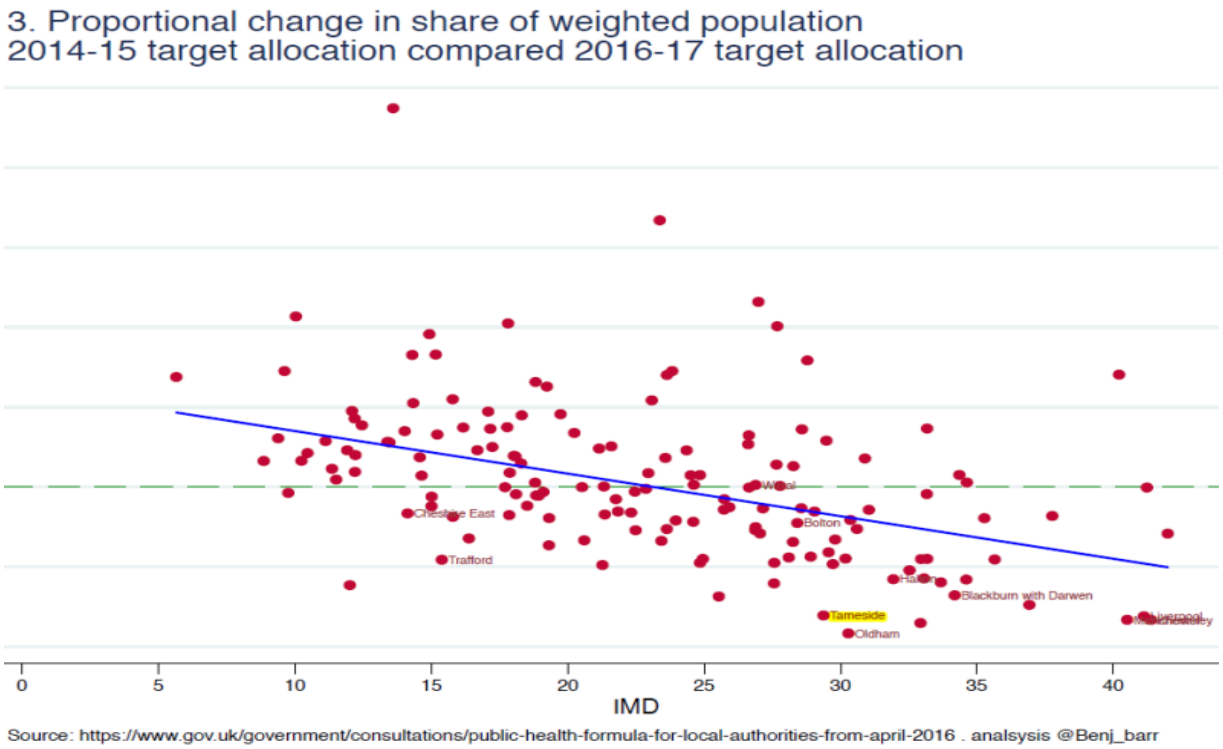



3.15 In our consultation response we would want to highlight the following:

- That the impact of deprivation on the need for 0-5 years children's public health services is under estimated
- Similarly, the formula ignores safeguarding, which has a massive impact on Health Visitor workload in deprived areas

3.16 **<u>Overall impact</u>**

3.17 **The overall impact on Tameside of the proposed target allocation formula for 2016/17 is shown below, which represents a 0.1% reduction of relative share.**




3.18 Timetable

3.19 The tentative timetable for the 2016/17 Public Health allocations is as follows,

i. Response to consultation closes 6 November 2015
ii. Analysis and review by ACRA and Final Recommendation to Ministers Mid November 2015
iii. Allocation finalised subject to Spending Review settlement End November 2015
iv. Allocations announcement December 2015/January 2016

## 4. FINANCIAL IMPLICATIONS

4.1 The public health grant in 2015/16

| | £'000 |
|---|---|
| Public Health Baseline Grant | 13,463 |
| 0-5 Health Visiting | 3,454 |
| Total | 16,917 |

4.2 The 1% decrease in the Tameside MBC allocated share will decrease from 0.25% to 0.24%, which in financial terms is equivalent to a reduction of £340k in grant allocation for Tameside. Based on the 2015/16 baseline grant allocation this would mean the Tameside allocation reducing from £13,463m to £13,123m.

## 5. LEGAL IMPLICATIONS

5.1 The local authority decides how best to spend the public health grant, having regard to the needs of the population, its statutory responsibilities and the grant conditions.

## 6. RESOURCE IMPLICATIONS

6.1 The formula for public health grants is on a weighted capitation basis. The consultation suggests that the proposed target allocation for each Local Authority area can be summarised as either % share of overall weighted population or % share of weighted population per 100,000.

6.2 For Tameside, the target allocation for 2014/15 using the current formula is 0.25% of overall weighted population. The proposed target allocation for 2016/17 using the fully updated formula and data is 0.24% of overall weighted population, a 0.1% reduction of relative share.

## 7. CONSULTATIONS:

7.1 Between 8 October and 6 November 2015 the Department of Health is consulting, on behalf of the Advisory Committee on Resource Allocation (ACRA), on interim recommendations for a number of changes to the target formula for the public health grant for 2016-17 onwards. See **Appendix 2** for copy of the consultation response from Tameside Council.

**THE CURRENT FORMULA, USED TO SET TARGET ALLOCATIONS FOR 2013-14 AND 2014-15 FOR PUBLIC HEALTH GRANTS TO LOCAL AUTHORITIES**

A summary of the current formula is as follows:

The formula is principally based on a population health measure, the standardised mortality ratio for those aged under 75 years (SMR<75). Many of the mortality and morbidity measures are highly correlated, and are in turn highly correlated with deprivation. The SMR<75 is used as an indicator of the whole population's health status and should not be interpreted as meaning that the allocation should not reflect the needs of those aged over 75 years or that morbidity is unimportant.

The SMR<75 is applied at middle layer super output areas (MSOA) level to take account of inequality within LAs as well as between LAs;

The gradient of the formula across small areas is exponentially weighted at a ratio of 5:1 to target funding per head towards areas with the poorest health outcomes; obesity and physical activity, alcohol misuse, tobacco misuse, sexual health services, children's 5-19 services, and drugs misuse.

An age-gender adjustment is applied for those services with the highest proportion of public health spend which are also directed at specific age-gender groups, to weight for relative needs between different age-gender groups;

A component to support drug treatment services funded through the pooled treatment budget (PTB) up to 2012-13 which broadly follows the approach used to allocate that budget. This is based on a need component, an activity component and an outcome component. The need component in the PTB formula was replaced with the SMR<75;

An unavoidable cost adjustment, the Market Forces Factor (MFF); the MFF is that used in NHS allocations to Clinical Commissioning Groups (CCG), mapped to LAs.

The weights per head from the above are applied to Office for National Statistics resident population projections for LAs to give weighted populations for each LA. Each LA's share of the total weighted population gives its target share of the national budget (once known).

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Department of Health

# Public health grant: proposed target allocation formula for 2016/17

Proforma for responses to consultation exercise

November 2015

# Public health grant: proposed target allocation formula for 2016/17

## Summary of consultation questions

Name : Angela Hardman

Position : Director of Public Health

Organisation : Tameside Council

Email : angela.hardman@tameside.gov.uk

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**Q1 : Do you agree that a modelled SMR<75 should be developed for use in the longer term?**

Response :

Yes, Tameside Council are in favour of the development of a modelled SMR<75 that reduces volatility in allocation over time.

**Q2 : Do you agree that the sixteen groups outlined above provide a sensible balance between sensitivity to the most extreme mortality rates and protection against volatility of measurement?**

Response :

Yes, overall Tameside Council supports to move to the use of 16 groups as this increases the weighting for the most deprived areas and achieves a more progressive allocation. However, some moderation of the beneficial impact for the most affluent LAs would need to added in to prevent this approach also increasing inequality.

**Q3: Do you agree that the proposed new substance misuse formula component should be introduced?**

Response :

No, Tameside Council does not support this change as although most of the impact is to target more resources at the most deprived areas, this change would reduce the local allocation. This approach fails to provide sufficient continuing support to those LAs that have invested in effective preventive programmes that reduce demand, seeming to reward those that haven't invested in effective prevention and encouraging them to maintain service usage. This approach also discourages more deprived areas from developing local access to services to reduce drift to urban centres for treatment.

The existing model for drugs misuse uses a combination of recent provision and recent success rates, in line with the approach used in the past for Pooled Treatment Budgets (PTBs). Whilst this formulation can be volatile and could be subject to perverse incentives, such as the incentive to treat more people rather than to invest in prevention and the formula change proposed by ACRA will help to control for effects that may drive up utilisation, but are not connected to need; however, more work is needed to make this component more robust.

**Q4 : Do you agree that the proposed new sexual health services formula component should be introduced?**

Response :

No, Tameside Council do not support this change, in line with the Consultation Document statement: "Outside London the effect is predominantly to target more resources in more affluent areas and away from more deprived areas". As for substance misuse services, this approach fails to provide sufficient continuing support to those LAs that have invested in effective preventive programmes that reduce demand, seeming to reward those that haven't invested in effective prevention and encouraging them to maintain service usage. This approach also discourages more deprived areas from developing local access to services to reduce drift to urban centres for treatment.

We do not feel that any of the models are appropriate for implementation at this time, primarily because none of the models include the use of SHRAD. In 2013/14, SHRAD was not mandatory and was a transition period between KT 31 and SHRAD for the collection of contraception activity. None of the outlined models reflect need for preventative services rather than need for treatment services.

**Q5 : Do you agree that the proposed new services for children under five years formula component should be introduced?**

Response :

No, Tameside Council would not support this change. Whilst accepting that birth rate is an important factor in need for 0-5 years services, deprivation and safeguarding account for such a significant amount of the variation in need that a factor that reduces the share to more deprived areas is regressive. Travel times are higher in

more affluent County LAs, where need associated with deprivation and safeguarding makes up a smaller proportion of the total service demand.

The deprivation element based on an arbitrary weighting of the percentage of children in poverty is the least distributive of all the deprivation formulae in the proposal. This doesn't make sense in view of the importance of early years' health in influencing health in later years, which is a key underlying driver for the Greater Manchester Early Years New Delivery model. Therefore we suggest that it be replaced either by the SMR<75 weight or that the weighting ratio of 1:4 be increased significantly, certainly 1:5 as a minimum.

The formula for services for children under 5 should include an age weight. This is because:

a. Spend is skewed to births and the earlier ages of years 0 to 4.

b. The fractions of the England population at ages 0-1,1-2,2-3,3-4 and 4-5 vary within local authorities. This variation appears systematic in that in general urban areas have higher fractions for the earlier years (and for births) while rural and some suburban areas in general have the opposite - higher fractions in the later years of 0-5. This pattern reflects migration of families with very young children who migrate from urban to suburban or rural areas. Urban areas often have a greater burden of births and very early years high costs while many suburban and rural areas have a greater 0-5 population at the higher ages where costs are less.

Thank you for your response to the consultation.

Email to: PHformula2016/17@dh.gsi.gov.uk

**or**

Post to: Engagement on Local Authority Public Target Allocations 2016/17
Department of Health
Public Health Policy and Strategy Unit
Room 165
Richmond House
79 Whitehall
London
SW1A 2NS

| | |
|---|---|
| **Report to :** | **HEALTH AND WELLBEING BOARD** |
| **Date :** | 12 November 2015 |
| **Executive Member / Reporting Officer:** | Cllr Allison Gwynne, Executive Member Children and Families<br>Angela Hardman, Director of Public Health<br>Debbie Watson, Head of Health and Wellbeing |
| **Subject :** | **UPDATE – TRANSFER OF 0-5 HEALTHY CHILD PROGRAMME FROM NHSE TO TMBC** |
| **Report Summary :** | This document aims to update the Health and Wellbeing Board of the transfer of commissioning responsibilities for 0-5 public health services from National Health Service (England) (NHSE) to the Council and the transformation undertaken by the provider of Health Visiting and Family Nurse Partnership (FNP) services. It will seek to inform future local commissioning decisions and strategy development. |
| **Recommendations :** | The Health and Wellbeing Board are asked to note the key issues presented and updates on the transfer of commissioning responsibilities for 0-5 public health services from the NHSE to Tameside MBC |
| **Links to Health and Wellbeing Strategy :** | Early Years is a key priority programme for action for the Health and Wellbeing Strategy and will add impetus to achievement of the health goals. |
| **Policy Implications :** | Delivery of the 0-5 Healthy Child Programme is a mandatory public health programme for the local authority. This work will inform the work and annual business planning of the Tameside Health and Wellbeing Board. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | The confirmed funding that will be allocated to the Council for the commissioning of children's 0-5 public health services from October 2015 is £1.771m. |

| | 15/16 Confirmed £'000 |
|---|---|
| 6 Month: HCP & FNP Allocation From 1 Oct 2015 | 1,712 |
| 6 Month : CQUIN | 44 |
| 6 Month: Commissioning | 15 |
| 6 Month Total | 1,771 |

The evaluation of the estimated expenditure appears adequate with the service at full capacity of 66.6 WTE Health Visitors. If the service is at less than full capacity the contract price will be appropriately adjusted to reflect the level of service provided.

The £15,000 commissioning element has been allocated to the Public Health efficiencies programme and therefore will not be spent.

| | |
|---|---|
| | The expectation is that this funding will be included within the Council's Public Health grant allocation from 2016/2017 onwards. However the Department of Health have stated that there will be no new unfunded burdens placed on local government in relation to the transfer of this responsibility. Future funding arrangements will follow from the government's spending review decisions. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | Local Authorities acquired new statutory responsibilities on 1 April 2013 under the Health and Social Care Act 2012 to carry out public health functions. The Government completed the transfer of responsibility from NHS England to local authorities for the commissioning of children's 0-5 public health services for 1 October 2015. The Council needs to consider the most appropriate way to align resources to meet its statutory duties. |
| **Risk Management:** | Risks will be managed via the Early Years Strategy Group. |
| **Access to Information:** | The background papers relating to this report can be inspected by contacting Debbie Watson by:<br>Telephone:0161 342 3358<br>e-mail: debbie.watson@tameside.gov.uk |

## 1. PURPOSE

1.1 This document aims to update the Health and Wellbeing Board of the transfer of commissioning responsibilities for 0-5 public health services from NHSE to the Council and the transformation undertaken by the provider of Health Visiting and Family Nurse Partnership (FNP) services. It will seek to inform local commissioning decisions and strategy development. A library of supporting documents (LoSD) will be made available to Local Authorities to provide further information and guidance.

1.2 This report covers the period that NHS England has commissioned these services (April 2013 onwards).

## 2. BACKGROUND

2.1 The Health Visiting 'Call to Action' programme started in 2011 as a National programme of work to deliver on the Government's commitment by 2015 to:

- Increase health visitors by 4,200 whole time equivalent (WTE)
- Create a transformed, rejuvenated health visiting service providing improved outcomes for children and families with more targeted and tailored support for those who need it.

2.2 The significant investment in services for young children and families is intended to:

- Improve access to services;
- Improve the experience of children and families;
- Improve health and wellbeing outcomes for under-fives; and
- Reduce health inequalities.

2.3 On 30 November 2010, the Government published the White Paper *Healthy Lives, Healthy People: Our strategy for public health in England*, which established a vision for a reformed public health system. As a consequence of the White Paper it was agreed that commissioning of children's public health services from pregnancy through to 5 years would transfer from NHSE to Local Authorities 1 October 2015. The delay in transfer was to allow NHSE sufficient time to deliver on the Government's commitment to raise the number of health visitors and support improved stability of the system before the transfer of services.

2.4 The transfer of responsibilities will join up the commissioning already done by Local Authorities for public health services for children and young people aged 5-25 years.

## 3. MANDATION

3.1 In 2014 it was agreed that some elements of the Healthy Child Programme (HCP), would be mandated for 18 months (until March 2017) to further support a stable transfer. In this context mandation means a Public Health step prescribed in regulations made under section 6C of the NHS Act 2006. Each local authority must, so far as reasonably practicable, provide or make arrangements to secure the provision of a universal health visitor review to:

- a woman who is more than 28 weeks pregnant;
- a child who is aged between one day and two weeks;
- a child who is aged between six and eight weeks;
- a child who is aged between nine and 15 months; or
- a child who is aged between 24 months (two years) and 30 months (two years and six months).

3.2 A “universal health visitor review” means an assessment of the health and development of an eligible person as set out in the HCP.

3.3 A universal health visitor review must be carried out by a Health Visitor or FNP Family Nurse, or a suitably qualified health professional under the guidance and delegation of the Health Visitor.

3.4 Health Visitors in Tameside and Glossop (T&G) also work with communities in order to help build community capacity. This includes supporting community groups. A particularly successful project has been working with Homestart to train volunteers in parent infant mental health. A project supporting extended families in promoting health messages is also just starting.

3.5 Health Visitors work with all families from Universal to targeted, as outlined in the four levels of Health Visiting in **Figure 1**.

## 4. HEALTH VISITING

### 4.1 Background and evidence: Health Visiting

- Pregnancy and the first two years of life are critical to emotional and physical health across the entire life span. Adults who were exposed to adverse childhood experiences are much more likely to have poor mental and physical health in later years.

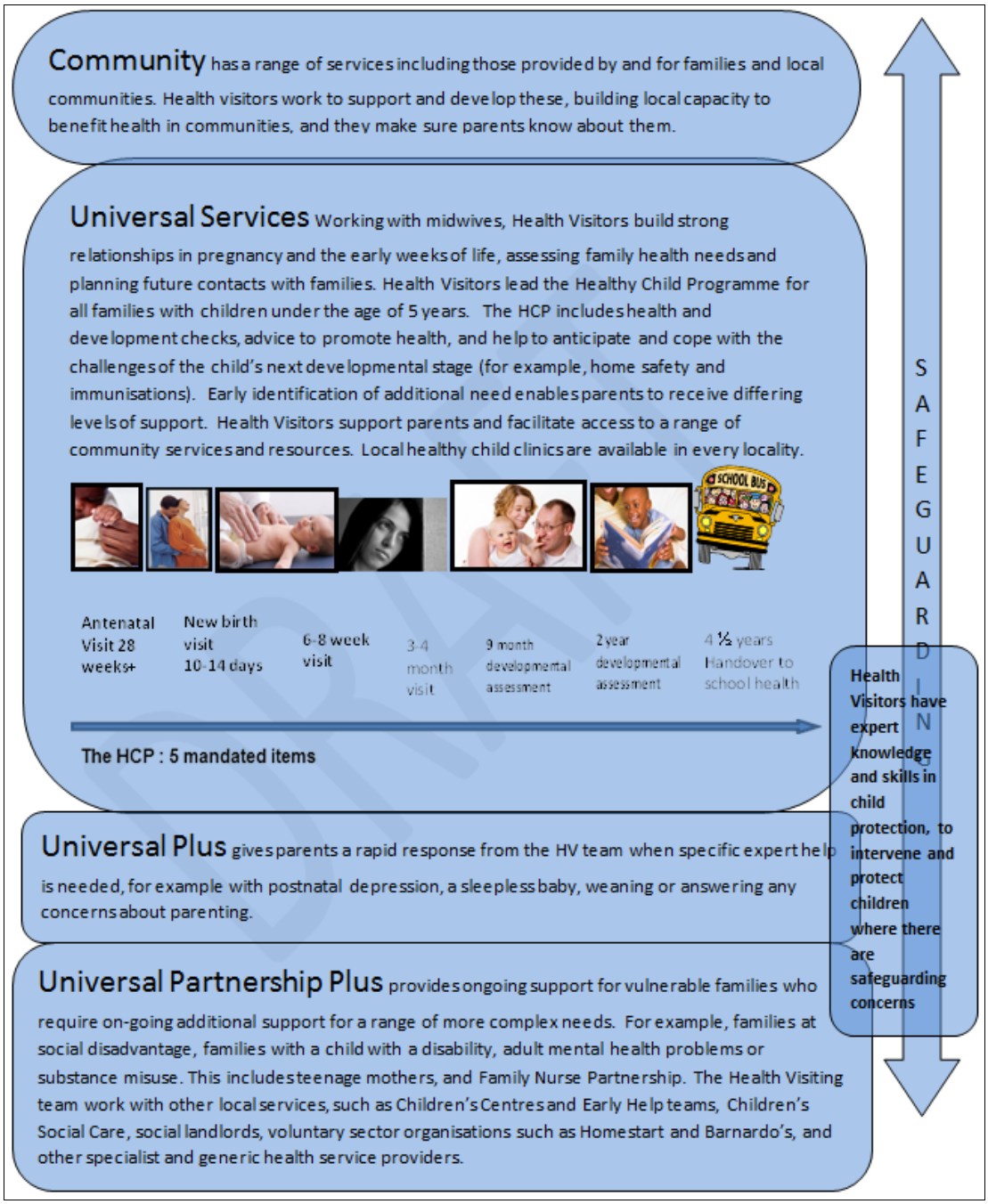
- Early experiences shape a baby’s brain development, and have a lifelong impact on that baby’s mental and emotional health.

- Health visiting is a front line public health service, supporting parents through evidence based public health interventions, carried out in the family home or in community settings. The service is the first to assess the health needs of babies and children under the age of 5, and their families, in these contexts. These holistic assessments are completed at key points starting in the antenatal period. As a universal service, Health Visiting therefore has a vital role in identifying, with every family, their needs at the earliest opportunity possible, and at a time when families are most receptive to change.

- In Greater Manchester, Health Visitors have around 1 million client facing contacts per year to improve the public health outcomes for babies, pre-school children and their families. These contacts include prevention, early identification of and response to child protection issues, breastfeeding, childhood illnesses, parenting and school readiness.

- The Department of Health and Local Government Association (2014) have identified six areas in which there is evidence that health visiting can make the highest impact in children’s early years, leading to improved outcomes for children, families and communities (see table below). There is an obvious synergy between identified local and national public health priorities. The Health Visiting service has a significant contribution to make in key areas in which the population of T&G fares below the national average, which create increased risk of long term poor health and social outcomes and inequality.

**FIGURE 1: FOUR LEVELS OF HEALTH VISITING**




- Health visitors lead delivery of the full Healthy Child Programme and they are commissioned to deliver the National Service Specification with some additional Greater Manchester items in line with the Early Years New Delivery Model. The current Service Specification ensures full delivery of the 0-5 Healthy Child Programme and articulates the health visitor's role in meeting key outcomes for babies and children.

- Intervening early, working with families to build on strengths and improve parenting confidence and, where required, referring early for more specialist help, including specialist mental health services, is the most effective way of dealing with health, developmental and other problems within the family. Health visitors, working in partnership with GPs, midwives, Sure Start Children's Centres, day care settings and other local organisations, have a crucial role in ensuring that this happens (Health Visitor Implementation Plan 2011-2015).

- As highly skilled public health practitioners, Health Visitors have a key leadership role to play in the delivery of the public health agenda for children 0-5 years, their families and their communities. Health visitors in T&G have embraced the Early Years New Delivery Model and Tameside is the only local authority in Greater Manchester to have two early adopter sites. They have been leaders in the development of innovative and quality services and multi-agency pathways. As the workforce now reaches full capacity, Health Visiting leadership will be vital to the success of the full roll out of the New Delivery Model in Tameside.

**The Six Early Years High Impact Areas**
**Tameside and Glossop Health Visitors deliver evidence based interventions and work within multi-agency pathways: this is a brief overview**

1. **Transition to Parenthood and the Early Weeks**
    - *Antenatal and Postnatal Promotional Interviewing (Family Partnership Model)*
    - *Family Nurse Partnership Model*
    - *Teenage Pregnancy Pathway*
    - *Brazelton Neonatal Behavioural Assessment Scale (NBAS) and Newborn Behaviour Observation (NBO) System*
    - *Tameside and Glossop Getting it Right from the Start DVD and Booklet*
    - *Maternity Antenatal Communication Pathway in development*
    - *Solihull Approach, and Solihull Approach Parenting with early years services*
    - *Mellow Parenting programme for high risk / safeguarding families*
2. **Maternal Mental Health (Perinatal Depression)**
    - *Multi-agency parent infant mental health pathway*
    - *Edinburgh Postnatal Depression Scale*
3. **Breastfeeding (Initiation and Duration)**
    - *UNICEF Baby Friendly Stage 3 accredited (with children's centres)*
    - *Infant and pre-schoolchildren feeding guidelines*
4. **Healthy Weight, Healthy Nutrition (including Physical Activity)**
    - *Healthy weight 0-4 years pathway*
    - *Maternal healthy weight pathway*
5. **Managing Minor Illness and reducing Accidents (Reducing Hospital Attendance/Admissions)**
    - *Accident and Emergency unit liaison*
    - *Safety, immunisation, dental health and safe sleep promotion, smoking cessation advice and minor illness advice*
    - *Non-medical prescribing*
6. **Health, Wellbeing and Development of the Child Age 2** – Two year old review (integrated review) and support to be 'ready for school'
    - *Ages and Stages Questionnaire - 3 (Also at 9 Months)*

## 4.2 **Health Visitor performance**

*New birth Visit (10-14 days), 9-12m review, 2-2.5 year review: % delivered within timescales (Tameside & GM):*


4.2.1 The graphs above demonstrate that performance across the three areas measured is improving overall. This reflects the increase in Health Visitor establishment. The service

has worked hard over the past year to improve performance data collection and quality, so that there is now a high degree of confidence in reported data.

4.2.2 All children and families are seen and the graphs above represent those that are seen within prescribed timescales only. Historically in T&G children received a development review between 7 and 15 months of age and coverage was 92% in 2014-15. The graph showing performance for the 9-12 month review measures those children seen by 12 months of age only. Since 2014, considerable effort has gone into meeting the requirements of both the new HV service specification and the AGMA New Delivery Model; the number of children seen by 12 months of age has consequently increased and was at 87% in Q1 of 2015-16. It is expected that performance will improve further.

4.2.3 The 2 year review demonstrates a similar pattern in terms of the effort made to ensure children are reviewed within the prescribed time scales. Nationally it is shown that this older age group is a more challenging review to achieve full coverage on. The service has experienced some additional problems with data collection and reporting and has invested considerable time in understanding and rectifying these problems. Additionally the service has introduced the ASQ-3 and a self-book appointment system to improve overall efficiency, but the transition period has affected performance. The service expects that with increased staffing numbers and the above issues being addressed, performance will improve.

4.2.4 Antenatal health promoting visits have been the last area that Health Visiting teams have chosen to focus on as their teams have grown. It is anticipated that the service will increase significantly from the baseline of 13% coverage when the workforce is at full capacity. The greatest challenge to increasing antenatal visits has been that the main local maternity provider is a different NHS Trust and information sharing has been a major challenge. A new maternity management structure, the introduction of a shared CQUIN between maternity/Health visiting (from 1st October 2015) should see this improve considerably.

4.2.5 The remaining mandated review is the 6-8 week review which has not been reported previously but is well embedded within the majority of Health Visiting teams in GM. T&G was the highest performing service across GM at 96% for Quarter 1 (average 80%; range 51% - 96%).

4.2.6 The data-reporting mechanisms in place between the Provider and NHSE will be replicated by Local Authorities following the transfer.

4.2.7 To quality assure Health visiting services a local nurse-led self-assessment assurance tool was developed and introduced to providers in Quarter 2 14-15. The tool provides a useful frame of reference to help services with self-assessment and highlight areas for development. The T&G Health Visiting service has shown the following improvements evidenced by the quality assurance tool:

- Progressive discussion with the new maternity leadership team at Tameside Hospital regarding the maternity communication pathway
- Ongoing training in NBO and NBAS, Solihull, ASQ-3 and the antenatal and postnatal promotional interviewing tool
- Achievement of UNICEF Baby Friendly Level 3 with children's centres
- Training in and application of the Communication Pathway for Early Years with Speech and Language Therapy and children's centres

- Engagement in the development of several multi-agency pathways including domestic violence

- Health visitor engagement in multi-agency safeguarding training.

### 4.3 Health Visitor Workforce Growth

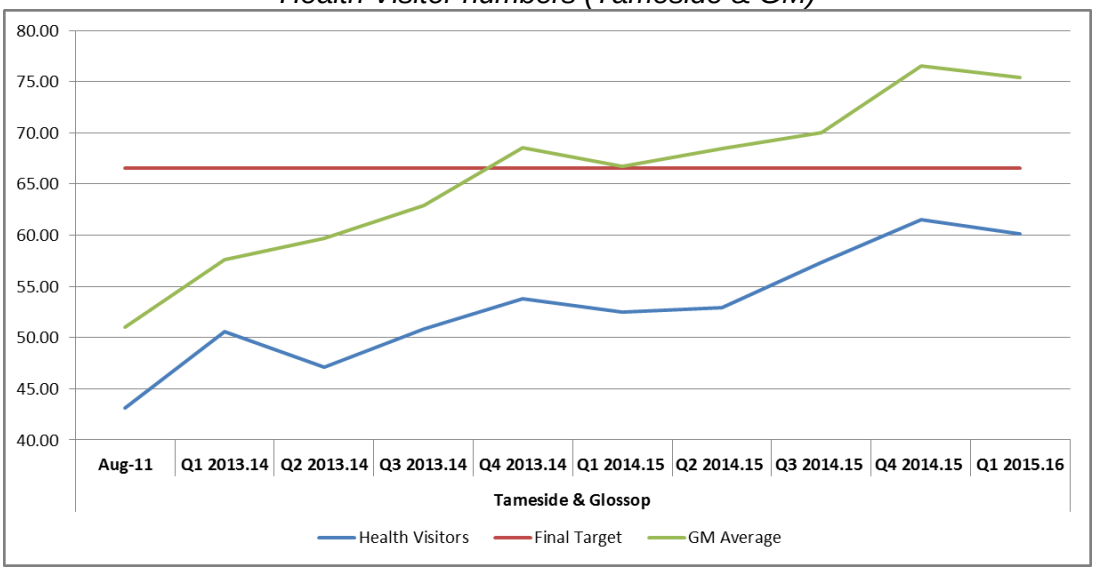
4.3.1 T&G have had a significant challenge to increase workforce numbers from a very low starting point. The workforce has grown by over 50% since 2011. The growth required exceeded all other areas, however despite this the management team worked hard to ensure that the Health Visitors entering the T&G workforce are of an exceptionally high quality.

4.3.2 There has been significant investment in training experienced Health Visitors to take on the role of Community Practice Teacher (CPT), in order to facilitate the extra requirement for student training. T&G have trained 10 CPTs since 2011 (from a baseline of 2 CPTs), ensuring that all students receive quality individual placements and the service is resilient moving forward.

4.3.3 Since 2011 T&G have trained 34 students and another 10 will commence training in September 2015; in this 4 year period T&G would normally have expected to train a maximum of 8. T&G have also supported a 'return to practice' placement and that Health visitor is now employed by T&G.

4.3.4 Workforce numbers have increased steadily over the two years that NHS England has commissioned the service. Plans are in place to ensure that the service is close to full capacity (66.6 WTE) at point of transfer. By the end of October the service expects to be at full capacity and will maintain its commitment to promoting retention and participation rates amongst existing staff. Neighbouring providers are still actively recruiting students due to qualify in mid-October. October numbers will be verified in early November.

*Health Visitor numbers (Tameside & GM)*




4.3.5 Health Visitors are all Registered Nurses with an additional qualification in Specialist Community Public Health Nursing which is a Masters level qualification. The increase in the workforce has been hugely positive, bringing enthusiasm, energy and innovation to teams, and making service improvement and development feel achievable in a way that was not possible in the past. However, the amount of skilled teaching, management, support and supervision that has been, and still will be required must not be underestimated. In October 2015, only 51% of Tameside (67% of Glossop) Health Visitors will have more than 2 years' experience.

4.3.6 Newly qualified Health Visitors undergo a 1-2 year preceptorship period, following the *Department of Health National Induction and Preceptorship Framework for Health Visitors*. This ensures that skills and confidence are developed with the support of an experienced Health Visitor preceptor, and the team leader. Full caseload responsibilities including safeguarding cases can be taken on from 6 months post-qualification. It is important to note that newly qualified Health Visitors may have qualified as Registered Nurses relatively recently, but most have many years' experience in diverse areas of nursing and midwifery.

4.3.7 In T&G a number of Health Visitors have specialist and leadership roles. These include safeguarding, infant feeding, early attachment, public service hub, asylum seeker and refugee, women's refuge, integration lead, team leaders and pathway lead. There is also the Family Nurse Partnership Supervisor and Family Nurses.

4.3.8 Health Visitors are accountable for geographical caseloads. Their teams also include 11.3 Whole Time Equivalent community nursery nurses, who have Nursery Nursing Examination Board, or NVQ Level 3 or equivalent qualifications. Health Visitors are professionally accountable for all duties delegated to Community Nursery Nurses work, as described in the Nursing and Midwifery Council Code of Conduct.

### 4.4 Patient Experience: Health Visiting

4.4.1 The T&G Health Visiting Service has rich client feedback from the following sources:

- Patient Stories;
- Patient Journey;
- 'How Did We Do Today?' Census 20 May 2014;
- UNICEF Baby Friendly Stage 3 Accreditation June 2014;
- Student Health Visitors' Parent Survey July 2014;
- Early Attachment Service Patient Satisfaction Questionnaire;
- Compliments and Complaints.

4.4.2 Positive themes identified are:

- Health Visitors explained their role, arrived on time, parents felt treated with dignity and respect, trusted the Health Visitor, and the Health Visitors' listening skills were specifically valued.
- The Health Visitor's interest in the parent's mood was valued.
- There was high general satisfaction with the visits.
- Information given was useful and easy to understand.
- The service is effective in reaching parents who are 'disengaged' from wider services.

4.4.3 The Service has made significant progress with its action plan to collect comprehensive feedback from clients and is committed to improving services further. Recent data collected includes a number of patient stories, a survey of 228 families in June 2015 and FutureGov qualitative research with parents receiving Health Visiting and early years/ children's centres services in May 2015. Actions include ensuring all parents have information about how to make a complaint if needed, discussing what information is kept about families and how it is used, increasing antenatal visits to promote health behaviours, and improving technology.

### 4.5 Summary of Progress: Health Visiting

4.5.1 The T&G Health Visiting Service has shown steadily increased numbers of families receiving the five mandated contacts and systems are embedded for ensuring that families receive the Healthy Child Programme 0-5.

4.5.2 The Service is working closely with Tameside Council to deliver the Greater Manchester 'New Delivery Model' in the Early Adopter areas, with full roll out already commencing. Health Visiting is in a strong position to move towards integration with Early Years services, and to provide the leadership necessary for the success of the model and full delivery of the Healthy Child Programme. Health Visiting service leaders have been influential in developing aspects of the wider Greater Manchester New Delivery Model and are committed to its principles and success. There is a positive relationship between LA commissioners and the Health Visiting leaders.

4.5.3 The T&G Health Visiting service has strong, positive leadership, with a wealth of experience in delivering services for children. Several aspects of the service are already high profile. In 2014 a Department of Health team shadowed the Stalybridge Health Visiting team to find out what health visiting is really like – and reported they were "really impressed". The Infant feeding Co-ordinator is a UNICEF Baby Friendly national assessor.

4.5.4 The Early Attachment Service and parent infant mental health model is the only service to be named as an exemplar of good practice in the national Health Visiting service specification, several papers have been published and it has been shared at national conferences.

4.5.5 T&G Health Visiting Service is part of Stockport NHS Foundation Trust. The Service has been able to fully benefit from the increased numbers of health visitors because it was already a good and innovative service despite having lower numbers at the start of the 'Call to Action'. Moving forward, there is a will within the organisation and within T&G CCG to deliver services in a locally organised and integrated way. The health visiting service and its leaders are in a strong position to engage in this.

**4.6 Challenges: Health Visiting**

4.6.1 The demographics of the population including the levels of disadvantage, poverty, transience and child protection present a significant challenge to the health visitors.

4.6.2 Record Keeping and Data Collection: There remain challenges to data collection and record keeping with the T&G HV Service still keeping paper based records. Their IT systems do not fully support effective data collection including ASQ 3 scores and demographic information.

4.6.3 Record keeping and collection of KPIs and demographic data should be enabled through use of a single electronic system of data collection and records entry for the health visitors. This will enable service improvement to be fine-tuned. The Service will need support from senior managers in the Trust with responsibility for IT systems to develop this aspect.

4.6.4 Maintenance and stability: With 49% of HVs qualified for under 2 years and 17% newly qualified, it will take at least 6-12 months for the service to reach full operational capacity. Maintaining numbers of health visitors and maintenance of the existing service specification will be important for improving outcomes for children.

4.6.5 The service has always been provided to two local authorities and when the Glossop Health Visiting team TUPE to Derbyshire Community Health Services in April 2015 this will create some temporary disruption.

4.6.6 T&G Health Visiting Service already works closely with LA colleagues and GPs and this can develop further as the partners work towards structural integration and place based services.

## 5. FAMILY NURSE PARTNERSHIP PROGRAMME

5.1 The Family Nurse Partnership (FNP) programme is a targeted offer within the 0-5 healthy child pathway, focusing on vulnerable young mothers (under the age of 20 at conception) in their first pregnancy. This evidence based, licensed programme is highly structured and supports families from early pregnancy until the child is 2 years old. Teenage pregnancy is strongly associated with the most deprived and socially excluded young people and the programmes aim to improve outcomes for these mothers in pregnancy alongside improving child health and development and improve parental self-efficiency.

### 5.2 FNP across Greater Manchester

5.2.1 FNP has operated successfully in the City of Manchester for 8 years and Wigan and Bolton for 4 years. The remaining seven Greater Manchester areas commenced delivery of FNP in 2014/15, commissioned by NHS England (Greater Manchester Area Team). The number of places available in GM has increased from 420 in April 2013 to 1,250 in April 2015.

### 5.3 Predicted level of FNP need.

5.3.1 Across Greater Manchester there were 1,713 live births to mothers under the age of 20 years in 2013 (latest data available). This is a 23.4% decline over a three-year period. The decline in Tameside is in line with the Greater Manchester average with a fall of 23.6% live births to mothers under the age of 20 between 2011 and 2013.

| FNP Area | 2011 | 2012 | 2013 | % Change |
|---|---|---|---|---|
| **Tameside** | 212 | 198 | 162 | -23.6% |
| **GM** | 2,236 | 2,043 | 1713 | -23.4% |

*Source: ONS (accessed Oct 2014)*

5.3.2 To improve robustness of the data NHS England (Greater Manchester area) have created a modelled estimate of the eligible FNP population by local authority area, taking into account births to first time mothers only and births to mothers aged 20 who were 19 years at conception. The modelled data suggests that the eligible population across Greater Manchester in 2013 was 1,780 mothers. In Tameside the modelled estimate of need is 171 clients per year.

### 5.4 Modelled estimate of eligible first time mothers in Tameside (2013)

| Local Authority | Live Births to mothers aged <20 at birth | Births to mothers aged 20 - 20.75yrs[1] | Total Births to mothers aged <20 at conception | Births to first time mothers only [2] |
|---|---|---|---|---|
| **Tameside** | 162 | 73 | 235 | 171 |
| **GM** | 1713 | 806 | 2,442 | 1,780 |

### 5.5 Tameside FNP Programme

5.5.1 The Tameside FNP programme commenced taking notifications in March 2015. The FNP team is currently made up of 1 supervisor, 4 full time nurses and 1 quality support officer. Each full time FNP nurses have a capacity commissioned caseload of 25 clients and the

[1] Figure taken from ONS birth data by area of residence (2013) for 20 yr. old mothers and then multiplied by 0.75 to account for first 9 months only.

[2] All mothers under 20 have the same rate of being first time mothers applied to them (72.9%), as provided by ONS and used in FNP National Modeling

FNP supervisor has a capacity caseload of four clients. When at full capacity (March 2016) the Tameside FNP team capacity caseload is for 100-104 clients.

5.6 **Tameside FNP Team Capacity and predicted levels of need**

| FNP Area | Number of FNP Nurses (Inc. Supervisor) | WTE FNP Nurses (Inc. Supervisor) | Capacity Case load |
|---|---|---|---|
| **Tameside** | 5 | 5 | 104 |
| **GM** | 62 | 59.47 | 1,267 |

5.6.1 Assuming clients are engaged on the FNP programme for 2.5 years and if the national FNP fidelity goal of 75% of mothers offered the programme accepting, we can predict met/unmet need across each local authority. Across Tameside there will be an estimated unmet need for 216 clients. An additional 8.5 nurses would be required to fully meet need (based on modelled estimates).

| Local Authority | Annual number of eligible mothers (75% acceptance) | Number of clients over 2.5 years | Current team capacity | Estimated unmet need | Number of nurses to meet unmet need |
|---|---|---|---|---|---|
| **Tameside** | 128 | 320 | 104 | 216 | 8.5 |
| **GM** | 1336 | 3322 | 1267 | 2055 | 82 |

5.6.2 As the Tameside FNP programme only commenced taking notifications in March 2015 there is limited data available. Tameside FNP has received 20 eligible notifications. This is 47% of the predicted quarterly modelled estimate (43 eligible clients) indicating that further work is required in developing the notification pathways (GM = 77%).

| | Eligible Notifications Received (31st May 2015) | Estimate of expected numbers (6 months) | % of expected Eligible Notifications |
|---|---|---|---|
| **Tameside** | 20 | 43 | 47% |

5.7 **Tameside FNP performance data**

5.7.1 FNP programme performance is monitored by the local Advisory Board (chaired by the Local Authority) and on an annual basis through a local Annual Review by the local Advisory Board and the FNP National Unit. NHS England have put in place a quarterly monitoring system to provide live data on workforce, caseloads and notifications.

5.8 **Recruitment and Enrolment**

5.8.1 At the end of June 2015 the capacity caseload for Tameside FNP was 28 clients. At this point Tameside had an actual caseload of 18 clients meaning they were operating at 64% of current capacity (GM = 72%).

5.8.2 There is a national FNP fidelity goal to recruit clients onto the programme within 16 weeks of gestation, as evidence suggests that the earlier a client is recruited the more effective the programme. In Tameside only 25% of clients (up to end June 2015) were recruited within 16 weeks compared to a programme average of 50.7%. An additional 50% were recruited 17-22 weeks.

5.9 **Intake characteristics**

5.9.1 The following data on the intake characteristics of clients is taken from the FNP Dashboard and covers the period from programme start – 30th June 2015. At this period there were 18

clients enrolled on the Tameside FNP Programme. Due to the very low number of clients the data below needs treating with caution and no significance can be drawn from it.

5.10 **Clients by age of mother**

5.10.1 Whilst the percentage of clients that are aged under 18 reflects the national FNP averages there are fewer Tameside clients aged 19 and over than would be expected across the cohort.

| | <15yrs | 15yrs | 16yrs | 17yrs | 18yrs | 19yrs | >19yrs |
|---|---|---|---|---|---|---|---|
| **Trafford** | 6% | 13% | 19% | 31% | 25% | 6% | 0% |
| **National FNP** | n/a | 6% | 15% | 27% | 25% | 22% | n/a |

5.11 **Ethnic distribution of clients**

5.11.1 All Tameside FNP clients are of white ethnicity. Whilst Tameside is a predominantly White population (94.6%), 4% of the ethnic population are Asian, which at the moment is not representative of the FNP cohort population.

| | White | Asian | Black | Mixed | Other |
|---|---|---|---|---|---|
| **Tameside** | 100% | 0% | 0% | 0% | 0% |
| **National FNP** | 85% | 2% | 6% | 5% | 2% |

5.12 **Intake Characteristics and FNP Public Health Outcomes**

5.12.1 The FNP Dashboard can report on specific intake characteristics of mothers such as education, NEET, mental health, Child in Need Plan and many more. It also reports on public health outcomes such as breastfeeding, smoking in pregnancy, immunisations etc. However Tameside FNP has not been operational for long enough to report on this and therefore the data is not included in this document. The data is available on request from the FNP Supervisor.

## 6. FINANCE

6.1 Levels of funding for Health Visiting services across GM are a direct legacy of Primary Care Trust commissioning. The current level of funding is a combination of the level of funding at transition in April 2013 + total growth in Health Visitors. No other calculations have been made and the Health Visiting contracts have not been rebased. Final values have been inserted into the contract for 2015-16.

## 7. BENCHMARKING

7.1 There have been several approaches to benchmarking service costs by Provider the most frequently observed approach is cost/Health Visitor however this ignores wider skill-mix within the service and leads to false assumptions.

7.2 In late 2014 the Department of Health undertook a *Baseline Agreement Exercise (BAE)* which identified a benchmark formula. The total spend per head was calculated by dividing the allocations by the projected mid-year population figures from ONS, for children under 5 years. To ensure that these figures are comparable at Local Authority level, the allocations were divided by the Market Forces Factor (MFF), which takes account of the differences in the cost of delivering services across the country.

7.3 As part of the BAE the Department of Health introduced a minimum funding floor for Health Visiting services. All GM areas are funded well above this level. From 2016-17 the allocations are expected to be based on population needs following guidance from the Advisory Committee on Resource Allocation (ACRA).

7.4 After the inclusion of necessary 'overheads' such as estates, administration, IT support, and clinical management; much of the remaining costs within Health Visiting services are direct staffing costs. Consequently any increase or decrease to this budget is likely to have a direct impact upon frontline delivery.

| Adjusted spend per head by LA area (0-4 years population) | | |
|---|---|---|
| | Local Authority | Spend |
| **1** | X | £313 |
| **2** | X | £299 |
| **3** | X | £293 |
| **4** | X | £292 |
| **5** | X | £286 |
| **6** | X | £284 |
| **7** | X | £279 |
| **~** | GM Average | £278 |
| **8** | X | £279 |
| **9** | Tameside | £239 |
| **10** | x | £219 |

## 8. CURRENT CONTRACT SITUATION

8.1 A NHS standard contract is in place between T&G CCG and Stockport FT. NHS England and Tameside Council are associate commissioners to this contract. The terms of the contract will vary to transfer the commissioning responsibility from NHSE to Tameside Council 1 October 2015. 6 months' notice is required to terminate this contract which has an end date of 31 March 2016.

8.2 Stockport FT have given notice to T&G CCG on the portfolio of contracts that includes Health Visiting and FNP, consequently this contract will end March 2016.

## 9. GOVERNANCE

- NHSE meets with each Provider up to four times/quarter via six-weekly contract and performance meetings and six-weekly Quality Assurance meetings. From Quarter 3 2014-15 Local Authority commissioners were invited to the contract and performance meetings.

- FNP Advisory Boards are in place in all Local Authority areas.

- Quarterly Early Years Advisory Committee chaired by the Director of Nursing (Lancashire and Greater Manchester) NHSE.

- Bi-monthly AGMA Early Years Transition Group chaired by the Chief Executive of Tameside Council.

- Bi-monthly 0-5 Public Health commissioners group supported by the GM Public Health Network

## 10. PUBLIC HEALTH OUTCOMES

10.1 Children and young people under the age of 20 years make up 24.4% of the population of Tameside with 18.6% of school children from a minority ethnic group and 22.7% of children aged under 16 years are living in poverty (worse than national average).

10.2 The health and wellbeing of children in Tameside is generally worse than the England average. From the table below it can be seen that breastfeeding rates and smoking in pregnancy are significantly worse than the GM average.

10.3 Health Visitor workforce distribution across T&G is regularly reviewed using a weighting tool so that areas with the greatest deprivation and need receive more staff, and levels of Health Visitor experience are balanced with this.

**Health Visiting Caseloads in T&G: breakdown by locality and level of need.**

| | Ashton | Denton, Droylsden & Audenshaw | Mossley, Stalybridge & Dukinfield | Hyde, Hattersley & Longdendale | Glossop | Total |
|---|---|---|---|---|---|---|
| **Universal** | 2,685 | 3,312 | 3,086 | 2,329 | 1,531 | 12,943 |
| **Universal Plus** | 366 | 228 | 167 | 247 | 113 | 1,121 |
| **Universal Partnership Plus** | 202 | 240 | 212 | 186 | 50 | 890 |
| **Total** | 3,253 | 3,780 | 3,465 | 2,762 | 1,694 | 14,954 |

*Data from iPM (May 2015)*

| School readiness: the percentage of children achieving a good level of development at the end of reception (PHOF 1.02i) | 2009/10 | 2010/11 | 2011/12 | 2010/11 | 2012/13 | 2013/14 |
|---|---|---|---|---|---|---|
| Tameside | | | | | 41.80% | 52.13% |
| Greater Manchester | | | | | 47.29% | 55.62% |
| | | | | | | |
| **Low birth weight of term babies (PHOF 2.01)** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | 3.92% | 3.55% | 3.03% | 3.13% | 2.41% | |
| Greater Manchester | 3.25% | 3.24% | 3.17% | 3.25% | 3.04% | |
| | | | | | | |
| **Breastfeeding - Breastfeeding prevalence at 6-8 weeks after** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | | | 34.88% | 32.82% | 34.03% | 22.07% |
| Greater Manchester | | | 37.97% | 38.25% | 38.90% | 34.80% |
| | | | | | | |
| **Smoking status at time of delivery (PHOF 2.03)** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | | | 22.92% | 20.92% | 20.89% | 17.84% |
| Greater Manchester | | | 16.75% | 16.16% | 15.43% | 14.38% |
| | | | | | | |
| **Under 18 conceptions (PHOF 2.04)** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | 59.77 | 58.45 | 46.14 | 45.21 | 32.71 | 29.14 |
| Greater Manchester | 49.37 | 46.61 | 41.57 | 37.80 | 33.32 | 28.23 |
| | | | | | | |
| **Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years) (PHOF 2.07i)** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | | | 207.56 | 213.54 | 206.73 | 152.43 |
| Greater Manchester | | | 203.64 | 229.85 | 208.61 | 158.21 |
| | | | | | | |
| **Population vaccination coverage - MMR for two doses (5** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | | | 87.15% | 88.63% | 90.77% | 90.27% |
| Greater Manchester | | | 86.94% | 88.16% | 91.24% | 92.13% |

## 11. GREATER MANCHESTER DEVOLUTION, STARTING WELL: NEXT STEPS

11.1 In the November 2014 Devolution Deal, GM made a commitment to work with Government, developing an effective, robust framework of services for Early Years.

11.2 The March 2015 Health and Social Care Devolution agreement committed to the creation of a clinically and financially sustainable health and social care system in GM predicated on the greatest and fastest growth in population health in GM. The contribution of Early Years interventions to this objective are well evidenced (for example in Marmot 2010).

11.3 Further to this in July 15, Greater Manchester Combined Authority, Public Health England and NHS England signed a unique Memorandum of Understanding to secure a unified public health leadership system for GM. A major programme of work within this, 'Starting Well', will focus on Early Years. In particular, it proposed to build on the strengths of the GM Early Years New Delivery Model and create a broader and unified Early Years: Starting Well Strategy.

11.4 This will be delivered through integration of public services and focusing all Early Years resources on improving the life chances for every child through improved provision of evidence based assessments and interventions, building on the transfer of 0-5 public health services including Family Nurse Partnership and health visiting and the significant resource currently provided through midwifery, early education and Children's Centres.

11.5 Next steps locally include the development of a new integrated universal 0-5 delivery model for Tameside aligned to the Greater Manchester new delivery model for Early Years, an approach that Tameside is already testing and was instrumental in shaping from the start. The model will ensure the delivery of the 8 stage assessment process, the associated intervention pathways and the direct link to the Early Help Offer.

11.6 Key elements of the 8 stage model are being piloted by current providers in Tameside as the implementation phase of the 8 stage project. Full roll out of the programme is set over two phases, beginning 1st April 2014 across the borough, with full roll out to be completed by March 2016.

## 12. RECOMMENDATIONS

12.1 The Health and Wellbeing Board is asked to consider the recommendations set out on the front of the report.

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# Update: Transfer of 0-5 Public Health services

Debbie Watson
Head of Health and Wellbeing
TMBC

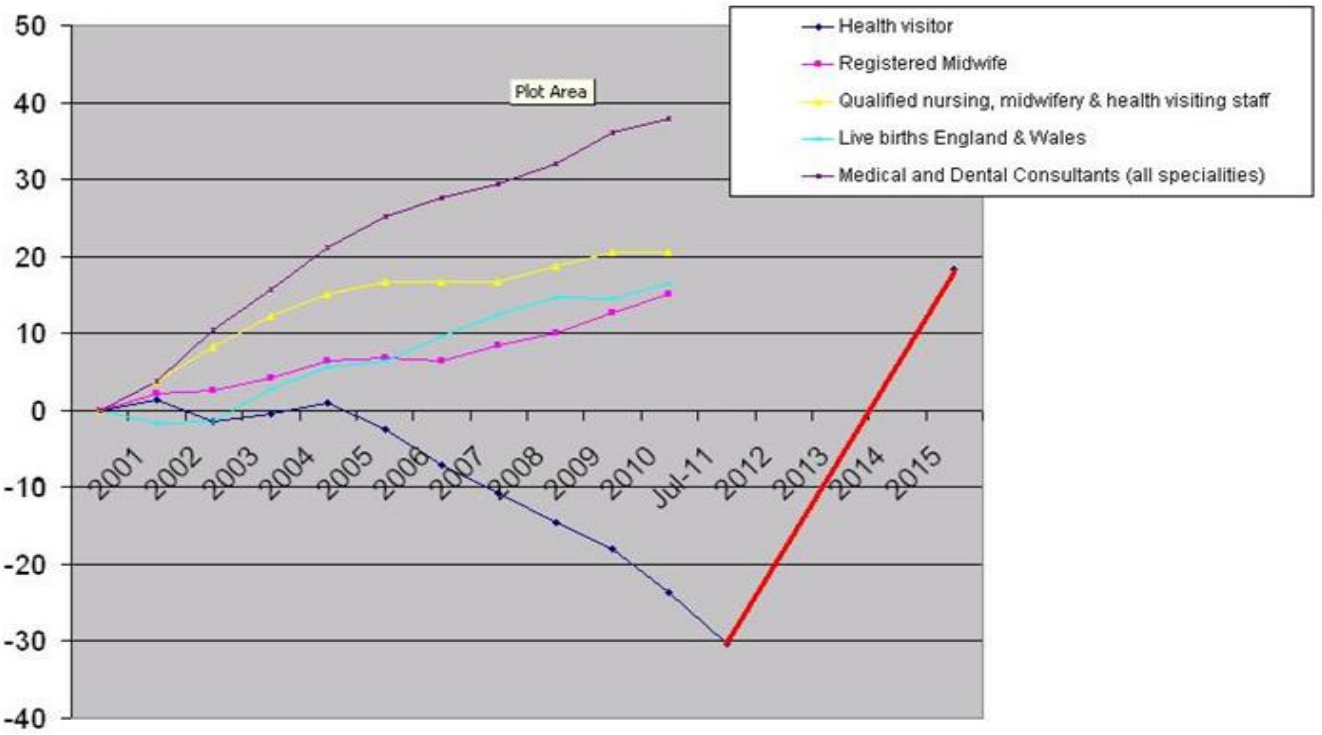
Martin Ashton
Senior Programme Manager
NHSE

Oct 2015

# Background

- HV Call to Action started in 2011 to:
  - Increase HVs by 4200 WTE.
  - Create transformed, rejuvenated HV service providing improved outcomes for CYPF with more targeted & tailored support for those who need it.
  - Increase access to FNP by offering at least 16,000 places by March 2015.
- From 1st October 2015 Local Authorities will take over responsibility from NHS England (NHSE) for commissioning Health Visiting and FNP services.



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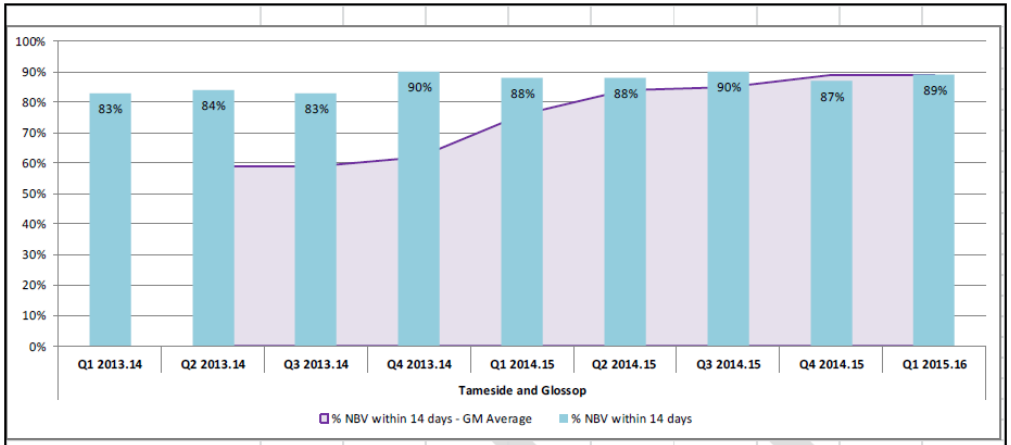
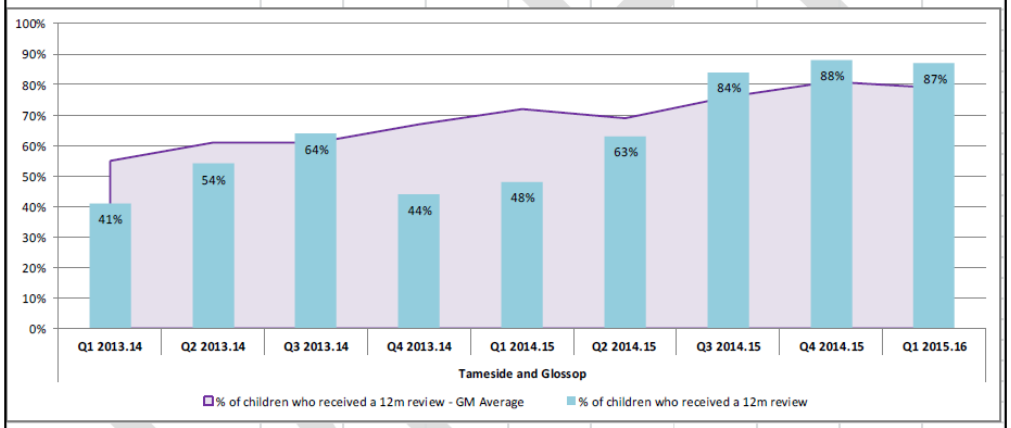
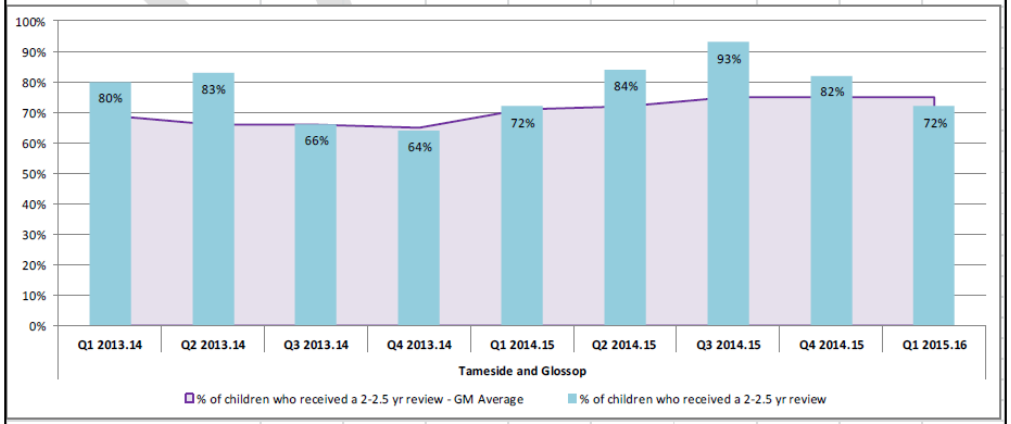
# HV performance

- High-profile service, good at start of call to action.
- Data accuracy has been a concern.
- NHSE is confident that the performance will improve further as the workforce embeds.
- Antenatal (13% vs GM 22%)
- 6-8 week (96% vs GM 80%)
- **All families are seen.**
- **reporting mirrors current requirements*.

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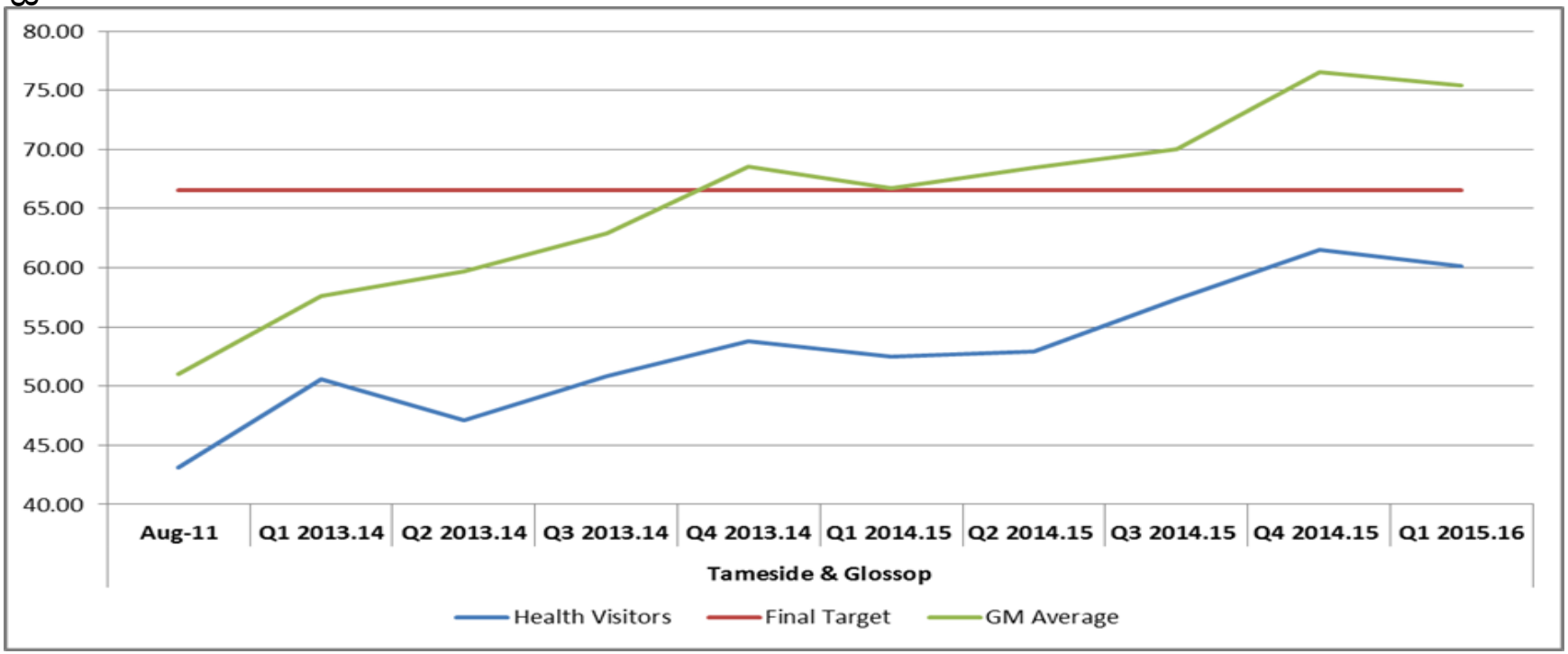
# HV workforce

- GM grown by more than any other area in the North (509-777.5WTE)
- GM: Major challenge with loss of staff to FNP / movement.
- The workforce challenge in has been significant (50%+ growth); Apr 11 – 43.1WTE – 64.96WTE Q1 15-16 (Target 66.6WTE).
- Plans in place to ensure the service is at full capacity at point of transfer.
- Only 51% of HVs have more than 2 years experience.
- Skill-mix is in place (11.3WTE Nursery Nurses).





# Finance

## Background

- NHSE transferring £51m to LAs.
- Current level of funding = the level of funding at transition in April 2013 + growth in HV.
- HV budget closely linked to staffing costs.

## Benchmarking:

- Tameside is the 2nd lowest in GM for cost / head of population.

## Risks & opportunities:

- LAs are required to make significant savings, **BUT:**
- Surplus in commissioning budget.
- Underperformance on workforce = opportunity to vary out underinvestment (Sep & Mar).

| Adjusted spend per head by LA area (0-4 years population) | | |
|---|---|---|
| | Local Authority | Spend |
| 1 | X | £313 |
| 2 | X | £299 |
| 3 | X | £293 |
| 4 | X | £292 |
| 5 | X | £286 |
| 6 | X | £284 |
| 7 | X | £279 |
| ~ | GM Average | £278 |
| 8 | X | £279 |
| 9 | Tameside | £239 |
| 10 | x | £219 |

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# Challenges

- Data collection & record keeping
- Improving and maintaining performance
- Reporting of outcomes
- Patience:
  - Embedding of students
  - Improvements in outcomes
- Maintaining stability of the workforce
- FNP resilience
- Understanding the safeguarding system
- Finance



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| | |
|---|---|
| **Report to:** | **HEALTH AND WELLBEING BOARD** |
| **Date:** | 12 November 2015 |
| **Executive Member / Reporting Officer:** | Alan Ford Commissioning Business Manager for Children, Young People and Families – NHS Tameside and Glossop Clinical Commissioning Group |
| **Subject:** | **CHILDREN AND YOUNG PEOPLE'S EMOTIONAL WELLBEING AND MENTAL HEALTH TRANSFORMATION PLAN 2015 - 2020** |
| **Report Summary:** | To provide Tameside Health and Wellbeing Board the Children and Young Peoples (CYP) Emotional Wellbeing (EWB) and Mental Health (MH) Plan, 2015-2020, which has been produced by the CYP EWB and CAMHS Transformation Programme Board – led by the CCG. |
| **Recommendations:** | To accept the plan and to support CYP EWB and CAMHS Programme Board to progress with the priorities and deliverables under the plan and receive further future updates on progress. |
| **Links to Health and Wellbeing Strategy:** | Developing Well – there is a need to identify opportunities in relation to improving our commissioning and delivery systems to achieve better outcomes for children and young people with respect to emotional wellbeing and mental health, and review the whole system from prevention to specialist services to make sure we are providing better outcomes. |
| **Policy Implications:** | There are no policy implications at this stage. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | There are no direct financial implications for Tameside Council arising within this report. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | https://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf provides guidance for local areas - CCGs, working closely with their Health and Wellbeing Boards and partners from across the NHS (including NHS England Specialised Commissioning), Public Health, Local Authority, Youth Justice and Education sectors - on the development of Local Transformation Plans to support improvements in children and young people's mental health and wellbeing. The guidance and the programme of support that goes with it are designed to empower local partners to work together to lead and manage change in line with those key principles through the development of Local Transformation Plans for Children and Young People's Mental Health and Wellbeing. The Strategy proposed should be produced in line with *Future in Mind* which:<br>□ sets out the strategic vision for delivering improvements in children and young people's mental health and wellbeing |

over the next 5 years;
 outlines a phased approach to securing locally driven sustainable service transformation and includes details of how the extra funding announced in the autumn statement (December 2014) and Budget (March 2015) will be used to support this work;
 provides guidance to support local areas in developing their Local Transformation Plans through a planning process that can be tailored to meet the individual needs and priorities of different local areas; and
 provides information on the assurance process and programme of support that will be available.
It also includes:
 a template to capture high level summary information from Local Transformation Plans);
 a self-assessment checklist for the assurance process. which will support the allocation of further funding;and
 a tracking template to monitor and review progress

**Risk Management :**

If the plans meet the assurance criteria in full set by NHSE, CCGs will receive all the funds allocated as shown in the Finance Plan (section 7.8).

