Tameside Metropolitan Borough

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

HEALTH AND WELLBEING BOARD

Day: Thursday
Date: 28 June 2018
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 1 - 8

To receive the Minutes of the meeting of the Health and Wellbeing Board held on 7 March 2018.

ITEMS FOR DISCUSSION / DECISION

4. TAMESIDE AND GLOSSOP CARE TOGETHER ECONOMY 2017/18 CONSOLIDATED FINANCIAL MANAGEMENT STATEMENT / BETTER CARE FUND MONITORING REPORT AS AT 31 MARCH 2018 9 - 32

To consider the attached report of the Executive Leader / Deputy Executive Leader / Executive Member for Economic Growth and Housing and Director of Finance.

5. CARE TOGETHER UPDATE 33 - 44

To consider the attached report of the Interim Director of Commissioning.

6. PACT ENDORSEMENT AND UPDATE 45 - 50

To consider the attached report of Liz Windsor-Welsh, Chief Executive, Action Together.

7. HEALTH PROTECTION UPDATE 51 - 58

To consider the attached report of the Director of Quality and Safeguarding / Consultant Public Health on:

- Influenza Update
- Outbreak Capability Plan

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.

ITEMS FOR INFORMATION

8. JOINT STRATEGIC NEEDS ASSESSMENT - OUR LIFE IN TAMESIDE AND GLOSSOP 59 - 94

To consider the attached report and demonstration of the Our Life in Tameside and Glossop website from Jacqui Dorman, Public Health Intelligence Manager.

9. HEALTH AND WELLBEING BOARD FORWARD PLAN 95 - 98

To consider the attached report of the Interim Assistant Director (Population Health).

10. URGENT ITEMS

To consider any additional items the Chair is of the opinion shall be dealt with as a matter of urgency.

11. DATE OF NEXT MEETING

To note that the next meeting of the Health and Wellbeing Board will be held on Thursday 20 September 2018.

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

8 March 2018

Commenced: 10.00 am **Terminated: 12.00 pm**

PRESENT: Dr Alan Dow (Chair) – Chair, Clinical Commissioning Group
Councillor Gerald P Cooney – Executive Member (Healthy and Working)
Councillor Jim Fitzpatrick – Executive Member (Children's Services)
James Thomas – Interim Director of Children's Services
Trish Cavanagh – Director of Operations
Phil Nelson – Greater Manchester Fire and Rescue Service
Andrew Searle – Independent Chair, Tameside Adult Safeguarding Partnership Board
Tony Powell – Deputy Chief Executive, New Charter Group
Mark Tweedie – Chief Executive, Active Tameside
Liz Windsor-Welsh – Action Together

IN ATTENDANCE: Debbie Watson – Interim Assistant Director of Population Health
Jessica Williams – Interim Director of Commissioning
Stephen Wilde – Financial Business Partner

APOLOGIES: Councillor Brenda Warrington – Executive Leader
Steven Pleasant – Chief Executive, Tameside MBC, and Accountable Officer for Tameside and Glossop CC
David Swift – Lay Member for Governance, CCG
Stephanie Butterworth – Director (Adults), Tameside MBC
Superintendent Neil Evans - Greater Manchester Police
Sian Schofield – Pennine Care FT
Karen James – Chief Executive, Tameside and Glossop ICFT
Julie Price – Department of Work and Pensions

42. DECLARATIONS OF INTEREST

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

43. MINUTES OF PREVIOUS MEETING

The Minutes of the Health and Wellbeing Board held on 25 January 2018 were approved as a correct record.

44. TAMESIDE AND GLOSSOP CARE TOGETHER ECONOMY 2017/18 – CONSOLIDATED FINANCIAL MONITORING STATEMENT

Consideration was given to a report of the Director of Finance providing a 2017/18 financial year update on the month 9 financial position at 31 December 2017 and the projected outturn at 31 March 2018. The total Integrated Commissioning Fund was £486m in value. However, it was noted that this was subject to change as new inter authority transfers were actions and allocations amended.

Particular reference was made to details of the summary 2017/18 budgets, net expenditure and forecast outturn of the Integrated Commissioning Fund and Tameside and Glossop Integrated Care NHS Foundation Trust. Supporting details of the forecast outturn variances were explained within Appendix A to the report. Members of the Strategic Commissioning Board noted that there

were a number of risks that needed to be managed within the economy during the current financial year, the key risks being:

- Significant budget pressures for the Clinical Commissioning Group relating to Continuing Care related expenditure of £4.3m.
- Children's Services within the Council was managing unprecedented levels of service demand currently projected to result in additional expenditure of £7.8m when compared to the available budget.
- The Integrated Care Foundation Trust was working to a planned deficit of £24.5m for 2017/18 and that efficiencies of £10.4m were required in order to meet this sum.

A summary of the financial position of the Integrated Commissioning Fund broken down by directorate was provided in Table 2 and outlined in more detail at section 2.

In terms of the 2017/18 efficiency plan, the economy had an efficiency sum of £35.1m to deliver of which £24.7m was a requirement of the Strategic Commissioner. Supporting analysis of the delivery against this requirement for the whole economy was provided at Appendix A to the report. It was noted that there was a forecast £4.1m under achievement of this efficiency sum by the end of the financial year, £3.6m of which related to the Strategic Commissioner. It was therefore essential that additional proposals were considered and implemented urgently to address this gap on a recurrent basis thereafter.

The Strategic Commission risk share arrangements in place for 2017/18 were also outlined.

RESOLVED

(i) That the 2017/18 financial year update on the month 9 financial position at 31 December 2017 and the projected outturn at 31 March 2018 be noted.

(ii) That the significant level of savings required during the period 2017/18 to 2020/21 to deliver a balanced recurrent economy budget be noted.

(iii) That the significant amount of financial risk in relation to achieving an economy balanced budget across this period be noted.

45. CARE TOGETHER UPDATE

The Interim Director of Commissioning presented a report providing the Board with progress on the implementation of the Care Together Programme including developments since the last presentation in January 2018 covering the following areas:

- Care Together Programme Assurance;
- Care Together Structure and Objectives 2018/19;
- Care Together Funding; and
- Greater Manchester Health and Social Care Partnership reporting.

Particular reference was made the Care Together Programme Board approving the latest version of the Care Together Principles and also the objectives for delivery 2018/19. These were included as Appendix A and Appendix B to the report.

The January monthly highlight report submitted to the Greater Manchester Health and Social Care Partnership was attached at Appendix C to the report. The programme continued to make progress, however, there were risks including the lack of expected capital funding being made available to support Estates and IM&T schemes and ongoing concern over information governance and the potential General Data Protection Regulations.

RESOLVED

(i) That the update be noted.

(ii) That a further update be received at the next meeting of the Board.

46. INTEGRATED NEIGHBOURHOOD MODEL FOR CHILDREN AND FAMILIES

Consideration was given to a report of the Interim Director of Children's Services setting out proposals for steps to improve support to vulnerable families and how to engage with a wide range of core partners to develop and deliver the proposals. Recent service mapping and needs assessment had confirmed the need to maximise capacity to support vulnerable families in the borough, both through better use of existing resources and through increasing resources where that was possible.

The core objectives of an Integrated Neighbourhood model were to build more effective partnership working at the local level and thereby deliver effective help to families at the point they needed it. There was a need to be clear about three tiers of need and of service in conceptualising a joined up system, although this did over simplify some of the complexities of need and service straddling the tiers as follows:

- Universal Services – working with all children and families;
- Targeted Early Help Services – working with vulnerable families;
- Social Care or Specialist Services – working with risk and high need.

The opportunity that an Integrated Model provided was to find ways of working joining up all three tiers of services to support and enable strong relationships between professionals, new joined up systems considering children's needs at earlier stages and prioritising relationship based work with families. It was proposed that there would be four neighbourhoods and new key ways of working within each neighbourhood would include:

- Joint workforce development – providing the underpinning foundations of effective partnership working both by bringing partners together to foster good working relationships by introducing a shared framework of how work was undertaken with families to either a Restorative Practice or a Sign of Safety model.
- Team Around Approach – finding the effective way of building multi-agency Team Around the core universal services for Early Years, Primary and Secondary Schools and Colleges – characterised by Early Help and Specialist / Social Care services going to the universal provider systematically to consider children causing concern at an earlier stage.
- Joint Allocation Approach – finding the effective Tameside model of multi-agency consideration of families with significant additional needs which would then agree the most appropriate response and which partner would take the lead. This approach was about to be piloted within the Hub for referrals where an Early Help response was appropriate, whilst the Youth Engagement Panel was another existing example of such an approach based at the Youth Offending Team.

Whilst the overall context remained one in which resources were reducing, there was an opportunity in the medium term to seek additional funding from the next round of Troubled Families investment. The proposed timeline and opportunities to engage were also detailed in the report.

RESOLVED
That the content of the report and proposed timeline for the development of the model be noted.

47. PHARMACY NEEDS ASSESSMENT

Consideration was given to a report of the Public Health Intelligence Manager which explained that the Pharmaceutical Needs Assessment was an important strategic document produced on behalf of the Tameside Health and Wellbeing Board. It reviewed the current provision of pharmaceutical services across the Borough, examined whether the pattern of services provided met identified health needs of local communities and assessed if there were any gaps or any over provision in both place and type of services available.

The Pharmaceutical Needs Assessment was an important reference for the NHS England Local Area Team to use in their determination of applications to join the pharmaceutical list under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

Each new pharmacy places and new and very significant cost to the NHS and more pharmacies did not necessarily mean a better service for local people as the resource to fund new pharmacies would need to be diverted from other health services, plus there were further risks in creating over-provision and unhealthy competition.

The Board discussed the review of low value prescription items being undertaken by NHS England and the introduction of new guidance for Clinical Commissioning Groups (CCGs), with a view to substantially saving NHS expenditure in this area. It followed extensive work by NHS Clinical Commissioners which identified significant areas where potential savings could be made, up to potentially £400m per year. Whilst it was understood that the NHS was under significant pressures, it was important that there was appropriate scrutiny and understanding of the implications of this proposal on patients and their wellbeing, particularly for those on low incomes.

RESOLVED:
That the Joint Strategic Needs Assessment be approved and released in the public domain by 1 April 2018.

48. SYSTEM WIDE SELF-CARE PROGRAMME UPDATE – STRENGTHENING COMMUNITIES

Consideration was given to a report of the Head of Strategy Development, Tameside and Glossop Integrated Care Foundation Trust providing an update on the System Wide Self Care Programme established as part of the Care Together Transformation Programme and accounted for around £4.9m of the budget across the three years of delivery. It was based upon the principle that in order to transform health and care to the extent that a financially and clinically sustainable health economy was delivered, as part of that transformation the system's relationship with the public must be reshaped. Although this principle applied to the whole of the Tameside and Glossop population, the issue was particularly pronounced amongst people with long term conditions or ongoing care and support needs. It was also important to note that this programme of work connected directly both with national policy in relation to personalisation, choice and self-care and also Greater Manchester's Person and Community Centred Approaches Programme.

The System Wide Self-Care Programme was broken down into a series of streams of work and a brief overview and progress to date along with key plans for 2018/19 and 2019/120 was highlighted for the following:

- Social prescribing;
- Asset based approaches;
- Volunteering in primary care;
- Self-management, education and support;
- Person centred Care and Support Planning and Patient Activation;
- Workforce Development and Culture Change;
- Public Behaviour Change and Communications;
- Infrastructure and Systems;
- Commissioning.

The Board welcomed the update report providing an introduction to some of the activity taking place under the banner of the System Wide Self-Care Programme alongside highlighting some of the scale, complexity and challenge associated with a magnitude of transformation required to make these approaches a reality. It was expected that this programme of work would deliver significant rewards in terms of outcomes, experience, satisfaction and utilisation, but in order to do so it was important to emphasis the sum of the parts and a system wide view of change.

RESOLVED
That the update on progress on the System Wide Self-Care Programme be noted.

49. INCREASING PHYSICAL ACTIVITY IN TAMESIDE

Consideration was given to a joint report of the Interim Assistant Director of Population Health and the Chief Executive of Active Tameside explaining that the evidence base for the preventative effects of physical activity on ill health, disease and premature mortality was exceptionally strong. Presently 32.7% of people in Tameside undertook no physical activity whatsoever.

