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HEALTH AND WELLBEING BOARD

Day: Thursday
Date: 9 March 2017
Time: 10.00 am
Place: Lesser Hall 2 - Dukinfield Town Hall

Item No.	AGENDA	Page No
	GENERAL BUSINESS	
1.	**APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from Members of the Health and Wellbeing Board.	
3.	**MINUTES** The Minutes of the meeting of the Health and Wellbeing Board held on 19 January 2017 to be signed by the Chair as a correct record.	1 - 8
	ITEMS FOR DISCUSSION / DECISION	
4.	**CARE TOGETHER PROGRAMME UPDATE** To consider the attached update report of the Executive Member (Adult Social Care and Wellbeing) and the Programme Director, Tameside and Glossop Care Together.	9 - 12
5.	**GREATER MANCHESTER POPULATION HEALTH PLAN** To consider the attached report of the Executive Member (Healthy and Working) and the Executive Director of Public Health, Business Intelligence and Performance.	13 - 134
6.	**GREATER MANCHESTER CANCER PLAN** To consider the attached report of the Executive Member (Healthy and Working) and the Executive Director of Public Health, Business Intelligence and Performance.	135 - 186
7.	**HOUSING AND HEALTH** To consider the attached report of the Deputy Chief Executive, New Charter Housing Group.	187 - 190
8.	**TAMESIDE CHILDREN'S SERVICES IMPROVEMENT PLAN** To consider the attached report of the Executive Director (People).	191 - 248

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

Item No.	AGENDA	Page No
9.	**CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICE TRANSFORMATION PLAN UPDATE** To consider the attached report of the Director of Commissioning.	249 - 278
10.	**TAMESIDE ADULT SAFEGUARDING PARTNERSHIP ANNUAL REPORT 2015/16** To consider the attached report of the Executive Member (Adult Social Care and Wellbeing) and the Independent Chair of the Tameside Adult Safeguarding Partnership.	279 - 316
11.	**JOINT WORKING PROPOSAL BETWEEN TAMESIDE HEALTH AND WELLBEING BOARD, TAMESIDE ADULT SAFEGUARDING PARTNERSHIP BOARD AND TAMESIDE SAFEGUARDING CHILDREN'S BOARD** To consider the attached report of the Chair of the Tameside Adult Safeguarding Partnership Board and the Chair of the Tameside Safeguarding Children's Board.	317 - 322
12.	**REALISING THE VALUE** To consider the attached report of the Chief Executive, Action Together.	323 - 330
	ITEMS FOR NOTING / INFORMATION	
13.	**HEALTH AND WELLBEING BOARD FORWARD PLAN 2017/18** To receive the attached report of the Executive Director of Public Health, Business Intelligence and Performance.	331 - 334
14.	**URGENT ITEMS** To consider any additional items the Chair is of the opinion shall be dealt with as a matter of urgency.	
15.	**DATE OF NEXT MEETING** To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 29 June 2017.	

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

TAMESIDE HEALTH AND WELLBEING BOARD

19 January 2017

Commenced: 10.00 am **Terminated: 12.10 pm**

PRESENT: Councillor Brenda Warrington (in the Chair) – Tameside MBC
Councillor Peter Robinson – Tameside MBC
Councillor Gerald P Cooney – Tameside MBC
Graham Curtis – Clinical Commissioning Group
Christina Greenhough – Clinical Commissioning Group
Stephanie Butterworth – Tameside MBC
Angela Hardman – Tameside MBC
Karen James – Tameside Hospital NHS Foundation Trust
Steven Pleasant – Tameside MBC
Clare Watson – Clinical Commissioning Group
Andrew Searle – Independent Chair – Tameside Adult Safeguarding Board

IN ATTENDANCE: Dominic Tumelty – Tameside MBC
Catherine Moseley – Tameside MBC
Alan Ford – Clinical Commissioning Group

APOLOGIES: Councillor Kieran Quinn – Tameside MBC
Alan Dow – Chair Clinical Commissioning Group
Tony Powell – New Charter Group
Paul Starling – GM Fire and Rescue Service

77. DECLARATIONS OF INTEREST

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

78. MINUTES OF PREVIOUS MEETING

The Minutes of the Health and Wellbeing Board held on 10 November 2016 were approved as a correct record.

79. MILITARY VETERANS

The Chair welcomed Dr Robin Jackson who briefed the Health and Wellbeing Board on the role of the NHS Armed Forces Network (North West) and the report by the Forces in Mind Trust and its implications for the Board's Joint Strategic Needs Assessment.

Dr Jackson reported that there were possibly 560,000 veterans in the North West of which two thirds would be aged 65 or over and half would be aged over 75. An average GP practice would have 384 veterans as patients. It was notoriously difficult to collect data in respect of military veterans, veteran status was not routinely recorded, veterans were often dispersed and sometimes they could be reluctant to identify themselves as military veterans.

Dr Jackson asked that the Board agree that any commissioning and delivery of services should consider and take into account the following principles in order to improve the assessment of the mental and related health needs of veterans and their family members and ensure better wellbeing outcomes:

(i) Targeted and Intelligent use of data and information – veterans and their family members need to be routinely identified and included in health and social care data collection as part of a targeted and intelligent approach to assessment of their mental and related health needs.
(ii) Appropriate and sensitive evidence based services – responding to the needs of veterans and their family members required services that were sensitive to their identify and culture and provided evidence based interventions as part of an appropriate pathway.
(iii) Involvement and participation of veterans and family members – assessing and responding to the mental and related health needs of veterans and their family members should be done with their active involvement and participation.

The three building blocks were interdependent and proposed as key mechanisms for creating a sustainable and lasting framework for action that would improve the assessment of the mental and related health needs of veterans and their family members and inform the commissioning and delivery of services to meet those needs.

The Director of Public Health advised that contact had been made with the Ministry of Defence regarding the issues being faced by military veterans and data in respect of military veterans was also contained in the Joint Strategic Needs Assessment. There was now an opportunity to undertake further work to enhance and improve this information and consider how the needs of military veterans could be reflected in future commissioning of services. Reference was made to the clinical system used in General Practice supporting a range of patient details, READ codes, and it was important for continued healthcare and monitoring that veterans informed practices of their military status.

RESOLVED
(i) That Dr Robin Jackson be thanked for his attendance and presentation.
(ii) That the Director of Public Health / Director of Commissioning jointly undertake an exercise to ascertain the needs of military veterans, identify any gaps and consider how their needs could be reflected in future commissioning of services.

80. GM AGEING HUB: INTRODUCTIONS AND ENGAGEMENT

The Chair welcomed Paul McGarry, Strategic Lead for the Greater Manchester Ageing Hub and Age Friendly Manchester, and his colleague Gareth Williams.

Mr McGarry explained that it was estimated that in the UK by the early 2030s, half of the UK adult population would be over 50 and by 2037 the over 80s group would have expanded to six million. At a GM level, by 2036, 14% of the total population would be 75 and over, an increase of 75% from 2011. An increase in older people living alone and at risk of social isolation and loneliness was forecast with related impacts on physical and mental health and wellbeing.

The Greater Manchester Ageing Hub had been created so that Greater Manchester partners could co-ordinate a strategic response to the opportunities and challenges of an ageing population. The vision was for older residents in Greater Manchester to be able to contribute to and benefit from sustained prosperity and enjoy a good quality of life, achieved through the delivery of the following strategic priorities:

- GM would become the first age friendly city region in the UK;
- GM would be a global centre of excellence for ageing, pioneering new research, technology and solutions across the whole range of ageing issues; and
- GM would increase economic participation amongst the over 50s.

As ageing was such a far reaching agenda, in order to effectively manage the work programme and areas which would sit within the Hub's remit, activity would be aligned under core Hub activities or within one of six thematic blocks highlighted in the presentation.

GM was in a unique position, with a wealth of experience and expertise across a wide range of leading academic, policy and practitioners, and the GM Ageing Hub would provide a co-ordinating point to work collaboratively to design and develop thinking, new ideas and interventions, developing economic opportunities and enabling people to longer, happier and healthy lives.

In terms of governance, a GM Ageing Hub Steering Group had been established reporting to the Greater Manchester Combined Authority.

Members of the Board discussed the challenges to be faced as the population aged and that it was also increasingly important to recognise and address the many opportunities. Many networks for older people, in a variety of forms and with varying purposes, already existed and it was essential that relationships continued with these networks, celebrating what they do and had done and encouraging them to support future local priorities.

RESOLVED

(i) That Paul McGarry and Gareth Williams be thanked for their attendance and the content of their presentation be noted.

(ii) That the Health and Wellbeing Board continued to engage with the GM Ageing Hub to ensure alignment of local priorities.

81. OFSTED INSPECTION OF SERVICES FOR CHILDREN IN NEED OF HELP AND PROTECTION, CHILDREN LOOKED AFTER AND CARE LEAVERS

Consideration was given to a report of the Executive Leader / Executive Member (Children and Families) / Chief Executive / Executive Director (People), which updated the Health and Wellbeing Board on the recent Ofsted inspection of services for children in need of help and protection; children looked after; and care leavers. Ofsted had also undertaken a review of the Tameside Safeguarding Children Board.

The Health and Wellbeing Board was provided with a summary of the Ofsted activity, Ofsted's judgements and findings about Tameside and the future work Ofsted would undertake as a result of Tameside's Children's Services being judged as inadequate.

The report also set out an approach to a Tameside Children's Services Improvement Programme including the establishment of a Tameside Children's Services Improvement Board.

Detailed consideration was given to the response to the findings and the approach to be taken to ensure service improvement. Particular reference was made to the action plan and performance and improvement framework being put in place together with the approach to overseeing the development and implementation plan.

RESOLVED

That the contents of the report be noted and the following recommendations agreed by the Council's Executive Cabinet:

(i) The establishment of a Tameside Children's Services Improvement Board with an independent chairs on the basis of the terms of reference laid out in Appendix 1 be approved;

(ii) That the development of the Tameside Children's Services Improvement Plan and Business Plan together with an Investment Plan based on the outline explained in the report be approved.

82. SEND REFORM UPDATE

Consideration was given to a report of the Commissioning Business Manager for Children, Young People and Families and the Head of Access and Inclusion, providing an update on the implementation of the Special Education Needs and Disability (SEND) reforms enshrined in Part 3

of the Children and Families Act 2014 in identifying and meeting the needs of Children and Young People with SEND in the local area. The report asked members of the Board to consider their roles in contributing to Tameside's responsibility to these young people and how they could contribute to addressing the gap analysis. This area of work would be inspected by Ofsted and the Care Quality Commission at some point and would include the Local Authority, Clinical Commissioning Group and Public Health.

The local area had completed a comprehensive self-evaluation which clearly documented strengths and areas for improvement which had led to an area wide action plan in addition to individual organisation plans.

Members of the Board welcomed the report and commended the work already undertaken. There were still challenges ahead to ensure that the reforms were fully embedded across all services to meet the needs of children and young people with SEND. However, the evidence to date would stand the area in good stead with the forthcoming Ofsted and the Care Quality Commission SEND Local Area Inspections.

RESOLVED
That the content of the report be noted and the relevant steps to be taken to progress arrangements to further the implementation of the SEND reforms as follows:

(i) Ensuring the co-production, development and delivery of a shared vision and strategy across the local area for young people with SEND.
(ii) Ensuring families, children and young people with SEND were at the centre of the development of the strategy and services.
(iii) Support the creation of a governance framework for the SEND agenda, ensuring executive oversight and reflected on performance report implications.
(iv) Ensure the establishment of a clear line of sight and accountability to the Health and Wellbeing Board.
(v) Ensure the development of a performance matrix for SEND that included prevalence and outcome information.

83. CARE TOGETHER ECONOMY FINANCIAL MONITORING STATEMENT

The Assistant Executive Director (Finance), presented a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the revenue financial positon of the economy. It provided a 2016/17 financial year update on the month 8 financial position at 30 November 2016 and the projected outturn at 31 March 2017. There needed to be careful management of the pressures faced by the each of the Tameside and Glossop Care Together constituent organisations.

The overall financial position of the Care Together economy had improved month on month reducing the projected year end deficit to £5.9m. Work continued to deliver improvement on the CCG QIPP position of the recovery plan and there had been an improvement to the CCGs projected year-end financial positon but it was important to note that the majority of this improvement was a result of non-recurrent means.

Overall, the Tameside MBC year end forecast position had deteriorated since period 7 predominantly due to expenditure to address the outcomes of the recent Ofsted Inspection of children's social care services. The Tameside and Glossop Integrated Care NHS Foundation Trust was currently forecast to achieve the planned £17.3m deficit.

Reference was also made to the 2016/17 Better Care Fund allocation sum of £15.323m. All spend was being monitored through the Integrated Care Fund and details of how the allocation was being spent was included in the quarter 2 monitoring statement.

RESOLVED

(i) That the 2016/17 financial year update on the month 8 financial positon at 30 November 2016 and the projected outturn at 31 March 2017 be noted.
(ii) That the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget be acknowledged.
(iii) That the significant amount of financial risk in relation to achieving an economy balanced budget across this period be acknowledged.
(iv) That the 2016/17 quarter 2 Better Care Fund monitoring statement be noted.

84. CARE TOGETHER PROGRAMME UPDATE

Consideration was given to a report of the Programme Director, Tameside and Glossop Care Together, providing an update on the progress and developments within the Care Together Programme since the last presentation in November 2016 covering the following areas:

- Greater Manchester Health and Social Care Partnership;
- Operational Progress;
- Organisational updates; and
- Recommendations.

RESOLVED
That the content of the update report be noted.

85. UPDATE ON HEALTHY NEIGHBOURHOOD PROGRAMME

The Chief Executive, Tameside and Glossop Integrated Care Foundation Trust gave a presentation providing Board members with an update on the development of the Healthy Neighbourhood Model and implementation in Tameside and Glossop.

Five Integrated Neighbourhoods would provide health and care services for their populations, including GP services, community health services, district nursing, social care services and voluntary sector services, through multi-disciplinary teams. Recruitment was underway for key transformational roles within neighbourhoods that supported delivery of exciting new ways of providing services within the community.

Supporting the five Integrated Neighbourhoods, the intermediate tier would provide short term specialist services to patients either following or to avoid emergency acute admission for patients including the Integrated Urgent Care team, Re-ablement, community bed base, IV Therapy services, long term conditions Extensivist Care, End of Life teams, mental health and pharmacy services. The Extensivist Care Service was part of the neighbourhood core offer and would be a targeted wrap-around tailored service to provide care for a risk stratified cohort of patients to reduce unnecessary crisis admissions and hospital attendances. Recruitment to the Extensivist roles had now been completed.

Embedded within the five Integrated Neighbourhoods, a system wide self-care programme would deliver non-medical care and support for their populations to improve people’s knowledge, skills and confidence to manage their own health and well-being more effectively.

The Chair commented that the content of the presentation and update demonstrated that the new model was progressing and the willingness of the Neighbourhood Leads working differently to achieve objectives and move the programme forward was highlighted.

RESOLVED
That the update on the healthy neighbourhood programme be noted.

86. PRIMARY CARE UPDATE

Consideration was given to a report of the Director of Commissioning briefing the Health and Wellbeing Board on the priorities and scope for primary care over the next two to five years based on national and regional documents as follows:

- The Five Year Forward View;
- The General Practice Forward View;
- New Care Models: The multispecialty community provider emerging care model and contract framework;
- NHS Operational Planning and Contracting Guidance 2017-19;
- Greater Manchester Primary Care Strategy (Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021.

Tameside and Glossop had 41 practices working across 5 neighbourhoods. All 3 of the current nationally recognised GP contracts were in place within the economy: general medical services, personal medical services and alternative provider medical services.

In terms of local implementation, although the neighbourhood model of peer support had been in place for a number of years more recently this had developed and expanded to promote new ways of working across and by, neighbourhoods. The ambition of this was to improve efficiency and achieve the care delivered by population based models approach and further alignment of commissioning staff to neighbourhoods had strengthened the support offer and work programme with practices. The review of risk stratification patients, as outlined in the description of the extensivist model was being implemented locally through this extended support and it was anticipated that this would become embedded in practice culture. The national direction of new models of care described through national strategy, although in its infancy in Tameside and Glossop, was moving forward and would further develop over the coming years.

Neighbourhoods were designing models of care for their population based on local need, fostering relationships between providers to deliver the best outcomes. These Integrated Neighbourhoods had been formed across all neighbourhoods bringing together providers to work in collaboration. Different models of working and widening the range of professionals within the primary care workforce was a key strand throughout all national documentation and this was being taken forward locally. New models of care and the direction of the GP Forward View and GM Strategy had been fully reflected in the documentation for the Alternative Provider Medical Services re-procurement. Although a new contract model was not yet available, the context in which the contracts were being re-procured and the future vision for these practices had been outlined and would form part of the assessment of bids.

The Primary Care Quality Scheme refresh required for 2017/18 must reflect the current landscape both financial and policy. This redesign must therefore address the direction for primary care outlined through the documentation to support the formation of new models of care and deliver people empowered care and place based, population based models. This redesign would address the ‘must do’s’ and mandates from the planning guidance outlined in the report as well as ensuring Tameside and Glossop fulfilled its commitment to the delivery of the GM standards. The drive to improve use of technology and change the way people accessed services would also be reflected, ensuring people powered change could be achieved. This refresh was underway and would go through a period of patient and practice consultation.

In conclusion, it was reported that the CCG Commissioning Business Managers and Neighbourhood Clinical Leads continued to support the further development and implementation of the Integrated Neighbourhood model with a number of activities and projects across the borough detailed in **Appendix 2** to the report.

RESOLVED

(i) That the scale of the ambition for Primary Care nationally be noted.

(ii) That the delivery of this ambition through local implementation, development of neighbourhoods and progression of new models of working and through the refresh of the Primary Care Quality Scheme be supported.
(iii) That the competing priorities on scarce financial resource and the CCG investment already in place as part of the Primary Care Quality Scheme, noting the refresh of this aligned to national policy and GM standards and the investment in respect of neighbourhoods through the Transitional Fund be acknowledged.

87. ACTIVE TAMESIDE

The Chair welcomed Mark Tweedie, Chief Executive, Active Tameside, who gave a presentation to accompany his report updating Board members on the development of Active Tameside facilities, programmes and strategic vision and, in particular, the Live Active Programme. The presentation sought to identify opportunities to deliver on the ambitions of the Locality Plan and Commissioning Strategy by reducing levels of inactivity in Tameside.

The Active Tameside Live Active service had achieved exceptional success over a relatively short period, evidenced by the performance metrics detailed in the report. The service was working to accommodate a wide range of long term conditions within the same pathway, whilst offering a diverse exercise therapy offer and exit routes into long term activity. Chronic obstructive pulmonary disease, falls, mental health, musculoskeletal conditions and stroke were some of the main conditions that incurred significant and escalating costs to the NHS through hospital and NHS service visits. It was well evidenced that by offering a specific physical therapy intervention, patient outcomes were not only improved but could produce significant demand and therefore cost reductions to the health and social care system.

Members of the Board commented favourably on the presentation and the potential that high quality leisure facilities could play in encouraging and sustaining the take-up of physical activity to address inactivity and empower more people and communities to take charge of their own health. Members of the Board were keen to receive a breakdown on the uptake of activities and a cost benefit analysis at a future meeting.

It was proposed that the Board recommend to Council, the appointment of Mark Tweedie, Chief Executive, Active Tameside, as a member of the Health and Wellbeing Board and welcomed his contribution towards increasing physical activity which cut across all life course priorities in the Health and Wellbeing Strategy.

RESOLVED
(i) That the content of the report and accompanying presentation be noted.
(ii) That the Board recommends to Council the appointment of Mark Tweedie, Chief Executive, Active Tameside, as a member of the Health and Wellbeing Board.
(iii) That a further report providing a breakdown on the update of activities and a cost benefit analysis would be presented to a future Health and Wellbeing Board.

88. HEALTH AND WELLBEING BOARD PRIORITIES 2017/18 AND FORWARD PLAN 2016/17

Consideration was given to report of the Director of Public Health outlining the wider determinant priority focus areas for collective action for 2017/18 relating to the following:

- Health and Housing;
- Strengthening Communities;
- Health and Work;
- Mental Health and Wellbeing.

It was proposed that a plan of action working across the system be developed and a lead officer identified to take forward the work in each priority focus area.

The forward plan 2016/17 designed to cover both the statutory responsibilities of the Health and Wellbeing Board and the key projects identified as priorities by the Board were also detailed.

RESOLVED

(i) That the wider determinant priority focus areas for collective action for 2017/18 be agreed and lead officers identified to take forward the work in each area.

(ii) That the content of the forward plan 2016/17 be noted.

89. URGENT ITEMS

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

90. DATE OF NEXT MEETING

To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 9 March 2017 commencing at 10.00 am.

CHAIR

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	9 March 2017
Executive Member / Reporting Officer:	Councillor Brenda Warrington, Executive Member (Adult Social Care and Wellbeing) Jessica Williams, Programme Director, Tameside and Glossop Care Together
Subject:	**INTEGRATION REPORT – UPDATE**
Report Summary:	This report provides an update to the Tameside Health and Wellbeing Board on the progress and developments within the Care Together Programme since the last presentation in January 2017.
Recommendations:	The Health and Wellbeing Board is asked: 1. To note the progress of the Care Together Programme including the strategic and operational aspects; and 2. To receive a further update at the next meeting.
Links to Health and Wellbeing Strategy:	Integration has been identified as one of the six principles agreed locally to achieve the priorities identified in the Health and Wellbeing Board Strategy
Policy Implications:	One of the main functions of the Health and Wellbeing Board is to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.
Financial Implications: (Authorised by the Section 151 Officer)	The healthcare system in Tameside and Glossop has a projected £70m financial gap by 2020/21 which the Care Together Programme is designed to address. The Finance Economy Wide (FEW) Group meets fortnightly to ensure effective tracking of the locality finances and projections, reporting through to the Care Together Programme Board for further review. It is essential that the approved GM Health and Social Care Partnership funding is expended in accordance with the investment agreement and recurrent efficiency savings are subsequently realised across the economy
Legal Implications: (Authorised by the Borough Solicitor)	It is important to recognise that the Integration agenda, under the auspices of the 'Care Together' banner, is a set of projects delivered within each organisation's governance model and delivered jointly under the Single Commissioning Board together with the Integrated Care Foundation Trust. However, the programme itself requires clear lines of accountability and decision making due to the joint financial and clinical implications of the proposals. It is important as well as effective decision making processes that there are the means and resources to deliver the necessary work. This is to provide confidence and oversight of delivery. We need to ensure any recommendations of the Care Together Programme Board are considered / approved by the

	constituent bodies to ensure that the necessary transparent governance is in place.
Risk Management :	The Care Together Programme has an agreed governance structure with a shared approach to risk, supported through a project support office
Access to Information :	The background papers relating to this report can be inspected by contacting Jessica Williams, Programme Director, Tameside and Glossop Care Together Telephone: 0161 304 5389 e-mail: jessicawilliams1@nhs.net

1. INTRODUCTION

1.1 This report provides an update to the Tameside Health and Wellbeing Board on the developments within the Care Together Programme since the last meeting.

1.2 The report covers:

- Greater Manchester Health and Social Care Partnership;
- Operational Progress;
- Organisational updates;
- Recommendations.

2. GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP

2.1 Of the full £23.226m transformational funding award, £5.2m has been allocated within 2016/17. Transformational programmes are now being implemented at pace across the economy and expenditure profiles are being examined to understand the potential benefits in year.

2.2 Monitoring of the Investment Agreement within the locality is taking place on a monthly basis and it is envisaged that progress updates will be provided to Greater Manchester on a quarterly basis. The format for this is not yet finalised by the Greater Manchester Health and Social Care Partnership but it is hoped that the Care Together Programme Board will be an appropriate assurance vehicle.

2.3 The transformational funding award unfortunately does not include any capital for IM&T and Estates. The Programme Support Office continues to liaise with GM Health and Social Care Partnership and NHS Improvement to understand the potential for funding bids and ensure that as soon as funding opportunities arise, Tameside and Glossop will be prepared to make a submission.

3. OPERATIONAL PROGRESS

Programme Management

3.1 In order to ensure robust economy wide financial delivery plans and provide the necessary assurance to the Greater Manchester Health and Social Care Partnership on the expenditure and associated benefits of transformational funding, additional capacity and project management capability is required in the Care Together Programme Support Office. This has now been procured via Tameside MBC on behalf of the economy and will be in operation by the end of February 2017. The aim is for rigorous assessment of plans to inspire confidence across the system.

Adult Social Care Transaction

3.2 The Adult Social Care Transaction Steering Group continues to meet monthly. A strategic business case is currently in development and subject to approval by the Integrated Care Foundation Trust Board, will commit the economy to the transaction of staff by 1 April 2018. This however is secondary to the transformation of health and social care services which is already underway with the development of Integrated Neighbourhoods. This will be presented at the next Health and Wellbeing Board.

Integrated Neighbourhoods

3.3 The GP Clinical Leads for Neighbourhoods (and the associated funds from the Clinical Commissioning Group) are in the process of transferring into the Integrated Care Foundation Trust. A role specification and objectives for 2017/18 are being discussed which will provide real focus and pace to the implementation of transformational schemes. This is innovative, exciting and shows significant leadership commitment to the building of effective, high quality pathways of care across the health and social care system.

3.4 The Integrated Care Foundation Trust has created a new senior, executive and clinical monthly Joint Management Team which encompasses GP clinical leads, social care, public health as well as secondary care clinical directors. This is chaired by the Chief Executive and will be responsible for prioritising expenditure in neighbourhoods and ensuring the delivery of benefits.

Operational plans and new contract

3.5 The contracts between the Single Commission and key partners, including the Integrated Care Foundation Trust were agreed according to national timetable despite the extremely challenging financial position. This is testament to the collective commitment and team work by Finance colleagues.

4. ORGANISATIONAL UPDATE

Single Commissioning Function

4.1 As part of the drive to improve the efficiency of commissioning, New Century House has been vacated and commissioning staff have been allocated in their teams across three new Tameside MBC owned sites. Staff have been very accommodating and have adapted to the need to be more agile. Plans are now being developed to maximise the potential for strategic commissioning functions within the new Ashton building.

Integrated Care Organisation

4.2 Work continues to determine the full remit of the Integrated Care Foundation Trust and to align services accordingly. As well as the transformation and transaction of Adult Social Care, there is likely to be a transfer of some current commissioning functions and associated staff. This is being worked through and timelines being determined. How the Integrated Care Foundation Trust works with mental health and primary care services will also be developed in due course.

5. NEXT STEPS

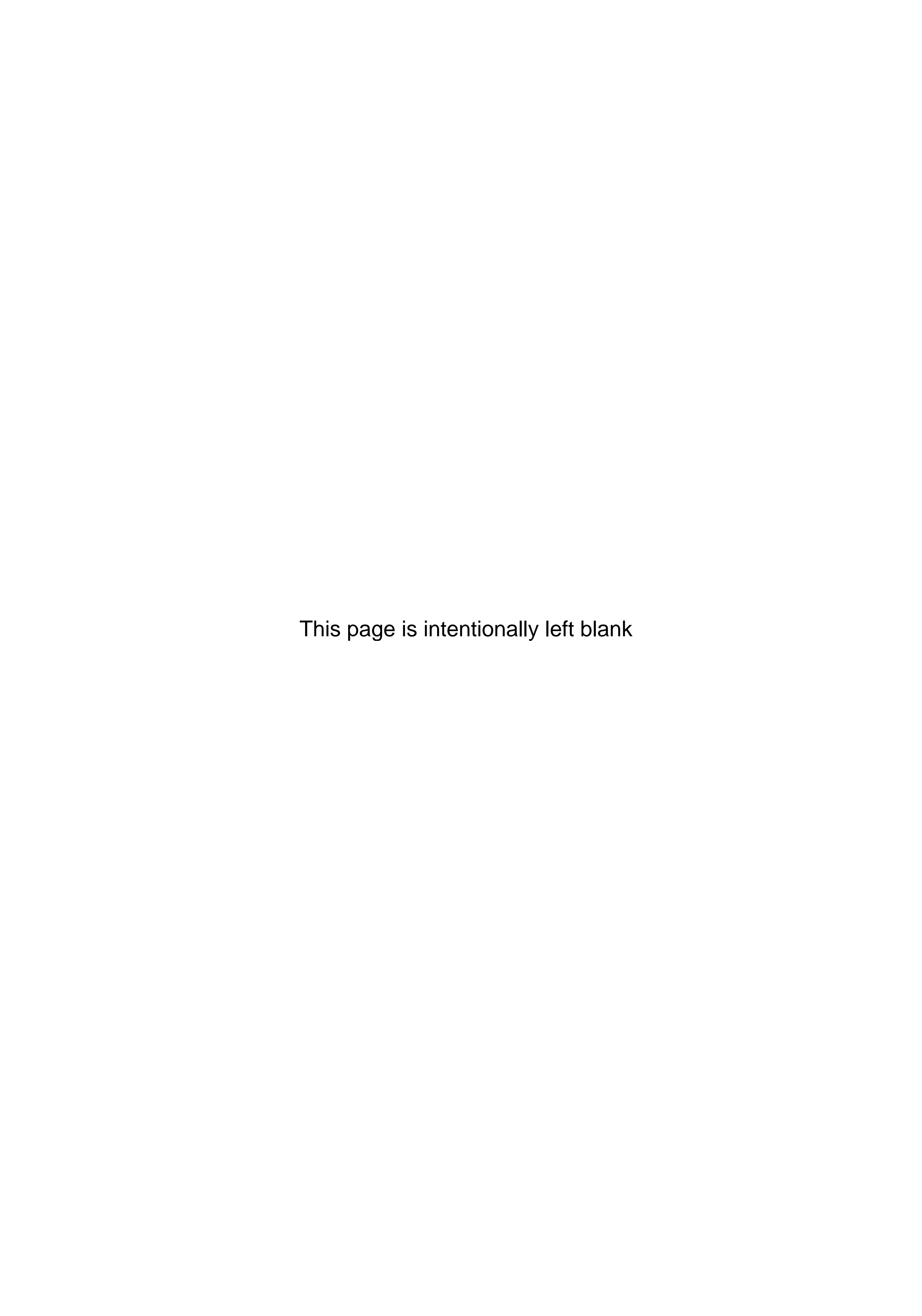
5.1 As well as the continuation of all work above, notable next steps are as follows:

- Reporting to the Greater Manchester Health and Social Care Partnership on 2016/17 transformational fund expenditure and benefit realisation and agreeing the plans for 2017/18;
- Implementation at pace of the Integrated Neighbourhoods across Tameside and Glossop;
- Demonstrating the start of delivery of significant financial savings across the economy;
- Development of the Primary Care Strategy;
- Development of the Intermediate Care Strategy;
- Obtain capital funding for IM&T and Estates plans;
- Strategic business case and due diligence process agreed for the transaction of adult social care;
- Finalising the role and structure of the Strategic Commissioning function;
- Development of a balanced scorecard/outcomes framework which will demonstrate the improvement of healthy life expectancy, reduction in inequalities and the movement towards a financially sustainable economy.

6. RECOMMENDATIONS

6.1 As set out on the front of the report.

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	9 March 2017
Executive Member / Reporting Officer:	Cllr Ged Cooney, Executive Member (Healthy and Working) Angela Hardman, Executive Director, Public Health, Business Intelligence & Performance
Subject:	**GREATER MANCHESTER POPULATION HEALTH PLAN**
Report Summary:	This plan and presentation sets out a Greater Manchester (GM) approach to delivering a radical upgrade in population health. It is informed by the best empirical evidence and by the views of the people of Greater Manchester. It sets out the health challenges we face and the approach to population health at the Greater Manchester level. The priorities for change set out in this plan have also been chosen to support the locality delivery described in each of the ten locality plans. The plan then focuses on those programmes of work with the GM Health and Social Care Partnership will deliver in collaboration with localities. This plan sets out the high level ambitions for Population Health and the targeted interventions that will be necessary to deliver on this ambition over the next 4 years until 2021.
Recommendations:	The Health and Wellbeing Board are asked to note and endorse the Greater Manchester Population Health Plan.
Links to Health and Wellbeing Strategy:	The Population Health Plan aligns to all life course priorities of the Health and Wellbeing Strategy
Policy Implications:	Greater Manchester has the chance to take a co-designed approach to radically reframe the role of Population Health in the context of a devolved system, creating a unified population health system across ten localities and GM that is better able to achieve improved health outcomes for the citizens of GM.
Financial Implications: **(Authorised by the Section 151 Officer)**	Adoption of the proposed plan will play a crucial role in improvement the health and wellbeing of the local population. As a result of this it is envisaged that fewer people will require complexed / acute interventions, this will ultimately contribute to closing the local Health and Social Care economy financial gap of c£70m.
Legal Implications: **(Authorised by the Borough Solicitor)**	It is important that decisions regarding resources are made on an evidence based approach. This report sets out the evidence of the challenges and how we should tackle health inequalities.
Risk Management :	There are no risks associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson, Head of Health and Wellbeing, by: Telephone: 0161 342 3358 e-mail: debbie.watson@tameside.gov.uk



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in Greater Manchester

GREATER MANCHESTER HEALTH PLAN

HEALTH PLAN AIMS

PEOPLE AND COMMUNITIES MAKING POSITIVE HEALTH CHANGES

Achieve positive change using people's own knowledge, skills and experiences of the issues they come across in their own lives.

Develop a network of cancer champions – cancer survivors, friends, relatives or anyone.

START WELL

Helping children develop socially and emotionally, so they are ready for school.

Use technology to help monitor children's progress.

Help mums to be to stop smoking during pregnancy.

Tooth decay – We want all children under one to go to a dentist and brush their teeth – reducing the need for emergency dental treatment.

LIVE WELL

Bring together health, employment and other services to improve people's health.

GPs to work more closely with people who could have poor health in the future.

Provide new lifestyle and wellness services, including online advice and support to encourage people to lead healthier lives.

Work with cancer champions and health professionals to improve peoples chances of not getting cancer.

Increase early screening to reduce potential cancer – lung cancer is one of the biggest killers in Greater Manchester.

Get rid of HIV within a generation.

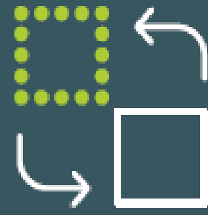
HEALTH PLAN AIMS

AGE WELL

Work with partners to tackle issues around poor quality housing to improve health.

Improve older peoples health caused by lack of food and drink by rolling out the same nationally recognised work done in Salford, across Greater Manchester.

Reduce the number of older people needing hospital treatment for broken bones caused by falling using tested ways of improving their health and balance.



SYSTEM CHANGE

Work with partners to develop shared ambitions and a detailed plan of how we will improve people's health.

Involve, engage and collectively design care services with the voluntary community and social enterprise groups to benefit local communities.

Increase the spending power of every pound spent on public services by ensuring there is always a wider benefit to the local community – such as employing local people.

TAKING CHARGE GOALS

START WELL

More children will be more socially and emotionally developed so they are ready for school.

Fewer babies will have a low birth weight resulting in better health for the baby.

LIVE WELL

More families will have jobs or have more chances of getting higher paid roles.

Fewer people will die early from cancer and heart, lung and breathing diseases.

Increase HIV testing to help get rid of HIV within a generation.

AGE WELL

More people will be supported to stay well and live at home for as long as possible.

STRONGER TOGETHER

A fairer, healthier, safer and more inclusive place to live.

Change health and social care-improve access to quality, joined up services; greater independence, improved wellbeing and stronger communities.

Improve early years – support families to give children the best start in life and help families towards work, if they haven't got a job.

STRONGER TOGETHER

Support unemployed residents into work and enable them to move up into higher skilled, higher paid roles.

Known for excellent, efficient, value for money services – encourage self help and reduce demand on public services.

Create the conditions for growth and place Greater Manchester as a centre for excellence for science and technology.

Working together in partnership – strong leadership.

To find out more visit www.gmhsc.org.uk

The Greater Manchester Population Health Plan

2017-2021

Greater Manchester
Health and Social Care Partnership

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Foreword

April 2016 was a milestone in Greater Manchester's history. It marked the start of the era in which we take charge of health and social care in our region.

We've said before that that's a huge privilege - it gives us the chance to make decisions locally about how best to spend our £6 billion budget to bring the greatest, fastest improvement to the health and wellbeing of our 2.8 million people. It gives us chance to focus on our people and communities, helping them to take control of and make decisions about their own health, looking after themselves and each other. And it gives us chance to strengthen the links between health, work and economic prosperity. Put simply skilled, healthy and independent people are crucial to bring jobs and investment, we therefore want to support as many people as possible to contribute and benefit from the opportunities economic growth brings.

It's also a huge challenge as we seek to tackle the deep rooted health inequalities and high levels of long term conditions such as diabetes, which mean that Greater Manchester people not only have a shorter life expectancy, but can expect to experience poor health at a younger age than in other parts of the country. In turn this means many thousands of people here are not always able to benefit from that increased prosperity we want to bring to the region.

Our strategic plan, Taking Charge, set out our ambitious goals for everything from community health services, to hospitals, IT and our public sector buildings. This Population Health plan is our commitment to the people who live and work in the ten towns and cities of Greater Manchester - and that includes the carers, the volunteers and the workforce - that we will make changes which we know will work and at the right scale in order to help people have the best start in life, to live well and to age well.

With your support and assistance we can turn this bold and ambitious strategy into an effective plan to transform lives and achieve a healthier Greater Manchester.

Peter Smith

Lord Peter Smith
Chair GMHSC Strategic Partnership Board
Leader of Wigan Council

Summary

Vision	To achieve the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people who live in Greater Manchester

Strategic framework

Person and community centred approches	Start Well	Live Well	Age Well	System reform

Health Challenges

- Greater Manchester's population is predicted to increase by 3%, with an ageing profile, and people aged over 70 predicted to increase by 15.2% by 2021.
- Greater Manchester has significant health inequalities both in relation to England averages and across Greater Manchester between local authorities and within them.
- Our life expectancy is below the national average, and we have poorer levels of healthy life expectancy.
- Rates of employment are lower – 70.5% compared with 74% across England.
- Across the life course, risk factors that lead to illness and reduced life expectancy in general are worse than the respective England averages e.g. in 50% of all Greater Manchester local authorities smoking prevalence is significantly higher than the England average of 16.9%, and one in three children in Greater Manchester did not achieve a good level of attainment by the end of Reception.
- 9.8% of adults reported they had a long-term condition or disability that significantly impaired their everyday activities, compared to 8.3% across England.

Taking Charge Together Consultation

- 90% wanted to improve their lifestyles, with most people citing being more active, eating healthier and tackling stress as their key areas of need.
- People were willing to take charge of their own health and wellbeing, but recognised their ability to do so was limited by the wider determinants of health such as income, transport and housing.
- While improving health and social care services was seen as important, people emphasised the role of personal and community support structures. Mental health was seen as equally as important as physical health.
- People recognised that one size does not fit all and that certain groups had additional needs e.g. LBGT.
- They emphasised the importance of self-confidence and self-efficacy in changing health-related behaviours.
- People highlighted the important legislative powers of local government and the role of public sector organisations in creating the right conditions for people to take charge of their own health, and the important role of staff as health ambassadors within local communities.
- They wanted greater use of behavioural insights to identify how people really behave, not how policy makers think they should.

Wider strategic linkages

- Our plan is aligned with the broader approach to reform across Greater Manchester that is predicated on: a new relationship between people and public services; connecting people to the opportunities of growth and reform; place-based integration of services and orientating the system towards early intervention and prevention.
- We are clear that change happens in communities, supported by localities. The priorities for change set out within this plan have been chosen to support the locality delivery described in each of the 10 locality plans.
- While the plan focuses on the programmes of work that the Greater Manchester Health and Social Care Partnership will deliver in collaboration with localities, achieving a radical upgrade in population health will be dependent on both the priorities of this plan and the broader reform of services being taken forward across Greater Manchester.
- Nor can this plan be disconnected from the rest of our health and care transformation programmes, in particular the development of locality care organisations (LCOs) and the primary care strategy will lead to embedding more proactive, person-centred prevention and early intervention practice consistently into the design and delivery of community-based services.

Taking Charge Together consultation

Findings from Greater Manchester people, carers and staff conversations online and face to face, with over 6,000 responses and 50,000 visits online about how they might better take charge of their own health.

Quick wins

Opportunities to implement evidence-based local best practice at scale across other parts of Greater Manchester.

Common theme in locality plans

An audit earlier this year of locality plans highlighted areas for standardised approaches across Greater Manchester.

Economics of prevention

The 'economics of prevention' work was developed by New Economy Manchester and Public Health England and group interventions by their gestation or notional rate of return in order to recognise that dividends for different interventions are likely to be realised over different time periods.

Summary

Greater Manchester Population Health Plan Objectives

Person and community centered approaches

- To build a Greater Manchester framework and support capacity and capability building for person and community centred approaches
- To work in partnership with VSCE sector to develop and test an exemplar social movement focused on cancer prevention.

Start Well

- To support localities to implement the core elements of the Greater Manchester Early Years model, including the development of an IMT proposition to improve data processes to track progress and allow earlier intervention.
- To develop a sustainable, resilient and consistent Greater Manchester approach to stopping smoking in pregnancy.
- To implement evidence-informed interventions at scale in a targeted and consistent manner across Greater Manchester to improve oral health and reduce treatment costs within 3-5 years.

Live Well

- To build and test an approach to work and health that improves the integration and alignment of health, employment and other services.
- To test and evaluate the ‘focused care’ approach model in a number of deprived practices in Greater Manchester with a view to supporting the future expansion and mainstreaming of the new care model, including exploration of sustainable funding mechanisms.
- To develop a whole systems approach to lifestyle and wellness services, including innovative digital options for incentivising and supporting lifestyle behaviour change.
- To deliver the cancer prevention workstream of the national cancer vanguard, testing innovative approaches to awareness and behaviour change, social movement, cancer screening uptake and lifestyle -based secondary prevention.
- To roll out a lung health-check programme across Greater Manchester.
- To help develop a Greater Manchester city-region approach to eradicating HIV within a generation.

Age Well

- To facilitate the roll-out, testing and evaluation of an approach to tackling issues around poor quality housing.
- To facilitate the roll-out, testing and evaluation of an approach to tackle dehydration and malnutrition based on the nationally recognised work in Salford.
- To facilitate the roll-out ,testing and evaluation of fracture liaison services, integrated with locally designed falls prevention services in a number of Greater Manchester boroughs.

System reform

- To develop a population health commissioning plan, and develop and test a proposal for a new Greater Manchester population health function including future resourcing model.
- Maximise the social value benefit from health and social care commissioning and contribution of the voluntary, community and social enterprise sector.

Taking Charge

Start Well

More Greater Manchester children will reach a good level of development cognitively, socially and emotionally.

Fewer Greater Manchester babies will have a low birth weight resulting in better outcomes for the baby and less cost to the health system.

Live Well

More Greater Manchester families will be economically active and family incomes will increase.

Fewer people will die early from cardiovascular disease.

Fewer people will die from cancer.

Fewer people will die from respiratory disease.

Age Well

More people will be supported to stay well and live at home for as long as possible.

Stronger Together

Greater Manchester is a fairer, healthier, safer and more inclusive place to live

Reform health and social care with improved access to quality, integrated services. Greater independence, improved well-being and stronger communities.

Improve early years support for parents to give children the best start in life and help workless parents towards work.

All people are valued and able to fully participate in and benefit from the city regions success. Support unemployed residents into work and enable progression into higher skilled, higher paid roles.

Greater Manchester is known for excellent, efficient and value for money services. Encourage self-reliance and reduce demand on services.

Create the conditions for growth and place Greater Manchester at the leading edge of science and technology. Expand and accelerate the commercialisation of research.

Collaboration and partnerships. Strong collective and individual leadership.

1. Introduction

"The greatest wealth is health"
– Virgil

Greater Manchester's (GM) future success depends upon the health of its population. For too long our city-region has lagged behind national and international comparators when it comes to key health outcomes. Deeply embedded health inequalities, often between communities little more than a stone's throw apart, have blighted individual lives and acted as a drag on our economy.

That is why we are committed to achieving the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people who live here. Each of the towns and cities of Greater Manchester is determined to do this by: helping people to take control of their own and their family's health; connecting people to the opportunities created by economic growth and reform; tackling the root causes of poor health; focusing on improving the health of the most vulnerable; and providing excellent care for people when they need it.

Our plan is unashamedly focused on people and communities. Communities, both place-based and where people share a common identity or affinity, have a vital contribution to make to health and wellbeing. We know that connected and empowered communities are healthy communities. That it is the assets within communities, the skills and knowledge, the social networks and the community organisations that are building blocks for good health and wellbeing. So we have put person and community-centred approaches at the centre of our plan.

This plan sets out our approach to delivering a radical upgrade in population health. It is informed by the best empirical evidence and by the views of the people of Greater Manchester. It sets out the health challenges we face and our approach to population health at the Greater Manchester level.

We are convinced that the key to better population health is to get upstream of the impact of illness and disease in focusing on prevention and early intervention. We are also committed to a life course approach; we believe that from pregnancy right through to ageing we have multiple opportunities to enhance future quality of life.

We are clear that most change happens in communities, supported by local organisations, so the priorities for change set out within this plan have been chosen to add value to the local delivery described in each of the 10 locality plans. The plan then focuses on those programmes of work that Greater Manchester Health and Social Care Partnership (GMHSC Partnership) will deliver in collaboration with localities. It does not seek to duplicate those priorities that are best delivered at the locality level.

The choices we have made in the plan are based on the best available evidence of impact and seek to achieve a balance of short, medium and long-term improvements. There will be some programmes that we will work up in future years, and

others that we will take forward through our commissioning plans and by working with localities.

We know a lot about what we need to do to improve health and wellbeing and reduce health inequalities. The ambition of this plan lies in our desire to implement and embed these proven approaches consistently at scale across Greater Manchester in a way that has never been achieved before. Right now, there are multiple examples of good practice across the conurbation but they tend to be small in scale and operating at the fringe rather than at the heart of the health and social care system. This plan will act as a key driver to re-orientate the system towards prevention and a focus on population health and wellbeing.

1.1 Wider strategic linkages

The overall Greater Manchester Strategy, ‘Stronger Together’, places reform of services to the public at the heart of our strategic ambition. The subsequent Growth and Reform Plan, devolution agreements, and the Health and Social Care Strategic Plan ‘Taking Charge’ have restated that commitment to reshaping our services, supporting as many people as possible to contribute to and benefit from the opportunities economic growth brings.

The various elements of the overall Greater Manchester strategy – Stronger Together, the Greater Manchester Spatial Framework (the plan to manage the supply of land for jobs and new homes across Greater Manchester) and the Greater Manchester Local Transport Plan, together with more targeted strategies such as the Greater Manchester Alcohol Strategy, the Greater Manchester Primary Care Strategy and The Greater Manchester Mental Health Strategy – all have important contributions to make to population health. It’s not possible, nor is it appropriate, to reference the full range of strategies that contribute to population health in this document. However, we have signposted to the most important strategies and programmes of work for population health wherever possible.

Across Greater Manchester, we are clear that people’s lives do not neatly fit into public service sectors. Aligning our reform strategies means we are placing people at the heart of what we do rather than expecting people’s lives to neatly map to our organisational boundaries. It also means that this is not just a traditional public health plan, in that it seeks to draw on the widest possible range of services and support options to help people achieve the best possible health and wellbeing outcomes.

Nor can this plan be disconnected from the rest of our health and care transformation programmes and projects. Our aim is that people across Greater Manchester are able to access the right services, at the right time, in the right way to help them tackle challenges they may face and to build on their strengths and assets. We must do this in collaboration, across sectors so that people no longer have to navigate fragmented systems and services. This will mean that when we consider any pathway of care, for any condition or group of conditions, we will think about the whole journey from prevention right through to specialist care.

1.2 Taking charge together of our health and wellbeing

In order to develop the proposals in this population health plan, our starting point is the views and experiences of local people. In 2016, we engaged with Greater Manchester people including the “seldom heard”, carers, and health and social care staff by working in partnership with Healthwatch, the Voluntary Community and Social Enterprise (VCSE)

sectors and across all 37 public sector organisations that form GMHSC Partnership. 50,000 visited our websites and more than 6,000 were involved in our conversations face to face from all walks of life in a conversation specifically about health and wellbeing and how they might better take charge of their own health. This innovative engagement exercise generated feedback via crowdsourcing (online conversations) and a health snapshot online questionnaire.

The engagement with seldom heard people, led by a unique partnership between Healthwatch and Greater Manchester Voluntary, Community and Social Enterprise (VCSE), sign-posted these groups to our online conversations. Their feedback included:

It's all environmental: A range of factors commonly defined as wider health determinants were recognised as having either a direct impact on health or on people's ability to adopt healthy behaviours such as healthy eating or exercise. Factors included income and costs, work and employment, transport, housing, skills and education, town and city planning, crime and community safety, pollution, social and cultural norms, climate and weather.

It's all about people: People highlighted the role of social and community support structures, the harmful effects of social isolation and the importance of people as positive role models and motivators. VCSE groups and organisations were seen as key in facilitating social support and providing opportunities for creating meaningful connections.

It's all in the mind: Mental health was given equal, if not more, importance as physical health. Self-confidence, a sense of self-efficacy (especially in relation to perceptions of behaviour change as possible, and likely to result in positive health impacts), and motivation all featured strongly in discussions.

It's all relative: People emphasised the relative nature of health and wellbeing and referred to significant levels of diversity in relation to individual, social and cultural differences as well as transitions across the life course. 'One size does not fit all', and a particular focus was put on the additional access and inclusion requirements of particular communities, such as disabled, Deaf, lesbian, gay, bisexual and trans (LGBT) and young people, and people for whom English isn't their first language.

It's all about equality: Participants drew a direct connection between structural inequality and ill health, in line with mainstream theory on health inequalities. This suggests that addressing structural inequalities in society has to be at the centre of all health improvement work.

It's all about knowledge: While participants generally reported good levels of knowledge about healthy living, they recognised an unmet need for accessible information for particular groups and communities, and for consistent messaging and education from a young age. Also, gaps in knowledge among professionals around particular issues and the needs of particular communities were highlighted.

These conversations have given us a unique insight into the opportunities and barriers that people are experiencing and the key messages and have been fundamental in shaping this population health plan.

Overall, people are willing to take charge of their health and wellbeing while recognising that their ability to do so on an individual basis is limited by other factors, mainly time to do this, place and confidence. While improvements to health and social care services are seen to play a role in this, people put more emphasis on improving personal and community support structures. To find out more visit www.takingchargetogether.org.uk

It follows that creating conditions in which people are enabled to take charge of their own health and wellbeing will require a truly holistic approach based on radical improvements of the physical and socio-economic environment and transformative grassroots community development.

1.3 Greater Manchester's health challenge

Where are we starting? Greater Manchester is the fastest growing economy in the country and is a great place to live and work for many people. Yet people here die younger than people in other parts of England. Our aspirations for good health need to recognise our starting point and also the challenges of an ageing population and the inequalities that currently exist between the most affluent and most deprived parts of the local population.

1.3.1 Demographics

We have an ageing population. Between 2016 and 2021 the number of people aged over 70 living in Greater Manchester is predicted to increase by 15.2%, while the overall population will increase by 3% (figure 1).

Greater Manchester has a diverse population and it is important to recognise how this diversity is dispersed across the areas as this can lead to significant inequality. For example, the 2011 Census shows that local populations have different ethnic characteristics (see figure 2).

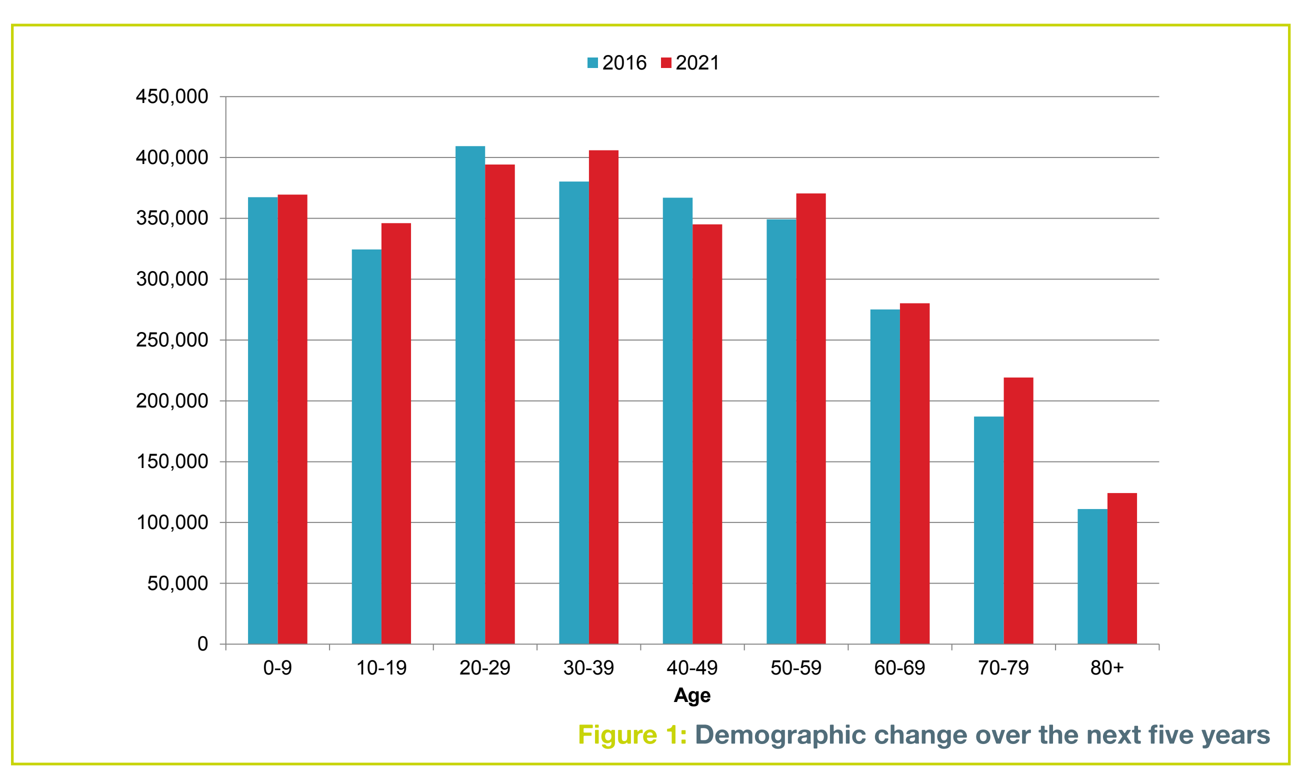


Figure 1: Demographic change over the next five years

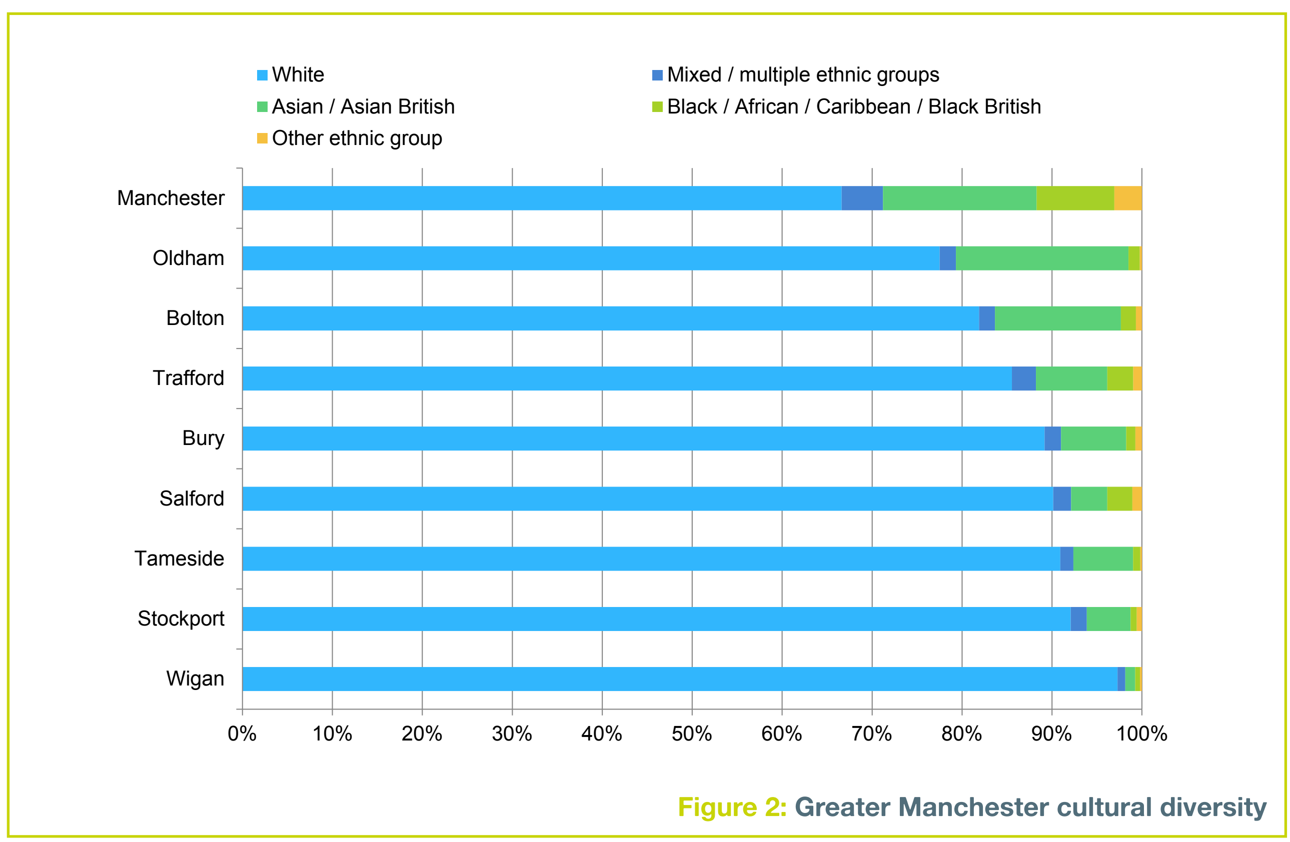


Figure 2: Greater Manchester cultural diversity

1.3.2 Life expectancy and deprivation

Around 680,000 Greater Manchester people live in areas that fall into the 10% most disadvantaged areas in the country, and three local clinical commissioning groups (CCGs) are in the bottom 10 nationally for healthy life expectancy at birth.

Life expectancy varies between local authorities, but also within them. Published figures for the 2009-2013 period show that there is considerable variation between relatively small areas (middle super output areas or MSOAs) within each local authority. The MSOAs with the highest and lowest life expectancies within each local authority are shown in figure 3.

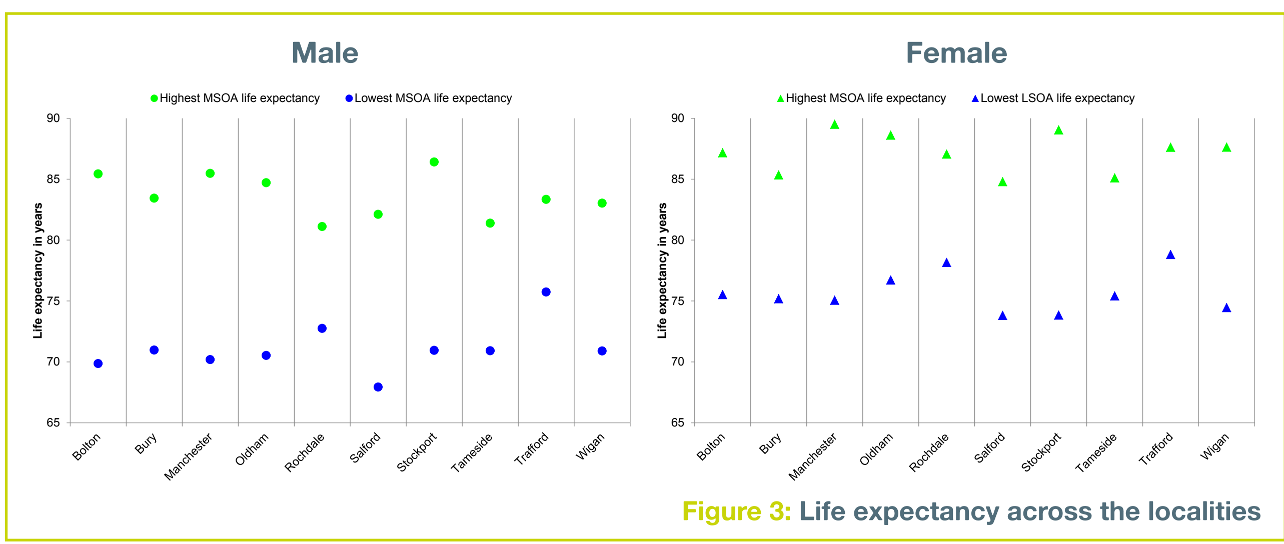
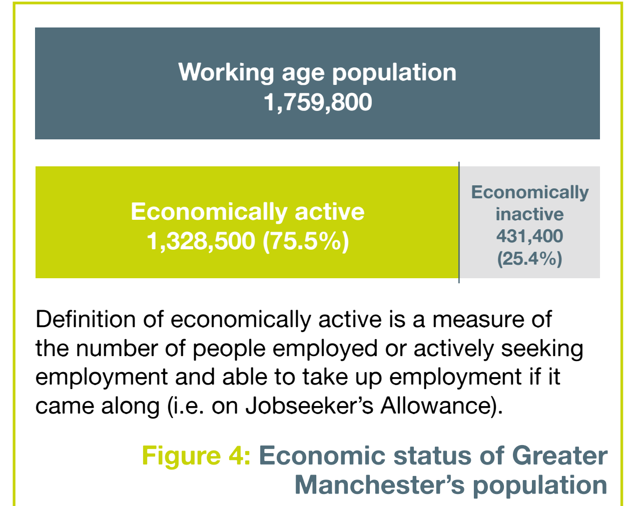


Figure 3: Life expectancy across the localities

1.3.3 Work and health

The benefits of work for your overall health and wellbeing are well understood; being in good work is beneficial for your health. The economic status of Greater Manchester's working age population is shown right.

Disability and long-term health conditions are not a total bar to employment, but the working age population who have health conditions or illnesses lasting more than 12 months are less likely to be in employment than the total working age population. And employment rates are lower in Greater Manchester than across England. In Greater Manchester, 70.5% of the total working age population are in employment compared with 74% across England; similarly, 59.2% of those who have a health condition or illness lasting more than 12 months are in employment compared with 65.3% across England (Active People Survey, July 2015 to June 2016).



Definition of economically active is a measure of the number of people employed or actively seeking employment and able to take up employment if it came along (i.e. on Jobseeker's Allowance).

Figure 4: Economic status of Greater Manchester's population

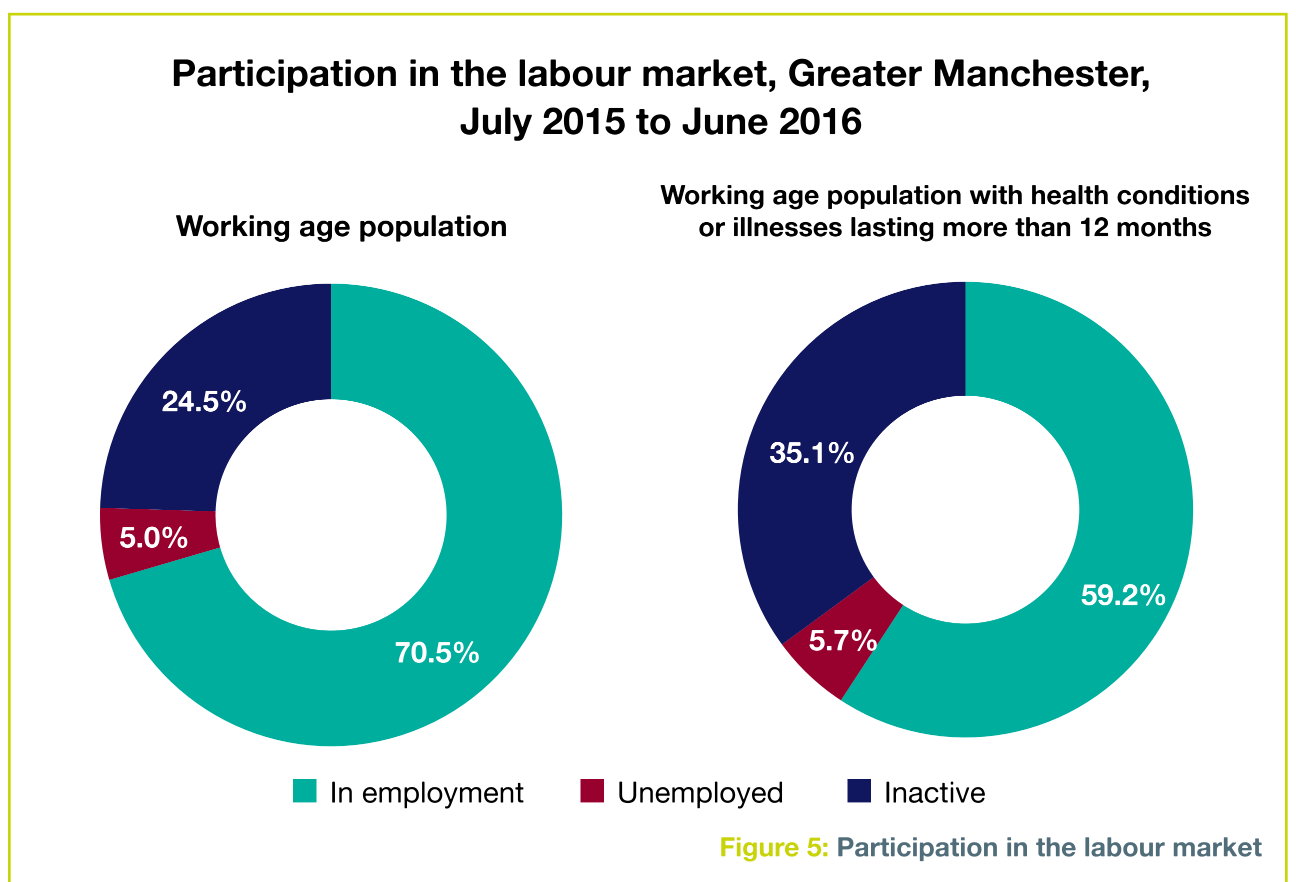


Figure 5: Participation in the labour market

1.3.4 Over the life stages

One in five adults in Greater Manchester smokes. Smoking prevalence in 2015 ranged from **15.1**% in Stockport to **22.7%** in Manchester. In **50%** of Greater Manchester local authorities, smoking prevalence is significantly higher than the England average of **16.9%.**

Across almost all standard published measures of alcohol harm, including alcohol-related mortality and alcohol-related hospital admissions, Greater Manchester local authorities have significantly worse figures than the respective England averages.

Smoking prevalence in routine and manual occupations is higher than across the general population, and across Greater Manchester it varies from **24.4%** in Wigan to **36.3%** in Oldham. In Rochdale, Bolton and Oldham prevalence is significantly higher than the England average of **26.5%.**

35.5% of Greater Manchester children have dental decay, with an average of **1.41** filled, decayed or missing baby teeth in children.

The proportion of adults who are physically active varies from **45.0%** in Oldham to **57.7%** in Stockport, compared with the England average of **57.0%.**

In 2016, **one in three** children in Greater Manchester (over 12,700 children) did not achieve a good level of development by the end of Reception.

Around **two-thirds** of adults in Greater Manchester are overweight or obese. The proportion varies from **61.5%** in Manchester to **69.7%** in Rochdale, compared with **64.8%** across England.

9.8% of adults in Greater Manchester reported they had a long-term condition or disability that limited their day-to-day activities a lot, and a further **9.5%** said that their day-to-day activities were limited a little, compared to England averages of **8.3%** and **9.3%** respectively.

In 2015, **4.6%** of the over-65s in Greater Manchester were recorded as having dementia. The England value is **4.3%.**

1.4 Mental health and wellbeing

The importance of mental health and wellbeing is a recurring theme of our plan and we want to draw this out explicitly from the start. More than anything else, mental health and wellbeing is recognised by local people as fundamental to all our lives and to the communities where we live. It underpins everything we do, how we think, feel, act and behave. It is an essential and precious individual, family, community and business resource that needs to be protected and enhanced.

Wellbeing is about lives going well, the combination of feeling good and functioning effectively. It includes the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence, empathy and affection, the development of one's potential, having some control over one's life, having a sense of purpose (e.g. working towards valued goals), and experiencing positive relationships.

Mental health and wellbeing is a key cross-cutting priority of the Greater Manchester strategic plan, 'Taking charge of our health and social care in Greater Manchester' ('Taking Charge'). The Greater Manchester Mental Health and Wellbeing Strategy focuses on early intervention and prevention, supporting people in communities and improving access to services. It takes a 'whole system' view of how to address mental health and wellbeing and in doing so ensures we all have a role to play in transforming outcomes and the wellbeing of local people.

Aligned to this whole system approach, the principles and priorities of the Greater Manchester Mental Health and Wellbeing Strategy are embedded through every section of this plan, recognising that poor mental health cannot be tackled in isolation. The Early Years integrated new model of care supports secure attachment between parent and infant, preventing future problems; the work and health programme supports more people into work recognising the importance of good work to health; the person and community-centred approaches build self-efficacy and resilience, basic building blocks for good wellbeing; and the digital platform to support behaviour change is built on the promotion of self-efficacy and self-care using nationally recognised patient activation measures.

Improving child and adult mental health, narrowing the gap in life expectancy for people with mental health conditions and ensuring parity of esteem for people with mental health conditions are fundamental to unlocking the power and potential of Greater Manchester communities. Shifting the focus of care to prevention, early intervention and resilience and delivering a sustainable mental health system requires simplified and strengthened leadership and accountability across the whole system. Enabling resilient communities, engaging inclusive employers and working in partnership with the third sector will transform the mental health of Greater Manchester residents.

1.5 Taking charge of our outcomes

We've turned our ambition of achieving the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people into a set of high-level outcomes that are supported by all 37 organisations in GMHSC Partnership.

What do we want to achieve?	How will we know if we've succeeded?
START WELL	
More Greater Manchester children will reach a good level of development (GLD) cognitively, socially and emotionally.	Improving levels of school readiness to projected England rates will result in 3,250 more children starting school ready to learn, and ultimately better educational attainment by 2021.
Fewer Greater Manchester babies will have a low birth weight, resulting in better outcomes for the baby and less cost to the health system.	Reducing the number of low birth weight babies in Greater Manchester to projected England rates will result in 270 fewer very small babies (under 2,500g) by 2021.
LIVE WELL	
More Greater Manchester families will be economically active and family incomes will increase.	Raising the number of parents in good work to the projected England average will result in 16,000 fewer Greater Manchester children living in poverty by 2021.
Fewer people will die early from cardiovascular disease (CVD).	Improving premature mortality from CVD to the projected England average will result in 600 fewer deaths by 2021.
Fewer people will die early from cancer.	Improving premature mortality from cancer to the projected England average will result in 1,300 fewer deaths by 2021.
Fewer people will die early from respiratory disease.	Improving premature mortality from respiratory disease to the projected England average will result in 580 fewer deaths by 2021.
AGE WELL	
More people will be supported to stay well and live at home for as long as possible.	Reducing the number of people over 65 admitted to hospital due to falls to the projected England average will result in 2,750 fewer serious falls.

Table 1: Life course strategic aims

Work is ongoing to develop a set of sub-indicators that will enable us to monitor progress against these high-level outcomes.

1.5.1 Place-based integration and locality working

The ambitions within the 'Taking Charge' health and social care plan are reflected in the work that is already underway to transform and integrate health and social care services in each of the 10 Greater Manchester boroughs. This thinking dates back to 2013 when the Government issued a national commitment to providing jointly delivered and co-ordinated health and community care services, with the explicit aim of improving

the experience of patients, service users, their families and carers. In practice, this means that social workers, district nurses and GP practices – and in some cases wider therapy services and the voluntary sector – will work as a single team to co-ordinate their efforts to support an individual and their family to recover from ill health and maintain independent living.

Some examples of how this should improve people's experience of health and social care include the following.

- People will tell their story once, including the role of any informal family carers, and a 'key worker' will be responsible for co-ordinating the support needed.
- Medical, social and emotional needs will be identified in one process, leading to more timely and appropriate support from the people or services that are best placed to help.
- Hospital discharge will be better co-ordinated from hospital to home, supporting more effective and rounded recovery, including emotional wellbeing and adapting to being back in the home environment.

In Greater Manchester there are a number of boroughs that are moving quickly towards formalising these arrangements by creating new organisations called locality care organisations (LCOs), which means that public sector health and care workers will be employed by one organisation and led by one management team, which will be responsible for community care provision in that borough.

This goes beyond the traditional models of health and care we see now, and will allow people and their carers to take more control over their own health and be more easily connected into existing voluntary and community support and to wider public sector services such as housing, employment, schools and the fire and police services. A 'place' or neighbourhood approach recognises that our health, mental wellbeing and ability to live independently starts with living well day to day, supported by our families and wider community. The basic premise is that if people are supported to live well in their community, connected to family, friends and activities in an environment in which they feel safe and included, they are more likely to sustain a good quality of life and less likely to see a deterioration in their health and independence.

In Greater Manchester we are therefore positively extending the original concept of integrated health and social care to recognise the important role of family, community and place in promoting the health and wellbeing of our population.

1.6 Primary care

High-quality primary care services – general medicine, general dentistry, pharmacy and optometry – have always had an essential role in supporting population health. In many instances, contact with these professionals is a natural opportunity to identify wider health issues or worries and intervene positively at an early stage. Many prevention services such as immunisation and screening programmes are already delivered through GP practices nationwide e.g. flu immunisation, cancer screening. Some health conditions such as diabetes, high blood pressure and cancer can be picked up early through regular eye or dental checks, while the advice and support of pharmacists can help people to self-care or better manage the medicine they need to take to stay well.

However, primary care leaders in Greater Manchester want to embed 'proactive, person-centred' prevention and early intervention practice consistently in how they plan and deliver their services, which should lead to fewer people needing planned or emergency health and social care. The primary care strategy identifies some great examples of best practice in this area and

highlights how they will scale up this work across their 2,000 points of delivery, such as the commitment to roll out the Healthy Living Framework* across all pharmacy, optical and dental practices by April 2018.

Primary care is at the heart of Greater Manchester's new integrated community care and the ambition for primary care mirrors the principles described in the previous section about the importance of place and community and the broad range of factors that influence good health, including the impact of inequality on health and wellbeing. Taken together, this is sometimes described as primary care adopting a 'more than medicine' approach i.e. recognising the non-clinical support that gives people the confidence to improve their health and wellbeing. This will mean:

- enabling different consultations, including health coaching and shared decision making
- expanding the primary care workforce to include health trainers and neighbourhood and community connectors to provide support to people in the community
- connecting people to non-clinical support (community assets). This would include exploring opportunities for social prescribing in primary care to refer patients to 'cook and eat' sessions or housing energy and efficiency measures.

1.7 Acute and specialist healthcare

There are thousands of contacts with acute care and specialist care services in Greater Manchester, and hence many opportunities for primary and secondary prevention interventions to support improving the population's health. Standardising acute and specialist care is one of the themes of the Greater Manchester health and social care reform programme. This offers some transformational opportunities to support population health improvements and reduce health and care service demand in the short to medium term. The development of consistent and best practice specifications, which include prevention activities, will help reduce variation in care, and through the development of the Health Education England programme: Making Every Contact Count initiatives, evidence-based interventions can be delivered to people at a time they are receptive. Examples of such interventions include: smoking (implementing consistently the National Institute for Health and Care Excellence guidance on smoking harm reduction and including smoking interventions in mental health and maternity services); alcohol (brief advice and care teams); and cardiovascular disease (preventing strokes in people with atrial fibrillation).

The scaling up of such interventions across different organisations will maximise the impact and benefits for Greater Manchester and support work being undertaken across the wider system in primary care and neighbourhoods and communities.

1.8 Our Greater Manchester priorities

We know that poor health and disadvantage are inextricably linked and that disadvantage starts before birth and accumulates throughout life. We have therefore structured our programme using the Start Well, Live Well, Age Well approach. Furthermore, we want to bring to life our conviction that connected and empowered communities are healthy communities with some programmes that cross the age range. And finally we need to adapt and change our systems to fit our population health ambitions. Putting all that together, we developed five work programmes, which we have tested extensively with the Greater Manchester system.

1. Person and community-centred approaches

The capabilities of the public are extraordinary. They understand communities'

needs and can identify solutions because they are those communities; they are experts by experience. Their support is vital to developing a sustainable healthcare system and culture that delivers for all.

Person and community-centred approaches mean putting the comprehensive needs of people and communities, not only diseases, at the centre of health systems, and empowering people to have a more active role in their own health. We aim to put people and communities at the heart of what we do, concentrating on what is most important to them, what skills and attributes they have to offer, and what strengths exist naturally in the people and places we serve.

The VCSE sector will play a central role in the leadership and delivery of this work programme, which aims to develop an infrastructure across Greater Manchester to reliably and consistently deliver social models of support to enable people to live better. The programme includes:

- developing the capacity and capability across Greater Manchester to support the embedding of person and community-centred approaches into the reform of the system
- developing a Greater Manchester framework for action that provides a consistency of approach but also allows flexibility to respond to local needs
- developing an exemplar social movement focused on cancer prevention.

2. Start Well

Building on the principles of early intervention and prevention, the aim of the Start Well programme is to deliver integrated early intervention and prevention services for children across all localities in Greater Manchester. We know that disadvantage starts before birth and accumulates throughout life, so we have developed a new care model for early years that focuses on action in pregnancy and the earliest years of life to give us the best opportunity to successfully reduce health, educational and social inequalities. By establishing a framework for the delivery of appropriate services at the right time, we will support children and families to become healthier, resilient and empowered.

Our Early Years new delivery model is based on universal and targeted services, using evidence-based assessments to identify and intervene effectively to avoid or minimise escalation of need. In addition, this Start Well population health programme is focused on two key drivers of poor Early Years outcomes and inequality i.e. smoking in pregnancy and poor oral health where scaling up evidence-based interventions at Greater Manchester level could enable rapid improvements in health outcomes and deliver economies of scale.

Another recognised area for intervention is our desire to focus on the health challenges for children and young people aged 5-25 years, with mental health and wellbeing a specific focus for this population group. This area of work will be developed further in the next stage of the plan under a Developing Well theme.

3. Live Well

This programme focuses primarily on the opportunities to improve the health of Greater Manchester residents in mid-adulthood, taking into account the pressures and priorities upon this large working age population. Live Well recognises that good work is an essential prerequisite of health, wellbeing and socio-economic outcomes. The wealth of evidence to support employment as a route to achieving good health and mental wellbeing, and the relevance of good levels of health in retaining stable and meaningful employment, makes the work and health proposal a critical component within our population health plan.

Alongside the influence of meaningful

work on the mental and physical health of individuals and families, we also recognise the undermining impact of poverty and socio-economic deprivation on health and emotional wellbeing. These inequalities can range from greater prevalence of unhealthy lifestyle choices to poorer access to health and care services, all of which have a negative impact on health and wellbeing outcomes, leading to shorter life and healthy life expectancy. Our proposal to create a new model of primary care for deprived communities seeks to give health practitioners the time and capacity to offer greater continuity of care and target their service towards medical needs more effectively, but also to connect individuals to the wider support services in their community that could help make a difference to their lives. This will include a focus on some of our most vulnerable groups, including the traveller communities, homeless people, offenders, and asylum seekers and refugees.

Lifestyle and health behaviour presents one of the biggest challenges to good health and wellbeing in adulthood and the accumulated effects of those choices contribute significantly to the ill health experienced in later life as we age. Our population continues to suffer higher than national instances of heart disease, diabetes and other lifestyle-related illnesses. An important component of our Live Well strategy is therefore to find new and innovative methods to stimulate and incentivise healthier behaviours in adulthood. However, achieving population-scale changes in behaviour, which have often become normalised over many years, can be difficult to achieve quickly and needs different approaches. The programme will therefore utilise the natural opportunities in adulthood and new thinking to stimulate 'whole system' approaches to smoking, alcohol, physical activity and obesity.

In addition, we will develop digital platforms for lifestyle and wellness to support individual behaviour change, and we are working with localities to develop a set of standards for integrated local wellbeing services for those people who need a bit more support.

The final elements of the Live Well programme focus on addressing two conditions where early identification and treatment can have a very positive impact on quality of life, health outcomes and life expectancy. These are HIV and cancer. The link between lifestyle risk factors and cancer is also very well documented, and there is a clear opportunity to make the link between lifestyle and reduced cancer risk in later life.

4. Age Well

Greater Manchester is leading the way in its efforts to promote healthy ageing, creating a vision for a society where older age is seen positively and people in later life are empowered to secure a healthy future and good quality of life for themselves. Our specific Age Well proposals aim to support people to maintain good health, wellbeing and independence for as long as possible and the programme focuses on interventions that, when delivered consistently and effectively at scale, will enable this to happen.

Evidence shows that improving the quality and suitability of the home environment can be effective in preventing and reducing demand for health and social care. Equally, enabling people to manage their health and care needs can allow them to remain in their own homes for longer. Creating a home environment that supports people's independence – which is often incredibly important for older people – and remains connected to their local community, friends and family, also has a positive effect on emotional wellbeing and can reduce the risk of social isolation.

We acknowledge that suitable housing actually benefits all people at every stage of their life course; however, our evidence to date has found that interventions directed towards the older population can return particular benefits.

Malnutrition and dehydration are estimated to be very prevalent in the older population but are often hidden or unnoticed. Left unchecked, they can undermine mobility, steadiness (leading to falls), healing and recovery, mental alertness and energy levels. Outcomes are therefore much worse for older people who are malnourished and the same is true of dehydration. The Age Well programme is therefore focusing on this issue and will work with Greater Manchester boroughs to implement community-level, locally led programmes of support to improve awareness and understanding of the impact of malnutrition and dehydration.

Falls are a commonly recognised problem in older age that requires a system response to manage and address effectively, but this is also an area where there is a lot of independent evidence of what works. Fracture liaison services, which identify people at risk of injurious fracture and then co-ordinate services and appropriate care for the individual, are well evidenced and cost effective and are included in the programme for that reason.

5. System reform for population health

It is clear that an ambition of this magnitude around the delivery of the Greater Manchester Population Health Plan requires the support of a population health system that is organised to deliver at pace and scale.

We therefore need to build a single population health system across the Greater Manchester economy – one that maximises both the impact and the capacities of a small and specialist public health workforce, but also supports the embedding of the pursuit of population health as being everybody's business and sees collaboration across a range of sectors and wider communities – between NHS organisations, local authorities, the third sector and other local partners, as well as patients and the public working together as population health systems.

Greater Manchester therefore has the chance to take a co-designed approach to radically reframe the role of population health in the context of a devolved system, creating a unified population health system across 10 localities that is better able to achieve improved health outcomes for the people of Greater Manchester.

In addition to creating a unified leadership system for population health, we need to create a unified approach to commissioning population health that enables us to commission services at the right spatial level, in collaboration with one another, and to improve population health outcomes and health inequalities as well as contributing to a more sustainable public health, health and care system.

We have a number of programmes of work underway to do this, namely:

- the development of a population health commissioning plan that brings together the NHS England commissioning responsibilities set out in Section 7a of the Health and Social Care Act 2012, together with local government-commissioned population health services and the new service models set out in this plan
- the development and testing of a proposal for a new Greater Manchester population health leadership system serving localities, CCGs and Greater Manchester structures that is future-proof and financially sustainable
- reviewing how public sector spend can produce a wider benefit to the community i.e. the social value benefit to the people of Greater Manchester from public sector commissioning and procurement and maximising the contribution made by the VCSE sector.

1.9 Our 'whole system' approach to population health

Figure 6 sets out our 'whole system' approach to population health, recognising the central importance and contribution of a healthy and thriving population to economic growth and prosperity, and, equally, the contribution of economic growth to a healthy population. Our aim is to ensure we have a mutually reinforcing cycle between our growth and health ambitions across all our Greater Manchester plans.