If the plans need minor clarification or amendment or are not aligned to the requirements set out in Future in Minds further funding will not be released until the plans are satisfactory.

Failure to confront the issues the report seeks to address will have potentially serious future consequences for the vulnerable children and young people who it seeks to protect, with a consequential impact on the legal framework within which they find themselves.

**Access to Information :**

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

Telephone:0161 304 5300

e-mail: alan.ford4@nhs.net

TAMESIDE and GLOSSOP

# Children and Young People's Emotional Wellbeing and Mental Health

# TRANSFORMATION PLAN

# 2015 - 2020

Version: FINAL v.10.1

Date: October 2015

| Document Version Control | |
|---|---|
| **Document title:** | Children and Young People's Mental Health and Emotional Well Being Transformation Plan 2015-2020 |
| **Edited version** | Version Final (v10.1) |
| **Number of pages** | 70 |
| **Agreed by** | Tameside Health and Wellbeing Board<br>Derbyshire Director for Children's Services<br>Tameside and Glossop CCG; &<br>Tameside and Glossop EWB & CAMH Services Programme Board |
| **Date** | 14th October 2015 |

| Tameside and Glossop Local Transformation Programme Board | | |
|---|---|---|
| Name | Designation/Role | Organisation |
| Alan Ford | Programme Chair | Tameside & Glossop CCG |
| Frazer Kamwendo | Project Manager | Tameside & Glossop CCG |
| Pat McKelvey | Board Member | Tameside & Glossop CCG |
| Anna Hynes | Board Member | CVAT |
| Ben Gilchrist | Board Member | CVAT |
| Subbian Saravana | Board Member | Pennine Care NHS Foundation Trust |
| Julie Jakeman | Board Member | Pennine Care NHS Foundation Trust |
| Sarah Leah | Board Member | Pennine Care NHS Foundation Trust |
| Simone Spray | Board Member | 42nd Street |
| Elaine Healey | Board Member | Our Kids Eyes |
| Penny King | Board Member | Stockport NHS Foundation Trust |
| Helen Mellor | Board Member | TMBC - Education |
| Emma McDonough | Board Member | TMBC - Early Help |
| Adele Smith | Board Member | TMBC - Children's Social care |
| Thomas Johnson | Board Member | TMBC - PSR |
| Ian Young | Board Member | Off the Record |
| Barbara Smith | Board Member | NHS England |
| Stewart Todd | Board Member | Tameside Safeguarding Children's Board |
| Pam Watt | Board Member | TMBC Public Health |
| Linda Dale | Board Member | Derbyshire County Council |
| Louis Hughes | Board Member | Derbyshire County Council |
| Sally Dickin | Board Member | Tameside Youth Offending Services |
| Jane Dutton | Board Member | Tameside Hospital NHS Foundation Trust |

# CONTENTS

# Section 1: Executive Summary

1.1 Children and young people's emotional and mental well-being is a high priority for all in Tameside and Glossop. From earliest development in pregnancy to early years, school age, teenage and into adulthood we aim to work with parents, carers to promote and support good emotional and mental health development and build resilience, providing children and young people with a great start in life and lifelong resilience. We also aim to ensure that, when it is required, children young people and their families have swift and easy access into evidence based specialist support.

1.2 The effective assessment of children's and young people's mental health needs is an early and crucial determinant of their subsequent pathway through an emotional wellbeing and mental health system, and their consequent use of resources.

1.3 Across Tameside and Glossop, there are concerns that open access to Child and Adolescent Mental Health Services (CAMHS) is not always being achieved in practice. Some children and young people still have to wait too long to be seen by services. Across a larger Greater Manchester footprint there is a geographical variation in access and service offer.

1.4 Some families and professionals find the procedures for accessing services unclear and confusing. Pathways into support services are not clear as demonstrated by the data from our provider of Tameside and Glossop CAMHS, where almost 40% of referrals to CAMHS are rejected (including over 50% of GP referrals).

1.5 Despite these barriers to getting the right timely support, demand for mental health services for children and young people in Tameside and Glossop is increasing with escalating presentations around anxiety, self-harm, eating disorders and new demands from Child Sexual Exploitation (CSE) and an increase in the Children Looked After population.

1.6 We recognise the evidence and compelling arguments for a focus on early intervention - preventing mental health problems escalating and becoming entrenched through joined up timely early help and support. Universal services, including primary care, health visitors, school nursing, Children's Centres, schools, colleges and youth services, play a key role in preventing and promoting emotional wellbeing and mental health. We will ensure CAMHS support this responsibility within their dual function in delivering direct help and treatment and providing information, advice and guidance (IAG) on how to

ensure good mental health and emotional wellbeing in children and young people, and how best to support those who care for them.

1.7 Juxtaposed with this position, we are faced with increasing financial pressures in public services and associated challenges in the third sector, resulting in reductions across all services.

1.8 Clearly if we are to improve and sustain access to services then this requires more than additional funds but rather a new whole system approach that includes the active participation of all partners and key stakeholders, notably parents and carers. We hold a view that CAMHS should be integrated within a wider network of services providing a range of support for emotional and mental health needs, which includes General Practitioners, Schools, Health Visiting, Youth Offending, Social Care and Third Sector provision (to name a few). It falls beyond the resources of a single provider to effectively promote and meet the emotional wellbeing and mental health needs of children and young people.

1.9 Therefore to address these mounting concerns and pressures we should act together, jointly, with a collective aim to improve access through a partnership approach to providing an emotional wellbeing and mental health system; improving partnership working to ensure children, young people and families have:

- Access to timely and appropriate information and support from pregnancy to adulthood
- Clearly signposted routes to support, including specialist CAMHS
- An ‘open door’ into a system of joined up support that holds a ‘no wrong door’ approach, which is easy to navigate
- Clear understanding of the service(s) offer (what support should be received and what the expected outcomes are)
- Timely access to this support that is as close to home as possible
- Integrated parent infant mental health provision from pregnancy across all partners

1.10 Our vision for children and young people is an emotional wellbeing and mental health system that is truly personalised, joined up, supports children and young people to stay well and provides the very best support and care, when and where they need it. For children and families, this means we will put them at the heart of all what we do to ensure better outcomes and experiences that meet their needs and of those who care for them.

1.11 As such, the new approach will review and strengthen our referral pathways to make them more effective. It will deliver a clear offer to meet the emotional wellbeing and mental health needs of children and young people through

integrated partnership service delivery. This will require the development of pathways across an array of services, including school support services, health provision, social care and the third sector.

1.12 The plan seeks to be as ambitious as possible so that by 2020, the foundations for a sustainable system wide service transformation to improve children and young people's (including the most vulnerable such as looked after children, those connected to the criminal justice system or those who have learning difficulties) emotional wellbeing and mental health has been laid. This will lead to closing the treatment gap so that more children and young people with concerns about their mental health can access timely and high quality care coordinated and embedded within the other support they may be receiving.

1.13 The Government has committed to make children and young people's mental health and emotional wellbeing a priority. The government through the Children and Young People's Mental Health and Wellbeing Taskforce in early 2015 released the document Future in Minds, which highlighted the inconsistencies and challenges we face locally are nationally not uncommon. The document also articulated the way forward in addressing these anomalies.

1.14 Tameside and Glossop Clinical Commissioning Group (CCG) along with its partners, was selected as one of the pilot sites to respond to the challenges of children's and young people's emotional wellbeing and mental health. This response would be based on the guidelines articulated in the Future in Minds document. The transformation of the children and young people's mental health services in Tameside and Glossop is based on three key elements engagement, transparency and transformation through continual monitoring for improvement.

1.15 This Transformation Plan and strategy seeks to lay the foundations and aspirations for the ultimate vision for 2020 of having a system that is based on:

- The voice of the child - reforming care delivery based on the needs of young people, children and those who care for them;
- Developing resilience, prevention, early intervention and promoting good mental health and emotional wellbeing;
- Improving access to appropriate services that are as close to home as possible and at the right time that are implementing evidence based pathways;
- Promoting working across agencies leading to a clear joined up approach for the benefit of children and young people in Tameside and Glossop;
- Improved accountability, transparency and ownership of an integrated whole system; and
- Development of training programmes that lead to an appropriately skilled workforce across the whole system.

1.16 This is a five year programme of change and this transformation plan should be viewed as the first phase. The aims of this first plan are to reflect our collective vision and intention to work jointly, as a whole local system, over the next five years, building, refining and stretching our ambition as we progress. In readiness this plan establishes the baseline and builds system readiness to deliver the longer term sustainable system wide transformation envisaged locally and in the Future in Mind.

1.17 It is important that this plan should be viewed as a living document that will be refreshed as required and delivered through action plans for the 5 year life of this strategy. However, the vision of this transformation plan and strategy will remain the same - that is to ensure that children and young people's emotional wellbeing and mental health is 'Everyone's Business'. Throughout this document you will find examples and information as to why we need to do this.

1.18 Finally, we recognise that in producing this plan and agreeing the first phase of priorities that our focus is on mild to moderate mental health needs and specialist CAMHS provision. However to meet our aims of building resilient children, young people and communities, we will also focus and strengthen prevention, early intervention and promote good mental health and emotional wellbeing, aiming over time to develop a system in balance; ensuring a stronger focus on developing resilience, prevention, and early intervention.

# Section 2: Introduction

**Introduction**

2.1 The seriousness of mental health issues, particularly around children and young people, is reflected by key statistics highlighted by the Office for National Statistics (2005) that one in ten children and young people aged 5-16 years old in the UK has a diagnosable mental disorder, of which five per cent have a diagnosable conduct disorder and four per cent have a diagnosable emotional disorder. Some researchers have suggested that nationally, close to 60 % of adults with a diagnosed mental illness would have been diagnosed with a mental disorder by the age of 15. The findings of the Children and Young People's Mental Health Taskforce have identified inconsistences and anomalies that have to be addressed with particular emphasis on transformation plans for mental health services being tailored to local needs, expectations and aspirations.

2.2 The recent report of the Children and Young People's Mental Health Taskforce, 'Future in Mind', establishes a clear defined and powerful consensus about how to make it easier for children and young people to access high quality mental health care when they need it

2.3 In doing so Simon Stevens, CEO of NHS England articulated in the report:

> *There is now a welcome recognition of the need to make dramatic improvements in mental health services. Nowhere is that more necessary than in support for children, young people and their families. Need is rising and investment and services haven't kept up. The treatment gap and the funding gap are of course linked.*
>
> *Fortunately that is now changing. However, in taking action there are twin dangers to avoid. One would be to focus too narrowly on targeted clinical care, ignoring the wider influences and causes of rising demand, over medicalising our children along the way. The opposite risk would be to diffuse effort by aiming so broadly, lacking focus and ducking the task of setting clear priorities. This document rightly steers a middle course, charting an agreed direction and mobilising energy and support for the way ahead. I'm pleased to give it NHS England's full support".*
>
> Simon Stevens, 'Future in Mind' (March 2015)

2.4 Locally, Tameside and Glossop CCG with its partners was selected in November 2014 as 1 of the 8 Co-Commissioning National Pilots sites tasked with considering what changes and improvements are needed in the current system and identify innovative and effective solutions for achieving progress; feeding the findings into the work of the Children and Young People's Mental Health Taskforce.

2.5 Our findings locally at this time identified:

- The effective assessment of children's and young people's mental health needs is an early and crucial determinant of their subsequent pathway through an emotional wellbeing and mental health system, and their consequent use of resources.
- Concerns that open access to Child and Adolescent Mental Health Services is not always being achieved in practice. Across a larger Greater Manchester footprint there is a geographical variation in access and service offer.
- Some families and professionals find the procedures for accessing services unclear and confusing.
- Managing the emotional wellbeing and mental health of children is complex and challenging, requiring close working between multiple parties, including education. Children and young people's mental health and emotional wellbeing produce costs across the whole social system of Tameside and Glossop including Education.
- The complex fragmented nature of current CAMHS commissioning arrangements and lack of coordination between agencies held – and still does in certain parts - the potential for children and young people to fall though the net.
- Our partners, in particular but not limited to the third sector, face insecure and short term funding or have had to make cuts as a result of wider socio economic pressures and the impact of central funding reductions to local government.
- Despite these barriers to getting the right timely support, demand for mental health services for children and adolescents in Tameside and Glossop is increasing with escalating presentations around anxiety, self-harm, eating disorders and new demands from Child Sexual Exploitation (CSE).

2.6 Clearly if we are to improve and sustain access to services, then this requires more than additional funds but rather a new whole system approach that includes the active participation of all partners and key stakeholders. We hold a view that CAMHS should be seen as part of a wider network of services providing a range of support for emotional and mental health needs, which includes General Practitioners, Schools, Health Visiting, Youth Offending, Social Workers and Third Sector provision (to name a few). It falls beyond the resources of a single service or provider to effectively meet the emotional wellbeing and mental health needs of our children and young people. Therefore to address these mounting concerns and pressures, we recognise the need to act together, jointly, with a collective aim to improve access through a partnership approach to providing an emotional wellbeing and mental health system; improving partnership working to ensure children, young people and those who care for them have better outcomes.

2.7 The Tameside and Glossop Children and Young People's Emotional Wellbeing and Mental Health Programme Board was formed in February 2015. The

Programme Board is a partnership to lead the shared mission, vision and the ambition to improve access and support within an integrated approach to providing an emotional wellbeing and mental health system. See Appendix 1 for Terms of Reference for the Programme Board.

2.8 Our Local Transformation Plan has therefore been developed through a strong partnership approach and the active involvement of all stakeholders, specifically children, young people and those who care for them. Further to this is the development of the participation and engagement agenda and a commitment at both the commissioner and provider level to involve children, young people and those who care for them in emotional wellbeing and mental health service design, delivery, monitoring and evaluation.

*Images 1: Ensuring young people's views from Consultation Workshops held August, 2015.*


2.9 We recognise to deliver the vision and ambition set out in the plan, the CCG and its partners are committed to ensuring that the Emotional Wellbeing and CAMHS Transformation Plan is embedded within a whole system of change and development.

**Connected Programmes of Work**

2.10 The following programmes and have been identified that are interdependent in delivering our vision and ambition by 2020.

a) ***Child and Adolescent Mental Health Service and Schools Link National Pilot Scheme*** – Tameside and Glossop CCG and its partners were delighted to have been selected by NHS England and the Department for Education as a national pilot to improve joint working between school settings and NHS funded Child and Adolescent Mental Health Services (CAMHS).

b) ***Care Together*** – approved by Monitor in September 2015, NHS Tameside and Glossop CCG, Tameside Hospital Foundation Trust, Tameside Metropolitan Borough Council, Derbyshire County Council and NHS England are all committed to reducing demand on more intensive health and social care services by focussing on community based prevention and early intervention initiatives.

As organisations we have come together too fundamentally address the health and social care challenges faced by our population. We have created a "Care Together Programme" to redesign and realign health and care services to provide joined up care to the population of Tameside and Glossop. This will ensure that people get the right care in the right place from the most appropriate professional and within the resources available. Care Together aims to introduce a new form of provision into the Health and Care economy namely a fully Integrated Care Organisation spanning primary, community, mental health, social and local hospital based care.

c) ***Tameside Public Service Reform Hub*** – strategic vision to radically reform public services in Tameside to improve outcomes for families and residents as well as tackle issues of increased demand. *The Public Service Hub is a pooled resource from across a range of services, bringing together skills, expertise and knowledge that will:*
   - *Identify and respond to risk of harm*
   - *Prevent escalation to complex dependency*
   - *Support people to live well and be self-reliant*

   CAMHS Practitioners are embedded within the Hub and we are exploring options to develop this further into a single point of entry into all children's services to ensure there is no wrong door.

d) ***Greater Manchester (GM) Devolution*** – the twelve GM CCGs, ten Councils and all health and social care providers have a long history of working effectively together and the Devolution Agreement brings new opportunities to do this. The CAMHS elements that we hope to progress include:

   - GM Commissioning of in-patient beds and alternatives to admission
   - GM Commissioning of Specialist Perinatal Mental Health Inpatient and Community Provision, including alternatives to admission
   - GM Self Harm and Suicide Prevention Strategy
   - GM Crisis Care Concordat updated to strengthen crisis support to children and young people, and develop consistent access to age appropriate crisis support
   - GM Starting Well Strategy including the Early Years New Delivery Model – aims to continue to roll out this evidence based approach to services in pregnancy and early years to promote the capacity of families to ensure their children are ready for school. Parent Infant Mental Health is at the heart of this model.

e) ***The GM Transforming Care for People with Learning Disabilities Fast Programme*** – we have been a partner in the development of the Greater Manchester Transforming Care Fast Track Programme and are committed to including the need of children, young people and their families as well as those of adults. Within our CAMHS Transformation Plans we have included an Early Intervention Project for children with challenging behaviours, looking at how we can use our resources within CAMHS, schools, children's services and the community more effectively in

childhood to improve outcomes and reduce the numbers requiring high cost out of area health and social care placements. This includes ensuring that our At Risk Register and Plans includes consideration of children and young people as well as adults.

f) ***Tameside Early Years New Delivery Model (EYNDM)*** - aim is to provide integrated early years services delivered by health, education, early help, social care, private and voluntary service partnerships to improve outcomes and school readiness for the under 5's

g) ***Pennine Care Commissioning Footprint*** – the six CCGs who commission CAMH provision from Pennine Care NHS Foundation Trust work closely together with the Provider to co-commission quality CAMH services. We are currently working together to jointly commission Specialist Community Eating Disorder services in line with NHSE Standards.

h) ***CQUINs*** - Commissioning for Quality and Innovation (CQUINs) payments framework encourages NHS healthcare providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. We are utilising this framework to reward excellence, by linking a proportion of NHS healthcare providers' income to the achievement of local quality improvement goals. QUINs have been established that seek:

- Improved access and partnership working delivering improved/stretched waiting times targets or CAMHS; and
- Children's integrated care pathway delivering integrated pathways for children with long term conditions / complex needs, which is delivering an integrated Self Harm pathway, from the Emergency Department to admission onto the paediatric ward in Tameside Hospital Foundation Trust.

*i)* ***Local Safeguarding Children's Board (LSCB)*** – Tameside LSCB have established their priorities below for 2015-18. They have been developed based on the needs identified through quality assurance activities and case reviews during 2014/15 and from the TSCB Annual Report 2014/15.

- Domestic Abuse - To develop and deliver an educational awareness programme to universal services
- Child Sexual Exploitation - To ensure that a tiered package of support is available for victims of CSE and increase awareness of CSE amongst children and young people, parents and community
- Self-Harm – To develop and promote a self-harm and preventing suicide policy in conjunction with a package of self-harm and suicide training and support and work with the Emotional Wellbeing and Mental Health Board to develop the referral pathways and service offer for CAMHS.

j) ***NHS England Mental Health Access and Waiting Time Standards*** – children and young people's needs are being taken into account within our local plans to meet the new/emerging standards for:

- ***Liaison Psychiatry*** – within our review of RAID services in our local acute Trust we are reviewing access to CAMH specialists with a view to ensuring parity of esteem for children and young people. This includes 7 day access to crisis support, direct pathway into CAMHS, avoiding A&E and CAMHS support to our Street Triage programme.

- ***Early Intervention in Psychosis*** – we are ensuring that our EIP developments take into account the NICE Ante and Post Natal MH recommendations and that our Integrated Parent Infant Mental Health Pathway is effective for all EIP service users.

- ***Improving Access to Psychological Therapy*** – Healthy Minds, our local IAPT service, has a Babies Can't Wait policy so all pregnant women or those with an infant under the age of two, and their partners have direct access to a range of psychological therapies. The IAPT service works with young people from the age of 16, including supporting those in colleges.

- ***Eating Disorders*** – we are working with other CCGs and the provider to establish specialist eating disorder service for all young people up to the age of 18 in line with NHSE Standards. We are also aiming, with additional CCG investment, to extend the age range to 25 years for those who need it, to ensure that there will be no need for a transition at the age of 18.

- ***Perinatal Mental Health*** – we are refreshing our Integrated Parent Infant Mental Health Pathway in line with the Antenatal and Postnatal Mental Health NICE Guidance and are preparing to work in partnership within Greater Manchester to meet the imminent NHS England Perinatal Mental Health Standards.

k) ***Parity of Esteem*** – the CCG is committed to continuing to aim for more equal distribution of resources between physical and mental health disorders and ensuring the association between the two are supported in all commissioning.

l) ***SEND Reforms*** - places duties on local authorities and other services in relation to both disabled children and young people and those with Special Educational Needs (SEN). As part of the reforms the CCG is seeking to expand the offer of a personal health budgets, from April 2016, wider to those children and young people with Education Health and Care Plan (EHC Plan).

# Section 3: Future in Mind - Our Vision and Ambition

**Our Vision**

3.1 The vision for Tameside and Glossop is for a children and young people's emotional wellbeing and mental health system that is truly personalised, joined up, supports all children and young people to stay well and provides the very best support and care when and where they need it. For children, young people and those who care for them this means we will put them at the heart of all what we do to ensure better outcomes and experiences that meet their needs.

3.2 We want to create an integrated system where every child and young person in Tameside and Glossop receives the best, consistent, care and support; delivered as locally as possible - in our communities - with services designed in a joined up way so that they are seamless. This requires us to establish a comprehensive system wide approach to providing support and care, which puts children, young people and those who care for them first and to ensure a better understanding of all of a child or young person's needs. This is what we understand is to be truly holistic and person-centred, which necessitates the child and those who care for them being at the heart of our approach.

3.3 Currently we know there are inconsistencies in the way support and care is planned, commissioned and delivered across the many partners involved. Children, young people and those who care for them tell us that they experience time delays, duplication, fragmentation and a lack of clarity and uncertainty. With growing demand and rising expectations, the current system is generally seen as unfit for purpose and it is not sustainable. We need to develop a coordinated and integrated approach to children and young people's emotional wellbeing and mental health to improve experiences and achieve better outcomes.

3.4 We believe that emotional wellbeing and mental health is not about feeling positive all the time or solely focusing on providing treatment following assessment or diagnosis, but having the resilience and ability to cope from an early age through childhood and into adulthood. We recognise that mental health is as important as physical health, indeed it is the foundation of physical health. We acknowledge that it is not the responsibility of one agency or profession but about all organisations genuinely working together to meet the needs of the child, young person and those who care for them. We must have services that are accessible to all children, young people and those who care for them regardless of background or make up. We need to take active steps to reducing the barriers to support. Our children's emotional wellbeing and mental health is everyone's business.

3.5 To deliver our vision we must take a truly joint approach to commissioning and service delivery that ensures stakeholder engagement at all times. To underpin the transformation of the system we are committed to placing children, young people and those who care for them at the heart of change. To achieve this we will look to sustainable creative and innovative ways to make this happen.

**Our Principles**

3.6 Our principles are based on participation and collaboration. To help create and underpin our vision and ambition we have listened – and will continue to do so - to children and young people who have told us what they want and what we will aspire to deliver. Their voice provides us a set of principles, which will be seen as the right of any child or young person who maybe experiencing emotional wellbeing and/or mental health issues. See Appendix 2 for the voice of the child full findings.

| **The Voice of the Child** | |
|---|---|
| **1.** | I should be listened to, given time to tell my story and feel like what I say matters |
| **2.** | I want my situation to be treated sensitively and I should be respected and not feel judged |
| **3.** | I want the professionals that I come into contact with to be kind and understanding and realise that I need to trust them if they are going to help me |
| **4.** | I should always be made to feel safe and supported so that I can express myself in a safe environment |
| **5.** | I should be treated equally and as an individual and be able to shape my own goals with my worker |
| **6.** | I want my friends, family and those close to me to understand the issues so that we can support each other |
| **7.** | I want clear and up to date detailed information about the services that I can access |
| **8.** | I want to get the right type of help, when things first start to be a problem, at the right time in the right place and without having to wait until things get worse |
| **9.** | I want to feel that services are shaped around my needs and not the other way round, but I also want to know that I am not alone in how I am feeling |
| **10.** | I want my support to feel consistent and easy to find my way around, especially if I need to see different people and services |

**Our Ambition**

3.7 Our vision requires the following aims to be achieved:

- To improve access and partnership working to bring about an integrated whole system approach to promoting emotional well-being and resilience

and meeting the emotional wellbeing and mental health needs of children and young people.

- To ensure children, young people and families have:
  - Access to timely and appropriate information and support from pregnancy to adulthood
  - Clearly signposted routes to support, including specialist CAMHS
  - An 'open door' into a system of joined up support that holds a 'no wrong door' approach, which is easy to navigate
  - Clear understanding of the service(s) offer (what support should be received and what the expected outcomes are)
  - Timely access to this support that is as close to home as possible

- To maintain a commitment to promotion of emotional wellbeing and mental health prevention of problems developing through whole system approaches and aligned strategic programmes, such as:
  - Continued roll out of the Early Years New Delivery Model for all families including those with High Needs.
  - Integrated parent infant mental health provision from pregnancy across all partners.

3.8 We recognise our aims to improve access and partnership working through an integrated whole system approach to meeting the emotional and mental health needs of children and young people holds a number of inherent challenges. We know that delivering better coordinated care and support centred on the child or young person's needs is challenging and there are barriers at national and local level. The fragmented nature of current CAMHS commissioning arrangements, lack of coordination between agencies and explicit organisational boundaries holds the potential for children and young people to fall though the net, which has been highlighted in several recent national reports and, sadly, serious case reviews. As such the new approach will increase capacity of the whole system to promote emotional and mental well-being while at the same time, also strengthening our specialist services and referral pathways to make them more effective and accessible. It will deliver a clear offer to meet the emotional wellbeing and mental health needs of children and young people through partnership service delivery. This will require the on-going development of skills, knowledge and support plus pathways across an array of services including, schools, health, social care, third and public sectors.

3.9 In addition, we recognise the increasing evidence and compelling arguments for a focus on early intervention - preventing mental health problems escalating and becoming entrenched through joined up timely early help and support. We will ensure the early effective assessment of children's and young people's emotional wellbeing and mental health needs by providing access to the 'experts' across the system; particularly placing them where children and young people are most vulnerable so that there are no gaps through which they can fall. Where children and young people require support we will equip all front line staff to be able to identify and respond to mental health issues within an agreed

framework for intervention providing clear pathways and access supported by an assertive consultation, information, advice and guidance (IAG) model.

3.10 Through these steps our fundamental ambition is to improve access so that children and young people have easy access to the right support from the right service at the right time and this is as close to home as possible. This includes implementing clear pathways for community based care and crisis intervention to avoid unnecessary admissions to hospital and inpatient care. Where children and young people are cared for based on their needs and not through a system on how agencies organise '*their*' services. Our ambition requires the voice of child to be held at the heart of change. We will ensure meaningful involvement of children, young people and those who care for them. They are the experts by experience.

3.11 We recognise this is a five year programme of change and our challenge and successes to date should be viewed as the start of longer planning process with subsequent updated action plans to follow; ensuring a phased approach that address not just system changes but also develops the culture for sustainability and learning. Our ambition and vision set out in this plan has been decided at a local level in a co-production between children, young people and those who care for them, our commissioner and providers.

3.12 Our journey is very much aligned to the Governments aspirations for 2020 and the key themes and recommendations outlined in the 'Future in Mind'. As such in this plan we bring together the local vision and ambitions reinforced and expand upon, with the key themes and recommendations from the 'Future in Mind'.

In summary, the themes are:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Future in Mind recommendations that by 2020 Government wishes to see:

1. Improved public awareness and understanding, where people think and feel differently about mental health issues for children and young people. Also where there is less fear, and stigma and discrimination are tackled.
2. In every part of the country, children and young people having timely access to clinically effective mental health support when they need it.
3. Moving away from a system defined in terms of the service organisations provide (the 'tiered' model) towards one built around the needs of children, young people and their families
4. Increased use of evidence-based treatments with services rigorously focused on outcomes.
5. Making mental health support more visible and easily accessible for children and young people.

6. Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible
7. Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour
8. A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it.
9. Improved transparency and accountability across the whole system, to drive further improvements in outcomes
10. Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.

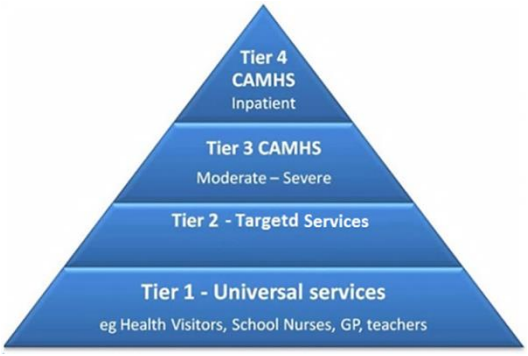
# Section 4: Where Are We Now?

4.1 In this section we summarise where we are in 2015, as regards the current delivery, in relation to the emotional wellbeing services for children, young people and those who care for them. We provide an overview on the transformation that has occurred to date and the investment that goes into these services.

**Phase 1 (2015-16) CAMHS Redesign - Moving to a system without tiers.**

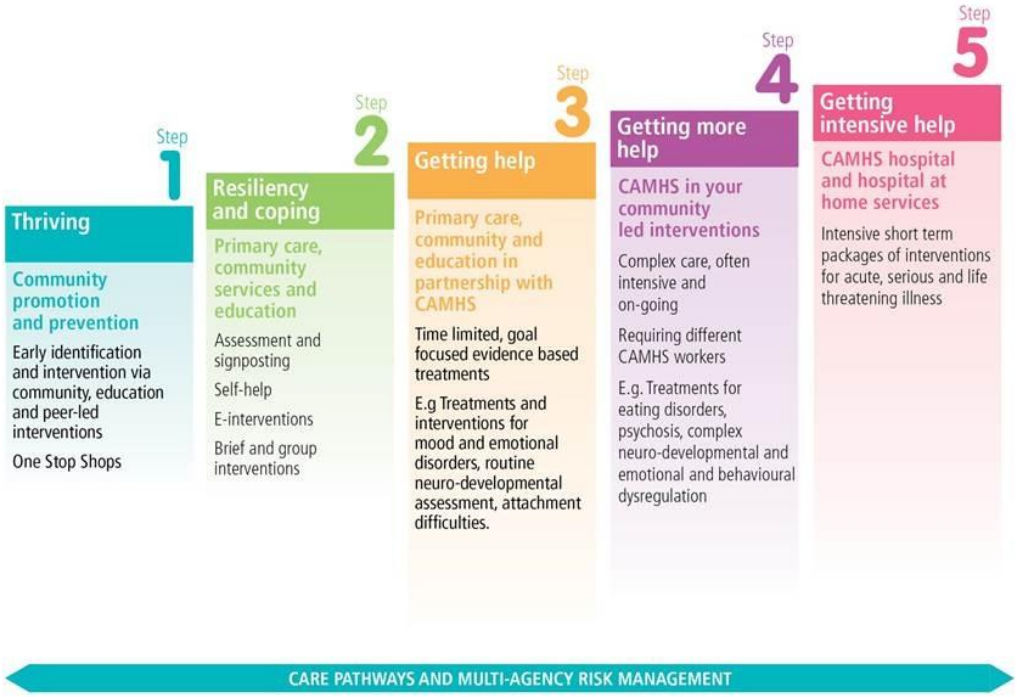
4.2 At the beginning of 2015, we embarked upon Transforming CAMHS with the mandate outlined in our vision and ambition set in Section 3. In response the Stepped Care Framework for Children's Emotional Well-being Mental Health in Tameside and Glossop initiated the start on the redesign of CAMHS, moving the service from the Tiers of Need model, shown in *figure 1* below to a new model for CAMHS. The Tiers of Need was developed as part of the first national review of CAMHS in 1995. The tiered model for CAMHS provided at the time a useful means for helping differentiate between the forms of support that might be available to children and young people. However it is now increasingly criticised for providing barriers to getting help and support; through its denoted thresholds and the escalator journey required to getting the 'expert' help at the end of the journey and not the start.

*Figure1. CAMHS Tiered Model (NHS HAS 'Together We Stand' 1995)*




4.3 The new framework in 2015, shown below (*Figure 2*), was innovative by nature and focuses on a community based, Stepped Care approach promoting prevention, early intervention and supporting the Early Help agenda across Tameside and Glossop. The model is based on the notion of 'Flexible Rigidity'. This concept offers some key principles around consultation and liaison, brief intervention and clear pathways for sentinel conditions i.e. ASD, ADHD and long term conditions, which are flexible enough to be tailored to, and meet the needs of different children, young people and families, communities and neighbourhoods.

*Figure2: The Stepped Care Framework for Children's Emotional Well-being Mental Health (Pennine Care Foundation Trust, 2015)*




4.4 The stepped care model is heavily focused on helping workers within Universal and Early Help services, GP's and other children's services to develop skills to support the promotion and management of children's emotional health within communities. The service model seeks to support staff in children's services e.g. Youth Offending Teams, Primary Care Health Services and Children's Social Care, as well as GP's and schools to develop the required skills by the provision of consultation, liaison and training offers delivered by workers from what is currently known as the specialist CAMHS service. These consultations offer and serve as gateways for children's emotional health pathways at higher steps of the model, with the exception of the urgent care pathway. At steps 2 and 3, assessments, limited individual brief intervention and a group offer should be available and the goal is for capacity to be developed in other agencies following this year's non recurrent investment provided by the CCG to deliver these interventions. At step four, a time limited, goal and outcome focused CAMHS pathway will be available and delivered predominately by CAMHS clinicians. Partnership engagement will be essential to achieve full implementation of this way of providing emotional wellbeing and mental health services in the medium to long term.

**Phase 2 (2016-17) CAMHS Redesigned - THRIVE model for CAMHS**

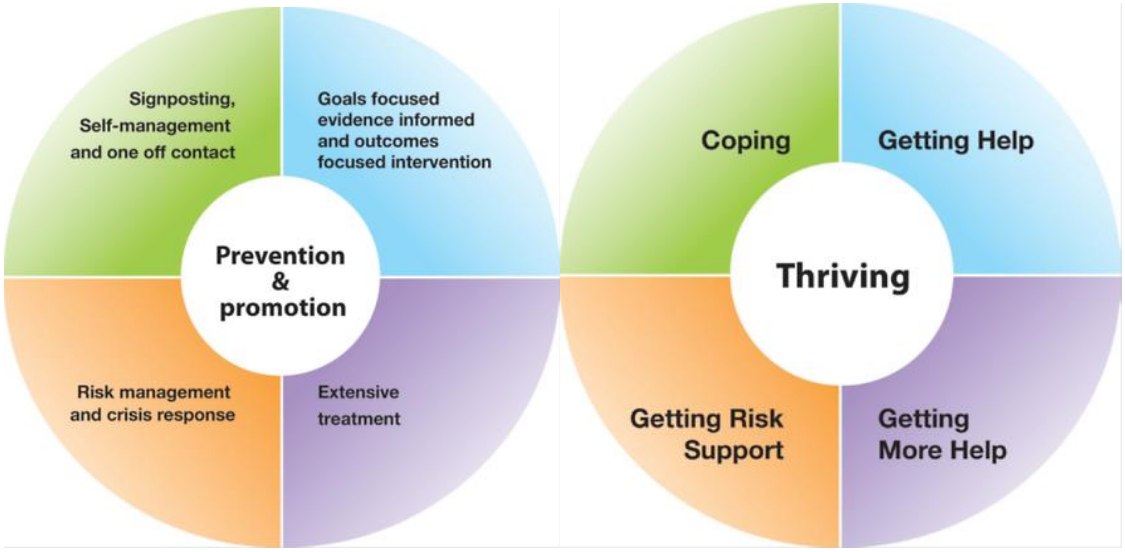
4.5 In the back drop to our initiated local CAMHS redesign, the Tavistock and Portman NHS Foundation Trust and the Anna Freud Centre have been collectively and individually considering what CAMHS could and should look like for some time. In 2014, they formed a consortium to further develop and refine a new model for CAMHS based on shared thinking in this area: this is now known as the THRIVE model. The Thrive Model is growing in support to replace the previous CAMHS tiered model with a conceptualisation that is aligned to emerging thinking on multi agency partnership working, providing timely support not based on diagnosis but to meet the emotional wellbeing and

mental health needs of the child or young person. It seeks to ensure that the most experienced professionals with expert knowledge of children and young people's mental health are accessible from the start and not at the end of a journey based on escalation. The model outlines groups of children and young people and the sort of support they may need and draw a clearer distinction between treatments on the one hand and support on the other.

4.6 Rather than an escalator model of increasing severity or complexity, they suggest a model that seeks to identify somewhat resource-homogenous groups (it is appreciated that there will be large variations in need within each group) who share a conceptual framework as to their current needs and choices. The Thrive model below (*figure 3*) conceptualises four clusters (or groupings) for young people with mental health issues and their families, as part of the wider group of young people who are supported to thrive by a variety of prevention and promotion initiatives in the community.

4.7 The image below to the left describes the input that is offered for each group; that to the right describes the state of being of people in that group - using language informed by consultation with young people and parents with experience of service use.

*Figure3: The Thrive Model for CAMHS (The Tavistock and Portman NHS Foundation Trust the Anna Freud Centre November 2014)*




In our approach we will deliver a phased change in how care is provided – moving away from a system defined in terms of the services' organisational structures towards one built around the needs of children, young people and their families. Our emphasis is on building resilience, promoting good mental health and wellbeing, prevention and early intervention and ensuring timely treatment support; through cohesive multiagency and integrated working.

**The Current Local Offer (September 2015)**

4.8 In this following subsection an overview is provided on current local services, in 2015-16, providing interventions to build resilience and to reduce risk around emotional wellbeing and mental health. The Local Offer is produced here under four domains: Local NHS services, Local Authority, Third Sector and Schools.

**Local National Health Service (NHS)**

***Children and Adolescent Mental Health Service (CAMHS)*** *(Pennine Care Foundation Trust)*

4.9 Tameside & Glossop child and family therapy service (CAMHS) supports families and professionals who are concerned about children and young people who may be experiencing mental health difficulties. They see young people at all levels of ability. Some of the difficulties this team can help with include:

- Depression
- Self- Harm
- Anxiety Disorders (including phobias)
- Obsession/Compulsive disorders
- Attention Deficit Hyperactivity Disorder (ADHD)
- Eating Disorders
- Trauma, including Post-Traumatic Stress Disorder (PTSD)
- Psychosis
- Bi-Polar disorder

The service is made up of a team of mental health professionals, staffed by child and adolescent Psychiatrists, clinical nurse specialists, psychologists, family therapists and mental health practitioners. There are staff who specialise in working with young people with a learning disability.

The team can offer short term consultation and intervention to parents/professionals. They work individually with young people and their families. They offer urgent same day consultations to professionals worried about a child's risk via a duty system. The length of support offered is based on the child's and family's needs.

The service is working in partnership with the Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) as part of a Learning Collaborative. Currently staff have and are receiving training in psychological therapies that are NICE approved. In addition the service offers a broad range of interventions, Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), Interpersonal Psychotherapy (IPT), Family Therapy and medication (prescribing).

Any professional involved with a young person is able to refer to CAMHS with the appropriate consent. Referrals are screened daily; at this point some referrals will be re-directed to a more appropriate service (for service accomplishment see 4.65).

***Inpatient (Tier 4/Getting Risk Support) Children and Adolescent Mental Health Service (CAMHS)*** *(Pennine Care Foundation Trust)*

4.10 Pennine Care Foundation Trust provides Tier 4 services in two inpatient units. The Hope Unit is an acute unit which provides short term crisis intervention to young people aged 13 – 18 years whose mental health needs cannot be managed safely in the community. Typically the length of stay in this unit is 6 – 8 weeks with the aim of formulating mental health needs, identifying appropriate support and intervention pathways, stabilising a young person's mental state and managing risk. The Horizon Unit is a unit for young people aged 13- 18 with more complex and enduring mental health needs. Typically the length of stay in this unit is 9 months plus in order to provide treatment and rehabilitation to young people and their families.

The North West as a region can be seen as well-resourced in terms of inpatient provision with other inpatient units available that are provided by other NHS Trusts.

***Early Attachment Service (EAS)*** *(Stockport NHS Foundation Trust, Pennine Care NHS FT and Home Start).*

4.11 Led by a CAMHS Consultant Clinical Psychologist, the Tameside and Glossop Early Attachment Service (EAS) was established in 2007. It is based on a unique model that is comprehensive, cost-effective and sustainable. It aims to meet the needs of parents, including those who need a high level of professional expertise and skill to help them, as well as those who would benefit from simpler information and support. The overarching principle of the Tameside and Glossop Early Attachment Service (EAS) is "holding the baby in mind", from a universal level to targeted individual parent-infant relationships, from the antenatal to postnatal period, across services, and with all professionals and families; placing the baby at the centre of everyone's thinking in the community. The service works with families from pregnancy through to the child's third birthday; the small core staff team working in close partnership with midwifery and health visiting, who are trained and supervised in parent-infant mental health, enabling them to become proficient in the use of a range of universal interventions, and also in early identification when problems emerge. An embedded Home Start worker also supports parents.

***Healthy Minds (Improving Access to Psychological Therapy Service)*** *(Pennine Care Foundation Trust)*

4.12 Provides a Tier 2 and 3 Improving Access to Psychological Therapy (IAPT) Service to people from the age of 16 years, offering support and treatment for those who are experiencing symptoms such as difficulty sleeping, low mood / depression, stress, worry or anxiety, feelings of hopelessness or panic attacks. The team also helps those dealing with the effects of a long-term health problem or chronic pain, Post Natal Depression, Obsessive Compulsive Disorder, phobias, or eating difficulties.

***School Nursing Service*** *(Stockport NHS Foundation Trust)*

4.13 Children who are happy and healthy achieve more at school. The School Nursing Service aims to promote optimal health, well-being and opportunities for all children and their families within Tameside and Glossop. The service

works closely with children and their families and carers, schools and other agencies to provide a child focused flexible, accessible service to meet their health needs.

The School Nursing Service aims to provide:

- Named school nurse for each high school
- Drop-ins at all high schools
- Support all school aged children and young people to attain good emotional, physical, sexual and mental health
- Healthy Child Programme: 5-19 years
- Supporting children, young people and families to navigate the health and social care services to ensure timely access and support;
- Promoting emotional wellbeing through the school-age years working alongside children and young people to support those with emotional and mental health difficulties, referring to CAMHS where appropriate;
- Care and support to keep children and young people healthy and safe within their community.
- Early identification of children, young people and families where additional evidence based preventive programmes will promote and protect health in an effort to reduce the risk of poor future health and wellbeing;
- Working in partnership with primary and secondary care colleagues to support children and young people with long term conditions or complex needs and facilitate appropriate management of health conditions to ensure hospital admissions are kept to a minimum;
- Provide advice and support to parents and carers to enable them to address their needs and those of their children
- Work collaboratively with colleagues and with other professionals in order to deliver the best possible service to children and young people
- Educate school staff in the management of children and young people with long term conditions

***Health Visiting*** *(Stockport NHS Foundation Trust)*

4.14 The service works to keep parent and child healthy and provide advice and support to parents and carers until children reach school age. They offer support to all new mothers around all aspects of childcare, infant feeding and post natal depression. Health Visitors work with partner agencies to offer support and work with families as required protecting vulnerable children and families, with particular emphasis on early intervention. They offer consultation and advice on immunisation, contraception, smoking cessation, alcohol consumption and all aspects of childcare.

Health Visitors aim to provide:

- All children 0-2 have a named Health Visitor
- All Parents receive an 6-8 week Edinburgh Postnatal Depression Scale assessment
- New born Behavioural Observations (NBO) and Neonatal Behavioural Assessment Scale (NBAS) provided
- Listening visits - for parents with emotional issues
- Out of the Blues groups run by HVs
- Family Health Mentors

***Integrated Service for Children with Additional Needs (ISCAN)*** *(Stockport NHS Foundation Trust and TMBC)*

4.15 This multi-disciplinary team comprises of Occupational Therapy, Physiotherapy, Speech and Language Therapy Learning Disability Nursing, Complex Needs Nursing, Social Workers and Nursery Nurses. The Integrated Service provides:

- Nurses and therapists that work as lead professionals for parents with children with identified disabilities
- Packages of care provided for children, young people and their families to ensure healthiest outcomes achieved in the areas of physical, cognitive and emotional development
- Speech therapists work with children with communication needs and neurological disorders such as Autism. Therapy focusses on improving communication environments and developing skills (Children with language disorders more likely to have mental health issues).
- Family Therapy to support parents to manage communication deficits
- Speech and Language Therapy providing interventions for young people within the youth justice team
- Provides evidence based therapy and nursing interventions within schools, homes and other settings
- Trains parents, teachers and other professionals around the needs of the child

***Paediatrics Services*** *(Tameside Hospital Foundation Trust)*

4.16 The children's ward comprises of a 21 bedded inpatient unit, 8 bedded day case unit. They provide nursing care for children aged between 0 to 16 years of age (in secondary education) with a variety of medical, surgical, orthopaedic, ENT, dental and gynaecological problems. On the unit they are able to provide care for children and young people requiring a higher dependency of care. The team comprises of experienced paediatric nurses and auxiliaries who provide holistic family centred care 24 hours, 7 days a week. The team works closely with all members of the multi-disciplinary team in order to deliver evidence based care to a high standard which ultimately empowers children, young people and those who care for them in preparation for discharge.

Referrals are accepted from General Practitioners, Accident and Emergency Department, the Observation and Assessment Unit and other health professionals. Patients are not able to self-refer to this service.

***Primary Health Care (GPs)***

4.17 Primary Health Care provides the first point of contact in the health care system. In the NHS, the main source of primary health care is general practice. Across Tameside and Glossop there are 41 GP practices that offer for registered patients appointment times for medical advice, examinations and prescriptions. GPs also provide an out-of-hours service via contact the practice directly.

The aim is to provide an easily accessible route to care, whatever the patient's problem. Primary health care is based on caring for people rather than specific diseases. This means that professionals working in primary care are generalists, dealing with a broad range of physical, psychological and social problems, rather than specialists in any particular disease area.

**Local Authority Offer (TMBC)**

***Behaviour for Learning and Inclusion Service (BLIS)*** *(TMBC)*

4.18 BLIS plays an important supporting role, providing schools with support which is both preventative and also directly supporting children with emotional, behavioural and social difficulties (EBSD). It offers:

- Supports students with Education Health Care Plans where EBSD is a priority need.
- Provides six day cover for Primary excluded pupils.
- Provides support for Key Stage 1 pupils at risk of a permanent exclusion/permanently excluded.
- Supports the identification of pupils with BESD adopting offering an overview of need through a comprehensive in depth assessment process ensuring a multi-agency approach response and building capacity in school
- Offers advice, support and training to schools, their pupils, parent/carers and governors in the promotion of positive behavioural, emotional and social development (BESD) and the effective management of behaviour.
- Supports through training, advice and sharing of good practice the promotion of an ethos which encourages and facilitates positive BESD including the recognition of the link between good teaching and learning and an emotionally healthy school where pupils are able to achieve
- Where appropriate acts as a critical friend in terms of identifying and supporting the needs of children and young people and monitoring and evaluating school interventions
- Facilitates, where appropriate, referral for further assessment/involvement of other professionals and access to support through a multi-agency approach
- Supports identification of pupils at risk of exclusion and support for reintegration of those who have been excluded

***Communication Language and Autistic Spectrum Support Service (CLASS)*** *(TMBC)*

4.19 This service enables pupils with Social Communication Difficulties including Autistic Spectrum Disorders (ASD) or with Specific Language Impairments (SLI) to reach their maximum academic and social potential in an inclusive educational environment. It offers:

- Support for pupils with an Education Health Care Plan where ASC is a priority need
- Advice and support for school staff on specific and appropriate targets and strategies for pupils with diagnosis of Autistic Spectrum Disorder (ASD), Asperger Syndrome or with Social and Communication Difficulties
- Liaison with professionals, parents and carers
- Monitoring and review of progress
- Support for transitions, especially KS2 to KS3 and KS4 to KS5
- Provision of recommendations regarding future placements and support
- Training is provided on particular skill development:

- General ASD awareness
- Delivery of Social Skills Programmes (KS1, KS2 KS3 and KS4)
- Pupil focused sessions for all staff

***Children's Social Care*** *(TMBC)*

4.20 The main responsibility of the service is to safeguard and promote the welfare of 'Children in Need'. Children subject to protection plans remain vulnerable to mental health issues; they remain living in family environments where neglect or abuse has been identified. This is often due to parental substance misuse and or mental health impacting on parenting ability and in turn on the emotional wellbeing and mental health of the child.

The Government sets standards that Children's Social Work has to meet. These include:

- The child and family assessment must be completed within 45 working days.
- Families are usually entitled to have a copy of the assessment.
- Families will be given clear information about the services which are available as a result of the assessment.
- Children are at the centre, their wishes, views and voice will be heard and will inform the assessment and plan
- Social workers must work in partnership with parents

***Tameside Youth Offending Team*** *(TMBC)*

4.21 The Youth Offending Team is made up of professionals from several different organisations in Tameside, working with young offenders aged 10 -17 and their families within the borough.

The main aim of the team is to prevent children and young people from offending. The team provides the following services:

- Working with young offenders who receive Out of Court disposals (formerly Police Cautions)
- Providing a variety of services to the Tameside Youth Court including - writing Pre-Sentence Reports; the supervision of Court Orders.
- Restorative justice work as part of the above orders.
- Supervision of young offenders during and after custody.

***Service for Children with Disabilities and their Families***

4.22 Jubilee Gardens is a resource centre for children with disabilities and their families. They work directly with families to look at needs and identify appropriate support where needed. The Centre's facilities include:

- Play sensory room, SNOEZELEN® Room, filled with special lights, soothing music, a variety of textures, mirrors and sounds. The floors and walls are cushioned and there are special chairs that are placed for relaxation
- Staff from the ISCAN (Integrated Service for Children with Additional Needs) are based at the centre.

**Third Sector**

4.23 The following provides details of third sector offers and the organisations who are delivering emotional health and wellbeing services and activities across Tameside and Glossop. The organisations featured here are delivering targeted services under the Thrive model of Coping to Getting Help. There is a wider group of third sector organisations who deliver emotional health and wellbeing work as a part of their positive activities offer, these organisations are currently being mapped and a service directory will be available from the CVAT website by the end of 2015.

***42nd Street***

4.24 It is a regional charity that provides services to young people under stress. They work with young people between the ages of 11-25 living in parts of Greater Manchester, providing a range of services including one to one counselling, therapy and psycho-social support. They also offer targeted and needs led group work and offer a growing creative programme. Currently in Tameside and Glossop a 42nd Street counsellor is seconded to CAMHS to provide 2 days of counselling per week for aged 16+ in Tameside College, Hyde Clarendon and Ashton 6th Form supporting transition.

***The Anthony Seddon Fund***

4.25 It is a Tameside Charity involved in raising funds for mental health & wellbeing projects in our local area. The charity is passionate about helping people who are living with mental illnesses and the effects. The charity aims to raise awareness and challenge the stigma, discrimination and lack of resources endured by those with mental health issues in our community. The Antony Seddon Fund work in partnership with other agencies to provide therapeutic services to young people at risk of suicide or associated issues (self-harm, low mood, low confidence etc.). Services provided through the following groups/projects are:

- Rethink Mental Illness Family & Friends Group - Suitable for people who provide support to someone with a mental health diagnosis, age 18+
- One-to-one Counselling Sessions age 13 – 28 years
- Therapeutic Art-based Project age 7 – 11years Sunshine Social Group – a peer led drop-in group – suitable for people with low level mental health issues
- Time to Change - LGBT Youth Group – starts in July 2015

***Off the Record (OTR)***

4.26 Delivers the Emotional Wellbeing Service in Tameside for Young People aged 10 to 25. OTR currently provides:

- A person centred counselling service based in Hyde and at other young person friendly venues, including; supported accommodation projects and with partner organisations, e.g. the Anthony Seddon Trust and Cavendish Mill.
- Two drop-ins for young people 'in immediate crisis', offering brief interventions. In November 2015 there will be an additional internet based Skype Drop-In.
- Schools based counselling service, with counsellors based in 6 primary and secondary schools in Tameside.

- The ‘Time-2-Talk’ projects offering specialist counselling provision for young people who are the victims of Domestic Abuse or Child Sexual Exploitation. These projects are funded through Comic Relief and the Step Up Programme.
- A new internet based service to be launched in November 2015 – www.wtfaffirmation.co.uk. Young people and their families will be able to access advice and guidance through a message board and a range of ‘self-serve’ tools called Affirmations.
- The ‘What Makes You Tick?’ is an accredited personal development training programme. The training programme targets the victims of domestic abuse, CSE and young people working with YOT.

***Tameside Oldham and Glossop Mind***

4.27 It is a mental health charity covering Tameside and Glossop (*and Oldham*), providing counselling and therapeutic group work and activities.

- Currently providing emotional wellbeing and mental health awareness assemblies in all secondary schools in Tameside.
- Providing resilience building workshops in all secondary and 30 primary schools.
- Part of National Department for Education pilot in 5 Tameside schools offering workshops and facilitated self-help services.
- Counselling, Therapeutic courses and solution focused therapy also provided in Oldham schools and self-funding Tameside schools.

***Lifeline***

4.28 It is a national charity which in Tameside is providing a Tier 3 young people’s substance use treatment service, working with young people up to the age of 25 that also includes family support and interventions.

- A TMBC Public Health project in conjunction with the Child Sexual Health team is planned from September 2015, focusing on Year 8 pupils identified with risky behaviours
- Strengthening Families (parenting programme for families with alcohol or substance misuse) project is funded until July 2015.
- Hidden Harm project supporting Young Carers

**Papyrus**

4.29 It is a national suicide prevention charity focussing on young people and young adults

- It has a project in Tameside training a group of 20 young people to provide support in the community for self-harm and potential suicide.

***Making a Difference Tameside***

4.30 Provides fully trained workers in mental health and coaching skills provide individually tailored practical support to people in their own homes including household management, cooking and budgeting. Volunteers and fellow members from the workshop also help with decorating and maintenance work. Working towards goals and needs identified by the person themselves their support workers assist, enable and empower them to be more confident and independent. The workshop is a dynamic, supportive yet challenging centre which seeks to develop self-esteem and relationship skills through a range of

social and vocational activities. The approach is built on befriending, participation and the ethos of a “therapeutic community”.

***Home Start***

4.31 Home-Start is a family support charity that works with families who are suffering from stress and who have at least one child under the age of five. They are an early intervention charity that aims to support parents to give their children the best possible start in life, to improve the ability of parents to care for their children, and to prevent family crisis and breakdown by ensuring the health and social needs of families are met. They do this by recruiting, training and supporting volunteers (who are all parents themselves) to go into family homes for a few hours on a weekly basis to offer practical help and much needed emotional support. Home-Start has a dedicated Parent Infant Mental Health worker who is a member of Tameside’s Early Attachment Service and who works primarily with families with children in the 0-2 period.

4.32 Many of the families supported by Home-Start are affected by mental health issues, including post natal depression, as well as other mild to moderate mental health issues that affect a parent’s confidence, self-esteem and motivation. Through the support and reassurance of their volunteer, families are enabled to widen their support networks, to gain confidence and self-esteem and to establish routines that lead to a more settled home life. Parents consistently report feeling more able to cope as a result of Home-Start support and the emotional wellbeing of parent and child is greatly enhanced.

***Crossroads - Harmony Home***

*4.33* Harmony Home is a refuge for women 16-24 year olds that provides transitional housing for women who are in the process of recovery providing a number of programmes of support/Interventions from substance abuse treatment, to psychological assistance, domestic abuse. It operates a support group for children aged 5 – 15 who have experienced domestic abuse.

***Life You Choose***

4.34 Life You Choose is a Community Interest Company (“CIC”), which is required to use its profits and assets for the benefit of the community rather than for private gain. It was set up to create and discover opportunities within the Glossop community for people with learning disabilities. It provides a social group focussing on media related activities for those with learning disabilities.

***Hidden Gems - Glossop Autism Support Group***

4.35 The aim of the group is to provide support, guidance, encouragement and inclusion for families and their children who are affected by ASD and all related conditions. They promote a safe, relaxing and non-judging environment where children and their parents, carers can meet to share advice and for all the family to make new and local friends. They offer support for children aged 4 - 15 years and their siblings. The group is open to parents, relations and carers and their children who have Autism Spectrum Disorder, Attention Deficit Hyperactive Disorder, DAMP, SPD, Dyspraxia and all related conditions including behavioural issues and delayed development. Families awaiting a diagnosis for their child are also welcomed.

4.36 Taking the term 'emotional wellbeing' in its widest sense to mean being happy and confident, able to build good relationships with others and have the emotional strength required to be resilient, then the following range of activities in the third sector, which could be classed as supporting wellbeing, may be relevant:

- Sports Clubs: There are a wide range of sports clubs across Tameside and Glossop
- Uniformed Groups e.g. brownies, guides, rainbows, beavers, cubs, scouts, explorers, army cadets. There are packs in Hadfield and Glossop plus an army cadet base in Glossop.
- Youth Groups: Millennium Cellar, Simmondley Youth Projects Group, Youth Café at Jericho Café, Gamesley. Also a number of Church based groups for children and young people e.g. Methodist Church, St Lukes, St Andrews.
- Drama Groups: Partington Players

**Schools Offer**

4.37 Future in Minds proposes that there is a dedicated named contact point in targeted or specialist mental health services for every school that seeks to improve communication and access. Tameside and Glossop CCG and its partners are working with NHS England and the Department for Education to test the named lead approach and training programme. The CAMHS and school link scheme will support the promotion of mental health awareness, thus empowering staff within education to more confidently identify mental health difficulties, leading to more timely assessments and more effective interventions at the 'getting help' stage of the Thrive Model. NHS England and the Department for Education have recruited a training organisation to develop and deliver a joint training programme that aims to:

- Raise awareness and improve knowledge of mental health issues amongst school staff;
- Improve CAMHS understanding of specific mental health and well-being issues within schools; and
- Support more effective joint working between schools and CAMHS.

We expect the training to be undertaken in the autumn term 2015 and spring term 2016.

4.38 The following provides details of individual school offers that have been received during the schools mapping programme prior to the national pilot scheme outlined above. These individual school offers build upon and/or liaise with the service offer's outlined in paragraphs 4.18 and 4.19 (BLISS and CLASS services). In addition the CCG, Tameside and Glossop CAMHS and the ADHD Foundation have ensured training to over half of the schools' teachers who hold the function of Special Educational Needs Co-ordinator (SENCO's) in around ADAH and its application within a school setting.

**Astley Sports College / A + Trust Schools**

4.39 Work directly with Pennine Care NHS Foundation Trust CAMHS offering the school trust an enhanced emotional wellbeing and mental health service. They

offer a broad range of school-based counselling, therapy and parenting support services with a single point of access. Services can be tailored to the needs of individual schools.

The offer is committed to providing high standards of care and governance and will link into other universal, targeted and specialist support services provided in your school and community, for example school nursing and health visiting. The schools work in Partnership with CAMHS:
1) To improve students' emotional wellbeing
2) To help overcome barriers to learning
3) To enable students to maximise their education and fulfil their potential

***Hawthorns***

4.40 It provides 'A Quiet Place', a 6 week programme within AQP environment, for pupils led by trained Hawthorns staff. Manage emotions, breathing, anger management, and explore personal issues. In addition, a children's counsellor works one day a week in the school (available for staff at lunchtime).

- Family and Multi-agency link worker- supports families
- Key workers - support child in school and family where needed
- Educational Psychology advice
- ISCAN support
- Behaviour team support
- BLIS
- CLASS
- MIND Resilience sessions for Year 6 to help with transition.
- Resilience training for staff
- School nurse

***White Bridge College***

4.41 Provides SENCO, Key Teacher and Pastoral Support with Educational Psychologist input. Liaison with a variety of agencies including CAMHS, MAAT, YOT, The Phoenix Team, Branching Out, Off The Record, Inspire and MST.

***Yew Tree***

4.42 They provide a SENCO and pastoral supervisor, who works with children who are emotionally vulnerable e.g. dealing with bereavement, members of family in prison and/or social care issues. Receives input from an Educational Psychologist and BLIS support team, who offer support for those children who are finding it difficult to cope in the mainstream classroom. They offer advice and practical guidance and support for teachers, including coaching.

4.43 CLASS also provide invaluable support for those children on the Autistic Spectrum. In addition they work with external services to gain advice on particular situations.

***St Damien's***

4.44 Provides a student support officer, pastoral/attendance officer and behaviour and guidance support manager. In addition to its SENCO**,** T.A.'s and carers also has: Peer Mentors; Father (Priest).

The school works with Off the Record, CAMHS and the Tutor Trust. Receives support from BLIS Intervention CLASS support and School Nurse plus Health Mentors.

***St Paul's RC***

4.45 TA and Class Teachers provide pastoral support to pupils with emotional and mental health issues, although they have received little/no training in relation to this.

***Russell Scott***

4.46 Provide the social and emotional aspects of the Learning (SEAL) programme, Teacher and TA support and School Nurse – with advisory capacity. Learning Mentor – Individual programmes of work e.g. self-esteem, anger, friendship etc. They receive input from an educational psychologist and is supported by BLIS support.

***Fairfield***

4.47 Provides KS3 and KS4 Learning Mentors, individual programmes for students for anger management and self-esteem, Young Carers, Friday Friendship and Peer Mentoring (SHINE) groups. Receives support and input from C.L.A.S.S., Tameside Young Carers Project and Early Help, School Nurse, Health Mentor, SALT and Educational Psychology

In addition provides:

- Relateen (7hours per week)
- Hilary Quigley (exam techniques, relaxation strategies)
- Home Tutor linked to LAC students
- Behaviour buddies (provided by Teaching Personnel)

***Copley***

4.48 Learning Support and Behaviour Support units provide a school nurse and weekly health mentor, counselling (weekly sessions run by 'off the record') and 'relateen'. They receive input from Education Psychology.

4.49 Students can access stress management, Young Carers support and emotional wellbeing support from the Pastoral Team – has one trained Counsellor leading intervention. 1:1 or small group. They also provide relaxation sessions and anxiety reduction sessions with students. They also work with parents about how to support their families.

***Longdendale***

4.50 Longdendale provides SEAL intervention from their Pastoral Team 1:1 and a small group of identified students and also receive input from Education Psychology.

4.51 Available is support for students who are coping with stress in an unsafe way - self harm coping strategies, working in alignment with CAMHS professionals - 1:1 support by trained counsellor for vulnerable and at risk students. There are family sessions in school with trained counsellors – emotional support for families in conflict. Self-esteem and body image sessions – booking sessions from the 'Dove' project.

4.52 Longdendale work with MIND to provide sessions for students – targeted small groups and assemblies – focus: strengthening resilience. MIND offers evening workshops to parents re: building resilience with their families and focus: strengthening community resilience. LHS is one of the Centres for this project working with MIND.

***Mossley Hollins***

4.53 The Learning Support Unit provides access to a school nurse and health mentor (weekly). Receive input from Educational Psychologist BLIS, Early Help Team and You think. They access advice and support from CAMHS and make referrals to CAMHS as required.

***Canon Burrows***

4.54 Provides pastoral support from teachers, TAs, SSA and SMT and school nurse as required.

- SEALs taught through PSHE sessions.
- Peer support – buddy systems.
- Targeted interventions e.g. anger management, self-esteem, friendship building etc.
- Reward systems to encourage success and positive self-esteem.

Receive input from BLIS, CLASS, Educational Psychologist, Early Help Team, and Inspire.

***Moorside***

4.55 Moorside provides a small team who support children and parents with their emotional wellbeing and some issues relating to mental health. They receive input from BLIS – social groups and 1:1 support.

***Silver Spring***

4.56 Provides a Family and Community Engagement Co-ordinator, trained in therapeutic play techniques, bereavement support, sexual exploitation awareness and supports learners in KS2. They support those children with the most complex needs with Play Therapy and compliment this with Family Therapy for parents. This is provided by IntraQuest.

4.57 The School has established effective links with MIND, Social Care, CAMHS, Neighbourhood Teams, Early Help, the Children's Centre team and Inspire and the implementation of "Strengthening Families, Strengthening Communities". All classroom based staff in the school and Welfare Assistants have been trained in Attachment Theory and Practice on which Family Mechanics is built.

4.58 A qualified teacher provides Nurture Group support for a group of six children with emotional and behavioural needs each afternoon in KS1. One of their HLTAs delivers Hotshots. The head teacher, SENCO and two other teachers have specialist training in supporting challenging behaviour.

***St Raphael's***

4.59 Provides a Class teacher, SENCO, SLT and Family liaison officer/safeguarding.

***Ravensfield***

4.60 Provides two learning mentors in school that have accessed a range of training to enable emotional support (self-esteem, friendships, anger management, nurture and massage, bereavement, relationships, managing feelings, attachment disorders). In addition provides Art Psychotherapy – purchased by the school.

4.61 Delivers: SEAL programme and their own SEALs wheel modelling of situations. Commando Joe - respect, aspiration and self-control resilience cooperation. Early identification of feelings through their own Feelings Register. They facilitate every 8 week referral meetings to assess developing need and discussion with pastoral and leadership team for accessing further intervention of support. Available is a learning support unit to provide internal exclusion, and focus emotional support and access to BLIS for advisory support or assessment and 1-1 work with individuals or groups.

***The Heys***

4.62 Provides learning mentors, one to one support with key workers, SENCO support, and Play Therapy. They receive input from Educational Psychologist, BLIS, School Nurses and CAMHS. They also deliver the Social and Emotional Aspects of the Learning (SEAL) programme.

***Leigh***

4.63 Support is given via the school's inclusion team. A new Welfare Officer/Mentor is to be appointed during the summer term. At present the school accesses Inspire to support some identified families.

**Our Investment in 2015/16**

4.64 This subsection seeks to provide an overview of the 2015-16 emotional wellbeing and mental health services for children, young people and those care for them investment - by the CCG and its partners.

*Figure 4: Tameside and Glossop Emotional Wellbeing and CAMHS 2015-16 Investment*

| Tameside and Glossop Emotional Wellbeing and CAMHS 2015-16 Investment | | | | |
|---|---|---|---|---|
| **Funded From** | **Service** | **Pay** | **Non Pay** | **Total** |
| | | **(Note 1)** | | |
| TMBC Public Health | Off The Record | | 91,670 | 91,670 |
| TMBC Public Health **(Note 2)** | Parenting Programmes | | 41,663 | 41,663 |
| TMBC Public Health **(Note 3)** | Perinatal / Infant Mental Health | | 238,544 | 238,544 |
| TMBC Public Health | School Based Programmes | | 16,000 | 16,000 |
| | | **0** | **387,877** | **387,877** |
| NHSE | Specialised Commissioning (Inpatient) | | 1,268,990 | 1,268,990 |
| NHSE **(Note 4)** | Tameside Youth Justice Liaison & Diversion Scheme | 50,500 | 7,100 | 57,600 |
| | | **50,500** | **1,276,090** | **1,326,590** |
| TMBC **(Note 5)** | BLIS | | 125,000 | 125,000 |
| LA Maintained Primary Schls | BLIS | | 443,000 | 443,000 |
| Academies & LA Maintained Secondary Schls | BLIS | | 65,000 | 65,000 |
| | | **0** | **633,000** | **633,000** |
| DfE - Dedicated Schools Grant | CLASS | | 721,000 | 721,000 |
| | | **0** | **721,000** | **721,000** |
| CCG **(Note 6)** | CAMHS (excluding CQUIN) - PCFT | 1,607,194 | 530,822 | 2,138,016 |
| CCG | Young Persons Alcohol Nurse - THFT | | 48,000 | 48,000 |
| CCG | Inreach/ Outreach Team - PCFT | | 62,165 | 62,165 |
| CCG | 42nd Street | | 32,240 | 32,240 |
| CCG | Homestart (Parent Infant Menatl Health) | | 40,299 | 40,299 |
| CCG | ISCAN - SFT | | 14,105 | 14,105 |
| | | **1,607,194** | **727,631** | **2,334,825** |
| | **TOTAL** | **1,657,694** | **3,745,598** | **5,403,292** |

**Note 1:** Where financial breakdown and analysis does not enable pay and non pay separation all funding is applied under non-pay

**Note 2:** TMBC Public Health parenting programmes consists of Solihull Approach and parenting training and manuals £21,529; Incredible Years parenting training and manuals £18,344; Mellow parenting training £1,790

**Note 3:** TMBC Public Health Perinatal - Infant consists of Early Attchment Service £225,734 (An additional £145,080 has been invested from Oct15, therefore a part year effect for 15/16); & Neonatal Behaviour Assessment Scale training £1,800; Neonatal Behaviour observation training (links to parenting attachment/bonding) £11,010

**Note 4:** Tameside Youth Justice Liaison & Diversion Scheme funded from NHSE directly pays for a 0.4wte AfC band 6 Mental Health practitioner is will end 31.03.16

**Note 5:** From the total service costs of £633k for 2015-16, £125k is funded via TMBC budgets, however with the remaining balance of £508k this is income generated funding by a combination of schools budgets.