The Interim Assistant Director of Population Health reported that around 170+ lives were lost in Tameside annually as a result of inactivity. Tameside consistently ranked amongst the lowest performing for outcomes of cancer, heart disease and stroke. The current picture of premature mortality showed action on physical activity was an absolute must.

The biggest gains and best value for public investment was found in addressing the people who were least active. For the remaining majority of residents who met the Chief Medical Officer's guidelines for physical activity and there was an onus and responsibility to ensure the opportunities for physical activity continued to be improved and expanded upon. The local challenge, context and potential key actions for physical activity in Tameside were outlined.

The Greater Manchester Moving blueprint for Physical Activity and Sport in Greater Manchester set out 10 priorities for Greater Manchester. The objectives of Tameside had been set out to align closely with the wider aims for the city region, thus contributing to the overall vision and local deliverables under the plan were detailed in the report.

The Tameside Active Alliance had responsibility for ensuring delivery against local objectives and provided a formal collaborative leadership network for representatives of key Tameside stakeholders to optimise their endeavours to increase the physical activity levels of the Tameside population. The Alliance provided the environment for effective strategic planning, and the design, implementation and further development of a broad, balanced, accessible and sustainable physical activity offer in Tameside.

The Chief Executive, Active Tameside, continued by advising that the Live Active scheme was an exercise on referral programme for those with long term conditions, for whom physical activity must commence with an element of caution / supervision. The scheme was integral to the overarching objective to get those who were inactive active and support those who perceived that they were unable to exercise safely. In addition, the proposed Active Ageing project would work with older people to seek out and address barriers to adopting healthier behaviours. The Active Ageing project would also be aligned with strategically with Greater Manchester's and Tameside's developing health and care system transformational plans.

The Board discussed Tameside's strong existing asset base of sports and social clubs, attractive greenspaces, a network of canals and cycle ways, and excellent sporting facilities both indoor and outdoor. A call to action to those in the latter stages of behaviour change would encourage prospective 'new movers' to connect with any number of groups already in operation within Tameside.

RESOLVED

(i) That progress to date with regard to the establishment of Active Alliance, the development of strategic priorities under the Greater Manchester Moving Blueprint, and the vision of a physically active Tameside be noted.

(ii) That strategic support be offered to the Active Alliance to ensure physical activity remained a priority.

(iii) That the Greater Manchester Moving blueprint local priorities and related key activities be endorsed.

50. TOUR OF TAMESIDE

The Interim Assistant Director of Population Health presented a report updating the Board on the successes of the Tour of Tameside and requesting collaborative support from the Health and Wellbeing Board to grow the event to promote and increase physical activity in the Borough and raise funds for local charity.

She introduced Graham Jackson, Race Director, Sports Tours International, who outlined the work undertaken with local communities to enable a wide audience participating in the Tour. Furthermore, Sports Tours International worked alongside local charities giving the opportunity to fund raise at these events with the arrangement to providing volunteer support.

Mr Jackson explained that the Tour of Tameside was founded by Dr Ron Hill MBE in 1983 and after a 14 year absence was reborn in 2015 by Sports Tours International and since 2016 had returned as a 4 day-long event. Particular reference was made to the success of the 2017 Tour of Tameside, the number of partners across Tameside who had supported the event, engagement with local businesses, community and charity groups. The 2018 was projected to grow and there would be engagement with schools via a Schools Challenge regarding the history of the Tour and involvement of the Tameside Youth Football League.

In conclusion, Mr Jackson outlined the positive outcomes of the Tour of Tameside for the Borough, firstly as an attraction and increasing the use of trails and building on community assets such as community groups, schools and local charities and promoting inclusion.

RESOLVED

(i) That the success of the Tour of Tameside to date be noted.

(ii) That to sustain and build on the legacy of the Tour of Tameside the proposals for future working alongside Sports Tours International for future events be supported.

(iii) That thanks be extended to Graham Jackson for his attendance and informative presentation.

51. DEVELOPMENT OF NEW RELATIONSHIP BETWEEN THE VOLUNTARY, COMMUNITY AND FAITH SECTOR

The Chief Executive of Action Together, provided an update on progress to date with developing a new relationship between the communities and the voluntary, community, faith and social enterprise (VFSCE) sectors with public sector services. This was formerly known as Compact and had now been developed into three Commitment Pledges. The draft Commitment Pledges were included and set within the context of current Greater Manchester partnership agreements between these sectors. In addition, the relationship of this work with the developing Population Health Investment Plan was referenced. The draft Commitments were based on the principles of equal partnership and co-production and SMART objectives were in the process of being jointly developed by the VFSCE and public sector colleagues. It was envisaged that there would be 2 to 3 measurable ambitions implemented for each Commitment Pledge. Discussions were also beginning with Derbyshire County Council and potential alignment with their Compact agreement.

Members of the Board welcomed the report and indicated their support for the approach outlined.

RESOLVED

(i) That the content of the report be noted.

(ii) That the approach outlined and the development of objectives for each Commitment Pledge and consultation with colleagues across the economy to ensure a robust means of promoting system enablers and a mechanism for resolving blocks be supported.

52. URGENT ITEMS

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

53. DATE OF NEXT MEETING

To note that the next meeting of the Health and Wellbeing Board would take place on Thursday 28 June 2018 commencing at 10.00 am.

CHAIR

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	28 June 2018
Executive Member / Reporting Officer:	Councillor Brenda Warrington – Executive Leader and Adult Social Care & Wellbeing Councillor Gerald P. Cooney – Executive Member (Economic Growth and Housing) Councillor Bill Fairfoull – Executive Member – (Finance, Governance, Performance and Digital) Kathy Roe – Director of Finance – Tameside & Glossop CCG and Tameside MBC
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2017/18 CONSOLIDATED FINANCIAL MONITORING STATEMENT AT 31 MARCH 2018** **TAMESIDE HEALTH AND WELLBEING BOARD 2017/18 BETTER CARE FUND MONITORING REPORT – PERIOD ENDING 31 MARCH 2018**
Report Summary:	This is a jointly prepared report of the Tameside & Glossop Care Together constituent organisations on the consolidated financial position of the Economy. The report provides the 2017/2018 financial year end position. 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 and to highlight the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the financial gap next year and through to 2020/21. The report also provides details of the Tameside Health and Wellbeing Board Better Care Fund 2017/18 monitoring report for the period ending 31 March 2018. It should be acknowledged that the associated Better Care Fund resources are included within the Integrated Commissioning Fund of the economy which is reported on a monthly basis to the Strategic Commissioning Board.
Recommendations:	Health and Wellbeing Board Members are recommended: 1. To note the 2017/2018 financial year end position **(Appendix A).** 2. To acknowledge the significant level of savings required to achieve control totals and the financial sustainability of the economy on a recurrent basis. 3. To acknowledge the significant amount of financial risk associated with the achievement of the associated financial control totals.

4. To note the 2017/2018 Better Care Fund monitoring report for the period ending 31 March 2018. **(Appendix B)**

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)

This report provides the consolidated 2017/18 financial year end position of the Care Together Economy for each of the three partner organisations **(Appendix A).**

The report explains that there is a clear urgency to implement associated strategies to ensure the projected funding gap is addressed and closed on a recurrent basis across the whole economy.

A risk share arrangement is in place between the Council and CCG relating to the residual balance of net expenditure compared to the budget allocation at 31 March 2018, the details of which are provided within the report.

It should be noted that the Integrated Commissioning Fund for the partner Commissioner organisations are bound by the terms within the Section 75 agreement and associated Financial Framework agreement which has been duly approved by both the Council and CCG.

Health and Wellbeing members should also note that the Better Care Fund allocations relating to **Appendix B** are included within the Section 75 funding allocation of the Integrated Commissioning Fund.

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:

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

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

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1. INTRODUCTION

1.1 This report aims to provide an update on the year end financial position of the care together economy in 2017/18 and to highlight the increased risk of achieving financial sustainability over the long term. Supporting details are provided in **Appendix A**.

1.2 The report includes the details of the Integrated Commissioning Fund (ICF) and the progress made in closing the financial gap for the 2017/18 financial year. The total ICF is £485.47m in value.

1.3 The Tameside & Glossop Care Together Strategic Commissioning Board are required to manage all resources within the Integrated Commissioning Fund and comply with both organisations' statutory functions from the single fund.

1.4 It should be noted that the report also includes details of the financial position of the Tameside and Glossop Integrated Care NHS Foundation Trust. This is to ensure members have an awareness of the overall Tameside and Glossop Care Together economy position.

1.5 Board members should also note that the outturn net expenditure details for the three Council services within the ICF (Adult Services, Children's Social Care, Public Health) are provisional at this stage and are subject to external audit validation.

1.6 Please note that any reference throughout this report to the Tameside and Glossop economy refers to the three partner organisations within the Care Together programme, namely:

- Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT)
- NHS Tameside and Glossop CCG (CCG)
- Tameside Metropolitan Borough Council (TMBC)

2. FINANCIAL SUMMARY

2.1 **Table 1** provides details of the summary 2017/18 budgets and net expenditure for the ICF and Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT). Supporting details of the outturn variances are explained in **Appendix A**. While financial control totals have been achieved by the three statutory organisations in 2017/18, members should be aware of significant pressures within the economy during the financial year, the key ones being:-

- Following transaction of the ICF risk share the CCG was able to show a balanced financial position in 2017/18. However this ignores significant underlying pressures in individualised commissioning of approximately £6.393m compared to the opening budget.

- Children's Services within the Council is managing unprecedented levels of service demand which is currently projected to result in additional expenditure of £8.609m when compared to the available budget

2.2 **Table 2** provides details of the Strategic Commission risk share arrangements in place for 2017/18. Under this arrangement the Council agreed to increase its contribution to the ICF by up to £5.0m in 2017/18 and 2018/19 in support of the CCG's QIPP savings target. There is a reciprocal arrangement where the CCG will increase its contribution to the ICF in 2019/20 and 2020/21. For 2017/18 an increased Council contribution of £4.2m has been transacted in line with this agreement.

Any variation beyond is shared in the ratio 80:20 for CCG : Council. A cap is placed on the shared financial exposure for each organisation (after the use of £5.0m) in 2017/18 which is a maximum £0.5m contribution from the CCG towards the Council year end position and a maximum of £2.0m contribution from the Council towards the CCG year end position. The CCG year end position is adjusted prior to this contribution for costs relating to the residents of Glossop (13% of the total CCG variance) as the Council has no legal powers to contribute to such expenditure.

The Strategic Commission net funding gap of £ 7.885m in 2017/18 primarily relates to demand pressures within the Council's Children's Social Care service. This net funding gap within the Council will be resourced via a £0.5m additional contribution to the ICF from the Tameside and Glossop Clinical Commissioning Group as per the terms of the Integrated Commissioning Fund risk share agreement, with the residual balance financed via a combination of Council in year revenue and existing general reserve balances.

Table 1 – Summary of the Tameside and Glossop Care Together Economy – 2017/18

	Year End				
Organisation	**Budget**	**Actual**	**Variance**	**Previous Month**	**Movement in Month**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
Strategic Commission	485,466	493,351	-7,885	-7,429	-456
ICFT	-22,088	-22,054	34	0	0
Total	**463,378**	**471,297**	**-7,851**	**-7,429**	**-456**

Table 2 – Risk Share

Risk share contributions transacted in 2017/18

Risk Share		**£000's**
CCG Reduction to Risk Share	Continuing Healthcare	3,700
	Mental Health - Individualised Commissioning	500
Sub Total		**4,200**
TMBC Increase to Risk Share	Children's Services	500

There are a number of additional risks which each partner organisation has managed during the financial year, the details of which are provided within **Appendix A.**

2.3 A summary of the financial position of the ICF analysed by directorate is provided in **Table 3.**

Table 3 – 2017/18 ICF Financial Position

Service	Year End Position		
	Budget	Actual	Variance
	£'000	£'000	£'000
Acute	203,291	206,251	- 2,960
Mental Health	29,954	29,940	14
Primary Care	83,109	81,777	1,332
Continuing Care	13,623	14,329	- 706
Community	27,451	27,477	- 26
Other	26,756	26,138	619
QIPP	-	-	-
CCG Running Costs	5,197	3,469	1,728
Adult Services	44,185	43,642	543
Children's Social Care	35,192	43,801	- 8,609
Public Health	16,708	16,527	181
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**
CCG Expenditure	389,381	389,381	0
TMBC Net Expenditure	96,085	103,970	- 7,885
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**
A: Section 75 Services	265,511	264,721	790
B: Aligned Services	186,721	195,926	- 9,205
C: In Collaboration Services	33,234	32,704	530
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**

2.4 **CCG Surplus –** The significant change to the CCG position since M11 is a change to the CCG surplus. On 20 March Paul Baumann, Chief Finance Officer, NHS England sent a letter to all CCGs which resulted in two changes:

- **System Risk Reserve**. In line with guidance The CCG retained £1.722m of resource on reserves to offset any wider system pressures across the NHS. The CCG has been asked to release this reserve and increase the value of our reported surplus. Nationally commissioner surpluses will increase by around £560m as a result of this which will be used to offset the deficit position in the provider sector.
- **Category M Drugs**. As reported previously a clawback arrangement has been in operation in 2017/18, where the benefit of price reductions for Cat M drugs has sat with NHS England rather than the CCG. In light of other pressure faced by CCG (most notably around NCSO drugs), Paul Baumann has agreed that the Cat M rebate will be returned to all CCG to improve the bottom line position.