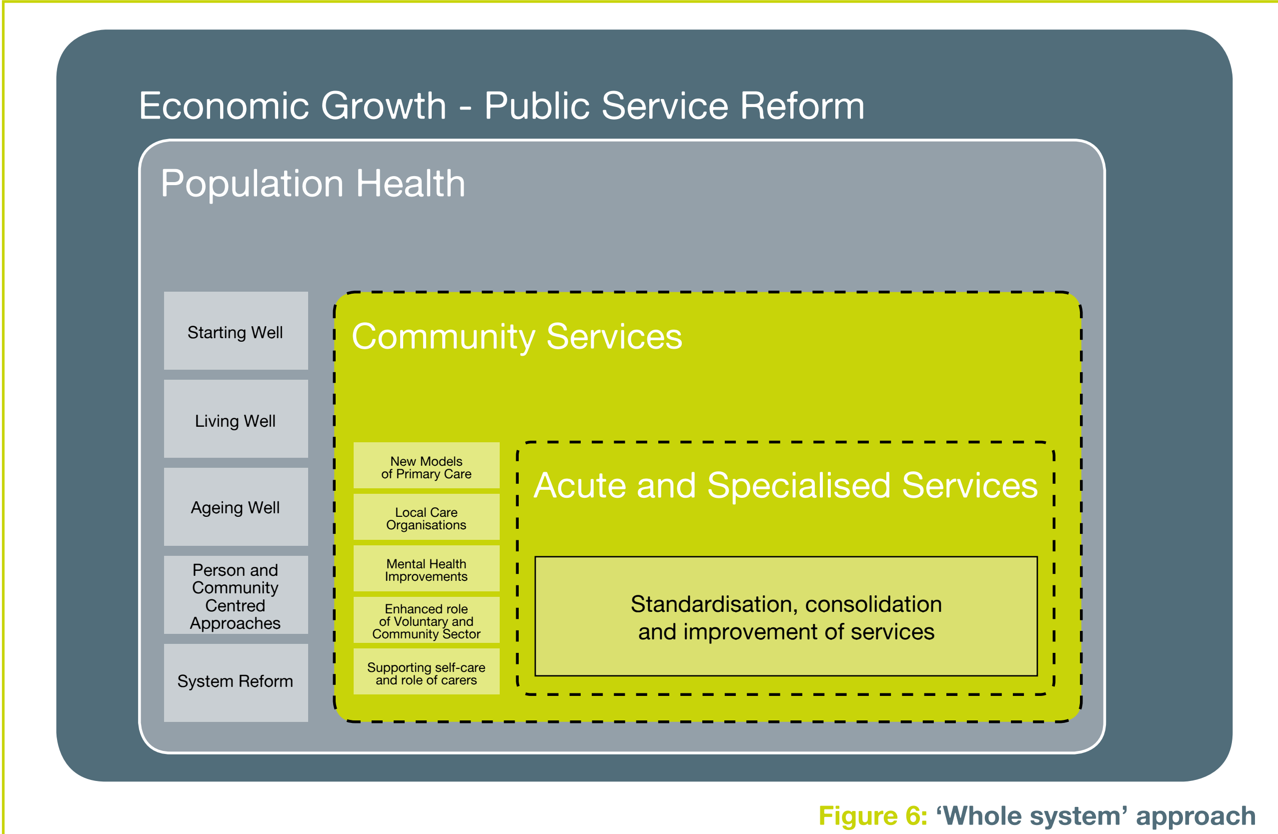


Figure 6: 'Whole system' approach

During 2016 we have:

- swiftly set out our five transformation work programmes – person and community-centred approaches; Start Well; Live Well; Age Well; and system reform
- developed a set of proposals, which we will deliver with the system
- developed programme governance to support decision making and delivery
- aligned our programme to other transformation work that forms 'Taking Charge'
- built cohesion across the wider public service reform programmes, ensuring decisions we take together are cognisant of broader activity across our system
- taken a collaborative view on the outcomes we are seeking to achieve across Greater Manchester, ensuring all the work we do is focused on supporting the achievement of the Greater Manchester strategic outcomes that will improve the life chances of people in Greater Manchester.

The remainder of this document provides a comprehensive delivery plan for those programmes of work to be led by GMHSC Partnership and, where appropriate, signposts to other Greater Manchester-led pieces of work contributing to population health.

This plan was constructed by looking at…

1	**Taking Charge Together consultation**	Findings from consultation with 50,000 Greater Manchester residents about how they might better take charge of their own health
2	**Quick Wins**	Opportunities to implement evidence-based local best practice at scale across other parts of Greater Manchester
3	**Common themes in locality plans**	An audit earlier this year of locality plans highlighted areas for standardised approaches across Greater Manchester
4	**Economics of prevention**	The 'economics of prevention' work was developed by New Economy Manchester and Public Health England on groups' interventions by their gestation or notional rate of return in order to recognise that dividends for different interventions are likely to be realised over different time periods
5	**Work already underway**	Work already underway which now aligns with the population health themes and programme.

All principles **underpinned by the evidence base** where possible

or

utilising innovation to test new approaches to service delivery

Figure 7: 'Whole system' approach

2. Person and community-centred approaches

Patients, peers and communities represent a huge resource. Whether in terms of effective behaviour change at scale, high-quality volunteering, informal networks of care, impactful models of voluntary sector practice or growing social enterprises, there is a significant opportunity within Greater Manchester to support people living with long-term conditions, prevent ill health and reduce costs.

Our starting point is that health and care services need to work alongside individuals, carers, families, social networks and thriving communities. This means working in ways that are 'person and community-centred' – in other words, approaches that put people and communities at the heart of their health and wellbeing.

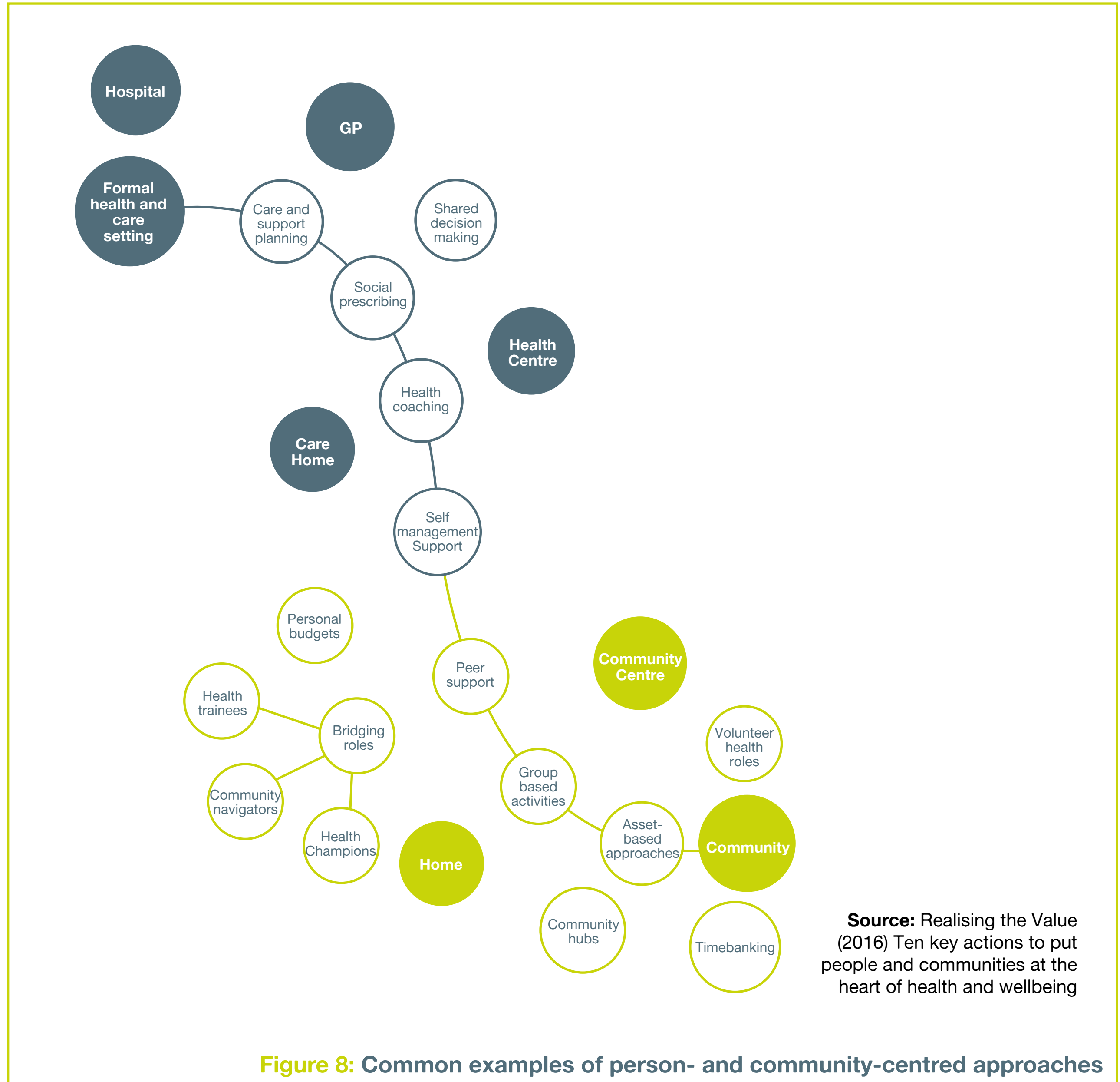
We want our health and care system to support people to have the knowledge, skills and confidence to play an active role in managing their own health and to work with communities and their assets. For this vision to become reality, person and community-centred ways of working need to become widely understood and valued as core to the whole health and care system, not just 'nice to have'. This requires systematic change in the way people access, interact with and experience health and care services, and wider support.

2.1 Background

The NHS Five Year Forward View sets out how the health service needs to change, and argues for a more engaged relationship between health and care services and patients, carers and citizens. NHS England funded the Realising the Value programme, an 18-month programme led by innovation charities Nesta and The Health Foundation to support this vision. Realising the Value strengthened the case for change, identified evidence-based approaches that engage people in their own health and care, and developed tools to support implementation across the NHS and local communities. Two organisations based in Greater Manchester were involved in Realising the Value, and the findings and tools can be built on to deliver the ambitions set out in this Greater Manchester plan.

2.2 What are person and community-centred approaches?

Approaches that are person and community centred include a very broad range of practice, ranging from 'more than medicine' support that complements and enhances clinical care for people with long-term conditions (such as peer support) to everyday community activities that enable people to improve their health and wellbeing (such as a local football team or gardening club). Many of these activities can be enjoyed and engaged in by all citizens, whether or not they have health conditions. They can happen in formal health and care settings, people's own homes and in the wider community.



Source: Realising the Value (2016) Ten key actions to put people and communities at the heart of health and wellbeing

Figure 8: Common examples of person- and community-centred approaches

People can access person and community-centred approaches in a number of ways, such as the following.

- Personalised care and support planning: A systematic process in which people with long-term conditions and their carers work in partnership, very often with health and social care professionals, to identify their treatment, care and support needs.
- Personal budgets: Giving people control over how the money allocated for their health and care is spent.
- Social prescribing: People can receive a 'social prescription' as a way to connect to services and groups outside of formal health or social care.
- Bridging roles, such as health trainers and community navigators: Roles undertaken

by people, often drawn from the local community, who work with individuals to connect them with local services and help them to navigate these services.

Although wide-ranging and varied, these approaches are all focused on genuinely putting people and communities at the heart of health. And for years there has been sustained work by many to work in this way. There is now strong enthusiasm for this to become the norm across health and care, rather than the experience of the few. And there is a growing – and increasingly convincing – body of evidence from research and practice that these approaches lead to better outcomes and significant benefits for individuals, services and communities.

2.3 The case for investment

There is a strong moral and ethical case for person and community-centred approaches for health and wellbeing: put simply, it is the right thing to do. It enables people to have a voice, to be heard, to be connected and to have the opportunity to choose how best to live their lives, and gives them the support to do so.

The other key rationale for these approaches is that they 'work'. They can lead to significant benefits for individuals, services and communities. They can improve individuals' health and wellbeing and reduce demand on formal services such as unplanned hospital admissions, and they can also contribute to wider social outcomes such as employment and school attendance.

There is a clear financial imperative to embed these changes into the fabric of Greater Manchester.

In 2013, Nesta's 'Business Case for People Powered Health' calculated that the NHS could realise savings of at least £4.4 billion a year if it adopted self-care innovations that involve patients, their families and communities more directly in the management of their long-term conditions. These savings represent a 7% reduction in A&E attendance, planned and unplanned admissions, and outpatient attendances.

More recently, the Realising the Value programme has undertaken economic modelling that suggests that implementing person and community-centred approaches at scale has the potential to contribute to efforts to slow the demand pressures on the system. Realising the Value used this economic modelling to develop a tool for commissioners, to assess the potential impact of commissioning person and community-centred approaches in a local area. This will help localities within Greater Manchester that want to commission these approaches to build their business case for doing so.

2.4 Approaches that are asset-based

The family of person and community-centred approaches described above are all asset-based, or strengths-based. This means they have a different starting point to traditional health and care services. Fundamentally, they ask the question 'what makes us healthy?' rather than 'what makes us ill?'

Person and community-centred approaches focus on what is important to people, what skills and attributes they have, the role of their family, friends and communities and, given all this, what they need to enable them to live as well as possible. This includes enabling people to:

- look after themselves better, including understanding their condition, managing their symptoms and improving their diet, and education tailored to particular conditions
- have meaningful relationships that help them improve their health and wellbeing through, for example, peer support networks and community groups
- work collaboratively with professionals, such as collaborative consultations and health coaching.

Source: At the heart of health; Realising the Value of people and communities (Nesta, 2016)

Figure 9: What defines this way of working

While our health and care system is getting better at drawing on the strengths and assets of individuals and communities to improve and maintain good health, we know that there is still some progress to be made.

We all have a role in making this happen – including community-based and voluntary organisations, faith communities and social enterprises. Many faith-based groups have long-established traditions of providing social, emotional and spiritual support that can be an important part of health and wellbeing, and we are committed to working closely with these groups. Social enterprises play a role in incubating new ideas in health and wellbeing, and in some cases work with people to build their confidence and capability to get back into work.

2.4.1 Co-production, volunteering and social movements for health

The only way to understand and support what matters to people and communities is to work with them, in a variety of ways.

- **Carers.** We need to recognise and value the role of carers, who are a huge asset and resource; by supporting the lives of the people they care for, they sustain and support the wider health and care system.
- **Volunteers.** Volunteers are an increasingly important part of the health and care workforce and there is evidence that high-quality, well-supported volunteering can benefit patients and health and care services, as well as having reciprocal benefits for people who volunteer.

- **Co-production.** The most successful examples of person and community-centred approaches in practice are those developed by people and communities, working with and alongside commissioners and policymakers, to co-design and co-deliver solutions that work. Support and training is needed to support good co-production.
- **Social movements.** Social movements happen when people come together to fight for their rights, solve problems, shift how people think, support each other and demand what they need. There are incredible stories in health of the power of passionate people working together to drive change. For example, over the last few decades the disability rights movement and HIV/AIDS campaigns have challenged social attitudes and have transformed the way the health system responds to these issues. The breast cancer movement has addressed the deep cultural stigma associated with the disease, given women the words to explain their experiences, and changed the culture of care. The value of people getting involved in social movements in this way was recognised in the NHS Five Year Forward View.

2.5 Greater Manchester context

We want to enable more people to take control of their own health and wellbeing, and to help others within their communities to do the same. In 'Taking Charge', we set out our view that changing the relationship between people and public services is vital if we are to enable people to prevent and manage long-term health conditions, maintain their independence, improve their health and wellbeing and, in doing so, live happier and healthier lives while also reducing demand on services.

We know the following.

- Over 560,000 people (30%) of adults in Greater Manchester have one or more long-term condition, and this number is increasing. People within this cohort are often frequent users of health services, accounting for 50% of all GP appointments and 70% of all inpatient bed days.
- Around 70-80% of all people with long-term conditions would benefit from support to manage their condition(s).
- While we often provide great care, at times we focus on people's problems rather than looking to their capabilities and resources.
- Too many people are going into residential and nursing care, particularly from hospital, in part because of a lack of clear and planned alternatives.
- Earlier, community and family-based support could help people to maintain and improve their health and wellbeing.

Greater Manchester has a rich history of working in these areas and has many examples of best practice that could be drawn on, such as those below.

2.5.1 The Wigan Deal

The Wigan Deal has been successful in taking forward a community-centred approach. Driven by the critical need to find fiscal savings, Wigan proposed 'The Deal' with its residents and businesses, creating an informal agreement that through cooperation has addressed the financial pressures while improving resident collaboration and engagement in the use and delivery of services.

2.5.2 People Powered Health in Stockport

Stockport has demonstrated the potential of mobilising communities to help deliver care over a number of years, embarking on an ambitious programme as a selected vanguard site to include social action at the core of the developing new care model. The Stockport approach has four core strands.

- Workforce and organisational culture: Adopting person-centred practice within a strengths-based approach, working with people and communities to co-design solutions to meet rising demand.
- Develop place-based health and community networks of support: Bridging the health and care service model to the communities in which people live to grow more resilient communities with access to targeted prevention.
- Promote social action/health as a social movement: Recognise and include the resource of the people both within and outside of the system as part of the solution.
- Commission differently: Alignment and collaboration over cost and competition as primary drivers.

Stockport is a national exemplar in this area, particularly in terms of being a model of social action led 'from the inside' – from commissioning teams themselves. Stockport is currently working to spread the learning from its approach more widely.

2.5.3 Health as a Social Movement

NHS England's Health as a Social Movement programme aims to support social movements in health and care, and is currently working with six new care model vanguards, two of which are in Greater Manchester:

Stockport Together (multispecialty community provider), which aims to support social movements in Stockport, Oldham and Tameside boroughs and across Greater Manchester, building on the People Powered Health programme to 'hard-wire' social action into a transformed health and care system

The Greater Manchester Cancer Vanguard, which will apply at scale a multi-faceted approach to nurture a social movement across the entire cancer prevention spectrum that is ultimately self- sustaining.

2.5.4 Realising the Value

Realising the Value was a programme funded by NHS England to enable the health and care system to support people to have the knowledge, skills and confidence to play an active role in managing their own health and to work with communities and their assets. At the heart of the programme were five sites that exemplify the best of approaches of this kind. Two of these sites were in Greater Manchester:

- Unlimited Potential with Inspiring Communities Together: Unlimited Potential works to deliver, with local people, a range of asset-based approaches in a health and wellbeing context in Salford, such as 'Salford Dadz' – finding new ways to improve the wellbeing of fathers experiencing severe and multiple disadvantages
- Big Life Group with Being Well Salford: Big Life delivers health coaching to anyone who wishes to make changes to two or more of their lifestyle behaviours; this includes low mood, isolation and anxiety.

2.5.5 People Powered Results and Elective Care Rapid Testing (ECRT) programme

NHS England and Stockport Together worked with Nesta on a 100-day innovation programme to improve elective care. The programme aimed to test ways of improving patient experience of, and speeding up access to, elective care, by better managing demand. Challenge focus areas included gastroenterology, cardiology and respiratory, and orthopaedics. Teams were made up of representatives from across the health and care system, including GPs, consultants, nurses, VCSE representatives, mental health professionals and representatives from the council and social care.

2.5.6 Arts, health and social action

Greater Manchester has a long history of interest and action in arts and health. Engaging in arts activity can help people to make social connections, enable self-expression, create the conditions for social action and enable people to have more power over their lives. We intend to position the strong inter-relationship between arts and individual and community health as one of the key foundations of building sustainable and resilient communities across Greater Manchester. As part of the next iteration of the Greater Manchester Population Health Plan we are committed to further developing a programme of activity on arts in healthcare and social care, and in social action on wellbeing, and aim to embed this approach in commissioning of health and social care services and commissioning for wellbeing in Greater Manchester.

These activities are further strengthened with a well-developed, varied and diverse voluntary sector in each area and various Greater Manchester umbrella organisations.

Our challenge now is to make this form of engagement between the public and public services a common and defining feature across the whole of Greater Manchester.

2.6 Opportunity

The capabilities of the public are extraordinary; they understand communities' needs and can identify solutions because they are those communities; they are experts of experience. In Greater Manchester we recognise their support is 'mission critical' to developing a sustainable health and social care system and culture that delivers for all.

We want to work with our partners across the system, including the VCSE sector, to implement high-impact person and community-centred approaches at scale across Greater Manchester. Delivering this will require changes in: commissioning; organisational and clinical processes; workforce development; and the relationships between clinical professionals and the people and communities they serve.

Putting people and communities genuinely in control of their health and healthcare requires a shift away from a traditional biomedical model of health towards a model that takes into account the expertise and resources of people and their communities. In order for this shift to happen, we will need to support a cultural shift across the system and underpin this with a willingness to identify and 'unblock' system barriers and engage system levers at both a Greater Manchester-wide and a locality level.

By engaging differently with the people we serve, we can start to learn what resources, physical and social, are available to support this agenda. We can identify and better support grassroots initiatives through different commissioning processes. We can help to build links to better utilise available assets. And we can learn from carers, patients, families and volunteers what more we can do to support them to start, live and age well.

A further opportunity that GMHSC Partnership has begun to explore is the contribution of housing and the home environment to asset-based working and our people and place-based agenda. Evidence suggests that the right home environment can: improve health and wellbeing and prevent ill health; enable people to manage their health and care needs; and allow people to remain in their own homes for as long as they choose. This area of work will be developed more in our next iteration of the population health plan.

2.7 Plan

A radical upgrade in population health brings with it a need for radical action and solutions – one of which is, as we have described, to shape a new relationship with the people of Greater Manchester.

The VCSE sector will play a central role in the leadership and delivery of this project. We want to mobilise communities and networks to support people on their terms. This will complement medical care by developing an infrastructure to reliably and consistently deliver social models of support to enable people to live better.

The Public Health England (PHE) 2015 report 'A guide to community-centred approaches for health and wellbeing' emphasises that: "Community engagement is more likely to require a 'fit for purpose' rather than 'one size fits all' approach." This is crucial for how we deliver across Greater Manchester, recognising that the form and function of our plan must allow the local flexibility that responds to the specific characteristics of each local community.

2.7.1 Objectives

A number of objectives have been identified at a Greater Manchester level to support the development of person and community-centred approaches locally. These include:

- **Objective 1:** To help build capability and capacity within localities, recognising the need for a consistent approach while allowing sufficient flexibility for localisation
- **Objective 2:** To build a Greater Manchester framework for person and community-centred approaches
- **Objective 3:** To support a strong system leadership commitment to the approach
- **Objective 4:** To work as part of NHS England's Health as a Social Movement national exemplar programme to test and spread effective ways of mobilising people in social movements that improve health outcomes.

2.7.1.1 Approach to delivering objectives

Objective 1: To help build capability and capacity within localities, recognising the need for a consistent approach while allowing sufficient flexibility for localisation.

The project will seek to:

- identify a group of 'explorers/enablers' who can help to seek out the best practice and strengths to build capacity and sustainability from the start
- develop an offer for explorer roles to skill them to do this work
- bring together the organisational development community across health and social care in Greater Manchester to act as a network of supporters.
- provide tools and resources to assist places to understand the conditions for success and assess readiness
- build a menu of development programmes and tools to support shared decision making, strength-based conversations, quality improvement, team coaching and consultancy support, which support systems to understand which approaches are likely to be most effective and in what circumstances
- build place-based support teams and a network of skilled facilitators/enablers to support places
- develop system capacity through approaches such as 'skills pools' and 'time banks'.

Objective 2: To build a Greater Manchester framework for person and community-centred approaches.

This project will seek to:

- map and capture existing practice on asset-based approaches across Greater Manchester
- bring together the 10 localities across Greater Manchester to share best practice within a system-wide learning event
- define key principles to develop a Greater Manchester framework for action that describes consistency of approach, including evaluation
- develop a platform to enable localities and local and national partners to connect with Greater Manchester against an

agreed framework that provides some consistency of approach
- gain agreement from the system to adopt and implement the framework
- launch the framework to cement support across the system for this way of working with people and communities
- from the evidence, identify existing and exemplar communities that offer the potential to invest and build a network of best practice
- develop a network of delivery leads with third sector partners to test and spread innovative solutions.

Objective 3: To ensure a strong system leadership commitment to the approach.

This project will seek to:

- work with the VCSE sector in Greater Manchester to co-produce the leadership model for this work
- work with system leaders to sign up to a statement of commitment to demonstrate strong support to self-care/person and community-centred approaches
- work with system leaders to develop a road map to delivery that will feed into the framework for action
- connect with work underway through the Greater Manchester leadership framework, the nine leadership expectations and the wider Greater Manchester workforce, enabling work to inform the development of the existing and future workforce.

Objective 4: To work as part of NHS England's Health as a Social Movement national exemplar programme to develop, test and spread effective ways of mobilising people in social movements that improve health outcomes.

To develop a network of 20,000 cancer champions by August 2019.

- Work in partnership with the third sector to develop an exemplar social movement, focused on cancer prevention.
- Apply at scale a multi-faceted approach to nurture a citizen-led social movement across the entire cancer prevention spectrum.
- Develop a network of 20,000 cancer champions and expert patients to provide a 'more than medicine' approach.
- Demonstrate 'what works' using rigorous evaluation approaches.
- Support spread by identifying approaches that could be scaled or adapted and adopted in other communities.

2.7.1.2 Target outcomes for 2016/17 and 2017/18

The programme will work towards achieving five key outcomes:

- **Outcome 1:** Localities have more local capability, appropriate for their needs and assets
- **Outcome 2:** A Greater Manchester framework for action agreed by system leaders to support local implementation, building on work already underway in each locality
- **Outcome 3:** An agreed roadmap for delivery with strong leadership commitment to deliver
- **Outcome 4:** The development of a mass social movement across the entire cancer prevention spectrum that is ultimately self-sustaining, to include an army of cancer champions networking across the conurbation, driving the cancer prevention agenda
- **Outcome 5:** Digital opportunities tested and evaluated

2.7.1.3 Programme of work – scope

This programme will work with system leaders from across Greater Manchester and partner organisations, including the VCSE sector, to influence and support ways of working at locality level. With an initial focus on asset-based approaches, it has the potential to develop and spread across wider reform and at all levels of the system.

The scope of the social movement work specifically includes all people of Greater Manchester, community groups, charities and volunteers linked to cancer-related activities. The project will also need to connect to Greater Manchester's broader communications work and the digital platform work linked to the proposed Greater Manchester Lifestyle Hub. Similarly, it has the potential to link to the wider Greater Manchester Cancer Vanguard prevention projects, including the lifestyle-based secondary prevention work, the large-scale social marketing project, and the enhanced screening offer for Greater Manchester residents.

3. Start Well

One of the most important foundations for building caring, productive and healthy families and communities is the nurturing of children in early life. In other words, helping children to get a better start is good for them and good for all of us. We are all instinctively motivated to care for and protect our children and promote their future wellbeing. This motivation is increased during pregnancy and when a child is most dependent in early life. However, sometimes this motivation can be missing or frustrated as a result of internal factors such as mental health problems or external factors such as poverty. We need to connect to the deep motivation of parents and provide extra support to parents when this is challenged.

The aim of the Start Well programme is to deliver integrated early intervention and prevention services across all localities in Greater Manchester. We know that disadvantage starts before birth and accumulates throughout life so we have developed a new care model for Early Years that focuses action in pregnancy and the earliest years of life to give us the best opportunity to successfully reduce health, educational and social inequalities. Greater Manchester is leading the way in efforts to prioritise Early Years with significant progress see across all 10 localities.

3.1 Background

It is much more difficult and costly to repair the damage done by child maltreatment in later life than to prevent it during the Early Years. It is estimated that 40% of public funds are currently being spent on problems that could have been prevented earlier. People who suffer adverse events in childhood achieve less educationally, earn less, and are less healthy, making it more likely that the generational cycle of inequality is repeated.

The Marmot Review report 'Fair society, healthy lives' (2010) recommended that 'giving every child the best start in life' was the highest priority to tackle health and social inequalities. In 2013, the WAVE Trust report, 'Conception to age two – the age of opportunity', agreed that the Early Years are the crucial phase of development and the time when early intervention will reap great dividends for society. The way in which we support very young children (0-2 years) shapes their lives and ultimately our society. These reports clearly identify the window of opportunity from pregnancy to age five that establishes the foundations for life, including physical and mental health, social and communication skills, behaviour and future academic success. Indeed, it is not an exaggeration to say that the prosperity of Greater Manchester is dependent on our ability to support the development of the very young much more effectively.

We know that investing in early education is vital to addressing the social gradient in children's positive early experiences. Studies have shown that, by age three, children from low-income families are exposed to an average of 30 million fewer words than children from the most affluent families. Children within affluent families also hear twice as many unique words and twice as many 'encouraging' as 'discouraging'

conversations. This work highlights the importance of integrating early education services and that later interventions, although important, are considerably less effective where good early foundations are lacking.

Early Years investment is proven to be the best route to overcoming intergenerational inequalities. Figure 10 illustrates the rates of return on investment for education and training over a person's working life. The earlier the investment is made, the higher the return on this investment.

A great deal of work has been undertaken in Greater Manchester to understand the costs and benefits of intervening in the Early Years. This work shows that while there will be significant short-term gain, the principal impact of savings to the public sector will be realised up to 10 years after the Early Years period. In the longer term, a failure to effectively intervene to address the complex needs of an individual in early childhood can result in a nine-fold increase in direct public costs. Significantly, the organisations that benefit most from the interventions are not the organisations that traditionally fund the services. Devolution arrangements provide an opportunity to address this. The devolution commitment to integrated partnership working provides significant incentives to invest in transformational reform, removing those barriers that precluded investment in preventive approaches, particularly those where investments provided benefit to other agencies.

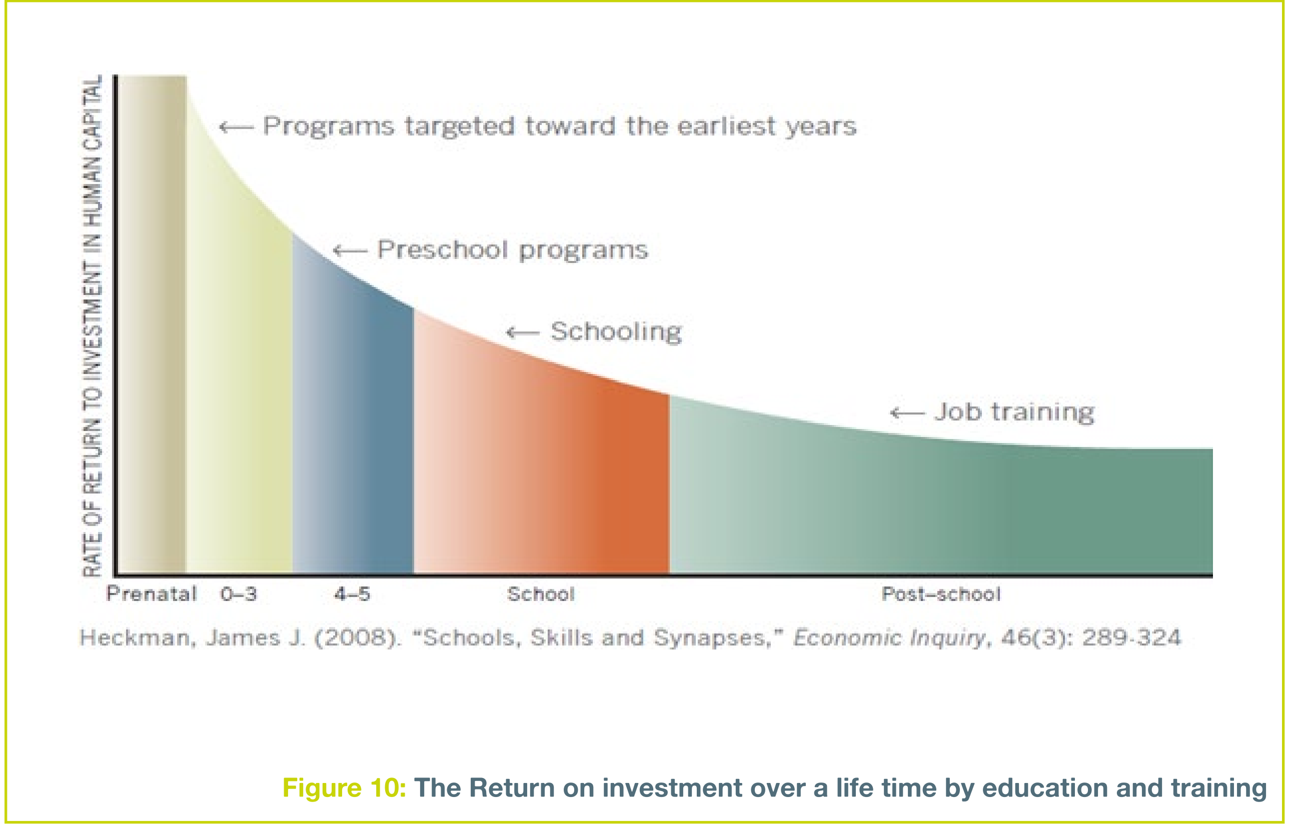


Figure 10: The Return on investment over a life time by education and training

Every **£1** invested in quality early care and education saves taxpayers up to **£13** in future costs.

For every **£1** spent on early years education, **£7** has to be spent to have the same impact in adolescence.

Source: Centre for Research in Early Childhood (2013) The impact of early education as a strategy in countering socio-economic disadvantage

Figure 11 Impact of investing in early years

3.2 Greater Manchester context

We want every child in Greater Manchester to have the best start in life. This means that every child grows up in an environment that nurtures their development, derives safety and security from their parents/care givers, can access high-quality Early Years services and has a belief in their goals and their ability to achieve them. Our ambition is that every child in Greater Manchester acquires the skills necessary to negotiate early childhood and flourish in primary and secondary school, further education and employment.

In Greater Manchester we have set ourselves an ambition of supporting every child to reach a good level of development (GLD) and closing the gap between Greater Manchester and England. Table 2 sets out percentages of children reaching a GLD at age five for the period 2013 to 2016.

% achieving a good level of development (GLD)	2013	2014	2015	2016
Bolton	48	54	61	65
Bury	51	56	66	69
Manchester	47	53	61	64
Oldham	41	52	57	61
Rochdale	42	50	57	63
Salford	53	57	61	65
Stockport	54	62	68	69
Tameside	42	52	58	63
Trafford	61	69	73	73
Wigan	38	55	64	67
ENGLAND	**52**	**60**	**66**	**69**
North West	**50**	**58**	**64**	**67**
Greater Manchester	**47**	**56**	**62**	**66**

Table 2: percentage of children reaching a GLD at age five for the period 2013-2016

Table 2 shows that GLD for Greater Manchester in 2016 is 66% compared to 69% nationally. However, nearly one in every two children in receipt of free school meals is not reaching a GLD. Raising overall attainment for the most disadvantaged and vulnerable groups of children is a challenge for every locality; however, we are encouraged by the fact that the gap between Greater Manchester and the England average has reduced from 5% to 3% over the period.

3.3 A new model of care for Early Years

At the heart of the health and social care reform ambitions is the recognition that we need to see a significant shift in activity; shifting the balance from reactive, crisis services to preventative services that help reduce escalation of need. The Start Well Early Years Strategy was approved by the Greater Manchester Strategic Partnership Board in June 2016 and sets out the Greater Manchester vision for transformational system change and a long-term and sustainable shift from expensive and reactive public services to prevention and early intervention. The strategy aims to reduce duplication and make more efficient use of resources to achieve better outcomes wherever possible within existing budgets, including a vision for integrated leadership, commissioning and delivery.

The need for targeted and specialist services is acknowledged; however, the strategy recognises the requirement for a core universal offer to all Greater Manchester families in the Early Years to identify abuse, neglect, developmental delay, and special educational needs and/or disability at an early stage to ensure swift access to support and interventions.

The overall objective of this work is to increase the number of Greater Manchester children who are school ready, and over the next five years we intend to close the gap between current Greater Manchester performance and the national average for the following selected outcomes:

- to improve the percentage of children achieving a GLD at the end of the Early Years Foundation Stage
- to increase the percentage of children achieving age-related expectations at 2-2½ years (measured using the 'Ages and Stages Questionnaire' (ASQ 3)
- to increase the percentage of two- and three-year-old children who take up their free entitlement in schools and settings that are judged 'good' or 'outstanding' by Ofsted (with a particular focus upon vulnerable groups)
- to improve the percentage of children in receipt of free school meals who achieve a GLD at the end of the Early Years Foundation Stage
- to reduce the number of full-term babies with a low birth weight
- to increase breastfeeding rates at 6-8 weeks
- to reduce the rates of smoking at time of delivery
- to reduce levels of overweight and obesity at age 4-5 years
- to reduce the number of decayed, missing and filled teeth in children aged five
- to reduce attendance at Accident and Emergency for children aged 0-4 years
- to protect vulnerable children and families by ensuring that all general practices meet national targets for childhood routine vaccinations and pre-school flu vaccinations
- to improve parent and infant mental health
- to safely reduce the number of looked-after children (LAC).

3.4 Opportunity

The Greater Manchester devolution agreement, the transfer of health visiting and Family Nurse Partnership (FNP) commissioning to local authorities, free early

education places for disadvantaged two-year-olds, the Early Years pupil premium grant, the Greater Manchester Children's Services Review and the development of integrated services for 0-19 years present a golden window of opportunity to ensure a concerted approach to improving child development.

To reduce the steepness of the social gradient in child development, actions must be universal, but with a scale and intensity that is proportionate to the level of need. The universal components of the Greater Manchester Early Years Delivery Model (EYDM) were fully implemented prior to the transfer of the commissioning responsibility for health visiting to local government in in October 2015. Numbers of health visitors in Greater Manchester rose by 57% between 2013 and 2015, with substantial increases in the delivery of evidence-based assessments and an additional 40% investment of £13 million from NHS England. During the same period FNP programmes were implemented in every Greater Manchester locality, increasing access by almost 300%. Significant workforce transformation to identify need earlier has also been delivered. This increase was urgently required to meet universal requirements; however, there is still a significant amount of unmet need in localities. A self-assessment undertaken within localities has identified that each locality is well placed to build upon this strong foundation by implementing the evidence-based targeted interventions identified as part of the Greater Manchester Early Years delivery model.

There have been significant changes to the provision of free early education during the last three years, including new places for two-year-olds and an Early Years pupil premium for the most disadvantaged three and four-year-olds. Since September 2014, 55% of two-year-olds in Greater Manchester have been entitled to 15 free hours of free early education per week for 38 weeks of the year. Take-up of two-year-old places across the 10 localities varies, with an average 71% of eligible children taking up their free entitlement across Greater Manchester with a local variance of 63-85% (2015).

The Greater Manchester Early Years delivery model presents a unique opportunity to develop system-wide transformation that supports a sustainable shift from expensive and reactive public services to prevention and early intervention. The model aims to reduce duplication and variation and achieve better outcomes within existing budgets; however the challenge of implementing the Early Years model at scale alongside diminishing local authority budgets is recognised and understood.

3.4.1 Programme of work – scope

The Greater Manchester EYDM is an ongoing universal and targeted pathway based on consistent, integrated age-appropriate assessment measures promoting early intervention and prevention, implemented through assertive outreach and improved engagement with families with young children from pre-birth to school. Assessments will be evidence-based, timely and ongoing from pre-conception to five years (see diagram below). Services will identify needs early and intervene effectively to minimise the escalation of need. This is reinforced by a series of evidence-based interventions supporting short and long-term benefits. Implementation of the EYDM has progressed at different rates across all areas of Greater Manchester.

There is a requirement to focus on remodelling existing Early Years services within budgets that are under pressure. This requires new multi-agency delivery models, reducing commissioned activity with no evidence base, and moving public sector money associated with poor outcomes into programmes that rapidly improve the performance across Greater Manchester.

The Greater Manchester Early Years Delivery Model comprises three key components:

1. an eight-stage assessment pathway (see below)
2. a range of multi-agency pathways
3. a suite of evidence based assessment tools and targeted interventions.

When the EYDM is fully implemented across Greater Manchester to a standard of the highest performing localities, families will be in receipt of a proportionate multi-agency tailored response relevant to their level of need. The EYDM has the full engagement of all authorities but commissioning, service delivery and provision remain inconsistent across Greater Manchester, with progress hard to evidence. To increase momentum there is a need to develop a new approach to commissioning Early Years services across Greater Manchester, specifically integrated commissioning of the Greater Manchester EYDM.

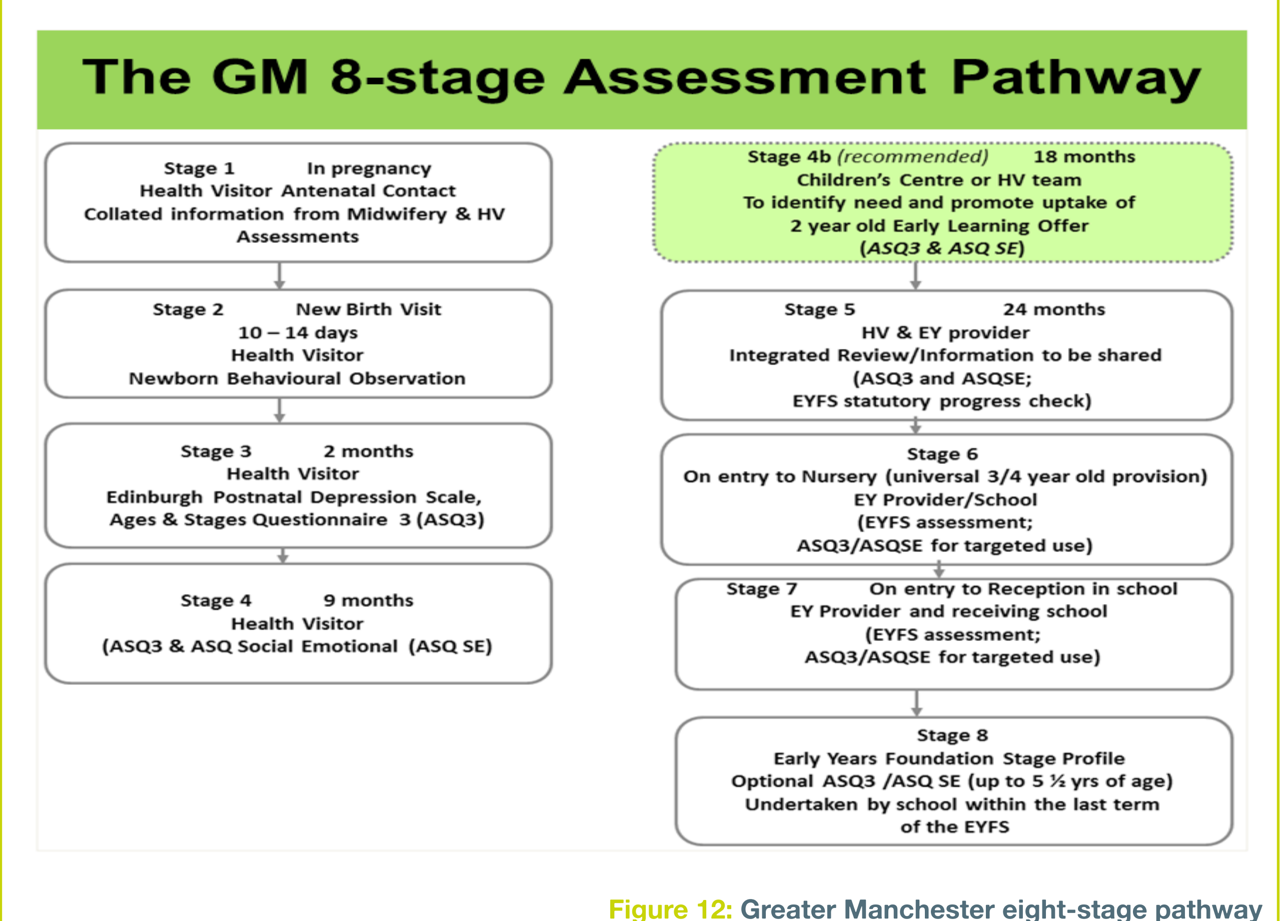


Figure 12: Greater Manchester eight-stage pathway

Figure 13 below sets out the universal, targeted and locally determined components of the Greater Manchester Early Years delivery model of integrated provision.

1: Core model elements Universal entitlements within ALL localities	2: Core model elements Evidence-based targeted interventions/entitlements within ALL localities	3: Core model elements Evidence-based targeted interventions/entitlements within ALL localities
Use of agreed evidence-based universal assessment tools (e.g. ASQ3, EPNDS) Greater Manchester 8-stage New Delivery Model assessment pathway	Use of agreed evidence-based targeted assessment tools	
Maternity services Core Greater Manchester offer: including stopping smoking in pregnancy, PIMH pathways	Family Nurse Partnership	High-needs pathway for vulnerable pregnant women requiring intensive support, including pathway for pregnant teenagers not accessing FNP.
Antenatal and Newborn Screening	Specialist screening and intervention	
Unicef Baby Friendly Initiative: Acute, Community, Neonatal Units and Children's Centres	Breastfeeding support (best practice = peer support service)	
Health Visiting core offer	Health Visiting targeted / early help offer	
Childhood routine immunisations	BCG vaccination	
Free early education entitlement for all 3 and 4 year olds.	Free early education entitlement for the most disadvantaged	Communication -friendly environments / Raising Early Achievement in Literacy (REAL)
Speech , Language and Communication programmes and initiatives (Greater Manchester intervention pathway to be ratified).	Well-Comm	Parent and Child Interaction / Therapy / Elklan / Communication-friendly environments
Evidence- based parenting programmes, including Solihul approach Greater Manchester antenatal parent preparation guidance and classes	Incredible Years Baby (0-1 Bm) Incredible Years Toddler (18m-30m) Incredible Years Pre-school (30m-7 years)	Solihull Parenting Groups / Family Partnership Model / Baby Steps antenatal programme / Mellow Parenting / Perinatal PEEP / Triple P / Baby Links Nurturing / Video Interactive Guidance
Children 's Centre core offer	Children 's Centre targeted offer	Communication-friendly environments
PIMH & Attachment (Greater Manchester intervention pathway to be ratified) Neonatal Behavioural Observation	Neonatal Behavioural Assessment Scale	

Figure 13: Early Years delivery model

The Greater Manchester EYDM will require integrated commissioning arrangements to include a local commitment to commission and deliver all core model elements (1) and (2) within each locality, delivered by multi-disciplinary integrated teams. If evidence-based local targeted variations are in place it is recognised that there may be a desire to retain these at the expense of specific core model elements (2); the model intends to support this flexible approach. Examples of these are listed within local elements (3). Significantly, any services agreed as core components (1) and (2) of the model should not be decommissioned at a local level.

3.5 Smoking in pregnancy

Smoking is 'the single biggest modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health outcomes' (NHS England National Maternity Review, 2016). A recent North West review that focused on child deaths under one year identified that smoking was the most prominent modifiable risk factor associated with infant mortality. A concerted, collaborative effort to reduce smoking in pregnancy will save babies' lives, improve childhood development and narrow health and social inequalities.

Parental smoking quadruples the chance of children becoming smokers. A system-wide approach to smoking cessation in pregnancy to target the most vulnerable will lay the foundations for securing a smoke-free environment not only in pregnancy but for children throughout their childhood years. Smoking prevalence in the under-20s is reported to be two to three times higher than overall rates, and this translates through into higher smoking rates among young mothers.

The identification of women who are smoking at their booking visit is key if services are going to be able to support a woman to quit smoking. The NHS England 'Saving Babies Lives Care Bundle' guidance recommends universal carbon dioxide (CO2) monitoring at antenatal booking. Across Greater Manchester the implementation of CO2 monitoring is variable.

Smoking cessation services are commissioned by local authority public health teams on behalf of their populations. Localities can have several providers of maternity services, which may not be commissioned by coterminous CCGs. Initiatives such as the Saving Babies' Lives care bundle provide opportunities for collaborative commissioning approaches. A single Greater Manchester evidence-based pathway for stopping smoking in pregnancy is needed to support systematic collaboration between CCG commissioners, local authority commissioners and maternity service providers to ensure consistent high-quality provision and access across Greater Manchester.

3.6 Better oral health

Good oral health in children means freedom from pain and discomfort, confidence to smile, talk and socialise without embarrassment, to attend school and be ready to learn. It also means that the requirement for urgent or routine clinical care is greatly reduced. The most common reason for young children to be admitted to hospital is for the extraction of decayed teeth, with many also attending A&E due to dental pain. Improved clinical care pathways would mean that many children who may ultimately receive general anaesthetic for dental treatment would be cared for through appropriate early intervention within primary care.

To achieve the fastest improvement in the oral health of young children we need to implement a co-ordinated programme of universal and targeted interventions across Greater Manchester. There is a strong evidence base for population-level oral health improvement interventions employing a range of measures, at scale, to achieve maximum

population coverage and reduce inequalities. The current cost to the Greater Manchester health system of treating tooth decay in children is approximately £19 million per year. Enabling the most effective use of resources to support evidence-based programmes will require bold decisions to decommission activities that are not supported by the evidence base.

When oral health is poor, children experience pain, infection, sleepless nights and absence from education that affect their ability to learn, thrive and develop. Parents must also take time off work to care for their children. Tooth decay is strongly associated with deprivation and chaotic lives, with some of the most vulnerable children facing very poor oral health. Risk factors include poor nutrition, high consumption of sugar and lack of access to fluoride due to starting toothbrushing late or infrequently.

In 2015, 36% of Greater Manchester five-year-old children had experienced tooth decay, compared to 27% in England. In addition, there are marked inequalities both within and between localities, ranging from 50% in Oldham, to 22% in Stockport. Due to persistently high levels of tooth decay in five-year-olds, Oldham, Salford, Rochdale and Bolton have recently been highlighted as four of the 13 'priority areas' for child oral health in England.

In order to reduce tooth decay in five-year-olds to the England average within five years, we need to ensure the following.

1. Oral health is on everyone's agenda: Our ambition is that every child in Greater Manchester has accessed preventively-focused dental services by the age of 12 months. To achieve this we need greater integration between Early Years services and dental services, with clear pathways to support facilitated access to professionally delivered prevention and early intervention.
2. The Early Years workforce has access to evidence-based oral health improvement training.

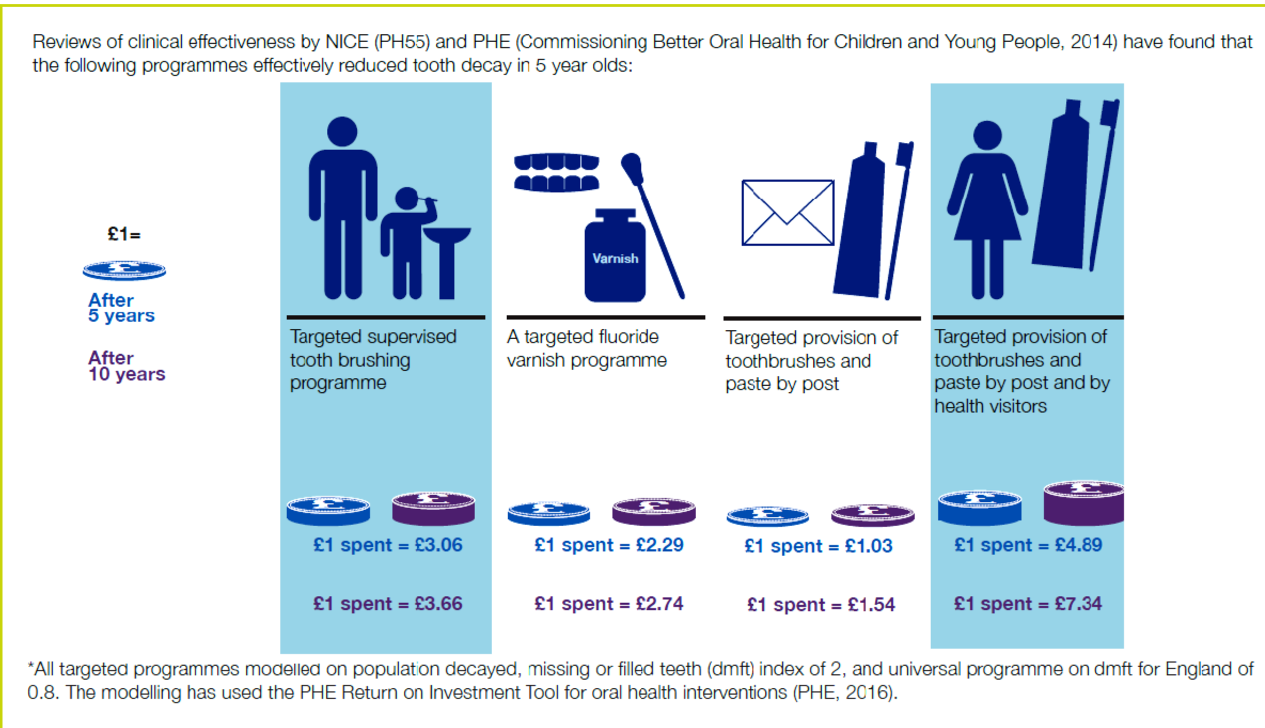


Figure 14: Clinical effectiveness of oral health initiatives

3. Oral health data and information is used to the best effect by all stakeholders.
4. Population-level oral health improvement interventions that have the strongest evidence base are delivered at scale.
5. Child oral health improvement is communicated effectively: Opportunities are identified to communicate oral health information as part of broader communications.

3.7 Developing Well (5-25 years)

While Greater Manchester is taking a pioneering approach to prioritising the Early Years, we acknowledge the requirement to address population health challenges in children and young people aged 5-19 years. Scoping the requirements for 5-25 year olds will require significant partnership working and engagement with schools, further education and higher education establishments and the community and voluntary sector. We intend for this work to be incorporated into phase two of the population health planning process. This will be captured under the theme of Developing Well. Initially, we will champion the aspirations of the Greater Manchester Children's Services Review led by the Greater Manchester directors of children's services. The review aims to support the development of a clear Early Help offer for 5-19 year olds in all Greater Manchester localities that helps children and young people achieve better outcomes and reduces demand for targeted and specialist services. Further work is required to establish the key priorities for young people aged 19-25 years; the initial area of focus will be on young people who remain within education.

Mental health and wellbeing is a key priority across GMHSC Partnership, where it is a cross-cutting theme across all workstreams. The implementation of this workstream will be delivered via the Greater Manchester Mental Health Strategy. Shifting the focus of care to prevention, early intervention and resilience, and delivering a sustainable mental health system in Greater Manchester, requires simplified and strengthened leadership and accountability across the whole system. The Greater Manchester stakeholder survey for the Greater Manchester Mental Health Strategy reported that mental health should be embedded within the school curriculum as part of a wider health and wellbeing approach in schools. There is a requirement for every school and college to identify when a young person may be struggling and to intervene early and effectively to nurture and support young people's mental health and resilience, focusing on key attributes such as self-esteem and empathy. This is vital as 75% of all adult mental health problems start by the age of 18 and only 25% of young people with mental health problems get access to the right support. Improving child and adult mental health, narrowing social, educational and health inequalities, and ensuring parity of esteem with physical health is fundamental to the overall future health and wellbeing of our communities.

To support this we have drafted five key asks of schools, colleges and universities to support the establishment of Greater Manchester standards for local implementation. These are:

1. encouraging young people to develop healthy lifestyles
2. supporting young people (and their families) in developing core resilience to tackle problems and face issues
3. working with other community organisations to provide a strong support network for children and young people
4. being a good employer in proactively supporting the health and welfare of staff
5. getting involved in Greater Manchester work on health and care of young people, so that they can benefit from best practice and mutual support across the region.

3.7.1 Plan

3.7.1.1 Objectives

It is now well understood across Greater Manchester that investing in new models for Early Years services is the right thing to do from a moral, economic, financial, performance and resilience perspective. The next stage of the work will seek to give confidence to system investors that the Early Years model will deliver improved outcomes.

- **Objective 1**: Fully implement the core elements of the Greater Manchester Early Years delivery model within all 10 Greater Manchester localities.
- **Objective 2**: Develop a sustainable, resilient and consistent set of Greater Manchester interventions to stopping smoking in pregnancy.
- **Objective 3**: Develop information management technology (IMT) proposition to improve data processes to track progress and allow earlier intervention.
- **Objective 4**: Implement evidence-informed interventions at scale in a targeted and consistent manner across Greater Manchester to improve oral health and reduce treatment costs within 3-5 years.
- **Objective 5**: Develop a clear Early Help offer for 5-19 year olds in all Greater Manchester localities that helps children and young people achieve better outcomes and reduces demand for targeted and specialist services. This objective will be delivered via the Greater Manchester Children's Services Review led by Greater Manchester directors of children's services.
- **Objective 6**: Develop a consistent Greater Manchester approach to improving the mental health and wellbeing of children and young people in education. This objective will be delivered via the implementation of the Greater Manchester Mental Health Strategy.

3.7.1.2 Approach to delivering objectives

Objective 1: Implement the core elements of the Greater Manchester Early Years model within all 10 Greater Manchester localities.

The programme will seek to:

- identify local gaps in the delivery of the Early Years model and develop locality implementation plans
- formulate investment proposals to pursue and agree funding options
- update the cost benefit analysis model
- undertake a commissioning options appraisal
- develop an engagement strategy around achieving the aspiration of the Start Well Early Years Strategy. Specifically, it will seek to scope the vital contribution of schools, community and voluntary organisations and a public health maternity workforce in achieving the objectives of the Start Well Early Years Strategy.

Objective 2: Develop a sustainable, resilient and consistent Greater Manchester approach to stopping smoking in pregnancy.

The programme will seek to:

- scope current approaches to commissioning stop smoking services in pregnancy
- review the evidence and formulate sustainable investment proposals
- commission a Greater Manchester approach to stop smoking services in pregnancy to ensure consistency.

Objective 3: Develop IMT proposition to improve data processes to track progress and allow earlier intervention.

The programme will seek to:

- work with the Greater Manchester-Connect data and information programme

to identify the potential scale, impact and efficiency savings

- explore the opportunities identified within capturing data, storing data and sharing data
- identify localities to test a proof of concept
- develop a Greater Manchester model that will realise efficiencies and enable the workforce to spend more quality time working with families.

Objective 4: Implement evidence-informed interventions at scale in a targeted and consistent manner across Greater Manchester to improve oral health and reduce treatment costs within 3-5 years.

The programme will seek to:

- commission a co-ordinated oral health improvement programme across all of Greater Manchester that focuses on increasing access to fluoride via:
  - supervised brushing in all Early Years settings
  - promotion of brushing with fluoride toothpaste in the home environment via 'take home' packs and information
  - toothpaste distribution by health visitors and school nurses as part of the checks undertaken in the 0-5 year old age groups
- ensure that child oral health is seen as everyone's agenda, with child oral health improvement messages communicated effectively by all stakeholders
- create links between Early Years and dental services, in order to facilitate access to preventively-focused dental care for all Greater Manchester infants by the age of 12 months. This will be achieved by a programme of training and updates to all key health and Early Years staff across Greater Manchester
- evaluate the effectiveness of a programme promoting attendance at local dental practices before a child's first birthday. This programme will involve partnership working between health visitors and local dental practices to promote delivery of evidence-based prevention. This programme will be tested and evaluated in priority localities where levels of dental decay in young children remain consistently high.

Objective 5: Develop a clear Early Help offer for 5-19 year olds in all Greater Manchester localities that helps children and young people achieve better outcomes and reduces demand for targeted and specialist services. This objective will be delivered via the Greater Manchester Children's Services Review led by Greater Manchester directors of children's services.

The programme will seek to:

- develop a Greater Manchester integrated health and Early Help strategy
- engage a wide range of key stakeholders around the development and implementation of the strategy and what it means for their organisation
- develop locality implementation plans to meet the objectives of the strategy.

Objective 6: Develop a consistent Greater Manchester approach to improving the mental health and wellbeing of children and young people in education.

Via the implementation of the Greater Manchester Mental Health Strategy the programme will seek to identify opportunities to:

- implement mental health-promoting activities for children and young people integrated into normal school life

- introduce mental health promotion and mental health issues into the school policy and mandatory curriculum subjects
- offer mental health liaison at all Greater Manchester schools, providing support for teachers when working with children and young people at key life stages.

3.7.1.3 Target outcomes for 2016/17 and 2017/18

Year 2016/17:

- Early Years delivery plans developed in all localities
- Investment proposals developed to deliver core Early Years model in pioneer localities
- Investment proposition developed for a Greater Manchester stop smoking in pregnancy service
- Investment proposition developed for a Greater Manchester oral health improvement programme

Year 2017/18:

- Greater Manchester stopping smoking in pregnancy service commissioned
- Investment proposals developed in remaining localities
- IMT rolled out in initial areas
- Evaluation process developed to give confidence in investment

4. Live Well

As stated previously, this plan is focused around those key points and stages in people's lives when mental and physical health can be most strongly influenced. The aim of the Live Well theme is to support adults to be healthier, empowered and more resilient; key here will be connecting people to the opportunities created by economic growth and reform, behaviour change at scale to respond to the rise in chronic disease, and a real focus on reducing health inequalities.

The programme of work will include addressing key wider determinants of health such as work, focusing on whole system approaches to the key lifestyle risk factors of smoking, physical inactivity, obesity and alcohol that are driving premature mortality, inequality and illness, and developing new service responses that support general practices to work differently with people who face severe disadvantage. In addition, work is focusing on two key mid-adult life diseases that impact on our population – cancer and HIV.

The programme of work outlined in the 'System reform' chapter of this plan to create a unified population health commissioning system for Greater Manchester will also contribute significantly to the delivery of Live Well. By moving away from a fragmented Greater Manchester approach to commissioning more strategic and collaborative approaches at the right spatial level, we have the potential to improve at scale the response to the key lifestyle risk factors for midlife adults.

Greater Manchester is leading the way in its work on adult health improvement, forging groundbreaking strategic partnerships with national bodies such as Sport England to develop insight-led radical new propositions to address our high levels of physical inactivity, and with philanthropic and charitable organisations, focusing on our shared aims of tackling health inequalities. There is a wide range of activity already underway across the system that complements and enhances the projects in the population health plan. They include:

- local care organisations: The new locality care organisations (LCOs), which each of our 10 localities is developing, have a crucial role in delivering proactive, preventative, population healthcare to consistently high standards
- primary care strategy, which encourages a population-based approach to improving health and care through the delivery of place-based care and includes specific proposals on oral health and the introduction of a Greater Manchester Pharmacy Healthy Living Framework
- 'Greater Manchester Moving: the blueprint for physical activity and sport in Greater Manchester', (2015), the foundation to drive forward work across the system to increase physical activity

- Greater Manchester Combined Authority's alcohol strategy, which continues to take forward a programme of work, including licensing, regulation and compliance, and alcohol awareness campaigns
- the Greater Manchester sexual health partnership, which since its inception 13 years ago has driven significant improvements in sexual and reproductive health outcomes and service quality. Recent developments include cluster commissioning arrangements and proposals are currently being developed to secure further improvements and economies of scale by seeking to commission sexual health services at a single Greater Manchester level.

As identified above, a key element of the Live Well work programme will be advancing equality and reducing health inequalities, and therefore focusing on some of our most vulnerable groups, including the Traveller communities, homeless people, offenders, asylum seekers and refugees. This work will build on and align with activity already underway across the system.

Asylum seekers and refugees

Greater Manchester has one of the largest populations of asylum seekers and refugees in the country. It is recognised that this community holds a range of health needs, both physical and mental. Greater Manchester has been working with the North West Strategic Migration Partnership and other stakeholders, such as the Home Office, local authorities and providers, to better define and understand how the needs of asylum seekers and refugees are assessed.

GMHSC Partnership has recently secured funding from NHS England to improve access to routine primary care and address the barriers that many asylum seekers experience in accessing healthcare, leading to increased pressures on emergency services and poorer health outcomes.

Offender health

The Greater Manchester devolution agreement made a commitment to greater collaboration in the planning and delivery of a range of justice provision. An increased role in commissioning offender management services is enabling Greater Manchester to build improved pathways through services, tackling the challenges that can occur at transition points in the system.

Greater Manchester is developing plans for an integrated health and justice pathway, across all points of the criminal justice system, including consideration of mental health (including child and adolescent mental health services), substance misuse and learning disabilities. As an example of these new ways of working, Greater Manchester has recently become the first area in the country where the NHS and police and crime commissioner have worked together to jointly commission integrated police custody healthcare and liaison and diversion services. This is an optimal model that will operate within police custody, at court and in the community for those at risk of entering the criminal justice system.

Homelessness

Homelessness is increasing across Greater Manchester, in terms of statutory homelessness and also rough sleeping, which has been the most evident and visible. We have also seen increasing movement and transience of some elements of the homeless community, reflecting the economic and social conditions in some boroughs, and which is increasingly requiring a cross-boundary response. Plans are being put in place to develop a Greater Manchester homelessness prevention system that will operate across local government geographical boundaries. This means a focus on more effective, proactive investment in prevention and driving down reactive costs. Local services will be integrated in a place-based way to provide people with an individually

tailored pathway, based on their needs, to promote sustainable life chances.

4.1 Work and health

4.1.1 Background

There is a strong association between worklessness and poor health. Being out of work can lead to poor physical and mental health, across all age groups, with major impacts for the individual concerned, their partner and family. Getting back into work improves people's health, as long as it is good quality work.

There is strong evidence that unemployment is generally harmful to health, linked to:

- increasing death rates by 1.5 to 2.5 times
- higher mortality
- poorer general health and long-term limiting illness
- increased alcohol and tobacco consumption
- lower levels of physical activity
- higher rates of medical consultation, medication consumption and hospital admission rates.

Being in work and having a purpose in life have a positive effect on wellbeing. Conversely, being out of work can result in health harms such as the following.

- One in seven men develops clinical depression within six months of losing their job.
- Prolonged unemployment increases the incidence of psychological problems from 16% to 34%, with major impacts on the individual's partner.
- Young people are particularly at risk. Suicides attempts are 25 times more likely for unemployed young men than employed young men, with mental health problems in general much higher among unemployed populations.

There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. The magnitude of this improvement is more or less comparable to the adverse effects of job loss. The exception to this can be young people.

- Unemployed young people are particularly affected by 'scarring', when, a bad early experience in the labour market can last for 20-30 years and restrict ability to progress.
- Young people who are not in education, employment or training (NEET) for a substantial period are less likely to find work later in life, and more likely to experience poor long-term health.

Staying in work is key to improving outcomes. National Institute for Health and Care Excellence (NICE) evidence indicates that those out of work with a health condition for 6-12 months have a 2% chance of returning to employment, and after two years are more likely to die than return to employment.

The Government published the 'Work, health and disability: Improving lives' Green Paper in October 2016, which recognises the importance of work as a health outcome, and the need to give this greater focus within health services. It sets ambitious targets to halve the gap in the employment rate for those living with long-term health conditions or disability in relation to non-disabled people. The Department of Health and Department for Work and Pensions (DWP) established the joint Work and Health Unit to lead the drive for improving work and health outcomes for people with disabilities and long-term health conditions, as well as improving prevention and support for people absent from work through ill health and those at risk of leaving the workforce.

The NHS Five Year Forward View gives a clear statement on the need for the NHS to do

more to help people to get into, and remain in, employment. It sets out the fiscal impact of health-related absence and benefit claims to employers and taxpayers, and the low employment rate of people with mental health problems. The role of employers, and the NHS in supporting employers, is identified as key to supporting a healthier workforce and reducing long-term costs.

4.1.2 Greater Manchester context

Very high rates of health-related worklessness have persisted in Greater Manchester regardless of the economic climate, and the number of health-related benefit claimants has remained high even during times of economic growth.

Greater Manchester health and social care devolution, as demonstrated in the vision document 'Taking Charge', presents opportunities to further test and embed approaches that integrate employment and health. It is well understood that employment is a key determinant of health at strategic level. Despite this, there is still further work needed to make sure it is given the priority it should have in relation to patient care. This includes a recognition that more should be done around early interventions to improve employment outcomes for those residents at risk of falling out of work due to health or disability and those recently unemployed or inactive due to health or disability.

The scale of the challenge in Greater Manchester is significant. There are approximately 225,000 people in Greater Manchester claiming out-of-work benefits, and of these, 140,000 claim as a result of a health condition. Since 2012, unemployment in Greater Manchester has been reducing overall, but disability-related worklessness has not. There are a further 200,000 families in work and reliant on Working Tax Credit to move them out of poverty. The cost to Greater Manchester of worklessness and the impact of low pay has now reached over £2 billion a year.

- In Greater Manchester, mental health and musculoskeletal issues are the main health problems cited by workless claimants of sickness-related benefits. The Greater Manchester Working Well programme demonstrates that 68% of clients state that poor mental health is their biggest barrier to employment and 62% cite physical health, while 41% state that both mental and physical health issues are equally considered the largest barrier to employment.
- Of the Greater Manchester economically inactive population, 26% are out of work due to long-term sickness, compared to 22% in England as a whole. Levels are highest in Rochdale (32%), and lowest in Stockport and Trafford (20%). Temporary sickness accounts for 3.4% of the Greater Manchester economically inactive population, well above the England average of 2.3%.
- In 2015, nearly a third (31%) of the Greater Manchester working-age population had a health condition or illness lasting more than 12 months, compared to the England average of 29%. However, the Greater Manchester average masks considerable variation across localities, ranging from 27% in Manchester to 37% in Tameside.
- Data from the 2011 Census shows that 7.4% of the Greater Manchester working-age population reported that they had a long-term health problem or disability that limited their day-to-day activity 'a lot'. There is similar variance by locality, ranging from 5.6% in Trafford (equal to the England average) to 8.7% in Rochdale.
- It is estimated that less than 30% of presenting issues at GP surgeries actually require clinical intervention, and 70% of appointments are actually down to issues around wider social determinants ('social prescribing'); furthermore, this figure rises in more deprived areas.

Strong progress has been made with the Government to co-design testing of an alternative approach to welfare to work. The Working Well programme assists those with health-related barriers, and other complex benefit claimants, to secure and sustain employment. Notwithstanding Greater Manchester Working Well's success, it is critical to note that Working Well, and its successor the Work and Health programme, will not have the capacity to address the issue of health-related worklessness at the scale required to make the impact we need in the numbers of claimants within Greater Manchester.

The new DWP/Greater Manchester Work and Health programme aims to deliver to circa 20,000 claimants over five years, which reaches only a small proportion of those with health conditions that need support to return to work. There is a need to focus on what can be achieved at scale through a greater focus on work as a health outcome by taking a different approach to integrating the support offer from the health and social care system with Jobcentre Plus and other key partners.

4.1.3 Opportunity

Our ambition is for work for health to be given the priority it should have in relation to patient care and approaches to improve population health within Greater Manchester. A systematic approach to integrate healthcare provision with programmes designed to address the social and economic determinants of health will better support health outcomes for the individual, and realise the ambitions set out in the GMHSC Partnership Strategic Plan: Taking Charge of our Health and Social Care.

In terms of the opportunities available when looking at the different segments of the population, key areas to focus on are those employees who become ill and are at risk of falling out of employment, those newly out of work who need an enhanced health support offer, and those who are economically inactive with health conditions and get little in the way of support from Jobcentre Plus. It is recognised that there are differing characteristics within this population group that need to be considered, for example, the needs of older workers, or those with particular disabilities. We will be working closely with all partners including the Centre for Ageing Better, and disability and equalities groups, to test and learn what works for whom.

In work but at risk: The current national offer is not meeting local need. The national Fit for Work service, which is available to employers, employees or GPs to refer to once the person has been off sick for four weeks, has struggled to engage general practice or receive referrals from employers; neither does it provide rapid access to treatment.

In contrast, there is evidence from the Manchester Fit for Work service that demonstrates that an earlier intervention offer that meets GP and patient need can be effective. The local service has 86% of Manchester GP practices making regular referrals and is achieving effective outcomes using a biopsychosocial approach. The return on investment demonstrated in an initial cost benefit analysis (CBA) suggests that this model offers good value for money.

We will test the approach at a wider scale in conjunction with discussion around the devolution potential of the national scheme.

Out of work: Currently the most significant gap is systematic support for those with health conditions who are recently unemployed, or economically inactive, such as those in the Employment and Support Allowance (ESA) group and who do not meet the access criteria for Working Well. In Greater Manchester the majority of such claimants are in the Employment and Support Allowance (ESA) Group (84,430) and therefore are unlikely to get much in the way of support.

Figure 15: Health and employment

There is no coherent pathway for those with health conditions to access employment and skills support, condition management and other social determinants, at the scale required.

The 'Work, health and disability: Improving lives' Green Paper proposes steps to address earlier intervention for people making new claims for benefit/Universal Credit as a result of a health condition. This presents opportunities for collaboration between Greater Manchester and the Government to improve support across the spectrum of out-of-work claimants.

For both of these priorities, two of the key system interfaces at these critical risk points are Jobcentre Plus and NHS primary/secondary care services that hold responsibility for issuing fit notes and for treating those with long-term health conditions. In most cases, there is little clinicians can offer to support a return to work. Local examples from Salford, Bury and Manchester demonstrate that a trusted health and work pathway from primary care can be effective and well-used by GPs for those in or out of work with a health condition, and offer potential to enhance the proposals set out in the Green Paper.

Cost benefit analysis

Initial cost benefit analysis of the Manchester Fit for Work (in-work) and Healthy Manchester (out-of-work) models suggests that they offer good value for money. For a relatively low unit cost per client, significant fiscal benefits were delivered, including reduced worklessness and associated benefit payments (flowing to government), and reactive cost savings (flowing to local partners) associated with reduced mental health disorders, GP and physiotherapy appointments, and alcohol dependency. The gross five-year fiscal return on investment for the in-work service was an estimated 1.25,

and 1.35 for the out-of-work service; for both services, payback (when the benefits begin to outweigh the initial investment) should be achieved in four years. The wider public value delivered by the Manchester services incorporates increased economic output and reduced costs to employers, along with softer social benefits related to improved individual well-being – the public value return on investment was estimated at £5.74 for the In-work service and £2.36 for the Out-of-work.

When scaled up across further localities, the fiscal return on investment reported above is likely to increase, not least due to the economies of scale and potential efficiency savings that delivery on a Greater Manchester platform might generate

Opportunities still to be scoped
The significant efforts made at both Manchester and Greater Manchester level to move people back into employment will not achieve maximum gain if the work is not 'good work'. The role that employers can play is critical and significantly under-developed, both in terms of protecting health, supporting skills development and career progression, and promoting longer, healthier lives. There is an economic case for stronger leadership across public, private and third sector partners at Greater Manchester and locality levels.

Further work will take place over the next 12 months to scope the opportunities to support employers to provide 'good work', and employees to stay well in work.

4.1.4 Plan

The vision of this programme is to ensure that Greater Manchester has effective prevention and early intervention systems in place that support as many adults with health conditions as possible to return to, and remain in, good quality work. In order to do this, the programme is to build and test an approach to work and health that improves the integration and alignment of health, employment and other services, to ensure that the target group can access the support they require at an early stage and before falling into long-term unemployment. It also aims to give individuals the tools to manage health conditions in the longer term, build resilience and know where to go for other support when they need it.

The programme is set up to achieve the following core objectives.

Objective 1: Develop a work and health support model that addresses the needs of the identified cohorts, underpinned by data, evidence and cost benefit analysis, and secure endorsement by stakeholders across Greater Manchester.

Objective 2: Scope and determine the extent of current local work and health support delivered within Greater Manchester, tested against the work and health model described under Objective 1, scope procurement and delivery options and Greater Manchester/ locality approach.

Objective 3: Support a number of localities to implement the work and health model.

Objective 4: Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion and mainstreaming of the programme across the whole of Greater Manchester, based on the evidence.

4.1.4.1 Approach to delivering objectives

Objective 1: Define the work and health support model that addresses the needs of the identified cohorts, underpinned by data, evidence and cost benefit analysis, and agree appropriate funding mechanisms.

The programme will seek to:

- undertake detailed cohort analysis and modelling
- define and agree the key features that need to be in place to deliver effective services to the cohort

- define the metrics through which to measure success
- develop a CBA model
- undertake a communication and engagement exercise with Greater Manchester stakeholders
- pursue and agree funding options, including:
  - The national Work and Health Innovation Fund
  - Greater Manchester Transformation Fund.

Objective 2: Scope and determine the extent of current local work and health support delivered within Greater Manchester to the defined cohort, tested against the defined work and health support model.

The programme will seek to:

- work with localities to identify the 'as is', taking into account local place-based delivery models
- hold discussions with localities where no offer is currently in place to understand appetite for implementing model and agree participation
- undertake an options appraisal of the appropriate procurement and funding models to progress implementation with participating localities.

Objective 3: Support a number of localities to build on existing services or implement new provision to address gaps in service for the cohort.

The project will seek to:

- secure and put in place agreements with a number of localities to implement the model and test locally
- undertake a procurement exercise or implement agreed funding arrangements
- provide programme management and delivery support to assist localities to develop
- provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 4: Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the programme across the whole of Greater Manchester, based on the evidence.

The programme will seek to:

- collate analysis from implementation sites from across Greater Manchester
- update and further develop cost benefit analysis
- collate local lessons learned to inform future development of the model for wider Greater Manchester adoption
- gain agreement from the system to expand the work and health support model to ensure coverage of remaining Greater Manchester boroughs
- produce and agree a plan for Greater Manchester-wide coverage.

4.1.4.2 Outcomes

The programme will work towards achieving four key outcomes.

- **Outcome 1:** A work and health support model that addresses the needs of the identified cohorts, has been developed, endorsed by stakeholders and is supported through an agreed investment approach.
- **Outcome 2:** The 'as is' support service landscape for the target group is understood and locality appetite to test an at scale new approach model has been explored.
- **Outcome 3:** A number of Greater Mchester boroughs are implementing and testing the model for agreed cohorts and participating in evaluation.

- **Outcome 4:** A business case and plan for refinement and extension of a Greater Manchester-wide roll-out of the model has been produced and agreed.

4.1.4.3 Programme of work – scope

Overall the programme will work to the following principles:

1. Early intervention when employees become ill and risk falling out of employment
2. Early intervention for those with a health condition who have become recently unemployed or are long-term economically inactive to support them to make a return to work
3. Support for employers to provide 'good work', and for employees to stay healthy and productive in work

There are significant gaps within the system offer for each of these areas. Prevention from leaving the labour market is key. NICE evidence indicates that those out of work with a health condition for 6-12 months have a 2% chance of returning to employment, and after two years are more likely to die than return to employment.

Population in scope

We are looking to test and evaluate approaches that address the work and health needs of the following groups of working age adults:

- employed people who have been off sick for two weeks or more, and who require a biopsychosocial intervention to return to work as quickly as possible
- employed people who are at work but struggling with health conditions, and are at risk of going off sick and require a biopsychosocial intervention to remain effective and productive in work. This particularly includes those who are self-employed, or work for small and medium-sized enterprises (SMEs).
- people who have a health condition who are economically active and would benefit from integrated health and a wider support offer to move closer to the labour market.

4.2 New model of primary care for deprived communities

4.2.1 Background

We know that people experiencing multiple disadvantages are more likely to have poor health, alongside a range of other challenges including homelessness, worklessness, substance misuse, mental illness, poverty, violence and abuse.

Tackling these inequalities in health requires universally proportionate services to address the larger part of the inequalities gradient. There is also a need for tailored provision for the most disadvantaged communities, where multiple social determinants of ill health, clustering of risk behaviours, and early impact of multi-morbidities come together. These communities often experience (statistically) significant differences from the rest of the population.

Intervention through services can widen health gaps if attention is not focused on inequalities in access and outcomes. Often it is the most disadvantaged that make the least effective use of services and this can be exacerbated if they are offered poor levels of service (the 'inverse care law'). This mismatch of need and demand can be portrayed as those 'missing' from services.

People who face severe disadvantage need genuine opportunities to transform their lives; opportunities that help the individual overcome all aspects of the disadvantage so that they can reach their full potential in life.

Too often, people struggle to get the support they need and there is a strong chance that the disadvantages they face will become more severe. This means that when they do present to support agencies, the focus is on

managing problematic behaviours and the risks these present rather than addressing the person's underlying issues. This can escalate the severity of problems even further. Rather than responding to what the person is experiencing, a range of disconnected services are delivered, each tackling individual problems. This means that people who most need support find it difficult to navigate a complex structure of help, meaning they access services late or not at all.

4.2.2 Greater Manchester context

In spite of Greater Manchester's increasing economic prosperity, health inequalities persist, with 20% of our population (680,000 people) living in the 10% of most disadvantaged areas nationally.

Across Greater Manchester, we are developing models of place-based integration of services intended to identify early those people at risk of developing more complex issues that, over time, could place significant pressure on services and lead to poorer outcomes for individuals or families.

Each locality across Greater Manchester is in the process of implementing an approach to place-based integration. Based on the learning from these early adopter sites, district-wide roll-out plans will then be developed. By April 2017, plans will be in place for place-based integration across each part Greater Manchester.

Through Greater Manchester's place-based integration work, teams are being brought together from a wide range of organisations, bringing together the police, local authorities, health, housing and fire services, the voluntary sector, and others as needed. They are working with local residents in a new way. Rather than assessing and referring across the system, place-based teams are working together to agree how they can actively work with people to address the range of challenges they may face. They are sharing information, taking time to understand what may be the underlying factors contributing to the challenges faced by residents and agreeing what action to take through asset-based conversations with the residents they are working with.

This work is having a positive impact. Early analysis has highlighted that up to 70% of referrals across public services are generated by other parts of the public sector. Currently people are assessed and referred, passed around the system rather than being helped to directly address the challenges they are facing. By working in a new way, by intervening early and collaborating in our approach we can cut down that referral across the system and reduce the likelihood of issues escalating for the people we are working with.

Health and social care services are already engaged in this work. However, there is scope to increase that involvement, drawing in a wider range of health and social care services. Early work has identified the value of mental health professionals being full-time members of these teams. GP engagement in place-based integration models has been invaluable in those areas that have trialled work with GPs. The link into social care will be fundamental to the success of this new way of working. By aligning our population health strategy with Greater Manchester's approach to place-based integration we have the capacity to enrich our collective approach to new models of support.

Through place-based integration models there is significant opportunity to address issues that contribute to poor population health outcomes. Alongside this, there is also opportunity to build system-wide alignment with other elements of our health and care transformation work, such as social care.

Work is ongoing to support further integration and alignment of the health and social care programme with place-based integration by: developing a health and social care offer

in a broader place-based early intervention model; supporting localities to identify the specific health and social care services and interventions that could strengthen place-based integration in their locality; supporting the development of a cross-sector Early Help strategy in each locality; and ensuring this work is reflected in and informed by locality plans.

We will ensure the Greater Manchester place-based integration roll-out delivers on our Greater Manchester-wide reform ambitions, including the delivery of our health and social care strategy. Our goal is to ensure people will no longer need to navigate fragmented systems and services.

4.2.3 Opportunity

General practice has a pivotal role to play in supporting the most disadvantaged and in place-based integration of services. GPs are usually the first point of contact with NHS provision, although this is set against the context of the capacity challenge associated with serving populations who have a lower healthy life expectancy and experience more years of living with multi-morbidities.

Being able to provide preventative interventions and continuity of care are seen as the two key assets that GPs can deploy. GPs have repeated contact with their patients and are therefore ideally placed to understand the underlying causes of poor health, whether medical or social.

However, delivering effective primary care in the poorest communities is challenging. Some diseases are more prevalent in practices serving deprived populations, particularly mental health conditions, and there are higher levels of A&E attendances, emergency hospital admissions and primary care usage among these communities. Consultations in these practices are characterised by: higher demand, greater time constraints, greater psychological and physical morbidity, more multi-morbidity, less enablement reported by patients with complex problems, and greater GP stress. Furthermore, people's medical needs are intimately interwoven with emotional, psychological, financial and social problems.

Focused care is a model that has been developed in Greater Manchester from the work of Hope Citadel Healthcare CIC. It is a response to the frustration GPs feel when seeing patients experiencing multiple disadvantage, knowing they cannot do much in a 10-minute appointment but recognising great need. Often these patients are the most invisible to the normal workings of the NHS but they are often very expensive. They present late with significant conditions, and they turn up frequently and randomly at acute services.

Focused care is a systemised, standardised holistic approach now operating in eight GP practices in Greater Manchester. The model has been shown to change both patient and clinician behaviour and has led to improved outcomes and improved engagement and utilisation of services.

In essence, focused care is a holistic approach that:

- makes the invisible visible and keep them visible
- uses a clinical case discussion across disciplines and agencies, by people who know the patient
- keeps the responsibility for the patient at the GP surgery; the promotion of the value that these are our patients and we will do our best for them
- recognises the importance of relationships and that trust is a valuable commodity
- uses a focused care practitioner to enable households to be supported by mutually agreed plans
- fosters close working relationships with other agencies.

It has been likened to a Macmillan Cancer Support service for very deprived communities. Early cost benefit analysis suggests a 3:1 return on investment can be achieved.

4.2.4 Plan

The vision for this programme of work is to ensure that Greater Manchester has an effective system in place to meet the needs of the most disadvantaged in our communities. We have developed a unique collaboration with the Shared Health Foundation (SHF), an initiative of the Oglesby Charitable Trust (OCT), which is seeking to tackle health inequalities across Greater Manchester. We will develop new service responses that support general practice to work differently for people who face severe disadvantage by enabling genuine opportunities for people to transform their lives, opportunities that help the individual overcome all aspects of the disadvantage so that they can be and do the things they value in life.

The programme is set up to achieve the following core objectives:

- **Objective 1:** Provide proof of concept for the focused care approach by testing the model in 10 deprived practices in Greater Manchester
- **Objective 2:** Test the focused care approach to facilitate general practice involvement in place-based integration
- **Objective 3:** Develop a business case to support the future expansion and mainstreaming of the new care model, including exploration of sustainable funding mechanisms.

4.2.4.1 Approach to delivering objectives

Objective 1: Provide proof of concept for the focused care approach by testing the model in an agreed number of deprived practices in Greater Manchester.

The programme will seek to:

- identify an agreed number of suitable practices serving the most deprived areas and providing a good geographical spread across Greater Manchester
- work with SHF to develop an appropriate delivery vehicle for focused care
- work with SHF and New Economy Manchester to develop outcome framework and key success measures.

Objective 2: Test the focused care approach to facilitate general practice involvement in place-based integration.

The programme will seek to build on the testing of the model as described in Objective 1 by:

- documenting and developing the general practice contribution to the health and social care offer in a broader place-based early intervention model
- supporting the development of a cross-sector Early Help strategy in each locality
- ensuring this work is reflected in and informed by locality plans.

Objective 3: Develop a business case to support the future expansion and mainstreaming of the new care model, including exploration of sustainable funding mechanisms.

The programme will seek to:

- develop a cost benefit model
- pursue and agree funding options, including Social Impact Bonds, the Greater Manchester Transformation Fund and Life Chances Fund.

4.2.4.2 Outcomes

The programme will work towards achieving three key outcomes:

Outcome 1: A systemised, standardised holistic approach that supports behaviour

change in both patient and clinician, resulting in improved outcomes and improved engagement and utilisation of services.

Outcome 2: The focused care approach to facilitate general practice involvement in place-based integration and appetite to scale up has been explored and is understood in localities.

Outcome 3: Business case and plan for Greater Manchester roll-out procured and agreed.

4.2.4.3 Programme of work – scope

Overall the programme will work in the following way.

