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

Tameside and Glossop Locality Plan November 2015

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1. EXECUTIVE SUMMARY

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

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

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

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

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

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

2. STRATEGIC CONTEXT

2.1 Tameside and Glossop

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

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

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

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

2.2 Population and Public Health

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

Table 1 - Healthy Life Expectancy in Tameside

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

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

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

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

Tameside JSNA
Derbyshire JSNA

2.3 Public Service Reform

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

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

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

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

2.4 Contingency Planning Team

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

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

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

However, financial reasons are not the main reason why we believe health and social care services in Tameside and Glossop will need to look very different in the future. Integrating preventative and proactive care, GPs, social care and the services provided in the hospital will deliver better health and social care service for local people. Those in need of support will receive it in a more co-ordinated way, without having to work their way through a complex system of multiple organisations and teams. Care will, wherever possible, be provided closer to home (preferably in people's homes) and we will do all we can to keep people out of hospital and where effective, provide early support to prevent a stay in hospital.

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

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

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

3. OUR AMBITION

3.1 Our focus

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

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

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

3.2 Our principles and values

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

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

3.3 Our determinants of success

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

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

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

Tameside and Glossop example of current best practice - Charmaine

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

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

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

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

3.4 Partnership and participation

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

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

Tameside and Glossop example of current best practice - Engagement

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

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

4. OUR APPROACH

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

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

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

4.1 Healthy Lives (early intervention and prevention)

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

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

4.1.1 Starting & Developing Well

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

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

We will intervene early where our children, young people and families need help and we will strengthen the support provided during pregnancy and the first five years of a child's life to ensure every child is given the best start in life, is fit to learn and able to fully develop their potential, communication, language and literacy skills. A key priority is to increase the proportion of children who are 'school ready' by continuing the implementation of the Greater Manchester Early Years new delivery model to improve early intervention and prevention for children and families in need.

- **Healthy Schools Programme**

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

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

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

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

Tameside and Glossop example of current best practice - Jade

Jade started experiencing difficulties after the birth of her second child. Her family was experiencing significant stress which was linked to domestic abuse, substance misuse, mental health needs and financial difficulties. These, combined with isolation and lack of support networks began to affect the children's development and attachment. Jade was reluctant to work with social care and support services due to her own childhood experiences, so for a short time the children were taken into care.

Different organisations came together in partnership with Jade and her family to work through their issues. They made sure the children were at the centre of the picture. A Family Intervention Worker from Jade's local children's centre supported the family to manage debt and access benefits. Jade was supported to allow her older child to access a free 2 year old place and speech and language therapy at a local nursery. She built good relationships with the Health Visitor and Early Attachment Specialist who supported Jade with parenting, and enabled the family to get back on track. Both parents accepted the help and support they needed to make changes and the children were returned to the family. They continue to make significant progress. Jade is very proud of her children and is keen they have a positive childhood experience. Jade no longer needs a Family Intervention Worker but often pops into the children's centre to attend the groups where she has built confidence and made new friends.