The net impact of these changes is an increase in the surplus to £9.347m. It is important to note that there is no mechanism through which the CCG would be able to draw down any of this surplus in 2018/19:

	£'000s
Planned Surplus (i.e. 1% plus carry forward from 16/17)	7,174
System Risk Reserve	1,722
Category M Drugs	451
Total 2017/18 Surplus	**9,347**

2.5 **Acute** - Against a full year budget of £203.291m, there was expenditure of £206.251m. This represents an overspend of £2.960m. The acute position has deteriorated by £0.394m since last month, driven by an increased number of out of area admissions and demand for treatment in the private sector. Emergency admissions and critical care continue as the chief contributors to the overall pressure:

	(Over) / Under Performance
POD	**£'000**
A & E	(180)
Urgent Care	(1,165)
Excess Bed Days	(85)
Outpatients	(539)
Planned Care	336
Critical Care	(588)
Other	48
Total	**(2,173)**

The year end position in includes settlement positions on associate provider contracts. For Stockport, Salford, The Christie, Pennine Acute and Bolton these are fixed final agreements which will not change to reflect actual activity in February/March. For all other providers, while the position is fixed in terms of income & expenditure for the 2017/18 accounts, we will make post reconciliation adjustments based on actual activity when final data is available in June.

2.6 **Mental Health** – There is a £0.014m underspend against core budgets. This is a £0254m favourable movement on the position reported last month due to slippage in implementation of schemes reaching a settlement with Pennine Care. The CCG has achieved the Mental Health Investment Standard (MHIS) for 2017/18, with an increase in mental health spend over 2016/17 of 2.8% against a target of 2.00%

2.7 **Primary Care** – Total underspend in 2017/18 was £1.332m, which is broadly consistent with the position forecast at M11.

2.8 **Continuing Care** – There is a £0.706M overspend against core budgets which is broadly consistent with the position forecast at M11. This includes a £3.5m contribution through the ICF risk share which offsets some of the reported overspend versus the original budget.

Growth in individualised packages of care remains the CCGs biggest financial risk. Across CHC and individually commissioned packages in mental health and neuro rehab there is a total pressure of £6.393m, £4.200m of which is mitigated by the increased Council contribution to the risk share.

2.9 **Community** - The majority of spend within this directorate is within the block contract for the ICFT. The final outturn was broadly consistent with the position forecast at M11.

2.10 **Other** – This area includes BCF, estates, transformation funding and reserves. The movement of £1.590m against this directorate is largely presentational and relates to the accounting treatment required in order to increase the surplus as discussed earlier in the report, offset by the forecast QIPP reserve naturally dissipating at year end.

2.11 **QIPP** – Against an annual savings target of £23.9m, all £23.9m has been fully achieved in year. However less than half of this was achieved on a recurrent basis, leading to a 2018/19 requirement of £19.8m.

2.12 **CCG Running Costs** – While the table shows an in month movement of £1.72m against this directorate, this movement is presentational. It relates to required adjustments to ensure the

correct year-end accounting for QIPP schemes (running costs and estates savings relating to New Century House).

2.13 **Adult Social Care –** Increase of £0.2m in Fairer Charging income received for community based services, this is income based on the individual client financial assessments of approximately 1000 clients (this number varies throughout the year). Employee related expenditure is £0.4m less than budget. The number of assessed hours required for the Council provided Learning Disabilities Homemaker Service are less than budgeted due to services being delivered by the independent sector.

2.14 **Children's Services** – Net expenditure in excess of revenue budget of £8.61m – primarily due to increased expenditure on children's placements and agency social workers as a result of increased demand. In addition there were appointments to senior posts to the approved budget allocation which were necessary to support the implementation of required improvements within the service. As reported in previous periods, there is an ongoing strategy within the service to transition agency social workers onto permanent contracts as this is a lower cost alternative and also improves the quality and stability of service delivery.

For context, the number of Looked After Children increased from 519 at April 2017 to 613 in March 2018 (590 in January 2018).

An additional non recurrent £ 18m budget allocation has been approved by the Council to support the levels of unprecedented service demand, £10 million of which has been allocated in 2018/19. The details of the demand management and reduction strategy will be reported during the 2018/19 financial year ICF monitoring reports.

3. 2017/18 EFFICIENCY PLAN

3.1 The economy has an efficiency sum of £35.07m to deliver in 2017/18, of which £24.67m is a requirement of the Strategic Commissioner.

3.2 **Appendix 1** provides supporting analysis of the delivery against this requirement for the whole economy. It is worth noting that there was a £0.360m under achievement of this efficiency sum at the end of the financial year and the Control Totals were delivered.

3.3 It is therefore essential that additional proposals are considered and implemented urgently to address this gap on a recurrent basis thereafter.

4. BETTER CARE FUND

4.1 Health and Wellbeing Board members are reminded that the better care fund was introduced during 2015/16 and has continued in the current financial year. The funding is awarded to the Economy to support the integration of health and social care to ensure resources are used more efficiently between Clinical Commissioning Groups and Local Authorities, in particular to support the reduction of avoidable hospital admissions and the facilitation of early discharge.

4.2 **Appendix B** provides supporting details of the 2017/18 quarter four (1 April 2017 to 31 March 2018) Better Care Fund monitoring statement recently submitted to NHS England. Guidance recommends that the quarterly monitoring returns are also presented to Health and Wellbeing Board members.

5. RECOMMENDATIONS

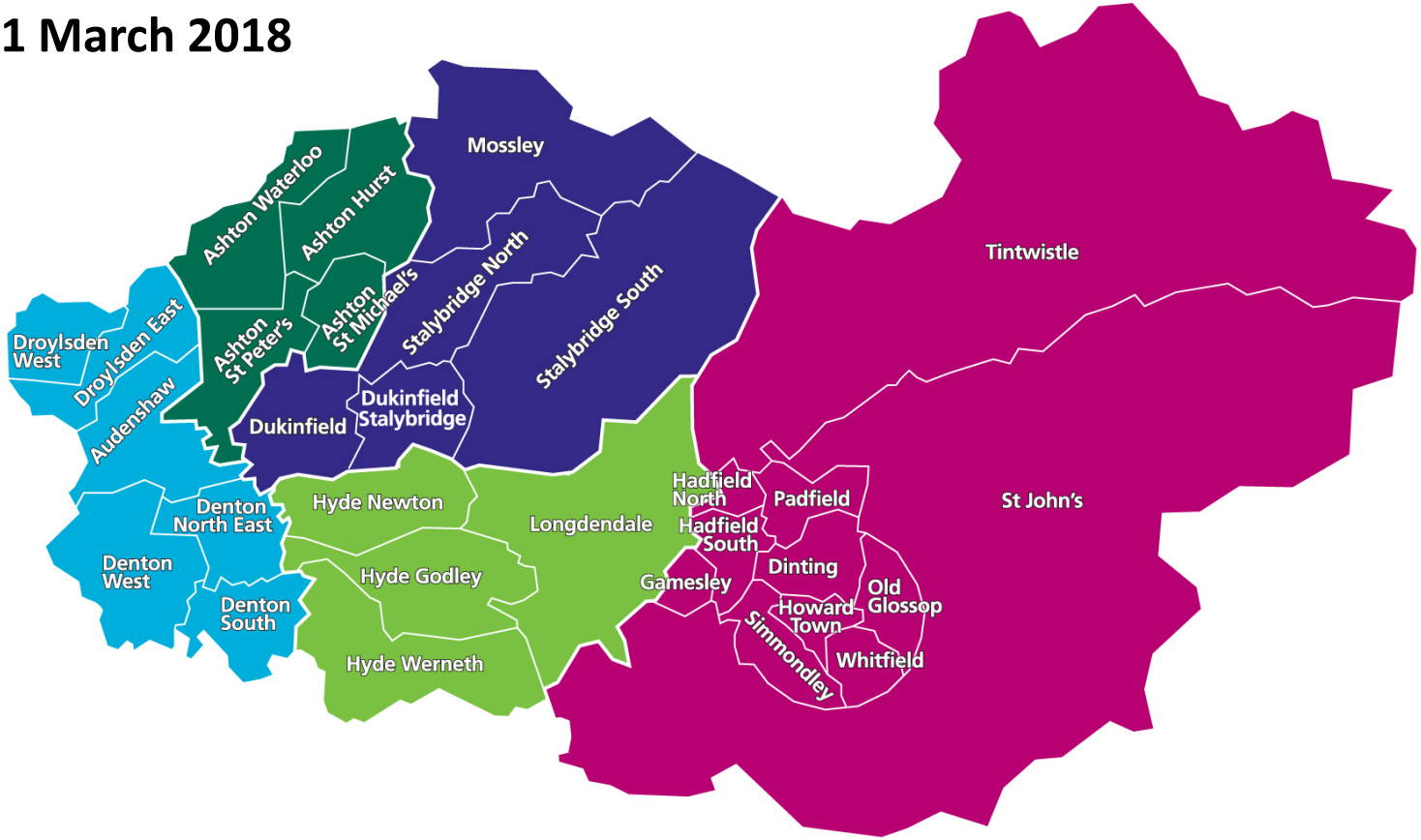
5.1 As stated on the report cover

TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position

financial monitoring statements

Period Ending 31 March 2018
Month 12



Kathy Roe
Claire Yarwood

NHS Tameside and Glossop Clinical Commissioning Group
Tameside Metropolitan Borough
NHS Tameside and Glossop Integrated Care NHS Foundation Trust

Integrated Care Together Economy Financial Position

The 2017/18 financial gap has been closed but approximately half as a result of non recurrent funds.
Significant challenges remain in order to recurrently balance 2018/19.

