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HEALTH AND WELLBEING BOARD

Day: Thursday
Date: 29 June 2017
Time: 10.00 am
Place: Lesser Hall 2 - Dukinfield Town Hall

Item No.	AGENDA	Page No

GENERAL BUSINESS

1.	**APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from Members of the Health and Wellbeing Board.	
3.	**MINUTES** The Minutes of the meeting of the Health and Wellbeing Board held on 9 March 2017 to be signed by the Chair as a correct record.	1 - 8

ITEMS FOR DISCUSSION / DECISION

4.	**CARE TOGETHER 2016/17 CONSOLIDATED FINANCIAL MONITORING STATEMENT** To consider the attached report of the Executive Member (Adult Social Care & Wellbeing) / Executive Member (Healthy & Working) / Executive Member (Children & Families) and Kathy Roe, Director of Finance.	9 - 44
5.	**IMPLEMENTING CARE TOGETHER: KEY PROPOSED DELIVERABLES OVER NEXT 12-18 MONTHS** To receive a presentation from the Programme Director, Care Together, and Director of Strategy and Partnership, Tameside Integrated Care Foundation Trust. Accompanying integration update report attached.	45 - 58
6.	**TRENDS IN LIFE EXPECTANCY AND MORTALITY RATES - UPDATE** To consider the attached report of the Executive Director (Public Health, Business Intelligence and Performance).	59 - 102
7.	**GREATER MANCHESTER POPULATION HEALTH PLAN - STOCKTAKE FOR TAMESIDE** To consider the attached report of the Executive Member (Healthy and Working) and the Executive Director (Public Health, Business Intelligence and Performance.	103 - 136

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

Item No.	AGENDA	Page No
8.	**SYSTEMS OUTCOME FRAMEWORK** To consider the attached report of the Executive Director (Public Health, Business Intelligence and Performance).	137 - 142
9.	**STRATEGIC APPROACH TO SUBSTANCE MISUSE** To consider the attached report of the Executive Director (Public Health, Business Intelligence and Performance).	143 - 166
	ITEMS FOR NOTING / INFORMATION	
10.	**HEALTH AND WELLBEING BOARD FORWARD PLAN 2017/18** To receive the attached report of the Executive Director of Public Health, Business Intelligence and Performance.	167 - 170
11.	**URGENT ITEMS** To consider any additional items the Chair is of the opinion shall be dealt with as a matter of urgency.	
12.	**DATE OF NEXT MEETING** To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 21 September 2017.	

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

TAMESIDE HEALTH AND WELLBEING BOARD

9 March 2017

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

PRESENT: Councillor Kieran Quinn (Chair) – Executive Leader
Councillor Peter Robinson – Executive Member (Children and Families)
Councillor Brenda Warrington – Executive Member (Adult Social Care & Wellbeing)
Stephanie Butterworth – Director of Children's Services
Alan Dow – Chair, Clinical Commissioning Group
Ben Gilchrist – Action Together, Healthwatch Representative
Angela Hardman – Director of Public Health
Steven Pleasant – Chief Executive, Tameside MBC, and Accountable Officer for Tameside and Glossop CCG
Graham Curtis – Deputy Chair and Lay Member, CCG
Neil Evans – Chief Superintendent, Greater Manchester Police
Christina Greenhough – Clinical Vice Chair & Lead for Mental Health, CCG
David Niven – Independent Chair, Tameside Safeguarding Children's Board
Tony Powell – Deputy Chief Executive, New Charter Group
Andrew Searle – Independent Chair, Tameside Adult Safeguarding Board
Paul Starling – Borough Commander, GM Fire and Rescue Service
Sandra Stewart – Director of Governance, Resources and Pensions
Clare Watson – Director of Commissioning
Giles Wilmore – Tameside Hospital NHS Foundation Trust

IN ATTENDANCE: Alan Ford – Clinical Commissioning Group
Chris Easton – Tameside Hospital NHS Foundation Trust

APOLOGIES: Councillor Gerald P Cooney – Executive Member
Mark Tweedie – Chief Executive, Tameside Sports Trust

91. DECLARATIONS OF INTEREST

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

92. MINUTES OF PREVIOUS MEETING

The Minutes of the Health and Wellbeing Board held on 19 January 2017 were approved as a correct record.

93. CARE TOGETHER PROGRAMME UPDATE

The Programme Director (Tameside and Glossop Care Together) presented a report providing an update on the progress and developments within the Care Together Programme relating to the following:

In terms of transformational funding, £5.2 million had been allocated within 2016/17 and transformational programmes were now being implemented at pace across the economy and expenditure profiles were being examined to understand the potential benefits in year. Monitoring of the Investment Agreement was taking place on a monthly basis and updates would be provided to Greater Manchester quarterly.

Operational progress in relation to the following was also highlighted:

- Programme Management;
- Adult Social Care Transaction;
- Integrated Neighbourhoods;
- Operational plans and new contract.

It was reported that as part of the drive to improvement the efficiency of commissioning, New Century House had been vacated and commissioning staff had been allocated in their teams across three Tameside MBC owned sites. Work continued to determine the full remit of the Integrated Care Foundation Trust and to align services accordingly. As well as the transaction of Adult Social Care, there was likely to be a transfer of some current commissioning functions and associated staff. This was being worked through and timelines were being determined and how the Integrated Care Foundation Trust worked with mental health and primary care services would also be developed in due course.

The Board emphasised the importance of the implementation of transformation plans at pace and system wide engagement in the integration agenda to ensure the ambition of the care together programme was realised. It was agreed that mental health should be an area of focus and the continued importance of engaging Pennine Care NHS Trust in current and future integration plans was highlighted.

Members expressed concern regarding the new governance arrangements within the ICFT noting some cross over with the role of the Professional Reference Group. In addition, it was reported that the recruitment process for the new Director of Neighbourhoods had not yet commenced and Members expressed concern as this role was seen as crucial in the development of the Integrated Neighbourhood model.

The Chair requested an update on the care together governance to ensure alignment with the care together vision and avoidance of duplication.

RESOLVED

(i) The Chair to write to the Chief Executive of Pennine Care NHS Trust to request a named director level representative to attend the Health and Wellbeing Board.

(ii) The Director of Strategy and Policy at the Integrated Care Foundation Trust to feedback Members' concerns regarding the appointment of the Director of Neighbourhoods.

(iii) The Programme Director to include an update on the Integrated Neighbourhood Model and reviewed Care Together Governance arrangements in her report to the 29 June 2017 meeting of the Health and Wellbeing Board.

94. GREATER MANCHESTER POPULATION HEALTH PLAN

The Director of Public Health, Business Intelligence and Performance presented a report and Greater Manchester Population Health Plan setting out a Greater Manchester approach to delivering a radical upgrade in population health. It was informed by the best empirical evidence and by the views of the people of Greater Manchester and detailed the health challenges being faced and the approach to population health at a Greater Manchester level.

The priorities for change set out in the Plan had also been chosen to support the locality delivery described in each of the ten locality plans. The Plan then focused on those programmes of work that the GM Health and Social Care Partnership would deliver in collaboration with localities. This Plan detailed the high level ambitions for Population Health and the targeted interventions that would be necessary to deliver on this ambition over the next four years until 2021.

Board Members commented favourably on the report which complemented the individual work in the ten areas of the region and highlighted where issues could be tackled more effectively by working together from a Greater Manchester stance.

The Director of Public Health and Performance stated that she intended to submit a report to the next meeting of the Health and Wellbeing to start the conversation with partners regarding their contribution towards the delivery of the priorities contained in the Population Health Plan.

RESOLVED
(i) That the Greater Manchester Population Health Plan be noted and endorsed.
(ii) That the Director of Public Health and Performance submit a report to the next meeting of the Health and Wellbeing Board regarding the delivery of the priorities contained in the Population Health Plan.

95. GREATER MANCHESTER CANCER PLAN

The Director of Public Health, Performance and Business Intelligence, introduced the Greater Manchester Cancer Plan – Achieving World Class Cancer Outcomes: Taking Charge in Greater Manchester. The Plan set out the ambitions for Greater Manchester Cancer, the cancer programme of the Greater Manchester Health and Social Care Partnership. It was divided into eight domains reflecting a combination of the five key areas for change set out in Taking Charge and the six key work streams of the national cancer strategy. This was the first time that health and social care organisations had come together across a whole region to develop an action plan to tackle cancer.

Much of the work contained in the Plan would be delivered by the current and proposed Greater Manchester Cancer infrastructure. A substantial part of the Plan in 2016/17 and 2017/18 was part of the vanguard innovation programme and funded by NHS England's New Care Models Team.

Greater Manchester Transformation funding would be sought to deliver other key parts of the programme and, if appropriate, to roll out successful pilots from the vanguard innovation programme beyond 2017/18. A full implementation plan would be developed by June 2017.

Board Members welcomed the Greater Manchester Cancer Plan setting out the evidence of the challenges and how these could be tackled to improve cancer outcomes.

RESOLVED
That the content of the Greater Manchester Cancer Plan – Achieving world class cancer outcomes: taking charge in Greater Manchester.

96. HOUSING AND HEALTH

The Deputy Chief Executive, New Charter Group, presented a report providing an update on the Greater Manchester Housing Providers role in influencing and shaping the Greater Manchester health agenda. It also provided details of the local challenges and action being taken.

Within Tameside there was a history of partnership working with all the local social housing providers and over the years a range of supported housing and specialist services had been developed. There was a commitment going forward to work together and build on existing and delivering new housing solutions / services to reduce health and social care demand. This involved a spectrum of services and solutions, the main themes and areas for action detailed as follows:

- Transition of care;
- Home care;

- Homelessness;
- Asset based community development; and
- New build and remodel.

Registered social landlords such as New Charter supported some of the most vulnerable residents across the most deprived neighbourhoods. Health outcomes for these residents were generally lower than for the Borough as a whole and consequently they were high users of health and social care services. As a result New Charter delivered and co-delivered numerous support services and engaged and supported residents to improve their health and wellbeing as well as tenancies. However, the options available to address poor property conditions from some private landlords were discussed.

The Board discussed the demand on homelessness which was increasing and new and innovative ways needed to address the challenge from housing providers in Greater Manchester. Locally, New Charter had provided an additional £100,000 to expand the homelessness prevention agenda and develop a social lettings offer. Discussion also ensued on the availability of Spice, a synthetic cannabinoid, and similar substances which were now a community safety issue in Greater Manchester.

RESOLVED
That the content of the report be noted and a update report be provided to a further Board meeting.

97. TAMESIDE CHILDREN'S SERVICES IMPROVEMENT PLAN

Consideration was given to a report of the Executive Member (Children and Families) and the Executive Director (Place) outlining the approach that had been taken to produce the draft Tameside Children's Services Improvement Plan which was appended to the report. It also set out a summary of the consultation responses received which had been considered in drafting the Plan and the timeline for further engagement activity prior to final submission to Ofsted on 20 March 2017.

The draft Improvement Plan included a range of actions to be delivered by partners and staff at all levels with a focus on improving outcomes and supporting successful lives for children and their families in Tameside.

RESOLVED
That the content of the draft Improvement Plan and the timeline for further engagement prior to final submission to Ofsted on 20 March 2017 be noted.

98. CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICE TRANSFORMATION PLAN UPDATE

Consideration was given to a report of the Director of Commissioning which explained that the Tameside and Glossop Local Transformation Plan was finalised in October 2015 and assured at the end of 2015/16 through NHS England bespoke process, with a view to aligning it in 2016/17 with mainstream Clinical Commissioning Group planning and assurance cycles. However, the Government and national public interest surrounding children and young people's mental health ensured that robust assurance and auditing remained in place with additional scrutiny from Greater Manchester Health and Social Care Partnership. The Tameside and Glossop Local Transformation Plan had been in place for a year and it was required to be refreshed to reflect local progress and further ambitions at the end of 2016. The refresh of the Local Transformation Plan was seen by NHS England as the evidence that progress was being made, that the funding was being spent as intended and would provide evidence on how services were being transformed.

The Health and Wellbeing Board agreed that this was a very positive report in terms of the discussions taking place, the work being undertaken and the huge benefits of galvanising the partnership and engaging schools in the prevention agenda.

RESOLVED
(i) That the Local Transformation Plan refresh and finance plans for the deliverables for 2017/20 be approved and the approach set out in the report be supported.
(ii) That the alignment of the Local Transformation Plan with Greater Manchester approaches where populations and needs require thus delivering efficiencies be supported.
(iii) That the national context and building national pressures and assurance measures to increase spending on CAMHS and ensure the publication of the Local Transformation Plan be noted.

99. TAMESIDE ADULT SAFEGUARDING PARTNERSHIP ANNUAL REPORT

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

He stated that Public Service Reforms had impacted on several of the Board's partner organisations during the 12 month period and made reference to continuing changes including the integration of Health and Social Care.

In conclusion, the Independent Chair stressed that safeguarding be it children or adults was everybody's business and reporting matters of concern provided an opportunity to intervene as early as possible.

RESOLVED
That the Tameside Adult Safeguarding Partnership Annual Report 2015/16 be received by the Health and Wellbeing Board.

100. JOINT WORKING PROPOSAL BETWEEN TAMESIDE HEALTH AND WELLBEING BOARD, TAMESIDE ADULT SAFEGUARDING PARTNERSHIP BOARD AND TAMESIDE SAFEGUARDING CHILDREN'S BOARD

Consideration was given to a joint report of the Chair of the Tameside Adult Safeguarding Partnership Board and the Chair of the Tameside Safeguarding Children's Board which explained that in November 2014 a joint working protocol was agreed between the Health and Wellbeing Board and Tameside Safeguarding Children's Board and was due to be reviewed. In response to the Care Act, each local authority had a safeguarding adults board and in Tameside this was the Tameside Adults Safeguarding Partnership Board.

The report set out proposed working arrangements between the Health and Wellbeing Board, the Tameside Adults Safeguarding Partnership Board and the Tameside Safeguarding Children's Board, proposing that the relationship developed as a protocol towards aligned priorities and joint strategy. It provided an overview of roles and responsibilities of each Board or Partnership and identified the way in which they would co-operate to ensure there was effective communication and co-ordination to achieve statutory responsibilities and achieve the best possible outcomes for the residents of Tameside.

It was stated that safeguarding was everybody's business and as such all key strategic plans, whether they be formulated by individual agencies or by partnership forms, should include

safeguarding as a cross-cutting theme. This would ensure that existing strategies and service delivery as well as emerging plans for change and improvement included effective safeguarding arrangements that ensured that all people of Tameside were safe and their wellbeing was protected.

RESOLVED
(i) That the proposed working arrangements between the Health and Wellbeing Board, the Tameside Adults Safeguarding Partnership Board and the Tameside Children's Safeguarding Board be endorsed.
(ii) That the areas of joint priority and focus for 2017/18 detailed in the report be agreed.

101. REALISING THE VALUE

The Deputy Chief Executive, Action Together, presented a report outlining the Realising the Value programme's eighteen months of work to build the evidence base about person and community centred approaches to health and wellbeing. This work was commissioned by NHS England to support delivery of the NHS Five Year Forward View and the recognition that new ways of working with people and communities was needed to address current challenges. The work showed how to make a reality of the vision for a new relationship with people and communities which was a central focus of Greater Manchester and Tameside and Glossop strategic approaches.

Realising the Value's final report concluded that person and community centred approaches were pivotal to improving health and wellbeing outcomes during financially restrained times. Practical tools, recommendations and economic modelling had now been published to show how such approaches could be successfully implemented. This provided timely and important evidence for health and care system leaders, commissioners and front-line professionals.

It is well recognised that there was an urgent need to design a sustainable health and care system and that one of the major ways of achieving this would be through enabling people to live better with health conditions. This work had clearly set out that the best way to do this was by putting people and communities at the heart of health and wellbeing – so that they felt in control, valued, motivated and supported.

Person and community centred approaches should be seen as integral to creating better health and care. Realising the Value had found that these approaches would be most likely to be achieved through local action. It affirmed a role for the voluntary and community sector that was no longer fringe, but core to decision making and supported through proper funding models. The Programme has demonstrated the value of volunteering and social action in enabling person centred, community focused care and health and in improving outcomes for people with care and health needs. Also it was clear that 'value' in health and care needed to be redefined according to what mattered to people, rather than the system.

To develop this work further needed a health and care workforce skilled and knowledgeable in these approaches working with a flourishing voluntary and community sector, alongside better ways of measuring the outcomes that mattered to people. This had the potential to transform the relationships between the health service, people and communities. Sustained and coordinated leadership at a local as well as national level could ensure these innovations were embedded into mainstream change and realised the power of people and communities at the heart of health and wellbeing. This was already a clear priority and focus for the Health and Wellbeing Board especially through the implementation and further development of Care Together. The work and evidence that was part of Realising the Value could be part of strengthening the strategic approach and activity to deliver on this potential.

RESOLVED
(i) That the Health and Wellbeing Board note the tools and modelling produced by the Realising the Value programme of work.

(ii) That these materials be shared with other leaders and professionals in particular those with commissioning responsibilities.
(iii) That the role for the voluntary and community sector, volunteering and social action in enabling person centred, community focused care and health as central improving outcomes for people with care and health needs, especially through Care Together, be supported.
(iv) That 'value' in health and care continue to be redefined according to what matters to people, rather than the system, be championed.
(v) That help in developing a health and care workforce skilled and knowledgeable in these approaches be provided.
(vi) That sustained and co-ordinated leadership be provided to ensure these approaches were embedded into mainstream change.
(vii) That the clear priority and focus on this area of work for the Health and Wellbeing Board, be maintained, especially through the implementation and further development of Care Together.

102. HEALTH AND WELLBEING BOARD FORWARD PLAN 2017/18

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

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

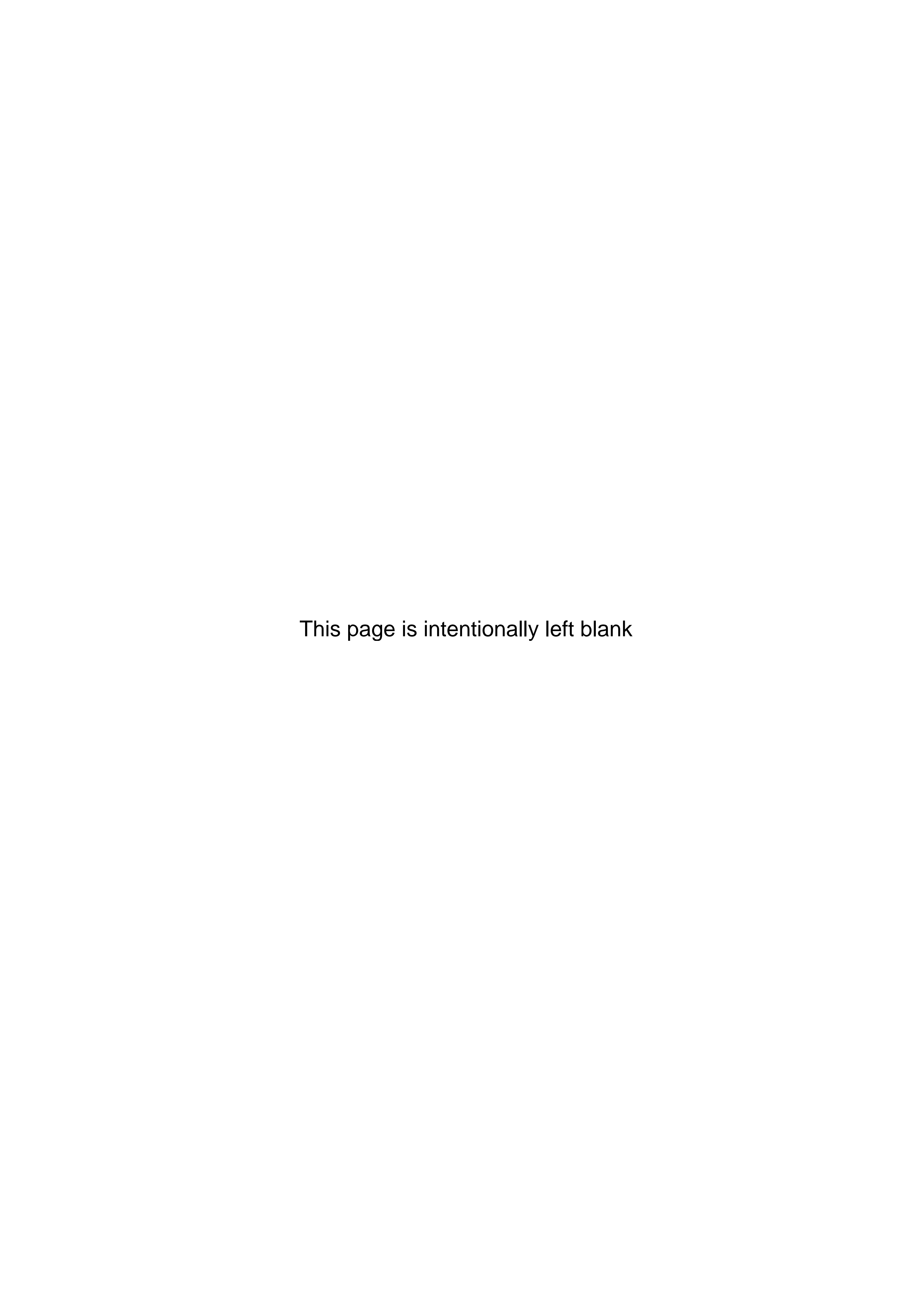
103. URGENT ITEMS

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

104. DATE OF NEXT MEETING

To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 29 June 2017 commencing at 10.00 am.

CHAIR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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	29 June 2017
Executive Member / Reporting Officer:	Councillor Jim Fitzpatrick – First Deputy (Performance and Finance) Councillor Brenda Warrington – Executive Member (Adult Social Care & Wellbeing) Councillor Gerald P. Cooney – Executive Member (Healthy & Working) Councillor Peter Robinson – Executive Member (Children & Families) Kathy Roe – Director Of Finance – Single Commission
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2016/17 CONSOLIDATED FINANCIAL MONITORING STATEMENT**
Report Summary:	This is a jointly prepared report of the Tameside & Glossop Care Together constituent organisations on the consolidated financial position of the Economy for 2016/2017. A summary of the Tameside and Glossop Integrated Care NHS Foundation Trust financial position is also included within the report. This is to ensure members have an awareness of the overall financial position of the whole Care Together economy. The report also provides details of the savings realised in 2016/2017 together with the significant level of savings required in 2017/2018 to ensure control totals are delivered and financial sustainability is achieved on a recurrent basis thereafter. It should be acknowledged that the delivery of additional savings beyond 2017/2018 will also be required the details of which will be reported to future meetings.
Recommendations:	Health and Wellbeing Board Members are recommended to note / acknowledge: 1. The final 2016/2017 consolidated financial position of the economy. 2. The significant level of savings delivered in 2016/2017 and required during 2017/2018 (section 4) to achieve confirmed control totals and the financial sustainability of the economy on a recurrent basis thereafter. 3. The significant amount of financial risk associated with the achievement of financial control totals during this period. 4. The 2016/17 quarter four Better Care Fund monitoring statement **(Appendix A)**

Links to Community Strategy:	The Sustainable Community Strategy and Local Area Agreement are key documents outlining the aims of the Council and its partners to improve the borough of Tameside (agreed in consultation with local residents). Within health the CCG's Commissioning Strategy and Primary Care Strategy are similarly aligned to these principles and objectives.
Policy Implications:	The Care Together resource allocations detailed within this report supports the strategic plan to integrate health and social care services across the Tameside and Glossop economy.
Financial Implications: **(Authorised by the Section 151 Officer))**	The report provides the final consolidated financial position statement of the 2016/17 Care Together Economy for each of the three partner organisations. Each constituent organisation is responsible for the financing of any associated deficit at 31 March 2017. Section 4 of the report provides details of the 2017/2018 funding allocations of each constituent organisation together with details of the significant levels of savings required which have been risk rated. It should be noted that the Integrated Commissioning Fund for the partner Commissioner organisations is bound by the terms within the Section 75 and associated Financial Framework agreements. Health and Wellbeing members should also note that the 2016/2017 Better Care Fund allocation sum of £15.323m is included within the Section 75 funding allocation of the Integrated Commissioning Fund as this is a revenue funding allocation. Actual expenditure is included within section 1. The Disabled Facilities Grant sum of £1.978m is excluded from this total as it is a capital funding allocation. However associated details are provided within section 2.
Legal Implications: **(Authorised by the Borough Solicitor)**	There is a need to deliver a balanced budget. Consequently, there are significant changes required to achieve this and reduce the current levels of spend which previously have been bailed out. This requires new models of working and relentless focus on budgets without compromising patient care and safety. Many of the new models are intended to achieve this rather than simply look to cut out waste.
Access to Information :	Any background papers relating to this report can be inspected by contacting : Stephen Wilde, Finance Business Partner, Tameside Metropolitan Borough Council Telephone:0161 342 3726 e-mail: stephen.wilde@tameside.gov.uk

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

Telephone:0161 304 5449

e-mail: tracey.simpson@nhs.net

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

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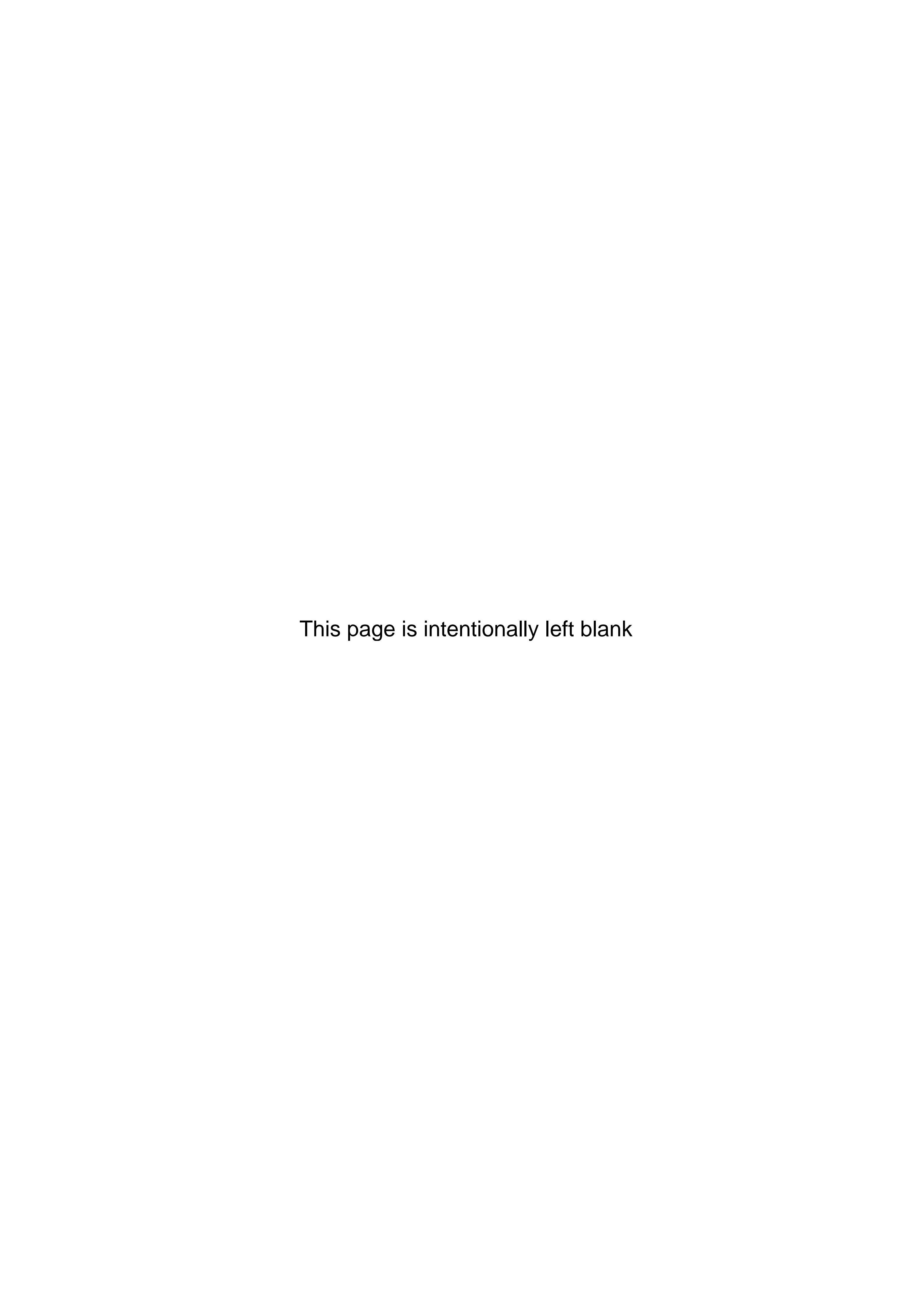
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TAMESIDE AND GLOSSOP
Care together

Tameside and Glossop Integrated Financial Position

2016/2017 Revenue & Capital Monitoring Statements

Period Ending 31 March 2017 (Month 12)

29 June 2017

Kathy Roe
Claire Yarwood
Ian Duncan

NHS
Tameside and Glossop
Clinical Commissioning Group

Section 1

Care Together Economy

Revenue Financial Position

Care Together Economy Revenue Financial Position

Organisation	Year End			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Tameside & Glossop CCG	388,441	381,272	7,169	3,491	3,678
Tameside MBC	69,272	71,904	(2,632)	(4,011)	1,379
Total Single Commissioner	**457,713**	**453,176**	**4,537**	**(520)**	**5,057**
ICFT Deficit	(17,300)	(13,840)	(3,460)	(2,525)	(935)
Total Whole Economy	**440,413**	**439,336**	**1,077**	**(3,045)**	**4,122**

2016/17 position in all 3 organisations has now been finalised. We are currently in the process of completing year end accounts and annual reports as separate statutory organisations. The audit process is underway.

All three organisations have met financial control totals in 2016/17:

- CCG has delivered a 1% surplus. The movement in the table above is in line with latest guidance on treatment of national system risk reserve and is explained in more detail on a separate slide
- The net deficit at outturn relating to the three Council services included within the ICF will be financed from Council reserves. The significant deficit primarily arose within Children's Services and was due to exceptional additional demand during the year. Details of the variations for each service are provided on the Tameside MBC slide
- ICFT had an authorised deficit of £17.3m for 2016/17. The actual normalised deficit was £13.3m, so exceeding the target by almost £4m.

While financial control totals have been met across the economy, this has only been possible because of non-recurrent actions. On a recurrent basis there remains an underlying deficit across the economy, which increases risk in future years.

Tameside & Glossop CCG

Description	Year End Position			Movement	
	Budget £000's	Actual £000's	Variance £000's	Previous Month £000's	Movement in Month £000's
Acute	197,310	197,708	(398)	(526)	128
Mental Health	29,052	28,757	295	99	196
Primary Care	81,657	81,715	(58)	(732)	674
Continuing Care	12,251	13,388	(1,137)	(377)	(760)
Community	27,483	27,530	(47)	(51)	4
Other	35,510	27,763	7,747	4,413	3,334
QIPP		0	0	0	0
CCG Running Costs	5,178	4,411	767	665	102
CCG Expenditure	**388,441**	**381,272**	**7,169**	**3,491**	**3,678**
CCG Surplus	**3,491**	**7,169**	**3,678**		

The 2016/17 financial position has now been finalised and the CCG has met all of its key financial duties, including:

- Delivery of 1% surplus (£3,491k),
- Full achievement of £13,500k QIPP target.
- Kept 1% of allocation uncommitted to fund a national system risk reserve
- Growth in Mental Health spend of 3% to meet Mental Health Investment Standard
- Remaining within the running costs allocation

We are currently in the process of producing the annual report and accounts and are working collaboratively with our external auditors whilst they undertake the final accounts audit.

Recommendations

- Note the final year end position and the diligent efforts undertaken to meet the 2016-17 QIPP target.
- Acknowledge the significant recurrent savings still required to close the long term financial gap.

Changes in the position since Month 11 include:

- **Acute**: Improvement in position as year end settlements agreed with providers. Details on a separate slide.
- **Mental Health**: Improvement in reported position following discharge from high cost out of area placements. Mental Health Investment standard met.
- **Primary Care**: Absence of a winter spike in prescribing, together with progress against QIPP have resulted in a significant reduction in spend. A detailed report on the current prescribing position is provided later in this report.
- **Continuing Care**: New data has highlighted significant pressure in this area, which is offset slightly by clawback on Personal Health Budgets.
- **Community:** Broadly consistent with position last month
- **Other:** Since the start of this year the CCG has been maintaining a reserve of 1% of its allocation (£3,678) in line with nation planning guidance on uncommitted spend. The intention of this was to create a national system risk reserve which would be used mitigate significant financial risk across the NHS as a whole, in particular within the provider sector.
  A letter was received from Paul Bauman on 15 March asking us to release this reserve, increasing the value of the CCG surplus to £7,169k. In total commissioners across the country have released around £800m to increase CCG surpluses in March. This will be used in national consolidated accounts to help to offset the provider deficit position and help to secure a balanced position for the NHS overall.
- **CCG Running Costs**: Credit note from GM Shared Services, estates savings and reduced payroll cost.

Key Movements & Narrative: CCG

Acute Provider Drilldown

- **Acute Providers**: Yearend positions agreed with providers, favorable movement to full year forecast of £156K.
- **Central Manchester**: Adverse movement against agreed outturn of (£89k) due to Critical Care (£74k) and continued increases within Non Elective Pathways.
- **Stockport:** Favorable movement against agreed outturn of £248k due to projected reductions in Neuro Rehab £136K/Non Elective pathways £60k, remaining savings across multiple pathways.
- **UHSM:** Adverse movement against agreed outturn of (£78K) attributable to Day Cases (£30K)/Outpatients (£32K)
- **SRFT:** Favorable movement against agreed outturn of £178K, full year Neuro Rehab £217k/ Adhoc (£60k).
- **Pennine Acute:** Adverse movement against agreed outturn of (£49k) due to continued increases in Ophthalmology/High Cost patient/Maternity.
- **ICFT:** An agreed end of year settlement is in place which has mitigated any potential over performance.

Provider	Year to Date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
TFT	126,421	126,421	()	126,421	126,421	()
CMFT	22,280	23,533	(1,253)	22,280	23,533	(1,253)
SFT	11,969	10,864	1,105	11,969	10,864	1,105
UHSM	6,568	6,985	(417)	6,568	6,985	(417)
PAHT	4,029	3,970	58	4,029	3,970	58
SRFT	3,226	3,273	(48)	3,226	3,273	(48)
WWL	1,409	1,300	109	1,409	1,300	109
BOLT	80	72	8	80	72	8
Total	175,980	176,418	(438)	175,980	176,418	(438)

Acute Referrals Analysis – UPDATE BELOW

- ICFT GP Referrals are down -9.8% compared to same period 15/16 (Apr-Feb). Other referrals have also improved over the same period -0.9%.
- The main areas of GP referral reduction are shown in the below table

GP Referrals to Tameside & Glossop ICFT				
Specialty	2015/16	2016/17 FOT	% Change	Reduction in number of referrals
NEUROSURGERY	159	100	-37%	-59
VASCULAR SURGERY	1,043	687	-34%	-356
ENT	4,215	3,035	-28%	-1,180
GENERAL SURGERY	1,568	1,183	-25%	-385
RHEUMATOLOGY	1,145	925	-19%	-220
NEPHROLOGY	274	223	-19%	-51
Unknown/Other	2,563	2,093	-18%	-470
TRAUMA & ORTHOPAEDICS	4,798	3,980	-17%	-818
OPHTHALMOLOGY	2,807	2,374	-15%	-433
UROLOGY	2,681	2,379	-11%	-302

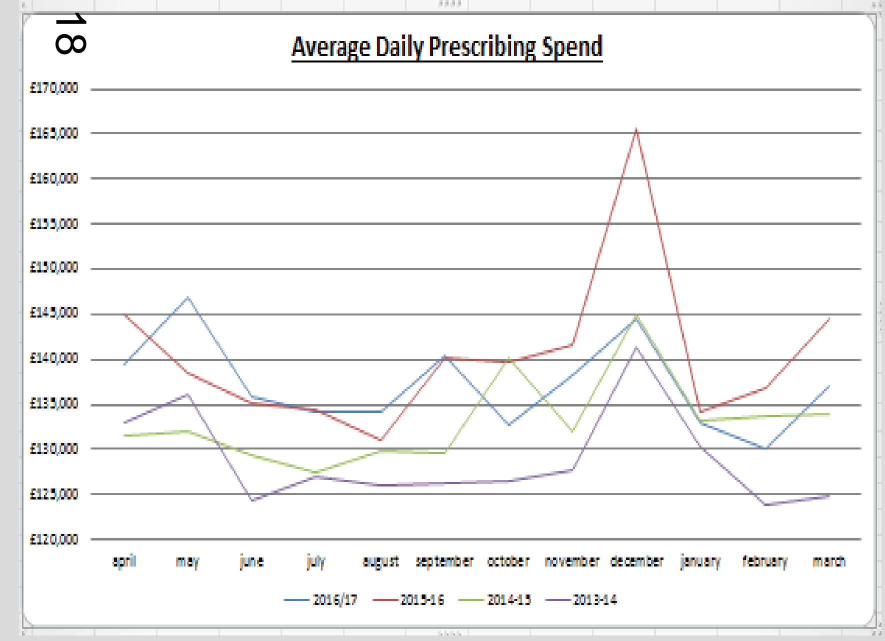
- The main areas of Other referral increase are shown in the below table .