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

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

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

4.1.2 Living & Working Well

- **Stronger families**

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

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

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

- **Housing**

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

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

- **Physical inactivity**

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

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

- **Mental health and wellbeing**

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

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

- **Work and Health**

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

- **Transport and Health**

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

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

4.1.3 Ageing & Dying Well

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

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

- **Increased Life Expectancy**

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

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

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

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

- **Housing**

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

- **Urgent Integrated Care Services**

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

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

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

Tameside and Glossop example of current best practice - Grace

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

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

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

4.2 Community Development

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

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

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

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

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

Tameside and Glossop example of current best practice – Jill

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

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

4.3 Enabling self care

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

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

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

4.4 Locality Based Services

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

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

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

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

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

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

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

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

4.5 Urgent Integrated Care Services

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

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

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

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

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

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

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

4.6 Planned Care Services

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

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

5. DELIVERING OUR AMBITION

5.1 Leading the change

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

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

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

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

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

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

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

5.2 The financial challenge

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

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

Source: PwC Contingency Planning Team Report: 28 July 2015

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

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

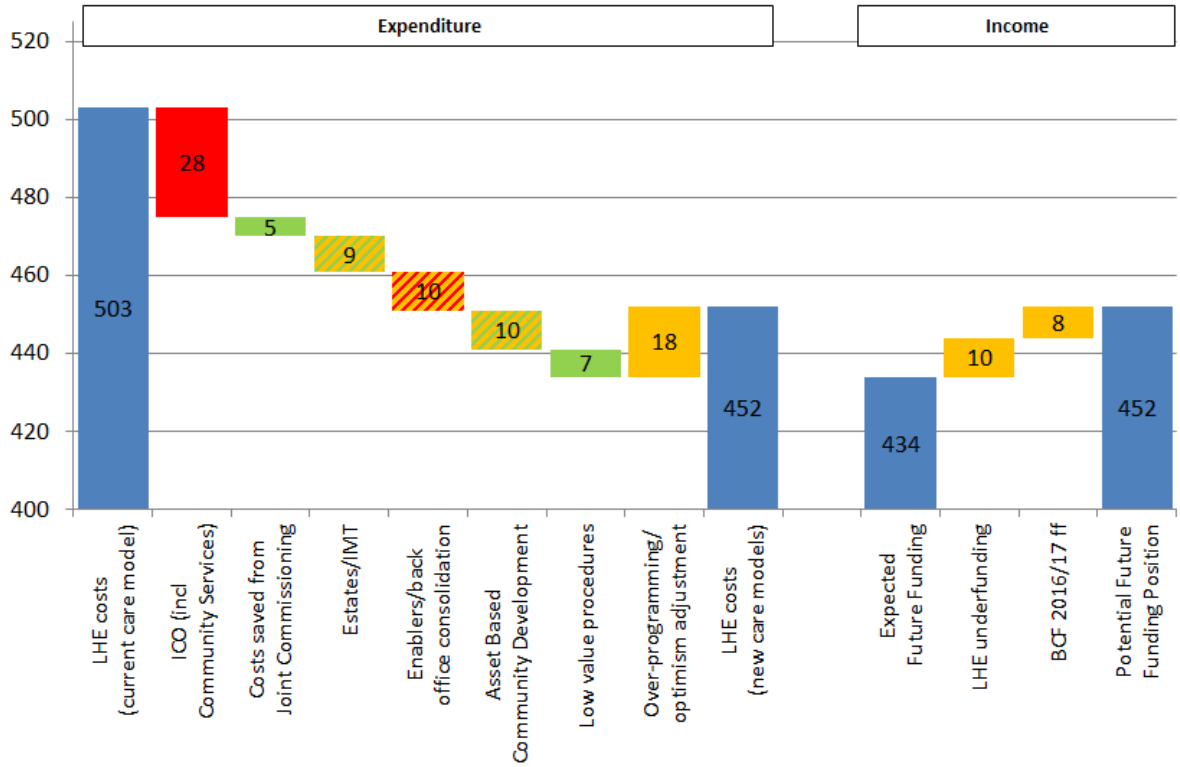
- The economy receives the required revenue and capital transitional funding to deliver the ambition. A robust coherent business case is currently being prepared outlining the request to Devolution
- Department of Health financial support (i.e. public dividend capital), for THFT continues to be received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