Focused care has no acceptance criteria. In an environment of social complexity and 'chaotic-ness', referral criteria are not helpful. There is no single clearly defined population group affected. For example, a single mother with four children might actually be thriving in life while a single man in his 50s may not be. Experience has shown that often patients on focused care don't meet criteria for other services, or have been rejected for other services. Patients in this cohort often end up being passed from pillar to post.

Population in scope

Focused care has a case load of 50 households per two days of focused care time. In previous analysis this represents about 2-4% of a deprived practice list per year. The equation used is two days of focused care per 2,500 patients on a list.

4.3 Incentivising and supporting healthy behaviours

4.3.1 Background

People's health behaviours are widely known to affect their health and risk of mortality. Close to half of the burden of illness in developed countries is associated with the four main unhealthy behaviours: smoking, excessive consumption of alcohol, poor diet and low levels of physical activity.

As outlined in the NHS Five Year Forward View, the future health of the nation, the sustainability of the NHS and future economic prosperity all now depend on a radical upgrade in prevention and public health. Over a decade ago, the Wanless Review in 'Securing our future health: Taking a long-term view' warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded – and now we are facing a crisis in our health and social care services.

Despite improvements in population health, 70% of us still engage in two or more lifestyle risk factors. Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smokes. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two-thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities that can cascade down to generations. For example, smoking rates among routine and manual workers range from 15.8% in Bromley to 36.3% in Oldham.

The number of obese children doubles while children are at primary school. Fewer than one in 10 children is obese when they enter Reception. By the time they are in their final year, nearly one in five is obese.

As our population's health risk gets worse, the burden on our health and social care system increases. To take just one example from the Five Year Forward View – Diabetes UK estimates that the NHS is already spending approximately £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic.

Our current health challenges require widespread behaviour change. We need behaviour change at scale to respond to the rise in chronic disease. New types of approaches are needed that reduce unhealthy behaviours, such as smoking, and increase healthy behaviours, such as physical activity. In particular, we need to find effective ways to help people in lower socio-economic groups to reduce their multiple unhealthy behaviours, as evidence indicates that reductions in unhealthy behaviours achieved to date are mostly confined to the higher socio-economic groups, who respond better to social marketing campaigns.

4.3.2 Greater Manchester context

Evidence supports the need to upscale behaviour change support services across the conurbation. There are just under two million adults aged over 19 living in Greater Manchester. Among these it is estimated that:

- 730,000 adults regularly consume less than four portions of vegetables and/or fruit per day
- 270,000 adults smoke every day
- 560,000 adults binge drink (consume twice the daily recommended alcohol levels at least once a week or once a month among men and women, respectively)
- 677,600 adults are physically inactive (less than 30 minutes of physical activity per week).

Evidence from the King's Fund: Clustering of unhealthy behaviours overtime (2012) also estimates that approximately 1.4 million adults in Greater Manchester (circa 70%) will engage in two or more of these unhealthy behaviours. The same study also highlighted that over time inequalities regarding multiple lifestyle risks have increased, with those from the lowest socio-economic groups and with the least education being three to five times more likely to have all four risk behaviours than professionals.

We also know from the 'Taking Charge' engagement that 90% of people want to improve their lifestyles, with most people citing being more active, eating more healthily and tackling stress as their key areas of need.

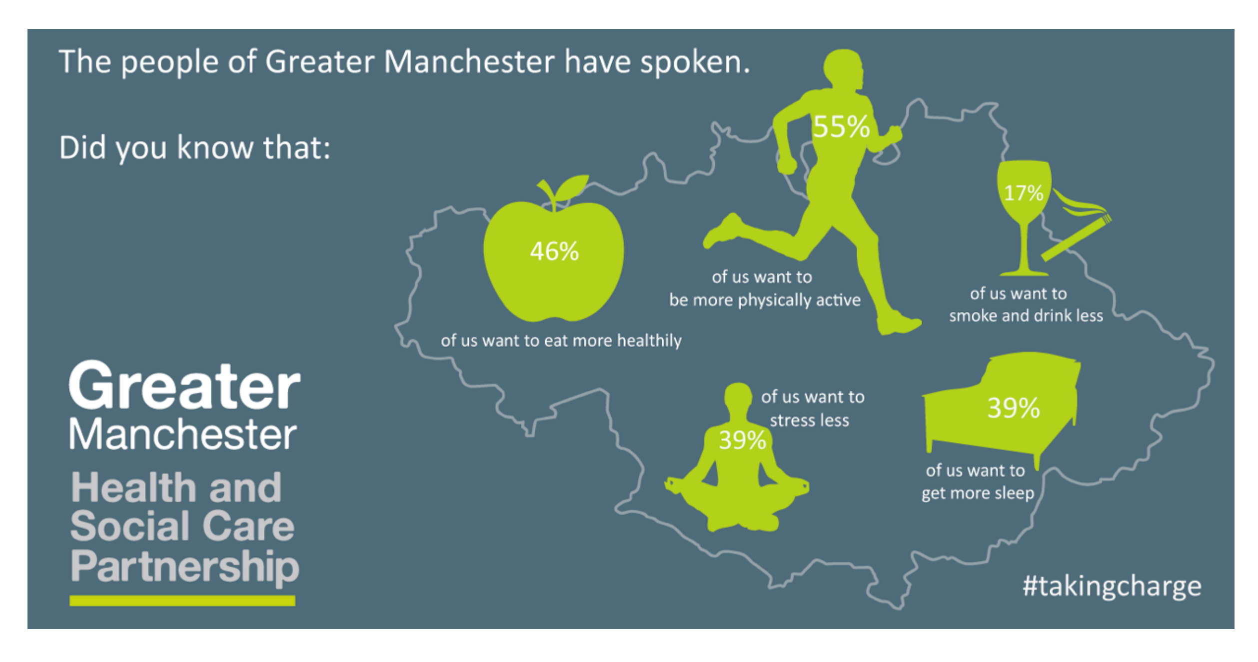


Figure 16: Greater Manchester population engagement responses to improving their lifestyle

This engagement process also generated new insights into the Greater Manchester population, which enabled us to group Greater Manchester people into one of six personas detailed below. However further ethnographic research is required to explore and refine these typologies further.

Figure 17: Greater Manchester population personas

4.3.3 Smoking

Despite good progress made in recent years, there are still over 423,000 adult smokers among the city-region's circa 2.8 million population. This is well above the England average (about 20% in Greater Manchester versus 17% nationally) and equates to around 63,500 more smokers than if at the England average.

Smoking is by far the biggest single cause of ill health as well as early death in Greater Manchester and in England. Figure 18 illustrates the scale and diversity of the deaths caused by smoking in England. Our Greater Manchester figures across localities for smoking-related cancers, respiratory and circulatory disease are higher than the England average, consistent with our higher than average smoking rates.

Smoking is also the biggest single contributor to health inequalities. More than half of the inequity in life expectancy between social classes is linked to higher smoking rates among poorer people. In Greater Manchester people in routine and manual (R&M) groups are far more likely on average to smoke than the general population, and R&M smoking rates in Greater Manchester are higher than the R&M England average.

Smoking prevalence remains lower than average in Black and minority ethnic groups, particularly in women, however, other tobacco use, such as oral and chewing tobacco and shisha use, is higher in some groups than in the general population and is a concern in some areas of Greater Manchester such as Oldham and Bolton and Manchester. The highest use of other tobacco products is in Manchester at 17.6% of the population and this extends to shisha use in the wider population.

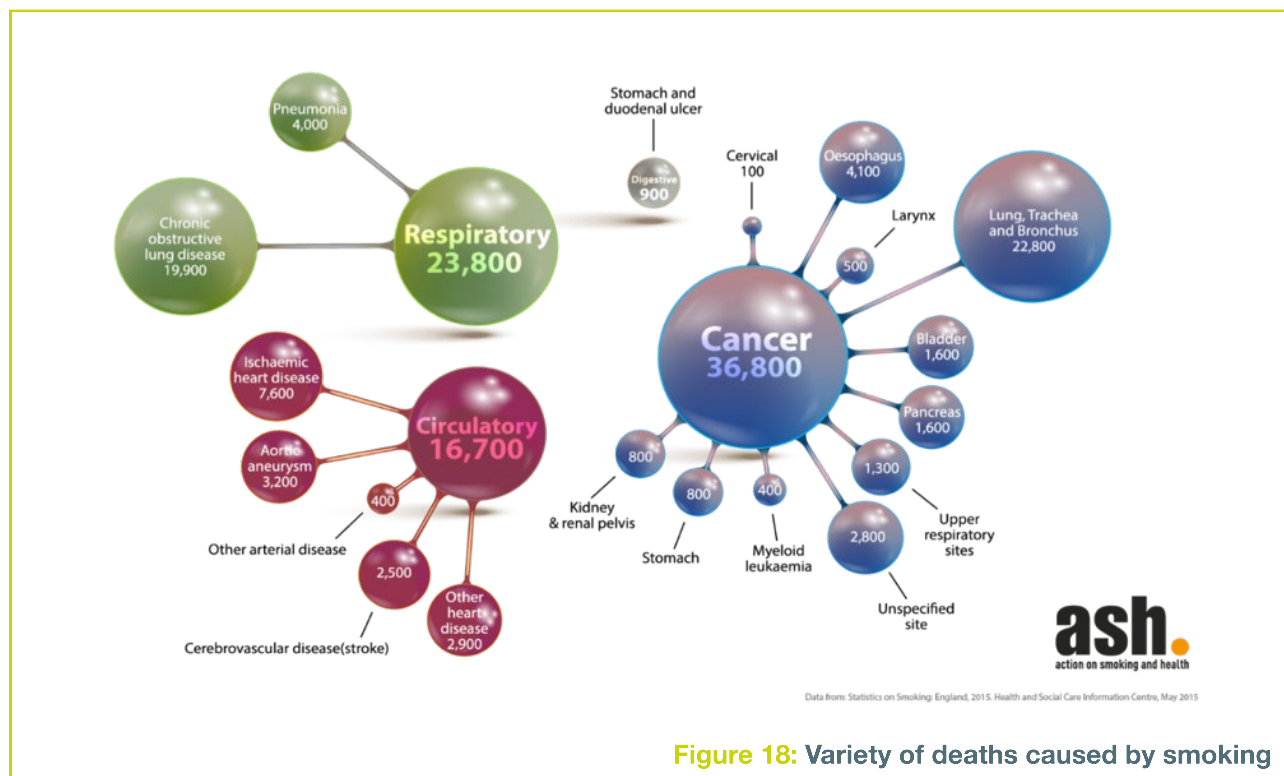


Figure 18: Variety of deaths caused by smoking

Figure 19 ('Smoking Still Kills', ASH 2015) illustrates the social divide in smoking rates in England that is reflected in Greater Manchester.

Smoking also has significant economic impacts in Greater Manchester at societal, systems, family and individual levels. The societal/systems costs of smoking are estimated to be £785 million a year (equating to £1,739 per smoker). This includes increased costs of health and social care, lost productivity, and house fires caused by cigarettes.

Research by ASH also shows that cutting smoking rates has the potential to lift some of Greater Manchester's poorest families out of poverty, as shown in Figure 20.

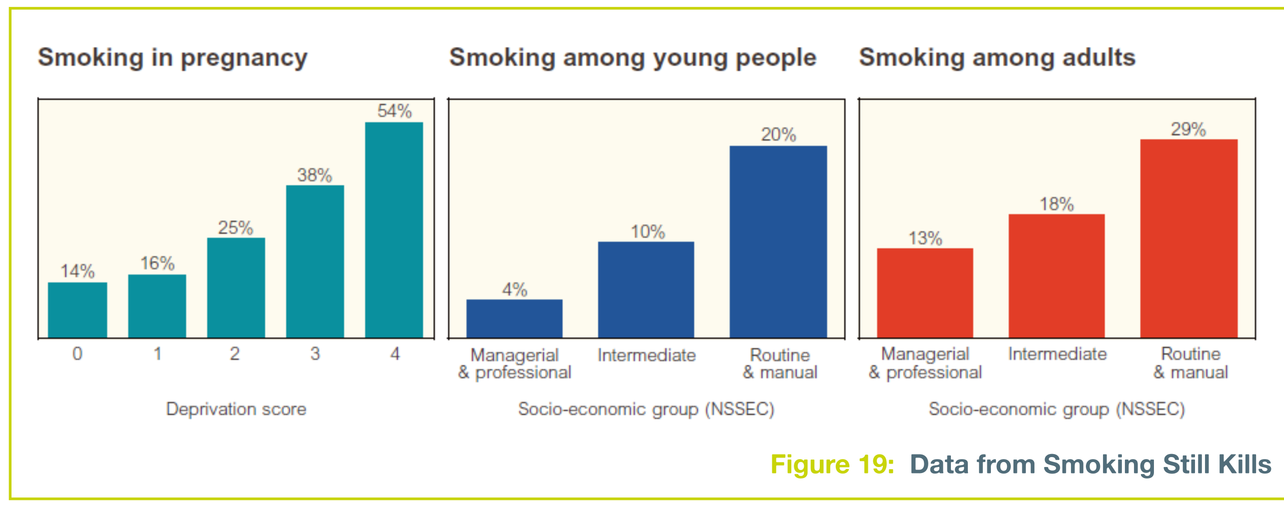


Figure 19: Data from Smoking Still Kills

Figure 20: Smoking and poverty

Sustained action is also needed to reduce the supply of, and demand for, illegal tobacco, which is cheap and unregulated. Its low price undermines high taxation that is key to encouraging 'cut-downs and quits' (the World Bank estimates a 10% price rise leads to circa 4% less consumption). The illegal trade also makes it easier for children to start and keep on smoking, and is linked to low-level and organised crime/terrorism. In Greater Manchester, illicit tobacco can be purchased for as little as £3 for a standard pack compared to the legitimate price of £7 for a standard retail pack of cigarettes.

While only 17% of respondents to the 'Taking Charge' engagement exercise wanted to smoke or drink less, we know from YouGov polling that actually the majority of those who smoke in Greater Manchester want to quit (only 10% of smokers don't want to quit) and two-thirds are supportive of efforts to tackle smoking.

4.3.4 Alcohol

Alcohol is inextricably linked with premature mortality – particularly through the causal link with at least seven types of cancer, including liver, bowel and breast cancer – and causes 80% of liver disease deaths.

Greater Manchester mortality rates are among the highest in the country in relation to alcohol-specific conditions (see figure 21).

Lower socio-economic status (SES) is associated with higher mortality for alcohol-attributable causes, despite lower socio-economic groups often reporting lower levels of consumption. People living in the most deprived decile are twice as likely to die from alcohol harm (16.1 per 100,000) than those living in the least deprived (8.3 per 100,000).

The demands placed on the NHS as a result of alcohol, both in terms of attendance at A&E departments at busy times and in terms of the impact on availability of beds, are significant. The rate of admissions for alcohol-related conditions has doubled nationally in a decade and is continuing to rise. Over 2014/15, there were over one million admissions in England, including 66,790 across Greater Manchester. The rate of admissions per 100,000 people is higher than the England average in all 10 Greater Manchester localities, and a disproportionate number relate to young people; there were 956 under-18s admitted to hospital due to alcohol, a rate of 52.1 per 100,000 compared with the England rate of 36.6 (see figure 22).

The combination of crime, worklessness and health and social care costs to Greater Manchester arising from alcohol-related harm are estimated at approximately £1.2 billion, equivalent to £436 for every man, woman and child living in Greater Manchester.

Alcohol-specific mortality (persons) 2012 to 2014

Directly standardised rate – per 100,000

Area	Value	Lower CI	Upper CI
England	11.6	11.4	11.8
Greater Manchester	-	-	-
Bolton	17.9	15.0	21.1
Bury	18.3	14.8	22.2
Manchester	24.1	21.1	27.3
Oldham	16.3	13.2	19.7
Rochdale	20.6	17.0	24.6
Salford	19.4	16.0	23.2
Stockport	17.3	14.6	20.3
Tameside	18.9	15.7	22.6
Trafford	17.9	14.7	21.4
Wigan	17.6	15.0	20.4

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates

Figure 21: Alcohol mortality in the Greater Manchester region (CI=Confidence intervals)

Persons under 18 admitted to hospital for alcohol-specific conditions

Area	Value	Lower CI	Upper CI
England	36.6	36.0	37.3
Greater Manchester	52.1	48.9	55.5
Bolton	43.1	34.5	53.3
Bury	44.8	34.0	58.1
Manchester	47.9	40.8	55.9
Oldham	60.0	49.0	72.8
Rochdale	40.8	31.3	52.3
Salford	72.0	59.4	86.6
Stockport	59.5	48.8	71.8
Tameside	67.8	55.1	82.6
Trafford	32.1	23.9	42.2
Wigan	56.6	46.7	67.9

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates

Figure 22: Alcohol-related under-18 hospital admissions in the Greater Manchester region

4.3.5 Physical inactivity and obesity

Doing less than 30 minutes of physical activity per week is one of the top 10 causes of early mortality. Greater Manchester has a high level of inactive population – around 677,600 residents (31% of the population versus the England average of 27.1%), with an estimated cost to health services in Greater Manchester of £26.7 million per year (2013/14 prices) related to the main chronic diseases (heart disease, diabetes, CVD and cancer) that could be prevented by exercise.

Levels of inactivity vary between localities, ranging from 22-33% across the 10 boroughs of Greater Manchester, and also across various under-represented groups.

- More than one in three females (35%) is inactive, compared to one in four males (26%).
- More than double the number of disabled people (56%) are inactive compared to non-disabled people (25%).
- Levels of inactivity range from 16% between the ages of 16-25 and 49% for those aged 65 and over.
- Between the upper National Statistics Socio-economic Classification (NS SEC) 1-4 and the lower NS SEC 5-8, levels of inactivity rise from 24% to 49%.

Physical activity programmes at work can reduce absenteeism by up to 20% and on average physically active workers take 27% fewer sick days. Nationally 131 million days were lost due to sickness absences in 2013, and 15 million days in the North West. A 20% reduction in the North West would reduce this by three million days. Furthermore, research suggests that participating in 3 x 30 minutes of activity per week could translate to an average increase in earnings of 7.5% due to improved productivity, social capital/networks and motivation to perform.

As well as being a risk factor for premature death in its own right, leading increasingly inactive and sedentary lifestyles – linked to time, work and more reliance on travelling by car – has also contributed to the steady rises seen in levels of obesity. While everyone would benefit from being more active every day, this is especially true in Greater Manchester, with 65% of adults and 28% of

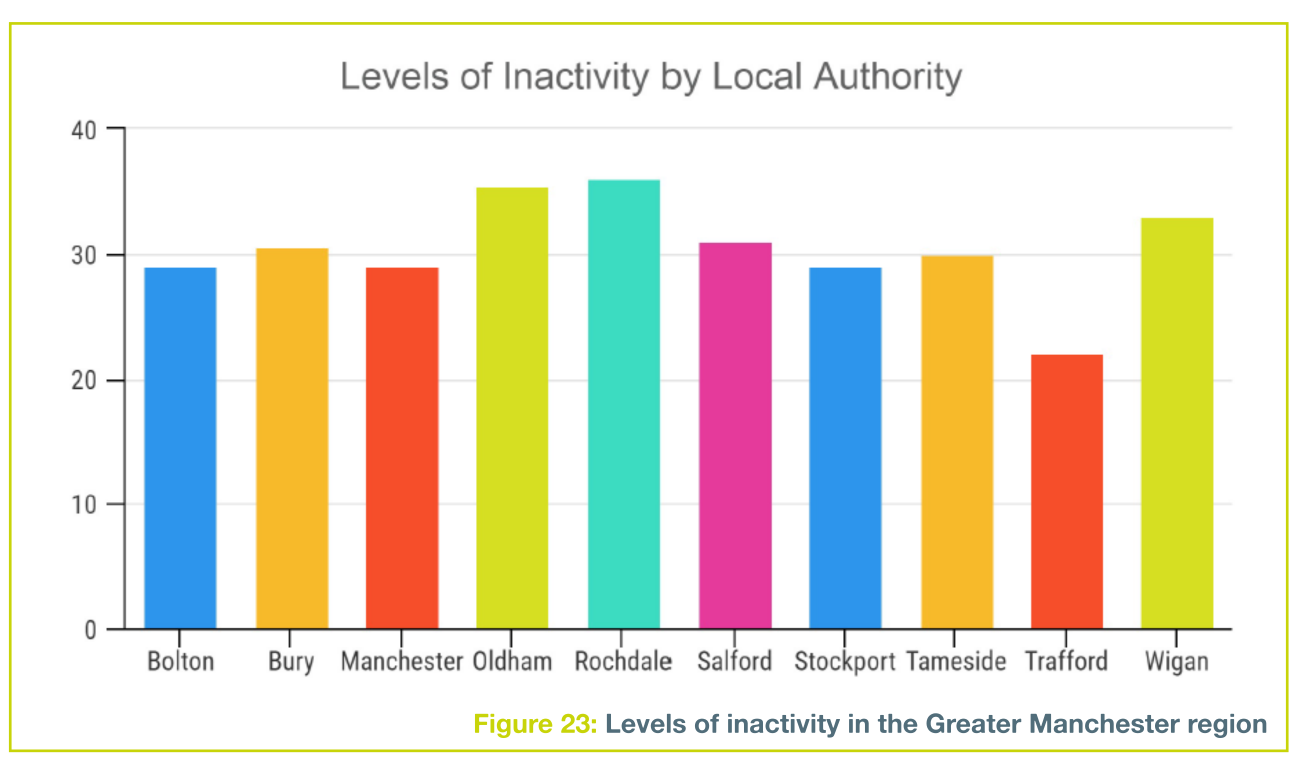
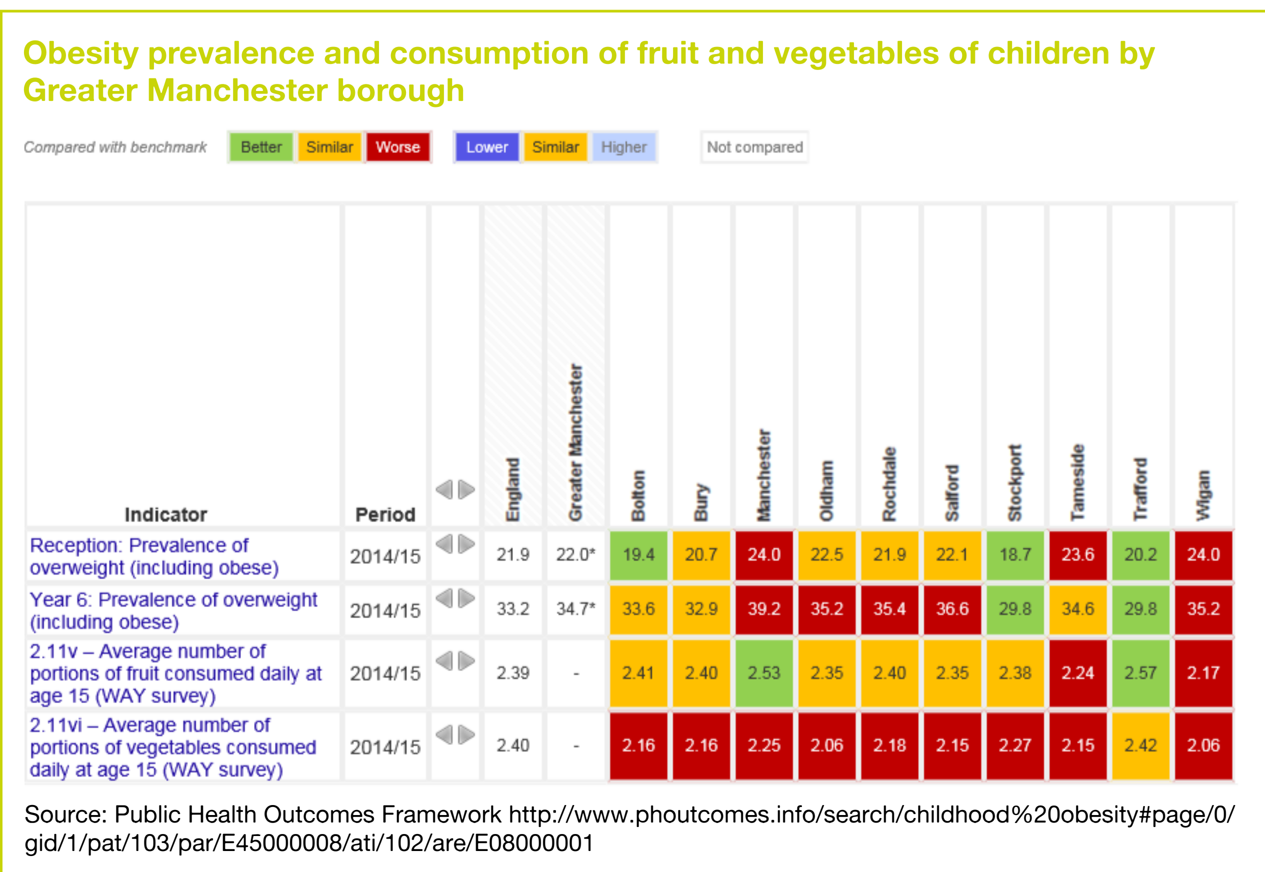


Figure 23: **Levels of inactivity in the Greater Manchester region**



Obesity prevalence and consumption of fruit and vegetables of children by Greater Manchester borough

Compared with benchmark Better | Similar | Worse — Lower | Similar | Higher — Not compared

Indicator	Period	England	Greater Manchester	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Reception: Prevalence of overweight (including obese)	2014/15	21.9	22.0*	19.4	20.7	24.0	22.5	21.9	22.1	18.7	23.6	20.2	24.0
Year 6: Prevalence of overweight (including obese)	2014/15	33.2	34.7*	33.6	32.9	39.2	35.2	35.4	36.6	29.8	34.6	29.8	35.2
2.11v – Average number of portions of fruit consumed daily at age 15 (WAY survey)	2014/15	2.39	-	2.41	2.40	2.53	2.35	2.40	2.35	2.38	2.24	2.57	2.17
2.11vi – Average number of portions of vegetables consumed daily at age 15 (WAY survey)	2014/15	2.40	-	2.16	2.16	2.25	2.06	2.18	2.15	2.27	2.15	2.42	2.06

Source: Public Health Outcomes Framework http://www.phoutcomes.info/search/childhood%20obesity#page/0/gid/1/pat/103/par/E45000008/ati/102/are/E08000001

Figure 24: Obesity prevalence in the Greater Manchester region

children classified as overweight or obese, which is significantly worse than the UK average.

Bury, Oldham, Rochdale and Wigan have significantly higher levels, with between 67% and 69.5% of adults living with excess weight and obesity.

For children and young people, 22% of pupils in Greater Manchester are starting school in Reception with excess weight, which increases to over 35% when leaving primary school. These are much higher rates of childhood obesity than the rest of the country, according to the most recent National Child Measurement Programme (NCMP) data.

Obesity impairs lives. It raises the risk of serious physical health conditions such as diabetes, heart disease, stroke and cancer. Prevalence of obesity is higher among women of Black Caribbean, Black African and Pakistani ethnicities, compared to the other ethnic groups. It affects our mental health too and can stop us from fulfilling our potential and living a full and happy life.

Being overweight or obese is the main modifiable risk factor for type 2 diabetes, which is also on the increase and is a serious and incurable condition that has lifelong health implications. Currently 90% of adults with type 2 diabetes are overweight or obese. There are currently five million people in England at high risk of developing type 2 diabetes. In Greater Manchester, currently 164,000 people have type 2 diabetes and at least the same number of people are at risk of developing it.

If these trends persist, one in three people will be obese by 2034 and one in 10 will develop type 2 diabetes. However, evidence shows that many cases of type 2 diabetes are

preventable. There is also strong international evidence that demonstrates how behavioural interventions, which support people to maintain a healthy weight and be more active, can significantly reduce the risk of developing the condition.

Obesity is widespread and appears to be increasing, but it can be very difficult to address at a whole-population level at the scale that is needed in Greater Manchester, and many approaches have already been tested. This plan presents an opportunity to think differently about how to address its root contributors – food and physical activity.

4.3.6 Opportunity

Devolution in Greater Manchester provides the opportunity to look at whole system innovative approaches to these major health risks, in order to fully harness the positive potential health impacts of the third sector, local government, employers and local communities themselves.

We will develop comprehensive, broad-based and hard-hitting Greater Manchester action at multiple levels and across sectors to address the major lifestyle risk factors, working in partnership with key national lead agencies such as Sport England and Public Health England.

A key principle behind the development of these new approaches will be building on the assets and skills we have in Greater Manchester, whether as individuals or communities, including forging stronger partnerships with charitable and voluntary sector organisations.

Work is already underway in the following areas.

The Greater Manchester Cancer Board has made reducing smoking a key focus within the emerging Greater Manchester Cancer Plan and is sponsoring work to develop a comprehensive Greater Manchester Tobacco Control Plan. The board believes that Greater Manchester should be a UK leader in becoming smoke free. Building on evidence from New York and other cities our approach will be:

- helping significantly more smokers to quit, working in partnership with smokers and a renewed commitment to meet their needs, to help them quit in whatever way works for them; greater investment in targeted year-round mass media and social marketing campaigns to educate and motivate quit attempts; and working across all sectors to exploit every opportunity to help smokers quit
- creating more smoke-free spaces. The mayor could lead the way for Greater Manchester by making the public places controlled by Greater Manchester authorities smoke free
- exploration of how further freedoms and flexibilities for Greater Manchester can reduce smoking prevalence through, for example, use of bye-laws for smoke-free spaces; consulting on raising the age of tobacco sales to 21; introduction of a Greater Manchester licensing scheme for tobacco retailers and wholesalers
- launching a fresh crackdown on the trafficking in, and selling of, illegal tobacco.

The GMCA's Greater Manchester Alcohol Strategy 2014–2017 continues to take forward a programme of activity across 11 strategic priorities, seeking to: support a focus on growth and reform; promote effective practice within Greater Manchester; and challenge the status quo on key national policy issues. Work taken forward through the strategy has contributed to a range of business areas, including the following.

Licensing, regulation and compliance – Greater Manchester authorities are promoting the effective and consistent use of licensing/ regulatory tools and powers, with a best-

practice toolkit devised, strong lobbying for change in respect of the 2003 Licensing Act, and a suite of devolution ‘asks’ tabled with government.

Alcohol campaigns and awareness raising – supporting the principle of local democratic leadership on public health, work through the strategy has maximised the impact of Greater Manchester campaign activity (with a particular focus on protecting young people from the harm of alcohol advertising). This has complemented local targeted campaigns to reach priority groups such as middle-aged drinkers and female drinkers, and specific programmes looking at the issue of drinking at home.

New solutions to addressing the key drivers of avoidable ill health – a Communities in Charge of Alcohol (CICA) programme is being developed, which recognises that the citizens of Greater Manchester will be active participants in supporting and enabling their own better health outcomes, and seeks to establish a new network of health champions. Parallel, asset-led work is also pursuing fresh collaboration opportunities with Greater Manchester universities and unions in respect of building a culture of responsible attitudes towards alcohol. At the locality level, Greater Manchester’s recent status as a Home Office initiative: Wave 1 Local Alcohol Action Area has provided continued impetus to address alcohol health harm through effective, recovery-oriented treatment, with a greater focus on early intervention and prevention.

‘Greater Manchester Moving: The Blueprint for Physical Activity and Sport’ was established in 2015 as the foundation for a social movement to reduce inactivity and increase physical activity across Greater Manchester. Subsequently, in 2016 a memorandum of understanding (MoU) was signed between Sport England, the GMCA and the NHS in Greater Manchester. This provides an agreed framework to explore the delivery of both the Government’s and Sport England’s strategies for sport and physical activity at a Greater Manchester level, placing the customer first and central to all thinking and delivery while contributing to the strategic priorities of Greater Manchester, particularly regarding health, economic growth and social wellbeing.

The MoU will:

- have a framework that provides fundamentally different propositions to enable healthier, more resilient and empowered residents to take charge of their own wellbeing, including supporting inactive neighbourhoods and communities
- develop an insight-led, behaviour-change approach to sport and physical activity, starting with the individual and their communities and designing and delivering sport and physical activity according to their specific needs and wishes
- have shared metrics, performance measures and a robust cost benefit analysis for all joint areas of work, which will specifically include decreasing the number of inactive people, increasing participation of under-represented groups and increasing the number of people taking part in sport and physical activity more regularly
- demonstrate impact across government’s five outcomes for sport and physical activity – physical health, mental wellbeing, individual development, social/ community development, and economic development.

We recognise that work needs to be developed at a Greater Manchester level to address the significant challenges related to obesity. We need to build on the best practice already underway such as the NHS Diabetes Prevention Programme (NHS DPP). The NHS DPP is a joint commitment from NHS England, Public Health England and Diabetes UK to deliver at-scale, evidence-based, behavioural interventions for individuals

identified as being at high risk of developing type 2 diabetes. Framing the problem posed by obesity in the context of diabetes is one important element of a wider programme to address obesity, but this needs to sit alongside collaborative approaches targeting the achievement of higher levels of physical activity in the general population as the 'norm', and innovative approaches towards food and nutrition. A focus on socio-economic and wider inequalities must form part of this.

From April 2017, all areas of Greater Manchester will start to offer behavioural interventions to people at risk of developing type 2 diabetes. This follows Salford leading as a demonstrator site, Bury, Oldham and Rochdale being early adopters and a successful bid led by the Greater Manchester Strategic Clinical Network to incorporate a further eight areas in to the NHS Diabetes Prevention Programme (NHS DPP). Those people identified and found to be applicable will be invited to attend an evidence-based course that either delays the possibility of developing type 2 diabetes or prevents it altogether.

Lifestyle and wellness services

The drive to more person-centred wellness and lifestyle services, which recognises that many of our Greater Manchester population have multiple unhealthy lifestyle risk factors and requires person-centred approaches that address the psychosocial and wider determinants of health, has been around for a number of years; however, progress has been slow. In addition, the reach of such services into the populations most at need is limited and more work needs to be done to extend such service offers into the C2DE cohort (the three lower socio-economic groups) with particular focus on 40 to 60-year-olds. Devolution offers us an opportunity to deliver a radical upgrade in lifestyle behaviour change support that delivers innovative approaches at scale to drive long-term behaviour changes and reduces current and future demand on health services from lifestyle-related long-term conditions.

Our role as public sector employers

We also want to ensure that, as a public sector and major employer accounting for over 18% of all jobs in the region, we are a positive role model for workplace health, innovating and implementing best practice to support our 219,400 staff to stay healthy and serve as health champions in their local communities.

4.3.7 Plan

4.3.7.1 Objectives

The objectives of this programme are to develop Greater Manchester-wide approaches to tackle the main lifestyle risk factors, i.e. smoking, physical inactivity, alcohol, poor diet and obesity, including developing innovative approaches that can be tested at scale.

Objective 1: To develop a comprehensive Greater Manchester Tobacco Control Plan that is fully aligned to the Population Health Plan priority themes and wider reform agenda.

Objective 2: To support the development and implementation of a refreshed and integrated GMCA Substance Misuse Strategy.

Objective 3: To develop a comprehensive plan to reduce inactivity and increase participation in physical activity and sport that is aligned to the Population Health Plan priority themes and wider reform agenda.

Objective 4: To develop a comprehensive plan for better nutrition and healthy weight that is fully aligned to the Population Health Plan priority themes and wider reform agenda.

Objective 5: To develop a whole systems approach to lifestyle and wellness services, including testing innovative service delivery models for incentivising and supporting lifestyle behaviour change, and to:

- work with a pathfinder local provider to test out and develop an effective delivery model aimed at promoting a radical upgrade in self-care and lifestyle prevention, which can be tested at scale in parts of Greater Manchester
- develop and test an innovative incentives-based digital platform to support lifestyle behaviour change at scale aimed at Greater Manchester's public sector workforce
- develop standards and a performance framework for Greater Manchester integrated wellness services to ensure a more standardised offer for Greater Manchester residents
- develop the role of wider primary care in supporting lifestyle behaviour change

4.3.7.2 Approach to delivering objectives

Objective 1: To develop a comprehensive Greater Manchester Tobacco Control Plan that is fully aligned to the Population Health Plan priority themes and wider reform agenda.

The project will seek to:

- develop a costings model that includes staffing costs and non-pay budget to secure services of an expert reference group
- utilise best evidence and modelling analysis for Greater Manchester to identify the key components of a comprehensive plan
- engage with all key sectors, organisations and localities to identify their contribution to a Greater Manchester plan
- produce a detailed plan and implementation timeline
- work with New Economy Manchester to carry out cost benefit analysis to support bid to Transformation Fund and development of evaluation framework for plan
- develop and secure transformation funding to resource key elements of plan.

Objective 2: To support the development and implementation of a refreshed and integrated GMCA Substance Misuse Strategy.

The project will seek to:

- secure full support of the Greater Manchester health and social care system to the process of refreshing the strategy and defining an integrated suite of shared priorities
- leverage support for all relevant workstreams within the Greater Manchester Substance Misuse Review – with the ultimate aim to ensure that substance misuse service delivery for drugs, alcohol and new psychoactive substances is better co-ordinated and delivering the best possible outcomes across Greater Manchester
- embed strategic dialogue on alcohol harm in the wider context of devolution, and promote collaborative commissioning through a recognition of alcohol as a cross-cutting priority in other Population Health Plan theme areas.

Objective 3: To develop a comprehensive plan to reduce inactivity and increase participation in physical activity and sport that is aligned to the Population Health Plan priority themes and wider reform agenda.

The project will seek to:

- engage with all key sectors, organisations and localities to identify their contribution to a Greater Manchester plan
- develop an insight-led, behaviour-change approach to sport and physical activity, starting with the individual and their communities
- produce a detailed plan and implementation timeline to drive the outcomes of the MoU

- develop opportunities to secure Greater Manchester and national resource to enable delivery of key elements of plan, which would include having shared metrics, performance measures and a robust cost benefit analysis for all joint areas of work.

Objective 4: To develop a comprehensive plan for better nutrition and healthy weight that is fully aligned to the Population Health Plan priority themes and wider reform agenda.

The project will seek to:

- develop a costings model that includes staffing costs and non-pay budget to secure services of an expert reference group
- utilise best evidence and modelling analysis for Greater Manchester to identify the key components of a comprehensive plan
- engage with all key sectors, organisations and localities to identify their contribution to a Greater Manchester plan
- produce a detailed plan and implementation timeline
- work with New Economy Manchester to carry out cost benefit analysis to support bid to Transformation Fund and development of evaluation framework for plan
- develop and secure transformation funding to resource key elements of plan.

Objective 5: To develop a whole systems approach to lifestyle and wellness services, including testing innovative service delivery models for incentivising and supporting lifestyle behaviour change.

Objective 5.1: Work with a pathfinder local provider to test out and develop an effective delivery model aimed at promoting a radical upgrade in self-care and lifestyle prevention, which can be tested at scale in parts of Greater Manchester.

This project will seek to:

- use national exemplars and local good practice to document a replicable and scalable model that can be tested at scale in parts of Greater Manchester
- develop a costings model that includes staffing costs and non-pay budget to secure services of an expert reference group
- secure local provider partners to be part of the trial
- work with New Economy Manchester to develop an initial cost benefit analysis based on work to date and to support development of transformation bid
- develop a business case to support the adoption and testing of the new model across two or three localities and secure monies from Greater Manchester Transformation Fund
- support a number of localities to collaborate to implement the described model, recognising the local variations that may be required
- develop a business case that builds on the evaluation of testing the model to support expansion of the project across other parts of Greater Manchester.

4.3.7.3 Programme of work – scope

The proposal is to develop a three-tiered behaviour-change support offer across Greater Manchester (see figure 25). This is in effect a hub and spoke model. The first two tiers, including a web portal and virtual telephone support, can be provided at a sector level and will integrate with the third tier, which is the locality-based lifestyle and wellness service offer.

A key principle is that of proportionate universalism, where the service response will be according to need.

The primary audience for the service will be the target demographic for the Public

Health England One You lifestyle campaign. This is C2DE aged 40-60, because evidence suggests a strong link between unhealthy behaviours and social class and NICE identifies the 40-60 age group as a key window of opportunity to engage adults in their own health to prevent disease in later life. This enables Greater Manchester to capitalise on the current national campaign of focus (One You) and prioritise digital content to support its delivery.

Objective 5.2: Develop and test an innovative incentives-based digital platform to support lifestyle behaviour change at scale aimed at Greater Manchester's public sector workforce.

The project will seek to:

- secure an existing developer to develop a bespoke incentivised digital health platform to support at scale self-care, and pilot the programme with Greater Manchester public sector staff
- undertake consumer research to ensure that the incentives package is attractive to the target audience
- work with developer and New Economy to carry out cost benefit analysis to support bid to Transformation Fund
- develop a costings model that includes staffing costs and non-pay budget to secure services of an expert reference group
- develop and secure transformation funding to resource the development, commissioning and evaluation of a pilot programme for Greater Manchester public sector staff
- evaluate service model to inform further roll-out.

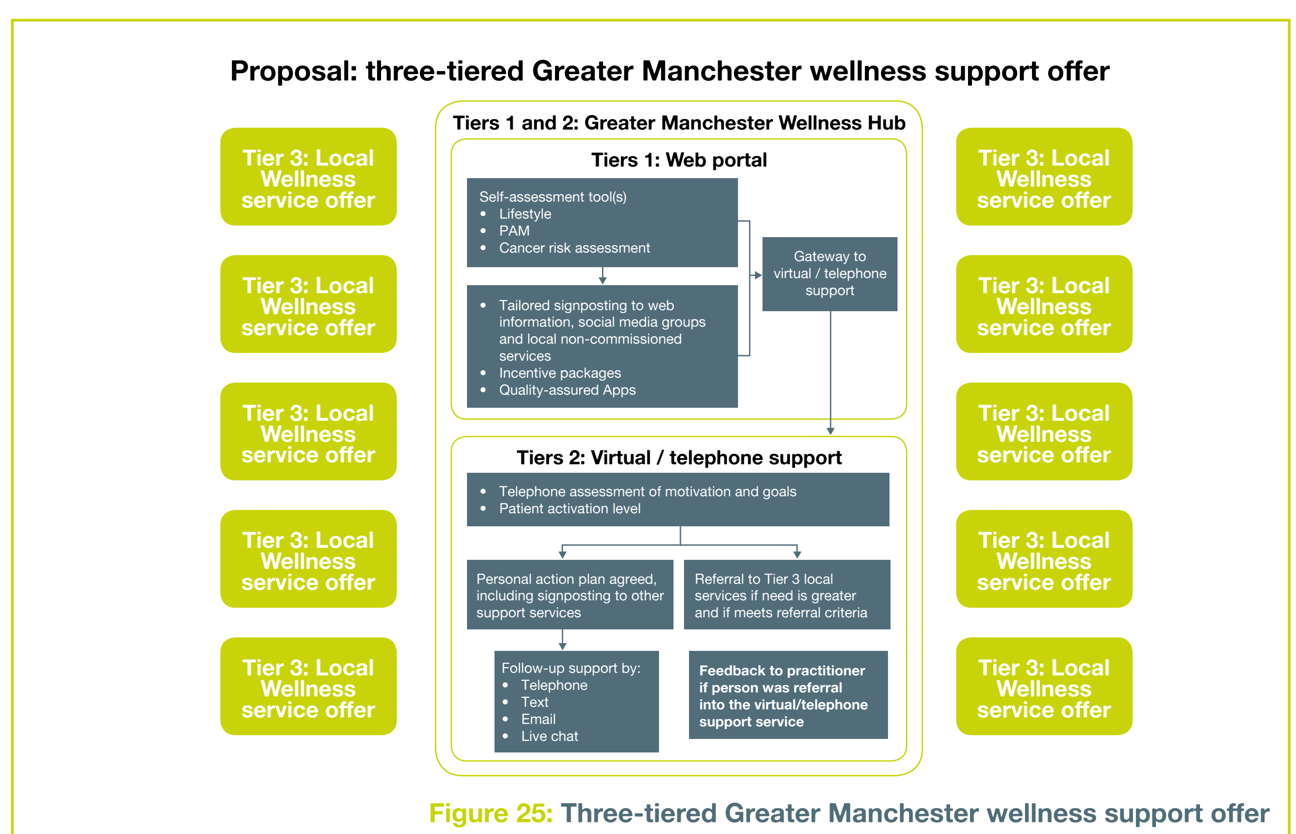


Figure 25: Three-tiered Greater Manchester wellness support offer

4.3.7.4 Programme of work – scope

This is a more basic service delivery model in comparison with the lifestyle and wellness hub described above.

Its central feature is the provision of an online incentives package that rewards participants for undertaking health promoting behaviours such as screening or quitting smoking.

It would take the form of a digital platform, with an interactive directory and incentivised health platform (see figure 26).

Such a platform could also support other digital offers, such as Orcha, a Wakelet page for community champions to collect and share content, and access to managed social media options.

Objective 5.3: Develop standards and a performance framework for Greater Manchester integrated wellness services to ensure a more standardised offer for Greater Manchester residents.

The project will seek to:

- define key standards and performance metrics that describe a consistency of approach and quality against which services can be commissioned, monitored and evaluated
- gain agreement from the system to adopt and implement the standards and performance framework
- launch the framework to cement support across the system for this way of working.

Objective 5.4: Develop the role of wider primary care in supporting lifestyle behaviour change.

The project will seek to:

- develop the role of the primary dental care setting in delivering brief interventions, particularly focusing on smoking cessation and reduction of harmful drinking (both significant risk factors for mouth cancer as well as other health conditions)

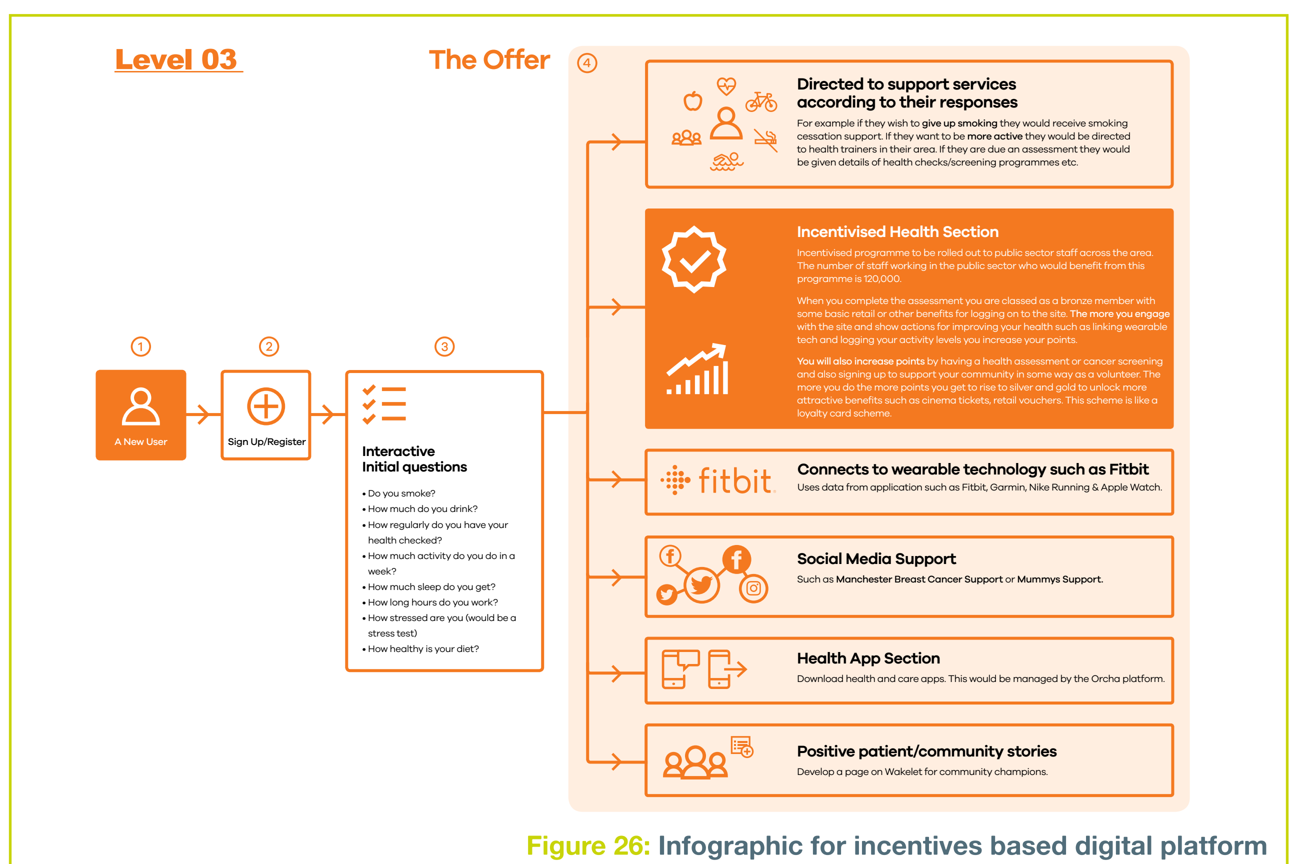


Figure 26: Infographic for incentives based digital platform

- facilitate the roll-out of the Healthy Living Framework to all pharmacy, optometry, dental and general practice providers.

4.3.7.5 Target outcomes for 2016/17 and 2017/18

Outcome 1: Comprehensive Greater Manchester Tobacco Control Plan produced that is fully aligned to the Greater Manchester Population Health Plan priority themes and wider reform agenda

Outcome 2: Refreshed and integrated GMCA Substance Misuse Strategy developed and implemented

Outcome 3: Comprehensive physical activity plan produced aimed at reducing inactivity and increasing participation in sport and physical activity, and fully aligned to the Greater Manchester Population Health Plan and wider reform agenda

Outcome 4: Comprehensive plan for better nutrition and healthy weight produced, linked to the Population Health Plan priority themes and wider reform agenda

Outcome 5a: New delivery model tested and evaluated with pathfinder local provider, aimed at promoting a radical upgrade in lifestyle prevention and self-care

Outcome 5b: Innovative incentives package to support lifestyle behaviour change for public sector workforce tested and evaluated

Outcome 5c: Greater Manchester will have a standards and performance framework for lifestyle services agreed by all commissioners to support localities

4.4 Cancer prevention and early detection

4.4.1 Background

Cancer survival rates are at their highest, with more than half of those diagnosed living for at least 10 years. However, it is estimated that by 2020 more than one in two people will be affected by cancer at some point in their lives, which is particularly alarming given evidence suggesting that 42% of the country's most common cancer cases could be preventable. In the last five years, almost 600,000 cancer cases in the UK could have been prevented by modifications to lifestyle factors.

The NHS Five Year Forward View signalled a continued focus on improving care, treatment and support for everyone diagnosed with cancer. It set an ambition to improve outcomes across the whole pathway, including:

- better prevention
- swifter diagnosis
- better treatment, care and aftercare.

In 2015, following the publication of the NHS Five Year Forward View, NHS England established the Independent Cancer Taskforce to look at how cancer services are currently provided and to set out a vision for what cancer patients should expect from the health service. The taskforce produced a report, 'Achieving World-Class Cancer Outcomes – A Strategy for England 2015-2020', which included 96 recommendations to help transform the care that the NHS delivers for all those affected by cancer.

A plan has now been launched to deliver these changes. It is designed to increase cancer prevention, speed up diagnosis, invest in technology, improve patient experience and help people living with and beyond cancer.

As part of this plan, new models of care piloted by the National Cancer Vanguard will aim to radically improve patient outcomes and save thousands of lives every year by developing new models of care that are ambitious and transformational, and provide replicable models for cancer care nationally that will act as blueprints for the NHS. Its key objectives are to:

- improve rates of earlier diagnosis and detection

- improve patient outcomes
- reduce variation
- improve patient experience

The National Cancer Vanguard is led by The Christie, The Royal Marsden and University College London Hospitals. The three organisations will lead a local delivery system – Greater Manchester Cancer, Royal Marsden Partners and University College London Hospitals Cancer Collaborative – which comprises health organisations in their area, including clinical commissioning groups, NHS acute trusts, community services and hospices, that will develop and trial new models to improve cancer care along the patient pathway.

4.4.2 Greater Manchester context

A key commitment in 'Taking Charge' is to deliver improvements in our cancer services and outcomes, with a particular focus on reducing premature mortality from cancer by 1,300 fewer deaths by 2021. This is based on the transformation of our health and social care system towards prevention and earlier intervention.

Half of people born since 1960 will be diagnosed with cancer in their lifetime, and every 30 minutes someone in Greater Manchester is told they have cancer. The incidence of cancer is growing at a rate of about 2% per annum; in 2013, 14,500 people were diagnosed with cancer in Greater Manchester. This means the burden of cancer on our health and social care system is growing. There were 89,200 GP referrals for suspected cancer to Greater Manchester hospitals in 2014/15, up from 77,800 the year before. The National Audit Office estimates cancer-related costs for the NHS in England – extrapolating from these costs for Greater Manchester gives approximate costs of £335m in 2012/13, rising to £650m by 2020/21 (acknowledging that these do not capture all costs, such as those incurred by primary care).

Clearly we will not be able to sustain comprehensive health and social care coverage unless we take more concerted action on prevention. Rising numbers of cancer cases that could be prevented should be seen as unacceptable. It is within our control to prevent many cases of cancer and we should seize this opportunity. More than four in 10 cases of cancer are caused by aspects of our lifestyles that we have the ability to change. Tobacco remains the main risk factor, followed by obesity, alcohol consumption and physical inactivity.

Earlier diagnosis of the disease is also essential if we are to take meaningful steps in improving survival for our patients. The key here is a strong focus on improving the uptake of the three national cancer screening programmes. Screening contributes to reducing incidence and improving outcomes for those patients whose cancers can be treated at an earlier stage. England's existing cancer screening programmes already save thousands of lives each year. However, there is potential to do better, to reduce the considerable variation in uptake of these programmes and further develop the programmes by introducing new tests.

With increasing numbers of people surviving their primary cancer, we also need a stronger focus on preventing secondary cancers.

4.4.3 Opportunity

In 2015 Greater Manchester was designated as part of the National Cancer Vanguard. The two-year vanguard programme will allow the testing of clinical innovations and a new approach to the commissioning of cancer and delivery for the Greater Manchester population. It began delivery in April 2016. Central to the Greater Manchester programme is a prevention workstream, which incorporates primary and secondary prevention projects as well as a focus on screening.

In summer 2016 a new Greater Manchester Cancer Board was established to oversee all cancer activity in the area, and it will develop a five-year cancer plan to transform services and re-orientate the system towards prevention and early detection. This is an opportunity for Greater Manchester to strengthen and build on the work of the National Cancer Vanguard and other innovations such as the Macmillan Cancer Improvement Partnership (MCIP), led by the three CCGs in Manchester.

As identified above we want to reduce premature mortality from cancer by 1,300 fewer deaths by 2021. On average, over a three-year period from 2012-14, cancer was responsible for 7,571 deaths in Greater Manchester and half of those were preventable. The main driver of premature mortality and health inequalities in Greater Manchester is related to tobacco. Despite significant improvements made in recent years to reduce smoking, smoking rates in Greater Manchester are significantly higher than in the rest of England and 21% or about 450,000 adults still smoke. This equates to around 70,000 more smokers than if Greater Manchester was at the England average. Smoking also significantly contributes to health inequalities, as smoking rates among our poorest families are twice the Greater Manchester average. Therefore a key focus of work for the Greater Manchester Cancer Board will be tobacco control.

4.4.4 Plan

4.4.4.1 Objectives

The overall objectives of the programme are to effectively deliver the cancer prevention workstream of the National Cancer Vanguard by April 2018, testing and evaluating innovative approaches to awareness and behaviour change, social movement, cancer screening uptake and lifestyle-based secondary prevention. This includes four key objectives.

- **Objective 1:** To develop new Greater Manchester-wide social marketing strategies for cancer to scale up prevention and earlier detection
- **Objective 2:** To apply at scale a multi-faceted approach to nurture a social movement across the entire cancer prevention spectrum that is ultimately self-sustaining, as part of the national pilot programme Health as a Social Movement
- **Objective 3:** To improve access to, and uptake of, three national cancer screening programmes (bowel, breast, and cervical) among the eligible population of Greater Manchester residents
- **Objective 4:** To develop a Greater Manchester-wide service model that increases tailored lifestyle support for those surviving cancer, focusing on reducing the chance of secondary cancer (metastasis)

Furthermore, through the MCIP work the three Clinical Commissioning Groups in Manchester are pilot testing an innovative service that aims to detect lung cancer earlier. The pilot service offers people at high risk of lung disease an opportunity to attend a lung health check. If the pilot of the MCIP lung health check is shown to be successful we will roll it out across Greater Manchester to transform our lung cancer outcomes.

4.4.4.2 Approach to delivering objectives

Objective 1: To develop new Greater Manchester-wide social marketing strategies for cancer to scale up prevention and earlier detection.

In Year 1 the project will seek to:

- work in partnership with PHE/Cancer Research UK (CRUK) to test out, deliver and evaluate a major bowel screening campaign to improve uptake, featuring mass media (TV, outdoor media etc) and direct mail

- commission additional behavioural insights research into Greater Manchester to gain a deeper understanding of the core behavioural attitudinal barriers and motivators for our population
- use the insights gained to amplify the CRUK/PHE campaign activity to nudge further Greater Manchester audiences into participation
- undertake evaluation to inform future national and local campaign activity.

In Year 2 the programme will:

- commission primary and secondary qualitative and quantitative research to segment, profile and prioritise our smoking population
- using the above audience profiling and behavioural insights, design a social marketing programme
- co-ordinate delivery and evaluation of Greater Manchester social marketing programme
- undertake evaluation to inform future campaign activity.

Objective 2: To apply at scale a multi-faceted approach to nurture a social movement across the entire cancer prevention spectrum that is ultimately self-sustaining, as part of the national programme to pilot Health as a Social Movement.

The project will seek to:

- work in partnership with the third sector to develop an exemplar social movement –focused on cancer prevention
- apply at scale a multi-faceted approach to nurture a citizen-led social movement across the entire cancer prevention spectrum
- develop a network of 20,000 cancer champions and expert patients to provide a ‘more than medicine’ approach
- demonstrate ‘what works’ using rigorous evaluation approaches
- support spread – in Year 3, identifying approaches that could be scaled or adapted and adopted in other communities
- explore the digital opportunities that would support mass involvement, such as social media approaches.

Objective 3: To improve access to, and uptake of, three national cancer screening programmes (bowel, breast, and cervical) among Greater Manchester’s eligible population.

The project will seek to:

- increase the effectiveness of the initial invites letters through the application of innovative behavioural insight techniques. This will involve running randomised control trials over a six-month period to test out the different approaches
- commission health equity assessments (HEAs) for all providers of cancer screening services to identify inequities in service usage and test out service changes based on findings of HEAs
- design and test out innovative patient engagement approaches to improve people’s experience of screening and to increase uptake of screening and self-care
- evaluate different approaches to inform local and national roll-out.

Objective 4: To develop a Greater Manchester-wide service model that increases tailored lifestyle support for those surviving cancer, focusing on reducing the chance of secondary cancer (metastasis).

The project will seek to:

- develop and test out an effective delivery model of lifestyle-based secondary prevention as part of the vanguard‘s new aftercare pathways for breast, urology and colorectal cancer

- develop and roll out a locality-based, lifestyle behaviour change support offer with a focus on Greater Manchester-wide access to exercise referral programmes for cancer survivors, providing increased access to tailored physical activity programmes
- develop and test a digital platform (tech bundle) to enable cancer patients to access professionally approved secondary prevention self-management content, mobile applications, managed social support networks and links to locality-based prevention services
- evaluate different approaches to inform further roll-out.

4.4.4.3 Outcomes

The overall objective is to make a significant contribution to reducing the number of premature deaths due to cancer by 1,300 fewer deaths by 2021, through improved prevention and earlier diagnosis. More specific outcomes include:

- **Outcome 1:** Increased uptake of bowel screening (+10% in first timers and +3% in non-responders)
- **Outcome 2: I**ncrease in smoking quitters
- **Outcome 3:** The development of a mass social movement across the entire cancer prevention spectrum that is ultimately self-sustaining, and spread of effective approaches to other communities/areas
- **Objective 4:** Improved uptake to the three national cancer screening programmes (bowel, breast, and cervical) among the eligible population of Greater Manchester residents
- **Objective 5:** The development of lifestyle support offer for cancer survivors in Greater Manchester with a focus on secondary prevention of cancer

4.5 Scaling up our response to HIV eradication

4.5.1 Background

A 2015 report by Public Health England (PHE) estimated that 103,700 people were living with HIV in the UK in the year 2014. Once people are diagnosed they are able to receive very effective treatment. However, nationally 17% of people living with HIV are unaware of their status. Furthermore, 40% of adults newly diagnosed with HIV were diagnosed late, after they should have started treatment (PHE, 2014).

Late diagnosis reduces health outcomes for HIV-positive people, as well as increasing the likelihood of onward transmission of HIV. In addition to the negative effects of late HIV diagnosis on an individual's and population's health, it also makes an impact upon the public purse; the lifetime treatment cost of living with HIV is estimated to be around £360,000. Late diagnosis increases further the cost of HIV treatment by 50%.

It is well recognised that HIV symptoms are frequently missed. As a consequence, many people that have been diagnosed with HIV have previously presented at a healthcare setting but HIV diagnosis had been missed. Furthermore, while HIV is a condition that can affect all population groups, some communities are more disproportionately affected by HIV.

- Gay, bisexual and other men who have sex with men (MSM): Across the UK, one in 20 gay men is living with HIV. In large cities like Manchester, the figure is more likely to be one in 10. A total of 44,980 gay, bisexual and other men who have sex with men are living with HIV (prevalence of 4.8%).
- People from Black and minority ethnic groups (BME) made up 40% of HIV-positive individuals accessing treatment and care in Greater Manchester in 2015, a substantial over-representation compared

to the proportion of BME groups in the Greater Manchester population as a whole (16%).

- Transgender population: One worldwide meta-analysis of 39 studies from 15 countries found that transgender women had an HIV prevalence rate of 19% – 49 times higher than that of the general population. In high-income countries the prevalence was 22%, with the highest rate among transgender women of colour (aidsmap, 2016).

Late diagnosis of HIV is a key public health issue as identified within the Public Health Outcomes Framework. If someone has a late HIV diagnosis, they are 10 times more likely to die within the first year of diagnosis compared to people diagnosed promptly (PHE, 2014).

It has also been recognised that further progress needs to be made in improving early diagnosis of HIV; nationally, there is a need to increase and target HIV testing in order to improve early diagnosis and to reduce onward transmission by getting people onto treatment. Early diagnosis results in earlier treatment (National Institute for Health and Care Excellence, 2016).

We have an opportunity in Greater Manchester to strengthen a city-region approach to eradicating HIV within a generation, by adopting a similar approach to the Fast-Track Cities Initiative.

The Fast-Track Cities Initiative aims to build upon, strengthen and leverage existing HIV programmes and resources in 'high HIV burden' city-regions to strengthen local AIDS responses, including attaining the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 targets:

- 90% of all people living with HIV (PLHIV) will know their status
- 90% of all PLHIV will receive sustained antiretroviral therapy (ART)
- 90% of all PLHIV on ART will have durable viral suppression.

4.5.2 Greater Manchester context

There is clear synergy with a city-region approach to eradicating HIV within a generation and the vision of transforming population health in Greater Manchester; to deliver the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million people of Greater Manchester.

In particular, a city-region approach fits with the Greater Manchester objective to transform our health and social care system to help more people stay independent and well and take better care of those who are ill. It does this by preventing onwards transmission of HIV, both through earlier diagnosis and identification of undiagnosed people living with HIV; across Greater Manchester there are estimated to be 984 people living with undiagnosed HIV. These individuals are very much a part of the 'missing thousands' (i.e. those that are unknown to the system, but live and work in the community) identified within Greater Manchester priorities. An innovative, ambitious programme of upscaling of HIV testing and associated interventions, particularly targeted at and with those communities most at risk of acquiring HIV, is an opportunity for Greater Manchester.

The Fast-Track Cities Initiative complements and adds value to the Greater Manchester focus on Health as a Social Movement through utilising the assets of communities, supporting people to talk about the importance of HIV testing and sharing people's stories of how they maintain their wellbeing. This is focused upon communities taking charge of their own health.

Reducing late diagnosis of HIV is a key Public Health Outcomes Framework indicator. Upscaling targeted HIV testing is a key mechanism to achieve this. A combination approach to prevention is a key part of the Fast-Track Cities Initiative, which includes not

only testing but also pre-exposure prophylaxis (PrEP), prompt access to treatment and support with adherence.

- 4,922 HIV-positive Greater Manchester residents accessed treatment and care in 2014, a 5% increase on the number reported in 2013 (4,682 individuals).
- It is estimated that one in six people living with HIV in the UK is yet to be diagnosed.
- This means there could be approximately a further 984 people living undiagnosed with HIV in Greater Manchester.
- Overall prevalence of HIV in Greater Manchester is 2.78 per 1,000 population, (significantly higher than the England rate of to 2.1 per 1,000).
- Two local authorities in Greater Manchester, Manchester (5.83 per 1,000 population aged 15-59) and Salford (4.8) have an adult prevalence of over two per 1,000 population, the threshold at which the British HIV Association recommends routine testing for all medical admissions and new GP registrants.
- The dominant mode of HIV exposure is men who have sex with men (MSM) at 57% of new cases, followed by heterosexual sex, representing 37% of new cases.
- The predominant route of infection for new cases in 2014 was MSM (57%) but this varied across local authorities, with the majority of new cases in Stockport, Bury and Trafford being among MSM (71%, 62%, and 62% respectively) while in Wigan a higher proportion of new cases were acquired heterosexually (56%).
- People from BME groups made up 40% of HIV-positive individuals accessing treatment and care in Greater Manchester in 2015, a substantial over-representation compared to the proportion of BME groups in the Greater Manchester population as a whole (16%).
- Compared to other people living with HIV, people who died of an AIDS-related cause in 2014 had the highest mean number of outpatient visits (5.8) and spent the greatest mean number of days as inpatients (19.6 days).

4.5.3 Opportunity

There is opportunity to develop a city-region approach to eradicating HIV within a generation. Greater Manchester devolution and closer integration and collaborative approaches present opportunities for cross-sector partnership working to eradicate HIV within a generation, with public, voluntary and private sectors developing an ambitious programme to identify the missing 984 people living with HIV.

Deeper exploration of the barriers and enablers of reducing late and undiagnosed HIV across Greater Manchester will help formulate a Greater Manchester strategy to eradicate HIV within a generation. Shared Greater Manchester system leadership will provide opportunities for analysis of how both more frequent and earlier HIV testing, at scale and targeted at those communities most at risk, could be implemented.

This Greater Manchester-wide city-region approach will also encompass transferable learning for addressing other health priorities and inequalities. This would include the similar challenges with early diagnosis of hepatitis B and hepatitis C, which this Greater Manchester approach can also help to tackle.

There are pockets of existing or recent best practice in individual Greater Manchester boroughs, which could be more fully explored to identify areas that could be scaled up via a Greater Manchester approach. Regarding community-based HIV testing, LGBT Foundation is working in partnership with health equalities charity BHA, local PHE teams and sexual health commissioners to provide point-of-care HIV testing in community settings, churches etc. This approach is

particularly targeting those most at risk of acquiring HIV infection; gay, bisexual and other MSM and Black African communities. The project is currently in its delivery phase but it is proving to be successful and there are opportunities to explore scaling up provision and replicability in its community-led and focused approaches.

A city-region approach and Greater Manchester strategy also provides opportunities to explore associated enablers for eradicating HIV within a generation. These could include evaluation of access to post-exposure prophylaxis (PEP) and exploration of how partner notification is currently working in Greater Manchester.

4.5.4 Plan

4.5.4.1 Objectives

The objectives of this programme of work are to help develop a Greater Manchester city-region approach to eradicating HIV within a generation. It would facilitate the roll-out, testing and evaluation of an approach to tackling issues around undiagnosed and late diagnosis of HIV. The project would be informed by existing good local practice, including the current PHE community-based point of care test project, access to HIV testing within healthcare settings and PEP. The project is set up to achieve the following core objectives.

- **Objective 1:** Review and map out current HIV testing approaches and related interventions across Greater Manchester, to inform the ambition of eradicating HIV within a generation.
- **Objective 2:** Develop a business case that builds on the robust review and mapping exercise of HIV testing provision and associated interventions, and which demonstrates the economic and health benefits of a Greater Manchester city-region approach to eradicating HIV within a generation. To then pilot and evaluate a Greater Manchester city-region approach to eradicating HIV within a generation.

4.5.4.2 Approach to delivering objectives

Objective 1: Review and map out current HIV testing approaches across Greater Manchester, to inform the ambition of eradicating HIV within a generation.

The project will seek to:

- describe a Greater Manchester vision around reducing undiagnosed and late HIV diagnosis
- work with the Greater Manchester Sexual Health Network, mapping out current HIV testing methods and associated interventions
- utilise data within the public health domain to inform future HIV testing approaches
- develop a costings model for the possible expansion of HIV testing services, targeted at Black African and gay, bisexual and other MSM communities, across Greater Manchester
- develop and secure transformation funding to fund roll-out to adopt and test the model.

Objective 2: Develop a business case that builds on the robust review and mapping exercise of HIV testing provision and associated interventions, and which demonstrates the economic and health benefits of a Greater Manchester city-region approach to eradicating HIV within a generation. To then pilot and evaluate a Greater Manchester city-region approach to eradicating HIV within a generation.

The project will seek to:

- provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model
- collate HIV data from a range of sources for analysis across Greater Manchester

- develop cost benefit analysis for a city-region approach to eradicating HIV within a generation, particularly the upscaling of HIV testing
- collate lessons learned in targeting HIV testing for Black African and gay, bisexual and MSM communities in order to inform future development of HIV testing models across Greater Manchester
- explore different sustainability and investment models.

4.5.4.3 Target outcomes for 2016/17 and 2017/18

The programme will work towards achieving three key outcomes.

- **Outcome 1:** Through partnership working across Greater Manchester and mapping of current practice, a Greater Manchester-wide HIV strategy for eradicating HIV within a generation, has been developed.
- **Outcome 2:** A model to increase HIV testing and associated interventions has been developed.
- **Outcome 3:** A business case and plan for the Greater Manchester-wide roll-out of the model has been produced and agreed and a Greater Manchester pilot implemented.

4.5.4.4 Programme of work – scope

Greater Manchester residents who are currently living with undiagnosed HIV are the primary target cohort who would benefit from this intervention. It is estimated that 984 people are currently living with undiagnosed HIV across Greater Manchester. Thus, the programme would seek to target, reach and work alongside this key population group, through a community-led, assets-based approach.

The specific sub-groups within this proposal, who are intended to benefit most from this programme, are those communities that shoulder a disproportionate burden of HIV; gay, bisexual and other MSM, Black African and trans communities.

The new delivery model would be a city-region approach to eradicating HIV within a generation. It would be a cross-sectoral collaboration, with the key driver being evidence-led interventions. This city-region approach would also capture wider benefits and learning for other health issues, and how these can be tackled Greater Manchester wide.

Central to the new approach is an evidence-led delivery model. System leadership and the development of a shared response to eradicating HIV within a generation will enable greater analysis and exploration of the barriers and enablers to reducing late diagnosis.

5. Age Well

Greater Manchester is leading the way in its efforts to promote healthy ageing, creating a vision for a society where older age is seen positively and people in later life are empowered to secure a healthy future and good quality of life for themselves. There is a wide range of activity already underway that complements and enhances the projects in the Greater Manchester Population Health Plan.

They include the following.

- In September 2016 Greater Manchester achieved European Innovation Partnership on Active and Healthy Ageing reference site status.
- The Greater Manchester Ageing Hub and the national Centre for Ageing Better have agreed funding that will support the work of the hub to work to achieve a world-class age-friendly city-region.
- The collaboration between Salford Royal NHS Foundation Trust and the Haelo innovation and improvement science centre, through Dementia United, aims to make Greater Manchester the best place in the world to live for people with dementia and improve the lived experience of people with dementia and their carers.
- Greater Manchester Centre for Voluntary Organisation (GMCVO) has established and continues to lead the Big Lottery funded Ambition for Ageing programme, which aims to tackle at a community level the risks to health and wellbeing presented by social isolation and loneliness in older age.
- The developing Greater Manchester adult social care strategic proposals identify ‘support for carers’ as one of eight priorities, recognising that many carers are in later life themselves and can experience poor wellbeing due to health, economic and wider factors.

The aim of the Age Well theme in this plan is to promote active ageing and implement preventative and early intervention services to enable people to stay well and healthy in their own homes. We have focused on supporting people currently in early older age (65-75+) to maintain good health, social and emotional wellbeing, independence and quality of life for as long as possible, while also managing the current pressures associated with people who are very old (80-85+) where the challenge is to identify appropriate support and positive risk management to restore daily functioning and independence as far as possible or desirable. Our focus is on age-associated issues within the health, social care and housing sectors that are ‘modifiable’, based on evidence and effective interventions, and which will enable more people to stay well and live independently at home for as long as possible as they age.

The individual programmes of work within Age Well highlight common issues affecting health and wellbeing in older age that cross all ethnic and social groups. But each one will recognise the cumulative effect, over a lifetime, of social or economic disadvantage and how this can manifest in the earlier onset of physical and emotional ill health. These inequalities will be taken into account by effectively targeting all three projects towards the people who need support the most, which will include disadvantaged individuals and communities.

The three programmes of work have a good fit with the creation of locality care organisations (LCOs) and can be incorporated on a longer-term basis into the usual practices adopted and support offered through integrated health and social care teams. Current cost benefit analysis modelling suggests that there is a good case for each proposal to release savings back into the local health and social care system and for this reason we are suggesting that a central bid to the Transformation Fund is made for each project, to pump-prime the roll-out the proposals across Greater Manchester, with a view to them being locally financially sustainable after a given number of years.

5.1 Housing

5.1.1 Background

Poor housing is a driver of health inequalities, and those living in poverty are more likely to live in poorer housing or precarious housing circumstances or lack accommodation altogether. Generally speaking, the health of older people, children, disabled people and people with long-term illnesses is at a greater risk from poor housing conditions.

Direct effects of cold homes on a person's health can include: heart attacks, stroke, respiratory disease, flu, falls and injuries, and hypothermia. The indirect effects are poor mental health and risk of carbon monoxide poisoning. This in turn can lead to greater demand for health and emergency services. Inadequate housing causes or contributes to many preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer. Poor housing is estimated to cost the NHS at least £600 million per year.

In England and Wales trends in excess winter deaths have decreased by about 30% since 2008/09, when there were 36,450 deaths attributable to all causes. In 2010/11 there were 25,700 excess winter deaths. The majority of these occurred among those aged 75 and over.

From estimates of the Excess Winter Mortality Index (EWM Index) by the Office for National Statistics, circulatory diseases caused 37% of excess winter deaths in 2009/10. Respiratory diseases came in second and accounted for 32%. Cold homes are one contributor to this, and increase the risk of cardiovascular, respiratory and rheumatoid diseases as well as hypothermia and poorer mental health. Older, retired people are particularly at risk.

Around 1.8 million homes had damp problems in 2009. Privately rented homes were most likely to experience damp problems: 15% compared to 8% of owner-occupied homes and 10% of social housing. Twelve per cent of poor households lived with damp problems compared with 7% of other households.

There is evidence that interventions to improve the quality and suitability of the home environment can be effective in preventing, delaying and reducing demand for social care and health care; can enable people to manage their health and care needs; and can allow people to remain in their own homes for as long as they choose. There are substantial health benefits associated with improvements to housing conditions; for example, cavity wall insulation can deliver improvements equating to a health saving of £969.

One in three people aged over 65 and half of those aged over 80 fall at least once a year.

Falls are the commonest cause of death from injury in the over-65s, and many falls result in fractures and/or head injuries. Falls cost the NHS more than £2 billion per year and also have a knock-on effect on productivity costs in terms of carer time and absence from work.

Unsuitability of housing and the need for suitably adapted property can also prevent a timely transfer of care for patients back to their home from hospital. In a six-month period in 2015, 916 days were reported as delayed waiting for adaptations; a potential cost of £732,800 per year, assuming the cost of an acute bed to be £400 per day.

Housing plays a critical role in helping older people and adults with disabilities or mental health problems to live as independently as possible, and in helping carers and the wider health and social care system offer support more effectively. Evidence shows that Government investment in specialised housing for these groups is cost effective, with a positive impact on health and social care spend through for example, the prevention of falls, or a reduction in the levels of readmittance to hospital. Poor or inappropriate housing has been shown to put the health and wellbeing of people at risk. Evidence also demonstrates that a wide variety of outcomes are better for those living in specialised housing compared to regular housing.

The lack of an adequate supply of specialised housing means people are not able to make suitable housing choices, and are forced to stay in less suitable accommodation when, given the opportunity, they may wish to move. Furthermore, there is a lack of public awareness of the wider variety of housing models or solutions available.

In terms of the national policy context, the recent 'Memorandum of Understanding to support joint action on improving health through the home' (2014), recognises that the home environment is essential to health and wellbeing. Ensuring homes are safe, warm and dry can:

- delay and reduce the need for primary care and social care interventions, including admission to long-term care settings
- prevent hospital admissions
- enable timely discharge from hospital and prevent readmissions to hospital
- enable rapid recovery from periods of ill health or planned admissions.

The 'home' becomes a vital component in developing successful integrated services. The role that the housing sector can play in assisting people to live independently for longer is often underestimated and unrecognised by commissioning bodies.

The provision of adaptations to the home through Disabled Facilities Grants (DFGs) is a statutory requirement for local authorities. The funding stream recently became part of the Better Care Fund. The Care Act 2014 placed a responsibility on local authorities to ensure suitability of the living environment and recognised that preventative services such as 'handyperson' schemes can play a key role in ensuring people are able to live independently for longer.

5.1.2 Greater Manchester context

Housing growth is a priority for Greater Manchester and having the right type of homes to meet the needs of the population is fundamental to this. The emerging Greater Manchester Spatial Framework highlights the increasing ageing population and provisions that will need to be put in place to accommodate the changing demographic.

The Greater Manchester Low Carbon Hub has a priority to reduce fuel poverty through retrofitting existing homes with energy-efficient measures and behaviour change. More generally, local authority housing

officers and registered providers recognise the contribution that providing good-quality housing can have on an individual and their ability to live independently. However, this also has an impact on the health and social care system by reducing demand for health and social care through the integration of housing interventions.

By aligning our housing priorities with the vision for health at a Greater Manchester strategic level, we will be able to achieve:

- a better quality of life for our residents by 2020 and assist with closing the health inequalities gap
- a clear focus on prevention and re-enablement
- promote self-care at home and improve community resilience
- support effective discharge from hospital.

Greater Manchester-wide schemes focused on fuel poverty and energy efficiency have been successful in the past, ensuring the delivery of a baseline offer of insulation, boiler replacements, energy switching and behaviour-change advice to residents in Greater Manchester. However, these programmes have been reliant on Government funding, which has ceased, and now the emphasis is to work with private sector energy companies, which have an obligation to assist vulnerable households. However, this tends to be restrictive and cannot deliver at the same scale as when Government funding was available.

5.1.3 Opportunity

The next decade will see dramatic growth in the number of older people seeking help to remain at home as long as possible, while local authorities and health and social care conversely face continuing pressure to reduce costs and seek efficiencies. Home improvement agencies (HIAs) carry out small handyperson jobs and project-manage larger repairs and adaptations, as well as providing housing information and advice, for older and disabled customers. One main source of grant funding for the sector's activities, the Disabled Facilities Grant (DFG), is now part of the Better Care Fund (BCF), and the HIA sector has a central role in the Government's ambition for an integrated health and care system that promotes wellbeing at home and can provide a preventative response to reduce, delay or remove the need for costly institutional alternatives.

Integrating a home improvement agency model into a much larger jigsaw will ensure a greater range of resources, products and services can be deployed to keep a person living healthily at home. For health trusts and clinical commissioning groups, HIAs provide 'home-readying' services to ease hospital discharges, prevent readmission and provide the means to better self-manage health conditions.

Across Greater Manchester, different approaches have been taken to understanding the extent of poor-quality housing and also the level of interventions available. About half of the local authorities run a home improvement agency; however, some are more comprehensive than others. A number of local authorities use Age UK's handyperson service. There are best practice examples within Greater Manchester including Manchester Care and Repair, Bolton Care and Repair and St Vincent's Homecare and Repair.

Discussions have been undertaken with health, strategic housing, registered providers and the Low Carbon Hub on the concept of a Greater Manchester HIA model, and there is broad support.

The establishment of a Greater Manchester home improvement agency model, which builds on existing models in operation, would ensure that all districts are able to provide a basic offer to older and disabled residents, while also providing a single access point for health and social care professionals to

refer into. Procurement of adaptations and a handyperson service for Greater Manchester is also likely to lead to efficiencies. There is also scope to link Greater Manchester Fire Service Safe and Well checks into the model.

Targeting of customers most likely to be living in unsuitable housing, suffering from respiratory diseases, at risk of falls etc, and in receipt of homecare packages, would ensure resources are spent where most needed.

5.1.4 Plan

5.1.4.1 Objectives

The objective of this programme of work is to help facilitate the roll-out, testing and evaluation of an approach to tackling issues around poor-quality housing based on the work already taking place across Greater Manchester, in line with the other Population Health Plan proposals aimed at promoting an effective response to population ageing. The project is set up to achieve the following core objectives.

- **Objective 1:** Develop and document a replicable and scalable model, which can be tested at scale in a cluster of districts in Greater Manchester
- **Objective 2:** Support a number of localities in implementing the described model, recognising the local variations that may be required
- **Objective 3:** Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of Greater Manchester based on the evidence

5.1.4.2 Approach to delivering objectives

Objective 1: Develop and document a replicable and scalable model, which can be tested at scale in a cluster of districts in Greater Manchester.

The project will seek to:

- describe a Greater Manchester vision around tackling issues of poor quality housing and a Greater Manchester HIA
- work with Greater Manchester districts that already have an HIA in operation to carry out an initial cost benefit analysis based on the findings to date and agree metrics for evaluation of future Greater Manchester implementation sites
- develop a costings model that includes staffing costs, service provision and interventions, and identify sources of funding
- develop and secure transformation funding to fund roll-out in totality for all agreed localities to adopt and test the model.

Objective 2: Support a number of localities in implementing the described model.

The project will seek to:

- secure and put in place agreements with a number of localities to implement the model and test locally
- provide programme management and delivery support to the initial and roll-out model across each of the boroughs (this could be shared across more than one borough)
- provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 3: Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of Greater Manchester based on the evidence.

The project will seek to:

- collate analysis from implementation sites from across Greater Manchester
- update and further develop cost benefit analysis developed for the model

- collate local lessons learned to inform future development of the model for wider Greater Manchester adoption
- gain agreement from the system to fully roll the model out to the remaining Greater Manchester boroughs
- produce and agree a plan for Greater Manchester-wide roll-out.

5.1.4.3 Target outcomes for 2016/17 and 2017/18

The programme will work towards achieving three key outcomes:

- **Outcome 1:** Partnership working with existing HIAs and New Economy Manchester has developed a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester using transformation funding
- **Outcome 2:** A number of Greater Manchester boroughs have implemented the model
- **Outcome 3:** A business case and plan for the Greater Manchester-wide roll-out of the model produced and agreed

5.1.4.4 Programme of work – scope

The Greater Manchester HIA model would be available to all older people aged 60-plus and disabled people across Greater Manchester. It is envisaged that there would be a core service and a menu of options that localities can adopt/commission.

Within the scope of the service, the intention is to include:

- delivery of Disabled Facilities Grants (DFGs)
- handyperson service
- fuel poverty/energy efficiency measures
- home improvements
- project management/'handholding' service
- advice and assistance – fuel poverty, housing options, benefits
- referral mechanisms
- home safety checks e.g. Safe and Well checks.

There is also scope to include:

- home from hospital/hospital discharge services
- hoarding service
- community equipment
- community alarm and assistive technology services
- falls prevention.

It will be important that referrals are enabled into and out of the service by housing, health and social care workers. Self-referral and self-funding will also be integral to the model.

Funding sources are likely to be varied, with a management fee taken from DFG funding being the core and sustainable contributor. Other sources of funding could include bidding for grants, private sector and fee generation. Transformation funding is likely to be required to develop the scalable model and kick-start delivery.

5.2 Nutrition and hydration

5.2.1 Background

There is a good evidence base, drawing on the literature and operational experience, relating to the role of nutrition and hydration in supporting good overall health, independence and avoidable deterioration in older age. The risk and prevalence of malnutrition increases with age so we should expect the rate of malnutrition to rise as the population ages (NICE). Some experts place the potential prevalence of malnutrition at as much as 40% of the 65+ population. NICE guidance for commissioners (2012) estimates the following prevalence in different settings: 30% of hospital admissions, 35% of care home residents, 10-14% of people living in sheltered housing.

However, the King's Fund: Making our health and care systems fit for an ageing population report, observed in its 2014 report on the readiness of the health and care system to respond to an ageing population that malnutrition is often regarded as a 'minor' factor in maintaining independence and wellbeing, alongside issues like foot health, visual and hearing impairment, incontinence and oral health (King's Fund, 2014).

What is perhaps different about malnutrition and dehydration is that it can go unnoticed and therefore untreated – the majority (93%) of people at risk of malnutrition live in the community, it often develops over the medium to long-term and there is rarely a specific, treatable 'symptom' associated with it until it becomes very severe. Yet it can undermine mobility, steadiness (leading to falls), healing and recovery, mental alertness and energy levels. Outcomes are therefore much worse for older people who are malnourished and the same is true of dehydration.