Other Referrals to Tameside & Glossop ICFT				
Specialty	2015/16	2016/17 FOT	% Change	Increase in number of referrals
PAEDIATRIC NEUROLOGY	11	26	138%	15
CARDIOTHORACIC SURGERY	111	145	31%	34
ANAESTHETICS	12	15	27%	3
RESPIRATORY MEDICINE	855	1,075	26%	220
OPHTHALMOLOGY	638	799	25%	161

CCG Key Movements & Narrative: CCG

Prescribing

- As reported previously there has been considerable pressure on the prescribing budget this year. However the year end figure of £41.8m is better than has been anticipated in recent months. This figure includes an accrued figure for March which will prevent a repeat of the cross-year pressure that emerged last year on the prescribing budget .
- The additional pressure on the budget that has been reported in previous months has not fully materialised, which in part is because the winter spike seen in previous years has not been as severe. This is reflected in the graph below which shows the average daily spend for each month.



- The QIPP initiatives implemented by the Medicines Management Team continue to be effective and have resulted in an average daily spend in February of £129,989 on prescribing which is the first time since September 2014 it has fallen below £130k per day.
- Savings on the budget have also been achieved relating to the costs of the Scriptswitch licence and higher than expected rebates being received.
- There is a challenging target for 2017/18 on prescribing which requires additional savings to be achieved if the budget figure of £40.9m is to be achieved. This will require a sustained effort to reduce volumes and will need continued support for both new and existing initiatives implemented by the Medicines Management Team.
- It has been identified that where a reduction in usage of certain drugs has been achieved there has been an increase applied in the prices meaning little impact is seen in overall costs for those drugs. This is indicative of one of the external variables that continue to make accurately forecasting the prescribing position difficult and results in a situation where this particular cost centre will be subject to a degree of volatility that others are not.
- Prescribing remains an area in need of a high level of focus.

Key Movements & Narrative: CCG

Continuing Health Care

- A preliminary review of Continuing Health Care (CHC) costs took place a number of months ago. The data at the time indicated that there was not a significant pressure to the CHC budgets.
- However, at year end, when the full actuals have been extracted from SBS there is an increase than those earlier indications. Also, the charges from TMBC were significantly higher than those expected when the previous review was done.
- The average monthly CHC spend has increased from the first half of the year to the second half of the year. The first 6 months of the year there was an average monthly spend of circa £1.3m across all the CHC cost centres. The second 6 months of the year there was an average monthly spend of more than £1.395m. This surge of costs along with increase in full year costs from TMBC, has a created a further pressure on the CHC budgets than those anticipated.
- Fast Track patients are creating a significant part of this pressure and some of these patients are exceeding the short term timeframe.
- There is an added pressure to next years CHC budgets from the increase in cost of care fees across the economy. There is a increasing concern that the budget set for 2017/18 is already insufficient.

Personal Health Budgets

- The movement in month in Adults PHBs is due to a review of unused funds of some patients. The monies unused have been claimed back from the patients following a detailed clinical review. There is a slight increase in the children's PHBs due to a back payment of one patient's package.

Better Care Fund

- There is a total better care fund of £17,301k in Tameside. Separately the CCG contributes £448k toward the Derbyshire BCF. Total spend has been in line with budgets and is reported to NHS England via the Health & Wellbeing board. Final Q4 metrics are currently being assessed and will be available by June.

Tameside MBC

Narrative	Year End			Movement	
	Budget	Actual	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's
Adult Social Care & Early Intervention	41,995	41,956	39	(1,165)	1,204
Children's Services, Strategy & Early Intervention	25,877	28,684	(2,807)	(2,846)	39
Public Health	1,400	1,264	136	0	136
TMBC Sub Total	**69,272**	**71,904**	**(2,632)**	**(4,011)**	**1,379**

The Council year end financial position has shown an improvement of **£1.379m** from the previously reported figure at month 11. Details of the year end variation's are provided below :

Children's Services (£2.807m deficit)

- Savings initiatives unrealised (£0.9m)
- Increases in the cost of Looked After Children placements due to exceptional additional demand (£1.2m) and agency staff recruitment to address social work caseloads (£0.6m).

Public Health (£0.136m surplus)

- Savings have been realised within Public Health contracts and associated overhead related expenditure.

Adult Social Care (£0.039m surplus)

- There has been a significant improvement in the Adult Social Care financial position. The main improvements are ;
- Additional Homecare expenditure of c£0.303m that had been expected to incur in the final quarter of the financial year did not materialise. This is as a result of commissioned hours being significantly in excess of actual hours provided.
- February 2017 and March 2017 income from client contributions towards community based care packages was higher than expected. This is a significant increase on the previous year's position (£0.250m)
- Funded Nursing Care placements income was greater than projected (£0.356m)
- There have been further reductions in Direct Payments expenditure due to a reduction in client numbers (£0.100m)

Tameside and Glossop ICFT

Description	Month 12 Year End Position			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Income	202,453	212,355	9,902	210,439	(1,916)
Expenditure	210,365	217,166	(6,801)	216,186	(980)
EBITDA	**7,912**	**4,811**	**3,101**	**5,747**	**(936)**
Financing	9,388	8,509	879	8,509	0
Normalised Surplus/(Deficit)	**17,300**	**13,320**	**(3,980)**	**14,256**	**(936)**
Exceptional Items	**0**	**520**	(520)	**520**	0
Net Deficit after Exceptional Costs	**17,300**	**13,840**	**(3,460)**	**14,776**	**(935)**

Financial Position

- For 2016/17 the ICFT has delivered a normalised deficit of £13.3m against its control total which is £3.98m better than plan.
- An exceptional item in relation to the impairment of the value of buildings has increased the Trust's net deficit position to £13.8m.
- In delivering this position the ICFT has:
  - Delivered the Efficiency savings target.
  - Successfully appealed for Q3 and Q4 STF associated with the A&E trajectory.
  - Matched STF for delivery of an improved deficit against plan.
  - Agreed and finalised the Block with Tameside and Glossop CCG
  - Small over performance on associate PbR contracts and we have not fixed these positions.
  - Broadly delivered agency expenditure within the NHSI agency ceiling.

Key Risks going forward.

- The impact of IR35 and renegotiation of rates.
- Delivery of key performance targets and potential increases to the expenditure run rate.

Key Information

- The Trust has successfully appealed the reduction of STF funding relating to delivery of the A&E trajectory for Q3 & Q4.
- Due to the timing of the receipt of any additional cash, a short term uncommitted loan was agreed to fund the deficit.
- The Trust received an additional £1m of STF from NHSI in month 12 to reflect the Trust delivering a deficit better than the plan.

The Financial Gap

Establishing the Financial Gap

- The financial gap as outlined in the locality plan across the health and social care economy in Tameside & Glossop is estimated to be £70.2m by 2020/21.
- In 2016/17 the opening gap was £45.7m which consists of £13.5m CCG, £8m council and £24.2m ICO. Progress towards closing these gaps has been made throughout the year.
- The provider gap represents the non-recurrent financial position for the ICFT. The Trust is forecasting receipt of £8.3m of sustainability and transformation funding in 2016/17 resulting in a forecast year end deficit of £14.5m.
- A detailed savings tracker is currently being developed to include an economy wide position of progress made in bridging the financial gap. This will comprise a variety of informative dashboards which will be used to track progress and highlight any areas of concern and risk. This will be presented to the next meeting.

CCG QIPP Target

- The CCG has fully met the £13.5m financial gap in 2016/17:

Summary of QIPP £'000s	2016/17			
	R	A	G	Total
PRIORITY 1 - Prescribing	0	0	0	**0**
PRIORITY 2 - Effective Use of Resources / Prior Approval	0	0	0	**0**
PRIORITY 3 - Demand Management	0	0	500	**500**
PRIORITY 4 - Single Commissioning Function Responsibilities	0	0	553	**553**
PRIORITY 5 - Back Office Functions and Enabling Schemes	0	0	200	**200**
PRIORITY 6 - Governance	0	0	0	**0**
Other Schemes in progress/achieved:	R	A	G	Total
Neighbourhoods	0	0	459	**459**
Primary Care	0	0	698	**698**
Mental Health	0	0	232	**232**
Acute Services - Elective	0	0	500	**500**
Enabling Schemes to facilitate QIPP	0	0	0	**0**
Technical Finance & Reserves	0	0	6,167	**6,167**
Other efficiencies	0	0	4,191	**4,191**
Grand Total:	0	0	13,500	**13,500**

- The majority of the gap in 2016/17 was closed on a non-recurrent basis.

Recurrent vs Non Recurrent Savings	R	A	G	Total
Recurrent Savings	0	0	1,744	**1,744**
Non Recurrent Savings	0	0	11,756	**11,756**
Total	0	0	13,500	**13,500**

Integrated Commissioning Fund 2016/17

	Year to Date (M12)			Year End			Movement	
Narrative	Budget	Actual	Variance	Budget	Actual	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Acute	197,310	197,708	(398)	197,310	197,708	(398)	(526)	128
Mental Health	29,052	28,757	295	29,052	28,757	295	99	196
Primary Care	81,657	81,715	(58)	81,657	81,715	(58)	(732)	674
Continuing Care	12,251	13,388	(1,137)	12,251	13,388	(1,137)	(377)	(760)
Community	27,483	27,530	(47)	27,483	27,530	(47)	(51)	4
Other	35,510	27,763	7,747	35,510	27,763	7,747	4,413	3,334
CCG Running Costs	5,178	4,411	767	5,178	4,411	767	665	102
CCG Sub Total	**388,441**	**381,272**	**7,169**	**388,441**	**381,272**	**7,169**	**3,491**	**3,678**
Adult Social Care & Early Intervention	41,995	41,956	39	41,995	41,956	39	(1,165)	1,204
Children's Services, Strategy & Early Intervention	25,877	28,684	(2,807)	25,877	28,684	(2,807)	(2,846)	39
Public Health	1,400	1,264	136	1,400	1,264	136	0	136
TMBC Sub Total	**69,272**	**71,904**	**(2,632)**	**69,272**	**71,904**	**(2,632)**	**(4,011)**	**1,379**
GRAND TOTAL	**457,713**	**453,176**	**4,537**	**457,713**	**453,176**	**4,537**	**(520)**	**5,057**

	Year to Date Budget	Year to Date Actual	Year to Date Variance	Year End Budget	Year End Actual	Year End Variance
A: Section 75 Services	**236,568**	**232,790**	**3,778**	**236,568**	**232,790**	**3,778**
CCG	194,544	190,954	3,590	194,544	190,954	3,590
TMBC	42,024	41,836	188	42,024	41,836	188
B: Aligned Services	**188,468**	**188,312**	**155**	**188,468**	**188,312**	**155**
CCG	161,220	158,244	2,975	161,220	158,244	2,975
TMBC	27,248	30,068	(2,820)	27,248	30,068	(2,820)
C: In Collaboration Services	**32,677**	**32,074**	**603**	**32,677**	**32,074**	**603**
CCG	32,677	32,074	603	32,677	32,074	603
TMBC	0	0	0	0	0	0

Risk and Other Issues

- 2016/17 financial year is now complete and we have delivered all required financial targets. Accounts have not yet been audited, but we do not anticipate any issues in this process.
- The main financial risks to the recurrent position of the the Integrated Commissioning Fund are listed below.
- Detailed registers including further information on risk and mitigating actions are regularly reviewed at Audit Committee. Copies are available on request.
- IR35 – With effect from 6 April 2017, the legislation associated with employing 'off payroll' workers will change. This has a potential financial risk due to a reduction in the availability of 'off payroll' workers which could lead then to higher related costs if they are subsequently employed by the Economy. This is a particular risk to staffing at the A&E department.

Transformation Funding

- Transformation funding of £23.2m has been approved by Greater Manchester Health & Social Care Partnership. The Investment Agreement that will support the release of the funding been developed and was signed on 16 December 2016. The year 1 funding of £5.2m has now been made available to the economy and it is expected that this money has been fully accounted for in 2016-17.

Financial risk impacting recurrent position of ICF	Probability	Impact	Risk	RAG
Not spending transformation money in a way which delivers required change	2	4	8	A
Over spend against GP prescribing budgets	4	4	16	R
Over spend against Continuing Health Care budgets	4	4	16	R
Operational risk between joint working.	1	5	5	A
Over spend on PbR contracts	3	4	12	A
CCG Fail to maintain expenditure within the revenue resource limit and achieve a 1% surplus.	1	4	4	G
In year cuts to Council Grant Funding	2	3	6	A
Care Home placement costs are dependent on the current cohort of people in the system and can fluctuate throughout the year	4	4	16	R
Looked After Children placement costs are volatile and can fluctuate throughout the year	3	4	12	A
Unaccompanied Asylum Seekers	4	3	12	A
Care Home Provider Market Failure	3	5	15	R
Funded Nursing Care – impact of national changes to contribution rates and potential legal challenge	4	3	12	A
IR35 – the potential impact of reduced availability of 'off payroll' workers from 6 April 2017 and the increased cost impact if they are subsequently employed by the Economy.	4	4	16	R

Section 2

Care Together Economy

Capital Financial Position

Tameside MBC

Scheme	Approved Capital Programme Total	Approved 2016/2017 Allocation	Total Expenditure 2016/2017	2016/2017 Outturn Variation	Scheme Comments
	£'000	£'000	£'000	£'000	
Children's Services - In Borough Residential Properties	**912**	**912**	**786**	**126**	Purchase of 2 additional in-borough properties including associated property adaptations. Options to provide an Edge of Care establishment are currently being considered.
Public Health - Leisure Estate Reconfiguration	**20,268**	**3,814**	**3,580**	**234**	**Active Dukinfield (ITRAIN)** - The scheme is complete and the facility fully operational. **Active Longdendale (Total Adrenaline) -** The scheme is complete and the facility is fully operational **Active Hyde (Pool Extension)** – Enabling works have been completed. The scheme is out to tender and will take 8 months to complete from contract award. **Denton Wellness Centre –** Key Decision being developed which seeks approval for proposals to secure the timely delivery of the Denton Wellness Centre project. Its is anticipated that work will start in late 2017.
Adult Services - Disabled Facilities Grant - Adaptations	**1,978**	**1,978**	**1,474**	**504**	The residual value of grant remaining will be utilised in 2017-18 to ensure as many people as possible are supported to live independently within their own homes.
Total	**23,158**	**6,704**	**5,840**	**864**	

Section 3

GM Transformation Fund

Progress Update

GM Transformation Funded Schemes

Scheme Description	Progress
Home First	Underway – delivering reduced length of stay
Digital Health	Underway – pilot commenced in March 2017
Neighbourhoods	Recruitment to some posts completed. Caseload reviews commenced in April 2017
System Wide Self Care	Delivery commenced 1 April 2017 in Glossop. Tender launched 31 March 2017 for Tameside
Flexible Community Beds	Beds opened in November 2016
Home Care	In Development
Organisational Development	Economy OD engagement events taken place. Future sessions in neighbourhoods to be arranged
Estates	Underway

Section 4

Tameside & Glossop

2017/2018 Funding Allocations

2017/2018 FUNDING SUMMARY

Economy Summary	2017/2018 Net Resource	2017/2018 Net Expenditure Forecast	Control Total Deficit / (Surplus)	Savings Target
	£'000	£'000	£'000	£'000
CCG	381,491	401,895	(3,496)	23,900
TMBC	96,438	96,438	0	773
ICFT	204,752	239,424	24,347	10,325
Total				34,998

RAG Rating Of Savings Target

	RED	AMBER	GREEN	TOTAL
	£'000	£'000	£'000	£'000
CCG	4,098	3,437	16,365	23,900
TMBC	0	347	426	773
ICFT	3,421	3,757	3,147	10,325
Total	7,519	7,541	19,938	34,998

CCG

Savings presented are after the application of optimism bias
Unidentified savings are categorized as red
Does not factor in impact of post budget setting pressures (e.g. CHC & Healthier Together)

TMBC

Related overheads are excluded
The additional funding for Adult Social Care announced by the Government on 8 March 2017 is also excluded

ICFT

The ICFT 2017/18 plan is for a deficit of £24.3m.
The Trust therefore requires a £24.3m revenue loan from the Department of Health to provide the cash to fund the deficit. There is a risk this could be repayable in future years.

Cover

Q4 2016/17	
Health and Well Being Board	**Tameside**
completed by:	Ali Rehman
E-Mail:	alirehman@nhs.net
Contact Number:	0161 342 5637
Who has signed off the report on behalf of the Health and Well Being Board:	Members of the Health and Wellbeing Board

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

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. I&E	19
5. Supporting Metrics	13
6. Year End Feedback	13
7. Additional Measures	67
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board: Tameside

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you now confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Tameside

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?
1) Plans to be jointly agreed	Yes	Yes	Yes	Yes	
2) Maintain provision of social care services	Yes	Yes	Yes	Yes	
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes	Yes	Yes	
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be	Yes	Yes	Yes	Yes	
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	No - In Progress	No - In Progress	No - In Progress	No	The testing and roll out of Liquidlogic's Personal Demographic System has been stalled due to the decision by NHS Digital in December 2016 to put a hold on all current applications for approval whilst they amended their Governance process. Tameside have been in regular contact with NHS Digital and have also had support from
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes	Yes	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes	Yes	
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes	Yes	Yes	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes	Yes	Yes	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes	Yes	
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes	Yes	

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed
The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2016-17.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number
The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that,
Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may
Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.
This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Tameside

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	£16,941,000
	Forecast	£3,855,000	£3,855,000	£6,500,000	£3,090,756	£17,300,756	
	Actual*	£3,855,000	£3,855,000	£6,788,103			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	£16,941,000
	Forecast	£3,855,000	£3,855,000	£6,500,000	£3,090,756	£17,300,756	
	Actual*	£3,855,000	£3,855,000	£6,788,103	£2,802,653	£17,300,756	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	N/A

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	£16,941,000
	Forecast	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	
	Actual*	£3,365,751	£3,401,754	£6,788,103			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	£16,941,000
	Forecast	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	
	Actual*	£3,365,751	£3,401,754	£6,788,103	£3,745,148	£17,300,756	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	The pooled fund was £17.301m in 16-17, the annual total agrees with the pooled fund arrangement
Commentary on progress against financial plan:	All funds were spent in accordance with national conditions and locally agreed priorities to support hospital discharge and independent living.

Footnotes:
*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Tameside
Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	We have increased our reduction in non-elective admissions throughtout the year. Our focus on Home First builds on our schemes to avoid Non-elective admissions. We have seen an increase against plan in regards to Ambulatory Emergency Care and the Alternative to Transfer and Integrated Urgent Care Team are providing alternatives to A&E attendance and admissions. We are using practice level risk
Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	There has been a reduction in the number of people delayed in December 2016 onwards. Our Home First model includes a discharge to Assess process that has reduced DTOCs. Improvements in home care have reduced delays due to social care. The key issue is more complex patients requiring care home placements and families waiting for homes of choice. Work is ongoing to recduce delays due to
Local performance metric as described in your approved BCF plan	Newly diagnosed patients on primary care dementia registers
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our Dementia Diagnosis rate for 16/17 is not yet available however our practices are continuing their work to identify new patients and provide appropriate support. Dementia is currently an area the CCG has been assessed in the IAF as performing well.
Local defined patient experience metric as described in your approved BCF plan	Overall satisfaction of people who use services with Their Care and Support. The original submission used financial years building on a baseline of 61.6 from 2013/14 and had a Q4 14/15 position of 64.6 15/16 out-turn was 58.74
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Annual - Adult Social Care Survey The information in the template needs to be amended, the 61.6 relates to 2013-14 out-turn and the 64.51 relates to 2014-15 out-turn. The 15/16 out-turn was 58.74. The out-turn for 4th Quarter 2016-17 is 60.38%.
Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	4th Quarter 2016-17 permanent admissions to residential and nursing care 65+ is 241 for the period April 2016 - March 2017.
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	This indicator is an annual indicator and no further data is available, the measure captures all service users 65+ who have been discharged from hospital into reablement / rehabilitation service for the period October 2016 - December 2016 and then a follow up review is completed during January - March 2017 to see if they are still at home 91 days later. The out-turn figure 2016-17 is 81.76%.

Footnotes:

For the local performance metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB.

For the local defined patient experience metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB, except in cases where HWBs provided a definition of the metric for the first time within the Q1 16-17 template.

Year End Feedback on the Better Care Fund in 2016-17

Selected Health and Well Being Board: Tameside

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Neither agree nor disagree	The Care Together integration plans for Health and Social Care within Tameside and Glossop have been developing over three to four years and the BCF was only a small part of the plans and it has been the whole system plans rather than the BCF that has driven the integration
2. Our BCF schemes were implemented as planned in 2016/17	Agree	The implementation of the transformed services has continued.
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Neither agree nor disagree	The Care Together integration plans for Health and Social Care within Tameside and Glossop have been developing for many years and we now operate as a Single Commissioning (CCG and TMBC) and an Integrated Care Foundation Trust. The BCF was only a small part of the plans and it has been the whole system plans rather than the BCF that has driven the integration
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Neither agree nor disagree	The teams and proactive work that is designed to reduce NEL are parter of the wider health and social care integration not just within the BCF. Much of the work was already being developed and some teams were already integrated although funding was separate
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Neither agree nor disagree	The teams that support reduced DTOC whilst part of the BCF were already integrated and part of the wider Care Together Plan. The increase in Home First and Discharge to Assess has reduced the level of Delayed Transfers of Care particularly in an acute bed.
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Neither agree nor disagree	The service was already delivering good outcomes for people and this has been maintained
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Neither agree nor disagree	The wider integration work around Home First has reduced the need for more complex packages of care in someone own home and as the team work with people whoare more complex they may be able to reduce the need for a care home admission

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **successes**	Response category:
Success 1	The development of the voluntary sector offer to local people as part of a wider health and social care offer is a key element to our integration plans and build on the success of the over 75s work that was funded through BCF	3. Collaborative working relationships

Success 2	The role of Pharmacists in the wider care of people working across primary and secondary care has been developed building on the learning from the over 75s work that was part of the BCF	4. Integrated workforce planning
Success 3	The integrated teams and wider focus on Care Together has faciliatated more cross organisational development and fostered greater understanding which has resulted in improved holistic care for people	4. Integrated workforce planning

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	The development of integrated data and information systems across health and social care remains a challenge.	7. Digital interoperability and sharing data
Challenge 2	The BCF metrics tend to focus on immediate benefits rather than the longer term benefits that come form increased integration around proactive care.	5. Evidencing impact and measuring success
Challenge 3	The BCF was a very small part of our Care Together plans has meant it is impossible to attribute success to the BCF schemes as individual schemes	5. Evidencing impact and measuring success

Footnotes:

Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Shared vision and commitment
2. Shared leadership and governance
3. Collaborative working relationships
4. Integrated workforce planning
5. Evidencing impact and measuring success
6. Delivering services across interfaces
7. Digital interoperability and sharing data
8. Joint contracts and payment mechanisms
9. Sharing risks and benefits
10. Managing change

Other

Additional Measures

Selected Health and Well Being Board: Tameside

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	No	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Hospital	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Live	In development	In development	In development	In development	Unavailable
Projected 'go-live' date (dd/mm/yy)		31/12/2017	31/12/2017	31/12/2017	31/12/2017	01/01/9999

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	No pilot underway

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	13
Rate per 100,000 population	6

Number of new PHBs put in place during the quarter	2
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	85%

Population (Mid 2017)	222,966

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).

https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1

Population figures were updated to the mid-year 2017 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board: Tameside

Remaining Characters	31,937

Please provide a brief narrative on overall progress, reflecting on performance in Q4 16/17 and the year as a whole. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

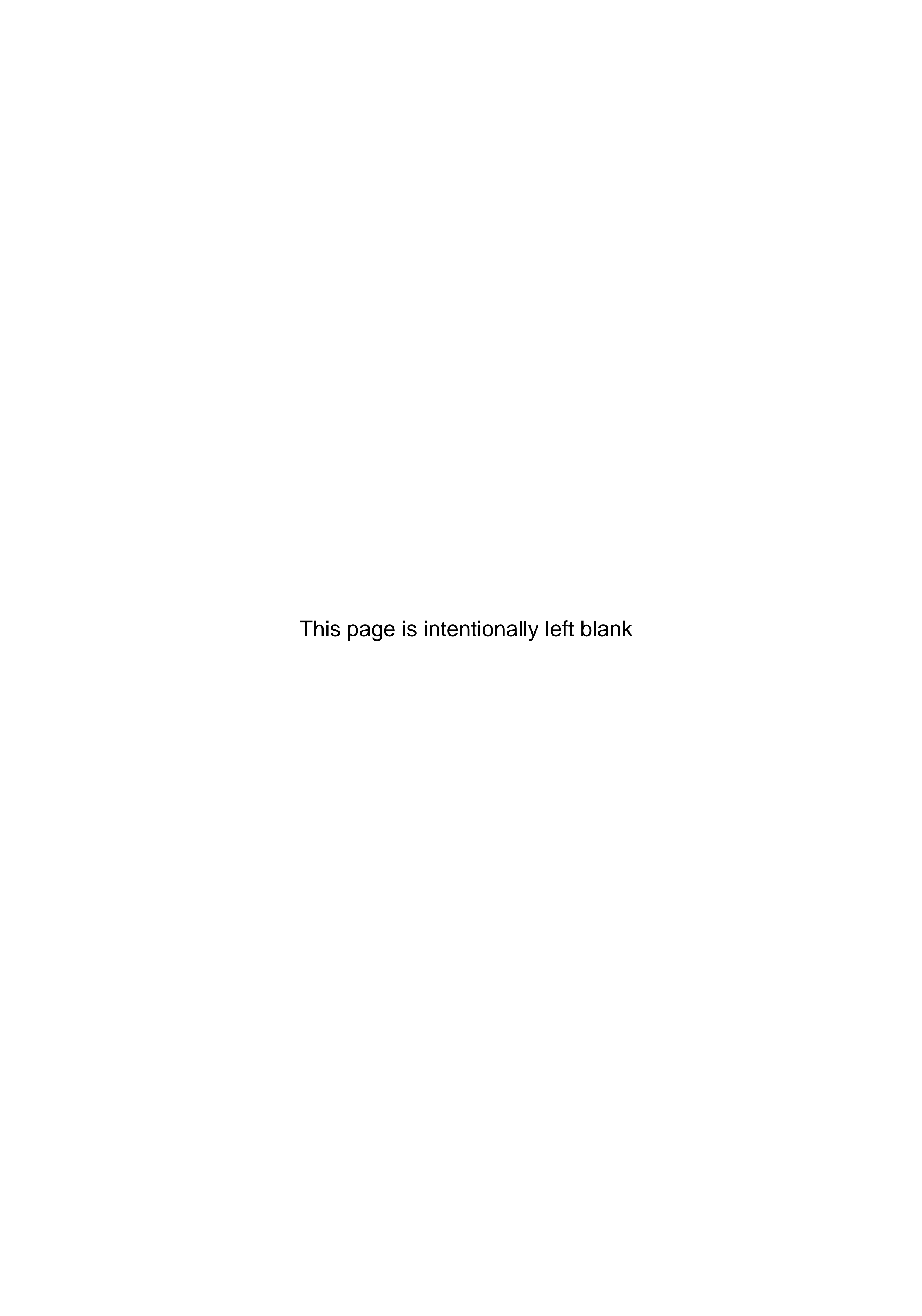
Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Our Transformation Plans are being implemented at both commissioner and provider levels , with the Single Commission comprising NHS Tameside and Glossop CCG and TMBC and the Tameside and Glossop Integrated Care NHS Foundation Trust both fully operational.

Our Integrated Neighbourhood and Home First plans are providing a strong foundation for improving the health and wellbeing of our local population and supporting people who need additional care to remain at home for as long as possible.

The wider integration work has a strong focus on building community assets with the local voluntary sector being fully integrated into the wider health and social care offer. This whilst not part of BCF as such has built on some of the initiatives that the local GPs developed through their over 75s offers that were part of the BCF.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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	29 June 2017
Executive Member / Reporting Officer:	Councillor Brenda Warrington, Executive Member (Adult Social Care and Wellbeing) Jessica Williams, Programme Director, Tameside and Glossop Care Together
Subject:	**INTEGRATION REPORT – UPDATE**
Report Summary:	This report provides Tameside Health and Wellbeing Board with progress on the implementation of the Care Together Programme and includes developments since the last presentation in March 2017. The report will be accompanied by a showcase presentation on the delivery plans for social prescribing. High level milestones for 2017/18 and 18/19 are included to demonstrate alignment with Greater Manchester Health and Social Care Partnership plans and to meet our collective ambitions.
Recommendations:	The Health and Wellbeing Board is asked: 1. To note recent developments of the Care Together Programme including the move from design to implementation phase of the programme; 2. To note from the report and presentation the high level deliverables of the programme within 2017/18 and into 18/19 including the strategic and operational aspects; 3. To note the approach and implementation plan for social prescribing across Tameside and Glossop and; 4. To receive a further update at the next meeting.
Links to Health and Wellbeing Strategy:	Integration has been identified as one of the six principles agreed locally to achieve the priorities identified in the Health and Wellbeing Board Strategy
Policy Implications:	One of the main functions of the Health and Wellbeing Board is to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.
Financial Implications: **(Authorised by the Section 151 Officer)**	The Tameside and Glossop health and social care economy had a projected £70 million financial gap by 2020/21, the delivery of which will be supported by the Care Together Programme. It is essential that the approved Greater Manchester Health and Social Care Partnership funding of £23.2 million is expended in accordance with the investment agreement and recurrent efficiency savings are subsequently realised across the economy.
Legal Implications: **(Authorised by the Borough Solicitor)**	It is important to recognise that the Integration agenda, under the auspices of the ‘Care Together’ banner, is a set of projects delivered within each organisation’s governance model and delivered jointly under the Single Commissioning

	Board together with the Integrated Care Foundation Trust. However, the programme itself requires clear lines of accountability and decision making due to the joint financial and clinical implications of the proposals. It is important as well as effective decision making processes that there are the means and resources to deliver the necessary work. This is to provide confidence and oversight of delivery. We need to ensure any recommendations of the Care Together Programme Board are considered / approved by the constituent bodies to ensure that the necessary transparent governance is in place.
Risk Management :	The Care Together Programme has an agreed governance structure with a shared approach to risk, supported through a project support office
Access to Information :	The background papers relating to this report can be inspected by contacting Jessica Williams, Programme Director, Tameside and Glossop Care Together Telephone: 0161 304 5389 e-mail: jessicawilliams1@nhs.net

1. INTRODUCTION

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

1.2 The report describes the high level milestones for the programme within 2017/18 and 18/19 in order to ensure alignment with the Greater Manchester Health and Social Care plans and also to meet our collective ambitions.

1.3 The report covers:
- Greater Manchester Health and Social Care Partnership;
- Programme Management;
- Programme Milestones;
- Operational Progress;
- Recommendations.

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

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

2.2 Monitoring of the Investment Agreement within the locality takes place on a fortnightly basis at the Finance Economy Workstream and at the quarterly Care Together Programme Board. It is envisaged that progress updates will be provided to Greater Manchester on a quarterly basis although the format for this has not yet been finalised by the Greater Manchester Health and Social Care Partnership.

2.3 The transformational funding award unfortunately does not include any capital for IM&T and Estates. The Programme Management Office continues to liaise with the Greater Manchester Health and Social Care Partnership and NHS Improvement to understand the potential for funding bids and has taken steps to ensure that as soon as funding opportunities arise, Tameside and Glossop are able to make a strong submission.

2.4 The original funding award also did not include programme management support. As other Localities have now been granted support to develop the transformational funding bids, Tameside and Glossop have been invited to request additional funds. This bid was submitted on 23 March for £0.995 million and we are waiting to hear the outcome.

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

3. PROGRAMME MANAGEMENT

3.1 In order to ensure robust economy wide financial delivery plans and provide the necessary assurance to the Greater Manchester Health and Social Care Partnership on the expenditure and associated benefits of transformational funding, additional capacity and project management capability has been procured and a Care Together Programme Management Office has been established. This support has been procured from

Pricewaterhouse Coopers following a comprehensive procurement process and has been in operation since March 2017.

3.2 Pricewaterhouse Coopers were commissioned to support the programme to establish a robust programme management framework to drive the successful delivery of the Care Together programme, and strengthen the existing transformation schemes in order to reach their full potential. To date, we have rolled out a gateway approach and standardised reporting and processes for: scheme planning, funding spend, benefit tracking and early warning indicators.

3.3 This work has been commended by the Greater Manchester Health and Social Care Partnership and we have shared our learning through their "Deep Dive" assessment process. The aim is to recruit a substantive Programme Management Office to take forward this work within the economy and to start to work on further options to strengthen existing transformational schemes and develop additional schemes to help achieve the significant economy wide financial challenge.

3.4 Previously known as the Adult Social Care Transaction Steering Group, this continues to meet monthly and now incorporates the transaction of operational commissioning staff to support the development of Integrated Care Foundation Trust. This group is supporting the development of an Outline Business Case for approval through respective organisations governance processes in August 2017, a full business case in December 2017 and a transaction on 1 April 2018.

3.5 The GP Clinical Leads for Neighbourhoods transferred into the Integrated Care Foundation Trust from April 2017 and are now working across the economy to build effective, high quality pathways of care across the health and social care system. The Integrated Care Foundation Trust Joint Management Team which encompasses GP clinical leads, social care, public health as well as secondary care clinical directors has been responsible for prioritising transformation funding expenditure in neighbourhoods and will be supporting the delivery of benefits.

3.6 It should be noted however, that transactions are secondary to the transformation of health and social care services already underway with the development of Integrated Neighbourhoods. The detail of how these teams are starting to perform will be described within the presentation accompanying this report.

4. OPERATIONAL PROGRESS

Single Commissioning Function

4.1 Following an internal review of the way forward for commissioning across Tameside and Glossop and understanding more about Greater Manchester Health and Social Care Partnership views on the future of commissioning, a consultation process has been held and new senior management structure implemented. This identifies our direction from operational commissioning to strategic, place based public sector commissioning and shows the correlation with the life course, as outlined and approved in the Health and Wellbeing Board strategy.

4.2 Next steps to achieve strategic commissioning include alignment of clinical leadership to the life course, review of commissioning governance structures, identify the process to develop a longer term outcomes based contract with the Integrated Care Foundation Trust and the development of high level milestones to ensure delivery of progress. Updated and comprehensive governance structures will be presented at the next Health and Wellbeing Board once these have been subject to discussion and where appropriate, decision by the statutory bodies.

4.3 During 2017/18, there is also the intention to roll out of an organisational development programme to test and reaffirm the Care Together vision and to ensure political, clinical and managerial alignment.

Integrated Care Foundation Trust

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

4.5 Key in the development of the Integrated Care Foundation Trust is the development and roll out of the Integrated Neighbourhood teams and social prescribing. This work is at the core of the transformation of services and further detail on social prescribing will be provided via the accompanying presentation.

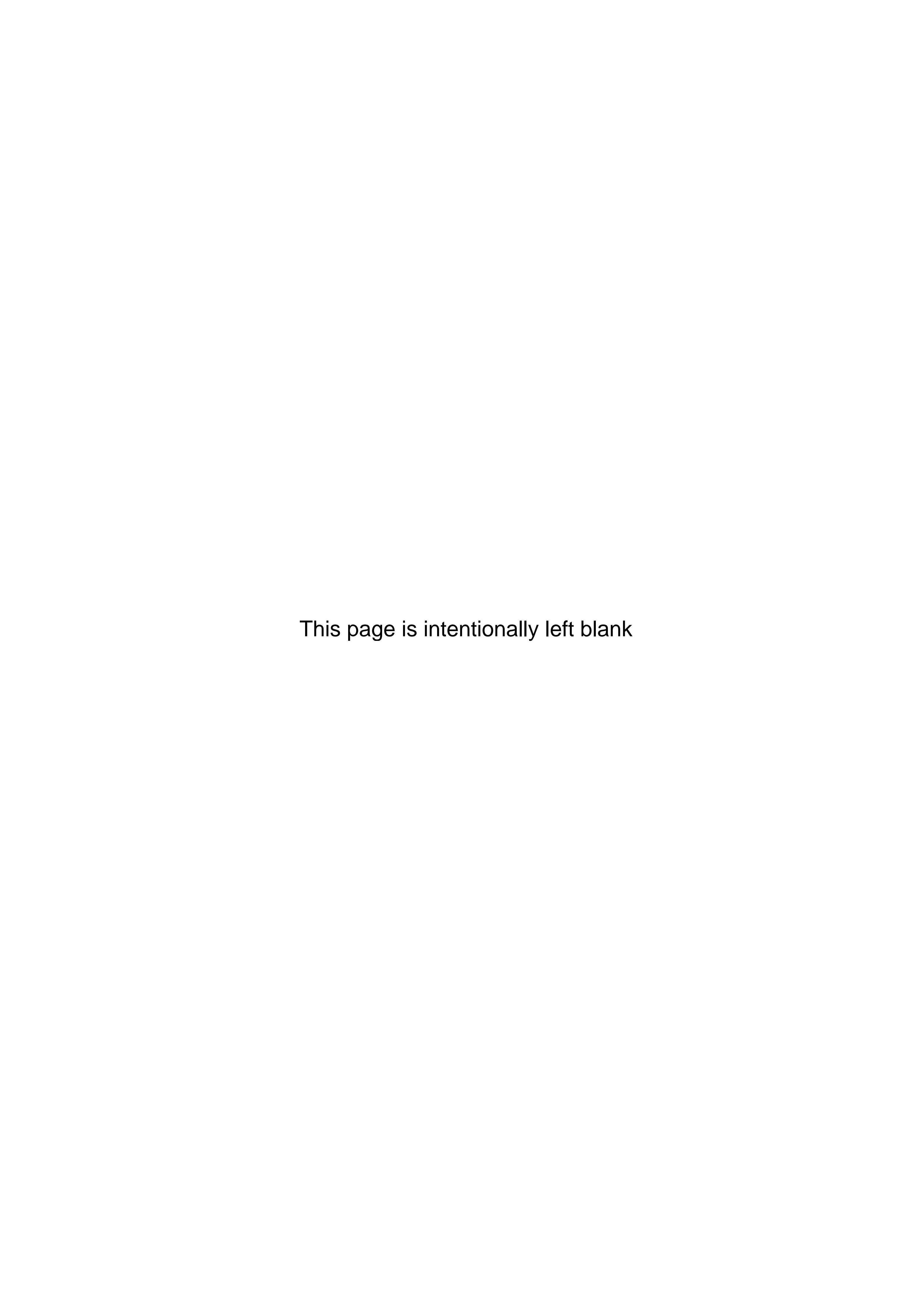
5. PROGRAMME MILESTONES

5.1 The Care Together programme is now in implementation phase. Transformation schemes are being rolled out with key performance indicators and benefits being constantly assessed and where appropriate, strengthened.