**Note 6:** CCG CAMHS Investment 2015-16 includes £200k non-recurrent funding

4.65 The CCG investment in Tameside and Glossop CAMHS, outlined in Figure 4, enable the following CAMHS service composition summarised in table 1 below. The composition is of the 1st October 2015 and reflects the transformation to date. It does not reflect the new Allocation of Mental Health Funding to CCGs and the proposed expenditure outlined in section 7.9 Table 1.

*Table 1: Tameside and Glossop CAMHS Service Composition as of the 1st October 2015.*

| **Tameside and Glossop CAMHS Service Composition** | | |
|---|---|---|
| Whole Time Equivalent (W.T.E) | Role / Designation | Narrative |
| 2.7 | Consultant Psychiatrist | Contribute to the management and core CAMHS delivery; leading on Transitions (16-18 |

| | | |
|---|---|---|
| | | years), ASD and Learning Disability |
| 0.7 | Band 8C Psychologist* | 2 x posts 0.5 holds caseload of complex cases and contributes to the management team. 0.2 Hold a case load within the Early Attachment Service |
| 2.5 | Band 8a Psychologist | Contribute to ASD, LD, paediatrics and core CAMHS. Between them they hold specialist skills in CBT, IPT, DBT, and Parenting. They offer supervision and teaching on the IAPT courses |
| 1 | Band 8a Operational Manager | Responsible for day to day management of the CAMHS team |
| 4.1 | Band 7 Senior Mental Health Practitioners (0.5 of which is a specified family therapist) | Hold management responsibility in their roles as well as taking leads on multi-agency pathways, delivering specialist mental health interventions to complex clients. The post holders have additional skills in NMP, parenting, DBT, CBT and Family Therapy. 2 of the band 7's have been on the initial IAPT in 2012 and are accredited in parenting and CBT. They continue to offer supervision support to current IAPT attendees and contribute to wider system peer supervision amongst the agencies |
| 6.7 | Band 6 Mental Health*Practitioners | These staff offer assessment/ interventions/ consultation/duty cover. They work across the pathways, supporting the leads. Most staff have additional skills in the areas of CBT, DBT, and Family therapy. 1 member of staff completed the SFP training on IAPT in 2014 and another is due to complete the CBT IAPT in December 2015. 1 member of staff is on the EEBP IAPT and due to complete in January 2016. |
| 1 | Band 4 Practitioner | Offers support to the team in supporting group interventions, specialist play work and is also completing the EEBP IAPT, |
| 1 | Band 4 Service Administrator * | Administrative lead |
| 3 | Band 3 Secretaries | Offer admin support across the service |
| 1 | Band 2 Receptionist | Provides reception duties and inputs data |

* Note: From the CCG £ 200k non recurrent investment, funded till March 31.03.2016, relates to 0.3 of a 8C Psychologist time that sits in the management CAMHS team, plus a band 6 and a band 4 admin time

*(Source: Adapted from Tameside and Glossop CAMHS, Pennine Care NHS Foundation Trust, 2015*

# Section 5: Our Needs - Local Needs Assessment

5.1 This section seeks to provide a description of the current mental health and wellbeing needs of Tameside and Glossop's children and young People. These needs have been used to inform and target service provision in tackling health inequalities and along with other findings, inform the Transformation Plan recommendations. The findings contained in this section draw upon the Tameside Joint Strategic Needs Assessment (JSNA) 2015/16, the National Child and Maternal Health Intelligence Network and an epidemiological literature review.

### Tameside and Glossop Children and Young People

#### *Age*

5.2 Children and young people under the age of 20 years make up 23.8% (n=57,042) of the population of Tameside and Glossop.

*Table 1: Tameside and Glossop CCG population 2014, Age distribution*

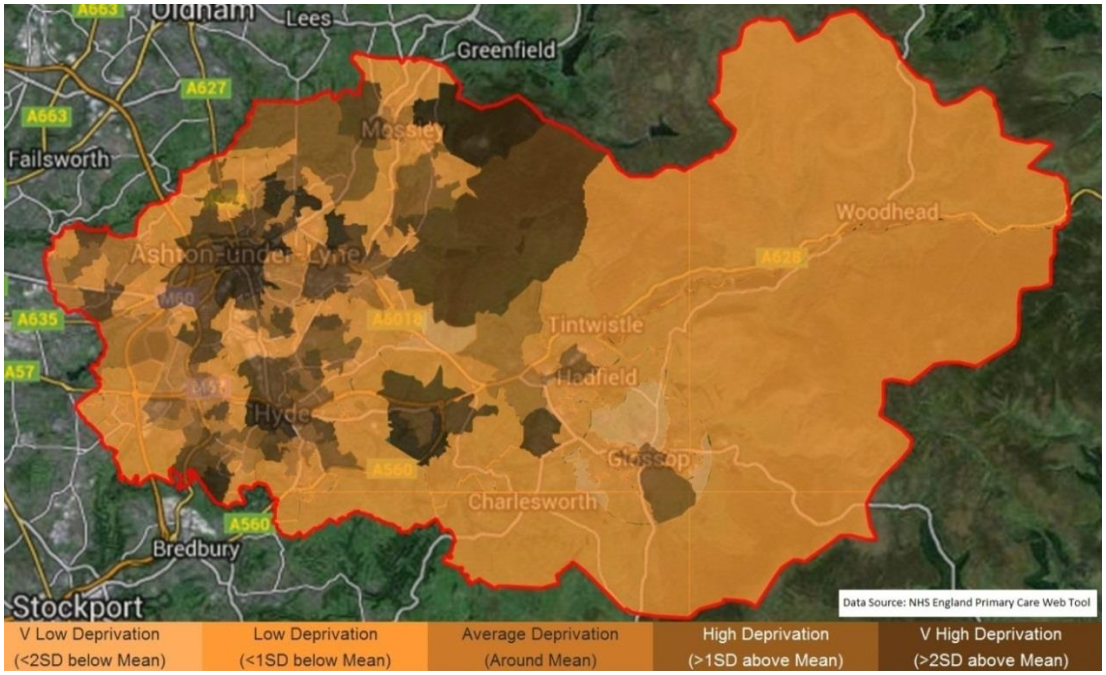
| Age | Male | Female | Persons |
|---|---|---|---|
| 0 – 4 years | 7,775 | 7,482 | 15,257 |
| 5 - 9 years | 7,284 | 6,921 | 14,205 |
| 10-14 years | 6,680 | 6,503 | 13,183 |
| 15-19 years | 7,423 | 6,974 | 14,397 |
| 20+ | 89,996 | 92,272 | 182,268 |
| Total | 119,158 | 120,152 | 239,310 |

(Source: ONS, 2015)

#### *Deprivation*

5.3 Some major risk factors for mental health problems include poverty, poor education, unemployment, social isolation/exclusion and major life events. A review of large-scale studies of mental health problems evidences that such problems are more common among children and young people who are have fewer educational qualifications, have been looked after or accommodated, are in a low income families or have a low standard of living. When considering inequalities in mental health and wellbeing, it is therefore important to consider deprivation as a driver. Just over a third of the Tameside population lives in areas that fall within the most deprived 20% of areas nationally, with just 3.2% of the Tameside population living within areas that fall within the least deprived 20% of areas nationally. In Glossopdale, the Gamesley residential area falls in the most deprived 10% of areas nationally. This means that based upon the level of deprivation in Tameside and Glossop health inequalities would be expected to exist between Tameside and Glossop and England as a whole.

*Map 1: Deprivation in Tameside and Glossop (IMD 2010)*




(Source: NHS England Primary Care Web Tool)

### *Child Poverty*

5.4 Child Poverty is currently defined by the national child poverty measure: the percentage of children who live in families in receipt of out-of-work benefits or in working families with income less than 60% of the median national income. The wider determinants of poverty include a range of social and economic factors and are currently being reviewed under the banner of 'life chances' and 'social mobility'. The consequences of allowing a child to grow up in poverty are severe, not only for the child but for the family, for society and for the wider economy as well. For a child, consequences can be wide ranging and can affect health, education, employment, behaviour, finance, relationships and their well-being.

5.5 A child growing up in poverty has a greater likelihood of experiencing health problems from birth and of accumulating physical and mental health problems throughout their life. Poverty and inequalities proportionately increase the chances that someone will develop a disability or life limiting illness and ultimately decrease their life expectancy. Though poverty can affect anyone, a number of groups are more at risk than others. These include, children in care, teenage parents, asylum seekers, single parents and particular ethnic groups. The levels of child poverty in Tameside are higher than both the North West and England (national Child Poverty Data from 2011). Local data had indicated that the levels of poverty had increased over the past 4-5 years. Local data is no longer comparable due to welfare changes. National data from HMRC continues to be available but in arrears. This data indicates a relatively static position in the percentage of children living in poverty in Tameside.

### *Ethnicity*

5.6 Ethnicity has a major impact on a person's mental health (Persuad, R. 2007). It is important to consider the ethnic breakdown of the local area when planning services, given that different ethnic groups have differing needs. There may be barriers to accessing services in some ethnic communities due to limited knowledge of English. Research on the risk factors for young people developing mental health problems has highlighted that those from black and ethnic minority groups may be disproportionately affected, as indicated by the numbers excluded from school, being looked after, in local authority accommodation or being homeless (Young Minds, 2005).

5.7 The largest ethnic groups within Tameside are the South-Asian ethnicities Indian, Pakistani, and Bangladeshi accounting for 1.7%, 2.2% and 2% of the Tameside population respectively. Glossopdale is one part of the High Peak area, which has a predominantly white population with less than 3% of residents from black and minority ethnic (BME) groups. The overall white British population is considerably higher in Tameside at 88.5% compared to the England average of 79.8%.

## At Risk and Vulnerable groups

### *Pregnancy and early years*

5.8 Pregnancy and early years lay the foundations for health, wellbeing, cognitive development and economic security throughout one's life. The transition through pregnancy, birth and early parenthood is a vital window of opportunity. A baby born into a home with parents that are well educated and financially comfortable has a better chance of living longer (and without disease and disability) than a baby born into poverty. This is in a large part because the social and economic inequalities in our society are reflected in and help to determine our health and wellbeing outcomes.

### *Looked After Children*

5.9 Evidence from literature reviews reflect that looked after children are more likely to experience mental health problems than the general population. It has been highlighted that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders, such anxiety or depression, and 7% were hyperkinetic (Meltzer, H. et al 2003). As such it should be viewed as all looked after children are vulnerable hence a reasonable expectation that appropriate services should be in place. Failure to meet the needs of those most vulnerable impacts not just on their childhood but also on their adulthood and on their ability to parent and the cycle continues.

*Table 2: Looked after children in Tameside and Glossop*

| | |
|---|---|
| Total number of Looked After Children (LAC) in Tameside and Glossop | 766 |
| Number of LAC placed in Tameside and Glossop (from other areas) | 467 |
| Number of LAC placed in other areas by Tameside and Glossop | 136 |

(Source: NHS Tameside and Glossop CCG, September 2015)

The number of Tameside and Glossop children who are looked after is higher than the England average.

***Youth Offending***

5.10 There is a considerable agreement that levels of mental health problems among young people connected to any part of the criminal justice system are higher than in the general population. Literature reviews indicate the prevalence rates of mental health problems to be at least three times as high for those within the criminal justice system as within the general population (Leon, L. 2002). A recent evaluation of the Youth Justice Liaison and Diversion pilot scheme (Haines, A. et al. 2012), found that 80% of young people had between one and five vulnerabilities, which range from mental health issues, behavioural issues, and social problems.

5.11 In Tameside, between April 2014 to March 2015, 112 children entered the youth justice system for the first time. This is a 21.7% increase compared with (n=92) the previous equivalent 12 months. Although this gives a similar rate to the England average for young people receiving their first reprimand, warning or conviction. Tameside Youth Offending Team (YOT) use Asset as their assessment tool, the nationally recognised assessment framework for young people involved in the criminal justice system. Asset aims to look at the young person's offence or offences and identify a multitude of factors or circumstances – ranging from lack of educational attainment to mental health concerns - which may have contributed to such behaviour. The extent to which a section is associated with the likelihood of further offending is rated on a 0 – 4 scale.

0 Not associated at all
1 Some association
2 Associated
3 Strongly associated
4 Very strongly associated

5.12 While there are a number of domains within the assessment, those relating to emotional and mental health and vulnerability, most clearly demonstrate the prevalence of need amongst the YOT cohort. An analysis of assessments completed by Tameside YOT during the 1st April 2014 to 31st March 2015 shows the following results:

*Table 3: Young People Assessed by Tameside YOT using ASSET- 1st April 2014 to 31st March 2015*

| Asset Section | Asset Score / Vulnerability Indicator | Total Number of Assets | Total Number of young people | % of young people |
|---|---|---|---|---|
| Emotional & Mental Health | 2 | 201 | 53 | 31% |
| | 3 | 55 | 27 | 16% |
| | 4 | 10 | 7 | 4% |
| Vulnerability | No | 98 | 38 | 22% |
| | Yes | 516 | 133 | 78% |

(Source: Tameside Youth Offending Team, 2015)

The table demonstrates, in 51% of all cases, the assessments evidenced an association between emotional and mental health, equating to 87 young people in total, suggesting that half of the YOT caseload would benefit from intervention and support in this area.

**Domestic Abuse**

5.13 Domestic Abuse often remains hidden. Abuse is not disclosed for a variety of reasons, shame and stigma, fear of not being believed, confidence in both services and often victims themselves in dealing effectively with abuse and the relationships where it occurs. As such the data reported should be viewed as an under representation of the true prevalence of domestic abuse. Data for 2011/12 shows that Tameside is ranked fourth highest out of ten Greater Manchester Authorities in terms of rate of domestic abuse per 1,000 population. Within Tameside the rate has fluctuated year on year rising from 5.9 crimes per 1,000 population in 2009/10 to 6.9 on 2010/11 and decreasing again to 6.3 in 2011/12. Almost 80% of domestic abuse crimes in Tameside are linked to violence compared to an average of 76% across Greater Manchester as a whole (Tameside Domestic Abuse Strategy 2013-16). There is a long lasting impact on children and young people's emotional well-being due to being exposed to the trauma of witnessing domestic abuse.

5.14 Some of the effects on children and young people as a result of witnessing domestic abuse are as follows:

- Anxiety or depression
- Difficulty in sleeping or nightmares
- Experience of physical pain
- Temper tantrums
- Low self-esteem
- Use of drugs or alcohol
- Eating disorders

Some children may also experience many mixed emotions such as being angry, powerless, frightened, lonely, insecure and confused and they are often unable to articulate these feelings.

**Tameside and Glossop Children and Young Peoples Mental Health**

***Prevalence***

5.15 The following application of prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with the criteria that the disorder causing distress to the child or having a considerable impact on the child's day to day life.

***Preschool***

5.16 The National Child and Maternal Health Intelligence Network reports relatively little data on the prevalence rates for mental health disorders in preschool age children. However from a literature review of four studies looking at 1,021 children aged to 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorders was 19.6% (Egger, H et al 2006) Applying this

prevalence rate to the population of Tameside and Glossop gives a figure 2,350 aged 2 to 5 years.

### *School age*

5.17 The report 'Mental Health of Children and Young People in Great Britain, 2004 (Green et al (2004) provides a prevalence estimate for mental health disorders in children aged 5 to 16 years. Prevalence varies by age and sex, with boys more likely (11.4%) to have experienced or experiencing mental health problems than girls (7.8%). Children aged 11 to 16 are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. Using these rates, the following tables highlight the estimated prevalence of mental health disorders by age group and sex in Tameside and Glossop. *Note: in the following tables the numbers do not add up as the numbers in each age group are different*.

*Table 4: Estimated Number of Children with mental health disorders by age group and sex*

| | Estimated number of children aged 5-10 years with mental health disorders (2012) | Estimated number of children aged 11-16 years with mental health disorders (2012) | Estimated number of children aged 5-16 years with mental health disorders (2012) | Estimated number of boys aged 5 -10 years with mental health disorders (2012) | Estimated number of boys aged 11 -16 years with mental health disorders (2012) | Estimated number of girls aged 5 - 10 years with mental health disorders (2012) | Estimated number of girls aged 11 -16 years with mental health disorders (2012) |
|---|---|---|---|---|---|---|---|
| Tameside & Glossop | 1,275 | 1,925 | 3,190 | 860 | 1,070 | 415 | 850 |

(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Green, H et al (2004))

### *Mental Health Disorders*

5.18 Prevalence rates of mental health have been broken down by the following disorders:

- Conduct (a range of antisocial types of behaviour);
- Emotional (person's ability to be happy, control their emotions e.g. anxiety);
- Hyperkinetic (enduring pattern of severe, developmentally inappropriate inattention, hyperactivity and impulsivity)

The following tables show the estimated number of children with these disorders In Tameside and Glossop.

*Table 5: Estimated Number of Children with conduct disorders by age group and sex*

| | Estimated number of children aged 5-10 years with conduct disorders (2012) | Estimated number of children aged 11-16 years with conduct disorders (2012) | Estimated number of children aged 5-16 years with conduct disorders (2012) | Estimated number of boys aged 5 -10 years with conduct disorders (2012) | Estimated number of boys aged 11 -16 years with conduct disorders (2012) | Estimated number of girls aged 5 -10 years with conduct disorders (2012) | Estimated number of girls aged 11 -16 years with conduct disorders (2012) |
|---|---|---|---|---|---|---|---|
| Tameside & Glossop | 810 | 1,105 | 1,915 | 580 | 690 | 230 | 420 |

*Table 6: Estimated Number of Children with emotional disorders by age group and sex*

| | Estimated number of children aged 5-10 years with emotional disorders (2012) | Estimated number of children aged 11-16 years with emotional disorders (2012) | Estimated number of children aged 5-16 years with emotional disorders (2012) | Estimated number of boys aged 5 -10 years with emotional disorders (2012) | Estimated number of boys aged 11 -16 years with emotional disorders (2012) | Estimated number of girls aged 5 -10 years with emotional disorders (2012) | Estimated number of girls aged 11 -16 years with emotional disorders (2012) |
|---|---|---|---|---|---|---|---|
| Tameside & Glossop | 400 | 840 | 1,240 | 185 | 340 | 205 | 505 |

*Table 7: Estimated Number of Children with Hyperkinetic disorders by age group and sex*

| | Estimated number of children aged 5-10 years with Hyperkinetic disorders (2012) | Estimated number of children aged 11-16 years with Hyperkinetic disorders (2012) | Estimated number of children aged 5-16 years with Hyperkinetic disorders (2012) | Estimated number of boys aged 5 -10 years with Hyperkinetic disorders (2012) | Estimated number of boys aged 5 -16 years with Hyperkinetic disorders (2012) | Estimated number of girls aged 5 -10 years with Hyperkinetic disorders (2012) | Estimated number of girls aged 11 -16 years with Hyperkinetic disorders (2012) |
|---|---|---|---|---|---|---|---|
| Tameside & Glossop | 265 | 235 | 500 | 230 | 435 | 35 | 35 |

(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Green, H et al (2004))

### *Autism-Spectrum conditions*

5.19 A survey by Baron-Cohen et al (2009) of Autism-Spectrum conditions using the Special Educational Needs (SEN) register alongside a survey of children in schools aged 5 to 9 years produced prevalence estimated of autism-spectrum conditions of 94 per 10,000 and 99 per 10,000 respectively. The ration known to unknown is about 3:2. Taken together, a prevalence of 157 per 10,000 has been estimated, including previously undiagnosed cases. The following table shows the estimated prevalence of children in Tameside and Glossop with Autism-Spectrum disorders.

*Table 8: Estimated Number of Children with Autism-Spectrum conditions*

| | Estimated Autism in Children aged 9 - 10 years (2012) | Estimated Other ASDs in Children aged 9 - 10 years (2012) | Estimated Total of all ASDs in Children aged 9 - 10 years (2012) | Estimated Autism-Spectrum conditions disorders in children 9 -10 years (2012) |
|---|---|---|---|---|
| Tameside & Glossop | 110 | 215 | 320 | 245 |

(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Baron-Cohen, S. et al (2009))

### *Children and Young People with Learning Disabilities*

5.20 People with learning disabilities are more likely to experience mental health problems (Emerson, E. et al 2008). Despite this, prevalence rates of learning disabilities prove to be difficult. Emerson et al (2004) calculates prevalence in children and young people with learning disabilities for different age groups as follows: 5 to 9 0.97%; 10 to 14 years 2.26%; 15 to 19 years 2.67%. The following table applies these rates to Tameside and Glossop.

*Table 9: Estimated total number of children with learning disabilities*

| | Estimated Children aged 5 - 9 years with a learning disability (2012) | Estimated Children aged 10 - 14 years with a learning disability (2012) | Estimated Children aged 15 - 19 years with a learning disability (2012) | Estimated Children aged 5 - 19 years with a learning disability (2012) |
|---|---|---|---|---|
| Tameside & Glossop | 150 | 305 | 400 | 855 |

(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Emerson, E. et al (2004))

These rates reflect that as children get older, more are identified as having a mild learning disability. The Foundation for People with Learning Disabilities (2002) estimates an upper estimate of 40% prevalence for mental health problems associated with Learning disability, with higher rates for those with severe learning disabilities. The following table shows how many children with learning disabilities who also experience mental health problems expected estimation for Tameside and Glossop.

*Table 10: Estimated total number of children with learning disabilities with mental health problems*

| | Estimated Children aged 5 - 9 years with a learning disability with mental health Problems (2012) | Estimated Children aged 10 - 14 years with a learning disability with mental health Problems (2012) | Estimated Children aged 15 - 19 years with a learning disability with mental health Problems (2012) | Estimated Children aged 5 - 19 years with a learning disability with mental health Problems (2012) |
|---|---|---|---|---|
| Tameside & Glossop | 60 | 125 | 160 | 345 |

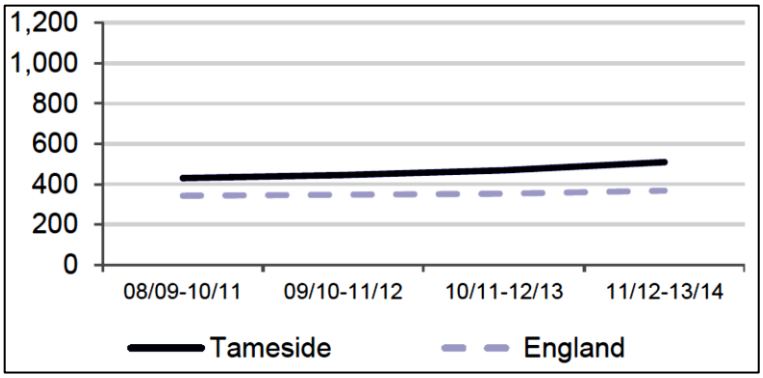
(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Foundation for People with Learning Disabilities (2002))

### *Self-Harm*

5.21 Literature reviews evidence the levels of self-harm are higher among young women than young men. However, self-harm SUS data for Tameside 2011 to 2013 shows that from the age of 20, 53% of those who self-harm are male. The rates of self-harm in young women averaged 302 per 100,000 in 10 to 14 year olds and 1,423 per 100,000 in 15 to 18 year olds. Whereas for young men the rates of self-harm averaged 67 per 100,000 in 10-14 year olds and 466 per 100,000 in 15 to 18 year olds (Hawton, K. 2012). Nationally self-poisoning was the most common method (Hawton, K. 2012).

5.22 In comparison with the 2008/09 - 2010/11 periods, the rate of young people aged 10 to 24 years who were admitted to hospital as a result of self-harm was higher in the 2011/12 - 2013/14 period. The admission rate in the 2011/12-2013/14 period was higher than the England average.

*Figure 1: Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)*

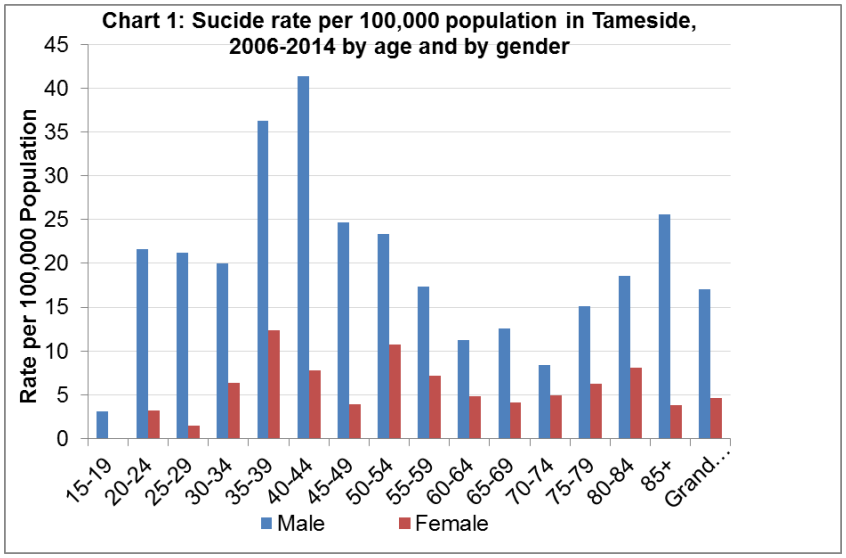



(Data source: Hospital Episode Statistics, Health and Social Care Information Centre)

Three years of pooled data on hospital admissions for self-harm in Tameside show that under the age of 20, 79% of those admitted for self-harm were female.

***Suicide***

5.23 In England, men are at three times more likely to die by suicide than women (DoH, 2012). Suicide is the leading cause of death in British men under 50 years of age. In Tameside, the peek age range for male suicide is 35 to 54 years and the peek age group is 40 to 44 years. There is also a relatively high level of suicide in younger males aged 20 to 34. For suicide in females there are two peak age groups of 35 to 39 and 50 to 54 (H&SCIC, 2015). *See chart 1 below*




*(Source: PCMD data, 2015 courtesy of Ruth du Plessis, Specialty Registrar TMBC Public Health)*

For males there is a clear gradient across the deprivation quintiles with those in the most deprived quintile having a significantly higher rate of suicide than those in the least deprived quintile.

***Estimated Service Demand***

5.24 Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tier 1, 2, 3 and 4 have been provided by Kurtz (1996). A description of the CAMHS Tiered model of care is provided in Section 4.

5.25 The following Table shows the estimates for the poplulation aged 17 and under in Tameside and Glossop who may experience mental health problems.

*Table 11: Estimated number of children and young people who may experience mental health problems requiring intervention and CAMHS services*

| | Estimated Tier 1 needs (2012) | Estimated Tier 2 needs (2012) | Estimated Tier 3 needs (2012) | Estimated Tier 4 needs (2012) |
|---|---|---|---|---|
| Tameside & Glossop | 7,730 | 3,610 | 995 | 40 |

(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Kurtz, Z. (1996))

The above Table shows that an estimated 12,375 children and young people potentially need an intervention applying the CAMHS Tiered Model of Care.

***Tameside and Glossop CAMHS Activity Data***

5.26 Tameside and Glossop in the period between 1st April 2014 and 31st March 2015 received 1,889 referrals; of which 1,366 (62%) were accepted, 749 (35%) were rejected and a further 46 (3%) classified as pending a decision. The table below provides a breakdown on the referrals and the presenting problems. It evidences the current high level of demand on our service and that this is higher than the estimated number of children and young people who may experience mental health problems requiring a CAMHS services.

*Table 12: Tameside and Glossop CAMHS Referrals 1st April 2014 to 31st March 2015*

| Accepted Referrals - Presenting Problem ICD / Description | Total |
|---|---|
| Anxiety disorder, unspecified | 80 |
| Atypical autism | < 5 |
| Childhood disorder of social functioning, unspecified | < 5 |
| Childhood emotional disorder, unspecified | 62 |
| Conduct disorder, unspecified | < 5 |
| Depressive episode, unspecified | 81 |
| Developmental disorder of scholastic skills, unspecified | < 5 |
| Developmental disorder of speech and language, unspecified | < 5 |
| Eating disorder, unspecified | 18 |
| Feeding disorder of infancy and childhood | < 5 |
| Hyperkinetic conduct disorder | < 5 |
| Hyperkinetic disorder, unspecified | 26 |
| Mental & behaviour disorder multiple/psychoact drug: unspecified mental & behaviour disorder | < 5 |
| Mixed disorder of conduct and emotions, unspecified | 40 |
| Mixed specific developmental disorders | < 5 |
| Moderate mental retard sig impairm of behav req attent /treat | < 5 |
| Nonorganic encopresis | < 5 |
| Obsessive-compulsive disorder, unspecified | 7 |
| Occurrence at unspecified place | 103 |
| Other childhood emotional disorders | < 5 |
| Pervasive developmental disorder, unspecified | 119 |
| Phobic anxiety disorder of childhood | < 5 |
| Predominantly obsessional thoughts or ruminations | < 5 |
| Problem related to social environment, unspecified | < 5 |
| Problems relating alleged child sex abuse | < 5 |
| Tic disorder, unspecified | 8 |
| Unspecified behaviour emotion disorder | < 5 |

| | |
|---|---|
| Unspecified disorder of psychological development | 14 |
| Unspecified organic or symptomatic mental disorder | < 5 |
| Not specified (blank) | 775 |
| **Accepted Total** | **1,366** |
| **Pending Total** | **46** |
| **Rejected** | **749** |
| **Total of all Referrals received** | **2,161** |

(Source: Tameside and Glossop CAMHS, Pennine Care NHS Foundation Trust, 2015)

5.27 The table below (table 13) provides a breakdown of the referral source. It shows that the majority (58%) of the referrals to Tameside and Glossop CAMHS are from GPs, which would be expected in relation to the access pathway at this time.

*Table13: Tameside and Glossop CAMHS Referral Source – 1st April 2014 to 31st March 2015*

| Referral Source | Total |
|---|---|
| Accident and Emergency | 7% |
| Consultant | 8% |
| Education Establishment | 18% |
| Emergency Services | 0% |
| GP | 58% |
| Internal (from across the NHS Trust) | 1% |
| Judicial Establishment | 0% |
| Local Authority | 3% |
| Non-medical individual | 0% |
| Nursing | 3% |
| Other | 39% |
| Other Medical Practice | 0% |
| Health Worker | 2% |
| Grand Total | 100% |

(Source: Tameside and Glossop CAMHS, Pennine Care NHS Foundation Trust, 2015)

As of the 30th of June 2015 the average waiting list for unseen clients in weeks was 16.3, or 113 days (Pennine Care NHS Foundation Trust, 2015). This is within the national target to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral.

**Benchmarking CAMHS Activity data**

5.28 In reviewing Tameside and Glossop CAMHS activity we are able to draw comparisons with four other Greater Manchester CCGs (Bury, Oldham, Stockport and Heywood Middleton and Rochdale), which all commission CAMH services from Pennine Care NHS Foundation Trust.

5.29 Regionally within this cluster of localities, Tameside and Glossop CAMHS holds the highest proportion of assessments that lead to treatment (retention rates), with 91% of all assessments leading to children and young people coming back

for a second appointment and commencing treatment. This is higher than the national expectation. The mean average for the five localities is 74% and the lowest is proportion being 39%. In addition Tameside and Glossop CAMHS has the has the highest proportion of contacts recorded.

*Table 14: Number of contacts recorded by CAMHS services across five Pennine Care locality services, 2014/15*

| Locality | Contacts |
|---|---|
| Tameside & Glossop | 17,932 |
| HMR | 14,144 |
| Stockport | 13,009 |
| Oldham | 11,450 |
| Bury | 7,739 |

(Source: Pennine Care NHS Foundation Trust, 2015

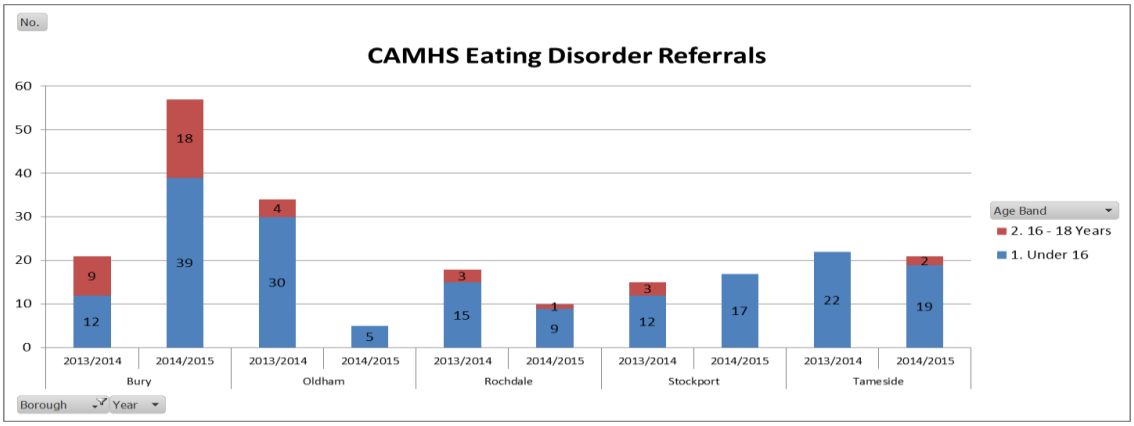
5.30 In summary, benchmarking our activity with the regional cluster of Bury, Oldham, Stockport and Heywood Middleton and Rochdale (HMR) CCGs we able to extrapolate:

- Our locality holds the second highest (after Bury) for number of referrals to a CAMHS services.
- Our locality CAMHS service holds the highest percentage of referrals that are rejected – not authorised for assessment.
- Our locality CAMHS service holds the shortest average waiting time in performance for routine referrals.
- Our locality CAMHS service holds the highest proportion of assessments that lead to treatment (retention rates), with 91% of all assessments leading to treatment (second appointment).
- Our locality CAMHS service has the highest proportion of contacts recorded - *see table 14.*

**In Patient activity for Eating Disorders**

5.31 The table below highlights that within the regional cluster Tameside and Glossop has the second highest referrals rate for Pennine Care inpatient eating disorders. In 2014/15, Pennine Care Hope and Horizon units received 21 referrals, for 18's years of age and under, from the Tameside and Glossop locality.18 (85.7%) of these were accepted (authorised). The number of bed days, based on OBD reports for the Hope and Horizon Unit, shows that Tameside and Glossop required 1,907 days in 2014/15. This is increase on the 1,800 bed days required in 2013/14. Currently in 2015/16 to date (September 2015) Tameside and Glossop has the highest number of beds days (n=1,015) from across the five localities.

*Table 15: Number of Eating Disorder referrals for Pennine Care NHS Foundation Trust services by age and borough for the periods 2013/14 and 2014/15*




(Source: Pennine Care NHS Foundation Trust, 2015)

## Transition 16-18 Activity Data

5.32 The following Table provides a summary of the activity of 16-18 years olds that are excluded in the CAMHS activity and that sit within Pennine Care Adult Adults Mental Health (AMH) Services.

*Table 16: Under 18 year of Age activity undertaken with Adult Mental Health services, for the period 01/04/2015 - 31/08/2015*

| Description | Number of Under 18s | All AMH Activity | <18 as % of all AMH Activity |
|---|---|---|---|
| Referrals accepted - All Access (inc RAID ) | 129 | 3548 | 3.6% |
| Referral Tameside Health Minds (IAPT) | 478 | 3366 | 14.2% |
| Total | 607 | 6914 | 8.78% |
| | | | |
| Attended Activity ( appointments /contacts) | 3947 | 36874 | 10.7% |
| Open Caseloads* (T&G Registered Patients) | 700 | 4326 | 16.2% |

* Open Caseload taken as snap shot on 31/08/2015

(Source: Pennine Care NHS Foundation Trust, 2015)

## Tameside and Glossop Key Findings

5.33 Listed below is a summary of the key findings related to the Tameside and Glossop area:

- Almost a quarter of our population is under 19 years of age
- 18.6% of school children are from a minority ethnic group.
- Tameside secondary schools exclusions (fixed period and permanent) rate in 2012/13 was higher than the England average and the highest in the North West*
- The health and wellbeing of children in Tameside and Glossop is generally worse than the England average.
- The level of child poverty is worse than the England average with 22.7% of children aged under 16 living in poverty.
- The number of Tameside and Glossop children in a looked after care setting is higher than the England average.

- 51% of all Tameside YOT cases during 2014-15 (financial year), the assessments evidenced the need for emotional and mental health intervention, of which 39% could need a clinical intervention.
- The admission rate for self-harm among 10 to 24 years in the last three years is higher than the England average; 79% of those admitted for self-harm were female.
- An estimated 12,375 children and young people could need an intervention applying the CAMHS Tiered Model of Care, of which 1,035 would require specialist input
- 41,785 5-19 years olds would benefit from awareness and prevention programmes in over 100 schools across Tameside and Glossop
- Referrals to our CAMHS service are higher than estimated expected demand, with 62% of all referrals in 2014-15 accepted.
- The average waiting list for unseen clients is 113 days from referral to assessment as of 30.06.2015
- Tameside and Glossop has a higher than expect demand for inpatient eating disorder services
- Within our Adult Mental Health provision just under 9% of accepted referrals are for under 18's, whilst under 18's makes up 16.2% of the open case load (as 31.08.2015)

(Additional Source: Public Health England, Child Health Profile June 2015, * Department for Education)

# Section 6: Harness the Power of Information

6.1 In this section the plans to develop and monitor the performance of the Transformation Plan across the life of the five year strategy is summarised. Through this work we seek to support and sustain a culture of continuous evidence-based service improvement, promote transparency and accountability across the whole system and ensure collaborative decision making.

**Introduction**

6.2 Robust service planning is based on good information and requires access to data that demonstrates outputs and outcomes. Locally there are significant gaps in information and data that we seek to address. This gap is reflected nationally not just here in Tameside and Glossop. The document 'Future in Mind' highlights that in order to drive improvements in the delivery of care, and standard of performance to ensure we have a better understanding of how to get the best outcomes for children, young people and their families and value from our investment we need to harness the power of information (Future in Mind 2015).

6.3 We consider the following areas that we need to address to achieve transformation and deliver our local vision and that set out in the Future in Minds:

- Transparency, Accountability and Governance
- The Voice of the Child
- Data Sets and Key Performance Indicators (KPIs)
- Clear Outcomes and the use of Routine Outcome Measures
- CAMHS Commissioner Modelling Tool

Through the triangulation in applying and combining multiple observers, methods (both quantitative and qualitative) we aim to overcome the gaps in our information and weakness that come from single method approaches.

**Transparency, Accountability and Governance**

6.4 As outlined in Section 2, Tameside and Glossop CCG have formed a Children and Young Peoples Emotional Well Being and Mental Health Programme Board. The Programme Board is accountable for the delivery of the Transformation Plan and continued development of working relationships between health and social care commissioners and provider organisations. The Programme Board is a partnership that takes whole system ownership of the priorities, challenge performance and manage risk to deliver a whole system approach and accountability on behalf of the population of Tameside and Glossop. Each member organisation has a responsibility to report back through its own governance structures and collectively to the Health and Wellbeing Boards (Tameside and Derbyshire). See Appendix 1 for the Terms of reference.

6.5 The Programme Board was initially set up with a fixed term remit, until the 31st of March 2016, to develop and produce this plan. However the Programme Board came into operation before the publication of the Future In Mind document. Since then an agreement by the board is to continue until 2020 to:

- Ensure constant stakeholder engagement throughout the plan's life span
- Ensure stakeholders are committed and enabled to take the work forward
- Ensure all stakeholders having the ability to challenge, input and embrace new models of thinking and service delivery
- Ensure continued robust structures for programme governance
- Ensure multi agency and collective monitoring and evaluation of the Transformation Plan

6.6 The assurance process requires the Transformation Plan to be signed off by the Health and Wellbeing Board. All Local Transformation Plans are then assured by NHS England, led by the regional Director of Commissioning and Operations (DCO's). It is the intension beyond 2015-2016 to integrate assurance within the mainstream planning framework that requires the CCG to work closely with our Health and Wellbeing Boards, NHS England and other key agencies including the third sector and education to refresh the plan and monitor improvements, making an annual declaration.

6.7 The Transformation Plan ensures transparency about service provision and the levels of investment, our base line information and stretched target - outlined under KPIs. The Transformation Plan and subsequent annual action plans and annual declarations will be published on the CCG and our partners' websites and making sure it is accessible to all. We are committed to improving all aspects of transparency in connection with the plan. As part of this commitment in order to ensure our investment has the most impact, on improving experiences and delivering the outcomes for children, young people and those who care for them, we have embarked upon unpicking the mental health block contract that potentially limits our understanding and future system modelling. This is a substantial piece of work and undertaking, which NHS Mental Health Providers across the country are working to resolve.

6.8 Tameside and Glossop CCG invests £22.4million through a block contract with Pennine Care NHS Foundation Trust to provide Mental Health services for the population of Tameside and Glossop. The Trust has been unable to provide a detailed breakdown of the costs and therefore only divisional level information is available, i.e. the operational budget for services across Tameside, Stockport, Bury, Oldham and Rochdale, plus additional cross boundary elements. This provides a fundamental challenge to our intention to achieve transparency within this Plan.

**The Voice of the Child**

6.9 At the heart of our vision is to ensure the voice of children and young people is heard and acted upon, shaping the design and delivery of services and ultimately this Transformation Plan. Children and young people are experts in their own lives and when they are equipped and supported to influence commissioning, delivery and monitoring of the services they and their peers use, those services improve and in turn they develop and build skills and confidence. In 2016, we will build on our young people's voice and influence, working to establishing a service user fora for children and young people who are receiving or have been in receipt of interventions. The service user fora will

have a direct voice into our programme board to ensure decisions around design and delivery are shaped by those best placed to know what works and that our impact and effectiveness is also scrutinised by service users. In this way, we will continually learn and improve what we do as a result of the genuine involvement of our service users' experiences.

**Data Sets and Key Performance Indicators (KPIs)**

6.10 We support the introduction of the new Mental Health Services Data Set (MHSDS). This new data set requires our CAMHS commissioned service to measure referral to treatment pathway activity and outcomes for the assessment and treatment of children and young people. Providers are mandated to begin collecting the relevant data no later than 1 January 2016 as such our commissioned service is putting in place plans for the collection of the MHSDS. In addition to the national data set, for our NHS CAMHS commissioned service, we seeking to ensure a local data is implemented by April 2016 that can be applied to a system wide approach and the collaborating services. The application of minimum data set, will support the evaluation of the effectiveness of our services and the Transformation Plan as whole.

***Key performance indictor's for CAMHS 2015-16***

6.11 The following targets have been established and supported through the application of a CQUIN in 2015-16. The targets seek the improvement on access and reduction on the waiting times:

- Total number of referrals received
- Total number and percentage if referrals accepted
- Fewer rejected (inappropriate) referrals (% decrease on baseline);
- First contact (consultation, triage or assessment) within 12 weeks of referral;
- 98% of accept referrals treatment is commenced in 18 weeks of referral.

**Clear Outcomes and the use of Routine Outcome Measures**

6.12 Services need to be outcomes focused as such a core set of outcomes are being defined that will be embedded in contractual Service Specifications going forward for 1st April 2016. It is our intention to develop a robust set of metrics covering access, waiting times and outcomes (covering patient experience and treatment concordant and effectiveness) that enables benchmarking of local services at regional (Greater Manchester) and national level.

6.13 The National Institute for Health and Care Excellence (NICE) documents a wide range of well-evidenced interventions that can be used to treat children and young people with mental health disorders effectively. We will ensure that all providers commissioned across Tameside and Glossop are NICE concordant, adhering to the latest evidence based practices.

6.14 In addition we will ensure as local commissioners and providers we are meeting NHS England Access and Waiting time Standards in Mental Health including the recently published Eating Disorders guidance and Early Intervention in Psychosis.

6.15 As we embark on a five year journey our new approach in collectively monitoring evaluating the effectiveness of plan will be refined over this period, year on year. As such we will strive to seek data quality, compliance and completeness improvement year on year. This desire will be reflected by commissioners placing into contracts the clear requirements for data and information. As part of this work, Tameside and Glossop is accessing support to develop a linked local area data set to monitor the implementation of Transformation Plan over the next 5 years.

6.16 Building on their existing funded work, the CAMHS Evidenced Based Practice Unit (EBPU) with input from Child Outcome Research Consortium (CORC), part of the Anna Fraud Centre, are working with us offering support to:

- Selecting the best outcome measures and indicators across education, health and social care to use with your particular populations and ensuring local consensus and ownership
- Determining best options for linking data across agencies and organisations to ensure comprehensive monitoring of the progress of your Local Transformation Plan and service user outcomes
- Feedback of cross agency and organisational trends in outcomes and performance to commissioners, providers and users of services, facilitating the review and refinement of your plan over time

6.17 Work has already begun on establishing and enabling the application of routine outcome measures across the system. Working with CORC and our partners we have agreed the use of the following outcome measures:

- Child Outcome Rating Scales (CORS) for 6 to 12 year olds and Outcome Rating Scales (ORS) for 13 plus years
- Child Session Rating Scales (CSRS) for 6 to 12 year olds and Session Rating Scales (SRS) for 13 plus years
- Goal Based Outcomes (GBOS)

***ORS and CORS***

6.18 The Outcome Rating Scales is a session by session measure designed to assess areas of life function known to change as result of intervention. ORS assess four domains of young person functioning that are widely considered to be valid indicators of successful outcomes (Lambert et al. 1996).

- Personal or symptom distress (measuring individual Wellbeing)
- Interpersonal Wellbeing (measuring how well the young person is getting along in relationships)
- Social role (measuring satisfaction with work/school and relationships outside of the home
- Overall wellbeing

***SRS and CSRS***

6.19 The application of these routine outcome measures enables the 'service user' to rate their experience of the session within an intervention. The ORS and SRS give children, young people and those who care for them a voice in treatment as it allows immediate feedback on what is working and what is not. The application of these routine outcome measures improves retention and

outcome, whilst decreasing deterioration, length of stay and costs (Law, D. et al, 2014).

***GBOS***

6.20 Goals based outcomes are a way to evaluate progress towards a goal. They simply measure how far a young person feels they have moved towards reaching a goal they set at the binging of intervention. The setting of the goals should be collaborative and reflect the wishes of the young person (Law, D. et al, 2014). They help determine the aim of the intervention from the start.

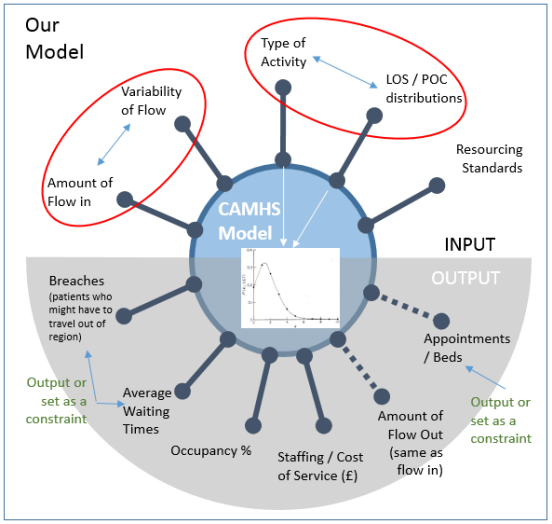
**CAMHS Commissioner Modelling Tool**

6.21 In October 2014 NHS England commissioned Central Southern Commissioning Support Unit in partnership with HCD Economics and Oxford Health Foundation Trust to develop a modelling tool to support the delivery of improved mental health services for children and young people. Tameside and Glossop CCG with its partners are piloting the use and application of the CAMHS Commissioner Modelling Tool (Version 1.0 Beta Release)

6.22 The tool is designed to be a practical planning tool for Commissioners of CAMHS services. The tool has multiple aims, but in brief summary it:

- Helps the commissioner meet the needs of its population by providing data on historic activity, and augmenting this with local prevalence information.
- Helps to record future commissioning intentions
- Creates an auditable record of intentions and scenarios for making changes to where that activity might take place. For example considering scenarios like more crises outreach to substitute for Inpatient Care.
- It helps with estimating cost of services and allows you to compare scenarios.
- Allows the Commissioner to model and optimise their future service.
- Supports commissioners to help plan and invest in services that will improve the transition between children's mental health services and other services for young adults including adult mental health services.

*Figure 1: Schematic showing the information the tool makes explicit***.**



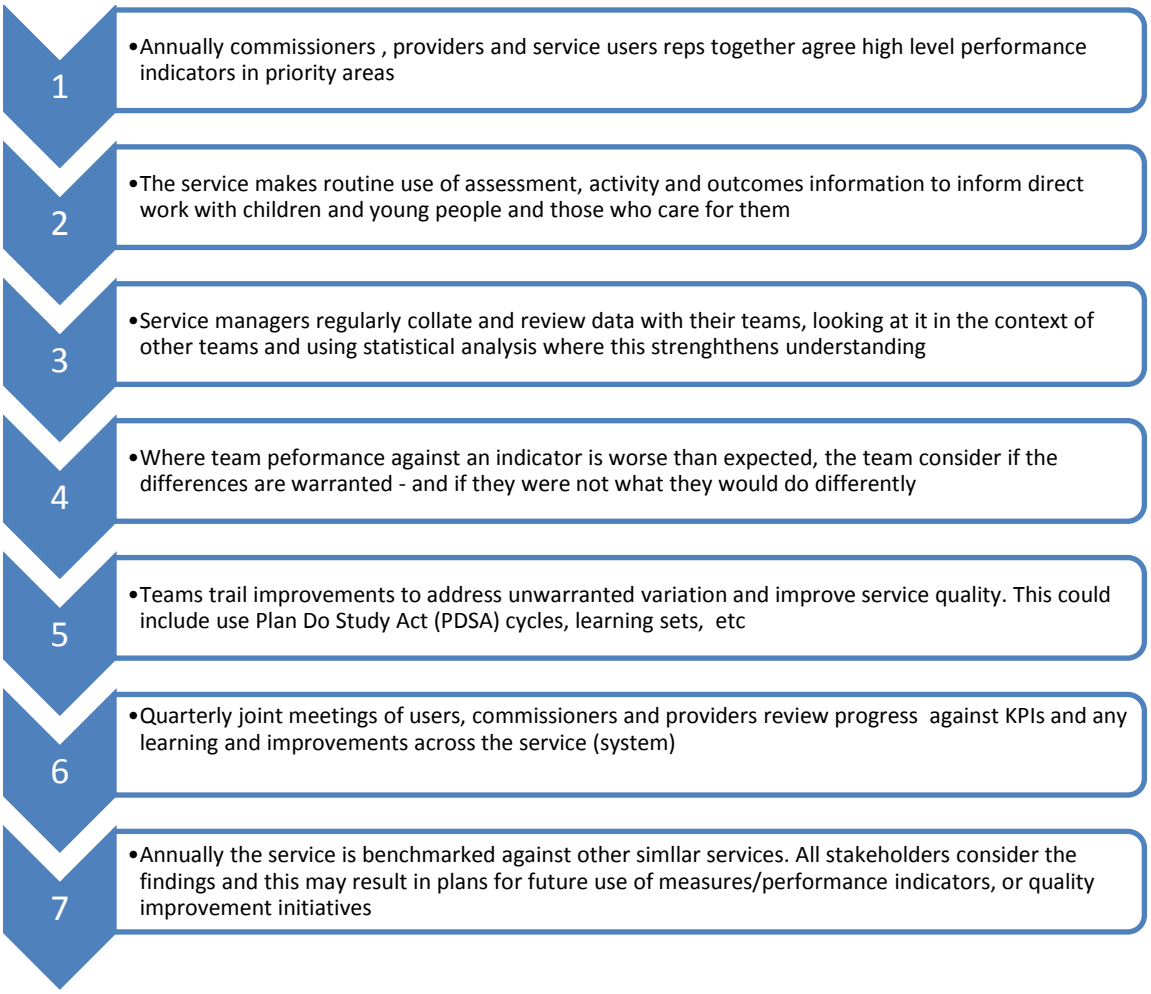

(Source: CAMHS Commissioner Modelling Tool Business Guide, Central Southern Commissioning Support Unit, HCD Economics and Oxford Health Foundation Trust, July 2015)

**7 Steps to MINDFUL Performance Management**

6.23 In combining multiple observers we ensure transparency and the ability draw on the strengths of each of our partners – stakeholders - so that we are best placed to deliver our vision and ambition. Working with CORC ensure the ability to benchmark our findings regionally and nationally and thus avoid seeing interpreting our findings in isolation. Services and teams will hold an emphasis on continual learning supported by the application of routine outcome measures. Embedding service users within our performance management approach ensures that we continually hold their views and experiences centrally.

6.24 Acting on this approach and recognising that this is a five year programme of change, which applies a phased approach in transforming system wide delivery, it is vital that learning collaborations are embedded from the start. As such within our performance management approach we seek to ensure making better use of information by applying and adapting the CORC 7 Steps to MINDFUL use of PROMS for performance management. This framework provides a useful model to ensure transparency, joint ownership and accountability. Going forward the following performance framework will be embedded at the heart our governance and contractual service specifications.

*Figure 2: 7 Steps to MINDFUL Performance Management*




(Source: Adapted from CORC, 2015 & steps to MINDFUL use of PROMs for performance management)

# Section 7: Our Plan with the Future in Mind

7.1 This final section of the transformation plan outlines and summaries our priorities in taking forward and delivering our vision and ambition. In addition it outlines the proposal for the new Emotional Wellbeing and CAMHS funding.

7.2 We have already started to take forward our vision and aim for children, young people and those who care for them in Tameside and Glossop. Our initial phase, in this first period 2015 to 2016, sees our focus and attention on access and partnerships and developing learning collaborations (developing robust information and monitoring and performance systems). We have embarked upon linking services so that care pathways can be joined up, simplified and to seek the removal of artificial barriers and duplication. We are developing creative and initiative ways to ensure that the voice of the child is held at the heart of our transformation.

**Community Eating Disorders Service**

7.3 Tameside and Glossop CCG is working with 5 others CCGs (Trafford, Stockport, Oldham, Bury and Heywood, Middleton and Rochdale) and Pennine Care NHS Foundation in a partnership to develop and deliver a community based eating disorder service that meets the requirements established by NHS England (July 2015), 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder'. *See Appendix 3 for full details on PCFT Eating Disorders Business case*

7.4 In summary the proposal is to provide a comprehensive locally based service to young people, who are resident in the identified Boroughs and who have an eating disorder. The pathway will be delivered through the development of a dedicated Community Eating Disorder Service (CEDS) staffed by a range of multi-disciplinary professionals. The national guidance states that there should be a dedicated team per 500,000 of the general population. Across the localities covered there is a population of 1.3 million and this would require the development of a minimum of two teams. It has been agreed in partnership with other CCG commissioners and the provider that two teams will be developed as follows:

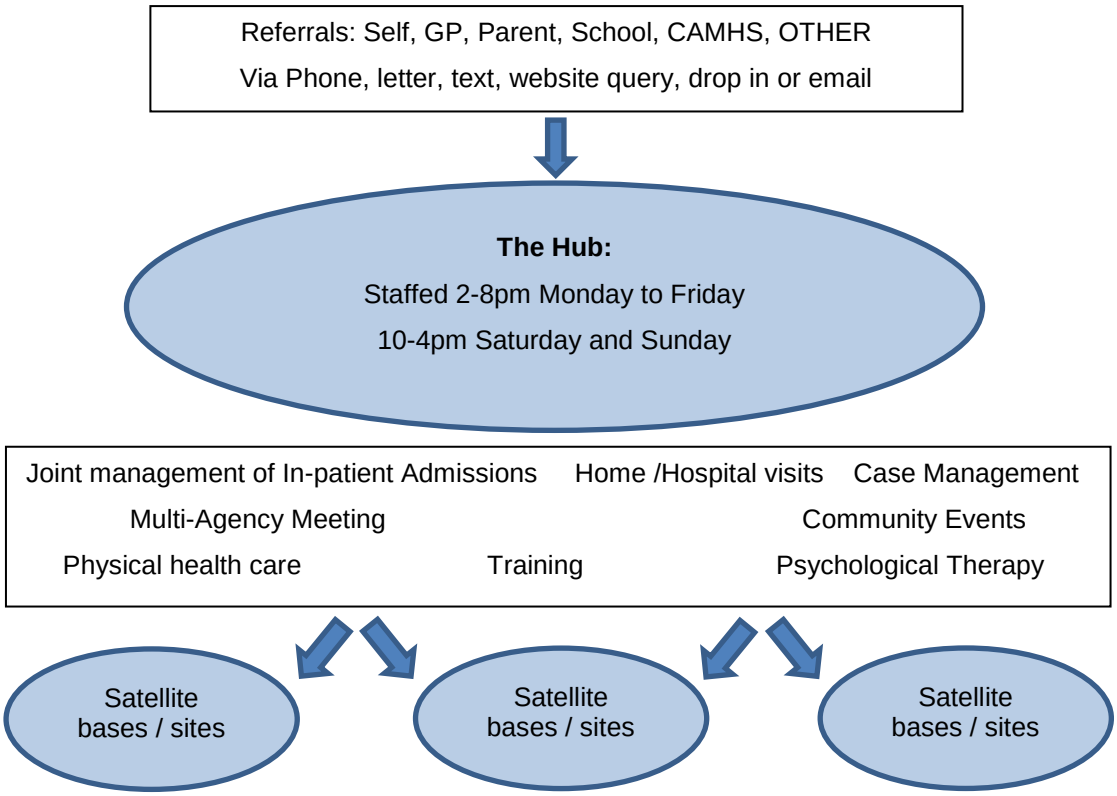
- South Hub –Tameside and Glossop, Trafford, and Stockport
- North Hub – Bury, Heywood, Middleton and Rochdale (HMR), Oldham.

The teams will mirror each other in terms of skill mix and pathway but the development of two separate teams allows for the evolution of local identity over time as the team becomes embedded.

7.5 The service will be structured on a hub and spoke model due to the large geographical area covered and the relatively small size of the teams. The following has been agreed in principle. The South Hub will be based in Stockport with satellite bases in Trafford and Tameside and Glossop. The North Hub will be based in Oldham with satellite bases in HMR and Bury.

7.6 We envisage The Hub as a vibrant, child oriented, community facility, located centrally. The Hub will be staffed 7 days a week and will be the main base offering drop ins, groups, assessments and treatments. Our ambition is for it to be a thriving community resource including a library of self-help resources, a café and a centre for training events, groups and meetings/talks. Staff at the hub will be able to offer same day responses to screen referrals and will be able to travel to carry out emergency visits where needed. Routine and specialist services will be available including family based approaches. There will also be a number of smaller satellite bases/sites that can offer assessments and treatments, located conveniently in separate geographical locations

*Figure 3: Visual representation of the Hub Model*




7.7 The expected outcomes for this service are:

- A more equitable and standardised level of provision for children, young people and their families
- More timely access to evidence based community treatment
- Fewer transfers to adult services
- Earlier step down and discharge from inpatient settings
- Reduced use of both medical and mental health inpatient.
- Reduction in crisis presentations and re referrals to specialist services
- Increased awareness and skill within the community including families/carers and peers
- Extend the Early Help offer to include lower level eating disorders
- Release capacity within generic CAMHS to enable shorter access times into the service

**Our Priorities 2015-2017**

| Period | Key Priority | Thematic Domain |
|---|---|---|
| June 2015 to March 2016 | **Getting Help** – we will ensure children, young people and those who care for them can access help when and where they need it through a single point of access that covers the whole system and not just specialist CAMHS; providing a clear understandable service offer (what support should be received). We aim to: -<br>• Review access pathways for specialist CAMHS, benchmarked with other similar partnership area service(s).<br>• Undertake referral mapping and audit to identify low and high referral sources; Identify key sources of redirected referrals and focus of redirection (which services are families signposted to); Re-referral rates.<br>• Identify the hard to reach young people and families by locality and collect baseline information on access to specialist CAMHS and benchmark findings<br>• Develop and produce access pathways and a clear, '*understandable'* CAMHS 'local offer' for meeting emotional wellbeing and mental health needs, which includes self-referral<br>• Develop and plan, in partnership, interventions (training needs analysis and programme, supervision, link practitioners) to encourage self-referral and improve referral quality and appropriateness (address low and high referral sources/routes).<br>• Ensure that the most experienced professionals with expert knowledge of children and young people's mental health are accessible from the start' across the system; particularly placing them where children and young people are most vulnerable (LAC, Youth Offending), so that there are no gaps through which they can fall<br>• Work with NHE England and the Department for Education to pilot and test the named lead approach and the training programme with schools.<br>• We will ensure that all GPs have a named CAMHS Consultant to improve communication and access between primary care and CAMHS<br>• Implement Single Point of Access (SPA) within the integrated Public Service Reform Hub to improve access for children, young people and those who care for them<br>• Place the third sector within the management of the NHS CAMHS service to enable a joined up offer between statutory and voluntary services; offer mediation within referral appeals<br>• Implement local waiting time targets that seek the improvement in access specialist CAMHS services support and treatment<br>• Agree our parenting programme offer, ensuring that we have consistent access to high quality evidence based parenting programmes, delivered to model fidelity | A, C, D, E, F |
| September 2015 to | **Community Eating Disorders Pathway** – we will work with our identified CCG partners and Pennine Care NHS Foundation Trust to develop and deliver a community based eating disorder service that meets | A, B, C, D, E |

| | | |
|---|---|---|
| March 2017 | the requirements established by NHS England (July 2015), 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder'. We aim to: -<br>• Ensure the service model is developed in partnership with key stakeholders, placing the voice of the child and those who care for them at the heart; utilising national guidance, local clinical expertise, performance data and service user feedback<br>• Review the range of services available for young people with eating disorders, including inpatient treatment, support from the In reach/Outreach team (IROR) and community CAMHS intervention ensuring that the new service provision builds on and takes into account existing provision and expertise<br>• Explore the true need in providing support to young people across a full pathway form emerging, lower levels to moderate and severe, ensuring support is readily available for all levels of need<br>• Scope and ensure that Paediatric and Dietician services are seamless delivered within an integrated Eating Disorders Pathway<br>• Ensure the reduction of inequalities in access and outcomes; service design and communications should be appropriate and accessible to diverse communities. Scope building services in more visible, more central and more accessible sites may assist in addressing socio-economic or cultural barriers to access.<br>• Review and consider the findings from the Surveillance Review December 2013 of the 2004 NICE Eating Disorders Guidance with emerging evidence that day patient care is equally effective as in-patient care but associated with lower cost<br>• Ensure CYP accessing the service are offered a generic mental health assessment to identify/exclude any co-morbid needs, a specialised eating disorder assessment, a baseline physical health screening and an individualised care plan.<br>• Ensure the service can offer a range of therapeutic interventions, which are evidence based and underpinned by a multidisciplinary team (MDT) ethos and approach. The MDT will work in close collaboration with the virtual team members that they regularly interface with such as Acute Trust Paediatric and Medical services, and with Primary Care, to ensure young people's co-existing physical health needs are met. | |
| October 2015 to October 2016 | **Transition to Adulthood** – we will continue to explore all avenues to smooth the transition from children's to adult services by taking a developmental, personalised approach rather than being dictated by chronological birthdates. We aim to:-<br>• Establish an all age Eating Disorder Service, enabling young people to stay on within the same service until they are ready to be discharged. | A, B, C, D, E |

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| | • Establish an all age ADHD service to support CAMHS graduates and families as well as adults.<br>• Review mental health provision for young people aged 16 and 17 and engage young people in the design of options for consideration<br>• Strengthen the integrated pathways between CAMHS and AMHS, using the learning from the transformation plan to better support the service transition in particular for vulnerable groups including CSE, Looked after young people and young people who self-harm.<br>• Explore evidence base and options for vulnerable young people to continue within the CAMH service until they are ready to leave.<br>• Develop a CQUIN that builds upon and improves transition arrangements between CAMHS and Adult Mental Health. | |
| September 2015 to December 2016 | **Parental Mental Health** – we will continue our focus on Parent Infant Mental Health and expand this to include parents of children of all ages. We aim to:-<br>• Undertake a whole system audit of practice based on the NICE Guidance on Ante and Postnatal Mental Health and check our findings against gathered experiences of care in the perinatal period from parents.<br>• Refresh our Integrated Parent Infant Mental Health Pathway in line with recent developments including NICE Guidance on Ante and Postnatal Mental Health. Review training programme and amend as required.<br>• Establish a pathway for families with high needs, such as those within the child protection system and parents with learning needs, from early pregnancy to school. To support this we will extend the capacity of our Early Attachment Service to deliver intensive evidence based parenting programmes such as Mellow Parenting to prospective mothers and their partners and to extend provision for dads.<br>• When published, work with partners across GM to agree a sector solution to the expectations of the NHS England Perinatal Mental Health Standards to ensure women have access to specialist perinatal services when they are required, including access to Mother and Baby Units/community based alternatives as an option for all expectant mothers or those in the first year after birth.<br>• Build on last year's Parental Mental Health CQUIN, CCG Carers review, evidence base on outcomes for children where parents have mental health needs and agree whole system requirements to promote good outcomes for children. | A, B, C, D, E, F |
| October 2015 to May 2016 | **Neurodevelopmental Umbrella Pathway** – we will work with all partners across the health and economy and children's social care and education to deliver an umbrella pathway for children and young people where there are queries or concerns about difficulties in the following areas: Attention, concentration, | A, B, C, D, E |

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| | impulsivity and hyperactivity (ADHD and ASD). In addition we will strive to widen the pathway within a phased approach to also cover: Learning, thinking behaviours; Tics and other motor mannerisms; and other difficulties such as sensory processing. We aim to:-<br>• Work with CYP and those who care for them to improve assessment, diagnosis, management, on-going support and outcome plans for all children and young people, whether a specific diagnosis is reached or not<br>• Establish multi agency partnership and steering group to review, develop and implement a pilot Neurodevelopmental Umbrella Pathway, continuing to work in partnership with the ADHD Foundation<br>• Deliver the GM and Lancashire Strategic Clinical Network ADHD standards<br>• Ensure timely access to NICE concordant care through the delivery of Neurodevelopmental Umbrella Pathway - drawing on, but not limited to, Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults; and Autism: The management and support of children and young people on the autism spectrum<br>• Ensure clear ownership and accountability for the pathway<br>• Review and monitor the effectiveness and impact on resources and ensure provision is sustainable | |
| August 2015 to June 2016 | **Develop the Workforce** – we develop training programmes that lead to an appropriately skilled workforce across the whole system that seek to ensure a 'no wrong door' approach and promotes early invention and timely access. We aim to:-<br>• Implement workforce audits that leads to the development of training pathway and programme that cuts across the whole workforce; including volunteers, support staff and receptionists<br>• Establish multi agency partnership and steering group to review, develop and implement a training programme that can be accessed by all agencies and organisations across Tameside and Glossop that are working with children, young people and those who care for them. This will include training and development on adult mental health to enable children's services staff to support parents into adult mental health provision if required<br>• Promote access to e-learning and tuition lead courses to all CYP workforces, including volunteers, across Tameside and Glossop; minimising the barriers to access<br>• Develop and implement Self-Harm and Suicide Strategy, guidance for all practitioners across setting supported by training and supervision (action learning model)<br>• Maintain and roll out CYP IAPT from our NHS CAMHS service to all partners, including the third sector and education.<br>• Develop and implement training programme for parents and carers | B,C D, F |

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| September 2015 to April 2016 | **Coping** – we will ensure access to a range of information and develop the infrastructure that enable those children, young people and those who care for them the choice over their care that enables self-directed care and management. We aim to:-<br>• Develop and support infrastructure that enables self-directed care and management (e-platforms and apps), one off contact (online or face to face) and peer mentoring<br>• Develop choice and control for children, young people and those who care for them through: promotion of the local offer; Personal Health Budgets (PHB); establish and maintain Service User Fora<br>• Ensure promotion of mental health and emotional wellbeing through tackling stigma campaigns, workshops and local events (e.g. World Mental Health Day) | A, B, C |
| September 2015 to June 2016 | **Getting Risk Support** – we will continue to develop preventative and proactive as well as intervention services for children and young people who are vulnerable such as those who are looked after, in the criminal justice system, those with a mental Health crisis and those requiring in-patient care. We aim to:-<br>• Review interface between CAMHS community based and inpatient services (including secure)<br>• Build effective risk management and early intervention for children and young people at risk of a crisis<br>• Refresh our Crisis Care Concordat to ensure that children and young people are appropriately reflected.<br>• Review crisis care for children and young people within our evaluation of RAID services at Tameside General Hospital in line with NHS England Psychiatric Liaison Standards.<br>• Review CAMHS In-reach Outreach Service in conjunction with the development of the home treatment aspect of the Community Eating Disorder service and develop urgent/crisis care home treatment model, ensuring cross organisational support and integrated delivery.<br>• Scope opportunities in conjunction with the LA to develop Edge of Care services in localities to prevent family breakdown and reduce the use of unplanned care episodes<br>• Work with colleagues in GM to develop a local approach to commissioning CAMHS Inpatient care and alternatives to in-patient care in line with GM Devolution.<br>• Ensure, with the Local Safeguarding Children's Boards (LSCBs), that findings from Serious Case Reviews (SCRs) in relation to emotional well and mental health are implemented | A, B, C, D, E |
| September 2015 to March 2017 | **Joint Commissioning** – in line with our Care Together plans we will integrate the commissioning of emotional and mental health services and ensure a Mindful approach to commissioning that ensures services meet the emotional wellbeing and mental health needs of children, young people and those who care for them. We aim to:-<br>• Maintain our commitment to systematically ensuring the voice of the child is heard and acted upon | A, B, C, D, E, F |

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| | within commissioning arrangements<br>• Build on our engagement with children and young people by developing and maintaining Service User Fora to provide a direct voice into our Programme Board and future commissioning intentions; ensuring decisions around design and delivery are shaped by those best placed to know what works and help monitor effectiveness<br>• Place the Voice of Child statements within all service specifications commissioned to deliver emotional wellbeing and mental health service for CYP and those who care for them<br>• Ensure all service specifications (including physical health) highlight emotional wellbeing and mental health requirements of the provider.<br>• Expand the remit and terms of the current Children, Young People's emotional Wellbeing and Mental Health Transformation Programme Board until 2020.<br>• Pilot CAMHS Modelling Tool to support the of improved mental health services for children and young people beyond 2016/17<br>• Ensure outcome based commissioning is developed and that Routine Outcomes Measure (ROMS) are stipulated within service specifications<br>• Establish New service specification for Community CAMHS 2016/17 based on Local Transformation Plan principles and Thrive Model for CAMHS; placing the voice of child 'I' statements at the heart service specifications<br>• Develop and Maintain Pennine Care CAMHS Commissioning and Provider interface, with those CCGs who commission Pennine Care NHS Foundation Trust as their CAMHS provider (Tameside and Glossop, Oldham, Trafford, Stockport, Bury and Haywood, Middleton and Rochdale)<br>• Work with all partners within our work to create an Integrated Care Organisation that supports a single point of access to all children and young people's provision (including Mental Health). This will ensure smooth pathways into a range of support with a significant reduction in 'asks for help' being rejected and/or referred on. We will ensure direct access to help for children, young people and those who care for them. | |

Thematic Domain Key:

A. The voice of the child - reforming care delivery based on the needs of young people, children and those who care for them;
B. Developing resilience, prevention, early intervention and promoting good mental health and wellbeing;
C. Improving access to appropriate services that are as close to home as possible and at the right time that are implementing evidence based pathways;
D. Promoting working across agencies leading to a clear joined up approach for the benefit of children and young people in Tameside and Glossop;
E. Improved accountability, transparency and ownership of an integrated whole system; and
F. Development of training programmes that lead to an appropriately skilled workforce across the whole system.