In terms of the national policy context, the Malnutrition Prevention Programme overseen by the Malnutrition Task Force (MTF) is a Department of Health funded scheme to help the one million older people in England suffering from or at risk of malnutrition. The pilot programme was part of the Government's response to the Francis Report into the failings at the Mid Staffordshire Foundation Trust (see 'Recommendation 241' on the Department of Health website). The report revealed that patients, many of them older, had been unable to eat or drink properly and that nutrition and hydration was not treated as a priority. The programme aimed to engage whole communities – local NHS trusts, local authorities, GP practices, care homes and the third sector to come together to tackle malnutrition. The aim is to significantly reduce the number of people aged 65 and over in these areas who are malnourished. The pilot areas were Gateshead, Salford, Purbeck in Dorset, Kent and Lambeth and Southwark.

5.2.2 Greater Manchester context

In Greater Manchester, the effects of malnutrition and dehydration do seem to be recognised in parts of the health and social care system. It is seen or identified at point of hospital admission, often as a complicating factor alongside a wider set of clinical issues, and the Greater Manchester Directors of Adult Social Services Group also recognise it as in issue for people with eligible social care needs, in particular those people living in long-term residential care.

There are pockets of relatively recent work focusing on food and nutrition in individual Greater Manchester boroughs (certainly work in Salford as part of the MTF national pilot and in Manchester relating to care homes), but it would seem that this issue does not have a high or consistent profile across Greater Manchester. Given the impact it can have on individuals and the care system, this is a potentially missed opportunity that could provide a strong focus for collaboration at a Greater Manchester level.

The analyses below by the Salford public health team in 2015 show hospital admissions across Greater Manchester where malnutrition has been coded in the hospital admission record, with a breakdown by gender. The overall trend between 2010 and 2015 appears to be rising, which could be a reflection of the ageing population, or an independent increase in the rate of malnutrition, or a combination of both. The analyses give us an insight into hospital admissions where malnutrition has been explicitly recognised, but it is important to appreciate that this cannot be used to gauge overall prevalence, which is estimated to be much higher (see previous sections).

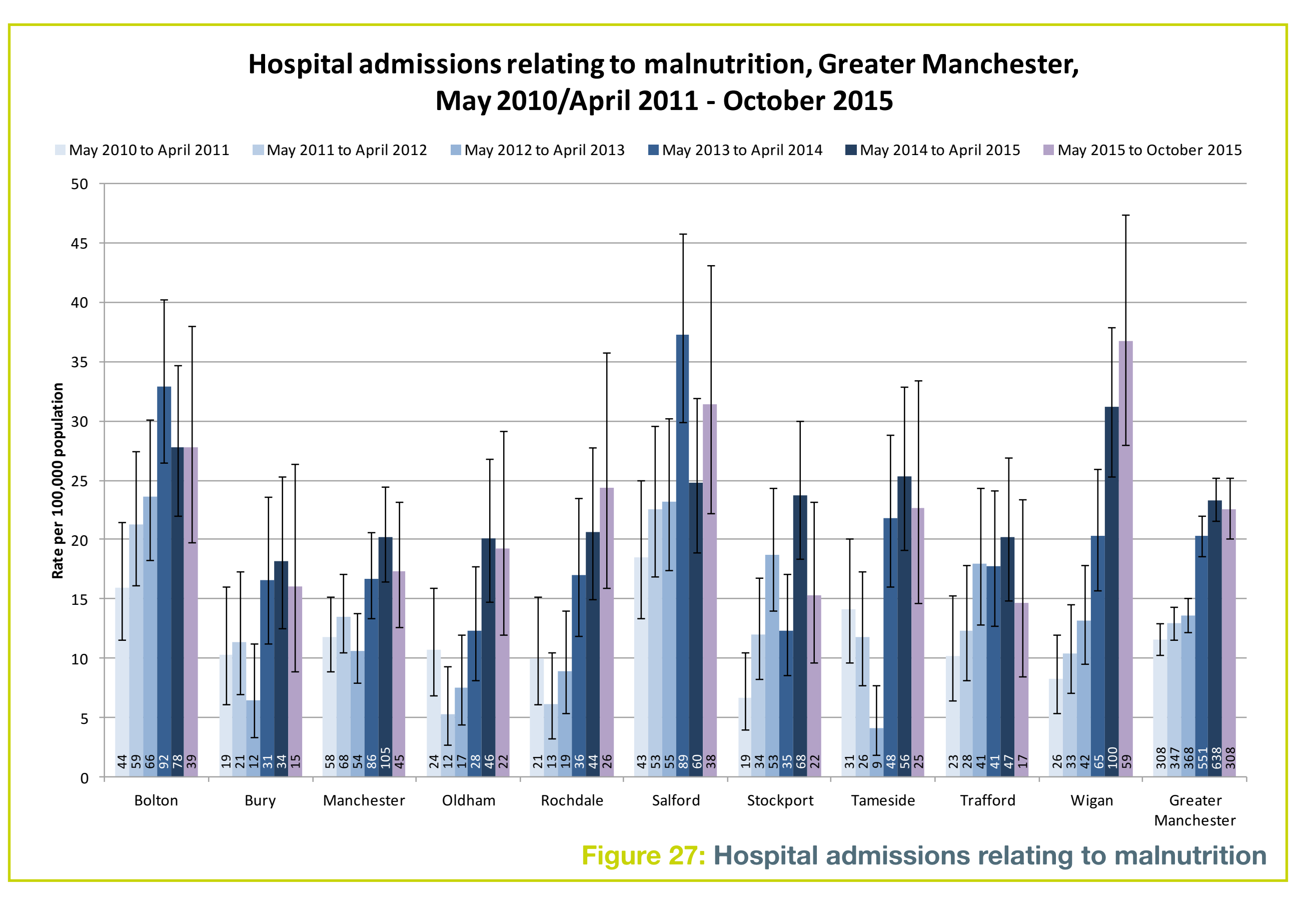


Figure 27: Hospital admissions relating to malnutrition

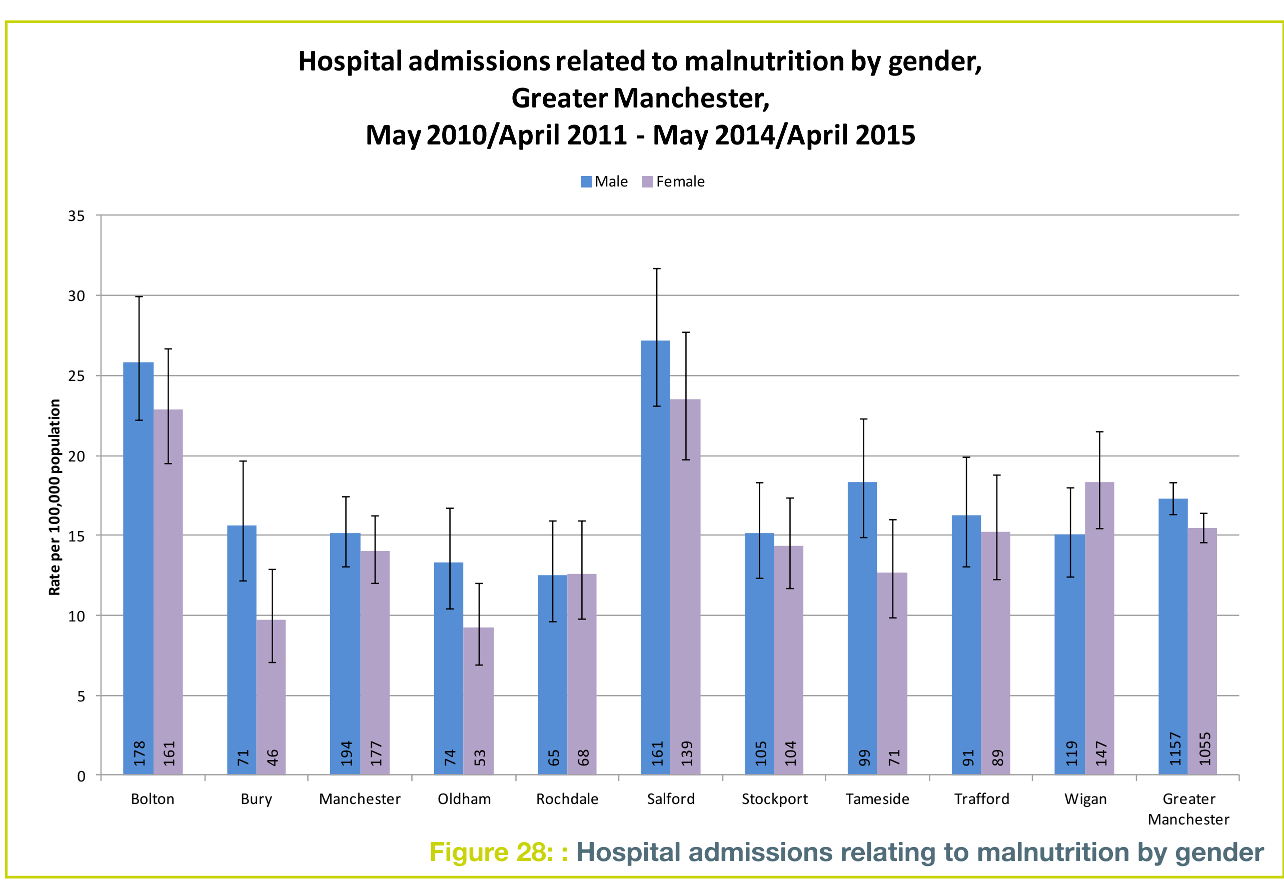


Figure 28: : Hospital admissions relating to malnutrition by gender

5.2.3 Opportunity

A number of reports and guidance sourced around food, hydration and nutrition refer to the very good availability of nutritional guidelines, yet there clearly remains a gap between knowledge and application, which is confounded by the wide range of individual and environmental factors that can contribute to the development of malnutrition, usually over a long period of time.

In the community, the potential solution is to raise individual, family, carer and practitioner awareness and promote a stronger understanding of the particular groups of older people that may be especially at risk of malnutrition and hydration – they might typically include men, people living on their own, those who are recently bereaved and people with a psychological or cognitive impairment. NICE,2012: 'Nutrition support in adults QS24, suggests that nutritional support is an ongoing process involving the following steps:

1. Raising awareness
2. Screening
3. Recognising malnutrition or the risk of malnutrition
4. Documenting nutritional support goals in a management care plan
5. Treatment
6. Reviewing nutritional care to identify and respond to changes in nutritional status.

Steps 1-3 are equally applicable to the identification of dehydration. In care home settings, and domiciliary care arrangements such as home care or extra care, although the same issue of promotion and awareness-raising is important, because the groups of older people being supported by these arrangements are likely to be much more vulnerable – needing more support with food and drink at mealtimes, alongside very specific dietary needs – the issues may need to be approached in different ways. The higher numbers of hospital admissions from these settings, care homes in particular, and the more rapid physiological effects of dehydration generally and on more frail older people specifically, may point towards a stronger emphasis on hydration in these settings.

Salford has emerged as already leading and developing local good practice in the area of malnutrition in particular and, as referred to above, is a pilot site for a whole community approach to prevention under the national Malnutrition Prevention Programme. The site has developed the Salford Together Nutrition Armband, which is gaining traction nationally and has been rebranded as PaperWeight Armband©. The Salford team have been nominated by Barbara Keeley MP for a public health excellence award due to their work. The armband is a simple and non-intrusive way of gauging potential malnutrition by measuring the non-dominant upper arm. Importantly, this has proved to be a way of opening up a conversation, through a wide range of community contacts with older people, about food and nutrition in a non-threatening way and providing access to high-quality, tailored information about relevant local services, support and advice on the topics.

Kirstine Farrer, one of few consultant dieticians nationally who is based at Salford Royal, and partners in Salford (including Age UK Salford and local integrated care programme colleagues) have already done much of the thinking on ways to open up conversation on malnutrition, having developed their own local scheme during the past three years. They are now continuing to pilot work in care homes and have developed an e-learning package designed to improve understanding of nutrition and hydration among practitioners and care staff working in the community and also relevant hospital staff.

The approach is relatively simple and likely to be replicable across other boroughs

– delivered through effective project management at a Greater Manchester level; supported by local buy-in to ensure that it fits and reflects existing local provision; and with expertise and learning from colleagues at Salford.

New Economy has undertaken initial indicative analysis of the Salford Malnutrition Pilot to understand the financial case for the initiative. This analysis suggests that the gross fiscal return on investment over a five-year period is 3.20 and the net present budget impact is around £800,000. The long-term cashable fiscal return on investment is estimated at 2.69.

The costs comprise staff input (predominantly GP capacity in screening elderly patients), resource and distribution of materials, and project management costs including initial outlay on programme design. The benefits are driven by the significant reactive cost savings from a reduction in falls associated with addressing malnutrition and dehydration – this includes savings from non-elective admissions, residential care admissions and a reduced need for intermediate care, re-enablement and home care. Considerable benefit is also anticipated from reduced GP appointments and a reduction in the use of enteral feeds and nutritional supplements.

Further work will need to be undertaken to test these emerging findings with partners and to replace national level assumptions with additional local evidence. As they stand, the cost benefit analysis (CBA) outputs should be considered as indicative and subject to change. To reflect plans for scaling up more widely across Greater Manchester, the CBA can be re-run on a multi-locality footprint. It is likely that this will increase the return on investment through cost efficiencies related to procurement and savings in the project design phase.

5.2.4 Plan

5.2.4.1 Objectives

The objectives of this programme of work are to help facilitate the roll-out, testing and evaluation of an approach to tackle dehydration and malnutrition based on the nationally recognised work in Salford, in line with the other Theme 1 proposals aimed at promoting an effective response to population ageing. The project is set up to achieve the following core objectives.

- **Objective 1:** Using the Salford approach, develop and document a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester
- **Objective 2:** Support a number of localities in implementing the described model, recognising the local variations that may be required
- **Objective 3:** Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of Greater Manchester based on the evidence

5.2.4.2 Approach to delivering objectives

Objective 1: Using the Salford approach, develop a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester.

The project will seek to:

- describe a Greater Manchester vision around tackling issues of malnutrition and dehydration
- work with Salford to carry out an initial cost benefit analysis (CBA) based on the findings to date and agree metrics for evaluation of future Greater Manchester implementation sites

- develop a costings model that includes staffing costs, plus all the materials, a working budget and funds to secure the services of an expert reference group
- develop and secure transformation funding to resource two to three localities to adopt and test the model.

Objective 2: Support a number of localities in implementing the described model.

The project will seek to:

- secure and put in place agreements with a number of localities to implement the model and test locally
- provide programme management and delivery support to roll out the model across each of the boroughs (this could be shared across more than one borough)
- provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 3: Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of Greater Manchester based on the evidence.

The project will seek to:

- collate analysis from implementation sites from across Greater Manchester
- update and further develop cost benefit analysis developed for the Salford model
- collate local lessons learned to inform future development of the model for wider Greater Manchester adoption
- gain agreement from the system to fully roll the model out to the remaining Greater Manchester boroughs
- produce and agree a plan for Greater Manchester-wide roll-out
- ultimately embed the use of the PaperWeight Armband into routine contact with older people; improve awareness and vigilance of malnutrition and dehydration in the community; and reduce the impact of malnutrition and dehydration on the quality of life, health and care outcomes of older people
- implement a financially sustainable approach, using transition funding to mainstream good preventative practice, which can then continue to be overseen and developed in the medium to longer-term by a local multi-disciplinary expert reference group.

5.2.4.3 Target outcomes for 2016/17 and 2017/18

The programme will work towards achieving three key outcomes.

- **Outcome 1:** The partnership working with Salford and New Economy Manchester has developed a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester using transformation funding
- **Outcome 2:** A number of Greater Manchester boroughs have implemented the model
- **Outcome 3:** A business case and plan for the Greater Manchester-wide roll-out of the model produced and agreed

5.2.4.4 Programme of work – scope

This proposal is intended to be implemented across community and allied healthcare, social care (public and independent sector) and voluntary sector services delivered within a locality, which are already in contact with older people in the normal course of delivering their services or support.

The proposal and model for delivery

- The model is designed explicitly to be a community-level preventative approach that can be applied in a wide range of care and health scenarios with older people. It does not require clinical expertise

to use the armband, so it has wide application across the social care and health workforce based in the community. Although the armband and its associated resources could be used in secondary care settings, that is not the focus of this proposal as it is expected that secondary care practitioners are likely to have more direct experience of malnutrition and dehydration and more tools at their fingertips to identify and assess it clinically.

- The target group to be identified, prompted and supported to benefit from the intervention will largely be an older cohort of adults living in their own homes in the community, some of whom may be experiencing signs of mild frailty, and many are also likely to have co-morbidities that they are managing medically. A key sub-group will be older people living in a care home setting, where the emphasis of the intervention may be more tailored to that environment e.g. training for residential care staff.
- The chief purpose of the model is to embed better awareness and understanding of malnutrition and dehydration in older age and introduce a simple tool, which doesn't require any specialist or clinical knowledge to apply (the PaperWeight Armband), to prompt its identification. The Salford model was overseen and implemented by a cross-sector team who also collectively designed and produced the materials used. A multi-disciplinary team, which is jointly committed to the implementation of the project, creates shared ownership and disperses leadership, both of which strengthen the model.
- In practice, a local project co-ordinator takes lead responsibility for introducing the PaperWeight Armband, and its associated support materials, to a wide range of practitioners who regularly come into contact with older people in the community, including family carers. It can also be used/promoted at one-off community events or alongside preventative interventions targeting older people e.g. 65+ flu clinics.

5.3 Falls

5.3.1 Background

Falls, osteoporosis and fragility fractures are three sides of the same problem. Falls can happen to anyone at any time, but they are more common among older age groups and strongly associated with chronic conditions. Falls are a major cause of disability and the leading cause of mortality due to injury in people aged over 75 in the UK. Annually, around 35% of people aged 65 and over will experience one or more fall and this rate doubles for those living in care homes. Falls are implicated in the majority of fractures in older people. Most of these are fragility fractures affecting the pelvis, wrist, upper arm or hip. Around half of all women and one in six men will experience a fragility fracture in later life. Fragility fracture is often the first indicator of undiagnosed osteoporosis.

Falls-related injuries range from minimal to serious, including loss of confidence. Falls can increase isolation and reduce independence, with around one in 10 older people who fall becoming afraid to leave their homes in case they fall again. Falls trigger over 40% of admissions into nursing and residential care and are the commonest reason for referrals into intermediate care.

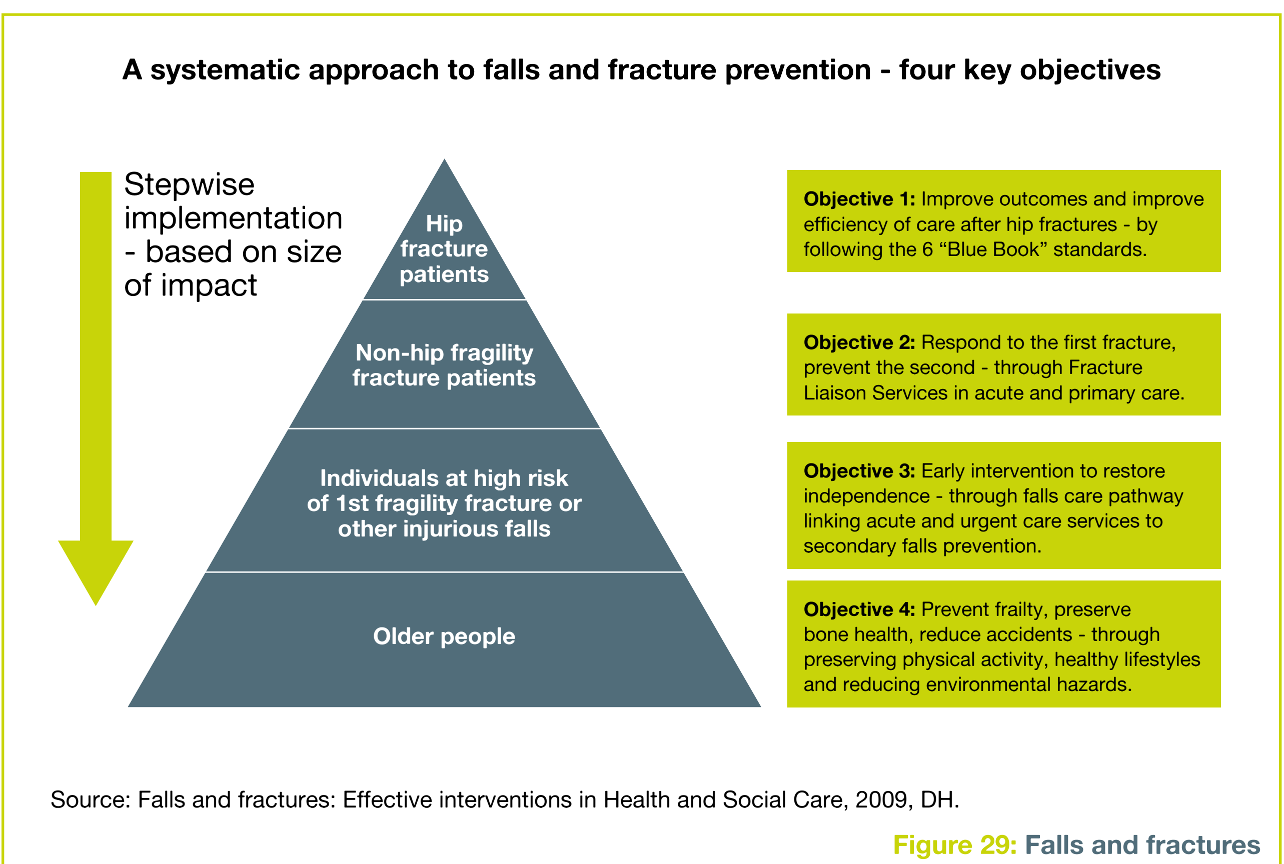
Hip fracture is the most serious consequence of a fall, the commonest reason for older people to need emergency surgery, and the most common cause of accident-related death in older people. Around 30% of over-65s experiencing a hip fracture will die within a year, and a quarter will need long-term care. Hip fracture patients take up 1.5 million hospital bed days each year and cost the NHS and social care £1 billion. This one injury carries a total cost equivalent to about 1% of the whole NHS budget.

5.3.2 Greater Manchester context

'Taking Charge' sets out our ambition to reduce falls-related injurious falls admissions in older people to the England average, resulting in 2,750 fewer serious falls. All locality plans across Greater Manchester have identified falls as a priority issue and/or an area for development. An understanding of key deliverables right across Greater Manchester will be vital to ensure we are maximising all our potential to reduce injurious falls and we collaborate where possible. Ensuring falls pathways are in place that link acute and urgent care services to secondary falls prevention will be key to intervening early and restoring independence. Work with care homes, where falls prevalence is much higher than in the general 65+ population, will also be needed and exploring how we can scale up relevant physical activity interventions will also be key. There is much to learn and share from existing practices across Greater Manchester and beyond, and we will seek to facilitate that and collaborative approaches where possible.

5.3.3 Opportunity

Given the ambition set out in 'Taking Charge' there is now an opportunity in Greater Manchester to support the development of integrated systems geared to falls and fragility fracture prevention, informed by the available evidence. A Greater Manchester falls programme could utilise the Department of Health (DH) model for a systematic approach to falls and fracture prevention as set out in Figure 29. Falls and osteoporosis are essentially long-term conditions and this needs to inform preventative approaches in parallel with other long-term conditions.



Source: Falls and fractures: Effective interventions in Health and Social Care, 2009, DH.

Figure 29: Falls and fractures

A Greater Manchester approach around falls could aim to:

- reduce the incidence of falls
- reduce the severity of injuries
- ensure effective treatment and rehabilitation for those who have fallen.

Two high-impact changes have been identified for Years 1 and 2, in keeping with the stepwise implementation suggested in the model above. These centre around reducing variation in, and improving the quality of, hip fracture care outcomes (to be delivered through Theme 3) and testing the potential of fracture liaison services integrated with local falls prevention services across Greater Manchester through the delivery of this plan. These two areas are now described below:

5.3.3.1 Hip fracture care

Quality in hip fracture care is incentivised through a best practice tariff (BPT). The National Hip Fracture Database (NHFD) captures a range of clinical audit data in relation to hip fracture care by provider site. Comparative data for achievement of BPT shows some sub-optimal care and variations across Greater Manchester. This component of the programme will drive up improvements in hip fracture outcomes, implementing relevant recommendations from the 'NHFD Annual Report 2016', and seek to:

- support quality improvement
- implement relevant NICE guidance and quality standards
- review and revise the whole hip fracture pathway beyond acute care, and bring into scope rehabilitation, intermediate care and community care.

This element of the Greater Manchester Falls Programme will be taken forward by the Greater Manchester MSK and Orthopaedics Programme within Theme 3.

5.3.3.2 Fracture liaison service (FLS)

Sustaining a fragility fracture at least doubles the risk of a future fracture. A study of the Glasgow FLS established that 80% of re-fractures that occur over a three-year follow-up period happen during the first year after the initial (post-index) fracture, with 50% of re-fractures having occurred during the first 6-8 months. A significant proportion of fragility fractures are recurring fractures that could have been prevented if steps had been taken to diagnose and treat osteoporosis after the initial or index fracture and to address any falls risk. This leads to a situation where "hip fracture is all too often the final destination of a 30-year journey fuelled by decreasing bone strength and increasing falls risk".

An FLS will systematically identify, treat and refer to appropriate services all eligible patients over 50 years old within a local population who have suffered fragility fractures. An FLS is regarded as clinically and economically efficient. An FLS in an acute setting can intervene in 50% of future hip fracture cases and, in a primary care setting, increase compliance with NICE guidance on secondary prevention of osteoporotic fracture by up to 64%. These reductions are realised quickly and certainly within three years of the commencement of relevant drug treatment. It is generally recognised that, in the absence of follow-up (which an FLS can provide), compliance with treatment is generally very poor.

Interventions to reduce future fracture risk in patients who have already broken a bone takes priority over primary fracture prevention due to:

- the 2-3 fold greater risk of fracture (any skeletal site) following index fracture
- 50% of hip fractures occurring in patients who have previously sustained a fracture
- achieving the same reduction in fracture incidence through primary prevention would necessitate identification and assessment of 5-6 times more patients.

A secondary fracture prevention strategy will achieve substantially greater fracture risk reduction for any investment of resources than can be achieved through primary fracture prevention.

Fracture liaison services originated in acute settings. However, more models are emerging within community-based settings, which support the drive for care closer to home. A community model can be more easily facilitated with a 'reporting radiographer' approach rather than case finding in acute fracture care, which some earlier models adopted. This also maximises opportunities to identify vertebral fractures. Wigan, for example, currently has a community-based FLS+ that has an extended role into primary care. Wigan's FLS is also integrated with its falls prevention service on the basis of the inter-relationship between falls, osteoporosis and fragility fractures.

High-level predictive CBA undertaken by New Economy suggests an overall gross fiscal return on investment of 2.26 with a net present budget impact of £11.2 million over five years. While there is a significant increase in benefits as the target cohort increases over time, it is anticipated that the investment in FLS across Greater Manchester will have been 'paid back' during the first year of activity.

The largest benefits created by the FLS are those pertaining to prevented hip fractures. These benefits include savings as a result of both a reduction in acute care presentations and the circumvented need for residential care. The most significant costs of the FLS are those associated with staffing. However, there are also costs linked to the increased number of patients prescribed medication, and to a lesser extent, those likely to undergo bone scans.

Findings reflect indicative reactive savings that could be made through the provision of fracture liaison services based in an acute setting within each of Greater Manchester's hospital sites, and are subject to decision-making around service configuration. Findings are presented here in isolation from other strands of the Age Well workstream, but in future will be considered as part of a wider portfolio of work.

Opportunities still to be scoped

Work is still needed to develop and agree further opportunities at Greater Manchester to complement the work at a locality level to reduce injurious falls in older people. Work will take place over the next 12 months to further define these pieces of work in collaboration with localities. Initial areas for consideration are described in the sections below.

5.3.3.3 Falls care pathway

Ensuring falls pathways are in place that link acute and urgent care services to secondary falls prevention is key to intervening early and restoring independence.

All locality plans have identified falls as an issue or area for development. An understanding of key deliverables right across Greater Manchester will be vital to ensure we are maximising all our potential to reduce injurious falls and we collaborate where possible. There is much to learn and share from existing practice across Greater Manchester and beyond in relation to multi-factorial risk assessments, falls pathways and falls prevention practice. For example, Stockport has developed a falls pathway that supports the implementation of relevant NICE guidance.

The rate of falls in care homes is almost three times that of older people living in the community and 30% of hip fracture hospital admissions are from a care home. Scotland and Derbyshire have developed good practice toolkits.

Work could include steps to:

- identify and share examples of practice from across Greater Manchester

- stimulate collaborative approaches to implementing relevant NICE guidance on falls prevention
- work with localities to identify toolkits and best practice around falls prevention in care homes, and share for implementation.

Evidence-based physical activity programme for falls prevention

Poor gait and balance is the most significant intrinsic risk factor for a fall. The most effective component of multi-factorial interventions is therapeutic exercise. Any therapeutic exercise should be individually prescribed, focus on building strength and balance, be progressive, and meet the right dosage criteria to sufficiently reduce falls risk. FaME, Otago, and LiFE are all evidence-based therapeutic exercise programmes, which variously reduce falls risks by at least 35% and up to 54%. Compliance, however, is known to be problematic and, ideally, activity needs to be sustained beyond the initial therapeutic phase.

Delivery requires instructor training in one of the evidence-based programmes, with relevant prerequisites. Instructors can come from a number of backgrounds, including physiotherapists, occupational therapists, sports scientists, and registered exercise professionals. There are varied approaches to, and provision of, falls prevention physical activity programmes and we need to understand, learn and share from all Greater Manchester districts.

Work could include steps to:

- identify and share delivery models
- facilitate an asset-based approach to build capacity for physical activity interventions for falls prevention
- work with localities to identify options to scale up therapeutic physical activity programmes for falls prevention.

5.3.4 Plan

5.3.4.1 Objectives

The objectives of this programme of work are to help facilitate the roll-out, testing and evaluation of fracture liaison services integrated with a range of locally designed falls prevention services in a number of Greater Manchester boroughs. The programme is set up to achieve the following core objectives.

- **Objective 1:** Using national guidelines and learning from developments locally in Wigan, develop and document a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester
- **Objective 2:** Support a number of localities in implementing the described model, recognising the local variations that may be required
- **Objective 3:** Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the model across the whole of Greater Manchester based on the evidence.

5.3.4.2 Approach to delivering objectives

Objective 1: Using national guidelines and learning from developments locally in Wigan, develop and document a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester.

The project will seek to:

- work with Wigan and the National Osteoporosis Society to carry out an initial cost benefit analysis based on the findings to date and agree metrics for evaluation of future Greater Manchester implementation sites
- develop a costings model that includes staffing costs, plus all the materials, a

working budget and funds to secure the services of an expert reference group

- secure transformation funding to roll out fracture liaison services in a number of localities, which align with new models of care locally.

Objective 2: Support a number of localities in implementing the described model, recognising the local variations that may be required.

The project will seek to:

- secure and put in place agreements with those 'early implementer' sites for provision of fracture liaison services
- provide programme management and delivery support to the early implementer sites
- provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 3: Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of Greater Manchester based on the evidence.

The project will seek to:

- support evaluation of FLS provision
- collate analysis from implementation sites from across Greater Manchester
- update and further develop cost benefit analysis developed for original model
- collate local lessons learned to inform future development of the model for wider Greater Manchester adoption
- gain agreement from the system to fully roll the model out to the remaining Greater Manchester boroughs
- produce and agree a plan for Greater Manchester-wide roll-out.

5.3.4.3 Target outcomes for 2016/17 and 2017/18

The programme will work towards achieving three key outcomes.

- **Outcome 1:** Transformation funding secured, via a robust business case, for roll-out of fracture liaison services in 'early implementer' sites
- **Outcome 2:** A number of Greater Manchester boroughs will have developed and implemented an FLS
- **Outcome 3:** A business case and plan for the wider roll-out of FLSs across Greater Manchester will be developed

5.3.4.4 Programme of work – scope

An FLS is typically developed around a fracture liaison co-ordinator, usually a nurse specialist, in collaboration with and supported by a metabolic bone disease specialist as named lead clinician.

The FLS and care pathway will provide specialist secondary fracture prevention assessment and management to all patients over 50 years old. The service will promote co-ordination between acute, community and primary care to ensure that care is seamless and consistent. This integrated approach will include:

- case finding in fracture clinics, emergency departments, inpatient wards and outpatient clinics
- triage and assessment of identified patients by co-ordinators/specialist nurses
- diagnosis of osteoporosis using DXA scans
- initiation of treatment for fracture risk reduction in line with agreed guidelines
- appropriate pharmacological treatment
- identification of the 'modifiable faller' and referral to a falls prevention service

- liaison with the patient's GP with the aim of optimising long-term treatment
- telephone follow-up of patients to provide education and support in primary care
- promotion of FLS to relevant hospital teams in order to maximise case finding
- specialist clinic support for secondary care clinicians in managing complex and rare bone conditions
- a database of patients assessed through the service to support follow-up and quality reporting.

The service will be available to all patients over the age of 50 years who have suffered a fragility fracture, with the primary aim of preventing subsequent fracture. The figure below provides an overview of an FLS and its key interfaces.

In some more recently established services, case finding is via diagnostics with reporting radiographers identifying patients and notifying the FLS.

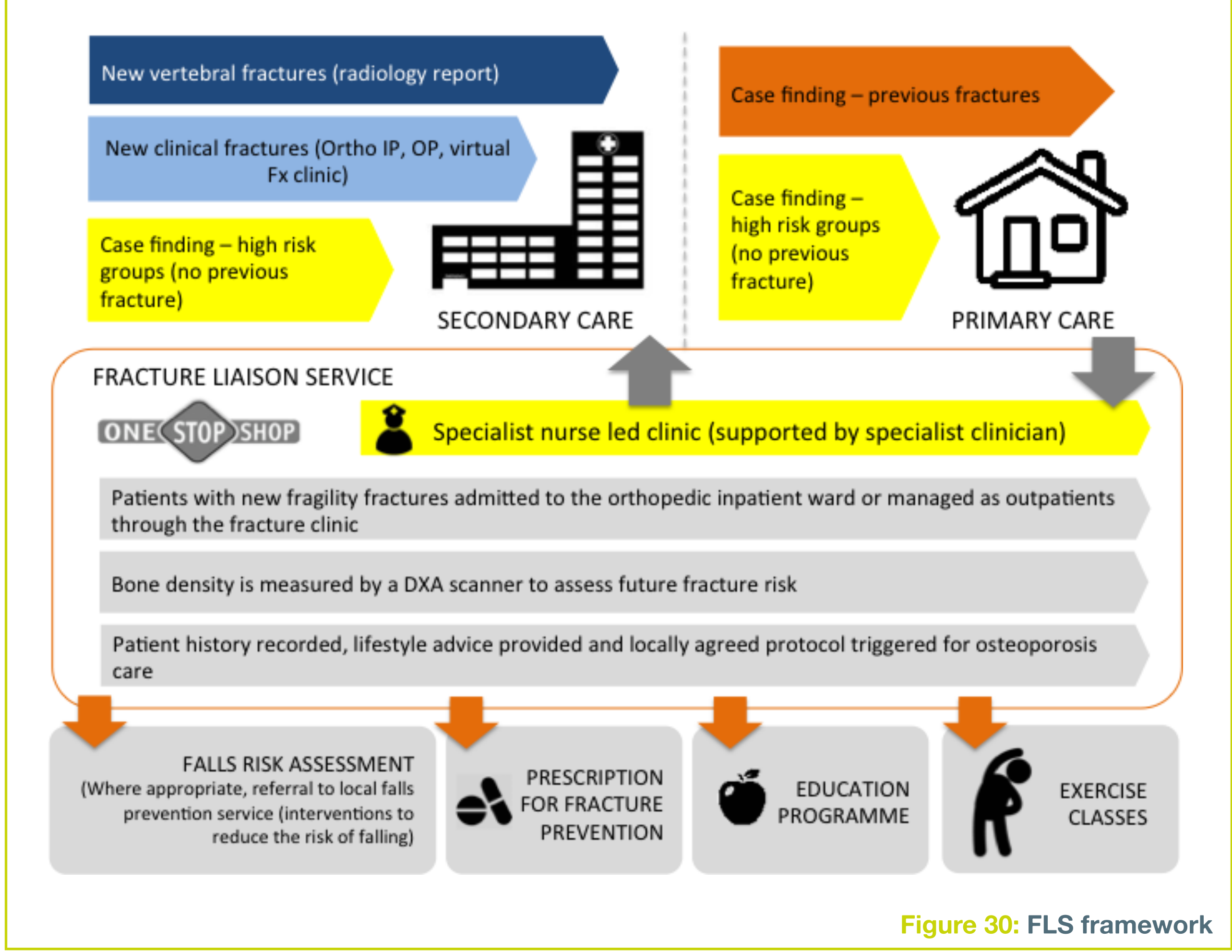


Figure 30: FLS framework

6. System reform

It is clear that an ambition of this magnitude around the delivery of the Population Health Plan requires the support of a population health system that is organised to deliver at pace and scale.

'Population health systems: Going beyond integrated care' (King's Fund 2015) identified that population health is affected by a wide range of influences across society and within communities. Improving population health is not just the responsibility of health and social care services, or of public health professionals. Instead, it requires co-ordinated efforts across population health systems.

Making this shift towards population health requires collaboration across a range of sectors and wider communities – between NHS organisations, local authorities, the third sector and other local partners, as well as patients and the public working together as population health systems.

Greater Manchester has the chance, therefore, to take a co-designed approach to radically reframe the role of population health in the context of a devolved system, creating a unified population health system across 10 localities and Greater Manchester that is better able to achieve improved health outcomes for the citizens of Greater Manchester.

Our system reform proposal will therefore look to create a leadership, governance and delivery model with clear lines of accountability and responsibility for achieving Greater Manchester's population health ambitions that delivers financial sustainability and is able to future-proof against further funding changes.

In addition, the reform proposal will include the development of a unified approach to commissioning population health. This will take into account Section 7a (public health functions agreement) commissioning, local authority regulatory commissioned public health services, as well as the commissioning intentions and approaches arising from the new models of care outlined in the plan.

The final aspect of the system reform programme is looking at how public sector spend can produce a wider benefit to the community i.e. the social value benefit to the people of Greater Manchester from public sector commissioning and procurement and maximising the contribution made by the voluntary, community and social enterprise (VCSE) sector.

6.1 System reform – Creating a unified population health system for Greater Manchester

In Greater Manchester, we have a shared commitment to the most ambitious approach yet in England to place population Health at the heart of public service reform and economic growth. Rebalancing our economy also requires rebalancing our public services.

Since the implementation of the Health and Social Care Act 2012, public health leadership has become fragmented and capacity is dispersed across local authorities, the work of the Greater Manchester Directors of Public Health Group, PHE and NHS England, resulting in fragmentation of health protection, intelligence architecture and commissioning functions. This has created duplication and overlap and limited the capacity to effect significant change across Greater Manchester.

In July 2015, Greater Manchester signed a memorandum of understanding (MoU) with PHE with an ambition to create a unified public health system. This provides an opportunity to support and add value to local working by reducing the fragmented nature of public health leadership in Greater Manchester and drive the necessary prevention and integration that will be central to improving outcomes in a landscape of diminishing resources.

6.1.1 Opportunity

Reforming how public health functions are delivered within Greater Manchester is now a critical part of the wider devolution transformation, and needs to be reformed in partnership across all public services in order to deliver Greater Manchester's ambition of a well population and productive workforce.

Sharing of public health capacity (which is about embedding knowledge, skills and expertise across society in a place-based model) across Greater Manchester or within sectors in Greater Manchester, with managed deliberate intent, would enable better public health leadership on aspects of population health management.

There is an opportunity therefore to build a single population health system across the Greater Manchester economy – one that maximises both the impact and the capacities of a small and specialist public health workforce, but also that supports the embedding of the pursuit of population health as being everybody's business. This requires;

- a step-change in the way already devolved public health leadership capacity is organised across Greater Manchester
- the realignment and re-orientation of PHE resource and capacity
- building on the devolution of NHS England commissioning resource.

In addition to creating a unified leadership system for population health, we need to create a unified approach to commissioning population health that enables us to commission services at the right spatial level, in collaboration with one another and enabling us to improve population health outcomes and health inequalities as well as contributing to a more sustainable public health, health and care system.

We want to move away from focusing on organisations and separate areas of spend with a single-service planning approach, which results in a fragmented approach to commissioning health, social care and public health services. We want to focus on integrated strategic planning to achieve cumulative impact and outcomes, creating economies of scale across Greater Manchester with integrated delivery around individuals and families at neighbourhood level.

We intend therefore to:

1. Create a leadership, governance and delivery model with clear lines of accountability and responsibility for achieving Greater Manchester's population health ambitions
2. Look at extending commissioning at Greater Manchester level of activity to improve health that achieves additional impact and is complementary to that at locality level
3. Strengthen health protection functions, to be commissioned and organised on a Greater Manchester footprint with additional responsibilities aligned to wider Greater Manchester resilience and civil contingency arrangements
4. As agreed in the MoU, establish, where appropriate, a pooled budget to which all councils contribute to commission Greater Manchester-level activity and a district level budget for district activity
5. Ensure all local authorities have ready and effective access to all the necessary public health experience and skills to ensure they can fulfil their statutory requirements, and identify an appropriate public health presence in each local authority area
6. Set standard commissioning specifications required for ensuring the delivery of a population health approach across providers.

In doing this we will work to a core set of principles, such as:

- subsidiarity – the principle that decisions should always be taken at the lowest possible level or closest to where they will have their effect, for example in a local area rather than for a whole country
- looking in the first instance at functions where there are sensible economies of scale and where genuine added value is demonstrated
- ensuring far closer alignment at Greater Manchester level with the locality plans
- ensuring any proposed Greater Manchester population health resource needs to do what only makes sense to do at Greater Manchester level and still produces functionality and services that are timely and sufficiently relevant, reflective of or flexible to local requirements and integral to locality care organisation development.

6.1.2 The plan

Work has already been underway since the signing of the MoU to move towards reforming the system to achieve a unified leadership across the population health system. The devolution of NHS England Section 7a commissioning resources to Greater Manchester as outlined in the Greater Manchester Delegation Agreement was the first opportunity taken to unify public health commissioning.

The agreement saw the transfer of relevant resources to Greater Manchester Health and Social Care Partnership (GMHSC Partnership), as well as the responsibility for commissioning screening (cancer and non-cancer), immunisation and vaccination programmes, and child health information services. Screening and immunisation programmes are the largest public health interventions in Greater Manchester, delivering high-quality services across the whole life course that reduce the burden of disease and save lives. A population health team within Greater Manchester Health and Social Care Partnership was established with embedded staff from NHS England (NHSE) and Public Health England, namely NHSE public health commissioners and PHE assigned staff. A PHE relationship manager has been assigned as an associate within GMHSC Partnership's wider leadership team as the interface between PHE and the Greater Manchester population health team.

The ‘Greater Manchester Commissioning Strategy: Commissioning for reform’ (October 2016) signalled the intent to take a new approach to commissioning that would overcome the barriers of fragmented decision making and overlapping or duplicated investment, and to address the longstanding challenge of co-investment. Using the Greater Manchester Commissioning Strategy as a framework, we will develop a commissioning plan that will be co-created with the system, recognising that there are significant variations that currently exist across and within the ten boroughs, towns and cities of Greater Manchester. We will look to the development of the emerging LCOs to ensure how best we can commission and deliver services that meet our population health outcomes through the LCO models.

Work is already underway across Greater Manchester to align commissioning intentions and we intend to learn from that work and successful approaches being taken.

- We want to continue to commission services on a Greater Manchester footprint for Section 7a services (screening and immunisation) as it is the most effective way to deliver at scale with a lean workforce. Devolution provides an opportunity to align these programmes with the emerging LCOs and explore new opportunities for workforce planning and to build on social and digital innovation to enable people to take charge of their own health. We have the opportunity of identifying further opportunities to expand the commissioning portfolio as need dictates.
- We will ensure future commissioning and procurement approaches will take more of a social value approach and be rooted within the needs of the GMHSC partnership and public service reform.
- We need to build on existing work, such as the work undertaken by the sexual health commissioners and sexual health network, which have worked collaboratively to successfully produce a single service specification for genitourinary (GU) and contraception and sexual health (CASH) services that is being used consistently across Greater Manchester, and have also established sector-based recommissioning of core services.
- We want to look at how best to replicate the approach taken to the successful work underway under the leadership of the Association of Greater Manchester Authorities (AGMA) wider leadership team, the Police and Crime Commissioner for Greater Manchester, local authority executives and directors of public health, which is delivering a co-ordinated approach to commissioning substance misuse (for drugs, alcohol and new psychoactive substance) to deliver the best possible outcomes across Greater Manchester.

More recently we have seen the production of a set of high-level proposals – covering population health commissioning, population health intelligence systems and population health policy, strategy and workforce functions – for taking forward a unified population health system for Greater Manchester with broad stakeholder engagement.

Further work is now needed to develop those high-level proposals into a set of evidence-based options that will lead to a set of decisions and then a period of managed transition. It is the intent that we ensure that any proposed Greater Manchester population health resource needs to do what only makes sense to do at Greater Manchester level and still produces functionality and services that are timely and sufficiently relevant, reflective of or flexible to local requirements, and integral to locality care organisation (LCO) development.

6.1.3 Objectives

To deliver the plan we want to achieve the following core objectives.

- **Objective 1:** Develop a population health commissioning plan that brings together the NHS England commissioning responsibilities set out in Section 7a of the Health and Social Care Act 2012, together with local government-commissioned population health services and the new service models set out in this plan
- **Objective 2:** Develop and test a proposal for a new Greater Manchester population health function serving localities, CCGs and Greater Manchester structures
- **Objective 3:** Develop a model for future resourcing of population health in Greater Manchester

Approach to delivering the objectives

Objective 1 – Develop a population health commissioning plan that brings together the NHS England commissioning responsibilities set out in Section 7a of the Health and Social Care Act 2012, together with local government-commissioned population health services and the new service models set out in this plan. The population health commissioning plan will be a coherent vison and plan for population health commissioning in line with Greater Manchester's Commissioning for Reform Strategy.

The programme will seek to do the following.

1. With key stakeholders across the system, undertake an in-depth review of the 'as is' approach to commissioning for population health, and:
    - analyse current and planned population health commissioning arrangements
    - identify different population health commissioning approaches currently in use e.g. outcomes based, alliance neighbourhood level
    - review current contracts and spend for Section 7a services and council-commissioned population health services
    - Identify commissioning plans and intentions, including planned cluster level commissioning; PH grant commissioning plans.
    - review alignment of locality commissioning plans with Greater Manchester Theme 1 transformation programmes
    - identify any standard operating models and options for replicability on Greater Manchester footprint
    - review wider considerations for LCO models and pooling of commissioning budgets
    - determine different commissioning approaches currently in use e.g. outcomes-based, alliance, neighbourhood level and best fit for purpose.
2. Based on the activities outlined above, further develop a set of options for inclusion in the commissioning plan for population health.
3. Undertake an assessment and review of stakeholder support underpinned by an understanding of implementation issues, including resource requirements and the risks and barriers that will need to be addressed, with an outline timetable for change.

    Target outcomes for 2016/17 and 2017/18

    - **Outcome 1** – January 2017: The production of a set of proposals for inclusion in the commissioning plan
    - **Outcome 2** – March 2017: A supporting implementation plan that has been co-designed with stakeholders across the system
    - **Outcome 3** – 2017: An agreed programme of activity to ensure a managed transition into a new way of working

Objectives 2 & 3: Develop and test a proposal for a new Greater Manchester population health function serving localities, CCGs and Greater Manchester structures, and develop a model for future resourcing of population health in Greater Manchester.

The programme of work will seek to do the following.

1. With key stakeholders across the system, undertake an in-depth review of the 'as is' approach to determine the evidence base for the production of a set of proposals, and:
    - determine the scope of services that fall currently within Greater Manchester's remit (aligned with NHSE public health Section 7a commissioning intentions 2017/18) and those at the locality level
    - map and review current provision of those functions at various levels including Greater Manchester, cluster, locality and neighbourhood
    - benchmark cost and quality for key public health functions
    - assess current workforce provision and future provision
    - review current public health expenditure and determine any wider implications of changes to the grant such as the residual business rates pilot across Greater Manchester.
2. Based on the activities outlined above, a small number of options for a new Greater Manchester population health function serving localities, CCGs and Greater Manchester structures will be developed and tested. It is intended that those options will maximise both economies of scale and scope while staying true to the principle of subsidiarity embedded within the devolution framework. We intend to look in the first instance at functions where there are sensible economies of scale and where genuine added value is demonstrated.
3. Undertake an assessment and review of stakeholder support for the different options, with clear recommendations made on the shape and distribution of population health functions within Greater Manchester. This will be underpinned by an understanding of implementation issues, including resource requirements and the risks and barriers that will need to be addressed, and an outline timetable for change.

6.1.3.1 Target outcomes for 2016/17 and 2017/18

Outcome 1 – January 2017: The production of a set of evidence-based proposals for creating a unified leadership system for population health across Greater Manchester

Outcome 2 – March 2017: A supporting implementation plan that has been co-designed with stakeholders across the system

Outcome 3 – 2017: An agreed programme of activity to ensure a managed transition into a new way of working

6.2 Social value

6.2.1 Background

Social value asks the question: "If £1 is spent on the delivery of services, can that same £1 be used to also produce a wider benefit to the community?" This involves looking beyond the price of each individual contract or activity and considering the collective benefit to an area. A social value approach includes consideration of the social, environmental and economic wellbeing of a place and its citizens during the planning, commissioning and delivery of services, buying of goods or the procurement of works.

However, the same argument about gaining wider benefit can also be applied to business and non-commissioned VCSE activity, thereby increasing the whole economic footprint of Greater Manchester.

Since January 2013, all public bodies have had to consider social value as part of their commissioning activities under the Public Services (Social Value) Act 2012, both as part of contract specifications and as 'added value'. Under the Act, social value is an enabler that delivers additional benefits for suppliers and partners across all procurement and commissioning activity.

It is a legal obligation for local authorities and the NHS to consider the social good that could come from the procurement of services before they embark upon it. The Act allows authorities to choose a supplier under a tendering process that not only provides the most economically advantageous service but one which goes beyond the basic contract terms and secures wider benefits for the community.

The themes of social value fall broadly into three categories: economic (local jobs and growth), social (resilience and strong voluntary and community sector), and environmental (clean and protected environment). The spectrum of potential activities and measures within these categories is wide and varied, enabling individual authorities to match them to priorities and, to some extent, the resources they may have to support this work.

Furthermore, recent EU procurement regulations have increased the emphasis on achieving wider societal goals through procurement and commissioning, and with these regulations embedded within public sector procurement, Greater Manchester is now able to better commission social value.

6.2.2 Greater Manchester context

The Greater Manchester Combined Authority (GMCA) Social Value Policy approved in November 2014 provides a consistent approach across each of the Greater Manchester councils. The GMCA Social Value Policy sets out how social value is used to underpin the core objectives of 'Stronger Together: Greater Manchester Strategy 2013', which are to stimulate growth in the economy and reform the way in which public services are delivered.

The Greater Manchester Police and Crime Commissioner (PCC) has also produced a social value policy, which echoes the principles of the GMCA policy, and the AGMA Procurement Hub is currently in dialogue with the PCC and other partners to identify how a consistent approach can be taken to social value policy and measurement..

Furthermore, the Manchester Growth Company provides capacity building support to local businesses, particularly SMEs, around the generation of added value and wellbeing outcomes through being a responsible employer, undertaking sound environmental practices and contributing towards local economic gain.

Social value is an enabler that delivers additional benefits for suppliers and partners across all procurement and commissioning activity. Social value should be used to underpin the core objectives of the Greater Manchester 'Stronger Together' and 'Taking Charge' objectives by stimulating growth in the economy and reforming the way in which public services are delivered. It can be used to increase the spending power of every pound spent in Greater Manchester.

6.2.3 Opportunity

An opportunity exists to derive relevant social, environmental and economic value from everything that we do, in our business, in service delivery, commissioning and procurement; to use the huge purchasing power of the Greater Manchester devolution partners to obtain the greatest benefit for local people.

The proposed approach to social value across Greater Manchester is to use this duty to increase the spending power of every pound spent in Greater Manchester, therefore maximising the social value benefit to the

people of Greater Manchester from public sector commissioning and procurement, as well as increasing purposeful activities in the business sector and maximising the contribution made by the VCSE sector.

The longer-term impacts of this approach will be to reduce dependency on, and demand for, public services, and contribute towards increased economic growth in Greater Manchester. This is a £6 billion opportunity to create local economic, social and environmental benefit, if all procuring organisations were to adopt a common approach, and follow similar processes in relation to procurement, contract management and delivery of outcomes.

6.2.4 Plan

Objectives

Our research shows that there is a great deal of work ongoing across Greater Manchester to develop social value approaches in commissioning, procurement, business, voluntary and community activity and social enterprise – the proposed programme will seek to ensure that all Greater Manchester health and social care commissioning and procurement maximises social, environmental and economic wellbeing. Furthermore it will put in place arrangements for health and wellbeing outcomes to be realised from wider public, private and third sector investment. This will involve culture change across all devolution partners and significant effort into co-production of social value outcomes.

The objectives of the work supported through the Theme 1 population health programme will be:

- **Objective 1:** To understand and embed social value in Greater Manchester Health and Social Care Partnership commissioning and seek to work with CCG partners to scale up this work across the healthcare economy
- **Objective 2:** To develop the GMCA Social Value Policy to cover health and wellbeing outcomes described in the Greater Manchester Strategic Plan 'Taking Charge' for implementation across all public sector procurement in Greater Manchester
- **Objective 3:** To embed social value into the culture of the health and social care workforce, through values-based discussion, training, awareness raising and participation in service design to maximise social value benefits
- **Objective 4:** To put in place a number of enabling activities that will maximise the co-production of social value from the expenditure of health and social care budgets, including work with NHS providers, the VCSE sector and relevant parts of the business sector.

Approach to delivering objectives

The activities that will deliver these objectives will all take place within the period April 2017 to March 2019, and can be summarised as follows.

Objective 1: To understand and embed social value in Greater Manchester Health and Social Care Partnership (GMHSC Partnership) commissioning and seek to work with CCG partners to scale up this work across the health care economy.

- Provide training for commissioning staff around social value
- Undertake a review of current practice and policy and undertake a procurement spend analysis
- Develop a social value framework through which GMHSC Partnership can continuously monitor the social value of its suppliers
- Develop a toolkit for practitioners to use when commissioning social value

- Identify, test and share good practice in return on investment in a healthcare commissioning situation
- Work with CCGs to look at how this work could be scaled up across Greater Manchester

Objective 2: To develop the GMCA Social Value Policy to cover health and wellbeing outcomes described in the Greater Manchester Strategic Plan 'Taking Charge' for implementation across all public sector procurement in Greater Manchester.

- Further develop the existing GMCA Social Value Policy for procurement activity across all public sector partners, to include the strategy and outcomes described in 'Taking Charge'
- Work with partners to agree a clear description of what social value means in Greater Manchester for all of the partners in Greater Manchester devolution
- As required, work to support and embed the revised policy into custom and practice across the Greater Manchester reform partners, including the health and social care system

Objective 3: To embed social value into the culture of the health and social care workforce, through values-based discussion, training, awareness raising and participation in service design to maximise social value benefits.

- Build from and roll-out the existing Greater Manchester Commissioning Academy work to embed the single methodology for commissioning social value across health and social care into practice
- Support individual leadership and responsibility in social value across the health and social care workforce, embedding a culture of 'social value is everyone's business' through a series of interactive service design events
- Develop a small number of thematically or geographically focused projects that engage the workforce in activities to generate more social value; including employee volunteering schemes, wellbeing activities and energy-efficiency projects

Objective 4: To put in place a number of enabling activities that will maximise the co-production of social value from the expenditure of health and social care budgets, including work with NHS providers, the VCSE sector and relevant parts of the business sector.

- Build capacity for the devolution partners to monitor, report and be accountable for their own social value as employers of local people, in their own right and spenders of public money
- Work with the Greater Manchester Social Value Network to roll out a series of information-sharing and networking events throughout the programme
- Develop a web portal/website for the programme to allow the consistent sharing of practice case studies, documentation, policies and other information
- Provide a health and social care perspective in wider discussion around social value in Greater Manchester

6.2.5 Outcomes (2017 - 2019)

The following 'signs of progress' will be evaluated to demonstrate the difference that this proposal has made over the two years of its operation.

- Social value is embedded in GMHSC commissioning arrangements
- Social value framework model tested in GMHSC rolled out to interested CCGs
- Increased understanding of social value and how to maximise its achievement through commissioning and procurement among the partners in Greater Manchester health and social care devolution

- Achievement of the outcomes in the Greater Manchester Strategic Plan ‘Taking Charge’ as ‘added benefits’ from investment outside of the health and social care budget
- Increased volume of ‘purposeful’ business sector activity in Greater Manchester that targets Greater Manchester population health outcomes
- The development of a values-based culture in both the health and social care workforce and the operational leadership of the devolution partners
- Increased ability of the partner organisations in health and social care devolution to monitor, report and be accountable for the social impact that they generate
- Increased return on investment/value for money in health and social care expenditure
- Evaluation work carried out as part of this programme will put in place a comprehensive dashboard and methodology for measurement of these outcomes

7. Next steps

7.1 Scoping and delivering via a blended approach

Over the coming months there will be a concentrated effort to mobilise a core team that will drive delivery and implementation of the Population Health Plan's aims and objectives, realising the outcomes and benefits that are to be delivered through the initiatives identified and those that are burgeoning within the localities.

There are some fundamental principles for delivery:

1. Governance will be transparent.
2. GMHSC Partnership will provide enabling and oversight as a minimum capability.
3. Implementation will be a blended-delivery model based on the party best placed to deliver the business and social impact.
4. Delivery will be driven through an alliancing model, where each member contributes and takes specific responsibility in delivery.

7.1.1 Governance will be transparent

To maintain momentum and also to hold to account the system partners, it is important to have good governance across the system. A Theme 1 Executive Board, with membership from providers and commissioners from health and social care across Greater Manchester, has been established to organise, direct and ensure delivery of the work set out in this plan as well as to oversee the deployment of any transformation resource and the achievement of investment deliverables. Each of the programme areas outlined in this plan has its own delivery arrangements, which will bring together resources from across the system to enable delivery.

The Theme 1 Executive Board has direct lines of reporting and accountability into the Transformation Portfolio Board, which reports directly into the Greater Manchester Strategic Partnership Board Executive and the Greater Manchester Strategic Board. Resources are being allocated across the system, such as a dedicated senior responsible officer (SRO) plus operational support in each of the localities, to support the implementation of the plan. The GMHSC Partnership team will be supporting the SROs in the wider leadership and delivery, and has invested in an enabling portfolio/programme/project

management office (PMO). All localities, through the submission of their locality plans, have aligned their local priorities with the commitments laid out in this plan.

As we move into delivery we will seek to define and design a localised light-touch governance model that will provide autonomy to implement and rigour in oversight to enable effective decision making and progress monitoring without creating unyielding bureaucracy.

7.1.2 GMHSC Partnership will provide oversight and enabling as a minimum capability

As many localities will embark upon the delivery and implementation of the initiatives it is anticipated that there will be a requirement for a core capability that will be able to support the localities. These core capabilities are the enablers in Figure 31 that will be required for all the initiatives implemented. The benefit of providing these centrally is that it will enable a specialist function to develop that can be deployed and allocated to each initiative, creating the rapid transfer of knowledge and learning quickly between initiatives. This will also have the benefit of reducing project overhead costs as these are carried centrally instead of by each project.

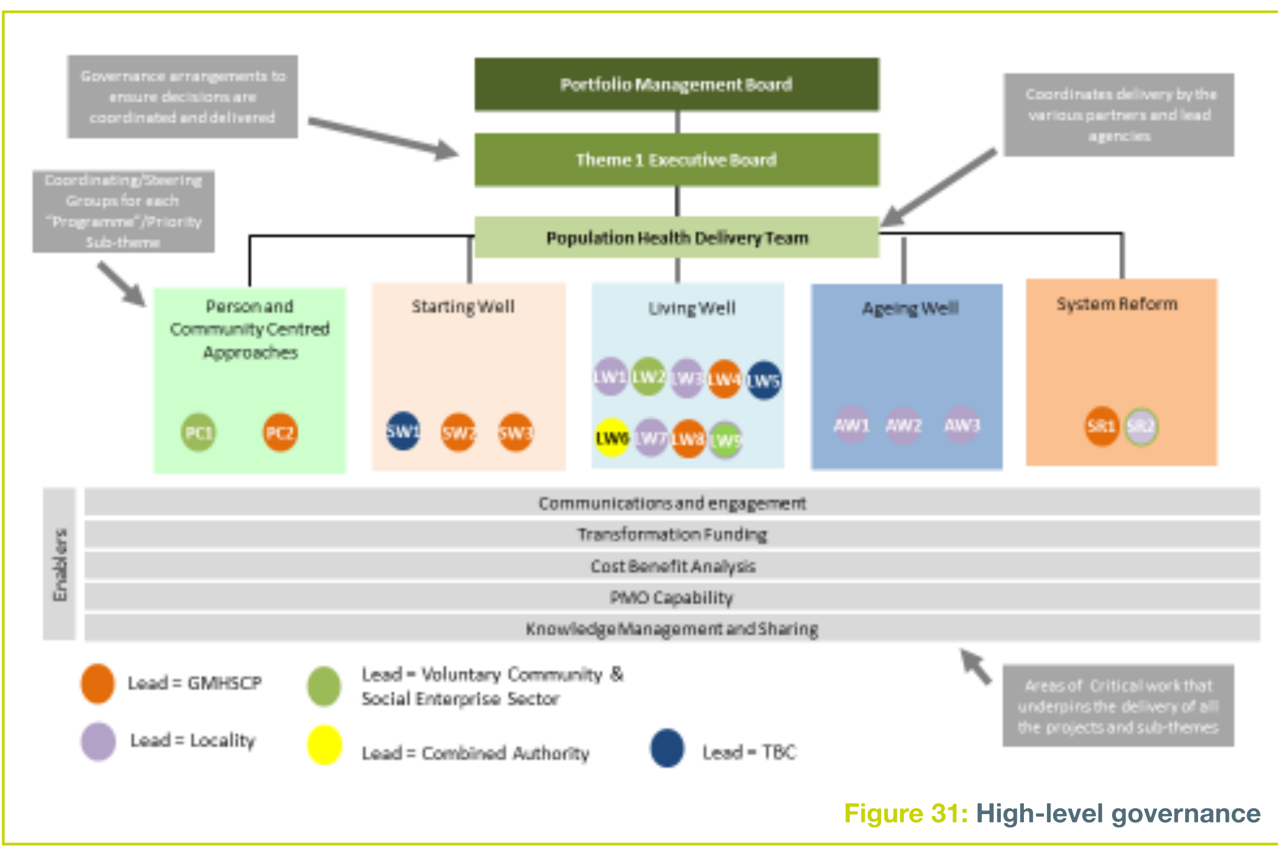


Figure 31: High-level governance

7.1.3 Implementation will be blended, based on the party best placed to deliver the business impact

Throughout the Population Health Plan we have identified a number of initiatives that are either ready for scaled deployment or concept testing i.e. ‘piloting’. To be able to generate the changes and reform proposed, it will be necessary for the entirety of Greater Manchester community members to work collectively in the delivery of the volume, scope and scale of the work ahead. We believe that the most opportune means to achieve this is through a blended responsibility for delivery by GMHSC Partnership, localities, the voluntary, community and social enterprise (VCSE) sector and the Greater Manchester Combined Authority, as proposed in Figure 31 and Figure 32.

7.1.4 Delivery will be driven through an alliancing model - where each member contributes and takes specific responsibility in delivery

Due to the multiple parties involved in the delivery of each initiative, the approach to commencing each project will need to be established clearly. This will include clear terms of reference, objectives and benefits, and a clear schedule and profile. It is important that responsibility and scope is clear from the outset and that the accountable parties are clear on their role and remit.

A full project initiation approach and structure will be developed for all stakeholders to critique and endorse in the early part of 2017. This process of engagement with stakeholders will also enable all parties to reach a consensus on leadership roles and responsibilities.

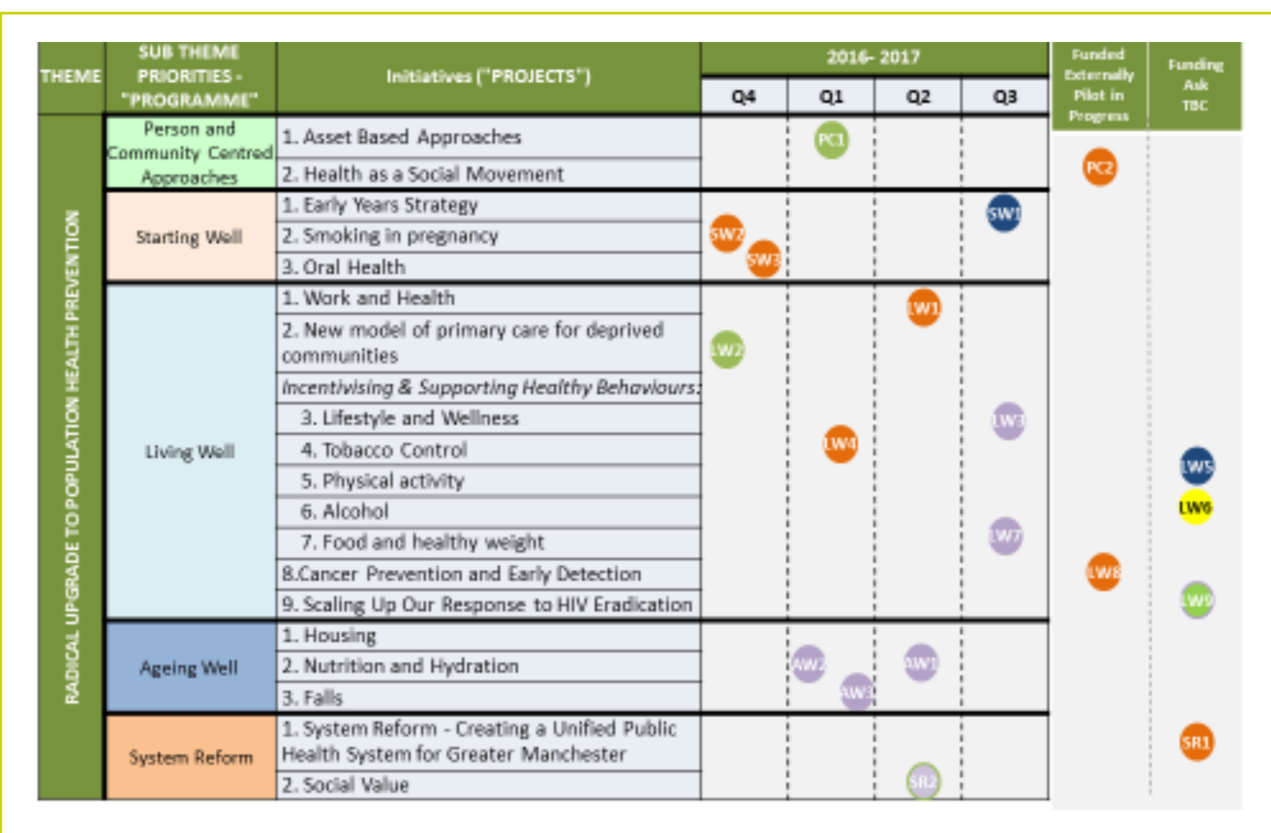


Figure 32: Transformation funding application development phases

7.2 Equality analysis and impact assessment

In alignment with the Greater Manchester Strategic Plan, this Population Health Plan is to be delivered with the ongoing commitment to advance equality and reduce health inequalities. The aim is to ensure that equality and diversity are prioritised in the design of the new system, and are embedded into the structures and delivery frameworks governing key relations between GMHSC Partnership, Greater Manchester Combined Authority and the VCSE sector. Working under the guidance of the expanded remit of the Greater Manchester Equalities Group, the Population Health Plan will seek to assess the equality impact of this plan and within each initiative to ensure they seek to mitigate and minimise any inequalities through their development and implementation

7.3 Delivery schedule

A detailed delivery scheduled will be developed and held for monitoring by the GMHSC Partnership core team as an enabling capability. A high-level schedule has been outlined in Figure 33 and will be developed in greater detail in collaboration with all the delivery partners.

7.3.1 High-level schedule

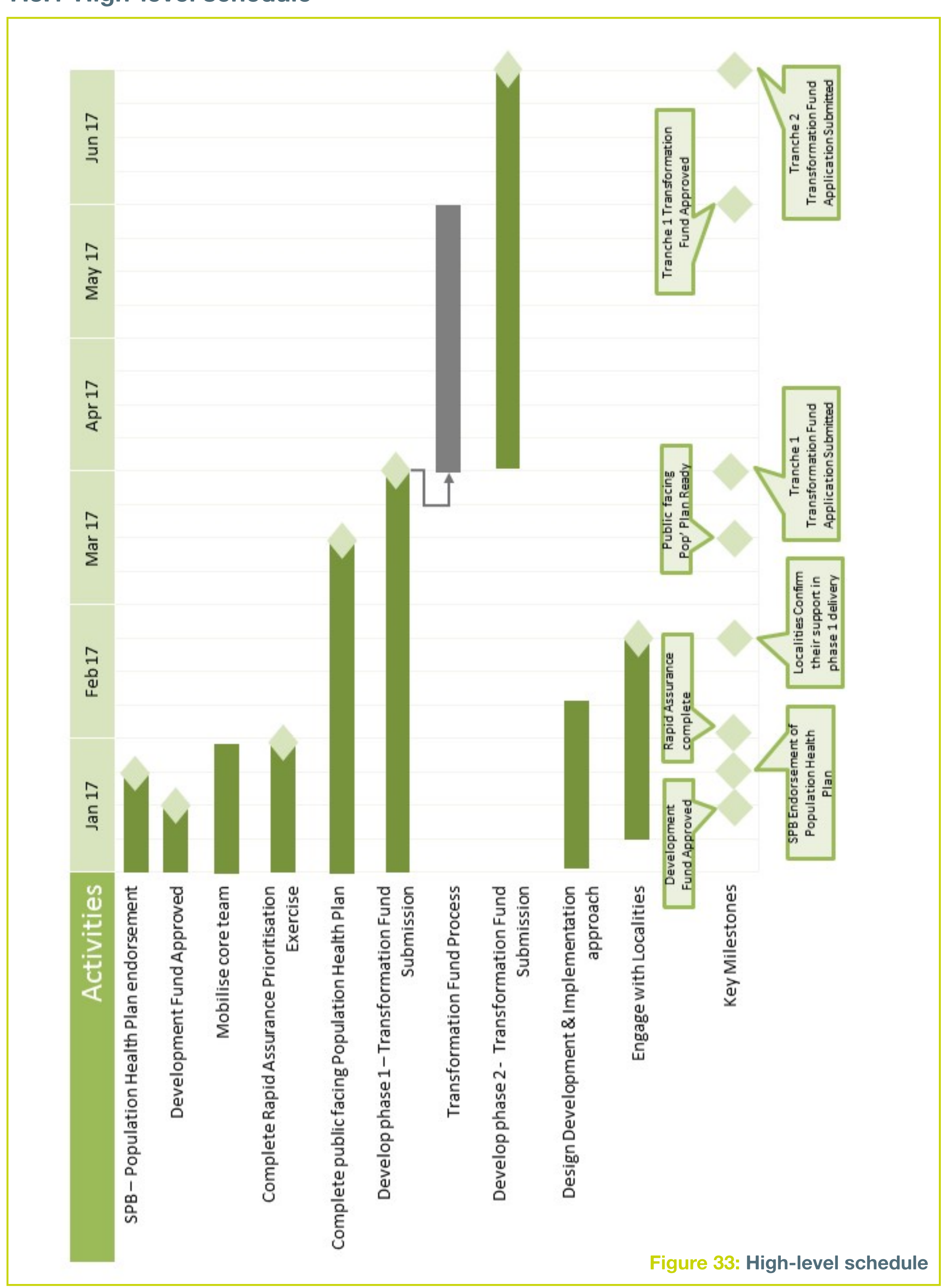


Figure 33: **High-level schedule**

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	9 March 2017
Executive Member/Reporting Officer:	Cllr Ged Cooney, Executive Member (Healthy and Working) Angela Hardman, Executive Director, Public Health, Performance and Business Intelligence
Subject:	**GREATER MANCHESTER CANCER PLAN**
Report Summary:	The paper is to introduce the Greater Manchester Cancer Plan – Achieving world-class cancer outcomes: Taking charge in Greater Manchester. The plan sets out the ambitions for Greater Manchester Cancer, the cancer programme of the Greater Manchester Health and Social Care Partnership. It is set out in eight domains reflecting a combination of the five key areas for change set out in Taking Charge and the six key workstreams of the national cancer strategy. Much of the work set out in the plan will be delivered by the current and proposed Greater Manchester Cancer infrastructure. A substantial part of the plan in 2016/17 and 2017/18 is part of the vanguard innovation programme and funded by NHS England's New Care Models Team. Greater Manchester Transformation funding will be sought to deliver other key parts of the programme and, if appropriate, to roll out successful pilots from the vanguard innovation programme beyond 2017/18. A full implementation plan will be developed by June 2017
Recommendations:	The Health and Wellbeing Board are asked to note the Greater Manchester cancer plan – Achieving world-class cancer outcomes: Taking charge in Greater Manchester.
Links to Health and Wellbeing Strategy:	Cancer is the most common cause of death in Tameside for males and females, and there are significantly more deaths than there should be, given the population age and gender profile, so improving cancer outcomes delivers against all life course priorities of the Health and Wellbeing Strategy.
Policy Implications:	The Greater Manchester Health and Social Care Strategic Partnership Board approved the plan for implementation on 24 February 2017.
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications arising from the report at this stage. However, it is essential that appropriate governance arrangements are implemented relating to any future Greater Manchester Transformation funding which is allocated to the Tameside and Glossop economy to support the implementation plan.

Legal Implications: **(Authorised by the Borough Solicitor)**	It is important that decisions regarding resources are made on an evidence based approach. This report sets out the evidence of the challenges and how we tackle improving cancer outcomes.
Risk Management :	The plan contains a substantial amount of work, much of which contributions from all parts of the cancer system. Support will be required to encourage this. Support is required for the agreement of contributions from the system towards the baseline costs of the infrastructure of the Greater Manchester Cancer Board. The proposed accountable cancer network model as part of cancer vanguard programme requires further substantial Greater Manchester system debate and engagement. Transformation funding will be sought to deliver some of the signature proposals in the plan, including lung health check (if pilot successful) and delivery of the recovery package.
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson, Head of Health and Wellbeing, by: Telephone: 0161 342 3358 e-mail: debbie.watson@tameside.gov.uk

Greater Manchester **Cancer**

Achieving world-class cancer outcomes:
Taking charge in Greater Manchester
2017-2021

Version 0.8, January 2017

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1. Introduction

There have been considerable improvements in cancer services in Greater Manchester in recent years. A cancer patient diagnosed here today has the same chance of surviving as the average for England as a whole. This was emphatically not the case two decades ago.

These improvements are testament to the hard work and collaboration of the different parts of the cancer system over this time. But there remains a lot of work to do to give the people of Greater Manchester cancer services that match the best in the world. The national cancer strategy *Achieving world-class cancer outcomes* gives us a framework to carry out this work.

In 2015 our progress as a region was underlined when we were designated as part of the national cancer vanguard by NHS England. This status gives us both the freedom to test new clinical ideas, and the responsibility to test a radical new way of organising cancer care in the future.

This document is the plan to implement the key parts of the national cancer strategy in Greater Manchester. It also sets out where we, as an area that has a devolved health and social care system and is part of the national cancer vanguard, have the ambition to go beyond what is required of us nationally.

To develop this plan we have come together in a new single board covering the whole cancer system and all parts of the patient pathway. By implementing it we will achieve world-class cancer outcomes for the people of Greater Manchester.

The Greater Manchester Cancer Board, January 2017

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2. The cancer landscape in Greater Manchester

2.1 The burden of cancer

Cancer touches the lives of everyone. Half of all people born since 1960 will be diagnosed with cancer in their lifetime[1]. The other half will undoubtedly be affected by the cancer diagnosis of a loved one.

And the incidence of cancer is growing. In 2014, 14,500 people were diagnosed with cancer in Greater Manchester, compared to 13,800 in 2011[2]. In 2014, cancer was responsible for 6,700 deaths in the region[3].

There is also a large population in the areas neighbouring Greater Manchester that use our cancer services. The largest of these is Eastern Cheshire*, where, in 2014, there were 1,200 cancer cases and 520 deaths from cancer.

The burden of cancer on our healthcare system is also growing. There were 89,200 GP referrals for suspected cancer to Greater Manchester's hospitals in 2014/15, up from 77,800 the year before[4].

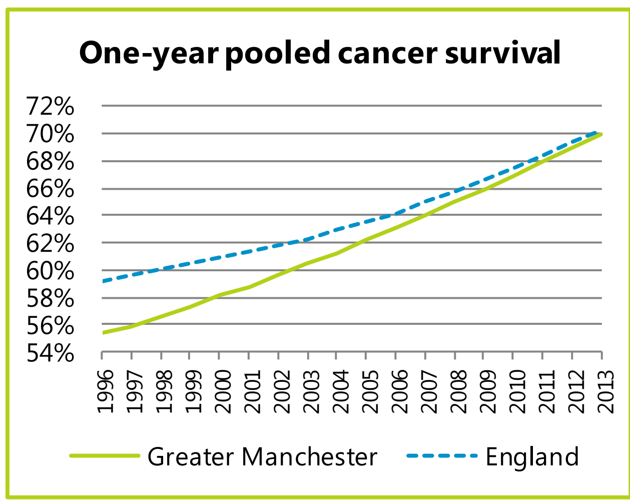
The National Audit Office estimated cancer-related costs for the NHS in England of £6.7bn in 2012/13[5], acknowledging that this does not capture all costs, such as some of those incurred in primary care. Greater Manchester contains around 5% of the population of England, so the region's cancer costs in 2012/13 can be estimated as upwards of £335m.

Achieving world-class cancer outcomes estimates that cancer-related costs to the NHS in England could grow to around £13bn a year by 2020/21[6]. That would mean a cost in Greater Manchester of £650m.

2.2 The improvements made

Greater Manchester has a history of relatively poor cancer outcomes but the picture has improved in recent years. In 2000 the overall chance of surviving a year following a diagnosis of cancer in Greater Manchester was 58%[7]. This compared to an average of 61% across England and in comparable cities.

The survival gap has been gradually closing over the last twenty years. The latest information shows that Greater Manchester's patients can now look forward to almost the same survival at one year following diagnosis as patients in comparable cities and across England as a whole (see figure).

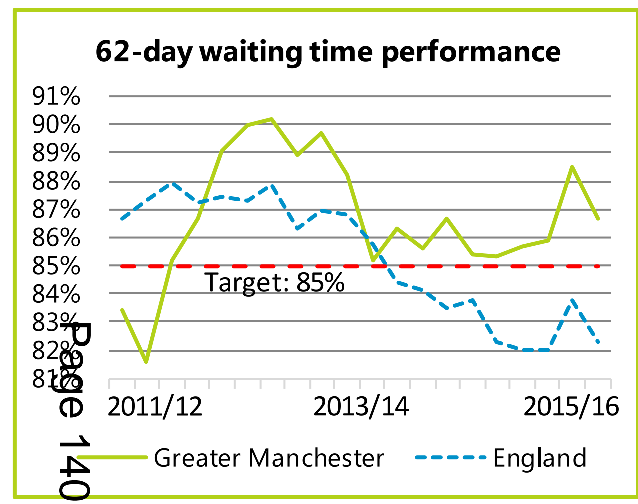


Greater Manchester also continues to comply with the national waiting time standard of 62 days between referral and beginning of treatment (see figure)[8]. This ongoing compliance is all the more impressive set against a backdrop of falling performance nationally.

These improvements have come about through the hard work of those involved in cancer care in Greater Manchester over the last decade. However, the region continues to perform very poorly in other ways of measuring cancer care.

*This relationship is such that in this plan Eastern Cheshire and its population are included when we refer to Greater Manchester

2. The cancer landscape in Greater Manchester



2.3 The challenges that remain

Smoking rates are significantly higher in Greater Manchester adults than in the rest of England. In addition, the uptake of breast, cervical and bowel screening programmes (to prevent some cancers and detect others at an earlier, more curable stage) is significantly lower.

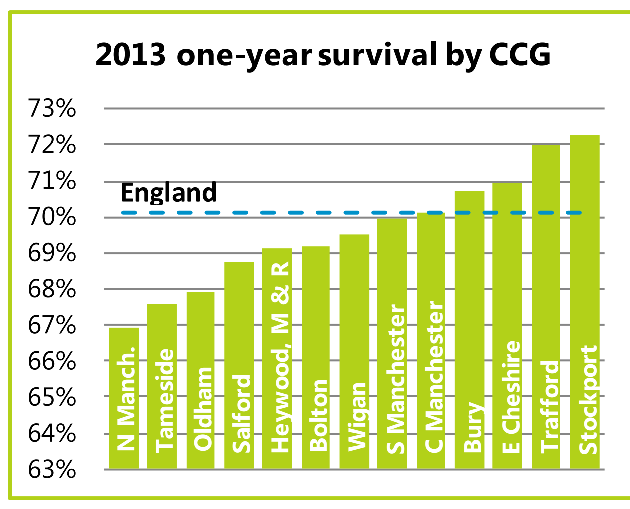
While Greater Manchester's survival rates compare well nationally, this aggregated figure masks a wide disparity in survival depending on where patients live (see figure). The chances of surviving one year after a diagnosis of cancer are less than 67% in North Manchester but more than 72% in the more affluent areas of the region[9].

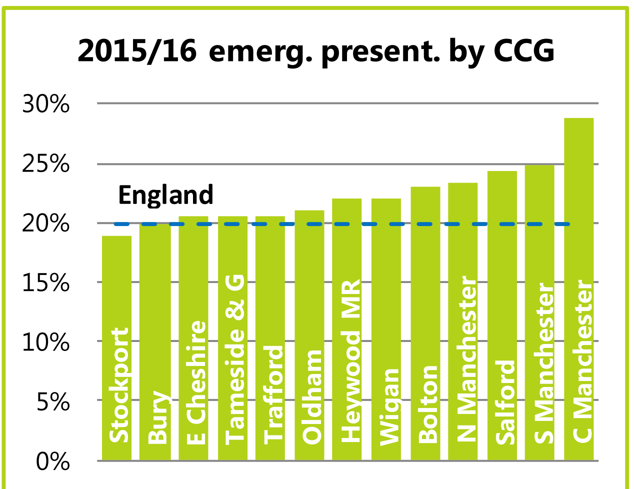
There is also great geographical variation in the proportion of Greater Manchester's cancer patients that present for the first time as an emergency (see figure)[10]. Cancer patients that are first identified this way generally have poorer outcomes.

In 2013 Public Health England published information on the number of premature deaths from cancer in each region, defining this as death before 75 years of age.

Each of the 150 local authorities in England was ranked according to its performance. Six of Greater Manchester's ten local authorities were ranked in the worst 20%, with the city of Manchester itself ranked bottom[11].

If the national average had been matched across Greater Manchester then it is estimated that over 600 fewer premature cancer deaths would have been recorded in the region from 2010 to 2012.





3. The cancer system in Greater Manchester

Prior to the reorganisation of the NHS through the Health and Social Care Act 2012, the work to improve cancer services in the region was led by the **Greater Manchester and Cheshire Cancer Network.**

Three factors came together in 2013 that created a clear impetus for our hospital providers to work together against cancer:

- Greater Manchester's patient outcomes were below the standard they should be.
- The way that some surgical services were arranged did not meet important standards set by NHS England.
- There was a risk of losing coordinated clinical leadership due to the reorganisation of the NHS.

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The region's hospital providers created **Manchester Cancer**, envisioned as an integrated cancer system bringing together cancer research, education and clinical services. They created the **Manchester Cancer Provider Board** to lead the clinical services arm of Manchester Cancer and committed to fund a full set of cancer clinical directors and their support team.

At around the same time, NHS England proposed the creation of strategic clinical networks in acknowledgement of the need to maintain regional clinical networks. The **Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network** was formed in April 2013 and its cancer team has worked with Manchester Cancer to minimise the potential for duplication.

In July 2014, Macmillan Cancer Support and the three CCGs in the city of Manchester launched the **Macmillan Cancer Improvement Partnership** (MCIP). The programme to improve cancer services in the city has had a focus on improvements in primary, community and palliative care across all tumour groups and improvements in breast and lung cancer pathways.

Also in 2014, Greater Manchester's 12 clinical commissioning groups agreed that **NHS Trafford CCG** should take a lead role in the commissioning of cancer services. Trafford led the development of the **Greater Manchester Cancer Commissioning Board**, bringing together local commissioners with those responsible for:

- Specialised commissioning (**NHS England**),
- Public health commissioning (**the Greater Manchester Health and Social Care Partnership**) and delivery (**local authorities**), and
- National cancer screening (**the Greater Manchester Health and Social Care Partnership**).

In the meantime, the commissioner-led transformation of specialist cancer surgery services has continued, supported by the **Greater Manchester Transformation Unit**.

In 2015 Greater Manchester was designated as part of the **national cancer vanguard**. The region's success in this was due in large part to our recent history of collaboration in cancer services. As a vanguard area we have a two-year vanguard innovation programme testing clinical innovations and a new approach to cancer care commissioning.