5.2 High level implementation milestones are proposed in **Appendix A** but it should be noted that these cannot be viewed in isolation. As the Tameside Corporate Plan develops, public engagement and consultation continues, the Partnership/Stakeholder Board informs strategy and guidance from the Greater Manchester Health and Social Care Partnership is adopted when agreed, these milestones or priorities may change.

6. RECOMMENDATIONS

6.1 As stated on the front of the report.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APPENDIX A – CARE TOGETHER PROPOSED HIGH LEVEL MILESTONES

	2017/18				2018/19
	Q1	Q2	Q3	Q4	
Transformation	IN GP leads transferred to ICFT Roll out of IN working Roll out of GM funded schemes	Increase Estates capacity Social prescribing embedded OD for Strategic Commissioning	IN "Hub" full business cases Intermediate care strategy implementation Workforce detailed action plan including new roles	Integrated Urgent Care system in place New Home Care Contract Aligned General Practice / IN incentives	Optometry, Dentistry and Pharmacy alignment with Neighbourhood schemes Engaged workforce IM&T full connectivity across health and social care
Transaction /contractual	2yr bilateral contract with Pennine Care 17/18 pooled budget	Recruit PMO for 18 mths Agree MH integrated approach	Formal TUPE engagement and consultation Agree key outcomes for ICFT contract 18/19	Complete due diligence on transaction Agree benchmark for contractual outcomes	Transfer and embed Adult Social Care into ICFT Transfer and embed operational commissioning functions into ICFT
Governance/ Process	Pennine Care join CTPB Continue public engagement	Introduce stakeholder partnership board New clinical & mgt in Commissioning Consultation on service strategies	Implement T&G Information Governance Board to Board to Board to define principles	Identify key milestones for 18/19	Transfer PMO to ICFT by year end

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TAMESIDE AND GLOSSOP

Care together

Implementing Care Together

Jessica Williams, Programme Director &

Giles Wilmore, Director of Strategy

Health and Wellbeing Board

29th June 2017

Our Care Together Programme

- Improving public sector outcomes through comprehensive place based strategies based on more successful families, maximising employment and people who age well
- Aligned political, clinical and managerial leadership
- Key aims of driving up Healthy Life Expectancy (HLE), reducing inequalities and creating financial sustainability
- Two main programmes;
  - Development of a strategic, place based commissioner focused on improving outcomes
  - Creation of a lead provider to manage majority of health and social care service provision (T&G uses FT license)
- Aligned to GM HSCP vision and objectives

Defining success

- Improvements in population outcomes e.g.; reducing isolation & loneliness, increased levels of employment, reducing demand for health and social care services
- Development of high quality, place based services used optimally and understood by the population
- Reduced financial pressure across stakeholders
- Supportive, mature relationships with variety of providers
- Increased capacity and capability across economy to drive innovative models of care
- Recognised as commissioning and delivering excellence

Objectives moving forwards

	2017/18				2018/19
	Q1	Q2	Q3	Q4	
Transformation	IN GP leads transferred to ICFT Roll out of IN working Roll out of GM funded schemes	Increase Estates capacity Social prescribing embedded OD for Strategic Commissioning	IN “Hub” full business cases Intermediate care strategy implementation Workforce detailed action plan including new roles	Integrated Urgent Care system in place New Home Care Contract Aligned General Practice / IN incentives	Optometry, Dentistry and Pharmacy alignment with Neighbourhood schemes Engaged workforce IM&T full connectivity across health and social care
Transaction /contractual	2yr bilateral contract with Pennine Care 17/18 pooled budget	Recruit PMO for 18 mths Agree MH integrated approach	Formal TUPE engagement and consultation Agree key outcomes for ICFT contract 18/19	Complete due diligence on transaction Agree benchmark for contractual outcomes	Transfer and embed Adult Social Care into ICFT Transfer and embed operational commissioning functions into ICFT
Governance/ Process	Pennine Care join CTPB Continue public engagement	Introduce stakeholder partnership board New clinical & mgt in Commissioning Consultation on service strategies	Implement T&G Information Governance Board to Board to Board to define principles	Identify key milestones for 18/19	Transfer PMO to ICFT by year end

Social Prescribing Components

- Procurement process complete – implementation for Tameside from Sept 17
- Commenced in Glossop

Delivery of access to more than medicine interventions

Social Prescribing

Asset Based Approaches

Self Management Education

Social Action and Volunteering

Enablers

Workforce and Culture

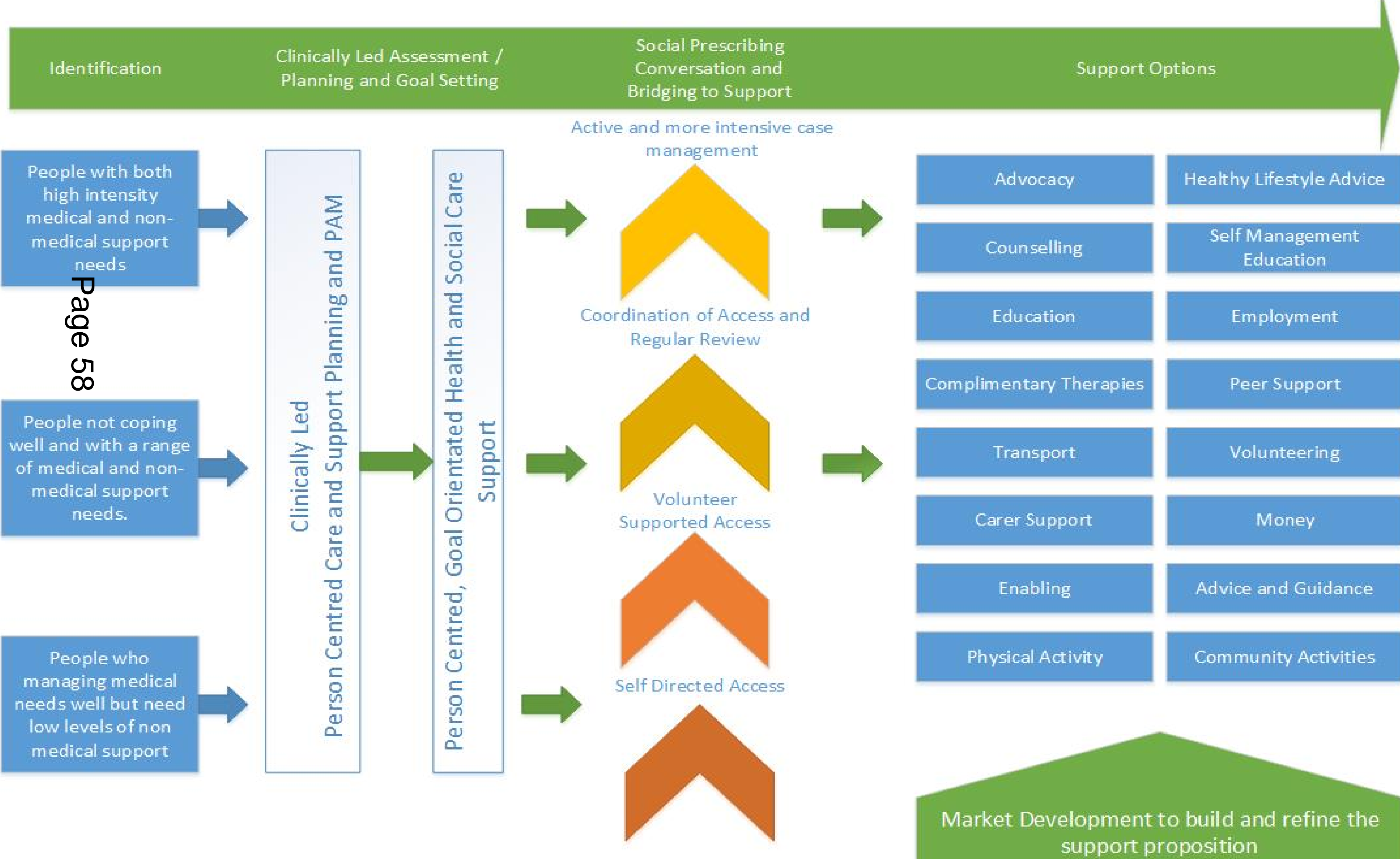
Person Centred Care and Support Planning

Partnership Approaches

Public Behaviour Insights and Change

Evaluation and Evidence

Social Prescribing Pathway



Report to:	**HEALTH AND WELLBEING BOARD**
Date:	29 June 2017
Executive Member / Reporting Officer:	Angela Hardman, Executive Director – Public Health, Business Intelligence and Performance Gideon Smith, Consultant in Public Health Medicine
Subject:	**UPDATE ON TRENDS IN LIFE EXPECTACY AND MORTALITY RATES**
Report Summary:	The report analyses the most recent mortality data, outlining changes in the calculation of Healthy Life Expectancy. At the meeting in January Health and Wellbeing Board members agreed that while the priorities of the Health and Wellbeing Strategy were upheld, that a refresh and alignment with the recently developed Locality Plan into a Population Health Implementation Plan for Tameside would be developed. The findings in the report aim to inform the refresh.
Recommendations:	The Health and Wellbeing Board is asked to: • Note the content of the report; • Consider the challenges for improving life expectancy and healthy life expectancy and the recommendations for future action; • Endorse a refresh of the Locality Plan to ensure a local Population Health Implementation Plan is developed to be presented to September's Health and Wellbeing Board.
Links to Health and Wellbeing Strategy:	The Health and Wellbeing Strategy reflects the local needs and priorities for health identified in the most recent Joint Strategic Needs Assessment. This report updates elements of the JSNA, and confirms the main existing priorities of the Strategy.
Policy Implications:	This review confirms the key priorities of a range of current local strategies, plans and policies. Changes in the calculation of life expectancy mean that the current Tameside and Glossop Locality Plan ambition will need to be reviewed.
Financial Implications: (Authorised by the Section 151 Officer)	There are no direct financial implications arising from the report at this stage. However it is essential to note that consideration should be given to the financial implications associated with the local population health improvement plan once it has been updated later this financial year. Available resources should be aligned and prioritised to the expected health needs of the local population and reviewed on an ongoing basis thereafter. The locality currently has an existing projected financial challenge of £ 70.2 million to address by 2020/2021.

Legal Implications: (Authorised by the Borough Solicitor)	The Council has a statutory duty to deliver value for money services – to be value for money they must be services that are required and deliver improved outcomes for residents. Consequently an important outcome in setting the Council's priorities within a reducing budget is to gather intelligence to understand both need and whether maximum impact can be made.
Risk Management :	There are no risks associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Gideon Smith, Consultant in Public Health, by: Telephone: 0161 342 4251 Gideon.smith@tameside.gov.uk

1. PURPOSE AND KEY ISSUES

1.1 The report analyses the most recent mortality data, outlining changes in the calculation of Healthy Life Expectancy. At the meeting in January Health and Wellbeing Board members agreed that while the priorities of the Health and Wellbeing Strategy were upheld, that a refresh and alignment with the recently developed Locality Plan into a Population Health Implementation Plan for Tameside would be developed. This report aims to inform that refresh.

1.2 Review of the most recent mortality data reconfirms the commitments of current local strategic statements:

- Recent mortality trends highlight the importance of tackling premature cardiovascular, respiratory and liver disease.
- The Tameside and Glossop Right Care programme highlights the importance of tackling circulatory and respiratory disease.
- Current Tameside Health and Wellbeing Board 'Turning the Curve' priorities of smoking, physical activity and blood pressure will impact on circulatory and respiratory disease.
- The updated Tameside Alcohol Strategy will contribute to reducing circulatory and liver disease.
- Local impact of implementation of the Greater Manchester Population Plan will make important contributions to reducing premature deaths.

1.3 Changes in the calculation of life expectancy mean that the current Tameside and Glossop Locality Plan ambition will need to be reviewed.

1.4 Care Together continues to be the key vehicle for realisation of the Locality plan ambition to increase healthy life expectancy at pace.

1.5 Challenges for improving life expectancy highlighted in this review:

- Reducing deaths in people aged 15 years to 64 years; this means a reduction in male deaths of at least 51 each year and 21 less deaths for females.
- Targeting females in particular around life style issues
- Finding the missing thousands from the disease registers. People with a condition will then get the appropriate care and interventions that will help them live longer and manage their condition better.
- Using risk stratification data to ensure that people in the risk groups 20% to 69% have access to the relevant services and interventions that allows them to improve their outcomes

2. CHANGES TO THE METHOD FOR CALCULATING LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY

2.1 In November 2016, the Office for National Statistics implemented a revised methodology for the calculation of healthy life expectancy and life expectancy at birth by using an upper age band of 90 and over; whereas previously the upper age band was set to 85 and over. The change was made to reflect an increasing proportion of deaths at ages 85 and over, and

results in greater accuracy of healthy life expectancy estimates. The new methodology has been implemented for healthy life expectancy figures from 2009-11 onwards.

Local impact (see Appendix A)

2.2 For Tameside this change in methodology has had a profound effect on both healthy life expectancy and life expectancy at birth outcomes.

The table illustrates the change in life expectancy at birth between the old and new methodology for Tameside for 2009/11 to 2013/15. It shows that the new calculation has had a positive impact on overall trends in life expectancy over the last five years with the new methodology showing a higher life expectancy result over all.

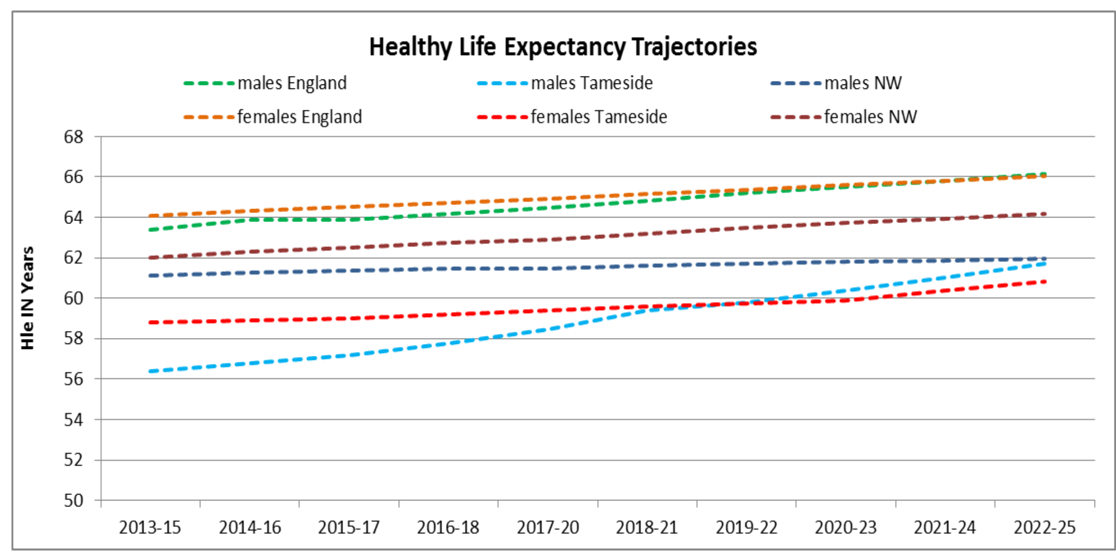
Old Methodology		New Methodology	
Life Expectancy			
Males	Females	Males	Females
75.6	80.2	75.8	80.4
75.9	80.5	76.3	80.6
76.3	80.6	76.8	80.4
76.9	80.3	77.2	80.7
77.3	80.6	77.3	80.7

2.3 For Healthy Life Expectancy the change has increased the figures for 2009/11 and 2010/12, but there is reduced Healthy Life Expectancy for males for 2012/14 and 2013/15, and although for females the movement is positive overall the increase is not as steep as the with the previous method.

Why has the male Healthy Life Expectancy has reduced by 2 years?

2.4 Male death rates in Tameside and in particular deaths under 75 years are significantly worse than the England average and that there are wide inequalities between male and female life expectancy and mortality within Tameside and Glossop. In addition, unlike Life Expectancy which uses purely population and mortality data, Healthy Life Expectancy also uses survey data relating to people’s perception of their own health as ' good to bad'. This is very subjective and is not a whole population perspective. The survey is annual and the results fluctuate somewhat each year and this would have an effect on the final Healthy Life Expectancy figures.

2.5 **Projected Healthy Life Expectancy**



The chart above summarises the projected Healthy Life Expectancy for males and females for Tameside, NW and England up to 2025 recalculated using the new ONS method. It is evident that the Locality Plan ambition to reach NW average by 2020 will not be achieved, nor reaching the England average by 2025.

2.6 Despite the low starting point for males, the rate of improvement should mean that the NW average will be met by 2025 for men. Progress for women is predicted to be slower than for NW or England, and also slower than for men. This means that Healthy Life Expectancy is predicted to be lower for women than for men in Tameside from 2022.

2.7 These projections are based on mortality since 2009. Implementation of the Locality Plan will help to improve premature mortality and Healthy life Expectancy going forward.

3. TAMESIDE AND GLOSSOP LOCALITY PLAN AMBITIONS

3.1 "A Place-Based Approach to Better Prosperity, Health and Wellbeing", the Tameside and Glossop Locality Plan 2015 has the key aim:

"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."
"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

DRAFT

3.2 Over the period 2009 to 2014 Tameside's healthy life expectancy for males improved by 1.4 years to 58.8 years and for females 2 months to 58.8 years. In comparison, the North West improved by 1 month for both males and females, and England improved by 2 months for males and decreased by 2 months for females.

3.3 If this trend of a faster local improvement than those for NW and England continues, we will reduce the inequalities gap and make progress towards the goal of a healthy life expectancy similar to or greater than the North West in 5 years and England in 10 years.

3.4 However, changes in the method of calculating healthy life expectancy have increased the scale of the local challenge.

4. LOCAL TRENDS IN LIFE EXPECTANCY AND MORTALITY

4.1 **Outline (see Appendix A)**

- Mortality across Tameside and Glossop has remained fairly static, but is reducing.
- There are large reductions in deaths from cardiovascular conditions but increases in deaths from respiratory conditions and infections.
- Life expectancy is on the increase at a much faster rate than healthy life expectancy and this will have implications for the health economy as people live longer with long term conditions.
- Inequalities in life expectancy still exists in life expectancy at birth but this narrows significantly in the age groups of 65 years and older.
- The gap in life expectancy between Tameside and England is wider now than it was ten years ago.
- The gap between males and females in Tameside and Glossop is closing, but to the detriment of female life expectancy which has slowed down significantly in the last few years.
- The main causes of death are still similar to those 10 years ago with the exception of dementia, which has significantly increased, possibly due to better death certification coding. Many of our dementia deaths are for vascular dementia, which like many of the cardiovascular deaths is mainly preventable.
- The main causes of death for females are concerning as they are related to life style behaviours such as smoking and alcohol use.
- Although death rates are reducing for many causes, an increase in the number of older people and the proportion of older people in the population mean that the total numbers of deaths will rise, as will the overall death rate of the population.
- A peak in deaths in the six week period of December/January 2014/15 showed that people waiting longer than 4 hours and delayed discharges were higher than the annual average.
- There were high levels of preventable deaths occurring across the borough in 2014/15.

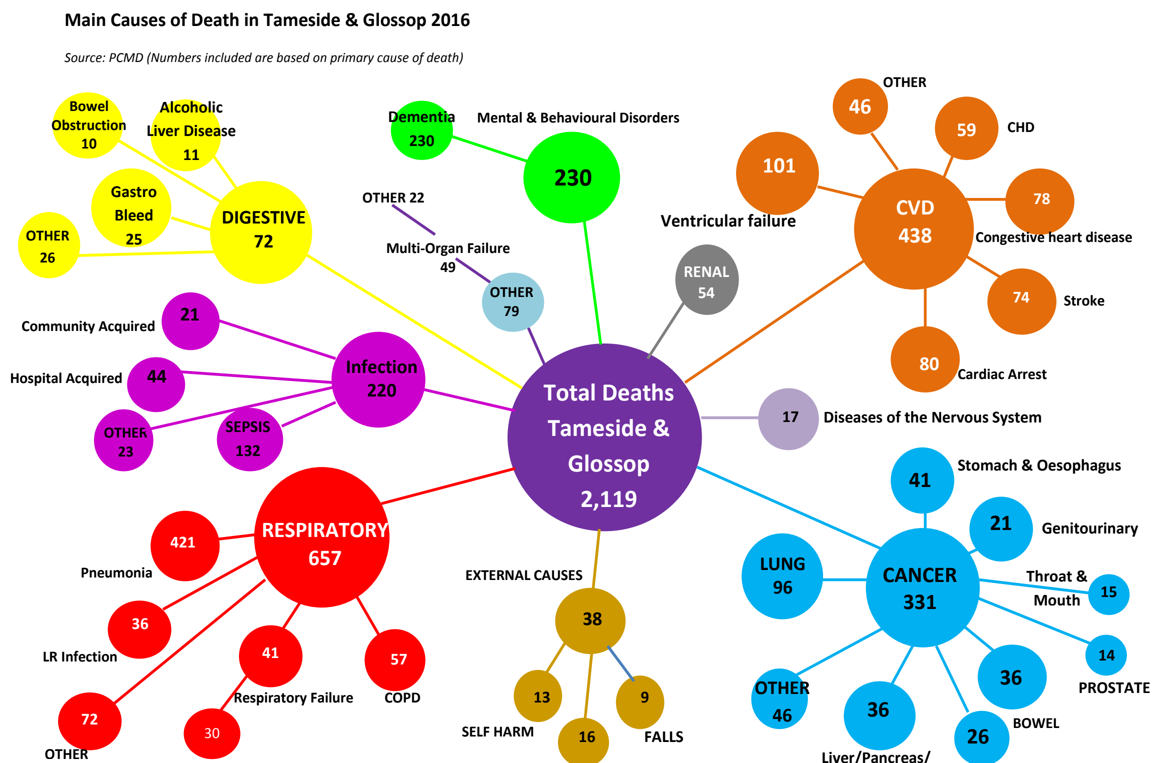
Life expectancy

4.2 If we look at future life expectancy for our population the forecast shows a steady rise year on year. Life expectancy is on the increase at a much faster rate than healthy life expectancy and this will have implication on the health economy as people live longer with long term and complex conditions.

4.3 Inequalities in life expectancy still exists in life expectancy at birth but this narrows significantly in the age groups of 65 years and older. The gap between T&G and England females is actually widening. For males however the gap is predicted to close slightly but not to the ambition originally included in the Locality Plan.

4.4 We need to continue to focus improvements in premature mortality, in particular in people under the age of 65 years.

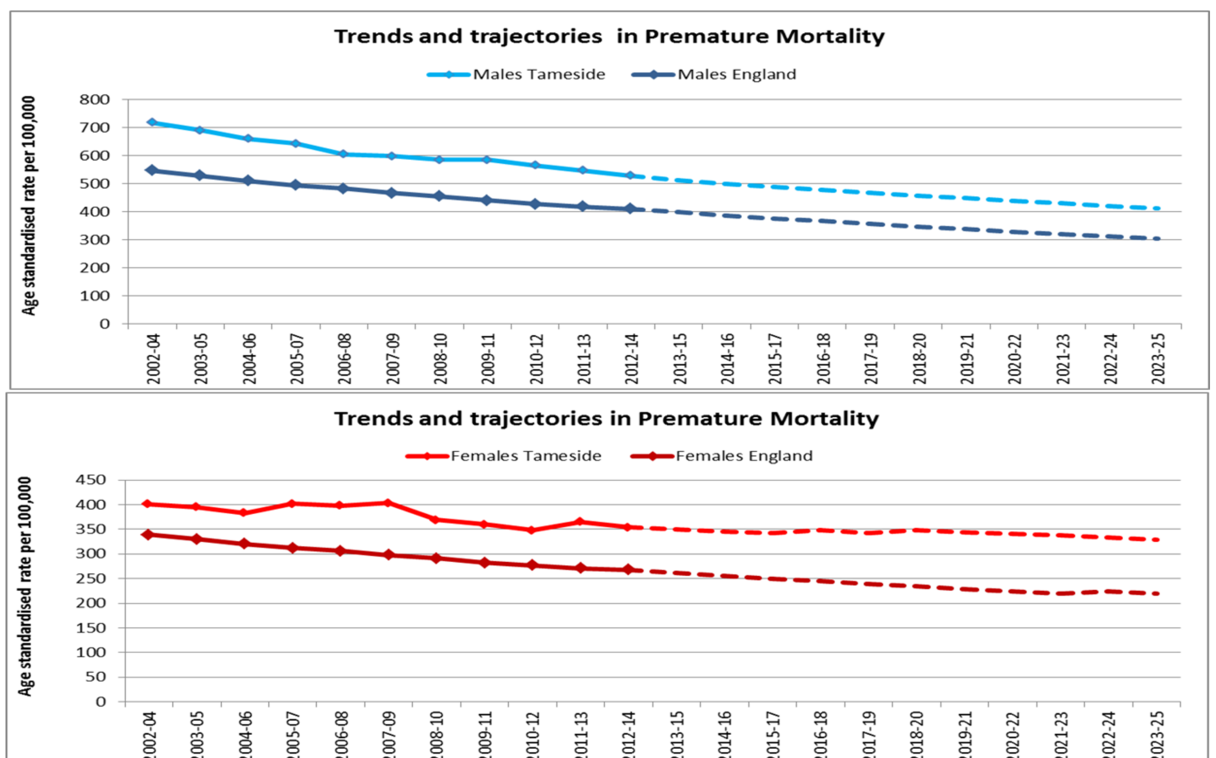
4.5 Causes of death



4.6 Overall, the main causes of death are still similar to 10 years ago, with the exception of dementia. As a cause of death dementia has significantly increased but this is probably due to better death certification coding. However many of our dementia deaths are for vascular dementia, which like many of the CVD deaths is mainly preventable.

Premature mortality

4.7 Premature mortality across Tameside and Glossop is reducing. And the gap between England and Tameside males has closed a little since 2002. However for females the progress is not so positive, and although the rate has reduced, the gap with England has increased. There are large reductions in deaths from cardiovascular conditions but increases in deaths from respiratory conditions and infections.



4.8 The charts above illustrate the improvement in premature mortality over the last 11 years and it shows that the gap between England and Tameside males has been closing since 2002, with Tameside showing an overall 30% reduction compared to 28% for England 28%.

4.9 But for females the difference between Tameside and England increased between 2004 and 2010 and from 2011.

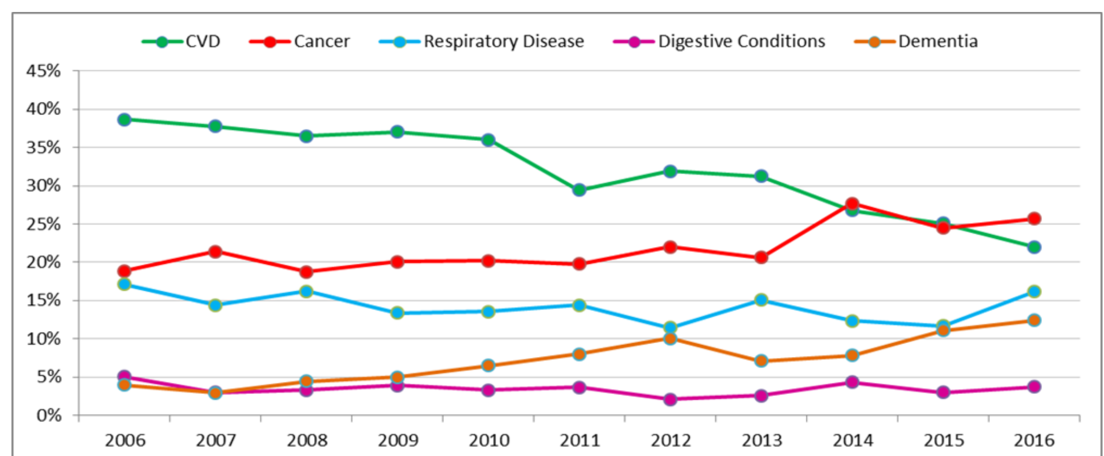
Deaths in females

Main causes of death for females in Tameside include:

Cause of Death	number	%
CVD	4,095	32%
Cancer	3,191	25%
Diseases of the Respiratory system	1,904	15%
Dementia	1,133	9%
Diseases of the Digestive system	615	5%
Diseases of the nervous system	436	3%
Falls	249	2%
Conditions of the Genitourinary system	221	2%
Other	846	7%
All Deaths	12,690	100%

4.10 The chart above illustrates the main causes of death for females in Tameside. 72% of all deaths are in three disease areas: Cardiovascular, Cancer and Respiratory disease. Whilst male deaths from these conditions have started to decrease, female death rates have remained persistent.

4.11 The chart below shows the movement in female deaths over the last 10 years and although Cardiovascular Disease is showing signs of decline, other causes such as respiratory disease and cancer are on the rise.



Life expectancy at 65

4.12 The data for life expectancy in people aged 65 years plus illustrates something unexpected. As people in Tameside and Glossop get older the gap in life expectancy between us and England narrows significantly. So once people reach the age of 65 years plus their life expectancy is pretty equal to that of the England average. This means that life expectancy at birth and healthy life expectancy is affected by deaths in people under 65 years rather than older. So, as people in Tameside die earlier than the England average, if we are to improve Life Expectancy and Healthy Life Expectancy overall, we need to concentrate on mortality under 65 years.

Trend in causes of death

Year	Circulatory Disease		Cancer		Digestive conditions		Suicide and injuries undetermined intent		Respiratory Disease		Other	
	male	females	male	females	male	females	male	females	male	females	male	females
2006	31%	19%	29%	45%	8%	9%	9%	4%	6%	8%	17%	16%
2007	30%	23%	35%	42%	7%	9%	3%	2%	9%	7%	17%	17%
2008	33%	19%	25%	38%	8%	9%	9%	5%	6%	12%	20%	18%
2009	27%	15%	25%	44%	11%	12%	7%	2%	8%	9%	21%	17%
2010	29%	17%	30%	45%	10%	9%	5%	2%	6%	9%	20%	18%
2011	25%	10%	31%	43%	11%	13%	7%	4%	6%	7%	20%	23%
2012	24%	22%	31%	46%	11%	10%	6%	1%	5%	6%	24%	15%
2013	28%	24%	33%	41%	11%	10%	6%	1%	7%	8%	14%	16%
2014	28%	16%	29%	47%	10%	13%	6%	1%	5%	7%	22%	15%
2015	26%	12%	31%	42%	16%	11%	9%	2%	5%	9%	14%	22%
2016	26%	19%	30%	34%	10%	15%	7%	4%	8%	10%	18%	18%

4.13 The table above summarises the conditions that contribute most to death rates and life expectancy in Tameside and Glossop. Cardiovascular disease in males has reduced by 16%, from 2006 whilst females has not reduced.

- Cancer has reduced for both males and females;
- Digestive conditions, including liver disease have risen and for females quite significantly;
- Respiratory conditions are also not reducing for both males and females.

4.14 Without a reduction in deaths from Cardiovascular, respiratory and digestive diseases, will not reach our ambition to reduce Healthy Life Expectancy. But if we were to reduce the following number of deaths before 65 each year we would surpass our target:

Reaching the Locality Plan Healthy Life Expectancy target: - number of deaths under 65 needing to be prevented each year	
Males	13 heart attacks 9 strokes 10 suicides 10 accidents 8 respiratory 10 alcohol related
Females	10 alcohol related 8 strokes 3 suicides 5 respiratory 8 breast cancer

4.15 The tables below summarise the number of people on disease registers in Tameside and Glossop. Once on a register, people with a condition then get regular input from their GP or practice nurse on how to manage their condition, medicine reviews and annual checks. If the number of people missing off the register were engaged with their GP for treatment and care this would have a major impact on people dying prematurely from that disease.

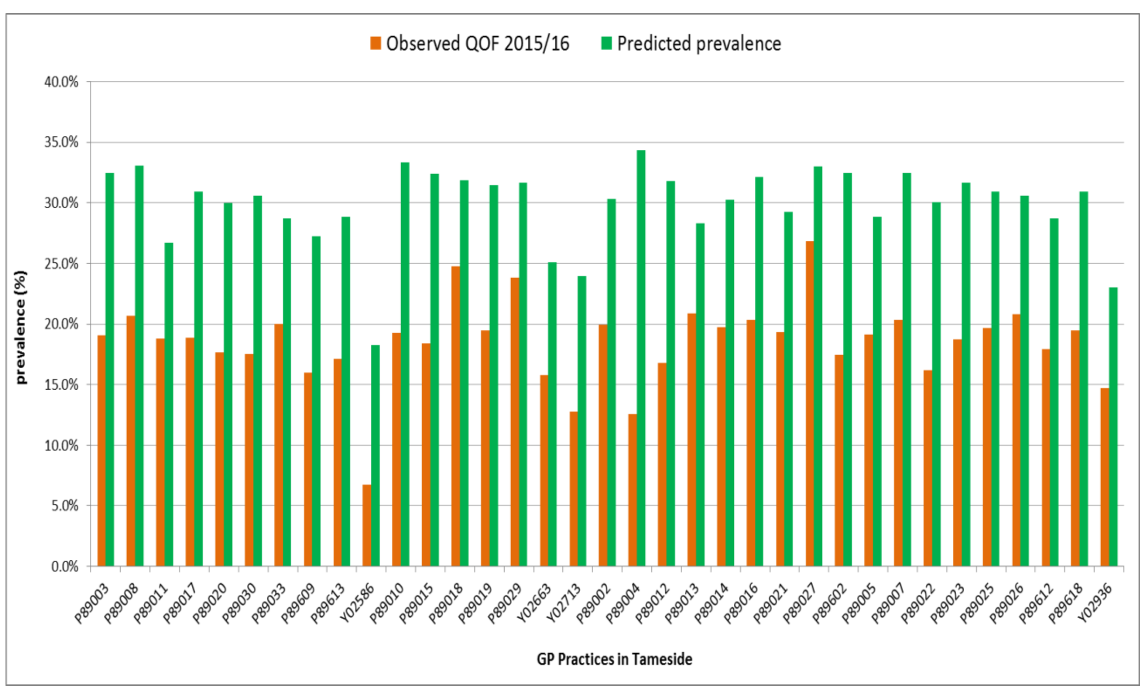
Heart Failure		**Coronary Heart Disease**		**Atrial Fibrillation**		**Stroke**	
Registered	*Missing*	*Registered*	*Missing*	*Registered*	*Missing*	*Registered*	*Missing*
3,563	1,534	11,361	1,570	5,570	1,556	4,791	-160
Exceptions	2,361		2,081		281		1,170

Hypertension		**Kidney Disease**		**COPD**	
Registered	*Missing*	*Registered*	*Missing*	*Registered*	*Missing*
61,071	23,684	17,365	11,480	10,378	3,693
Exceptions	1,061		123		3,612

4.16 The tables also include the number of ‘exceptions’ - people who have been identified by their practice as having clinical reasons for not receiving a standard service. Whether they continue to be ‘exceptions’ is reviewed annually - there is probably scope for a local Quality Initiative to ensure common practice across Tameside and Glossop.

4.17 The chart below illustrates the variation between local practice populations in the predicted and actual numbers of people with high blood pressure. Increasing the identification of high blood pressure is one of the three Health and Wellbeing Board ‘Turning the Curve’ priorities to tackle local health inequalities and a social marketing programme is in progress as part of the Action Plan. The Action Plan is also a Primary Care Quality Initiative led by the

Tameside and Glossop Primary Care Delivery and Improvement Group and the Tameside and Glossop Quality Improvement Clinical Lead.



Winter 2014/15

4.18 There was substantial increase in the death rate during the winter of 2014/15, and this has been the subject of recent independent research and a review by the Office of National Statistics.