Organisation	Year End Budget	Year End Actual	Year End Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's
Strategic Commission	485,466	493,351	-7,885	-7,429	-456
ICFT	-22,088	-22,054	34	0	0
Total	**463,378**	**471,297**	**-7,851**	**-7,429**	**-456**

- Following transaction of the Integrated Commissioning Fund risk share, the Strategic Commission funding position shows a gap of £7,851k. This gap relates primarily to pressures within Children's Social Care as explained within the Executive Summary. This net funding gap within the Council will be resourced via a £500k contribution from the CCG into the ICF risk share agreement, with the residual balance financed via a combination of Council in year revenue and existing general reserve balances. Both CCG and council continue to report that we will meet financial control totals.
- The Trust has delivered against its Planned net deficit of £23.7m, this is c£4k favourable to plan
- The Integrated Commissioning Fund has now received the extra non-recurrent contributions from the risk share agreement ensuring a balanced position is now achieved.
- While the financial gap is a large figure, it is important to appreciate this equals 1.7% of the total budget:

Economy Wide Highlights

- The full £23,900k QIPP target has been achieved in year (£12,252k delivered recurrently). As such the CCG has met financial control totals.
- CCG surplus has increased to £9,347k in line with national planning guidance.
- Risk Share contributions transacted
  > £3,700k – Continuing Care
  > £500k – MH Non-CHC
  > **£4,200k Sub Total**
  > £500k Children's Social Care
- CHC/MH Non-CHC and Neuro Rehab has overspent by £2,193k. However, it is important to recognise this includes the increased contribution from the risk share highlighted above. The underlying position is a £6,393k cost pressure in this area.
- £8,609k overspend on Children's Services predominantly driven by out of area placements & agency social workers. £500k from the risk share contribution was transacted in this area as outlined above.
- £2,960k overspend on acute, driven by increased activity (mainly emergency admissions) at providers other than the ICFT
- £23.7m ICFT Control total was delivered

Tameside and Glossop Strategic Commissioner Financial Position

- Overspend of £7,885k is driven by significant pressures in children's services, which has seen further deterioration of £456k in M12. This deterioration relates primarily to an increase in the number of looked after children.
- Both organisations are currently reporting that statutory duties and financial control totals have been met. The CCG is reporting that the QIPP target has been fully achieved, with post mitigation risks of zero. The significant change since M11 is a change to the CCG surplus. On 20 March Paul Baumann, Chief Finance Officer, NHS England sent a letter to all CCGs which resulted in two changes
  - System Risk Reserve. In line with guidance The CCG kept £1,722k of resource on reserves to offset any wider system pressures across the NHS. We have been asked to release this reserve and increase the value of our reported surplus. Nationally commissioner surpluses will increase by around £560m as a result of this, which will be used to help offset the deficit position in the provider sector.
  - Category M Drugs. As reported previously a clawback arrangement has been in operation in 2017/18, where the benefit of price reductions for Cat M drugs has sat with NHS England rather than the CCG. In light of other pressure faced by CCG (most notably around NCSO drugs), Paul Baumann has agreed that the Cat M rebate will be returned to all CCGs to improve the bottom line position.
  - The net impact of these changes is an increase in the surplus to £9,347. It is important to note that there is no mechanism through which the CCG would be able to draw down any of this surplus in 2018/19:

	£'000s
Planned Surplus (i.e. 1% plus carry forward from 16/17)	7,174
System Risk Reserve	1,722
Category M Drugs	451
Total 17/18 Surplus	**9,347**

Service	Year End Position		
	Budget	Actual	Variance
	£'000	£'000	£'000
Acute	203,291	206,251	- 2,960
Mental Health	29,954	29,940	14
Primary Care	83,109	81,777	1,332
Continuing Care	13,623	14,329	- 706
Community	27,451	27,477	- 26
Other	26,756	26,138	619
QIPP	-	-	-
CCG Running Costs	5,197	3,469	1,728
Adult Services	44,185	43,642	543
Children's Social Care	35,192	43,801	- 8,609
Public Health	16,708	16,527	181
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**
CCG Expenditure	389,381	389,381	0
TMBC Net Expenditure	96,085	103,970	- 7,885
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**
A: Section 75 Services	265,511	264,721	790
B: Aligned Services	186,721	195,926	- 9,205
C: In Collaboration Services	33,234	32,704	530
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**

Tameside Integrated Care Foundation Trust Financial Position

High level financial overview

	Month 12			Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Normalised Surplus/(Deficit)	(1,642)	(1,672)	(30)	(23,730)	(23,726)	4
Capital Expenditure	1,269	2,375	1,106	4,825	4,827	2
Cash and Equivalents	1,190	1,415	225	0	0	0
Trust Efficiency Savings	1,263	1,306	43	10,397	10,038	(359)
Use of Resources Metric	3	3	0	3	3	0

Outturn Net position is £23.7m deficit, the Trust delivered against its 2017/18 plan.

Trust Efficiency Programme is c. £0.36m behind the in year Target. In Month, it delivered £43k above plan

Cash is £0.2m above the planned balance

Key risks and highlights

Key Risks – I&E

- **Control Total –** The Trust has delivered against its Planned net deficit of £23.7m, this is c£4k favourable to plan.
- **Medical Staffing -** The level of medical agency expenditure is providing a financial pressure for the Trust, particularly within ED, T&O and Medicine.
- **Winter Schemes** – Funding for Tranche 2 Winter schemes has ceased at the end of March, therefore all winter schemes/initiatives not ceased will cause a financial pressure into the new financial year.
- **IT Outage –** The Trust has incurred costs relating to the unexpected IT outage at the end of March
- **Rates (PFI)** – The Trust incurred c£150k in rates for periods 2015-2018 for retail outlets in the PFI, this is unfunded.
- **Activity levels -** Income on smaller clinical contracts is falling, but no corresponding reduction in costs.
- **TEP –** The Trust reported an in year shortfall to TEP of c£0.36m

Key Risks – Balance Sheet/Other

- **Loans -** At the end of 2016/17, the Trust had loan liability of £54.8m. It is anticipated that this will increase to £75.4m in 2017/18. The Trust will be required to repay part of this liability in 2018 and a further loan may be required to service this repayment.
- **Cash -** The March month end cash balance was £0.2m above the expected £1.2m plan.
- **Winter Tranche 1 & 2** – The Trust have been in receipt of Tranche 1 & 2 monies of £618k & £725k. T1 will reduce the Trusts Planned deficit to £23.7m. The Tranche 2 monies of £725k have been used to support winter schemes
- **Agency Cap -** The NHSI requirement is for the Trust to reduce medical agency expenditure by £1.2m. The Trust outturn in 2017/18 is £10.8m which is c£0.7m better than the NHSI target.

Pressure/High Risk Improvement/Low risk

Overall Risk Rating - Medium

Integrated Commissioning Fund Risks

Individualised Commissioning (A)

- While the 17/18 financial position is now balanced, growth in individualised packages of care remains one of the CCGs biggest financial risks going forward. While overspend in the ledger is £2,193, this includes mitigation through increased council contribution to the ICF risk share. The underlying pressure against opening budgets is £6,393k.
- A financial recovery plan is in place and work is underway to implement the schemes and a paper looking at procurement of care home beds for patients with dementia went through the governance process in February.

Children's Services (R)

- Net expenditure in excess of revenue budget of £8.61m – primarily due to increased expenditure on children's placements and agency social workers as a result of increased demand. In addition there were appointments to senior posts to the approved budget allocation which were necessary to support the implementation of required improvements within the service..
- The number of Looked After Children has increased from 519 at April 2017 to 613 in March 2018.
- An additional non recurrent £ 18m budget allocation has been approved, £10 million of which has been allocated in 2018/19. The details of the demand management and reduction strategy will be reported during 18/19

QIPP (G)

- The CCG had an annual savings target of £23,900k in 17/18, which has been reported as fully achieved in year.
- However less than half of this was achieved on a recurrent basis, meaning we will start 2018/19 with a target of £19,800k. Post optimism bias, we have schemes in place to deliver approximately £13m of savings in 18/19. Further work is required to identify new schemes to close this gap and enable 18/19 control totals to me delivered.

Acute services (A)

- Demand Management for emergency services at the associate providers remains a key risk for the CCG. Total overspend of £2,173k is driven by emergency admissions and critical care

£000's	(Over)/Under Spend
A&E	-180
Urgent Care	-1,165
Excess Bed Days	-85
Outpatients	-539
Planned Care	336
Critical Care	-588
Other	48
Total	-2,173

- This risk will continue into 18/19, where a QIPP planning assumption has been made that future growth can be contained and activity will not increase over 17/18 levels.

Mental Health: (A)

- Heightened levels of out of area placements at premium prices due to shortage of MH beds locally are a significant driver of overspend
- Cost pressures to deliver requirement of Five Year Forward View present a significant medium term risk to financial position of Strategic Commissioner (though slippage in implementation of schemes in 17/18 has improved the in year position slightly).
- Sustainability of local MH providers and safer staffing requirements are also a risk.

Adult Social Care (A)

- In 17/18 there is an underspend of £543k , however, there is significant medium term risk in this area as a result of:
  - increased demand for social care services to support improvement in DTOCs and as a result of demographic growth
  - financial pressure from living wage legislation and care home market

Financial Gap and Efficiency Position 17/18

- In order to deliver financial control totals, an economy wide savings target of £35,070k was set for 2017/18. This is made of £10,397k Trust Efficiency Plan (TEP) savings at the ICFT and £24,673k across the strategic commissioner (made up of £23,900k CCG QIPP and £773k of planned council savings).
- The table below details achievement against this target. In total, savings of £34,710k were delivered, which left a shortfall of £360k on the TEP within the ICFT. However, the provider planned deficit will still be met as a result of other means.
- For the commissioner, the full £23,900k QIPP target has been reported as achieved in full since month 10. The council delivered the full target of £773k.

Key Headlines:

- Final projected economy savings are £360k lower than target.
- £19,592k (56%) of expected savings are due to be delivered on a recurrent basis.

£000's	Annual Target	Risk Rated Forecast Position				Savings	Variance
		Posted	Low	Medium	High		
ICFT	**10,397**	**10,037**	**-**	**-**	**-**	**10,037**	**- 360**
Strategic Commissioner	**24,673**	**24,673**	**-**	**-**	**-**	**24,673**	**- 0**
Technical Target	1,875	10,611	-	-	-	10,611	8,736
Primary Care	1,748	2,279	-	-	-	2,279	532
Single Commissioning	1,137	1,221	-	-	-	1,221	84
Neighbourhoods	781	781	-	-	-	781	-
Acute Services - Elective	1,116	586	-	-	-	586	- 530
Other	1,324	724	-	-	-	724	- 600
Effective Use of Resources	1,500	815	-	-	-	815	- 685
Mental Health	994	296	-	-	-	296	- 698
GP Prescribing	2,516	1,185	-	-	-	1,185	- 1,331
Back Office Functions	2,024	562	-	-	-	562	- 1,463
Demand Management	8,885	4,840	-	-	-	4,840	- 4,045
Adult Social Care	336	336	-	-	-	336	-
Public Health	437	437	-	-	-	437	-
Total Economy Position	**35,070**	**34,710**	**-**	**-**	**-**	**34,710**	**- 360**

Financial Gap and Efficiency Position 18/19

- In 18/19 there is a QIPP target of £19.8m for the CCG. The latest QIPP position for the CCG is detailed below.

Summary of 2018/19 QIPP Achivement	R	A	G	B	Grand Total	Expected Saving
Tameside ICFT	**0**	**0**	**2,480,000**	**0**	**2,480,000**	**2,480,000**
Reverse Demographic Growth	0	0	2,480,000	0	2,480,000	2,480,000
GP Prescribing	**180,000**	**1,645,000**	**175,000**	**0**	**2,000,000**	**1,015,500**
Individualised Commissioning Recovery Plan	**0**	**700,000**	**626,552**	**0**	**1,326,552**	**976,552**
Dementia Care Home Tender	0	495,000	0	0	495,000	247,500
Chairing of MDT	0	205,000	0	0	205,000	102,500
Broadcare/Liaison	0	0	200,000	0	200,000	200,000
Fast Track Recovery plan	0	0	132,000	0	132,000	132,000
CareTech 10% reduction	0	0	104,552	0	104,552	104,552
Dowry Income	0	0	190,000	0	190,000	190,000
Other Established Programme Related Schemes	**0**	**2,918,607**	**1,329,848**	**0**	**4,248,455**	**2,789,152**
Associate Provider Demand Management Schemes	0	1,300,000	0	0	1,300,000	650,000
Urgent Treatment Centre/Urgent Primary Care	0	133,333	0	0	133,333	66,667
VCS Grants	0	0	65,122	0	65,122	65,122
Estates Strategy	0	250,000	0	0	250,000	125,000
QPP Achivement	0	500,000	0	0	500,000	250,000
Budget Management	0	600,274	399,726	0	1,000,000	699,863
Running Costs Savings	0	135,000	865,000	0	1,000,000	932,500
Technical Financial Adjustments	**0**	**1,000,000**	**5,471,000**	**0**	**6,471,000**	**5,971,000**
Release of reserves	0	0	3,500,000	0	3,500,000	3,500,000
Release 0.5% contingency	0	0	1,971,000	0	1,971,000	1,971,000
Slippage on Mental Health	0	1,000,000	0	0	1,000,000	500,000
Capped Expenditure Process	**2,185,000**	**0**	**0**	**0**	**2,185,000**	**218,500**
Activity related policy changes	2,052,000	0	0	0	2,052,000	205,200
Transforming Care for people with learning disabilities	98,000	0	0	0	98,000	9,800
TARGET	35,000	0	0	0	35,000	3,500
FSG	**0**	**0**	**0**	**0**	**0**	**0**
Grand Total	**2,365,000**	**6,263,607**	**10,082,400**	**0**	**18,711,007**	**13,450,704**

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Better Care Fund Template Q4 2017/18