## Finance Plan

7.8 The following Finance Plan shows the new funds allocated to Tameside and Glossop and our commissioning intentions as to its potential use, subject to assurance process for final agreement.

*Figure 1: Tameside and Glossop Commissioning Intentions 2015-17 utilising NHSE CAMHS Transformation investment*

| | Tameside &Glossop CAMHS New Funding | 2015/16 | | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|---|---|
| | **New CAMHS Income** | | | | | | |
| | Community ED (initial allocation on submission of plan - October 2015 | 145,589 | | | | | |
| | Following assurance (Nov/Dec time) | 364,423 | | | | | |
| | All | 510,012 | | 510,012 | 510,012 | 510,012 | 510,012 |
| | **Potential Expenditure** | **Forecast Outturn 2015-16** | Notes | ***2016-17 Plan*** | | | |
| | **Core Programmes:** | | | | | | |
| | Community Eating Disorders | 145,589 | 1 | *147,045* | | | |
| | Parent Infant Mental Health | 10,000 | *2* | *40,000* | | | |
| | Access and Transitions | 8,000 | *3* | *32,000* | | | |
| | Early Help | 0 | *4* | *43,772* | | | |
| | Neurodevelopment Umbrella Clinics | 9,000 | *5* | *36,360* | | | |
| | LAC Psychology | 14,910 | *6* | *60,237* | | | |
| | YOS Forensic & Transition | 0 | *7* | *51,575* | | | |
| | Schools Liaison and Consultation | 12,766 | *8* | *43,772* | | | |
| | Workforce Development (Training Post) | 10,835 | 9 | *43,772* | | | |
| | CYP/Service User Fora | 10,000 | 10 | 3,678 | **All Schemes subject to review and evaluation for continuation to 2020.** | | |
| | LTP Benefits Realisation (Monitoring and Evaluation) | 16,000 | | 7,800 | | | |
| | **Non Recurrent Service Development:** | | | | | | |
| | Neurodevelopment Umbrella Service Development and Coordination | 34,000 | | 0 | | | |
| | Neurodevelopment Umbrella Clinical Development | 45,000 | | 0 | | | |
| | School Health and CAMHS Service Development | 45,000 | 11 | 0 | | | |
| | LAC Emotional Well Being and Mental Health Service Development | 45,000 | | 0 | | | |
| | Challenging Behaviour Service Development | 46,000 | | | | | |
| | **Non Recurrent Programmes:** | | | 0 | | | |
| | Voice of the Child Findings & Development | 20,000 | | 0 | | | |
| | Public Health Campaign Awareness/resources | 15,000 | 12 | | | | |
| | Youth Mental Health First Aid Course (2 trainer the trainers) | 5,476 | | 0 | | | |
| | Training Materials Non Pay Costs | 17,436 | | *0* | | | |
| | **Total** | **510,012** | | **510,012** | | | |
| | **Remaining** | **0** | | **0** | | | |

| | Notes |
|---|---|
| 1 | Planning & Delivery of an Integrated Service |
| 2 | Expansion of Early Attachment Service (EAS) and perinatal Care |
| 3 | *3rd Sector Funding to improve access and transition for children and young people and to coordinate and embed 3rd sector offer within our statutory CAMHS service* |
| 4 | Early Help funded through non-recurrent funding and ends 31.03.2015 |
| 5 | New Umbrella Neurodevelopment Pathway with additional Community Paed Clinics |
| 6 | New dedicated LAC service with Psychology |
| 7 | NHSE divisionary funding end 31.03.2015 establish New dedicated YOS service with MH practitioner based in YOT |
| 8 | New CAMHS School Consultation and Liaison Service |
| 9 | New MH Training Officer post |
| 10 | Support Cist for CYP service user Fora |
| 11 | New service developments cost |
| 12 | Non Recurrent programmes - Public Health Campaigns and Training Programmes |

7.9 The plan is built on sustainability and supports a phased approach in delivering our vision and ambition. As such this first phase of commissioning intentions outlines the potential expenditure to 31st March 2017, building on the existing Emotional Wellbeing and CAMHS 2015-16 Investment outlined in 4.64. The commissioning intensions makes explicit our plans in prompting equality and addressing health inequalities. As such the commission intentions hold a focus

around those children and young people deemed vulnerable to mental health issues.

7.10 Following assurances at a local, regional and national level we will adhere to the performance management framework outlined in section 5 that will review and decide upon subsequent use of monies pass this date. As such the commissioning intentions outlined here as all subject to review and evaluation going forward to 2020.

# APPENDIX

Appendix 1: Emotional Well Being and CAMH Services Programme Board Terms of Reference

ToR Final.doc

Appendix 2: Voice of the child full findings

*a) Report on the Findings from Focus Groups on Emotional Wellbeing and Mental Health Services in Tameside and Glossop August 2015*

Report on the Findings from Focus G

*b) Tell Us Survey- Tameside and Glossop July 2015*

Tell Us Survey Report.docx

Appendix 3: Eating Disorders Business Case Pennine Care NHS Foundation Trust

Eating Disorder Business Case PCFT F

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| **Report to:** | **HEALTH AND WELLBEING BOARD** |
| **Date:** | 12 November 2015 |
| **Executive Member / Reporting Officer:** | Councillor Allison Gwynne, Executive Member (Children and Families)<br>David Niven, Independent Chair, Tameside Safeguarding Children Board |
| **Subject:** | **TAMESIDE SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2014/15** |
| **Report Summary:** | The Tameside Safeguarding Children Board (TSCB) Annual Report provides an overview of the Board's safeguarding activity against its 2014/15 priorities. It identifies particular vulnerable groups and outlines any emerging themes. The report provides details of the strategic priorities for 2015/16. |
| **Recommendations:** | To identify shared agendas and priorities and ensure subsequent actions are joined up. |
| **Links to Health and Wellbeing Strategy:** | The TSCB Strategic Priorities for 2015/16 are to tackle Child Sexual Exploitation, Domestic Abuse, Self-Harm, and Neglect and to improve the Early Help offer. Links between these issues and drug and alcohol abuse and mental health are well documented as are the links between domestic abuse and homelessness. There are also established links between child poverty and potential child maltreatment, particularly neglect and physical abuse.<br>There is lots of scope for joint work between the TSCB and that of the Health and Well Being Board for example in relation to work on the Sexual Health Strategy, Mental Health Services provision and in relation to addressing child poverty. The full extent of those linkages should, in the first instance be mapped out to determine the best way of working together on them. |
| **Policy Implications:** | To be determined subject to mapping exercise if agreed. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | The current annual Council contribution to the TSCB is £0.129 million. This together with partner agency contributions, are provided in **Appendix B** of the report. The residual unspent balance at the end of each financial year is retained within the Council's accounts and carried forward to subsequent financial years to support the TSCB strategic priorities. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | Safeguarding Children requires strong leadership, shared intelligence and appropriate joint commissioning arrangements to be effective. Safeguarding means:<br>*"Protecting children from maltreatment, preventing impairment of children's health or development, ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully." (Working Together to Safeguard Children, 2010)* |

The 'Working Together to Safeguard Children' guidance from 2010 sets out how organisations and individuals should work together to safeguard and promote the welfare of children. The 2011 Munro review of child protection made 15 recommendations for reforming the child protection system, focusing on a system that values professional expertise, clarifying accountabilities and improving learning, sharing responsibility for the provision of early help, developing social work expertise, and supporting effective social work practice. The need for interagency cooperation to improve safeguarding arrangements, early intervention, and improved support is well documented. The ambition is for children in Tameside to be safer through protection from maltreatment, prevention of impairment to health and/or development, ensuring safe and effective care, and ensuring a safe environment.

**Risk Management :** The Tameside Safeguarding Children's 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 Stewart Tod, Business Manager by;

 Telephone:0161 342 4344

 e-mail: stewart.tod@tameside.gov.uk

**TAMESIDE SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2014/15**

**FOREWORD**

**David Niven- Chair of Tameside Safeguarding Children Board**

The fundamental purpose of the Board is to ensure that the children of Tameside are safe and to improve how all agencies and stakeholders work together to achieve that shared goal.

Since I joined the Board in January of this year I've listened to representatives of all agencies and understand their work and their challenges. This is not a task that will ever end as I constantly find new initiatives and changes vital to the safeguarding of our children.

Of course we have the headline areas that sit large in our business plan such as child sexual abuse, domestic violence, early help, mental health, quality assurance etc. but so many more vital pieces of work continue in children's services, health, education, law enforcement and the voluntary sector.

Increasingly there are multiple points of crossover between the Adult Safeguarding Board and the Health and Wellbeing Board. With adult services domestic violence, mental health of parents or carers and substance abuse are strong areas of overlap and, of course, they and childhood accidents, obesity, self-harm and sexual health to name a few are all areas where we liaise closely with colleagues in the Health Service. In Education we work closely with schools on all matters of safety that are both well established such as bullying, and more recent issues such as raising awareness about female genital mutilation. The responsibilities that Law Enforcement has regarding child protection are comprehensive and increasing. The Phoenix Team provides an excellent example of the multi-agency work that has been developed in relation to child sexual exploitation (CSE). This integrated approach focuses on providing a tailor made service for each individual child in order to provide the best possible outcome.

All services face serious challenges with the savings that have had to be made over the last year and with more on the horizon. We can never be complacent. The Board is well aware of the challenges other Boards in the country face where significantly higher numbers of CSE cases are emerging and, with colleagues across Greater Manchester, we are implementing good preventative practice.

This year has seen the publication of two serious case reviews and the messages coming from them will be helpful in improving practice and ensuring the protection of other young people. At the heart of the work of the Board is the desire to improve outcomes for Children and Young people across Tameside. The Board has progressed multiple changes throughout this period, including significant structural changes within its governance arrangements in order to strengthen its commitment to safeguarding and promoting the welfare of children within this Borough.

Whilst significant progress has been made in 2014/15, significant challenges also lie ahead in 2015/16. Whilst our response and ability to address Child Sexual Exploitation has been significantly strengthened, we must continue to work hard with all Board members and partner agencies to ensure that at risk children are identified and all appropriate actions are taken wherever possible.

Domestic abuse remains a significant problem in Tameside. The Board is committed to working with all agencies involved to help ensure that our response to domestic abuse is robust and ensures that children and young people are protected to the fullest extent. New initiatives are encouraging but we can never rest in combatting this as one of our core targets. Figures nationally suggest at least 50% of child abuse cases have an element of domestic abuse in the family. In 2015/16 the Board will continue to work with the Tameside Neighbourhood Partnership to ensure that the impact and incidence of domestic abuse is reduced and that our response to abuse is as effective as possible.

I would like to pay tribute to the staff of the Board. Since taking up the post I've been impressed by the work rate, dedication and professionalism of our staff group and this compliments the high quality of staff in all the agencies we connect with in Tameside.

Should you require any further information regarding the work of the Board please do not hesitate to contact us.

Tameside Safeguarding Children Board

General Enquiries

0161 342 4348

**CONTENTS**

## EXECUTIVE SUMMARY

Tameside Safeguarding Children Board has been through a period of significant change during 2014/15. A new Independent Chair and Business Manager have been appointed. 3 Serious Case Reviews have been completed that have inevitably led to a lot of learning and action against a series of recommendations. Tameside's 'Thresholds of Need' were launched in April and a new Public Service Hub went live in November which is at the forefront of the Public Service Reform agenda.

Good progress has been made against the Board strategic priorities including improvements to its quality assurance framework through the adoption of a Greater Manchester data set and completion of 2 multi-agency audits. Work to strengthen strategic partnerships has been undertaken including the creation of the Joint Working Protocol with the Health and Well Being Board and regular meetings between the Children and Adult's Safeguarding Board.

Against a backdrop of increased child protection activity and at a time of reduced resources the Board's partners have worked hard to further develop services that meet, and respond to, the needs of those affected by safeguarding issues. In particular services to support those affected by child sexual exploitation and domestic abuse continue to provide individual support plans to the most vulnerable. In addition efforts to raise awareness via theatre productions in schools, high profile weeks of action and social media campaigns have helped the community to identify and understand these issues so that they can protect themselves, their family and friends.

The Early Help service in Tameside has been established for a number of years. In 2014/15 665 families were referred to the Early Help service with 800 to 900 children being supported at any one time. Tameside's Early Help offer includes Early Help family intervention teams, Young Carers, Early Years Children's Centre locality teams, Provider Development team for Private Voluntary and Independent settings in early years, Family Information Service and Portage, YOU Think sexual health team, and Special Educational Needs and Disabilities Information and Advice Support Service. It works closely with partner agencies to deliver support plans via the Common Assessment Framework to prevent problems escalating.

A new Early Years Delivery Model, introducing 8 different stages of assessment, has been developed and piloted. As part of the model evidence based interventions are delivered to meet the needs of young children who require communication, gross and fine motor and social and emotional development in partnership with Midwifery, Health Visiting, Speech and Language and Early Attachment / CAMHS colleagues.

Despite the achievements and successes Tameside Safeguarding Board recognises that difficult challenges remain. The annual report, whilst highlighting the progress and good practice in 2014/15, also clearly outlines what the Board considers to be its priorities and areas for action looking ahead to 2015/16. There have been areas of work that it has not fully completed or developed such as its Section 11 audit and continual engagement with children and young people. There are new and emerging trends that the Board needs to understand better before putting together a comprehensive plan of action. These include for example an increase in the proportion of child protection cases under the category of neglect and the need to tackle domestic abuse at an earlier stage. The Board has agreed its strategic priorities for 2015-18 and developed action plans to deliver against during 2015/16. The Board is in a strong position to work with partners and affect change and is confident that is it has the resources and partnership commitment that it needs to do so.

## WHAT IS TAMESIDE SAFEGUARDING CHILDREN BOARD?

Tameside Safeguarding Children Board is made up of various partner agencies such as the Local Authority, Health, Police, & Education. They all have a legal responsibility to safeguard children through their day to day work. We want to make sure that children and young people in Tameside are protected from abuse, neglect and feel safe and cared for.

### Core Objective

The core objective of Tameside Safeguarding Children Board is to encourage all of the different partner agencies to work together so that the safeguarding arrangements in Tameside are the best that they can be. We do this by supporting our partner agencies to learn from good practice, case reviews and quality assurance activity and by challenging them to make improvements where they are needed.

### This objective is met by:

- Developing multi agency policies and procedures.
- Raising awareness of safeguarding issues.
- Influencing the planning and commissioning of services.
- Monitoring and evaluation of the effectiveness of the Board and its partners in carrying out its legal duties.
- Undertaking Serious Case Reviews and advising the Board and its partners on the lessons learnt from these reviews.
- Reviewing and responding to all child deaths.
- Publishing an annual report of the effectiveness of local arrangements to safeguard and promote the welfare of children in Tameside and to identify priorities and challenges for the year ahead.

## LEGAL FRAMEWORK

Tameside Safeguarding Children Board and all other Local Safeguarding Children Boards are established in accordance with The Children Act 2004 (Section 13).

Tameside Safeguarding Children Board reflects the core functions of The Local Safeguarding Children Boards Regulations 2006 and is governed by Working Together to Safeguard Children 2015 which sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people.

### Public Law Outline

In order to ensure that the plans made for children are timely and avoid delay, guidance on legal planning processes was introduced by Government in 2006 with an update based on practice findings in 2014. The aim of the guidance is to ensure that Children in Need and those at Risk of Significant Harm have robust plans in which legal advice is sought at an appropriate time in case planning. This process can work as a catalyst for achieving change in that highlighting the seriousness of neglecting a child's needs can prompt positive action from families. However, the aim of Public Law Outline is that should the contingency of care proceedings for a child become necessary, some planning has already taken place and there is a timescale set around the actions needed.

Changes to policy and practice required as a result of the Public Law Outline will have a significant impact on the safeguarding of children and young people and may ultimately serve to increase the overall number of Looked After Children. It is the Board's role to ensure that the potential for positive impact is maximised and the potential for negative impact is minimised within this process.

## STRUCTURE AND SUPPORT OF THE TAMESIDE SAFEGUARDING CHILDREN BOARD

### TSCB Team

The Board has a staff team comprising a Business Manager, Quality Assurance Officer, Training Organiser, Training Assistant and Board Administrator. Since the new Business Manager began in post in September 2014 the Board has approved recruitment to all vacant posts which are expected be filled in the 1st quarter of 2015. This will include a full time Quality Assurance Officer and Training Assistant and a part time Administrator. In addition the Board has had a change of Chair between December 2014 and January 2015.

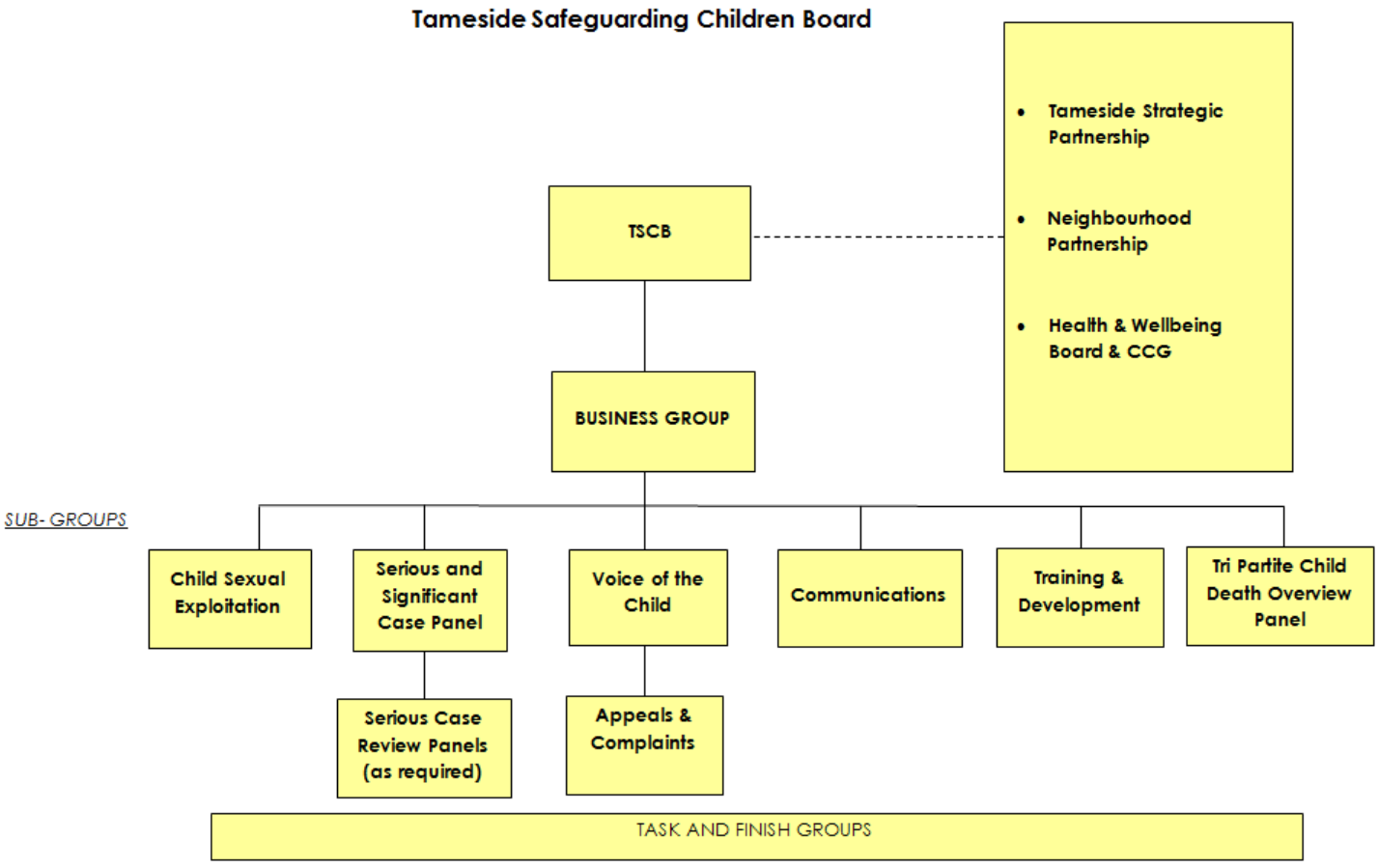
### TSCB Structure

The Board has a three tiered structure:

1. **The Strategic Board –** meets every quarter and sets the strategic direction for the Board, agrees priorities and monitors effectiveness of both single agency and the collective arrangements.

2. **The Business Group –** meets every six weeks and is the operational arm of the Board. It discusses emerging safeguarding themes in Tameside and agrees how work in these areas will be progressed. The group implements the Business Plan and Serious Case Review action plans through its Sub Groups, monitors progress and reports to the Strategic Board.

3. **Sub Groups –** under Business Group member leads Sub Groups carry out the work of the Board in the areas of, Voice of the Child (under taking Quality Assurance activities),, Serious and Significant Cases, Child Sexual Exploitation, Training and Development, Communications and Child Death Overview. Sub groups report their progress to the Business Group.



**Key Roles**

The Board is comprised of statutory partner agencies, identified in Working Together (2013), and by key appointments and professionals. They include;

- **Independent Chair –** The Board is led by an Independent Chair who can hold all agencies to account. It is the responsibility of the Chief Executive (Head of Paid Service) of Tameside Metropolitan Borough Council to appoint or remove the Chair with the agreement of a panel including Board partners and lay members. The Chief Executive, drawing on other Local Safeguarding Children Board partners and, where appropriate, the Lead Member will hold the Chair to account for the effective working of the Board.

- **Partner Agencies –** All partner agencies in Tameside are committed to ensuring the effective operation of Tameside Safeguarding Children Board. Members of the Board, where they hold a strategic role within an organisation are able to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account.

- **Local Authority –** Tameside Council is responsible for establishing a Local Safeguarding Children Board in their area and ensuring that it is run effectively. The Director of Children's Service is held to account for the effective working of the Board by the Chief Executive of Tameside Council and is challenged where appropriate by the Lead Member. The Lead Member is a 'participating observer' of the Local Safeguarding Children Board and regularly attends Board meetings.

- **Designated Professionals –** The Local Safeguarding Children Board includes on its Board, appropriate expertise and advice from frontline professionals from all the relevant sectors. This includes a designated doctor and nurse, the Director of Public Health, Principal Child and Family Social Worker, Legal Advisor and the voluntary and community sector.

- **Local Authority Designated Officer –** The role of the Local Authority Designated Officer is to oversee investigations into allegations of child abuse by professionals who work with children and young people and to investigate behaviour which may place children at risk. The aim of the role is to promote an effective, consistent and proportionate response by employers, police and child protection agencies. The role is financed by Tameside Safeguarding Children Board. In 2013/14 there were a total of 98 referrals to the Local Authority designated Officer, this is a 32% increase on the previous year. The majority of referrals have concerned professionals with the greatest and most regular direct exposure to children i.e. school staff, foster carers, residential workers and early year's services.

- **Lay Member –** The role of the lay member is to help to make links between the Local Safeguarding Children Board and community groups, support stronger public engagement in local child safety issues and an improved public understanding of the LSCB's child protection work. Stronger links with the Voluntary and Community Sector have been made during 2014/15 with additional members being brought in to the work of the Business Group and Child Sexual Exploitation sub-group. The Board has also consulted with young people as part of the National Youth Takeover Day on the use of CSE resources within schools and other youth settings. Efforts to recruit a lay member in early 2015 led to the appointment of a new member who is due to start upon their retirement in May 2015.

Board members are required to sign a membership agreement which sets out their roles and responsibilities. A full list of Board members and advisors is available at Appendix A for information. Since October 2014 a revised Induction Programme has been written for all new members and offered to existing members as a refresher. 2 induction sessions were run between December 2014 and March 2015. Induction sessions will continue to be run as required.

**FINANCIAL MANAGEMENT**

Tameside Safeguarding Children Board has always been well supported by monetary contributions from both statutory and non-statutory partners and for the last 4 years the Board has been in a position to carry a reserve into the new financial year. This reserve has been maintained in order to finance unexpected commitments including the costs of Serious Case Reviews.

At the end of 2012/13, Tameside Safeguarding Children Board carried forward £109,464 making the total reserve £204,387. The Board agreed that approximately £70,000of the financial reserve would be used in 2013/14 to fund the Phoenix Tameside Child Sexual Exploitation team manager. This reduced the reserve to £148,400 and the Board agreed to the fund the post again for a further financial year in 2014/15. Despite this, due to an under spend against staffing costs, the total reserve carried forward into 2015/16 is still £142,549.

**STRATEGIC PRIORITIES 2014/15**

Four strategic priorities were set by Tameside Local Safeguarding Children Board for 2014/15. The TSCB Business Plan 2014/15 details the actions required to meet the broader strategic priorities and each of the sub-group work plans contribute toward both the Business Plan and strategic priorities.

The strategic priorities for 2014/15 were as follows:

1. **To implement an effective quality assurance framework and demonstrate that the voice of the child has been effectively heard.**

2. **To ensure that relationships between the TSCB and other relevant strategic partnerships are efficient, effective and complementary**

3. **To evaluate the impact of the existing Child Sexual Exploitation (CSE) strategy and reflect the outcome in our service response. Also to develop effective multi-agency responses to children missing from home and/or education**

4. **To evaluate the effectiveness of the current Domestic Abuse strategy and plan interventions aimed at reducing the impact on children**

Progress and success against the first 2 strategic priorities are detailed below. Progress against the Child Sexual Exploitation and Domestic Abuse strategic priorities are addressed under the section 'Specialist Intervention for 'at risk' groups' on page 19.

**QUALITY ASSURANCE FRAMEWORK AND VOICE OF THE CHILD**

The Board's 'Learning and Improvement Framework 2014-16' details all the quality assurance and audit activity that is to be undertaken by its Voice of the Child Sub-Group. In addition it outlines how the different tiers and sub-groups of the Board work together to drive change and improvement.

http://www.tamesidesafeguardingchildren.org.uk/professionals/seriouscasereviews.aspx

In September 2014 the Board agreed to adopt the Greater Manchester data set as the basis for its quarterly report. Subsequent work to develop a local recording template and to agree additional local data requirements has also been completed. Quarterly reports are routinely reported to the Business Group and Strategic Board for scrutiny of performance and subsequent challenge. In 2014/15 the Board has been able to use the intelligence gathered to challenge partner agencies on their early help and homelessness data and raised issues with the recording of safeguarding concerns on I.T. systems.

All partner agencies had returned their S.11 Audit by January 2015 although the quality of the audits was variable. Members of the Quality Assurance and Performance Management Sub-Group met throughout February and March 2015 to verify that agencies had met the audit standards. Audits from Tameside and Glossop Foundation Trust, Stockport Foundation Trust and Greater Manchester Police were of good quality with sufficient evidence because they are subject to their own internal audit processes. Much of the evidence from other agencies to show that standards had been met was not submitted though. Therefore a decision was made that the Business Manager and, once in post, Quality Assurance Officer would meet with those agencies to support them in the full completion of the audit with clear evidence of compliance.

**Tameside Safeguarding Children Board will continue to support agencies in the full completion of their S.11 Audit so that they provide clear evidence of compliance.**

**It is only on those grounds that the Board will be satisfied that the requirements of the S.11 Audit standards have been met.**

Schools returned their S.175 Audits to the Schools Advisor at the end of the 2014/15 and a summary of the findings were presented to the Voice of the Child Sub-Group in July 2015.

- **73** Primary Schools completed and returned their audit forms and only **1** did not.
- **14** Secondary Schools completed and returned their audit forms and only **1** did not
- **All 5** of the Special Schools and both Pupil Referral Units completed and returned their forms

The findings of the audits are mostly positive although, as is the purpose of the audit, a number of further actions have arisen from the exercise. The Schools Advisor will support schools to ensure those actions are addressed promptly. The Head of Education will be contacting the schools that did not return their audit. Some of the headlines within the full report include;

- All schools had a child protection, anti-bullying, behaviour and school trips policy in place
- All schools had completed their whole school safeguarding training
- 48 schools reported that they had not raised awareness of Female Genital Mutilation in their schools
- 33 schools did not have a staff code of conduct policy in place. This is a statutory requirement under the new 2015 'Keeping Children Safe in Education Guidance'
- 27 schools did not have a Records, Guidance, Access and Storage Policy in place
- 25 schools did not have an E-Safety policy in place

The Voice of the Child Sub-Group completed 2 multi-agency audits in 2014/15. In August 2 cases that were subject to a child protection plan under the category of neglect were audited and in November 2 child protection cases where the child had a disability were audited. The audit methodology and process has been both efficient and insightful but future audits will seek to involve practitioners more actively in the process. The findings and recommendations from the 2 multi-agency audits were reported back to the TSCB Business Group for actions to be agreed and implemented. The Board's ability to quickly report and respond to such quality assurance activity has however not been efficient enough. In recognition of this, work to merge the Training and Development Sub-Group with the Communications Sub-Group into one Learning and Improvement Group will be progressed in 2015/16.

**A new Learning and Improvement Group will deliver practical solutions to the learning and recommendations from the Board's quality assurance and case review activity. It will bring together managers and practitioners and help to promote the work of the TSCB and improve practitioners understanding of a range of safeguarding issues.**

In 2014/15 the Board consulted with young people on the best way to roll out a range of different CSE resources within schools and other youth settings and gathered feedback and suggestions on the children and young people's section of the TSCB website. As a result the Board will support the roll out of an educational awareness programme using Barnardo's 'Real Love Rocks' DVD and resource pack from June 2015.

The Board has been re-assured by the fact that Tameside has a committed and focused Local Authority youth forum and other youth groups including Lesbian, Gay and Trans-Gender group, Looked After Care group and Disabilities group who are providing valuable contributions to the relevant service areas. The LGBT group contributed their thoughts and experiences of services for the TSCB Annual Conference on 'Vulnerable Teenagers and Self Harm'.

**TSCB will establish its own youth group that will directly influence and contribute toward the Board's future strategic priorities, action planning and support and challenge functions.**

**The exact role of such a group will need to directed by young people themselves but the Board will encourage and hope to create strong links with those existing youth groups.**

In March 2014 TSCB successfully recruited to the Quality Assurance post. That post will be crucial to the further development and implementation of TSCB's quality assurance framework and engagement with children and young people.

**STRATEGIC PARTNERSHIPS**

Tameside as a local authority benefits from cross representation from partner agencies on a variety of strategic boards and groups. For example the Local Authority Director of People, with responsibility for both Children's and Adult's Services, and the Designated Nurse from the Clinical Commissioning Group have been representatives on the Tameside Safeguarding Children Board, Health and Well Being Board, Adult Safeguarding Board and Domestic Abuse Steering Group throughout 2014/15, This has helped to ensure that the work of the Boards is effectively joined up and that there are regular updates on shared strategic priorities such as Domestic Abuse.

A Joint Working Protocol has been developed between the Health and Well Being Board and Tameside Safeguarding Children Board. This formalises the attendance and reporting arrangements between the 2 Boards throughout the financial year.

Tameside Safeguarding Children Board has a forward planner which ensures that the Business Group and Strategic Board receive annual reports from a wide range of multi-agency safeguarding arrangements such as Multi-Agency Public Protection Arrangements, Multi-Agency Risk Assessment Conference, Child Death Overview Panel etc. Further opportunities for the Board to add value to these multi-agency safeguarding arrangements will be explored in 2015/16.

Future strategic priorities will be set every 3 years and reviewed and updated together with their respective Business Plans annually. Strategic partners will be encouraged to contribute toward the TSCB Business Plan so that they have specific deliverables to contribute and report back on. In the same way, TSCB will expect to contribute toward the agendas and action plans of the Health and Well Being Board, Adult Safeguarding Board, Domestic Abuse Steering Group and other relevant strategic partnerships. The importance of shared agenda setting, strategic priorities and action plans will become increasingly apparent during Devolution Manchester, for which planning will progress rapidly during 2015/16.

**The priorities, business plans and actions of all strategic boards will be closely aligned to ensure that they complement and add value to one another. In this way shared safeguarding, community safety and public health concerns will be tackled in a holistic and sustainable way.**

## LOCAL DEMOGRAPHICS

Tameside has an overall population of 220,597 with a youth population aged 0-19 of 53,847 which is 24% of the total.

Table 1: Tameside's Youth Population 0-19

| | Mid-2013 Tameside Population | | |
|---|---|---|---|
| | **Males** | **Females** | **Persons** |
| 0-4 | 7,514 | 7,319 | 14,833 |
| 5-9 | 6,765 | 6,561 | 13,326 |
| 10-14 | 6,254 | 6,065 | 12,319 |
| 15-19 | 6,922 | 6,447 | 13,369 |

The breakdown of Tameside's population by ethnic group is shown in Table 1. National studies show that different ethnic groups are at greater risk of specific safeguarding issues such as Female Genital Mutilation and Forced Marriage for example.

The largest ethnic groups within Tameside are the South-Asian ethnicities Indian, Pakistani, and Bangladeshi accounting for 1.7, 2.2 and 2% of the Tameside population respectively. The overall white British population is considerably higher in Tameside at 88.5% compared to the English average of 79.8%.

Table 1: Population Breakdown by Ethnicity in England, the North-West and Tameside

| | England (%) | North-West (%) | Tameside (%) |
|---|---|---|---|
| White: English/Welsh/Scottish/Northern Irish/British | 79.8 | 87.1 | 88.5 |
| White: Irish | 1 | 0.9 | 0.7 |
| White: Gypsy or Irish Traveller | 0.1 | 0.1 | 0 |
| White: Other White | 4.6 | 2.1 | 1.7 |
| Mixed/multiple ethnic group: White and Black Caribbean | 0.8 | 0.6 | 0.6 |
| Mixed/multiple ethnic group: White and Black African | 0.3 | 0.3 | 0.2 |
| Mixed/multiple ethnic group: White and Asian | 0.6 | 0.4 | 0.4 |
| Mixed/multiple ethnic group: Other Mixed | 0.5 | 0.3 | 0.2 |
| Asian/Asian British: Indian | 2.6 | 1.5 | 1.7 |
| Asian/Asian British: Pakistani | 2.1 | 2.7 | 2.2 |
| Asian/Asian British: Bangladeshi | 0.8 | 0.7 | 2 |
| Asian/Asian British: Chinese | 0.7 | 0.7 | 0.4 |
| Asian/Asian British: Other Asian | 1.5 | 0.7 | 0.3 |
| Black/African/Caribbean/Black British: African | 1.8 | 0.8 | 0.5 |
| Black/African/Caribbean/Black British: Caribbean | 1.1 | 0.3 | 0.2 |
| Black/African/Caribbean/Black British: Other Black | 0.5 | 0.2 | 0.1 |
| Other ethnic group: Arab | 0.4 | 0.3 | 0.1 |
| Other ethnic group: Any other ethnic group | 0.6 | 0.3 | 0.1 |

*Source: NOMIS, 2015*

A comparison of those largest ethnic groups to the percentage of child protection cases shows that Tameside Children Social Care have engaged with a proportionate amount of Bangladeshi children, half of the proportionate amount of Pakistani children and no Indian children. 75 (3.44%) child protection cases had recorded ethnicity as not known and this could impact on these figures.

The ethnic breakdown of the populations of Tameside's wards is detailed in table 3. It shows that higher proportions of Indian and Pakistani populations exist in Ashton Wards, whereas higher proportions of Bangladeshi population exist in Hyde. This means that the TSCB could target particular safeguarding messages to certain communities. However, there is a risk that by adopting such an approach any isolated ethnic groups are missed. In addition the Board recognises that ethnicity is not a definitive indicator of religion or cultural practices and therefore increased vulnerability to certain types of safeguarding issues cannot be determined by ethnicity alone.

**Tameside Safeguarding Children Board needs to consider the most effective approach of raising awareness on safeguarding issues including Female Genital Mutilation and radicalisation.**

Table 2: Ethnic Breakdown of Tameside Ward Populations (%)

| | Ashton Hurst | Ashton St Michael's | Ashton Waterloo | Audenshaw | Denton North East | Denton South | Denton West | Droylsden East | Droylsden West | Dukinfield | Dukinfield Stalybridge | Hyde Godley | Hyde Newton | Hyde Werneth | Longdendale | Mossley | St Peter's | Stalybridge North | Stalybridge South |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| White: Total | 85.4 | 81.0 | 85.1 | 93.7 | 95.5 | 95.7 | 95.5 | 93.3 | 95.8 | 94.3 | 95.8 | 89.9 | 93.4 | 80.5 | 97.1 | 96.8 | 70.3 | 95.4 | 95.5 |
| White: English/Welsh/ Scottish/Northern Irish/British | 82.8 | 76.4 | 82.9 | 91.6 | 93.3 | 93.6 | 93.2 | 91.4 | 94.0 | 91.9 | 94.0 | 87.7 | 91.4 | 78.9 | 95.3 | 94.6 | 64.3 | 93.2 | 93.4 |
| White: Irish | 0.5 | 0.6 | 0.5 | 0.9 | 0.9 | 0.9 | 1.5 | 1.0 | 1.0 | 0.6 | 0.6 | 0.6 | 0.7 | 0.5 | 0.9 | 0.8 | 0.6 | 0.4 | 0.5 |
| White: Gypsy or Irish Traveller | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.0 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| White: Other White | 2.0 | 4.0 | 1.6 | 1.1 | 1.2 | 1.2 | 0.8 | 0.8 | 0.8 | 1.8 | 1.1 | 1.5 | 1.4 | 1.0 | 0.9 | 1.4 | 5.4 | 1.7 | 1.6 |
| Mixed/multiple ethnic group: White and Black Caribb | 0.4 | 0.5 | 0.5 | 0.7 | 0.6 | 0.8 | 0.8 | 0.9 | 0.9 | 0.4 | 0.5 | 0.5 | 0.7 | 0.6 | 0.6 | 0.5 | 0.7 | 0.4 | 0.5 |
| Mixed/multiple ethnic group: White and Black African | 0.2 | 0.4 | 0.4 | 0.2 | 0.3 | 0.3 | 0.3 | 0.2 | 0.3 | 0.2 | 0.1 | 0.2 | 0.2 | 0.1 | 0.1 | 0.2 | 0.3 | 0.3 | 0.1 |
| Mixed/multiple ethnic group: White and Asian | 0.5 | 0.7 | 0.7 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.2 | 0.4 | 0.3 | 0.3 | 0.4 | 0.3 | 0.2 | 0.4 | 0.7 | 0.3 | 0.3 |
| Mixed/multiple ethnic group: Other Mixed | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.3 | 0.3 | 0.4 | 0.2 | 0.2 | 0.1 | 0.3 | 0.2 | 0.1 | 0.2 | 0.3 | 0.3 | 0.3 | 0.1 |
| Asian/Asian British: Indian | 5.4 | 6.4 | 5.9 | 0.6 | 0.6 | 0.3 | 0.5 | 0.9 | 0.4 | 1.2 | 1.1 | 0.2 | 0.4 | 0.6 | 0.3 | 0.4 | 3.7 | 1.4 | 1.3 |
| Asian/Asian British: Pakistani | 5.2 | 6.7 | 4.1 | 2.0 | 0.5 | 0.2 | 0.8 | 0.8 | 0.3 | 1.1 | 0.8 | 0.5 | 0.6 | 0.7 | 0.2 | 0.0 | 15.2 | 0.4 | 1.2 |
| Asian/Asian British: Bangladeshi | 0.5 | 0.9 | 1.5 | 0.3 | 0.2 | 0.3 | 0.2 | 0.2 | 0.2 | 0.4 | 0.1 | 6.8 | 3.0 | 15.7 | 0.2 | 0.6 | 5.1 | 0.3 | 0.1 |
| Asian/Asian British: Chinese | 0.3 | 0.5 | 0.2 | 0.7 | 0.6 | 0.4 | 0.5 | 0.9 | 0.6 | 0.5 | 0.3 | 0.3 | 0.3 | 0.4 | 0.1 | 0.2 | 0.7 | 0.4 | 0.4 |
| Asian/Asian British: Other Asian | 0.5 | 1.1 | 0.4 | 0.2 | 0.3 | 0.3 | 0.2 | 0.4 | 0.1 | 0.3 | 0.3 | 0.1 | 0.1 | 0.4 | 0.1 | 0.2 | 0.9 | 0.2 | 0.2 |
| Black/African/Caribbean/Black British: African | 0.7 | 0.9 | 0.4 | 0.7 | 0.4 | 0.7 | 0.2 | 1.2 | 0.7 | 0.4 | 0.2 | 0.4 | 0.3 | 0.2 | 0.5 | 0.2 | 1.5 | 0.5 | 0.1 |
| Black/African/Caribbean/Black British: Caribbean | 0.1 | 0.2 | 0.2 | 0.2 | 0.1 | 0.2 | 0.3 | 0.3 | 0.2 | 0.1 | 0.1 | 0.1 | 0.2 | 0.1 | 0.2 | 0.1 | 0.3 | 0.1 | 0.1 |
| Black/African/Caribbean/Black British: Other Black | 0.1 | 0.2 | 0.2 | 0.1 | 0.2 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.0 |
| Other ethnic group: Arab | 0.3 | 0.1 | 0.1 | 0.1 | 0.1 | 0.0 | 0.0 | 0.1 | 0.0 | 0.1 | 0.1 | 0.1 | 0.0 | 0.1 | 0.0 | 0.0 | 0.1 | 0.0 | 0.1 |
| Other ethnic group: Any other ethnic group | 0.1 | 0.2 | 0.3 | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 | 0.1 | 0.2 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 | 0.1 | 0.0 |

*Source: NOMIS, 2015*

## EARLY HELP & STATUTORY INTERVENTION FOR VULNERABLE GROUPS

### 1. Thresholds for Assessment and Continuum of Need

In response to 'Working Together 2013' the Board developed and launched the 'Thresholds for Assessment and Continuum of Need' in April 2014. A series of multi-agency workshops were run between April and June 2014 to over 200 practitioners from a range of different agencies. The document and workshops included guidance on;

- The process for early help assessment and the type and level of early help services to be provided
- The criteria, including the level of need, for when a case should be referred to the local authority children's social care service for assessment and for statutory services under section 17 (child in need), section 47 (risk of significant harm), section 31 (care orders), or section 20 (duty to accommodate) of the Children Act 1989.

The guidance is available via the Tameside Safeguarding Children Board website:

http://www.tamesidesafeguardingchildren.org.uk/professionals/localpoliciesproceduresandpublications.aspx

## 2. Public Service Hub

A new Public Service Hub was launched on the 1st October 2014 to bring Tameside's early help, complex dependency and safeguarding services together into one multi-agency partnership. Its Operating Functions are as follows:

- Prioritise tackling issues of demand due to complex dependency
- Draw together intelligence and information and carry out research to identify critical and high risk cases
- Define and identify families who would benefit from early intervention and reduce future dependency
- Create and deliver bespoke interventions and packages of support using a whole family approach
- Coordinate interventions across public services, agencies and agendas
- Progress and develop the integration of public services
- Encourage and promote the sharing of information

The creation of the Public Service Hub has led to a move from public services operating in 'silos' to a seamless service;

- not determined by individual agency boundaries and agendas.
- providing a 'coordinated response' to complex issues.
- which addresses issues beyond isolated individual needs and moves beyond a simple, single child, single family, single adult response.

The Partnership group which developed the concept of the Public Service Hub included all relevant partners from across the Public Services. Representative from these agencies sit on the Strategic Public Service Hub Group and continue to develop and improve policies and procedures to ensure information sharing, risk assessment and management etc. are robust.

| Agency/Service |
|---|
| Greater Manchester Police |
| TMBC Strategy and Early Intervention |
| TMBC Children's Social Care |
| Job Centre Plus |
| NHS Pennine Care Mental Health and Substance Misuse |
| National Probation Service |
| Community Rehabilitation Company |
| Greater Manchester Fire and Rescue Service |
| TMBC Neighbourhood Services |
| TMBC Education |

| |
|---|
| New Charter Housing |
| TMBC Public Health |
| NHS Clinical Commissioning Group |
| Community and Voluntary Action Tameside |
| NHS Stockport Foundation Trust |
| TMBC Performance and Development |
| Tameside Hospital NHS Foundation Trust |

The Public Service Hub is working with the Local Authority Performance and Development Team to develop an effective way of monitoring activity in the multi-agency service.

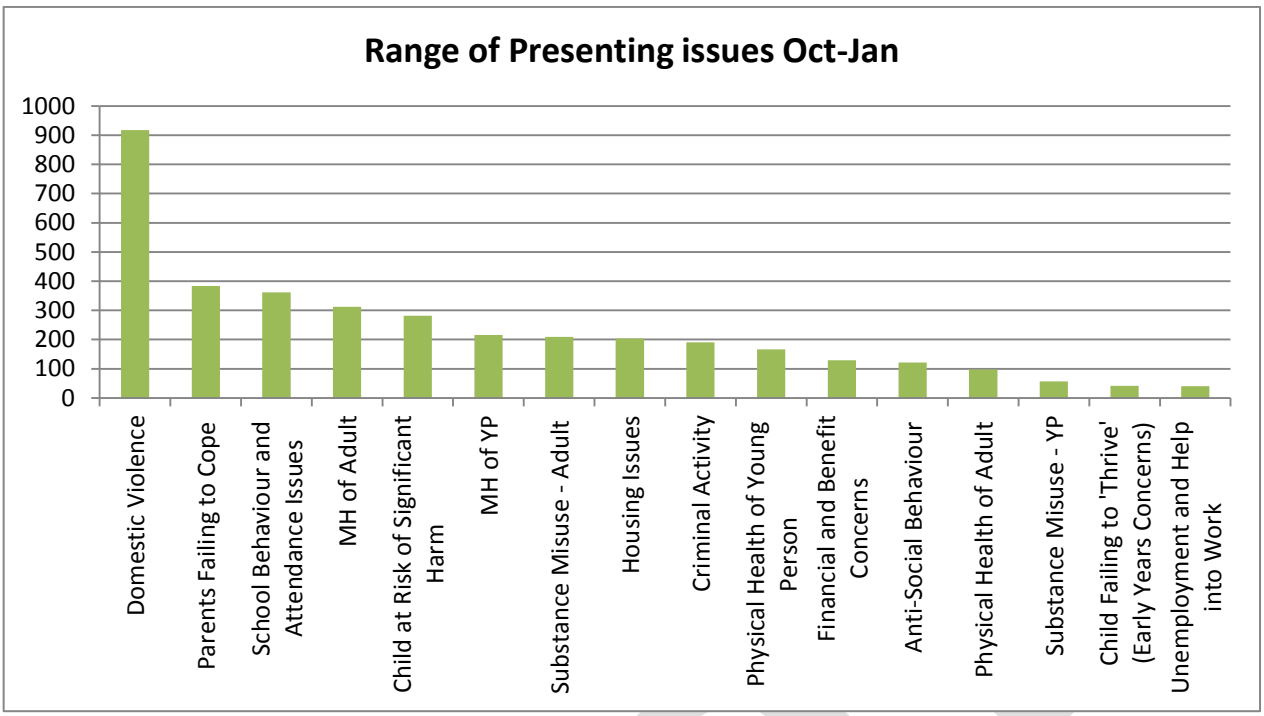
The table below illustrates the total number and percentage of contacts received by the Public Service Hub and those that progressed to a referral into Children's Social Care.

Table 4: Contacts & Referrals to Public Service Hub 2014/15

| Month | Number of contacts received 2013/14 | Number of contacts received 2014/15 | No. of Contacts Progressed to Referral 2014/15 | % progressed to a referral 2014/15 |
|---|---|---|---|---|
| Sep-14 | 968 | 777 | 207 | 26.6 |
| Oct-14 | 1211 | 1023 | 178 | 17.2 |
| Nov-14 | 916 | 1114 | 149 | 13.3 |
| Dec-14 | 780 | 918 | 155 | 16.7 |
| Jan-15 | 916 | 1199 | 125 | 10.4 |
| Feb-15 | 778 | 980 | 106 | 10.7 |
| Mar-15 | 854 | 1396 | 153 | 11.3 |

As the service is also set up to coordinate responses to demand across services, the Public Service Hub has also been monitoring the types of presenting issues for contacts to the Hub. This should be taken as an illustration of the range of demand and not the total level of demand for each issue. In addition these figures will be skewed by reporting rates (e.g. all Domestic Violence notifications are recorded but staff are not yet routinely recording employment issues):

Chart 1: Presenting Issues at Public Service Hub 2014/15




### 3. Early Years & Early Help

Currently the Children's Centres reach in Tameside covers 13,498 children aged 0-5. Out of this number 10,992 are registered with a Tameside Children's Centre (81%) and 8,064 have sustained engagement with the centres (60%).

**The 2 year offer for disadvantaged children to access a good or outstanding setting continues to be a priority and is currently at 69% of eligible children accessing a place. This figure has improved significantly during 2014/15 and the aim is to be at 80% by year end 2015.**

Children's Centres have extended their targeted service provision in two early adopter sites. This is part of a shared Greater Manchester vision to improve school readiness rates via an 8 stage assessment model. Evidence based interventions are then delivered to meet the needs of young children who require communication, gross and fine motor and social and emotional development in partnership with Midwifery, Health Visiting, Speech and Language and Early Attachment / CAMHS colleagues. The positive impact of the new Delivery Model can be seen through service evaluations and ultimately in improved school readiness figures in the Hattersley and Ridgehill schools where the model has been developed throughout 2014/15.

In 2014/15 665 families were referred to the Early Help service. The service worked with approximately 350 families at any one time which equates to between 800 to 900 children. Of those cases 483 were stepped down to universal service provision indicating their additional needs requiring targeted support had been provided and subsequent support could be managed via those universal services. 63 cases were referred down from Children's Social Care into Early Help and 39 cases were stepped up from Early Help to Children's Social Care.

Early Help locality teams have been operating in Tameside for a number of years focused on developing an early intervention model for Tameside families, developing the Troubled Families offer and meeting Children's Centres agenda for early years. Tameside's Early Help offer includes Early Help family intervention teams, Young Carers, Early Years Children's Centre locality teams, Provider Development team for Private Voluntary and Independent settings in early years, Family Information Service and Portage, YOU Think sexual health team, and Special Educational Needs and Disabilities Information and Advice Support Service.

Family intervention workers support families with children aged 0-19 that have emerging needs, or that are being stepped down from specialist support. Up until October 2014 family intervention workers were also supporting child in need cases and some commissioned child protection work. Since the launch of the Public Service Hub in October 2014 the Early Help family intervention teams have only been allocated cases at level 2 of the Threshold of Need. They employ 3 early help social workers who support more complex families and take early help pre-birth families to intervene prior to statutory pre-birth assessments. The Early Help team also delivers services to improve quality in Private Voluntary and Independent settings in the pre-school years, a sexual health promotion service working with schools and vulnerable young people and Young Carers Service working across Tameside to deliver support to children and young people who undertake a caring role within their family. Teams are supported by coordinated commissioned services including Homestart, Breastfeeding Peer Support, Positive Steps careers advise service and Branching Out support for young people with substance misuse and alcohol issues.

## 4. Children in Need

A child in need is seen as one for whom the threshold for statutory services has been met, where assessment and intervention is necessary but which stops short of formal child protection planning or becoming a child in care. Throughout the year, Children's Social Care have worked with around 1400 children on this basis at any one time which is a high number leading to workers having caseloads above the national average. However with good quality supervision and oversight these numbers have been managed.

As the year progressed it was clear that a number of these children had plans which had been in place for some time. An exercise was undertaken to ensure that decisions were made to either step the matter up where there had been no change, or down where it was safe to do so. As a result the data shows a reduction in the number of Children in Need in the final quarter of 2014/15. However this is less to do with fewer children being identified and more to do with effective planning and allocation.

## 5. Child Protection

The total number of children subject to an initial Child Protection Conference in 2014/15 was 268 compared to 225 in 2013/14 an increase of 19.1%. At the end of March 2015, 212 children and young people were the subject of a child protection plan, an increase of 43 cases (25%) from the previous year.

### Repeat Child Protection Plans & those open for more than 2 years

Over the course of 2014/15 the proportion of young people subject to a child protection plan for a second or subsequent time increased each quarter from 3 cases (6.8%) in quarter 1 to 49 cases ( 20.8%) in quarter 4. This is a similar percentage to that of 2012/13 (24%). Work carried out in the early part of 2013 to address the high number of repeat plans identified the need to strengthen step down arrangements and this successfully brought the percentage down to 8.9% at the end of 2013/14. Children's Social Care are again exploring the reasons why the number of repeat plans has increased and remains higher than the statistical neighbour comparator at 14.9% and national comparator of 15.8 %.

The number of Child Protection cases open for 2 years or more had reduced from 8 (4.9%) to 5 (2.4%) over the course of the year. At year end 2013/14 the figure was 11 (6.5%) and this continued decrease reflects national trends. The statistical neighbour comparator for 2014/15 is 5.1% and national comparator 4.5%.

### Child Protection by Category of Abuse

At 31 March 2014 the breakdown of child protection cases by category of abuse nationally was as follows: 43 per cent neglect; 33 per cent emotional abuse; 10 per cent physical abuse; 9 per cent multiple reasons; and 5 per cent sexual abuse. (NSPCC, 2015 p57). Chart number 2 and 3 below show that compared to the national figures in 2014/15 Tameside has;

- a similar percentage of neglect cases,
- 16% more cases under the category of emotional abuse,

- 3% less cases under the category of physical abuse
- 1.2% less cases under the category of sexual abuse.

Chart 2: Category of Abuse 2014/15 Year End

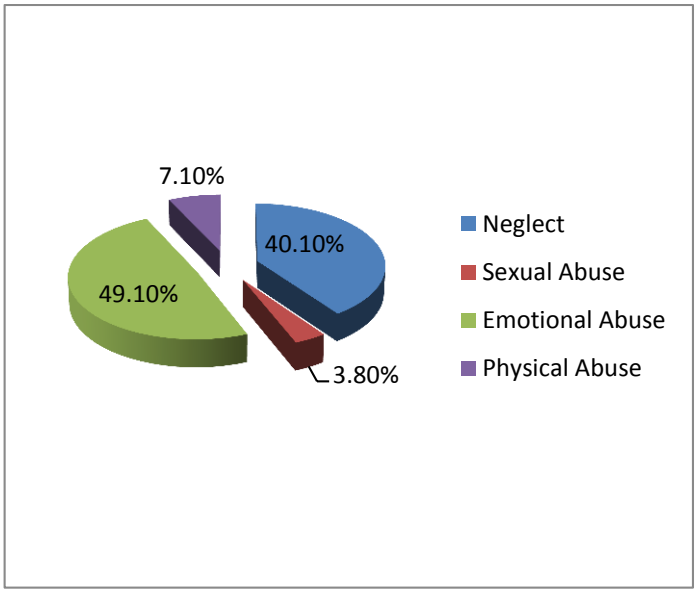
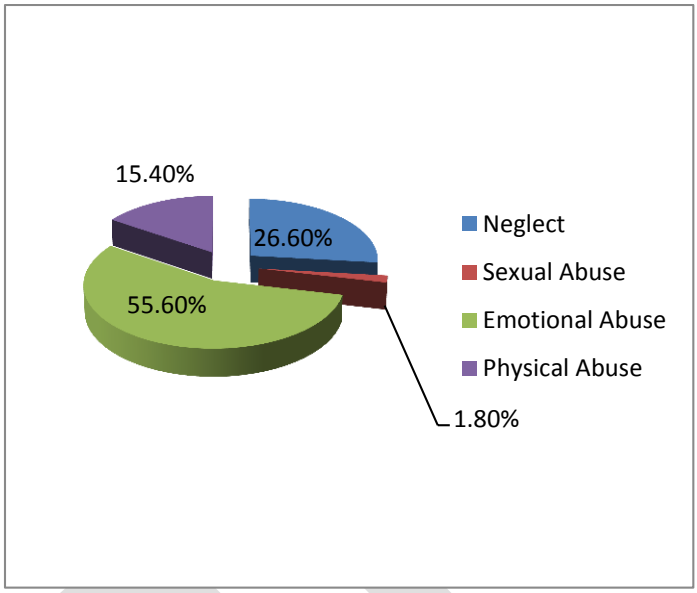



Chart 3: Category of Abuse 2013/14 Year End




The share of child protection cases under the category of physical abuse has roughly halved and the proportion of sexual abuse cases roughly doubled from 2013/14 to 2014/15. During that period there has been a 14% increase in neglect cases and 6.5% increase in emotional abuse cases.

Nationally there has been a 39% increase in the number of recorded sexual offences against under 18 years old between 2012/13 and 2013/14 which is underpinned by an increased confidence in reporting (NSPCC, 2015). Some of those reports will relate to historical abuse and therefore will not necessitate child protection proceedings. However, amongst a backdrop of increased reporting it seems reasonable to expect an increase in the level of child protection plans due to sexual abuse as Tameside has done.

It is important to note that despite the high profile abuse cases and subsequent activity to tackle child sexual exploitation, neglect remains a much more common form of abuse and it has increased significantly in the year 2014/15. The NSPCC Report 'How Safe are our Children' warns against losing sight of the need to find new ways to tackle neglect and to understand what works.

**The proportion of child protection cases under the category of neglect has increased from 26.6% in 2013/14 to 40.10% in 2014/15. Tackling neglect therefore will be a strategic priority within the TSCB Business Plan 2015-18.**

## 6. Disabled Children with a Child Protection plan

The percentage of children subject to a child protection plan with a disability rose throughout the year of 2013/14 from 1.84% in June 2013 to 2.39% in March 2014. The average over the year 2014/15 was 2.8% with an end of year high of 4.7% equating to 10 child protection cases.

As reported in the 2013/14 Annual Report this is an increase from the 0.6% recorded for the year 2012/13 and reflects an increased focus on ensuring the needs of children subject to a child protection plan are taken into account. Whilst this increase is encouraging, overall numbers are low, and the Board recognises that further steps should be taken to ensure that the identification of safeguarding issues for disabled children is as effective as possible.

It is well established through various research studies that children with disabilities are at increased risk of abuse and yet are less likely to be subject to child protection.

"Sullivan and Knutson (2000) found that children with behaviour disorders were approximately seven times more likely to experience neglect, physical and emotional abuse and 5.5 times more likely to experience sexual abuse. Children with speech and language difficulties were found to be nearly five times more at risk of neglect and physical abuse, almost three times more at risk of sexual abuse and almost seven times more at risk of emotional abuse. Children with "mental retardation" were approximately four times more at risk of all forms of abuse. Children with health-related conditions and deaf children were also amongst the higher-risk groups." (NSPCC, Protecting Disabled Children from Abuse, Oct 14, p21).

"Research suggests that disabled children, sadly, are more likely to be abused than children without disabilities. Yet they are less likely than other children to be subject to child protection. This report examines in depth, through the experiences of individual children, some of the reasons for that discrepancy." (OFSTED, Protecting Disabled Children, August 2012)

## 7. Children in Care

Children in care are those looked after by the local authority. Only after exploring every possibility of protecting a child at home will the local authority seek a parent's consent or a court decision to remove a child away from his or her family. Such decisions, whilst incredibly difficult, are made when it is in the best interest of the child.

As of 31 March 2015, 483 children were being looked after by the local authority compared to 423 at 31 March 2014 and 390 at 31 March 2013. Of the total number, 322 (67%) were placed in the Tameside area and 161 (33%) placed out of the borough.

Table 5: Placement Breakdown

| **Type of placement** | **No. of children placed in Borough** | **No. of children placed out of Borough** |
|---|---|---|
| Placement with foster carer provided by LA | 185 | 54 (9 exceeded 20 mile radius) |
| Placement with foster carer provided by Independent agency | 21 | 26 (2 exceeded 20 mile radius)) |
| Placement with foster carer provided by other LA carers | 1 | 3 |
| Placed with parents | 42 | 4 |
| Foster placement with relative or friend | 41 | 24 |
| Children's Homes (inc. Supported Lodgings | 29 (2) | 30 (6 exceeded 20 mile radius) |
| Placed for adoption | 0 | 12 (2 exceeded 20 mile radius) |
| Independent Living | 3 | 2 |
| Residential Care Home | 0 | 1 (exceeded 20 mile radius) |
| Residential Family Centre or Mother and Baby Unit | 0 | 1 |
| Young Offender Institution or Prison | 0 | 4 (all 4 exceeding 20 mile radius) |
| **Total** | **322** | **161 (24 exceeded 20 mile radius)** |

As of 31 March 2014 the Local Authority had a record of 330 children placed in care from out of borough. The majority (86%) were placed in foster care and the remainder in residential placements. In early 2015 Greater Manchester Police questioned the validity of the Out of Borough Data due to the disparity between Local Authority and Health data. Since March 2015 Children Social Care have agreed to cross reference their figures with those collated by the NHS and to share them with Greater Manchester Police. This will help to ensure that the health needs of all children are met and any associated risks relating to vulnerable groups and CSE are better understood and responded to.

## SPECIALIST INTERVENTION FOR 'AT RISK' GROUPS

Tameside Safeguarding Children Board identified 2 'at risk' groups as strategic priorities for the year 2014/15. Those were children at risk of child sexual exploitation and children at risk due to domestic abuse.

### Child Sexual Exploitation

The Strategic Priority for the Board in 2014/15 was;

**To evaluate the impact of the existing Child Sexual Exploitation (CSE) strategy and reflect the outcome in our service response. Also to develop effective multi-agency responses to children missing from home and/or education**

The CSE Strategy and work plan were re-written during the course of the 2014/15 to reflect the findings and recommendations from the Coffey report 'Real Voices' and Jay Report. In addition they addressed some of the learning and actions from local case review activity. A new referral pathway between the Public Service Hub and Phoenix Tameside was created to ensure all CSE related safeguarding concerns were passed to the specialist team. Phoenix Tameside adopted the Greater Manchester CSE Risk Assessment Tool which is now used to assess the needs and put in place a package of support for all cases. An operational 'Missings' group was established and meets bi-weekly to respond to cases based on levels of risk such as repeat missings and children in care. The Board and Phoenix Tameside has agreed a data set as part of the quarterly performance reports for CSE and Missing cases.