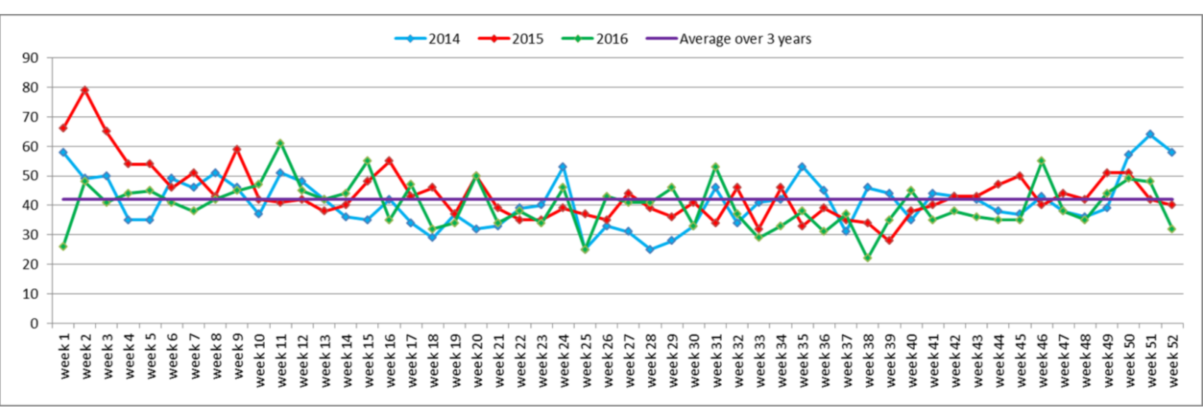
4.19 Two papers linking the 30,000 excess deaths in 2015 to cuts in health and social care were published in the Journal of the Royal Society of Medicine in February 2017 (See **Appendix B**). The paper reviewed potential causes, and finding no evidence that data, weather or flu accounted for the pattern, concluded that failure of health and social care could not be discounted, and several factors supported this possibility. The authors expressed concern that this experience may be a sentinel event for future system failures rather than a one off.

4.20 In response the Department of Health noted that the increase is not so evident using a financial rather than calendar year, and that the number of excess deaths during the winter months dropped from about 43,000 in 2014-15 to about 24,000 in 2015-16.

4.21 Office of National Statistics published a review of 2015 deaths in April 2016, noting increases in deaths in over 75s, deaths attributable to dementia, respiratory including flu deaths and low effectiveness of flu vaccine.

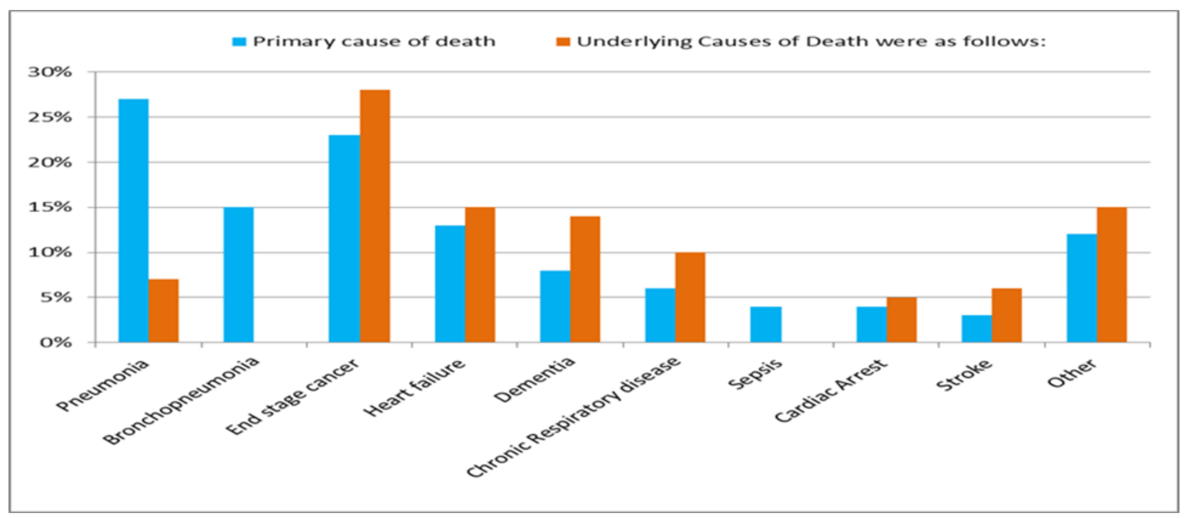
Winter 2014/15 in Tameside (see Appendix A)

4.22 Over a year the weekly number of deaths varies from week to week and on average is around 22 deaths per week. The chart below illustrates that during a 6 week period between December and January 2014/15 there was a peak in deaths in Tameside in line with the national picture at that time.



4.23 Explanations include extreme weather, a disease outbreak or system failure. In 2014/15 the following was observed over the 6 week peak period:

- The average number of A&E attendances over this 6 week period was similar to the annual weekly number.
- Average proportion that was seen in A&E before 4 hours was 88% over the 6 week period 9 December 2014 to 19 January 2015 compared to the annual average of 94%.
- However, the proportion of people waiting between 4 and 12 hours during tis 6 week period was 10, compared to the annual average of 3 people (70% higher than normal).
- Delayed transfer of care averaged 15 per day over this 6 week period compared to the annual daily average of 2 (87% higher).
- The winter weather over this week period was average for the time of year with no significant low temperatures. (Average temperature between December 2014 and February 2015 was 4.2ºC.) However, there was some snow fall over this period and an amber level cold weather warning was issued on 27 December 2014 which could have had some impact on mortality rates.
- The main primary and underlying causes of death can be seen in the chart below.
- Of the deaths occurring over the 6 week peak, 56% occurred in hospital, 14% in a care home, 10% in a hospice and 20% at usual address (home).
- By age, the majority of deaths were in people over 75 years (74%).



4.24 People registered with 11 GP practices accounted for just over half of all the deaths in this 6 week period. (51%), with 3 of these practices accounting for nearly 20% of all the deaths over the same time frame. Practice size does not seem to account for this picture, and a more detailed review of mortality by practice is planned.

5.0 RIGHTCARE PROGRAMME

5.1 RightCare is a NHS programme committed to improving people's health and outcomes. It makes sure that the right person has the right care, in the right place, at the right time, making the best use of available resources.

5.2 NHS RightCare focuses on:

- intelligence – using data and evidence to shine a light on unwarranted variation to support an improvement in quality;
- innovation – working in partnership with a wide range of organisations, national programmes and patient groups to develop and test new concepts and influence policy;
- implementation and improvement – supporting local health economies to carry out sustainable change;
- make the best use of resources – offering better value for patients, the population and the tax payer;
- understand how they are doing – by identifying unwarranted variation between demographically similar populations;
- get talking about the same stuff – about healthcare rather than organisations;
- focus on the areas of greatest opportunity by identifying priority programmes which offer the best chances to improve healthcare for populations;
- use tried and tested processes to make sustainable improvement to care to reduce unwarranted variation.

5.3 Tameside and Glossop have identified four main 'transformation' priorities for NHS RightCare, and these link with the local integration and transformation programme:

- Circulation;
- Respiratory;
- Musculo Skeletal conditions;
- Trauma and Injuries.

These priorities link with what the mortality statistics are telling us and the following NHS RightCare priorities will be further analysed and addressed through existing opportunities and programmes of work:

- Cancer;
- Gastro-intestinal;
- Mental Health;
- Endocrine.

6.0 TAMESIDE ALCOHOL STRATEGY

6.1 The refreshed Tameside Alcohol Strategy – "Rethinking Drinking" gives priority to:

- Recovery and treatment;
- Enforcement and regulation;
- Attitude and norms.

6.2 Implementation of the Strategy will contribute to reducing local deaths from circulatory disease and liver disease as highlighted in paragraphs 4.15 and 4.16 of this report.

7. GREATER MANCHESTER POPULATION PLAN 2017-2021

7.1 The Greater Manchester Population Health Plan 2017-2021 was reviewed at the March 2017 meeting of Tameside Health and Wellbeing Board, and Stocktake of the current local position against its 24 Objectives has been prepared.

7.2 Its objectives highlight the importance of person and community centred approaches, early years, wellness and lifestyle services, cancer prevention, housing and falls prevention, and sit well with local priorities.

8. IMPLICATIONS

8.1 Tameside and Glossop residents experience some of the worst health and mortality outcomes in England and Tameside currently ranks 137 out of 150 local authorities for premature death.

8.2 Changes in the calculation of life expectancy mean that the current Tameside and Glossop Locality Plan ambition will need to be reviewed. Current projections of Healthy Life Expectancy based on the new method for calculation suggest that the Locality Plan ambition to reach NW average by 2020 will not be achieved, nor reaching the England average by 2025. These projections are based on mortality since 2009.

8.3 Review of the most recent mortality data re-confirms the commitments of current local strategic statements:

- Implementation of the Locality Plan will help to improve premature mortality and Healthy life Expectancy going forward.
- recent mortality trends highlight the importance of tackling premature cardiovascular, respiratory and liver disease
- the Tameside and Glossop RightCare programme highlights the importance of tackling circulatory and respiratory disease
- current Tameside Health and Wellbeing Board 'Turning the Curve' priorities of smoking, physical activity and blood pressure will impact on circulatory and respiratory disease
- the updated Tameside Alcohol Strategy will contribute to reducing circulatory and liver disease
- local impact of implementation of the Greater Manchester Population Plan will make important contributions to reducing premature deaths

8.4 Care Together continues to be the key vehicle for realisation of the Locality plan ambition to increase healthy life expectancy at pace.

8.5 Local challenges and responses for improving life expectancy highlighted in this review and are summarised in the table:

Challenge	Response	*Current Strategy link*
Reducing deaths in people aged 15 years to 64 years; this means a reduction in male deaths of at least 51 each year and 21 less deaths for females	Strategic approach to mental health and wellbeing including suicide and self harm prevention programme RightCare Programme including Respiratory Pathway Cardiovascular disease prevention: physical activity; blood pressure; smoking; diet; obesity; alcohol; NHS Health Checks Work and health programme GM Cancer Vanguard including enhanced screening and social movement National Diabetes Prevention Programme	*Health and Wellbeing Strategy and 'Turning the Curve'* *Locality Plan* *GM Population Health Plan* *GM Cancer Plan*
Targeting females in particular around life style issues	Targeting NHS Health Checks and lifestyle change behaviour programmes Well Women campaign Cancer early detection	*Health and Wellbeing Strategy* *Locality Plan* *GM Population Health Plan* *GM Cancer Plan*
Finding the missing thousands from the disease registers. People with a condition will then get the appropriate care and interventions that will help them live longer and manage their condition better	Community engagement and social marketing Blood pressure Atrial Fibrillation NHS Health Checks RightCare programme Primary Care Quality Initiatives	*Health and Wellbeing Strategy and 'Turning the Curve'* *Locality Plan*
Using risk stratification data to ensure that people in the risk groups 20% to 69% have access to the relevant services and interventions that allows them to improve their outcomes	Active case finding through Integrated Neighbourhood Teams Wider community engagement and lifestyle behaviour change System wise self care programme including social prescribing, volunteering and asset based approaches Active Tameside – geographical targeting of community outreach	*Health and Wellbeing Strategy* *Locality Plan*
A focus on the wider determinants of health: housing; strengthening communities; health and work; mental health and wellbeing	Housing: - Homelessness - Supported Accommodation - Fuel poverty - Private rented	*Health and Wellbeing Strategy* *Locality Plan*

	Strengthening communities - Integrated neighbourhood working - Asset based approaches - Place based commissioning - Social prescribing Work and health programme - Working well - Healthy Hattersley	

9. RECOMMENDATIONS

9.1 As stated on the front of the report.

THE CHANGING PICTURE OF MORTALITY AND LIFE EXPECTANCY IN TAMESIDE AND GLOSSOP

Abstract

The potential to live a long and healthy life is a fundamental aspect of human development.[1] Over the last few decades the UK has seen tremendous gains in mortality reductions and increased life expectancies. However, disparities exist across the UK and in particular within smaller geographical areas such as Tameside and Glossop, where the current life expectancy gap between the highest and the lowest in more than 10 years.

Premature mortality and life expectancy are significant indicators of the health of the population. Generally areas with higher life expectancy and lower rates of premature mortality contain populations that are both socially and economically advantaged.

For Tameside and Glossop, residents here experience some of the worst health and mortality outcomes in England and currently rank 137 out of 150 local authorities for premature death.

In November 2016, ONS implemented a revised methodology for the calculation of healthy life expectancy and life expectancy at birth by using an upper age band of 90 and over; whereas previously the upper age band was set to 85 and over. The change was made to reflect an increasing proportion of deaths at ages 85 and over, and results in greater accuracy of healthy life expectancy estimates. The new methodology has been implemented for healthy life expectancy figures from 2009-11 onwards.

This prompted the need to look at premature mortality, healthy life expectancy and life expectancy across the Tameside and Glossop area with a view to gain an in-depth understanding into the main causes of premature mortality and the major impacts on life expectancy for both males and females.

In Summary the following report illustrates the key challenges

- Mortality across Tameside and Glossop has remained fairly static, but is reducing.
- There are large reductions in deaths from cardiovascular conditions but increases in deaths from respiratory conditions and infections.
- Life expectancy is on the increase at a much faster rate than healthy life expectancy and this will have implication on the health economy as people live longer with long term/complex condition.
- Inequalities in life expectancy still exists in life expectancy at birth but this narrows significantly in the age groups of 65 years and older.
- The gap in life expectancy between Tameside and England is wider now than it was ten years ago.

[1] http://www.un.org/esa/population/publications/levelsandtrendsinmortality/Changing%20levels%20and%20trends%20in%20mortality.pdf

- The gap between males and females in Tameside and Glossop is closing, but to the detriment of female life expectancy which has slowed down significantly in the last few years.

- The main causes of death are still similar to 10 years ago with the exception of dementia. This cause of death has significantly increased but this could be due to better death certification coding. However many of our dementia deaths are for vascular dementia, which like many of the CVD deaths is mainly preventable

- The main causes of death for females are concerning as they are related to life style behaviours such as smoking and alcohol use.

- A peak in deaths in the six week period of December/January 2014/15 showed that people waiting longer than 4 hours and delayed discharges were higher than the annual average.

- There were high levels of preventable deaths occurring across the borough in 2014/15 that could have been prevented through improving vaccination coverage of both influenza and pneumonia.

- Tameside and Glossop have high levels of deaths in people under 65 years compared to the England average. With a high proportion of these deaths being mainly preventable and related to lifestyle such as cardiovascular and respiratory disease, and cancer including bowel cancer. This is the main cause of low healthy life expectancy figures for Tameside & Glossop

- Tameside & Glossop will not reach its ambition of a similar Healthy life expectancy to the North West in 5 years for females. Male HLE will have improved to be similar to that of the North West.

- Tameside and Glossop will not reach its ambition of a similar healthy life expectancy to England in 10 years for females. Male healthy life expectancy will have improved to be no longer significantly lower.

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Introduction

In England in 1901 life expectancy was 45 years for men and 49 years for women. By 2012 this had increased to 79.2 years for men and 83.3 years for women[2].

This is expected to rise further by 2032 to 83.3 years (an increase of 4.1 years) for men and to 86.8 years (an increase of 3.8 years) for women. The gap between male and female is predicted to be consistent, i.e., 3.7 years in 2012 and 3.6 years in 2032. Both biological and non-biological factors play a role in this difference[3].

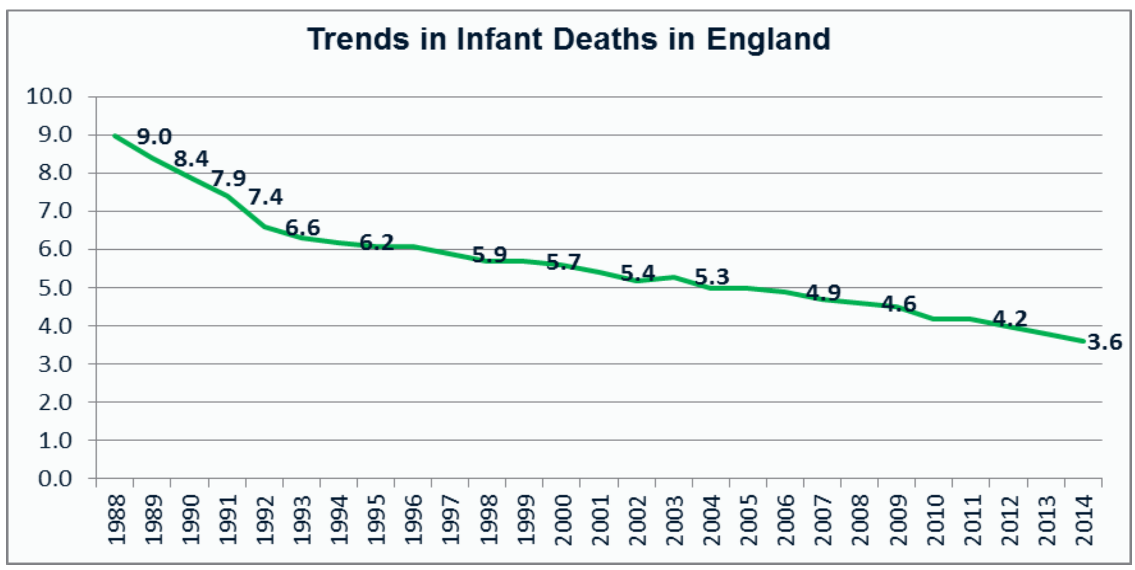
This projection is based on the current trend. The precise extent of the increase will depend on patterns of disease and the population lifestyle. Predictions by the Office for National Statistics over the next 70 years show a possible variation of 20 years by 2085[2].

Life expectancy at birth is the average number of years that a person can be expected to live from birth, assuming that age-specific mortality levels remain constant.

Life tables calculate the number of years a person is expected to live given that they have already reached a certain age. For example, a girl born in 2011 is expected to reach age 82.8 in England, however someone who was 60 years old already in 2011 was expected to live a further 25.2 years, that is until that are 85.

The low life expectancies of the past can be explained by the higher number of infant deaths. Survival past the first years of life was historically a predominant factor in life expectancies and once a child had reached five years of age, he or she was much more likely to reach a greater age.

The chart below illustrates the change in infant mortality rates in England over the past 25 years



Source: ONS

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[2] Office for National Statistics (2009). Statistical Bulletin. Period expectation of life, England, 1981-2032 (uses 2008-based population projections)

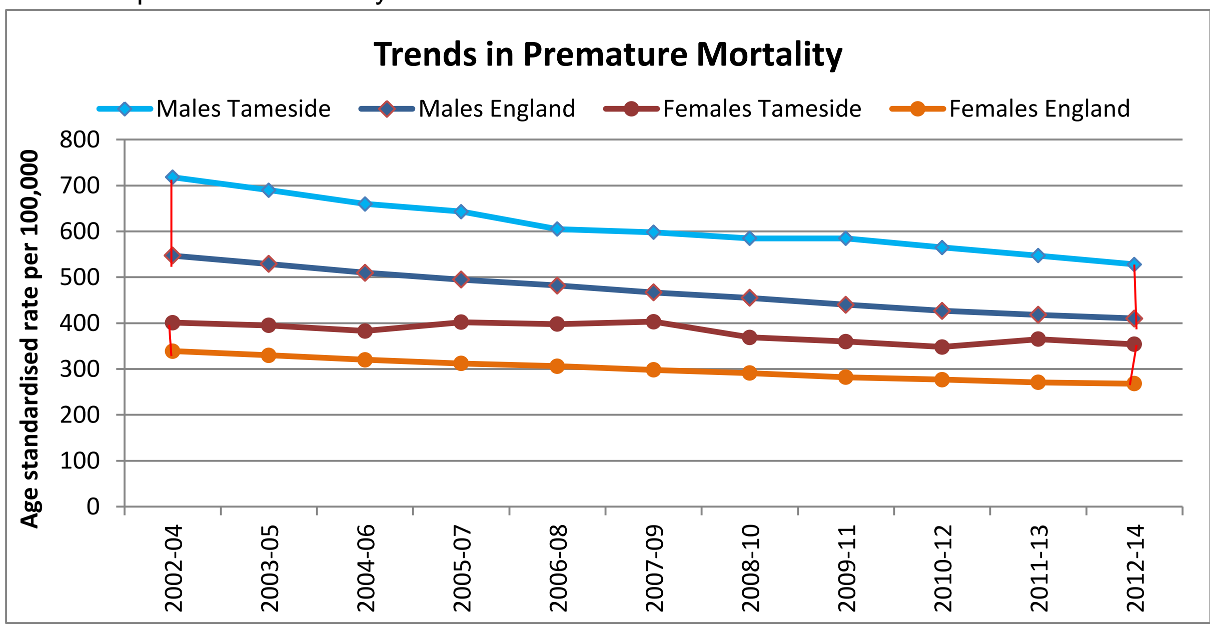
[3] Office for National Statistics (2009). Statistical Bulletin. Period expectation of life, England, 1981-2032 (uses 2008-based population projections)

So what does this mean for Tameside and Glossop?

Tameside was created on 1 April 1974, by the Local Government Act 1972 as one of the ten metropolitan districts of Greater Manchester. It took over the local government functions of nine districts which were formerly in the administrative counties of Lancashire and of Cheshire. In 1986 Tameside effectively became a unitary authority with the abolition of the Greater Manchester County Council.

The area of Tameside has a history of being an industrial area and health outcomes have historically been worse than the England averages. However over time both nationally and locally there has been year on year increases in both life expectancy and the numbers of people reaching 85 years plus. This is mainly due to the fall in infant mortality and the reduction in people dying prematurely. However for Tameside between 2013 and 2015 2,450 people died before the age of 75 years. This makes Tameside the 137th out of 150 local authorities in England, which makes us significantly worse than the England average, a pattern that has not changed over the last 20 or so years.

Trends in premature mortality



Source: ONS

The chart above illustrates the improvement in premature mortality over the last 11 years and it shows that the gap between England and Tameside males has closed somewhat, with Tameside showing an overall 30% reduction compared to England's 28% reduction since 2002. However for Tameside females the improvement is less dramatic, with the gap in premature mortality now wider between England and Tameside than in 2002-04. Overall Tameside's reduction in premature mortality has only decreased by 12% compared to the rest of England's 23%, this therefore will have a knock-on effect on the life expectancy measures for females because the younger people die the higher the impact on life expectancy estimates.

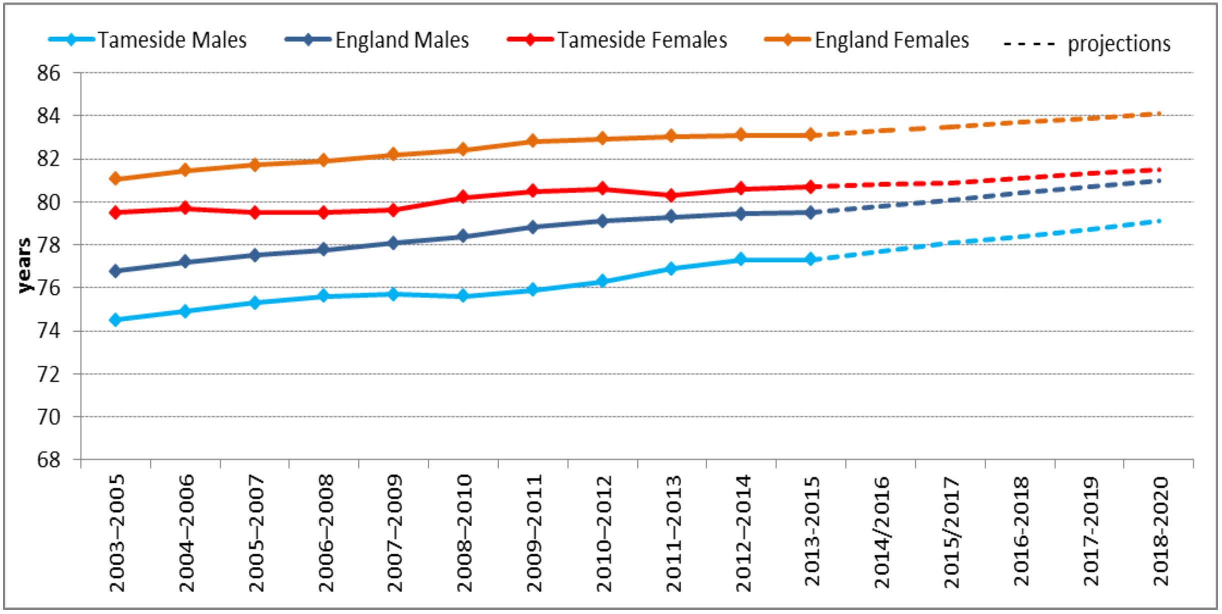
Trends in Life Expectancy at birth, 65 years, 75 years and 85 years

Life expectancy at birth reflects the overall mortality level of a population. It summarises the mortality pattern that prevails across all age groups in a given year – children and adolescents, adults and the elderly.

The increase in life expectancy for both men and women over the last few decades can be attributed to a number of factors including improvements in public health, nutrition and medicine, health and safety at work, the environment; with vaccinations and antibiotics greatly reducing deaths in childhood, and fewer people smoking.

The charts below illustrate the trends in both males and females at various stages in the life cycle, birth, 65 years, 75 years and 85 years.

Trends in Life Expectancy at Birth



Source: ONS

The chart above clearly illustrates the improvement in life expectancy over the last two decades; the chart also clearly illustrates the inequalities gap between England and Tameside with the gap between England and Tameside increasing somewhat over the same time period. For males however, we are starting to see a reduction in the gap after a brief period between 2004 and 2010, where the gap suddenly started to widen. The projections for male life expectancy are good with the predicted life expectancy in males in Tameside in 2018-2020 expected to reach approximately 79.1 years (81 yrs. Eng.). A 14% reduction in the gap between Tameside & Glossop and England and a similar life expectancy to the England average but not equal to.

For females though the trend is quite different and although we can see that female life expectancy is increasing over time, it is not increasing at the same rate as the rest of the country and therefore the gap between Tameside and England is getting wider and wider year on year. If current trends continue life expectancy for females is estimated to be 81.5

years by 2018-2020 (84.1 yrs. Eng.). This means that Tameside & Glossop will not meet our intended target of a similar life expectancy to England in 10 years.

Life expectancy for males at both England and Tameside level has increased since 1991 by 7%, but for females in England the increase was 5% and for Tameside only 3%. This has closed the gap between males and females but to the detriment of female life expectancy.

If Tameside & Glossop want to achieve the target laid down in our Locality Plan and Care Together plan, we need to reduce the number of deaths in people under 65 years, in particular female deaths. For males this means 51 less deaths per years in men aged between 15 and 64 years. For females this means 21 less deaths per year in women aged between 15 and 64 years. Currently in Tameside and Glossop 232 males die and 137 females die in the age group 15 to 64 years each year. Therefore this is the age group that needs to be targeted if we are to accelerate or life expectancy and healthy life expectancy target.

The table below illustrates the underlying causes of death in the 15 to 64 years age groups for both males and females

Underlying Causes of Death in Tameside & Glossop 2014 to 2016 for males and females aged 15 to 64 years							
		Number	%			Number	%
MALES		**631**	**20%**	**FEMALES**		**493**	**15%**
CVD		**174**	**28%**	**CVD**		**70**	**14%**
of which	heart attacks	41	24%	of which	heart attacks	8	11%
	Ischaemic Heart Disease	75	43%		stroke	23	33%
	Stroke	29	17%		Ischaemic Heart Disease	23	33%
cancer		**193**	**31%**	**Cancer**		**182**	**37%**
of which	oral	10	5%	of which	lung	44	24%
	oesophagus	14	7%		bowel	17	9%
	bowel	18	9%		breast	31	17%
	liver & pancreas	16	8%		female gental organs	25	14%
	lung	55	28%		multple sites	12	7%
	urinary tract	17	9%	**Respiratory**		**38**	**8%**
	multiple sites	12	6%	of which	COPD	24	63%
Respiratory		**38**	**6%**		pneumonia	7	18%
of which	pneumonia	10	26%	**Digestive**		**58**	**12%**
	COPD	18	47%	of which	Alcoholic liver disease	35	60%
Digestive		**76**	**12%**	**Other**		**145**	**29%**
of which	alcoholic liver disease	52	68%	of which	diseases of the nervous system	14	10%
Other		**150**	**24%**		accidental poisoning	14	10%
of which	self harm and undetermined intent	49	33%		self-harm and undetermined intent	11	8%
	accidents	32	21%		infection	5	3%
	accidental poisoning	15	10%		nutritional and metabolic conditions	6	4%
	diseases of the nervous system	19	13%				
Total deaths all age groups		**3192**				**3342**	

The table clearly shows that a high proportion of these deaths are preventable. And if we were to reduce the following number of deaths each year in this age group, we would surpass our target and our health life expectancy and life expectancy would improve significantly.

Males: 13 heart attacks, 9 strokes, 10 suicides, 10 accidents, 8 respiratory and 10 alcohol related deaths each year.

Females: 10 alcohol related, 8 strokes, 3 suicides, 5 respiratory and 8 breast cancer deaths each year.

So even though there are fewer deaths in females than males, what could be the cause of the slowdown in life expectancy in females?

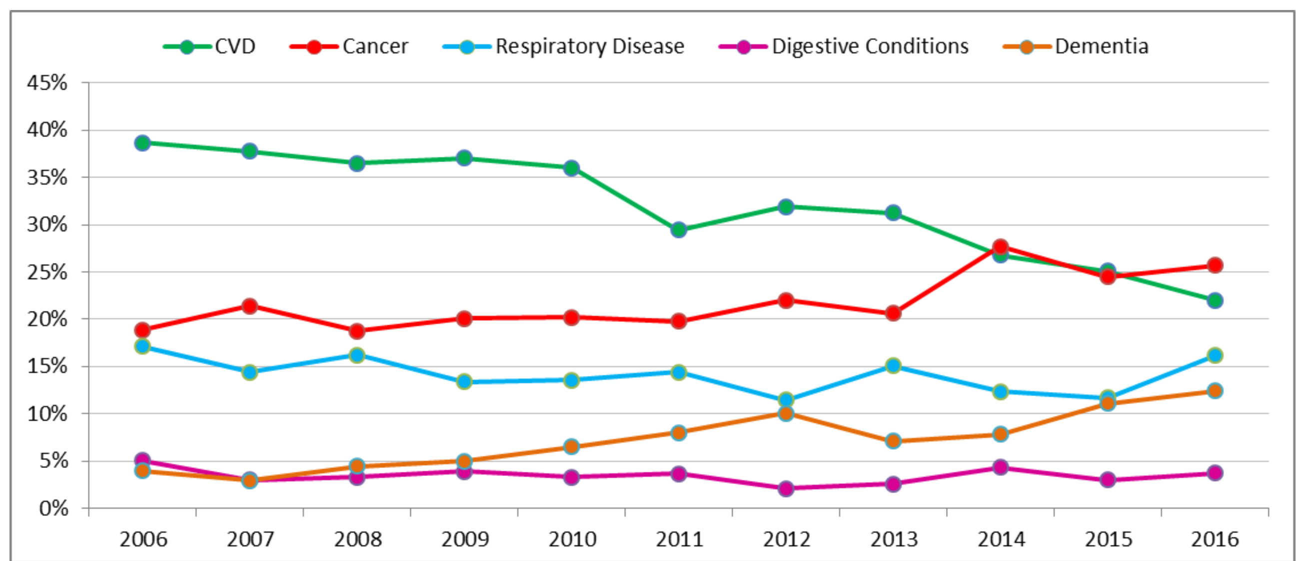
We firstly need to look at the average age of death for women over the last five years. Deaths for females over the last five years have reduced by 11% compared to males 16%. The average age of death for females is currently 61.8 years compared to the male average of 62.3 years. This statistic has only improved by 1% for females but 4% for males. This will have a major impact on life expectancy at birth estimates.

Main causes of death for females in Tameside & Glossop between Jan 2012 and December 2016 include:

Cause of Death	number	%
CVD	4,095	32%
Cancer	3,191	25%
Diseases of the Respiratory system	1,904	15%
Dementia	1,133	9%
Diseases of the Digestive system	615	5%
Diseases of the nervous system	436	3%
Falls	249	2%
Conditions of the Genitourinary system	221	2%
Other	846	7%
All Deaths	12,690	100%

The table above illustrates the biggest causes of deaths for females across Tameside & Glossop. With CVD, Cancer and Respiratory conditions making up the biggest proportion of all deaths.

The chart below illustrates the movement of deaths from the 5 big killers in Tameside & Glossop and it is clear that over the last 10 years, CVD as started to decline quite significantly.



However, mortality from Cancer respiratory disease and Dementia are on the rise rather than decline and conditions relating to the digestive system, such as alcoholic liver disease, pancreatitis and hepatic diseases have remained very static. This will have a major impact on female healthy life expectancy and life expectancy at birth.

In terms of life expectancy, women are known to have advantage over men. This advantage is partly due to genetic and biological differences between the genders.[4] Under normal circumstances women can except to outlive men by several years. Where women's life expectancy is only slightly higher or the gap between males and females starts to close significantly; cultural, social, economic and environmental factors detrimental to women may offset this 'natural' advantage.[5] This seems to be the case for the women of Tameside and Glossop and there are several factors that drive the increase in the conditions shown in the table above. Some of these factors are amenable to interventions such as stopping smoking, lowering alcohol intake and being more active etc. Others are down to the environment and social and demographic changes that females find themselves in. [6] However over the last 5 years 44% of deaths (2,486) in Tameside & Glossop were deemed preventable, so relevant interventions aimed at females could slow or reverse the downward trend in female life expectancy. Therefore we need to target the conditions that are more prominent in females and either stop females getting the condition in the first place or ensure diseases are caught early enough allowing for effective treatment. The rest of the deaths are related to the environmental factors such as health and social care provision, the economic climate and social and cultural change etc.

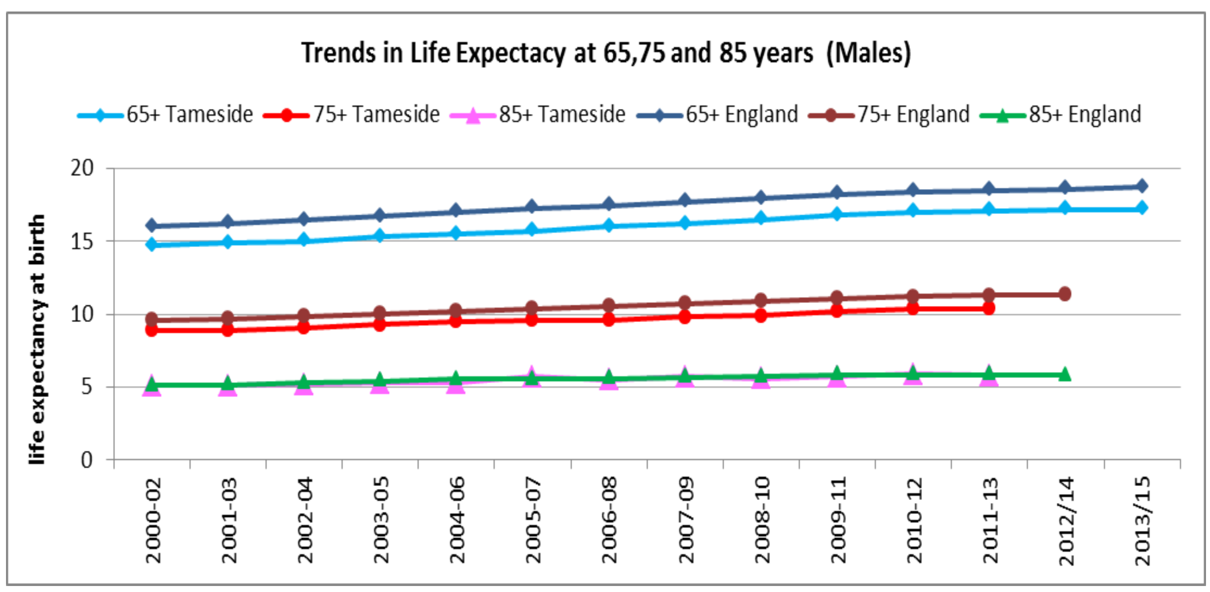
Trends in life expectancy at 65 years, 75 and 85 years

One aspect of falling mortality rates, in particular deaths in older people is that in 2015 around 55% of all deaths nationally occurred in people aged 85 years and over. As the average age of death increases, patterns of mortality in older age groups become increasingly important. For Tameside the percentage of deaths in people 85 years and over was 34%, lower than the national average.