1. Cover

Version 1.1

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Health and Wellbeing Board:	Tameside
Completed by:	Elaine Richardson and Paul Dulson
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Who signed off the report on behalf of the Health and Wellbeing Board:	Stephanie Butterworth

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'

Complete

	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Income & Expenditure	0
6. Year End Feedback	4
7. Narrative	0

Better Care Fund Template Q4 2017/18

2. National Conditions & s75 Pooled Budget

Selected Health and Well Being Board: Tameside

Confirmation of National Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**
1) Plans to be jointly agreed? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	Yes		

Better Care Fund Template Q4 2017/18

3. Metrics

Selected Health and Well Being Board: Tameside

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Not on track to meet target	Acuity has increased. Whilst the Strategic commission and ICFT habe managed NEL for pateints in the locality ther have been increases in admissions for people registered with CCGs	Had seen significant reductions for Straegic Commission registered pateints until Q3 when saw 0.6% above plan (37 people). However admissions across all CCGs are 2.4% above plan Admission avoidance	none
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	Not on track to meet target	there have been more placements over the last 12 months per 100,000 than in previous years.Need to build on existing community resources to ensure people remain at home for as long as its safe to do so. Also need to	Continue to work with integrated urgent care team, reablement service, community response service to ensure that care packages are as comprehensive as possible.	Now introducing a more focussed asset based model of working that is looking at individual and community strengths and assets . SCIE currently helping us with these developments. Working with hospital
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	This continues to be a challenging target and is dependnet upon the success of good reablement as well as good hospital discharge.	Restructured reablement service and rapid response element now embedded within the Integrated Urgent Care Team which ensures faster response for hospital discharges and for admissions avoidance.	Working with SCIE and NAIC to ensure that we continually review current practice against national developments.
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	Not on track to meet target	A review of DTOC processes and guidance at one of our providers (Pennine Care Trust), to ensure consistency and accuracy of DTOC recording across the trusts has resulted in an increase in DTOC incidence at	Acute hospital delays have improved significantly. Integrated Urgent Care Team managing discharges. Strong focus on Home First and Discharge to Assess.	We have been made aware of a review of DTOC processes and guidance at one of our providers (Pennine Care Trust), to ensure consistency and accuracy of DTOC recording across the trust. This has resulted in an

** Your assessment of progress against the Delayed Transfer of Care target should reflect progress against the monthly trajectory submitted separately on the DToC trajectory template*

Better Care Fund Template Q4 2017/18

4. High Impact Change Model

Selected Health and Well Being Board: Tameside

		Maturity assessment					Narrative			
		Q2 17/18	Q3 17/18	Q4 17/18 (Current)	Q1 18/19 (Planned)	Q2 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	Early discharge planning	Plans in place	Plans in place	Plans in place	Plans in place	Plans in place		The 8 HICs are intricately linked therefore in order to achieve maximum output and/or impact in one HIC field, it is significantly dependent on other areas becoming established and working	Ticket Home service is rolled out across most Wards and volume of request to Urgent Care Community for support once a person has been discharged has increased	None
Chg 2	Systems to monitor patient flow	Established	Established	Mature	Mature	Mature	Patient Flow manager in the local Integrated Care provider. Close monitoring of Red Green days on wards with daily calls to highlight delays and agree solutions. Whole system awareness of pressures and delays and good escalation when needed	The 8 HIC's are intricately linked therefore in order to achieve maximum output and/or impact in one HIC field, it is significantly dependent on other areas becoming established and working collaboratively/effectively.	System working very collaboratively. Focus at acute level on Stranded patients. Neighbourhoods now more closely engaged with acute teams to progress flow	None
Chg 3	Multi-disciplinary/multi-agency discharge teams	Mature	Mature	Mature	Mature	Mature	Integrated Urgent Care Team manages discharges with links to Integrated Neighbourhood teams that include social prescribers. Discharge to Assess processes in place with	The BCF HIC model aims to help reduce non-elective admissions and reducing DToC and although we are seeing an improvement in our activity/performance, there is still work to sustain/maintain the required standards.	Improved integrated working with providers across the UC spectrum Strong links established with the Social Prescribing model/teams to support AA and	None
Chg 4	Home first/discharge to assess	Mature	Mature	Mature	Mature	Mature	Home First and Ticket Home in place Digital Health in place and supporting admission avoidance as well as discharge back to a residential home Discharge to assess process in place	Ensuring complex discharge planning takes place in the Discharge to Assess beds. Evidence suggests Long Term Care patients seem to be assessed in Acute beds and not as much in the Discharge to Assess beds which	Learning from the 'reset' week (wk. beginning 5th Jan) where the focus will be on community, HF and DtA - to be shared/implemented as appropriate	None
Chg 5	Seven-day service	Established	Established	Established	Established	Established		In the main, 7 day offer is in place however there is still work required to bring equilibrium throughout the wider System so full benefits can be realised – evidence/reports confirm 7 day access is more	Social Care to establish the areas that currently work/don't work well within their established 7 day model to help to identify gaps in the wider system	None
Chg 6	Trusted assessors	Mature	Mature	Exemplary	Mature	Mature	Integrated Urgent Care Team manages discharges Digital Health supporting discharges	Regulations from CQC require manager/deputy manager to assess potential admissions therefore TA will not be effective here	Improved relationships through Digital Health	None
Chg 7	Focus on choice	Established	Established	Plans in place	Mature	Mature		Consistent application of policy in all areas. Engagement with patients, families, carers in place – particularly around the Home of Choice	Adopted GM Discharge standards and Choice policy.	None
Chg 8	Enhancing health in care homes	Mature	Mature	Mature	Mature	Mature	Care Home Quality Team Care Home Forum Digital Health GP zoning of Care Homes	Care Home Quality Improvement Team has been recruited to (but not operational as yet – serving out Notice periods) Care Home Managers Forum has been re-	Red bag scheme in place – bags purchased – project plan in place with scheme due to commence in in Ashton for Care Homes Engagement with all Care Homes and NWAS	None

Hospital Transfer Protocol (or the Red Bag Scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q2 17/18	Q3 17/18	Q4 17/18 (Planned)	Q1 18/19 (Planned)	Q2 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.	Challenges	Achievements / Impact	Support needs
UEC	Red Bag scheme	Plans in place	Plans in place	Plans in place	Plans in place	Established		Engagement and commitment required from multiple providers for scheme to work. Loss of Bags	Building on Message in a Bottle that was implemented 16/17. Preparing for implementation of a pilot of the Red Bag scheme in Q4 as part of GM scheme	Financial support for initial Red Bags, Passport documentation Posters and leaflets. Support to release capacity for project leads

Better Care Fund Template Q4 2017/18

5. Income & Expenditure

Selected Health and Wellbeing Board: Tameside

Income

	2017/18 Planned		2017/18 Actual	
Disabled Facilities Grant	£ 2,152,698		£ 2,152,698	
Improved Better Care Fund	£ 6,343,181		£ 6,343,181	
CCG Minimum Fund	£ 15,597,033		£ 15,597,033	
Minimum Subtotal		£ 24,092,912		£ 24,092,912
CCG Additional Contribution			£ -	
LA Additional Contribution			£ -	
Additional Subtotal		£ -		£ -

	Planned 17/18	Actual 17/18
Total BCF Pooled Fund	£ 24,092,912	£ 24,092,912

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2017/18	

Expenditure

	2017/18
Plan	£ 24,092,911
Actual	£ 21,295,756

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2017/18	The 2017/18 iBCF non recurrent grant allocation was £5.335m, a number of initiatives have been launched with a view to reducing DTOC's, service transformation and addressing backlogs in Social work caseloads. Unfortunately there were delays in 2017-18 due to HR sign-off to fill posts which led to an underspend of £2.7m, all isues have now been resolved and all relevant staff are in posts to support delivery of the agreed projects. The slippage will be fully utilised within the agreed 3 year timeframe

Better Care Fund Template Q4 2017/18

6. Year End Feedback

Selected Health and Wellbeing 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	Plans for an integrated commissioning function and provider were developed before the BCF and so the BCF has been incorporated into the wider Care Together plans rather than being a separate enabler for integration in either the Tameside and Glossop Strategic Commission or Tameside and Glossop Integrated CareNHS Foundation Trust
2. Our BCF schemes were implemented as planned in 2017/18	Strongly Agree	Care Together is the programme that delivers the integrated services that are within the BCF
3. The delivery of our BCF plan in 2017/18 had a positive impact on the integration of health and social care in our locality	Neither agree nor disagree	BCF schemes are only part of the wider Care Together Programme
4. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Non-Elective Admissions	Strongly Agree	The schemes in BCF are part of the wider Care Together Programme of transformation with a focus on Admissions Avoidance
5. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Delayed Transfers of Care	Strongly Agree	The schemes in BCF are part of the wider Care Together Programme of transformation with a focus on Discharge to Assess and Home First
6. The delivery of our BCF plan in 2017/18 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	Strongly Agree	The schemes in BCF are part of the wider Care Together Programme of transformation with a focus on maintaining people in their own homes
7. The delivery of our BCF plan in 2017/18 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	We have seen a slight increase in the proportion of people being admitted to residential and nursing care. Some analysis work is currently being undertaken to understand the increase however we are continuing with our plans to develop a wider range of community and neighbourhood services to mitigate against the need to more residential beds.

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and three Enablers which you have experienced a relatively greater degree of challenge in progressing. Please provide a brief description alongside.

8. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2017/18.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest **successes**
Success 1	8. Pooled or aligned resources	The Strategic Commission and the Integrated Care NHS Foundation Trust operate a single finance report and we operate a single Finance Economy Wide committee and Locality wide Finance Savings Groups
Success 2	2. Strong, system-wide governance and systems leadership	Cohesive, consistent and positive leadership of health and social care system Agreed set of principles across all partners Clarity of vision for raising healthy life expectancy, reducing inequalities and creating professional/financial sustainability Well established programme governance and management arrangements

8. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2017/18.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest **challenges**
Challenge 1	3. Integrated electronic records and sharing across the system with service users	Data Sharing continues to be the greatest challenge to an effective MDT approach involving wider partners
Challenge 2	6. Good quality and sustainable provider market that can meet demand	The Care Home and Home Care market have at times created challenges with Delayed Transfers of Care. The availablity of appropraite provision for our complex people.

Footnotes:

Question 8 and 9 are should be assigned to one of the following categories:

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

Better Care Fund Template Q4 2017/18

7. Narrative

Selected Health and Wellbeing Board: Tameside

Remaining Characters:	17,253

Progress against local plan for integration of health and social care

Care Together is our economy wide change programme to deliver integrated care. This programme aligns political, clinical and managerial leadership and focuses on improving healthy life expectancy, reducing inequality, improving experience of services and improving financial sustainability.
For the past two years, strong and steady work has continued to develop a Strategic Commission made up of Tameside Metropolitan Borough Council and NHS Tameside and Glossop CCG. This has culminated in a single place-based commissioning body which aims to support the implementation of a new model of care, based on our place and which realigns the system to support the development of preventative, local, high quality services.

The Strategic Commission has clear governance arrangements with a Strategic Commissioning Board, clinically led and which has been established as a joint committee of the two organisations with delegated decision-making powers and resources. This creates unifying statutory and collaborative governance arrangements.

The Strategic Commissioning Board considers commissioning proposals which are funded from our Integrated Commissioning Fund. This fund is comprised of three elements
Section 75 - This comprises all services which legislation permits to be held in a pooled fund between NHS bodies and local authorities at a local level
The Strategic Commissioning Board makes decisions on this funding which are binding upon the two statutory partner organisations.