**Tameside's Missing Panel works to the Greater Manchester Missing from Home protocol but has identified the need for a local protocol to be developed in 2015/16 which outlines specifically how missing episodes for children known to be at risk of CSE are classified as high risk and lead to a trigger plan. A local protocol will also clarify the return interview procedure.**

Prior to 2013, combatting child sexual exploitation was dealt with by an individualised response from isolated professionals, posing significant limitations. In response the Phoenix Tameside team was established in August 2013. Project Phoenix is a Greater Manchester model that aims to tackle child sexual exploitation through the following three strands:

- **Prevention** – Educating those at risk, the community and other professionals on how to identify, reduce or avoid the dangers of CSE
- **Protection** – Safeguarding those identified as at risk of vulnerable to CSE through multi-agency assessment, support and intervention.
- **Prosecution** – Investigating and prosecuting those identified as committing CSE offences or disrupting where the opportunity is present through multi-agency, proactive enforcement.

The Phoenix Tameside team is managed by a Detective Inspector, which the board funded in 2014/15. The team is comprised of;

- a Detective Sergeant
- 2 Detective Constables
- 2 Police Constables
- 2 Police Community Support Officers
- 1 Local Authority Social Worker and Support Worker

In addition there are virtual partners which include a Looked After Care Nurse, Drug and Alcohol Support, multi-systemic therapy and schools.

The number of positive outcomes under the 3 strands has significantly grown since the team was established.

**Prevention**

Professional Awareness and Training

CSE Train the Trainer sessions were rolled out across a range of agencies in 2014/15. 90% of schools sent representatives and have since delivered awareness sessions to staff in those schools. Greater Manchester Police, Greater Manchester Fire and Rescue Service, New Charter Housing Association, and the Youth Offending Service have all delivered CSE Awareness sessions to their staff. The DCI and Head of Safeguarding have presented 2 Elected Member Briefings in 2014 to reassure members that Tameside's response to CSE is thorough and robust.

In 2014/15 TSCB commissioned out the delivery of their multi-agency Level 3 CSE course and was delivered to approximately 60 practitioners. This will continue to be delivered in 2015/16 as will the train the trainer sessions.

Educational and Community Awareness

A GW Theatre Production 'Somebody's Sister, Somebody's Daughter' was delivered to nearly 2000 year 9 & 10 pupils across 13 of the 16 secondary schools in 2014/15.

The TSCB's Safe and Healthy Relationships group has secured funding for the Barnardo's 'Real Love Rocks' resource pack and training. Staff from a range of service, including schools, will be trained in the use of the resource in June and July 2015 with the plan to use the resource with children and young people from September 2015.

Two CSE weeks of actions were run in September 2014 and March 2015. Phoenix Tameside has been particularly successful at these events, leading the way in terms of innovation and originality. September's week of action saw Phoenix support New Charters Crucial Crew to deliver online safety awareness to 3,000 year six pupils over an 8 week period. The March 2015 multi-agency week of action, based around a CSE tour bus visiting schools and colleges (courtesy of New Charter) was successful in winning GMP's Public Protection Division's Excellence Award for Partnership Working.

Considerable effort has been put into raising awareness of the work of the team using social media via GMP Tameside's Twitter and Facebook accounts with the team posting under #tamesidephoenix. The posts have reached far and wide with figures for the March 2015 week of action being 113 posts over 6 days reaching 28,600 accounts with a number retweets by Project Phoenix and neighbouring borough councillors.

**Protection**

119 referrals were made to Project Phoenix in 2014/15, a significant increase, compared to the 43 referrals in 2013/14 and 75 referrals in 2012/13 that were made to the CSE Meetings before the Phoenix Team was established. In 2014/15 Greater Manchester Police systems identified 189 children at risk of Child Sexual Exploitation in Tameside compared with 221 in 2013/14 and 149 in 2012/13. This suggests that CSE activity has not increased but that be due to an increased awareness of Child Sexual Exploitation as a safeguarding concern the number of referrals to the team has. A referral pathway between the Phoenix Tameside Team and the Public Service Hub was devised in January 2014 to ensure that all CSE related concerns were passed to the Phoenix Team. At the same time the Phoenix Team adopted the use of the CSE risk assessment tool for all cases. This arrangement will have also contributed to the increased number of referrals to the Phoenix Team and to better information sharing and assessment in the final quarter of 2015/15.

Operation Labyrinth

Commencing in January 2015, the operation seeks to identify and develop intelligence opportunities around public places, open spaces and premises where initially, identifiable victims are not currently known which would allow for a criminal investigation to take primacy. Through visits by plain-clothes officers on Friday and Saturday evenings, information is developed which can then lead to either further criminal investigation or disruption tactics including multi-agency enforcement visits by Licensing/ Trading Standards/Environmental Health / Fire Service. As a result of Operation Labyrinth there have been 14 locations targeted (offenders home addresses, premises with concerns identified), 8 business premises visited by enforcement teams, 65 offender visits (with a third receiving multiple visits), 15 children & young people being visited to provide reassurance and advice and 15 abduction warnings served.

Operation Madison

Operation Madison is now supported by the Phoenix team and information sharing has increased regarding CSE & Missing from Home around LAC children. Madison has also served to improve the standard of MFH reports by Children's Care Homes and taking action against those who display poor management of their residents. Advice and guidance around causes of MFH reports is also dealt with effectively at strategy meetings where Madison & Phoenix are in attendance and support children's care homes & parents to make decisions e.g. suggesting altering curfew times to compromise with CYP's and to deter them from going MFH. Tameside Police have also implemented 'Gold Reviews' of MFH cases to assess how effectively the Police have responded to CSE MFH reports and how to improve, should the CYP go MFH again. This has seen improvements in the use of trigger plans, CSE markers, what information is available and how police manage the initial investigation into a MFH report. All of the progress made by Police has on the whole, encouraged care home & parents to improve their knowledge of who and where their children are before choosing to report them MFH.

**Prosecution**

In June 2015 the Phoenix team had 30 open investigations with nine cases awaiting Crown Prosecution Service review.

GMFRS is also pursuing a prosecution under Fire Safety legislation around an Off-Licence after a multi-agency enforcement visit identified a number of concerns. The premises was stripped of its licence following a Licensing Review panel supported by evidence from Phoenix Tameside. There have been a number of other licence reviews following such multi-agency enforcement visits.

Information shared with New Charter and other Registered Social Landlords has resulted in problem tenants who are associated with CSE either being evicted or having visitor restrictions imposed on them which are also enforced by visits from Operation labyrinth.

**Domestic Abuse**

The Strategic Priority for the Board in 2014/15 was;

**To evaluate the effectiveness of the current Domestic Abuse strategy and plan interventions aimed at reducing the impact on children**

The most reliable data in relation to Domestic Abuse are the figures concerning children involved in cases heard at the Multi-agency Risk Assessment Conference (MARAC) which pertains to those victims of domestic abuse deemed at highest risk of serious injury or death.

**Tameside has a high number of referrals to the Public Service Hub for incidents of Domestic Abuse and there is a high proportion of children on child protection plans where domestic abuse is a factor.**

**TSCB recognises that in order to better understand and tackle Domestic Abuse more work needs to be undertaken to address the issues at an earlier stage.**

**Multi-Agency Risk Assessment Conference (MARAC)**

2014/15 saw an increase in the number of cases heard at MARAC compared to the previous year; this could indicate an increase in the number of Domestic Abuse incidents occurring in Tameside or, conversely, an increase in knowledge and awareness of Domestic Abuse and risk and therefore more cases being assessed as meeting the MARAC threshold. Additionally, around 27% of cases were defined as 'repeats', reflecting more than one referral into MARAC during a 12 month period. On average, just over 65% of cases referred into MARAC during 2014/15 involved children.

The highest number of referrals into the MARAC are made by Greater Manchester Police with an average of 60.4% of cases during 2014/15. This is most likely due to the police being the first service to come into contact with and complete a DASH risk assessment with the client following a reported incident of abuse.

Across Greater Manchester, Tameside had the lowest percentage of referrals into MARAC from BME communities. A review of the demographics of victims referred to MARAC highlights the lack of breakdown in ethnic detail for referrals, negating the opportunity to explore additional factors surrounding the domestic abuse risk, which may be unique to specific minority groups such as Honour Based Violence and Female Genital Mutilation. In addition, the data does not distinguish between intimate partner abuse and familial Domestic Abuse.

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Tameside is shown to have the highest percentage of perpetrators of domestic abuse aged 16/17 across Greater Manchester although this figure has decreased each quarter during 2014/15. However it should be noted that these figures are relatively low, with the Tameside 2014/15 average being 1.98%. The period also showed very low figures for victims identified as being Lesbian, Gay, Bi-Sexual or Tran-Gender, victims with a disability, or male victims; this again may reflect a lack of reporting and adequate risk assessment rather than a low incidence.

**Effectiveness of Domestic Abuse Support**

In 2014/15 'Foundation for Families' completed a study which consulted with female survivors of domestic abuse, male perpetrators of domestic abuse and children and young people affected by the issue. An interim report presented to the Neighbourhood Partnership in March 2015 recommended a whole system transformation of the way in which agencies respond to domestic abuse together with a strong focus on early intervention and prevention.

The Domestic Abuse Strategic Partnership will be taking forward the work to ensure that senior staff/chief officers across the statutory and voluntary sectors understand the need to have strategic oversight and a whole systems approach to affect positive changes in domestic abuse work across Tameside.

A further Domestic Abuse Needs Assessment resulted in a revised multi-agency action plan for 2015/16. TSCB has already developed and piloted a new training course 'Whole Family Approach to Domestic Abuse' in November 2014 and February 2015. This promotes the use of additional risk assessment tools that assess the needs of children and young people and promotes ways of working with all members of the family that are affected by Domestic Abuse. This course will continue to be part of the Training Programme for 2015/16.

**Support for Victims of Domestic Abuse**

Support for victims of Domestic Abuse in Tameside, is carried out by Bridges, an organisation providing support, advice and information to victims of abuse at all risk levels. The Bridges contract brings together three previous services, the Women's refuge provision, Substance Misuse provision from Turning Point and the IDVA service. The provision includes a refuge for women and children and the IDVA (Independent Domestic Violence Advisor) service. The IDVAs in Tameside have a case load of approximately 100 between 3.5 IDVA'S. In addition support is given to approximately 80 standard and medium cases in a quarter between 4 keyworkers. In 2014/15, Bridges supported 682 victims of domestic abuse, the majority of these (53%) being high risk. A holistic package of support is offered based on an individual safety plan. This can include a number of different interventions such as substance misuse, courses for both victims and perpetrators and work in schools.

During 2014/15, Bridges also piloted a CHIDVA (Children's IDVA) service, for children whose parent(s) are assessed as of very high risk of serious injury from Domestic Abuse; due to this being in the early stages, numbers of children supported and outcomes are not available at present.

Tackling Domestic Abuse has been, and continues to be, a key priority for partners and Tameside Safeguarding Children Board as well as the Neighbourhood Partnership. There are a wide range of services across Tameside that work across the tiers of prevention. There is strategic support for work on Domestic Abuse, and a desire across the partnership to see its incidence, prevalence and impact reduced. Services include primary and secondary care, criminal justice and probation, social care, and the voluntary sector. Governance for Domestic Abuse is held at a strategic level by the Domestic Abuse Strategic Partnership and reports into Tameside Safeguarding Children Board.

**At risk groups identified from case review activity**

A further 2 at risk groups of children have been identified as a result of the Board's Serious Case Review activity during 2014/15. These include children that self-harm and children presenting as homeless.

**1. Children who Self-Harm**

Chart 4 and 5 below show that intentional Self-Harm is the main cause of Accident & Emergency (A&E) Admissions for females aged 10-14 and 15-19. Intentional self-harm amongst males does not feature for the age bracket of 10-14 and is only the 4th most common cause of A&E Admissions for 15-19 year olds. Learning and recommendations from a number of case reviews, including Serious Case Reviews in 2014/15 have led to self-harm and suicide amongst vulnerable children becoming a growing area of concern.

**Vulnerable teenagers and self-harm was the focus of the Board's Annual Conference and is agreed as a Board priority for 2015/16.**

**Chart 4: Top 5 Injury Admissions by Gender in 10-14 year olds (2011-12 to 2013-14)**

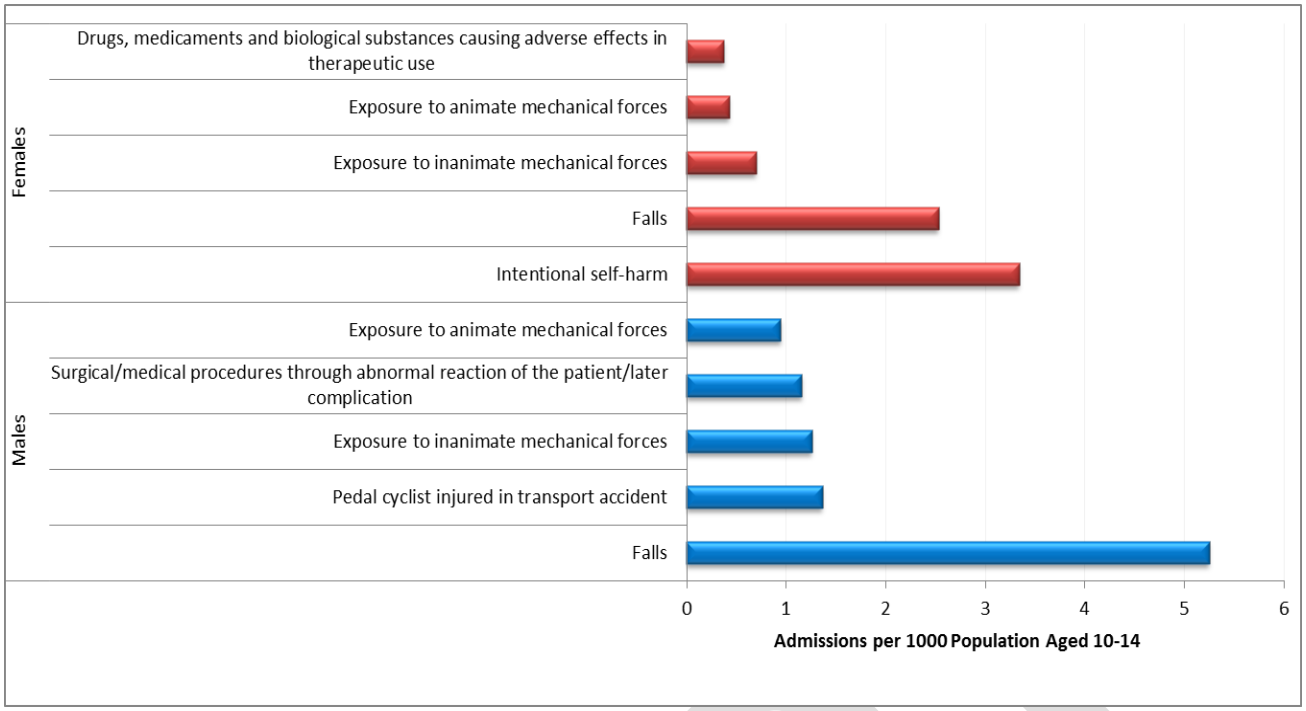
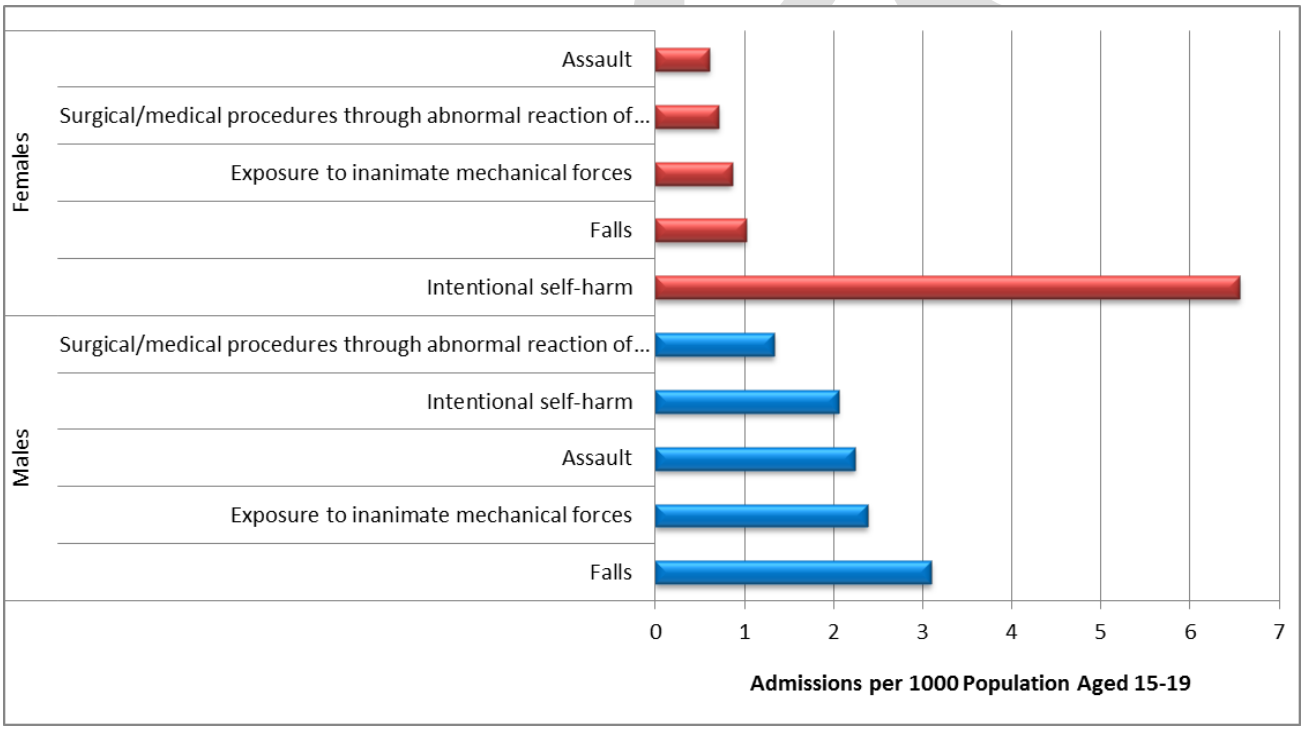



**Chart 5: Top 5 Injury Admissions by Gender in 15-19 year olds (2011-12 to 2013-14)**




A reoccurring theme from case reviews has been self-harm and risk of suicide amongst vulnerable teenagers. This together with the figures shown above on A&E attendances for self-harm led to the Board running its Annual Conference on this issue. The event was attended by approximately 180 practitioners and managers from a broad range of services. It included input from Serious and Significant Case Panel members on each of the cases and presentations from the National Charity Papyrus and the local CAMHS. Further information has been disseminated via a series of a 7 minute briefings on each of the Serious Case Reviews and 'Respectful Challenge'. This new method of communication has been particularly successful as organisations use them to present and discuss the learning at their team meetings.

Attendees wrote 'pledges' to highlight how they would change or improve their practice as a result of their learning from the conference. Further follow up work in 2015/16 will take place to determine whether those pledges have been put into practice and to check the impact that they have had. Teenage self-harm and the wider issue of emotional and mental health will be a priority for the Board in 2015/16 and the Board will work with the Emotional Health and Well Being Board to develop a revised CAMHS offer which will address some of the outstanding actions from the Board's Serious Case Review action plans. In addition the Board will develop and also commission suitable training to equip practitioners with the skills required tosupport those young people that are at risk.

**2. Young People presenting as Homeless**

In June 2014 a Joint Agency Protocol between Housing Advice and Children's Social Care was implemented as an action from a Serious Case Review. This clearly outlines the referral process for young people presenting as homeless or with a housing need in order to ensure they are supported appropriately. This protocol also ensures there is follow-up to establish the eventual outcome if the young person has been referred to the Public Service Hub from Housing Advice, but subsequently does not attend the appointment. In addition a Social Worker has been recruited to specifically support vulnerable young people that were care leavers or homeless. The post holder carries out assessments of young people in need due to homelessness, and mediates with young person's families and friends to provide support and housing or identify suitable provision; this includes the management of the independent temporary accommodation within Tameside for young people.

**SPECIFIC RESPONSIBILITIES UNDER WORKING TOGETHER TO SAFEGUARD CHILDREN (2013)**

**CHILD DEATH OVERVIEW PANEL**

The Child Death Overview Panel is tri-partite sub-committee of the Local Safeguarding Children Boards for Stockport, Tameside and Trafford. It is a statutory requirement for each local authority to form part of a Child Death Overview Panel. Child Death Overview Panels should cover populations of at least 500,000 and it was for this reason that the three authorities of Tameside, Stockport and Trafford came together form 1st April 2009. The Child Death Overview Panel carries out a multi-disciplinary review of child deaths (0-17 years) with the aim of understanding how and why children in Stockport, Trafford and Tameside die. Panel members consider whether there are any factors which could have been modified to prevent or reduce the chances of a similar death in future and to report any recommendations to the Board.

**Progress on recommendations from the Child Death Overview Panel Annual Report**

The CDOP Annual Report for Stockport, Tameside and Trafford 2013/14 was presented to the September 2014 meeting of the TSCB together with a series of recommendations. Progress during 2014/15 against those recommendations was subsequently reported back to the Board and the recommendations are summarised below;

Recommendation 1:

**There is evidence of a disproportionate number of child deaths in Quintile 1(most deprived). Each Authority should assess the work currently in place to target vulnerable groups and an action plan should be developed to identify how the number of deaths can be reduced.**

In Tameside, giving priority to vulnerable groups is built into service specifications, the Health and Wellbeing Strategy, Early Years Strategy, Early Help Strategy and work on Complex Families. All health and social care services work within a model of universal, universal plus and universal partnership plus provision that enables a proportionate response to need that recognises a wide range of vulnerabilities. Going forward, health and social care services are in scope for the local 'Care Together' health and social care integration programme, and the need to give appropriate priority to vulnerable groups is being built into the design, specification and tendering of new services.

Recommendation 2:

**It is a consistent feature, both locally and nationally, that children under 1 year old account for two thirds of child deaths. These deaths have common features around low birth weight, prematurity and maternal smoking and associated issues of hypertension, diabetes and obesity. Given that year on year the percentage of deaths remains high, Public Health should review current work and devise an updated action plan to address the areas identified.**

The population of Tameside faces particular challenges with smoking and healthy weight, and these are reflected amongst pregnant women. The local Healthy Weight Strategy and Tobacco Control Strategy give priority to work with pregnant women. Tameside Hospital maternity service is currently involved in two pilots of novel approaches to stop smoking in pregnancy, the outcomes of which should be available in 2015.There is a Maternity Healthy Weight Pathway in place which has been reviewed and revised during 2014. The infant mortality rate for Tameside is lower than expected considering its level of social deprivation.

Recommendation 3:

**Injury is a significant factor in childhood deaths, particularly in the older age ranges. Evidence indicates that Tameside in particular has a high rate of admissions, (5th highest rate in the GM table) and higher than the GM average. It is recommended that Public Health carry out work to analyse the injury admissions with a view to identifying any correlation with the CDOP data.**

A project in response to a previous high rate reviewed local data and accident prevention activity, identified accidents at home in under 5s as a key issue, and secured funding for a partnership programme to provide home safety equipment. A further project in response to new data is currently in progress focussing on data quality and clinical pathways, and will report during 2015.

Recommendation 4:

**CDOP's have been in existence since 2007 and child deaths have remained relatively constant over this time period. It is recommended that a 5 years 'snapshot' is under taken across the 3 Authorities and GM to evaluate CDOP data in more detail. This would allow standardisation of the data sets, complete correlation to understand if there is a relationship between child deaths and areas such as smoking at time of delivery (SATOD), deprivation, and ethnicity. It would also allow robust benchmarking to take place across GM to highlight Local Authorities that need more support in reducing child deaths in their area.**

The Public Health Intelligence Manager, TMBC, has started work on this review.

**LEARNING FROM CASE REVIEWS**

Tameside has a Serious and Significant Case panel, which oversees serious case reviews, with a membership of experienced senior managers drawn from Tameside Safeguarding Children Board member agencies.

The purpose of a serious case review is to establish what lessons can be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.

In the year 2014/15 two serious case reviews were undertaken by TSCB. These were Child H published in December 2014 and Child M published in April 2014. In addition Tameside has been involved in a Serious Case Review commissioned and led by Salford Safeguarding Children Board. The report was published in March 2014. During 2014 Tameside was still delivering actions from earlier reviews including a multi-agency critical review for Child G and Individual Management Report for Child 10. As a result there has been a sizeable amount of action to implement, monitor and review the learning and recommendations from all case review activity. Some of the key outcomes to date include;

a) a review of the Appropriate Adult scheme and promotion of new referral processes and pathways into the Hub (to ensure all contacts are discussed with the referrer in person).

b) The development of a new Housing Protocol for 16-17 year olds presenting as homeless and the recruitment of a Social Worker to support those young people.
c) School governor training on permanent exclusions and a new information sharing agreement between schools and the pupil referral unit.
d) a review of the format for recording Strategy meetings and review of Child in Need processes as part of a wider business process review of the ICS workflow.
e) Learning events on the Voice of the Child have been attended by Children's Social Care staff
f) 'Respectful Challenge' sessions being delivered via multi-agency safeguarding updates, school networks and targeted training to Children's Social Care.
g) Youth Offending Service staff having access and training on how to use ICS
h) A new risk assessment and vulnerability plan for young people under the age of 18 in custody and vulnerability training for custody staff.

**LOCAL AUTHORITY DESIGNATED OFFICER**

The Local Authority Designated Officer (LADO) task is to oversee investigations into allegations of child abuse by professionals working with children and young people or behaviour which may place children at risk. It includes the chairing of inter-agency Professional Abuse Strategy Meetings (PASMs) on behalf of the Tameside Safeguarding Children Board and being available for advice and consultation.

Allegations against professionals working with children are varied. Many arise within the context of behaviour management, there are a small number of very serious allegations and there are others involving professional boundaries. They come to light through a variety of sources, most frequently children and parents who may complain to the agency concerned or contact the police.

**Professional Abuse Strategy Meetings**

Professional Abuse Strategy Meetings (PASMs) are convened in agreement with referring and employing agencies and investigators. PASMs are necessary when a clear and documented allegation against an individual arises and there is possibly significant harm caused to a child or children. Strategy Meetings are also held when there is a need for a formally agreed inter-agency strategy for dealing with the case. Complaints to the police have generally required PASMs.

**Consultations**

Consultations concern matters that do not require co-ordinated inter-agency action. These have increased year on year since the LADO has been in post which indicates that the awareness raising of this role and of partners responsibilities has been effective.

Strategy Meetings are not convened following a consultation when all appropriate action has been taken, only one agency was involved, or where the evidence of risk to children was very weak.

Many of the consultations have involved inappropriate behaviour of staff working with children. Incidents such as saying inappropriate comments, use of social media and giving children lifts. To address this issue the LADO has issued and promoted the 'Guidance for Safer Working Practice for Adults who work with children and young people'.

**Table 6: Breakdown of All LADO Referrals**

| Year | PASMs | Consultations | Total |
|---|---|---|---|
| 2012/13 | 25 | 49 | 74 |
| 2013/14 | 31 | 67 | 98 |
| 2014/15 | 22 | 106 | 128 |

**Table 7: Breakdown of Employing Agencies**

| | | *2013/14* | | *2014/15* |
|---|---|---|---|---|
| Foster Carers | | 16 | 14 | |
| Residential care workers | | 14 | | 17 |
| Other Social Care | | 4 | 6 | |
| Health | | | 10 | 7 |
| Education | | | 26 | 40 |
| Early Years | | 11 | 24 | |
| Other | 4 | | 20 | |

(Other includes agencies such as OFSTED, parents etc.)

The majority of referrals have concerned professionals with the greatest and most regular direct exposure to children i.e. school staff, foster carers, residential workers and early year's services. The impact of the work the LADO has undertaken with early years settings and early year's provider service is reflected in the increase in contacts and referrals from those services with a year on year increase of 118% from 11 to 24.

**TRAINING AND DEVELOPMENT**

**TSCB Training Programme**

The TSCB training organiser and training pool continue to successfully run the same core programme as in previous years. This includes 16 training courses ranging from level 1 awareness training to level 4 training for managers. The pattern of attendance has been that Health Trusts; Schools; Social Work; Early Help and TMBC occupy the highest number of practitioners attending. This is followed by Early Years and Residential Providers; Housing – particularly New Charter and Adullam; Inspire and Bridges; Homestart; Adult Services, Police; Probation and the Voluntary Sector.

The training pool membership which is crucial to the delivery of the training programme has reduced significantly in the past year. It is vital that this is rejuvenated during 2015/16 otherwise there is a danger that the current training programme will become unsustainable.

The programme and content of training is regularly reviewed by the Training and Development Sub-Group and extended annually in response to learning needs, local and national guidance. In 2014/15 a new 'Whole Family Approach to Domestic Abuse' training course was piloted in October 2014 and run again in January 2015. The will continue to be run as part of the core TSCB training programme.

Messages from national and local serious case reviews are constantly incorporated into the TSCB training programme. During 2014/15 this has been a significant area of work given Tameside's level of case review activity and the learning from them. All TSCB courses incorporate the general learning and specific courses are adapted in the light of learning. For example the Vulnerable Teenagers and Vulnerable Infants course focus carefully on the learning from Tameside Reviews as do Safeguarding Practice Update Sessions.

Key themes from the Serious Case Reviews inform Safeguarding Practice Updates. These shorter training sessions have proved popular with practitioners from all agencies in Tameside. They are delivered bi-monthly and have been attended by up to 50 practitioners. The following topics have been covered in 2014/15 have covered the following topics:

- Domestic Abuse & Tameside's Domestic Homicide Review
- Child Sexual Exploitation – The Phoenix Team & the local picture
- Vulnerable Teenagers & Recognising/Understanding Teenage Behaviour
- Learning from Child H Serious Case Review and Child KSP case review

**Evaluation**

The TSCB has an Evaluation Strategy which is partly implemented. Participants on all courses complete an evaluation form which indicates levels of satisfaction on the day and asks how practice will change as a result of the learning. These evaluations are all held and indicate a high level of satisfaction with TSCB training.

There has been some follow up of individual trainees regarding impact on practice 3 – 6 months later. This will be implemented more fully in 2015/16. In September 2015 participants that attended two courses, 'Whole Family Approach to Domestic Abuse' and 'Working Together to Safeguard Children' will be invited to attend a focus group as part of a 3-6 month post evaluation.

A full analysis of multi-agency attendance by course will also be completed from September 2015 when a new Training Assistant will be in post and provide crucial administrative support to the Training Organiser.

**New Training Courses for 2015/16**

The extensive Train the Trainer programme in CSE rolled out in 2014/15 will continue as the Real Love Rocks training packages are offered to all agencies, with schools forming the first cohort in June and July 2015.

New training is planned in Female Genital Mutilation, alongside training already in the programme on Forced Marriage. The Mosques and Madrassahs in Tameside are due Refresher training in Safeguarding and this is planned for September 2015 onwards. The TSCB course on Safeguarding Disabled Children will be run as an awareness course and a more advanced day is in development.

**POLICIES AND PROCEDURES**

Tameside along with the 9 other Greater Manchester Local Authority areas has adopted the Greater Manchester Safeguarding Procedures Manual. The online resource provides a set of common multi-agency policies for use across Greater Manchester.

The manual is updated twice a year with the support of Tri-x and input from LSCB Business Managers. The TSCB Business Manager has attended all of the meetings to review and amend relevant policies and procedures in accordance with new legislation or learning from case reviews in 2014/15.

Tameside continues to have its own 'Thresholds for Assessment and the Continuum of Need' guidance that all agencies and practitioners work to. The guidance was launched in April 2014 and a series of multi-agency workshops were run between April and June 2014 to over 200 practitioners from a range of different agencies.

**STRATEGIC PRIORITIES FOR 2015-18 AND BUSINESS OBJECTIVES 2015-16**

Based on the Board's current and ongoing safeguarding activity and the emerging safeguarding trends locally the following Strategic Priorities have been agreed for 2015-18.

**Domestic Abuse**

- To develop and deliver an educational awareness programme to universal services
- To continue to deliver multi-agency training on the 'whole family approach to Domestic Abuse' and to evaluate its impact
- To explore and develop ways to tackle domestic abuse at an earlier stage

**Child Sexual Exploitation**

- To improve intelligence gathering from multi-agency partners
- To ensure that a tiered package of support is available for victims of CSE
- To increase awareness of CSE amongst children and young people, parents and community
- Develop a local Missing from Home Protocol that reflects the response to missing children who are known to be at risk of CSE

**Self-Harm**

- Develop and promote a self-harm and preventing suicide policy
- Develop and deliver a package of self-harm and suicide training and support
- Improve practitioners understanding that patterns of risk taking behaviour e.g. substance use & eating disorders may also be a form of self-harm
- Work with the Emotional Health and Well Being Board to develop the referral pathways and service offer for CAMHS

**Early Help**

- Review the Public Service Hub
- Revise Children's Needs Framework including an updated Thresholds of Need, Escalation and Step Up/Step Down procedure
- Strengthen joint working through effective and timely information sharing across the thresholds of need
- Improve recognition and understanding of children's disabilities and specifically the impact that they can have upon safeguarding
- Improve offer of early help at the early years stage where threshold for statutory intervention is not met i.e. refer to Children's Centres and to free Child Care Placements

**Neglect**

- Develop a multi-agency neglect strategy that enables partners to identify and respond to neglect at the earliest opportunity and escalate when necessary
- Encourage the consistent use of the Graded Care Profile in all cases of known or suspected neglect and develop a system to track progress and improvement against the Graded Care Profile

**APPENDIX A**

Tameside Safeguarding Children Board Membership 2014/15

| **Working Together (2015) LSCB Membership requirements** | **TSCB Membership** | **Representative** |
|---|---|---|
| Metropolitan Borough Council; | TMBC, Chief Executive | Steven Pleasant |
| | TMBC, Executive Director for Communities, Adults, Children's and Health | Stephanie Butterworth |
| The NHS Commissioning Board and clinical commissioning groups; | Director of Nursing & Quality, Tameside & Glossop CCG | Nikki Leach |
| | Acting Director of Operations and Delivery NHS England | Margaret O'Dwyer |
| NHS Trusts and NHS Foundation Trusts all or most of whose hospitals, establishments and facilities are situated in the local authority area; | Associate Director, Stockport Foundation Trust Community Healthcare Business Group | Michelle Lee |
| | Service Director, Pennine Care NHS Foundation Trust (Mental Health Services) | Stan Boaler |
| | Deputy Director of Nursing, Tameside Foundation Trust (Emergency and Specialist Services) | Peter Weller |
| Public Health | Director | Angela Hardman |
| Chief officer of police; | Chief Superintendent, Tameside Police | Donna Allen |
| Greater Manchester Community Rehabilitation Company | Strategic Lead for Criminal Justice Interventions | Enda Ross |
| Tameside and Stockport Probation Service | District Manager | Fuschia Allen |
| Cafcass; | Service Manager, CAFCASS | Glen Hagan |
| Voluntary & Community Sector | Community and Voluntary Action Tameside (CVAT). | Ben Gilchrist |

| | | |
|---|---|---|
| 2 Lay Members | 2 Lay Members | Cathy Wilde<br>Vacant post |
| Education | Assistant Executive Director | Heather Loveridge |
| The governing body of a maintained school | Head Teacher, Primary School | Carolyn Divers |
| | Head Teacher, Secondary School | Carol Lund |
| Further education institution situated in the authority's area. | Assistant Principal, Tameside College | John McCall |
| Housing | Strategy Housing Officer | John Hughes |
| Children's Services | Assistant Executive Director | Dominic Tumelty |
| **Advisers to the Board** | | |
| | TSCB Business Manager | Stewart Tod |
| | Head of Children's Safeguarding | Lorna Schlechte |
| Designated Doctor | Designated Doctor | Munera Khan |
| Designated Nurse | Designated Nurse | Gill Gibson |
| Legal Adviser | Legal Adviser | Alison Robertson |
| **Observer** | | |
| | Councillor | Allison Gwynne |

**APPENDIX B**

Tameside Safeguarding Children Board Financial Statement 2014/15

| TAMESIDE SAFEGUARDING CHILDREN BOARD INCOME | |
|---|---|
| In 2014/15 total annual income equalled £386,950 and was made up as follows: | |
| Tameside Council contribution | £123,330 |
| School/Academies | £90,268 |
| Clinical Commissioning Group | £134,700 |
| Police | £13,200 |
| New Charter Housing | £3,569 |
| Probation | £3,333 |
| CAFCASS | £550 |
| Public Health – CSE Resource Contribution | £6,000 |
| New Charter Housing – CSE Resource Contribution | £12,000 |
| **Total Contributions 2014/15** | **£386,950** |
| **Reserve carried forward from 2013/14** | **£148,400** |
| **Funds From 1 April 2014** | **£535,350** |

| TAMESIDE SAFEGUARIDNG CHILDREN BOARD EXPENDITURE 2014/15 | | | |
|---|---|---|---|
| **Account Code Description** | **Budget 2014/15** | **Spend 2014/15** | **Variation to budget** |
| Staffing costs | £152,410 | £103,984 | -£48,426 |
| TSCB General | £178,460 | £240,443 | £61,983 |
| Training Strategy | £24,000 | £21,388 | -£2,612 |
| Serious Case Review | £30,900 | £26,987 | -£3,918 |
| **TOTAL EXPENDITURE** | **£385,770** | **£392,802** | **£7,032** |

| RESERVE | |
|---|---|
| **Headings** | **2014/15** |
| Funds from 1 April 2014 | £535,350 |
| Total Expenditure | -£392,802 |
| **Balance in Reserve 31/03/15** | **£142,548** |

## GLOSSARY

| | |
|---|---|
| **CAFCASS** | **Children and Family Court Advisory and Support Service** |
| **CAMHS** | **Child and Adolescent Mental Health Service** |
| **CCG** | **Clinical Commissioning Group** |
| **CDOP** | **Child Death Overview Panel** |
| **CSE** | **Child Sexual Exploitation** |
| **GMP** | **Greater Manchester Police** |
| **ICS** | **Integrated Care System** |
| **IDVA** | **Independent Domestic Violence Advisor** |
| **LADO** | **Local Authority Designated Officer** |
| **LGBT** | **Lesbian, Gay, Bi-Sexual, Trans-Gender** |
| **LSCB** | **Local Safeguarding Children Board** |
| **MARAC** | **Multi-Agency Risk Assessment Conference** |
| **TMBC** | **Tameside Metropolitan Borough Council** |
| **TSCB** | **Tameside Safeguarding Children Board** |
| **PASM** | **Professional Abuse Strategy Meeting** |
| **YP** | **Young Person** |

| | |
|---|---|
| **Report to :** | **HEALTH AND WELLBEING BOARD** |
| **Date :** | 12 November 2015 |
| **Reporting Officer:** | Councillor Lynn Travis – Executive Member (Health and Neighbourhoods)<br>Ben Gilchrist – Chief Executive, Healthwatch Tameside |
| **Subject :** | **HEALTHWATCH ANNUAL REPORT** |
| **Report Summary :** | This is the Healthwatch Tameside Annual Report 2014-15. It highlights their statutory functions, activities during the year and outcomes that have been achieved. The report notes:<br>• Healthwatch Tameside engaged with significant numbers of local citizens, including people from seldom heard communities.<br>• Tameside Hospital welcomed and acted on a set of Enter & View visits undertaken by Healthwatch Tameside.<br>• Healthwatch Tameside has established a large online following as well as providing face to face contact in a number of community settings.<br>• Healthwatch Tameside took on the NHS complaints advocacy function this year with no additional funding. They have seen a 55% increase in active cases during the year (due to being more accessible to the local population).<br>• Healthwatch Tameside played a significant role in ensuring that local residents responded to the Healthier Together consultation. Our Borough had the highest number of responses for any area where the future role of the local hospital was not being consulted on.<br>• The report includes three examples of 'impact stories' where Healthwatch has made a difference to local people or services.<br>• Future Healthwatch priorities include helping the local population to engage with Care Together and the GM Devolution agenda. |
| **Recommendations :** | The Health and Wellbeing Board is asked to note the contents of the report and to thank the staff and volunteers of Healthwatch Tameside for their work on behalf of the local population. |
| **Links to the Health and Wellbeing Strategy :** | The Health and Wellbeing Strategy commits to working together to provide effective community engagement opportunities that help services better respond to need linked particularly to the delivery of the nine underpinning programmes. This report delivers on and further enables this commitment. |

| | |
|---|---|
| **Policy Implications :** | One of the main functions of the Health and Wellbeing Board is to promote active engagement with and listening to our communities as a key part of delivering large scale change for sustainable health improvement and achieving lasting reductions in health inequalities. This is linked to the rights to involvement in healthcare under the NHS Constitution. The findings in this report provide useful context and insight for future planning and commissioning decisions and alongside detailed output from the current follow-up data collection exercise should support work with commissioners and providers to identify and implement improvements in patient experience. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | The Healthwatch Tameside contract was delivered within the 2014/15 allocated funding of £136,000. It should be noted that the existing contract expires on 31 March 2016. There is an option to extend the contract for up to a further two years which will be subject to a separate decision. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | Under the Health and Social Care Act 2012, Tameside MBC has a statutory duty to commission Healthwatch Tameside.<br>Healthwatch works across a broad spectrum that ranges from local organisations and specialist partners to national bodies and government ministeries and its aim is to work towards a society in which people's health and social care needs are heard, understood and met. Achieving this vision will mean that:<br>People shape health and social care delivery;<br>People influence the services they receive personally;<br>People hold services to account.<br>Healthwatch use evidence based on real experiences to highlight national issues and trends and raise these at the highest levels. |
| **Risk Management :** | Healthwatch Tameside is sustainable at the current level of funding if demand remains stable. Should demand increase or funding reduce this will have a significant negative effect on Healthwatch Tameside's ability to deliver a good quality service and meet the statutory requirements of the services provided. CVAT and Healthwatch management monitor demand on a regular basis. |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting Ben Gilchrist, Tameside Healthwatch by;<br>  Telephone: 0161 339 4985<br>  e-mail: ben.gilchrist@cvat.org.uk |

healthwatch Tameside

# Annual Report 2014/15

# Contents

# Note from the Chair

**This has been a year of development for Healthwatch Tameside. Our work has extended in both scope and impact. Our staff have worked tirelessly to ensure that we fulfil our role as "People's Champion for Health and Care".**

At the start of the year we were faced with a difficult choice. We could either take on an additional service within our existing funding or we could continue to deliver the same services but with a significant budget cut. The additional service we had the option to take on was to help people who wanted to make a formal complaint about NHS Care they had received. In some areas this is called an independent complaints advocacy service.

We agreed to take on this additional service and our staff have made me and the whole Board proud of the way that they are supporting our local residents when things go wrong for them.

Our role isn't just about when things go wrong though. We undertook our first Enter and View visits this year. These were at Tameside Hospital and showed that improvements have been made in many areas that members of the public had expressed concerns about in the past.

Although more improvements are still needed at the hospital we feel that we now have an effective and positive working relationship with senior managers and operational staff there. Our staff and board have been working with that organisation for over ten years now and we feel that the hospital's leaders are more open and transparent than they have been at any other time in those ten years. This can only be good for improving the quality, safety and experience of care.

NHS and social care services are planning and working much more closely together than ever before – both within Tameside and across the Greater Manchester area. Examples of this include: Healthier Together, Care Together and GM Devolution. We have played a major role in ensuring local people's voices have been heard in this (including being shortlisted for a Healthwatch England award for our work on Healthier Together). Our board feel that this is such an important topic that they have prioritised this in our 2015/16 work plan.

We have also developed a close and positive working relationship with our neighbours at Healthwatch Oldham – including having a single Operational Manager working across both organisations.

This year saw a significant increase in our contact with the local population. The figures later in this report will tell the full story of this. I must pay tribute, however, to the dedicated hard work of all our staff and volunteers. Without them, none of this would have been possible.

Thank you all.

**Dr Kailash Chand OBE**

# About Healthwatch

**We are often described as the local consumer champion for health and care. This means we want to make health and social care better for people in Tameside. We believe that the best way to do this is by designing local services around local people's needs and experiences.**

Everything we do is informed by our connections to local people and our expertise is grounded in their experience. We are the only body looking solely at people's experience across all health and social care.

As an organisation with statutory powers our role is to ensure that local health and social care services, and the local decision makers, put the experiences of people at the heart of their care.

## Our vision/mission

We describe our work in four main ways:

1. We listen to people's experiences of using health and social care services. This gives us **insight** – so we can understand better what's working well for people and also where improvements can be made.
2. We work with the people who plan, pay for and run NHS and social care services. We use our insight to try to **influence** services – so that quality improves based on local experiences. We also work with them when they are planning changes to services – so that quality is maintained wherever possible.
3. We provide **information and support** to people accessing NHS and social care services. This could include basic information signposting through to helping someone to make a formal complaint about an NHS service they have received.
4. We need to have good **internal systems and processes** to make sure we are doing our best with the limited resources we have. Our funding works out at roughly 65p for each person who lives in Tameside.

## Our strategic priorities

In **2014-15** our priorities included:

a) Ensuring that local people are involved in plans around changes in local health and care services – and that when changes have been made, the impact on patients and service users has been evaluated effectively.
b) Establishing our new service to help people who want to make a complaint about NHS care they have received.
c) Recruiting and training Enter & View volunteers.
d) Following up topics raised by Tameside Health and Wellbeing Scrutiny Panel's work looking at care homes.
e) Undertaking Enter & View visits at Tameside Hospital – to determine whether the hospital's improvement plans have resulted in better care in terms of some of the concerns raised by Tameside Link.

# Engaging with people who use health and social care services

## Understanding people's experiences

In Tameside we have a diverse population spread across a number of different towns. We have therefore developed **a range of ways for local people to engage with us and tell us their stories** about health and care services. These include:

- Online surveys
- Use of the Patient Opinion feedback system (we offer online, paper based, face to face and telephone access)
- Outreach visits to voluntary and community groups (e.g. Age UK, Stroke Association, Tameside Deaf Club)
- Targeted engagement with specific groups (e.g. a project to gather the views and experiences of pupils at Denton Community College)
- Referral by 'word of mouth'
- A network of volunteer Healthwatch Champions who run regular sessions in community venues including: supermarkets, libraries, GP waiting rooms and hospital waiting areas.

We think we are unique in our area in being the only organisation that allows people a way for their experience to be fed back anonymously to their health or care provider. We find that doing this enables us to gather experiences from people who would otherwise be unwilling to tell their stories.

During 2014/15 we collected the following experiences from people:

- 136 stories via Patient Opinion
- 103 written patient stories
- 202 completed general survey forms
- 49 pharmacy survey forms
- 96 Enter & View interviews with patients and/or their relatives

We undertook **outreach activity** with the following groups:

- Alzheimer's groups
- Older people's groups
- Mental Health service user groups (including a women's group)
- LGBT community group
- Deaf people's organisations
- CCG Long term health conditions engagement activity
- Healthier Together engagement events
- Stalls on Ashton market
- CAB volunteers – to help them raise awareness of our services

**We have face to face contacts with approximately 250 people each month through our volunteer Healthwatch Champions and our outreach activities.**

## Enter & View

This year we undertook one set of Enter & View visits. These were at Tameside Hospital. The hospital has faced a number of challenges for several years. We have been part of a Quality Oversight Group which has monitored how the hospital has implemented its improvement plans. Our Enter & View visits were designed to see what the impact of these improvement plans was – particularly in terms of the topics that local people had told us (and the LINk before us) were important to them. We were pleased to note that many improvements had been made.

The hospital was very receptive to our Enter & View report, including the further improvement areas we identified and recommendations we made. We have been invited back to see the changes they have made since our visits.

**"I thank you for your report and in particular the recognition of the partnership work between the Trust and Healthwatch. I can assure you that your comments & recommendations will feed into our Improvement and Assurance Programme."**

*Karen James, Chief Executive, Tameside Hospital NHS Foundation Trust*

Thanks to all our staff and volunteers who took part in these Enter & view visits. Names of our authorised Enter & View representatives are listed on our website. Thanks also to the hospital staff who were very welcoming and supportive of our visits – it felt like they really did want to hear how we thought they could improve.

# Providing information and signposting for people who use health and social care services


## Helping people get what they need from local health and social care services

We have developed a number of **ways for people to get information about health and care services**:

- Online resources on our website, signposting people to reliable sources of specialist information.
- Incorporating the Patient Opinion and Care Opinion portals into our website – so people can read about other people's experiences of care before deciding which service they want to choose.
- Training our Healthwatch Champions and providing them with paper resources so they can provide basic information signposting during their visits to community venues.
- Redesigned our telephone information service which now also supports members of the public who call in to our offices.
- Developed and improved our eBulletin so it is now sent out fortnightly to a growing distribution list.
- Established a regular Twitter feed which sends out key messages daily and has seen our number of followers more than double.

**Our eBulletin is now distributed to over 630 people every two weeks**

Our **eBulletin and Twitter** feed contain a mixture of messages that we feel are important in keeping our local population informed. These include:

- Signposting to information, advice and guidance from reliable local and national sources
- Promoting active citizenship through participation in activities that can improve an individual's

health and wellbeing (e.g. physical activity, mindfulness sessions, etc.)

- Sharing data about how health and care services are currently performing
- Raising awareness of opportunities to have their say and influence services through other organisation's engagement activities.

We also provide a **"Help with NHS Complaints"** service as part of our information and support service. This service helps people to 'self advocate' if they are unhappy with the care they received and want to make a formal complaint to the NHS.

Demand for this service has increased significantly during the year.

**Our active NHS Complaints caseload increased from 26 to 40 during this year. In total we worked with 71 people who wanted to complain about NHS services.**

**We have grown our Twitter following to over 1,100 people with posts regularly reaching 4,500 people and our most popular ones reaching over 30,000 people**

We have continued to provide content for the **Healthwatch Hour show on Tameside Radio**. Our contributions to this show are also available for download from our website. The topics we covered on the radio this year included:

- Stoptober
- Sexual health – access to services
- Sexual health - contraception
- Heart – know your numbers
- Eye health
- Migraines
- Weight loss
- 'Feeling under the weather'
- HIV testing week
- Baggy Trousers UK (testicular cancer)
- Safe drinking & Dry January
- Bug busting
- Cardiac Support Group
- Prostate cancer support
- Adult autism support

# Influencing decision makers with evidence from local people

## Producing reports and recommendations to effect change

This year we have produced **one formal report and one response to a statutory consultation**:

- We undertook a set of formal Enter & View visits at Tameside Hospital. These were undertaken with the hospital's full co-operation and support. Both the Hospital and the CCG responded positively to our report and recommendations and we have recently been invited back for an informal 'walk around' to see the changes they have made.
- We made a formal response to the 'Healthier Together' consultation which focused mainly on proposals to change some hospital services across Greater Manchester. There is more information on this in impact story three (see below).

We have also **raised a number of individual care issues and highlighted patterns that we have noticed emerging in patient stories.** For example, we heard a few stories about pain management during colonoscopies – the hospital agreed to add this to the scope of a review of that service that they were undertaking.

## Putting local people at the heart of improving services

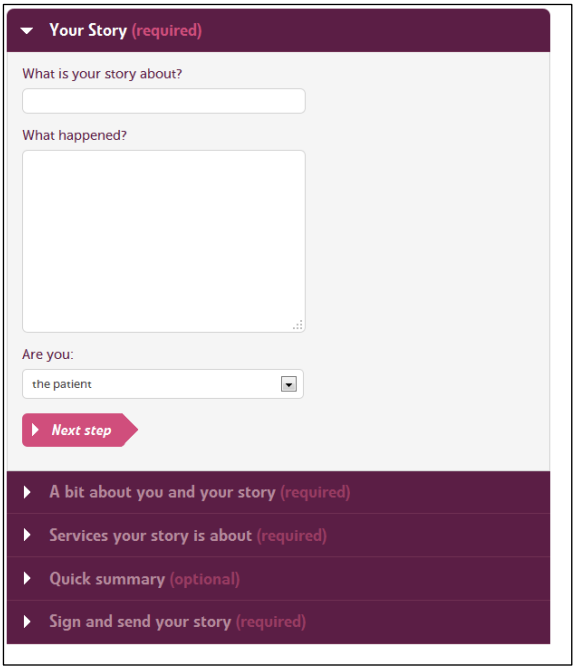
We play an active role in **ensuring that local people are heard in key discussions about the quality and development of local services**. We represented the public as their consumer champion in the following regular forums:

- Tameside Health and Wellbeing Board
- Tameside Adult Safeguarding Partnership
- Tameside Hospital Quality Oversight Group
- Tameside Hospital Patient Experience Group
- Tameside and Glossop Clinical Commissioning Group Quality Committee
- Tameside and Glossop Clinical Commissioning Group Patient and Public Impact Committee
- Tameside and Glossop Local Improvement Group (focusing on GP practices)
- Tameside Pharmaceutical Needs Assessment Steering Group

We actively **promoted opportunities for the public to get directly involved** in the following:

- Healthier Together
- Monitor Adult Hearing Loss Review
- Pharmacy Needs Assessment (Tameside)
- GM Patient Transport focus group (looking at future service specifications)

- Care Together (integration of health and social care in Tameside and Glossop)
- Wellness Service consultation
- Congenital heart disease review
- Red Cross mobility aids service
- Carers workshops




We have also actively promoted the use of the **Patient Opinion platform** across local health and care organisations. This is a way for stories that people tell us about their experience of care to be read, responded to and acted on quickly – often within only a few days of us receiving them. Many of our key local services use Patient Opinion and we have seen an improvement in responses this year (though we still want to see more feedback about what changes have been made as a result of people's stories).

## Working with others to improve local services

We have some statutory powers and requirements about working with regulatory bodies and other partners. Here is a summary of our activity relating to these:

- We made no recommendations to the Care Quality Commission to undertake special reviews (themed investigations) or investigations (responsive inspections). We did, however, offer them access to patient stories we had collected to help inform their planned inspections. We would like to strengthen our working relationship with the Care Quality Commission through more direct engagement between their staff team and ours.
- All service providers and commissioners we requested information from responded to our formal requests.
- We sent Healthwatch England copies of our formal reports via e-mail.
- We met regularly with the Chair of the Tameside Health and Wellbeing Scrutiny Committee but felt no need to formally refer any items to them.

**Partnership working outside these statutory requirements is extremely important to us**. We were involved in the following wider partnership activities:

- We are an active member of the Greater Manchester Healthwatch network. This helps us to ensure that local people's voices and experiences are heard in activities that stretch beyond the Tameside boundary.
- We contributed to the Healthier Together External Reference Group.
- We provided interim management support to Healthwatch Oldham whilst their support & delivery contract was out for tender.

# Impact Stories

## Case Study One

### *Positive outcome from a complaint*


**A member of the public contacted Healthwatch Tameside by telephone.** This was a difficult conversation as the caller was very wary of any type of 'official' organisations and he did not want to give any information apart from his name and mobile telephone number. It was clear that he wanted to make a complaint about NHS services that he had received but he did not want to give any details in case of reprisals.

We had a number of telephone conversations and eventually he agreed to come in for a face to face meeting. In the meeting it became clear that there were several issues, some of them were outside the remit of Healthwatch Tameside, but all interlinking. After some discussion that included a lot of re-assurance and 'confidence building' we agreed that a referral to another organisation would beneficial to the caller.

With his agreement we set up a joint meeting with the other organisation when we discussed the support that they can give. At this stage the person said that he wanted to think about everything that had been said and come back to us. He did get back in touch and with further re-assurances another meeting was set up with the other organisation. In this meeting it was agreed that Healthwatch would work in partnership with the other organisation on the NHS complaint with the other issues being addressed by them. We all worked together to obtain the best outcome for this person.

Over the time that this person was coming into the Healthwatch offices, his confidence started to grow and independently he made enquiries about other projects that are run from the building which we share with Volunteer Centre Tameside. He is now volunteering with another project, and attending a short training course.

**As a result of this phone call to us a member of the public has achieved positive outcomes in terms of their complaint about NHS care. It also helped them to build their confidence and they are now successfully volunteering in their local community too.**

## Case Study Two

### *Information for a local young person*

**NHS staff from out of area ask for help…**

**Healthwatch Tameside was contacted by a ward sister from a hospital outside our area.** She was enquiring about services in the Tameside area.

A young person from Tameside was in hospital and had been for several months. She had been badly affected by the death of her partner about 12 months previously. As this person was recovering the staff at the hospital were keen to put into place, prior to discharge, services that could support continued recovery in the community.

We researched specialist services who offer bereavement counselling and other services for young people who are in or recovering from a crisis. This information included:

- Who is eligible to access the service?
- How to access the service
- When is the best time to make a referral?
- Who is best placed to make the referral?
- What experience the service had working with young people who had experienced bereavement?

The ward sister already knew about the more well-known mental health services and organisations.

**As a result of this enquiry to our information signposting service the patient's ongoing care plan was changed to include referral into a specialist local young persons' mental health support service.**

Our team investigated options and found out about a local voluntary organisation that provides mental health services and support to young people. We found out about referral criteria, contact details and information about 'drop in' support sessions and passed these on to the ward sister.

## Case Study Three

## *Influencing Change across the system*

### Helping shape service redesign

**Healthier Together is a Greater Manchester initiative looking at service redesign in terms of Primary Care, Secondary Care and Integrated Care.** It is aligned with local Tameside plans both in terms of our hospital's long term sustainability and the ambition for integrated health and social care.

Although much of our work related to the Healthier Together statutory consultation, our Board felt this should be a priority because:

- We felt that the statutory consultation resources and plans did not fully take into account the needs and preferences of our local population.
- This was a significant opportunity for the population to influence future services and (as local consumer champion) we had a responsibility to help our local population to have their various voices heard.

In terms of the collection of evidence relating to Healthier Together, we were clear that this was a statutory responsibility of the Healthier Together team. Our engagement therefore took a different form:

- We raised awareness of the consultation and how local people could have their say.
- We helped the local population to understand what the proposals were about.
- We worked with our local CCG to ensure that we had a joined up approach.

**Our engagement took a number of forms:**

- We used our volunteer Healthwatch Champions, our weekly Healthwatch Hour slot on local radio, Twitter, our website, eBulletins and postal circulation list to raise awareness of the consultation – directing people to paper and online consultation resources.
- We worked in partnership with our local CCG to share consistent messages about how people could get involved.
- We worked in partnership with Healthwatch Oldham to provide a plain English document about the consultation (this was subsequently used by a number of other Greater Manchester Healthwatch organisations and formally adopted by the Healthier Together team)
- We worked in partnership with a local newspaper to produce a series of weekly articles explaining each of the key question areas in the consultation.
- We took part as a panel member in Healthier Together formal debates – enabling information from the pre-consultation business case to come to light which would not otherwise have been easily accessible to the public.
- We listened to the questions and concerns raised by members of the public at consultation events.

We ensured that evidence included in the pre-consultation business case was included in our briefings and at the public debates where we spoke.

- We used our understanding from public comments and questions at consultation events to inform our involvement in the 'invitation only' sessions we attended in terms of transport implications and the impact assessment of the proposals.
- We produced our own formal response, based on things we had heard local people say.
- We contributed to the Healthier Together External Reference Group report on the efficacy of the engagement and public consultation.

**Out of all the Greater Manchester areas where the status of our local hospital wasn't in question, Tameside residents submitted the largest number of responses.**

We are still awaiting the formal announcement of the next stage of Healthier Together. However, we have already seen the following outcomes:

- Out of all the Greater Manchester areas where the status of our local hospital wasn't in question, Tameside residents submitted the largest number of responses. This was greater than the number of responses from some areas where the future status of the local hospital was up for discussion as part of the proposals. We feel this means that local people in Tameside were able and empowered to have their say.
- Healthier Together has formally agreed and adopted closer working relationships with Healthwatch across Greater Manchester, learning from feedback about this formal consultation and the pre-consultation engagement.
- Conversations with the Greater Manchester Devolution team suggest that they are also taking on board the learning from the Healthier Together engagement and consultation.

This work on Healthier Together was shortlisted for a national award by Healthwatch England.

# Our plans for 2015/16

## Opportunities and challenges for the future

Greater Manchester has been granted a unique Memorandum of Understanding for devolution of many health and social care decisions. This could have significant implications for our local population. In addition, local plans ('Care Together') for health and social care are bold and on a large scale. When combined with a hospital which was one of the 'Keogh Trusts' and is in Special Measures this gives us a number of significant topics of interest for our local population.

Added to this we have some of the worst health outcomes and health inequalities in the country with both life expectancy and healthy life years figures significantly lower than average. Put in the national context of stretched funding, more people living longer with more complex health and care needs and national shortages of qualified, experienced staff there is clearly much that needs to be done.

We are committed to ensuring that the voices of local people are heard by decision makers. We have some key principles to enable and support this:

- We work closely in partnership with other local Healthwatch organisations across the Greater Manchester area.
- We work collaboratively with our local NHS, social care and public health partners. Where there is negative feedback for a service we see this as an opportunity for improvement rather than an opportunity to criticise.
- We have an 'open source' approach to the data and patient stories we collect. We share these freely with our partners whilst maintaining anonymity when people have asked for it.
- We must retain our independence. We work hard to promote good practice in public engagement and to encourage people to get involved but we don't normally engage with the public on behalf of our partners.

Specifically our priority areas are:

- **GP and outpatient appointments.** Some local people have told us they have problems getting appointments but others tell us it's fine. We are working to understand why we get different views and will then work with partners to try to identify potential improvements.
- **Impact of the Care Act.** We will be asking local people to tell us what impact the new Care Act has had on their care.
- **System Change** including GM Devolution and Care Together. This has the potential to have a significant impact on our local population. We will play a role in ensuring local people's voices are encouraged and listened to.
- **Communication between the NHS and Patients**. Again this is an area where there is variation in patient feedback and some people have expressed concerns. We want to better understand what works well and what creates barriers.

# Our governance and decision-making

## Our board

Our Board is a mixture of people elected by our members and people appointed because of the specific skills, knowledge and experience they have. We believe this allows us to strike a good balance and enables our highest level decisions to be based both on 'grass roots' experience and appropriate specialist knowledge.

Our Board has an independent Chair.

During 2014/15 our Board comprised:

- Dr Kailash Chand OBE (Chair)
- Dorothy Cartwright (elected)
- Frank Downs (elected)
- Janet Fenton (elected) – until March 2015
- David Hoyle (appointed)
- Hanif Malik (appointed)
- Bernard Nagle (elected)
- Cllr Gill Peet (appointed)
- Phil Spence (appointed)
- Lesley Surman (elected) – until September 2014
- Pamela Watt (appointed)
- Lyndsey Whiteside (appointed)
- Ian Young (appointed)

Elections will take place during 2015 to replace Janet Fenton and Lesley Surman. Following the elections the appointed places will also be reviewed to ensure the Board has the necessary skills and experience.

## How we involve lay people and volunteers

In addition to the five elected places on our Board, local people have a number of ways to influence our work. These fall into two main areas:

1. We invest significant staff time in 'triangulating' all the data we receive. We compare survey responses, Patient Opinion posts, complaints data and individual stories people tell us. Where we spot patterns (or sometimes a single particularly worrying experience) these become priority areas for us to engage with commissioners and service providers on behalf of the local community.
2. Our Healthwatch Champion volunteers come from a broad cross section of our population. They shape where we go to engage with the public and gather their stories. This helps to ensure we are targeting the right groups within each community and community of interest. Through their regular network meetings, the Healthwatch Champions help us to identify emerging community messages that we then look at as priority areas for our work.

This year we recruited six new Healthwatch Champion volunteers. We also recruited and trained 10 new Enter & View volunteers.

Our volunteers gave us 549 hours of their time this year – varying from just a few hours through to two volunteers who gave us over 130 hours each!

# Financial information

2014-15 saw similar levels of Healthwatch Tameside expenditure as the previous year. As expected, demand for our services increased. This was as a result of increased awareness and taking on the 'Help with NHS Complaints' service. There was no additional income to cover this extra service and the cost of delivering it has been met from our core local authority funding. The table below provides a summary of our finances from 1 April 2014 to 31 March 2015.

| INCOME | £ |
|---|---|
| **Funding received from local authority to deliver local Healthwatch statutory activities & 'Help with NHS Complaints' service** | 136,000 |
| **Additional income** | nil |
| **Total income** | **136,000** |
| Brought forward balance from 2013/14 | 24,452 |

| EXPENDITURE | |
|---|---|
| **Office costs** | 14,748 |
| **Staffing costs** | 90,430 |
| **Direct delivery costs (including professional fees)** | 26,053 |
| **Total expenditure** | **131,231** |
| Balance carried forward to 2015/16 | 29,221 |

It should be noted that our initial contract with Tameside MBC expires on 31 March 2016 but may be extended up to a further two years. We are grateful that prudent expenditure and monitoring mean that we have some reserves from which cost of living and other increases can be met for the potential full duration of the contract (until March 2018). We are concerned that any significant increase in demand for services or partnership working will be difficult to meet totally using the current funding received from the local authority. Guidance suggests having reserves that equate to approximately three months operating costs is good practice. Our reserves are currently below that level.