5.3 Closing the financial gap

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

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

Table 3 - Closing the financial gap by 2020



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

5.3.1 Expenditure Components

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

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

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

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

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

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

£5m - Costs saved from joint commissioning

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

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

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

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

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

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

£10m - Enablers/back office consolidation

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

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

£10m - Asset Based Community Development

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

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

£7m - Low Clinical Value Procedures

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

£18m - Over-programming/optimism adjustment

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

£452m – Cost of the New Care Models

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

5.3.2 Income Components

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

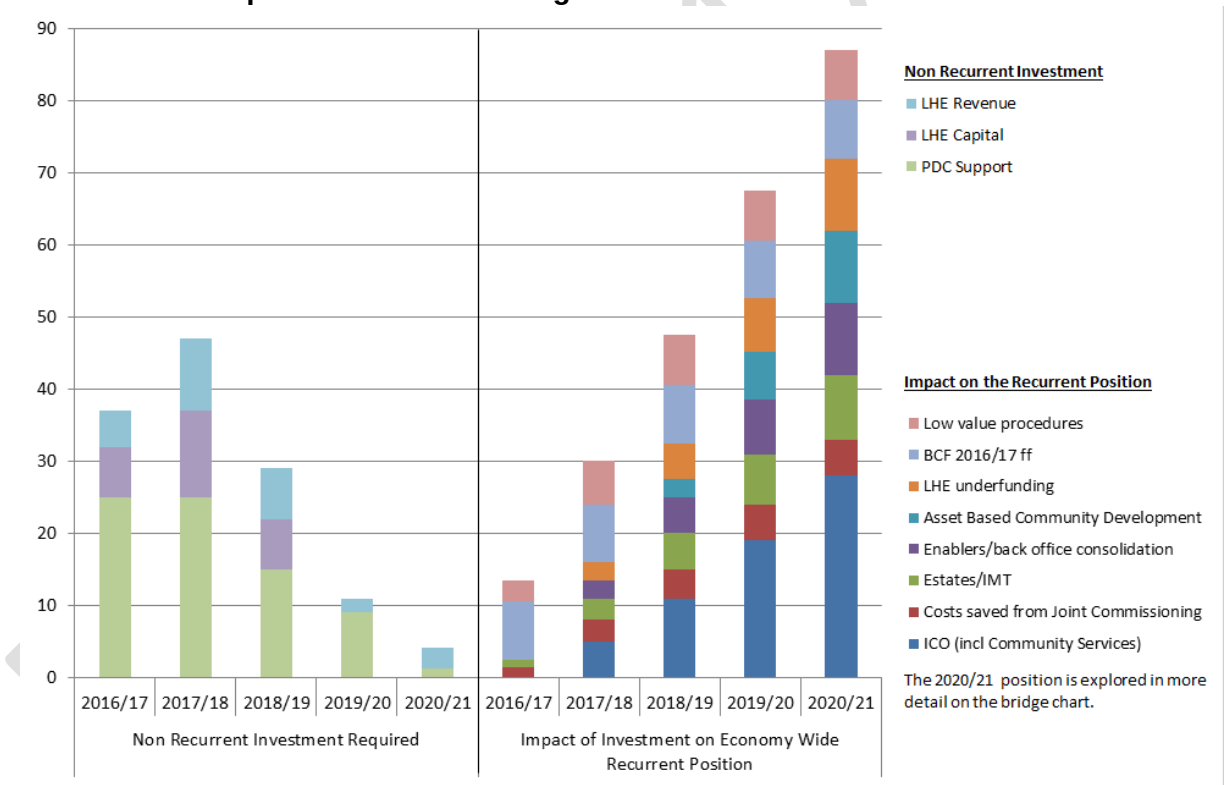
£10m - LHE Underfunding
Government data for CCG distance from target and Local Government financial settlement figures highlights that Tameside and Glossop is underfunded by approximately £14m. Therefore, if fair shares were applied, we should receive circa £14m more than we do currently. However, being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

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

5.4 Profile of Implementation

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

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



5.5 Costs of Implementation

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

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

Table 5 - Transition/Implementation Costs

Area	Description	Capital	Revenue	Implementation/ Transition
		£ m	£ m	£ m
Public sector estate re-design	Reconfiguration of the Trust's estate as per the CPT's report comprising: - assessment, planning and design of the new estates, - moving services within the estate, - development of premises for LCCTs, - building work around the new front end of the hospital and demolition costs associated with the Charlesworth building.	6.5		6.5
Workforce costs/organisational leadership development	Requirements for cultural and associated workforce changes to support the new ICO and the development of the ICO leadership team.		6.3	6.3
Implementation management and professional costs	External/temporary support for: - Implementation support, programme management, communications/engagement, contracting; and - Due diligence, actuarial advice, legal advice and other transaction costs.		5.5	5.5
Double running costs	Where services are to be replaced with services in alternative settings, or where facilities are closed to new patients but need to retain staffing for a period while existing bedded patients are cared for until discharge/transfer, there will be some need for overlap of services.		4.3	4.3
Investment in integrated IT and communication systems	Set up cost and capital investment in new IT including community migration, equipment to support community diagnostics, gap modelling, and infrastructure investment.	19.5		19.5
Contract terminations	Transfers of services between organisations or changes to where and how services are delivered may mean that some support contracts need to be terminated, modified or transferred. There could be financial costs and penalties associated with this.		5.8	5.8
Contingency	In developing a model which is a first of its type in the UK, it is important to ensure there is a contingency to mitigate risk.		5	5
	TOTAL TRANSITION/IMPLEMENTATION FUNDING REQUIRED:	26	26.9	52.9

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

5.6 Profile of transition costs

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

Table 6 – Profile of transition costs[2]

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

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

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

5.7 Moving forwards

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

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

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

APPENDIX A

Summary of Tameside Health and Well Being

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

Key statistics (compared to the England average)

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

Source; Tameside JNSA 2015-16

APPENDIX B

Summary of Glossop Health and Well Being

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

Key statistics (compared to the England average)

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

APPENDIX C

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