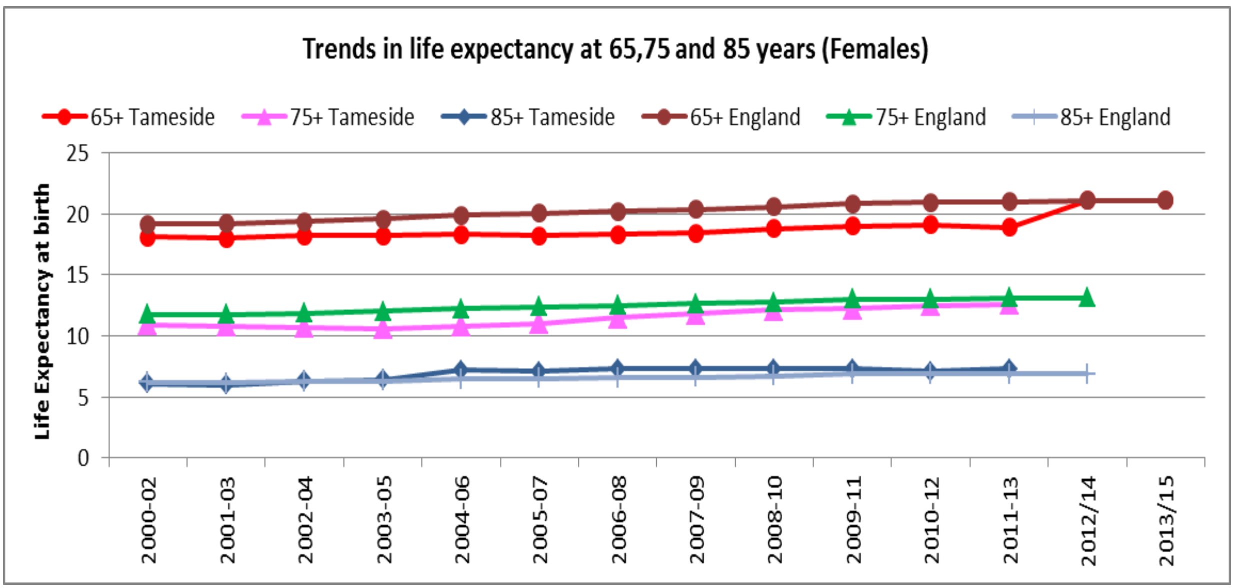
[4] Women and the rapid rise of noncommunicable diseases. WHO 2002
[5] Women and the rapid rise of noncommunicable diseases. WHO 2002
[6] Women and the rapid rise of noncommunicable diseases. WHO 2002

In February 2016, Public Health England produced a report of life expectancy among those aged 65 years and older in England. The report confirmed that there had been an overall upward trend in life expectancy in this age group.

The charts below illustrate the increasing life expectancy for England and Tameside in this age group.



Source: ONS

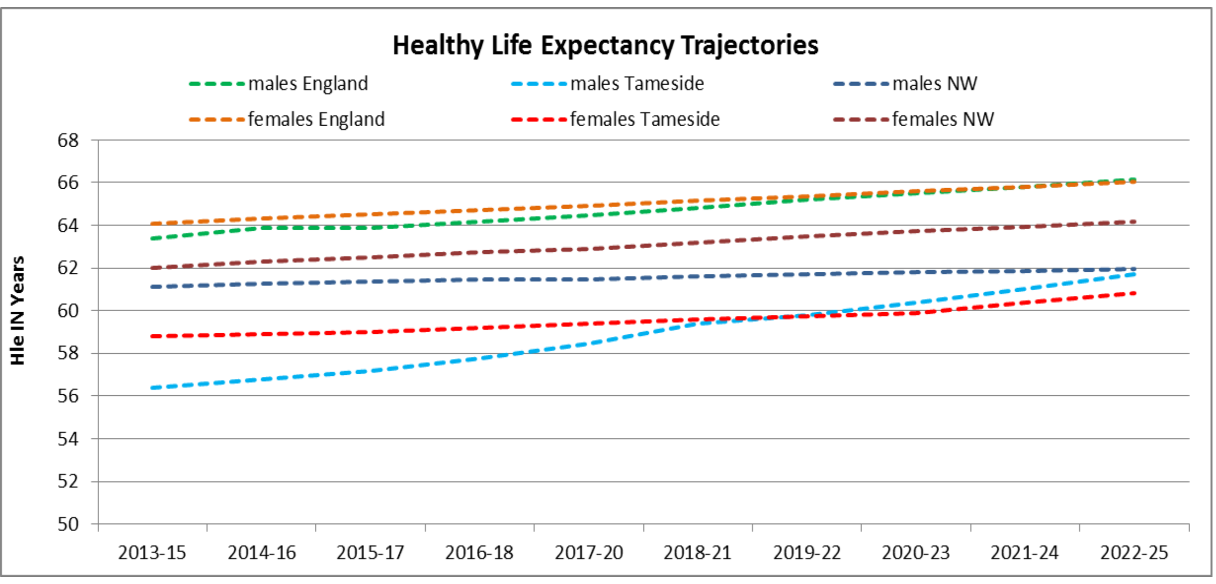


Source: ONS

The charts for both males and females show that life expectancy in these age groups have risen steadily over time. What is interesting is that the inequalities gap is very narrow in the older age groups compared to life expectancy at birth. Reiterating, that people in Tameside die younger, but once they do reach older age groups their life expectancy is similar to the rest of the country.

Healthy Life Expectancy Trajectories

However, as you will see from the chart below. The healthy life expectancy gap is quite significant between Tameside and England. This means that although life expectancy at 65 years plus is very similar to the England averages, older people in Tameside will be living longer with long term health conditions that have an impact of their quality of life and the health economy.

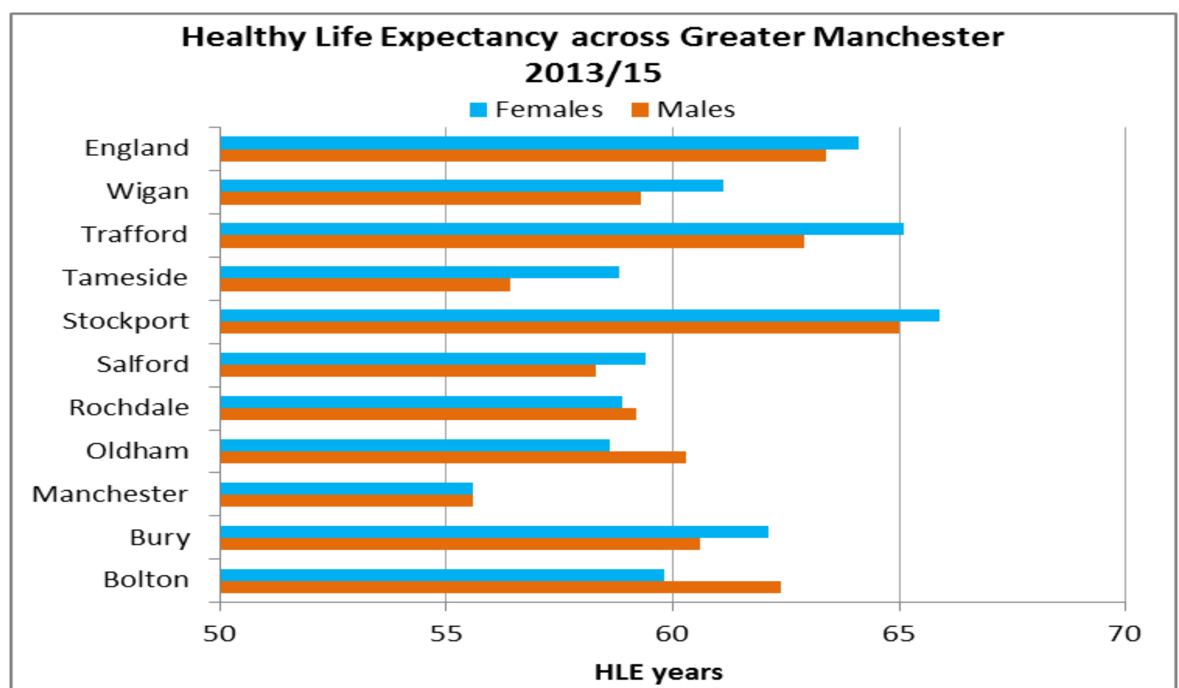


Source ONS

Where life expectancy is an estimate of average expected life span, healthy life expectancy is an estimate of the years of life that will be spent in good health. There are important socio-demographic differences in healthy life expectancy. Not only can people from more deprived populations expect to live shorter lives, but a greater proportion of their life will be in poor health.

Healthy life expectancy is the average equivalent number of years of full health that a new-born could expect to live, if he or she were to pass through life subject to the age-specific death rates and ill-health rates of a given period. The new measurement of healthy life expectancy was done to harmonise the calculation of healthy life expectancy with that of the European Union.

The chart above clearly illustrates that for Tameside healthy life expectancy is considerably lower than the England average. The chart below also shows that for the majority of local authorities across Greater Manchester, the outcome is similar, with the exception of Stockport and Trafford.



Projections for healthy life expectancy are difficult to forecast due to the complexity of the methodology. However using life expectancy at birth projections as an indicator for demonstrating the movement of Health Life Expectancy, projections show that healthy life expectancy will increase in Tameside for both males and females. With an estimated healthy life expectancy in 2017-2012 being 57.8 years for males and 59.4 years for females. This prediction is a low end estimate and therefore these predictions could be higher.

The length and quality of people's lives differ substantially. Some of these differences are unavoidable (e.g., genetic differences) or random (e.g., accidents). However, factors that are amenable to change, such as socio-economic status, education and quality of immediate living environment, also play a significant part, leading to large inequalities in life expectancy[7].

The gap in life expectancy between rich and poor persists. After some fluctuation, the gap is larger now than in the early 1970s. Men and women from the richest social class can on average expect to live more than seven years longer than those in the poorest social class. [8] For Tameside this gap is now more than 10 years.

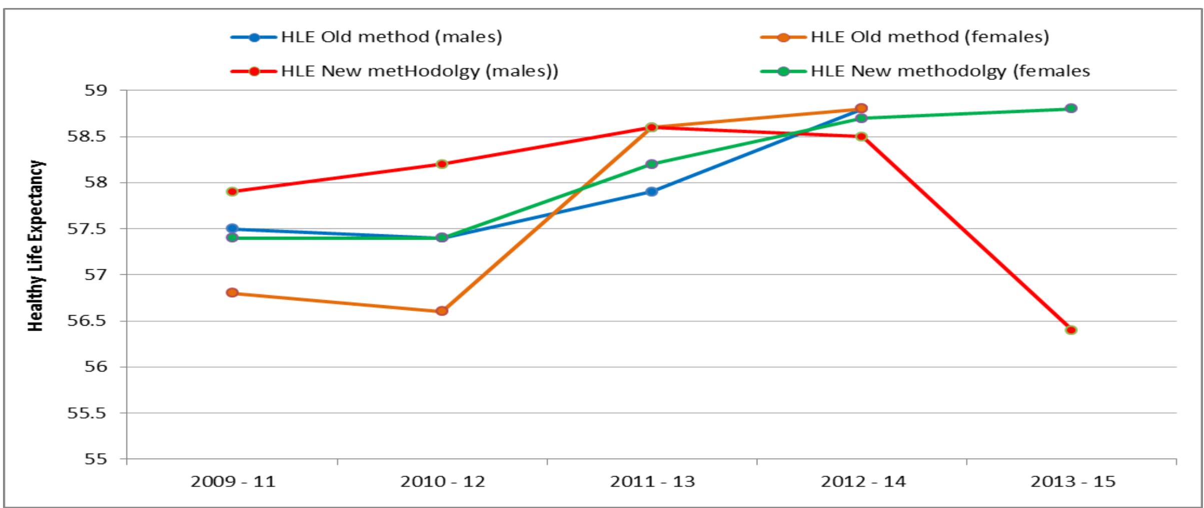
Changes in calculating life expectancies

In November 2016, ONS implemented a revised methodology for the calculation of healthy life expectancy and life expectancy at birth by using an upper age band of 90 and over; whereas previously the upper age band was set to 85 and over. The change was made to reflect an increasing proportion of deaths at ages 85 and over, and results in greater accuracy of healthy life expectancy estimates. The new methodology has been implemented for healthy life expectancy figures from 2009-11 onwards. A detailed explanation of the

[7] https://www.kingsfund.org.uk/time-to-think-differently/trends/demography/life-expectancy#healthy
[8] 4.Department of Health (2011). Statistical Bulletin. Life expectancy, all-age-all-cause mortality, and mortality from selected causes, overall and inequalities

methodology change and the impact on healthy life expectancy estimates can be found on the ONS website: new methodology for life expectancies

For Tameside this change in methodology has had a profound effect on both healthy life expectancy and life expectancy at birth outcomes. For Healthy Life Expectancy the change is negative as it has reduced HLE for males in 2013/15, but on the whole it has made previous years better and for females the movement is still positive although the increase is not as steep as in previous years. *Please see chart and table below.*



The impact on the change in methodology will have a similar impact on all areas similar to Tameside and Glossop due to the fact that fewer people in Tameside & Glossop reach the age group 85 years plus. Again this will affect males more than females and thus the decrease in HLE for males in particular. Latest population figures illustrate this with Tameside and Glossop's current resident population figures (October 2016), showing that only 1.1% of the resident male population are aged 85 years and above, compared to the England average of 1.7% and for females 2.3% of the Tameside and Glossop resident population are aged 85 years plus, compared to the England average of 3%. This equates to approximately 1,180 less people reaching their 85th birthday compared to the rest of England.

It is important that we understand the methodology used in calculating healthy life expectancy, unlike Life expectancy at birth which uses purely population and mortality data. Healthy Life Expectancy also uses survey data relating to peoples perspectives around their own health ' good to bad'. This is very subjective and is not a whole population perspective. The survey is annual and the results fluctuate somewhat each year and this would have an effect on the final HLE figures. However it is still important to understand why the male HLE has reduced by 2 years. We do know that males deaths in Tameside and in particular deaths under 75 years are significantly worse than the England average and that there are wide inequalities between male and female life expectancy and mortality within Tameside and Glossop and there are various reasons for this, including genetics, work environment, life style choice and income.
Extending the open-ended final age group interval from 85 years and over to 90 years and over, results in greater accuracy of life expectancy estimates across all age groups. The end estimate of life expectancy tends to be slightly lower when life tables were closed at 90 and

over compared with 85 and over.

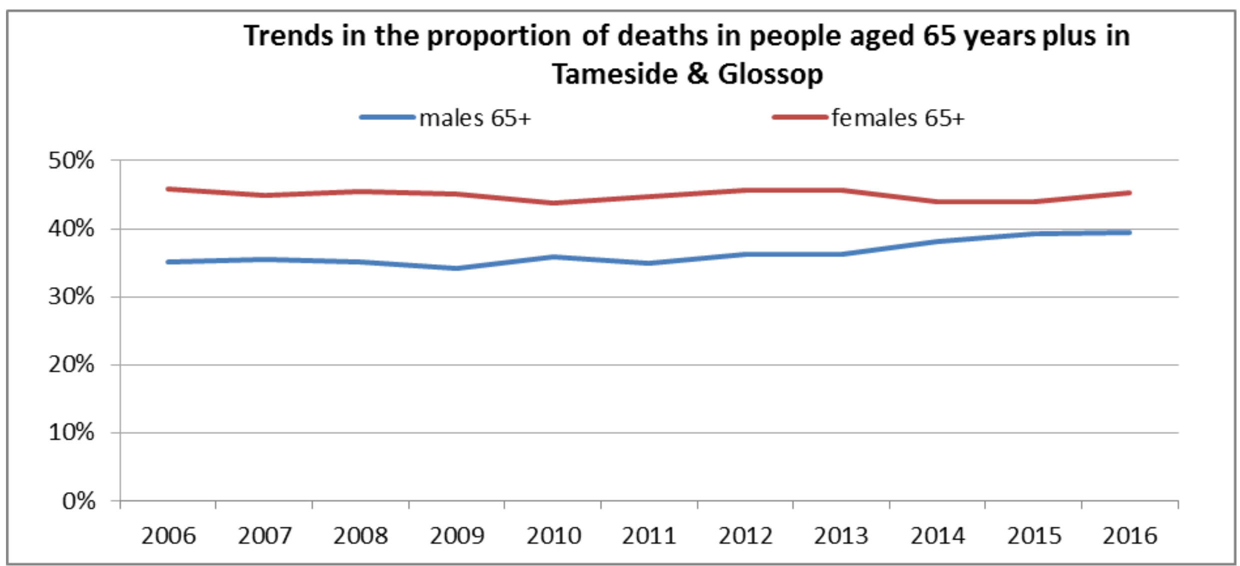
Year	Old Methodology		New Methodology	
	Life Expectancy			
	Males	Females	Males	Females
2009-11	75.6	80.2	75.8	80.4
2010-12	75.9	80.5	76.3	80.6
2011-13	76.3	80.6	76.8	80.4
2012-14	76.9	80.3	77.2	80.7
2013-15	77.3	80.6	77.3	80.7

The table opposite illustrates the change in life expectancy at birth between the old and new methodology. It shows that the new calculation has had a positive impact on overall trends in life expectancy over the last five years with the new methodology illustrating a high life expectancy result over all.

For areas like Tameside and Glossop who have a lower population of people aged 90 years plus, the impact will be a lower life expectancy at birth and healthy life expectancy overall. This impact will be felt in most areas where there are high levels of deprivation and poverty.

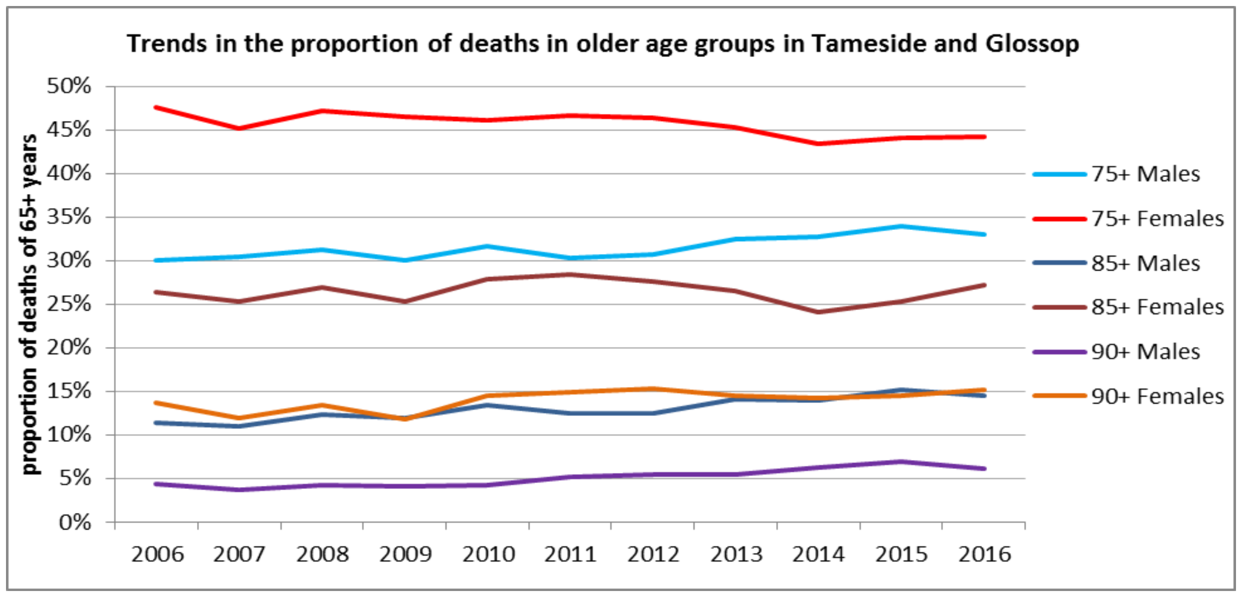
The aging population

The number of deaths occurring in Tameside as a proportion of all deaths shows that a high proportion of deaths occur in age groups 65 years and over. (85% of all deaths in 2016)



Source: PCMD

People are living longer both nationally and locally. The chart below illustrates the proportion of deaths in people over 75 years by age bands 75+, 85+ and 90+ years.



Source: PCMD

It is clear from the chart above that for females the trend in deaths in the 85+ age groups are increasing and although small increases can be seen in males across all the age groups represented in the chart, there is a clear indication that the proportion of male deaths in the 0ver 75s age groups have started to decline. This will have a knock on effect for life expectancy and healthy life expectancy at birth for males, as the higher the proportion of deaths in the older age group categories the higher the life expectancy estimates will be. However from the chart above it is also clear that for females aged 75 years plus the proportion of deaths in this age group is actually lower now than it was in 2006, dipping to its lowest level in 2014 (2006 = 48% of all deaths versus 2016 = 44%). Whereas males, although showing a decline between 2015 and 2016, the proportion of male deaths in the over 75s category is higher than it was 10 years ago.

For those reaching 100 years plus in Tameside, the inequalities between males and females is significant with only 18 males in ten years reaching the 100 years mark or above compared to 157 females. And this inequality between males and females is persistent across all the older age groups.

Causes of Death in males and females under 65 years and over 75 years (T&G)

The table below highlights the main causes of death in people under 65 years as a proportion of all deaths by year.

- It illustrates that for males CVD mortality has reduced for males but stayed fairy static for females.
- The proportion of people dying from cancer has stayed fairly static for males and females and is the biggest cause of death in this age group
- Deaths from respiratory disease is higher now than it was 10 years ago but again as remained fairy static

The biggest rise in mortality is from digestive conditions including alcohol related liver disease, this increase as a proportion of all deaths is 21% higher in 2016 for males than in 2006 and 37% higher for females.

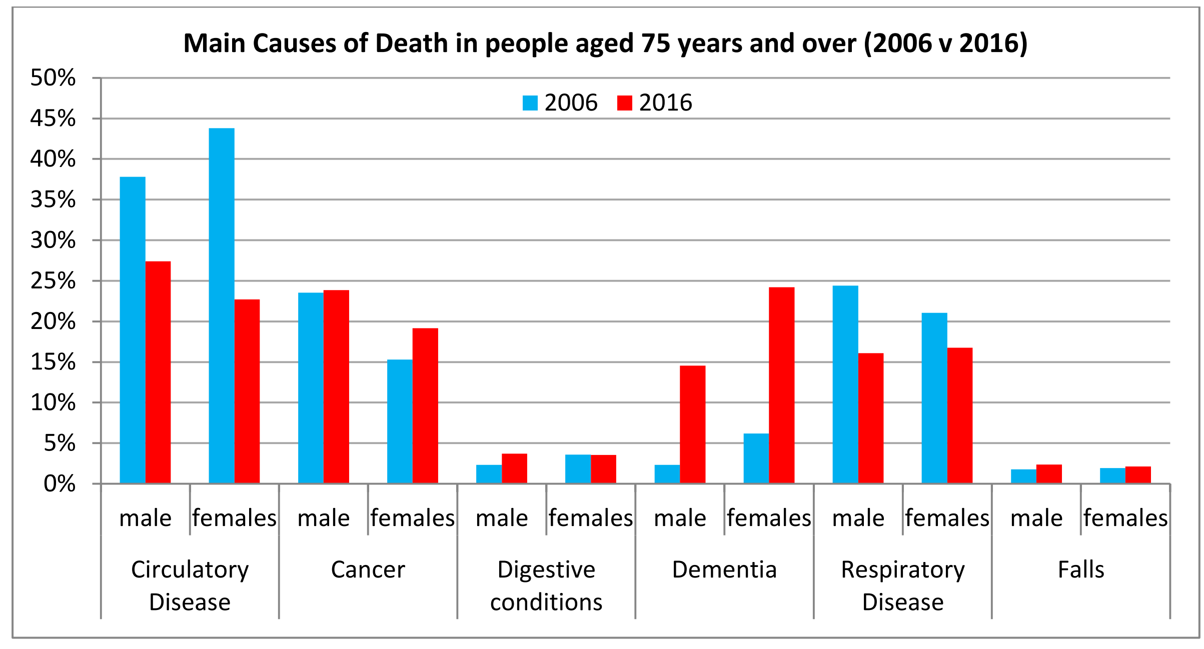
Year	Circulatory Disease		Cancer		Digestive conditions		Suicide and injuries undetermined intent		Respiratory Disease		Other	
	male	females	male	females	male	females	male	females	male	females	male	females
2006	31%	19%	29%	45%	8%	9%	9%	4%	6%	8%	17%	16%
2007	30%	23%	35%	42%	7%	9%	3%	2%	9%	7%	17%	17%
2008	33%	19%	25%	38%	8%	9%	9%	5%	6%	12%	20%	18%
2009	27%	15%	25%	44%	11%	12%	7%	2%	8%	9%	21%	17%
2010	29%	17%	30%	45%	10%	9%	5%	2%	6%	9%	20%	18%
2011	25%	10%	31%	43%	11%	13%	7%	4%	6%	7%	20%	23%
2012	24%	22%	31%	46%	11%	10%	6%	1%	5%	6%	24%	15%
2013	28%	24%	33%	41%	11%	10%	6%	1%	7%	8%	14%	16%
2014	28%	16%	29%	47%	10%	13%	6%	1%	5%	7%	22%	15%
2015	26%	12%	31%	42%	16%	11%	9%	2%	5%	9%	14%	22%
2016	26%	19%	30%	34%	10%	15%	7%	4%	8%	10%	18%	18%

Source: PCMD

- Circulatory disease, cancer, digestive conditions and respiratory conditions account for 75% (males) and 79% (females) of all deaths in 2016 compared to 74% and 81% respectively in 2006.

A full break down of causes of death in Tameside and Glossop (2016) can be seen in Appendix 1.

In the older age groups (75yrs+), the main causes of death can be seen in the chart below. These deaths account for 88% of deaths in males and 89% in females (2016).



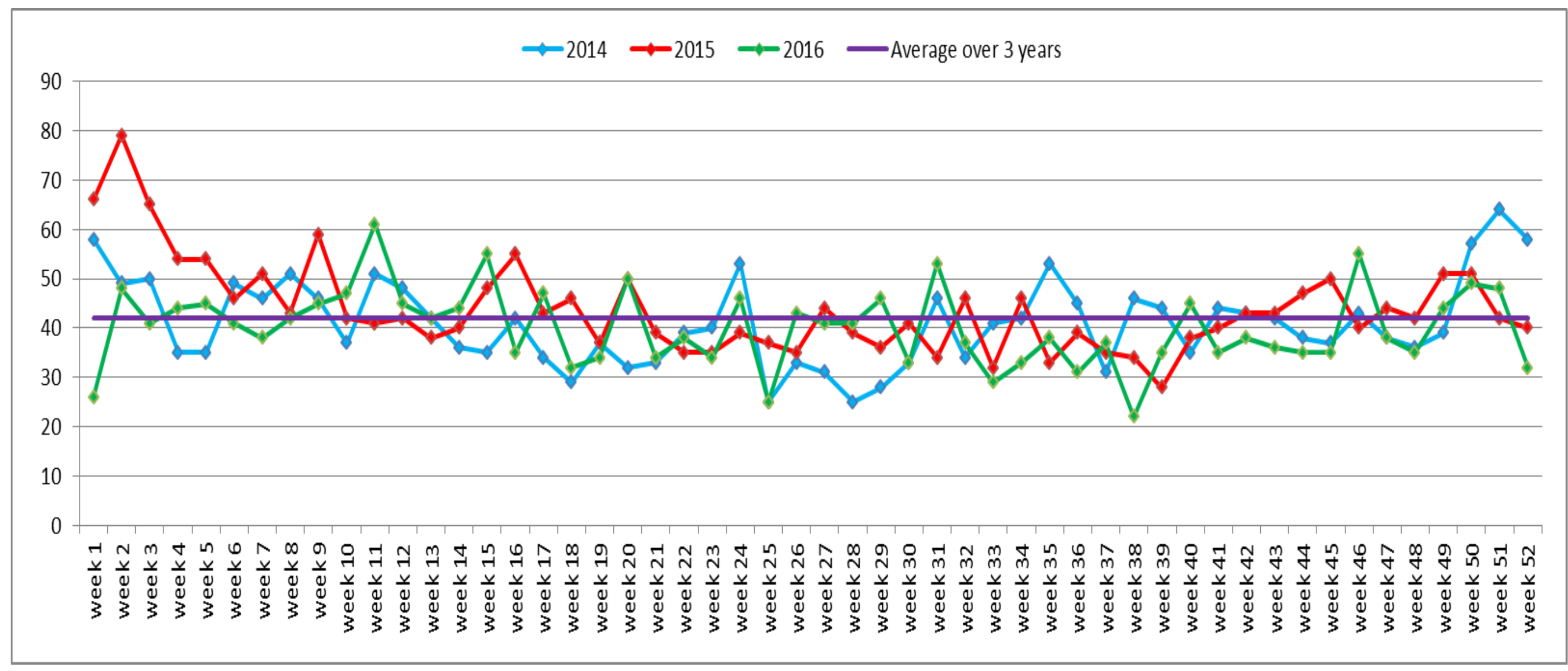
Source: PCMD

It is clear from the chart above that circulatory disease has significantly reduced as the main cause of death since 2006. Although for males it still is the major cause of death. The proportion of deaths from cancer in this age group as remained fairly static for males but has increased somewhat in females. The biggest increase in the deaths is for dementia which now accounts for around 39% of all deaths in 2016 compared to 8% in 2006. However, pre 2010 the coding of dementia was not always consistent, so these figures need to be treated with caution. However, large increases in deaths and the prevalence of dementia are seen nationally.

Changes in patterns of mortality by weeks (2014.2015.2016)

When analysing deaths statistics on a weekly or monthly basis, it is important to use the date of death, as this gives a more accurate picture of changes and fluctuations. During the twentieth century, mortality rates have declined quite rapidly in the United Kingdom. This is due to the reduction of cardiovascular disease in the elderly and the prevention of death in infancy. But deaths fluctuate week on week month on month and there are many reasons for this. The chart below shows the fluctuation in Tameside and Glossop during 2014, 2015 and 2016.

Weekly Mortality Statistics for Tameside and Glossop

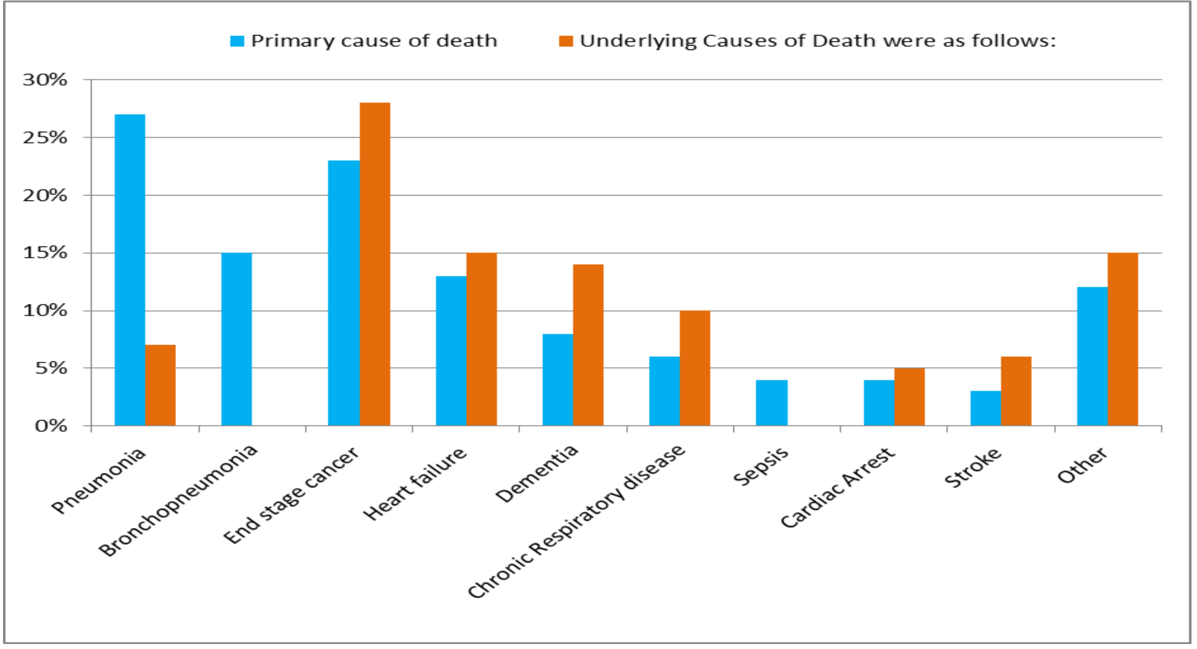


Source: PCMD

The high weekly mortality statistics that can be seen in weeks 1 to 4 and weeks 49 to 52 (2014/15) could be due to a number of external issues ranging from excess winter deaths of which Tameside is similar to the England average. Natural fluctuations in population mortality rates (more people reaching old age), harsher winters, infectious diseases and system failure. Looking at what was going on across the health and social system over the 6 weeks of December 9th to January 19th 2014/15.

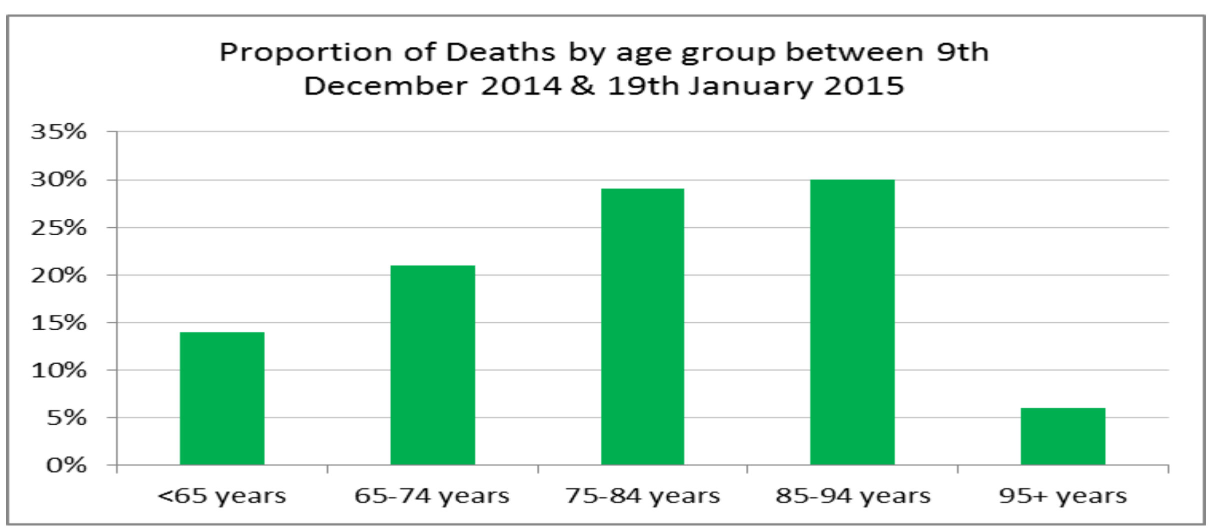
- On average there were 22 deaths more per week than would be seen across the year. 64 deaths per week compared to the annual average of 42 per week.

- The average number of A&E attendances over this 6 week period was similar to the annual weekly number.
- Average proportion the were seen in A&E before 4 hours was 88% over the 6 week period 9th December 2014 to 19th January 2015. Compared to the annual average of 94%.
- However; the proportion of people waiting between 4 and 12 hours during this 6 week period was 10, compared to the annual average of 3 people. (70% higher than normal)
- Delayed transfer of care averaged 15 per day over this 6 week period compared to the annual daily average of 2. (87% higher)
- The winter weather over this week period was average for the time of year with no significant low temperatures. (Average temperature between December 2014 and February 2015 was 4.2^{o}C). However there was some snow fall over this period and an amber level cold weather warning was issued on the 27th December 2014 which could have had some impact on mortality rates.
- The main primary and underlying causes of death can be seen in the chart below



Source: PCMD

- Of the deaths occurring over the 6 week peak, 55% occurred in hospital, 14% in a care home, 10% in a hospice and 20% at usual address (home)
- By age, the majority of deaths were in people aged over 75 years (74%)



Source: PCMD

- The proportion of deaths by gender was males (49%), females (51%)
- People registered with 11 GP practices accounted for just over half of all the deaths in this 6 week period. (51%), with 3 of these practices accounting for nearly 20% of all the deaths over the same time frame.

Sicker patients with more complex conditions are the main reason for worsening performance in A&E departments, according to the King's Fund.

80% of NHS finance directors who responded to a survey identified higher numbers of patients with severe illnesses and complex health needs as a key reason for the pressures on A&E units, while 70% cited delays in discharging patients from hospital. This contrasts with 27% who pointed to poor access to GPs and 20% to shortages of clinical staff as key factors.

Responding to the challenge

The rise in preventable mortality can be reversed if appropriate action such as improved surveillance, prevention programmes, and community based interventions, health care reform and use of fiscal and taxation policies to encourage health lifestyles and services are implemented.

Right Care: is a programme committed to improving people's health and outcomes. It makes sure that the right person has the right care, in the right place, at the right time, making the best use of available resources**.**

NHS Right Care is all about:

- Intelligence – using data and evidence to shine a light on unwarranted variation to support an improvement in quality
- Innovation – working in partnership with a wide range of organisations, national programmes and patient groups to develop and test new concepts and influence policy

- Implementation and improvement – supporting local health economies to carry out sustainable change.
- make the best use of resources – offering better value for patients, the population and the tax payer
- understand how they are doing – by identifying unwarranted variation between demographically similar populations
- get talking about the same stuff – about healthcare rather than organisations
- focus on the areas of greatest opportunity by identifying priority programmes which offer the best chances to improve healthcare for populations
- use tried and tested processes to make sustainable improvement to care to reduce unwarranted variation

The areas of Right Care that Tameside and Glossop have prioritised are 4 priorities form our main 'transformation' priorities for NHS Right Care, and link with the integration and local transformation programme:

- Circulation
- Respiratory
- MSK
- Trauma and Injuries

These priorities link with what the mortality statistics are telling us and the following NHS RightCare priorities will be further analysed and addressed through existing opportunities and programmes of work:

- Cancer
- GI
- Mental Health
- Endocrine

Prevention and Early Intervention: To increase life expectancy and reduce premature mortality we need to prevent our local population from getting health problems in the first place and to ensure that when diagnosed they are diagnosed at the earliest possible stage so that individuals are able to manage their conditions effectively and to ensure a high quality of life is sustained for as long as possible.

Screening and vaccinations programmes have a strong evidence base and are proven to save lives and be cost effective. Therefore it is important to maximise vaccination and screening across the population where possible in order to detect and vaccinate against potential life threatening conditions.