# Contact us

## Get in touch


| | |
|---|---|
| Addresses: | **Healthwatch Tameside (Head Office),**<br>131 Katherine Street, Ashton-under-Lyne, OL6 7AW<br><br>**Healthwatch Tameside (Staff Base),**<br>95-97 Penny Meadow, Ashton-under-Lyne, OL6 6EP |
| Phone number: | 0161 667 2526 |
| Email: | info@healthwatchtameside.co.uk (general e-mails)<br>NHSComplaints@healthwatchtameside.co.uk (confidential mailbox for our 'help with NHS complaints' service) |
| Website URL: | www.healthwatchtameside.co.uk |


We will be making this annual report publicly available by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Tameside & Glossop Clinical Commissioning Group, Tameside Health and Wellbeing Overview and Scrutiny Committee, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

| | |
|---|---|
| **Report to :** | **HEALTH AND WELLBEING BOARD** |
| **Date :** | 12 November 2015 |
| **Reporting Officer:** | Councillor Lynn Travis – Executive Member (Health and Neighbourhoods)<br>Ben Gilchrist – Chief Executive, Healthwatch Tameside |
| **Subject :** | **HEALTHWATCH ANNUAL INTELLIGENCE REPORT** |
| **Report Summary :** | This is a summary of the aggregated data from 770 patient stories and survey responses received by Healthwatch Tameside during 2014. The purpose of this is to enable themes and patterns to be identified that are not always immediately obvious when ready a single storing in isolation. The report pulls together data from:<br>• Patient opinion;<br>• Healthwatch surveys;<br>• Patient stories we have been told but asked not to share on an individual basis;<br>• Informal comments collected by our Healthwatch Champions;<br>• Themes from NHS complaints where we have provided help for people to use the formal complaints system. |
| **Recommendations :** | The Health and Wellbeing Board is asked to:<br>1. Recognise the report as part of the evidence base for the Joint Strategic Needs Assessment with a new version being sent to the Board annually;<br>2. Note and share the three main themes emerging from patients' comments especially where it may provide useful context and insight for future planning and commissioning decisions:<br>• Appointments (GP and hospital);<br>• Communication (explanations, information, listening, advice and correspondence);<br>• Staff.<br>3. Support Healthwatch Tameside's intervention to work with commissioners and providers to identify and implement improvements in patient experience when the more detailed output from the follow-up data collection exercise around appointments, communication and staff is complete. |
| **Links to the Health and Wellbeing Strategy :** | The Health and Wellbeing Strategy commits to working together to provide effective community engagement opportunities that help services better respond to need linked particularly to the delivery of the nine underpinning programmes. This report delivers on and further enables this commitment. |

| | |
|---|---|
| **Policy Implications :** | One of the main functions of the Health and Wellbeing Board is to promote active engagement with and listening to our communities as a key part of delivering large scale change for sustainable health improvement and achieving lasting reductions in health inequalities. This is linked to the rights to involvement in healthcare under the NHS Constitution. The findings in this report provide useful context and insight for future planning and commissioning decisions and alongside detailed output from the current follow-up data collection exercise should support work with commissioners and providers to identify and implement improvements in patient experience. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | There are no direct financial implications relating to this report. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | Under the Health and Social Care Act 2012, Tameside MBC has a statutory duty to commission Healthwatch Tameside. Healthwatch works across a broad spectrum that ranges from local organisations and specialist partners to national bodies and government ministeries and its aim is to work towards a society in which people's health and social care needs are heard, understood and met. Achieving this vision will mean that:<br>People shape health and social care delivery;<br>People influence the services they receive personally;<br>People hold services to account.<br>Healthwatch use evidence based on real experiences to highlight national issues and trends and raise these at the highest levels. |
| **Risk Management :** | Failure for this report, and the detailed follow up work, to form part of the evidence base for the Joint Strategic Needs Assessment would weaken insight for future planning and commissioning decisions. Lack of commissioner and provider engagement with Healthwatch based on these report findings would hamper the identification and implementation of improvements in patient experience. This would weaken the Board's active engagement with and listening to our communities and the fulfilling of people's rights to involvement in healthcare. Healthwatch are active in updating partners around progress in use of local evidence and engagement and service improvement activity. |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting Ben Gilchrist, Tameside Healthwatch by;<br>  Telephone: 0161 339 4985<br>  e-mail: ben.gilchrist@cvat.org.uk |

# A report on the data collected by Healthwatch Tameside during 2014

**Published August 2015**

Healthwatch Tameside, 95-97 Penny Meadow, Ashton-under-Lyne, OL6 6EP

www.healthwatchtameside.co.uk @HealthwatchTame

# Contents

## Introduction

This report brings together all the data collected by Healthwatch Tameside during 2014. There are a number of sources of the data:

- **Patient Opinion** – there are different ways for people to tell their story (or report their experience) using Patient Opinion:
  - They can type it themselves via the Healthwatch Tameside website or directly onto the Patient Opinion/Care Opinion (referred to as Patient Opinion for the rest of this report) websites.
  - They can record comments on the NHS Choices website. These show on Patient Opinion, but without a criticality rating (see explanation below).
  - They can complete a paper form and send it to the Healthwatch Office.
  - They can speak to a member of staff or Healthwatch Champion, who will record the details.

  When information is sent to the office, it is recorded on Patient Opinion using a staff account, so maintaining anonymity, if requested.

  When Patient Opinion receive a story, it is looked at by a member of their team and moderated. The story is not usually changed, although anything which could be seen to be defamatory may be reworded. They also allocate a level of criticality to the story. This is not a level of criticism, but is based on the impact on an individual if something going wrong. This ranges from 0 (not critical) through to 5 (severely critical). It will then be published. A level 5 will result in the provider being contacted directly by Patient Opinion, instead of waiting for them to see the story online.

- **Do Not Publish** – sometimes people want their story to be heard, but do not want it publishing on Patient Opinion. We record this information on a spreadsheet, to be used when we analyse data.

- **Surveys** - Healthwatch Tameside have a survey form which asks questions about which services have been used by people in the past 12 months. It also asks which gave the best service and which the worst, along with what was particularly good and how they think the services can be improved. There are two ways to complete the survey:
  - Online via the Healthwatch Tameside website.
  - On a paper questionnaire. The details from the paper copies are then manually added to the online data.
- **Comments collected by Healthwatch Champions** – these will be a few words from a person, but not a full story.

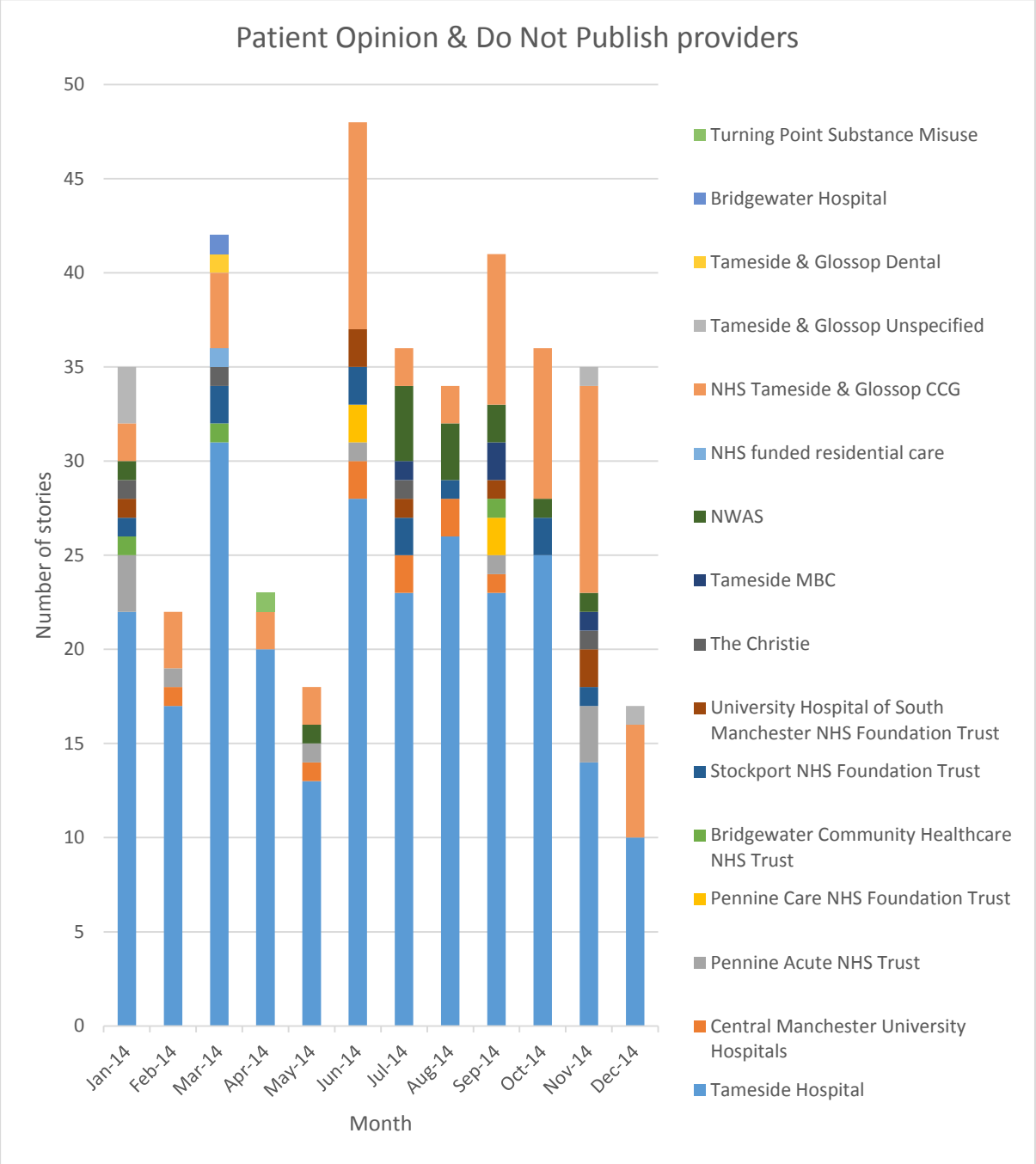
- **NHS Complaints** – Healthwatch Tameside assist people to access the complaints system.

This report looks at the data, and provides some detailed information about the areas we have large numbers of stories. The total number of sources of data collected in 2014 is 770, split:

| | | |
|---|---|---|
| Patient Opinion – 262 | Do Not Publish – 91 | Surveys – 311 |
| Comments – 30 | Complaints – 76 | |

Within each of these sources there can be multiple stories/experiences, particularly the surveys. Of the 76 complaints which were live in 2014, a few of these related to experiences from previous years. These details have not been included in the analysis.

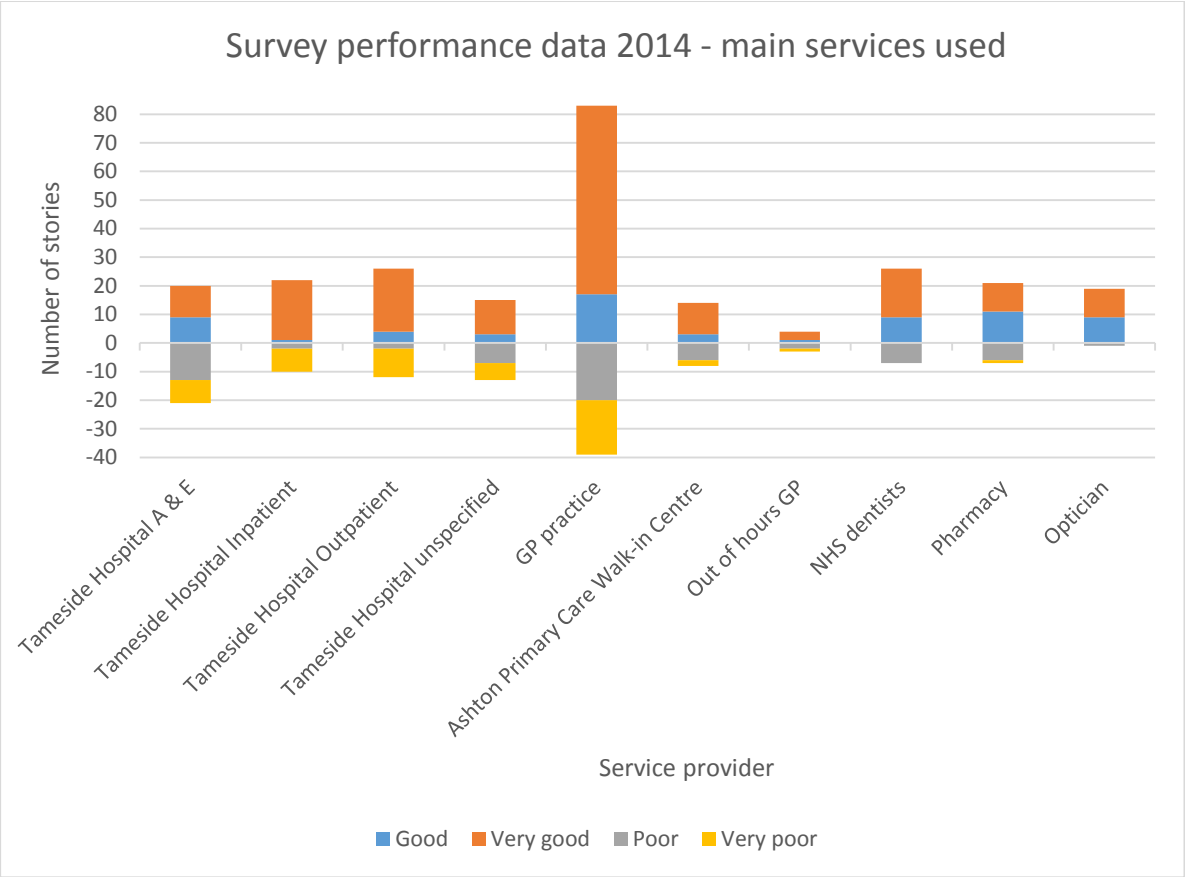
**Providers used** as identified in the stories on Patient Opinion and Do Not Publish.

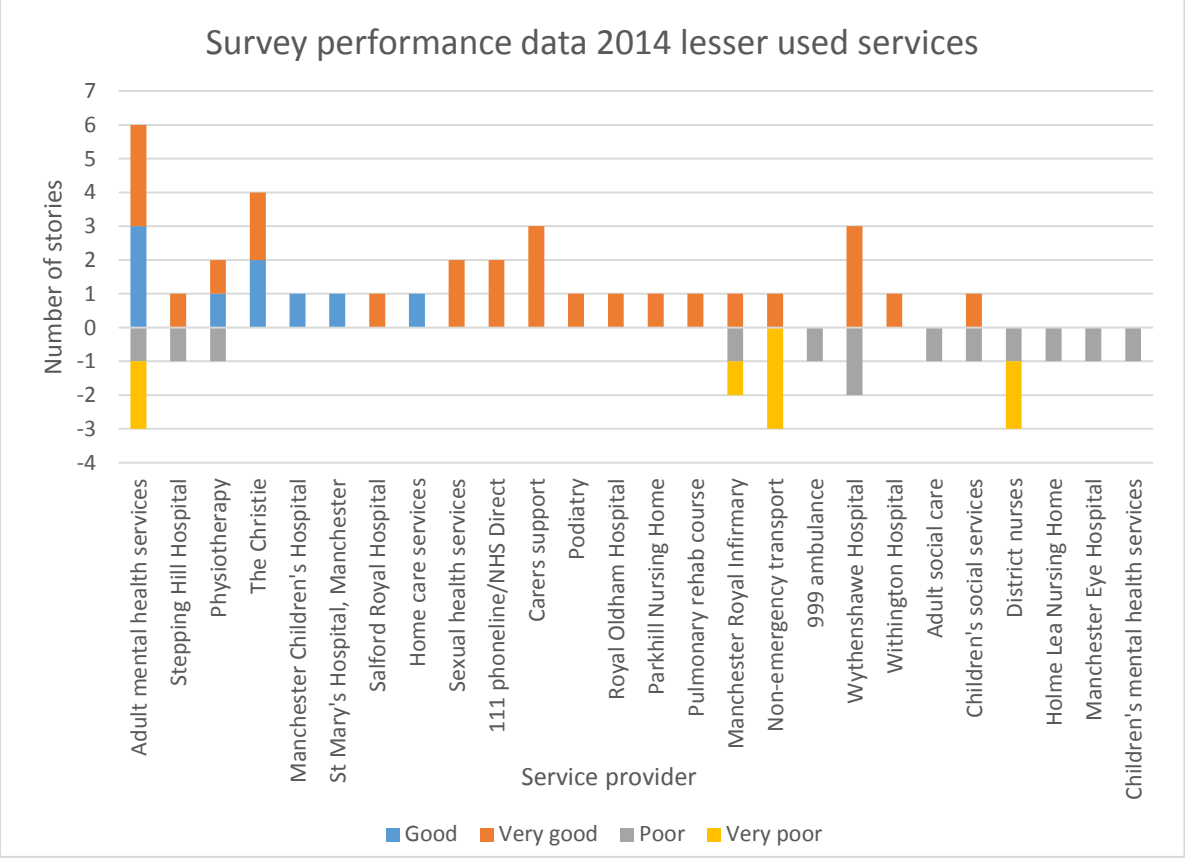



**Performance** - the survey data we collected asked the respondent which services they had used in the last 12 months. Most people had used their GP, and many had used an optician, NHS dentist, pharmacy and hospital.

It is also noticeable that the people who are out in the community, chatting to the Healthwatch Champions, are not generally the people using Social Care services, Community Health services and Mental Health Services. This is an area Healthwatch Tameside are considering, when we plan our outreach for the future.

In the survey, we asked people to rate their best service and worst service – Very Good, Good, Poor or Very Poor.



## Themes

Within the stories, there are common themes, with both positive and negative comments. The main themes are:-

- Appointments (GPs and hospital)
- Communication (explanations, information, listening, advice, and correspondence)
- Staff

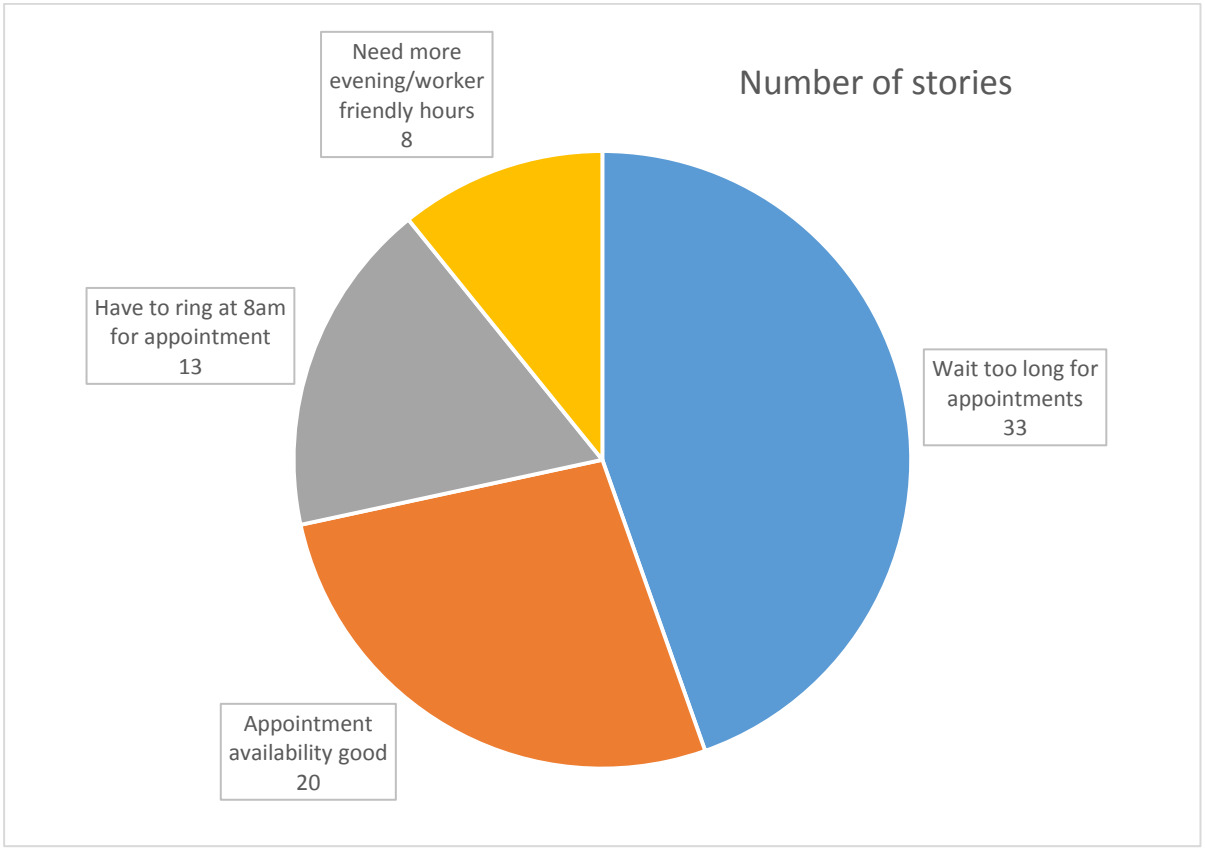
We are going to explore these in more detail in this report. There are summaries included in the body of the report, with more details in the appendices.

## Appointments

### GP Appointments

We collected 104 stories about GP appointments in 2014. Most of the stories have been collected in face-to-face conversations with a Healthwatch Champion, or from the survey.

There seem to be a number of different ways for patients to book a GP appointment, depending on which surgery they are registered with. It is difficult to be sure from the information collected so far whether this affects how people rate their satisfaction with the service provided, so we will be looking into this further.



Generally, once a patient gets to see a doctor, they are happy with the service provided.

Within the stories and comments, a number of suggestions have been made:-

- 'Why can blood tests requested by a doctor during an appointment not be done while you are there, instead of having to make another appointment?'
- 'Have a system whereby a patient can discuss more than one problem during an appointment, instead of having to book separate appointments, eg. longer appointment time on request.'
- 'Be able to see the same doctor throughout a course of treatment, without having to wait weeks for an appointment to see that specific person.'
- 'Try and keep to the appointment times as much as possible.'
- Patients want to be able to get appointments without explaining all their symptoms to receptionists, especially if they feel embarrassed.

**Tameside Hospital appointments**

Many of the comments are about waiting times for appointments or letters not arriving. However, there are also a number of positive comments about the appointment itself.

Looking at all these stories (72 in total), we can see:

| | **Number of stories** |
|---|---|
| Appointment letter not sent or not received | 10 |
| Longer than expected wait for appointment | 19 (not including delays caused in 10 stories above) |
| Cancelled appointments/operations | 6 |
| Appointment times not kept to | 5 |
| Referral not received/didn't happen | 5 |
| Patients happy with appointments | 20 |

Other comments and suggestions included:-

- 'Delays in diagnosis mean treatment is not started is early as it could be, which can have implications.'
- 'Improve the flexibility of appointments.'
- The disabled parking was considered to be quite far from the dermatology outpatients department.
- 'A reduction in the number of outpatient clinics has affected the length of time waiting for an appointment.'
- A few patients commented on the length of time they had to sit in the waiting room beyond their appointment time.

**Communication**

This theme includes explanations, information provided, listening, advice given and correspondence, as well as general conversation.

More details can be found in the appendices.

Looking at communication about diagnosis and treatment between staff and patients/relatives, the balance between positive and negative comments is fairly even.

| | **Number of stories relating to Tameside Hospital** | **Number of stories about other health and social care services** |
|---|---|---|
| Patient/family happy | 21 | 27 |
| Patient/family not happy | 31 | 24 |

**Tameside Hospital**

We collected 57 stories about the hospital, which mentioned communication. The negative comments can be split into a few areas, including:-

- Medical Assessment Unit (MAU)
  - Patient moved to ward at midnight but family not told
  - Poor communication with patients and relatives
- Discharge
  - Most comments relate to discharge from MAU
  - Ongoing health and care arrangements not always in place
  - Not enough information provided about condition
- Knee Operations
  - Lack of information about length of waiting time until procedure, making it difficult to arrange holidays
- Visually impaired Patients
  - When meals are provided, the patient does not always know they are there – they are left to go cold as they can't see them
  - Loss of independence if large fonts are not used on correspondence and medication. Yellow paper requested, but not provided.
- Communication between providers
  - Delays getting test results from Wythenshawe Hospital
  - Notes lost
  - Information not passed between GP and hospital and vice versa
- Patient notes
  - Doctors do not always read patient notes
  - Patient notes illegible
  - Notes from Care Home not always taken into account
- Failure to return calls
  - When patients leave a voicemail message, they do not always receive a call back.

**Other services** – these comments included:-

- 'Need to listen to patients who are the best judge of what hurts.'
- One pharmacy sends text reminders when prescriptions are ready to be collected, which the patient thought was a good idea.
- District nurses – some positive comments. Also, there is sometimes a breakdown in communication between the hospital and the nurses – patients are expecting a visit, but do not get one.
- Doctors do not always read patient notes at Stepping Hill Hospital and Manchester Royal Infirmary.
- Go-to-Doc – Can be a long wait for call back. Doctors with poor English make communication difficult. Doctors need to listen to patient about allergies when prescribing medication.
- 'Adult Social Care – difficulties getting phone calls returned.'
- Patient not told NHS dentist retiring or provided with information about new dentist.
- Dentist and optician who both speak Urdu refused to speak anything other than English, leaving daughter to translate for her mother.
- 'Side effects of drugs prescribed to help with mental health issues should be explained to patients.'

**Staff**

We have collected 235 stories, where staff are mentioned. These come from all the different methods of data collection (except complaints) noted in the introduction to this report.

| | **Positive** | **Negative** |
|---|---|---|
| GP surgeries | 44 | 20 |
| Tameside Hospital | 172 | 54 |
| Other hospitals | 17 | 2 |
| Walk-in Centre | 0 | 3 |
| Social care | 4 | 3 |
| 999, NHS Direct and 111 | 4 | 1 |
| NHS Dentists | 5 | 4 |
| Pharmacies | 5 | 2 |
| Opticians | 6 | 0 |
| Community care | 4 | 2 |
| Other | 2 | 0 |

The total numbers exceed the number of stories, as some stories contained both positive and negative comments.

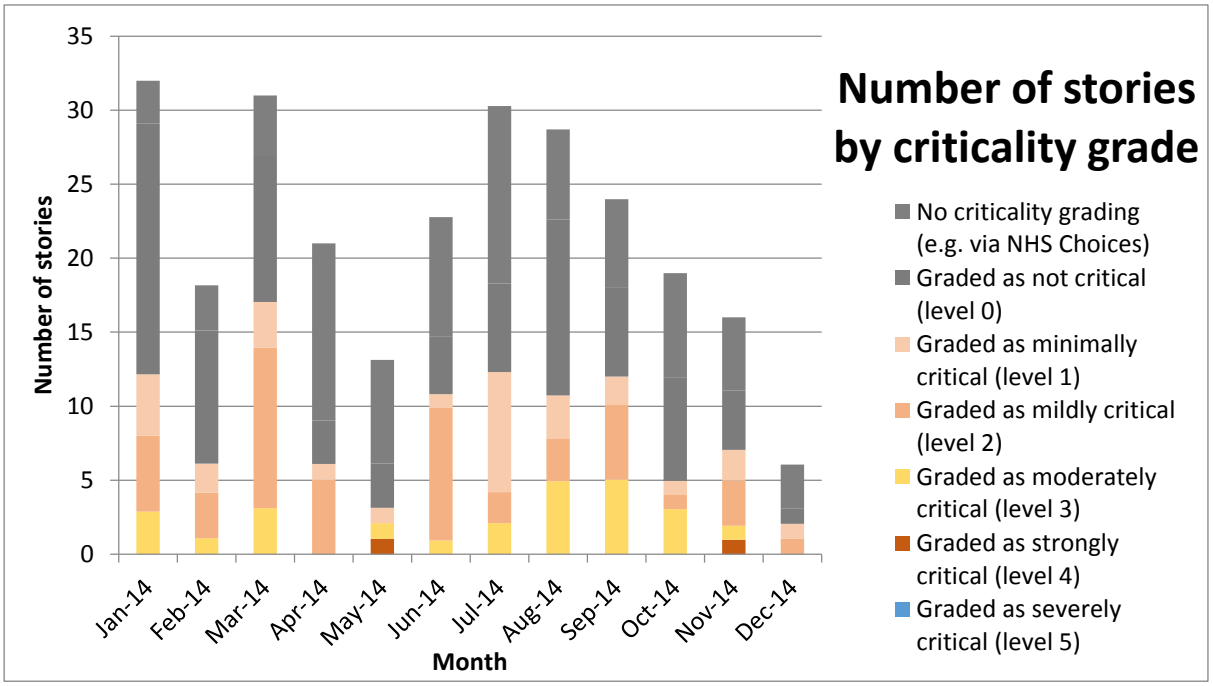
Some examples of the words used to describe staff are shown below. These were mainly used in a positive way, although not always, eg. 'Staff should listen to the patient and show courtesy and kindness.'

| | How often used | | How often used |
|---|---|---|---|
| Kind | 25 | Nice | 19 |
| Understanding | 17 | Respect | 18 |
| Compassion | 14 | Support | 25 |
| Helpful | 58 | Attitude | 11 |
| Listen | 15 | Fantastic | 23 |
| Manner | 11 | Excellent | 52 |
| Polite | 13 | Dignity | 15 |
| Efficient | 25 | Calm | 10 |
| Friendly | 49 | Rude | 18 |
| Caring | 42 | | |

We have lifted the comments about staff out of the stories, and included them in the appendices, using the words used by the patient or family member. This summary is split up to show which comments relate to specific service providers (where known).

**Patient Opinion Criticality 3 and over**

Please refer to the introduction for information regarding the rating of criticality of stories by Patient Opinion.



There were 28 stories posted in 2014 which were rated criticality 3 or higher (10% of the total). There may have been others which were posted via NHS Choices which had a similar level of criticality, but which have not been rated, so are not included here.

Many of the stories posted on Patient Opinion are about Tameside Hospital. A number of these 28 stories also relate to Tameside Hospital, but not all.

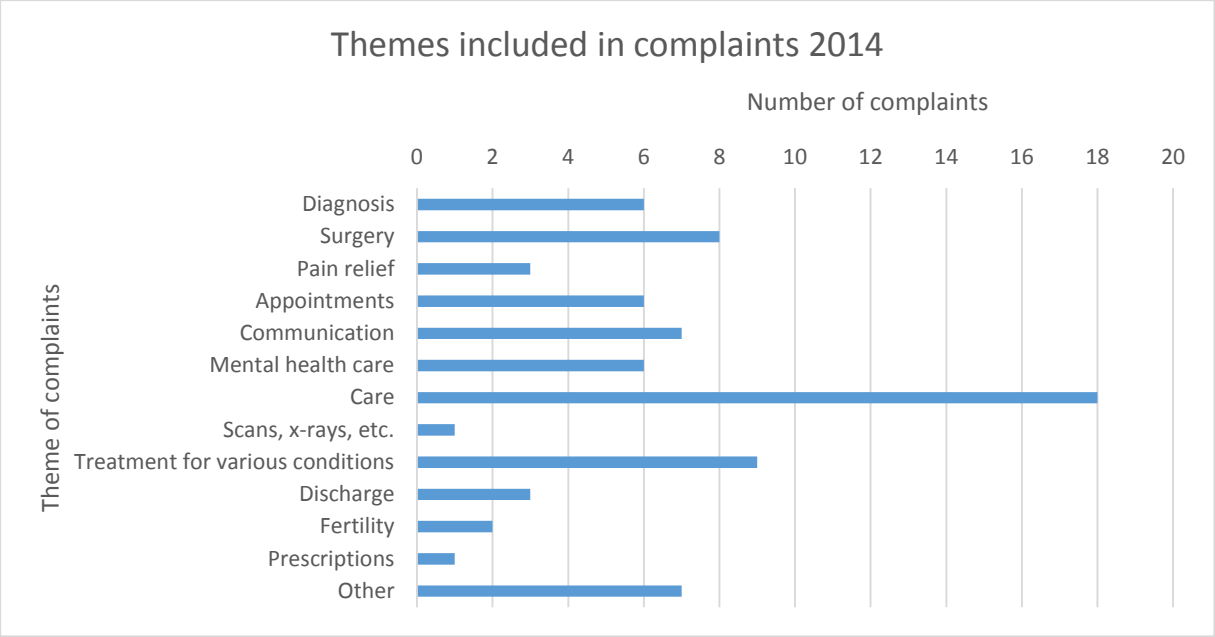
Here is a summary of the services included (some stories mention more than one service).

Full details of the stories and responses are included in the appendices.

| **Service** | **Number of stories** |
|---|---|
| | |
| **Tameside Hospital** | |
| A & E - delays | 1 |
| A & E – no information provided | 1 |
| Appointments not received | 2 |
| Children's ward – referral not made | 1 |
| Elective Unit – care provided | 1 |
| Endoscopy unit – care provided | 1 |
| Fracture clinic – care provided | 1 |
| MAAU – care provided | 1 |
| Maternity – care provided | 2 |
| Orthopaedic – care provided | 2 |
| Patient needing psychiatric care admitted to medical ward, where the care received made their condition worse | 2 |
| Stroke treatment – care provided | 2 |
| Unspecified clinic – care provided | 1 |
| Unspecified ward – care provided | 2 |
| Ward 31 – care provided | 3 |
| Ward 46 – care provided | 1 |
| | |
| **Other services** | |
| | |
| Unspecified GP – delayed referral | 1 |
| District nurses - not attending when expected | 3 |
| 999 ambulance - delays | 2 |
| Grange View – care provided | 2 |
| Dentist – care provided | 1 |

## Complaints

Healthwatch Tameside has been guiding people through the complaints process, where help is needed, since 1 April 2014. The types of complaints are varied, and, up to the end of 2014, included the themes shown in the following graph. A summary is included in the appendices, but no details, as these complaints could still be ongoing.




## Next steps

Following discussion with the Healthwatch Tameside Board, they have directed us to undertake further investigation.

Healthwatch Tameside are collecting up-to-date information about experiences of visits to GP surgeries in Tameside and hospital visits in the last six months. The questions cover the three themes of appointments, communication and staff. The survey went live in early June 2015, and will continue for three months. It can be completed online, on a paper version, or by speaking to a staff member or Healthwatch Champion. Analysis will begin in September 2015, and the findings will be shared with providers.

Healthwatch Tameside arrange many visits to community groups and events, to provide an opportunity for people to tell us their experiences of health and social care provision. This outreach will include groups of people who may not otherwise come into contact with Healthwatch Tameside or a Champion. Many of these visits are at the request of the group. We will also be making direct contact with groups who may use the services highlighted by our survey, and where little data was provided to us in 2014.

**Appendix 1**

**Appointments – comments (2014 stories/comments)**

**GP appointments** (104 stories/comments)

Some surgeries have a system where people feel they are seen/spoken to by a doctor whenever they need it. There are a few with open surgeries at certain times and others have online booking, which allows booking up to 3 or 4 weeks in advance for non-emergency appointments.

Many surgeries ask for an early morning call (from 8am), then the phone will be engaged, and when you finally get through, appointments for that day have gone, and you have to try again the next day. Some of these surgeries seem to not allow for appointment booking in advance, even for follow-up appointments. One surgery insists on a phone call to get a follow-up appointment even when the patient has just seen the doctor who made the request and could make an appointment while they are there.

Healthwatch Champions generally see patients who are more elderly or not working. A few comments relate to difficulties in getting appointments outside working hours, especially if you are well enough to work but need to see a doctor. If you can only make same day appointments, it is difficult to request time off work without any notice.

| | Number of stories |
|---|---|
| Wait too long for appointments | 33 |
| Appointment availability good | 20 |
| Have to ring at 8am for appointment | 13 |
| Need more evening/worker friendly hours | 8 |

Generally, once a patient gets to see a doctor, they are happy with the service.

Within the stories and comments, a number of suggestions have been made:-

- Why can blood tests requested by a doctor during an appointment not be done while you are there, instead of having to make another appointment?
- Have a system whereby a patient can discuss more than one problem during an appointment, instead of having to book separate appointments, eg. longer appointment time on request.
- Be able to see the same doctor throughout a course of treatment, without having to wait weeks for an appointment to see that specific person.
- Try and keep to the appointment times as much as possible.
- Patients want to be able to get appointments without explaining all their symptoms to receptionists, especially if they feel embarrassed.

**Go-to-Doc**

Out of five stories/comments only one was happy. This involved a child being sent to the Primary Care Centre straight away, where treatment was provided without much of a wait.

One caller had to wait from late morning until 'night-time' to be called back. The doctor who called had very poor English, so communication was difficult.

Another person said it was hard to get to see a doctor, and another said they needed a home visit, but this was not available.

**NHS dentists**

Out of 11 stories/comments, three wanted better access to NHS dentists, and five felt the wait to get an appointment was too long. Two were able to get appointments quickly when needed.

One Urdu speaking dentist refused to speak anything but English, so the patient's daughter had to translate.

**Primary Care Centre – Ashton-under-Lyne**

We had eight stories/comments, of which five were pleased they could be seen by a doctor without needing to make an appointment. There can be a long waiting time to be seen.

One person had been transferred to the Centre for diabetic care, but had not been sent an appointment.

**Tameside Hospital**

**Cancer** (6 stories)

Breast cancer –

- Treated and now has 6 monthly appointments, with access to McMillan nurses.
- First appointment within a week, with results of the tests on the same day. Surgery arranged shortly after that.

Bowel cancer

- Appointment for endoscopy not sent out. Mis-communication caused delay of 6 weeks in diagnosis

Lumps

- Forehead – appointment letter not sent out, so missed appointment. The delay in treatment resulted in the need for plastic surgery, for which the consultant failed to refer the patient. Further delays.

- Finger – follow-up appointment not received. The consultant has sorted a date, but still no letter received confirming where to go.

Unspecified

- Waiting for test results, but didn't get the appointment letter so missed the appointment.

Out of the six stories, only the breast cancer patients received prompt treatment. The others all had problems with appointment letters not being received.

**Orthopaedics** (8 stories)

- Three of the stories are from people waiting for knee operations who have been waiting months without an appointment being sent, and are unable to find out what is happening. One transferred to Oldham Hospital after more than two years waiting.
- Another person did eventually get their knee replacement, after problems with appointments not being sent and the operation being cancelled. She is now 'knock-kneed', in more pain than before and unable to straighten the leg. At the follow-up appointment, she felt the consultant did not listen to her.
- One person had several visits to hospital and tests, but it was a year before a hip fracture was diagnosed. She had a hip replacement, but is still in great pain with reduced mobility. She has had a number of outpatient appointments, but still has no answers to why it took so long to discover the fracture, and why she is still in pain.
- Another person praised the outpatient hip specialist highly.
- A GP referred a patient to this department, and they had been trying to get an appointment for over a month at the time the story was told.
- The final story is from a patient who was referred for a surgical corset, following a lumbar fracture. The only size available was too small, which was uncomfortable. She tried to make another appointment, but was sent one when her daughter was on holiday. She has tried to ring to cancel, but is unable to get in touch.

**ENT** (3 stories)

All these stories are about difficulties getting appointments:

- Child – the appointment time was not kept to, notes were written up incorrectly and a follow-on referral was not received.
- Child – Ear clinic. Long term patient – mother has to chase for appointments. Should be three months, but wait six – apparently the number of clinics has reduced.
- Adult booked an appointment online, which was available within a month. This was then cancelled, and when they rang to re-book, had to wait for 13 weeks. The patient wanted to know if this was a ploy to meet targets?

**Women's health** (6 stories)

Only one person was unhappy. This related to delays in getting appointments and then delays getting results from Stepping Hill. Four months passed since pre-op started, and still not complete.

Other women praised the efficiency of appointments and the excellent care received.

**A & E** (2 stories)

Both stories were about delays and follow-up appointments:

- 4 hour wait breached, so person admitted to ward. They were seen at 4am and told to go home & ring back at 8am to see if a bed was available for surgery, and told not to eat. After ringing all day, they gave up and went to Manchester Royal Infirmary.
- The second story was about a young child with ongoing leg problems. The GP had said if a certain thing happened, to go straight to A & E. After triage, seeing the nurse and eventually insisting on seeing a doctor the doctor wouldn't listen and they were told to wait until their next appointment which was a few days later.

**Gastroenterology** (2 stories)

Both stories included long waits for appointments:

- A GP referred after a number of tests had been carried out from the surgery. After 13 weeks, and reminders from the GP, there was still no appointment.
- A Person was diagnosed with diverticulitis, but a follow-up appointment was not received. They rang and were told there was a four month waiting list.

**Dermatology** (3 stories)

- The first story is about a child admitted to the children's ward on a Friday with an infected skin condition. The doctor said nothing could be done over the weekend, and the family left with the promise of a referral on Monday. They tried to chase for an appointment, but the referral had not been made, even though it was on the discharge notice.
- The other two stories were from disabled people. One rang for directions within Hartshead building when they arrived for their appointment, but the person who answered the phone was unable to help. The other said the dermatology department is quite far from the disabled parking.

**Maternity** (1 story)

This person had a great first antenatal appointment.

**Urology** (2 stories)

Two opposite opinions given here – one patient praised highly the speed and efficiency of their appointment without any waiting time, while the other wants patients to be seen near the time of their appointments.

**Cardiology** (4 stories)

Two patients had no problems with appointments, one person had a number of appointments cancelled after they arrived and the last has to travel to various hospitals to be able to see the same consultant each time.

**Dental** (2 stories)

- The first patient had delays getting appointments.
- The second didn't receive a letter with the appointment date, just a text message the day before. Attended the appointment anyway, then problems during pre-op, which were traumatic and eventually they were transferred to another hospital for the operation at a later date.

**Colorectal** (3 stories)

All three patients had problems getting appointments:

- Delay getting urgent referral, then appointment cancelled
- Waiting for results of tests – appointment letter not sent. New appointment made but a two month anxious wait
- Bowel tests carried out. Follow-up appointment should have been four months later, but not sent. GP has no information and can't find anything out. Going private.

**Hearing clinic** (2 stories)

Both patients were happy with appointments.

**Eye clinic** (1 story)

Appointment times were not kept to – this patient says to allow +/- 2 hours

**Neurology** (1 story)

Waiting time for diagnosis of Parkinson's disease is 16 weeks. Patient said this is too long, when early prescribing of medication is essential. The GP resolved this and was able to get an earlier appointment.

**Unspecified outpatients** (18 stories)

Eight people were satisfied with their appointments.

GP referral

- Appointment letter did not arrive. Then received letters saying the appointment had been missed. There was a long wait to be seen.
- Urgent referral requested – two month wait in pain
- Urgent referral requested – three month wait whilst worrying there could be an internal bleed

General comments about appointments

- Details lost from the system, so had to start again.

- Need to improve the flexibility of appointments
- Better appointment system is needed.
- Appointment missed as there were no parking spaces available.
- Don't let consultants cancel long-standing appointments for holidays

One person asked why stitches have to be removed at hospital. Why can't appointments be sent for a local clinic?

**Unspecified surgery** (3 stories)

All three stories were unhappy about appointments:

- An appointment was given for early morning, but then the person had to wait 2 ½ hours before being taken into the waiting area.
- "Messed us about for 6 months". Problems getting epidural.
- Waiting over 2 years for a gullet operation. Appointments have been cancelled and at the time of the story, the operation had still not happened.

**Scans/radiology** (3 stories)

Each of the people who told us their story had problems with scan procedures and appointments:

- After scan, uncertainty about whether further scans should be done as an emergency or with an appointment. Five months later he still doesn't know what is wrong.
- Problem with booking service for MRI scan.
- Delay getting results following Doppler test. Waited 10 weeks and still no appointment.

Looking at all these stories (72 in total) from Tameside Hospital, we can see:

| | **Number of stories** |
|---|---|
| Appointment letter not sent or not received | 10 |
| Longer than expected wait for appointment | 19 (not including delays caused in 10 stories above) |
| Cancelled appointments/operations | 6 |
| Appointment times not kept to | 5 |
| Referral not received/didn't happen | 5 |
| Patients happy with appointments | 20 |

**Manchester Royal Infirmary** (1 story)

GP referred for urgent operation. Chased up, but said referral not received. It took nearly 3 months to get an appointment.

**Manchester Eye Hospital** (1 story)

Had an appointment and was told would have another in two weeks' time. Nothing arrived, and at time of story it had been over 13 weeks and still nothing heard. When letters do arrive, the font is too small.

**Rochdale Hospital** (1 story)

The Tameside resident was given an appointment at 8am which they can't get to on public transport. They rang to change it, but were sent back to the bottom of the 18 week waiting list. GP referred elsewhere.

**Stepping Hill outpatient cardiology** (1 story)

In six years of six-monthly appointments, didn't see same consultant twice and they didn't read the notes.

**Patient Transport Services** (1 story)

The patient said "They should keep appointments".

**Opticians** (1 story)

Leigh Mitchell of Hyde – appointment service is good. Should have more than one appointment per year.

**Sexual health service** (1 story)

Opening time is convenient for workers, and you get follow-up appointments.

**Miscellaneous**

Appointment letters for visually impaired people – ask for large print but doesn't usually happen. Print on drugs labels is too small. Yellow paper is better. Not getting these prevents independence.

**Appendix 2**

**Communication Summary 2014**

The majority of the stories are about Tameside Hospital. Where this is not the case, we have highlighted the provider of the service.

**MAU (Medical Assessment Unit)**

- Patient moved to ward at midnight, family didn't know
- Husband discharged with wrong medication, although a different doctor had arranged for him to go to a ward
- Assessments not completed as requested, food/drink problems, lack of care, despite daughter pointing things out. When daughter rings ward no-one can tell her anything about mother.
- Poor communication with patient and relatives, discharge procedure inefficient

**Discharge**

- Staff filling out forms for wrong patient and before care package at home arranged (ward 46 or 31).
- Discharged without being sent to get heart monitor (which required on permanent basis). Had to wait for appointment to outpatients (ward 31).
- Discharged from MAU even though more senior doctors had recommended moving to ward for tests. Sent home with wrong medication (sister apologised, but couldn't change what doctor decided).
- Tried to discharge from MAU before SALT assessment, eventually moved to ward.
- MAU – after several admissions, family state discharge procedure is inefficient.
- Discharged with no real explanation of what wrong. Discharge note passed to friend and told I could go. (unspecified ward)
- Discharged from MAU without endoscopy being done.

**Knee operations**

- Not told about infection until physio found it. Consultant didn't listen at follow-up. Left with unresolved problems.
- Waited over three months and heard nothing. Just want information to be able to plan a holiday. Calls not returned.
- Been waiting over two months with no communication. Can't get past voicemail. Trying to plan holiday.
- On waiting list for two years. Got date for operation, then it was cancelled. Three to four month wait for new appointment. Transferred to Oldham for treatment.

**Visually impaired**

- Meals provided on ward, but patient not always told they are there, so they are left to go cold, as they can't see them.
- Loss of independence when requests for large font and yellow paper ignored. Drugs are provided with tiny instructions.

**Communication between providers**

- Problem with communication between **The Christie** and Tameside Hospital. Notes lost, information not transferred, treatment details at The Christie not on notes at Tameside.
- Referral by TGH cardiology department to **Wythenshawe** for tests not sent. Patient chased up after four weeks. More information which was later supposed to be sent by post by Tameside was delayed. Weeks of waiting for tests to take place.
- Women's health – lady has been diagnosed with a fibroid. Back and forward between GP and TGH. Keeps being sent appointments and offered a coil, which she doesn't want, or put on the pill, but no treatment for the fibroid. Information not being passed between the GP and hospital.
- Lady went to A & E elsewhere and referred to Tameside Hospital for tests. Her notes couldn't be found. As a nurse she knew she needed the tests and had to beg for them.
- GP referred patient to Tameside Hospital for urgent review for possible heart surgery. The GP can't get the test results. They were sent by Tameside to **Wythenshawe** for a surgeon's opinion. Family need to know what's happening.
- Unspecified comment about communication between Tameside Hospital and GP.

**Patient notes**

- Illegible notes in ward records.
- Notes from care home said patient having trouble swallowing. MAU tried to discharge as medically fit, although no food/drink for 2 days and choking when daughter tried to give a drink.
- Notes on traumatic first pregnancy not read by doctors during second pregnancy.
- **Stepping Hill** – doctor didn't read notes, which showed previous heart attack and blood thinning medication.
- **Manchester Royal Infirmary** – doctors don't read notes and give conflicting advice.

**Failure to return calls**

- Knee replacement – rang secretary four times and no call back. Not knowing is affecting well-being of patient.

- Knee operation – contacted hospital, just got voicemail with pre-recorded message saying there were no appointments available. No communication.
- MRI scan – something missing in report. Tried to contact secretary over two days, left messages. Tried two other phone numbers. No-one able to take call and no call back.
- **Go-to-Doc** – contacted at 11.30am. Didn't ring back until 'night time'. The doctor spoke poor English which made communication difficult. The doctor didn't listen when told about allergies and prescribed medication which caused a bad reaction.
- **Adult Social Care** – problems getting calls returned.

**Communication about treatment between staff and patient/relatives**

This includes whether the patient/family understand what they are being told, and whether they feel they have enough information.

| | Number of stories relating to Tameside Hospital | Number of stories about other health and social care services |
|---|---|---|
| Patient/family happy | 21 | 27 |
| Patient/family not happy | 31 | 24 |

**Other comments/feedback**

- **Clarendon Medical Centre, Hyde** - Need to listen to patients who are the best judge of what hurts.
- **Bedford House, Stalybridge** – responded to pharmacy message with call for immediate appointment.
- **Pharmacies** – five stories where all patients happy with information provided. One so concerned they left message for GP (see above). Another sends text reminders when prescriptions are ready to be collected.
- **District nurses** – one person felt they had time to explain things. Another did not receive a visit at all for a dressing to be changed, following a hospital visit.
- **Pulmonary rehab course** – provided comprehensive information. Information about the service should be available via GPs if needed, the patient feels.
- **Walk-in Centre, Ashton-under-Lyne** – mixed response to communication – some good, some lacking. One person wanted more detail about what they can deal with on the website, to avoid wasted visits.

- **Shire Hill** – good care and physio provided for torn knee ligament. Made sure mobile before discharging. Sorted out bath aid at home and key system on front door.
- **Dentists** – Glebe Street, Ashton-under-Lyne – patients not told dentist was retiring and no information provided about new dentists. Penny Meadow, Ashton-under-Lyne – explains what doing. An unspecified Urdu speaking dentist refused to speak anything but English leaving daughter to act as interpreter.
- **Mental Health Services** – two people happy that they were listened to and good information was provided, but two really not happy. These people felt the psychiatrist was off-hand, rude, abusive and showed no understanding.
- **Holme Lea Nursing Home** – poor communication from staff to relatives (related to a few years earlier).
- **Opticians** – three people happy with the explanations received.
- **Non-emergency transport** – waiting at the hospital for over three hours. There was no communication. The transport request was not received from outpatient staff.

**Appendix 3**

**Staff stories summary 2014**

**GP surgeries**

**Ann St Surgery, Denton**

- Receptionists are very rude & demand full details of medical conditions.
- They were very polite, courteous and efficient.
- Dr Johnson - An excellent doctor who cares about his patients & supports all the family
- Reception staff unhelpful. Patients made to feel a nuisance. Staff not sympathetic to mental health issues.

**Audenshaw Medical Centre**

- supportive, approachable at all times & very re-assuring. This applies to the medical staff & the receptionists alike. Emotional care of the family when my husband died was excellent.

**Bedford House Medical Centre**

- Very polite & helpful.

**Brook surgery**

- Sympathetic doctors, helpful reception staff.
- Need Speaking friendly.

**Clarendon Health Centre, Hyde**

- Doctors efficient and kind.

**Davaar Medical Centre, Dukinfield**

- Friendly staff.
- Problem through receptionists. Need to improve the manner and job roles of receptionists.
- Everyone including the staff was courteous & helpful & doctor who listened to me intently.

**Donnybrook Surgery**

- Treated with respect.
- Receptionists unhelpful.
- Completely & utterly rude with just one particular receptionist.

**Droylsden Medical Practice**

- Doctor Glairti = worst service - rest of doctors and staff very good.

**Grosvenor Medical Centre, Stalybridge**

- The receptionists are always very helpful.
- Doctors are kindly and efficient

**Hollies Surgery, Dukinfield**

- From the receptionists, practice nurse and our GP Dr Proctor – caring.
- Good doctors, nurses.
- They care, from excellent receptionists to the nurses & especially my GP - Dr Proctor.

**Lockside Medical Centre, Stalybridge**

- Understanding doctors. Nice receptionists.
- Doctors easy to talk to and 'have time for you'.
- Very impressed with doctors and staff.
- Kind and efficient doctor.
- Treated sympathetically.
- Care, compassion.

**Medlock Vale Medical Practice**

- The doctor was rude and didn't refer.
- GP was understanding.

**Mossley Road GP practice**

- All staff very friendly.

**Pennine Health Centre, Mossley**

- Reception staff not always understanding & should not enquire what is wrong with you.
- Respect my wishes. Respect me.

**Simmondley Medical Practice**

- All staff were nice & well mannered.

**St Andrews Medical Centre, Stalybridge**

- Was treated very kindly and efficiently, Reassurance given.
- Dr Raj - he was great.

**Staveleigh Medical Centre**

- Receptionists excellent – helpful.

**Tame Valley Medical Centre**

- Receptionists - need to improve - helpfulness, less negative attitude

**Thornley House Medical Centre, Hyde**

- Receptionist need to talk with respect.
- Need Interaction with patients - better service for students.
- Caring action

**Waterloo Surgery, Ashton-under-Lyne**

- Dr Sadiq and the receptionists are very kind and helpful.

**West End GP practice, Ashton**

- Helpful receptionists.

**Unspecified GPs**

- Dealt with by reception with terrible impatience and rudeness. Affected mental health problem.
- GP doesn't seem to care. No interest!
- Lack of care, listening and speed, my GP - his manner was appalling, he was rude, had no feeling, gave no sense of sympathy, nothing. He was like a robot.
- Controlling GP - failed me and alerted me to serious concerns about practice, care and quality.
- Doctor very impersonal.
- Courteous staff.
- Dr. went extra mile, brilliant service.
- They were all very attentive & pleasant.
- Good manners.
- Staff are stroppy and impatient.
- GPs are courteous and listen to problems.
- Attending, polite, understanding.
- To improve - More care and understanding that my daughter is a human being.
- They were very caring and understanding of Mental Health issues.
- Kindness.
- GP was friendly and the staff were helpful.
- Could be more sympathetic.
- How nice the staff were.
- Helpful staff.
- Good - the attitude of both clinical and clerical staff.
- Are friendly, knowledgeable, helpful.

**Tameside Hospital**

**Cancer**

- All staff extremely helpful and kind. She can phone McMillan nurses any time, which is reassuring.
- I can't fault any of the staff, doctors, surgeons.
- Everyone I came into contact with was absolutely brilliant.

- I was treated with the utmost dignity and my worries were respected.
- The staff were kind and caring and appreciated the worrying and emotion time I and my family were experiencing.
- All the nursing staff were excellent.
- Mr Ellenbogen and team excellent. After-care from nurses and mammogram service kind and professional.

**A & E**

- The doctor and the team on duty couldn't have treated me with more respect and dignity they need a medal.
- From the moment I arrived I was treated with total respect, courtesy and concern from everyone concerned.
- Excellent care, professional staff.
- Reassuring charge nurse, two very calm and competent nurses and a registrar
- Both helpful and caring.
- Staff were polite.
- Staff were second to none. The doctors and nurses were attentive.
- The reaction of the medical staff was superb.
- Need to improve the staff.
- They were all very attentive & pleasant.
- Staff in general were helpful.
- Need to employ the good natured staff. Dig deeper in their past when employing.
- Everyone was pleasant, they made me feel comfortable.
- Staff were excellent and caring.
- Efficient & friendly.
- The staff - attitude & knowledge.
- Staff should listen to patient and show courtesy and kindness
- Plastered by very pleasant staff member.
- Quick, doctor was friendly.
- Need to improve - Friendlier, quicker
- Quick response, caring, knowledgeable, efficient, understanding.
- Helpful staff.
- Staff were lovely - no complaints. Was well cared for. Need more nurses.
- Dealt with respectfully.
- Staff and doctors - they couldn't have been better.
- I wish to thank all the staff involved for reassuring and caring for me at such a frightening and stressful time.
- Supportive.
- Staff kind and caring and made me feel like I was in good hands. I think your reception staff need extra training on caring for people in shock who might be disorientated that they are in A&E at all.
- The nurses were fantastic nurses, but I was not impressed with the doctor.
- Found all staff approachable, friendly and reassuring.
- Staff were professional yet very friendly.

- The reception staff I met were like Vicky Pollard, answering everything with it's nothing to do with them and I'd have to wait
- I felt like an unwelcome guest in their home. Poor as usual.
- Staff were smiley and friendly.
- The nurse was lovely.

Out of 35 comments about A & E staff, only 8 were negative.

**Paediatric A & E**

- Staff amazing & doctor equally as nice.
- Staff are great.
- Doctor who had no greeting for us, if I tried to explain the situation I was dismissed after 2 words, doctor spoke rudely, I have never felt so belittled by a professional body.
- Fantastic staff.
- The staff were amazing. I would just like to thank all the staff for the kindness and friendliness they showed to myself and my son. They deserve recognition for the great work they do.

**Inpatients**

**Cardiology**

- I have nothing but praise for them.
- Staff never stopped working for the whole time I was an inpatient. Probably help if they had a bit more room.
- The male auxiliary nurses on ward 46 were very caring.

**Children's observation and assessment unit**

- I was extremely impressed with the professionalism and compassion of all the staff.

**Children's ward**

- All the nurses and doctors were great.
- The response I got from the doctor in charge was... what do you want me to do its Friday?
- I cannot thank the doctors and nurses enough!

**Paediatrics**

- The nurses were friendly and chatted to my daughter to help make her feel at ease.

**Elective unit**

- I found all the staff very helpful and efficient.
- Have nothing but praise and gratitude to the surgical and elective unit staff.
- I had no staff nurse or Ward Sister showing me any care at any time of my stay. Dignity just doesn't seem to exist on that ward. There were a couple of members of staff that were very good, especially Vicky. This apparent bullying and humiliation went on for about 4 days.
- The Unit did seem very understaffed at night-time and some of the Bank Staff were more hindrance than help. Apart from 2 members of staff, everyone was wonderful. I was extremely well cared for and treated with total respect.
- Nurses very helpful. Nothing too much trouble.
- Found all the staff, Dr's, nurses, physio's and the domestic staff kind, caring and polite.
- The care assistant although caring and pleasant, omitted to remove her gloves and apron straight away after toileting a patient on a commode.

7 stories about the elective unit, with 2 negative stories and 1 poor practice

**General medical ward**

- Collaboration by the staff who did everything possible to cover their mistakes.
- Why was she sent to the wrong department (to be ridiculed and taken the mickey out of by members of your staff?)

**Intensive care**

- Tameside really do need to evaluate their whole team, how can a fit and healthy 18 year old nearly lose her life?

**MAAU**

- Crash team did a fantastic job.
- Fantastic nursing, then let down by the arrogant doctor/consultant .
- I cannot praise the staff enough, from A&E to the wards, they have all been brilliant.
- Many thanks to the staff especially the nurse in bay 5, she was tremendous.
- Need more staff on wards.
- Nurse on Duty and the Auxiliaries, I cannot praise them enough, they were brilliant and professional, more than can be said for the Doctors.
- Nursing staff showed excellent care and consideration to all patients - well staffed & dedicated staff.
- Service was just as good (as A & E).
- Several admissions. No reassurance or compassion shown by staff.
- Some staff are very understanding but some seem to resent his wife staying with him.

- The staff were both helpful and caring.
- The staff, Consultants, doctors, nurses and auxiliaries, displayed a level of professionalism the Management can be proud of.
- The wonderful nursing staff who worked so hard to care for every patient under their care - they are truly angels!

**MAAU & ward**

- Shocking and disconnected approach to care of the elderly.

14 comments about MAAU - 2 negative comments about doctors and 3 general negative staff comments.

**Trauma unit**

- Shortage of staff, disorganised.

**Unspecified Ward**

- All the staff and the surgeon were excellent.
- Compassion of staff good
- Good - Mr Saddiqui (bowel surgeon) and all staff involved in colostomy and reversal of colostomy for this lady's elderly father.
- Good - The work rate of the 'caring staff' (doctors, nurses, orderlies, etc.) and in spite of their heavy workloads - have time for the patients' problems.
- Mr Perivali did a FANTASTIC job on my painful shoulder and would like to nominate him for an award.
- Nurses, surgeons and staff excellent.
- Staff (although short) cared about myself and because it helped, along with the doctors. Overall the nurses should treat patients with more care.
- Staff don't stop from the start of their shift till the finish they need a medal.
- Staff too busy laughing and joking around a computer to update partner on how I was.
- The care I received from Debbie was excellent and Vicky who I believe is an auxiliary is absolutely lovely – she reassured me + even held my hand. These 2 nurses never stopped all night.
- The care was excellent.
- The care, consideration, treatment he received was remarkable and just fantastic. Everyone really cared.
- The staff were really good. Staff very respectful and helpful.
- They really took care of me, and nurses were so nice.
- They were all very attentive & pleasant.
- They were kind and caring and made me feel like I was in good hands.
- Unhappy about a number of things, including nurse being asleep when I needed help to go to the toilet.
- Ward staff have the remarkable ability not to see you, while looking directly at you, and taking an age to carry out any request for help.

- Was treated wonderfully, with dignity and respect.
- We would like to thank Dr Sarah Rose, Charge Nurse Andy and Nurse Sam and Student Nurse Natalie for their excellent care.
- When my father in law passed away, staff did not see how much their incompetence in dealing with the death certificate hurt my family.
- Volunteer visitor – no complaints about medical staff but sometimes care/service staff are quite rude. Patients made to wait up to 10 mins to go to toilet.

22 comments about unspecified wards, of which 5 are negative.

**Ward 31**

- All the staff have treated him (dad) with care, respect and been attentive although it seemed to me that they were woefully understaffed for the number of patients and the challenges some of them presented with.
- Not enough staff on ward to deal with patients. Many have a terrible attitude towards patients and visitors. DISGUSTED WITH CARE, HOSPITAL AND STAFF!
- The doctor was considerate and patient with me due to my hearing loss.
- The level of professionalism by the staff there was apparent.

**Ward 40**

- Pleasant, helpful, efficient staff - felt valued.

**Ward 41**

- The nurse dealing with him said he was aggressive, and she was not prepared to put up with his behaviour. His wife assured staff that he was not usually like this, and she (a qualified, retired midwife) knew it was confusion due to the infection. Wife not happy about his care.

**Ward 42**

- All the staff were absolutely brilliant.

**Ward 43**

- Not enough staff on ward. Most staff didn't seem to know patient diabetic & registered blind. On final two evenings one nursing assistant very helpful - monitored how much patient was drinking which saw the patient make a rapid improvement leading to discharge.

**Ward 45**

- Her care has been fantastic.
- Nurse comments – "Oh she's not got a lot going for her". There were limited caring staff.

- Speech therapy staff very pleasant and patient. Nice doctor who explains things.
- During the first week, no-one was answering when I pressed the buzzer. Things seemed to get better after that and the rest of my stay was good.
- All staff nice & helpful - nurses to cleaners.
- The staff were both helpful and caring.

**Ward 46**

- My husband and myself could not have been treated with more care and compassion, and ward staff and medical teams helped me through a tough time.

**Ward 46/ Ward 31**

- The medical teams have been extremely good, and most of the staff have been good, there just are not enough of them, some go 'above and beyond' what they are paid to do, some work with 'their heads and their hearts' and my thanks go out to them, some do their jobs efficiently, and others just seem to have been worn down by the system. My experiences over the past few weeks have been 'soul destroying'

**Ward 5**

- I would like to pass on my appreciation and thanks to everyone who contributed to the excellent standard of healthcare I received.
- Sr Abrahams and her staff were fantastic. They were professional and caring.
- Staff lack of understanding/training about importance of adequate fluid intake.

**Woman's Health Ward**

- To thank all the staff for the exceptional treatment and support I received.
- Consultant, theatre staff and ward staff were friendly and reassuring and the domestic staff appeared hard working and friendly.
- Day staff was lovely, reassuring and helpful. Got to about 6pm and the most rudest nurse was 'looking after' me.
- Nurses on the ward were very friendly and helpful and a big thank you to Dr Veeravallis who me treated me with the utmost respect.
- Staff were friendly, compassionate and worked very hard to ensure all my needs were met. . Even the domestic staff was friendly and helpful. Nothing was too much trouble. The theatre staff were fantastic and put me at ease.
- The staff treated me with respect and with dignity.
- From nurses, theatre staff, anaesthetist , Ward Drs and domestic staff, were brilliant, I was made to feel comfortable and confident in the care I received. The nursing staff were very caring and hard working. I would be grateful if you could share my comments with all the staff.
- They were second to none!

8 stories about the women's health unit, with only 1 partially negative comment.

**Outpatients**

**Breast clinic**

- The nurses - particularly one named Victoria - were very helpful and very reassuring. I thought that the overall attitude in the clinic was warm.

**Cardiac Rehab**

- I have been very impressed by all the physiotherapists - their caring nature, the holistic approach they take and their good humour.

**Cardiology**

- The initial staff are helpful and friendly but the doctor's attitude is insulting and abrupt.
- Staff were friendly and put me at ease.

**Clinic**

- Staff are really friendly.

**Co-ag clinic**

- Staff great support.

**Colonoscopy**

- All staff were very understanding and efficient.

**Day surgery clinic**

- All the staff treated her well.

**Dermatology**

- All staff were friendly in dermatology and my specialist was great. However the receptionist in the main Hartshead building was very rude, their attitude was a disgrace to say they are the first face you see I wasn't impressed.
- I was treated with dignity throughout and the staff were very nice.

**Endoscopy**

- I felt unwelcome and an unfriendly atmosphere. No-one asked if I was ok or if I needed anything until I was in recovery bay & I was so embarrassed at the time.
- The staff and nurses in this unit were absolutely wonderful. They were so understanding and really helpful.

**ENT**

- Caring and competent staff.

**Gastro Department**

- Great so far.

**Hearing Centre**

- Helpfulness of staff.
- She is very happy the staff are doing all possible to help her.
- Kind and caring staff.
- Quite good.
- The young nurse Elaine, who welcomed us, was on time, and welcomed my friend and I with courtesy and openness.

**Hospital alcohol liaison service (HALS)**

- Very compassionate staff in all departments.

**Orthopaedic department**

- While I was having my consultation doctor took a phone call - instead of saying please ring back I'm in with a patient he continued with call. I found this very rude.
- Doctor, who has got a horrible bedside manner, is very sarcastic and very rude.

**Outpatients**

- All the nurses/doctors were really friendly.
- Casual attitude of staff.
- Doctors v. good. Staff helpful.
- Need to improve - friendlier staff.
- The receptionist at **Outram Road** one friendly and staff are really helpful & supporting.
- A smiling, helpful receptionist. All staff seen were pleasant and efficient.
- All of the staff I interacted with were polite and caring.
- Always treated with patience & courtesy.
- Quick, pleasant staff.

**Radiography**

- The 2 members of staff who did it were wonderful.
- Amazing.

**Rheumatology**

- Everyone is polite, thorough and helpful.

**Urology**

- The staff couldn't have been better.
- Sensitive to your needs, courteous, professional.

**Well Woman clinic**

- Find all staff, particularly Dr Stopman, very caring and helpful.

**X-ray**

- Polite and very pleasant.
- A lovely reassuring nurse.
- Staff were very comforting throughout the procedure. It was obvious to me that they care very much about their patients.
- Was very impressed by the assistance provided.

**Mental Health**

- **Hague Ward** - the nurses were caring and understanding. Good group of staff who despite always busy have time to care.
- **Rehab high dependency unit** - They took really good care of me.
- **Taylor Ward (Pennine Care)** - staff do not accommodate my needs. Ward sister really good, easy to talk to, very re-assuring, never too busy & makes time.
- **Psychiatric dept. -** Psychiatrist very off-hand about this problem.
- **Mental Health (Dr Creighton especially)** - - No care, understanding. He was rude & abusive.
- **Mental Health -** good - Nursing staff. Improve - Maybe more night staff on to talk to.
- **Mental health services Dr Creighton Tameside Psychiatrist -** – to improve - Being able to change psychiatrist.
- Via **A & E** - I do have an issue with the way she spoke to me. Cold and patronising, she kept saying things like 'what do you want me to do?' and 'there's nothing we can do', always lovely things to hear when struggling with low mood.

**Maternity**

- They sadly did not survive, but the care and compassion from staff shown to me and my family was just brilliant. The staff have gone above and beyond for us, and still continue to do so with the post-natal care.
- Ward 27 - staff were really helpful and friendly.
- Emergency section and elective section staff were amazing both times I felt comfortable and well looked after.
- Antenatal clinic - I was greeted by friendly and helpful staff including a doctor and midwife who all introduced themselves and explained the procedures they needed to carry out and ensured my consent was obtained. Thank you to the lovely staff today in the antenatal clinic.
- During labour the midwives were lovely. After my son was born the problems started. I felt judged and certainly not supported. The last day the midwife was shouting and screaming for me to feed my own baby and to not be lazy and distant! Just when I thought I could no longer take it anymore a lovely midwife took over the night shift and I left the next day.
- Birth - my deepest gratitude to the midwives**.** The ladies in aftercare were knowledgeable, helpful and very nice to us. They really care.
- Have gestational diabetes - the whole of the team were absolutely fantastic, especially Dr Gondane and Erica Thomasson. The whole team is an asset to the Trust.