In the summer of 2016, both provider and commissioning boards agreed to set up a single system-wide cancer board for Greater Manchester. The new board, the **Greater Manchester Cancer Board**, oversees all cancer activity in the area and is the latest step in the collaboration that has been developed in Greater Manchester in recent years. This is the board's plan for cancer services in the next five years.

4. National cancer policy and Greater Manchester devolution

In October 2014, the NHS in England set out how the NHS needed to change in its **Five Year Forward View**.

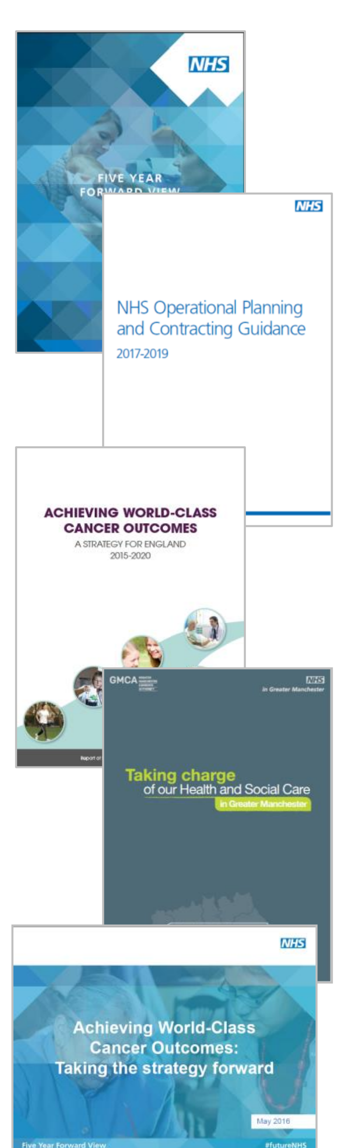
The forward view made clear the NHS's intention to support and stimulate the creation of a number of major new care models, including in cancer services.

It also began to set out a series of five-year ambitions for better prevention, faster diagnosis and better treatment and care for all.

In July 2015, **Achieving World-class Cancer Outcomes**, the report of the Independent Cancer Taskforce, applied a cancer lens to the themes of the Five Year Forward View.

In total it made 96 recommendations, including that 'cancer alliances' should be created and that a new way of providing cancer care under a single lead organisation for a region should be tested.

In May 2016 NHS England committed to delivering the Independent Taskforce's report by 2020. In **Taking the strategy forward** it sets out the first steps towards this, focussing on the major building blocks for change. NHS England has issued further guidance on implementing the strategy as 2016 has progressed.



The **NHS planning guidance 2017–2019** published in September 2016 set out the 'must dos' for 2017-19 for every local system. In cancer it stipulates the:

- Reduction of smoking prevalence
- Increased uptake of cancer screening
- Implementation of NICE suspected cancer referral guidelines and increasing GP direct access to tests
- Achievement of current and new waiting time standards, including the 62-day standard
- Improvement of one-year survival rates, diagnosis at early stage, reduced diagnosis as an emergency
- Stratified follow-up of breast, colorectal and prostate patients
- Commissioning of the Recovery Package
- Access for all to a clinical nurse specialist or other key worker

Taking charge of our health and social care in Greater Manchester was published in 2015. It details the collective ambition for the region's devolved health and social care system over the next five years.

It identifies five key areas for transformational change:

1. Radical upgrade in population health prevention
2. Transforming community based care and support
3. Standardising acute and specialist care
4. Standardising clinical support and back office services
5. Enabling better care

The plan contains a high-level summary of the ambition for cancer in Greater Manchester and signals that a detailed plan for cancer care in a devolved Greater Manchester will be developed.

5. The Greater Manchester cancer plan

5.1 Introduction

The starting points for this plan are the national cancer strategy: *Achieving world-class cancer outcomes: taking the strategy forward*, and the local sustainability and transformation plan: *Taking charge of our health and social care in Greater Manchester*.

We will implement the key recommendations of the national strategy in Greater Manchester in full by 2021. This document sets out the activities that will be necessary to do so. As would be expected from a cancer vanguard area, we also have ambitions that go beyond national requirements This document sets these out.

5.2 The eight domains

The achievement of world-class cancer outcomes in Greater Manchester will require activities to be undertaken in eight domains. The domains reflect a combination of the five key areas for change set out in Greater Manchester's plan for its devolved health and social care and the six key workstreams of the national cancer strategy.

Four domains cover the four broad parts of the cancer pathway. The remaining four are cross-cutting areas. The domains are set out in the figure below.

5.3 The format of this plan

The next chapter sets out our key objectives. Following this there is a separate section dedicated to each domain. For each domain the plan sets out:

- What is already happening,
- Our objectives and current performance (where relevant), and
- What we are going to do to meet our objectives

The final sections set out how this Greater Manchester cancer plan has been developed during 2016 and how it will be implemented.

5.4 Delivering this plan

The delivery of this plan will require contributions from the entire cancer system. Its delivery will be supported by a core team with responsibility for clinical networks, user involvement and cancer commissioning, funded recurrently for the life of the plan. Additional transformation funding will be required for other key projects.

Prevention
Earlier and better diagnosis
Improved and standardised care
Living with and beyond cancer and supportive care
Commissioning, provision and accountability
Patient experience and user involvement
Research
Education

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6. Our vision and key objectives

6.1 Our vision

Our vision is simple. We want to achieve world-class cancer outcomes and experience for the people of Greater Manchester through the delivery of cancer services that are sustainable and offer value for money.

6.2 World-class outcomes for all

We know that there is variation and inequality in cancer outcomes and experience across the localities that make up Greater Manchester. So as well as looking at our performance as a conurbation we will also monitor and seek to improve performance across all of our localities to match the best.

6.3 Our key objectives

The following sections set out our specific and measurable objectives relevant to each stage of the cancer pathway in Greater Manchester.

While all of these objectives are important we have picked six of them out as our key objectives. This will allow us to have an at-a-glance assessment of our performance across the cancer system and across the pathway.

1. We will reduce adult smoking rates to 13% by 2020
One in five adults in Greater Manchester still smoke nearly a decade after smoking was banned in enclosed public places in England.

2. We will increase one-year survival to more than 75% by 2020
Our rate of survival one year after cancer diagnosis is rising but further substantial improvement will need additional focus on detecting cancers at an earlier stage.

3. We will prevent 1,300 avoidable cancer deaths before 2021
We have some of the highest rates of avoidable cancer deaths in the country – matching the national average will save hundreds of lives.

4. We will offer class-leading patient experience, consistently achieving an average overall rating of 9/10 in the national survey from 2018
Our patients report good experience compared to other conurbations with an average overall rating of 8.76 in 2015, but there remains room for improvement.

5. We will consistently exceed the national standard for starting treatment within 62 days of urgent cancer referral
Working as a system we have met the 62-day standard for a number of years, but we want to keep reducing the amount of time people wait to start their treatment.

6. We will ensure that the Recovery Package is available to all patients reaching completion of treatment by 2019
The Recovery Package is a combination of important interventions that, when delivered together, can greatly improve the outcomes and coordination of care.

7. Prevention

7.1 What is already happening

There are existing **national plans** related to key lifestyle risk factors such as the national Tobacco Control strategy. There are also innovative integrated public health campaigns such as Change4Life, One You and single issue campaigns such as Stoptober.

Taking Charge makes a commitment to placing prevention and population health at the heart of the reform agenda in Greater Manchester. It sets out an ambition to deliver the fastest and greatest improvement to the health and wellbeing of Greater Manchester residents.

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To support delivery of this ambition the first transformational programme set out in *Taking Charge* is a **radical upgrade in population health and prevention**. By upgrading prevention and self-care we are proposing to change the way the people of Greater Manchester view and use public services, creating the conditions that enable people and communities to become resilient and empowered.

This means more people managing their health, looking after themselves and each other. Healthy and independent people play a key part in enabling us to **achieve our ambitions** for a growing and sustainable Greater Manchester in the future.

As part of the **vanguard innovation programme** we have a cancer prevention work stream which aligns with the themes in *Taking Charge* and includes: creating a citizen led social movement, social marketing and behaviour change support, and using new insights into human behaviour to help design preventative services and make it easier for people to live healthy lives.

7.2 Our objectives and current performance

Nationally-set objectives

We aim to reduce adult smoking rates to 13% by 2020 and 5% by 2035
Currently, 19.9% of the adult population in Greater Manchester smokes compared to 16.9% nationally[12]. There is great variation in smoking rates across the region's local authority areas, ranging from 22.7% in Manchester to 16.4% in Trafford.

We aim to reduce smoking rates in routine and manual workers to 21% by 2020
29.9% of routine and manual workers in Greater Manchester currently smoke, compared to 26.5% of this type of worker in the country as a whole[13].

Current adult smokers in Greater Manchester:
423,000

Adult smokers who must quit by 2020 to achieve 13%:
150,000

7. Prevention

Locally-set objectives

We aim to reduce smoking rates in pregnancy to 8% by 2021 and to reduce regular and occasional smoking in 15 year olds to 5% by 2021
The current rate of smoking in pregnancy in Greater Manchester is 12.9%[14]. We will tackle this as part of our long term ambition to give all our children and young people the best start by making smoking history. There is no Greater Manchester figure for regular and occasional smoking in 15 year olds but in our localities this ranges from 5.3% in Trafford to 10.3% in Tameside[15].

7.3 What we are going to do

Our current health challenges require widespread behaviour change. Greater Manchester Health and Social Care Partnership is developing a Greater Manchester population health plan. This will set out a bold vision to radically upgrade our population health and prevent disease, including cancer.

The plan is built around five transformation themes:

1. **Person and Community Centred Approaches**: The aim is to put people and communities at the heart of things, focusing on the assets within communities, the skills and knowledge, the social networks and the community organisations which are the building blocks for good health.
2. **Start Well**: The early years plan aims to establish a framework for the delivery of appropriate services at the right time, supporting children and families to become healthier, resilient and empowered.
3. **Live Well**: The adults programme recognises that good work is an essential prerequisite of health and socio-economic outcomes. It will have a priority focus on supporting people with health problems to stay in work. Greater Manchester will also do a lot more to help people change their behaviour utilising innovative digital technologies to support behaviour change at scale.
4. **Age Well**: The aim is to support people to maintain good health, wellbeing and independence for as long as possible. Year one of the programme prioritises housing and health, nutrition and hydration, and falls prevention.
5. **System Reform**: Greater Manchester will radically reform the role of public health in the context of a devolved system, creating a unified population health system across ten localities that is better able to achieve improved health outcomes.

Prevention is also a major focus of our vanguard innovation programme, bringing additional resources to support the ongoing work of the Greater Manchester Health and Social Care Partnership in this area.

Raise awareness of lifestyle risk factors and change behaviour

Updated national plans are expected imminently for obesity, tobacco control and alcohol consumption. The Greater Manchester population health plan will set out a comprehensive programme of interventions that provides new and hard-hitting approaches to the well-known lifestyle risk factors such as physical inactivity, alcohol, tobacco and obesity.

7. Prevention

We will work to better understand our population and how best to reach out to the different groups of people within it. We will use the latest evidence, including local insights into human behaviour, to help develop large-scale social marketing campaigns to change behaviours with regard to lifestyle decisions that raise the risk of a cancer diagnosis.

These campaigns will be supported by the development of innovative digital approaches to support behaviour change at scale including social media platforms and new ways to help people assess their individual risk of cancer.

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What and when?

- Greater Manchester population health plan produced by January 2017

Smoking is by far the biggest single cause of ill health and early death in Greater Manchester. The Greater Manchester Cancer Board has therefore made preventing tobacco related harm a key focus for this strategy and is sponsoring the work to develop a comprehensive tobacco control plan for Greater Manchester.

What and when?

- Greater Manchester tobacco control plan produced by April 2017

Help people to understand their individual risk of cancer

We will support the development of innovative online resources to help the people of Greater Manchester to quickly and easily understand their individual risk of cancer and support them in modifying their lifestyles and behaviours.

What and when?

- Online tool for the assessment of individual risk of cancer available to people in Greater Manchester by September 2017

Create a citizen-led social movement

The more connected, empowered and resilient people and communities are, then the greater is the likelihood they will live healthy and fulfilled lives. A central focus of *Taking Charge* is changing the relationship between people and public services, putting people and communities genuinely in control of their own health.

We will work with a broad range of partners from the voluntary and community sector to start a social movement in Greater Manchester focussed on cancer prevention.

As part of this programme we will develop a network of up to 20,000 'cancer champions', members of the public who will help us spread prevention and early detection messages and action throughout their communities and support people to make and maintain healthy behaviours as part of their daily lives.

What and when?

- An exemplar citizen-led social movement focused on cancer prevention delivered by March 2019

Increase HPV immunisation uptake

Human papilloma virus (HPV) infection is one of the most common sexually transmitted infections. Persistent infection with high risk HPV types can lead to the development of cervical and other cancers.

All girls aged 12 to 13 are offered HPV vaccination as part of the NHS childhood vaccination programme. The programme is a

7. Prevention

two-dose schedule. The vaccine used protects against the types of HPV responsible for more than 70% of cervical cancers in the UK. The target is to achieve a 90% uptake, currently in Greater Manchester only half of local authority areas are achieving this.

Tackling falling uptake figures for our schools based programme and expanding the vaccination programme to those at high risk for HPV infection such as men who have sex with men are key priorities.

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We will:

- Develop a specific plan to significantly improve HPV vaccination within school-aged girls (11-18 year-olds)
- Implement the men who have sex with men HPV programme following the current national piloting phase
- Implement a HPV vaccination programme for boys if and when this is adopted to the national immunisation programme.

What and when?

- A plan to significantly improve HPV vaccination within school-aged girls (11-18 year-olds) by March 2017

Deliver lifestyle-based secondary prevention

We will work to better understand why some people living with and beyond a cancer diagnosis either do not have access to or do not use the support available to change their lifestyles and help prevent further cancer diagnoses.

Research has shown that people who have had cancer would like more information about how to approach lifestyle changes and would welcome support tailored to their individual needs.

As part of the vanguard innovation programme we will make sure that all improved aftercare pathways provide health promotion messages and access to the necessary tailored support for people who want to have a healthier lifestyle.

What and when?

- Delivery model of lifestyle-based secondary prevention developed as part of new aftercare pathways by April 2018

Prescribe drugs that are effective in preventing cancers

The use of drugs to prevent cancer (including secondary cancers) is increasingly likely to play a key role. Nationally, the National Institute for Health and Care Excellence (NICE) is developing updated guidelines considering the use of:

- Aromatase inhibitors for untreated post-menopausal women at high risk of breast cancer,
- Bisphosphonates to prevent secondary cancers in women previously treated for early stage breast cancer, and
- Aspirin for individuals with hereditary non-polyposis colorectal cancer (HNPCC) or Lynch Syndrome.

NICE assessment processes can be lengthy. We will develop a process to make our own assessments of the evidence with regard to the use of these drugs to prevent cancer and, if appropriate, make sure they are available across Greater Manchester.

What and when?

- Assessment of evidence of effectiveness of drugs to prevent breast cancer and business cases agreed by May 2017

8. Earlier and better diagnosis

8.1 What is already happening

The **national cancer screening programmes** are changing. The current bowel screening test (the faecal occult blood test) will be replaced with a new test (the faecal immunochemical test or FIT). A new complementary bowel scope programme for 55-year-olds is currently being rolled out. In cervical cancer the roll-out of primary HPV (human papilloma virus) testing is being assessed.

Greater Manchester Health and Social Care Partnership has a three year **cancer screening improvement plan**. This aims to reduce variation in uptake and includes implementing the most recent evidence and research consistently across Greater Manchester.

In addition the prevention work stream of the **cancer vanguard innovation** programme is starting a number of innovative projects focused on improving access to and uptake of the national screening programmes and other early detection initiatives.

Our charitable sector partners have played a key role in efforts to diagnose cancer earlier in Greater Manchester. We have for some years had an active group of **Macmillan GPs**, practising GPs who devote an average of a day per week to work with Macmillan and primary healthcare teams to improve cancer care, including through earlier diagnosis.

Greater Manchester's Macmillan GPs have led our cancer system in the revision of the existing referral pathways in the light of the 2015 NICE guidance for **suspected cancer referral**. New and improved Greater Manchester-wide referral forms have been designed and uploaded onto GP systems across the region. Review of the new forms will take place during 2017.

From July 2015 **Cancer Research UK facilitators** have also been in place in all Greater Manchester CCGs, supporting healthcare professionals and organisations to improve prevention and early diagnosis, offering practical support to help them change the way they manage cancer.

Through the **Macmillan Cancer Improvement Partnership** (MCIP), Macmillan Cancer Support and the three CCGs in Manchester are pilot testing an innovative service that aims to detect lung cancer earlier. The pilot service offers people at high risk of lung disease an opportunity to attend a lung health check. Those that have a high lung cancer risk will go on to have a CT scan with the aim of detecting lung cancer earlier.

The NHS England, Macmillan Cancer Support and Cancer Research UK **ACE programme** (Accelerate, Coordinate, Evaluate) is looking at a portfolio of projects that aim to improve the early diagnosis of cancer. Greater Manchester has a number of projects in the first phase of the programme, three of them through our pathway boards.

Greater Manchester was also successful in securing funding from **wave 2 of the ACE programme**. This programme is piloting on two sites (Oldham and South Manchester) a new pathway for patients presenting with non-specific but concerning symptoms along with new diagnostic models to identify or rule out cancer as a cause. This work is now being combined with the **rapid cancer investigation unit** project within the vanguard innovation programme.

8. Earlier and better diagnosis

A system for the transfer of cancer patients between hospitals and the responsibilities of those involved has been in place for some years in Greater Manchester. This **communication and referral protocol** has allowed us as a region to consistently meet the 62-day cancer waiting time target.

When there are problems that result in a breach of the national waiting time targets then the hospitals involved often **share responsibility** for this. This mature and collaborative arrangement has inspired a national change in policy.

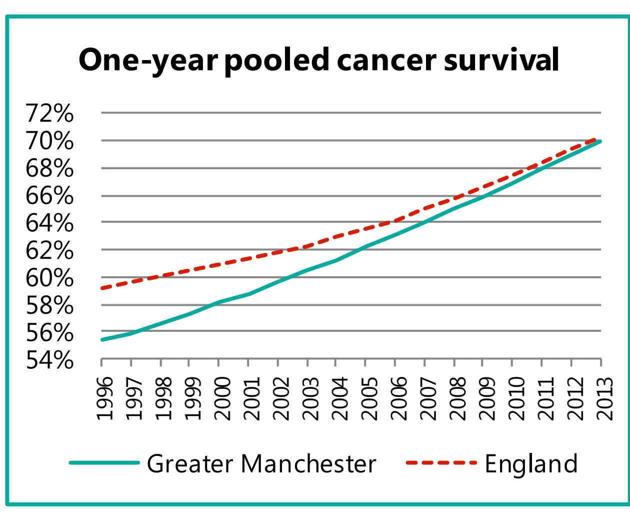
8.2 Our objectives and current performance

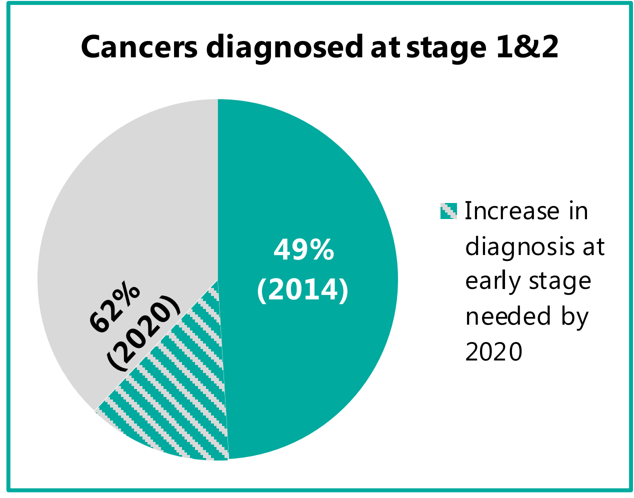
Nationally-set objectives

We aim to achieve bowel cancer screening uptake of 75% by 2020, for both the FIT programme and the bowel scope programme for 55 year old people
In Greater Manchester the uptake of the faecal occult blood bowel screening programme for the year to September 2015 was 52.3%[16]. Achieving this ambition will mean the screening of an additional 60,000 people and the screening of an additional 30,000 people a year from 2021 onwards.

We aim to increase one-year survival to 75% or more by 2020, with a reduction in CCG variation
The one-year survival rate for patients diagnosed in Greater Manchester in 2013 was 69.9%[17]. This constitutes a continuation of the improvement in survival rates seen in recent years and a narrowing in the gap with the rate for England as a whole (70% for 2013, see figure). There is considerable variation between CCGs though, ranging from 66.9% in North Manchester CCG to 72.3% in Stockport for patients diagnosed in 2013.

We aim to increase the proportion of patients whose cancers are diagnosed at stage 1 or 2 to 62% by 2020
In the latest data available (2014), 49% of the cancer patients diagnosed in Greater Manchester had stage 1 or 2 disease[18]. In England as a whole this figure was 51%. Increasing the proportion of patients diagnosed with early disease to 62% by 2020 will require considerable effort (see figure).





8. Earlier and better diagnosis

We aim to consistently meet as a region the current waiting time targets of 96% for 31-days and 85% for 62-days
As a region we have consistently achieved the 31-day and 62-day targets since 2011/12. Nationally performance has been falling, with just 82.4% of patients beginning treatment within 62 days in 2014/15[19].

Rather than merely maintaining our performance at just above national targets we will continuously reduce the amount of time that people wait for cancer diagnosis and treatment in Greater Manchester.

We aim to consistently meet the waiting time targets of 96% for 31-days and 85% for 62-days in each of our localities by April 2018
While we continue to meet these operational standards as a region there is variation in performance between the different localities that make up Greater Manchester. For example, in the last three months of 2015/16 we achieved 86.7% for the 62-day target as a region but the performance of four of our localities was under 85%[20]. We will ensure that these targets are met across the region and continuously reduce the amount of time that people wait for cancer diagnosis and treatment.

We aim to increase the proportion of patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP to 95% by 2020
This is a new waiting time standard introduced in *Achieving world-class cancer outcomes* and performance against it is not currently measured.

Locally-set objectives

We aim to decrease premature mortality from cancer to match the England average, resulting in 1,300 fewer premature deaths by 2021
This is an aim set in *Taking charge of our health and social care in Greater Manchester.* Over 2012-14 Manchester was Public Health England's worst-ranked local authority with 534 premature deaths from cancer per 100,000 of population[21]. The rate for England as a whole is 337 premature deaths per 100,000 of population. Salford was 147th out of 150 with a rate of 471. In total, six of Greater Manchester's ten local authorities ranked in the bottom 20%.

We aim to reduce the one-year survival deficit for older people to less than 15% by 2020
In England as a whole 77.3% of cancer patients aged 55-64 when diagnosed in 2013 lived to one year[22]. The same figure for patients aged 75-99 was 58.4%. Figures for Greater Manchester are not currently available but we assume that the picture here is similar to England as a whole.

We aim to reduce the proportion of cancers that are diagnosed as an emergency to below 18% by 2020, with a reduction in CCG variation
In 2015/16 21.8% of Greater Manchester's cancer patients were diagnosed following an admission as an emergency[23]. The figure for England as a whole was 19.8%. The latest data show great variation among Greater Manchester's CCGs, ranging from 18.8% in Stockport to 28.8% in Central Manchester.

We aim to increase cervical screening coverage to 80% by 2021
In the year to December 2015 the coverage in Greater Manchester was 72.6%[24]. Achieving this ambition will mean an additional 52,500 women will need to have

8. Earlier and better diagnosis

been screened, and we will then be screening an additional 15,000 women a year from 2021 onwards.

We aim to increase breast screening coverage by 10% to 75% by 2021
In the year to December 2015 the coverage in Greater Manchester was 67.6%[25]. Achieving this ambition will mean that an additional 22,400 women will have been screened, and we will then be screening an additional 11,200 women a year from 2021.

We will recruit over 1,000 cancer patients to the national 100,000 Genomes Project by 2018
The 100,000 Genomes Project is a central element of NHS England's personalised medicine strategy, which aims to progress the move from a one size fits all approach to patient treatment to more effective personalised therapies.

We are committed to supporting national partners with the ambitions of the 100,000 Genomes Project. We will recruit over 1,000 cancer patients to participate by the end of 2018, and support the creation of a new genomic medicine service for the NHS.

8.3 What we are going to do

Enhance cancer screening

As well as detecting cancer, the bowel screening programmes also act as prevention programmes by allowing the detection and removal of pre-cancerous lesions that might have gone on to become cancer.

Full rollout of FIT (faecal immunochemical test) in the bowel screening programme in April 2018 will contribute to increasing uptake. In addition we will have the bowel scope programme for 55 year olds in place by 2020. This will provide increased coverage of bowel screening which will result in more cancers being detected earlier.

In relation to cervical screening, we will accelerate the local implementation of the primary HPV (human papilloma virus) testing in the cervical programme in 2017/18. Greater Manchester will work with national partners at NHS England and Public Health England to deliver this.

What and when?

- FIT in use in bowel screening programme by April 2018
- HPV testing in cervical screening programme implemented by April 2018
- Bowel scope programme for 55 year olds in place by April 2020

Through a vanguard innovation project we will launch series of innovative studies with the aim of increasing the uptake of cancer screening. These randomised control trials will use behavioural insights theory and will give us a better understanding of why people do not take up the offer of screening. We will then use the latest evidence to test new ways of inviting people in Greater Manchester to take part in screening programmes with the aim of increasing uptake (through GP endorsement of the programme, for example).

What and when?

- Breast screening improvement trial reports findings in May 2017
- Bowel and cervical screening improvement trials report findings in October 2017

We will also work to identify any parts of Greater Manchester where uptake of screening is particularly low through health

8. Earlier and better diagnosis

equity profiles. We will take targeted action to improve this, co-producing initiatives with patients and communities. We will also build on the developing cancer prevention social movement and engagement activities in Greater Manchester to promote uptake of cancer screening programmes.

What and when?

- Health equity profiles to identify areas of low screening uptake produced by July 2017

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Increase public awareness of screening, and cancer signs and symptoms

We will continue to support the national Be Clear on Cancer programme locally. In 2017 the vanguard innovation programme will include a major campaign on bowel cancer screening. The campaign will be run with Public Health England and Cancer Research UK and will include mass media and direct mail elements.

This work will gather evidence on the effectiveness of a Be Clear on Cancer campaign in support of screening programmes and will inform future national campaign activity. Behavioural insights research with our eligible population will also inform additional Greater Manchester campaign activity.

What and when?

- Be Clear on Cancer branded campaign to promote bowel screening, January-March 2017

Make the MCIP lung health check available to all if successful

If the pilot of the Macmillan Cancer Improvement Partnership (MCIP) lung health check is shown to be successful in the city of Manchester we will make the service available across Greater Manchester to transform our lung cancer outcomes.

As part of the vanguard innovation programme we will support the further development and delivery of the MCIP lung health check through an innovative behavioural insights randomised control trial designed to increase uptake of the check by people who have previously failed to respond to the invitation.

What and when?

- Decision on implementation of MCIP lung health check across Greater Manchester by May 2017

Implement the NICE suspected cancer referral guidelines

New and improved Greater Manchester-wide referral forms, based on the NICE guidelines, were developed and introduced across Greater Manchester in spring 2016. Review of the new forms and their use will take place during 2017. The new referral process will then be extended to other areas of primary care, such as dentistry and optometry.

What and when?

- GP use of updated standardised suspected cancer referral process and forms audited by June 2017
- Use of standardised suspected cancer referral process extended to other referrers by January 2018

Improve adherence to NICE suspected cancer referral guidelines

Through a Greater Manchester and Eastern Cheshire Strategic Clinical Network project

8. Earlier and better diagnosis

we will use the latest available evidence to look at GP referral behaviour across the region. Using behavioural insight theory we will test the effect of providing feedback to GPs on their referral behaviour compared to that of other practices in Greater Manchester. This randomised control trial will test whether this feedback brings referrals more into line with the NICE guidelines.

What and when?

- Study into the impact of feedback on GP referral behaviour reports findings by September 2017

Develop rapid cancer investigation units

The Greater Manchester ACE 2 project to develop a pathway for patients with non-specific but concerning symptoms and pilot a physician-led multidisciplinary diagnostic clinic is underway.

We will combine this work with the testing of a model of rapid cancer investigation units as part of the vanguard innovation programme. We will launch two units with the diagnostic capacity to confirm or exclude the presence of a broad range of cancers within seven days for most patients (a 'Query Cancer' service).

Most of those people referred to this service will know within a week whether or not they have cancer. Those with cancer will be rapidly referred to the appropriate specialists. Those without cancer will receive individualised discharge information, safety-netting advice, and be offered targeted interventions to reduce their primary cancer risk.

What and when?

- Non-specific but concerning symptoms clinic pilots start March 2017

Pilot patient self-referral

In year two of our vanguard innovation programme (2017/18) we will start to explore ways to allow people to refer themselves for cancer investigations. This work will start with a pilot looking to develop a risk-defined approach to direct symptom-based referral. It will also investigate the feasibility of direct referral of people with a risk score warranting further investigations to the developing multidisciplinary diagnostic clinics.

What and when?

- Self-referral system pilot launched by June 2017

Reduce diagnostic waiting times

The Find Out Faster programme has been set up to test ways of achieving the new national target to give a definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.

In May 2016, NHS Bolton CCG and Bolton NHS Foundation Trust submitted a strong expression of interest to test the new standard. We will support Bolton's excellent proposal through our vanguard innovation programme so that this work can proceed.

Through this project we will understand better the issues preventing faster cancer diagnosis in lung, colorectal and oesophago-gastric cancers in Greater Manchester and how to make improvements across the city. We will also contribute to the evidence base of the national programme.

8. Earlier and better diagnosis

What and when?
- Faster pathways in Bolton for lung, colorectal and oesophago-gastric cancers by May 2017
- Share learning on faster pathways locally and nationally by December 2017

We will also seek to reduce delays to patient pathways caused by poor communication between referrer, hospital and patient. We will bring hospitals, commissioners and people affected by cancer to co-produce and publish a Greater Manchester Cancer Patient Access Charter setting out the responsibilities of all parties to ensure a swift diagnostic pathway.

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What and when?
- A co-produced cancer patient access charter published by June 2017

Support pathway-specific efforts to deliver earlier and better diagnosis

We will support the development, evaluation and roll-out of pathway-specific efforts to improve and speed up diagnosis, such as:

Haematological cancer

A regional haematological malignancy diagnostic service (HMDS) to provide specialist diagnostics for haematological cancer patients within Greater Manchester.

What and when?
- Regional haematological malignancy diagnostic service in place by January 2018

Hepato-pancreato-biliary cancer

A regional jaundice pathway for pancreatic cancer, with one-stop diagnostic clinics in every hospital and fast-track referral for surgery at the specialist centre.

What and when?
- Regional jaundice pathway for pancreatic cancer in place by January 2018

Lung cancer

A regional lung cancer pathway based on, but going further than, the national optimal lung cancer pathway.

What and when?
- Regional optimal lung cancer pathway implemented by January 2018

Urological cancer

A standardised Greater Manchester approach to the use of modern imaging techniques to reduce unnecessary biopsies in prostate cancer diagnosis.

What and when?
- Standardised approach to prostate cancer diagnosis agreed and implemented by January 2018

Gynaecological cancer

A standardised approach to one-stop clinics for unexplained vaginal bleeding in all Greater Manchester hospitals.

What and when?
- Standardised approach to one-stop unexplained vaginal bleeding clinics by August 2018

Colorectal cancer

Piloting of a faster straight-to-test pathway for appropriate cancer patients referred with suspected colorectal cancer.

What and when?
- Pilot of straight-to-test pathway for colorectal cancer by October 2017

8. Earlier and better diagnosis

Develop sector-based multidisciplinary teams (MDTs) for colorectal cancer, reducing the existing number of MDTs in line with the changes agreed as part of Healthier Together.

What and when?

- Sector MDT model in colorectal cancer fully implemented by September 2017

Oesophago-gastric cancer

Piloting of a streamlined diagnostic pathway in oesophago-gastric cancer to minimise the number of patient attendances.

What and when?

- Pilot of streamlined oesophago-gastric cancer diagnostic pathway by January 2018

Breast cancer

Ensure that one-stop triple assessment clinics are available to all patients referred with suspected breast cancer in Greater Manchester.

What and when?

- Current provision of breast one-stop triple assessment clinics audited and plan developed by September 2017

Contribute to regional improvements in diagnostic services

Diagnostic services in Greater Manchester are already stretched and through implementing elements of the plan we are likely to increase demand. We will work with colleagues both inside and outside of cancer services in Greater Manchester to develop proposals for improved access to radiology and cellular pathology services across the region.

These proposals are likely to include:

- Integrated digital platforms to allow the transfer of diagnostic information across our region, such as a single integrated picture archiving and communication system (PACS) in radiology and a similar model for pathology images,
- Defined regional clinical leadership for diagnostic modalities,
- More effective use of resources, including the development of virtual networks to allow clinical teams to work in partnership, and
- Agreed co-produced clinical and operational standards for all diagnostic services across Greater Manchester.

What and when?

- Workshop to commence regional radiology development programme by March 2017
- Proposal for regional cellular pathology development programme produced by September 2017

9. Improved and standardised care

9.1 What is already happening

The work to **transform specialist cancer surgical services** in Greater Manchester to make them compliant with NICE Improving Outcomes Guidance has been happening for some time.

Significant progress was made in 2014/15, with the system supporting the region's specialised commissioners to deliver compliant services in two of these four areas: hepato-pancreato-biliary and gynaecology cancer surgery. A compliant oesophago-gastric cancer surgery service will be achieved in 2017 when the agreement to develop a single centre is implemented. The work to transform urology is ongoing.

In the meantime our **pathway boards** have been working to develop system-wide guidelines, protocols and quality standards to improve and standardise the cancer care that the people of Greater Manchester receive. Where necessary they have worked with colleagues and commissioners to begin to change services to deliver these common standards.

The lung pathway board has reduced the number of weekly lung cancer multidisciplinary team meetings (MDT) from ten to four. The **MDTs are now sector-based**, meaning that clinicians from different hospitals in the same area discuss all cases before recommending treatment. This ensures better communication between clinicians and improved access to services for lung cancer patients.

9.2 Our objectives and current performance

Nationally-set objectives

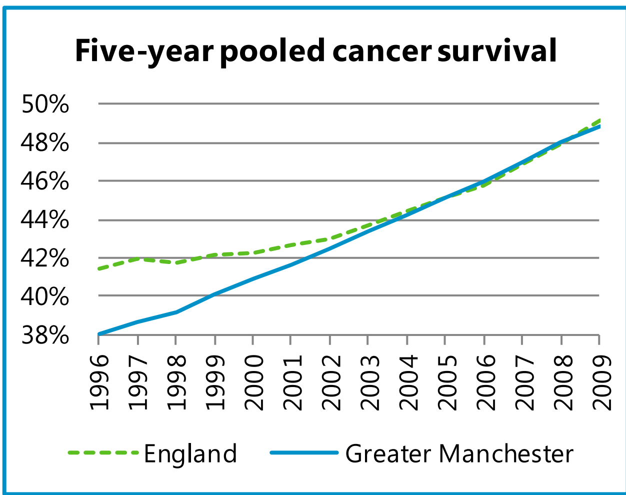
We aim to increase ten-year survival to 57% for patients diagnosed in 2020

In England as a whole, more than 50% of cancer patients are still alive ten years following their diagnosis[26]. This metric is not currently measured and reported below national level but we assume that our ten-year survival is at or around the same level.

Locally-set objectives

We aim to increase five-year survival to 62% for patients diagnosed in 2020

Five-year survival in Greater Manchester has increased significantly in recent years from 38% for patients diagnosed in 1996 to nearly 49% in 2009 (see figure)[27].



We will set pathway-specific metrics for each tumour type

We will set a range of metrics for each cancer type, including secondary cancers, by September 2017 and use data produced through the vanguard innovation cancer intelligence project to allow all pathway boards to measure their progress against them.

9. Improved and standardised care

9.3 What we are going to do

Complete the transformation of specialist urological and oesophago-gastric cancer surgery

NHS England recommendations on the need for further surgical service consolidation are expected by June 2017.

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In the meantime we will continue to work to transform oesophago-gastric and urology cancer surgery. Agreement has been reached on a single centre for oesophago-gastric cancer surgery and this will be implemented in 2017.

A detailed service specification for bladder, kidney and prostate cancer surgery has been signed off by commissioners and we will reach a decision on the lead and key providers for urology cancer surgery by June 2017. We will begin implementing this decision later in the year.

We will also make a significant contribution to the evidence base for the reorganisation of specialist cancer surgery through our continued involvement with London partners in a research study into its impact in these cancers (RESPECT-21).

What and when?

- Implementation plan for transformed oesophago-gastric cancer surgery agreed by May 2017
- Decision on transformed urology cancer surgery by June 2017
- Implementation plan for transformed urology cancer surgery agreed by December 2017

Transform colorectal cancer surgery

We will work with the Healthier Together project team within Greater Manchester Health and Social Care Partnership to transform surgery for colorectal cancer in line with the broader changes to colorectal services. We will start by building on the success of sector-based MDTs in lung cancer to develop a similar model in colorectal cancer.

What and when?

- Sector MDT model in colorectal cancer fully implemented by September 2017
- Transformation of colorectal surgery in line with broader timetable for implementation of Healthier Together

Transform breast cancer surgery

We will use the methodology developed to transform urology and oesophago-gastric cancer surgery to transform services for breast cancer in Greater Manchester. This work will address the long-standing issues in breast cancer in our region and deliver sustainable services that are fit for the future.

What and when?

- Greater Manchester model of care and specification for future breast services developed by September 2017

Improve multidisciplinary team working

We will review multidisciplinary team (MDT) working across our cancer services. We will assess the need for a standardised Greater Manchester approach to MDT working and explore the potential for innovative MDT models in some cancer pathways.

A more streamlined approach to MDT working would free up time for greater consideration of complex cases and the possibility of more reactive services, with MDT meetings more frequently than the

9. Improved and standardised care

current weekly meetings.

What and when?

- Greater Manchester's cancer MDT arrangements reviewed by September 2017
- Need for MDT proforma standardisation assessed by December 2017
- Pilots of innovative MDT models to begin by January 2018

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Speed up pathways to treatment

We will build on the work to reduce diagnostic waiting times, outlined in the previous section, to agree and implement new pathways that see our patients beginning their treatment well within the current standard of 62 days.

We will prioritise lung and hepato-pancreato-biliary cancers for this work as these are tumour types where faster time to treatment has the potential to affect a patient's outcome.

What and when?

- 50-day pathway in place in identified tumour types by December 2017
- 42-day pathway in place in identified tumour types by December 2018

As well as setting ourselves new maximum waiting time standards in some areas, we will also measure the average time that patients wait for all cancer types so we can work to continuously improve this.

What and when?

- System in place to report average and range of waiting times for all pathways by April 2017

Review and strengthen pathway boards

We will review our pathway boards (regional pathway-specific clinical groups informed by people affected by cancer). We will strengthen them to ensure that the membership of all boards is reflective of the whole cancer pathway.

We will identify a series of priority pathways based on which tumour types have the most profound impact on cancer outcomes in Greater Manchester. We will define the support that these priority pathways will be given and identify the best clinical leadership to take them forward.

For each priority pathway the board will work with commissioners and people affected by cancer to co-produce a detailed plan outlining its contribution to the overall Greater Manchester cancer plan. This will include the agreement and adoption of standardised approaches to diagnosis and treatment, such as the optimal lung pathway in development through that pathway board.

What and when?

- Identify priority pathways by April 2017
- Detailed plans developed for all priority pathways by October 2017

Agree challenging clinical standards

Our pathway boards will develop, review and regularly audit system-wide guidelines, protocols and quality standards to address the variations in cancer care in Greater Manchester. We will agree a timetable for the development of a series of optimal Greater Manchester service specifications for both primary and secondary cancer pathways.

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These will be co-produced between key stakeholders with a focus on priority pathways in the first instance, and will ensure that patients experience seamless pathways of care.

What and when?

- Timetable for development of pathway-specific optimal specifications by September 2017

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This work will be informed, in part, by the vanguard innovation project testing a new approach to the development of consistent and challenging clinical standards across the cancer pathway. The project will start with colorectal cancers and build on methodologies used in other medical specialities to test new ways of assuring that cancer standards in Greater Manchester are being met and reporting on this publicly.

What and when?

- Colorectal cancer standards proposed by March 2017

Deliver systemic anti-cancer therapies closer to home

Recent years have seen ever more systemic anti-cancer therapies (including chemotherapy) delivered away from The Christie and closer to patients' homes through a network of clinical services. With demand for therapies increasing, an updated strategy for systemic anti-cancer therapy in Greater Manchester was developed by our oncology leads in 2015/16.

The strategy sets out the ambition to continue this work, providing systemic therapies closer to home under a single governance agreement and thereby:

- Providing equity of access to patients across the region,
- Maintaining the quality and safety of services,
- Improving patient experience,
- Preserving access to clinical trials for patients, and
- Creating capacity at The Christie for the management of more complex disease.

The Greater Manchester Cancer Board will review the 2015/16 systemic anti-cancer treatment strategy and work with The Christie to oversee its implementation.

What and when?

- Review systemic anti-cancer treatment strategy to include the setting of clear objectives by August 2017
- Action plan for implementation of the Greater Manchester systemic anti-cancer treatment strategy by December 2017

Deliver an integrated acute oncology service

We will build on the progress made so far in establishing sustainable acute oncology services in our hospitals to agree and commission an integrated acute oncology service for Greater Manchester.

We will consider the different options for delivering an integrated service, which could include the setting of common regional standards, regional leadership models or sector-based collaborative arrangements.

What and when?

- Commissioning plan for integrated acute oncology service by October 2017

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- Agreed model for integrated acute oncology service implemented by October 2018

Develop the UK's first proton beam therapy service

Proton beam therapy can reduce the risks of long-term side effects from treatment as it spares normal tissue that conventional radiotherapy might irradiate. It also allows, in some cases, higher doses of radiotherapy to be given.

The Christie NHS Foundation Trust together with its partners, Central Manchester University Hospitals NHS Foundation Trust and Salford Royal NHS Foundation Trust, is working with the Department of Health to bring the UK's first high energy proton beam therapy service to Greater Manchester.

What and when?

- Proton beam therapy centre to open in 2018

Support and extend improvements to specialist surgical services

Across the system there is work going on to profile the risk of surgical cancer patients and develop plans to prepare them better for specialist surgery and thereby improve outcomes, complication rates and recovery times.

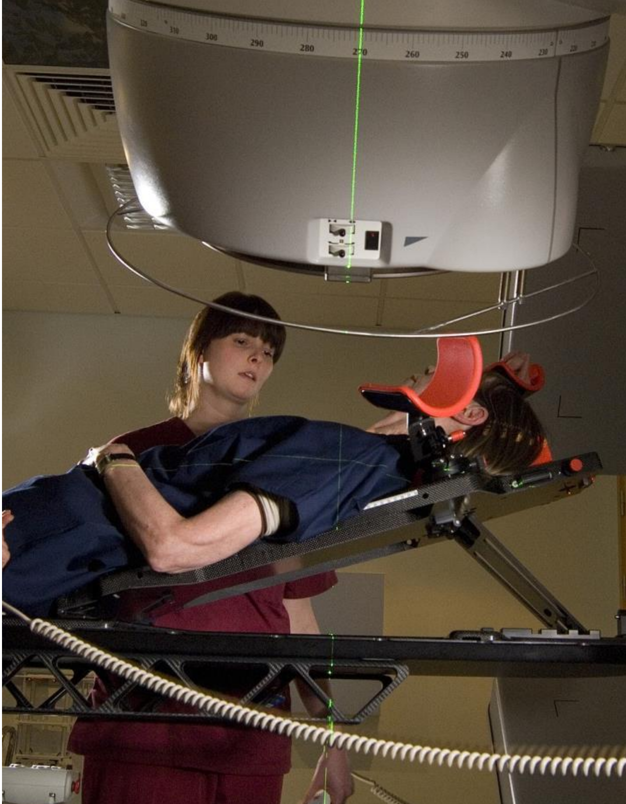
This includes:

- A prehabilitation programme for hepato-pancreato-biliary (HPB) cancer patients – pre-operative physical, psychological and nutritional support to optimise patients about to undergo major surgery, and
- A broader extended enhanced recovery after surgery (ERAS+) programme at Central Manchester Hospitals (part of the 2016 NHS Innovation Accelerator programme).

We will support this work and extend it to other specialist surgical services as appropriate.

What and when?

- Sustainable prehabilitation programme in place for hepato-pancreato-biliary cancer patients by April 2017
- Implementation timetable for broader adoption of prehabilitation and ERAS+ programmes to major cancer surgery and other forms of treatment in selected cancer pathways by October 2017



10. Living with and beyond cancer and supportive care

10.1 What is already happening

In 2014 Macmillan Cancer Support awarded Manchester Cancer a £350,000 **Living With and Beyond Cancer Innovation Fund** to give pathway boards the opportunity to develop and test innovative ideas for improving the outcomes and experience of those who are living with and beyond cancer. A final report of the projects supported by the fund will be published early in 2017.

The **Oldham Macmillan 1-1 Support Team** is a community based nursing and support team that supports the holistic needs of people affected by cancer. It was piloted from 2013 and kept in place beyond the pilot by Oldham CCG.

There is substantial amount of other Macmillan-supported activity taking place in different hospital trusts and primary and community care providers with the aim of implementing the **Recovery Package** for patients living with and beyond cancer.

The Recovery Package is a combination of **different interventions**, which when delivered together, can greatly improve the outcomes and coordination of cancer care, including better and earlier identification of consequences of treatment:

- Holistic needs assessment and care planning, at diagnosis and at other significant points in the patient pathway
- Treatment summaries, after significant phases of treatment
- Cancer care reviews, in primary care
- Health and wellbeing events, providing information and support

The Recovery Package also empowers patients to self-manage and therefore supports clinical teams to offer **new models of aftercare** based on an assessment of the patient's risk.

The **Macmillan Cancer Improvement Partnership** with the three Manchester CCGs has included the development and implementation of a new aftercare pathway for breast cancer patients in the city. It has also developed improved palliative care services in North Manchester.

Work is underway to significantly change the commissioning and provision of **lymphoedema** services. Lymphoedema is a chronic long-term condition that in a quarter of cases is caused by cancer treatment. There is currently variation in the availability and access to appropriate lymphoedema services across our region.

Evidence shows that early referral to supportive and palliative care leads to better quality of life, reduced symptom burden and less exhausting care. Work is ongoing to ensure that patients have **earlier access to supportive and palliative care** throughout their cancer treatment journey.

The Christie has pioneered a new model of **enhanced supportive care**. This model promotes the earlier integration of supportive care within cancer care, addressing more fully the needs of cancer patients and seeking to prevent and manage the adverse physical and psychological effects of cancer and its treatment. Enhanced supportive care has been recognised nationally by NHS England and is currently being rolled out across other cancer centres across the country.

The locally developed **North West End of Life Care Model** supports the people of Greater Manchester to live well before dying

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10. Living with and beyond cancer and supportive care

with peace and dignity in the place of their choice. The model involves both the individual and those important to them and is about meeting the palliative care needs of all those with an advanced progressive incurable illness or frailty during the last years, months or days of life.

The Greater Manchester and Eastern Cheshire Strategic Clinical Network (SCN) is working in partnership with local CCGs to fully implement electronic **shared care records** (Electronic Palliative Care Coordination Systems - EPaCCS) that encompass people's needs as they near death. This ensures coordinated care where people get the right help at the right time from the right people.

New resources have been developed by the SCN to improve **care in the last days of life** in line with national priorities of care for the dying person, their family and those close to them. These resources support service providers and commissioners to ensure that high quality care is focussed on the individual and those close to them in their last days and hours of life.

10.2 Our objectives and current performance

Nationally-set objectives

We aim to continuously improve long-term quality of life
A new national metric is in development to allow the measurement of long-term quality of life. Testing is expected to begin in April 2017 and Greater Manchester will seek to act as a pilot site.

We will increase the proportion of people who die in their usual place of residence to 47%
Many people would, given the choice, prefer to die in their usual place of residence, with few wishing to die in hospital. The proportion of deaths in usual place of residence is a key indicator for end-of-life care and acts as a quality marker for choice and access. Current performance in our region is 42.4%[28].

Locally-set objectives

We will ensure that the Recovery Package is available to all patients reaching completion of treatment by 2019
At present the extent of implementation of the Recovery Package in Greater Manchester is not known. There is a lot of relatively uncoordinated activity taking place in different pathways and different hospital trusts and other providers across the region.

10.3 What we are going to do

Commission the Recovery Package

We will make sure that the Recovery Package is the standard of care for all patients reaching completion of treatment. This will include:

- Written care plans based on holistic needs assessments (HNA),
- Treatment summaries,
- A cancer care review undertaken in primary care, and
- An invitation to a health and wellbeing event.

The Greater Manchester Cancer Board will oversee the implementation of the Recovery Package by acute and primary care services. The Living With and Beyond Cancer Board will support and co-ordinate the implementation work taking place across

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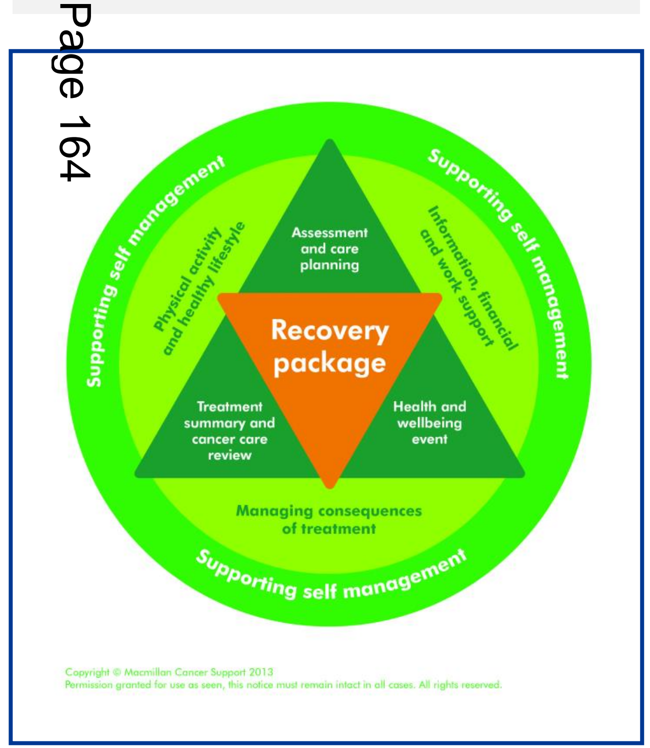
Greater Manchester to allow the learning to be applied across the system.

We will agree a standardised approach to the Recovery Package in Greater Manchester. This will include approved templates to be tailored to suit each tumour type, guidelines on the use of electronic tools (such as Macmillan's eHNA), and core information to include for each cancer.



In implementing the Recovery Package our emphasis in the first instance will be on ensuring that all patients receive a care plan both at the point of their diagnosis and treatment decision, and at the end of their treatment. These care plans will be based on holistic needs assessments.

At the end of treatment the care plan will sit alongside the patient's copy of their treatment summary and provide general advice and signposting information for living with and beyond cancer.

Inclusion of the Recovery Package in commissioning specifications will support its rapid implementation. We will also develop metrics to assess the degree and quality of implementation.

What and when?

- Standardised Greater Manchester approach to the Recovery Package agreed by August 2017
- All patients receive a care plan at the point of diagnosis and treatment decision, and at the end of their treatment, based on holistic needs assessments, by December 2017
- Health and wellbeing events in place for all breast, colorectal and prostate cancer patients to support new aftercare pathways by March 2018, with models for other pathways developed by March 2019
- Full Recovery Package available to all patients reaching completion of treatment by March 2019

Develop new aftercare pathways

The vanguard innovation programme will work with the relevant pathway boards to develop a new aftercare pathway for all early breast, colorectal and prostate cancer patients in Greater Manchester. We will move from the traditional hospital-based follow-up model to a more personalised and supported self-management approach for appropriate patients.

Through the Recovery Package, particularly health and wellbeing events, we will give these patients the information that they need to access care when they need it. Implementation will begin with a universal model of breast cancer aftercare for all patients in Greater Manchester, building on

10. Living with and beyond cancer and supportive care

the Macmillan Cancer Improvement Partnership work in the city of Manchester. We will also test new systems to ensure that we can effectively monitor patient aftercare.

What and when?

- New aftercare pathways defined and implemented for all breast, colorectal and prostate patients by March 2018
- New aftercare pathways pilots begin in further tumour types by March 2019

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Explore supported patient decision-making in progressing disease

We will explore supported patient decision-making in progressing disease through the vanguard innovation programme. We will aim to test ways to improve how information is presented to patients with progressing disease about the benefits and risks of further treatment.

We will explore new ways to support these patients in making decisions about their further treatment based on a shared understanding between professionals, patients and their families of the patient's goals for their own care.

What and when?

- Goals of Care tool tested in appropriate clinics at The Christie from March 2017
- Goals of Care tool pilot extended to other sites by March 2018

Improve access to psychological support

The impact of psychological morbidity when living with and beyond a cancer diagnosis is now well-recognised and has consequences, not only in terms of quality of life but also in overall outcomes.

We will empower the regional psychological support clinical group to develop a plan to improve access to these important services and lead its implementation. This plan will include:

- The development of standards for psychological care,
- A tiered model of care, including training for key staff in 'psychological first-aid',
- Equity of access to specialist services with expertise in psycho-oncology, and
- Integrated care pathways with mental health care providers.

What and when?

- Role of regional psychological support clinical group formalised by June 2017
- Psychological support clinical group to produce plan for improved access to psychological support by October 2017

Commission a comprehensive lymphoedema service

We will commission lymphoedema services that can meet specified standards for every patient in Greater Manchester. We will work with all providers to ensure that they can meet these standards and that services are sustainable.

What and when?

- Sustainable lymphoedema service by March 2020

Support people with long-term consequences of treatment

We will map the other potential long-term consequences of cancer treatments associated with each tumour type. We will assess the expertise that we have in primary, community and specialist care settings to support these consequences of treatment.

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What and when?

- Potential consequences of treatment mapped by pathway by June 2017
- Assessment of current consequences of treatment expertise in Greater Manchester by June 2017
- Action plan to address any gap in support for consequences of treatment by September 2017

Earlier integration of supportive care into cancer care

We will ensure that the adverse physical and psychological effects of cancer and its treatment are addressed more fully for patients through expanding access to the enhanced supportive care model.

What and when?

- Enhanced supportive care outpatient clinic piloted at the Christie centre at the Royal Oldham by April 2018

Ensure access to seven-day specialist palliative care advice and assessment

We will work to understand the variation in access to specialist palliative care advice and assessment across Greater Manchester. We will define the standards and scope of the specialist palliative care services that the people of Greater Manchester should have access to.

We will build on previous mapping work to develop a commissioning model for the provision of seven-day face-to-face specialist palliative care advice and assessment service. This model will ensure that everyone in Greater Manchester has access to specialist palliative care seven days a week.

What and when?

- A detailed map of specialist palliative care provision against national standards and competencies by March 2018
- An innovative economic modelling proposal for the delivery of a seven-day specialist palliative care advice and assessment by March 2018
- Qualitative and quantitative evaluation tools to measure the impact of seven-day specialist palliative care advice and assessment services agreed by March 2018

Deliver choice in end of life care

There is a national commitment to deliver choice in end of life care as highlighted in *What's Important To Me: A Review of Choice in End of Life Care* (2015). This is a simple expression of what should be offered to each individual who needs end of life care. Patients are considered to be approaching the end of life when they are likely to die within the next 12 months.

If we want to deliver high quality, personalised end of life care for all we must ensure that everyone has the choice and access they need with regard to:

- Good pain and symptom control,
- Emotional, social and spiritual needs,
- Place of care and death,
- Family/carer support and involvement, and
- Well-trained staff.

What and when?

- Dying Matters Coalition events across Greater Manchester by May 2018
- North West End of Life Care Model implemented by April 2019

10. Living with and beyond cancer and supportive care

- Training programme for staff involved in end of life care delivered by April 2019

- **Ensure that shared digital palliative and end of life care records are rolled out**

Palliative and end of life care records (shared through electronic palliative care coordination systems - EPaCCS) support the sharing of information between primary, secondary and community care and promote personalised care. Their use is supported by NHS England as part of its commitment for end of life care.

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What and when?

- Access to shared digital palliative and end of life care records by April 2018
- Full use and implementation of digital palliative and end of life care records by April 2020

11. Commissioning, provision and accountability

11.1 What is already happening

Although there have been significant improvements within cancer services in Greater Manchester, there remains a level of **fragmentation** of both the commissioning arrangements and the care that patients receive. As a result, pathways are neither optimised for patients nor for effective use of resources, and there is a lack of overall accountability for cancer outcomes and experience across the conurbation.

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Additionally, the current system of **payment and incentives** is not conducive to transformation in the structure and organisation of the delivery of cancer services. It does not incentivise adoption of innovative service models and new technology or support the redirection of investment 'upstream' within the cancer pathway.

Following the establishment of the system-wide cancer board, Greater Manchester is seeking to address this fragmentation by providing a mechanism for **scrutiny and collective accountability** across partner organisations through its oversight of all cancer activity.

NHS Trafford CCG, as lead commissioner of cancer services, has sought to secure equity of access to consistent high-quality care across the population of Greater Manchester by regularly **bringing together commissioning colleagues** from their respective organisations to work in partnership to commission consistent, high quality and cost-effective cancer services.

An additional goal of this coordination has been to ensure that there is **commissioner input to key pathways and projects** to enable innovations and improvements to be built into practice across Greater Manchester.

As part of the **vanguard innovation programme** we have established cancer commissioning, finance and intelligence work streams in order to produce proposals for revised commissioning and contracting arrangements for cancer care and the development of a cancer intelligence service.

This work has included system engagement work, with stakeholder one-to-one discussions and engagement events to clarify the vision, objectives, organisation form and potential payment mechanisms for an **accountable cancer network**.

In addition, the commissioner-led **transformation of specialist cancer surgery** services continues, supported by the Greater Manchester Transformation Unit.

11. Commissioning, provision and accountability

11.2 What we are going to do

Develop a cancer intelligence service

The first phase of the national cancer dashboard is now live and increased functionality is expected to be added by the end of 2016. We will use this resource as the basis for a cancer intelligence service and a bespoke dashboard for the Greater Manchester Cancer Board.

We will work with our partners in the national cancer vanguard to develop a robust service that can draw on the large amounts of cancer data that is already collected and turn this into intelligence that can be used to drive change and improvement. This will be supplemented by improved patient experience feedback, outputs from the vanguard innovation standards project, and pathway specific measures.

This integrated information and supporting analysis will enable:

- Clinical leaders and their teams to direct improvements,
- Commissioners to hold services to account, and
- The people of Greater Manchester to better understand the quality of the different cancer services in the region.

The cancer intelligence service will ultimately produce information on the progress towards each of the objectives outlined in this plan.

What and when?

- Cancer intelligence service established by January 2017
- First cancer intelligence report to Greater Manchester Cancer Board by April 2017

Test a new way of commissioning cancer services

The review of commissioning of cancer services will be aligned with the wider Greater Manchester review of commissioning. This includes identifying the most appropriate arrangements for commissioning cancer services to maximise improvements in outcomes and the utilisation of resources, to reduce fragmentation and minimise variation and to increase transparency and accountability. This work will also complement locality plans and local whole population arrangements.

Working with partners in the system, we will produce proposals for revised commissioning and contracting arrangements. This project will propose arrangements for an accountable cancer network in Greater Manchester and how this could be piloted.

What and when?

- Detailed accountable cancer network proposals considered by Cancer Board by September 2017

Test the more effective use of cancer budgets

Through the vanguard innovation programme we will develop proposals and test alternative methods of budgeting for cancer services. In addition, we will evaluate different payment mechanisms, placing an increased emphasis on improved outcomes and whole pathways of care, incentivising prevention, earlier diagnosis and improved aftercare.

What and when?

- Detailed proposals for alternative budgeting, payment and contracting mechanisms for cancer by December 2017

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12. Patient experience and user involvement

12.1 What is already happening

Our pathway boards review pathway-specific data from the **National Cancer Patient Experience Survey** when it is published. They use this information to seek to improve the experience that patients have of their pathways.

Some pathway boards have sought to get a better picture of their patient experience than the national survey provides by running **bespoke system-wide patient experience survey exercises**.

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The Greater Manchester cancer system has worked in partnership with Macmillan to develop a **Macmillan User Involvement Team**. Macmillan has provided funding of almost £500,000 over two years along with expertise and support for this programme. The team began in post in summer 2015. It has recruited over 100 people affected by cancer to get involved in the work of Greater Manchester Cancer, including trained and supported service user representatives for our boards.

The Macmillan/Greater Manchester Cancer user involvement programme uses the model of co-production. **Co-production** is an equal and reciprocal relationship between a team of professionals and service users who have agreed to work in partnership in order to achieve a common goal.

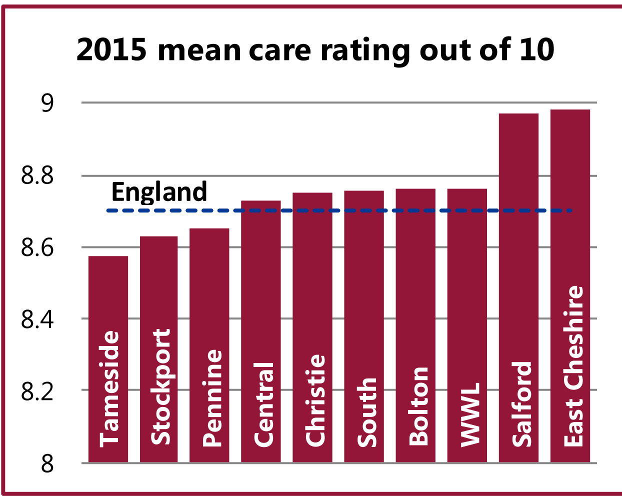
The programme has seen people affected by cancer co-producing a full **learning and development programme**, including a comprehensive induction for new service user representatives and a user involvement awareness session for our clinical leaders. People affected by cancer are also heavily involved in the recruitment of new clinical leads and members of our cancer support team.

12.2 Our objectives and current performance

Locally-set objectives

We will offer class-leading patient experience, consistently achieving an average overall rating of 9/10 in the national survey from 2018 onwards

In the 2015 National Cancer Patient Survey, the Greater Manchester patients surveyed gave their overall care an average rating of 8.73, very marginally above the England average of 8.7[29].



At a trust level, performance on this question of the survey ranges from 8.57 for Tameside Hospital patients to 8.98 for those at East Cheshire (see figure).

Changes to the survey mean that comparison with previous years is difficult. It is likely that expectations will increase in coming years so that maintaining or improving on this level of satisfaction will require considerable effort.

12. Patient experience and user involvement

We aim to have the best performance in core patient experience questions of any major conurbation in England
In an analysis of the 2015 survey results, the trusts in Greater Manchester and East Cheshire scored the highest of 6 metropolitan areas in seven key measures and was second in the remaining three.

12.3 What we are going to do

Define patient experience leadership

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We will define a dedicated lead for cancer patient experience across the region. They will be supported to bring together colleagues from across the system to provide regional patient experience leadership.

What and when?

- Cancer patient experience leadership defined by April 2017
- Greater Manchester cancer patient experience group formed by June 2017

Better understand our patient experience

We will continue to support the National Cancer Patient Experience Survey. Our cancer patient experience leaders will analyse in detail the results of the 2015 survey and develop a single system-wide action plan to address the issues that it raises. They will also assess how the survey is administered across Greater Manchester and consider if any improvements could be made.

What and when?

- Detailed assessment of the latest National Cancer Patient Experience Survey results by September 2017

Through the cancer intelligence part of the vanguard innovation programme we will commission a service to vastly improve the breadth and quality of the information that we collect on the experience of cancer patients in Greater Manchester. Our cancer patient experience lead will play a key role in championing this new service. In the meantime we will continue to support pathway boards to run their locally-developed patient experience surveys, sharing best practice with other boards.

What and when?

- Pilot of real time patient experience intelligence service to begin by April 2017

Improve our patient experience

Our cancer patient experience leadership group will use the cancer patient experience data produced nationally and locally to develop a single Greater Manchester-wide cancer patient experience action plan. This plan will concentrate on the issues that it is not possible to address through local patient experience improvement efforts.

What and when?

- System-wide cancer patient experience action plan by December 2017

Embed service users in the continuous development of services

We are committed to the involvement of people affected by cancer in the future of cancer services in Greater Manchester. We will build on our work to-date in partnership with Macmillan Cancer Support to further embed people affected by cancer in the running and development of our services.

A steering group comprising of people affected by cancer from across Greater Manchester drives the user involvement strategy for Greater Manchester Cancer with

12. Patient experience and user involvement

the support of the Macmillan User Involvement Team.

In the current phase of the user involvement programme (until March 2017) we will:

- Have two people affected by cancer on all pathway boards,
- Develop small communities of people affected by cancer for at least five pathway boards,
- Continue to recruit people affected by cancer,
- Deliver user involvement awareness sessions for professionals,
- Produce ten real life case studies on the benefits of user involvement and co-production, and
- Deliver user involvement to the vanguard innovation programme.

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Beyond March 2017 the Greater Manchester Cancer Board will work in partnership with Macmillan to continue and sustain our user involvement programme for the lifetime of this plan.

We will continue to:

- Recruit people affected by cancer to get involved in our work in a variety of ways,
- Provide them with the appropriate induction and training so that they can play a full part in our work,
- Have at least two people affected by cancer on all appropriate cancer groups and bodies in Greater Manchester,
- Raise awareness of the importance of user involvement among Greater Manchester Cancer professionals.

What and when?

- Current phase of user involvement programme delivered by March 2017
- Funding secured for ongoing user involvement programme by May 2017

Ensure access to a CNS or other key worker for all patients to help co-ordinated their care

Clinical nurse specialists (CNSs) treat and manage the health concerns of patients and work to promote health and wellbeing in the patients they care for. They use their skills and expertise in cancer care to provide physical and emotional support, coordinate care services and to inform and advise patients on clinical as well as practical issues, leading to positive patient outcomes.

Access to a CNS or other key worker has a significant impact on patient experience. We will ask nursing leaders in each trust to assess the access to CNSs and key workers across Greater Manchester's cancer pathways and develop a plan to that all patients have access to the support that they provide.

Our localities will develop new models of blended CNS working between primary, secondary and community care to improve co-ordination of both the diagnostic pathway and aftercare of cancer patients.

What and when?

- Access to CNSs and key workers audited to identify gaps by pathway and hospital provider by August 2017
- CNS and key worker access action plan by December 2017

Include cancer information in locality directories of services

We will work with providers, third sector partners and people affected by cancer to make sure that the comprehensive directories of services produced in each of our localities reflect the needs of cancer patients.

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What and when?

- Cancer information in all locality directories of local services by April 2018

Test innovative digital patient communications

The Greater Manchester and Eastern Cheshire Strategic Clinical Network will test the use of a real-time (text-based) electronic patient communication system which will support patient communication.

It will provide reminders, updates and advice on preparing for diagnostic testing. It will also provide the opportunity for post-diagnostic communications as a mechanism for delivering key messages at ‘teachable moments’.

The system will allow for patient responses and will provide them with an interactive platform that helps them to better understand and influence their journey through the cancer system.

What and when?

- Pilot of electronic cancer patient communication system operational by September 2017

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13. Research

13.1 What is already happening

Greater Manchester has, over the past few decades, **developed an international reputation for high quality cancer research**. Outstanding examples include being the first place in the world to:

- Run a randomised trial in cancer (1948),
- Offer Tamoxifen as a breast cancer treatment (1970),
- Use cultured bone marrow in leukaemia (1986) and blood stem cell transplants (1991),
- Devise the 5:2 diet to assist prevention of obesity related cancers (2010).

All of these developments have contributed to a **global impact** affecting millions of patients across the world receiving better cancer care.

As a consequence of our globally-recognised clinical research, Greater Manchester has in the last 15 years also developed international standards of care for patients with lung, hepato-biliary cancers and children's leukaemia, amongst other areas. Over the last ten years, Greater Manchester has substantially strengthened its cancer research tradition by **developing new relationships, infrastructure and ambitions**.

We are uniquely placed to be a world-leading **integrated cancer research community**. We have a growing and outstanding cohort of clinical and scientific researchers, extensive infrastructure development and investment, and a joined-up clinical network. This means that our population of 3 million can access a coherent cancer research programme.

Our hospitals

In The Christie, our region has the largest single-site cancer centre in Europe and was the first UK centre to be officially accredited as a comprehensive cancer centre by the Organisation of European Cancer Institutes (OECI). Its name brings **international recognition** to Greater Manchester both from a clinical and research perspective, and it has a strong relationship with industry partners with a strong commercial trial portfolio.

The Christie has a close working relationship with neighbouring NHS trusts in a number of collaborations designed to advance locally-driven cancer research, in particular the **University Hospital South Manchester Central Manchester Foundation Trust and Salford Royal Foundation Trust**.

University of Manchester

The **University of Manchester**'s medical research, led by world-renowned scientists, ranges from understanding the molecular and cellular basis of cancer to the development and testing of novel drugs and other therapeutic approaches. Through nursing, psychology and policy work, solutions to the physical, emotional and economic impacts of cancer are being researched and developed.

The university has recently led efforts to tilt our research efforts more towards **prevention of cancer**. This is an area where Greater Manchester has quickly established a leading role, hosting in autumn 2016 a major scientific conference on the prevention and early detection of cancer.

The **Cancer Research UK Manchester Institute** is a leading cancer research institute within the University of Manchester and core funded by Cancer Research UK, the

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13. Research

largest independent cancer research organisation in the world. The institute's research spans the whole spectrum of cancer research, from programmes investigating the molecular and cellular basis of cancer, to those focused on translational research and the development of therapeutics.

Manchester Cancer Research Centre

The Manchester Cancer Research Centre (**MCRC**) is a unique collaboration, formed in 2006, that brings together the above world-class expertise, vision and resources of Cancer Research UK, the University of Manchester and The Christie. In 2015, the MCRC opened its new state-of-the-art £28.5m research centre in Withington which brings together clinicians and scientists.

The MCRC has been successfully accredited as one of only three **major centres** for cancer research in the UK, acting as a vital research hub for the Cancer Research UK centre network, drawing together expertise, encouraging collaborative research, and bridging the gap between innovative laboratory work and benefits for patients.

In 2016 the MCRC renewed its CRUK major centre status, with CRUK committing to invest around £39 million over the next five years. This enables us to continue transforming the clinical care of cancer patients by developing and implementing an integrated personalised medicine strategy with a focus on six tumour-specific areas: lung, melanoma, prostate, ovarian, breast and haematological.

Within the MCRC sits the **Experimental Cancer Medicine Centre** (ECMC) and the **Manchester Centre for Cancer Biomarker Sciences** (MCCBS), both with an international reputation for cancer research. The ECMC is part of a nationwide collaboration bringing world-leading expertise in **early-phase clinical research** to generate new treatments for cancer, and the MCCBS is a new centre pioneering approaches in the development of **precision medicine**.

Greater Manchester's expertise in cancer research across disease areas has also been recognised through the creation of various internationally-recognised Centres of Excellence and collaborations with the MCRC. These include the:

- **CRUK Lung Cancer Centre of Excellence** (with University College London)
- **CRUK/EPSRC Cancer Imaging Centre** (with Cambridge)
- **Manchester Breast Centre**
- **Prostate Cancer UK Movember Centre of Excellence** (with Belfast).

Manchester Academic Health Science Centre

The Manchester Academic Health Science Centre (**MAHSC**) is a formal partnership between the University of Manchester and six NHS organisations (with further links to other NHS trusts). The goal is to provide patients and clinicians with rapid access to the latest discoveries, and improve the quality and effectiveness of patient care.

The **cancer domain** of MAHSC provides coordination and links across the cancer infrastructure, working closely with the MCRC and Greater Manchester's clinicians and research scientists.

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Greater Manchester Clinical Research Network

The Greater Manchester Clinical Research Network, which is part of the **National Institute for Healthcare Research** (NIHR), provides funding for cancer trials. It also provides data on cancer trial recruitment across our region to Greater Manchester Cancer's pathway boards through their nominated research leads. This information allows pathway boards to drive improvements in trial recruitment across the region.

NIHR Biomedical Research Centre status

Greater Manchester was awarded a NIHR Biomedical Research Centre (**BRC**) status in autumn 2016, a major aspect of which is cancer research. This accolade will bring around £11m cancer research funding to Greater Manchester over five years and serves as an international acknowledgement of our research status.

The MCRC and MAHSC, through the successful BRC and major centre status bids, have described a shared regional cancer research strategy for Greater Manchester. Alongside ambitions to recruit world-class researchers, create exciting national and international collaborations and bring the highest quality infrastructure to our city, Greater Manchester aims to focus on three research areas:

1. **Cancer prevention and earlier detection**
   To improve the targeting of cancer prevention and early detection strategies, by developing the early markers needed to diagnose cancer sooner and rapidly identify whether a treatment is having the desired response.
2. **Personalised treatment**
   Developing diagnostic tests to match an individual's cancer with the drug most likely to have the desired therapeutic effect. Also anticipating and appropriately managing drug resistant relapse, a common problem faced by patients with cancer.
3. **Radiotherapy-related research**
   Improving the delivery of radiation and developing markers to predict the benefit of different types of radiation and drug-radiation combinations, as well as the risk of long-term side effects.

13.2 Our objectives and current performance

We will maintain our position as the leading NIHR Clinical Research Network for patient recruitment in cancer research
In 2015/16, Greater Manchester successfully recruited approaching 4,500 patients[30] into over 250 clinical trials[31], received research awards totaling in excess of £65m and had over 650 cancer scientific publications.

Greater Manchester had the second highest cancer research trial recruitment of the 15 UK regions in 2015/16, and the highest if the recruitment was adjusted for size of population.

We will increase the proportion of patients who recall having clinical trials discussed with them following their cancer diagnosis to 40% by 2019, and reduce the variation between providers
In the 2015 National Cancer Patient Experience Survey 29% of Greater Manchester respondents recalled having cancer research discussed with them[32]. There was also great variation across Greater Manchester (see figure overleaf).

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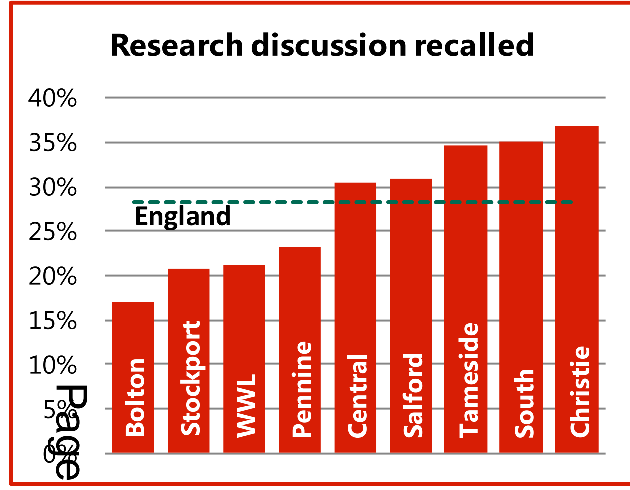

We aim to raise this percentage overall, and to reduce the variation seen across our provider organisations. Achieving this will raise the uptake of participation in trials.

13.3 What we are going to do

Deliver the cancer themes of the BRC

Through the delivery of the three BRC cancer research themes, we aim to provide a platform to support researchers, enabling them to become leaders in translating lab-based discoveries into new cutting edge treatments, technologies, diagnostics and other interventions into clinical settings. We will also begin to develop proposals and infrastructure for a subsequent successful bid from 2022.

Renew our NIHR Cancer Research Facility accreditation

In November 2016, as part of a One Manchester CRF application, we successfully renewed the cancer NIHR Clinical Research Facility (CRF) accreditation with refreshed funding of £4.5m. This will help increase the quantity and quality of clinical research and its relevance to more distant, deprived and ethnically diverse areas of our large and relatively unhealthy population, particularly where research participation rates are low. It will also increase the number of studies, particularly early phase medicines studies in collaboration with industrial partners, and training programmes.

Lead oncology patient safety translational research

We aim to support Greater Manchester in being a UK leader in patient safety translational research by contributing innovative oncology-based projects to the NIHR Patient Safety Translational Research Centre (PSTRC) competition (2017).

Grow our Experimental Cancer Research Centre

We will seek to become one of Europe's top five ECMCs by 2020. This will be delivered through a growth plan that will see over 500 patients per year being given the opportunity to participate in early phase cancer clinical trials. This expansion, by increasing the throughput of studies and participants, has the potential to further improve patient outcomes and ensure that we remain at the forefront of phase I clinical trial delivery both nationally and internationally.

Support the integration of genomic medicine into practice

We will support the integration of genomic medicine into normal clinical practice. Initially, the focus will be on supporting the substantial uptake of patient recruitment into the national 100,000 Genome Project (see section 8.2). The aim of the project is to create a new genomic medicine service for

13. Research

the NHS – transforming the way people are cared for and to enable new medical research.

Build new collaborations and international partnerships

We will seek to develop our research portfolio and reputation by:

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- Becoming the European partner in an innovative Obama 'Moonshot' programme with University of Southern California and the National Cancer Institute (US), working on maximizing the potential of high-definition single cell analysis and its potential as the most sensitive circulating tumour cell detection system
- Developing our relationships in lung and prostate cancer as set out in the Centres of Excellence collaborations
- Developing the iDecide collaboration with Astra Zeneca (£11.5m), an innovative programme for real-time patient data capture and integration with biomarker data
- Developing detailed proposals in relation to cancer aspects of the successful Medical Research Council (MRC) Centre bids in proteomics (Stoller Centre, £13m), single cell research (£5m) and for a Manchester Molecular Pathology Node (£4m)
- Collaborating with the Sarah Cannon Research Institute (US), currently the worlds largest ECMC, to support our ambition to become one of the top ECMCs in Europe.

Invest in our infrastructure and people

We will:

- Complete the construction of the Proton Beam Centre (£137m) on the Christie site by 2018 and develop a dedicated research laboratory to improve the scientific understanding of proton therapy.
- Recruit world leading academics to our cancer research infrastructure by further investment through the £37m Academic Investment Fund (AIP).
- Broaden and strengthen the MCRC into a collaboration including all NHS trusts across Greater Manchester that are active in clinical research in cancer.
- Explore the feasibility of a new build (MCRC2) to exploit our world-leading biomarker centre (MCCBS) and facilitate further expansion and galvanise resource and energy. The building would house the key activities from genomic testing and informatics to biomarker discovery, qualification and clinical testing. Exploratory translational research laboratories would be juxtaposed to a large and comprehensive suite of GCPL laboratories for nucleic acid and protein biomarker analysis.
- Complete the Integrated Procedures Unit (IPU) at The Christie in 2017 with a biopsy suite that will streamline the acquisition of sequential tissue biopsies for research.
- Further develop our position in radiotherapy research by completing the construction and delivery of an MRI-guided radiotherapy unit and associated research unit (£5m).

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- Further invest in the expansion of the MCRC biobank service across Greater Manchester. The biobank – which collects blood and solid tumour samples for local disease group research teams – supports projects such as Phase 2 of the CRUK Stratified Medicine Programme, TracerX and with the Early Phase Team on the TARGET study.
- Deliver a ground breaking outreach service for clinical trials in Greater Manchester to provide patients with access to experimental medicine. This will be delivered through the cancer CRF at the Christie.
- Invest in and further develop the MAHSC Clinical Trials Unit (CTU) so that by 2020 it will be a leading UK CTU with a strong focus on supporting early phase oncology trials.

14. Education

14.1 What is already happening

We have established **Cancer Education Manchester** as a forum to represent cancer education across Greater Manchester. The aim of Cancer Education Manchester is to improve outcomes through ensuring access to the very highest levels of cancer education.

The following groups and bodies are involved:

- The cancer theme of the Manchester Academic Health Science Centre (MAHSC)
- The Christie School of Oncology
- The Greater Manchester and East Cheshire Strategic Clinical Network
- Greater Manchester Cancer pathway boards
- Cancer Research UK
- Macmillan Cancer Support
- Clinical Commissioning Groups, and
- Health Education England

A **primary care cancer education network** was established in 2015. The network reports to Cancer Education Manchester and will formulate a practical action plan setting out priorities for cancer education in the primary care workforce for delivery by March 2018.

14.2 Our objectives and current performance

Locally-set objectives

Through Cancer Education Manchester we aim to:

- Ensure high quality education is available to all health and social care professionals raising standards in care across Greater Manchester,
- Develop a fair and equitable single service cancer education model across Greater Manchester,
- Ensure rapid translation of learning from research into practice,
- Provide a forum for dissemination of best practice, and
- Support and promote best practice in cancer and public health education.

14.3 What we are going to do

Develop a cancer education and information strategy for Greater Manchester

We will develop a strategy to ensure that educational providers across the region work together to support the delivery of world class outcomes and care for all patients in Greater Manchester. The strategy will ensure that education supports the improvement in standards in all health and social care sectors. It will also set out our plans to assess and standardise the information given to cancer patients across Greater Manchester.

What and when?

- A comprehensive cancer education and information strategy by April 2017

Create a primary care cancer education platform – “Gateway-C”

Through the vanguard innovation programme we will work with primary care professionals, cancer charities and other NHS colleagues to create a tailored and comprehensive online cancer education platform for primary care. This unique educational and informational environment will support GPs and primary care staff in delivering changes across the whole cancer pathway.

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The platform will provide education aimed at:

- Enhancing public health messages,
- Delivering improvements in cancer recognition and referral,
- Supporting care during treatment,
- Ensuring delivery of the Recovery Package, and
- Best practice for those living with and beyond cancer, including end of life care.

The platform will have searchable databases of educational materials and events, links to other online cancer resources and links to cancer support information within the local community.

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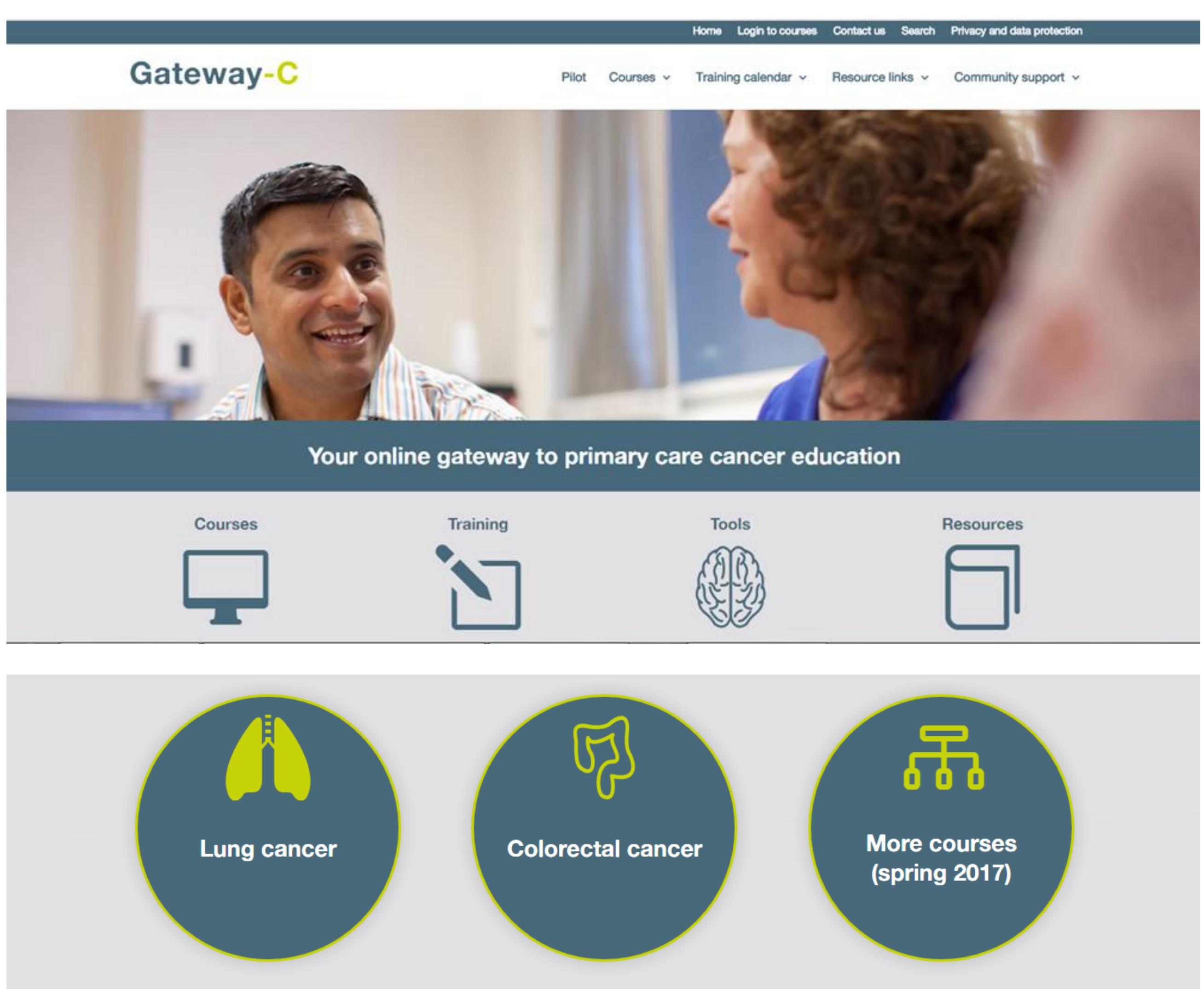
What and when?