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Remaining Characters:	17,406

Integration success story highlight over the past quarter

Our Journey so far
Cohesive, consistent and positive leadership of health and social care system
Agreed set of principles across all partners
Clarity of vision for raising healthy life expectancy, reducing inequalities and creating professional/financial sustainability
Well established programme governance and management arrangements
Strategic Commissioning function in place
Community services transferred into ICFT
5 x Integrated Neighbourhoods established, being developed at pace with strong Primary Care clinical leadership
Extensive and innovative organisational development programme in place

Strategic Commissioning
Aligned governance structure facilitating single, clinically led commissioning decision making for health and social care
CX TMBC substantive CCG Accountable Officer
Integrated Commissioning Fund of £477m in 17/18 with one Director of Resources

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	28 June 2018
Executive Member / Reporting Officer:	Councillor Brenda Warrington, Executive Leader Jessica Williams, Interim Director of Commissioning and 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 2018.
Recommendations:	The Health and Wellbeing Board is asked: 1. To note the updates as outlined within this report. 2. To receive a further update at the next meeting.
Links to Health and Wellbeing Strategy:	Integration has been identified as one of the six principles agreed locally to achieve the priorities identified in the Health and Wellbeing Board Strategy
Policy Implications:	One of the main functions of the Health and Wellbeing Board is to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.
Financial Implications: (Authorised by the Section 151 Officer)	The financial position of the Tameside and Glossop health and social care economy is reported monthly to the Strategic Commissioning Board. It is acknowledged there is a clear urgency to implement associated strategies to ensure the economy funding gap is addressed and closed on a recurrent basis. It is also important to note that the locality funding gap is subject to ongoing revision, the details of which will be reported to future Health and Wellbeing Board meetings as appropriate. The approved Greater Manchester Health and Social Care Partnership funding of £23.2 million referred to below is monitored and expended in accordance with the investment agreement. Recurrent cashable efficiency savings realised across the economy as a result of this investment will contribute towards the reduction of the estimated locality funding gap.
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 Strategic 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 the Programme Management 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 The focus of this report is the continued development and management of the overarching Care Together programme plan and provides details on progress.

2. CARE TOGETHER PROGRAMME ASSURANCE

2.1 The Care Together Programme Management Office tracks health and social care transformational schemes. These currently fit into three groups:

- **GM Transformation schemes (GM TF):** £23.2m to be invested over 2016/17 – 2019/20 with a target £16.8m recurrent benefit agreed in the Cost Benefit Analysis (CBA).
- **Transformational QIPP:** Savings largely from Commissioning budgets which have an element of transformational change
- **Adult Social Care transformation schemes:** iBCF funded schemes transforming ways of working within Adult and Social Care

2.2 Clarity on the expected Return of Investment (RoI) for Greater Manchester Transformation Schemes (GM TF) has been gained from the GM Health and Social Care Partnership. It has been agreed that the target for RoI (£16.8m) can exclude the cost of running the schemes (i.e. the RoI calculation is purely based on the financial benefits released by the schemes regardless of the cost required to gain this total).

2.3 The Investment Agreement for the GM TF is currently being refreshed in discussion with representatives from GM Health and Social Care Partnership. This refresh is not intended to amend the RoI target or how it is calculated and is focussed more on the types of indicators that localities could report on.

2.4 It must be noted that the £16.8m RoI target was based on the assumption that capital spend would be made available to support estates and IM&T schemes. This capital has not been forthcoming which presents a critical risk to the overall transformation.

2.5 Tameside MBC Policy and Performance Directorate is leading on development of Neighbourhood Scorecards to highlight progress made in the Integrated Neighbourhood model and identify areas requiring further intervention. This will also be supported by an external Evaluation partner (currently in procurement) and further detail on this will be presented to the next Health and Wellbeing Board.

3. CARE TOGETHER TRANSITION FUND

3.1 Due to the lack of capital funding available to support the essential IM&T investment during 2017/18, the Care Together Programme Board made the decision to use the Care Together Transition Fund (made up primarily from TMBC and CCG revenue allocations) to support the continued implementation of our IM&T interconnectivity strategy. This has altered the position as previously reported and resulted in significantly reduced funds for 2018/19.

Table 1: Transition fund position

	2015/16 £000's	2016/17 £000's	2017/18 £000's	Total £000's
£6m Local Transition Fund - Opening Balances:	6,377	4,668	1,278	**6,377**
Economy Expenditure Grand Total	1,709	2,087	560	**4,355**
	4,668	**2,582**	**717**	**2,021**

EMIS		1,304	658	**1,962**
£6m Local Transition Fund - Closing Balances:	**4,668**	**1,278**	**59**	**59**

3.2 2018/19 was always planned as the final year of the transition fund and the impact of the reduced funding this year is being explored with the future requirements for the PMO. An options appraisal will be discussed at the Care Together Programme Board in September. These recommendations will take account of substantial progress made in whole system monitoring which should help identify both areas of success and challenge.

4. CARE TOGETHER TRANSFORMATION FUND

4.1 Transformation schemes achieved savings of £5.924m savings in 17/18. The economy aims to achieve the £16.8million target from the GM Transformational schemes (see **Appendix A** for full benefits by scheme).

5. TAMESIDE AND GLOSSOP UPDATES TO GM HEALTH AND SOCIAL CARE PARTNERSHIP

5.1 The Programme Management Office submit highlight reports to GM Health and Social Care Partnership to update on progress against our transformation plan. The format for these reports changed at the end of last financial year and an update was not required in April.

5.2 Updates for February and March in the previous format as well as the recent May submission in the new format are attached at **Appendix B**.

5.3 All updates stress the key risk is a lack of access to capital for agreed Estates and IM&T developments.

6. STRATEGIC COMMISSIONING FUND ASSURANCE

6.1 On 3 May 2018, a review of the Strategic Commissioning Function was undertaken by GM Health and Social Care Partnership. Upcoming milestones discussed included the intention to have an longer term, outcome based contract with Integrated Care Foundation Trust (ICFT) by March 2019, the transaction of part of Adult Social Care into the ICFT by 1 April 2019 and an agreed approach to the future of mental health commissioning. In addition, GM Health and Social Care Partnership noted the creation of a single budget for CCG and Council from April 2018 which showed considerable maturity within the Tameside and Glossop economy.

6.2 Feedback received was positive and GM Health and Social Care Partnership stated their intention to share learning from their visit with other localities.

7. CARE TOGETHER COMMISSIONING UPDATE

7.1 The Integrated Neighbourhood vision is being further developed with the Commissioning Improvement Scheme (CIS) now being paid out on a neighbourhood level rather than at individual GP lists. This is a significant step forward to providing equitable neighbourhood services and enabling practices to consider new ways of working.

7.2 The Commissioning team, in alignment with Finance and supported by the Programme Management Office, have identified a number of commissioning schemes to enhance quality, improve patient experience and reduce the economy financial gap. This are largely

initiatives focussed on health but the aim is to work closer with the wider public sector to drive improved prevention strategies and provide increase resource into neighbourhoods as a result of the transformation of services.

8. CARE TOGETHER ADULT SOCIAL CARE

8.1 The Outline Business Case for the Adult Social Care Transaction is currently being considered by Boards at the ICFT and Council. Should this be approved by both parties, the process of due diligence, planning and staff consultation will commence with a transaction date of 1 April 2019.

8.2 The Council has committed £3m iBCF funding, over three years, to the ICFT to assist with the reduction in Delayed Transfer of Care (DTOC) (this also incurred stranded costs of £650k). The remaining £6.6m has been committed to schemes that address unmet need and support transformation projects to deliver improved quality and outcomes across the wider health and social care system.

9. RECOMMENDATIONS

9.1 As set out on the front of the report.

APPENDIX A – BENEFIT RELEASE OF GMHSCP FUNDED TRANSFORMATION BY INDIVIDUAL SCHEME

Planned Savings (as per IA)			17/18 Plan	18/19 Plan	19/20 Plan	20/21 Plan	Total
Original CBA			3,990	6,500	2,763	3,862	**17,115**
Less IM&T			-52	-218	0	0	**-270**
Planned Savings (as per IA)			**3,938**	**6,282**	**2,763**	**3,862**	**16,845**

Savings	Org.	Opening Target	17/18 Actual	18/19 Plan	19/20 Plan	20/21 Plan	Total	Variance from original Target
Integrated Neighbourhoods	SCB	**5,270**	2,790	2,480	0	0	**5,270**	**0**
Integrated Neighbourhoods	ICFT	**4,828**	0	0	2,160	2,668	**4,828**	**0**
System Wide Self Care	ICFT	**0**	0	0	0	0	**0**	**0**
Support at Home	SCB	**0**	0	0	0	0	**0**	**0**
GP Prescribing	SCB	**2,500**	1,185	500	500	315	**2,500**	**0**
Wheelchairs	SCB	**250**	551	0	0	0	**551**	**301**
Home First	ICFT	**1,199**	0	1,199	0	0	**1,199**	**0**
Digital Health	ICFT	**1,343**	0	1,240	103	0	**1,343**	**0**
Flexible Community Beds	ICFT	**705**	686	19	0	0	**705**	**0**
Flexible Community Beds Glossop	ICFT			-250	0	0	**-250**	**-250**
Estates	SCB	**750**	712	39	0	0	**750**	**0**
Evaluation	SCB	**0**	0	0	0	0	**0**	**0**
Performance Management	SCB	**0**	0	0	0	0	**0**	**0**
Organisational Development	ICFT	**0**	0	0	0	0	**0**	**0**
Total GM Planned Savings		**16,845**	**5,924**	**5,227**	**2,763**	**2,983**	**16,896**	**51**

APPENDIX B – GREATER MANCHESTER HIGHLIGHT REPORTS

Tameside and Glossop Care Together : SRO – Stephen Pleasant and Karen James **Programme Director - Jessica Williams** **February 2018**

High level description of the programme and the key projects within it.

Whole Locality focus on improving healthy life expectancy and a determination to reduce inequalities. By creating a single approach to health and social care, deliver significant improvements in population outcomes, patient experience, key performance targets and professional/financial sustainability.

- Strategic Commissioning Function; single strategy, budget, management team and decision making process. Aim to drive improvements to health and social care outcomes through developing a whole place based approach to public sector reform
- Integrated Care Organisation; building on FT license to create a lead integrator of local services including acute, community, social care and aligned mental health, primary care and the voluntary sector

Progress summary (this month) *(high level and by exception)*

- Following public consultation, Strategic Commissioning Board decision on preferred approach to Intermediate Care
- Concluded Urgent Care public consultation and analysis underway
- LCO GM peer review held with positive feedback received
- Board to Board to Board meeting confirmed updated principles of working in partnership and high level objectives for 2018
- Review of NHSE Capped Expenditure Process to identify additional potential saving schemes
- Further development of Adult Social Care Transaction business case
- Increased Derbyshire role within Care Together

Outlook summary (next month)

- Collective financial plan & benefits realisation agreed for 2018/19
- Population health priorities agreed and implementation plans developed
- Agreed new non medical model for Children's Integrated services focussed on Early Need
- Analysis of the NESTA 100 day challenge and identified next steps
- Process agreed on how T&G will develop a new model for mental health "Living Well" hubs based on the Lambeth model
- Restructure of Strategic Commissioning function commenced to align around the life course
- T&G transformation evaluation programme agreed

Any parts of the programme off track, why. Is resolution at programme or TPB level?

Lack of Information Governance/Data Sharing protocols now preventing improved multi-disciplinary working. Less than anticipated IM&T capital funding has resulted in significant re-planning of IM&T strategy and potential for benefit realisation. Continued challenges in recruiting additional staff for the integrated neighbourhoods has caused some slippage in releasing benefits. Whilst T&G aims to resolve these issues as far as possible at programme level, GM HSCP support may well be required.

Any changes to programme and rationale *(confirm approved within programme governance)*

Not applicable this month

Key challenges / issues for resolution (identify if locality or TPB)

- As above, concerns over information governance/data sharing and lack of sufficient capital to support our Estates and IM&T ambitions are our key issues.
- Significant financial challenge for 2018/19 with the potential to cause tension between Care Together partners.

Achievements to highlight / good practice to share (identify if locality or GM (relevant theme/programme)

- T&G NESTA 100 day challenge initial results are positive e.g. in Denton – the diabetic prevention programme had a 49% reduction in retested patients being diagnosed as pre-diabetic.

Development funding proposal submitted Y **Transformation Fund proposal submitted** Y **TF Investment Agreement in place** Y

Tameside and Glossop Care Together : SRO – Stephen Pleasant and Karen James Programme Director - Jessica Williams March 2018

High level description of the programme and the key projects within it.

Whole Locality focus on improving healthy life expectancy and a determination to reduce inequalities. By creating a single approach to health and social care, deliver significant improvements in population outcomes, patient experience, key performance targets and professional/financial sustainability.