Areas for improvement in Tameside and Glossop include finding the missing thousands of people with undiagnosed conditions through health checks, ensuring all eligible people attend screening such as breast and bowel cancer screening and ensuring the eligible population are vaccinated for influenza and pneumococcal infections. The latter being one of Tameside and Glossop's biggest main causes of death in older people with long term conditions.

Quality Outcomes Framework (Disease Registers)

QOF registers were constructed to underpin quality of care. Ensuring our residents with a condition are on the relevant QOF register is an important part of patients understanding and managing their condition effectively. Currently the number of people on a disease register does not correspond with the expected number for the following conditions.

Heart Failure		CHD		AF		Hypertension		CKD		COPD		Stroke	
QOF	Number Missing	QOF	Number Missing	QOF	Number Missing	QOF	Number Missing	QOF	Number Missing	QOF	Number Missing	QOF	Number Missing
3,563	1,534	11,361	1,570	5,570	1,556	61,071	23,684	17,365	11,480	10,378	3,693	4,791	-160
Exceptions	**2,361**		**2,081**		**281**		**1,061**		**123**		**3,612**		**1,170**

For the conditions above, the table illustrates that there are around 43,358 people with a potential long term condition that are currently not being managed through the QOF process. The QOF process includes annual checks on disease/condition progress and self-management such as appropriate medicine management. For more information on the QOF process the technical guidance can be found here QOF Technical Guidance.

Although QOF is voluntary for General Practice to partake in, QOF is a good indicator of disease prevalence in an area and the management of long term conditions through primary care. For those currently on a QOF disease register, so known to have a long term condition around 10,689 of these patients were deemed exceptions. Exception reporting means that 10,689 did not receive the intervention appropriate to their condition, such as an annual health check, medicine review, or intervention such as the flu vaccination. However these patients may still be managed by the GP by a different method. Unmanaged and unchecked disease can lead to unplanned hospital admissions and early death.

Patients can be exception-reported from individual indicators for various reasons, for example if they are newly diagnosed or newly registered with a practice, if they do not attend appointments or where the treatment is judged to be inappropriate by the GP (such as medication cannot be prescribed due to side-effects). They can also be exception-reported if they decline treatment or investigations.

The overarching principles that should be followed in deciding to exception a patient are that:

- The duty of care remains for all patients, irrespective of exception reporting arrangements
- It is good practice for clinicians to review patients from time to time to ensure the patient is managing their condition or the condition has not worsened
- The decision to except report must be based on clinical judgement with clear reasons why they are exception reporting.
- There should never be any blanket exception reporting

Conclusion

It is clear from the evidence throughout this report that Healthy Life Expectancy and Life expectancy for both males and females are improving somewhat. However the new methodology for calculating life expectancies has had an impact of life expectancy figures for Tameside and Glossop and indeed the rest of the country.

It is clear that moving the age limit from 85 years to 90 as had a significant impact for Tameside & Glossop and this is due to the fact that people in Tameside and Glossop die young and therefore the proportion of people reaching 90 years is significantly lower than the England average.

Main causes of death are similar to what they have been for the last 10 years, CVD, respiratory disease, vascular dementia, cancer and digestive conditions. However there has been marked improvement in the number of people dying from CVD related conditions.

The report highlights also that a peak death rate in the winter of 2014/15 was significant. What contributed could be a multitude of things happening over this particular 6 week period. However, there did seem to be a short lived system failure at the local hospital trust during this time that would have had an impact on outcomes for patients who were admitted. We need to ensure that this is prevented from happening in the future.

It is also pertinent to note that the inequalities gap between Tameside and Glossop and England for life expectancy in people over 65 years is similar to the England average in all age groups 65 years+, 75 years+ and 85 years+. So when our residents do reach 65 years their life chances are similar to the rest of the country.

It is clear from the evidence in the report that the age group 15 years to 64 years contribute the most to the low healthy life expectancy. Conditions such as alcoholic liver disease, self-harm, cardiac arrest, strokes, accidents, cancer and some respiratory conditions are the biggest contributors to deaths in people under 65 years.

Responding to the challenge of ensuring our residents reach the same age as the rest of the country and that once older their life is of good quality is achievable, but maybe not in the time scales that have been set.

However, the life expectancy projections do not take into consideration the new models of care that are coming to fruition of the Care Together programme of work. Therefore we

should recalculate the projects on an annual basis to understand the impact the changes in the system will have on outcomes for our patients.

Recommendations

It is clear that there is a lot of work happening across the health and social care system in Tameside & Glossop to improve the outcomes of our residents. This will help to improve healthy life expectancy. However we need to also incorporate the following into the plans to help accelerate and realise the ambition laid out in our locality plan.

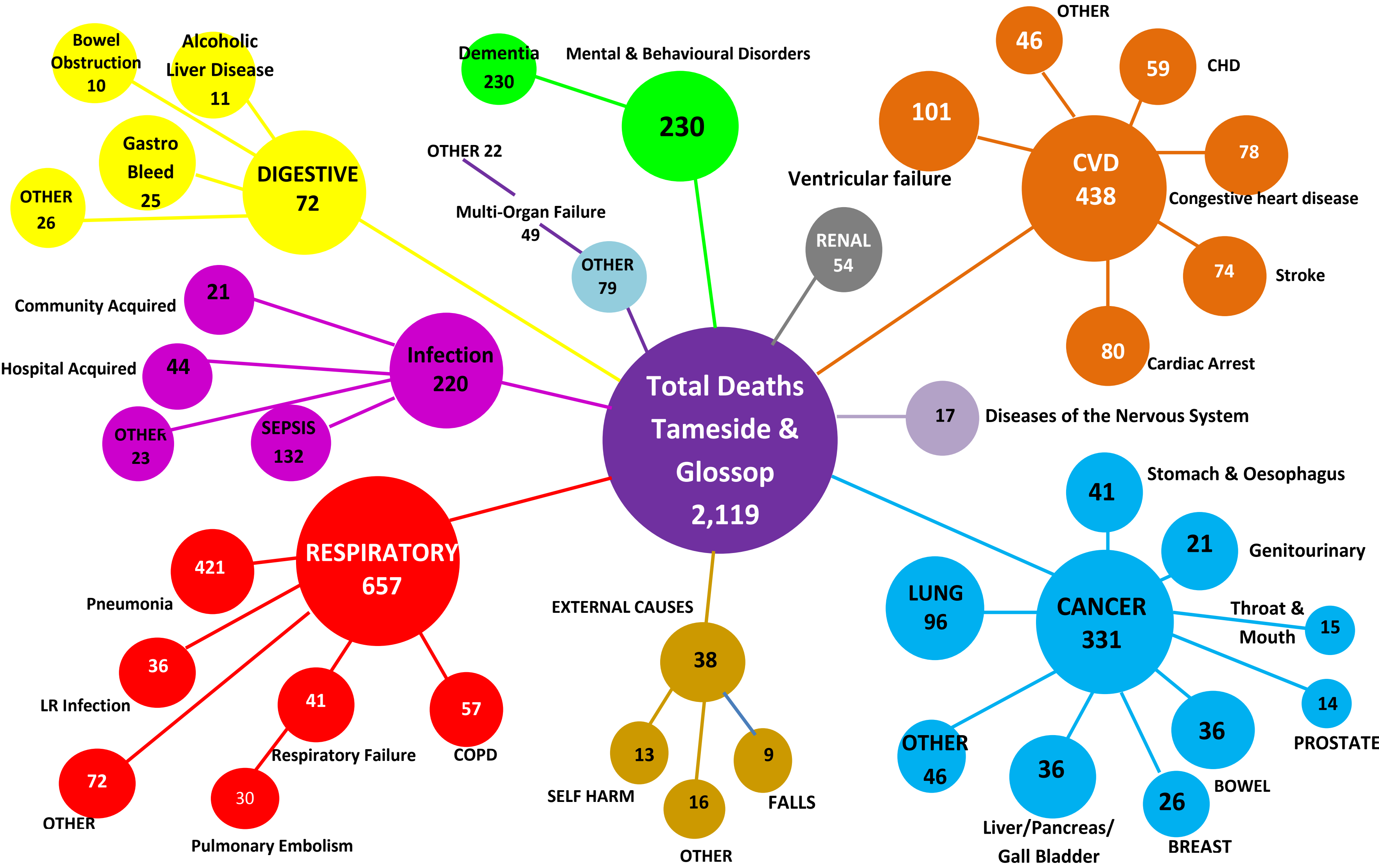
These include:

1. Reducing deaths in people aged 15 years to 64 years; this means a reduction in male deaths of at least 51 each year and 21 less deaths for females.
2. Targeting females in particular around life style issues
3. Finding the missing thousands from the disease registers. People with a condition will then get the appropriate care and interventions that will help them live longer and manage their condition better.
4. Using risk stratification data to ensure that people in the risk groups 20% to 69% have access to the relevant services and interventions that allows them to improve their outcomes.
5. Investigate further, death rates at GP practice level, to see if higher rates are due to positioning of the practices, the age profile of the practice or clinical practice/care. This will enable the wider system to support those practices improve patient outcomes.
6. There needs to be an accelerated programme of work to prevent our population from getting long term and life impacting conditions in the first place. This would be the best and most effective way of ensuring that patterns in mortality and life expectancy change completely.
7. When people do get a long term condition it is important to ensure their condition is monitored on a regular basis and that they are enabled to better care for themselves. Reducing exception reporting in QOF is therefore a must do, along with self-care interventions.

APPENDIX 1

Main Causes of Death in Tameside & Glossop 2016

Source: PCMD (Numbers included are based on primary cause of death)



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APPENDIX B

INDEPENDENT RESEARCH

Two papers linking 30,000 excess deaths in 2015 to cuts in health and social care, by Lucinda Hiam, Danny Dorling, Dominic Harrison and Martin McKee were published in the Journal of the Royal Society of Medicine in February 2017:

- *"Why has mortality in England and Wales been increasing? An iterative demographic analysis"*
- *"What caused the spike in mortality in England and Wales in January 2015?"*

In summary the research reported:

- Markedly higher death rate in 2015, principally in January
  - 5.6% more deaths than in 2014
  - 24.2% more deaths in January than 2104

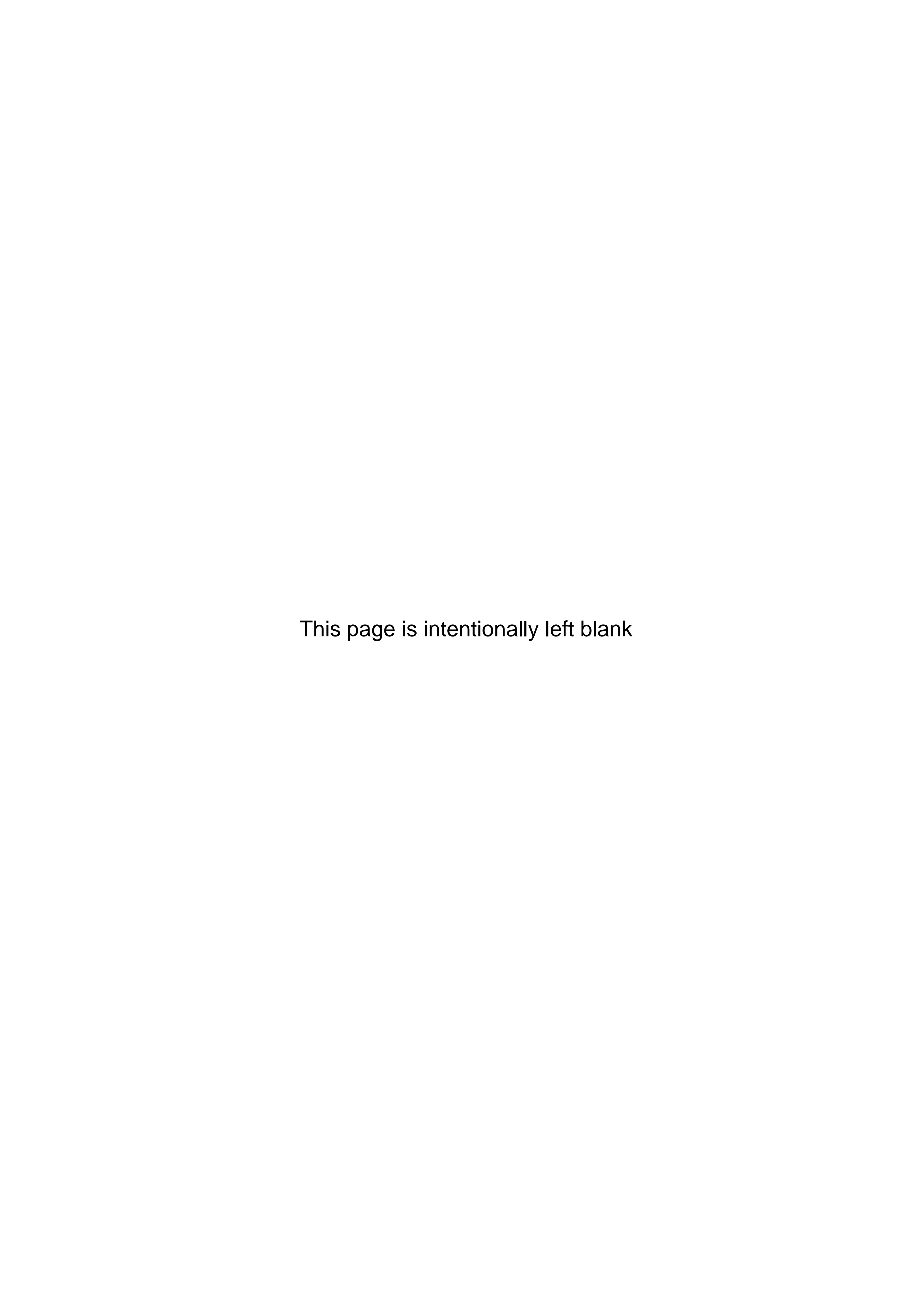
- Potential causes reviewed:
  - Data artefact
  - Environmental shock eg severe weather
  - Epidemic disease eg flu
  - Failure of health and social care system

- No evidence that data, weather or flu accounted for pattern

- Failure of health and social care could not be discounted, and several factors supported this possibility:
  - Increased 111 calls
  - Ambulance call-out time below target
  - A&E waiting times increased
  - Diagnostics waiting times increased
  - Cancelled operations increased
  - Delayed transfers of care increased
  - Staff absences rose

- Impact on life expectancy attributable principally to deaths in over 85s
  - Dementia made greatest contribution in for both sexes
  - Pneumonia also significant
  - Influenza deaths likely to be from pneumonia

- This event may be a sentinel event for future system failures rather than a one off.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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	29 June 2017
Executive Member / Reporting Officer:	Cllr Ged Cooney – Executive Member Healthy and Working Angela Hardman – Executive Director - Public Health, Business Intelligence & Performance
Subject:	**GREATER MANCHESTER POPULATION PLAN STOCKTAKE - SYSTEM REFORM TO CREATE A UNIFIED POPULATION HEALTH SYSTEM**
Report Summary:	The purpose of the report is to provide the Health and Wellbeing Board with a local stocktake against the 20 strategic objectives in the Greater Manchester Population Plan outlining local initiatives to deliver on the ambitions in the plan together with local challenges. The report also gives an update on the review of the current public health system across Greater Manchester.
Recommendations:	The Health and Wellbeing Board are asked to: a) Note the attached stocktake against the strategic objectives in the Greater Manchester Population Plan. b) Note the update on the review of the current public health system across Greater Manchester. c) Agree that any action needed to implement the Greater Manchester Population Plan is included in the refresh of our local Locality / Population Implementation Plan to be presented at September's Health and Wellbeing Board.
Links to Health and Wellbeing Strategy:	The Greater Manchester Population plan and system reform to create a unified population health system delivers on all strategic priorities in the Health and Wellbeing Strategy.
Policy Implications:	Greater Manchester has the chance to take a co-designed approach to radically reframe the role of Population Health in the context of a devolved system, creating a unified population health system across ten localities and Greater Manchester that is better able to achieve improved health outcomes for the citizens of Greater Manchester.
Financial Implications: (Authorised by the Section 151 Officer)	It should be noted that from 1 April 2017 the former Public Health grant is no longer a ring fenced grant within Greater Manchester. This clearly provides enhanced flexibilities on the use of this resource within Greater Manchester localities. It is essential that the transformation of the population health across Greater Manchester and within the Tameside and Glossop locality is integral to the delivery of the financial challenge which is currently projected to be £70.2 million by 2020/2021 within Tameside and Glossop.
Legal Implications: (Authorised by the Borough Solicitor)	The Council has a statutory duty to deliver value for money services – to be value for money they must be services that are required and deliver improved outcomes for residents. Consequently an important outcome in setting the Council's

priorities within a reducing budget is to gather intelligence to understand both need and whether maximum impact can be made. It will be critical that there is a clear performance and assurance system in place to ensure that any interventions/programmes are delivery what is required to improve health outcomes and reduce unaffordable demand.

Risk Management : There are no risks associated with this report.

Access to Information : The background papers relating to this report can be inspected by contacting Debbie Watson, Head of Health and Wellbeing

Telephone: 0161 342 3358

e-mail: debbie.watson@tameside.gov.uk

1. PURPOSE

1.1 The purpose of the report is to provide the Health and Wellbeing Board with a local stocktake against the 20 strategic objectives in the Greater Manchester Population Plan outlining local initiatives to deliver on the ambitions in the plan together with local challenges. The report also gives an update on the review of the current public health system across Greater Manchester.

2. INTRODUCTION

2.1 The Greater Manchester Population Health Plan (January 2017) provides a clear road map for what Greater Manchester wishes to achieve to improve the health and wellbeing of the population. The plan is intended to enable residents to "start well, live well and age well" and to lead happier and healthier lives. The plan covers the most crucial area for health and social care reform and puts strong focus on prevention and how better health and wellbeing helps with work prospects and economy. The plan will complement the individual work in the ten localities of the city region and highlights where issues can be tackled more effectively by working together from a Greater Manchester stance.

2.2 Reform, to create a unified population health system, is one of the key programmes of work and chapters within the Greater Manchester Population Health Plan. This further reinforces the commitment made by partners (10 Greater Manchester Local Authorities; Public Health England; NHSE; Association of Greater Manchester Clinical Commissioning Groups; Greater Manchester NHS providers and Greater Manchester 'blue light services') in July 2015 when they signed the Public Health Memorandum of Understanding to create a unified public health system for Greater Manchester.

2.3 This also builds on the Greater Manchester ambition and shared commitment to place Public Health at the heart of public sector reform and economic growth, and the recognition that rebalancing our economy means rebalancing our public services.

3. POPULATION PLAN PRIORITIES

3.1 Key priorities in the Greater Manchester approach include:

3.2 **Start Well**

Smoking in pregnancy – **what we know:** this is single biggest and preventable risk factor for both the baby and mother's health.

- **The Greater Manchester approach** – identifying mums-to-be who are smoking will be a key part of the booking in, initial ante-natal visit so that they can be offered help to give up smoking.
- Training will be given to key workforce groups to ensure pregnant women and their families are given the most appropriate advice and support.

Child dental health – **what we know:** the biggest reason for children having general anaesthetic surgery in Greater Manchester is to take out decayed teeth. It's also a key reason for children attending A&E due to dental pain.

- **The Greater Manchester approach** – we want every child in Greater Manchester to have had a dental appointment by the age of one.
- The oral health improvement programme will boost more children having access to fluoride through teeth brushing schemes in nurseries and pre-schools.

3.3 **Live Well**

Work and health – what we know: there is a strong link between not having or not being able to work and poor health. Being out of work can lead to poor physical and mental health, across all age groups, with major impacts for the individual concerned, their partner and family.

- **The Greater Manchester approach:** a programme to ensure that there is an effective prevention and early intervention system in place to support as many adults with health conditions as possible to return to, and remain in, good quality work. Key to this vision will be health, employment and other services working together to give help and support before people fall into long-term unemployment.

Cancer – what we know: by 2020 it is estimated that more than one in two people will be affected by cancer at some point in their lives. Every 30 minutes someone in Greater Manchester is told they have cancer.

- **The Greater Manchester approach:** A key commitment for Greater Manchester is to reduce early deaths from cancer by 1,300 fewer deaths by 2021. Plus we will recruit 20,000 'cancer champions' to promote and support their local communities.

3.4 **Ageing Well**

What we know: the risk of malnutrition and dehydration increases in people aged over 65. Malnutrition often develops gradually and can go unnoticed. It is estimated to be part of around 30% of hospital admissions; affect 10-14% of people living in sheltered housing; and be a factor for as many as 35% of people admitted to care homes.

- **The Greater Manchester approach** – recognising the need to raise individual, family, carer and practitioner awareness of the issues in older people, so that it can be spotted earlier and more easily in day-to-day situations and more people can benefit from information, advice and support to address the problem.

3.5 A Tameside stocktake against the 20 priorities listed in the GM Population plan, together with challenges can be seen at **Appendix 1.**

4. SYSTEM REFORM TO CREATE A UNIFIED POPULATION HEALTH SYSTEM

4.1 A review of the current public health system has been underway since November 2016 with the aim of developing a set of propositions for creating a unified population health system for Greater Manchester. Directors of Public Health, Local Authority Chief Executives, Treasurers, Commissioners and other key stakeholders across the System have been actively involved in this process.

4.2 An emerging set of propositions have been developed which have been further developed with Association of Greater Manchester Authorities Wider Leadership Team in early February 2017.

5. PROPOSED CHANGES

5.1 The implementation of the NHS and Social Care Act in 2013 resulted in a split in public health leadership and core public health functions, across local authorities, Public Health England, NHS England and some functions to Clinical Commissioning Groups.

5.2 There are strengths of the reformed system since 2013 e.g. the ability of Local Authorities to develop a more place based approach to public health and link public health functions to wider public services. There are also some weaknesses, such as greater fragmentation of public health functions such as health protection and public health intelligence nationally and across Greater Manchester. The impact of the reforms has led to variation in performance and in investments in public health services, limiting the effectiveness of the current Greater Manchester public health system.

5.3 The review has looked at public health functions, commissioning of public health services and system leadership across Greater Manchester and used that insight and intelligence to shape proposals for a unified population health system that abides by the key principle of subsidiarity and promotes local place-based leadership. In doing so there has been recognition of the current timeliness of the emerging Local Care Organisations as well as the development of single local commissioning functions and the move to place based integrated commissioning across Greater Manchester.

5.4 The Greater Manchester Health and Social Care Partnership have used the findings from the review and the understanding of local system changes to inform the development of the proposals towards a unified population health system for Greater Manchester. Summary findings from the review and outline proposals are outlined in **Appendix 2.**

6. IMPLICATIONS FOR TAMESIDE

6.1 The creation of a unified population health system will become an inherent part of the integrated place based approach to health and social care reform in each locality.

6.2 Population health place based leadership in Tameside and Glossop will be about ensuring the development of a culture of ‘population health is everyone’s business’. This creates opportunities for Health and Wellbeing Board members to champion and influence the health and wellbeing of their local populations.

6.3 Creating a culture of population health integrated into core business through:

- A consistent set of population health outcomes embedded into all locality plans.
- Common standards for public health services which lift the performance to the best in GM across the whole system.
- Using peer to peer support (such as sector led improvement programmes) as a tool to support this.
- Providing population health training programmes
- Investing in the wider community, voluntary and business sector infrastructure to be part of a reformed delivery system.
- Supporting the focus on a ‘whole system approach’ with GM and Localities working as a single system.

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

6.5 In Tameside, as a result of these reforms, we will see:

- A sustainable system that secures better outcomes for local people.
- A reduction in unwanted variation in standards and population health outcomes, with a more consistent adoption of evidence based practice and benchmarking data.

- The system working together to deliver the scaled implementation of the Population Health Plan's transformation programme of work.
- Accelerated knowledge and skills exchange, with the implementation of best practice and innovation consistently.
- A focus on the role of health and care provider system to make a substantial contribution to population health growth, both in their role in being part of the pathways ('making every contact count') and as a major employer.
- Visible integrated population health system leadership across the system which will minimise siloed working and enable join up conversations across and between children's, adults' and wider public services, spanning physical and mental health.
- Maximising the existing skills and capacity in the system towards delivering the Greater Manchester ambition for a radical upgrade in population health through more networked arrangements.
- Greater local determination in using and maximising available resources in the most efficient way, including communities making more decisions for themselves about the best way to secure improvements.
- Commissioning at Greater Manchester level to achieve additional impact complementary to that at locality level.
- The deployment of Population health intelligence in the context of a Greater Manchester place based function focused on Greater Manchester priorities of growth and reform.
- Creating a platform for further devolution 'asks' from central government to enable Greater Manchester to have more control over the key levers for securing population health gains, including regulatory and pricing mechanisms, and improvements to environmental quality.

7. NEXT STEPS

7.1 The proposals have recently gone through Greater Manchester's internal governance. The intention is to align the commissioning proposals with the outcomes of the current commissioning review taking place across Greater Manchester.

7.2 The next step is to develop a detailed delivery and transition plan, alongside an engagement and communications plan to support the transition. Greater Manchester Health and Social Care Partnership will work with colleagues across the system and from the various sectors to co-design the approach to delivery.

8. RECOMMENDATIONS

8.1 As set out on the front of the report.

GREATER MANCHESTER POPULATION HEALTH PLAN STOCKTAKE - TAMESIDE

STARTING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
To support localities to implement the core elements of the Greater Manchester Early Years model, including the development of an IMT proposition to improve data to track processes progress and allow earlier intervention	We have full implementation of the Early Years Delivery Model (EYDM) • Social marketing and Communications: 'Grow' brand identity development and implementation, Vloging with wider partners. • Communications pathway: baby babble, toddler talk, small talk, welcomm. • Parenting pathway: Solihull, Incredible Years, Mellow Bumps, Mellow Parents, under 3s course, PEEP, Parent Infant Relationship Tool, Brazelton NBO, Brazelton NBAS. • Gross and Fine Motor Skills pathway: Move and play up to 3 years. • Full ASQ Roll Out including PVI and Schools and Health visiting team. • Workforce Development	Our Early Years Delivery Model ambition in Tameside is to make sure that children are given the best start in life so they can be school ready and flourish during their school years and succeed as adults and contribute to the economy. The EYDM has at its heart improving outcomes for children and their families and reducing inequalities in child development, school readiness, aspirations and life chances. The model includes assessments in 8 stages, pre-birth to 5yrs and is implemented through integrated working through the early year's system. Where ASQ Assessment indicate the need for additional targeted support, wide range evidence base interventions are available.	There is a robust governance structure that sets the ambition and vision of the overall early years programme delivery. It includes: Early Years Steering Group, Early Years Operational Group, Pathway Groups including communication, motor skills and physical activity and parenting, Family Nurse Partnership Advisory Board, Children Centre Advisory Groups x4, Maternity Service Liaison Committee. The on-going development, implementation and evaluation of the programme operationally is	Areas of focus needed: • Extend Pathway for all vulnerable parents • Domestic Violence pathway • Primary care model for Incredible Years • Developing home learning environment, • active participation and engagement of parents in the planning and development of the programme

	Programme: ASQ training, Solihull, Incredible Years, NBO and NBAS, speech and language training, ELKLAN, Every Child a Talker. • Early Attachment Service and PIMH Pathway • Family Nurse Partnership • 3rd sector small grant scheme	Latest school readiness figures (63%) show an improving position, with improvements increasing at a faster rate than the Greater Manchester or England average, closing the gap.	underpinned by collaborative and integrated working across every element of the early years system and building partnerships with the community and school settings. Children and Young People's Outcome Framework in development	
To develop a sustainable, resilient and consistent Greater Manchester approach to stopping smoking in pregnancy	All pregnant women are offered the carbon monoxide reading at their first maternity booking. Women who smoke are referred to Be Well Tameside for Stop Smoking Support on an opt out basis. Pregnant women are also tested for carbon monoxide at 36 weeks. The Health & Wellbeing Advisors and the Specialist Maternity Stop Smoking Advisor arrange to see the pregnant women to assist them on a stop smoking programme. If women do not respond to invitations of support from Be Well, the referral is passed to the Midwife-led smoking cessation service to follow-up. The Midwife sees the majority of pregnant women who smoke and who agree to discuss	All community and hospital Midwives have received training on how to use the carbon monoxide monitor and how to assess and explain what carbon monoxide is. Alongside this they are trained to offer brief advice in smoking cessation and second-hand smoke advice to partners and family members. Smoking status at time of delivery in 2015/16 for Tameside was 15.8%	'Opt Out' referral pathway at the Maternity Unit; Be Well Tameside receive an electronic referral from from Euroking. Be Well Tameside receive the referral, the Health & Wellbeing Advisors attempt to make contact. After 3 contacts if there is no response, the referral is passed to the Specialist Stop Smoking Midwife to follow-up. The smokefree pregnancy work contributes to the action plan of the	Challenges include all Midwives being asked carry out carbon monoxide reading at each contact particularly at 36 weeks. To ensure brief advice is given systematically. As there is often a gap of more than a week between referral to Be Well and a subsequent referral to the Midwife-led service, the Public Health commissioner will be discussing the feasibility of a change to the referral pathway so that all pregnant women who smoke see the Stop Smoking Midwife in the first instance. The Midwife would then triage and refer women who are more motivated on to Be Well. This would present a need for admin support at the hospital which would need to be identified before this could be piloted. Should a GM approach to reducing smoking in pregnancy be adopted, for

	support for quitting.		Tameside Tobacco Alliance, which aims to work towards a smokefree Tameside and to make smoking history for children. The Tameside public health lead for tobacco control is a member of the GM tobacco commissioners group, and at times has been involved in GM partnership initiatives. A GM tobacco strategy is in development and activity on this will be co-ordinated via the GM commissioners group.	example by adopting the Babyclear approach, capacity could be an issue and there may be a need to invest in additional staff resource for the midwife-led service.
To implement evidence-informed interventions at scale in a targeted and consistent manner across Greater Manchester to improve oral health and	Oral Health Improvement, Brief Intervention & Dental Access training provided for- • Health staff (incl. Health visitors, family nurse partnership programme nurse's school nursing and assistants, health mentors, dental students/practitioners. • Early year's educational professionals' incl.	The latest survey of 5 year old children (2015-2016) in Tameside states that almost a third of children aged five (31.4%) had decayed, missing or filled teeth with an average of 1.2 teeth being affected. This is much higher than the England average of 24.7%. Tameside's levels of Early Childhood Caries	The core element of the service is to provide training using a capacity building model to increase evidence based oral health messages to the public in a range of health, social care, educational settings, voluntary and	Gaps in provision are: • Early Years - 2 year old specific oral health intervention at 24 month development check • Increase children's expose to fluoride Sugar Reduction Programme EY settings • Increase the uptake of fluoride varnish programmes by encouraging dental visiting

reduce treatment costs within 3-5 years.	children's centres, private and voluntary preschools, nurseries, child minders. • Voluntary organisations incl. Homestart • Housing providers working with vulnerable people. • Universal resources, (brush, paste and information on brushing/healthy start/weaning/detail access) posted to the families of all children 24 weeks old. • Universal resources (brush, paste and information on brushing/dental access) provided at the 9-12 month development check via Community Nursery Nurses. • To increase the uptake of fluoride use, all children's centres sell affordable quality brushes and paste.	stand at 8.8% in comparison to the England average of 5.6%. Dental extractions are the most common reason for hospital admissions in young children aged 5-9 years in England. In Tameside 194 children aged 0-19 years were admitted to hospital for dental extractions which is of substantive cost to NHS services at on average a general anaesthetic costing around £1000 per episode.	housing sector. The service is reliant on partners to distribute both evidenced based advice/information along with fluoride paste and brushes. Oral Health is a key priority across Tameside and delivery is enhanced through participation in the CYP Partnership Forum, PA and Healthy Eating Special Interest Group and the developing INT's	and targeted fluoride varnish programmes for three and above. • Provide targeted toothbrushing programmes in early year's settings and pre-schools and reception aged children. Challenges • Extra Cost of resources • Ability to deliver on a larger scale

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
To build and test an approach to work and health that improves the integration and alignment of health, employment and other services	Current activity includes: • Healthy Hattersley Service Provision • Enhancing and integrating Governance to improve future commissioning (Prosperous Board/Health and Wellbeing Board/Working Well Steering Group) • Building Skills for Business initiative	Tameside has implemented the Healthy Hattersley Pilot to test and learn how health and employment/skills services can integrate. The Pilot is based in the Hyde neighbourhood working with 4 GP practices. The pilot takes referrals from the GP practices and engages the patients in employment and skills support either with a local provider (Adullam) or the Working Well provider (Ingeus). Our approach has been designed to prepare Tameside for the Work and Health Programme in 2018. Working towards integrated commissioning we have ensured Public Health and Work and Skills representatives including Jobcentre Plus are engaged active members on our key decision making and	Work and Health is an identified priority for the Health and Wellbeing Board, Prosperous Board, implemented via the Working Well Steering Group	The main challenge is continuing a programme of work that begins to deliver public service reform by impacting on the culture and commissioning intentions of all organisations to ensure that work and health are not silo areas. Over the last 12 months we have implemented the Healthy Hattersley Pilot to ensure we have a significant piece of work on which to continue to build improved governance, strategy and policy making and support increased commissioning of joint projects.

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
		strategy partnerships. The Council has designed an initiative that can be delivered via Children's Centres to improve access to self-employment; this will have significant health impacts around early years.		
To develop a comprehensive Greater Manchester Tobacco Control Plan that is fully aligned to the Population Health Plan priority themes and wider reform agenda.	The Tameside Tobacco Alliance (TTA) is working towards a smokefree Tameside and also to make smoking history for children. The TTAs current objectives are: 1. Increase the numbers who seek support to quit (from the approx. 40,000 smokers in Tameside), particularly from higher prevalence groups such as the LGBT community. 2. Increase proportion of women who have a smoke free pregnancy 3. Increase the proportion of young people who choose not to smoke	The Tameside Tobacco Alliance is well established and has evolved and developed its approach to the agenda.	The TTA is led by the Public Health lead and includes members from Early Years, Healthy Child Programme, Be Well (integrated health and wellbeing service), environmental health, trading standards, New Charter Housing, Midwife-led stop smoking service, GMFRS, youth service, adult social care and Healthwatch.	Smoking prevalence in young women drives the smoking in pregnancy rates. The TTA youth service rep delivered a 'smoke and mirrors' project with young people in 2015-16, though further work needs to be done to target young women, and young men who are more at risk of taking up smoking. Capacity of the midwife-led service is limited to one part-time midwife. Additional funding for staff resource could increase the number of women who receive support to quit during pregnancy. Tobacco control in the hospital (including in mental health provision) is under-developed and new

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
	4. Increase the number of households signed up to 7 steps out (smoke free homes) 5. Review the smoke free playgrounds initiative in TMBC parks and greenspaces 6. Increase the number of smoke free events in the Borough 7. Review of tobacco control in the hospital 8. Continued action against illicit and illegal tobacco 9. Continued monitoring of e-cigarette evidence and legislation		The TTA links with other local partnerships such as the Children's and Young People's Forum and the Dementia Action Alliance. The Chair of the TTA is linked with the GM tobacco commissioners group, Healthier Futures (formerly Tobacco Free Futures) and the PHE NW lead for tobacco. The TTA has participated in a number of GM tobacco initiatives, e.g. Smokefree Summer, Smoke and Mirrors and the smokefree pregnancy incentive scheme.	partnership working will be explored during 2017-18.

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
To support the development and implementation of a refreshed and integrated GMCA Substance Misuse Strategy.	Tameside Alcohol Strategy consistent with GM agenda. Tameside have signed up for GM Communities in Charge of Alcohol programme, with commitment from Lifeline and Be Well to work together to support. Good local arrangements for licencing, including public health risk assessment tool. Recovery and treatment service commissioned from Lifeline incorporating ten year transformation programme. Good links to Domestic Abuse Strategy.	Tameside Alcohol Strategy recently refreshed with increasing future focus on changing public attitudes to alcohol.	Tameside Strategic Alcohol and Drugs Group. Lifeline service. GM Communities in Charge of Alcohol coordination group.	Service transformation is in progress, but only second year of ten year programme. Work focussed on public attitudes requires development.
To develop a comprehensive plan to reduce inactivity and increase participation in physical activity and sport that is aligned to the Population Health Plan priority themes and wider reform agenda.	Current programmes to reduce inactivity are delivered across the whole lifecourse examples including: • Early Years programme Move and play • School Sports Partnership • Education/ Coaching in schools/ youth services • Fit4Life family weight management • Active Travel – walking and cycling	Tameside has a physical activity strategy with leisure facilities delivered through Active Tameside. Active Tameside have worked with the Council to change the leisure offer in Tameside to promote health and community wellness. Locally we have ensured strong links to the developing work at GM	The Tameside Active Alliance drives the delivery of the Sport and Physical Activity Strategy. The governance arrangements are currently under review, with the proposal being that the Alliance meets quarterly but has an	Engagement of underrepresented groups and 40-65yr olds to impact life expectancy/ healthy life expectancy. Current governance and the strategic fit locally and at GM is a complex landscape and is currently being mapped led by a consultant Rob Young.