- Pilot lung and colorectal early diagnosis modules of primary care education platform Gateway-C with eight practices in January 2017
- Launch primary care cancer education platform Gateway-C to all GP practices in Greater Manchester in June 2017
- Additional Gateway-C modules and content developed by December 2017
- Launch of Gateway-C for all primary care and community pharmacy in April 2018
- Launch Gateway-C nationally in July 2018



14. Education

Deliver coordinated cancer education for each cancer pathway

Through Cancer Education Manchester we will continue to support and co-ordinate cancer education activity for each cancer pathway. Our pathway boards will be supported to develop their education leadership and will each develop an education plan by September 2017. Where appropriate, Cancer Education Manchester will support pathway boards to develop online units describing pathways and minimum standards of care. These will help ensure the right knowledge, skills and behaviours across each pathway.

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Pathway boards will also be supported to develop annual continuing professional development (CPD) events, sharing best practice and ensuring translation of research into care.

What and when?

- Pathway board education plans developed by September 2017
- First online pathway education units launched by September 2017
- Annual CPD education in each pathway from April 2018

Deliver a comprehensive programme of cancer care education for personal and social care providers

Social care is a vital part of the care delivered to cancer patients, in their homes and in care establishments. Across Greater Manchester many health care professions, hospices and charities are involved in supporting the social care workforce. Not all of those caring for cancer patients in some way have access to a basic level of training.

We will work with commissioners, community, social and personal care providers to identify how education can support the highest quality of social care for patients.

What and when?

- A co-ordinated cancer education programme for social care by March 2018

Create a Greater Manchester communication skills and patient experience training programme

Communication is at the heart of high quality care and good patient experience. Within the NHS a substantial proportion of complaints are about communication and attitudes.

We will develop a clinical communication and patient experience programme for all levels of staff, which will have compassionate communication, effective information giving, dignity and respect at its heart.

What and when?

- A programme of foundation, intermediate and advanced communication skills and patient experience training for all levels of staff by April 2018

15. Developing this plan

This document has been developed by the Greater Manchester Cancer Board. It has been subject to a consultation period running from late September 2016 to the early January 2017. The following groups and bodies have been involved in its development. Where this was at a specific meeting the date is given in brackets.

Greater Manchester Health and Social Care Partnership

- Joint Commissioning Board Executive (23/11/16)
- Joint Commissioning Board (13/12/16)
- Provider Federation Board (18/11/16)
- Primary Care Advisory Group (23/11/16)
- Transformation Portfolio Group (15/12/16)
- Association Governing Group of CCGs (03/01/17)
- Directors of Public Health Group (06/01/17)

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Greater Manchester Cancer

- User Involvement Steering Group
- Pathway Clinical Directors and Clinical Pathway Boards
- Cancer Education Manchester
- Vanguard Innovation Clinical Leads and programme office
- Voluntary Community and Social Enterprise Advisory Group (13/12/16)

Commissioners

- CCG Directors of Commissioning
- CCG Cancer Commissioning Managers
- NHS England

Hospital providers

- Directors of Operations Group
- Directors of Finance Group
- Directors of Nursing Group (18/11/16)
- Directors of Strategy Group
- Trust Cancer Leads (17/10/16)

Partners

- Greater Manchester and Eastern Cheshire Strategic Clinical Network
- Healthier Futures
- Macmillan Cancer Support regional team
- Cancer Research UK regional team
- Macmillan Cancer Improvement Partnership
- Macmillan GPs Group
- Black, Asian and Minority Ethnic Cancer Network (01/12/16)

16. Implementation

Subject to approval by the Strategic Partnership Board of Greater Manchester Health and Social Care Partnership this plan will be published in March 2017. It will be published alongside a shorter more accessible version so that the people of Greater Manchester know what to expect of their cancer services in future.

On publication, this plan will be accompanied by a number of annexes setting out the contributions required from each part of the cancer system in Greater Manchester to deliver it.

This work will set out the implications for:

- Greater Manchester Health and Social Care Partnership
- Commissioners
- Hospital providers
- Primary, community and social care providers
- Clinical Pathway Boards

It will also set out what should happen across Greater Manchester and what should happen at a locality level. A full implementation plan will then be developed by June 2017.

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Greater Manchester Cancer
The cancer programme of the
Greater Manchester Health
and Social Care Partnership
January 2017
gmcancer.org.uk
@GM_Cancer

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Agenda Item 7

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	9 March 2017
Executive Member / Reporting Officer:	Tony Powell, Deputy Chief Executive, New Charter Housing Group
Subject:	**HOUSING AND HEALTH**
Report Summary:	This report provides an update on the Greater Manchester Housing Providers role in influencing and shaping the Greater Manchester Health Agenda. It provides detail of the local challenges and action being taken.
Recommendations:	That the report is noted and an updated report be provided to a future Board.
Links to Health and Wellbeing Strategy:	Improving housing is an outcome in the Health and Wellbeing Strategy. Good housing is one of the social determinants of health, and poor health conditions undermine the health of families and older people through cold, damp, infections and accidents.
Policy Implications:	There are no policy implications.
Financial Implications: (Authorised by the Section 151 Officer)	There are no financial implications relating to this report – update report only.
Legal Implications: (Authorised by the Borough Solicitor)	The Council and its partners are required to work within its resources to deliver statutory services on a value for money basis. This report gives an overview of housing which is one of the main determinants of health and addressing health inequalities and sets out opportunities to address both.
Risk Management :	There are no risks associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Tony Power, Deputy Chief Executive by: Telephone: 0161 331 2000 e-mail: tony.powell@newcharter.co.uk

1. INTRODUCTION

1.1 There is a wide array of evidence which demonstrates that housing is critical to health across the life-course (Parliamentary Office of Science and Technology 2011). Suitable housing that is safe and warm is one of the foundations of personal wellbeing, whether in childhood or old age. It enables people to access basic services and build relationships with neighbourhoods and other members of their community, and can facilitate interventions designed to promote and improve health. For people with complex or severe needs – including the rising number of older people – good housing can help them maintain good health and independence for longer. Housing associations present the economic case in a number of areas.

- Poor housing costs the NHS in England between £1.4 billion and £2 billion each year due to excess cold, damp and safety issues. By providing decent and safe housing, housing associations can contribute to savings.
- Failure to fit adaptations or take other preventative measures is estimated to cost the NHS £414 million annually. Housing associations provide preventative adaptations.
- The total cost of dementia to the United Kingdom is £26.3 billion, £4.3 billion of which is accounted for by the NHS and £10.3 billion by social care costs. Appropriate housing options can provide support to allow people with dementia to live independently and safely.
- Delayed hospital discharges cost the NHS in England £820 million annually, though the true cost is probably higher. Housing associations have an important role in helping patients discharged from hospital to return home quickly and safely and avoid re-admission.
- The rate of hospital readmissions and accident and emergency (A&E) visits for homeless people is four times higher than the general public. Overall use of health services by homeless people is between four to eight times that of the general population, at an excess cost of £85 million per year. Provision of homes for more people will contribute to alleviating these costs.
- Domestic violence was estimated to cost the NHS £1.6 billion in 2009. Housing organisations have a key role to play in prevention.
- Registered Social Landlords such as New Charter support some of our most vulnerable residents across the most deprived neighbourhoods. Health outcomes for these residents are generally lower than for the Borough as a whole, and consequently they are high users of health and social care services. As a result New Charter deliver and co-deliver numerous support services and engage and support residents to improve their health and wellbeing as well as tenancies. These schemes are designed to meet the needs of particular client groups, such as people with mental health issues, learning or physical disabilities, people out of work, ex-offenders (Women and Families Centre at Cavendish Mill), victims and women at risk of domestic violence (Bridges Services), and older people (Threshold Home Services).

1.2 The ‘offer’ that the housing sector brings to the health sector is therefore a wide range of expertise and support to specific population groups such as older people or those experiencing specific problems such as domestic violence, and developing community engagement/resilience.

2. GREATER MANCHESTER

2.1 Within Greater Manchester 1 in every 5 homes in the city region, are provided by social housing provider’s home to over half a million residents. Greater Manchester Housing Providers (GMHPG) are long-established partners in local strategic partnership working on a broad range of issues connected to local growth and public service reform. A Memorandum of Understanding between Greater Manchester Combined Authority and the GM Housing Providers Group was approved on 27 May 2016.

2.2 Across Greater Manchester the Housing Providers Group have worked collaboratively with health colleagues, Housing Providers have helped to ensure that housing issues are included in each of the 10 locality plans. As implementation plans are taken forward, Housing Providers have reinforced the links to wider place-based working and integrated leadership. Some place based Housing Providers are working up specific locality agreements with their local authorities and Clinical Commissioning Group (CCG) colleagues.

2.3 A huge amount of dialogue has taken place with CCG and housing colleagues to assess and agree where housing providers can have a greatest impact of scaling up on key projects to support this agenda; 3 projects are being worked up to deliver across Greater Manchester, as follows:

Greater Manchester Wide Warm Homes
Partners (housing providers, local authorities and CCG's) create a sustainable investment fund to deliver energy efficiency measures (e.g. new boilers and insulation) and advice services.

Hospital Discharge and Preventing Re-Admission
Different models being piloted across Greater Manchester to see what works best. All essentially provide housing key workers in hospitals to work with NHS Acute Trusts, Council Adult Services and community care providers to deliver hospital discharge and preventative housing services.

Housing Options Older Persons (HOOP)
Housing Providers providing specialist housing options, care and support and early intervention advice to help older people to access and agree better housing and care solutions for themselves.

3. TAMESIDE PERSPECTIVE

3.1 Within Tameside there is a history of partnership working with all the local social housing providers. Over the years a range of supported housing and specialist services have been developed including:

- Sheltered/extra care provision
- Supported housing schemes for residents with learning disabilities, mental health and physical disabilities
- Supported housing for homeless households and those at risk of domestic violence

3.2 In addition to the above, New Charter have provided additional specialist accommodation and services. However, the commitment going forward is to work together and build on existing and delivering 'new' housing solutions/services to reduce health and social care demand. This involves a spectrum of services and solutions, the main themes and areas for action include the following:

Transition of Care

3.3 As part of the existing contract to deliver the statutory homelessness services in Tameside, a service based at the Hospital (Public Health funded) provides a transition of care into the community for homeless people. This includes the identification of suitable accommodation and support and reducing re-admission. The project is very successful with over 90% success rate, and is value for money in terms of financial/social return on investment calculations. Work is now underway to expand this project to include a wider client/patient group and provide a broader group of options, including additional floating support services interim accommodation and a "Housing First" model.

Home Care

3.4 New Charter already provides a specialised domiciliary care service. There is a clear need to develop a new "home care" offer to the residents of Tameside. Working in partnership with the Hospital Trust a business case is being shaped to expand the existing scheme and develop a new offer which will provide personal care and be Care Quality Commission Accredited.

Homelessness

3.5 The demand on homelessness is increasing. In addition to the Hospital Discharge Service new forms of supported housing and intervention and prevention services have been implemented. In order to support local authority funding, New Charter has provided an additional £100k to expand the homelessness prevention agenda and develop a social lettings offer.

Asset Based Community Development

3.6 There is an opportunity to redefine roles in the system, housing is not just bricks and mortar, from New Charter's perspective the focus is residents and the community. As part of the neighbourhood model and the neighbourhood hub approach, engagement with residents is crucial. In order to respond to the future commissioning strategy Action Together, New Charter and colleagues including Active Tameside and Age UK have created a consortium and a potential special purpose vehicle to shape and deliver new services.

New Build and re-model

3.7 In order to respond to the changing needs of residents and meet the growing demand, for specialist accommodation work is currently underway to identify new build supported housing provision and investigate options for remodelling existing schemes.

4. RECOMMENDATIONS

4.1 As set out on the front of the report.

Report To:	**HEALTH AND WELLBEING BOARD**
Date:	9 March 2017
Reporting Officer:	Stephanie Butterworth – Executive Director (People)
Subject:	**TAMESIDE CHILDREN'S SERVICES IMPROVEMENT PLAN**
Report Summary:	This report outlines the approach that has been taken to produce the draft Tameside Children's Services Improvement plan and sets out a summary of the consultation responses received which have been considered in drafting the plan. The report also sets out the timeline for further engagement activity prior to final submission to Ofsted on 20 March 2017. The draft Improvement Plan is attached at **Appendix 1** for the purposes of consideration and further feedback.
Recommendations:	Members of Health & Wellbeing Board consider the attached draft Improvement Plan and provide additional feedback on content.
Risk Management:	The attached report sets out the process for finalising the Tameside Children's Service Improvement Plan. Failure to finalise the plan prior to the statutory deadline of 20 March 2017 will result in considerable risk to Tameside Council and partners.
Access to Information:	The background papers relating to this report can be inspected by contacting James Smith, Policy & Communications, Governance, Resources and Pensions, Tameside Council. Telephone: 0161 342 3711 e-mail: james.smith@tameside.gov.uk

1. TAMESIDE CHILDREN'S SERVICES IMPROVEMENT PLAN

1.1 Following the inspection of Children's Services and Tameside Safeguarding Children Board in Autumn 2016 Ofsted published the report into its findings on 9 December 2016 rating the overall effectiveness of Children's Services as 'inadequate' and the Tameside Safeguarding Children Board as 'requiring improvement'.

1.2 In response to the concerns raised by Ofsted the Tameside Children's Services Improvement Plan has been drafted setting out how Tameside Council and partners across the borough are addressing the recommendations made by Ofsted to deliver sustainable improvement.

1.3 The draft Improvement Plan attached at **Appendix 1** includes a range of actions to be delivered by partners and staff at all levels with a focus on improving outcomes and supporting successful lives for children and their families in Tameside.

1.4 The following key steps have been undertaken to engage stakeholders as a part of the process for production of the draft Improvement Plan.

- Detailed analysis of Ofsted recommendations and associated actions.
- 2x Tameside Council workforce engagement sessions to determine staff views and priorities for improvement – 22 November 2016 and 26 January 2017.
- Elected members engagement session – 19 January 2017.
- Discussion by Tameside Primary Schools Head Teachers – 2 February 2017.
- Engagement with 2BeUs (Children in Care Council) – 7 February 2017.
- Email survey to engage stakeholders in shaping the development of the Improvement Plan – 2-15 February 2017.
- 2x half day drop-in engagement sessions with Tameside Director of Children's Services and Assistant Executive Director Children's Services – 10 and 14 February 2017.
- Wider discussions between partners and the Director for Children's Services and stakeholder regarding priority areas (such as domestic abuse notifications).
- Tameside Children's Service Management Team improvement planning sessions – Monthly.

1.5 Following the closing date for submission of written responses from partners on 15 February 2017, feedback from stakeholders has been collated and used to shape the draft Improvement Plan which has been circulated with meeting papers as a part of this report.

2. NEXT STEPS

2.1 The following process will be undertaken to ensure that Improvement Board members have the opportunity to further comment on and shape the content of the Improvement plan:

- The draft Improvement Plan has been shared with the Improvement Board on 23 February 2017 for review in readiness to provide feedback at the Improvement Board meeting on 2 March 2017.
- The draft Improvement Plan has also been shared with Executive Cabinet, Scrutiny Chair's, and both the Performance Clinic and Practitioner's Group as staff representatives for comment by 2 March 2017.
- Feedback on the draft Improvement Plan will be gathered during the 2 March meeting of Tameside Children's Services Improvement Board.
- Feedback will be used to shape a second draft which will be circulated to Board members for further comment between 8-10 March.

- During this period the second draft will also be shared with colleagues from Ofsted for comment and feedback.
- Following feedback a third draft will be produced which will be circulated for electronic sign off by Improvement Board members between 15-17 March.
- The final improvement plan will be submitted to Ofsted on 20 March.
- Executive Cabinet of Tameside Council on 22 March following publication.

2.2 The next steps activity described above will also include work to ensure all the actions outlined in the draft Improvement Plan are SMART.

2.3 Following submission to Ofsted a final version of the Improvement Plan will go through a design process prior to final publication on Tameside Council's website.

2.4 The purpose of the design process is to ensure that the finalised document is fully accessible and presented in a manner which is engaging. This process will involve the engagement of stakeholder to provide statements which demonstrate the supportive challenge which is being offered by partner organisations throughout Tameside and in the Greater Manchester region.

2.5 As a part of finalising the public facing Improvement Plan the engagement of children and young people in Tameside will be sought to ensure that information published is available in a manner that is accessible to a broad range of stakeholders.

3. FEEDBACK ON THE DEVELOPMENT OF THE IMPROVEMENT PLAN

3.1 As a part of the engagement process written feedback has been received from the following groups and organisations:

- 2BeUs (Children in Care Council).
- New Charter Housing Group.
- Greater Manchester Police.
- Buckton Vale Primary School.
- Millbrook Primary School and Lyndhurst Primary Schools.
- Stalybridge cluster group.
- Longdendale High School and Astley Sports College.
- Tameside College.
- Legal Services – Tameside Council.
- Access and Inclusion – Tameside Council.
- Tameside Safeguarding Children Board.
- NHS Tameside and Glossop Clinical Commissioning Group and Tameside and Glossop Integrated Care NHS Foundation Trust.
- Action Together.

3.2 Feedback has been collated and used to inform the development of the draft Children's Services Improvement Plan. The section below highlights the key themes raised in written responses. A more detailed summary of the suggestions from feedback is available at **Appendix 2** for information.

3.3 Key Themes

3.4 **Demand and Need –** All respondents raised points which relate directly to the ways in which services assess need and deal with demand. In particular a common theme was the strong need to develop a shared understanding of the way in which thresholds are applied in the safeguarding of children and young people. Further to this point several stakeholders also highlighted the need for there to be an opportunity for respectful challenges to decision

making in appropriate circumstances. This included the provision of feedback post-referral where cases are deemed no to meet threshold that is taken professionally and used constructively to lead improvements.

3.5 It was also suggested that the opportunity to submit written or electronic referrals may be helpful in reducing repeat requests for information when referring into the public service hub.

3.6 **Information Sharing –** A number of respondents raised points relating to the sharing of information between organisations involved in the safeguarding of children and young people. Particular emphasis was given to the following key areas:

- More effective information sharing in relation to: children returning after a period missing from home, children moving across local authority boundaries and when changes in social worker take place.
- Information made available in relation to support available from voluntary and community sector organisations operating in Tameside (i.e. early help community based offers).
- Changes to service delivery and remits, in particular with regard to changes in taking place in the Public Service Hub.

3.7 **Early Intervention and Prevention –** The majority of respondents stressed the need for effective early intervention and prevention to ensure children and young people receive support at the earliest possible opportunity and to achieve long term reduction of underlying demand.

3.8 Additional suggestions included the need for increased linkages between services such as Children's Social Care, Early Help Teams and the Integrated Neighbourhoods Service and the opportunity to co-locate staff within the Public Service Hub to restore a multi-agency approach to the service entry point.

3.9 **Partnership Working –** A range of opportunities to increase the level and scope of partnership working were suggested by respondents. Primarily these suggestions fell into the following main areas:

- Suggestions relating to increased training opportunities for staff involved in safeguarding and the provision of training that enables effective referrals into the Public Service Hub.
- Increasing opportunities for constructive dialogue at the point of decision making regarding referrals, particularly where different views are evident.
- Increased linkages between partner agencies and joined up working in relation to safeguarding, particularly in cases where domestic abuse is a factor.
- Increased workforce stability to ensure that children and young people are able to build effective relationships with social workers and other professionals.

4. PUBLICATION AND UPDATING OF THE IMPROVEMENT PLAN

4.1 The finalised improvement plan will be published on a dedicated webpage hosted on Tameside Council's website. Updates will be published not less than quarterly and contain information about progress towards the actions set out in the Improvement Plan together with information about other activities that are being taken to achieve improved outcomes for children and young people in Tameside.

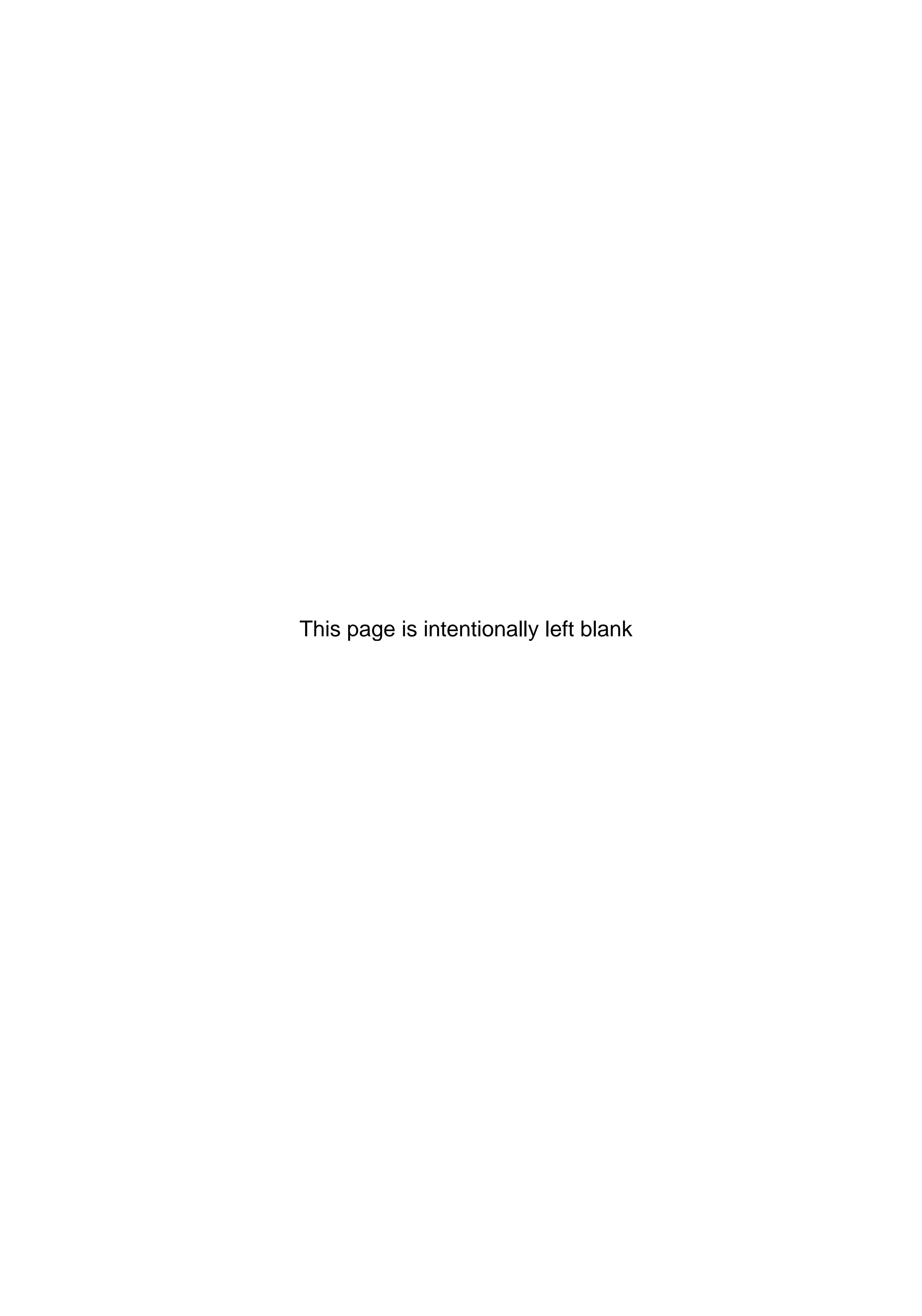
4.2 In addition to publication on Tameside's website, in order to ensure that progress towards improvement is widely discussed and understood and that all stakeholders have the opportunity to raise concerns and engage in delivery, quarterly reports will be discussed at the following key meetings:

- Executive Cabinet of Tameside Council
- Tameside Health and Well Being Board
- Tameside Safeguarding Children's Board
- Integrated Care and Wellbeing Scrutiny Panel
- Tameside and Glossop Single Commissioning Board
- 2BeUs (Children in Care Council)

4.3 A communications plan will be produced outlining the mechanisms by which progress towards achieving the actions set out in the Improvement Plan is explained to the public and wider stakeholders. This will be brought forward for discussion at the meeting of the Children's Services Improvement Board scheduled to take place on Thursday 30 March 2017.

5. RECOMMENDATIONS

5.1 As set out at the front of this report



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TAMESIDE CHILDREN’S SERVICES IMPROVEMENT PLAN

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1 - FOREWORD

There is no greater responsibility for public services than making sure that vulnerable children and young people are happy, safe and confident in their future. This improvement plan sets out how Tameside Council and partners intend to achieve this, acting on our self assessment, information from partners and the recommendations made by Ofsted to deliver rapid, comprehensive and sustainable improvement to services which help, protect and safeguard children and young people in Tameside.

We are committed to fundamentally changing how our services are received by residents, including supporting families to become resilient, independent and self-reliant, and reducing dependency on public services. We will work closely with our partners so that services meet the needs of people and are not delivered in silos and we will support children and their families to be successful.

We are committed to working together to support sustainability, reducing dependency and levels of need in our communities, and making best use of shared resources.

We have acted quickly following the Ofsted inspection to strengthen our approach and have established an Improvement Board, with an independent chair, to provide direction and challenge to our Improvement Plan. Our Improvement Board brings together decades of experience from the public, community and voluntary sectors.

Our Improvement Plan has been informed by the views of Tameside's young people and the experience of frontline staff both in the Council but also in our partner agencies. Since the inspection Tameside Council and partners have taken action on priority areas highlighted by Ofsted to ensure children's safety. The ambition must now build on this early good work, creating the conditions in which children and young people will be able to thrive. This plan sets out the work we will undertake to improve our services and the outcomes for children. During our improvement journey we will have an open and positive dialogue with our children and young people, our partners and our frontline staff in order to make the improvements needed.

Supporting vulnerable children and helping families turn their lives around are not just the responsibilities of one organisation so a partnership approach is essential. We have a track record in Tameside of working together with the local community and partners to solve a variety of problems. This challenge is no different. We have sought advice from the Local Government Association and other councils to develop a coordinated and thorough response based on experience, best practice and learning from others.

We have one simple aim; get Tameside to where we need to be to support our children and young people. And we have one simple ambition; children in Tameside are safe, healthy and happy and are positive about their future.

Councillor Kieran Quinn – Executive Leader, Tameside Council.

Councillor Peter Robinson – Executive Member for Children's Services, Tameside Council.

David Niven – Chair, Tameside Safeguarding Children Board.

Steven Pleasant – Chief Executive, Tameside Council and Accountable Officer, NHS Tameside and Glossop Clinical Commissioning Group.

Stephanie Butterworth – Director of Children's Services, Tameside Council.

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Children’s Services Vision

‘Our vision is for a profession that has fully confidenty and highly capable workers, who have been properly trained in the right way wilth the right knowledge and skills. They must have the opportunity to work in supportive environments, that facilitate critical thinking and enable them to make the best decisions for children and families’

- By working as a cohesive partnership across Tameside, we will provide consistent, high quality, support and care for children and their families.
- Our stall will be given every opportunity to grow and learn in an organisation which is outward looking, constantly developing and keen to embrace new ideas.

Partner organisations that will work together to deliver the Tameside Children’s Services Improvement Plan:

- Tameside Metropolitan Borough Council
- NHS Tameside & Glossop Clinical Commissioning Group
- Tameside & Glossop Integrated Care NHS Foundation Trust (Tameside Hospital)
- Tameside Safeguarding Children Board.
- Pennine Care NHS Foundation Trust
- 2 Be Us (the Tameside Children in Care Council)
- New Charter Housing and other registered social landlords
- Tameside primary and secondary schools, and the ‘virtual school’
- Tameside College
- Greater Manchester Police
- Other GM partners/Councils
- NHS England
- Local Government Association
- Active Tameside
- Action Together, on behalf of the Voluntary, Community and Faith sector

We will publish quarterly reports updating you on progress on the delivery of the Tameside Children’s Services Improvement Plan.

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2 - BACKGROUND

2.1 In September and October 2016 Ofsted carried out an inspection of the effectiveness of our Children's Services. Ofsted also carried out a review of the effectiveness of Tameside Safeguarding Children's Board. Ofsted published the report into its findings on 9 December 2016 rating the overall effectiveness of Children's Services as 'inadequate' and the Tameside Safeguarding Children Board as 'requiring improvement'. The overall judgement is broken down into categories as follows:

Judgement	Score
Overall Effectiveness	**Inadequate**
Children who need help and protection	Inadequate
Children looked after and achieving permanence	Requires Improvement
Adoption	*Good*
Experiences and progress of care leavers	*Requires Improvement*
Leadership, management and governance	Inadequate
Local safeguarding children board	Requires Improvement

2.2 Like other Local Authorities in the UK, Tameside has undergone the challenge of remaining resilient in the provision of frontline services while working with reduced funding from central government. However Tameside has seen a sizable increase in demand in recent years, placing pressure on the service. For example between December 2015 and December 2016 there was a 65% increase in the number of Children in Need and a 73.7% increase in the number of children subject to a child protection plan. In conjunction with this, the service's ability to cope has been hindered by significant rates of staff turnover and the struggle to recruit and retain experienced staff. This has invariably led to the loss of skills and knowledge, and the resources for staff to carry out good social work practices with their cases. While this is no excuse for inadequate practice, it lays out the circumstances we currently stand in, and the challenges that the improvement process must address in order to succeed.

2.3 We have already taken some preliminary steps to begin to turn around the recent judgement. The Tameside Children's Services Improvement Board was set up in January 2017, and appointed Jane Booth as the Independent Chair to deliver the improvement programme. External support has been added to the Board, with LGA and NHS England representation, while further advice from Greater Manchester has been sought. A Practitioner Improvement Group has begun to hold regular meetings with a view to share ideas from representatives from across the service as to what improvement should look like.

2.4 The plan will take the form of a 'bottom up' approach that will be built on the views and needs of frontline practitioners, managers and the voice of children looked after by the authority. It will focus on ensuring that there we focus on prevention strategies by developing the Early Help service, so that we pave the way for a sustainable service that helps children to remain with their families and achieve the best possible outcomes for children.

2.5 The Tameside Children's Service Improvement Board was established in January 2017 to deliver an improvement programme. The objective of the improvement programme is for partners including the Council and Tameside Safeguarding Children Board, to achieve sustainable improvement across the full range of services for children and young people in Tameside.

2.6 Tameside Safeguarding Children's Board is the partnership responsible for making sure that children and young people are kept safe in Tameside. As such the Safeguarding Board form an intrinsic part of the improvement process in Tameside. The Safeguarding Board has produced an Improvement Plan setting out the steps it will take to secure improvement. Progress towards this plan will be reported to Tameside Children's Services Improvement Board in order to ensure that improvement activity is co-ordinated across Tameside and there is a clear read across between improvement plans.

2.7 The Children's Services Improvement Board will lead and guide this process through the implementation of Tameside Children's Services Improvement Plan alongside the Tameside Safeguarding Children Board Improvement Plan to address the areas of concern identified in the Ofsted report; other areas for improvement identified and develop a sustainable model for future years.

2.8 The Board will be led by an Independent Chair. The Independent Chair of the Board will oversee the effective functioning of the Board, providing appropriate external challenge and rigour. The Chair is not accountable for improvement; that responsibility lies with the Council and its partners. The Board will report on progress to Tameside Council, the local Health and Wellbeing Board and both Ofsted and the Department for Education.

2.9 The Board is responsible for strategic direction and oversight of the improvement programme. It will provide challenge and rigour to the process whilst collaborating to achieve and sustain continuous improvement in Children's Services and across the wider partnership in Tameside.

2.10 Delivery of the Improvement Plan will come from the bottom up; the practical ideas and projects that will deliver the board's vision and the plans objectives are best developed by practitioners and shaped by the children and young people they support.

2.11 Achieving sustainable improvement will require new ways of working including careful analysis and tracking of performance to demonstrate effective improvement and tangible impact on outcomes for children and families.

2.12 Extensive work has been undertaken to identify the root causes of the problems identified by Ofsted and will continue until as a part of ongoing improvement activity. The findings of this work have informed the development of the Improvement Plan.

2.13 This document will be underpinned by a detailed action plan and performance scorecard which will provide a framework through which the improvement process will be monitored and delivered in Tameside.

2.14 A financial plan has been developed to enable the delivery of improvement activity, address increased demand and invest in the development of service and initiatives that reduce long term demand.

2.15 In order to ensure the Children's Services Improvement Plan is implemented effectively we are committed to transparency and accountability. Progress towards meeting the Improvement Plan will be reported to Tameside Children's Improvement Board meeting monthly and quarterly

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updates on progress will be published on Tameside Council's website following the publication of the Improvement Plan.

2.16 Underpinning these arrangements are a number of organisational and partnership structures that will be essential to securing effective improvement. The Board will work with in partnerships in order to ensure that whole system change is achieved. Key groups and decision making bodies include:

- Executive Cabinet of Tameside Council
- Tameside Health and Well Being Board
- Ofsted's Regional Director and Senior HM Inspector
- Department for Education Inspections and Interventions Team
- Tameside Safeguarding Children Board
- Integrated Care and Wellbeing Scrutiny Panel

2.17 Effective partnership working is essential to maintaining the long term sustainability of services in Tameside through reducing duplication, increasing the flexibility and responsiveness of services and developing a holistic understanding of the needs of vulnerable children in Tameside.

2.18 For children and young people to receive the right help at the right time it is essential that those who play a role in supporting them work together effectively. To support and improve the achievement of high quality outcomes we will work to ensure that there is a clear understanding of the roles and responsibilities of different partnership groups such as the Tameside and Glossop Single Commissioning Function.

2.19 The Single Commissioning function brings together NHS Tameside and Glossop Clinical Commissioning Group, Tameside and Glossop Integrated Care NHS Foundation Trust, and Tameside Council to deliver significant improvements in health and care for people in Tameside and Glossop. As such it is responsible the majority of health and social care services and will be a crucial partner in ensure that outcomes are achieved to the delivery of support to children, young people and their families in Tameside.

2.20 At a practitioner level strong partnership working will support robust decision making by developing mechanisms through which partners are able develop a shared understanding of decision making thresholds and have the opportunity to provide constructive challenge when it is appropriate to do so.

2.21 Transparency will also underpin our approach to service redesign. In particular using peer review and challenge and strong internal and external scrutiny arrangements to ensure Tameside Council and its partners are progressing towards strong and sustainable services that are meeting the needs of children and young people in Tameside.

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3 – EXECUTIVE SUMMARY

NOTE: To be completed once the rest of the content is finalised and agreed

4 – CHILDREN AND FAMILIES IN TAMESIDE

Tameside: total population = 221,692

- 0-17 years = 48,985 (22.1%), higher than the England average (21.3%)
- 0-21 years = 58,621 (26.4%)
- 0-25 years = 69,864 (31.5%)
- 18-64 years = 134,364 (60.6%)
- 65+ years = 38,343 (17.3%)

(ONS: mid-year population estimates 2015)

Population Projections

Between 2017 and 2022 Tameside's younger population is set to grow by:

- 0-17 years (1,987)
- 0-21 years (1,120)
- 0-25 years (39)

	Tameside	England	Tameside	England
	% population growth 2017-22		% population growth 2017-27	
0-17 years	4.0	5.1	4.5	7.3
0-21 years	1.9	3.0	4.3	7.1
0-25 years	0.1	1.7	1.3	4.5

- Between 2017 and 2022 the 0-17 population in Tameside is projected to grow by 4% compared to a decline in population for those classed as working age (18-64); a reduction of 0.6%. Population growth is slightly slower in Tameside than England overall.

(ONS: sub-national population projections 2014)

Deprivation

- In 2015 Tameside was ranked 41st most deprived area out of 326 local authorities.
- Tameside has 8 LSOAs in the worst 5% nationally for deprivation.
- Tameside has 7 LSOAs in the worst 5% nationally for income deprivation affecting children. This increased from 2 LSOAs in 2010.

(DCLG – Index of Multiple Deprivation 2015)

- Eligibility for free school meals also provides an indication of the percentage of children living in low income households. In 2016, 18.7% of secondary school pupils were eligible and claimed a free school meal, higher than England, NW and statistical neighbours (18.7%, 15.2%, 17.51% and 13.2%).

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- In 2014, 23.7% of under 16 olds lived in low income families higher than both England and the NW averages (20.1% and 22.8% respectively).

Vulnerable Children

As at January 2017:

- 1425 in need of help (up from 702 in January 2016); an increase of 103%
- 351 child protection (up from 206 in January 2016); an increase of 70.4%
- 495 looked after (up from 424 in January 2016); an increase of 16.7%

(Tameside Children's Services)

Education

- 63% of five-year olds achieved a good level of development in the Foundation Stage Profile, an increase of 5 percentage points on 2015 (58%). Although school readiness remains below the England average, the gap is closing and reduced from 8% points in 2015 to 6% points in 2016.
- 55% of pupils achieved the expected standard in reading, writing and mathematics at key stage 2, slightly higher than the England average at 53% and stat neighbours (53.5%).
- 58% of Tameside's pupils achieved 5 A*-C GCSEs including English and Maths, higher than the England average at 52.8% with the gap widening over the last three years from 0.3% points in 2014 to 4.5% points in 2016.
- In 2015 22.2% of looked after children achieved 5 A*-C GCSEs including English and Maths compared to 57.3% of overall Tameside pupils.
- 93.4% of primary school pupils attend a good or outstanding school compared to 90.2% nationally. The rate is much lower for Tameside secondary school pupils with 59% attending a good or outstanding school compared to 81.9% nationally.
- Local monitoring data shows that 3.8% of 16-18 years are not in education, employment or training at Q3 in 2016/17. This was an increase of 0.2% points on the same quarter in 2015/16.
- In 2016, 45% of care leavers aged 19-21 were in education, employment or training and increase of 9% points on the previous year, however Tameside still remains below the England and Statistical neighbours average (49% and 49.4% respectively).

Health

- In 2014, 3.68% of births are classified as low birth weight, this is higher than the England average (2.68%) and is the highest rate for 5 years.
- In 2016, at reception, 23.55% of pupils are overweight or obese, slightly higher than the England average (22.14%) but lower than the statistical neighbours average (25.09%). By Year 6, a third of pupils are considered to be overweight or obese in Tameside (33.97%), however this is lower than both the England and statistical neighbours average (34.17% and 37.24% respectively)
- The rate for under 18 hospital admission due to alcohol was 67.84 per 100,000 population in 2012/13-2014/15, this is almost double the England average (36.61 per 100,000).
- Teenage pregnancy - Teenage conception rate has fallen consistently over the last 7 years from 59.8 per 1,000 population for the year to March 2008 to 24.4 for the year to March 2015.

Children's Services

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- In 2015, 10% of looked after children have had 3 or more placement during the year, this equates to the England national average but is slightly higher than the NW (9%) and statistical neighbours averages (9.44%).
- 72% of looked after children have been in the same placement for at least 2 years or placed for adoption; higher than the England average (68%).
- In 2014-15, 26% of looked after children returned home after a period of being looked after, this reduced from 38% the previous year and is significantly lower than the England average of 34%.
- In 2016, Tameside's children in need rate per 10,000 population was 274.60 significantly below the statistical neighbours average (429.42) and the England and NW averages (337.70 and 380.10 respectively). However the percentage of children in need for 2 or more years stool at 41.8% in 2016, significantly higher than the England, NW and Statistical neighbours averages (30.9%, 31.3% and 29.41% respectively).
- In 2016 the rate of referrals to Children's Social care was 300.3 per 10,000 population, almost half the referral rate of the statistical neighbours (597.54) and lower than both England and NW averages (532.20 and 583.60 respectively). Between August 2016 and January 2017 the rate of referrals has risen to 579.11closing the gap between Tameside and its statistical neighbours considerably.
- In 2016, 14% of looked after children were adopted, a fall of 3% points on the previous year and now below the national average of 15% and the statistical neighbour average of 21.2%.
- 53% of children wait less than 16 months between entering care and moving in with their adoptive family, higher than the England and statistical neighbours averages (47% and 50.9% respectively).
- Between December 2015 and December 2016 the percentage of re-referrals within 12 months of a previous referral was 15.5%. This is Below the national average of 24% and statistical neighbour average of 23%
- The proportion of Child Protection Conferences within 15 days between December 2015 and December 2016 was 79.3%. Slightly above the 2015 national average of 74.7% and in line with the north west average of 79.5% for the same period. Performance remains worse than the statistical neighbour average of 99.6%.
- In touch with 86% of care leavers
- 91% of care leavers in suitable accommodation – above national average (81%)
- 4 Residential Children's homes run by Tameside Council including: Boyds Walk – Outstanding. Clough Fold – Good, Chester Avenue Good
- 7 Children's Centres

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5 – VOICE OF THE CHILD

5.1 We are committed to ensuring that the voice of the child is an essential part of service planning and that engagement with children and young people is meaningful. At every stage of the child protection process we will ensure that the child is listened to and kept informed of the decisions that are being taken around their care pathway to ensure they feel safe and able to voice their wishes and concerns. We will use a variety of techniques to engage with our young people including conversations, play and drawings to ensure that all children feel comfortable in providing their views. We will continue to review the findings from our engagement with our young people and combine the findings with our other engagement mechanisms such as 2BeUs.

5.2 We have supported 2BeUs – the Tameside Children in Care Council and listened to what they want from the service during their time growing up in care. We have collected these views and wishes and made them into a list of promises, the Tameside Pledge.

5.3 The Tameside Pledge includes promises to:

- Always involve children in the decisions that will affect them
- Help children stay in touch with important people in their lives
- Keep children safe, and help children to keep themselves safe
- Help children achieve their potential
- Help prepare children for independence and adult life
- Listen to 2BeUs

5.4 The refreshed Tameside Pledge was presented to the meeting of Full Council on 29 November 2016 with a speech to the assembled group from the Chair of 2BeUs. The pledge was agreed by Full Council and all the councillors individually signed the pledge.

5.5 Improvement Plan engagement with 2 Be Us

5.6 In February 2017 an engagement session took place with the members of 2BeUs to identify what they want to see in this Improvement Plan.

5.7 Children have told us that they want:

- They want more people to be available in the service, and they want them to be easy to get to know and get in touch with
- Social workers who stay with them for longer
- More Early Help services
- To get the right service at the right time if something happens
- Everyone to be aware of their own role in safeguarding children
- Support from specialists when needed
- Caring foster carers, who know their children and what they need

5.8 We recognise that regularly feeding back the ideas of children in care is crucial in order for us to be able to keep improvement not just on track, but on track with children's needs at the heart of the service. We will explore other opportunities and engagement mechanisms to capture the views of young people both in the care system and outside of it to understand how improvements in preventative work can be made to ensure better outcomes for young people and their families.

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6 – WHAT DOES/WILL GOOD LOOK LIKE

6.1 We want children and their families in Tameside to be successful. We will work to ensure that help is given at the earliest opportunity that enables children and their families to thrive wherever we can. In doing this we will seek to support families to break the cycle of reliance on services, and support children and young people to grow in a stable and settled environment. Children will have better experience of their time growing up and be supported to realise their aspirations.

6.2 Children and young people will be seen by a confident practitioner who is compliant with statutory guidance and applies the threshold of need accurately. This will ensure that children and young people are always given the best care possible and the most suitable placement.

6.3 Children and young people in care will be supported into stable placements where they are safe from harm and happy so that they are helped to live healthy lifestyles, and achieve at school. This will be possible because we see the voice of the child as a vital source of information that will direct future planning and implementation of the service.

6.4 Children, young people and their families will be actively involved in the plans that determine their care, both on an individual case level and a higher strategic level. Feedback from children and young people will be seen by elected members, senior leaders, managers and frontline practitioners, and will be used to draw up benchmarks of improvement so we know how well we are performing.

6.5 We will seek to achieve the following outcomes:

- Children and young people are supported to do well, be healthy both physically and emotionally, they feel safe from harm and their needs and wishes are listened to.
- Children in need and their families receive good, multi-agency support based on their needs, so that children are helped to remain with their families where it is safe and appropriate to do so.
- Children live healthy lifestyles and are enabled to do so by all professionals who know them
- Children looked after are equipped to manage their emotional and mental health, and professionals refer them to the right care at the right time when concerns are identified.
- Children in need of help and support are supported to attend and achieve at school, and any concerns such as missing lessons are identified and addressed by school and social work staff
- Children looked after will not be held back at school by their personal backgrounds, or special educational needs or disabilities.
- Care leavers will be supported and encouraged to be in education, training or employment as adults
- Overall our children will be safe, happy, healthy, well educated and prepared to make a positive contribution to society.

6.6 How will this be achieved?

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6.7 To achieve 'good', there will be a culture change that will allow for strong partnership among social work staff and across the partnership of the service and key partners such as Greater Manchester Police, schools, health and safeguarding bodies across Tameside. Social work teams will have appropriate caseloads, and cases assigned to them that are appropriate for their level of experience. Help and support will be provided holistically with no gap between agencies and organisations. Support provision will take account of a full range of needs including, health, emotional well-being, and education.

6.8 Elected members, strategic leaders, managers, frontline practitioners and all relevant partners will be aware of what good looks like and actively drive and support improvement. Feedback from children and young people and their families will inform care planning.

6.9 Team managers will carry out effective supervision which ensures they know their staff and their cases well and are able to support effective decision making. Reduction in caseloads to levels that are manageable and suited to the social worker's skills and experience will enable social workers to build positive relationships with children and see them regularly.

6.10 Assessments of children and young people will be carried out in a timely manner, capture their views and take into consideration a comprehensive view of their parents' capacity to look after them at home. Assessments will result in objective and tangible, positive outcomes for the safety and wellbeing of children. This will be measured by benchmarks drawn up from good quality and up to date performance management reporting.

6.11 How will we know when we are improving?

6.12 We will evidence our improvement journey in a number of ways to provide assurance to children and families, the Improvement Board, Elected Members and wider stakeholders that we are improving our services and supporting children and young people to lead successful lives. The tools we are using will include:

- **Performance Scorecard –** a comprehensive performance scorecard will bring together the key indicators we will use to evidence improvement. A subset of these indicators will be reported as focus areas at each Improvement Board meeting.
- **Team Plans –** Each team will produce a plan on a page which includes the improvement actions each team is taking and shows progress against indicators of success. Team managers will meet regularly at performance clinics to discuss their improvement journey, address challenges and highlight best practice.
- **Quality Audit –** a rolling programme of quality auditing will support and challenge the application of thresholds and decision making. Involvement of partners from key agencies such as health, education and Greater Manchester Police will ensure that decision making remains consistent and robust.
- **Monitoring and Accountability –** The improvement Board will form the central pillar of accountability and scrutiny of progress. Regular updates on progress will be provided to key decision making bodies such as the Single Commissioning Board, Tameside Councils

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Executive Cabinet and the Health and Well Being Board and the Integrated Care and Wellbeing Scrutiny Panel.

- **Practitioner Improvement –** Practitioner groups will support improvement led by frontline staff bringing together best practice and providing evaluation of service delivery.
- **Peer Review and Challenge –** Improvement will be supported by a programme of peer review and challenge. This will be taken forward through work in collaboration with organisations such as the Local Government Association, the North West Employers Organisation and sector leaders across Greater Manchester and the North West.
- **External Support –** Commission external support and expertise to support the improvement process through the analysis of the effectiveness systems and processes. Followed by critical friend review and testing of redesign.
- **Communication and Engagement –** A communications and engagement plan will set out the mechanisms for communication with stakeholders including use of social media, websites, newsletters and briefings. This will support the understanding of progress made in the delivery of the Improvement Plan, support engagement and collaboration and raise wider awareness of the support and services available to children and their families.

7 – OUR RESPONSE AND APPROACH

7.1 We are committed to rapidly addressing the concerns raised by Ofsted in order to ensure services within Tameside provide the best possible support to Children and Young People. To ensure that our approach is sustainable in the long term we will support children and young people and their families to become independent and self-reliant, and reduce dependency on public services. We will work closely with our partners so that services that meet the needs of children and young people are not delivered in silos. We will work together to support sustainability, reducing dependency and levels of need in our communities, and making best use of shared resources. The improvements we will undertake fall into 6 main themes:

- Leadership and Strategy
- Demand and Need
- Resources and Capacity
- Quality, Practice and Compliance
- Outcomes for Children
- Sustainability

7.2 One core principle that will underpin the above 6 themes will be the Voice of the Child. This will inform the actions taken towards improvement, given that the needs of children in our care are paramount in securing genuine and sustainable improvement.

7.3 **Leadership and Strategy** – improving the leadership of services and the quality of information used to inform decision making.

7.4 Our aim is to build the understanding of issues that impact on the lives of children and young people in Tameside and ensure that agencies across Tameside have the right information at the right time to make the effective protection and safeguarding decisions at the earliest possible opportunity. To achieve this we must ensure that they are fully involved decision making and that services are shaped by their experience and views.

7.5 Effective leadership equipped with the right range of decision making tools is essential to ensuring professionals are enabled to work together with children and young people to achieve positive outcomes.

7.6 Working with Tameside Safeguarding Children Board as a key partner we will ensure that performance management information provided to senior leaders and elected members is timely and high quality and an effective quality assurance framework is used to support improvement across all partners. Tameside Safeguarding Children Board will be a key partner providing support and challenge to the improvement process.

7.7 **Demand and Need** – understanding the demand on services and ensuring that services are equipped to respond rapidly and effectively to need.

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7.8 Our approach is to use accurate and up to date performance information to ensure that there is an understanding of demands on services and use this information to inform delivery and development of services which take account of underlying need. We recognise that frontline staff are one of our most valuable assets and whilst immediate demand has been met by an increase in agency staffing we are taking steps to ensure that workforce stability is increased and caseloads are reduced to allow staff to respond to need effectively.

7.9 Understanding need is about more than understanding the presenting needs of children and young people at the point of contact, it is about developing a holistic understanding of the support that it is required and ensuring that services are in place that are resourced to meet need effectively.

7.10 As a part of understanding holistic need we are focused on effective integration of services with key partners to enable effective early intervention.

7.11 **Resources and Capacity –** equipping services across Tameside to respond appropriately and deliver effective services.

7.12 The delivery of effective services for children and young people is reliant on the committed and skilled workforces of agencies across Tameside. A balanced financial plan has been put in place to ensure that adequate resources are committed to enable services to address both existing and emergent demand.

7.13 We recognise that in addition to financial resources effective delivery of services is reliant on the capacity both in terms of individual and collective skills of staff members and staffing numbers. To be able to practice well practitioners who work with children and young people must work in an environment which supports their development as professionals.

7.14 We are committed to ensuring that staff delivering services in organisations across Tameside have a suitable level of qualification for their job role and that they are supported in their professional development through an effective workforce development programme.

7.15 **Quality, Practice and Compliance –** ensuring that practice based decisions are made using consistent thresholds which result in high quality outcomes for children and young people in Tameside.

7.16 Consistent decision making based on a thorough understanding of needs and viewpoints of children and young people is essential to delivering services that are fit for purpose. We are committed to bringing partners together to ensuring that assessments are informed by consideration of family history and parental capacity and reflect changes in the child's needs and circumstances.

7.17 We will use regular quality audits and reflective practice across all agencies in Tameside to check that decision making is consistent and effective, and to ensure that the right help is delivered at the right time to support children and young people.

7.18 We will work in partnership with Tameside Safeguarding Children Board to ensure frontline practice is effectively evaluated and that learning is shared and informs decision making.

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7.19 **Outcomes for Children –** achieving the best possible outcomes for children by focusing improvement and development activity on understanding and meeting the needs of children and young people in Tameside.

7.20 We will work with partners to improve outcomes by ensuring that help and support is available at the earliest possible opportunity using effective early intervention to improve life chances.

7.21 We will work together with education, health and protection services in Tameside to ensure that young people who are vulnerable are supported by all services to realise their aspirations be that in relation to living independently, education, employment or other ambition. We will work with children and young people by listening to them and using their insight to shape services which meet their needs.

7.22 **Sustainability –** maintaining long term improvement by putting in place services and interventions which address systemic issues driving demand on services.

7.23 Most children who are at risk of abuse or neglect will have contact with professionals working in services such as health, social care and education throughout their lives. Early intervention work focusing on identifying risk to children at an early stage, will enable services to take the most appropriate action to support children and young people and start to break cycles of reoccurring need. We will work with partners such as schools to ensure that opportunities to support children and young people who are at risk are not missed. Our Integrated Neighbourhood Support service will be a key partner in the journey by being at the forefront of the prevention agenda.

7.25 We are committed to a sustainable approach to service improvement including investment in programmes of work designed to reduce long term need. This includes the creation of an Edge of Care Service focused on an intensive whole family response to children on the edge of care focused on supporting families to remain together where safe. Other projects aimed at increasing sustainability include:

- Investing in intervention models that enable extended family members to work together with services to identify family options that help to secure permanence for children where appropriate.
- Adopting more effective transition planning model for looked after young people that equips them with skills to continue their journey into adulthood. Working with partners such as, Pennine Care NHS Foundation Trust, Active Tameside and New Charter we will work creatively with young people to ensure that their needs are met and they are supported in respect of employability and life skills.
- Working together with partners on these and other projects we will seek out additional opportunities to ensure that effective intervention leads to reduced demand for services and supports the long term sustainability of services to support children and young people across Tameside.
- Work through the Tameside Single Commissioning Organisation to reduce duplication and increase sustailability in planning services to improve health outcomes which meet the needs of children and young people and their families.

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8 – IMPROVEMENT PLAN

The section below outlines each of the 6 thematic improvement areas in more detail including key actions that will be taken and measures we will use to monitor progress.

Leadership and Strategy

8.1 Leadership and the management of performance at a strategic level were identified as a key area of concern by Ofsted. In particular, recommendations for improvement were made in relation to:

- The quality of performance reporting to senior leaders, Elected Members and the Tameside Safeguarding Children Board
- The effectiveness of arrangements to scrutinise the performance of services
- The quality of supervision and management oversight
- The use of the Common Assessment Framework amongst partner organisations
- Delivery of the Corporate Parenting Strategy

Initial Response

8.2 A range of activity has been carried out in immediate response to concerns regarding Leadership and Strategy within the service. These include:

- Regular governance visits scheduled throughout the year to increase the oversight and visibility of senior managers
- Monthly whole workforce engagement sessions
- Reviewed induction framework for staff developed and ready for implementation by March 2017
- Weekly briefing email circulated to all staff by the Assistant Executive Director for Children's Services together with minutes of senior managers meetings to increase communications and increase the visibility of decision making processes
- An updated, improved performance scorecard to better inform strategic managers
- An updated and improved data booklet for frontline teams to enable them to address issues and celebrate positives at the earliest stage
- Training opportunity via STRIVE for front line managers available immediately and well attended
- Performance clinics monthly for all managers to be held to account and for them to be able to flag up danger areas or blockages to success

Key Actions

8.3 The following actions will underpin ongoing improvement in relation to the strategic leadership of services to safeguard vulnerable children and young people in Tameside:

- The introduction of a fully integrated performance framework underpinned by regular and timetabled reporting to key stakeholders, including partners, team leaders, senior managers, elected members and scrutiny panels.

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- Implementation of programme of activity enabling reflective learning including, regular staff workshops, programme of governance visits, and effective staff supervision to ensure that the impact of changing demand on services is understood.
- Work with Tameside Safeguarding Children Board to ensure that the Common Assessment Framework and Graded Care Profile processes are embedded across services in Tameside.
- All members of the Tameside Council Children's Leadership team will undergo a 360 evaluation programme. Following this and working in partnership with North West Employers a development and improvement programme will be put in place to ensure that there is is a clear performance management framework for senior leaders.

What Will Good Look Like?

8.4 Strong leadership and collaborative strategies between partners will be the crucial ingredient to improvement. The voice of Children, including those in our Care will be the fundamental driver of high-level strategic improvement of Children's Social Care. Senior and middle managers, leaders and elected members will frequently seek and use feedback from children and their families for service development.

8.5 The Tameside Safeguarding Children Board will have a reviewed business plan and structure and a refreshed outlook tailored to the insight from children and frontline practitioners' experience. Understanding of good safeguarding practice will scrutinise practice effectively and enforce timely application of thresholds. There will be strengthened reporting links between the Tameside Safeguarding Children Board and the Corporate Parenting Strategic Group and Family Justice Board, so that safeguarding children can be monitored effectively.

8.6 Senior and middle managers will have a strong grasp of the concerns of children at risk of sexual exploitation, and awareness of this will be the focal point of achieving good outcomes such as ensuring that children feel safe and protected from harm. Leaders will establish a collaborative approach by building relationships with key groups such as the Tameside Safeguarding Children Board and Corporate Parenting Strategic Group, so that all parties share an understanding of how well services are benefitting children and young people.

8.7 Leaders will regularly monitor performance data and feed this information back to workers and managers, so leaders, managers, frontline staff and key partners all have clear benchmarks upon which to measure the success of improvement.

8.8 Key Indicators

- Number of contacts at the service entry point
- Referrals per 10,000 of the child population (projected rate)
- Re-referrals received within 12 months of a previous referral
- Timeliness of response to referrals
- Timeliness of assessments, statutory visits, child protection conferences and child in care reviews
- Percentage of children with up to date reviews and care leavers with pathway plans which are effective
- Stability, experience and Caseloads of workers
- Findings from Audit on the quality of work being undertaken

- All staff will receive high-quality supervision and managerial oversight as often as they need it, and fitting with their level of skills and experience
- Reporting of performance management to senior leaders and elected members is timely and of a high calibre

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- A refreshed Corporate Parenting Strategy will be shared across the partnership, so that external bodies can support the improvement process
- There is an effective quality assurance framework in place that will monitor, improve and increase the use of Early Help services
- Safeguarding practice is well-informed and is kept up to date though regularly capturing information and evaluating the effectiveness of the current strategy

Demand and Need

8.9 During the Ofsted inspection concerns were raised regarding Tameside's ability to respond effectively to increased demand on services and understand the needs of vulnerable children in Tameside. Concerns were raised with regard to the following:

- Ensuring there were sufficient staff in key areas to deal with demand on services and that workloads are manageable.
- Ensuring that staff have suitable levels of qualification and experience for the role that are required to undertake.
- Ensuring that action is compliant with statutory guidance and that thresholds are applied appropriately at points of access to services.
- Tameside Safeguarding Children's Boards capacity to evaluate thresholds across the partnership effectively.

8.10 Initial Response

8.11 In response to concerns relating to management of and response to underlying demand and need for services the following actions were taken:

- Immediate increase in agency staffing to meet immediate needs and ensure that sufficient capacity is in place to meet the needs of vulnerable children and young people.
- Rolling programme of recruitment is underway to stabilise the workforce in the medium term.
- Commitment to ensuring there are sufficient resources in place to reduce caseloads to appropriate levels allowing social workers and other staff sufficient time to carry out assessments and deliver services that meet the needs of children and young people.
- Undertaken a staffing review to ensure that suitable staff are available, deployed effectively and in the right numbers to meet demands on the service provided.

8.12 Key Actions

8.13 The following actions will underpin the approach of Tameside Council and its partners in meeting the needs of children and young people in Tameside and in ensuring that services in place are able to meet current demand and respond effectively to changes demands on services in the coming years:

- Work will be undertaken in partnership with the Tameside Safeguarding Children Board to analyse underlying need across the Tameside including all critical points of access such as, schools, health, the police service, and children's social care.
- Development of a Tameside demand forecasting model to enable effective implementation of service development and early help methodology.

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- Ongoing review of service entry points to ensure that a sustainable model is in place that is responsive to changing demand levels and enables effective delivery of services to children and young people.
- Support the development of Tameside Safeguarding Children Board multi-agency data set to enable the effective delivery of scrutiny, support and challenge across Tameside.
- Review of all contact points to ensure a sustainable model is in place that is flexible to demand and able to respond effectively.

8.14 What Will Good Look Like?

8.15 Leaders and senior managers across Tameside are aware of changing and emergent demand and have sufficient information to enable effective decision making which supports timely response by services.

8.16 Children and young people in need of help and support will be seen by social workers who have the right knowledge and experience to be able to address each child's unique needs and formulate a plan based on the best outcome for that child.

8.17 Practitioners will have their caseload tailored to their ability to fulfil to job they undertake, and will have more time to deal with complex and varying circumstances with careful consideration. Children and young people in need of help and protection will not be delayed in receiving the right intervention that is consistently compliant with statutory guidance across the service, no matter what walk of life or type of care the child needs.

8.18 Leaders, managers and workers will have strong self-awareness of how application of thresholds benefits children in need, and how they are performing in this area. This will be guaranteed through higher level evaluation of whether the application of social work thresholds is both consistent across the service, and effective in ensuring the best outcomes for vulnerable children and their families. As a result, as soon as a child is identified as being at risk of harm, they will receive the right intervention at the right time.

8.19 Key Indicators

- Number of referrals
- Number of Children in Need
- Number of Children on a Child Protection Plan
- Number of Children on a Child Protection Plan for more than 18 months
- Number of children in our care
- The proportion of children who attend planning meeting
- The proportion of children in care who report that they feel supported and listened to.
- % contacts with a decision in 1 working day
- 5 initial child protection conference within 15 working days
- % child and family assessments completed within 45 working days

- All areas of service have a sufficient level of staff that are well-equipped for the role they are required to take.
- Quality assurance of work by senior and middle managers considers the quality of managerial decision-making at all stages of a child's involvement with the local authority
- The application of thresholds for support of children and young people is consistent across the service and results in appropriate, timely intervention for children.

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Resources and Capacity

8.20 Several improvement areas have been identified relating to the allocation of resources to support children and young people and the capacity of organisations in Tameside to respond effectively to need. In particular the following areas have been highlighted as priorities for improvement:

- Ensuring that all services have sufficient staff levels to cope with demand
- Ensuring staff have suitable qualifications for the role they are required to do
- Ensuring that newly qualified social workers on an assessed and supported year in employment receive sufficient support and training.
- Equipping staff across services with the skills they need to improve the services they deliver

8.21 Initial Response

8.22 In response to concerns regarding the resources and capacity available to meet the needs of vulnerable children and young people the following actions were taken:

- Increased opportunities for staff to share ideas and concerns via scheduled staff engagement sessions including regular staff surveys, the set-up of an improvement inbox and working groups to address specific development areas.
- The decision making protocol has been reviewed to ensure that managers are supported to make decisions in a timely manner.
- All newly qualified social workers are enrolled on a university assisted Supported Year in Practice programme.
- Additional funding has been made on an ongoing basis to meet immediate demands on service together with specific funding to support the long term improvement programme.

8.23 Key Actions

8.24 The following actions will be undertaken to ensure that sufficient resources are available and that services have capacity to deliver support that meet the needs of children and young people in Tameside.

- Implementation of a revised workforce development model focused on developing a stable and skilled workforce including a full development programme for Newly Qualified Social Workers.
- Revision of existing salary and progression structure to ensure that Tameside remains a competitive employer and supports staff retention.
- Implementation of an appropriate caseloads approach setting out Tameside's approach to managing caseloads and providing team managers with an established framework to address caseload pressures.
- Implementation of multi-agency involvement at points of access to children's social care including clearer multi-agency arrangements for planning for vulnerable families.
- Development of a shared understanding of the roles of different agencies to increase coordination and reduce duplication in meeting the needs of children and young people.
- Development of referral pathways into services such as the Child and Adult Mental Health Service. This action includes a review of transition into key health services and consideration of a 'fast track' process where appropriate.

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8.25 What Will Good Look Like?

8.26 Children looked after and children in need of help and protection from the authority will be seen by staff from a stable supported workforce. Children looked after and children in need of help and protection will consistently receive the level of service that they require, and decisions are made with careful consideration. The service overall will have a varied workforce with manageable caseloads. This means that social workers will have the time to visit children on their caseload and build positive relationships with families.

8.27 The authority is working towards a workforce made up of permanent staff and will reduce reliance on agency staff, so that children will be known well by their social worker, and will not have to repeat their story again and again. Newly Qualified Social Workers will be fully supported in their Assessed and Supported Year in Employment, guaranteeing that they are fully able to undertake their role and are supported in the decision-making process.

8.28 All social work staff will receive regular supervision and managerial oversight that reflects their level of experience, so children and their families can be sure that the right decision is being made about their future. Leaders and managers will be aware of and understand the volume of cases and the quality of care plans and decisions which will provide accountability for safe and effective social work practice. Supervision will boost confidence among teams and help to retain and develop staff for longer.

8.29 Key Indicators

- Average overall caseloads for social work staff
- Average caseload for none social work practitioners
- Average caseload of Newly Qualified Social Workers
- Number of permanent Social Work staff
- Looked after children and children on a child protection plan with 3 or more changes of social worker over the previous 12 months.

- Social work staff will have manageable caseloads that are appropriate for their skills and experience, so that they are guaranteed time with children and their families.
- All social work staff will receive regular supervision and managerial oversight that reflects their level of experience
- Staff on the Assessed and Supported Year in Employment will receive the appropriate level of management oversight according to their needs, and have access to external support

Quality, Practice and Compliance

8.30 A range of improvement areas has been highlighted regarding quality, practice and compliance with statutory requirements and guidance. These include:

- Ensuring that action taken is compliant with statutory guidance and that application of thresholds in casework with children and families is appropriate
- Effective consideration of history and parenting capacity that informs through analysis of risk
- Consistency of gathering, recording and use of children's views and wishes
- Ensuring assessments are updated regularly and reflect children's changing needs and circumstances

- Ineffective methods of ensuring the views of children and young people influence service planning
- The quality of managerial decision making and the application of thresholds and all stages of a child's involvement with the local authority
- Ensuring services promote the emotional health and well-being of children
- Effective scrutiny and evaluation of the quality of frontline practice and services provided to children
- Support 2BeUs to provide effective representation of the views of children of all ages and those placed at a distance from the local authority.

8.31 Initial Response

8.32 In response to concerns regarding quality, practice and compliance the following immediate steps have been taken:

- Practitioners group has been established to support high quality practice which feeds directly into team and service improvement plans.
- Performance clinics are held monthly and shared by the Assistant Executive Director, bringing increased focus on team level performance
- The use of online case management systems has been expanded to the Fostering service to increase consistency of practice and availability of information. Plans are in place to increase use of this system further.
- Voice and Experience of the Child working group has been established to support the development support and resources aimed at ensuring that the Voice of the Child is heard in all areas of service delivery, is evident in all areas of involvement with children and shapes care planning.
- The Tameside Pledge to Children in Care has been refreshed and approved at Full Council on 29 November 2016.

8.33 Key Actions

8.34 The section below outlines key actions that will be undertaken to ensure that quality and practice is sufficient to effectively meet the needs of children and young people in Tameside and that the authority complies with all statutory guidance and requirements in delivering these services:

- Review of Tameside's Quality Assurance Framework in order to ensure a consistent and rigorous approach to quality is the norm.
- Work with Tameside Safeguarding Children Board to embed effective application of thresholds across organisations working in Tameside including the review of existing thresholds where appropriate, overseen by a new sub group of the Strategic Board focusing on Threshold management.
- Review of the Child and Family Assessment to ensure there is adequate analysis of risk and consideration of the history and chronology of individuals.
- Review of operational and commissioning arrangement's to ensure multi-agency care provision can be delivered effectively.

8.35 What Will Good Look Like?

8.36 Thresholds for social care intervention will be reviewed and updated to ensure they are effective, and will be applied rigorously and consistently across the service. Children and families can be sure they will be seen by a workforce that is clear on the criteria for intervention.

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8.37 Practitioners will be thorough in assessments and care planning, ensuring that all issues with regard to the child's wellbeing is taken into account. For example, Child and Family Assessments will take full consideration of family history and parental capacity, with learning clearly articulated including from effective and up to date chronologies.

8.38 Assessments are regularly updated and shape care planning. When a child goes missing, a return home interview will always take place and information gathered will be used to safeguard the child, promote their emotional health and protect them from sexual exploitation.

8.39 The voice of children looked after will be heard and recorded through various channels. 2BeUS will be supported to represent children looked after, including those who have been placed away from the area. Data from groups such as this will inform planning at a strategic level, and the views of children and young people will be used to inform planning on an individual level.

8.40 Key Indicators

- % of Child protection reports, looked after children review reports and pathways plans completed within timescales and reviewed on a regular basis.
- Number of care leavers in suitable accommodation
- % of case file audits graded inadequate, Requires improvement, Good and outstanding respectively
- % of case audits with evidence of Childs voice recorded
- % Looked After Children attended by allocated social worker or team manager
- Number of episodes of children missing from home
- Number of return home interviews completed

- The views and wishes of children and young people of all ages are consistently recorded and taken into consideration when planning
- Children and young people receive the right help and are seen at the right time so that their health and emotional wellbeing are always put first
- Social work assessments are informed by careful consideration of family history and parental capacity, and will reflect children and young people's needs and changing circumstances.
- A sufficient programme of both single and multi-agency audits provides effective scrutiny and evaluation of frontline practice.
- The quality assurance of work by middle and senior managers considers the quality of managerial decision-making, and the application of thresholds at all stages of a child's involvement with the authority.
- Care leavers are always placed in suitable accommodation arrangements that are conducive to leading independent lives.
- Return home interviews are always conducted after a child or young person goes missing, and any information gathered is used for planning ahead and reducing future risk.

Outcomes for Children and Families

8.41 Ensuring that children and young people achieve the best possible outcomes is a central aim which underpins the delivery of services across Tameside. Ofsted's judgement of Tameside's Children's Services as inadequate and the Tameside Safeguarding Children Board as requiring

Improvement highlights that there are significant opportunities to improve outcomes for children and young people in Tameside across a range of services.

8.42 Tameside Council and its partners are committed to improving outcomes across the board with particular focus on the following areas:

- Timeliness of service delivered to support children and young people
- The use of single and multi-agency audits to evaluate the quality of practice and enable improvements to service delivery
- Ensuring that all children leaving care have access to suitable accommodation, including ceasing using bed and breakfast accommodation for care leavers aged 18-25.
- Supporting children and young people to shape decision making and have a say in service improvement.

8.43 Initial Response

8.44 The following actions have been taken to ensure that services across Tameside are focused on achieving the best possible outcomes for children and young people in Tameside.

- Review and relaunch of the Tameside Pledge to Children in Care setting out the how partners will work together to deliver services which will meet the needs identified by children and young people
- Development of an outcomes focused performance framework to support leader, manager and staff to understand progress towards improving outcomes for children and young people.
- Engagement with Tameside Safeguarding Children Board to develop joint approach to improving outcomes across Tameside in partnership with local agencies.
- Work with partners to ensure immediate improvement for children who are witnessing or suffering domestic abuse by eliminating delay
- Work with housing providers to ensure that our care leavers do not need to be placed in unsuitable accommodation
-

8.45 Key Actions

8.46 The second below contains the key actions that will support the achievement of positive outcomes for children and young people in Tameside.

- Development of 2BeUS to ensure that there is effective representation of children of all ages and from children who are placed at a distance from Tameside.
- Work with schools colleges and employers in Tameside to increase the support, help support networks, advice and guidance available to looked after children and young people who are moving towards independence.
- Engagement with health partners to ensure that the health needs of vulnerable children are addressed with particular regard to ensuring that mental health needs are considered and addressed at the earliest possible opportunity.
- Coordinate with partners in the voluntary sector to provide care leavers with life skills, volunteering & mentoring opportunities for young people.
- Development of engagement strategy with children and young people that ensures that the voice of the child is embedded within services that support vulnerable children and young people across the borough.

8.47 What Will Good Look Like?

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8.48 The overall goal for children and young people in Tameside is that we want them to achieve the best possible outcomes and have a smooth transition to independence, where care leavers feel prepared to make the tranisition to adulthood.. Children in care should have the same achievements and happiness as their peers who haven't been in care.

8.49 Pathway plans for children and young people are rigorous, up to date and are produced in a timely manner so that plans are carefully thought out and are suited to the young person's needs. Young people remain 'in touch' with their worker, who support them according to their needs. All care leavers will have access to suitable accommodation.

8.50 Young people will feel emotionally resilient and will be able to take on education, training or employment in their adulthood. This will be supported through the development of invest to save initiatives, such as From Care to Success, which would address the current issues of young people leaving care ill-equipped, and to ease the transition from semi-independent accommodation to complete independent living.

8.51 Key Indicators

- % of Personal Education Plans completed and reviewed
- % Pathway plans completed and reviewed
- School Readiness - % of pupils achieving a good level of development
- % of Looked After Children achieving A*-C in GCSE English and Maths
- % of Looked After Children achieving the expected standard in reading, writing and maths at Key Stage 2
- % of looked after young people aged 16-18 in Education Employment or Training.

- Support of the Children in Care Council enables representation of the views of children of all ages, included those placed at a distance from the local authority.

- Children and young people are made aware of the pledge to children looked after and care leavers.

Sustainability

8.52 We believe that long term sustainability is key to maintaining services that meet the needs and demands of children and young people in Tameside. Building sustainability must underpin the long term approach to services.

8.53 We are committed to fundamentally changing how our services are received by residents. We will work closely with our partners so that service meet the needs of people and are not delivered in silos and we will support children and their families to be successful. We will working together to support sustainability, reduce dependency and levels of need in our communities, and make the best use of our shared resources.

8.54 Key areas for improvement that have been highlighted that relate to increasing sustainability include:

- The quality and completion of pathway plans with particular regard to ensuring that plans are up to date and reflect their current needs and circumstances.

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- Ensuring that services are in place that meet the needs of children and young people in a timely fashion, including making sure that services meet emotional health and well-bring needs
- Development of services that reduce long term and underlying demand and seek to break the cycle of dependency.

8.55 Initial Response

8.56 The following actions have been taken which are aimed at increasing the long term sustainability of services through reducing demand and increasing long term sustainability:

- Implementation of invest to save proposals in the following area:
  - Family Group Conferencing – Working with extended families to identify options to secure permanence for children.
  - Edge of Care Service – Investing in supporting families to remain together where it is safe to do so.
  - From Care to Success – Effective transition planning for young people preparing for independence.
- Implement schemes with partner agencies such as New Charter Housing that support care leavers to have a smooth transition to independent living.
- Wider investment plan in place to map out a financially sustainable route to increasing the sustainability.
- Rolling recruitment programme targeted at increasing workforce stability in the medium to long term with targeted development aimed at ensuring long term skill develop helps to enable a responsive workforce.

8.57 Key Actions

8.58 The section below highlights the actions that will be undertaken to support the development of sustainable services in Tameside that are shaped by and meet the needs of vulnerable children and young people.

- Implementation of the revised quality assurance programme ensuring that action taken by social workers is always compliant with statutory guidance, that emotional health and wellbeing is always considered, the application of thresholds is appropriate, and interventions are timely so that the right help will support children and young people in the long run.
- Development of links between services that provide support and intervention relating to domestic abuse including development of a joined up approach to services provided to Adults and Children.
- Implementation of a revised early help model which builds on effective partnership working with education, and health partners and interventions with families to help ensure that support is delivered at the earliest point possible reducing long term need and demand.
- Integration of the Children's Hub service and Integrated Neighbourhood services teams to support demand reduction through an early help and prevention approach.
- Work through the Tameside Single Commissioning Organisation to reduce duplication and increase sustainability in planning services to improve health outcomes which meet the needs of children and young people and their families.

8.59 What Will Good Look Like?

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8.60 The improvement process in Children's Services in Tameside must have sustainable outcomes if they are to be successful. Actions in the short term to medium term reduce demand in the long term, and help children and their families lead happier healthier lives.

8.61 Extensive research and evidence has shown that early intervention, specifically before the point of need, makes for a more long-term, sustainable alternative to children becoming looked after by the authority.

8.62 Children and Young People will be involved in co-designing of services and have a clear voice at all levels of decision making.

8.63 The emotional health and well-being of children and young people is always considered in the delivery of services, intervention and care planning.

8.64 Key Indicators

- Reduction in demand at all levels in the service
- Percentage of case audits with evidence of Child's voice recorded
- Reduction in rate of children subject to a Child Protection Plan

- Implementation of Invest to Save Programmes. New models like Family Group Conferencing, Edge of Care Service and From Care to Success will create better, earlier support that reduces need for court intervention and allows families greater agency in care plans. It will also promote a smoother transition for care leavers into adulthood.
- Action taken by social workers is always compliant with statutory guidance, the application of thresholds appropriate, and interventions are timely so that the right help will support children in the long run.
- Stabilising the workforce – recruiting more agency social workers in the short term; rolling out the recruitment drive for permanent social workers will strengthen skilled workforce
- Good support/supervision/oversight of social work staff makes for happier workforce; increase staff satisfaction/retention in the long run.

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9 – ACTION PLAN

9.1 Below is the strategic action plan we will be guided by in our work to improve children’s services and outcomes for vulnerable children in Tameside. The action plan will change and evolve as we work on our improvement areas and identify new and emerging ways of achieving positive change. We will regularly update the public on progress against our Improvement Plan and these underpinning actions.

<u>Leadership & strategy</u>

Ref	Action / project	By who?	By when?
A1	Work with partner and peer organisations to engage peer support within the improvement process.	AED Childrens Services Dominic Tumelty	
A2	Engagement of the Local Government Association to develop and support peer review arrangements.	DCS Stephanie Butterworth	
A3	Engagement of external Directors of Children’s Services challenge visits alongside the ongoing improvement process .	DCS Stephanie Butterworth	
A4	Integrated programme of activity to enable reflective learning based on practitioner insight including: - Regular all staff workshops - Regular all managers meetings - Staff surveys and consultation with partners to gauge progress - Scheduled governance visits to increase oversight by and visibility of senior managers.	AED Childrens Services Dominic Tumelty	
A5	Review of the Looked After Children’s Strategy - Review to be carried out by Corporate Parenting Group Chaired by the Executive Member for Children and Families.	Sheena Wooding reporting to the CPG	
A6	Promotion of the Corporate Parenting Role across Tameside Council including embedding understanding of the corporate parenting role across services.	DCS Stephanie Butterworth Councillor Robinson	
A7	Development of wider links to support the Voice of the Child including development of Tameside youth Council and wider networks such as Tameside Safeguarding Children Board Youth Forum and support for the development of the youth champions network.	Head of Service , Safeguarding and Review Ged	

		Sweeney	
A8	Work in partnership with Tameside Safeguarding Children Board to increase the effective use of the Common Assessment Framework and Graded Care Profile by organisations across Tameside.	Head of Service, Early help and YOT and Chair TSCB Sally Dickin / David Niven	
A9	Introduction of a new performance framework involving: - Team self-assessment - Improvement planning process - Regular performance clinics (managers and staff) - Development of demand forecasting The performance framework will be underpinned by: - Weekly caseload reporting focusing on key cohorts including Child in Need, Child Protection Plans and Looked After Children - Monthly reporting of baseline indicators and Children's Services Improvement Plan framework, including workforce statistics and investment decisions - Regular timetabled reports to key stakeholders including, senior manager, elected members, scrutiny panels, Tameside Safeguarding Children Board and key partner organisations.	AED Childrens Services Dominic Tumelty Head of performance Jane Barker	

Demand and need

Ref	Action / project	By who?	By when?
B1	Maintain recruitment programme for agency staff to meet short term demand and develop approach to ensure that rapid recruitment options are available to manage short-term and unanticipated pressures on the workforce.	AED Childrens Services Dominic Tumelty Head of HR Tracy Brennand	
B2	Implement a rolling recruitment programme for permanent social work staff to increase workforce stability and reduce changes of social worker.	AED Childrens Services Dominic Tumelty Head of HR Tracy Brennand	

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B3	Identify causes and address issues within the Children's Hub following spike in unassigned contact ensure points of failure have been addressed and waiting times have been reduced. Performance will be monitored on an ongoing basis and reviewed as a part of the Continual Improvement process.	Head of Service referral and assesment	
B4	Review of all contact points to ensure a sustainable model is in place that is flexible to demand and able to respond effectively. Including increasing involvement from partner agencies including: - Colocation of staff from the Greater Manchester Police Public Protection and Investigation Unit - i.e. LAC Health Teams and Safeguarding Provider Teams. This model will be reviewed as a part of Continual Improvement processes, to ensure that it is working as effectively as possible.	Head of Service Referral and Assessment	
B5	Relaunch of the revised Children's Hub following review including engage of stakeholders in communicating revised points of access to ensure their role and function is understood and being used effectively. Including clearer multi-agency arrangements for planning for vulnerable families.	Head of Service Referral and assessment	
B6	Development of a financial plan which enables stabilisation of services and long term investment to reduce demand through invest in services that reduce long term demand through effective intervention at the earliest opportunity.	DCS Stephanie Butterworth Finance Manager Stephen Wilde	
B7	Carry out a review of data and information sharing approach to ensure interfaces between partners and agencies enable more effective and timely decision making. In particular relating to: - Children missing from home. - Looked After Children moving into Tameside from other local authority areas. - Safeguarding where family members attend different schools	Head of Service, Conference and Review Ged Sweeney Head of performance Jane Barker	
B8	Development of links between the Elective Home Education team and Children's Social Care to ensure that safeguarding is taken into consideration where home education is requested.	Head of Service, Referral and Assessment	
B9	Support the development of Tameside Safeguarding Children Board multi-agency dataset to enable the effective delivery of scrutiny,	Head of Performance	

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	support and challenge across Tameside.	Jane Barker Chair of TSCB David Niven	

Resources and capacity

Ref	Action / project	By who?	By when?
C1	Refreshment and implementation of a workforce strategy to support skills development and recruitment, and build workforce stability.	AED Childrens Services Dominic Tumelty Workforce Development Brendan kennedy	
C2	Design and implementation of a revised induction process to ensure that new staff are provided with the effective information and support.	AED Childrens Services Dominic Tumelty Workforce Development Brendan kennedy	
C3	Establishment of appropriate caseload levels based on an assessment of skills and experience of staff members.	AED Childrens Services Dominic Tumelty	
C4	Bring forward proposals based on salary and progression structures form across the region to ensure the Tameside offer is competitive and helps support the staff retention.	Head of HR Tracy Brennand AED Childrens Services Dominic Tumelty	
C5	Development audit process to ensure that supervision processes are embedded and effective and used at all levels within the organisation.	Head of Service QA Katherine	

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		MacKay	
C6	Undertake a programme of University supported training to support Newly Qualified social Workers.	AED Childrens Services Dominic Tumelty Workforce Development manager Brendan kennedy	
C7	Ensure that partners and safeguarding leads have are provided with sufficient information to support the understanding of processes for making referrals to Children's Social Care and that processes are fully understood.	Head of Service, Referral and Assessment	
C8	Ensure that staff and partners involved in making referrals to safeguard children and young people are able to challenge and discuss decision making where appropriate to ensure that there is mutual understanding of decision making and that the application of thresholds is effective and consistent.	Head of Service, Safeguarding and Review Ged Sweeney	
C9	Tameside Children's Services to engage with partners in Tameside Schools to develop a supportive approach to safeguarding decision making including: - Building relationships between agencies based on dialogue, mutual respect and shared understanding. - Effective and timely communication. - Decision making focused on the needs of the child. - Signposting to other agencies where appropriate. - Careful consideration of case closure.	AED Education Bob Berry Head of Service Early Help and Intervention and Sally Dickin	
C10	Development of electronic referral processes to enable effective and accurate recording of referral information and reduce delay in response to requests for services.	AED Childrens Services Dominic Tumelty Head of Performance Jane Barker	
C11	Work with Tameside Safeguarding Children Board to develop the partnership wide training offer which offers a range of training opportunities to all agencies.	Head of Service , Safeguarding and Review	

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C12	Development of referral pathways into services to support children and young people with mental health needs such as the Child and Adult Mental Health Service. This action includes a review of transition into key health services and consideration of a 'fast track' process where appropriate.		