- Strategic Commissioning Function; single strategy, budget, management team and decision making process. Aim to drive improvements to health and social care outcomes through developing a whole place based approach to public sector reform
- Integrated Care Organisation; building on FT license to create a lead integrator of local services including acute, community, social care and aligned mental health, primary care and the voluntary sector

Progress summary (this month) *(high level and by exception)*

- Population health priorities agreed, financial profile confirmed and implementation plans developed
- Spend profile for funded schemes agreed across partnership and submitted to GM
- Key outcomes agreed for ICFT contract
- Locality approach to public engagement agreed and launched
- Process agreed for developing an improved approach to neighbourhood mental health "Living Well" hubs
- Support at Home model roll out started
- Evaluation approach and timescales agreed with GMHSCP

Outlook summary (next month)

- Extensions to successful social prescribing schemes start the implementation of nest stage of asset based approaches/social prescribing schemes
- Completion of co-location of services (Intermediate Tier team)
- Finalise financial savings schemes to support overall economy challenge
- Agree approach to develop model for Integrated Children's Services
- Develop an approach for the future model of general practice in conjunction with our aspirations for Integrated Neighbourhoods
- Implementation plans for Intermediate and Urgent Care
- Procurement for Primary Care Access Service

Any parts of the programme off track, why. Is resolution at programme or TPB level?

Lack of Information Governance/Data Sharing protocols now preventing improved multi-disciplinary working. Less than anticipated IM&T capital funding has resulted in significant re-planning of IM&T strategy and associated benefit realisation.

Continued challenges in recruiting additional staff for the Integrated Neighbourhoods will potentially result in less than anticipated future benefits.

Whilst T&G aims to resolve these issues as far as possible at programme level, GM HSCP support may well be required.

Any changes to programme and rationale *(confirm approved within programme governance)*

Not applicable this month

Key challenges / issues for resolution (identify if locality or TPB)

- As above, concerns over information governance/data sharing and lack of sufficient capital to support our Estates and IM&T ambitions are key risks.
- Significant financial challenge for 2018/19 with the potential to cause tension between Care Together partners.

Achievements to highlight / good practice to share (identify if locality or GM (relevant theme/programme)

- Social Prescribing has over 300 referrals to date with the rate due to increase significantly

Development funding proposal submitted Y **Transformation Fund proposal submitted** Y **TF Investment Agreement in place** Y

Locality	Tameside and Glossop	SRO:	Stephen Pleasant / Karen James	Programme Lead:	Jessica Williams	Reporting Period	May-18

High level Description

Whole Locality focus on improving healthy life expectancy and a determination to reduce inequalities. By creating a single approach to health and social care, deliver significant improvements in population outcomes, patient experience, key performance targets and professional/financial sustainability.
Strategic Commissioning Function; single strategy, budget, management team and decision making process. Aim to drive improvements to health and social care outcomes through developing a whole place based approach to public sector reform
Integrated Care Organisation; building on FT license to create a lead integrator of local services including acute, community, social care and aligned mental health, primary care and the voluntary sector

Key Messages for Partnership Board Executive

Comprehensive programme approach in place to drive forwards integration of heath and social care services.
Economy wide financial position agreed between all stakeholders and clear process in place to work collectively to respond to financial challenge.
Adult Social Care Transaction process on-going and on target to transact on 1.4.19.
Following significant discussion regarding how to ensure and develop GP at the heart of integrated neighbourhoods, a new mechanism to incentivise neighbourhood working has been implemented from 1.4.18.
Capital restraints continue to be a major obstacle to transformation and risk to the Care Together programme.

Milestones	RAG	Due	Progress this reporting period	Next reporting period actions
Comprehensive economy wide health and care business inteligence and performance monitoring system in place	On Track	Sep-18	Data sets identified and agreed. Development of scorecard approach. Agreement for economy iwde approach to developing business intelligence. Evaluation process agreed and procurement of partner commenced.	Secure evaluation partner. Identify metrics and new KPIs for understanding health and care economy
Economy Financial Sustainability Plan in place	On Track	Aug-18	All stekeholders engaged. Process agreed. Initial economy wide workshoips completed. Project plan in development.	Project plan finalised and agreed.
Adult Social Care Transaction	On Track	Apr-19	Outline Business Case (OBC) completed and subject for approval at TMBC Cabinet and ICFT Trust Board in May.	Subject to OBC approval, due diligence process agreed and commenced.
Organisational Development programme for new integrated workforce within neighbourhoods in place	On Track	Aug-18	Plan developed. Staff recruited to lead the programme. Roll out being developed.	Commence the neighbourhood development programme.
Clarity on model to achieve greater alignment between physical and mental health	On Track	Dec-18	Initial paper discussed at Economy Executive meeting and approach agreed. Provisional timetable being developed.	Proviisonal programme agreed. Engagement with stakeholders commenced.

Full interconnectivinty of IM&T sytems across economy	Escalation required	Dec-18	Despite limited funding becoming available, progress continues with the EMIS and EMIS Community roll out and the development of Remote Access.	Further capital funds will be required to enable further developments at pace. Review of IM&T strategy. Identification of any potential contingency plans.
Roll out new capital estates changes that support national priorities and support new ways of working	Escalation required	Oct-18	Availability of capital funds is uncertain which has significantly hampered progress to create an Urgent Treatment Centre. Likley to cost a minimum of £600k additional this financial year and potentially impact into 2019/20. this is causing uncertainty	Understand potential contingency plans.

LCO development	RAG	Due	Progress this reporting period	Next reporting period actions
Adult Social Care Transaction	On Track	May-18	As above	OBC authorised
Full Business Case (FBC) for Adult Social Care Transaction authorised	On Track	Nov-18	Subject to Due Diligence process	Due Diligence commenced
Commissioning Improvement Schemes to refocus incentives for General Practice into Neighbourhood.	On Track	Oct-18	Process agreed.	Neighbourhood schemes to be developed.
New comissioning intentions for mental health Clarity on model to achieve greater alignment between physical and mental health	On Track	Apr-19	Work progressing	Development of potential plan.
Onward funding model for social prescribing to be agreed	On Track	Mar-19	Work progressing	Continuing

SCF development	RAG	Due	Progress this reporting period	Next reporting period actions

Strategic Commissioner fully established	On Track	Jul-18	Recruitment commenced for Director of Growth and Director of Public Health	Appointments made
Clinical leadership responsibilities around life course confimred	On Track	Jue-18	Subject to Governing Body confirmation in May 2018	Confirmed. Managerial arrangements to support this underway.
Organisational development of Strategic Commissioning teams to reflect move to integrtaed working with wider public sector	On Track	Oct-18	Resources secured and plans progressing	Roll out of OD programme

Investment Agreement Spend against plan	Month			Year to date			Full Year			Next step / action / mitigation
Area	budget / plan	actual	variance	budget / plan	actual	variance	budget / plan	actual	variance	
Integrated Neighbourhoods				2,750	1,744	(1,006)	2,750	1,744	(1,006)	Cost and spend commitments currently being examined
System Wide Self Care				1,679	895	(785)	1,679	895	(785)	Cost and spend commitments currently being examined
Support at Home				135	417	282	135	417	282	Cost and spend commitments currently being examined
Home First				545	283	(263)	545	283	(263)	Cost and spend commitments currently being examined
Digital Health				359	293	(67)	359	293	(67)	Cost and spend commitments currently being examined
Flexible Community Beds				580	2,672	2,092	580	2,672	2,092	Cost and spend commitments currently being examined
Estates				110	45	(65)	110	45	(65)	Cost and spend commitments currently being examined
Evaluation				200	0	(200)	200	0	(200)	Cost and spend commitments currently being examined
Performance Management				50	19	(31)	50	19	(31)	Cost and spend commitments currently being examined
Organisational Development				100	143	43	100	143	43	Cost and spend commitments currently being examined
Total				6,509	6,509	0	6,509	6,509	0	

View on Economy Financial Position
Challenging but with a clear commitment to address and achieve plan in year.

Digital fund or ETTF funding (if applicable)	Month			Year to date			Full Year			Next step / action / mitigation
	plan	actual	variance	plan	actual	variance	plan	actual	variance	
Digital Fund IA – IT Infrastructure	No funding received - causing issues									
Digital Fund IA – Estates	Uncertain funding									

Material Conditions:	RAG	Due	Next step / action / mitigation
Not available this month			

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	28 June 2018
Executive Member / Reporting Officer:	Jess Williams, Programme Director, Care Together and Interim Director of Commissioning, Tameside and Glossop Liz Windsor-Welch, Chief Executive, Action Together
Subject:	**TAMESIDE VCFSE AND PUBLIC-SECTOR PARTNERS – OUR PACT TO A BETTER FUTURE FOR TAMESIDE**
Report Summary:	This report details the final version of the PACT agreement set out in section 5. The new PACT agreement was formerly known as the "Compact". The PACT outlines a new working relationship between the communities and the voluntary, community, faith and social enterprise sectors (VCFSE) with public sector services. This paper provides a background to the GM context and how we have worked together locally, with Health and Wellbeing Board providing oversight. The PACT agreement consists of 3 core principles and 9 commitments. It is based on the principles of equal partnership and co-production which has implications on how we conduct our everyday work with the VCFSE, especially in the areas of commissioning, contracting and strategic /policy development. There are no immediate policy implications but as the work progresses with the Health and Wellbeing Board's approval there is likely to be an impact on approaches to: • Citizen and Patient engagement • VCFSE involvement in commissioning strategies and plans • Sustainability and investment strategies
Recommendations:	The Health and Wellbeing Board are requested to: 1. Agree and sign off the PACT agreement. 2. Agree that the PACT Leadership Group, with Health and Wellbeing Board's oversight, will continue to have a role in providing system assurance that the new relationship is being honoured; and we are experiencing the benefits of parity between the sectors with an annual report. 3. Advise on the promotion and implementation of the PACT agreement. Named officers are sought from each Health Wellbeing Board partner agency.
Links to Health and Wellbeing Strategy:	This work will support listening to citizen voices; building healthier and more resilient communities; promote health and wellbeing enabling self-care of the individual and enabling communities to be supportive of each other.
Policy Implications:	This paper proposes a reporting relationship to Health and Wellbeing Board for the PACT Leadership Group and its work programme.

Financial Implications: (Authorised by the Section 151 Officer)	There are no direct financial implications arising from this report.
Legal Implications: (Authorised by the Borough Solicitor)	Achieving this 'new relationship' will require clear leadership, governance and accountability. It would be helpful to set out expectations in a MOU.
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 Anna Moloney  Telephone: 0161 342 2189  Email: anna.moloney@tameside.gov.uk

1. DOCUMENT PURPOSE

1.1 This report details the final version of the PACT agreement set out in section 5 below. The PACT is a partnership agreement between the communities and the voluntary, community, faith and social enterprise sectors (VCFSE) with statutory services. The PACT document is comprised of 3 principles and 9 commitments. The partnership agreement was formerly known as the "Compact" and previous reports on progress have been submitted to the Health and Wellbeing Board for oversight.

2. BACKGROUND

2.1 Two key agreements are in place between the voluntary and statutory sectors across Greater Manchester.

- The Memorandum of Understanding between GM Health and Social Care Partnership and the VCFSE. It runs for 5 years until April 2021 and underpins the partnership between the sectors; recognising that transformational programmes are dependent on the VCFSE organisations given their critical role in supporting people to self-care and look after each other collectively.
- The GM Combined Authority Accord: This is a 5 year agreement between the GM Mayor and Greater Manchester Combined Authority (GMCA) that began on 27th November 2017. It is a living document which will be reviewed annually.

The two agreements form the basis of a framework for new ways of working but in each locality there remains a need to demonstrate how this plays out in practice.

2.2 The September 2017 Health and Wellbeing Board endorsed recommendations to establish a new and progressive way of working between statutory organisations and the VCFSE with senior staff to participate in the development of "principles" detailing our commitments to this process. A senior leadership group was established from key agencies across the system from Action Together, VCFSE organisations, Strategic Commission, TMBC and ICFT.

2.3 The PACT Leadership Group reviewed the old "Compact" and expressed a desire to move away from using this language with a view to a more dynamic and living framework involving active participation from the sectors. It was cognisant of the conclusions from the State of the Sector report that highlighted the need for sustained and coordinated leadership to ensure continued support for and partnership with, Tameside's voluntary, community, faith and social enterprise sector. The PACT is based on the principles of equal partnership and co-production.

3. GOVERNANCE

3.1 We envisage that the PACT Leadership Group will continue to have a role in providing system assurance that the new relationship is being honoured; and we are experiencing the benefits of parity between the sectors with an annual report. Commitment 2b below reinforces this point across partners where it asks that evidence and experiences (from VCFSE and public agencies) is gathered annually where the VCFSE has influenced decision making and policy setting to be recorded in annual reports where appropriate.