- Had to deliver bad news to me, from the minute they did this the care and compassion I was shown was second to none.
- Pool birth - The staff were so supportive and reassuring through the whole birth.
- Midwife - The care and compassion that was given was second to none. Same for all the other staff as well including the care on ward 27! Such a lovely experience and would highly recommend.
- Obstetric Dept. - about total lack of sympathy and compassion from hospital staff and midwife.
- All the midwives, nurses and consultants were very sympathetic for what we had been through (*IVF*), and took time to ensure we were ok and understood everything that would happen through pregnancy. Post-natal ward - and the midwives and nurses were fantastic.
- Midwives and staff on the labour ward were fantastic. The aftercare on ward 27 was especially good - every member of staff had time for you especially with those teary moments!
- Problematic pregnancy - Dr Gondani and her wonderful team of midwives looked after us from the start. We had continuity of care. I thank each and every one of this amazing team for all they did for us
- Wonderful staff whom supported myself and partner through a difficult birth of my son
- Birthing pool - The midwives could not have been more supportive- they were amazing.
- Birth - The rudeness of some staff left me furious and my partner still upset after several months.
- From the induction, consultant care, caesarean theatre team (in particular), labour ward and maternity ward aftercare - every member of the medical team made the whole process as comfortable as it could be. I was always reassured by empathetic professionals.
- The care I received was amazing, and I felt well looked after.
- I was dealt with professionally yet all the times the staff were friendly, personable + kind.
- All the staff, the midwives and the lovely polite young woman who made us tea and toast, were absolutely wonderful.
- I have seen familiar faces through all three pregnancies which is very comforting to see. The care has been excellent. However on many occasions they seem very short staffed and I get the impression they find it difficult to give the best care due to staff shortages.
- Their premature baby aged one week was admitted to Ward 27 with neonatal jaundice, in a side ward. No staff came to see mother or baby for over 24 hours. No treatment offered and they were left on their own in the room. The night staff were very kind, but day staff didn't seem to know why they were there.
- Doctors, midwives and all staff excellent.

There are 24 stories about maternity services, of which 4 were negative.

**Unspecified Tameside Hospital**

- Long waiting and felt uncomfortable and like I was wasting time – need more caring staff!
- It was local, nurses friendly. Needs more organisation, more professionals working.
- Reassurance of staff good.
- They very polite & helpful
- Care & sympathy
- Treated me nicely
- Fast response, considerate, caring and reassuring
- Efficiency, professionalism, caring manner, communication, understanding

**St. Mary's, Manchester**

- Staff in nuclear medicine excellent.
- My son also spent time in the Tameside children's unit until we was transferred to St Marys - I regretted the transfer and would only take my children to Tameside in the future.
- Good - helpful staff

**Manchester Royal**

- Clinic C staff absolutely wonderful. Consultant has recently changed, so a little worried – hope he is fine.

**Trafford General Hospital**

- Just want to say everyone was very kind.

**Manchester Royal Infirmary**

- A&E - the staff were all friendly caring and compassionate.

**Department of Nuclear Medicine**

- Extremely professional and very caring. Well done!
- The Dr I see is outstanding he always listens, chatty, has plenty of banter and offers good advice and treats me very well.
- I can't fault any of the staff, doctors, surgeons.

**The Christie**

- I can't fault any of the staff, doctors.
- Caring, efficient and professional staff who explain things and take time with patients.

**999 ambulance service**

- The first responders were fantastic, including the 999 operator and ensured I got to hospital quickly.
- NHS Direct - explained that my symptoms required a paramedic to be sent. They were wonderful, really kind and explained everything.
- Ambulance – discussion as to whether blue light required – delaying treatment for stroke.
- Ambulance men - So professional and most of all kind.

**Grange View**

- The family reported that they were told that staff shortages were to blame for issues around food and diet, but the family said they thought staff on duty appeared uncaring and to have little knowledge of patient care.
- Shortage of staff meant she was left on the commode in her room for three quarters of an hour because she couldn't reach the buzzer.

**Stepping Hill Hospital**

- **Bobby Moore Unit -** Appalling communication and poor after care where I experienced a 'Couldn't care less 'attitude.
- Colonoscopy - Nurse Practitioner was extremely sensitive to my mothers needs and made the whole experience as pleasant as possible.
- **Outpatient cardiology** – good - The nursing staff

**Dentists**

- **Millbrook Dental -** dentist was gentle and stopped when she wanted and re-assured her.
- **Lees of Henrietta Street, Ashton-under-Lyne** - dentist was very rude.
- **Crown Point Dental Centre -** didn't talk to patient about their teeth and care.
- **Clarendon Dental, Hyde** - Helpful staff and caring dentist
- **Unspecified Dentists**
    - Receptionist was OK
    - The receptionists are friendly
    - The dentist could be nicer
    - Friendly. But lack of concern about an abscess that developed under the tooth she had filled.

**Turning Point**

- Treated with respect and dignity & not judged for coming back in. Invaluable help and support from all the staff at the Smithfield services.
- The receptionist at Lee Street was very understanding when I explained that my son works & doesn't want to lose his job but wants help.

**Pharmacy**

- **Boots**
    - Informative, knowledgeable, friendly.
    - Friendly and efficient.
- **Co-op pharmacy**, **Stalybridge** - pleasant staff and good service.
- **Windmill Centre pharmacy, Ann Street, Denton -** - They discussed (in public) about how many times on a particular day they had to turn out. (My wife sometimes puts her prescription in on the same day. She suffers from short term memory loss.) I am changing my chemist.
- **Unspecified pharmacies**
    - All very attentive & pleasant.
    - Attending. Polite. Understanding.
    - Need Friendlier staff.

**Royal Oldham hospital**

- **Labour + maternity** - Staff were excellent

**Salford Hospital**

- All staff nice & helpful - nurses to cleaners.

**Optician**

- **Boots, Ashton** - Friendly staff.
- **Specsavers -** Friendly, helpful.
- **Unspecified Opticians**
    - Sensitive to your needs, courteous, professional.
    - Optician was nice.
    - Friendly staff, humorous.
    - Everyone is friendly.

**University Hospital South Manchester**

- **Out-patients** - Excellent reception.  Excellent consultant & nurse.

**Tameside Carers Centre, Ashton**

- Phatiba Mistry & Lindsay on return from maternity. The good care & support we get to continue our caring role. To improve - Less case load for each care worker.

**District nurse**

- Need more empathy.
- Follow-up access team at home & some GPs - Once I insisted they seemed to be more willing & helpful.
- Since returning home she has found the district nurses equally as helpful.

**Primary walk in centre**

- Need more staff - was busy.
- Need to improve - The people skills, organisation & communication.
- Need to improve - Less focused on staff.

**111 telephone advice**

- Staff v professional and knowledgeable

**Pulmonary rehab course**

- Comprehensive information and exercise relative to my condition delivered by caring staff

**Parkhill Nursing Home**

- Friendly, warm, caring attitudes of staff. Managers very approachable.

**Wythenshawe Hospital**

- **Heart surgery ward** - Staff very friendly and caring.

**Sexual health service**

- Staff friendly, knowledgeable staff

**Hospital outpatient @ Eye Hospital, MRI**

- Good - The attitude of staff

**Tameside Adult Social Care.**

- The equipment and adaptations service - They have been fantastic with me. I would've been lost without them.

**Adoption Service -Tameside Social Services**

- Kind, sensitive care. Always available

**Appendix 4**

**Complaints themes 2014**

The complaints below relate to a number of hospitals in the Northwest, GP Surgeries, Pharmacies and Dentists.

**Failure to diagnose**

- Possible asbestosis
- Mini-stroke
- Cancer
- 3 unspecified conditions

**Surgery**

- Shoulder
- Polyps
- 3 knee
- Broken wrist
- Hip
- Bowel

**Pain relief**

- Not enough

**Appointments**

- 4 GP
- 2 hospital

**Communication**

- 3 unspecified
- A & E doctor not listening and referring to other departments
- Lost notes
- Confidentiality issues (given wrong person's results)

**Mental health care**

- 4 unspecified mental health
- 2 about treatment received by relative prior to death

**Care**

- 6 about unspecified care
- Inpatient care
- 7 about care of elderly relative
- Poor care given by auxiliary
- 2 about treatment received by partner
- Sent home from A & E without treatment – later emergency admission

**Scans, etc.**

- Confusion over scans

**Treatments**

- Abdominal problems
- Cardiology
- Eye condition
- Treatment not carried out in past
- Problems treating glaucoma
- Negligent treatment
- Podiatry
- Problems with fillings falling out
- Prostrate

**Discharge**

- Unspecified
- Sent home from A & E without treatment

**Fertility**

- Refusal to reverse sterilisation
- Funding for fertility treatment

**Prescriptions**

- Delays obtaining from pharmacy

**Other**

- Size of font & colour of paper (has sight issue)
- Lack of food/drink in hospital
- Issues about level of oxygen for long-term condition
- Transport to medical appointments
- Problems relating to removal of object from eye
- Ambulance service provided to brother's 'cry for help'
- Removal of skin cancer near eye

**Appendix 5**

**Stories which have been published on Patient Opinion and which are Criticality 3 and above.**

We have included the responses received from providers also, as at the time we printed out the information.

**Dreadful GP Service....Amazing Tameside**

My main issue was with my GP service, which has been really poor. I have suffered from something (still not yet determined) for 18 months and I fail to see why a GP can not make a simple referral to a specialist, instead of delaying a problem which has subsequently got worse. It is a known fact that care in Tameside is poor and I do think GP's have a major part to play in this and that they impact on the hospital, which is renowned for its name, but in my case have been amazing so far. My GP (I saw three different ones in the same practice) 18 times, fell below standards and I truly hope that there lack of care, listening and speed has not impacted on my future quality of life. They were too quick to pin things on an existing condition when I clearly told them I needed further help and investigation. My GP arranged for an ultrasound to be undertaken at the practice. Within two days I was informed to attend and meet my GP to discuss my results and his manner was appalling, he told me, even though no bloods or other tests were conducted, just an ultrasound, it looked like I had Pancreatic Cancer, bare in mind I have two children and I am in my early 30's. He was rude, had no feeling, gave no sense of sympathy, nothing. He was like a robot. He then told me I would need a CT scan.....to which the referral was not sent correctly and ended up in the middle of no where and I was waiting and waiting and waiting. I know what pathway I should of been put on and what the GP should of done and that this is not the process for them to follow and the responsibility should be with the Practice Manager to link in with the Hospital in order to advise there team of how and where to make referrals. My GP refused to assign me to a Consultant/Department wanting control of my results and thus delaying me actually seeing a specialist. He said he would see me and give me my results when he returns from leave and I took this fantastic opportunity of seeing his colleague who shook her head in disbelief at what we had been told (my husband has been there throughout) the complete management and could not comprehend why this doctor would want control of a symptomatic lady who needed specialist help. I will be referring this GP to his professional body as I am concerned about my delay and I am sure this is happening to others in Tameside. A simple audit and investigation is needed and they will see this in my notes. In the past 6 weeks my care has been transferred to Tameside I have seen three specialists and have a care plan and follow up appointments arranged. I think that GP's need to learn valuable lessons and I will dispute any arguments this GP practice may have. They have failed me and have alerted me to serious concerns about practice, care and quality. Tameside your Radiology Department is amazing and your Gastro Department has been great so far. Keep up the good work and I sympathise for the mess you have to pick up from controlling GP's. He needs to know there is such a thing as patient choice and he had no right in dictating to my health needs.

**Response from Tameside Hospital**

Thank you for posting these positive comments regarding the service you received at Tameside Hospital in our Radiology department and the Gastroenterology department.

We've made the CCG aware of the comments regarding the other issues you raise.

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**If this can happen twice in one house how often is it happening to the general public?**

My story starts at my doctors surgery Thornley House, Hyde, where I was treated for a lump on my forehead. When I rang to make an appointment, my doctor told me to come straight away. After diagnosing a cancerous growth and a second doctor looking at it, it was decided the doctor would make an appointment at Tameside Hospital. This was August 2014. I anxiously waited for my appointment from Tameside Hospital. Approximately 4 weeks later in September a letter came to say I had not turned up for my appointment in August. They suggested I should make a new appointment but if I did not reply within 14 days they will discharge me from their clinic. I rang them to explain that I never received their appointment letter or a telephone confirmation. Their response to what I said appeared not to concern them at all. My doctor would receive a similar letter from Tameside stating the patient did not turn up. This could cause a bad relationship between GP and patient. I am still waiting for my operation and information received say it could be 14 weeks from beginning to operation. Several weeks unnecessary delay by Tameside Hospital is not acceptable. This same experience happened to my husband some years ago with Tameside Hospital. If this can happen twice in one house how often is it happening to the general public? This is a condensed version of my story.

**Response from Tameside Hospital**

Many thanks for posting your comments. Please can I ask that you contact the PALS and Complaints department in order for us to address your concerns?

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**Unhappy with treatment**

My Father attended A&E in October with a severe cut to his leg. The nurse applied strips to seal the wound and a bandage. The nurse informed me as we were leaving that a district nurse would visit him on Saturday to re-dress the wound as it would need re-doing every two days to avoid infection. I asked the nurse for a contact number in case they did not come. She assured me that they would and not to worry. No one came on Saturday, when he received a call he was instructed to attend the walk in centre in Ashton to have the leg re-bandaged. His sight is poor and because he could not read the machine he could not enter his registration and now has a parking fine. His leg is now infected and has been given a prescription for anti-biotics. To say we are unhappy with the shambolic nature of his treatment is an understatement. He has also been informed that he can no longer attend Ashton and needs to go the Cornerstone in Manchester. We will be pursuing this matter further.

**Response from Tameside Hospital**

Thank you for taking the time to post these comments. The District Nurses come under the Care Commissioning Group (CCG). We have also passed your comments onto them on your behalf. You might want to inform your GP & CCG about the lack of information you have received as they also should have engaged with you as part of the patient consultation process.

Many thanks for your comments.

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**Poor treatment at A & E**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… 83 year old lady fell at home. Severe pain in leg and large gash on calf, bleeding heavily. She lives alone, with no family apart from a niece who she couldn't contact. Ambulance took a very long time to arrive, then waited outside A & E for 1 ½ hours before they wheeled her in. Then waited 6 more hours before she saw a triage nurse. The wound was sutured. No x-ray was ordered although her mobility was very poor. She had to go home by taxi, still in pain. She was told district nurses would see her in 2 days, but they did not. She returned to A & E as wound still bleeding. Told it had been badly sutured, and had to be stitched again. Still no x-ray ordered and no doctor consulted. She has now been told she has a blood clot in the other leg, possibly sustained at the time of this injury. Her mobility is extremely poor. The district nurses have now received instruction to visit and dress wound, but had not done so at the time this information was provided.

**Response from Tameside Hospital**

Explanation provided about procedures covering all aspects of this story. Apologies offered.

**Response from North West Ambulance Service**

Offered further investigation if patient contacted them. Apologies offered.

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**Poor care for my mum**

I had promised my 96 year old mum never to let her go into Tameside Hospital. I had no choice when she had a stroke. From being in the ambulance to when she died one week later the whole experience was a shambles, I felt invisible, and treated as a bystander while I watched them appear to give up on her, with lack of expected treatment, physio, food, drink, and literally no sharing of information. Ambulance – discussion as to whether blue light required – delaying treatment. Stayed overnight most nights, and had family rota so never left till moved, when obviously dying, to Stroke Rehab! Told couldn't stay, left at 9. 30pm to be recalled at 1. 30pm & told to get family in. Nurse comments on ward 45 "Oh she's not got a lot going for her". and said they don't have open visiting since August as patients relatives were checking up on staff. Waiting 6 hours+ for food to be put on drip/xray. Leaving food empty for more than 6 hours. Machines bleeping no-one coming to check. Removing oxygen monitor &

food (same nurse) saying she didn't need these now as machine kept bleeping. Medication blocking food tube when dissolvable ones could have been used so tube had to be redone & more delays. There were limited caring staff.

**Response from Tameside Hospital**

Please accept my sincere apologies this is certainly not the care we expect for any of our patients. I am concerned about this and would like to investigate further. If you would like this to happen please can you contact Helen Howard Matron for Patient Experience on 0161 922 4652 or Helen.Howard@tgh.nhs.uk

**Response from North West Ambulance Service**

Please accept our sincere condolences for your sad loss and thank you for taking the time to provide feedback on your experience of North West Ambulance Service NHS Trust. We are sorry that the experience your mum had when she needed us the most, was not as you would have expected. We would welcome the opportunity to investigate your concerns and if you could provide your details to the following email address: patientexperience@nwas.nhs.uk we will contact you to ensure that a full investigation is undertaken.

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**Lack of physiotherapy after strokes**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… This lady, who is over 80 years old, has had two strokes. She was pleased with care in hospital and at follow-up sessions at outpatient clinic. However, physio is very disappointing. There was only one session – she was just given exercises to do at home. Her affected leg is now "giving way" so she can't walk very well. Her toes have curled under her foot and she is very afraid she will lose her mobility. It is making her depressed and fearful of going out. She is going to ask her GP for advice, and to see if she could have any further physio sessions.

**Response from Tameside & Glossop Clinical Commissioning Group**

Healthwatch has been contacted by Tameside & Glossop Clinical Commissioning Group (CCG) as they would like to contact this lady. They think that she is probably eligible for more support and want to help her to access it. Philippa Robinson from the CCG's long term conditions commissioning has asked us to pass her phone number (0161 304 5300) to the lady.

**Response from Peter Denton - Healthwatch Manager**

We don't have this lady's contact details (she chose not to give them to us when we heard her story) but our volunteer who collected this patient story has a recollection that she has seen them in the same venue before. We're therefore passing this information on to the volunteer in case she sees this lady again.

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**Poor care at Grange View**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… older lady discharged from hospital with severe diverticulosis, weight loss, reluctance to eat or drink, dehydration. Husband and family visited her at Grange View every day. They reported they thought she was not being offered food or drink in a form she could cope with. They also felt no assistance was given with diet or fluids. They said they feared she was prescribed fortified drinks but not given them. The family reported that they were told that staff shortages were to blame for issues around food and diet, but the family said they thought staff on duty appeared uncaring and to have little knowledge of patient care. We were told the lady was eventually re-admitted to hospital where she died.

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**Hospital admission at Tameside Hospital**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… – I was admitted by ambulance to A&E at Tameside Hospital with suspected heart attack. Within 2-3 hours I had been examined, had several routine tests, seen a medical doctor and was moved to MAU. The nursing staff on MAU showed excellent care and consideration to all patients as far as I could see. One nurse/auxiliary nurse in particular, kept checking and making sure an elderly lady who was sat in a chair, was comfortable and had a blanket over her knees. She restored the ladies dignity and her care was nice to witness. The MAU ward was well staffed and looked after. It had a good atmosphere, dedicated staff and cleanliness and all staff and doctors used the hand sanitizers. The panic button and water jug was in easy reach for everyone. All this was a great boost for helping to improve the patient experience. I was moved from MDU to ward 31, where it had a depressing atmosphere, with not as many staff and where I had to wait a long time to see the doctor. When I saw the doctor, he was considerate and patient with me due to my hearing loss. I was told I needed bed rest which I said I could easily do at home. When being discharged from ward 31 I was asked about what medication I was on, but I hadn't been given any medication during my 2 day stay. I was told that if I did need medication to take home I would have to wait 2 hours for the prescription. As I had plenty of medication at home I didn't need any. I saw a significant improvement in nursing staff and with the turnaround from admission in A&E & MDU to ward 31, since my last visit 9 months ago in April 13. (9 months ago when admitted to A&E there seemed to be no procedures in place for staff to adhere to for a suspected heart attack. I was waiting for a few hours for tests and then the doctor never came back to see me as he said he would. I was also left with nothing to eat or drink. )

**Response from Tameside Hospital**

Thank you for taking the time to post these very positive comments around your hospital admission and care you received. We have shared your comments with all the areas you have highlighted. We acknowledge the discharge process can on occasion be longer than expected however we would not want your safety compromised in any way. The environment on ward 31 is being addressed and we hope to improve the atmosphere for patients on this ward by having access to televisions.

**My mother's poor care at Tameside**

I feel that Tameside hospital caused my pensioner mother to become so ill and immobile she has never recovered enough to return home. My mother was not physically ill or injured when she went to Tameside hospital, she was suffering from a form of psychosis. Earlier in the year she had spent two months on the mental health unit with the same problem. However, she made a full recovery without additional medication and continued to attend the unit as an outpatient. Five months later the symptoms returned and she was badly in need of psychiatric care. In late August 2013 she rang the police who arranged for an ambulance to take her to the hospital. From the moment she entered Tameside hospital she became a victim of what I feel were serious mistakes, followed by covering up and lies. My mother became so physically ill (while I feel they were ignoring her psychosis) that she was on a medical ward for a month. Then, still unwell she was moved to Grange view which is owned and run by Tameside hospital for a further two months. Even then my mother was not well enough to go home. Following three months of hospitalisation, lack of exercise and an ignored fall she never regained her mobility. She lost her voice when she had an allergic reaction and that too has not returned. She became deconditioned, depressed, withdrawn and unable to communicate. She was sent to a care home, where she remains in this state of deterioration. Sadly my mother will remain there for the rest of her days. Tameside hospital had her medical notes for reference. In addition, I gave the doctor from a&e her mother’s medical history. I explained that my mother was a psychiatric patient and not physically ill. I gave details of her mother’s medication including a penicillin allergy. Here are some examples of the unacceptable way my mother was treated by Tameside hospital: ( a ) refused to acknowledge she was a psychiatric patient, and have the psychosis she was presenting treated. ( b ) refused to contact her psychiatrist despite assuring me they would. (The only reason her psychiatrist became remotely involved is because I made direct contact with his office. This was when I discovered my mother was being discharged after 72 hours. I told the hospital that my mother was not leaving until she had been treated her psychosis. It was unsafe for her to leave. That was the reason she was brought to the hospital) ( c ) informed by staff the mental health unit was full, with a waiting list of three weeks ( d ) put her on a general medical ward, where she did not belong. Not only was she treated medically badly, she was humiliated by the situation, as some of the other patients considered her odd behaviour to be a source of amusement. ( e ) given four consecutive doses of an antibiotic to which they knew she had an allergy. ( f ) antibiotics were unnecessary anyway as all her tests results were clear ( g ) collaboration by the staff who did everything possible to cover their mistakes ( h ) failed to inform us about the mistakes, and that she had been given penicillin. ( I ) prevented her from attending a much needed appointment with her psychiatrist. ( j ) prevented her from seeing a social worker. ( k ) she had a fall which left her badly bruised My mother became very ill. She was immobile incontinent had breathing difficulties and lost her voice. For four days, I was frantic with worry as I watched my mother’s health deteriorate and had no idea why. Yet the staff knew why, but did not say. I read her medical notes, and discovered my mother had been given penicillin. I confronted the nurse in charge, who refused to accept my mother was allergic to

penicillin. This nurse became angry when I was said my mother was most definitely allergic to the drug, but still refused to add it to her notes. Days later when she developed a rash was this nurse was forced to admit it. However, the nurse still would not include it in her notes When I questioned the staff they denied all knowledge of her mother falling. However when she was admitted to Grange view three weeks later, the bruising was still bad enough to warrant photographs being taken by the person in charge. I made a formal complaint to the hospital, which was made up of twelve complaints. I also asked them to fund my mother's care costs, which is the least they could do. I was disgusted by their response and their refusal to fund my mother's care. The hospital exaggerated their apologies for the minor complaints, in an attempt to overshadow the more serious matters which have been denied. Tameside Hospital have played a huge part in my mother's quality of life being reduced to zero. She has given up, and although she is not dead, she may as well be according to her. She repeatedly tells me that she wishes she were dead. I do not give up easily, and will continue my plight to seek justice.

**Response from Tameside Hospital**

On behalf of Tameside Hospital NHS Foundation Trust I would like to extend my sincere apologies to the daughter of one of our patients who has had cause to outline her story in detail.

I am very familiar with this specific complaint and the daughter's concerns and the comprehensive investigation that has taken place has been closely monitored. I am sorry that our investigation took longer than expected however the complexity of the issue warranted in depth review and analysis.

I cannot respond to the detail in this public arena because of my obligations to respect confidentiality but I can assure the complainant that all of the issues raised in the posting in relation to the care have been responded to. We have undertaken a significant improvement programme since the timeframe covered by the concerns and we provided a full response to the issues raised in detail.

The Trust responded to the complainants concerns for monetary recompense as referred to in the posting and advised as to the correct processes to be followed in relation to this.

I am very sorry that the complainant – the patient's daughter is unhappy with the factual response provided.

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**Leg injury treatment in A & E**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… 73 year old man fell and was in pain in lower leg and ankle. He attended A & E – no x-ray carried out. He was told to take paracetamol. Days later, still in a lot of pain he went back to A & E. He still didn't have an x-ray – he was given stronger painkillers and sent home. He is still in pain and finding walking difficult, but doesn't see the point of waiting for hours in A & E to be told to take painkillers he could buy from the chemist.

**Response from Tameside Hospital**

Thank you for taking the time to post your comment on Healthwatch.

In regard to us not taking X-rays on either visit, the usual clinical procedure is to physically examine the leg and check the range of movement and the ability to bear weight. If these finding are within a normal range (albeit that the injured part might still be painful), a diagnosis of muscular injury is highly likely and an X-ray not necessary.

On the second visit, although the pain was still present, it seems that the clinical findings were the same and therefore it was probably the right thing to do to increase the strength of the pain killers.

What is not acceptable is that is seems that nobody took the time and trouble to explain to you the reasons for not taking an X-ray nor talk you through the most likely cause of pain and give an estimate of when this might get better. This is a failing on our part and I am sorry about this oversight.

Staff are reminded frequently about the need to actively engage patients in conversation and explanations about the care and treatment they are receiving, and whilst this does happen more than 90% of the time, it appears this did not happen on either of your visits and I do apologise again for that.

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**Care of my mother**

My mother has been on ward 31 for 8 days, this ward is supposed to be for cardiac patients. Sorry but its not. I feel that the majority of patients have some sort of dementia, the ward is also supposed to be split one half men the other women, not so. men are wandering about half naked, using ladies toilets wash rooms. walking into womens bays at all times of day and night, not any of the nurses (and I use the term losely) because I dont think any are actually qualified, not enough staff on ward to deal with patients. Many have a terrible attitude towards patients and visitors, if you have any questions nobody can give you a straight answer. can never get to speak to an actual doctor, so after 8 days still no further on with my mothers treatment. The ward is old, dirty only a few of the televisions work, as staff cannot find remote controls, absolutely disgusting, my mother was perfectly alert when first went into hospital apart from her heart problem. Now she is slowly on a decline due to complete boredom, and as for the meals, *slop* not food half the time you cannot tell what its is, that's if you actually get what you ordered, will now be asking to get my mother transferred to a different hospital. DISGUSTED WITH CARE, HOSPITAL AND STAFF!

**Response from Tameside Hospital**

I am very sorry to read of your experience. I have discussed with the ward manager & matron your comments regarding staff attitude, which we take very seriously. These are not the Trust values and behaviours, we would expect from our staff.

The ward will be spot checked to ensure that males are not using female bathroom facilities which should remain separate.

I will also pass your comments on to the catering department regarding the standard of meals.

Patients with Dementia are often admitted to hospital due to another health problem - not due to their dementia. Therefore we care for them in the area of specialty, as we aim to do with all patients.

If you would like a more personal response please can you contact Sarah Williams Matron 0161 922 6000 - switchboard and ask for Bleep 2002 or email Sarah.Williams@tgh.nhs.uk

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**Endoscopy appointment system and delayed diagnosis of bowel cancer**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… This lady's husband was referred to Tameside Hospital. Seen in MAU, told he needed endoscopy. They were going to keep him in for it, but agreed to his going home. No appointment received, telephone calls got vague "it's in hand" response, until on one phone query she was told she had the system all wrong. Her husband had to be seen in outpatients before endoscopy could be arranged. She said the person she spoke to was 'offensive', apparently blaming them. After this, her husband was seen by a consultant in outpatients who arranged the endoscopy (but had already seen a consultant in MAU! ) Her husband was diagnosed with bowel cancer, treated, and is progressing well, but poor communication had caused a dangerous 6 week delay.

**Response from Tameside Hospital**

Thank you for your comment and apologies that we have not met your expectations. We are always striving to improve our communication and we are working with staff around behaviours and values expected from staff members. We have passed your comment onto the departments to ensure they learn from this. If you would like a more personalised and detailed response please contact our PALs services on 922 4466

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**Concerns about my partner's care at Tameside General Hospital**

This story has been posted by Healthwatch Tameside on behalf of a member of the public. We have their details and will forward any comments to them, as they do not have an email address. They said… “Since the end of June, my civil partner, who has been at home for only four days in this period, has been twice admitted (by ambulance, at my request – once at four in the morning) to our local hospital with a liver condition, caused by diabetes and/or alcohol. So far, he has had over thirty litres of abdominal fluid removed (on four separate occasions) and has been put through so many different tests to ensure that he was medically fit. He has given so much blood that I joke that he must be on the Dracula ward. He and I have been most frustrated at his not being discharged after almost 6 weeks, in his second stay, especially when he sees fellow ward-dwellers being discharged in, seemingly, far worse/more fragile states. He has absolutely hated being in hospital, being treated like a child, having no stimulation, with an unchanging, most boring, daily menu. He requested to speak to

the catering manager, but has had no response. I, almost daily, take in things for him to eat – to offer some variety. The hospital has been on “special measures” (that is, failing) for several years now. The latest report from the inspectorate says that the hospital is “inadequate”, especially regarding patient care. Don’t I know it! Ward staff have the remarkable ability not to see you, while looking directly at you, and taking an age to carry out any request for help. It has been most challenging to find out what has been actually going on, because I hardly ever see the same faces two days running on my partner’s ward and I have been told so many different prognoses/stories. I have, politely, foot-stamped, demanding information, but to little/no avail. I couldn’t speak to his consultant, despite telephoning his secretary to ask for a face-to-face meeting, or telephone consultation. On one occasion, I managed to have my partner deemed medically fit to be referred to a local, intermediate care hospital, to get him mobile, that is, with physio treatment. However, he was there for only three nights, before being referred back to our local hospital for further abdominal drainage and tests. His possessions were kept by the intermediate care hospital, in the hope and belief that he might return within the 48 hours, for which his bed was reserved. I only hoped so. However, because he was kept in our local hospital for more than forty-eight hours, I had to go to the intermediate care hospital to fetch his things. As I write, my partner is still in hospital. I keep asking what I consider to be key staff relevant questions to be less informed than when I started the process. It is most frustrating and irritating. Even contacting PALS seems a fruitless experience, as I have found on the occasions I have contacted it. P. S. I contacted PALS again after having written this. The person I spoke to was most helpful and forthcoming. ”

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**Awful gastroscopy experience at Tameside General Hospital**

I recently attended Tameside General hospital for gastroscopy procedure (I have had x 2 done previously). I feel upset that I felt unwelcome and an unfriendly atmosphere in the endoscopy room. The nurse in attendance sprayed my throat from the end of the bed and I could feel only half of my throat was anaesthetised. I was asked questions by the Dr whilst lying down and confused about the procedure and half of my tongue dead-end! I was retching a lot at first and my nose soon got blocked and I couldn't breathe through my nose, I didn't know that the tube in my mouth was so that I could breathe through my mouth. I got very panicky and was trying to ask the staff to wait a moment but was held still and kept being told to relax. I made a lot of retching sounds and felt very embarrassed and when the scope was removed I was left lying on a wet pillow and my face full of stomach liquids & saliva. The staff just walked out of the room & I had to ask the nurse who had her back to me for a tissue which seemed to be somewhat of an interruption to her record keeping. No-one asked if I was ok or if I needed anything until I was in recovery bay. I have never reacted like that before but I really did panic as I couldn't breathe! & I was so embarrassed at the time. I felt I was the talk of the unit and I am sure most other patients must have heard the commotion! I most definitely will never ever have this procedure done again even if my life depends on it. I remain traumatised by it and wake up sometimes in a panic about it.

**Response from Tameside Hospital**

Please accept our apologies for any distress that was experienced by you whilst receiving care on the endoscopy unit. The unit strives to maintain high standards of care therefore it is much appreciated that you have raised these concerns with us regarding your observations during your stay.

Your concerns have been passed to the unit and they are addressing them with the staff concerned.

If you would like to get in touch we will be able to look at the concerns you have raised Please contact Helen Howard Head of Patient experience on 0161 922 4652

Helen.howard@tgh.nhs.uk

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**Not offered tests and had to beg for investigations to be carried out**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… A young single mother with 2 children became dizzy and fell down stairs. Numb down right side. Went to A & E at hospital in another area but then referred to Tameside Hospital for further tests. She is a qualified nurse so was aware of the seriousness of her symptoms. Her notes couldn't be found at Tameside. She was not offered tests and had to beg for investigations to be carried out. Was eventually given ECG and 'cardiac tape' but no explanation about loss of sensation down right side of her body. Still has some weakness. Very disappointed with all aspects of care.

**Response from Tameside Hospital**

I am sorry to read about your experiences at Tameside.

I am concerned you felt you were not listened to and I want to let you know that we are working hard to improve our communication with our patients and people who visit our hospital.

If you would like this to be formally investigated please can you contact Sarah Williams, Matron Urgent Care & Cardiology. Telephone 0161 922 6000, Bleep 2002

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**Lack of understanding for dementia sufferer**

Our mother has dementia. She has been diagnosed with advanced alzheimer's, and was admitted to hospital via ambulance recently. When she got there she was admitted to a medical ward which was totally wrong she needed psychological care. After spending a horrific 10 hours in A+E and another 25 hours in a chair in a television room and was given a sedative there and the family were told to sit with her, as it appears she was too much for them to handle. She had been allocated a bed nobody told us we were just left to sit with her in this television room. After which we had to leave for the evening. The next day following the tests they had done, came back normal and was promptly sent home being told there was nothing wrong with her because all tests had come back negative I. e blood/water. We knew she did not have a medical problem it’s

her mind that is the problem, all these facts were known before she got to the hospital so why was she sent to the wrong department (to be ridiculed and taken the mickey out of by members of your staff?) Apart from the fact that her son was phoned to say they could not cope with her so could he come and try to calm her down, the reason we wanted to get her to hospital was so you could calm her down. We were told she would be sectioned because she is a danger to herself and others she is so aggressive, and then the next minute we get a phone call to say she's coming home. So much for the care that's given to people with this horrible condition. I read that people who are admitted into Tameside hospital with dementia wear badges to let people know they should be treated with respect and dignity. And we are still having problems with her not knowing who to turn to for help, there are plenty of people saying they help but this lady is really ill and needs proper care not just being passed from pillar to post. This is a cry in the dark can we get this lady some HELP. But I won't hold my breath as up to now it seems to me, you are hopeless.

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**Care at Tameside Hospital**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… This lady's husband is currently in Tameside Hospital. He has a previous history of colon and bladder cancer. He has had radical surgery to bowels and bladder. Treatment at The Christie and at Pennine Medical Centre excellent but if he ever has to be admitted to Tameside, he and his family have all been very unhappy with his care. Due to return home soon after treatment for Urinary Tract Infection and as usual his care has been sub-standard.

**Response from Tameside Hospital**

I am sorry that you are unhappy with the care your husband is receiving. This is certainly not the standard of care we expect for our patients. Without the details I am unable to establish where this process failed on this occasion

Can I please request that you contact Helen Howard, Head of Patient experience on 0161 922 5352 or email Helen.Howard@tgh.nhs.uk so that these issues can be sorted out for you.

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**GP is doing more for me**

I was taken into tameside hospital was kept waiting for 4hours had a heart condition. I was sent to mauu ward and had my blood pressure taken in the middle I was woken to have an injection in my stomach. They thought I had a blood clot. My doctor sent me for xray in morning they looked at that but later on that day I was sent home by a consultant. Started a 24 hr urine collection never completed my own GP is doing more for me sending me for echocardiogram which could have been done when I was in hospital.

**Response from Tameside Hospital**

Many thanks for posting these comments; it is difficult to comment on an individual case without more specific details.

However from a clinical perspective, a decision to treat and or discharge is based on the clinical information and how the patient presents on the day.

If you would like this looking into further please can you contact PALS and complaints department in order for us to address your concerns?

Telephone:0161 922 4466

Palsandcomplaints@tgh.uk

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**Lack of communication between hospital and district nurses**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… Elderly man had day care surgery in Tameside Hospital and was told the dressing had to be changed after 48 hours and District Nurses would visit to do this. After over 3 days they had not visited. Wife repeatedly phoned and left messages to which nobody replied. Husband was in severe pain and couldn't walk, so was unable to get to GP for dressing removal. Finally family member removed dressing.

**Response from Tameside Hospital**

Thank you for your comments. This is clearly not the standard of care we expect for any of our patients to receive. We take concerns very seriously and can only improve if we are made aware what is going wrong from the patients perspective. We will share your concerns with the district nursing services.

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**The experience has been very difficult emotionally as well as physically**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… This lady has two children aged 3 years and 9 months. After very traumatic first labour (large baby stuck in birth canal then emergency C-section), she received no help or advice during second pregnancy about whether she would need another C-section. In hospital (Tameside Obstetric Dept. ) doctors did not read notes and there was no discussion with her or her husband about her problems during first labour. Finally she had another section. She now has an abdominal hernia and has been told the muscles may never heal. She cannot have any more children. She approached PALS about total lack of sympathy and compassion from hospital staff and midwife but feels she has not been taken seriously. She was very distressed during labour to realise none of the staff knew if she should be having a C-section or not, even though there were notes in her case file from her previous pregnancy and her second one. The experience has been very difficult emotionally as well as physically and she feels betrayed and disillusioned with health care at Tameside Hospital.

**Response from Tameside Hospital**

We are sorry that you have had such a negative experience with maternity services. In these circumstances we try to talk with the mother about what has happened

previously and the reasons why it happened. Which should include information about any potential future pregnancies and birth.

Unfortunately a complication of major surgery is the development of a hernia but this can be repaired.

As part of the discussions that should take place in any future pregnancies it will include revisiting previous experiences to try to confirm the reason for the previous caesarian section and discuss the most appropriate pathway for this pregnancy. I can only apologise that we do not seemed to have supported you in this way.

We would like you to come and meet with an obstetrician and a senior member of the midwifery team to discuss your concerns and worries at a time convenient to yourself. This is really important for you and for us to ensure that anything like this does not happen again.

If you contact Anne Haggerty Matron on 0161 922 6173 or PALS team on 0161 922 4466 so this meeting can be arranged.

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**My partner still upset after several months**

After being induced, my partner was moved into a ward due to lack of space, which we were OK with. Once contractions started we were advised to have a bath which we did and my partners waters broke during the bath. I sought assistance and was told "no, she's not in labour, I should know love". We were then left alone again. My partner was in great pain and the midwife then reluctantly checked to find that she was in fact 6 cm dilated. They laughed at this and went to fetch gas and air. They came back after some time laughing and saying someone has moved it and no one can find it. Eventually we were moved to the delivery suite. As my partner was induced, the contractions were constant with no gaps in between. The midwife decided she needed Pethadine, even though it was late on. The babies heart rate slowed too much so a doctor was called. Forceps were tried by a very rude lady who shouted at my partner and thrust a form for her to sign even though she wasn't able to do so. I had to stop the bed being dragged across the room as she was pulling so hard. She was constantly saying "this is a waste of my time, she's not trying". I was then pushed out of the way with water spilt over me and told she's going for an emergency c section and a doctor is driving in as the baby isn't well. Blue overalls were thrown at me and I was left in a toilet to get changed not knowing what was happening. The rudeness of some staff left me furious and my partner still upset after several months.

**Response from Tameside Hospital**

Thank you for taking the time to post your comment, without specific details it is really difficult to comment on this situation. This is not the standard of care we expect for our patients. If you would like to get in touch, we will be able to look at the concerns you have raised. Please contact Anne Haggerty (Matron) on 0161 922 6078

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**My childs well being**

My child was admitted to childrens ward through a and e with really bad skin condition which was infected. My child is only 2 years old and is really suffering with the condition all I wanted was for them to help relieve discomfort, but the response I got from the doctor in charge was... what do you want me to do its Friday? In the end I left the hospital after a promise of a referral appointment to dermatology by Monday. No one contacted me back and when I tried to chase the appointment up the appointment had not been made despite me having it in writing on the discharge notice.

**Response from Tameside Hospital**

Thank you for sharing your experience, Stephen McLaughlin Divisional Manager for Children's service has been made aware of the clinical care and support related to your child's hospital visit.

Stephen is revisiting the discharge information and appointments and is personally monitoring the arrangements around a dermatology review

Stephen can be contacted on 922 5256 if you wish to discuss this in more personal detail.

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**Delay in reacting to a problem resulting from a hip operation**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… In September I had a new hip on the elective ward at TGH. As a result of this operation my operated on leg is now 26mm longer than the other leg. It took the hospital 3 months to get me in to measure this. In the meantime this was putting pressure on my other leg and I had to buy my own spacer for my shoe to try to alleviate this pressure. The surgeon said that this was a risk I took and signed the form to consent to that risk. I don't remember that being on the form. They are going to make something for the shoe on the other side but not until February. I am angry about the delay and also by their attitude - they don't seem bothered at all about the time delay.

**Response from Tameside Hospital**

Thank you for taking the time to post these comments. I am sorry that you have found the process poor and not to your satisfaction.

We have shared your experience with orthopaedic business manager Sarah Bradbury. It is difficult for her to comment in detail but she has provided information around the consent process and cancellation procedures. Patients are given an appointment to attend clinic for consenting and this is done either by the consultant or his /her middle grade usually several weeks before they are given a date for admission.

In relation to cancellations Sarah has described how we try and manage this; it depends on the reason for the cancellation and who cancels. E.g. if it is due to bed pressures and is done the day before admission it is either the business manager or the consultants secretary who cancels. We always inform the patient of the reason. If the cancellation is as a result of something arising out of pre-op then it would either be a

nurse or possibly the secretary. If it is the latter then the secretary would give the patient as much information as they could.

If you want a more personalized response please contact Sarah Bradbury Business Manager on 922 4105 or email Sarah.Bradbury@tgh.nhs.uk

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**Fractured arm or not?**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… (told by aunt) 21 year old girl injured her arm. Went to Tameside General Hospital for x-ray. First told it was fractured and a temporary plaster applied. A week later told it wasn't fractured, and a full plaster was said to be unnecessary. Still in pain, not sure what to believe. Afraid it may be fractured and may be making it worse by using it. Feels staff at TGH don't know what they are doing. Won't go there again.

**Response from Tameside Hospital**

Thank you for letting us know of issues regarding a query over a fracture you had during a recent visit to Tameside Hospital.

Without details of the case, it is a little difficult to know exactly what went on. The following is only therefore a supposition rather than a full explanation.

1. It is not unusual for a fracture to be 'missed' until the x-ray is seen by senior radiologist, but it is quite unusual for a fracture that is not actually there to be seen and a plaster to be applied

2. It is essential to know who, and in what clinic/hospital the patient was told that there was no fracture before this can be investigated

3. If the pain continues and does not resolve, then we would urge the patient to return to AE or to see their GP as soon as possible. If there is a fracture, then any movement will cause pain and automatically stop the person using the arm so the risk of making things worse is low.

We would encourage if at any time a patient or relative/carer does not understand what is going on or is unclear about treatment, they should ask the doctor or nurse treating them for a full explanation (although that should be given as a matter of course). In the unlikely event that an adequate explanation is not given, then the person should request that they be seen by the senior nurse or doctor in the department at that time. We can guarantee that any such request will be complied with politely and immediately. It is your right to know everything that is happening to you.

I apologise that this is a general overview rather than specific to your niece. If you require a more detailed explanation please contact Sarah Williams Matron on 0161 922 5201.

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**Knee replacement surgery at Tameside Hospital**

This story has been posted by Healthwatch Tameside on behalf of a member of the public. We have their details and will forward any comments to them, as they have not provided details of an email address. They said… This 71 year old lady recently underwent knee replacement surgery at Tameside Hospital. The pain is now worse than before the operation. She was in hospital, then rehab, for weeks. She had an infection in the wound but wasn't told until the physio detected it. Admin was very poor – appointments weren't sent, an op was cancelled late the night before she was due to be admitted, after she had made several personal and family arrangements. She is now "knock-kneed" and can't fully straighten or bend the knee even after many sessions of physio. She saw the consultant at a follow-up clinic but felt he did not listen to her. She is considering making a formal complaint.

**Response from Tameside Hospital**

I am sorry to hear of your complications following your surgery.

I am concerned you felt you were not listed too and I want to let you know that we are working hard to improve our communication with all our patients & visitors who visit our hospital.

Without this ladies specific details it is difficult to comment. If this lady would like this to be investigated further can I ask her to contact Helen Howard Head of Patient Experience on 0161 922 4652 or Helen.Howard@tgh.nhs.uk

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**Bad experience on Elective Unit**

Had TKR a few weeks ago at Tameside Hospital. It was a total nightmare. No complaints about Surgeon - he was excellent and my operation seems to be a success which is more than I can say about the care and dignity on the Elective Unit. It just didn't happen for me I'm afraid. My physical scars are healing but my mental scars are not. The spinal injection failed on me so I had to have a general anaesthetic so I didn't get back on the ward until 6pm. 30mins later my visitors arrived to find I had wet the bed. The nurse changed me because my daughter asked her to. That evening I was buzzing the nurse constantly because I was wetting the bed. Although the spinal hadn't worked for the knee op, I was still numb to the top of my legs so I was unable to control my bladder. Next day was the start of my nightmare. I had the staff nurse shouting at me for not telling her I was in pain when the reason I was in pain was down to apparent medical error. So I was prescribed morphine every 2hrs but the nurses refused to wake me when the medicine was due so I had to set my phone alarm instead. I was due a dose of morphine at 5pm. I buzzed at 5pm and 5.15pm to be told by two auxiliaries each time that she (presumably the nurse) was on her round. It was 6.30pm when I eventually got my morphine and all that time I had been in agony. I felt like it was intentional to keep me waiting. This apparent bullying and humiliation went on for about 4 days. It was as though I had been sent to Coventry. I can't forget what happened to me. I had no staff nurse or Ward Sister showing me any care at any time of my stay. Dignity just doesn't seem to exist on that ward and i think it's a farce that the unit displays a Dignity in Care award. It's disgraceful and serious malpractice in my

opinion There were a couple of members of staff that were very good, especially Vicky. The others I met need to take a leaf out of her book and if not, be retrained or more aptly dismissed due to lack of care and dignity. I have posted reviews on TGH websites but have not received a response from the Trust so I have resolved to take this further to protect other unfortunate patients who may be vulnerable on that unit.

**Response from Tameside Hospital**

Please accept our apologies for any further inconvenience, distress or problems that were experienced by you whilst receiving care on the Elective unit. The unit strives to maintain high standards of care therefore it is much appreciated that you have raised these concerns with us regarding your observations during your stay.

The Trust takes care to ensure that important matters such as a patients pain levels are correctly monitored and on this occasion your expectations were not met. Please accept our sincere apologies as we are disappointed that your experience has not been as positive as we would like.

We would like to assure you that since receiving your complaint every member of staff within the Elective unit will be made aware of your observations and it will be discussed at our ward meeting and divisional senior meeting.

**Response from patient**

Although I am grateful for a response, and a positive one, I still don't feel as though I have closure. There are so many things I still need to say such as the rest of the nightmare I experienced. And it is those Staff members who were directly responsible that should be saying sorry, not just the Heads of Nursing. My family were treated abysmally too, but who knows that, and more importantly, Who cares?

I would expect a meeting with the ones involved, to understand the reason why they behaved the way they did and to hear THEM say "Sorry" to me and my family. I may, then feel that the trauma of this awful experience can gradually be erased from my mind.

**Response from Tameside Hospital**

Many thanks for your latest comments. Please can I ask for you to contact me so we can help resolve your concerns?

Helen Howard Head of Patient Experience 0161 922 4652

helen.howard@tgh.nhs.uk

**Response from patient**

Would it be possible to contact Helen Howard on Friday

**Response from Tameside Hospital**

Please feel free to contact me on Friday. If I am not available I will ensure a message is taken and I can return your call.

Kind regards

Helen Howard

Head of Patient Experience

**Response from patient**

I rang the above number at 3.50pm (Friday) however there was no response and no facilities to leave a message. Please advise further.

**Response from Tameside Hospital**

I'm so sorry I missed you on Friday. I was away from my desk. Please can you contact me again. I have made arrangements with the ward manager to meet with you at your convenience.

Kind regards

Helen Howard

Head of Patient Experience

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**In patient experiences at Tameside**

As the wife of an in-patient at Tameside Hospital during May and June this year, firstly on ward 46 for four and a half weeks, then after being home for a week back into ward 31 for over two weeks, I have been appalled at some of the incidents that have occurred during my time on the wards. The shortage of staff being partly to blame, a lack of correct communication between members of staff and illegible notes in files that even other members of staff cannot decipher, and also problems with language barriers. It also appears that due to 'Hospital Protocol' and Health and Safety regulations, basic common sense is not allowed in a lot of situations. Having been with my husband on the wards morning till night during his stays I have picked up a buzz of discontent amongst several of the staff, who would agree there just are not enough 'hands on' staff to work efficiently. When agency staff are used matters get worse, many having far from perfect communication skills with the English language, which makes things difficult for patients and staff alike. Within 24 hours of admission, my husband had sustained two skin tears and a bruise on the back of his head although I had stressed to all concerned that his skin is very fragile on his arms and even a gentle grip would cause damage. By the time he was discharged he had several dressings on both arms due to skin tears, in my opinion unnecessary, I have handled my husband at home for over two years in this condition and have only ever caused skin damage once, this taught me to 'Handle with Care'. He was padded up for weeks, although I had made it clear that he was totally continent and could use a urine bottle if assisted, consequently he was constantly wet through and his skin became very fragile, his bowels had not been opened for approximately 10 days after admission, I had mentioned this to staff several times, he was eventually given an enema, which got things moving, but then he was plied with laxatives and lactulose, which then caused uncontrolled bowel movements in pads, until 2 days before his first discharge when I asked for a commode, which is probably how he contracted U T I. There seems to be more concern with weighing patients and taking blood sugars which in my husbands condition at the time were fairly irrelevant, but look good on paper, than individual

personal needs like has a person passed urine or had a bowel movement. Regularly during both stays my husbands feet were jammed against the bottom of the bed, with protective heel pads part way up his legs not on his heels, and his heels not raised off the bed, I had mentioned this on each occasion to the staff and the ward manager, on one occasion his feet were bruised by pressing on the pump fixture at the base of the bed, but it still continued to happen. There were errors in documentation on files, age 89 not 85, one statement said 'moves himself", which would indicate to staff that he did not need moving or repositioning in bed, 'I wish! , amongst other mistakes. My husband was put on a strict fluid restriction of 1 litre a day to include allowance for food, but behold communication from persons unknown changed this to one and a half litres, I queried this with two members of staff to be told it was correct as it had come over at handover, I checked with the doctors who said it should not have been altered, but no one knew who was responsible. On one occasion I was told they were moving my husbands bed where they could see him, this was another patient, another occasion a nurse came to put a bed pan under my husband, yet again, wrong patient, had I not been there he would not have known any different, another I was told in the morning he had had antibiotics for a U T I, including what sort they were, when I asked if he was to have them at lunch time I was told he was not on antibiotics, nurse said she had got confused it was another patient! There were several errors with medication which had I not been there would probably have passed without notice which I find inexcusable, I pointed this out to ward managers and staff, one of the occasions his tea time medication had been missed, which included warfarin and I N R was out of range, the member of staff had gone off shift, the medication had not been signed for but no one knew whether or not he had been given it, I knew he had not as I had only left the ward for a couple of minutes, it was eventually given to him as I insisted I knew he had not been given it earlier. During the first stay, hand hygiene between patient contact was not adhered to, again I spoke to the ward manager about this. Also during this stay a 94 year old man was taken into the toilet by an agency worker, who left him there and went off his shift without telling anyone, fortunately after 20 minutes another man on the ward heard him and went for a nurse. Although on thickened fluids due to dysphagia, my husband was given unthickened drinks several times, put into bed on an air pressure mattress and chair without the pump being on, an oxygen line left off after a procedure which I put back myself, only little things but still important. One day I arrived to find my husband naked in bed with just a pad on and a sheet covering him, no one knew how he came to be like this, I was told perhaps he was to warm, nevertheless, where is the dignity in that? , another 2 occasions I found him with a bottle in place under the sheets, but again nobody knew how it got there. During the 2 stays 2 pairs of pyjama bottoms and 2 towels mysteriously vanished I presume with the hospital laundry, for which I blame myself, I should not have taken them in the first place. Some recordings in files were illegible even other staff could not read them, no wonder there are breakdowns in communication, if they cannot be read why bother to log them? Surely patient files are supposed to be records of their treatments and what is going on, what is the point if they cannot be read and understood? If a bottle or commode was required, more often than not by the time staff had done what they were doing, and five minutes turns into half an hour, it would be too late, no disrespect to the staff who often needed more than two pairs of hands! My husband had a sheath on at night at my request but to use bottles in the daytime, sometimes it

would be on, sometimes not, sometimes left on half the day, surprisingly one member of staff had no idea what a sheath or convene was when I asked for it to be taken off, another had never had to put one on or take one off as it was not part of their training! On both occasions after having problems with bowels and urine incontinence, after 24 hours at home there was no longer a problem my husband was back to toileting during the day and using a bottle at night, so why did this happen in hospital? Even to the last when preparing for discharge, the person assessing for social input at home, got half way through filling the forms in and said 'so you are Elsie?', that is not my name, she was filling another patients form in, and to add insult to injury, even though my husband was discharged medically fit but going home before the care package was in place, I was assured by the ward that the referral would continue as they were just waiting on Cara contacting them, I had a friend coming in to help in a morning and son at night, after 4 days and hearing nothing, I phoned Cara who knew nothing about the referral and so gave it up as a bad job. I spoke to hospital inspectors during their 'planned visit' it was quite obvious that an inspection was pending although I had not been told about it, by the amount of staff on the ward running round like 'headless chickens' printing, sticking charts on walls, filling in bits of files that should have been done earlier, all to look good for the inspection, needless to say all this was at the expense of the patients welfare. Two weeks after admission I was asked to sign a valuables disclaimer, and also if my husband had his own teeth, a little late I might ask? What is the point in giving advance warning of an inspection, surely they need to see things as they really are. I could go on, there were lots of other things with other patients, but not for me to say, common thought seems to be 'we don't like to complain in case the patient suffers for it' although I know relatives of two other patients on the ward were putting in complaints. Surely there should be some 'plan of action' for each individual to be easily seen and understood by all members of the team, which would avert the inconsistency. Two years ago we had a similar experience at this hospital, which I had logged daily, but had not got the spirit to complain, but feel this time I can not remain silent. I must add that the medical teams have been extremely good, and most of the staff have been good, there just are not enough of them, some go 'above and beyond' what they are paid to do, some work with 'their heads and their hearts' and my thanks go out to them, some do their jobs efficiently, and others just seem to have been worn down by the system. My experiences over the past few weeks have been 'soul destroying' and leave me with little faith in the hospital or the N H S. I am hoping that this get 'read and digested' Hopefully and sincerely.

**Response from Tameside Hospital**

On behalf of Tameside Hospital NHS Foundation Trust I would like to extend my sincere apologies. Without having the personal details it is difficult to comment. I would like this to be investigated in more detail.

Please can I request that you contact Lindsay Stewart, Deputy Director of Nursing or Peter Weller, Director of Quality and Governance on 0161 922 5352 or email Lindsay.Stewart@tgh.nhs.uk or Peter.Weller@tgh.nhs.uk so that we can arrange for someone to meet or discuss with you.

Once again please accept my apologies

**Response from wife of patient**

Following my complaint regarding Tameside hospital, although nothing can take away the past, I must follow up with my more recent experience. Firstly I had a good response from hospital management, who took my complaint seriously and acted appropriately, therefore I would advise anyone with an issue to make it known.

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**Removed from patient list as a result of a complaint**

This story has been posted by Healthwatch Tameside on behalf of a member of the public who asked not to have their name published. They said… This lady complained about her former NHS dental practice – Lees of Henrietta Street, Ashton-under-Lyne. She was seen by a new dentist who had been taken on, who missed her dental nerve twice when injecting and paralysed her face. The same dentist was very rude to her daughter. After these two incidents she complained, but as a result was removed from the patient list, and left without a dentist. (Healthwatch Tameside has provided information on how to find a new dentist.) There was a third incident involving this lady's sister, who was charged twice for the same work. She returned because the first root treatment had failed. At the time this story was told to Healthwatch, the sister had not pursued this with the dentist, although her family were urging her to.

**Acknowledgements**

All the information contained in this report has been provided by people who have accessed services provided in Tameside, and/or who live in Tameside. They are sometimes referred to service providers located outside Tameside.

We would like to thank them for sparing the time to share their experiences. We have done our best to keep the anonymity of these people (apart from Patient Opinion stories which are stated exactly as they were published online).

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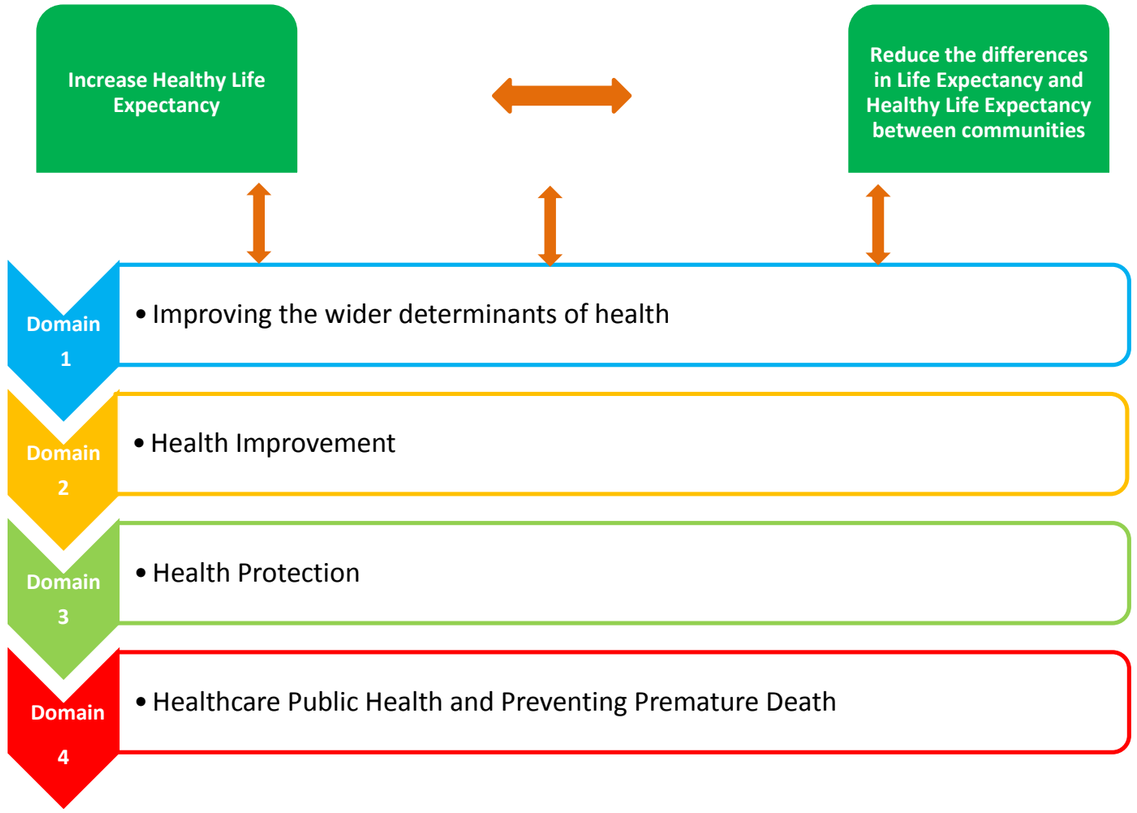
| **Report to:** | **HEALTH AND WELLBEING BOARD** |
| **Date:** | 12 November 2015 |
| **Executive Member / Reporting Officer:** | Cllr Lynn Travis – Executive Member Health and Neighbourhoods<br>Angela Hardman – Director of Public Health<br>Jacqui Dorman – Public Health Intelligence Manager |
| **Subject:** | **PUBLIC HEALTH OUTCOMES FRAMEWORK-SUMMARY UPDATE** |
| **Report Summary:** | This paper provides an update for the Health and Wellbeing Board (HWBB) members regarding the current position of the Tameside Public Health Outcome Framework (PHOF) indicators and the comments and any issues surrounding the indicators within the PHOF. |
| **Recommendations:** | Members of the HWBB read and digest the indicators and any comments against each indicator in the PHOF so they are aware of any emerging issues or concerns with indicator movements. |
| **Links to Health and Wellbeing Strategy:** | The PHOF Healthy lives, healthy people: Improving outcomes and supporting transparency sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected.<br>The framework concentrates on high-level outcomes to be achieved across the public health system that cover the full spectrum of public health. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life. |
| **Policy Implications:** | The PHOF focuses on achieving positive health outcomes for the population and reducing inequalities in health. The majority of indicators in this framework have the potential to impact on inequalities. The Public health outcomes framework links closely with the Joint Strategic Needs Assessment and Health and Wellbeing Strategy. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | There are no direct financial implications for the Council relating to this update. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | The data published in the tool are the baselines for the Public Health Outcomes Framework, with more recent and historical trend data where these are available. The baseline period is 2010 or equivalent, unless these data are unavailable or not deemed to be of sufficient quality.<br>A list of indicators updated, for the most recent and previous releases can be found in the Public Health Outcomes Framework Collection within www.gov.uk. |

| | |
|---|---|
| | Data are published as part of a quarterly update cycle in August, November, February and May. The next update will be on Tuesday 2 February 2016. Public Health Outcomes Framework data will be revised and corrected in accordance with Public Health England's Official Statistics Revisions and corrections policy and the Code of Practice for Official Statistics. This data enables the Board to consider where there are inequalities where strategies and resources need to be focussed. |
| **Risk Management :** | That the PHOF be used in the wider context along with other national and local intelligence to build a complete picture of health and wellbeing in Tameside. The PHOF indicators are updated intermittently throughout the year when the data becomes available. Public health Intelligence locally manage the nationally released data in the format of a local scorecard to allow us locally to assess trends and changes in indicator performance and to add context on what we are doing locally to improve outcomes for our residents |
| **Access to Information :** | All papers relating to this report can be obtained by contacting: Jacqui Dorman, Public Health Intelligence manager by:<br>Telephone:0161 342 3067<br>e-mail: Jacqui.dorman@tameside.gov.uk |

## Public Health Outcomes Framework

***The Vision: To Improve and protect the nations health and wellbeing and improve the health of the poorest first***




Over the last decade, health inequalities between different groups has widened, leading to widening discrepancy in public health outcomes.

Responding and acting upon these challenges is the prime function of the Public Health Outcomes Framework (PHOF). Also the government is radically shifting power to local communities, thus the public health outcomes framework is needed to provide a mechanism for transparency and accountability across the new public health system that has emerged as a result of the public health reforms.

Between 2000/02 to 2011/13 the relative gap in life expectancy between Tameside and England has fallen by 11.4% for males however, it has increased by 29% for females.

Health inequalities are not only apparent between people living in different geographical areas - they exist between different socio-economic groups, between different genders, different ethnic groups and the elderly and people with mental health problems or learning disabilities

The cause of health inequalities are complex and include life style factors such as smoking, nutrition and exercise and the wider determinants such as poverty, housing, education and access to services such as healthcare.

The recent Public Health Outcomes Framework data tool publication includes information/data on 169 high level outcome indicators. Of these 169 outcome indicators, Tameside have 58 (34%) outcomes that are significantly worse than the England averages, with the highest proportion of these falling under domain 2 (Health Improvement) and domain 4 (Healthcare Public Health and Premature Mortality). There are 29 outcome indicators that are significantly better than the England averages, with the remaining 82 outcome indicators having similar values to the England averages.

Reducing early deaths from preventable conditions would significantly impact on overall life expectancy. Premature mortality could be avoided through robust public health interventions such as increasing physical activity levels in our population, reducing smoking and alcohol, tackling the wider determinants of health and through healthcare interventions such as early diagnosis, improved disease management and equitable access to primary care facilities.

NICE PH15 recommendations include the following advice:

- GPs and other NHS staff working outside hospitals, including local authorities should set up systems to identify people who are disadvantaged and at high risk of heart disease.

- NHS organisations and local authorities should work together to provide flexible services to improve the health of these people. This might include advice and help offered in drop-in clinics and other places people can get to easily, at times that suit them. Information should be provided in a language people understand.

- The NHS and local authorities should ensure services aiming to improve the health of people who are disadvantaged are coordinated and that there are enough people trained to run them.