Quality, practice and compliance

Ref	Action / project	By who?	By when?
D1	In depth individual case audits to support learning and development together with wider case audits to quality assure decision making and practice.	Head of Service QA Katherine MacKay	
D2	Development of a programme of improvement activity to support good quality practice which complies with statutory requirements. Improvement activity to be led by the Consultant Social worker.	Head of Service QA Katherine Mackay Workforce Development manager Brendan kennedy	
D3	Increasing development activity and support of Children In Care Council following refreshment and reorganisation in 2016.	Head of Service, LAC	
D4	Undertake a review of Tameside's Quality Assurance Framework overseen by the Head of Service in Charge of Quality Assurance in order to ensure consistent and rigorous Quality Assurance is embedded into service delivery at all levels.	Head of Service QA Katherine MacKay	
D5	Ensure that where appropriate existing thresholds are applied effectively and reviewed where thresholds are deemed to be inappropriate. The focus of this activity will be on ensuring that decisions taken are consistent and appropriate.	Head of service, safeguarding and review	
D6	Work with Tameside Safeguarding Children Board to embed thresholds with partner agencies and ensure that there is a clear understanding and application of thresholds across organisations working in Tameside.	Head of Service, Safeguarding and Review	
D7	Child In Need procedures have been reviewed including: - Processes in place for when a Child in Need moves across Local Authority boundaries. - Clarification of step up and step down processes. Further work will be undertaken to ensure that process remains fit	Head of Service, Safeguarding and Review Ged Sweeney	

	for purpose and that data and information sharing takes place at appropriate points.		
D8	Review of the system of Domestic Abuse notifications in partnership with Greater Manchester Police to ensure a timely response to notifications.	Chair of Strategic Domestic Abuse Steering Group Stephanie Butterworth	
D9	Ensure that information regarding missing children is gathered and used effectively to inform planning and reduce future risk through: - Effective contract monitoring Missing children contract - Implementation of the recommendations of the review of the missing panel - Address gaps in performance information relating to children missing from home or care or those at risk of child sexual exploitation.	Head of Service, Safeguarding and Review Ged Sweeney	
D10	Prepare and bring forward a report on all assessments over 12 months old with further reviews to take place on practice and application of assessment processes. The report will include specific consideration of history and chronology of individuals as a part of the ongoing review and quality assurance programme.	Head of Service QA Katherine MacKay	
D11	Review the Child and Family assessment to ensure that adequate analysis of risk and consideration of the history and chronology of individuals as a part of the ongoing quality assurance and review process.	Head of Service QA Katherine MacKay	
D12	Increase the proportion of pathways plans completed within timescales. - Ensure that caseload levels are suitable and allow completion of pathway plans - Ensure consideration of entitlement is given in all pathway plans - Ongoing monitoring of pathways plans regular reporting of completion	Head of Service LAC Sheena Wooding	
D13	Ensure referral processes are clearly documented and available to those involved in safeguarding children. Including review of Common Assessment Framework processes to ensure that all partners understand how, why and when the Common Assessment Framework process is used and increases engagement from a range of agencies.	Head of Service, Early help Sally Dickin	
D14	Develop two-way communication process between key agencies that ensures: - Clear and timely feedback on decision making is provided where referrals do not meet threshold.	Head of Service Referral and Assessment	

	- Notifications take place when changes take place such as a change of social worker - Enables reflective learning processes		
D15	Recruitment of Common Assessment Framework coordinators to promote use of the framework amongst universal services.	Head of Service, Early help Sally Dickin	
D16	Review of operational and commissioning arrangements to ensure multi-agency care provision can be delivered effectively		
D17	Engagement with external experts to support the improvement process through system analysis and redesign.	AED Childrens Services Dominic Tumelty	

Outcomes for children

Ref	Action / project	By who?	By when?
E1	Development and implementation of Children in Care Council 'Owl' campaign promoting designated safe places in Tameside. Full offer to be developed focusing initially on public buildings and those used by key partner organisations. work to be taken forward in partnership with the children in care Council	Head of Service LAC Sheena Wooding	
E2	Work with partners to ensure that appropriate placements are available to ensure that Bed and Breakfast use is avoided. Work to include the agreement of processes with partners for ensuring bed and breakfast placements for Young People do not take place, even in extreme circumstances. Monitoring data to be included in key performance information to ensure that any cases where the use of bed and breakfast accommodation takes place are investigated thoroughly.	DCS Stephanie Butterworth	
E3	Implement learning from complaints, children's and young people's participation, and peer reviews to inform strategic planning.	Head of Service, Conference and Review Ged Sweeney	
E4	Develop engagement of Children and young people at a strategic and operational level to ensure that the Voice of the child is embedded within all systems, and processes. Including participation in case planning including structured audit and review process and use of young people's views at a case level to inform the strategic planning process as well as the individual journey of young people.	AED Childrens Services Dominic Tumelty	

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	Engagement of wider agencies to broaden the mechanisms to seek and gather the views of children and young people. Engagement of children and young people inside and outside of the care system to support the improvement of preventative services.		
E5	Development of 2BeUS to ensure that there is effective representation of children of all ages and from children who are placed at a distance from Tameside.	Head of Service LAC Sheena Wooding	
E6	Work with schools colleges and employers in Tameside to increase the support, help support networks, advice and guidance available to looked after children and young people who are moving towards independence.	AED education Bob Berry Head of Service LAC Sheena wooding	
E7	Engagement with health partners to ensure that the health needs of vulnerable children are addressed with particular regard to ensuring that mental health needs are considered and addressed at the earliest possible opportunity.	Hazel Chamberlain	
E8	Coordinate with partners in the voluntary sector to provide care leavers with life skills, volunteering & mentoring opportunities for young people and provide information to services that enables access to support available.	Head of Service LAC Sheena Wooding	

Sustainability

Ref	Action / project	By who?	By when?
F1	Implementation of Family Group Conferencing Invest to Save Programme Increasing Family Group Conferencing in order to ensure that wherever possible Family Group Conferences are completed before the implementation of Care Proceedings. This approach will help to reduce delay and increase opportunities for alternatives to long term care that will provide the best care outcomes for children.	Head of Service Conference and Review Ged Sweeney	
F2	Implementation of Edge of Care Invest to Save Programme - Creation of an intensive, whole family response to children at the edge of care that will provide: - Out-reach - In-reach - Family sessions	Head of Service Referral and Assessment	

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	- Short breaks residential provision where requested The aim of this service is to better support families to remain together where safe.		
F3	Implementation of from Care to Success transition programme for Care Leavers Invest to Save Programme Extending on the existing transition planning model for disabled children to all children in care. This approach will equip young people with the skills they need to enter adulthood through a person centred approach.	Head of Service LAC Sheena wooding	
F4	Implementation of revised foster carer payments scheme aimed at supporting the development of foster carers including a payments structure focused on the needs of individual children and skills of foster carers.	Head of Service LAC Sheena Wooding	
F5	Investment in the development of residential care homes in Tameside to reduce reliance on external placements for children who are looked after in residential settings.	Head of Service LAC Sheena Wooding	
F6	Review and relaunch of Tameside Councils Early Help service to ensure that staff are partners are clear about the provision available and able to access services effectively. To include review of information provided to support access to services available through other channels such as the Voluntary and Community Sector.	Head of Service Early Help Sally Dickin	
F7	Development of links between services that provide support and intervention relating to domestic abuse including development of a joined up approach to services provided to Adults and Children across partner agencies.	DCS Stephanie Butterworth	
F8	Develop resources which highlight and champions best practice and facilitates two way discussion of practice between partners to support the continual improvement.	Head of Service QA and Consultant Social Worker Katherine MacKay	
F9	Increased integration of the Children's Hub and Integrated Neighbourhood services teams to support demand reduction through an early help and prevention approach.	Head of Service Referral and Assessment AED Stonger Communities Emma Varnam	

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F10	Implementation of the revised quality assurance programme ensuring that action taken by social workers is always compliant with statutory guidance, that emotional health and wellbeing is always considered, the application of thresholds is appropriate, and interventions are timely so that the right help will support children and young people in the long run.	Head of Service QA Katherine MacKay	

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10 – PERFORMANCE SCORECARD

10.1 Achievement of the aims of our Improvement Plan, and progress towards those aims, will be measured in a number of ways.

10.2 Our performance framework will enable a clear assessment of progress towards improved quality of life. The action plan within the Improvement Plan will have milestones that will measure and report progress towards implementation. But it is important to have the performance scorecard alongside this to assess achievement of tangible outcomes for children and families. The scorecard will not just be indicators it will include quantitative and qualitative information such as outcomes from critical friend reviews of practice, service user feedback etc. The service has developed a new performance framework, team self-assessment process and improvement planning approach which will be monitored through regular performance clinics (a two-way process between managers & staff).

10.3 Below are the headline performance indicators against which we will measure progress and success.

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Contacts

Ref	Measure
1	Number of contacts received by Children's Services: a) Total number of contacts received by Children's Services b) Number of contacts received via the Children's Hub c) Number of contacts received from other teams
2	Number of contacts by outcome: a) Number of contacts referred into children's social care b) Number of contacts referred to early help c) Number of contacts where no further action is required d) Number of contacts where information/advise is provided e) Number of contacts referred to another agency
3	Percentage of contacts with a decision made within 1 working day: a) Percentage of contacts with a decision made within 1 working day for Children's Services b) Percentage of contacts with a decision made within 1 working day for the Childrens Hub c) Percentage of contacts with a decision made within 1 working day for other teams

Referrals

Ref	Measure
4	Total number of referrals received
5	Number and percentage of referrals where a decision was made within 24 hours
6	Number and percentage of re-referrals within 12 months of a previous referral

7	Number of referrals by source (top 5)

Assessment

Ref	Measure
8	Number and percentage of Children and Families Assessments completed within 45 working days

Caseloads

Ref	Measure
9	Children's Services caseloads: a) Total number of open cases b) Number of looked after children c) Number of children who are the subject of a Child Protection Plan d) Number of children in need cases (excluding LAC and CP)
10	Number of children stepping up and stepping down from the service by: a) LAC b) CP c) Children in need

Child protection

Ref	Measure
11	Number of Initial Child Protection Conferences (ICPC)
12	Percentage of children whose ICPC was held within 15 working days of strategy discussion
13	Number of children who become the subject of a child protection plan for a second or subsequent time in the last two years
14	Total number of child protection reviews held
15	Percentage of conferences held within the timescale

Looked after children (LAC)

Ref	Measure
16	Percentage of looked after children aged between 3 and 15 with a current PEP
17	LAC reviews: a) Total number of reviews due b) Total number of reviews undertaken c) Number of reviews held with statutory timescale d) Percentage of review held within statutory timescale
18	Educational attainment of LAC: a) Percentage of LAC achieving the expected standard in reading, writing and maths at KS2 b) Percentage of LAC achieving A*-C in English and Maths
19	Health of LAC:

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	a) Percentage of LAC with an annual health assessment completed b) Percentage of LAC with an annual dental check completed
20	LAC Placements: a) Percentage of LAC with 3 or more placements during the year b) Percentage of have been in the same placement for at least 2 years or placed for adoption c) Percentage of children looked after who are placed for adoption within 12 months of the decision that the child should be placed for adoption

Care leavers

Ref	Measure
21	In touch with care leavers: a) % of care leavers the service is in touch with b) Number and percentage of care leavers who are NEET c) Number and percentage of care leavers who are in suitable accommodation
22	Pathway Plan reviews for care leavers: a) Number of reviews held within timescale set on ICS b) Percentage of reviews held within timescale set on ICS
23	Percentage of young people participating at Pathway Plan review

Early help

Ref	Measure
24	School Readiness - % of pupils achieving a good level of development

Staff

Ref	Measure
25	Average social work caseload
26	Percentage of LAC or CP children with 3 or more changes of social workers in the previous 12 months
27	Average caseload for none social work practitioners
28	Average caseload of Newly Qualified Social Workers
29	Number of permanent Social Work staff

Voice of the child

Ref	Measure
30	The proportion of children in care who report that they feel supported and listened to.
31	% of case audits with evidence of Childs voice recorded
32	Number of return home interviews completed
33	Percentage of case audits with evidence of Child's voice recorded

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Other

Ref	Measure
34	Number of episodes of children missing from home

11 – OFSTED RECOMMENDATIONS

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11.1 Ofsted made 20 recommendations in their inspection report published on 9 December 2016 which are list below. The full report can be found on the Ofsted website at https://reports.ofsted.gov.uk/local-authorities/tameside

11.2 Inspection of services for children in need of help and protection, children looked after and care leavers.

1	Ensure that all areas of service have sufficient staff of a suitable level of qualification and experience for the role that they are required to undertake and that their workloads are manageable.
2	Ensure that action taken by social workers is compliant with statutory guidance and that the application of thresholds in casework with children and families is appropriate.
3	Ensure that social work assessments include an effective consideration of history and parenting capacity that informs thorough analysis of risk and ensures that assessments are updated regularly to reflect children's changing needs and circumstances.
4	Ensure that the quality assurance of work by senior and middle managers routinely considers the quality of managerial decision making and the application of thresholds at all stages of a child's involvement with the local authority, including contacts within the Children's Hub.
5	Improve the quality of performance management reporting to senior leaders and elected members, so that they have sufficient information to benchmark improvement against clear, good practice standards.
6	Ensure that all staff receive high-quality supervision and managerial oversight at a frequency that reflects their skills and levels of experience and agree levels of external support for newly qualified staff on the assessed and supported year in employment programme.
7	Ensure that children's views and wishes are consistently gathered, recorded on files and used to inform planning.
8	Work with partners to ensure coordinated early help for a wider group of children through increased use of early help assessment and plans via the common assessment framework, and implement an effective quality assurance framework to monitor and improve the quality of work done in early help.
9	Ensure that children looked after are provided with timely services to make certain that their emotional health and well-being are promoted.

10	Ensure that when children go missing from home or care, the information gathered at return home interviews is used to inform planning effectively and reduce future risk.
11	Care Leavers - Ensure that all care leavers have an up-to-date and good-quality pathway plan that reflects their current needs and circumstances and that they have full information about their entitlements to support them into adult life.
12	Ensure that support to the Children in Care Council enables effective representation of the views of children of all ages and those placed at a distance from the local authority. This should include work to ensure that the pledge to children looked after and care leavers is refreshed and communicated effectively to all children and young people.
13	Ensure that the use of bed and breakfast accommodation for care leavers aged 18 to 25 ceases.
14	Review and update the corporate parenting strategy to give clarity to the work of the board and ensure that this is shared across the partnership, so that external scrutiny can support improvement in services for children looked after.

Review of the effectiveness of the Local Safeguarding Children Board.

15	Undertake an urgent review of Tameside Safeguarding Children Board (TSCB) priorities and update its business plan to include concerns about frontline practice and service delivery at all levels of need, and ensure that an evaluation of the impact of safeguarding practice upon children's well-being and safety is undertaken and included in the board's annual report.
16	Establish a programme of sufficient multi-agency and single-agency audits to enable effective scrutiny and evaluation of the quality of frontline practice and service provided to children.
17	Ensure that the board is able to evaluate whether the application of thresholds across the partnership is effective and is resulting in timely and appropriate intervention for children.
18	Improve understanding and informed challenge of safeguarding practice in Tameside by regular critical analysis of accurate and up-to-date performance information from all partners. This is to include the development of an integrated multi-agency data set concerning children at risk of child sexual exploitation, ensuring that the prevalence is accurately captured and enabling an evaluation of the effectiveness of the current strategy.
19	Re-establish effective methods of ensuring that the views of children and young people influence the service planning needed to deliver TSCB priorities and plans.
20	Establish effective links with the corporate parenting strategic group and family justice board to ensure that the TSCB has appropriate oversight of outcomes for children looked after and those who are the subject of care proceedings.

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12 – GLOSSARY

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13 – CONTACTS AND FURTHER INFORMATION

Concerned about a child?

Tameside Council

Tameside Council provide support to children and families. We always seek to offer preventative support to children and their families in partnership with parents to promote the child's welfare and ensure parents and where necessary the wider families, are able to meet their children's needs.

The Children Act 1989 lays a duty on the Local Authority to make enquiries into any allegations

We work together with children, young people and their families to ensure that we have a complete picture of the problem so that we can offer the right support. We aim to keep families together by providing back-up and support to prevent problems getting too big.

If you are concerned about the welfare of any child or young person please contact the Children's Hub on **0161 342 4101.**

The Children's Hub is open Monday to Wednesday 8.30am - 5.00pm, Thursday 8.30am - 4.30pm, Friday 8.30am - 4.00pm.

Outside of these hours please call Tameside Council Emergency control on **0161 342 2222**

If the situation is **immediately dangerous for the child** please call **999** and ask for the Police.

Tameside Safeguarding Children Board

Tameside Safeguarding Children board is the partnership responsible for making sure that children and young people are kept safe in Tameside. You can find further information about safeguarding children and young people in Tameside on the Boards website:

https://www.tamesidesafeguardingchildren.org.uk

If you require further information about Tameside Safeguarding Children Board please call **0161 342 4348**

Other Help and Support

The following organisations also provide support, advice and guidance in relation to safeguarding children and young people.

Childline - https://www.childline.org.uk/ Phone – **0800 1111**

NSPCC - https://www.nspcc.org.uk/ Phone – **0808 800 5000**

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Appendix 2

SUMMARY FEEDBACK FROM CONSULTATION

1. Demand and Need

- Clear and definition of thresholds which identify the actions that should be taken
- Consistent application of thresholds and a shared understanding of the decision making process.
- Clear explanation provided where cases are not deemed to meet threshold with the opportunity to offer respectful challenge to referral decisions which is taken professionally and used constructively to lead improvements.
- The needs of children should be paramount in all decision making and not simply the thresholds that policy or practice dictate
- Consistent and tailored provision when children are in need of statutory services
- Support from specialists should be provided when needed, particularly in relation to mental health needs
- Ensure we check children and young people are happy and understand the care they receive.
- Make sure foster carers are doing what they should be
- Opportunity for development of written referrals to be submitted with timescales for feedback and clear outlines of what to expect and when to reduce duplication
- Review of operational and commissioning arrangements to ensure that multi-agency care provision can be delivered

2. Information Sharing

- Clarity regarding information governance and data sharing agreements in place including - Increased and more effective information sharing in relation to children missing from home, Looked After children moving across local authority boundaries.
- Clear direction about the role of none-statutory organisations in providing the best quality safeguarding practice
- Access to information about the VCS organisations available in Tameside which provide wider support.
- Co-location in the Public Service Hub to enable better communication and information sharing
- Development of framework that enables school to communicate alternative provision outside of school commissioned by schools.
- Clear communication of changes to the Public Service Hub and in terminology used.
- Better communication of information regarding changes in social worker is required.

3. Early Intervention and Prevention

- Increased linkages between the Integrated Neighbourhoods service and early help and intervention services to support families to access early help and intervention.
- Opportunity to co-locate early help worker and children's social care staff within Integrated Neighbourhood's service to support early intervention and prevention activity
- Focus should be on that appropriate help and support is available at the earliest opportunity
- Opportunity to co-locate Looked After Children Health teams and Safeguarding Provider Teams in the Public Service Hub to increase effectiveness and reduce duplication.
- Development of referral pathways for mental health services including processes for fast-tracking and transition into health services.

4. Partnership Working

- Greater cooperation when concerns are raised including more open mechanisms to share information without fear of repercussions
- Access to wider training programmes and training sufficient to enable safeguarding staff to make referrals into the Public Service Hub.
- Joined up service deliver to ensure that cases involving both adults and children are not dealt with holistically. Particularly in cases where Domestic Abuse is a factor.
- More consideration of closure of cases when there are concerns articulated that it may be premature to close a case.
- School co-ordinators should always feel listed to, supported and where appropriate sign posted to other agencies.
- Improved levels of mutual respect and levels of professionalism.
- Increase links between partner agencies and provide clearer referral routes to prevent multiple referrals.
- More consistent access of safeguarding training by schools
- Increasing understanding of the role of different agencies and organisations involved.
- Clearer multi-agency arrangements for planning for vulnerable families.

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	9 March 2017
Executive Member / Reporting Officer:	Clare Watson, Director of Commissioning
Subject:	**CHILDREN AND YOUNG PEOPLE'S EMOTIONAL WELLBEING AND MENTAL HEALTH LOCAL TRANSFORMATION PLAN UPDATE**
Report Summary:	The Tameside and Glossop Local Transformation Plan was finalised in October 2015 and assured at the end of 2015/16 through NHS England bespoke process, with a view to align it in 2016/17 with mainstream Clinical Commissioning Group planning and assurances cycles. However, the Government and national public interest surrounding children and young people's Mental Health sees that robust assurance and audit remains in place. Our Local Transformation Plan has been in place for a year and it is required to be refreshed to reflect local progress and further ambitions at the end of 2016. The refresh of the Local Transformation Plans is seen by NSH England as the evidence that progress is being made, that the funding is being spent as intended and will provide evidence on how services are being transformed.
Recommendations:	The Health and Wellbeing Board is recommended to: • Support the approval of the Local Transformation Plan refresh and finance plans for deliverables for 2017- 2020 and the approach set out in this report. • Support aligning Local Transformation Plan with GM approaches where populations and needs require; thus delivering efficiencies. • Note the national context and building national pressures and assurance measures to increase spending on children's and young people's mental health services and ensure the publication of the Local Transformation Plan Update.
Policy Implications:	NHS England has asked CCGs to continue and accelerate intensive work with local partners across the NHS, public health, children's social care, youth justice and education sectors to jointly develop and take forward local plans to transform the local offer to improve children and young people's health and wellbeing.
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 through: • Providing clear pathways • Providing a clear plan of how children's and young people's emotional wellbeing and mental health needs will be met.

- Producing strategy that will provide targeted awareness and improve identification

Financial Implications: **(Authorised by the statutory Section 151 Officer)**	This is connected to the externally funding Local Transformation Plan allocation which is ring-fenced and must be spent in line with the original business case to LPT. If we do not spend in line with the externally approved objectives, the funding would be withdrawn. Therefore, finance support this business case with both the income and associated expenditure covered by the S75 agreement.
Legal Implications: **(Authorised by the Borough Solicitor)**	The report seeks Health and Wellbeing Board support and approval to spend the allocation given to CCG from NHS England for the continued delivery of the Local Transformation Plan on the elements outlined under 8.2 and Table 1: Local Transformation Plan Funding and Recommendation Allocation. Where funding is ring-fenced for a specific purpose, care needs to be taken to ensure any terms and conditions attached to the funding are adhered to.
Risk Management:	By implementing and adhering to the Local Transformation Plan and aligning with Greater Manchester approaches it is expected that there would be an increase in children and young people accessing services, support and treatment.
Access to Information :	The background papers relating to this report can be inspected by contacting: Alan Ford, Commissioning Business Manager for Children, Young People & Families Telephone: 07500 980612 e-mail: alan.ford4@nhs.net

1. BACKGROUND

1.1. Future in Mind was published in March 2015, setting out a series of proposals to implement whole system transformation leading to improved outcomes for children and young people with mental health problems. The report emphasised the need for joined up provision and commissioning. These proposals were endorsed by the Five Year Forward View for Mental Health published earlier this year (February 2016).

1.2. NHS England agreed that access to the new funds for children and young people's mental health announced in the Autumn Statement 2014 and Spring Budget 2015 would follow the development of Local Transformation Plans that were required to describe how the national ambition could be translated and delivered locally.

1.3. Local Transformation Plans for Children and Young People's Mental Health and Wellbeing, led by Clinical Commissioning Groups (CCGs) require active engagement with all stakeholders, need to be transparent and are publicly available. The plans included detail how local areas are using the new resources given to CCGs to deliver extra capacity and capability.

1.4. The Tameside and Glossop Local Transformation Plan was finalised in October 2015 and assured at the end of 2015/16 through NHS England bespoke process, with a view to align in 2016/17 with mainstream CCG planning and assurances cycles. However, the Government and national public interest surrounding children and young people's Mental Health ensures that robust assurance and auditing remains in place; with additional scrutiny from Greater Manchester Health and Social Care Partnership.

2. INTRODUCTION

2.1. The Local Transformation Plans are 'living' documents that need to be refreshed as required and delivered through action plans for the 5 year life span of the programme. In support of this at the start of 2016, CCGs were advised of rising baseline funding for the next five years for implementing Future in Mind and the Five Year Forward View for Mental Health; providing the assurance and confidence for commissioning of increased resources to improve capacity and capability of Local Transformation Plans.

2.2. Our Local Transformation Plan has been in place for a year and it is required to be refreshed to reflect local progress and further ambitions at the end of 2016. The refresh of the Local Transformation Plan is seen by NSH England as the evidence that progress is being made, that the funding is being spent as intended and will provide evidence on how services are being transformed. At the same time Local Transformation Plans should be seen as part of the Sustainability and Transformation Plans.

2.3. A national review by Education Policy Institute's Mental Health Commission of all Local Transformation Plans notes that although our plan was assured there were areas for improvement in relation to Transparency, Governance, Involving Children and Young People and Ambition. In providing the following update on our Local Transformation Plan these areas have been addressed.

3. TRANSPARENCY AND GOVERNANCE

3.1. The Tameside and Glossop Local Transformation Plan 2015-2020, established key baseline information and needs utilising a variety of data (provided by numerous key sources, including Tameside Public Health, Providers and the National Child and Maternal Intelligence Network (ChiMat). Our Workforce development plans have delivered a training ladder for children and young people practitioners, regardless of the setting or employer, which is

hosted by Tameside Safeguarding Children Board. All information from the base line Local Transformation Plan been updated this year where available including workforce establishment, activity and stakeholder feedback. The Local Transformation Plan update and refresh outlines the progress to date along with further challenges and next set of priorities for the current system. In our approach access and waiting times, cross system outcomes measures and inpatient provision from Specialist Commissioners (NSH England) have been analysed. Our approach remains situated within a triangulated methodology applying activity data, outcome findings and needs analysis underpinned by stakeholder feedback. This approach continues to shape our priorities that remain aligned to the government report 'Future in Mind' and the Five Year Forward View for Mental Health.

3.2. To implement our Local Transformation Plan, Tameside and Glossop established a formal management structure with a Transformation Programme Board (Children and Young People's Emotional Wellbeing and Mental Health Board), which meets bi monthly. The board is made up of senior managers across Commissioning, NHS health providers, third sector providers, Action Together, Schools setting, Tameside Metropolitan Borough Council Children's Social Care, Tameside Youth Offending to name a few. The work of the board in delivering the Local Transformation Plan is driven by subgroups that have been created and align with the quadrants and domains of the new model of care - Thrive (Getting Advice, Getting Help, Getting More Help and Getting Risk Support). Governance documentation including terms of reference, risk register, highlight reporting templates, subgroup leads and subgroup priorities are in place. Each subgroup has agreed to a number of overall high level objectives and key tasks within an agreed action plan with timelines (Gantt Charts), which are overseen by the board to manage interdependencies and to ensure that the focus remains on making a real difference for children and young people across Tameside and Glossop.

3.3. Transparency and governance surrounding the refresh of our Local Transformation Plan has been strengthened within the developing alignment of the Greater Manchester Mental Health Strategy. Tameside and Glossop CCG chair the Greater Manchester Future in Minds Delivery group, a consortium of all 12 Greater Manchester CCGs / 10 Local Authorities with representation from the Strategic Clinical Network, NHS England Specialised Commissioning and Public Health.

3.4. Greater Manchester is now working towards a whole system approach to the delivery of mental health and well-being services that support the holistic needs of the individual and their families, living in their communities. This will bring together and draw on all parts of the public sector, focus on community, early intervention and the development of resilience. In this context, it is worth noting that six of the thirty two strategic initiatives identified with the Greater Manchester Mental Health Strategy relate to children and young people. Mental Health has also been identified as a key priority area within the review of Children's Services currently underway across Greater Manchester.

3.5. Tameside and Glossop, in meeting the challenges of these times and those ahead has moved to a Single Commissioning Board, integrating Tameside MBC Local authority Commissioning, Tameside MBC Public Health and Tameside and Glossop Clinical Commissioning Group. The Local Transformation Plan will receive executive oversight from multiple perspectives at a locality level through Single Commissioning Board and the Tameside Health and Wellbeing Board as well as at a Greater Manchester Health and Social Care Partnership level.

4. INVOLVEMENT OF CHILDREN AND YOUNG PEOPLE

4.1. Tameside and Glossop has – and will continue to - undertake a variety of engagement activities with children and young people to inform the development of its Local Transformation Plan. A full chapter of our Local Transformation Plan is dedicated to the

Voice of the Child and provides full details of all engagement activity. Following on and building on the initial Children and Young People review of our Emotional Health and Wellbeing services carried out in 2015 we are developing working relations with Tameside Youth Council / Youth Fora. In this, children and young people have reviewed and developed all priorities going forward; establishing a set of priorities from the voice of the child.

4.2. The voices of local children and young people have provided a set of quality standards, which are seen as the right of any child or young person who maybe experiencing emotional wellbeing and/or mental health issues. The 'I' statements as they have become to be known, are now embedded in children and young people's Emotional Wellbeing and Mental Health services specification Key Performance Indicators and grant agreements across the system.

Figure 1: The Voice of the Child I statements

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.

4.3. More widely, our commissioned services have now embedded and utilised the Experience of Service Questionnaire as one of the core Routine Outcomes Measures that evaluates children and young people and their carer's satisfaction with services. The findings of this are being used to improve services and delivery. The Experience of Service Questionnaire comes in three versions: the parent/carer, the child version for children aged 9-11, and the young person version for children aged 12-18. The application of this Routine Outcome Measure has been embedded within the cross system – and CAMHS – outcome framework.

5. LEVEL OF AMBITION

5.1. As detailed above, our Local Transformation Plan has been structured in line with the five priority areas set out in Future in Minds and the Forward View for Mental Health. By 2020/21, there is an expectation of significant expansion in access to high-quality mental health care for children and young people. At least 70,000 additional children and young people each year nationally will receive evidence-based treatment – representing an

increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions.

5.2. Our ambition 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.

5.3. We are working collectively 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 has, and still, requires us to establish a comprehensive system wide approach to providing support and care and an array of new and/or refreshed seamless pathways.

5.4. Our ambition requires the following aims to be achieved/embedded:

- 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.

5.5. We have learnt that 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 hold 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 multiple levels. As such, to maximise success we are aligning and driving changes at Greater Manchester Level through processes noted earlier.

5.6. This is a five year programme of change and our successes to date should be viewed as the start of a longer planning process with subsequent year on year updated action plans to follow; ensuring a phased approach that addresses not just system changes, but also develops the culture for sustainability and learning.

5.7. Our Local Transformation Plan is extremely ambitious both in its desire to effectively implement the recommendations set out in Future in Mind but also changes the model of care for CAMHS to the Thrive model (see **Appendix A**), fully incorporating universal, community and voluntary sector provision, and also the pace and volume of supporting activity required to make this happen. Our plan includes a mix of redesign, underpinned by the transformational restructure of our specialist Healthy Young Minds (CAMHS) service, and additional investment to increase capacity in specific pathways and services such as Eating Disorders and Neurodevelopmental conditions (Attention Deficit Hyperactivity Disorder and Autism Spectrum Condition). Details of all investment areas are provided in the finance section.

5.8. While last year's nationally mandated priority was for the design, development and delivery of extended specialist Eating Disorder Teams for children and young people (which we have delivered), this year's focus is on ensuring 'Better Crisis Care support'.

6. WHERE ARE WE NOW (NOVEMBER 2016 UPDATE)

6.1. Utilising its local transformation funding, Tameside and Glossop has invested in new early intervention and prevention services as well as expanding capacity within its CAMHS (renamed and branded Healthy Young Minds) service to ensure that children and young people receive the right level of support in a timely manner; aid recovery and prevent escalation to specialist services. Our specialist CAMHS workforce has been uplifted from 23.7 FTE in 2014/15 to 32.5 FTE in 2016/17 (a 37% increase on base line year). Both public and third sector services have been uplifted, providing accessible services in meeting need – an array of new pathways have been developed and implemented for children and young people with mild and moderate mental health issues.

6.2. The Local Transformation Plan has helped to deliver an increase in the number of children and young people receiving high quality treatment. In 2014-15 (baseline) there were 2045 referrals to CAMHS of which 1,184 were accepted. In 2015/16 those referrals accepted by the service had increased to 1,438 – an increase of over 21% more children and young people accessing treatment. Indications for 2016/17 suggest this trend will continue. Although evidence shows more children and young people are now accessing treatment, the reduction in waiting times previously gained, is under threat by the increased numbers accessing treatment. As of the 31 October 2016 only 72.3 % of children and young people were seen within the 12 weeks and 97.9% seen within 18 weeks. Reducing waiting times remains a Local Transformation Plan key priority for 2017 and beyond.

6.3. Tameside and Glossop hold a comprehensive service directory which is updated and maintained by the Getting Help (Coping) Work stream. This includes a wide variety of community and voluntary sector providers who are vital to the delivery of a comprehensive children's and young people's mental health system offer. A mapping exercise of all mental health provision available across Tameside and Glossop has been undertaken and will be shared with GPs so that they are able to effectively signpost children and young people to the most appropriate service. At a Greater Manchester level work is to be undertaken during 2017/18 to identify mental health leads within GP practices that are trained in mental health and well-being.

6.4. We have also invested in the development of a local training ladder and a programme of e-learning and face to face training informed by an initial workforce competency audit. The training ladder will be hosted by Tameside Safeguarding Children's Board from April 2017, where it will have a cross cutting impact on all organisation's and services working with children and young people.

6.5. Healthy Young Minds (CAMHS) has been working to improve the support available between referral and first appointment through the development of a waiting times initiative, which includes embedding Third sector providers within the core offer. In addition a new, user friendly, interactive and informative website has been launched. Work on the website has included reviewing and including a range of applications for young people, self-help information and links to social media such as Twitter. This work has been completed and the new website (http://healthyyoungmindspennine.nhs.uk/) went live in June 2016. The website now has a range of quality assured self-help information, links to local and national resources NHS applications approved by young people.

6.6. Tameside and Glossop was selected in 2016 as a national pilot site by Department for Education and NHS England to test the named CAMHS school link scheme expressed in Future in Minds. Early evidence shows a shift in referrals to CAMHS, with GP referrals reducing and schools direct referrals increasing and the overall number of inappropriate referrals declining. There is still further work to be undertaken with schools to incorporate self-care for non-service users as part of a whole school approach to mental health – and expanding the CAMHS school link to more schools.

6.7. The transformational restructure of our specialist CAMHS service renamed and branded Healthy Young Minds incorporates dedicated resource for School Liaison, Looked after Children, Neurodevelopmental conditions and those children and young people involved in the criminal justice system. In addition there has been the creation a new Community Eating Disorders service that went live on 4 July 2016. As such a large focus of the Local Transformation Plan has been the identification and support of children and young people "at risk" of mental health problems and increasing access to children and young people's mental health services.

6.8. The new innovative Community Eating Disorders Service launched in Tameside and Glossop is being rolled out in a phased approach with the next phases being key deliverables in 2017/18.

6.9. The Community Eating Disorders Service provides dedicated care and support to children and young people (up to their 18th birthday) with an eating disorder. It also offers advice and support to families and carers. The service accepts new referrals for young people aged 16 to 18 years. New referrals for young people under 16 years must be directed to the existing core CAMHS (Healthy Young Minds Service), in the usual way.

6.10 The Community Eating Disorders Service is also being delivered and jointly commissioned by Stockport, Trafford, Oldham, Heywood, Middleton and Rochdale (HMR) and Bury. It is commissioned by the clinical commissioning group in each borough. Rather than being a standalone service, the Community Eating Disorders Service is part of the core community-based CAMHS Healthy Young Minds Service in each borough. The new service is delivered by two teams with dedicated venues:

- South Team: covering Tameside and Glossop, Stockport and Trafford;
- North Team: covering Bury, HMR and Oldham.

6.10. Through the Local Transformation Plan and the work of the board and subgroups the early priorities that were established have been delivered or initiated (*see* ***Appendix B*** *for the initial early Local Transformation Plan 2015-2017 Priorities*). The following provides high level highlights on the developments under the Local Transformation Plan that have been achieved:

- Reviewed access pathways for specialist CAMHS that has led to developing new Mood Disorder, Vulnerable Groups and Conduct Disorder pathways and ways of working;
- Worked with NHS England and the Department for Education to pilot and test the CAMHS school link model - providing training programme within 14 schools and ensuring a named CAMHS practitioner for each of the school that has a mental health lead (champion) within its setting;
- Implemented a children and young people's mental health outcomes framework that has been developed and agreed with the voice of the child ;
- Implemented and developing a cross system outcome reporting framework that enables national benchmarking with other services ;
- Placed accessible expert knowledge of children and young people's mental health across the system; particularly placing them where children and young people are deemed most vulnerable (Looked After Children, Youth Offending);
- Ensured that all GPs have a named CAMHS Consultant to improve communication and access between Primary Care and CAMHS;
- Placed the third sector within the management and delivery of the NHS CAMHS service to enable a joined up offer between statutory and voluntary services;
- Strengthened the Third Sector offer for children and young people's emotional wellbeing and mental health;
- Delivered a new Integrated Parent Infant Mental Health Pathway in line with recent developments including NICE Guidance on Ante and Postnatal Mental Health;

- Established a pathway for families with high needs, such as those within the child protection system and care leavers;
- Delivered a Neurodevelopmental Umbrella pathway for children and young people where there are queries or concerns about difficulties in the following areas: Attention, concentration, impulsivity and hyperactivity (Attention Deficit Hyperactivity Disorder and Autism Spectrum Condition).
- Developed and implemented a children and young people's mental health workforce training ladder for all practitioners working with children and young people, and
- Established a new Community Eating Disorder service that meets new waiting time standards that treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases.

7. 2017 PRIORITIES AND BEYOND

7.1. The NHS Operational Planning and Contracting Guidance 2017-2019 has set out three national mandates for CCGs:

- To increase access to high quality mental health services for an additional 70,000 children and young people per year. As such local transformation plans need to deliver expanding access to children and young people's services by 7% in real terms in each of 2017/18 and 2018/19 (to meet 32% of local need in 2018/19).
- To deliver community eating disorder teams for children and young people to meet access and waiting time standards.
- To increase access to evidence-based specialist perinatal mental health care.

7.2. Going forward we ae committed to the continued rollout and embedding of the Thrive Model for CAMHS across a whole system approach to improving access to information, guidance, advice and high quality treatment. In 2017, the Thrive model (i-Thrive) is to be applied to the whole of Greater Manchester to help deliver improved access and reduced waiting times and help deliver the need efficiencies (more people seen within the resource envelope).

7.3. Our learning in Tameside and Glossop as an early adopter of the Thrive model will be shared with Greater Manchester. In return, the application of Thrive on the large GM population conurbation will help to tackle and support the system wide changes (governance, accountability and information) required to deliver the fidelity of the model and deliver/optimise service and pathway structures.

7.4. In addition to our commitment to the new model of care a multitude of priorities have developed to be taken forward in 2017 (for further details see **Appendix C**).

7.5. As part the mandate to increase access to high quality mental health services for children and young people, CCG are required to commission 24/7 urgent and emergency mental health services that can effectively meet the needs of diverse communities, and ensure submission of data for the baseline audit in 2017.

7.6. ***Crisis Care:*** One of the pillars (strategic golden threads) in the Greater Manchester Mental Health and Wellbeing Strategy is to improve access, which is responsive and holds clear arrangements that connect people to the support they need at the right time. Under this, an early priority has been established to introduce access to 24:7 Mental Health provision and 7 Day Community Provision for children and young people. To deliver this priority, a whole system approach is required that includes bringing together commissioning, simplifies the provider system, includes involvement from the independent and third sector and holds children and young people and those who care for them at the heart of change.

7.7. In addition to the Greater Manchester Strategy the national Five Year Forward View for Mental Health (2016) sets out a number of priorities for change over the next five years, including: Supporting people experiencing a mental health crisis – by 2020/21 expand crisis resolution and home treatment teams to ensure 24:7 community-based mental health crisis response is available.

7.8. Across Greater Manchester it is acknowledged there is a lack of community out of hours, 24:7 crisis care services for children and young people. As such the CCG should align and support the Greater Manchester aim to stabilise 24:7 specialist CAMHS on call and that by January 2018 we will have developed and implemented a 24/7 crisis care support pathway for children and young people providing easy access to services that are responsive and provide appropriate help across all of Greater Manchester.

7.9. The aim of this transformational change is to reduce duplication and make more efficient use of available resources to achieve better outcomes including a vision for integrated leadership, commissioning and delivery. There is a real opportunity to use the collective intelligence, experience and resources across Greater Manchester to develop a crisis care pathway for children and young people that is innovative, accessible and effective supported by extended community provision across 7 days to provide wraparound crisis prevention help.

7.10. To deliver our aim Greater Manchester-wide integrated mental health crisis prevention, assessment and support pathways for children and young people which are available 7 days per week are being developed.

7.11. Work has commenced through the Greater Manchester Children and Young Peoples Mental Health Board to review current provision from a range of perspectives; to scope best practice across the region and beyond; to consult widely with all stakeholders; and to connect with associated transformational processes e.g. GM Crisis Concordat, Mental health Liaison Strategy, Local Transformation Plans, Children's Services review, Youth Justice Review and NHS England CAMHS Tier 4 and Secure Procurement review.

7.12. The next stage is to co-produce and articulate a multi-agency and single system response that maps onto the Thrive model for CAMHS; developing an emotional well-being and mental health service for children, young people and those who care for them that is supported by locality wraparound services and provision that seeks to prevent a journey of escalation and/or increasing severity and complexity. The key principles of the emerging pathway are described below:

- *GETTING ADVICE (COPING*) - Prevention services across localities that are available 7 days a week through accessible range of mediums and in a range of settings.
- *GETTING HELP* - Early Intervention and improved and timely access to support for a young person in distress. Aimed at reducing risk and enhancing early interventions. This evidence based approach will be underpinned by enhanced training and support for multi-agency teams who may be first responders or who are already engaged with the young person.
- *GETTING MORE HELP* - Follow up and prevention of future crises through effective multi agency care planning, improved access to evidence informed interventions and increased delivery of help in community settings including a young person's home.
- *GETTING RISK (INTENSIVE) SUPPORT* – A flexible crisis response with access to risk assessment, advice and support 24:7 from a confident and well trained multi agency workforce with access to appropriate hospital and community based places of safety and/or intensive home treatment teams who can support young people in crisis in their own homes.

7.13. As part of the finance plan outlined in Section 8 there is a need for the Clinical Commissioning Group / Single Commissioning Board to invest and support the Greater

Manchester Crisis Care approach in order to improve health outcomes for young people across our locality and Greater Manchester, which seeks to reduce the requirement for acute and long term care.

7.14. The Greater Manchester offer will be underpinned by current best practice providing a range of options for young people in crisis, meeting their immediate needs effectively. It will reduce the use of A&E as a first response to crises and reduce the use of paediatric wards while awaiting assessment.

7.15. ***Eating Disorders***: Following the successful launch and implementation of the Community Eating Disorder Service, 2017 sees the continued development through phased incremental expansion.

7.16. During phase two the Community Eating Disorder Service plans are to:

- Continue to provide urgent home-based treatment for young people aged under 16 years. This includes interventions such as meal time support.
- Begin to offer enhanced planned home-based treatment for young people aged under 16 years.
- Begin to deliver support sessions and workshops to young people aged 14 years and above – along with their families and carers, where appropriate. This will focus on topics such as body image, self-esteem, parental support, mindfulness and relaxation.
- Offer bespoke training to those who work with or care for young people. This will be done in partnership with national eating disorder charity B-eat
- Establish an eating disorders champion in each borough's core Healthy Young Minds Service. This will enable the Healthy Young Minds Service and Community Eating Disorder Service staff to better work together to support the different needs of young people.
- Continue to develop a central hub for the north team and the south team (see 6.10 above for boroughs covered by each team). The hubs will offer drop-in support sessions, as well as appointments. A number of 'spoke clinics' will also be offered across each borough - throughout Tameside and Glossop.
- Offer seven day triage of new referrals for 16 to 18 year olds.
- Launch the new hubs for the north and south teams (it is hoped that the south hub covering Tameside and Glossop that is located in Stockport will be open January 2017).
- Further develop close working arrangements with a range of support services from the third sector in each borough and further afield.

7.17. ***Perinatal Mental Health Care:*** it is clear that parental mental health prenatally, postnatally and throughout childhood also has a significant impact on a child's outcomes, wellbeing and mental health. An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves.

7.18. Parental mental health is also a significant factor for children entering the care system. Childcare social workers estimate that 50–90% of parents on their caseload have mental health problems, alcohol or substance misuse issues.

7.19. The argument for intervening early and maximising the impact of change in the first 1001 days of a baby's life is a compelling one in light of the significant impact mental health needs have on parents, their children and the wider health and social care economy. Pathways need to be joined up from Perinatal through and into early years (0-5 years). The highly acclaimed Tameside and Glossop Early Attachment Service is recognised across Greater Manchester in providing the community 'blue print' for services that is evidence based.

7.20. Through the Local Transformation Plan the Parent Infant Mental Health pathway has been reviewed in line with recent developments including NICE Guidance on Ante and Postnatal Mental Health and remodel and mapped to Thrive. The service continues to develop through

the Local Transformation Plan with the new Vulnerable Families post, which represents a new formal partnership between Early Attachment Service and Children's Social Care.

7.21. The Vulnerable Families post focuses on Care Leavers as parents or potential parents. The new partnership and the work of the post aims to offer various ports of entry to engage and support care leavers and also manage risk differently, to prevent a 'revolving door' so that Child Protection is not the only response. The initiative involves a combination of (a) offering all care leavers' relationship focused workshops (New Beginnings), (b) specialist inter-agency staff training, and (c) targeted therapeutic support where appropriate. The formal partnership enables sharing expertise and knowledge, to enable to better meet the needs of care leavers and improve their future opportunities in life.

8. 2017-2020 FINANCE PLAN

8.1. The assurance of the Local Transformation Plan has ensured additional money for the CCG to support delivery and redesign of children and young people's mental health provision. The refresh of the Local Transformation Plans – and its publication - is seen by NSH England as the evidence that progress is being made, that the funding is being spent as intended and will provide evidence on how services are being transformed.

8.2. The table below outlines the NHS England funding received by the CCG to assist in the delivery of the Local Transformation Plan and the recommend programme to take forward till 2020.

Table 1: Local Transformation Plan Funding and Recommend Allocation

T&G Local Transformation Plan Funding	2017/18	2018/19	2019/20
NHS Tameside and Glossop CCG Local Transformation Plan Income			
Community Eating Disorders (CED)	141,000		
Local Transformation Funding	418,000		
Total Local Transformation Plan Income	559,000	559,000	559,000
Potential Expenditure			
Core Programme:			
Community Eating Disorders (PCFT)	141,000		
Perinatal Care (Therapeutic Social Worker 1 FTE - EAS / PCFT)	40,000		
Improving Access (Waiting Times Initiative & Vulnerable Groups - 42nd St)	17,500		
Neurodevelopment Umbrella Clinics (Paeds Consultant Clinics - TGICFT)	27,000		
Neurodevelopment Nurse Specialist (AfC B7 Neuro Nurse Specialist - PCFT)	51,575	Continuation of 2017/18 scheme till 31.03.2020	
Neurodevelopment Umbrella Coordinator (AfC B4 - PCFT)	*27,175*		
LAC Psychology (AfC B8a Psychologist - PCFT)	60,237		
LAC MH Post (AfC B6 PCFT)	43,772		
YOS Forensic & Transition (AfC B7 RMN - PCFT)	51,575		
HYM (CAMHS) Neighbourhood Link Post (inc School Link & Training PCFT)	43,772		
Schools CAMHS Link Project Management (Thomas Ashton Schl)	3,393		
CYP/Service User For a (Action Together)	3,000		
GM CAMHS Programmes (GM i-Thrive, GM Crisis Care, GM 24/7 on call)	49,000		
Total Expenditure	**559,000**	**559,000**	**550,000**
Balance	**0**	**0**	**0**

8.3. NHS England recognising the pressures, which are faced by localities in transforming their services, have reviewed and reprioritised spending on nationally-led programmes and identified an additional £25 million which is being made available for CCGs in 2016/17. This further funding is in addition to the already allocated monies to CCGs for children and young people's mental health in 2016/17 – outlined above. It brings forward the expected uplift in baseline funding to meet the published level of new monies in 2017/18 (£170 million) one year early, whilst also providing additional non-recurrent funding to support transformation this year.

8.4. As with all allocations of new money, it is critical that CCGs are able to demonstrate the impact of this investment. It is expected that these funds will support CCGs to accelerate their plans and undertake additional activities this year to drive down average waiting times for treatment, and reduce both backlogs of children and young people on waiting lists and length of stay for those in inpatient care. In order to secure release of the full additional

funding, CCGs will be asked to provide details of how they intend to improve average waiting times for treatment by March 2017. It is also expected that this funding will:

- Support CCGs to continue to invest in training existing staff through the children and young people's IAPT training programme, including sending new staff through the training courses; and
- Accelerate plans to pump-prime crisis, liaison and home treatment interventions suitable for under 18s, with the goal of minimising inappropriate admissions to in-patient, paediatric or adult mental health wards.

8.5. CCGs are free to pool this funding across a wider geography – such as Great Manchester or a cluster of CCGs - to support activity linked to local transformation plans for children and young people's mental health (Local Transformation Plans). Table 2 below outlines the additional non-recurrent funding being received in year 2016/17 in two tranches (end of October 2016 and January 2017) and its recommend allocation.

Table 2: Local Transformation Plan Additional Non-Recurrent in-Year (2016/17) Funding & Recommend Allocation

T&G Additional Non Recurrent Funding	2016/17
NHS Tameside & Glossop CCG additional non recurrent Local Transformation Plan Income	
First Tranche October 2016	
Second Tranche January 2017	
Total Non-Recurrent Income	117,000
Potential Expenditure	
Non Recurrent Programme:	
T&G Local Waiting Times Initiatives	21,000
T&G CYP IAPT	22,500
GM 24/7 specialist CAMHS on-call access (£10.2k per 100,000 pop)	16,000
GM Pump Priming of GM Crisis Care and GM i-Thrive	32,000
GM CYP RAID (6 month pilot)	19,500
GM CAMHS Future In Minds Programme Support	6,000
Total Expenditure	**117,000**

9. IDENTIFIED RISK

9.1. During our year of implementing the Local Transformation Plan the following risks have emerged that need to be continually monitored and mitigated.

- The funding allocation of the Local Transformation Plan beyond 2016/17 will no longer be ring fenced to children's and young people's mental health within the CCG's baseline budget;
- Ongoing capacity to enable transformation and service restructure within our specialist Healthy Young Minds (CAMHS) service and ongoing issues with the provision and accuracy of data, whilst we await the roll out of the new patient record system;
- Ongoing capacity of CCG/Single Commissioning Board officers to drive system wide transformation. These risks will be mitigated through Greater Manchester shared approaches;
- Delays to service implementation due to recruitment difficulties from a limited pool of qualified practitioners;

- Delay in establishing training and engagement for multi-agency practitioners;
- Autonomous commissioning across schools and other agencies not aligning with system model.
- Scale and pace of changes brings challenges in relation to how all partners are kept informed and aware of developments and new pathways.

10. CONCLUSION

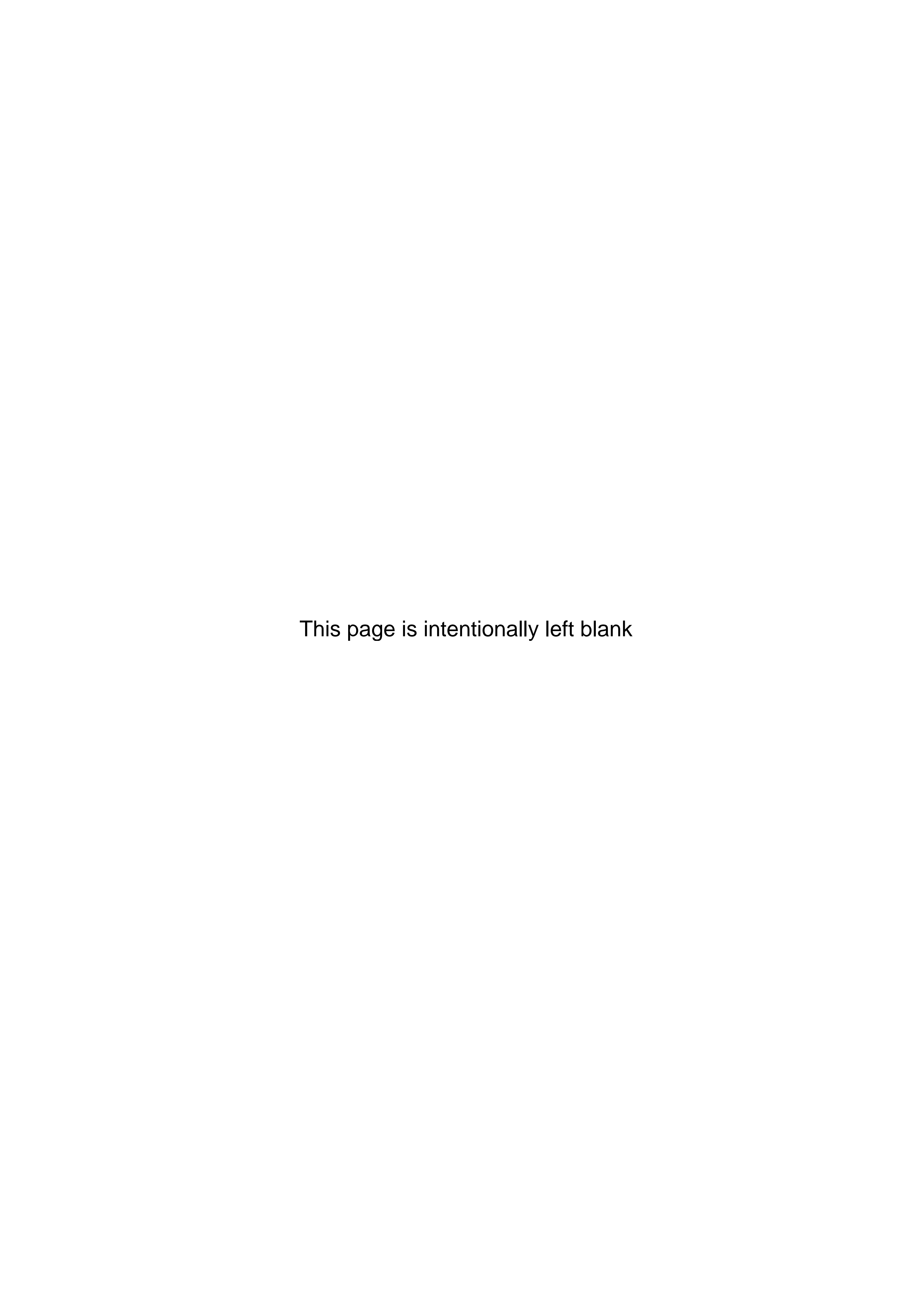
10.1. The substantial work undertaken within the Local Transformation Plan is building strong foundations for the next phase of work and transformation. Mental Health is everyone business and as such it falls beyond the resources of a single provider to effectively meet the emotional wellbeing and mental health needs of children and young people in Tameside and Glossop. Clearly if we are to improve and sustain access to services then this requires more than additional funds alone but rather a new, whole-system approach that includes the active participation of all partners and key stakeholders. We need to promote and deliver a view that Health Young Minds (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, School Nursing, Health Visiting, Youth Offending and third sector provision (to name a few) that is sited and accessible within our neighbourhoods.

10.2. Our aims to improve access and partnership working to bring about a whole system approach to meeting the emotional and mental health needs of children and young people may seem simple, but holds a number inherent challenges. As such our investment and energy should be supported and aligned with Greater Manchester Health and Social Care Partnership (GM devolution, GM Mental Health Strategy, GM Children's Review and GM i-Thrive) to maximise success and assist in mitigating any barriers.

10.3. Finally, it is imperative that the Single Commission function remains committed to delivering the Local Transformation Plan and the recommendations set out in Future in Minds and the implementation of Five Year Forward View for Mental Health and Parity of Esteem.

11. RECOMMENDATIONS

11.1. As set out on the front of the report.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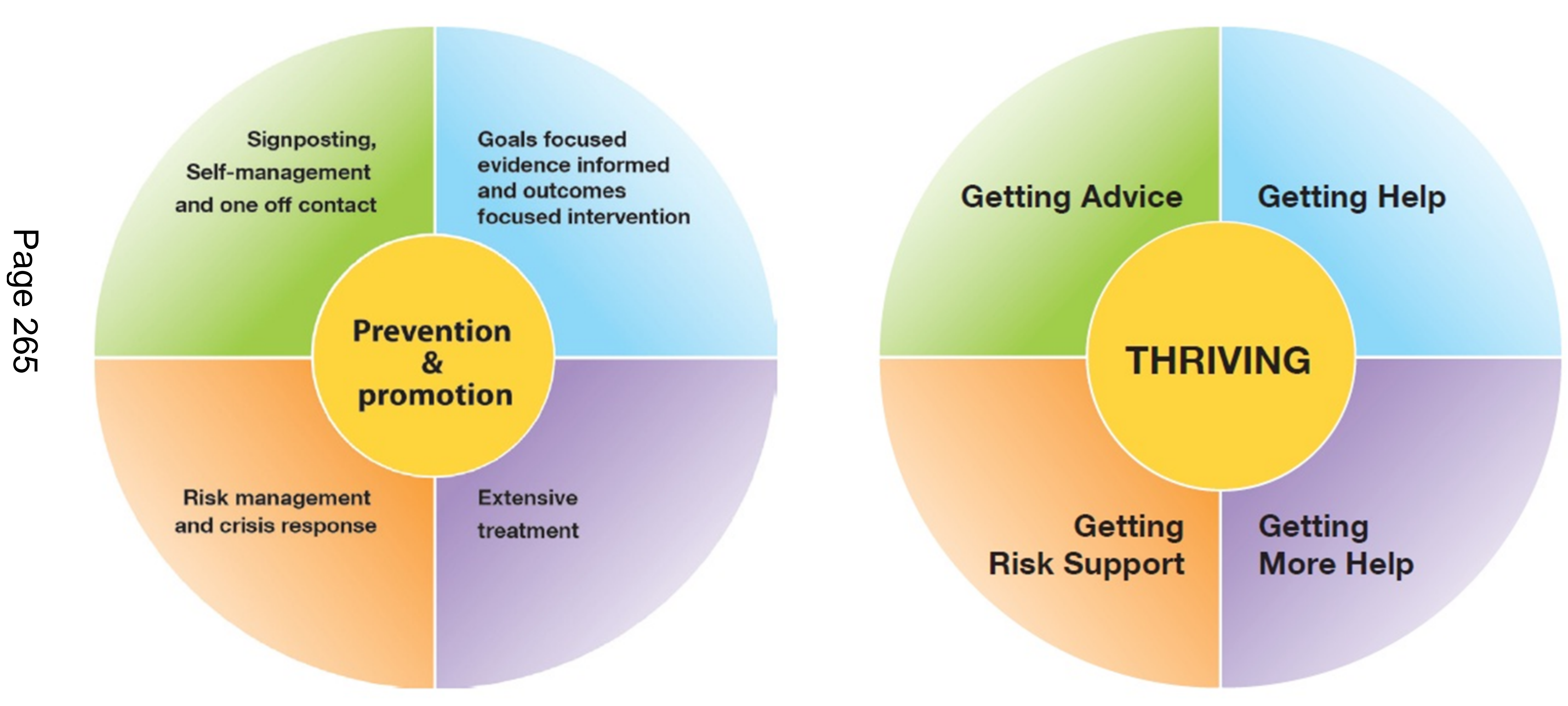
Thrive Model for CAMHS

The Anna Freud Centre and Tavistock and Portman NHS (2014)

The THRIVE model below 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.

The image to the left describes the input that 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.



Each of the four groupings is distinct in terms of:

Needs and/or choices of the individuals within each group6

- Skill mix required to meet these needs
- Dominant metaphor used to describe needs (wellbeing, ill health, support)
- Resources required to meet the needs and/or choices of people in that group
- The groups are not distinguished by severity of need or type of problem.

The middle designation of “thriving” is included to indicate the wider community needs of the population supported by prevention and promotion initiatives

Thrive replaces the tiered model with a conceptualisation of a whole system approach that addresses the key issues outlined above and is aligned to emerging thinking on payment systems, quality improvement and performance management. The framework outlines groups of children and young people, and the sort of support they may need, and tries to draw a clearer distinction between treatment on the one hand and support on the other. It focuses on a wish to build on individual and community strengths wherever possible, and to ensure children, young people and families are active decision makers in the process of choosing the right approach. Rather than an escalator model of increasing severity or complexity, we suggest a framework 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.

Getting Advice: Within this grouping would be children, young people and families adjusting to life circumstances, with mild or temporary difficulties, where the best intervention is within the community with the possible addition of self-support. This group may also include, however, those with chronic, fluctuating or ongoing severe difficulties, for which they are choosing to manage their own health and/or are on the road to recovery.

Getting Help: This grouping comprises those children, young people and families who would benefit from focused, evidence-based treatment, with clear aims, and criteria for assessing whether aims have been achieved. This grouping would include children and young people with difficulties that fell within the remit of NICE guidance but also where it was less clear which NICE guidance would guide practice.

Getting More Help: This grouping comprises those young people and families who would benefit from extensive long-term treatment which may include inpatient care, but may also include extensive outpatient provision.

Getting Risk Support: This grouping comprises those children, young people and families who are currently unable to benefit from evidence-based treatment but remain a significant concern and risk. This group might include children and young people who routinely go into crisis but are not able to make use of help offered, or where help offered has not been able to make a difference; who self-harm; or who have emerging personality disorders or ongoing issues that have not yet responded to treatment.

LTP 2015-2017 Early Priorities

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: - • Review access pathways for specialist CAMHS, benchmarked with other similar partnership area service(s). • 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. • Identify the hard to reach young people and families by locality and collect baseline information on access to specialist CAMHS and benchmark findings • Develop and produce access pathways and a clear, '*understandable'* CAMHS 'local offer' for meeting emotional wellbeing and mental health needs, which includes self-referral • 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). • 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 • Work with NHE England and the Department for Education to pilot and test the named lead approach and the training programme with schools. • We will ensure that all GPs have a named CAMHS Consultant to improve communication and access between primary care and CAMHS • 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 • 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 • Implement local waiting time targets that seek the improvement in access specialist CAMHS services support and treatment • Agree our parenting programme offer, ensuring that we have consistent access to high quality	A, C, D, E, F

	evidence based parenting programmes, delivered to model fidelity	
September 2015 to March 2017	**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 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: - • 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 • 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 • 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 • Scope and ensure that Paediatric and Dietician services are seamless delivered within an integrated Eating Disorders Pathway • 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. • 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 • 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. • 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.	A, B, C, D, E
October 2015 to	**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	A, B, C, D, E

October 2016	chronological birthdates. We aim to:- • Establish an all age Eating Disorder Service, enabling young people to stay on within the same service until they are ready to be discharged. • Establish an all age ADHD service to support CAMHS graduates and families as well as adults. • Review mental health provision for young people aged 16 and 17 and engage young people in the design of options for consideration • 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. • Explore evidence base and options for vulnerable young people to continue within the CAMH service until they are ready to leave. • 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:- • 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. • 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. • 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. • 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. • 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, 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:- • 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 • 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 • Deliver the GM and Lancashire Strategic Clinical Network ADHD standards • 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 • Ensure clear ownership and accountability for the pathway • Review and monitor the effectiveness and impact on resources and ensure provision is sustainable	A, B, C, D, E
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:- • 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 • 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 • Promote access to e-learning and tuition lead courses to all CYP workforces, including volunteers, across Tameside and Glossop; minimising the barriers to access • Develop and implement Self-Harm and Suicide Strategy, guidance for all practitioners across setting supported by training and supervision (action learning model) • Maintain and roll out CYP IAPT from our NHS CAMHS service to all partners, including the third sector	B,C D, F

	and education. • Develop and implement training programme for parents and carers	
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:- • 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 • 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 • 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:- • Review interface between CAMHS community based and CAMHS inpatient services (including secure) • Review interface between CAMHS (PCFT) and Paediatrics (THFT). • Establish interface meetings to ensure effective pathways and joint working between CAMHS and Tameside Hospital emergency department through to the Paediatric ward. • Build effective risk management and early intervention for children and young people at risk of a crisis • Refresh our Crisis Care Concordat to ensure that children and young people are appropriately reflected (see appendix 4 Tameside Template action plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat). • 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. • 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. • 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 • 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. • 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

	• Review CAMHS pathway for Child Sex Exploitation (CSE) and develop action plan based on findings	
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:- • Maintain our commitment to systematically ensuring the voice of the child is heard and acted upon within commissioning arrangements • 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 • Place the Voice of Child statements as KPI's and audit within all service specifications commissioned to deliver emotional wellbeing and mental health service for CYP and those who care for them • Ensure all service specifications (including physical health) highlight emotional wellbeing and mental health requirements of the provider. • Expand the remit and terms of the current Children, Young People's emotional Wellbeing and Mental Health Transformation Programme Board until 2020. • Pilot CAMHS Modelling Tool to support the of improved mental health services for children and young people beyond 2016/17 • Ensure outcome based commissioning is developed and that Routine Outcomes Measure (ROMS) are stipulated within service specifications • Review and consider implementation of online web based IT system to capture and collate data from CAMHS and partners agencies, ensuring business intelligence support form CORC. • 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 • Through the CCG Nursing and Quality Directorate undertake audit and quality visit to PCFT CAMHS and ensuring NICE concordant delivery • 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) • 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	A, B, C, D, E, F

	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

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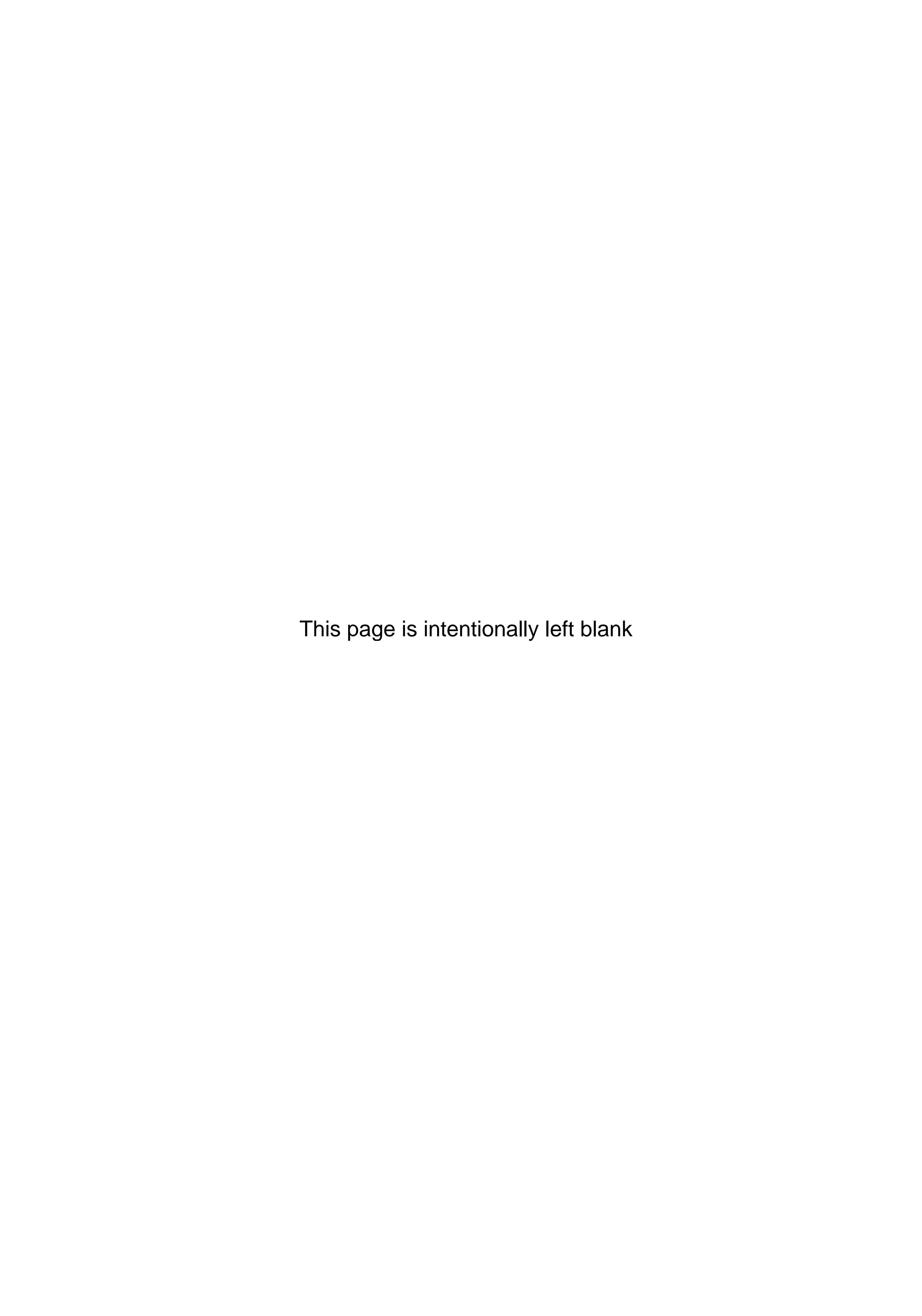
Priority	Thematic	Description Narrative	CYP Rating 0/90	CYP Range 0 -10	Board Rating	Total	Delivery grp
1	Voice of the Child / Schools and Ed	CYP Voice: Training for teachers about mental health to improve PHSE					Education
2	Voice of the Child / Schools and Ed	CYP Voice: Improve Teacher awareness of mental health issues					Education
3	Voice of the Child / Schools and Ed	CYP Voice: Improve awareness across 'whole school'/those working and support pupils that focus on understanding, respect & confidentiality					Education
4	Voice of the Child / Schools and Ed	CYP Voice: Improve Teachers ability to manage CYP are upset, angry, depressed or anxious					Education
5	Voice of the Child / Improving Access	CYP Voice : Raise the profile of those service who are providing mental health support - who can help					Coping/Getting advice
6	Voice of the Child / Improving Access	CYP Voice: Let us know who can help					Coping/Getting advice
7	Voice of the Child / Improving Access	CYP Voice: Help and support for those whilst waiting for treatment - formal support					Getting Help
8	Voice of the Child	Continuation of the engagement of Children, Young People and Families in the co-production of the CAMHS Service to ensure the Voice of the Child is embedded	90.0	10	10	100	LWW
9	Vulnerable Groups/Transition	Continuation of dedicated Youth Offending and Transition post to support those involved in the criminal justice system and post 16 years of age.	89.0	9 - 10	10	99	Getting Help
10	Improving Access	Ensure CYP are seen in the right place at the right time, close to home; and seek to reduce re-referrals.	86.5	9 - 10	10	97	Getting Help
11	Schools / Education	Develop Emotional Wellbeing and Resilience Programme in all Primary Schools	86.5	9 - 10	10	97	Education
12	Vulnerable Groups	Continuation of the dedicated Looked after Children (LAC) HYM/CAMHS provision	86.0	8 - 10	10	96	Getting Help
13	Neurodevelopmental	Vulnerable Groups: Continuation of dedicated Neurodevelopmental (ADHD ASC) additional resources within HYM/CAMHS ADHD and ASD	85.0	7 - 10	10	95	Getting More Help
14	Transition	Ensure seamless transition from Healthy Young Minds to Healthy Minds, CMT - from children's to adult services	84.0	9 - 10	10	94	GM/Cluster
15	Schools / Education	Expand CAMHS school link pilot to all schools across Tameside and Glossop with schools dedicated project support	80.0	8 - 9	10	90	Education
16	Vulnerable Groups	Continuation of the Vulnerable Families Post in Parent Infant Mental Health pathway	79.0	8 - 10	10	89	Getting More Help
17	Vulnerable Groups	Review children and young people from BME communities accessing support and ensure service are proactive	85.0	6 - 10		85	CCG
18	Improving Access	Review and clarify the support and treatment options for Borderline Personality Disorder	72.0	6 - 9.5	10	82	Getting Help
19	Making Better Use of Information	Continuation of cross-system evaluation and monitoring (partnership with CORC/Anna Freud Centre)	73.0	9 - 10	7	80	CCG
20	Vulnerable Groups	Continuation of dedicated vulnerable group work with all C/YP and their carers, to address EWB and mental health problems / issues	70.0	6 - 10	10	80	Getting Help
21	Improving Access / Workforce	Increasing access to timely advice, consultation and training to the children and young people's workforce	69.0	7 - 9	10	79	Getting Help
25	Partnership	Support Third Sector and partnership coordination, ensuring a whole system integrated approach to meeting needs	68.5	7 - 8	9	78	CCG
26	Parents and Carers	Develop and clarify Parent and Carers training and support (Mind Ed)	67.5	6- 10	7	75	CCG
27	Improving Access	Continuation of drop-in/open access support from Third Sector organisations, before during and after treatment.	61.0	5 - 9	9	70	Coping/Getting advice
28	Improving Access	Continuation of support from the Early Help Service and develop Neighbourhood (5) offers to ensure timely support that is close to home	60.0	6 - 9	9	69	Getting Help
29	Improving Access	Evaluate and look to increase clinic sites to improve access to services – where HYM/CAMHS can operate from, to minimise the barriers to engaging and enable better choice and control	81.0	7 - 10			
30	Schools / Education	Expand CAMHS school link pilot to all schools across Tameside and Glossop project support with dedicated HYM (CAMHS) clinical time	80.0	8 - 10			
31	Social Media Group	Ensure promotion of mental health and emotional wellbeing through tackling stigma campaigns, workshops and local events (e.g. World Mental Health Day)	53.0	4.5 - 9			Coping/Getting advice

32	Workforce	Offer and promote training for YOT staff in neurodevelopmental issues and speech and language issues					GM/Cluster
33	Workforce	Ensure Multi-agency ADOS training to increase capacity for ADOS assessments within the Neuro umbrella pathway					
34	Challenging Behaviour	*Funded: Challenging behaviour review and development - pilot project*					
35	GM Approaches	*Mandatory Greater Manchester Crisis Care Pathways*					
36	GM Approaches	*Mandatory Greater Manchester CAMHS 24/7 on call stabilisation*					
37	Crisis Care	*Mandatory/Funded: Ensure clarity within existing resources to deliver CYP MH liaison service*					
38	Eating Disorders	*Mandatory Expansion of new Community Earing disorder service through phased development*					

DO not use
Coping/Getting advice
Getting Help
Getting More Help
Getting Risk support
Other
GM/Cluster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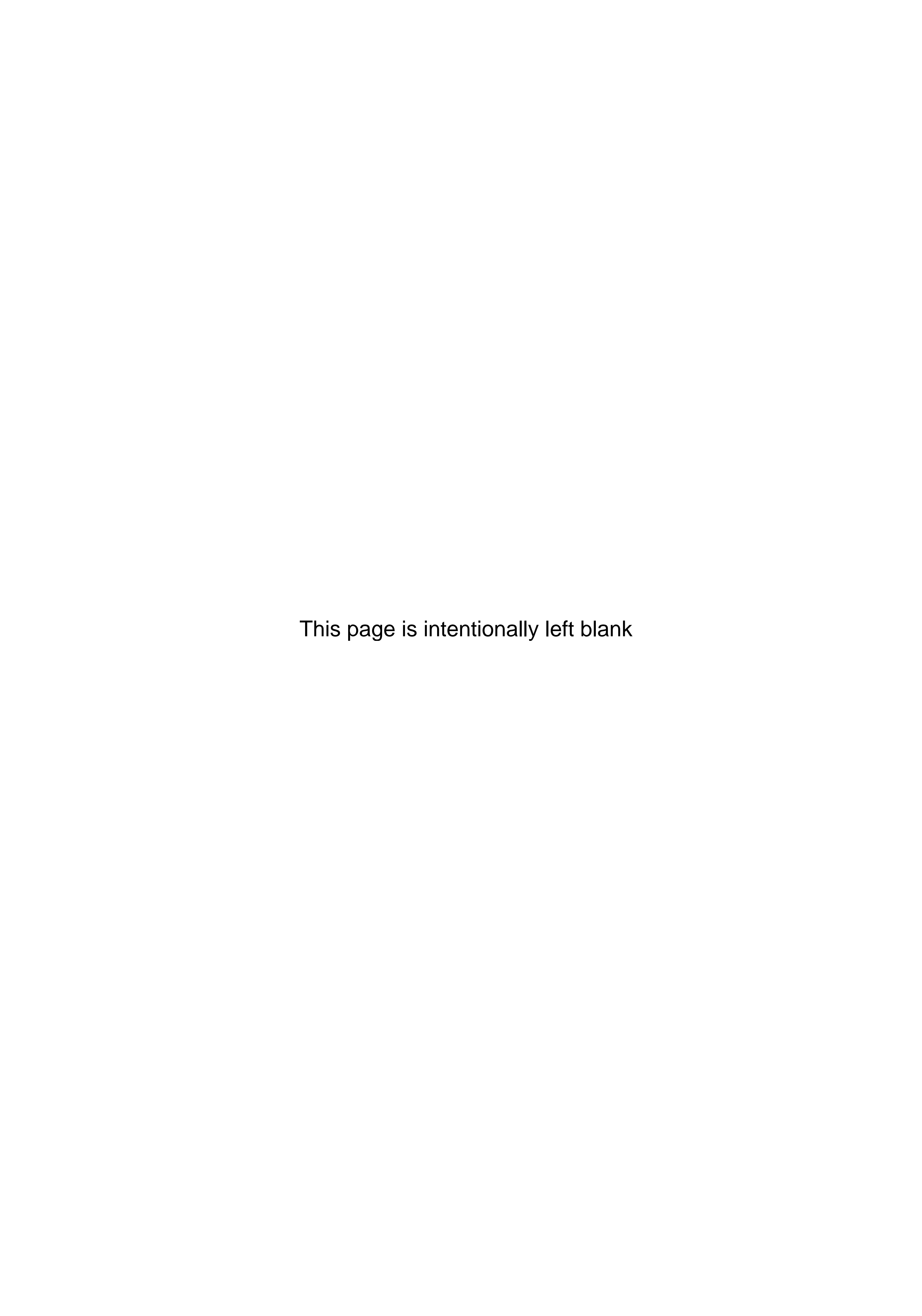
Report to :	**HEALTH AND WELLBEING BOARD**
Date :	9 March 2017
Reporting Officer:	Councillor Brenda Warrington – Executive Member (Adult Social Care and Wellbeing) Andrew Searle – Independent Chair of Tameside Adult Safeguarding Partnership Board
Subject :	**TAMESIDE ADULT SAFEGUARDING PARTNERSHIP ANNUAL REPORT 2015/16**
Report Summary :	This report sets out the activity and strategic work plan of the Safeguarding Board in Tameside and its partner organisations and agencies
Recommendations :	That the Health and Wellbeing Board receive the annual report of the Tameside Adults Safeguarding Partnership Board
Links to Health and Wellbeing Strategy :	Safeguarding vulnerable adults is a fundamentally important issue throughout the Health and Wellbeing Strategy. Priority 3 – Living Well Priority 5 – Ageing Well
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no financial implications arising from this report.
Legal Implications: **(Authorised by the Borough Solicitor)**	The report highlights the strategic direction of the Safeguarding Board and its partners. It is in line with the duties and responsibilities set out in the Care Act 2014. There is a statutory duty for the Safeguarding Board to produce an annual report setting out the work of the Board to improve the outcomes for older people.
Policy Implications :	In compliance with existing policies.
Risk Management :	The Safeguarding Board is required to produce an annual report and would be in breach of the legislative requirement if it failed to do so.
Access to Information :	The background papers relating to this report can be inspected by contacting Pam Gough, Safeguarding Adults Co-ordinator, by: Telephone:0161 342 5229 e-mail: pam.gough@tameside.gov.uk



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Tameside Adult Safeguarding Partnership Board (TASPB)

Annual Report 2015/16

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1 Foreword

As the Independent Chair of Tameside Adult Safeguarding Partnership Board I am pleased to introduce and welcome all readers to the Annual Report for 2015 –16 It provides information regarding the strategic approaches adopted by the partnership and our response to adult abuse and neglect, referred to as 'adult safeguarding'.

The Board has statutory responsibilities, one is to produce this annual report and here it is.

We are also required to develop and have in place a strategic plan, this I can report is the case, we adopted this approach several years ago prior to the statutory requirement to do so. It is referred to at each Board meeting and we have in place sub-groups which ensure the action plan that accompanies it is worked too and the Board has oversight.

A third requirement is to commission Safeguarding Adult Reviews fortunately during this period we have not had to do that, we have a process in place which reviews suspected cases and if there is a need I can give the assurance they would be carried out. We as a Board wish to learn and have a sub group specifically for continual improvement which not only looks at local incidents but also any potential learning from regional and national cases.

It needs to be stressed that Public Service Reforms have impacted on several of our partner organisations during this 12 month period; however, I am pleased to say the level of commitment to adult safeguarding has not diminished. Changes continue an example being; the integration of Health and Social care which I am sure will impact further but let's hope in a positive manner. There has been lots of talk that Health partners and Social Care partners don't work close enough, well here in Tameside there is nothing more certain that integration is here and here to stay and has already started to improve outcomes for individuals. So I am hopeful.

At the centre of everything we do surrounding adult safeguarding has to be the individual. We work to principles of making safeguarding personal and a section follows where this approach is explained in greater detail.

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I have made mention in previous annual reports that adult abuse and neglect is a reality and I do believe that society is recognising this unfortunate fact; we have read some very unfortunate cases in our press and it is no longer a seldom occurrence and our response here in Tameside needs to be appropriate. However, it is not sufficient to accept we are responding in a proper manner we should redouble our personal efforts to reduce the incidents as much as possible and when it occurs have in place, as we do a policy and procedures which gives guidance and ensures robust investigation.

Our work will always be required, I need to stress that safeguarding be it children or adults is everybody's business and if we all recognise that and report matters that gives us concern we give others the opportunity to intervene as earliest as possible.

I take this opportunity to publically thank my fellow board members and the Adult Safeguarding Team from the Council who support the boards continuing work.

Andy Searle
Independent Chair

PS. please remember

"Adult safeguarding needs to be everyone's responsibility".

2 Introduction

This is the second Annual Report of Tameside Adult Safeguarding Partnership Board (TASPB). The report is evidence of the robust Safeguarding Adult Framework in Tameside and TASPB commitment to conclude TASPB strategy 2013 -2016. Organisations represented at TASPB and who have been pro-active in their contribution to Safeguard Adults in Tameside during the last 12 months are:-

Statutory Agencies of the Board

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

Partner Organisations of the Board

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

Elected Members of the Board

- Councillor Brenda Warrington
- Councillor Lynn Travis

TASPB Annual Report 2015-2016 discusses the safeguarding activity in Tameside. The report illustrates the Board and the wider Community response to safeguard adults in Tameside, examining the overall key priorities, challenges and achievements of the last financial year.

3 Safeguarding Adult Activity in Tameside

Continuing to respond to TASPB priority for 2015/16, TASPB have revised the data collection systems. This will ensure IT systems within the Adult Safeguarding Team and Adult Social Care are utilised effectively and data can be retrieved as appropriate for the Annual Return. This has been ongoing work for several years which is near completion. Further work is required in conjunction with Adult Social Care to develop local reports.

Data sets have also been revised this year to respond to the Care Act and Annual reporting requirements. These include the introduction of new categories of abuse and new terminology and definitions referring to Safeguarding Enquiries i.e. Section 42 enquiries and Non – Stat enquiries:-

There are 2 types of safeguarding enquiry:

Section 42 Safeguarding Enquiries;-

The enquiries where an adult meets ALL of the Section 42 criteria. The criteria are:
(a) The adult has needs for care AND support (whether or not the authority is meeting any of those needs)

AND

(b) The adult is experiencing, or is at risk of, abuse or neglect

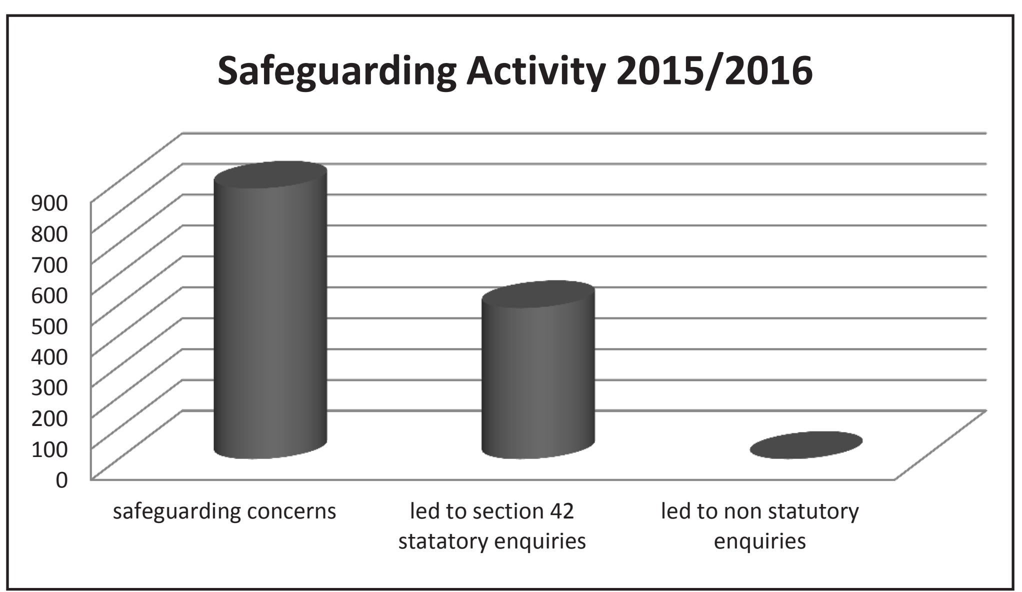
AND

(c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

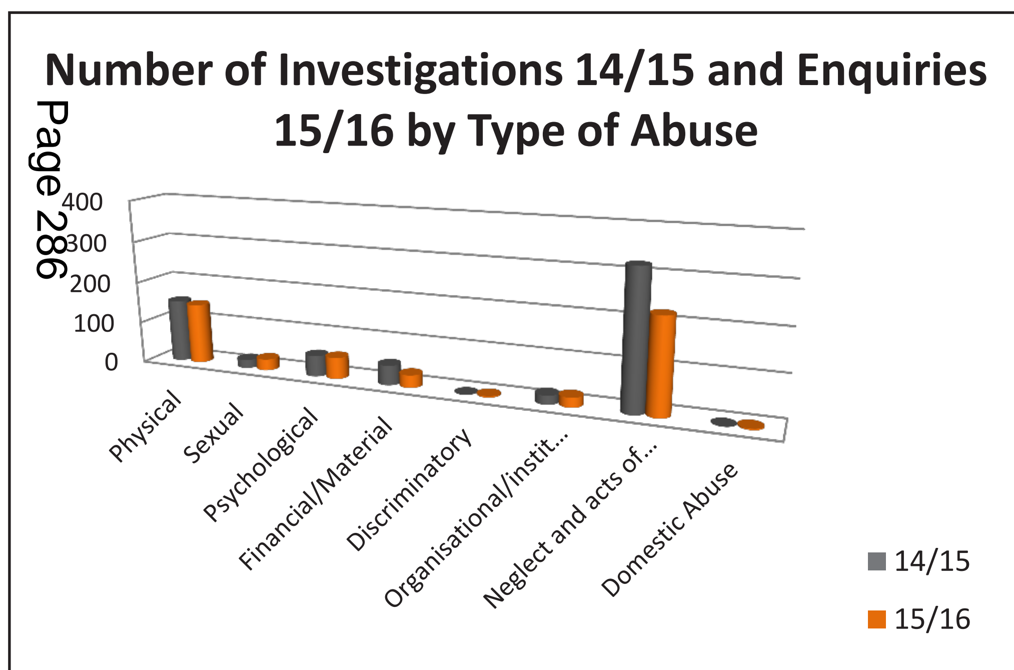
Other Safeguarding Enquiries (non-statutory enquiry)

The enquiries where an adult does not meet all of the Section 42 criteria but the council considers it necessary and proportionate to have a safeguarding enquiry.