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
	• Capital investment programme in top class facilities • Workplace progammes • Campaigns • Exercise Referral • Active Ageing • Falls Prevention exercise offer • Disability Sport • Programmes for women and girls – this girl can • MECC • Sports development • Support for Sports Clubs • Volunteers • Greenspaces/ Environmental Programmes • 2 x Parkrun and developing Junior Parkrun • Development of local plan/ spatial framework	through the MOU with Sport England, ensuring the Borough is engaged and contributing to transformation programmes and bids around inactivity and older people and Local Delivery Pilots.	implementation group which ensure delivery and progress against the action plan. Tameside also has representation on the GM Leisure Commissioners Group and the CEX of Active Tameside chairs GM ACTIVE a partnership of all the sport and leisure providers ion Greater Manchester.	
To develop a comprehensive plan for better nutrition and healthy weight that is fully	There are a wide range of services in Tameside that promote healthy eating and physical activity across the life courses. Healthy eating and good nutrition is promoted via:	Despite the wide ranging offer across the life courses, obesity rates in Tameside are not reducing.	The Healthy Weight Strategy Group has been working on the obesity agenda. However, with the	Bolder and more radical policies will be needed to address the obesogenic environment, particularly the food environment in order to support the population's efforts to maintain or achieve a healthy weight, and to

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
aligned to the Population Health Plan priority themes and wider reform agenda.	breastfeeding and weaning support, nutrition and oral health awards for under 5's providers and schools, health mentors, Be Well lifestyle support for adults, GM Healthier Catering Award, weight management for children and adults. Physical activity is promoted by the early years integrated motor skill development pathway, school sports partnership, Active Tameside (including Activate, Let's Get Active Together and Live Active as well as the universal offer), parks and greenspaces. Tier 3 specialist weight management is provided by ABL. A small number of residents are referred to bariatric surgery (9 people in 2015-16).	It is estimated that commissioned weight management services engaged only 1-2% of the population that is obese, with little evidence of long-term efficacy.	development of the Tameside Active Alliance, the current governance structure for food and nutrition and obesity will be reviewed. A food partnership for Tameside is proposed. This will need a senior level steering group for it to succeed in tackling the obesogenic food environment and realising gains in related agendas (waste management, sustainability, economic development etc).	increase the potential health gains from a healthier diet. This will be a political, economic and social challenge and a change in approach to food as an agent for health and wellbeing across manifold health, social, environmental and economic development goals. Examples of areas that could be developed are public sector and provider food procurement and provision standards, healthy catering awards, vending policies, drinking water policies, workplace policies, event catering, catering training, small business support, community cooking skill development, community growing. A food partnership for Tameside will be developed in 2017-18 in order to co-ordinate and augment interest in and access to healthier food. The response to food poverty needs to be reviewed with increased investment in resources to minimise the impact of this serious problem.

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
To develop a whole systems approach to lifestyle and wellness services, including innovative digital options for incentivising and supporting lifestyle behaviour change	Be Well Tameside provides a person-centred, holistic service which is flexible and responsive to the needs of local people. The service operates on 3 levels 1. support for multiple lifestyle issues (e.g. improving the quality of diet and nutrition, stopping smoking, reducing alcohol intake, increasing physical activity) 2. Community Liaison, outreach and capacity building. The service works with residents, groups and organisations to promote Health and Wellbeing and encourage greater access to Be Well Tameside services. 3. Training and Learning and Development . Be Well Tameside offers a health and wellbeing training programme to enhance and develop the competencies and skills of the wider public health workforce across organisations and the community. The training programme this year will include, Making Every Contact	All clients are given a holistic 'wellbeing' assessment will include: clients overall health, feeling connected to other people, affordable warmth concerns, money, emotional health and work/training. Clients are then supported to achieve their goals and to navigate the system and access appropriate services. The advisors will stay with the individual throughout their journey and ensure they access the services needed and don't fall through any referral gaps.	Be Well operates a referral service for professionals but also has an open door policy for self-referrals, anyone over the age of 16 years is welcomed into the programme. Clients can telephone, email, leave a message on social media or speak to an advisor in person at events to get referred. The service covers 6 days a week, working from 8.30am through to 7pm most evenings and a Saturday morning option for appointments. The service covers all of Tameside working from GP Practice, clinics, community venues and partner organisations. The service has a	Gaps for delivery of the service include hospital based care, long term and short stay, discharge planning for long term behaviour change and relationships within hospital services. Social care assessments for all age groups (lifestyle interventions that would impact positively on a family/individual) Youth and young adults 16+ (12 yrs + for smoking support) Challenges are our IT capability for innovative ideas to use Apps, software and website design for an interactive experience and a challenge for the service is to capitalise on the patient/client pathways throughout the borough

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
	Count, Brief Advice/Intervention, Stop Smoking, Weight Management, Oral Health and other health related subjects.		number of onward referral mechanisms in place to support clients with partner agencies and gathers a vast amount of knowledge of 'what's on' in the community to signpost, navigate and refer onwards to give individualised support to residents. The service actively supports partnership and strategy meetings and is involved in the implementation of patient pathways such as Cardiac Rehabilitation, COPD, Obesity (Maternal and Adult), Physical Activity, Alcohol and Drug, Cancer, Hypertension, Health Checks and many others. The Be Well Service is a key	

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
			partner in the developing Integrated Neighbourhood Teams's and the Care Together Self Care Programme.	
To deliver the cancer prevention workstream of the national cancer vanguard, testing innovative approaches to awareness and behaviour change, social movement, cancer screening uptake and lifestyle -based secondary prevention	Be Well Tameside provide a training package on cancer symptom awareness for staff and volunteers in Tameside. Be Well also recruit and support volunteers, including some who are trained in cancer symptom awareness.	The Be Well service is a legacy from the Macmillan funded Community Cancer Awareness Project.	The local Cancer Early Detection Network links local stakeholders including: public health, Be Well, Bowel Cancer Screening Team, Cancer Research UK, workplace health, Macmillan GP, CCG commissioner, Tameside Macmillan Centre.	Members of the Early Detection Network will be key to delivery. Once the model has been reviewed a local roll out plan can be developed. Will probably need a resource budget - although likely that Macmillan and CRUK will have contributions to make. Training capacity will need to be earmarked. A secondary prevention Cancer Pathway is being developed across Greater Manchester ensuring access to exercise referral. Many areas have standalone funded cancer rehab programmes – Tameside would look to align with the current Live Active service.
To roll out a lung health-check programme across Greater Manchester	This is currently a pilot lung cancer screening programme within Manchester Macmillan Cancer Improvement Partnership provided by	Plans for potential roll out awaited, and likely to require NICE and National Screening Committee approval.	GMHSCP plans awaited. May involve single provider across GM with links to local GP	Would be a new service. Likely to involve GP referral. Potential to involve additional surgical activity.

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
	University Hospital of South Manchester.		practices.	
To help develop a Greater Manchester city-region approach to eradicating HIV within a generation	GM authorities are already working very closely on sexual and reproductive health in general and this agenda has a fairly high profile. All 10 GM authorities have contributed funding to the GMSHIP – Greater Manchester Sexual Health Improvement service which will replace the contracts currently held with George House Trust, LGBTF and Black Health Agency (BHA). TMBC have maintained funding levels for GMSHIP.	The service has recently gone out to tender, tender responses have been evaluated and Salford are now going through governance before the contract can be awarded in approx. 2 months' time for July commencement. The GMSHIP will focus on HIV prevention and supporting people living with HIV across GM with a focus on those most at risk taking a GM approach. It includes Point Of Care testing (POCT) to continue with the pilot project that LGBTF and BHA have been doing through PHE funding. Tameside is signed up to the national test HIV service provided by Preventx- a framework available to all LAs on behalf of PHE. The service	The GM Sexual Health Network have a HIV group – PAG5 on which Tameside has a representative. Locally sexual health issues are driven through a Tameside Sexual Health group.	There are current staffing shortages in Sexual Health services. The new service will eventually offer an online offer which should include the ability to order test kits etc. A more expansive online offer should be the approach – test more and test often, make the right choices easy, and promote self-care. The current model does not capitalise upon primary care/pharmacy. Both of these could be more central to the model and this is an expectation for 2019. Our figures for HIV testing and coverage are all red indicators – Men having Sex with Men (MSM) testing coverage is amber. Our HIV prevalence rate is rising, however the rise is much greater than the number of new diagnosis which may indicate that some of the increase is due to people moving into the Borough who are HIV positive already.

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
		is fully funded by PHE during major campaigns and funded by signed up local authorities outside of these periods. Tameside have been signed up since December 2015. There is a Target education session for General Practice in March to specifically look at the issue of HIV late diagnosis. The session will cover a range of associated issues with the outcome being s a protocol for HIV testing in primary care and to increase the number of tests that are offered and done. GM Las have worked together to produce a common sexual health service specification and procure services in clusters in preparation for even closer working in 2019.		Condom distribution – we only have an adhoc condom distribution scheme. The GMSHIP will be distributing condoms for the Most At Risk Populations and be offering a mechanism for people to buy low cost condoms. Our main gap is for younger people and the need is probably more related to unplanned pregnancy and general sexual health. A review of condom distribution is needed. Currently we provide some condoms, distributed by Youthink, to General Practice and Pharmacies however we do not have a formal scheme. MECC – a MECC approach to sexual and reproductive health and HIV to increase the background knowledge in the wider PH workforce could be developed. To have any step change we need to change the culture and this would be a major foundation. Social marketing – we do not currently do any activity with regards to sexual health or HIV. For HIV the central issue is behaviour change and knowledge. Sex and Relationship Education in

LIVING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
		Our provider CMFT also provides HIV treatment and care – although this is under subcontract from Stockport FT.		schools and colleges – the work being led by public health on the new spiral curriculum should have an impact in terms of the education of our young people. Substance Misuse services – the service has a core Blood Born Virus's (BBV). Lifeline would like to offer sexual health clinics but there is no resource available from CMFT at the moment.

AGEING WELL				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
To facilitate the roll-out, testing and evaluation of an approach to tackling issues around poor quality housing.	Current provision is: • £1.9 million budget for Disabled Facilities Grants (DFG's) • 15/16 227 Adaptations Undertaken 173 For people over 60 • 16/17 230 Adaptations undertaken 187 for people over 60 • 15/16 253 Minor Works adaptation undertaken for people over 60 • 16/17 250 Minor Works adaptations undertaken • Currently joint commission with Oldham to deliver service maintenance of hoisting and lifting equipment – Exploring the possibility of Bury and Salford joining this commission to improve economies of scale. • Officers are exploring the possibility of creating a localised HIA that can link to Fuel Poverty, Welfare Rights Age UK to compliment the GM Position.	Local officers are aware of the GM HIA initiative via various GM Strategic and Private Sector Housing Groups that are attended.	We don't have a local partnership at this moment. The GM Housing Providers Group is working with GM Health to develop this initiative.	Staffing resources will be needed to deliver an enhanced service. Investment is needed in new Foundations Casework Management System that will improve reporting.

	• We also have a joint commission with Oldham to provide/ install lifting and hoisting equipment with a life of client warranty			
To facilitate the roll-out, testing and evaluation of an approach to tackle dehydration and malnutrition based on the nationally recognised work in Salford.	Each provider has a nutritional assessment tool in place. Many homes and most nursing homes use the MUST tool (Malnutrition Universal Screening Tool) as part of their admissions process. Care homes do implement food and fluid charts where they believe there is an issue, although this can present challenges. The contracts state that "*service users must be weighed at least monthly*", and that "*care plans must reflect reasons for losses above 3kgs within a 3-month rolling period and any action taken as a result of weight loss*". Appropriate action usually involves a referral to the dietician. Many homes do action weight loss accordingly The CQC Fundamental standards include nutrition in Regulation 9 (Person centred care) and Regulation 14 (Meeting nutritional and hydration needs). A full copy of the standards is at http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf	Dieticians have disseminated to all the care homes a "First Line Nutrition Plan". This plan should be implemented if the staffs have weight loss concerns and the pack provided includes diet and fluid charts, a list of high calorie foods, snacks and drinks and a referral form to the service. The dieticians have given staff a pathway to follow when there is evidence of weight loss which includes early intervention to increase calorie intake, weight recording and intake monitoring and it indicates the criteria for referral. All residents with an identified nutrition or hydration need would be expected to have a care plan in place to identify the interventions required to meet their needs. Any resident who has been reviewed by the dietician and has been provided a nutritional action plan the nurses normally include	We have a nursing and residential Care Home Provider Forum.	One of the key challenges for care homes staff is increasing levels of dementia in care homes. Residents are requiring more direct input, i.e. time, to ensure they eat/drink appropriately. Some of the key issues presenting are more residents: • won't sit and eat meals, or will only sit for short periods before getting up and leaving the room refuse to eat meals • need a lot of assistance to eat meals, ranging from constant prompting to feeding the residents • are looked after in bed, meaning that more staff time is taken up feeding residents on a 1 to 1 basis • have swallowing difficulties • Completing food & fluid charts can sometimes be not as complete as it could be. There is also variability on the level of detail included in the food & fluid charts • Fluid intake is probably better during summer months, as the hot weather serves as a

		these actions in to the nutrition care plan. Some homes have copies of the dietician nutritional action plan in the dining area with the intake charts for each resident or their bedroom if the client is nursed in bed to remind care staff of the level of support required to meet the individual's nutrition needs. In nursing homes from a monitoring point of view at the clients scheduled NHS funding review our CCG commissioning nurses would review if all the current care plans and risk assessments were meeting the identified client's health needs. If the review evidence indicated the plan was not being implemented and there was further evidence of weight loss this would be feedback to the management team to investigate why nutrition plans were not being followed. If the plans were noted to being followed however there was evidence these interventions were not being effective in sustaining someone's weight the care home nurses would be advised to contact the		reminder to hydrate residents. This awareness may reduce during the colder months • More people (at end of life) are being cared for in care homes. The number of co-morbidities that this cohort of people has is increasing, which compromises their ability to keep nourished.

		dietician and discuss the individual if they hadn't already done so.		
To facilitate the roll-out, testing and evaluation of fracture liaison services (FLS), integrated with locally designed falls prevention services in a number of Greater Manchester boroughs.	There is not a fracture liaison service in Tameside & Glossop at the moment. The economy has an Integrated Falls Prevention Group led/Chaired by ICFT to ensure any pathways are integrated across both community and acute. This Group recently coordinated a Falls Awareness Event involving providers and referrers to promote integrated working to achieve better outcomes with the aim of developing an integrated falls pathway. All providers/services achieved a better understanding, and looking at a person centred approach to ensure patients are getting the right service at the right time. From a GM perspective we are awaiting further information from Theme 3 on MSK as to when localities will develop an FLS.	A Task and Finish Group has been formed, and produced a flowchart of services available through the pathway which is currently being developed and will be rolled out to all providers/services shortly. Through the Falls Group there are a number of pilots around falls prevention taking place within the hospital setting targeting hot spot areas. Falls prevention is also included in the CCG's priorities for NHS Right Care which will be reported via the Integrated Falls Group. Additionally, a Bone Health Pilot is shortly to commence in primary care.	See previous column re Integrated Falls Prevention Group. This Group feeds into the ICFT governance structure. Members who attend the Integrated Falls group, which is led by ICFT are providers and commissioners. The whole pathway process (which the Task and Finish sub-group) are developing will support the governance structure.	ICFT does not have a Fracture Liaison Service. ICFT have advised the locality needs to await the outcome discussion resulting from Theme 3. The integrated falls pathway is in development. The Single Commissioning Function are currently are liaising with providers to gain a better understanding of what they provide and how they will link into the integrated falls pathway and a seamless service including better patient experience.

PERSONAL and COMMUNITY CENTRED				
Objective	**Current Activity/ Services/ Provision**	**Commentary**	**What are the delivery mechanisms, partnerships:**	**What are the gaps and challenges:**
To build a Greater Manchester framework and support capacity and capability building for person and community centred approaches.	We have a developing Self care Offer: Social Prescribing: Community and hospital Social Prescribing Model Social Marketing: community culture change, behavioural change Asset based approaches: A range of programmes and grants to support the development of community groups that support and enhance the social prescribing model Workforce Education Programme: Development programme to support the culture change within clinical teams Self-Care IT development: Supporting the development of My life in Tameside website Innovative approaches to Personalised care planning Patient Activation Measure: Implementation of the Patient activation measure across neighbourhood teams Social Action Development of a primary care and community health and well being programme Support the hospital volunteering	Action Together are well linked with the work happening at a GM level to support the delivery of the Population Plan. Action Together provides a variety of services and activities as a local VCS infrastructure agency including: Development of new and existing groups in terms of their business planning, policies and procedures, training and accessing funds. Asset Based Approaches to community development including; volunteer brokerage, working with local people to do more in their community and to build the skills and confidence of individuals and organisation to take part in/host volunteers examples include our lottery Programme - Ambition for Aging, delivered with Age UK Tameside, working with local GP's to develop a project for isolated older people. We also host a range of projects that aim to influence panning	As well as the Supportive Neighbourhood Partnership Board there is also a System Wide Self care reference group who are leading on the implementation of the Care Together transformation programme. There are implementation groups under the reference group leading on the strands of the programme etc social prescribing, ABCD, PAM and Volunteering. The VCFS infrastructure also allows wide engagement with both the sector and local communities.	Identifying and navigating a ever changing landscape, and helping VCFS groups to identify and build relationships with key partners. Short termism, in terms of us supporting the work of the VCFS, both in terms of our own contracts, but also the availability of secured monies for VCFS provision. The VCFS sector is under increasing pressure in terms of demand for services, particularly in terms of information and advice, crisis support, and supporting the most marginalised in our communities.

	The entire Care Together Programme is built on the principle of person centred care; * Establishment of system wide self care model to include, social prescribing, asset based approaches, social action/volunteering, workforce development and social marketing/movement; * Embedding Patient Activation Measure for 12.5k patients with LTC; * Integrated Neighbourhood model emphasises person centred care approaches, including person centred care and support planning; * Risk stratification approach supports move to proactive management and prevention of LTCs; * Extensivists will deliver proactive, coordinated clinical care for people at greatest risk; * Tameside and Glossop, along with Stockport and Oldham are part of the NHS England, Health as a Social Movement Programme exploring how communities can come together to meet health and wellbeing challenges;	and delivery in the borough, linking local people and VCS groups to partners and other VCS groups through our partnerships service e.g. we are involved in the delivery of the Integrated Neighbourhood Service, Host Healthwatch Tameside, and have undertaken a raft of Community engagement on behalf of the Care Together programme. We are involved in the GM Devolution VCSE Reference group as well as a raft of local strategic partnerships. we administer a range of grants on behalf of our partners, and host a local VCFS consortium. We have been a delivery partner in local workforce development programmes including on behalf of Public Health Tameside and the ICO - particularly around asset based approaches.		
To work in partnership with VSCE sector to develop and test	Ben Gilchrist (Action Together DCEO) is seconded to GM Project focussing on Voluntary Sector support for this work.	In Tameside we will be: • Building a coalition of existing cancer champions through	The programme will be led through the VCFS networks and Self-Care Alliance	Programme also linked to public sector to engage 20,000 cancer champions.

an exemplar social movement focused on cancer prevention.	The aim of the programme is: • To catalyse and connect a grassroots, citizen-led social movement for cancer prevention by working through the voluntary sector. The two main objectives for this project are: • To develop a network of 20,000 cancer champions over the course of the three years. • To explore the use of digital technologies including social media to support the development of a social movement and mass involvement across the entire cancer prevention spectrum that is ultimately self-sustaining.	the legacy of our MacMillan programme • Recruiting new champions through the voluntary sector and partners • Focusing on building on local examples of good practice • Developing a menu of easy ways to get involved e.g. GM spoken word campaign for bowel screening	with Ben Gilchrist the GM Cancer Vanguard lead for social movement. Primary route through VSNW.org.uk for sign up.	Opportunity to bring together grass route community groups to deliver a unique programme with organisations. May need additional resource or alignment with local commissioning.

APPENDIX 2

SUMMARY OF GM HEALTH & SOCIAL CARE PARTNERSHIP'S FINDINGS & PROPOSALS

The following summarises the findings:

1. Work has progressed since 2015 to change the premise from unifying a 'public health system' to creating a unified 'population health system'. This shift to a Population health approach signals a move to broaden the collaboration across a range of sectors and partnerships (such as health, social care, other public services, voluntary sector, businesses and wider communities) and move away from a Public health focus on the specialist expertise of a narrowly defined workforce. Instead; embedding knowledge, skills and expertise across systems in a place based approach.

2. Directors of Public Health (DPHs) appear to be at their most valued and effective when able to influence more broadly population health through commissioning, focusing on outcomes, managing partner relationships, lobbying and engaging with communities.

3. There is a long and strong history of partnership working of the DPHs across GM who have in the past provided leadership, in key work programmes for instance Stockport in spatial planning and Oldham in Asset based working.

4. There is a skilled public health workforce across GM but there are opportunities to deploy it more effectively to service both the GM and the locality level population health work. Although there has been investment in GM leadership for Population health, given the profile and ambition set for transformation this may require expansion.

5. We have a mixed provision of health protection functions across GM as well as varied governance and assurance arrangements. The system currently works because it is based on the good relationships between individuals and the partner organisations, but it is not a resilient system and GM level governance arrangements of it are not strong.

6. There is also a mixed picture of provision for public health intelligence, a small highly specialised workforce which is unevenly distributed, and often repeating work locality by locality. There is little resource at GM level and a need to understand better how to deploy this resource to best effect alongside other partners in Public Health England (PHE) and New Economy.

7. We have good examples of commissioners working collaboratively and moving to cluster based commissioning approaches, with lead commissioner arrangements in place and lead provider procurements underway. But this is not consistent across GM and for all commissioned services where this would make sense, and there is little current ability to tie localities to agreed GM approaches.

8. We are seeing little evidence yet of commissioning across a whole system, use of integrated budgets across programme areas, or commissioning for outcomes.

9. The position of the public health grant is complex; the impact of Business Rate Retention is not fully understood. It is clear that in many cases investment is not strongly related to outcomes and the use of the grant to support council savings programmes means that ring fencing has been notional at best across GM for some time.

Summary Proposals

Outline Proposal	Features	Benefits
Common population health goals	GM Common Standards Development of GM Strategies	Consistency of approach and common standards across GM for delivering outcomes. This supports, rather than replaces, local discretion in setting local priorities and reflecting how some of these functions are translated into the local public service landscape at locality level.
New System Design for Public Health Functions	A unified health protection function	Provides a consistent and safe offer to each LA. Brings health protection assets in line with LA AGMA CCRU. Maximises specialist expertise in health protection and supports succession planning. Drives out inefficiencies in the system.
	GM Unified Population health intelligence function	Maximising the capacity of specialist workforce. Enabling consistent access to specialist support to shape and inform commissioning and locality planning. Avoids duplication by commissioning products on a 'do-once' basis across GM
Commissioning for Population Health	GM Whole system integrated sexual health service GM Tier 4 Inpatient Detox & Rehabilitation GM Service Specifications GM Digital Platform	Transforming population health commissioning by doing things once across GM where it makes sense to e.g. high speciality, lower volume. Commissioning as a system, and for a pathway, enabling joined up commissioning for those areas which are multi-commissioner, multi budget. Ensures consistency in how we procure, commission and contract for population health – which are quality, improvement, outcome and cost driven.
System Enablers	GM Standard for NHS health checks GM Behavioural & Lifestyle social movements Sharing good practice Digital Tools	To support the delivery of the proposals and transformation work in the population health plan. Spread of learning at pace and scale.

Population health system leadership	Developing system wide leadership Networking our specialist public health workforce. Workforce development and support	Ensures all localities have ready and effective access to all necessary public health expertise and skills. Ensures that statutory responsibilities are still being met whilst working to a blended leadership and delivery model. Supports the culture of population health as being everybody's business. Maintaining and growing our expert resources and assets.

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	29 June 2017
Executive Member / Reporting Officer:	Angela Hardman, Executive Director of Public Health, Business Intelligence and Performance Jacqui Dorman Public Health Intelligence Manager
Subject:	**SYSTEM OUTCOMES FRAMEWORK (SOF)**
Report Summary:	The responsibility to improve and protect our population's health and wellbeing lies with us all- local government, health organisations, partner organisations, local communities, families and individuals. Our whole health and social care system is being refocused around achieving positive outcomes for our population and reducing inequalities. Rather than a focus on process targets the draft Tameside & Glossop System Outcomes Framework will set the context for the whole system. The framework sets out a broad range of opportunities to improve and protect health across our area. Our main objective is to increase Healthy Life Expectancy. This is key to all we do, as keeping our population as healthy as possible for as long as possible will impact on the whole economy by reducing the burden poor health currently has on the system.
Recommendations:	Health and Wellbeing Board Members are recommended to: 1. Comment on the future adoption of the Systems Outcomes Framework by the Health and Wellbeing Board as the principle intelligence tool for measuring economy progress towards improving healthy life expectancy. 2. Approve the structure and developmental direction of the draft System Outcomes Framework and seek to promote a wider partnership conversation that will allow for a definitive version to be presented at the September 2017 Health and Wellbeing Board.
Links to Health and Wellbeing Strategy:	The framework concentrates on high-level outcomes to be achieved across the whole system that covers the full spectrum from housing to health and therefore links directly to the Health and Wellbeing strategy.
Policy Implications:	The System Outcomes Framework focuses on achieving positive outcomes for the population and reducing inequalities. The framework will support our Locality Plan the Care Together Programme of work and integration.
Financial Implications: **(Authorised by the Section 151 Officer)**	It is essential that the System Outcomes Framework provides the relevant intelligence to the Tameside and Glossop locality to ensure the existing and future levels of investment resources available to the locality are utilised appropriately.

	The System Outcomes Framework intelligence should also support the necessary transformation of services required within the locality to address the financial challenge which is currently projected to be £ 70.2 million by 2020/2021.
Legal Implications: **(Authorised by the Borough Solicitor)**	The Council has a statutory duty to deliver value for money services – to be value for money they must be services that are required and deliver improved outcomes for residents. Consequently an important outcome in setting the Council's priorities within a reducing budget is to gather intelligence to understand both need and whether maximum impact can be made. It will be critical that there is a clear performance and assurance system in place to ensure that any interventions/programmes are delivery what is required to improve health outcomes and reduce unaffordable demand.
Risk Management :	The System Outcomes Framework needs to be used in the wider context along with other national and local intelligence to build a complete picture of health and wellbeing outcomes across Tameside and Glossop. The System Outcomes Framework should be the umbrella intelligence tool and therefore other local operational and strategic performance reports and dashboards should support the outcomes in the System Outcomes Framework by adopting it across the whole system.
Access to Information :	The background papers relating to this report can be inspected by contacting Jacqui Dorman: Telephone: 07813871010 e-mail: Jacqui.dorman@tameside.gov.uk

Tameside & Glossop

System Outcomes Framework

WHY WE NEED A SYSTEM OUTCOMES FRAMEWORK?

The whole system aim is to improve the healthy life expectancy of our population

Our 'WHOLE' system outcomes framework sets out what we want to achieve for Tameside & Glossop and how we understand our progress.

This cannot be achieved by health and Care organisations alone

'People should be at the centre of all we do if we want to achieve equitable outcomes, for all our citizens wherever they live and what ever their circumstances'

Therefore:

- our system outcomes framework takes into account the social determinates of health by taking a much broader Health & Wellbeing approach
- It provides a consistent approach for both commissioning and service provision
- It supports the refocusing of resources to achieve our ambition for our population and supports new and innovative ways of working
- It ensures accountability across the system
- It provides guidance and direction
- It pulls together relevant information from a range of sources

Our system outcomes framework as an over arching System Aim and Objective

3 system Outcomes
7 system themes

Our Outcomes reflect our aspirations for Tameside & Glossop residents and communities and guide our actions in the short, medium and long term.

The indicators through which we will track progress towards the achievement of our outcomes will seek to quantify the key changes we would expect to see as out outcomes are achieved

This Guide should help you understand how the System Outcomes Framework (SOF) fits with your roles and responsibilities and your organisations roles and responsibilities and across the whole health and social care system.

The responsibility to improve and protect our residents health and wellbeing outcomes lies with us all-local government, health organisations, partner organisations, local communities and ourselves.

Our whole system health and social care system will be refocused around achieving positive outcomes for our population and reducing inequalities.

Rather than a focus on progress targets the Tameside & Glossop System Outcomes Framework will set the context for the whole system.

The framework sets out a broad range of opportunities to improve and protect health across our area.

Our main objective is to increase Healthy Life Expectancy. This is key to all we do, as keeping our population as healthy as possible for as long as possible will impact on the whole economy including the health and care economy by reducing the burden poor health currently has on the system.

People can only work and participate in our community if they are in good health. Our current Healthy Life Expectancy is **56.4 years for males and 58.8 years for females**-significantly lower than the rest of the country.

This means that from the age of 56.4 years for males and 58.8 years fro females, health will be poorer or deteriorating, long term conditions will be prevalent and the burden of poor health on the health and care system will happen much sooner than other areas of the country.

However, Healthy Life Expectancy is not the sole responsibility of one area (health and care), there are many factors that influence health and wellbeing outcomes. A good start in life for our youngest members of society, educational outcomes, housing, the environment, employment and income.

So this System Outcomes Framework takes all these factors into consideration and allows all of us in our professional, organisational and personal capacity to influence and change the lives and outcomes of our population.

In some way or another what you do and whatever organisation you are in, this gives you and your organisation the opportunity to help transform the health and wellbeing outcomes of our population. This framework will be the umbrella in which everyone across the system will work towards.

Evaluating your current performance frameworks, scorecards, dashboards and performance reports at both operational and strategic level will allow you to look at the indicators within your working areas and see how they influence the outcomes within the SOF and allow you then to prioritise those that will have the biggest impact for improvement.

Everything we do, the priorities we strive for and the day to day operational and strategic decisions made need to have an impact on the 35 outcomes in this SOF.

Look at the themes within the SOF and the outcomes attached to the themes. Add the outcomes that you feel you, the team you work in and the organisation you work for are able to influence or impact on the most.

Add these to your current dashboards, reports etc.

Think about the performance or outcome measures you and your organisation are working towards, which ones will have the greatest or any impact on the SOF outcomes, flag these indicators

The SOF will go to Health and Wellbeing Board on a bi-annual basis, if everyone takes ownership of the outcomes within the SOF then we will start to see improvements in the SOF (reds turning amber or green)

Some of the indicators within the SOF can be lifted and dropped into contracts, some may be additions to current contracts or priorities or sit alongside current contract/priorities. SOF may also be used to identify priorities for your orgaisation or service.

TAMESIDE & GLOSSOP SYSTEM OUTCOMES FRAMEWORK

SYSTEM AIM
Increase in Healthy Life Expectancy

System Objective
People and Families living a full life and achieving their potential

System Outcomes

Personal	Social & Community	Economic
People and families are healthy and well	People and families are safe and connected to others in positive and supportive communities	People and families have the skills and support to participate in the economy and their community to their full ability

System Themes

Housing
People and families have suitable and stable housing

1. Fewer people and families who are homeless or in temporary accommodation
2. More people living in warmer homes
3. Fewer people living in Fuel poverty
4. More Adults with mental health problems and learning disabilities in stable accommodation
5. More people getting the support they need to live independently

Work & Meaningful use of time
People and families are meaningfully engaged

1. More people are economically active
2. Fewer workless households
3. More people in well paid jobs
4. More people with long term conditions (MH, LD CC) in employment
5. More people volunteering

Learning & Developing
People and families are learning and developing to the best of their ability

1. More children are school ready
2. More children leaving school with a good standard of education
3. More people with a qualification at level 3 and above
4. More people are health literate
5. Adults have access to lifelong learning opportunities

Community & Social Wellbeing
People and families are connected and supported in their communities

1. Fewer people in hospital experiencing Delayed transfers of care.
2. More People with LTCs receiving community based support during the year
3. More people feeling supported to manage their own health and care
4. More People experience choice and control over their health care and support
5. More people who Self-report their well-being-as good or above

Health
People and families are physically and mentally well

1. Fewer people under the age of 65 years dying prematurely for preventable causes
2. Food related indicator here
3. Fewer people experiencing inequalities
4. Reduction in suicide and self-Harm
5. Reduction in the number of non-elective admissions

Safety
People and families are safe

1. Fewer people experiencing domestic abuse
2. More People feel included and safe in their community
3. More people who use community services feel safe
4. Fewer people experience negative outcomes amenable to health and social care
5. Fewer people experience negative outcomes related to air pollution

Behaviours
People and families practice positive behaviours

1. More people are a healthy weight
2. More people being physically active
3. More people don't smoke
4. Fewer people drinking alcohol to harmful levels
5. Fewer people using A&E

The Theme Indicators

Key:

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

- should see change in the short term
- should see change in the medium term
- should see change in long term

England Key:

Worst | GM or NW Average | England Average | 25th percentile 75th | Best

no trend data available/no change

Themes		Indicator	Period	Direction of Travel	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
HOUSING	1	Eligible homeless people not in priority need (rate/1000)	2015/16	↑	168	1.7	0.9	4.0		4.0
	2	households in temporary accommodation (rate/1000)	2015/17	↑	75	0.8	3.1	35.0		0.1
	3	Fuel poverty (%)	2014/15	↑	9834	10.2	10.6	15.1		5.8
	4	Adults with a learning disability who live in stable and appropriate accommodation (Persons) (%)	2015/16	↓	423	93.8	75.4	18.9		94.4
	5	Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons) (%)	2015/16	↓	n/a	1.3	58.6	1.6		92.6
	6	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital (%)	2013/14	↓	385	87.5	59.7	50.0		100.0
	7	Permanent admissions into residential care per 100,000	2013/14	↑	205	119.2	105.0	214.6		0.0
Work & meaningful use of time	8	Economically active (%)	2016	↑	107400	75.4	78.1	100.0		0.0
	9	Workless households (%)	2015	↓	18000	18.0	14.9	100.0		0.0
	10	Claimant count for ESA and Incapacity benefit	2016	↓	11900	8.5	5.8	12.8		2.2
	11	Average earnings by residence (£)	2016	↑	460	460.0	545.0	413.1		785.1
	12	Gap in employment rate LTCs (percentage point)	2016	↓	n/a	7.8	8.8	14.9		0.4
	13	Gap in employment rate Mental health (percentage point)	2016	⇄	n/a	68.0	67.2	77.8		48.3
	14	Gap in employment learning disability (percentage point)	2016	↑	n/a	93.8	74.9	41.9		94.4
Learning and Development	15	Utilisation of outdoor space for exercise/health reasons (%)	2015/16	↑	n/a	14.5	17.9	5.1		36.9
	16	School readiness (%)	2015/16	↑	n/a	63.0	69.3	59.7		78.7
	17	School readiness (children entitled to free school meals) (%)	2015/16	↑	n/a	51.2	54.4	68.6		40.6
	18	GCSEs achieved (5A*-C including English & Maths) (%)	2015/16	↑	1381	57.7	57.8	44.8		74.6
	19	GCSEs achieved (5 A*-C inc. English and maths) for children in care (%)	2015/17	⇄	8	22.2	13.8	6.4		34.6
	20	Level 3 qualifications (%)	2016	↑	65100	47.3	56.7	32.9		82.4
	21	16-18 year olds not in education employment or training (%)	2015/16	↓	280	3.8	4.2	7.9		1.5
	22	Working age population with no skills/qualifications (%)	2016	↓	12800	9.3	7.8	24.8		2.1
Community and social wellbeing	23	Total delayed transfers of care (rate/1000)	2015/16	↑	36	20.8	10.6	29.5		0.0
	24	Delayed transfers of care attributable to adult social care (rate/1000)	2015/16	↑	24	13.9	4.7	15.4		0.0
	25	Adults who received any community based support during the year per 100,000	2014/15	↓	5912	3437.0	2482.0	983.0		6165.0
	26	Proportion of people who receive self-directed support (%)	2015/16	↑	4875	67.1	61.9	25.3		100.0
	27	Proportion of people who use services who have control over their daily life (%)	2015/16	↓	n/a	68.6	76.6	60.5		90.2
	28	Deaths in usual place of residence (%), Persons, All ages	2015	↑	765	35.1	46.0	28.5		56.9
Health	29	< 65 mortality rate per 100,000	2014/15	↓	397	228.4	174.9	351.2		115.4
	30	Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2014/15	↓	450	80.5	48.1	89.5		27.2
	31	Under 75 mortality rate from cancer considered preventable (Persons)	2014/15	↓	581	103.5	81.1	129.3		59.6
	32	suicide rate per 100,000	2014/15	↑	75	13.2	10.1	17.4		5.6
	33	Emergency Hospital Admissions for Intentional Self-Harm: Directly age-sex standardised rate per 100,000	2015/16	↓	647	290.4	196.5	635.3		55.7
	34	Emergency admissions for acute conditions that should not usually require hospital admission per 100,000	2015/16	↑	4606	2097.0	1318.9	10582.8		29.3
	35	CHD admissions (all ages) per 100,000	2014/15	↓	1736	747.8	539.7	1055.0		295.7
	36	Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	2013-2016	⇄	15927	23.8	27.4	11.0		55.7
	37	Cancer diagnosed at early stage (stages 1&2) (%)	2015	↓	455	49.5	52.4	0.0		63.1
SAFETY	38	Domestic abuse (16+ yrs) per 1000	2014/15	↓	n/a	22.5	20.4	38.4		9.4
	39	Hip fractures in people aged 65 and over per 100,000	2015/16	↓	249	708.0	589.0	820.0		391.0
	40	Proportion of people who use services who feel safe	2015/16	↑	n/a	67.2	69.2	55.1		80.4
	41	Air pollution: fine particulate matter (Mean - µg/m3)	2015	↓	n/a	7.4	8.3	11.8		5.5
	42	Fraction of mortality attributable to particulate air pollution	2015/16	↓	n/a	4.2	4.7	6.7		3.2
	43	Summary Hospital-level Mortality Indicator (SHMI) - SHMI data at trust level	2015/16	↓	1357	1.1	1.0	1.2		0.7
	44	Hospital Summary Mortality Ratio (HSMR)	2016/17	↓	n/a	94.5	98.9	120.0		66.9
BEHAVIOURS	45	Emergency readmissions within 30 days of discharge from hospital (Persons)	2015/16	⇄	3765	12.9	11.8	14.5		8.8
	46	% of reception children of a healthy weight	2015/16	↓	2391	76.5	77.9	85.7		69.9
	47	% of year 6 children of a healthy weight	2015/16	↓	1820	66.1	65.8	77.1		56.6
	48	% of adults of a healthy weight	2013/15	↓	59624	33.5	35.2	53.5		23.8
	49	Density of fast food outlets per 100,000 people	2013/15	⇄	242	109.2	88.2	198.9		33.3
	50	physical inactivity levels (%)	2013/15	↑	60692	34.1	28.7	43.7		17.5
	51	smoking prevalence (%)	2015	↓	38622	21.7	16.9	26.8		9.5
	52	Smoking Prevalence in adults in routine and manual occupations (%)	2015	↓	*	28.0	26.5	36.3		15.8
	53	SATOD (%)	2015/16	↓	400	15.8	10.6	26.0		1.8
	54	Hospital Admission episodes for alcohol-related conditions - narrow definition (per 100,000 Persons)	2015/16	↑	1754	821.0	647.0	1163.0		390.0
	55	A&E attendances per 1000 people (hospital trust level data)per1000 population	2016/17	↑	85639	336.0	426.6	494.0		22.0

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	29 June 2017
Executive Member / Reporting Officer:	Angela Hardman, Executive Director – Public Health, Business Intelligence and Performance Gideon Smith, Consultant in Public Health Medicine
Subject:	**STRATEGIC APPROACH TO SUBSTANCE MISUSE**
Report Summary:	This report proposes a reporting relationship to Health and Wellbeing Board for the Tameside Strategic Alcohol and Drugs Group and adoption of a new Tameside Alcohol Strategy – 'Rethinking Drinking'.
Recommendations:	The Health and Wellbeing Board is asked: 1. To review and adopt the Terms of Reference for Tameside Strategic Alcohol and Drugs Group. 2. To adopt 'Rethinking Drinking' – Tameside Alcohol Strategy. 3. To note the Tameside Strategic Alcohol and Drugs Group Action Plan 2017/18. 4. To note the contract novation for substance misuse service from Lifeline to CGL (Change, Grow, Live).
Links to Health and Wellbeing Strategy:	Local action to reduce the harm from alcohol and drugs is outlined in the Tameside Health and Wellbeing Strategy, particularly within the focuses on Developing Well and Living Well.
Policy Implications:	Tameside Alcohol Harm Reduction Strategy 2010-13, within the context of the Tameside Strategic Partnership, provided important direction for the response to the local challenge of alcohol harm. With the development of Tameside Health and Wellbeing Board and the Care Together programme local coordination has been achieved through the Tameside Strategic Alcohol and Drugs Group. This report proposes a reporting relationship to Health and Wellbeing Board for the Tameside Strategic Alcohol and Drugs Group and adoption of a new Tameside Alcohol Strategy – 'Rethinking Drinking'.
Financial Implications: (Authorised by the Section 151 Officer)	Section 5 of the report provides details of the recently novated contract to CGL (Change, Grow, Live) from 1 June 2017 which provides a drug and alcohol recovery service to the locality. The budget allocation for the contract in 2017/2018 is £3.469 million and is included within the section 75 agreement of the Tameside and Glossop Integrated Commissioning Fund, the decision body of which is the Single Commissioning Board. It should be noted that in response to the financial decline of the former provider it is essential that continual and regular reviews of the organisation's financial stability (CGL) are implemented within the ongoing monitoring of the contract.