## Annual Summary

### Wider Determinants

| | | 2014 | 2015 |
|---|---|---|---|
| **Indicators that have improved** | | | |
| 1.04i | 1st time entrants to youth justice system | 501 | 426 |
| 1.05 | 16-18 year olds NEETs | 6.6% | 4.6% |
| 1.11 | Domestic Abuse (rate per 1,000 population) | 27.7 | 23.5 |
| 1.12i | Violent crime (including sexual violence) hospital admissions for violence | 82.8 | 79.7 |
| 1.13i | Re-offending levels percentage of offenders who re-offend | 27.8% | 26.2% |
| 1.13ii | Re-offending levels average number of re-offences per offender | 0.87 | 0.83 |
| 1.15i | Statutory homelessness homelessness acceptances | 1.1 | 0.7 |
| 1.17 | Fuel Poverty | 11.9 | 10.4 |

| | | 2014 | 2015 |
|---|---|---|---|
| **Indicators improved but still worse than England** | | | |
| 1.01ii | Children in Poverty - under 20 ys | 23.1% | 21.9% |
| 1.01ii | Children in Poverty - under 16 yrs | 23.7% | 22.7% |
| 1.02i | School Readiness | 41.8% | 52.1% |
| 1.02i | School readiness with free meal | 23.2% | 38.1% |
| 1.02ii | Phonics screening check | 65.4% | 69.2% |
| 1.02ii | Phonics check with free meal | 52.3% | 57.2% |

| | | 2014 | 2015 |
|---|---|---|---|
| **Indicators that are in decline** | | | |
| 1.03 | Pupil Absense | 4.7% | 4.85% |
| 1.06ii | Adults in contact with 2$^{O}$ MH services who live in stable & appropriate accomm (P) | 76.6% | 45.1% |
| 1.08i | Gap in the emp rate between LTHC & overall emp rate | 11.3 | 12.2 |
| 1.08ii | Gap in the emp rate between LD and overall employment rate | 56.6 | 61.8 |
| 1.09i | % of employees with at least 1 day off in the prev week (sickness) | 1.9% | 2.4% |
| 1.09ii | % working days lost due to sickness absence | 1.6% | 2.1% |
| 1.12ii | Violent crime (incl sexual) offences | 11.7 | 12.2 |
| 1.12iii | Violent crime (incl sexual) - Rate per 1,000 population | 0.7 | 0.97 |
| 1.16 | Utilisation of outdoor space for exercise/health reasons | 15.3%* | 13% |
| 1.18i | Social Isolation: % of adult social care users who have as much social contact as they would like | 42.9% | 41.3% |

### Health Improvement

| | | 2014 | 2015 |
|---|---|---|---|
| **Indicators that have improved** | | | |
| 2.01 | Low birth weight of term babies | 3.1 | 2.4 |
| 2.04 | Under 18 conceptions | 32.7% | 29.1% |
| 2.04 | Under 18 conceptions: conceptions in those aged under 16 | 6.8 | 4.2 |
| 2.14 | Smoking prevalence adults (over 18s) - Routine & Manual | 34.9 | 30.4 |

| | | 2014 | 2015 |
|---|---|---|---|
| **Indicators improved but still worse than England** | | | |
| 2.02i | Breastfeeding initiation | 59.7% | 61.1% |
| 2.03 | Smoking status at time of delivery | 20.9 | 17.8 |
| 2.07i | Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4) | 206.7 | 199.6 |
| 2.07ii | Hospital admissions caused by unintentional & deliberate injuries in young people (aged 15-24) | 178.4 | 159 |
| 2.14 | Smoking prevalence adults (over 18s) | 25 | 22.4 |

| | | 2014 | 2015 |
|---|---|---|---|
| **Indicators that are in decline** | | | |
| 2.06i | Excess weight in 4-5 year olds | 23.2% | 24.50% |
| 2.07i | Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14) | 148.9 | 152.4 |
| 2.13i | Percentage of physically active and inactive adults **active** adults | 49.6 | 47 |
| 2.13ii | Percentage of active and inactive adults **inactive** adults | 32.8 | 38.1 |
| 2.15i | Successful completion of drug treatment opiate users | 9.2 | 7.1 |

| | | | |
|---|---|---|---|
| 2.15ii | Successful completion of drug treatment non-opiate users | 53.5 | 41.6 |
| 2.17 | Recorded diabetes | 6.82 | 7.16 |
| 2.20i | Cancer screening coverage breast cancer | 74.7 | 70.9 |
| 2.21vii | Access to non-cancer screening programmes diabetic retinopathy | 81.5 | 77.5 |
| 2.24i | Injuries due to falls in people aged 65 and over (Persons) | 2073 | 2345 |
| 2.24iii | Injuries due to falls in people aged 65 and over aged 80+ | 5045 | 6109 |

**Health Protection**

| | Indicators that have improved | 2014 | 2015 |
|---|---|---|---|
| 3.02ii | Chlamydia screening detection rate (15-24 year olds) CTAD (Persons) (per 100,000) | 2474 | 3157 |
| 3.03iii | Population vaccination coverage Dtap / IPV / Hib (1 year old) (%) | 95.7 | 96.5 |
| 3.03iii | Population vaccination coverage Dtap / IPV / Hib (2 years old) (%) | 96.9 | 97.8 |
| 3.03v | Population vaccination coverage PCV (%) | 95.7 | 96.3 |
| 3.03vi | Population vaccination coverage Hib / MenC booster (2 years old) (%) | 92.6 | 94.6 |
| 3.03vii | Population vaccination coverage PCV booster (%) | 94.0 | 95.0 |
| 3.03ix | Population vaccination coverage MMR for one dose (5 years old) (%) | 96.2 | 96.7 |
| 3.03xv | Population vaccination coverage Flu (at risk individuals) (%) | 58.0 | 58.9 |
| 3.05ii | Incidence of TB (per 100,000) | 15.5 | 13.8 |
| 3.01 | Fraction of mortality attributable to particulate air pollution (%) | 5.4 | 5 |

| | Indicators improved but still worse than England | 2014 | 2015 |
|---|---|---|---|

| | Indicators that are in decline | 2014 | 2015 |
|---|---|---|---|
| 3.04 | People presenting with HIV at a late stage of infection (%) | 68.0 | 66.7 |
| 3.05i | Treatment completion for TB (%) | 63.6 | 78.8 |
| 3.06 | NHS organisations with a board approved sustainable development management plan (%) | 66.7 | 33.3 |

**Healthcare/ Premature mortality**

| | Indicators that have improved | 2014 | 2015 |
|---|---|---|---|
| 4.01 | Infant mortality (per 100,000) | 4.2 | 3.0 |

| | Indicators improved but still worse than England | 2014 | 2015 |
|---|---|---|---|
| 4.03 | Mortality rate from causes considered preventable (provisional) (per 100,000) - persons | 278.2 | 277.9 |
| 4.05i | Under 75 mortality rate from cancer (revised provisional) (per 100,000) | 177.2 | 173.3 |
| 4.05ii | Under 75 mortality rate from cancer considered preventable (provisional) (per 100,000) | 112.2 | 110.1 |
| 4.06i | Under 75 mortality rate from liver disease (provisional)(per 100,000) | 27.5 | 26.9 |
| 4.06ii | Under 75 mortality rate from liver disease considered preventable (provisional) (per 100,000) | 24.5 | 23.6 |
| 4.1 | Suicide rate (provisional) (per 100,000) PERSON | 10.7 | 10.2 |

| | Indicators that are in decline | 2014 | 2015 |
|---|---|---|---|
| 4.04i | Under 75 mortality rate from all cardiovascular diseases (revised provisional) (per 100,000) PERSONS | 118.5 | 121.2 |
| 4.04ii | Under 75 mortality rate from cardiovascular diseases considered preventable (provisional) (per 100,000) PERSONS | 86.0 | 88.0 |
| 4.07i | Under 75 mortality rate from respiratory disease (provisional) per 100,000) | 43.3 | 45.5 |
| 4.07ii | Under 75 mortality rate from respiratory disease considered preventable (provisional) (per 100,00) | 26.7 | 27.7 |
| 4.08 | Mortality from communicable diseases (provisional) (per 100,000) | 74.0 | 82.8 |
| 4.15i | Excess Winter Deaths Index (Single year, all ages) | 11.8 | 16.9 |
| 4.15ii | Excess Winter Deaths Index (single year, ages 85+) | 24.3 | 27.1 |

| Overarching Indicators | | 2014 | 2015 |
|---|---|---|---|
| **Indicators that have improved** | | | |
| 0.2iv | Gap in life expectancy at birth between each local authority and England as a whole (Male) | -2.9 | -2.5 |

| | | 2014 | 2015 |
|---|---|---|---|
| **Indicators improved but still worse than England** | | | |
| 0.1i | Healthy life expectancy at birth (Male) | 57.5 | 57.9 |
| 0.1i | Healthy life expectancy at birth (Female) | 56.8 | 58.6 |
| 0.1ii | Life Expectancy at birth (Male) | 76.3 | 76.9 |

| | | 2014 | 2015 |
|---|---|---|---|
| **Indicators that are in decline** | | | |
| 0.1ii | Life Expectancy at birth (Female) | 80.6 | 80.3 |
| 0.2iii | Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional) (Male) | 10.9 | 11.3 |
| 0.2iii | Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional) (Female) | 6.3 | 10.3 |
| 0.2iv | Gap in life expectancy at birth between each local authority and England as a whole (Female) | -2.4 | -2.8 |

***N.B.*** ****Where indicators have not been included in the summary, this is because they have either not changed since May2014, the definitions for recording have changed or a full years data is not available***

| Code | Indicator | Period | England | Tameside August 2014 | Tameside November 2014 | Tameside February 2015 | Tameside May 2015 | Tameside August 2015 | Indicator lead Officer | Action | Comments | Date comments updated | Risk Log |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.01ii | Children in poverty (all dependent children under 20) | 2012 | 18.6% | 23.1% | 23.1% | 21.9% | 21.9% | 21.9% | Debbie Watson | ✓ | An assessment of child poverty in the borough was carried out in 2011. The Prosperous Tameside board will drive forward the 'people' action plan in order to tackle poverty and improve life chances of residents across the borough. Poverty Strategy launched in 2014. Tackling poverty remains a priority for the Council and partners. | 07/10/2015 | |
| 1.01ii | Children in poverty (under 16s) | 2012 | 19.2% | 23.7% | 23.7% | 22.7% | 22.7% | 22.7% | Debbie Watson | ✓ | | 07/10/2015 | |
| C&YPOF/1.02i | School readiness: % of children achieving a good level of development at end of reception | 2013/14 | 60.4% | 41.8% | 41.8% | 52.1% | 52.1% | 52.1% | Debbie Watson | ✓ | Interventions that work are high quality home visits by trusted professionals, a menu of provision for families requesting additional support and parenting programmes. Childrens Cantres have a crucial role to play by implementing their universal and targeted childrens services, providing easy access to a range of community health services, such as speech nd language therapy. health child promotion, parenting and family support and integrated early years educational programmes and childcare. All delivered through the | 07/10/2015 | |
| C&YPOF/1.02i | School readiness: % of children receiving free school meals achieving a good level of development at the end of reception | 2013/14 | 44.8% | 28.2% | 28.2% | 38.1% | 38.1% | 38.1% | Debbie Watson | ✓ | | 07/10/2015 | |
| 1.02ii | School readiness: % of Year 1 pupils achieving expected level in phonics screening check | 2013/14 | 74.2% | 65.4% | 65.4% | 69.2% | 69.2% | 69.2% | Debbie Watson | ✓ | The Health and Wellbeing Board are implementing recommendations from AGMA and DevoManc Public Health MOU to implement evidence based proposals to achieve an increase in the number of children who are learning ready when they begin school. Additional funding for the next two years has been identified from the public health grant. | 07/10/2015 | |
| 1.02ii | School readiness: % of Year 1 pupilswith free school meals status achieving expected level in phonics screening check | 2013/14 | 61.3% | 52.3% | 52.3% | 57.2% | 57.2% | 57.2% | Debbie Watson | ✓ | | 07/10/2015 | |
| 1.03 | Pupil absence | 2013/14 | 4.51% | 4.85% | 4.85% | 4.85% | 4.85% | 3.98% | Kate Benson | | Education welfare officers are working within youth & family services. Central & statutory services are being developed to ensure the council is able to identify schools that need additional support/resources. School nurses support parents and schools to maximise attendance. | 16/10/2015 | |
| 1.04i | First time entrants to the youth justice system | 2014 | 409 | 426 | 426 | 426 | 426 | 513 | Kate Benson | ✓ | YOT established a triage service to provide alternatives interventions that diverted young people from being charged. This has been extended by YOT and has attracted funding from the Department of Health to undertake Health Triage (Youth Justice and Liaison Diversion). GMP has introduced Restorative Justice and again this has diverted young people away from the criminal justice system by mediating between the young person and the victim to find an alternative to charge. This funding has now ceased, however there are | 16/10/2015 | |
| 1.05 | 16-18 year olds not in education employment or training | 2014 | 4.70% | 4.4% | 4.4% | 4.4% | 4.4% | 3.8% | Kate Benson | | Employer engagement to support apprentiships and work experience. Revised Connexions and TMBC service unit focus on vulnerable groups. Strategic focus on locality based interventions | 16/10/2015 | |
| 1.06i | Adults with a learning disability who live in stable and appropriate accommodation (Persons) | 2013/14 | 74.9% | 93.7% | 93.7% | 93.7% | 93.7% | 93.7% | David Boulger | | | | |
| 1.06i | Adults with a learning disability who live in stable and appropriate accommodation (Male) | 2013/14 | 74.5% | 93.9% | 93.9% | 94.0% | 94.0% | 94.0% | David Boulger | | We are refreshing the Learning Disabilities (LD) and Mental Health (MH) housing strategy to ensure that future housing is accessible for the MH and LD population. Promotion of personal budgets to offer increased choice and control.<br>Expansion of Re-ablement services, including the use of technology to promote independent living skills and ensure people are safe.<br>Development of Extra Care Housing schemes for people with LD and MH problems.<br>Applying for accreditation by National Autistic Society to enable us to provide better support for people with Autism within their own | | |
| 1.06i | Adults with a learning disability who live in stable and appropriate accommodation (Female) | 2013/14 | 75.4% | 93.4% | 93.4% | 93.3% | 93.3% | 93.3% | David Boulger | | | | |
| 1.06ii | Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons) | 2013/14 | 60.8% | 76.6% | 76.6% | 45.1% | 45.1% | 45.1% | David Boulger | | This has gone down by 5.2% points since the 2010/11 baseline | | |
| 1.06ii | Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Male) | 2013/14 | 59.4% | 75.2% | 75.2% | 42.1% | 42.1% | 42.1% | David Boulger | | | | |
| 1.06ii | Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Female) | 2013/14 | 62.5% | 78.0% | 78.0% | 48.3% | 48.3% | 48.3% | David Boulger | | | | |
| 1.07 | People in Prison who have mental illness or significant mental illness | 2012/13 | 4.35% | _ | _ | _ | _ | _ | David Boulger | | No data at local level | | |
| 1.08i | Gap in the employment rate between those with a long-term health condition and the overall employment rate | 2013/14 | 8.7 | 11.3 | 11.3 | 12.2 | 12.2 | 12.2 | Gideon Smith | | Joint pilot with probation services to increase the access to psychological therapies for offenders and promote joint working.<br>Increasing Access to Psychological Therapy (IAPT) - for the last 3 quarters the recovery rate has been over 50%. Targets include getting people back into work.<br>Everyone on the Care Programme Approach (CPA) has an annual health check.<br>Access to psychological services: Development of an employment pathway for all client groups Working towards the key objectives in "Valuing Employment Now" for people with learning disabilities. Link with the Work Programme to support long term unemployment into work.<br>Joint pilot with probation services to increase the access to psychological therapies for offenders and promote joint working.<br>Increasing Access to Psychological Therapy (IAPT) - for the last 3 quarters the recovery rate has been over 50%. Targets include getting people back into work. | | |
| 1.08ii | Gap in the employment rate between those with a learning disability and the overall employment rate | 2013/14 | 65.0 | 56.6 | 61.8 | 61.8 | 61.8 | 61.8 | Gideon Smith | | | | |
| 1.08iii | Gap in the employment rate for those in contct with the secondary metal health services and the overall employment rate | 2013/14 | 64.7 | 63.3 | 63.3 | 63.8 | 63.8 | 63.8 | David Boulger | | | | |
| 1.09i | Sickness absence The percentage of employees who had at least one day off in the previous week | 2010-12 | 2.5 | 1.9% | 2.4% | 2.4% | 2.4% | 2.4% | Monica Garside | | Focus on the wider determinants. The implementation of a 'Good Work: Good Health' charter for Tameside. Five ways to wellbeing campaign. The 'Mindful' employer scheme initiative as been commissioned for employers across Tameside. Community model for delivering health checks, targeting people in full time work. | | |
| 1.09ii | Sickness absence The percent of working days lost due to sickness absence | 2010-12 | 1.6 | 1.6% | 2.1% | 2.1% | 2.1% | 2.1% | Monica Garside | | | | |
| 1.10 | Killed and seriously injured casualties on England's roads | 2011-13 | 39.7 | 24.6 | 24.1 | 24.1 | 24.1 | 24.1 | | | A local safety scheme has been identified for highway locations with poor accident records. Traffic management, and street lighting programmes have been identified to reduce accidents.. The GM level GM casualty reduction partnership continues to target casualty reduction activities in high risk locations and behaviours and in support to vulnerable groups. | | |
| 1.11 | Domestic Abuse<br>(rate of domestic abuse incidents recorded by the police per 1,000 population) | 2013/14 | 19.4 | 27.7 | 27.7 | 27.7 | 23.5 | 23.5 | David Boulger | | New strategy- look at what are the gaps locally and what can be planned for the next 12 months that is cost free?<br>Non criminal justice perpetrator programme introduced - 'New Paths'<br>Workforce development programme relating to Domestic Abuse<br>New Statutory duty of domestic homicide reviews<br>New service that incorporates refuge, sanctuary, IDAAS, SUFS - 'Bridges'. | | |
| 1.12i | Violent crime (including sexual violence) hospital admissions for violence | 2011/12-13/14 | 52.4 | 82.8 | 82.8 | 82.8 | 79.7 | 79.7 | David Armitage | ✓ | GM police currently piloting domestic violence protection orders. IDVA service, sanctuary housing established. Development of a local top 10 premises scheme. GMP centralised rape unit in 2012. Develop a new strategy to identify gaps locally and what can be planned for the next 12 months.<br>Hospital admissions have for Violence have fallen since 2009/10 - 11/12 | | |
| 1.12ii | Violent crime (including sexual violence) violence offences | 2013/14 | 11.1 | 11.7 | 12.2 | 12.2 | 12.2 | 12.2 | David Armitage | | | | |
| 1.12iii | Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population | 2013/14 | 1.01 | 0.7 | 0.97 | 0.97 | 0.97 | 0.97 | David Armitage | | Investigations are under way with the potential to commission future independent sexual violence advocacy services locally. The realignment of counselling services for both domestic abuse and sexual abuse. Support is now avaiolable locally for male doestic abuse victims. Support and intervention for medium risk victims. Embedded workforce development. | | |
| 1.13i | Re-offending levels percentage of offenders who re-offend | 2012 | 25.9 | 27.8% | 27.8% | 26.2% | 26.2% | 26.2% | David Boulger | | The T&G CCG and Tameside council are pathfinders for the youth justice liaison and diversion project. Future work around the acknowledgement that targeting improvement at this group will have significant impact on overall health improvement and will bring savings to the NHS through prevention. Development of an offender health trainer service. Development of a multidisciplinary mental health diversion service. | | |
| 1.13ii | Re-offending levels average number of re-offences per offender | 2012 | 0.77 | 0.87 | 0.87 | 0.83 | 0.83 | 0.83 | David Boulger | | | | |
| 1.14i | The percentage of the population affected by noise Number of complaints about noise | 2013/14 | 7.4* | 5.3 | 5.4 | 5.4 | 5.4 | 5.2* | Anna Moloney | | Tameside have adopted the AGMA standardised approach to dealing with neighbourhood noise. Noise action plans need to be completed and built into planning guidance in areas for development. | | |
| 1.14ii | The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime | 2011 | 5.2 | 5.3% | 5.3% | 5.3% | 5.3% | 5.3% | Anna Moloney | | | | |
| 1.14iii | The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time | 2011 | 8.0 | 7.9% | 7.9% | 7.9% | 7.9% | 7.9% | Anna Moloney | | | | |
| 1.15i | Statutory homelessness homelessness acceptances | 2013/14 | 2.3 | 1.1 | 0.7 | 0.7 | 0.7 | 0.7 | David Boulger | | Working with partners to deliver new affordable homes through registered providers. Development of an empty properties strategy to increase supply and access to affordable homes. Development of a social letting agency to increase well managed accommodation in the private sector. Homelessness prevention-receiving upstream support to residents | | |
| 1.15ii | Statutory homelessness households in temporary accommodation | 2013/14 | 2.6 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | David Boulger | | | | |
| 1.16 | Utilisation of outdoor space for exercise/health reasons | Mar 2013 - Feb 2014 | 17.1 | 15.3 | 13.2 | 13.2 | 13.2 | 13.2 | Dan Clark | | Provision of a network of freely accessible parks and green spaces for informal grass root sports and activities. Activities led by volunteers/local community as part of locally led initiatives. Walking for health initiative. Parkrun launched in Stamford Park. PH funded audit of cycling infrastructure which has led to the development of a long term cycling infrastructure plan led by the TSCG | 16/10/2015 | |
| 1.17 | Fuel Poverty | 2013 | 10.4 | 10.4% | 10.4% | 10.4% | 10.4% | 9.8% | Debbie Watson | | Domestic retrofit (insulation) with more than 2000 referrals for free insulation. 'Kill the Chill' marketing campaign aimed at raising awareness. Expansion of CAB. Home energy assessment scheme: Age UK, help for vulnerable people not able to pay or access heating. Little Bill marketing campaign to encourage residents to swtich suppliers to save money. E-learning package purchased in 2015 for Council front line workers and partners including new charter. | 07/10/2015 | |

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| 1.18i | Social Isolation: % of adult social care users who have as much social contact as they would like | 2013/14 | 44.5 | 42.9% | 42.9% | 41.3% | 41.3% | 41.3% | Ursula Humpreys | | Delivering cultural activities to bring people together and increase their sense of belonging. Promotion of the 5 ways to wellbeing. | | |
| 1.18ii | Lonliness and Isolation in adult carers | 2012/13 | 41.3 | 44.3% | 44.3% | 44.3% | 44.3% | 44.3% | Ursula Humpreys | | The local strategy for carers 2011-2014 adopted its vision in line with the national strategy. A key theme throughout the strategy is for carers to have access to a wide range of services, adivice and information to support them in their caring role. The strategy will be refreshed in 2014 and should reflect the need to address lonliness and isolation. | | |
| 1.19i | Older people's perception of community saftey - safe in local area during the day | 2013/14 | 96.9 | _ | _ | _ | _ | _ | Ursula Humpreys | | | | |
| 1.19ii | Older people's perception of community saftey - safe in local area after dark | 2013/14 | 62.8 | _ | _ | _ | _ | _ | Ursula Humpreys | | No data at local level | | |
| 1.19iii | Older people's perception of community saftey - safe in own home at night | 2013/14 | 93.3 | _ | _ | _ | _ | _ | Ursula Humpreys | | | | |

***Improvements***

1.12i Violent crime (including sexual violence) hospital admissions for violence - Reduced to 79.7 from 82.8 however still above England of 52.4

1.11 Domestic Abuse(rate of domestic abuse incidents recorded by the police per 1,000 population) - Reduced from 27.7 to 23.5

***Declines***

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***N.B*** All other indicators have remained the same since February 2015

| Code | Indicator | Period | England | Tameside August 2014 | Tameside November 2014 | Tameside February 2015 | Tameside May 2015 | Tameside August 2015 | Indicator Lead officer | Action | Comment | Date Updated | Risk Log |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.01 | Low birth weight of term babies | 2012 | 2.8 | 3.1 | 2.4 | 2.4 | 2.4 | 2.4 | Debbie Watson | | Local women have good access to maternity services from the local hospital including additional support for vulnerable groups. Tailored stop smoking service to support pregnant women | | |
| 2.02i | Breastfeeding initiation | 2013/14 | 73.9 | 59.7 | 61.1 | 61.1 | 61.1 | 61.1 | Charlotte Lee | ✓ | Key local initiatives to improve performance include, the work of the infant feeding team who have now achieved WHO baby friendly accreditation, work to achieve UNICEF baby friendly initiative accreditation. Social Marketing campaign 'BreastMilk It's Amazing' learnt lessons from 14/15 and plan in place for 15/16 with refresh of Baby Welcome programme. Reprocurement of peer support programme following breastfeeding needs assessment due Nov 2015. | 07/10/2015 | |
| 2.02ii | Breastfeeding prevalence at 6-8 weeks after birth | 2013/14 | * | 34.0 | * | * | * | * | Charlotte Lee | | | 07/10/2015 | |
| 2.03 | Smoking status at time of delivery | 2013/14 | 12.0* | 20.9 | 17.8 | 17.8 | 17.8 | 17.8 | Liz Harris | ✓ | Take 7 Steps Out smoke free action plan for Children's Centres as part of Youth and Family team including Youth & family apprentices targeting baby clinics to give out messages<br>Smoking Cessation Midwife<br>• Opt-out system of referring all pregnant smokers to SSS is in place. Incentive scheme for women to quit smoking in pregnancy has come to an end and we are awaiting the GM evaluation. Locally it has had some good results but not significantly better than the standard midwife service results so not enough evidence to consider funding a future phase (which there are no funds for anyway). The service specification for the midwife post is in the process of being refreshed to take into account some of the recommendations from the external evaluation of the post. The recent data of smoking prevalence in 15 year olds shows that in Tameside there is twice the rate of 15 year old females smoking to males, and that Tameside has one of the highest rates of teenage female smoking in the country. This will require a more in depth look at prevention in young people especially girls and young women. | 13/10/2015 | |
| 2.04 | Under 18 conceptions | 2013 | 24.3 | 32.7 | 32.7 | 32.7 | 29.1 | 29.1 | David Armitage | ✓ | 19/10/15 TThe lastest data is for the first half of 2014, so far there have been fewer conceptions amounst those under 18 in 2014 than over the same period in 2013. GP links with the lead sexual health service have improved. Under 16 data now only released annually. YOUTHINK, a joint NHS/council initiative incorporating family planning, youth workers delivering brief intervention, sexual health awareness and prevention. The training of frontline staff who work with young people. Tameside Teenage Pregnancy Board is the local strategic group that develops and implements local strategy to reduce under 18 conceptions. Development of an interagency pathway for pregnant teenagers. Sexual health advice for everyone. Community based contraception and sexual health service. Week day drop in provision at a centrally located sexual health service. | | |
| 2.04 | Under 18 conceptions: conceptions in those aged under 16 | 2013 | 4.8 | 6.8 | 6.8 | 6.8 | 4.2 | 4.2 | David Armitage | ✓ | | | |
| 2.06i | Excess weight in 4-5 year olds | 2013/14 | 22.5 | 23.2 | 23.2 | 24.5 | 24.5 | 24.5 | Liz Harris | ✓ | Promotion of infant feeding, Leap4Life, nutrition training, award scheme for under 5s care provision providers, award scheme for school food. Child and family weight management service. Local breast feeding initiatives and peer support programmes. Primary school cook and eat with brief intervention. The service spec for the Children's Nutrition Team is being reviewed in conjunction with that of the Family Health Mentor specification with the aim of having more impact with more children and families. Healthy weight and healthy food are incorporated into the school on-line health check, 0-5 physical activity offer developed in partnership with Sports Trust to include community outreach and facility provision. Two new strategy and partnerships are being developed: a)food and nutrition and b)physical activity. A vending machine guidance/policy is being developed by the Healthy Weight Strategy Group. Participation in the Local Government Declaration on Healthy Weight is being considered. GULP was promoted at a recent health fair for schools and Food Active newsletters are shared with the C&YP Forum. | 13/10/2015 | |
| 2.06ii | Excess weight in 10-11 year olds | 2013/14 | 33.5 | 33.2 | 33.2 | 33.3 | 33.3 | 33.3 | Liz Harris | | | 13/10/2015 | |
| 2.07i | Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) | 2013/14 | 112.2 | 148.9 | 148.9 | 148.9 | 152.4 | 152.4 | Charlotte Lee | ✓ | A review of currently local activity against the NICE recommendations was very positive, highlighting good coverage of most elements and scope for increasing input on home safety. There is a need for high quality data form the local acute provider (TIIG)and targeted approaches by frontline health and early years staff and schools. GMFRS Equipment Scheme going well and due for evalution Oct/Nov 2015 - this scheme is noted a GM Level. Home Safety Checklist used in all Children Centres but need to be expanded by health visitors. To work and intergrate with the EYNDM and enagement/ sub group with Early Years Steerting Group. Presentations given at Health and Wellbeing Implementation Group and Safeguarding Business Board to stress importance. | 07/10/2015 | |
| 2.07i | Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years) | 2013/14 | 140.8 | 206.7 | 206.7 | 206.7 | 199.6 | 199.6 | Charlotte Lee | ✓ | | 07/10/2015 | |
| 2.07ii | Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24) | 2013/14 | 136.7 | 178.4 | 178.4 | 178.4 | 159.0 | 159.0 | Charlotte Lee | ✓ | | 07/10/2015 | |
| 2.08 | Emotional well-being of looked after children | 2013/14 | 13.9 | 11.7 | 11.7 | 11.9 | 11.9 | 11.9 | Kate Benson | | Targeted support for children and young people at risk of developing mental health problems, comprehensive specialists services for all children and young people. The young peoples health team work with looked after children through pupil referral units, youth offending team and care leavers. Ensuring access to NHS services for looked after children. Focus on Emtional Health and Wellbeing through the CYP Forum .Mind funded to do work across all schools that will include LAC. LAC part of CAMHS redesign and Education Workstream . Off the Record recommisioned including online support and advice. | 07/10/2015 | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.09i | Smoking Prevalence age 15 - current smokers (WAY Survey) | 2014/15 | 8.2 | - | - | - | - | 11.8 | Liz Harris | ✓ | The smoking prevalence at age 15 (both current and regular smokers) is significantly higher in Tameside than for England. This may well be expected as it mirrors the adult prevalence. The local ambition is to 'Make Smoking History for Children'. To work towards this the Tameside Tobacco Alliance is currently refreshing the 7 Steps Out project to help denormalise smoking to children. TMBC took part in the pilot of 'Smokefree Summer' in 2015 with a children and family theatre event being badged as smoke free, again to help denormalise smoking behaviours. Public Health have commissioned Tobacco Free Futures to deliver a peer education project called 'Smoke and Mirrors' which is involving young people from New Charter Academy in Ashton and young people from TMBC youth service's clubs. It is very concerning to see that the smoking prevalence for 15 year old females is 16.1% which is more than twice that of 15 year old males which is 7.2%. This will need further attention and possibly investment to be moved around so that this is addressed. If it is not addressed it will have knock on effects for future maternal and child health and the perpetuation of smoking behaviours in families. | 13/10/2015 | |
| 2.09ii | Smoking Prevalence age 15 years - regular smokers (WAY Survey) | 2014/15 | 5.5 | | No Data | No Data | No Data | 8.9 | Liz Harris | ✓ | | 13/10/2015 | |
| 2.09iii | Smoking Prevalence age 15 years - occassional smokers (WAY Survey) | 2014/15 | 2.7 | | No Data | No Data | No Data | 2.8 | Liz Harris | | | | |
| 2.09iv | Smoking Prevalence age 15 years - regular smokers (SDD Survey) | 2014 | 8 | | | | | No local data | Liz Harris | | | | |
| 2.09v | Smoking Prevalence age 15 years - occasional smokers (SDD Survey) | 2014 | 8 | | | | | No local data | Liz Harris | | | | |
| 2.11i | Fruit and Veg '5-a-day' | 2014 | 56.3 | | | | 49.8 | An error was discovered with the application of the survey weights. As a result the data for these indicators has been removed and it will be re-published in the November PHOF update | Liz Harris | | The development of the food and nutrition strategy will be an opportunity to set goals and an action plan for engaging all partners in promoting nutritious food across the lifecourse and all settings. | 13/10/2015 | |
| 2.11ii | Average portions of fruit eaten | 2014 | 2.64 | | | | 2.44 | | Liz Harris | | The development of the food and nutrition strategy will be an opportunity to set goals and an action plan for engaging all partners in promoting nutritious food across the lifecourse and all settings. | 13/10/2015 | |
| 2.11iii | Average portions of vegetables eaten | 2014 | 2.36 | | | | 2.15 | | Liz Harris | | The development of the food and nutrition strategy will be an opportunity to set goals and an action plan for engaging all partners in promoting nutritious food across the lifecourse and all settings. | 13/10/2015 | |
| 2.12 | Excess weight in adults | 2012 | 63.8% | | | 69.2 | 69.2 | 69.2 | Liz Harris | ✓ | The Care Pathway for healthy weight in pregnancy has been refreshed. Weight Matters Tier 2 service produces good results but for a small percentage of the population. The Healthy Weight Strategy Group are beginning to look at plans to address the obesogenic environment such as developing a vending machine policy and expanding the healthy catering award scheme. The development of the food and nutrition strategy will be an opportunity to set goals and an action plan for engaging all partners in promoting nutritious food across the lifecourse and all settings. Liz has proposed a healthy catering award scheme to be higher profile. Sharon Smith is talking to the person that co-ordinates the Pride of Tameside Awards to see if a new category for healthy food provision could be developed. | 13/10/2015 | |
| 2.13i | Percentage of physically active and inactive adults **active** adults | 2014 | 57.0 | 49.6 | 49.6 | 47 | 47 | 50.7 | Dan Clark | ✓ | Even though figure for active adults remains in the red this is due to move in national average as Tameside has actually seen an increase in those in the borough deemed to be active. Active Tameside have launch the new long term conditions program and is starting to develop the community offer. | 16/10/2015 | |
| 2.13ii | Percentage of active and inactive adults **inactive** adults | 2014 | 27.7 | 32.8 | 32.8 | 38.1 | 37.2 | 29.9 | Dan Clark | | | 16/10/2015 | |
| 2.14 | Smoking prevalence adults (over 18s) | 2013 | 18.4 | 25 | 22.4 | 22.4 | 22.4 | 22.4 | Liz Harris | ✓ | Free to access Stop Smoking Service. Workplace health improvement officer. Promotion of the smoke free environments including 7 steps out and updated TMBC smoking policy. Trading Standards and GM police working jointly to execute warrants on premises that sell illegal tobacco products or sell to under 16s. Piloted Smokefree Summer with one family theatre event in 2015 and it is planned to increase the proportion of events next year that are smoke free. CLeaR assessment undertaken in March 2015 - the recommendations from which are integrated into the TTA action plan. Local Government Declaration on Tobacco Control adopted by the Health and Wellbeing Board. The smoking in cars legislation may help to denormalise smoking in front of children and therefore this may contribute to a further decline in under 18s smoking prevalence - thus reducing future prevalence. | 16/10/2015 | |
| 2.14 | Smoking prevalence adults (over 18s) - Routine & Manual | 2013 | 28.6 | 34.9 | 30.4 | 30.4 | 30.4 | 30.4 | Liz Harris | | The Stop Smoking Service is targeting routine and manual workers and 20% of those that set a quit date in 2014-15 were from routine and manual occupations. The new TMBC staff smoking policy now includes smoke free policies for all routine and manual workers including those that work outdoors e.g. parks and bin men. Managers are receiving briefings to support staff to stop smoking.<br>The workplace health officer works with employers to promote cessation support within the workplace. | 16/10/2015 | |
| 2.15i | Successful completion of drug treatment opiate users | 2013 | 7.8 | 9.2 | 7.1 | 7.1 | 7.1 | 7.1 | David Boulger | | The Tameside Crime and Disorder Reduction partnership focuses on the rebalancing of the existing community drug treatment system, including addressing equality of access, improved care coordination and more focus on recovery. Hep C network of trained community providers such as pharmacies offering advice and screening and needle exchange facilities. | | |
| 2.15ii | Successful completion of drug treatment non-opiate users | 2013 | 37.7 | 53.5 | 41.6 | 41.6 | 41.6 | 41.6 | David Boulger | | | | |
| 2.16 | People entering prison with substance dependance issues, who are previously not known to community treatment | 2012/13 | 46.9 | | 22.5 | 22.5 | 22.5 | 22.5 | David Boulger | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.17 | Recorded diabetes | 2013/14 | 6.2 | 6.82 | 6.82 | 7.16 | 7.16 | 7.16 | Gideon Smith | | A clinical lead for diabetes as been identified and will lead on the redesign and improvement of local services. Diabetes is included in the QUIPP plans for 2012/13 with plans to deliver improved and increased care in the community and further develop the 'self care' model. LH: The development of the food and nutrition strategy will be an opportunity to set goals and an action plan for engaging all partners in promoting nutritious food across the lifecourse and all settings and will aim to reduce the prevalence of overweight, obesity and visceral fat and metabolic syndrome. | 13/10/2015 | |
| 2.18 | Admission episodes for alcohol related conditions (narrow definition) | 2013/14 | 645 | 831 | 831 | 831 | 831 | 835 | David Boulger | ✓ | The gap between England and Tameside is getting wider. Since 2010/11 the DSR for England Alcohol related admissions has fallen but in Tameside it has increased. A transforming Drug and Alcohol Service became operational on 3rd August 2015 with an ambition to radically improve health-related outcomes in Tameside. | 19/10/2015 | |
| 2.19 | Cancer diagnosed at early stage (experimental statistics) | 2013 | 45.7 | 44.1 | 44.1 | 44.1 | 42.2 | 42.2 | Gideon Smith | | The proportaion of invasive malignancies of breast, prostate, colerectal. lung, bladder, kidney, ovary, and uterus, non-Hodgkin lymphomas, and melanomas of skin, diagnosed at stage 1 or 2 | 13/10/2015 | |
| 2.20i | Cancer screening coverage breast cancer | 2014 | 75.9 | 74.7 | 70.9 | 70.9 | 70.9 | 70.9 | Gideon Smith | ✓ | Routine invitations and reminders are sent to eligible women. Pilots and new approaches using additional targeted written and text messages are in progress. An early equity audit of uptake of breast screening has recently been completed. T&G are part of the Macmillan funded community cancer awareness project. | 13/10/2015 | |
| 2.20ii | Cancer screening coverage cervical cancer | 2014 | 74.2 | 73.9 | 74.1 | 74.1 | 74.1 | 74.1 | Gideon Smith | | | 13/10/2015 | |
| 2.21i | Antenatal infectious disease | 2014 | 98.9 | | | No data | No data | No data | Gideon Smith | | | 13/10/2015 | |
| 2.21iii | Antenatal sickle cell and Thalassaemia screening - coverage | 2013/14 | 98.9 | | | No data | No data | No data | Gideon Smith | | | 13/10/2015 | |
| 2.21iv | Newborn bloodspot screening -coverage | 2013/14 | 93.5 | | | 98.4 | 98.4 | 98.4 | Gideon Smith | | | 13/10/2015 | |
| 2.21v | Newborn hearing screening -coverage | 2013/14 | 98.5 | | | 97.9 | 97.9 | 97.9 | Gideon Smith | ✓ | | 13/10/2015 | |
| 2.21vii | Access to non-cancer screening programmes diabetic retinopathy | 2012/13 | 79.1 | 81.5 | 77.5 | 77.5 | 77.5 | 77.5 | Gideon Smith | ✓ | All maternity units employ a screening midwife who takes the lead in ensuring that the antenatal and new-born screening programme are running in line with national guidance. Diabetic retinopathy screening is provided by high street optometrists and the local community health team | 13/10/2015 | |
| 2.21viii | Abdominal Aortic Anuerysm Screening | 2013/14 | 95.9 | | | 99.5 | 99.5 | 99.5 | | | | 13/10/2015 | |
| 2.22i | Take up of NHS Health Check Programme by those eligible health check offered | | | | | Indicator removed | Indicator removed | Indicator removed | Gideon Smith | | Increased healthcare assistant and practice nurse capacity to support delivery. Communications support to increase awareness and take up/ Increased health trainer capacity to support patients following an health check. Roll out of the community health check approach to target groups with lower uptake through GP practices. Health equity audit to understand gaps and barriers. **NOW REPLACED WITH2.22ii TO 2.22v (see below)** | 13/10/2015 | |
| 2.22ii | Take up of NHS Health Check programme by those eligible health check take up | | | | | Indicator removed | Indicator removed | Indicator removed | Gideon Smith | | | 13/10/2015 | |
| 2.22iii | Cumulative % of eligible population aged 40-74 offered an NHS Health check in a 5 year period 2013/14 - 2017/18 | 2013/14 | 18.4 | 14.2 | 14.2 | 14.2 | 14.2 | 14.2 | Gideon Smith | ✓ | | 13/10/2015 | |
| 2.22 iv | Cumulative % of eligible population aged 40-74 offered and received an NHS Health check in a 5 year period 2013/14 - 2017/19 | 2013/14 | 49.0 | 38.2 | 38.2 | 38.2 | 38.2 | 38.2 | Gideon Smith | ✓ | | 13/10/2015 | |
| 2.22 v | Cumulative % of eligible population aged 40-74 who received an NHS Health check in a 5 year period 2013/14 - 2017/20 | 2012/13 | 9.0 | 5.4 | 5.4 | 5.4 | 5.4 | 5.4 | Gideon Smith | ✓ | | 13/10/2015 | |
| 2.23i | Self-reported well-being people with a low satisfaction score | 2013/14 | 5.6 | 6.53 | 6.53 | 7.7 | 7.7 | 7.7 | Pam Watt | ✓ | Local key commisisoners are developing a planned and strategic approach to address positive mental health; NHS T&G are leading on transforming approaches for children and young people and have been awarded naitonal funding to support this; | 19/10/2015 | |
| 2.23ii | Self-reported well-being people with a low worthwhile score | 2013/14 | 4.2 | 5.16 | 5.16 | 6.8 | 6.8 | 6.8 | Pam Watt | ✓ | | 19/10/2015 | |
| 2.23iii | Self-reported well-being people with a low happiness score | 2013/14 | 9.7 | 12.86 | 12.86 | 10.7 | 10.7 | 10.7 | Pam Watt | ✓ | | 19/10/2015 | |
| 2.23iv | Self-reported well-being people with a high anxiety score | 2013/14 | 20.0 | 21.99 | 21.99 | 22.3 | 22.3 | 22.3 | Pam Watt | ✓ | | 19/10/2015 | |
| 2.23v | Average Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) score | 2012-12 | 37.7 | | No Data | No Data | No Data | No Data | Pam Watt | ✓ | | 19/10/2015 | |
| 2.24i | Injuries due to falls in people aged 65 and over (Persons) | 2013/14 | 2064 | 2073 | 2073 | 2073 | 2345 | 2345 | Angie Wild | ✓ | Redesign of the community based falls pathway. Age UK provide local falls prevention programme, home assessments and an exercise programme. Reduction in the number of in-patient falls. Local authority to ensure that community activities are available to all older people to reduce the risk of future falls and promote active aging. Physical activity provision to include more strength and postural stability sessions for people at risk of falls, planned programme in 14/15 with GMFRS to introduce falls audit tool within home safety checks. | | |
| 2.24i | Injuries due to falls in people aged 65 and over (Male) | 2013/14 | 1661 | 1708 | 1708 | 1708 | 1870 | 1870 | Angie Wild | | | | |
| 2.24i | Injuries due to falls in people aged 65 and over(Female) | 2013/14 | 2467 | 2437 | 2437 | 2437 | 2820 | 2820 | Angie Wild | ✓ | | | |
| 2.24ii | Injuries due to falls in people aged 65 and over aged 65-79 | 2013/14 | 989 | 1047 | 1047 | 1047 | 1047 | 1047 | Angie Wild | | | | |
| 2.24iii | Injuries due to falls in people aged 65 and over aged 80+ | 2012/13 | 5182 | 5045 | 5045 | 5045 | 6109 | 6109 | Angie Wild | ✓ | | | |



***Improvements***

2.04 Under 18 Conceptions - Improved from 32.7 to 29.1 but still worse than England at 24.3
2.04 Under 18s Conception in Under 16s - Improved. 6.8 to 4.2 but similar to England at 4.8
2.07 Hospital Admission for unintentional / deliberate injuries (0-4 yrs) improved.206.7 to 199.6 in May, but higher than England
2.07 Hospital Admission for unintentional / deliberate injuries (15-24 yrs) also improved from 178.4 to 159.0 but again higher than England at 136.7

***Declines***

| Code | Indicator | Period | England | Tameside August 2014 | Tameside November 2014 | Tameside February 2015 | Tameside May 2015 | Tameside August 2015 | Indiactor Lead Officer | Action | Comment | Date Updated | Risk Log |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.01 | Fraction of mortality attributable to particulate air pollution (%) | 2012 | 5.1 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | Anna Moloney | | Tameside council and other GM authorities have identified areas with poor air quality, designated them as AQMA and introduced a joint AQAP. The links between air quality and the reduction of our carbon footprint continue to be strengthened and developed. | | |
| 3.02i | Chlamydia screening detection rate (15-24 year olds) Old NCSP data (per 100,000) | 2011 | 2092 | 3072 | 3072 | 3072 | Indicator removed & cont with CTAD | Indicator removed & cont with CTAD data | David Armitage | | 19/10/15. No update, providers reminded of tariff, RUClear contract in last year and should go out to tender this financial year (GM approach). Increasing the total number of screens being carried out locally and increasing the proportion of screens being carried out. CaSH have changed their opening hours to become more young person friendly. LGBT foundation promote Tag sexual health services so local young people know when and where to access services. The Tameside pregnancy advisory service only perform TOP treatment if chlamydia screening as been carried out. | 19/10/2015 | |
| 3.02ii | Chlamydia screening detection rate (15-24 year olds) CTAD (Persons) (per 100,000) | 2014 | 2012 | 3157 | 3157 | 3157 | 3157 | 3058 | David Armitage | | | | |
| 3.02ii | Chlamydia screening detection rate (15-24 year olds) CTAD (Male) (per 100,00) | 2013 | 1387 | 2092 | 2092 | 2092 | 2092 | 1748 | David Armitage | ✓ | | | |
| 3.02ii | Chlamydia screening detection rate (15-24 year olds) CTAD (Female) (per 100,000) | 2013 | 2634 | 4206 | 4206 | 4206 | 4206 | 4440 | David Armitage | | | | |
| 3.03i | Population vaccination coverage Hepatitis B (1 year old) (%) | 2013/14 | - | 44.4 | 44.4 | * | * | * | Anna Moloney | | Providing regular training for all staff that advise on or administer immunisations. Monitoring uptake on a regular basis. Monitoring performance and uptake delivered by providers. Implementing change to service provision for the targeted childhood programmes namely BCG and Hep B with the aim of achieving early identification and timely vaccination. Supporting practices with clinical guidance documents. Dissemination of policy change, good practice and current infectious disease information to practitioners. Tameside Council and Tameside and Glossop CCG have used local media to highlight the importance of flu vaccination for the over 65s, 2-3 year olds and at risk groups Flu vaccination has been made available to at risk groups via pharmacies in Greater Manchester as part of a local pilot. Guidance on provision of flu vaccination for social care staff and people living in residential care has been included in care home contracts In 2013 3 new programmes were added to the national immunisation schedule: rotavirus and influenza for children, and shingles for people aged over 70. These programmes have been implemented locally. | | |
| 3.03i | Population vaccination coverage Hepatitis B (2 years old) (%) | 2013/14 | - | 21.6 | 21.6 | 21.6 | * | * | Anna Moloney | | | | |
| 3.03iii | Population vaccination coverage Dtap / IPV / Hib (1 year old) (%) | 2013/14 | 94.3 | 95.7 | 95.7 | 96.5 | 96.5 | 96.5 | Anna Moloney | | | | |
| 3.03iii | Population vaccination coverage Dtap / IPV / Hib (2 years old) (%) | 2013/14 | 96.1 | 96.9 | 96.9 | 97.8 | 97.8 | 97.8 | Anna Moloney | | | | |
| 3.03iv | Population vaccination coverage MenC (%) | 2012/13 | 93.9 | 95.6 | 95.6 | 95.6 | 95.6 | 95.6 | Anna Moloney | | | | |
| 3.03v | Population vaccination coverage PCV (%) | 2013/14 | 94.1 | 95.7 | 95.7 | 96.3 | 96.3 | 96.3 | Anna Moloney | | | | |
| 3.03vi | Population vaccination coverage Hib / MenC booster (2 years old) (%) | 2013/14 | 92.5 | 92.6 | 92.6 | 94.6 | 94.6 | 94.6 | Anna Moloney | | | | |
| 3.03vi | Population vaccination coverage Hib / Men C booster (5 years) (%) | 2013/14 | 91.9 | 94.2 | 94.2 | 94.2 | 94.2 | 94.2 | Anna Moloney | | | | |
| 3.03vii | Population vaccination coverage PCV booster (%) | 2013/14 | 92.4 | 94.0 | 94.0 | 95.0 | 95.0 | 95.0 | Anna Moloney | | | | |
| 3.03viii | Population vaccination coverage MMR for one dose (2 years old) (%) | 2013/14 | 92.7 | 94.3 | 94.3 | 93.9 | 93.9 | 93.9 | Anna Moloney | | | | |
| 3.03ix | Population vaccination coverage MMR for one dose (5 years old) (%) | 2013/14 | 94.1 | 96.2 | 96.2 | 96.7 | 96.7 | 96.7 | Anna Moloney | | | | |
| 3.03x | Population vaccination coverage MMR for two doses (5 years old) (%) | 2013/14 | 88.3 | 90.8 | 90.8 | 90.3 | 90.3 | 90.3 | Anna Moloney | | | | |
| 3.03xii | Population vaccination coverage HPV (%) | 2013/14 | 86.7 | 92.5 | 92.5 | 90.9 | 90.9 | 90.9 | Anna Moloney | | | | |
| 3.03xiii | Population vaccination coverage PPV (%) | 2013/14 | 68.9 | 69.4 | 69.4 | 69.4 | 67.2 | 67.2 | Anna Moloney | ✓ | | | |
| 3.03xiv | Population vaccination coverage Flu (aged 65+) (%) | 2014/15 | 72.7 | 76.2 | 76.2 | 75.5 | 75.5 | 75.6 | Anna Moloney | | | | |
| 3.03xv | Population vaccination coverage Flu (at risk individuals) (%) | 2014/15 | 50.3 | 58.0 | 58.0 | 58.9 | 58.9 | 56.5 | Anna Moloney | | | | |
| 3.04 | People presenting with HIV at a late stage of infection (%) | 2011-13 | 45 | 68.0 | 68.0 | 66.7 | 66.7 | 66.7 | David Armitage | ✓ | 19/10/15. Discussions held with lead provider re outreach sessions during testing week. Lead provider providing increased training to GP's. Providing high levels of access to GUM clinics. Increased HIV testing among GUM clients. Increasing access to local CaSH services. Promoting HIV testing to high risk groups. | 19/10/2015 | |
| 3.05i | Treatment completion for TB (%) | 2012 | 83.3 | 63.6 | 63.6 | 63.6 | 78.8 | 78.8 | Gideon Smith/ Anna Moloney | ✓ | The HPA coordinates TB control by local and national surveillance and the laboratory diagnostic service. The NW now have an established TB summit to direct TB prevention and control activities across the region. Tameside Foundation Trust manages the TB specialist service which is commissioned at a GM level. | | |
| 3.05ii | Incidence of TB (per 100,000) | 2011-13 | 14.8 | 15.5 | 15.5 | 15.5 | 13.8 | 13.8 | Gideon Smith/ Anna Moloney | | | | |
| 3.06 | NHS organisations with a board approved sustainable development management plan (%) | 2013/14 | 41.6 | 66.7 | 33.3 | 33.3 | 33.3 | 33.3 | | | Locally a multi-agency Tameside Sustainable Use of Resources group developed Low Carbon Tameside. NHS T&G board approved the 2010-2015 sustainable development plan in Jan 2010. The 10% carbon reduction in 2010 was achieved. | | |
| 3.07 | Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies | 2014/15 | 95.2 | | | 100.0 | 100.0 | 100.0 | | | | | |

***Improvements***

3.03xv Population Vaccination coverage flu (at risk individuals) - Although the result has stayed the same at 58.9 this is now better than the England result of 52.3

3.05i Treatment completion for TB - has improved from 63.6 to 78.8 however is still worse than England at 83.3

3.05ii Incidence of TB (per 100,000) has fallend from 15.5 to 13.8 which is similar to England at 14.8

***Declines***

3.03xiii Population Vaccination coverage PPV (%) - has falledn from 69.4 to 67.2 and is worse than England at 68.9

***N.B*** All other indicators have remained the same since February 2015

| Code | Indicator | Period | England | Tameside August 2014 | Tameside November 2014 | Tameside February 2015 | Tameside May 2015 | Tameside August 2015 | Indicator Lead Officer | Action | Comments | Date updated | Risk Log |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.01 | Infant mortality (per 100,000) | 2011/13 | 4.0 | 4.2 | 4.2 | 4.2 | 3.0 | 3.0 | Debbie Watson | | Targeted prevention work with teenagers at risk of pregnancy and support for pregnant teenagers and parents. Tailored smoking cessation support offered for whole family during and after pregnancy. Weight management service available. Unicef Baby Friendly compliance and programme to increase breastfeeding initiation and maintenance. Local women have good access to maternity services from the local hospital including additional support for vulnerable groups. FNP now in place from Feb 2015. | 07/10/2015 | |
| 4.02 | Tooth decay in children aged 5 (mean DMFT) | 2011/12 | 0.94 | 1.08 | 1.08 | 1.08 | 1.08 | 1.08 | Debbie Watson | | All babies aged 6 months receive a free toothbrush and tooth paste with more vulnerable children receiving additional support. Health visitors give brush, paste and advice at 12 month check. School nurse assistants deliver oral health sessions to parents and children in reception class. Targeted | 07/10/2015 | |
| 4.03 | Mortality rate from causes considered preventable (provisional) (per 100,000) - persons | 2011/13 | 183.9 | 278.2 | 277.9 | 277.9 | 277.9 | 277.9 | Gideon Smith | ✓ | The risk of dying early could be reduced by providing services to help people stop smoking and treatment for high cholesterol (statins) and other conditions that increase the risk of heart disease. NICE PH15 recommendations include the following advice:<br>GPs and other NHS staff working outside hospitals, and local authorities should set up systems to identify people who are disadvantaged and at high risk of heart disease. NHS organisations and local authorities should work together to provide flexible services to improve the health of these | 07/10/2015 | |
| 4.03 | Mortality rate from causes considered preventable (provisional) (per 100,000) -males | 2011/13 | 233.1 | | 343.2 | 343.2 | 343.2 | 343.2 | Gideon Smith | ✓ | | 07/10/2015 | |
| 4.03 | Mortality rate from causes considered preventable (provisional) (per 100,000) - females | 2011/13 | 138.0 | | 215.9 | 215.9 | 215.9 | 215.9 | Gideon Smith | ✓ | | 07/10/2015 | |
| 4.04i | Under 75 mortality rate from all cardiovascular diseases (revised provisional) (per 100,000) PERSONS | 2011/13 | 78.2 | 118.5 | 121.2 | 121.2 | 121.2 | 121.2 | Gideon Smith | ✓ | Tameside continue to see a reduction in CVD mortality but we are not addressing the gap between our population and the national population. We aim to reduce the incidence of CVD through prevention work and also improve the management of the disease. Support is being given to primary care to help with disease management, identifying patients at risk and monitoring and | 07/10/2015 | |
| 4.04ii | Under 75 mortality rate from cardiovascular diseases considered preventable (provisional) (per 100,000) PERSONS | 2011/13 | 50.9 | 86.0 | 88.0 | 88.0 | 88.0 | 88.0 | Gideon Smith | ✓ | | 07/10/2015 | |
| 4.05i | Under 75 mortality rate from cancer (revised provisional) (per 100,000) | 2011/13 | 144.4 | 177.2 | 173.3 | 173.3 | 173.3 | 173.3 | Gideon Smith | ✓ | The key issues currently are actions around prevention and treatment. A Cancer Prevention, Early Detection and Inequalities strategy for T&G are grouped into 4 work streams including Reducing Inequalities, Lifestyle, Targeted programmes, Early Detection. | 07/10/2015 | |
| 4.05ii | Under 75 mortality rate from cancer considered preventable (provisional) (per 100,000) | 2011/13 | 83.8 | 112.2 | 110.1 | 110.1 | 110.1 | 110.1 | Gideon Smith | ✓ | | 07/10/2015 | |
| 4.06i | Under 75 mortality rate from liver disease (provisional)(per 100,000) | 2011/13 | 17.9 | 27.5 | 26.9 | 26.9 | 26.9 | 26.9 | Gideon Smith | ✓ | Deaths from liver disease continue to be significantly higher than the England average. The main causes of liver disease are alcohol, obesity and hepatitis. More work needs to be done around lifestyle choice and prevention in areas of high risk. Robust plans need to be developed to ensure residents with alcohol and drug problems have better access to drug and alcohol services. | 07/10/2015 | |
| 4.06ii | Under 75 mortality rate from liver disease considered preventable (provisional) (per 100,000) | 2011/13 | 15.7 | 24.5 | 23.6 | 23.6 | 23.6 | 23.6 | Gideon Smith | ✓ | | 07/10/2015 | |
| 4.07i | Under 75 mortality rate from respiratory disease (provisional) per 100,000) | 2011/13 | 33.2 | 43.3 | 45.5 | 45.5 | 45.5 | 45.5 | Gideon Smith | ✓ | Tameside as a high incidence of COPD and as been identified as a priority area with support from the CCG to enhance the identification and management of COPD across the borough. A COPD project group as been established and they have developed a project plan that incorporates 6 objectives from the national outcomes strategy. | 07/10/2015 | |
| 4.07ii | Under 75 mortality rate from respiratory disease considered preventable (provisional) (per 100,00) | 2011/13 | 17.9 | 26.7 | 27.7 | 27.7 | 27.7 | 27.7 | Gideon Smith | ✓ | | 07/10/2015 | |
| 4.08 | Mortality from communicable diseases (provisional) (per 100,000) | 2011/13 | 62.2 | 74 | 82.8 | 82.8 | 82.8 | 82.8 | Gideon Smith | ✓ | Work with local healthcare providers to reduce their HCAI rates through the development of guidance with support for education around antibiotic prescribing and hand hygiene. Provision of specialist sexual health clinics, young person friendly community based sexual health and contraception service. A dedicated TB service. The targeting of vulnerable groups for administration of vaccine. | 07/10/2015 | |
| 4.09 | Excess Under 75 Mortality rate in adults with serious mental illness | 2012/13 | 347.2 | 441.1 | 441.1 | 471.7 | 471.7 | 471.7 | Gideon Smith | | | | |
| 4.10 | Suicide rate (provisional) (per 100,000) PERSON | 2011-13 | 8.8 | 10.7 | 10.2 | 10.2 | 10.2 | 10.2 | Anna Moloney | | GM police have conducted a hot spot analysis that identifies key areas where suicide and self harm take place. The GM suicide prevention group are to address the issues of serious mental health and suicide. Extensive training is delivered locally within acute settings to highlight links between | | |
| 4.10 | Suicide rate (provisional) (per 100,000) MALE | 2011-13 | 13.8 | 16.6 | 15.3 | 15.3 | 15.3 | 15.3 | Anna Moloney | | | | |
| 4.10 | Suicide rate (provisional) (per 100,000) FEMALE | 2011-13 | 4.0 | | No data | No data | No data | No data | Anna Moloney | | | | |
| 4.11 | Emergency readmissions within 30 days of discharge from hospital (Persons) (%) | 2011/12 | 11.8 | 12.9 | 12.9 | 12.9 | 12.9 | 12.9 | Gideon Smith | | Rates of emergency readmissions remain high across Tameside and more work needs to be done to prevent a readmission to hospital. T&G have a local Emergency Care Network with membership form both Tameside council, primary care, community services the local hospital and NW ambulance service. | | |
| 4.11 | Emergency readmissions within 30 days of discharge from hospital (Male) (%) | 2011/12 | 12.1 | 12.4 | 12.4 | 12.4 | 12.4 | 12.4 | Gideon Smith | | | | |
| 4.11 | Emergency readmissions within 30 days of discharge from hospital (Female) (%) | 2011/12 | 11.5 | 13.3 | 13.3 | 13.3 | 13.3 | 13.3 | Gideon Smith | | | | |
| 4.12i | Preventable sight loss age related macular degeneration (AMD) (crude rate per 100,000) | 2013/14 | 118.8 | 52.8 | 52.8 | 52.8 | 58.3 | 70.2 | Gideon Smith | | There is an established diabetic retinopathy screening service delivered from several community locations which as increased choice and ease of access for patients. There is also a community service for ocular hypertension which is provided by community optometrists, again increasing choice and ease of access for patients. A review as been under way to review ophthalmology pathways to ensure optimum care closer to home. As part of the review we need to raise awareness amongst the population around risk factors and early detection. | | |
| 4.12ii | Preventable sight loss glaucoma (per 100,000) | 2013/14 | 12.9 | 5.4 | 5.4 | 5.4 | 5.4 | 10.8 | Gideon Smith | | | | |
| 4.12iii | Preventable sight loss diabetic eye disease (per 100,000) | 2013/14 | 3.4 | 3.7 | 3.7 | 3.7 | 3.7 | *no data | Gideon Smith | | | | |
| 4.12iv | Preventable sight loss sight loss certifications (per 100,000) | 2013/14 | 42.5 | 19.5 | 19.5 | 19.5 | 19.5 | 29.5 | Gideon Smith | ✓ | | 07/10/2015 | |
| 4.13 | Health related quality of life for Older People | 2012/13 | 0.726 | | 0.69 | 0.69 | 0.69 | 0.69 | Ursula Humphreys | ✓ | | 07/10/2015 | |
| 4.14i | Hip fractures in people aged 65 and over (per 100,000) | 2013/14 | 580 | 592.6 | 592.6 | 592.6 | 592.6 | 592.6 | Ursula Humphreys | | Age UK provide a local falls prevention programme, home assessments and an exercise programme and investment is increasing in 2014<br>Tameside council commissions a Handy Person service via Age UK to provide balance & stability aids.<br>Tameside Foundation Trust participates in the National Hip Fracture Database and the Best Practice Tariff. | | |
| 4.14ii | Hip fractures in people aged 65 and over aged 65-79 (per 100,000) | 2013/14 | 240 | 261.9 | 261.9 | 261.9 | 261.9 | 261.9 | Ursula Humphreys | | | | |
| 4.14iii | Hip fractures in people aged 65 and over aged 80+ (per 100,000) | 2013/14 | 1566 | 1259 | 1259 | 1259 | 1259 | 1259 | Ursula Humphreys | | | | |
| 4.15i | Excess Winter Deaths Index (Single year, all ages) | Aug 2012 - Jul 2013 | 20.1 | 11.8 | 11.8 | 16.9 | 16.9 | 16.9 | Gideon Smith | | Excess winter deaths are similar to the England average, however a large proportion of these deaths could be avoided. A high proportion of winter deaths occur in the over 75 population so work to ensure this vulnerable group are able to stay warm, safe and healthy will help reduce the | | |

| Code | Indicator | Period | England | Tameside August 2014 | Tameside November 2014 | Tameside February 2015 | Tameside May 2015 | Tameside August 2015 | Indicator Lead Officer | Action | Comments | Date updated | Risk Log |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.15ii | Excess Winter Deaths Index (single year, ages 85+) | Aug 2012 - Jul 2013 | 28.2 | 24.3 | 24.3 | 27.1 | 27.1 | 27.1 | Gideon Smith | | work to ensure this vulnerable group are able to stay warm, safe and healthy will help reduce the impact of the cold on this population. Green Deal, refresh of the Affordable Warmth Strategy, 'Kill the Chill' marketing campaign aimed at raising awareness. Home energy assessment scheme: Age | | |
| 4.15iii | Excess Winter Deaths Index (3 years, all ages, persons) | Aug 2010 - Jul 2013 | 17.4 | | | | 18.3 | 14.5 | Gideon Smith | | | | |
| 4.15iv | Excess Winter Deaths Index (3 years, ages 85+, persons) | Aug 2010 - Jul 2013 | 24.1 | | | | 26.1 | 26.1 | Gideon Smith | | | | |
| 4.16 | Estimated diagnosis rate for people with dementia | 2013/14 | 52.5 | _ | _ | _ | _ | _ | Ursula Humphreys | | No data at local level currently available. | | |

| Code | Indicator | Period | England | Tameside August 2014 | Tameside November 2014 | Tameside February 2015 | Tameside May 2015 | Tameside August 2015 | Indicator Lead Officer | Action | Comments | Date updated | Risk Log |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Over arching Indicators** | | | | | | | | | | | | | |
| 0.1i | Healthy life expectancy at birth (Male) | 2011/13 | 63.3 | 57.4 | 57.4 | 57.4 | 57.9 | 57.9 | Gideon Smith | ✓ | Healthy Life expectancy is the average number of years a person would live in good/fairly good health. Tameside males and females have a significantly lower healthy LE than the England average, therefore Work needs to be done to enhance good health over time by improving life chances and prevention programmes. | 07/10/2015 | |
| 0.1i | Healthy life expectancy at birth (Female) | 2011/13 | 63.9 | 56.6 | 56.6 | 56.6 | 58.6 | 58.6 | Gideon Smith | ✓ | | 07/10/2015 | |
| 0.1ii | Life Expectancy at birth (Male) | 2011/13 | 79.4 | 76.3 | 76.3 | 76.9 | 76.9 | 76.9 | Gideon Smith | ✓ | Life expectancy as been increasing over the last decade, however there are still large inequalities between areas in England and locally between wards within the borough. Implementing robust partnership structures that are addressing the wider determinants of health, promoting financial inclusion and tackling income inequalities alongside embedding prevention and early intervention into all frontline services. | 07/10/2015 | |
| 0.1ii | Life Expectancy at birth (Female) | 2011/13 | 83.1 | 80.6 | 80.6 | 80.3 | 80.3 | 80.3 | Gideon Smith | ✓ | | 07/10/2015 | |
| 0.1ii | Life Expectancy at 65 (Male) | 2011/13 | 18.7 | | | 17.1 | 17.1 | 17.1 | Gideon Smith | ✓ | | 07/10/2015 | |
| 0.1ii | Life Expectancy at 65 (Female) | 2011/13 | 21.1 | | | 18.9 | 18.9 | 18.9 | Gideon Smith | ✓ | | 07/10/2015 | |
| 0.2i | Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (provisional) (Male) | 2011/13 | 9.1 | no data | no data | no data | no data | no data | Gideon Smith | | The slope index highlights the inequalities of LE in Tameside therefore there is a need to allow a strategic shift towards and investment in early intervention and prevention. The implementation of the HWB strategies which highlights key priorities for Tameside needs to be implemented and carried forward through effective engagement with a wide range of partners and council departments to improve life expectancy in the wards with the lowest LE outcomes. A programme of health equity audit to ensure different population groups get the services and interventions they need. A robust JSNA process that highlights need and works towards meeting need across Tameside. | | |
| 0.2i | Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (provisional) (Female) | 2011/13 | 6.9 | no data | no data | no data | no data | no data | Gideon Smith | | | | |
| 0.2ii | Number of upper tier local authorities for which the lcoal slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Male) | 2011/13 | 80 | no data | no data | no data | no data | no data | Gideon Smith | | | | |
| 0.2ii | Number of upper tier local authorities for which the lcoal slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Female) | 2011/13 | 73 | no data | no data | no data | no data | no data | Gideon Smith | | | | |
| 0.2iii | Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional) (Male) | 2011/13 | - | 10.9 | 10.9 | 10.3 | 11.3 | 11.3 | Gideon Smith | | | | |
| 0.2iii | Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional) (Female) | 2011/13 | - | 6.3 | 8.2 | 9.3 | 10.3 | 10.3 | Gideon Smith | | | | |
| 0.2iv | Gap in life expectancy at birth between each local authority and England as a whole (Male) | 2011/13 | 0 | -2.9 | -2.9 | -2.5 | -2.5 | -2.5 | Gideon Smith | ✓ | | 07/10/2015 | |
| 0.2iv | Gap in life expectancy at birth between each local authority and England as a whole (Female) | 2011/13 | 0 | -2.4 | -2.4 | -2.8 | -2.8 | -2.8 | Gideon Smith | ✓ | | 07/10/2015 | |
| 0.2v | Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Male) | 2011/13 | 19.2 | - | - | - | - | - | Gideon Smith | | | | |
| 0.2v | Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Female) | 2011/13 | 19.5 | - | - | - | - | - | Gideon Smith | | | | |
| 0.2vii | Slope Indec of inequality in life expectancy at birth within English regions base on regional deprivation deciles in each area (Males) | 2011/13 | - | - | - | - | - | - | Gideon Smith | | | | |
| 0.2vii | Slope Indec of inequality in life expectancy at birth within English regions base on regional deprivation deciles in each area (Females) | 2011/13 | - | - | - | - | - | - | Gideon Smith | | | | |
| | Supporting Information<br>Deprivation score (IMD 2010) | 2010 | *21.7* | - | - | - | *29.6* | *29.6* | | | This indicator has been added to the PHOF data tool to provide contextual information and has been classed as "supporting information". | | |
| | All Age All Cause Mortality ( standardised rate per 100,000 people) | 2011/13 | 529.6 | 664.1 | 664.1 | | | | Gideon Smith | | All age all cause mortality is an important indicator to life expectancy, as AAACM falls life expectancy increases | | |

***Indicators highlighted are indicators included in the NHS Everone Counts planning for patients NHS Contitution***

***Improvements***

4.01 Infant Mortality has improved from 4.2 to 3.0 which is still similar to England of 4.00

***Declines***

4.12i Preventable sight loss (AMD) per 100,00 has increased (so has gotten worse) from 52.8 to 58.3

***N.B*** All other indicators have remained the same since February 2015

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