Consequently, due to the transition of data and the introduction of the Care Act, resulting in a revised data set, it is a challenge to compare the data collection for 15/16 with previous year's data. This section of the TASPB Annual Report will, therefore, focus mainly on 2015/16 data collection as opposed to the comparator data of previous years. This will provide an analysis of 2015/16 safeguarding activity to inform TASPB to respond to the TASPB Safeguarding Strategy 2016-2019 and their responsibilities in response to the Care Act.



During 2015/16 Tameside Partner Organisations and the Commissioned Organisations in health and social care in Tameside have responded to a total of 878 safeguarding adult concerns. This reflects the activity as in previous years, which provides assurance to TASPB that working in Partnership; Organisations in Tameside continue to ensure Safeguarding Adults is everybody's business.



In Tameside, neglect appears to be more prevalent, than other types of abuse. However, it is evident during the past 12 months, in comparison to 14/15; there is a reduction in the number of enquiries where neglect has been the primary concern. This is an outcome of the work that TASPB undertook to explore and analyse the detail of the enquiries into neglect and understand what actions were being taken to protect adults who are at risk in this context. It became apparent that pressure ulcers and missed care calls contributed to a high proportion of the reasons for raising concerns, furthermore, many of these concerns were unfounded.

TASPB reviewed the approach in these cases to consider the most appropriate and proportionate response. Partner organisations responded, to ensure internal guidance was adhered to, to ensure risk is minimised and safeguarding enquiries avoided.

The outcomes of these actions are also reflected in the outcome of the enquiries. Last financial year 139 enquiries resulted in no action taken as abuse was unsubstantiated. This year 74 enquiries resulted in no action taken as abuse was unsubstantiated.

New categories of reporting adult abuse in the context of Safeguarding Adults have been introduced. These include:-

- Domestic Abuse
- Modern Day Slavery
- Self- neglect
- Sexual Exploitation

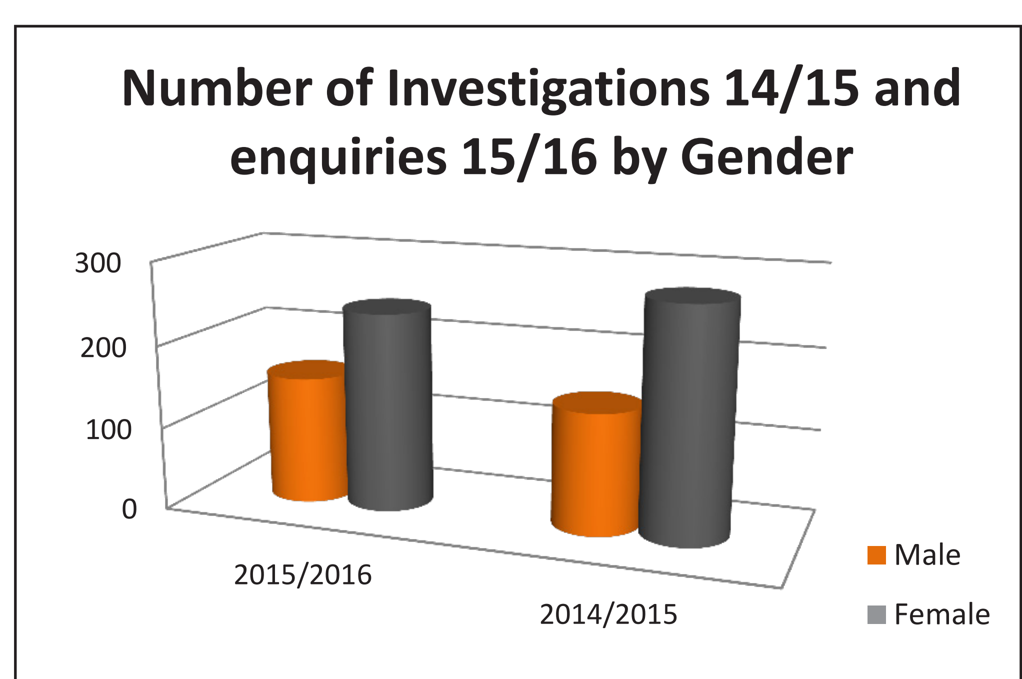
TASPB have responded to 3 Safeguarding adults enquiries of domestic abuse through the TASPB Safeguarding Multi-agency Policy and Procedures during 15/16.

TASPB also work closely with the Public Protection Unit in GMP and the Multi Agency Referral Assessment Conference (MARAC) initiative and it is an expectation that these forums will continue to be the primary response to safeguard individuals who are experiencing Domestic Abuse.

Adults who are in a situation of self-neglect continue to receive support from agencies as appropriate. Safeguarding concerns have been raised but as systems are already in place to respond to these circumstances, further enquiries have not been required, therefore, section 42 enquiries have not been identified. This is a positive approach as it highlights that there is a robust framework in place that evidences the response to safeguard individuals who experience Self Neglect is embedded in practice.

There have been no cases in 2015/16 in Tameside of Adults who meet the safeguarding adult criteria experiencing the abuse of Modern Day Slavery or Sexual Exploitation. However, activity to promote awareness of abuse in this context is ongoing via various forums.

As in previous years there are more Safeguarding enquiries for Females but there are no additional trends to evidence this gender is more at risk than Males. This reporting year has also evidenced a 5% increase of safeguarding concerns for Females and a 5% decrease for Males. TASPB have identified no specific reason for this trend.



During 2015/16 the location of abuse has seen an increase in concerns at the hospital by 5%. However, there are no specific trends and this is a positive indicator highlighting encouraged transparent practice.

As illustrated below the most prevalent location where Safeguarding Enquiries have been undertaken are Care Homes followed by a person's own home. One particular care home in Tameside did generate a number of Safeguarding Adult Enquiries.

The way in which this was promptly addressed via a partnership response to Safeguarding Adults, is evidence that the Safeguarding arrangements are integral to practice in statutory agencies. This episode contributed to the increase in safeguarding in care homes. However, as there are no other specific trends the increase is mainly due to the outcome of the work throughout 2015/16 that TASPB have worked closely with Commissioned Service Providers to adhere to the Safeguarding Policy and Procedures.

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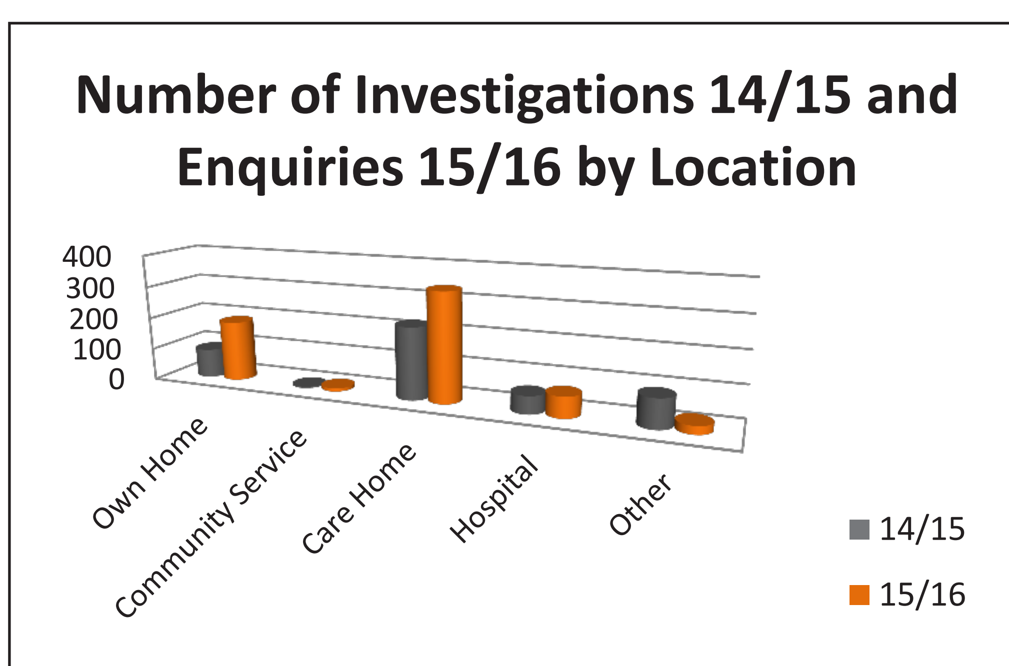
This work has been via a number of forums working in partnership with the Independent Sector:-

- Multi-agency training
- Safeguarding adult Team attendance at Provider Forums and a focus on themed safeguarding adult issues
- Safeguarding Adult Team, TASPB Leads, Single Commissioning meeting with individual Providers to explore challenges to evidencing the safeguarding enquiries and work in partnership to explore solutions.
- Amendment to reporting systems
- Commissioners of Services Providing a six monthly update at TASPB to provide assurance that Commissioners are confident that Providers of Care services in Tameside are demonstrating safe practice



4 Raising Awareness of Safeguarding Adults

TASPB are committed to raising awareness of safeguarding adults. TASPB Continual Improvement Principle meets quarterly to review the progress of the TASPB Training Strategy. The Training strategy is also informed by the TASPB Learning and Accountability Principle Group.

In response to the Care Act and the evaluation of training needs, this financial year, TASPB agreed to delete the Safeguarding Adult Investigator training and introduce Making Safeguarding Personal (MSP) Training. This training is for Practitioners who are or will be involved in Safeguarding Adults Activity across the partner organisations. This also provides an opportunity for further training for those staff requiring refresher training. It also supports TASPB ongoing strategic approach to the MSP agenda.

The initial evaluation of this training indicated Practitioners knowledge increased throughout the session and that it was positively received. Extracts from evaluations include:-

'This course has helped assure me that our organisation provide person centred care in all aspects of our work'

'Course delivery was good knowledge-however would be ideal if the safeguarding paperwork was shown to us. Would like to attend paperwork course'

Safeguarding Adult Managers (SAM) Training continues to be delivered and is in high demand by many of the partner organisations. During 2015/16, TASPB multi agency SAM training has accommodated 60 Safeguarding Adult Managers, providing reassurance to TASPB that the Local Safeguarding Adult Procedures are adhered too by all partner organisations and commissioned agencies.

Evaluations continue to be positive for SAM training and are used to inform the review of the training. Comments from staff attending training include:-

'Very useful training allowing a greater understanding of the SAM role and how the Care Act applies within partner organisations'

'Great course-clearly explained and support offered if needed'

'I have a much clearer understanding of the Policies and Procedures. Will need ongoing support and exposure to feel fully able to take on the role and responsibilities with confidence'

An example of evidence of how the evaluations inform training is the availability of support to complete documents to detail concerns and enquiry activity. This has been via multi-agency Paperwork training sessions. These have been delivered as demand arises and SAM's are encouraged to contact the Safeguarding Adult Team direct for guidance in completing these.

TASPB have continued to develop the links with the Domestic Abuse Strategy in Tameside. Training has also been revised to reflect this and the Tameside Safeguarding Children's Board has included a module on the Domestic Abuse training to reflect the Adult Agenda and how Safeguarding Adults in the context of domestic abuse is interpreted in the Care Act.

TASPB are committed to using resources effectively and promote various models to raise awareness of Adult Abuse. During 2015/16 to enhance the existing training materials adopted in Partner Organisations, e-learning packages for Female Genital Mutilation and Forced Marriage have been shared across TASPB. Although, Tameside have no Safeguarding Adult concerns raised in 15/16 regarding this abuse, Practitioners are pro-active in their response to this abuse. This is evidenced throughout the financial year, in discussions in Safeguarding Adult Manager forums and Workshops.

Following the TASPB Safeguarding Adult Review (SAR) last year, TASPB acknowledged the importance of sharing learning across Partner Organisations. Training to highlight learning outcomes was disseminated via a PowerPoint presentation and a model adopted from Tameside Safeguarding Children's Board (TSCB) to provide a 7 minute brief. This was very well received by Practitioners and was discussed at various forums including Team/Unit Briefings, to ensure operational staff had opportunity for further discussion to aid learning. It is an expectation that the 7 minute brief model will continue to be used to support future learning.

TASPB have sustained the Partnership working to raise awareness of safeguarding adults with the Independent and voluntary sector in Tameside during 2015/16 and continue to build on existing links. This has been evident with the alerters training delivered at Greystones to staff and volunteers at the supported accommodation. In addition Healthwatch Volunteers in Tameside have also participated in alerters training which will enhance their approach to safeguarding activity in their current roles.

5 Safeguarding in Partnership

Partner Organisations in Tameside are pro-active in acknowledging Safeguarding Adults is integral to daily business. Consequently, there are various forums to safeguard Adults who are at risk of abuse.

TASPB have had a particular focus in 2015/16 on the Public Service Hub in Denton. TASPB leads have had the opportunity to learn more about the activity and arrangements to safeguard adults via the hub. Practitioners have also been encouraged to use this resource. Work to establish robust links between the hubs and TASPB will continue during 2016/17.

TASPB Prevention Principle Group has continued to respond to the priority defined in last year's Annual Report of Mapping of Safeguarding Adult Arrangements in Tameside. A directory which identifies all services which assist to Safeguard Adults has been work in progress. It is expected this will be concluded during 2016/17 and available for reference for practitioners.

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TASPB Learning and Accountability Principle Group is represented on behalf of TASPB, by the Statutory Organisations and Pennine. During 2015/16, the outcome of various reviews of present Safeguarding Practice has facilitated the progression of significant work by this principle. This has resulted in the introduction of a file audit tool which is implemented to review cases quarterly. These cases are selected across the partner organisations and the review provides assurance to TASPB that the Safeguarding Policy and Procedures are being adhered to as appropriate. This work has also informed the role of this Principle Group to oversee Safeguarding Plans where complex safeguarding activity has taken place. Implementation of this audit tool is in its infancy and will be reviewed during 2016/17.

Self- Neglect has been a particular area which TASPB have explored via the TASPB Learning and Accountability Principle. Responding to a TASPB priority for 15/16 to develop self-neglect guidance, work is in progress to develop a Multi-agency risk assessment model. This will aid practitioners to respond to the most serious cases of self-neglect in which Adults who have capacity will not consent to support. This will be completed in summer 2016 and reviewed to ensure it is fit for purpose within 6 months of implementation.

TASPB Empowerment Principle Group meets quarterly to progress work to enhance TASPB communication of the Safeguarding Adult Agenda. In summer 2015, the TASPB priority to refresh the TASPB Communication Strategy was completed. This work has continued to aid the promotion of safeguarding adult events across Tameside;-

TASPB started off the year hosting an event within Tameside Hospital to raise awareness of Safeguarding Adults with patients, visitors and staff.

During Dementia Awareness Week May 2015 the Safeguarding Adult's Team worked closely with Public Health travelling across Tameside throughout the week on an information bus, speaking to as many members of the public as possible to raise awareness of both dementia and safeguarding adults.

World Elder Abuse Awareness Day June 15th 2015 was recognised throughout Tameside in a variety of different settings involving people of all ages to raise awareness of adult abuse.

Voluntary and community groups participated focusing their activities around raising awareness of adult abuse and wearing purple. The Cranberries invited the safeguarding adult team to present information on recognising signs and symptoms, how to report and statistics in Tameside.

Events included staff across organisations represented at TASPB wearing purple for the day making a focus on safeguarding adults when speaking with adults throughout the week.

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Throughout the week of WEAAD, there were information stands and displays, coffee mornings and afternoon tea with speakers to raise awareness of adult abuse. Many community groups took part in the safeguarding adult's quiz. Craft groups focussed on the colour purple while hosting discussions around adult abuse.

The week concluded with a purple balloon release at Ryecroft Hall, Audenshaw, supported by the Mayor Vincent Ricci, Cllr Maria Bailey and Cllr Theresa Smith and involving children from Aldwyn Primary School.

Table decoration made by the Cranberries Group

Throughout June to October the Safeguarding Adults Team worked alongside Community services and attended a number of Stay Safe events across all areas of Tameside and within the Black Minority and Ethnic (BME) and deaf communities. The event in the Deaf Community included TASPB British Sign Language (BSL) information DVD being shown and short verbal presentation with an interpreter, detailing statistics of safeguarding activity across England and Tameside, information around TASPB and their function, information about scenarios and a brief overview of procedure in Tameside.

This was followed by a questions and answers session:-

What people said…

"We do not always report it as it happens to us often"

"We didn't realise that so much abuse happened in Tameside and across England"

The DVD in BSL was welcomed by the group and they felt that it was good to see TASPB had considered their needs.

Members of the group said they were pleased to be able to understand some common scenarios and have an insight into what happens and who it happens to and can relate this to everyday life.

TASPB worked alongside Public Health on Older Peoples Day in October 2015 attending an event at Portland Basin Museum being on hand to provide information and answer questions to all those attending.

In February 2015 the Safeguarding Adults Team worked with Health Staff to promote dignity in care. This event was well attended and comments from discussions with the Public included:-

"It's really useful that you are here promoting both dignity and safeguarding and highlighting it especially in a care setting"

"Dignity means different things to different people and often people don't associate it with abuse"

"Sometimes when you become an older person, you become lonely and the information on Silverline is really useful to me"

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Dignity in Care Observational Training is a role that TASPB safeguarding team continue to remain proactive in, contributing to observational visits during 15/16.

These visits involve measuring outcomes regarding Dignity in Care for vulnerable adults to inform the daisy accreditation awards for the relevant establishments.

To enhance the work to raise awareness a short life focus group met to review communication which will inform the work of the Empowerment Principle to deliver TASPB strategy. An outcome of the meeting identified new strap lines to raise awareness of Safeguarding Adults:

- **Abuse can happen anytime, anywhere by anyone!**

- **Recognise it! Report it!**

TASPB Protection and Proportionality Principle Group hosted the annual workshop to assist Practitioners to explore the new categories for recording abuse in the context of safeguarding adults,:-

- Modern Slavery
- Domestic Abuse
- Self-Neglect
- Sexual Exploitation

This event was attended by Safeguarding Adult Managers and TASPB Leads from across the Partner Organisations. It also provided opportunity to promote the work of the Hub. The outcome of the discussions provided assurance to TASPB that there is a consistent approach across the Borough to the Safeguarding Adult Enquiries

TASPB Leadership and Partnership Principle has been instrumental in progressing TASPB strategy to ensure that TASPB is fit for purpose and representation from Organisations remains up to date in the midst of the many organisational changes. In response to local priorities, Public Health and Care Quality Commission have been invited to attend TASPB.

A great deal of effort has been exercised to engage with Housing Providers in Tameside to embrace the Safeguarding Adult Agenda. TASPB lead for Housing Strategy has had a significant role in this project and TASPB will continue to progress this work during 2016/17.

A remaining TASPB priority is the revision of TASPB 3 year strategy to continue to progress the Safeguarding Adult Agenda in Tameside through to 2019. Work to consider the evolvement of TASPB strategic response to Safeguarding Adults is ongoing. The focus is on best use of resources and ensuring that the work of the Board will also inform the Health and Well Being Strategy in conjunction with the Children's Board. It is anticipated that the TASPB revised strategy will be published in the autumn 2016.

6 Making Safeguarding Personal (MSP)

TASPB commitment to ensure that MSP remains a priority is evident in the development of the MSP framework to support the TASPB Safeguarding Adult procedures. The MSP Pilot completed in 14/15 provided the foundation for this work and the best practice agreed by TASPB in response to this agenda has continued to be embedded in practice during 2015/16. This person led approach is promoted as the key driver to progress the Safeguarding Agenda in Tameside.

As appropriate, practitioners are prompted to ensure that consideration is given to the desired outcomes for the Adult at risk and advocates are approached.

Initially, 95% of all outcomes were fully achieved or partially achieved. These outcomes included:-

- removal of perpetrators
- support with finances
- dignity to be maintained
- a full safeguarding enquiry to take place quality of care and reassurance of safety

Safeguarding Adult Managers responded as appropriate to the 5% of cases where outcomes were not achievable, exploring other options to provide support to ensure victims continued to feel safe in the future.

During 15/16, 13, people who had been involved as a victim of abuse or as an advocate agreed to take part in a survey at the end of the safeguarding adult arrangements. These surveys provide an opportunity to discuss their experience of the support provided. The feedback received has been extremely valuable to aid learning and to ensure that both the victim and advocate remain fully supported in feeling safe from abuse in the future.

- 100% of those interviewed stated that they now felt safer as a result of a safeguarding enquiry
- 84% said they felt listened to throughout conversations at meetings during the enquiry
- 69% felt that they received a lot or quite a lot of information regarding the enquiry
- 84% said they are either very happy or quite happy with the way people dealt with the enquiry throughout

Some participants interviewed suggested the enquiry should have been shared with the relative/carer much sooner and details of the safeguarding plan should be given when a conclusion has been reached.

Participants also discussed the high standards demonstrated by staff during the safeguarding enquiry, expressing that Safeguarding Adult Managers were approachable and made the safeguarding arrangements personal to them.

The survey model is proving both helpful for victims, families and staff and TASPB will continue to analyse this data to inform practice in the future. This will also assist in developing this MSP agenda to ensure a person led approach is enhanced and continues.

7 Individual Organisations Updates

Tameside Metropolitan Borough Council – Adult Services

Tameside Metropolitan Borough Council – Housing Strategy

Tameside and Glossop Clinical Commissioning Group (CCG)

Greater Manchester Police (GMP) – Tameside Division

Healthwatch Tameside

Greater Manchester Fire Service – (GMFRS)

Tameside Hospital Foundation Trust (THFT)

Pennine Care Foundation Trust (PCFT)

Tameside Adult Services Annual Report 2015/2016

The Care Act 2014 was finally implemented in April 2015 and with it a number of significant changes in the way that local authority Adult Social Care Departments interact with other key partners when assessing and care planning for the ongoing needs of their citizens.

In Tameside we had been planning for the Act's implementation for a couple of years and had trained all relevant members of staff in all aspects of the changes whilst at the same time using the opportunity to revisit many of our core principles including being person centred and focusing on abilities rather than inabilities to do things.

The Council, together with NHS partners continue to be committed to realigning services to be more community facing with a preventative and early intervention edge to them so that we are able to help and support people much earlier in their care journey before they become dependent and need more complex packages of care.

To give some idea of the type and volume of activity that Tameside Adult Services are involved in we currently work with over 3000 service users and 3000 carers.

Of these people around 1000 people receive homecare form a number of different independent domiciliary care providers across the borough, a further 1500 people are in residential or nursing care homes in Tameside, some being financially supported by the Council and some paying for their care in full. Over 400 people use some form of day service either in specific day centres or as part of older people's day care in care homes. There are nearly 200 people living in Extra Care accommodation and a further 400 living in some form of sheltered accommodation commissioned by the Council.

Tameside Adult Services also supports around 1200 people each year in its reablement service supporting people who are in crisis in their own homes or who are being discharged from hospital or emergency respite care. There are also over 4000 people using the Council's Community Response Service which enables people to remain at home and feel secure in the knowledge that assistive technology is available to alert the Council if people are struggling with aspects of daily living.

Hopefully this gives an idea of the vast array of services that Tameside Adult Services either directly provides or commissions from other providers and also the numbers of people who use those services. People who require ongoing services are identified following a period of assessment or reassessment carried out by social workers and trained assessors.

Safeguarding people who are vulnerable by virtue of their age, infirmity, disability, condition or situation is perhaps the most vital role that practitioners play in Tameside Adult Services. To coin the old phrase safeguarding is everyone's business and this is very much the case within Tameside Council. The Care Act brought new responsibilities and duties to local authorities but in Tameside, the Council and its partners were well ahead of the game. There has been a safeguarding partnership board for adults in the borough for many years and all partners are committed to maintaining its principles. The Board has also had an Independent Chair for many years and he holds partners to account on behalf of the Board.

Together with partners, Adult Services plays a key role in the identification and investigation of possible areas of neglect and abuse. In 2015/16 there were 729 safeguarding concerns regarding individuals which 393 led to s42 enquiry and investigation. Adult Services staff were involved in working with many of the individuals affected by these investigations and supported many through the difficult processes involved.

Adult Services have been particularly, although not exclusively involved in safeguarding investigations across the variety of services provided by the independent sector. Staff from Tameside Council work closely with homecare and care home providers to ensure that they are aware of signs of neglect and abuse and also know what to do if any are identified. We also work alongside colleagues from

Tameside and Glossop Clinical Commissioning Group to hold contracted services to account when safeguarding issues have been identified.

Looking ahead the health and social care economy is becoming more integrated with a clear strategic plan of having a single commissioning function and an integrated care organisation either commissioning or providing all aspects of health and social care in Tameside. This joined up working will ensure that the citizens of Tameside will not only get a more effective and efficient health and social care service but one that will be better placed to identify safeguarding issues and to react with the correct resources from within one organisation.

Paul Dulson
Head of Adult Assessment and Care Management

Housing Strategy

The implementation of relevant parts of the Care Act 2014's Statutory Guidance from April 2015 means that from that date all housing providers and housing support providers will be required to have clear operational policies and procedures in adult safeguarding to ensure that all housing staff are:

- familiar with the six principles underpinning adult safeguarding
- trained in recognising the symptoms of abuse
- vigilant and able to respond to adult safeguarding concerns
- have a senior manager taking a lead role in organisational and inter-agency safeguarding arrangements.

Housing Associations have historically provided accommodation and support to some of the most vulnerable households. However, since 2010, the Sector has needed to adapt to the gradual dismantling of the services that they were once encouraged to provide to their tenants. The Tenants Service Authority, which had previously ensured that the voice and safeguarding of tenants was heard within organisations was one of the first bodies closed down by the then Coalition Government. Instead Housing Associations were required to develop a series of "offers" to tenants, with the financial robustness and quality governance of the organisation apparently taking precedence over the needs of tenants. The sectors regulator, the Homes and Communities Agency, will now only intervene in tenant related matters where there is evidence of "serious detriment" to the wellbeing of the tenant.

It follows therefore, that the right level of engagement between TASPB and our housing association partners is vital to the Boards overall aims and objectives.

Ensuring that the sector is well informed on the agenda and familiar with their responsibilities and changes in relation to this agenda remains critical.

During October and November 2015, the ten largest Housing Associations in terms of dwellings in Tameside were contacted by the Independent Chair of the Tameside Adult Safeguarding Partnership (TASPB). This was to request their participation in a scoping exercise in order to understand if our Housing Association partners were aware of the new their new statutory responsibilities arising from the Care Act which came into force In April 2015.

The responses were encouraging, and TASPB can be re-assured that our locally based housing Associations are locked into the local safeguarding agenda. However, further work is required to improve communications with Safeguarding Leads in Housing Associations operating over multiple geographical boundaries, in order to keep them updated on the current and emerging Safeguarding agenda in Tameside.

Adult Safeguarding and the Private Rented Sector

Engaging with Housing Association partners is generally straight forward as most have a named senior officer for safeguarding. TASPB is well aware that access to social and affordable housing is now far more challenging and inevitably greater numbers of vulnerable people will find their way into the private rented sector.

The private rented sector in Tameside is continuing to expand, increasing by almost 45% between 2001 and 2011 and is now home to just over 13,000 people. It is likely that in many cases the health and well-being of private tenants may not necessarily be the primary concern of their Landlord. Engaging with PRS landlords on this subject will be a priority over the next 12 months. TASPB members are working with the National Landlords Association to promote awareness of the Adult Safeguarding Agenda and to ensure that local landlords are equipped with the right information so that if they are concerned about the health and well-being of any of their tenants, that they know who to contact in the event of concerns around abuse or the neglect of adults.

John Hughes - Housing Strategy Officer

NHS
Tameside and Glossop
Clinical Commissioning Group

Tameside & Glossop Clinical Commissioning Group (CCG)

Tameside & Glossop CCG will become a single commissioning organisation in April 2016. The emerging single commissioning function aims to ensure that safeguarding continues to be at the heart of all commissioning decisions and remains embedded in all aspects of the commissioning cycle.

Patient safety, safeguarding and quality will be at the heart of all our business and the CCG will ensure that safeguarding is embedded within it governance structure and all commissioning activity.

Leadership

The Director of Nursing and Quality leads on safeguarding arrangements and is responsible for ensuring safeguarding is a high priority within all CCG Business. This role is supported by the Deputy Director of Nursing and Quality who is also the Lead Designated Nurse for Safeguarding. Together they have developed and embedded a Safeguarding Commissioning Quality Framework which ensures we commission safe effective services for our population. Further commitment to ensuring effective Adult Safeguarding Leadership is present within the CCG has been demonstrated by the appointment of a Specialist Nurse for Adult Safeguarding and Quality in January 2016.

Partnership

The CCG continues to demonstrate its partnership working by its membership and attendance at Tameside Adult Safeguarding Partnership Board (TSAPB) and the TASPB Sub Groups. The Learning and Accountability Sub Group is Chaired by the Designated Nurse for Safeguarding and attended by the Specialist Nurse for Adult Safeguarding.

Empowerment

In 2015/2016 the CCG's revised and strengthened Quality Improvement Framework was developed this has ensured we have a more rounded and robust whole economy process for communication networks. Mechanisms are in place that enables us to actively listen to our public and ensures we capture their voice. We actively monitor compliments complaints and incidents with our providers and will endeavour to ensure they help influence future quality initiatives and commissioning decisions.

Prevention

The CCG provides Adult Safeguarding training for all staff and ensures that staff working directly with patients in our Individualised Commissioning Teams receives a higher level multi agency training in Adult Safeguarding / Mental Capacity Act and Deprivation of Liberty Safeguards. External training has also been offered to Primary Care in Adult Safeguarding, MCA & DOLS and Prevent.

In 2016/2017 the CCG will revise its training strategy to ensure it aligns with multi agency training strategy and NHS England Intercollegiate Safeguarding Adults Roles and Competencies for Health Staff 2016.

Protection and Proportionality

The CCG works closely with all Statutory and Non Statutory Partners to ensure that multiagency policies and guidelines are implemented to safeguard the public.

Staffs in our Individualised Commissioning Teams are supported through training supervision and leadership from the Designated Nurse and Specialist Nurse in Adult Safeguarding.

Learning and Accountability

The CCG is committed to ensuring it continues to contribute to multiagency working in all statutory investigations and will continue to ensure that lessons learned are cascaded both internally and externally. The CCG will do this by ensuring it provides representation and contribution to all appropriate Safeguarding Adult Enquiries, Safeguarding Adult Reviews, Mental Health Reviews and Domestic Homicide Reviews.

In 2016 the Tameside & Glossop CCG will see the emergence of a stronger more collaborative single commissioning organisation with shared objectives. The CCG will commit to ensure that Adult Safeguarding Leads will continue to have influence and leadership in all aspects of commissioning functions. It will ensure and assure itself that effective safeguarding arrangements are in place to protect adults at risk.

Hazel Chamberlain
Lead Designated Nurse for Safeguarding & Quality

Tracey Hurst
Specialist Nurse Adult Safeguarding & Quality

Greater Manchester Police – Tameside Division

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

The Public Protection Investigation Unit at Tameside continues as the professional lead for Safeguarding. Officers within the PPIU are trained to deal with Child Protection, Domestic Abuse and Vulnerable Adult incidents and investigations.

This ensures we don't miss opportunities to link safeguarding across these areas, especially when dealing with complex cases.

In June 2015 Tameside recorded 264 incidents identifying vulnerable adults, including 98 which involved mental health. In June 2016 this figure rose to 372, of which 122 involved mental health. This highlights both the volume and critical work completed by front-line officers and the PPIU.

It is difficult to ascertain whether this increase represents an increase in the number of calls to the Police or an improvement in identification of vulnerability issues by front-line officers, who have received additional training in the last twelve months.

Much of this extra training has been linked to the Public Service Hub and the Neighbourhood Hub, now based at Hyde Police Station. The latter has focused on vulnerable adult incidents and uses a "live time" multi-agency problem-solving approach in an effort to ensure effective help is given to the most vulnerable callers to the Police and other agencies. In time this should reduce demand by identifying and working with repeat callers to address their problems and improve their quality of life.

The additional training given to Response officers and PCSO's regarding standard-risk domestic abuse incidents was also given the Neighbourhood Officers towards the latter part of 2015 and many also attended a two day Safeguarding course. We are ensuring continuing professional development by providing refresher training beginning in October 2016 on a number of safeguarding topics, including domestic abuse.

Val Hussein PPIU Detective Inspector

Vulnerable Adults Detective Sergeant Zed Ali

Domestic Abuse Detective Sergeant Vicky McKinlay

Healthwatch Tameside

Healthwatch Tameside is the local consumer champion in health and care. Our role is to help the voice of patients, service users, carers and the public to be heard by the people who plan, manage and deliver health and social care services. We do this by listening to people's experiences and by talking to the people who are responsible for local services. We also have an information signposting service and help people who are making a formal complaint about NHS care they have received.

We hear approximately 900 patients or service user's stories a year and have over 50 NHS complaints cases open at any one time.

We play an active role on Tameside's Adult Safeguarding Board and chair the Empowerment Principle working group. This group focuses on how the partnership can help people to understand what safeguarding and adult abuse are.

We have a network of community based, volunteer Healthwatch Champions who have all received training to help them to identify and act on any safeguarding concerns they come across. We also include questions about awareness of adult abuse in many of our surveys and community engagement activities. This helps TASPB to understand how to target future awareness raising campaigns.

We are pleased to attend the full TASPB and to help patients', service users' and carers' experiences to shape the work of the Board and its members.

Peter Denton
Healthwatch Manager

Greater Manchester Fire and Rescue Service

To be Care Act Compliant, TASPB must publish an annual report that must clearly state what members have done to carry out and deliver the objectives and other content of its strategic plan.

Key areas for consideration

GM wide developments regarding Safeguarding Adults

- Identification and continued assimilation of key Care Act recommendations relating to Safeguarding, Transitions and Partnerships into GMFRS training, procedures and practice
- Enhanced focus on "hoarding" with its inclusion in the definition of "self-neglect"
- Refresher training for Designated Safeguarding Officers (Community Safety Manager and Community Safety Team Leader – CSM/CSTL) under the "3 year" best practice guidance
- Introduction of "Brigade wide" monitored Safeguarding E-learning package (including policy, principles, procedures, referral pathways, information exchange protocols and responsibilities)
- Introduction of "Safe and Well" visits to both build on the success of previous Home Safety Checks (HSC) and developed GMFRS's role as a health asset within the developing PSR and Devolution agenda
- Proactive membership of and contribution to Tameside Safeguarding Adults Partnership (TASP) and related groups by CSM on behalf of GMFRS

Specific Care Act Compliance developments

- GMFRS Safeguarding policy regularly reviewed through internal Safeguarding Policy Review Group
- Development and implementation of a specific Hoarding policy to complement the inclusion of hoarding in the Care Act (Self Neglect)
- Safeguarding E-learning package being reviewed in the light of Care Act implications
- Principles of Making Safeguarding Personal (MSP) and Making Every Contact Count (MECC) introduced into engagement and service delivery practice

Adult Safeguarding focus during 2015/2016

- Introduction of "Brigade wide" monitored Safeguarding E-learning package
- Refresher training for Designated Safeguarding Officers (CSM/CSTL) under the "3 year" best practice guidance
- Increased effective and appropriate utilisation of bespoke "in house"

Safeguarding referral mailbox in conjunction with appropriate referral being made directly to ASC/Safeguarding "partners" including "dip sample" based monitoring by DSO

- Embedding principles of Making Safeguarding Personal (MSP) and Making Every Contact Count (MECC)
- Implementation of "Brigade wide" monitored Safeguarding E-learning package with only a small number of staff yet to complete the package

- Embedding a knowledge and understanding of safeguarding issues within the delivery of our Safe and Well interventions
- Organisational recognition of the fundamental role of the DSO
- Engagement with, now statutory, Adult Safeguarding Boards

Internal Governance and quality assurance for safeguarding during 2015/2016

- Reinforcement of the role and function of the GMFRS Safeguarding Policy Review Group
- Introduction of the GMFRS Designated Safeguarding Officers forum
- Monitored E-learning package
- Weekly monitoring of the designated Borough based Safeguarding "mailbox" through which referrals are channelled to partner agencies (CSM/CSTL)
- Monitoring of written records on our PAIROF (Persons at Increased Risk of fire) register (CSM/CSTL)
- Feedback from "partner" agencies regarding referrals made/received and manner in which they have been addressed

Key areas of challenge going forward identified during 2015/2016

- Ensuring Safeguarding remains a fundamental focus as we move into further change in terms of both resources and service delivery
- Managing the capacity/demand dynamic given GMFRS now deal with more individuals with increasingly complex, challenging and chaotic lifestyles and needs
- Enhancing our "Safe and Well" service offer in conjunction with relevant partners and agencies
- Maintaining existing partnership arrangements/agreements given the external pressures on our "partners"
- Identify further opportunities to develop further beneficial partnerships
- Identify further opportunities to work within and influence the "prevention" agenda within the TASP
- Development of appropriate processes to ensure full engagement with the Care Act requirements around "transition" responsibilities as individuals progress from child/young person orientated interventions/support to adult engagement

Internal training and information sharing within the Safeguarding Agenda in addition to the above training detail:-

- GMFRS employs in excess of 2,100 staff in a combination of uniform "front line", Community Safety and "support" staff roles.
- All GMFRS staff, irrespective of role, are required to successful complete the E-learning Safeguarding package referred to above.
- In addition, within Tameside Borough, the CSM and CSTL are accredited and trained as Designated Safeguarding Officers (DSO's) as are other Uniform senior Managers who, between them, fulfil our responsibility to provide 24/7 and hence "out of hours" DSO availability should they be required.
- The DSO training is subject to the same 3 year "best practice" refresher regime as other public sector organisations.
- The current E-learning package is monitored for successful completion and regularly reviewed to ensure its currency and "fitness for purpose".

Martin Barber

Community Safety Manager

Tameside General Hospital Foundation Trust

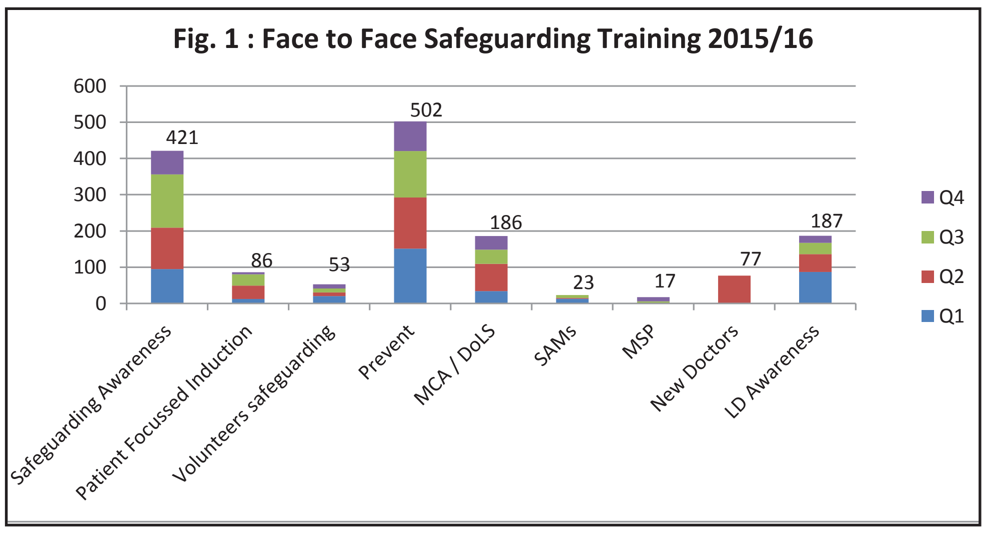
Building on our fast paced journey for the Trust we have, in 2015/16 continued to embed our integrated approach to Safeguarding into day to day practice to create a sustainable infrastructure. The team has also continued to work with our external agencies to promote partnership and collaborative working, through the various TASPB principle groups.

In addition to this, significant work has taken place to prepare for the integration of Community Services in April 2016 to ensure that support structures and systems are fit for purpose, consistent and in place to support the wider ICO work plan. This will result in the full integration of the existing community safeguarding processes and the managerial accountability of the safeguarding practitioner into the Trust adult safeguarding empowerment infrastructure in 2016/7.

Much of the focus has continued to be on the mainstreaming of safeguarding systems introduced over the past 18 month post Keogh to ensure the principles underpinning Making Safeguarding Personal are applied in daily practice, and that patient's personal choice and decision making is at the fore front of our work.

In doing so the Trust has continued to respond to its statutory responsibilities outlined within the Care act and its regulatory CQC requirements to ensure the workforce is skilled and able to be responsive to the additional challenges associated with the safeguarding agenda.

This is reflected in our 96.4% average compliance rating of mandatory safeguarding training and attendance at various face to face safeguarding training events (Fig 1)



In addition to this the Trust introduced a new E - Learning training module for clinical and non-clinical staff to meet its ongoing mandatory requirements. The annual Safeguarding adult's Think tank event which celebrated key improvements and preparations for new challenges was again positively evaluated with contributions from GMP, TASPB, and regional Human Trafficking lead.

A number of improvements were made following the review and reflect process used by the trust to aid continuous learning and improve care delivery following safeguarding incidents. These include links to safeguarding process into the Trust RCA process for Pressure ulcers, the introduction of a Learning disability visual sticker to aid communication and trigger LD processes, introduction of an integrated safeguarding incident reporting system to avoid duplication and ensure real time reporting, development of a flow chart to support staff responding to cases relating to human trafficking/forced marriages.

The Trust continues to work hard in successfully achieving its safeguarding obligations in relation to the wider work associated with deprivation of Liberties safeguards and Prevent, Adults with a Learning Disability. In doing so, we have continued to build upon and ensure sensitive, collaborative methods and where appropriate preventative strategies are embedded with our external partners to safeguard vulnerable adults within the context of the ICO.

This work will continue into 2016/7.

Peter Weller
Director of Quality and Governance

Naz Khadim
Head of adult Safeguarding & Prevent.

Pennine Care NHS Foundation Trust (PCFT)

Tameside Safeguarding Adults Key Areas Annual Statement	
National & Local Developments for Pennine Care NHS Foundation Trust (PCFT) in respect to Safeguarding adults.	On-going appraisal of the restructured safeguarding roles within the organisation. Further review of the role of the Adult Safeguarding Specialist Practitioner for Stockport and Tameside has resulted in this post now being substantive. Continued delivery of the Trusts Safety Improvement Strategy group encompassing 4 patient safety domains with a 3 year plan that proactively seeks to learn from care delivered to patients by systematically reviewing care following investigations of incidents, complaints, and claims. Lessons learned are shared by disseminating information through to the various Trust sub committees, the local borough Clinical Business Units, and via the internal governance structures. This Safety Improvement Plan builds on the Trust's Quality Strategy to improve patient safety and patient experience thus adhering to the safeguarding agenda. The Quality Strategy commits Pennine Care NHS Foundation Trust to improve the quality of patient care that is delivered to our service users, ensuring that it is safe, effective, and patient centred.

Page 308	Establishment of the following Trust sub-committees that will have responsibility within the 4 identified patient safety domains thus ensuring that the Trusts policies reflect national guidance and safe practice: Inpatient Falls Prevention Group Pressure Ulcer Strategy Group (PU policy now complete and on intranet) Tier 4 Group Acute Care Forum Safeguarding Adult and Safeguarding Families Forum. Drugs and Therapeutic Committee In addition the Integrated Strategic Safeguarding Group (ISSG) receives assurance reports from the Divisions and will strategically review the effectiveness and adequacy of both safeguarding and governance controls within the organisation. In addition the Integrated Strategic Safeguarding Group (ISSG) receives assurance reports from the Divisions and will strategically review the effectiveness and adequacy of both safeguarding and governance controls within the organisation.
Developments/ evidence for ensuring a duty of candour is embedded into the culture of your organisation (if applicable)	Changes to the Trust incident reporting requirements have been implemented with a number of alerts circulated to staff to include the following;
Post Winterbourne View related reporting information (if applicable)	Monthly MCA/DOLs and Mental Health Law sessions are delivered to qualified Mental Health staff across PCFT as part of their Core and Essential Skills Training (CEST) with additional sessions commissioned to increase compliance.

Care Act 2014 Compliance Update	On-going appraisal of safeguarding roles within the organisation to include a Named Nurse for MH Child and Adult safeguarding for Stockport and Tameside. Ongoing appraisal of Adult Safeguarding Practitioner role for Stockport and Tameside. Attendees identified at local operational sub groups. A Trust wide survey monkey undertaken Feb/March 2016 identified staff had a good knowledge of escalation procedures in relation to safeguarding adults and yielded a range of topics to further enhance their knowledge of the Care Act. Dates agreed and available via OL&D for the delivery of L2 Adult Safeguarding training for 2016 with bespoke sessions offered to ward areas to ensure continued patient care. Review of the Safeguarding Families Forum to include a wider audience attendance across a range of senior practitioners that embeds elements of the Trust's Safeguarding priorities.

The Adult Safeguarding focus of your organisation throughout 2015/2016.	Delivery of L2 Adult Safeguarding and MCA/DOL's training Continued development and promotion of a combined Child and Adult's safeguarding forum at practitioner level that promotes a Safeguarding "think families" agenda. (Good links established between PCFT adult safeguarding practitioner and TASPB). Further development and critique of safeguarding incidents reported by staff and where PCFT risk department is in the process of designing and populating a safety intelligence board. Part of the data collated will include incidents submitted against Safeguarding across all teams to give assurance that staff are inputting safeguarding incidents alongside any learning from the incidents. Implementation of a joint Safeguarding and Governance action learning set model for the mental health wards to cascade the learning from IR's , DHR's and SCR's. Review of Clinical Supervision policy to include more emphasis on Safeguarding supervision and development of a SOP in this area. Delivery of Care Act briefings at established Nursing, AHP and safeguarding families forums planned for June 2016. Attendance and contribution to all sub groups running. Development of an Adult safeguarding action plan. Development of a Trust Safeguarding training strategy.

The progress your organisation has made in respect of Making Safeguarding Personal throughout 2015/16.	MSP will form part of the Trusts case file audit process. The MSP principle is embedded in the Trusts risk assessment and care planning process which puts patient care and their involvement at the centre of any safeguarding enquiry/investigation.
PCFT organisational achievements in respect of safeguarding adults throughout 2015/2016.	Additional policies revised include Child visiting, Whistleblowing, VIPs Visiting, and Pressure Ulcers. Development of a L2 Adult safeguarding training package which has been shared with TASPB and CCG via the Learning and Accountability sub group and is currently being mapped against the recently published Adult Intercollegiate document. Dates for above agreed and available for booking via OL&D. Trust wide agreed PREVENT protocol written. PREVENT leaflet developed and distributed to all staff. PREVENT training being rolled out and current compliance for Tameside is 88% as of May 2016. Channel Panel arrangements in place and feedback from group as a positive contribution with this client group. Steady increase in training compliance with L1 Adult Safeguarding E learning and current compliance is 95.7% as of May 2016. Approx 400 staff trained across the Trust in L2 Adult safeguarding however not as yet reported by individual boroughs on CEST.

	Steady increase in staff undertaking MCA/DOL's training and commitment from managers to increase compliance figures. Development of Safeguarding consultation form for staff with increase in staff both reporting safeguarding concerns and incidents. All ward areas have safeguarding poster info. Increase in identified Safeguarding Champions on ward/service areas. Completion of an A6 Safeguarding Children, Adults and Families booklet to incorporate Care Act and MSP principles alongside additional child safeguarding straplines to promote a "think families" agenda in safeguarding. To be sent to staff in May wage slips. Development of a safeguarding CQC E board in all wards and service areas. Development of a quarterly Safeguarding newsletter. Development of a Trust Safeguarding Message of the Month via Intranet.
Internal governance and quality arrangements for safeguarding have been over 2015/2016.	Integrated Strategic Safeguarding Group (ISSG) Safeguarding Adults Group Safeguarding families Forum SUI internal and external Safeguard reporting system Patient Safety Investigation Group Integrated Governance groups across all business units. PCFT Trust Quality Group

What internal training/information sharing have you delivered in respect of Safeguarding Adults, MCA & DOLS	The information below is extracted data from the overall Trust Core and Essential Skills Training report (CEST) as of May 2016 for the Tameside borough. Going forward L2 adult safeguarding training will form part of this report 2016/17. **NB: to date approx. 400 staff has received L2 Adult Safeguarding training across the Trust.**

Adult Safeguarding Level 1	Target: 95% 382/399	Actual: 95.7%
Child Safeguarding Level 1	Target: 95% 382/399	Actual: 95.7%
Child Safeguarding Level 2	Target: 85%	Actual: 87.1%
Child Safeguarding Level 3	Target: 85% 21/27	Actual: 77.8%
Prevent	Target: 85% 351/399	88%

8 Summary

As TASPB conclude the work to complete the objectives of the TASPB strategy 2014-16, it is evident that robust foundations are now established in response to the Care Act. Going forward this work will inform the TASPB strategy for 2016-2019.

TASPB commitment to support the revision of the Safeguarding Adult recording systems, to enable an enhanced efficient and effective service to Partner Organisations is close to conclusion. It would appear that this transition has been timely with the changes to the data sets providing a challenge to compare data to previous years. However, the analysis of data for 2015/16 confirms that Safeguarding Adults remains a priority for Partner Organisations and Commissioned Care Services in Tameside.

It is evident that TASPB constantly review the Safeguarding activity, demonstrating a willingness to learn and inform future practice to improve the response to Safeguarding Adults in Tameside.

TASPB acknowledgement of the various Safeguarding Forums ensures a proportionate, person led approach to Safeguarding. This approach also strives to utilise resources effectively, avoiding duplication. However, TASPB also need to consider how all the Safeguarding activity is aggregated and presented to Board.

This is to provide assurance that whichever safeguarding arrangement is applied and Tameside residents will be safeguarded from adult abuse. In addition learning can be gained to inform the development of the Safeguarding Adult Framework in Tameside. This work will also impact on the future reporting of Safeguarding Activity in response to the Care Act. In addition TASPB should be mindful that whilst the Adult Board is moving forward to develop the Safeguarding Adult Arrangements in Tameside this should be in conjunction with other Boards and agencies to ensure that there is transition where agendas cross and learning is shared.

Raising awareness of the safeguarding adult agenda in Tameside is crucial to a successful consistent approach to safeguarding adult enquiries. The review of the training strategy and changes to the training programmes is clearly a positive step for TASPB. Staff appear to embrace the MSP training and continue to welcome the opportunity to attend SAM training. TASPB recognise that it is prudent to utilise various models to raise awareness and it acknowledges that TASPB demonstrate a willingness to learn from evaluations, other agencies and Boards to develop the Safeguarding Adult practice in Tameside. The evaluation of this work should remain a priority throughout 2016/17 to provide assurance to TASPB that awareness of the Safeguarding Adults agenda is integral to business across all partner organisations.

Partnership working is fundamental to ensuring the success of the safeguarding adult agenda. TASPB approach echoes this and the focus of the six key principles via TASPB sub groups enhances this. This model also ensures that all partner organisations, the community and the third sector have an opportunity to contribute to the development of the Safeguarding Adult Agenda. Furthermore this provides a continued focus that ‘safeguarding is everybody’s business’.

It is evident from the Safeguarding Adult Activity in Tameside that Safeguarding is embedded in partner organisations business. This has complemented the initial success of the MSP agenda in Tameside, which has been embraced by staff and welcomed by those who are victims of adult abuse. However, as this work is still in its infancy and will evolve, TASPB should consider the resources that may be required in the future to support this practice in the long term.

The work to date by TASPB and model demonstrated via the principle groups has provided the foundations for TASPB strategy 2016-2019. The focus of a reactive approach to pro-active is evident via all the TASPB Principle Groups.

This is demonstrated with the work to develop the prevention agenda, learn from safeguarding activity to date, empower people to promote safeguarding adults and the requirement to adopt making safeguarding personal practice. At the centre of all this work is Partnership and this is the key component to ensuring that TASPB can deliver against their priorities in 2016-2019;-

- Refresh of TASPB strategy
- Continue to Raise awareness of Safeguarding Adults Agenda
- Review TASPB reporting of safeguarding adult activity and data sets
- Strengthen Partnership working with the Housing Sector and a particular focus will be to develop partnership working with Private Registered Landlords in Tameside
- Develop the Making Safeguarding Personal Agenda
- Develop the Prevention Agenda
- To strengthen partnership working and consider crossover agendas with the Tameside Safeguarding Children's Board

Abuse can happen anytime, anywhere by anyone!

Recognise it! Report it!

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	9 March 2017
Executive Member / Reporting Officer:	Andrew Searle, Chair – Tameside Adult Safeguarding Partnership Board David Niven, Chair – Tameside Safeguarding Children's Board Debbie Watson, Head of Health and Wellbeing
Subject:	**JOINT WORKING PROPOSAL BETWEEN TAMESIDE HEALTH AND WELLBEING BOARD, TAMESIDE ADULT SAFEGUARDING PARTNERSHIP BOARD AND TAMESIDE SAFEGUARDING CHILDRENS BOARD**
Report Summary:	This paper sets out proposed working arrangements between the Health and Wellbeing Board, the Tameside Adult Safeguarding Partnership and the Tameside Safeguarding Children Board, proposing that the relationship develops as a protocol towards aligned priorities and joint strategy.
Recommendations:	The Health and Wellbeing Board is asked: • To endorse and comment on the proposed working arrangements. • To discuss and agree areas of joint priority and work for 2017/18.
Links to Health and Wellbeing Strategy:	Safeguarding is a cross cutting priority in the Health and Wellbeing Strategy.
Policy Implications:	In line with statutory requirements.
Financial Implications: (Authorised by the Section 151 Officer)	There are no direct financial implications arising from this report.
Legal Implications: (Authorised by the Borough Solicitor)	This report sets out a review of the working arrangements between Boards. There is no statutory requirement for joint working arrangements between the Boards. The paper provides an overview of roles and responsibilities of each Board or Partnership and identifies the way in which they will cooperate to ensure there is effective communication and coordination to achieve statutory responsibilities and achieve the best possible outcomes for the residents of Tameside.
Risk Management :	There are no risks associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson, Head of Health and Wellbeing Telephone: 0161 342 3358 e-mail: Debbie.watson@tameside.gov.uk

Stewart Tod, Business Manager TSCB
Telephone: 0161 342 4344
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Pam Gough, Safeguarding Adult Co-ordinator
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1. INTRODUCTION

1.1 In November 2014 a joint working protocol was agreed between the Health and Wellbeing Board (HWB) and Tameside Safeguarding Children's Board (TSCB). This protocol is now due to be reviewed. In response to the Care Act, each local authority has a Safeguarding Adults Board. In Tameside this is the Tameside Adults Safeguarding Partnership Board (TASPB).

1.2 This paper sets out proposed working arrangements between the Health and Wellbeing Board, the Tameside Adult Safeguarding Partnership and the Tameside Safeguarding Children Board, proposing that the relationship develops as a protocol towards aligned priorities and joint strategy.

1.3 The paper provides an overview of roles and responsibilities of each Board or Partnership and identifies the way in which they will cooperate to ensure there is effective communication and coordination to achieve statutory responsibilities and achieve the best possible outcomes for the residents of Tameside.

2. HEALTH AND WELLBEING BOARD

2.1 The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system will work together to improve the health and wellbeing of their local population and reduce health inequalities.

- The Health and Wellbeing Board will assess the needs of the local population and lead the Joint strategic Needs Assessment.
- The Health and Wellbeing Board will produce a Joint Health and Wellbeing Strategy.
- The Health and Wellbeing Board will promote integration and partnership working across a range of sectors (NHS, Clinical Commissioning Groups, Adult Social Care, Housing and Public Health, Children, Young People and Learning, Local Healthwatch).
- Support strategic joint commissioning where appropriate.
- Lead on local health improvements and prevention activity.
- Ensure the patient / public voice is heard and taken into account where relevant.

3. TAMESIDE SAFEGUARDING CHILDREN BOARD

3.1 The role of Tameside Safeguarding Children Board is to coordinate, monitor and support what is done by each person or body represented on the Tameside Safeguarding Children Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority. Tameside Safeguarding Children Board should ensure the effectiveness of what is done by each such person or body for that purpose.

3.2 Tameside Safeguarding Children Board responsibilities as set out in chapter three of Working Together to Safeguard Children (2015) include:
- Developing policies and procedures for safeguarding and promoting the welfare of children;
- Communicating the need to safeguard and promote the welfare of children, raising awareness of good practice and encouraging staff and services to carry out their safeguarding responsibilities to the best of their ability;
- Monitoring and evaluating the effectiveness of what is done by Board partners individually and collectively to safeguard children;
- Participating in the planning of services for children in the area;
- Conducting reviews of serious cases and advising Board partners on the lessons to be learned.

3.3 Tameside Safeguarding Children Board will, through its performance management, auditing and case review activity, identify areas for improvement. It will challenge and support

partners agencies to improve their individual and collective service delivery in relation to safeguarding and help to inform service planning based on identified need.

4. TAMESIDE ADULT SAFEGUARDING PARTNERSHIP BOARD

4.1 The Tameside Adult Safeguarding Partnership Board is a statutory board which works to ensure effective safeguarding arrangements are in place in the commissioning and provision of services to adults at risk by individual agencies and ensures effective interagency working. The Board is responsible for driving developments on adult safeguarding across Tameside.

4.2 The Safeguarding duties apply to an adult who is over 18 and:
- has needs for care and support (whether or not the local authority is meeting any of those needs and;
- is experiencing or at risk of abuse or neglect and;
- as a result of those care and support needs is unable to protect themselves from either the risk or the experience of the abuse or neglect.

5. KEY STRATEGIES/PLANS OF EACH BOARD

5.1 Each of the Boards described above produce a range of plans and strategies as described below.

Health and Wellbeing Board	Tameside Adult Safeguarding Partnership Board	Tameside Safeguarding Children Board
Joint Strategic Needs Assessment – Annual Review Joint Health and Wellbeing Strategy/ Commissioning for Reform Strategy Tameside & Glossop Locality Plan	Safeguarding Adults Strategy TASPB Annual Report	TSCB Strategy & Business Plan TSCB Improvement Plan TSCB Annual Report

5.2 The distinctive roles of the Health and Wellbeing Board, the Tameside Safeguarding Children Board, the Tameside Adult Safeguarding Partnership Board are clearly defined. By working together, each Board / Partnership can make a unique yet complimentary contribution to the others.

6. THE NEED FOR EFFECTIVE COMMUNICATION AND ENGAGEMENT BETWEEN THE BOARDS

6.1 Safeguarding is everyone's business. As such, all key strategic plans, whether they be formulated by individual agencies or by partnership forums, should include safeguarding as a cross-cutting theme. This will ensure that existing strategies and service delivery as well as emerging plans for change and improvement include effective safeguarding arrangements that ensure that all people of Tameside are safe and their wellbeing is protected. The two Safeguarding Boards have a responsibility to scrutinise and challenge these arrangements with the Chairs of the Boards Advisory members of the Health and Wellbeing Board.

6.2 The Commissioning for Reform Strategy is a key commissioning strategy for the delivery of services to children and adults across Tameside and Glossop and so it is critical that in drawing up, delivering and evaluating the strategy there is effective interchange between

the Health and Wellbeing Board and the two Safeguarding Boards. The Health and Wellbeing Board priorities for 2017/18 relate to tackling the wider determinants of health – improving mental health and wellbeing, strengthening communities through asset based approaches, health and housing and improving health to support people into good work.

6.3 The Tameside Safeguarding Children Board Strategic Priorities for 2015-18 are Domestic Abuse, Child Sexual Exploitation, Early Help, Neglect and Self-Harm.

6.4 The Tameside Adult Safeguarding Partnership Board priorities for 2016-19 are to:

- Continue to Raise awareness of Safeguarding Adults Agenda;
- Review Tameside Adult Safeguarding Partnership Board reporting of safeguarding adult activity and data sets;
- Strengthen Partnership working with the Housing Sector and a particular focus will be to develop partnership working with Private Registered Landlords in Tameside;
- Develop the Making Safeguarding Personal Agenda;
- Develop the Prevention Agenda
- To strengthen partnership working and consider crossover agendas with the Tameside Safeguarding Children Board.

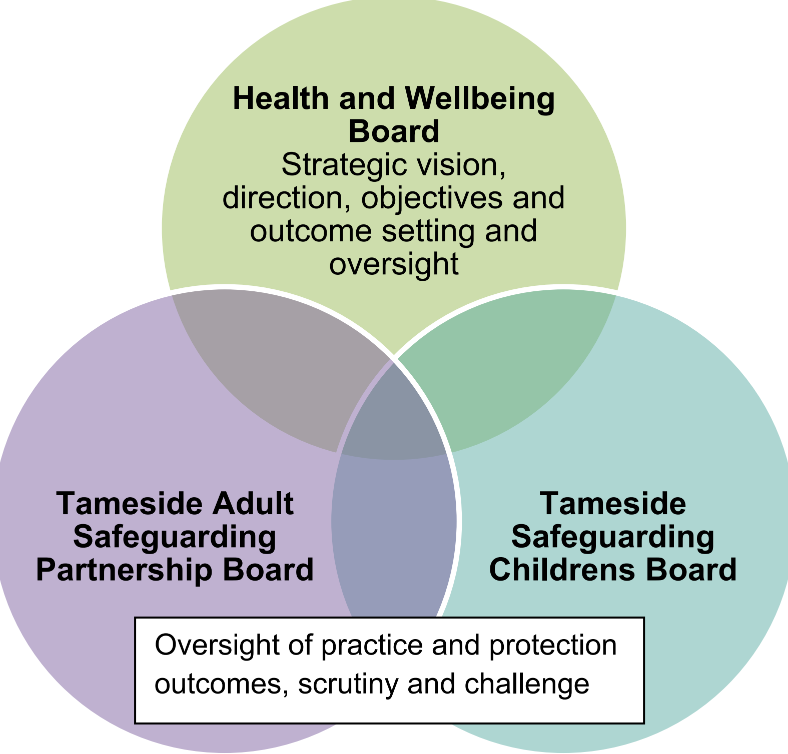
6.5 There is lots of scope for joint work between the Health and Well Being Board, Tameside Safeguarding Children Board and the Tameside Adult Safeguarding Partnership Board for example in relation to work on the Sexual Health/ Sexual Exploitation, Mental Health, domestic abuse and in relation to addressing poverty. The Board is asked to discuss one or two joint areas where all three Boards can work together to improve outcomes for people in Tameside.

7. PROPOSED WORKING ARRANGEMENTS

- A joint Safeguarding Strategy/action plan will be developed for 2017/18 with leads from each Board working together on agreed joint priorities.
- Where new plans are being developed, or reviewed each of the above Boards / Partnerships will ensure that there is a mechanism to consult with the other Board / Partnerships to seek their views. This is important to ensure multi-agency support for priorities and actions.
- All Boards / Partnerships will contribute to the development of the Joint Strategic Needs Assessment as relevant to ensure the information remains up to date and reflective of the needs of the residents of Tameside.
- The Health and Wellbeing Board will lead the development of the Health and Wellbeing Strategy through the implementation of the Commissioning for Reform Strategy. The Strategy will be shared with the other Boards / Partnerships to ensure consistent awareness and support on relevant priorities and actions.
- The Tameside Safeguarding Children Board is required to complete an annual report and will present the report to the Health and Wellbeing Board and the Tameside Adult Safeguarding Partnership Board. This will enable effective sharing of good practice, and to identify any safeguarding issues that require attention from one of the Boards / Partnerships. If recommendations are made regarding a specific Board / Partnership a response to those recommendations from the relevant Board will be expected.
- The Tameside Safeguarding Children Board will produce a Business Plan and will share the key priorities with the other Boards / Partnerships.
- The Tameside Adult Safeguarding Partnership Board will produce an annual report and will share this with the other Boards / Partnerships. If recommendations are made regarding a specific Board / Partnership a response to those recommendations from the relevant Board will be expected.
- Members of all Boards / Partnerships will ensure messages and information about keeping adults and children safe are disseminated within partner organisations.
- Ensuring that there is cross-Board representation to secure on-going communication.

- Cross Board scrutiny and challenge and ''holding to account'': the Health and Wellbeing Board for embedding safeguarding, and the Safeguarding Boards for overall performance and contribution to the Health and Wellbeing Strategy/ Commissioning for Reform Strategy.
- In October / November 2017 the three Boards will meet in a Board to Board to Board development session. The members of the three Boards shall take responsibility to ensure safeguarding action taken by one body does not duplicate that taken by another.
- Ensuring safeguarding is "everyone's business" will be reflected in the public health agenda and related health and social care commissioning strategies.

7.1 This proposed working arrangements will be reviewed annually to ensure it remains up to date with changing policy and legislation. The diagram below is intended to summarise the relationships set out in this proposal.



8. RECOMMENDATIONS

8.1 As set out on the front sheet of this report.

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	9 March 2017
Executive Member / Reporting Officer:	Ben Gilchrist, Deputy Chief Executive, Action Together Chris Easton, Head of Strategy Development, Tameside and Glossop Integrated Care NHS Foundation Trust
Subject:	**INTRODUCTION TO THE REALISING THE VALUE PROGRAMME AND EVIDENCE**
Report Summary:	This report outlines the Realising the Value (www.realisingthevalue.org) programme's 18-months of work to build the evidence base about person-and community-centred approaches to health and wellbeing. This work was commissioned by NHS England to support delivery of the NHS Five Year Forward View and the recognition that new ways of working with people and communities are needed to address current challenges. The work shows how to make a reality of the vision for a 'new relationship with people and communities' which is a central focus of Greater Manchester and Tameside and Glossop strategic approaches. Realising the Value's final report concludes that person- and community- centred approaches are pivotal to improving health and wellbeing outcomes during financially restrained times. Practical tools, recommendations and economic modelling have now been published to show how such approaches can be successfully implemented. This provides timely and important evidence for health and care system leaders, commissioners and front-line professionals.
Recommendations:	It is recommended that the Health and Wellbeing Board take note of the tools and modelling produced by this programme of work and: • Share these materials with other leaders and professionals especially those with commissioning responsibilities. • Support, especially through Care Together, the role for the voluntary and community sector, volunteering and social action in enabling person centred, community focussed care and health as central improving outcomes for people with care and health needs. • Champion that 'value' in health and care continue to be redefined according to what matters to people, rather than the system. • Help to develop a health and care workforce skilled and knowledgeable in these approaches • Provide sustained and coordinated leadership to ensure these approaches are embedded into mainstream change. • Maintain the clear priority and focus on this area of work for the Health and Wellbeing Board especially through the implementation and further development of Care Together.

Links to Health and Wellbeing Strategy:	This work has cross cutting relevance to the Health and Wellbeing strategy but in particular the focus on asset based community development, voluntary sector involvement and support for person-and community-centred approaches.
Policy Implications:	This work and evidence should contribute to the development of: - The Health and Wellbeing Strategy; - Health and Wellbeing Board priorities; - Commissioning strategies and plans; - Care Together implementation.
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no financial implications arising from this report – report for information only.
Legal Implications: **(Authorised by the Borough Solicitor)**	Good governance is achieved in part through effective evidence based decision making. This report helps to achieve this and implement the parties strategies.
Risk Management :	There are no risks associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Ben Gilchrist, Deputy Chief Executive, Action Together, by: Telephone 0161 339 2345 e-mail: ben.gilchrist@actiontogether.org.uk

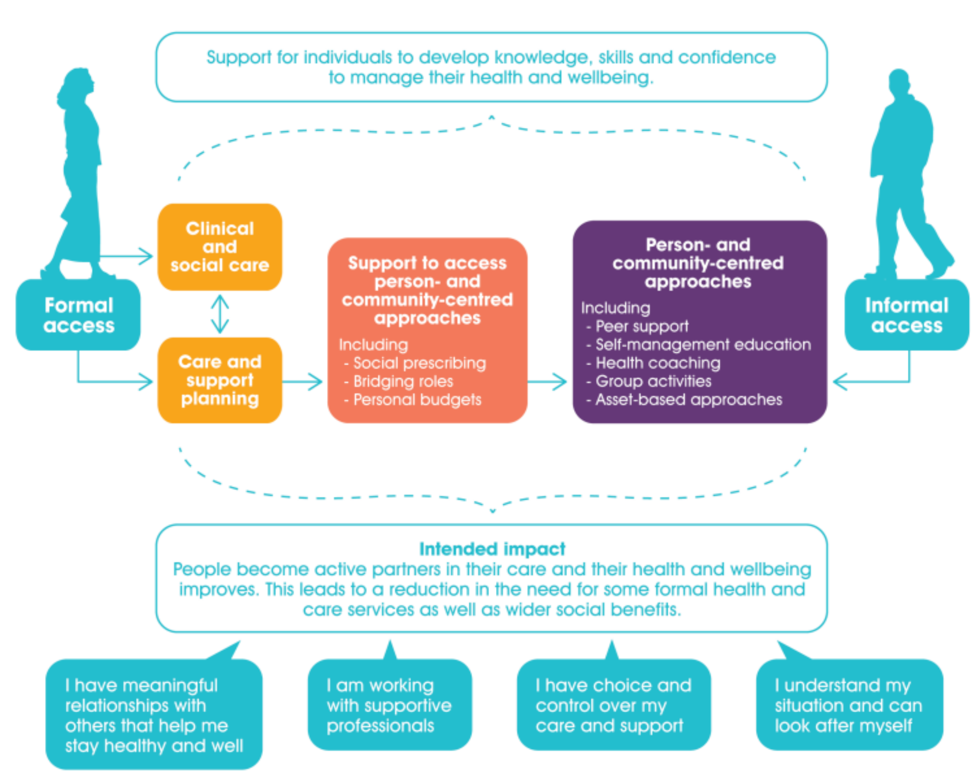
1. AN INTRODUCTION TO THE REALISING THE VALUE PROGRAMME AND EVIDENCE

1.1 This paper outlines the Realising the Value (www.realisingthevalue.org) programme's 18-months of work to build the evidence base about person-and community-centred approaches to health and wellbeing. This work was carried out with local partner sites who are delivering these approaches on the ground, many of whom have sister organisations carrying out such work in Tameside and Glossop. The *Realising the Value* programme was funded by NHS England and led by Nesta and the Health Foundation, working in partnership with NAVCA (Action Together's parent body), National Voices, Regional Voices, Volunteering Matters, the Behavioural Insights Team, the Institute of Health and Society at Newcastle University, and PPL.

1.2 This work was commissioned by NHS England to support delivery of the NHS Five Year Forward View, which recognises that new ways of working with people and communities are needed to address current challenges – such as more people living with long-term conditions, and an ageing population. The work shows how to make a reality of the vision for a 'new relationship with people and communities' set out in the Five Year Forward View and which is a central focus of Greater Manchester and Tameside and Glossop strategic approaches.

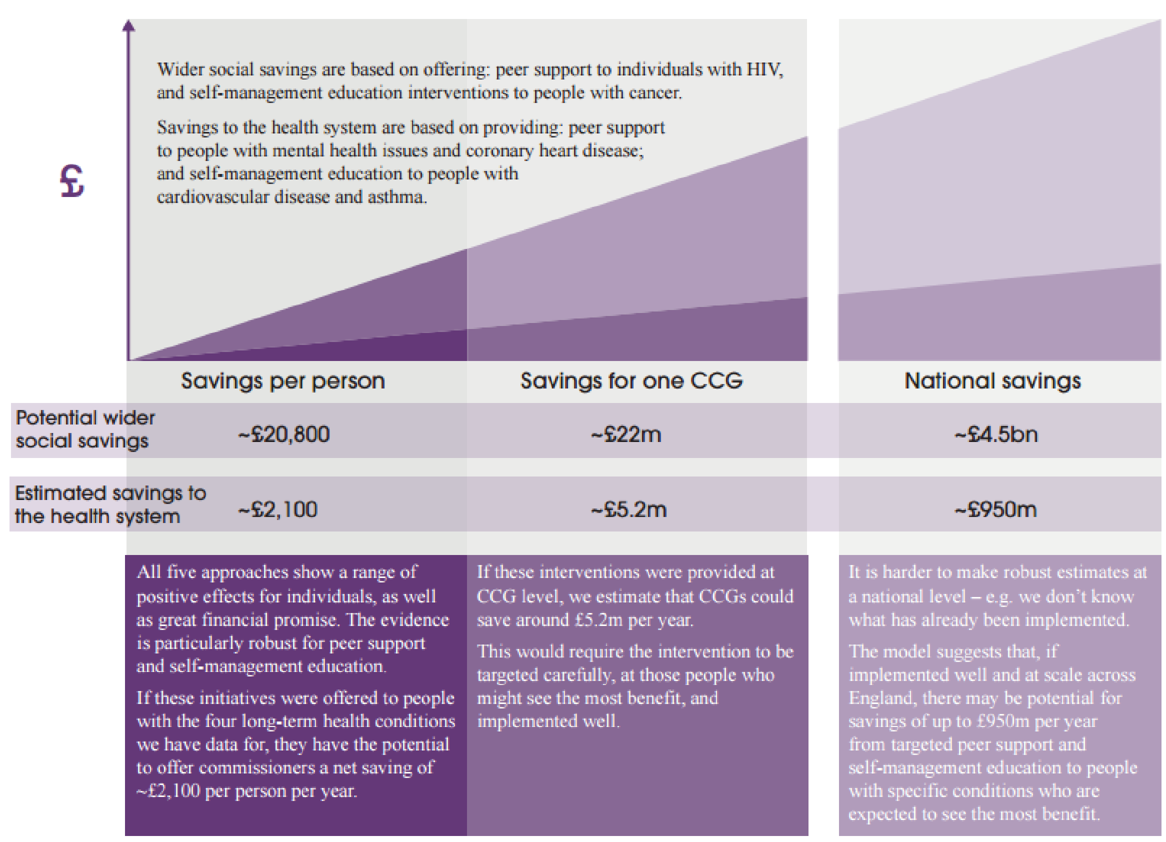
1.3 Realising the Value's final report concludes that person- and community-centred approaches are pivotal to improving health and wellbeing outcomes during financially restrained times. A thorough analysis was conducted of the evidence for person-centred and community-centred approaches for health and wellbeing, working with five frontline sites across England. Practical tools, recommendations and economic modelling have now been published to show how such approaches can be successfully implemented. This provides timely and important evidence for health and care system leaders, commissioners and front-line professionals.

Figure 2: An illustrative person- and community-centred model



1.4 Person and community-centred approaches entail focusing care around the priorities and motivations of individuals and the programme's evidence shows that this can improve health and wellbeing, reduce demand on services, and create wider social value, such as supporting people to get back to work or education. A whole system view was taken to increase understanding of how person- and community centred approaches add value, and of what works to embed and spread them in practice.

Figure 4: Estimated annual net savings from implementing targeted peer support and self-management education



	Savings per person	Savings for one CCG	National savings
Potential wider social savings	~£20,800	~£22m	~£4.5bn
Estimated savings to the health system	~£2,100	~£5.2m	~£950m
	All five approaches show a range of positive effects for individuals, as well as great financial promise. The evidence is particularly robust for peer support and self-management education. If these initiatives were offered to people with the four long-term health conditions we have data for, they have the potential to offer commissioners a net saving of ~£2,100 per person per year.	If these interventions were provided at CCG level, we estimate that CCGs could save around £5.2m per year. This would require the intervention to be targeted carefully, at those people who might see the most benefit, and implemented well.	It is harder to make robust estimates at a national level – e.g. we don't know what has already been implemented. The model suggests that, if implemented well and at scale across England, there may be potential for savings of up to £950m per year from targeted peer support and self-management education to people with specific conditions who are expected to see the most benefit.

1.5 Five different methods were explored in depth to assess their effectiveness, impact on patients, and wider benefits:

- peer support;
- self-management education;
- health coaching;
- group activities to support health and wellbeing;
- asset-based approaches.

1.6 Five voluntary, community and social enterprise sector organisations from around the country contributed their experience and insight. A key finding from the programme is that to move from intent to action, there needs to be a step change in ambition, leadership and commitment from across the system.

1.7 Realising the Value provides ten major actions (see below) to shift the system and put people and communities at the heart of health and wellbeing, along with a range of wider recommendations for system leaders and a set of practical resources. The actions include making best use of available tools, evidence, legislation and regulation to implement person and community centred ways of working across the system. The programme also calls for action to support people to work differently by developing strong networks and enabling

health and care professionals and the wider workforce to understand and work in person- and community-centred ways.

1.8 These actions hold potential to enable health and care system leaders, commissioners, practitioners and voluntary and community sector organisations to make changes that put people, families and communities at the centre of decision-making about their health and wellbeing.

1.9 **Key calls to action**

What needs to happen:

- Implement person and community-centred ways of working across the system, using the best available tools and evidence;
- Develop a single, simplified outcomes framework across health and care and community provision, focused on what matters to people;
- Continue to learn by doing, alongside further research;
- Make better use of existing levers such as legislation, regulation and accountability;
- Trial new outcomes-based payment mechanisms to support person and community-centred approaches, and implement these as part of wider national payment reform.

How people need to work differently:

- Enable health and care professionals and the wider workforce to understand and work in person and community-centred ways;
- Develop strong and sustained networks as an integral part of implementing and scaling up person and community-centred approaches;
- Value the role of people and communities in their health and wellbeing, including through co-production, volunteering and social movements for health.
- Make greater use of behavioural insights in implementing person and community-centred approaches and spreading change;
- Support a thriving and sustainable voluntary, community and social enterprise sector, working alongside people, families, communities and the health and care system.

1.10 The resources from the programme include:

- A guide with practical tips on designing, embedding and spreading the five person- and community-centred approaches to maximise their impact;
- An economic modelling tool for commissioners, which builds understanding of how person- and community-centred approaches can support health and wellbeing in local populations, estimates potential savings and wider social benefits, and helps to build the business case and to support investment decisions;
- A new articulation of value that focuses on what matters to people and communities. This includes a series of calls to action including the need to build a consensus on developing a single simplified outcomes framework, focused on what matters to people.
- A report on system levers setting out the role of national bodies in supporting the implementation and spread of person- and community-centred approaches;

2. CONCLUSIONS

2.1 It is well recognised that there is an urgent need to design a sustainable health and care system and that one of the major ways of achieving this will be through enabling people to live better with health conditions. This work has clearly set out that the best way to do this is by putting people and communities at the heart of health and wellbeing – so that they feel in control, valued, motivated and supported.

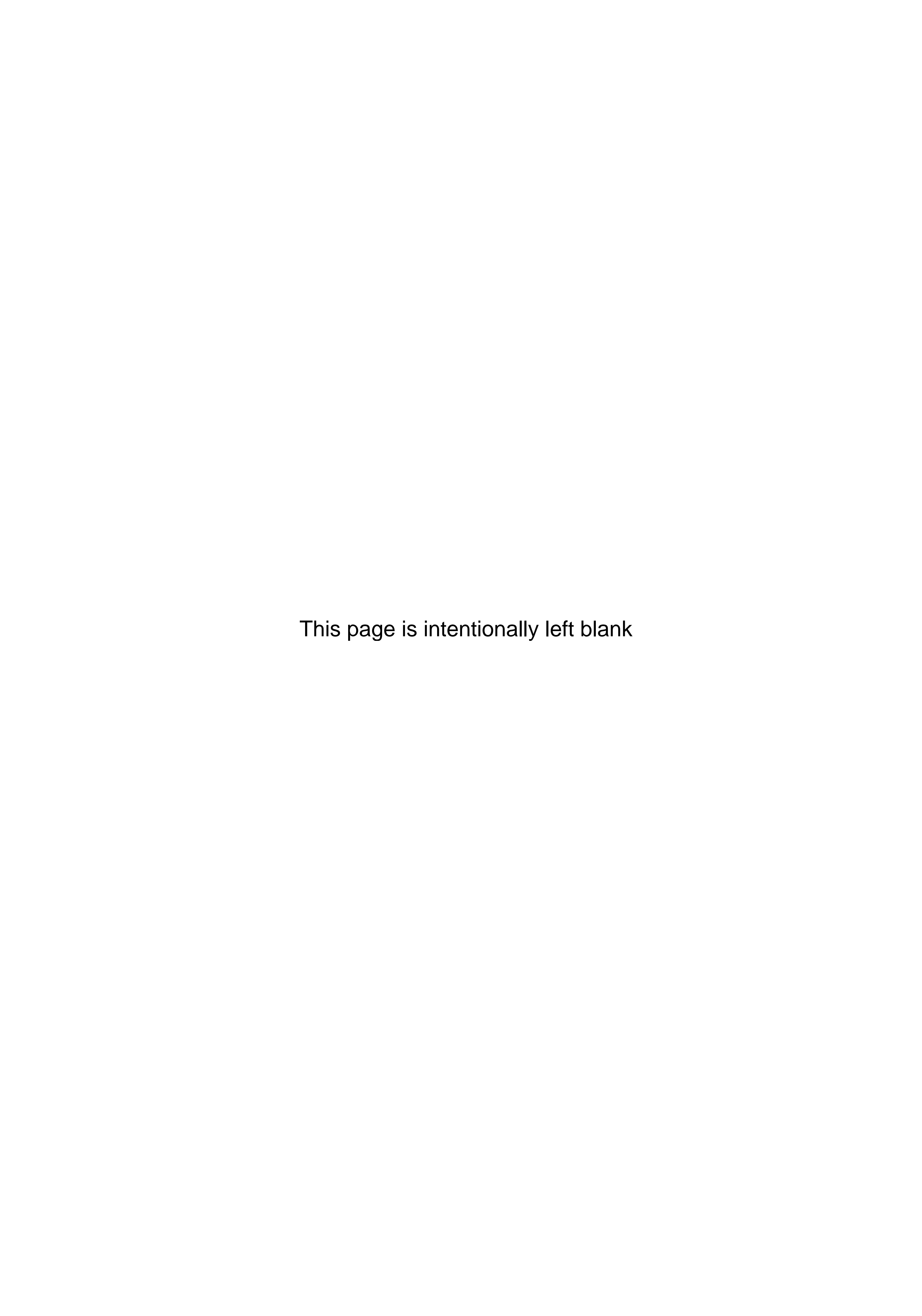
2.2 Person- and community-centred approaches should be seen as integral to creating better health and care. Realising the Value has found that these approaches, which draw deeply on the power of personal experience, peer relationships, and connection to community, are most likely to be achieved through local action. It affirms a role for the voluntary and community sector that is no longer fringe, but core to decision making and supported through proper funding models. The Programme has demonstrated the value of volunteering and social action in enabling person centred, community focussed care and health and in improving outcomes for people with care and health needs. Also it is clear that 'value' in health and care needs to be redefined according to what matters to people, rather than the system.

2.3 To develop this work further needs a health and care workforce skilled and knowledgeable in these approaches working with a flourishing voluntary and community sector, alongside better ways of measuring the outcomes that matter to people. This has the potential to transform the relationships between the health service, people and communities. Sustained and coordinated leadership at a local as well as national level can ensure these innovations are embedded into mainstream change and realise the power of people and communities at the heart of health and wellbeing. This is already a clear priority and focus for the Health and Wellbeing Board especially through the implementation and further

development of Care Together. The work and evidence that is part of Realising the Value can be part of strengthening the strategic approach and activity to deliver on this potential.

3. RECOMMENDATIONS

3.1 As detailed on the front of the report.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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	9 March 2017
Executive Member / Reporting Officer:	Councillor Gerald P Cooney – Executive Member (Healthy and Working) Angela Hardman – Director of Public Health Debbie Watson – Head of Health and Wellbeing
Subject:	**HEALTH AND WELLBEING FORWARD PLAN 2017/18**
Report Summary:	This paper provides an outline forward plan for consideration by the Board
Recommendations:	The Board is asked to agree the draft forward plan for 2017/18.
Links to Health and Wellbeing Strategy:	The Health and Wellbeing Strategy to address needs, which commissioners will need to have regard of in developing commissioning plans for health care, social care and public health. The Forward Plan ensures coverage of key issues associated with the Board's duties to deliver improved outcomes through the strategy
Policy Implications:	The Forward Plan has been designed to cover both the statutory responsibilities of the Health and Wellbeing Board and the key projects that have been identified as priorities by the Board.
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications for the Council relating to this report
Legal Implications: **(Authorised by the Borough Solicitor)**	Local Authorities are obliged to publish a forward plan setting out the key decisions and matters they will consider over a rolling 4 months.
Risk Management :	There are no risks associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson, Head of Health and Wellbeing by: Telephone:0161 342 3358 e-mail: debbie.watson@tameside.gov.uk

TAMESIDE HEALTH AND WELLBEING BOARD FORWARD PLAN 2017/18

	Strategy / policy and Board process	Priorities and performance	Integration	Other
29 June 2017	• Greater Manchester Population Health Plan – stocktake for Tameside	• Mental Health and Wellbeing	• Care Together Update	• Forward plan • Live Well service
21 September 2017	• JSNA update	• Public Health Annual Report • System Wide Self Care programme update/ Strengthening Communities	• Care Together Update	• Forward Plan
16 November 2017	Health and Wellbeing Board Development Session			
25 January 2018	• Tameside Safeguarding Children Annual Report • Tameside Adult Safeguarding Partnership Annual Report • Pharmaceutical Needs Assessment – review and sign off	• Health and Working Well	• Care Together Update	• Forward Plan
8 March 2018			• Care Together Update	• Forward Plan
NOTE: AGENDA ITEMS ARE SUBJECT TO CHANGE				

	Strategy / policy and Board process	Priorities and performance	Integration	Other
	Items to include: • JHWS – approval, alignment with other strategies • JSNA – updates and approval of arrangements • GM HWB and other strategy updates • National policy updates • Updates from linked governance processes – eg Health Protection Forum, Healthwatch.	Items to include: • JHWS Performance monitoring (outcomes) • JSNA updates • PH annual report • HWB performance	Items to include: • Regular public service reform updates • Integrated Commissioning Programme – Care Together • Partner member business planning updates (including CCG operating plan)	Items to include: • Forward Plan • Consultation on key issues and developments

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