	This is to ensure there is a sufficient period available for alternative arrangements to be implemented in the eventuality of organisational failure in the future. A report detailing these arrangements was presented to the Single Commissioning Board on 22 June 2017.
Legal Implications: (Authorised by the Borough Solicitor)	The Council has a statutory duty to deliver value for money services – to be value for money they must be services that are required and deliver improved outcomes for residents. Consequently an important outcome in setting the Council's priorities within a reducing budget is to gather intelligence to understand both need and whether maximum impact can be made. It will be critical that there is a clear performance and assurance system in place to ensure that any interventions/programmes are delivery what is required to improve health outcomes and reduce unaffordable demand. It is therefore critical that there is close monitoring of the drug and alcohol contract to ensure it is delivering the necessary outcomes as required by the contract. It will be particularly important to ensure that the company remains solvent and there are alternative plans in place for any contractual failure as it is expedient that this contract delivers given evidence set out in this report.
Risk Management :	There are no risks associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Gideon Smith Telephone: 0161 342 4251 Gideon.smith@tameside.gov.uk

1. INTRODUCTION

1.1 Misuse of alcohol and drugs is a long standing challenge for all communities. Current estimates suggest there are 14000 dependent drinkers and 1400 opiate or cocaine users in Tameside. Local action to reduce the harm from alcohol and drugs is outlined in the Tameside Health and Wellbeing Strategy, particularly within the focuses on Developing Well and Living Well.

1.2 Local substance misuse services are provided by My Recovery Tameside under a ten year contract that commenced in 2015, with a transformation vision to develop an effective recovery treatment service with capacity for early engagement and prevention. This contract novated on 1 June 2017 from Lifeline to CGL (Change, Grow. Live).

1.3 Tameside Alcohol Harm Reduction Strategy 2010-13, within the context of the Tameside Strategic Partnership, provided important direction for the response to the local challenge of alcohol harm. With the development of Tameside Health and Wellbeing Board and the Care Together programme local coordination has been achieved through the Tameside Strategic Alcohol and Drugs Group.

1.4 This report proposes a reporting relationship to Health and Wellbeing Board for the Tameside Strategic Alcohol and Drugs Group and adoption of a new Tameside Alcohol Strategy – 'Rethinking Drinking'.

2. TAMESIDE STRATEGIC ALCOHOL AND DRUGS GROUP

2.1 To provide local system leadership and enable a collaborative approach to meeting the challenges of substance misuse, members of the Tameside Strategic Alcohol and Drugs Group have worked together for the past year.

2.2 It was initially thought that the Group would best report to the Healthy Lives Model of Care work stream of Care Together, but with the move to an implementation phase for the Integrated Care Foundation Trust it is proposed that its system wide strategic remit is most appropriately located with the Health and Wellbeing Board.

2.3 Draft Terms of Reference attached at **Appendix 1**.

2.4 The proposed Purpose of the Group is to provide system leadership and a collaborative approach to realising the local vision to:

- adopt a partnership approach which is rooted in collaboration and integration, and which is underpinned by strong leadership and governance;
- provide exceptional Drug and Alcohol services which maximise the opportunities for long term, and sustained recovery;
- effectively challenge local attitudes towards alcohol and to de-normalise harmful alcohol consuming behaviours;
- maximise the impact of enforcement, regulation and the wider policy framework.

3. 'RETHINKING DRINKING' – A STRATEGY FOR TAMESIDE

3.1 The Tameside Strategic Alcohol and Drugs Group have drafted and consulted on the draft of a new strategy document: 'Rethinking Drinking' – A Strategy for Tameside attached at **Appendix 4**.

3.2 The Strategy emphasises that the level of alcohol-related harm in Tameside is significant and is considerably worse than the national average, that this harm is felt across all areas

of the public sector and impacts on all sections of our society. The Strategy outlines the local impact on:

- Health, social care and criminal justice system: £100,000,000 a year;
- A&E attendances;
- Children who become looked after;
- Deaths;
- Domestic abuse;
- Young people;
- The need for recovery and treatment services.

3.3 The Strategy sets out how the Strategic Alcohol and Drugs Group will work to reduce alcohol related harm in Tameside through a vision of:

- Partnership;
- Prevention and Early Intervention;
- Protecting Vulnerable People;
- Public Service Reform;
- Innovation.

with key focuses on:

- Recovery and Treatment;
- Enforcement and regulation;
- Attitudes and norms.

3.4 The Strategy outlines:

What we are going to do to reach our vision:

- Provide high quality treatment and recovery services which are an exemplar of best practice;
- Ensure we use enforcement where appropriate and maximise the way in which we use our regulatory powers;
- Challenging the attitudes that exist towards alcohol.

How we will underpin this with an approach which ensures:

- We have a robust partnership ethos and strong local leadership;
- Our primary focus is upon preventing harm and intervening at the earliest opportunity through early identification;
- Protects vulnerable people from the harm caused directly or indirectly through alcohol;
- We will fully support Public Service Reform, through the local and regional complex dependency work stream and the integration of health and social care services;
- We develop new, creative and innovative approaches to reducing harm and improving outcomes.

3.6 Consultation

Clients of My Recovery Tameside were invited to comment on the draft Strategy. In the 10 responses collected, there was a strong emphasis on the need for information and awareness of the scale and impact of alcohol misuse, as well as the role of services and enforcement. Full responses are attached at **Appendix 2**.

4. IMPLEMENTATION OF THE STRATEGY – TAMESIDE STRATEGIC ALCOHOL AND DRUGS GROUP ACTION PLAN 2017/18

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

4.2 The Action Plan for 2017/18 reflects four strategic priorities for substance misuse highlighted in the Terms of Reference for the Group:

- To adopt a partnership approach which is rooted in collaboration and integration, and which is underpinned by strong leadership and governance;
- To provide exceptional Drug and Alcohol services which maximise the opportunities for long term, and sustained recovery;
- To effectively challenge local attitudes towards alcohol and to de-normalise harmful alcohol consuming behaviours;
- To maximise the impact of enforcement, regulation and the wider policy framework.

4.3 The Action Plan 2017/18 takes forward work on building and maintaining strategic partnership, service transformation, enforcement and regulation, whilst expanding the work on challenging attitudes to alcohol within the community.

5. SUBSTANCE MISUSE CONTRACT NOVATION – 1 JUNE 2017

5.1 At its meeting in May 2017 Tameside and Glossop Single Commission adopted a recommendation to transfer the contract for the local Drug and Alcohol Recovery Service from Lifeline to CGL (Change, Grow, Live) from 1 June 2017. This was prompted by a request from Lifeline and CGL based on an agreement that had been reached between them following changes in the financial circumstances of Lifeline. In order to be assured of the capability and competence of CGL as an organisation and their ability to achieve and deliver the contractual obligations, a full organisational questionnaire was submitted by CGL, identical to the document provided by tendering organisations during the original service tender in 2015. CGL passed all sections of the document which includes elements on organisational information, financial details, insurance, equal opportunities, health and safety, clinical safety and governance, business contingency and safeguarding. Each section was been evaluated by lead officers.

5.2 The terms of the novated contract are the same as that agreed with Lifeline in 2015, and runs until July 2025.

6. RECOMMENDATIONS

6.1 As detailed on the cover of this report.

APPENDIX 1

Tameside Strategic Alcohol and Drugs Group
Terms of Reference
(DRAFT)

Purpose of the Group

To provide system leadership and a collaborative approach to realising the local vision to:

- adopt a partnership approach which is rooted in collaboration and integration, and which is underpinned by strong leadership and governance;
- provide exceptional Drug and Alcohol services which maximise the opportunities for long term, and sustained recovery;
- effectively challenge local attitudes towards alcohol and to de-normalise harmful alcohol consuming behaviours;
- maximise the impact of enforcement, regulation and the wider policy framework.

Core Functions

The group will have the following core functions:

- To develop and implement a Tameside Alcohol Strategy;
- To develop and implement a Tameside Drug Strategy;
- To develop and implement a Tameside Alcohol and Drug Action Plan;
- To ensure that consideration is given to the synergies between Alcohol and Drug-related harm, other associated work streams, and other strategic developments;
- To identify risks and to mitigate against them;
- To identify opportunities and to ensure they are maximised;
- To respond effectively to changes to sub-regional and national policy and strategy;
- To ensure that the Tameside approach is fully aligned to wider Public Service Reform objectives both locally and at a Greater Manchester level;
- To ensure that wide ranging expertise is harnessed and utilised;
- To support the development of frontline activity to support individuals and families with Alcohol and /or Drug needs;
- To scrutinise local activity and performance (including the Tameside Drug and Alcohol Recovery Service, to celebrate positive outcomes, and to respond to negative outcomes;

Timing of meetings

The group will meet every two months.

Governance

The Group will be a formal sub group of the Tameside Health and Wellbeing Board.

Chair

The Group will be chaired by the Public Health Strategic Lead for Substance Misuse.

Co-ordination

The Group will be co-ordinated by the Tameside Council Public Health Business Support.

Membership

TMBC – Executive Member: Health & Neighbourhoods
TMBC – Consultant in Public Health Medicine
TMBC – Public Health Manager
TMBC – Public Health Programme Officer

TMBC – Public Health Clinical Lead
TMBC – Children's Social Care - TBC
TMBC – Adult Social Care – TBC
TMBC – Poverty and Prevention Manager
TMBC – Licensing Manager
TMBC – Planning and Commissioning Officer
Tameside Youth Offending Service – Head of Service
National Probation Service – Senior Probation Officer
Greater Manchester & Cheshire Community Rehabilitation Company – Senior Probation Officer
Greater Manchester Police – Divisional Superintendent
Greater Manchester Fire and Rescue Service – Prevention Manager
Tameside and Glossop Integrated Care Foundation Trust – Hospital Alcohol Liaison Service Team Leader
Tameside and Glossop Integrated Care Foundation Trust – Children's Services Manager
Tameside and Glossop Integrated Care Foundation Trust – Accident & Emergency Manager
New Charter Housing Trust – Neighbourhood Manager
Pennine Care NHS Foundation Trust – Senior Health Improvement Manager
Pennine Care NHS Foundation Trust – Service Manager: Healthy Minds
My Recovery / Lifeline – Service Manager
Tameside and Glossop Clinical Commissioning Group – GP representative
Tameside and Glossop Clinical Commissioning Group – Mental Health and Learning Disabilities Manager
Tameside and Glossop Clinical Commissioning Group – Head of Medicines Management
Action Together - Partnership Services Manager

Review date:
May 2018

APPENDIX 2

My Recovery Tameside client responses to Alcohol Strategy consultation, April 2017

1. According to local statistics….. 14,200 Adults in Tameside are dependent drinkers, over 11,500 high risk drinkers, nearly 35,000 increasing risk drinkers and 46,000 are binge drinking.
   What do you think about this?

   - I think the statistics are shocking. People need to know about this in Tameside.
   - I think that there should be more help and information out there.
   - Quite shocked and surprised by these statistics. But there again, alcohol is promoted in a big way as being the norm for many people to go and have a few drinks. People think it helps them cope with stress but they don't understand the danger.
   - Stop offers from shops and supermarkets. Stop youths drinking on streets.
   - It is scary how many people alcohol effects in the area.
   - It doesn't surprise me how high these numbers are. It is worrying still and I feel action should be taken to reduce numbers.
   - I can believe this, and I believe it is a cultural issue.
   - I think this is very high – and surprised me.
   - I think they need to put more money into funding to help drugs and drink.

2. What would you like to see happening in Tameside to prevent future harm and protect people from alcohol related harm?

   - More education in schools, more information and awareness to Tameside residents.
   - More community get togethers. More information.
   - Education at school and in the community. People with experience of alcohol issues and related health problems need to come forward to help educate the community through their experience.
   - More resources: example Lifeline in Hattersley.
   - I know the services do as much as they can but more services are needed.
   - Increase in legal age to drink alcohol. More power to PCSOs regarding ASB.
   - Further support groups
   - More advertising and people being made aware of just how high the number, it may encourage more people to ask for help.
   - I think they need more staff because they're overloading the staff they already have.

3. Is there anything you think could be done differently to help people / family members in Tameside who have an alcohol problem?

   - Tackle stigmas, seeking help should be as easy and acceptable as asking for help with any help problems.
   - To speak about it and for people to be more aware.
   - More funding for alcohol services so more workers are available. Also funding for education.
   - More support to clients and help educate family.
   - Like I said, I think the services do the best they can do with what they have. More money needs to be available to services so they are in a position to expand and accommodate more clients.

- More education on available services and reduce waiting times when waiting to be seen.
- Understand the socio-economic reasons behind this and try to alleviate these problems, although government and local government must play their part.
- As above, more advertising and awareness days to be held in the borough.
- Yes, more home detoxs.

The Tameside Alcohol and Drug Action Plan 2017/18

The Tameside Strategic Alcohol and Drugs Group is taking forward a programme of activity that covers four strategic priorities which are rooted within local needs and the wider Public Service reform Agenda. These Strategic Priorities are:

- To adopt a partnership approach which is rooted in collaboration and integration, and which is underpinned by strong leadership and governance;
- To provide exceptional Drug and Alcohol services which maximise the opportunities for long term, and sustained recovery;
- To effectively challenge local attitudes towards alcohol and to de-normalise harmful alcohol consuming behaviours;
- To maximise the impact of enforcement, regulation and the wider policy framework.

The Tameside Alcohol Strategy is underpinned by this annual Action Plan under the direct leadership of the Strategic Alcohol and Drugs Group and reporting to the Tameside Health and Wellbeing Board.

This Action Plan for 2017/18 has been prepared by the Tameside Strategic Alcohol and Drugs Group following a stakeholder workshop to review progress with the Strategy in November 2016.

Contact Officers:

Gideon Smith – Consultant in Public Health medicine (gideon.smith@tameside.gov.uk)

Francine Cooper – Planning and Commissioning Officer (Francine.cooper@tameside.gov.uk)

STRATEGIC PRIORITY 1: To adopt a partnership approach which is rooted in collaboration and integration, and which is underpinned by strong leadership and governance

LEAD OFFICER: Gideon Smith

Key 2017/18 Activities	Specific Actions	Responsible Person	Deadline
Develop a Tameside Alcohol Strategy and a joint Alcohol and Drug Action Plan which establishes a shared vision and common narrative for consistent use across the partnership.	Produce Final Draft of Alcohol Strategy Produce Action Plan for Strategy Group	Gideon Smith	May 17 May 17
Review the Terms of Reference of the Strategic Alcohol and Drug Group to clarify purpose and ensure appropriate membership.	Term of reference to be signed off by Strategic Alcohol and Drugs group	Gideon Smith	May 17
Formalise the reporting of Strategic Alcohol and Drug Group to Tameside Health and Wellbeing Board	Term of Reference recommended to Health and Wellbeing Board	Gideon Smith	May 17
Develop a local alcohol and drug scorecard which enables the capture of data and information from a wide range of sources to provide a holistic overview of alcohol and drug related harm.	Review and update current Triage Toolkit	Jacqui Dorman	Dec 17
Continue to directly contribute to the Greater Manchester Alcohol Strategy and Implementation Plan	Licensing representative to provide input	John Gregory	Ongoing
Develop a mechanism by which substance misuse service can work effectively with other agencies and be part of a broader approach to working with complex dependency and wider public service reform	Identify and review options Provider recommendations for Strategic Alcohol and Drugs Group	Isobel Mann	Sept 17
Provide feedback and assist in developing strategic documents to ensure they have a richness that can assist in the direction and development of services.	Provide feedback on T&G Locality Plan, GM Taking Charge, Population Health Plan and Cancer Plan Contribute to Tameside JSNA refresh	Gideon Smith	Ongoing
Develop a partnership approach to launch of Strategy	Agree commitment from partners through Health and Wellbeing Board including: GMP, GMFRS, Action Together	Gideon Smith	June 17
Clarify and maintain connections with other local strategic themes	Develop protocols between strategic groups	Gideon Smith	Ongoing

STRATEGIC PRIORITY 2: To provide exceptional Drug and Alcohol services which maximise the opportunities for long term, and sustained recovery

LEAD OFFICER: Francine Cooper

Key 2017/18 Activities	Specific Actions	Responsible Person	Deadline
Develop a sharing of information protocol	Scope current arrangements Review workability with stakeholders Draft protocol	Francine Cooper	Sept 17
Develop joint case management of clients/collaborative care plans	Scope with stakeholders Draft protocols and supporting templates	Isobel Mann	Dec 17
Reduce barriers for more complex clients, improving cross referral	Develop and/or review protocols with Hospital Alcohol Liaison Service and Pennine Care	Isobel Mann	From Sept 17 onwards

STRATEGIC PRIORITY 3: To effectively challenge local attitudes towards alcohol and to de-normalise harmful alcohol and drug consuming behaviours **LEAD OFFICER: Gideon Smith**			
Key 2017/18 Activities	**Specific Actions**	**Responsible Person**	**Timescale**
Provide better support for local and national campaigns	Promote: - Dry January - One You - GM campaigns - Maternity programme	Charlotte Lee	Thoughout the year
Work with young people to understand the problem then develop a solution	Engagement Development Roll out Review	Charlotte Lee	Dec 17
Increase space/activities that are alcohol free	Promote - Dry January - Tameside Council Events Programme Review Licencing policy Explore options for: - drink free zones - promotion of alcohol free drinks in licenced premises	Gideon Smith	Through out the year
Participate in Public Health England GM Communities in Charge of Alcohol programme	Local engagement with GM programme Identification of local priority areas Engagement of My Recovery Tameside and Be Well Tameside in process Local start	Gideon Smith	2017 Mar 17 2017 Mar 18

STRATEGIC PRIORITY 4: To maximise the impact of enforcement, regulation and the wider policy framework

LEAD OFFICER: John Gregory

Key 2015/16 Activities	**Specific Actions**	**Responsible Person**	**Deadline**
Promote and support the use of the Self Exclusion scheme	Programme of information for retailers Feedback on activity to Strategic Alcohol and Drugs Group	John Gregory	Ongoing
Develop a Knowledge and Information Sharing Network of local stakeholders to facilitate effective enforcement	Identify stakeholders Review of options Draft protocols	John Gregory	Sept 17
Enhance joined up work between enforcement, regulation and recovery	Establish Knowledge and Information Sharing Network Review of benefits of activity of Network	John Gregory	Sept 17 Mar 18
Continue to advocate for national implementation of a minimum unit price.	GM licensing group, exploring the ability through GM devolution implement minimum unit pricing as a mandatory condition	John Gregory	Mar 18
Continue to advocate for the inclusion of Health as a 5th licensing objective.	GM licensing group, exploring the ability through GM devolution to set own objectives	John Gregory	Ongoing
Contribute to the GM workstream supporting implementation of best practice approaches to reduce alcohol and drug related harm in Greater Manchester's night-time economies (NTEs)	GM licensing group, exploring the ability through GM devolution to implement a single licensing policy	John Gregory	Thoughout the year

Rethinking Drinking

A Strategy for Tameside

ND EDUCATION / RECOVERY / ENFORCEMENT AND REGULATION / PARTNERSHIP / PREVENTION

F ILL HEALTH / PARTNERSHIP / KNOWLEDGE AND EDUCATION / RECOVERY / ENFORCEMENT AN

ND EDUCATION / RECOVERY / ENFORCEMENT AND REGULATION / PARTNERSHIP / PREVENTION

Strategic Change - An Introduction

The level of alcohol-related harm in Tameside is significant and is considerably worse than the national average.

This harm is felt across all areas of the Public Sector and impacts on all sections of our society.

This strategy sets out how we are going to reduce alcohol related harm in Tameside and has been produced in collaboration and consultation with the Strategic Alcohol and Drugs Group.

What are the guidelines for Alcohol?

The Chief Medical Officers' guideline for both men and women is that:

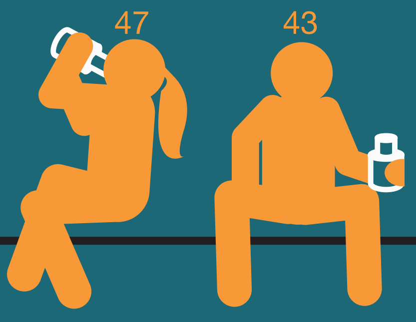
Both men and women should drink no more than 14 units per week.

If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more.

The risk of developing a range of illnesses increases with any amount you drink on a regular basis.

If you wish to cut down the amount you're drinking, a good way to help achieve this is to have several drink-free days each week.

Furthermore, The Chief Medical Officers for the UK recommend that if you're pregnant or planning to become pregnant, the safest approach is not to drink alcohol at all to keep risks to your baby to a minimum.



Average age of death for homeless men and women. The general population is 77

An estimated 44% of community mental health patients have reported problem drug use or harmful alcohol use in the previous year.

Alcohol has been identified as a casual factor in more than 60 medical conditions

Including:

- Mouth, throat, liver and breast cancers
- Cirrhosis of the liver
- Heart disease
- Depression
- Stroke
- Pancreatitis
- Liver disease

Over 50% of child protection cases involve alcohol abuse.

Over 25% of known cases of child abuse involve alcohol.

10.8 Million adults in England are drinking at levels that pose a risk to their health.

NATIONAL CONTEXT

Research typically finds that between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of assault. Sometimes this is as high as 73%.

1.6 Million adults may have some level of alcohol dependance.

78%
Of young offenders cases involving alcohol misuse, also had a history of parental alcohol abuse.

Alcohols cost to society:
£11 Billion alcohol related crime
£7 Billion lost productivity, through unemployment and sickness
£3.5 Billion cost to NHS

£21 Billion

45%
Of suicide vicitims, between 2002 and 2011, had a history of alcohol misuse.

Strategic Fit

The Tameside Alcohol Strategy will support a number of wider strategies including, but not limited to:

Tameside Corporate Plan
CLICK HERE for more information

Tameside Health and Wellbeing Strategy
CLICK HERE for more information

Tameside Health and Social Care Locality Plan
CLICK HERE for more information

Tameside Joint Strategic Alcohol Needs Assessment 2014/15
CLICK HERE for more information

GM Taking Charge
CLICK HERE for more information

Greater Manchester Alcohol Strategy
CLICK HERE for more information

HM Government Alcohol Strategy (2012)
CLICK HERE for more information

HM Government – Putting Full Recovery First: The Recovery Road Map (2012)
CLICK HERE for more information

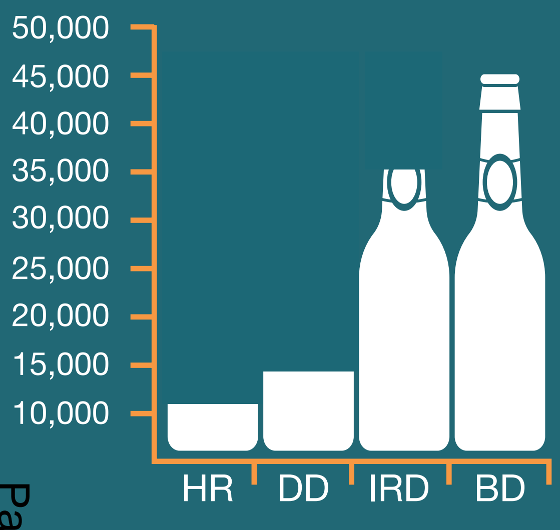
Tameside Domestic Abuse Strategy
CLICK HERE for more information

Public Service Reform

Public Service Reform focuses on developing a new model of public service delivery through the integration of public services. This is through both responding holistically to families and individuals with complex issues and also integrating health and social care with wider public services at a community and neighbourhood level.

This strategy will fully support the current work streams around data sharing, risk stratification, systems thinking, as well as the continuing integration of health and social care services in Tameside.

Alcohol in Tameside

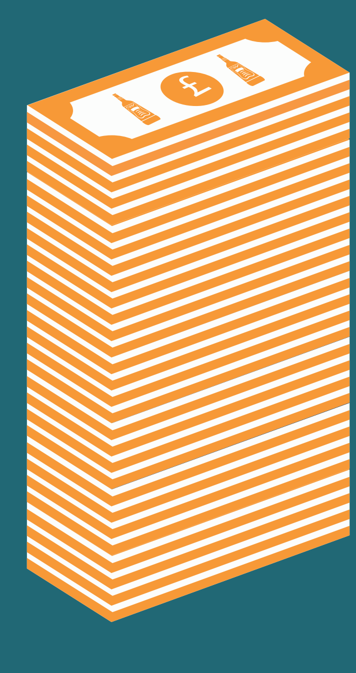


14,200 Adults in Tameside are dependent drinkers, over 11,500 high risk drinkers, nearly 35,000 increasing risk drinkers and 46,000 are binge drinking.

£100,000,000 a year
The cost of alcohol-related harm to Tameside's Health, Social Care and Criminal Justice system.

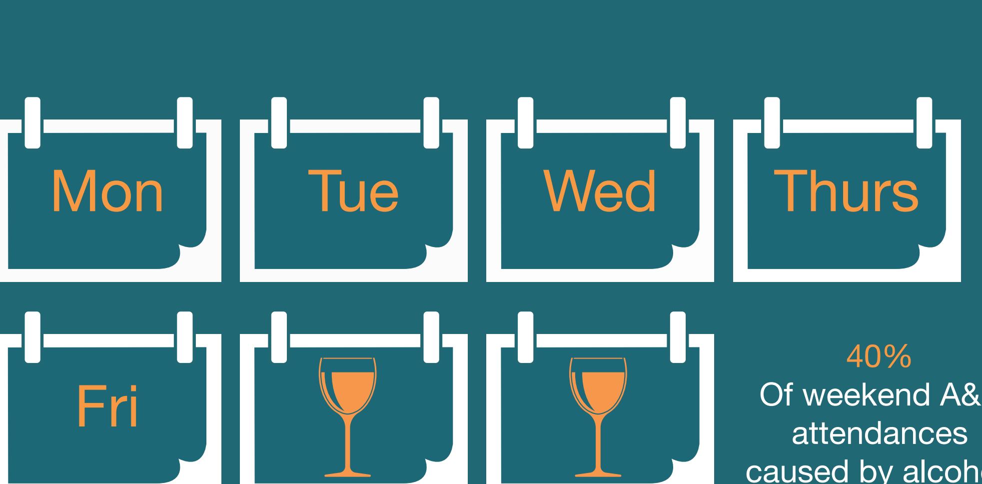
OR

£448
For every man, woman and child that lives here



70% of attendances at A&E in the early hours were alcohol related

36 children who became looked after and 81 children who were placed on a child protection plan in 2014/15 had parental alcohol misuse was a contributing factor.



40%
Of weekend A&E attendances caused by alcohol.

The peak age of death from alcohol-related or alcohol-specific conditions in Tameside is
50-54 years for males
60-64 years for females.

Group	Peak age of death (chart)
M	50
F	60
UK average	80

It is estimated that there are 4,170 people in Tameside who have experienced domestic violence, meaning between 1,043 and 2,085 cases were related to alcohol use, and some studies would suggest it could be as high as 3044 cases.

Chart axis: 1000–5000. Categories: Alcohol related; Domestic violence.

1 in every 100 children born in Tameside each year has Foetal Alcohol Syndrome (FASD). Children with foetal FASD can be born with distinctive features or deformities, as well as learning difficulties, hearing and sight problems, and poorly functioning organs.

Chart axis: 2–20. Categories: Tameside; National Average; NICE; Dep of Health guidance.

Too few people access support - Alcohol is by far the most significant local Substance Misuse need, but less than 5% of dependent drinkers in the Borough are accessing treatment and support, which is significantly less than the national average (6.9%), Department of Health guidance (10-20%), and the guidelines provided by the National Institute for Health and Clinical Excellence (NICE) (14.3%).

Alcohol can harm children, but it can also harm communities if placed in the hands of children. A significant number of anti-social behaviour incidents caused by 10-17 year olds in Tameside involve alcohol.

The Strategic Alcohol and Drugs Group - Governance

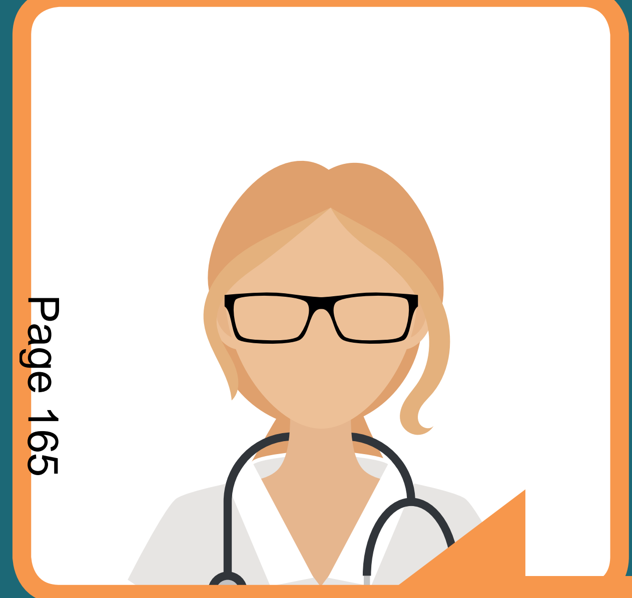
The Tameside Strategic Alcohol and Drugs Group is a wide ranging partnership of key stakeholder and will provide systems leadership and a collaborative approach to reducing alcohol and drug related harm in Tameside.

The Tameside Strategic Alcohol and Drugs Group will lead on the implementation of this strategy and the Tameside implementation of Greater Manchester Alcohol Strategy.

The Tameside Strategic Alcohol and Drugs Group will meet regularly and develop a comprehensive action and implementation plan to monitor and report directly to the Tameside Health and Wellbeing Board and any other partnership or leadership group of importance to the agenda.

The Strategic Alcohol and Drugs Group - Our Vision

RECOVERY AND TREATMENT



ENFORCEMENT AND REGULATION

ATTITUDES AND NORMS

Partnership and Leadership
Prevention and Early Intervention
Protecting Vulnerable People
Public Service Reform
Innovation

What we are going to do to reach our vision:

- Provide high quality treatment and recovery services which are an exemplar of best practice;
- Ensure we use enforcement where appropriate and maximise the way in which we use our regulatory powers;
- Challenging the attitudes that exist towards alcohol.

We will underpin this with an approach which ensures:

- We have a robust partnership ethos and strong local leadership;
- Our primary focus is upon preventing harm and intervening at the earliest opportunity through early identification;
- Protects vulnerable people from the harm caused directly or indirectly through alcohol;
- We will fully support Public Service Reform, through the local and regional complex dependency work stream and the integration of health and social care services;
- We develop new, creative and innovative approaches to reducing harm and improving outcomes.

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	29 June 2017
Executive Member / Reporting Officer:	Councillor Gerald P Cooney – Executive Member (Healthy and Working) Angela Hardman – Director of Public Health Debbie Watson – Head of Health and Wellbeing
Subject:	**HEALTH AND WELLBEING FORWARD PLAN 2017/18**
Report Summary:	This report provides an outline forward plan for consideration by the Board
Recommendations:	The Board is asked to agree the draft forward plan for 2017/18.
Links to Health and Wellbeing Strategy:	The Health and Wellbeing Strategy to address needs, which commissioners will need to have regard of in developing commissioning plans for health care, social care and public health. The Forward Plan ensures coverage of key issues associated with the Board's duties to deliver improved outcomes through the strategy
Policy Implications:	The Forward Plan has been designed to cover both the statutory responsibilities of the Health and Wellbeing Board and the key projects that have been identified as priorities by the Board.
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications for the Council relating to this report
Legal Implications: **(Authorised by the Borough Solicitor)**	Local Authorities are obliged to publish a forward plan setting out the key decisions and matters they will consider over a rolling 4 months.
Risk Management :	There are no risks associated with this report**.**
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson, Head of Health and Wellbeing by: Telephone:0161 342 3358 e-mail: debbie.watson@tameside.gov.uk

TAMESIDE HEALTH AND WELLBEING BOARD FORWARD PLAN 2017/18

	Strategy / policy and Board process	Priorities and performance	Integration	Other
29 June 2017	• Greater Manchester Population Health Plan – stocktake for Tameside • Tameside & Glossop System Wide Outcomes Framework	• Healthy Life Expectancy Mortality Review • Alcohol Strategy	• Care Together Update • Care Together 2016/17 Financial Monitoring Statement	• Forward plan
21 September 2017	• Tameside & Glossop System Wide Outcomes Framework	• Mental Health and Wellbeing • Public Health Annual Report • System Wide Self Care programme update/ Strengthening Communities • Physical Activity Strategy and update • Greater Manchester Cancer Plan – stocktake for Tameside & Glossop	• Care Together Update	• Forward Plan
16 November 2017	Health and Wellbeing Board Development Session			
25 January 2018	• Tameside Safeguarding Children Annual Report • Tameside Adult Safeguarding Partnership Annual Report • Pharmaceutical Needs Assessment – review and sign off	• Health and Working Well	• Care Together Update	• Forward Plan

	Strategy / policy and Board process	Priorities and performance	Integration	Other
8 March 2018			• Care Together Update	• Forward Plan
NOTE: AGENDA ITEMS ARE SUBJECT TO CHANGE				
	Items to include: • JHWS – approval, alignment with other strategies • JSNA – updates and approval of arrangements • GM HWB and other strategy updates • National policy updates • Updates from linked governance processes – eg Health Protection Forum, Healthwatch.	Items to include: • JHWS Performance monitoring (outcomes) • JSNA updates • PH annual report • HWB performance	Items to include: • Regular public service reform updates • Integrated Commissioning Programme – Care Together • Partner member business planning updates (including CCG operating plan)	Items to include: • Forward Plan • Consultation on key issues and developments

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