4. COMMUNICATION

4.1 The PACT Leadership Group recommends that the agreement requires promoting widely across the workforce to raise awareness. Staff working in commissioning, contracting,

policy and strategic development will have a pivotal role in the adoption of the PACT's 3 Principles and 9 Commitments.

5. THE PACT AGREEMENT: OUR PACT TO A BETTER FUTURE FOR TAMESIDE

5.1 This agreement is between Tameside's Voluntary, Community, Faith and Social Enterprise Sector VCFSE[1] and Tameside's public-sector agencies that hold seats across Tameside Partnership[2]. We are all committed to Tameside and improving the life chances of the people that live here. We care deeply about their future, especially focussing on those people that face additional challenge, inequalities, and lack of opportunity. Tameside is a place to be proud of, a place where there is a commitment to striving for better. We all want to build on the strong foundations, within neighbourhoods and within communities of geography and identity in Tameside and recognise that there is enormous potential for us to harness.

5.2 We want to be ambitious, we want the spirit of the people of Tameside to be with us on this change to ensure we take bold steps forward in the way we work together and achieve better outcomes as a result. This commitment should be visible, a living pledge to our promise to working together differently. Something to remind each other of, to be used as a guide and as an indication of the steps forward we take together and the shared ambitions we have.

5.3 **PACT Principle 1 – Hear diverse local voices more directly and more often**

We want local people to have a meaningful opportunity to be involved in decision making and local priority setting. In Tameside we want to embed ways to capture the voices of local people in decision making processes and co-design solutions. VCFSE groups are good at listening to, gathering insight from, and working to strengthen the voices of local people, with a particular focus on social inclusion. We are committed to working together to create the environment, support, and recognition for a range of diverse local voices in decision making.

5.4 **PACT Commitments**

(1a) The Partnership are required to demonstrate that engagement is carried out at the earliest possible point in the future planning of services and commissioning cycles.

(1b) Evidence will show that feedback is listened to and diverse voices from across Tameside are actively shaping services and local policy.

(1c) There is a strong Partnership link between the Partnership Engagement Network and Voluntary Sector Influencing Group and wider VCFSE.

5.5 **PACT Principle 2 – An equal partnership built on trust**

Tameside embraces creativity and difference and we want this to be reflected across our ways of working and partnership structures. We know that VCFSE organisations and Public-Sector Partners bring different strengths to the Borough and that we must harness all our assets to fully realise our shared potential. Relationships built on openness, honesty and integrity will be the key to our success and we must find more opportunities to have open dialogue with brave, respectful and professional communication across the full spread of governance and operational partnerships. We know there are barriers in our way sometimes, but we are committed to finding ways for genuine partnership working where

[1] VCFSE -we mean voluntary organisations, community groups, the community work of faith groups, and those social enterprises where there is a wider accountability to the public via a board of trustees or a membership and all profits will be reinvested in their social purpose.

[2] Tameside public sector partners include; Tameside and Glossop Clinical Commissioning Group, Tameside and Glossop Integrated Care Foundation Trust, Action Together, Active Tameside, Tameside Children's Safeguarding Board, Tameside Adult Safeguarding Partnership Board, Greater Manchester Police, Greater Manchester Fire and Rescue Service, Jigsaw Homes Group Ltd, Department of Work and Pensions, Pennine Care Foundation Trust.

we can re-dress the power imbalances, respectfully challenge each other when needed and come together to achieve our shared ambitions.

5.6 **PACT Commitments**

(2a) Partnerships include VCFSE representation across all decision making and governance partnerships unless a specific justification is agreed and the right support in place to enable this.

(2b) Evidence and experiences (from VCFSE and public agencies) gathered annually where VCFSE has influenced decision making and policy setting to be recorded in annual reports where appropriate.

(2c) Insight gathered and shared on the strength and integrity of the partnerships in place between VCFSE and public agencies

5.7 **PACT Principle 3 – Investment that matches the vision**

The VCFSE in Tameside brings significant investment into the Borough[3] both through their ability to lever in gifts in kind – volunteering and donations, but also through securing grants, contracts and trading. A significant contributor to many VCFSE organisations is the investment and support of public sector agencies, both in kind and in strategic, long term investment. We want Tameside to be a place where this contribution and the role of VCFSE is fully realised, one where being local with deep roots and adding social value into communities is fully acknowledged and where we can truly strengthen and grow the VCFSE's capacity to meet local needs and aspirations.

5.8 **PACT Commitments**

(3a) Publish the current spend (contracts, grants, and small grants) with the local VCFSE and what the aspiration is, with a plan in place to meet the aspiration.

(3b) Develop mutually respectful mechanisms in awarding funding (with early communication and timely decisions). Grant fund whenever feasible and with processes that are particularly mindful of what works with small community organisations and social action; and commitment to support with core funding.

(3c) Implement and monitor best practice on Social Value Frameworks that value local knowledge and track record and maximise investment secured through social value to the VCFSE.

6. RECOMMENDATIONS

6.1 As set out on the front of the report.

[3] State of Sector 2017 (Action Together) Centre for Regional Economic and Social Research Sheffield Hallam University - Total income in VCFSE in 2014/15 is estimated at £53 million.

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Report to:	**TAMESIDE HEALTH AND WELLBEING BOARD**
Date:	28 June 2018
Executive Member Reporting Officer:	Gill Gibson, Director of Quality and Safeguarding Dr Anna Moloney, Consultant Public Health
Subject:	**HEALTH PROTECTION UPDATE: SEASONAL FLU IMMUNISATION PROGRAMME AND OUTBREAK CAPABILITIES PLAN**
Report Summary:	This report is in 2 sections the first of which is the annual seasonal flu programme performance update. A National Flu Immunisation Guidance letter has been issued for the 2018/19 season. The success of the seasonal flu programme is dependent on the collaboration of many stakeholders across the Greater Manchester and local health and social care system. The role of targeted communications is pivotal to the success of the flu campaign. The Tameside and Glossop CCG performance for the 2017/18 seasonal flu performance is summarised. The second section of the report discusses the Outbreak Capabilities Plan to assure Board that local stakeholders have robust arrangements for a range of outbreak scenarios.
Recommendations:	Health and Wellbeing Board to note and comment on: 1. Local performance for the 2017/18 seasonal flu programme plus the arrangements for the 2018/19 flu immunisation programme and the relationship between programme success and winter preparedness planning. 2. Local stakeholders have worked collaboratively to produce an Outbreak Capabilities Plan that details our response to a range of outbreak scenarios. It is important for participating organisations to support staff to engage in appropriate exercising to embed the multi-agency response to an outbreak and create familiarity over key tasks.
Links to Health and Wellbeing Strategy:	Health protection is a core foundation programme of the strategy. Seasonal flu immunisation is a national targeted immunisation programme. It makes an important contribution to the health of older people and vulnerable groups including those with long term conditions and those living in residential care.
Policy Implications:	It is a national programme commissioned by NHS England. The Local Authority has an oversight role in assuring the delivery of a high quality effective flu immunisation programme and in doing so will have due regard to principles 3 and 5 of the NHS constitution: Principle 3: The NHS aspires to the highest standards of

	excellence and professionalism Principle 5: The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
Financial Implications: (Authorised by the Section 151 Officer)	It is essential that the associated resource allocations are utilised effectively to ensure immunisation plans in are in place to reduce the impact of the related demand on health and social care services. The implementation of health protection and preventative strategies are also crucial to enable the locality to close the projected financial resource gap over the medium and longer term.
Legal Implications: (Authorised by the Borough Solicitor)	Local authorities have a statutory duty to have regard to the NHS Constitution (patients charter) when exercising their public health functions under the NHS Act 2006: https://www.gov.uk/government/publications/the-nhs-constitution-for-england In particular, this means that when making a decision relating to public health functions, a local authority must properly consider the Constitution and how it can be applied, in so far as it is relevant to the issue in question. The report author confirms compliance with the NHS constitution in undertaking this programme.
Risk Management:	National programme commissioned by NHS England.
Access to Information:	The background papers relating to this report can be inspected by contacting Dr Anna Moloney Telephone: 0161 342 2189 e-mail anna.moloney@tameside.gov.uk

1. PURPOSE

1.1 The first section of this report reflects on the local and comparative performance of the national flu immunisation programme which is commissioned by the National Health Service England (NHSE). It highlights arrangements for next year's flu immunisation programme in response to national guidance with the aim of maximising uptake in targeted populations. The prevention of seasonal flu is one of the factors that is considered part of NHS winter preparedness plans.

1.2 The second section of this report discusses local assurance with regard to outbreak management by the Outbreak Capabilities Plan.

2. PARTNERS' ROLES AND RESPONSIBILITIES: NATIONAL FLU IMMUNISATION PROPGRAMME

2.1 The successful implementation of the national flu plan is dependent on a range of organisations fulfilling their roles. These responsibilities are summarised below:

2.2 Department of Health (DH) – National programme policy decisions and oversight of the supply of antiviral vaccines. It holds NHSE and Public Health England (PHE) to account.

2.3 Public Health England – The Greater Manchester Screening and Immunisation Team (GMSIT) implement the national approach across the city region with the support of their named co-ordinators for each locality. They undertake surveillance and provide specialist advice to clinical providers.

2.4 NHSE - Commission the flu vaccination programme. This includes commissioning of the flu immunisation school provider that is currently delivered for Tameside by Intrahealth.

2.5 Local Authorities – Directors Public Health (DsPH) provide oversight and advocacy to ensure good access to flu vaccination. Public Health provide leadership with partners if required to respond to flu outbreaks.

2.6 Clinical Commissioning Groups (CCGs) – Provide quality assurance and improvement of primary care services delivering the flu plan. Commissioning of flu immunisation for pregnant women is via the GM maternity services specification.

2.7 GP Practices are responsible for vaccine ordering for their eligible practice population and issuing patient invitations. Practices can prescribe antiviral medication according to Department of Health (DH) policy. They also facilitate flu vaccination of their own staff as an employer.

2.8 Pharmacists can choose to deliver the national flu vaccination specification where all eligible adults can choose to receive their vaccination by a participating pharmacist.

2.9 NHS and Social Care Employers - Management of flu vaccination for frontline staff.

3. NATIONAL GUIDANCE

3.1 A National guidance letter was issued in March 2018 for the 2018/19 flu immunisation programme and the key elements are highlighted below.

3.2 There has been one change in the programmes eligibility criteria with the extension of the school based programme to include children in year 5. Therefore the groups eligible for the 2018/19 programme are:

- Those aged 65 year or over (delivered by GP practices, pharmacists)
- Those aged under 65 in a clinical at risk group (delivered by GP practices, pharmacists)
- Pregnant women (delivered by midwives, GP practices, pharmacists)
- All 2 and 3 year olds (delivered by GP practice)
- Children in reception class and Year 1, 2 ,3, 4 and 5 (delivered by Intrahealth)
- Frontline health and social care workers (delivered by employer)
- People living in long stay residential care homes or other long stay facilities (delivered by GPs)
- Carers (delivered by GPs, pharmacists)

3.3 The national targets and interim ambitions are the unchanged for 2018/19 with the exception of the preschool programme where it is now set at 48% and for the school programme it is also increased to 65%; both targets having been increased from a 40% lower limit that was set during the 2017/18 season.

3.4 Flu vaccination of preschool and school aged cohorts is important for their own protection and also to reduce the risk of transmission in communities.

3.5 NHSE issued an enhanced service specification in late November 2017 for the vaccination of care home workers by a registered residential/nursing home or registered domiciliary care provider. Therefore GP practices and participating pharmacists could choose whether to sign up. In addition, locally we ran an adjunct to this national scheme via primary care offering vaccination to staff working in care homes or if a home care worker through the ICFT occupational health service vaccination flu clinics. We are awaiting a decision by NHSE whether these staff groups will be included in the national programme for the 2018/19 season.

3.6 Flu is one of the factors that the health and social care system considers as part of its winter preparedness plans. Risks to programme success are mainly related to vaccine effectiveness, disruption to supply networks or a change in the predicted circulating flu strains. Risk mitigation plans are prepared by PHE, NHSE and DH. Local surge and outbreaks plans would need to be activated if there were extra cases placing pressure on care locally.

4. VACCINES AND FLU STRAINS

4.1 The predominant flu strains that circulated during 2017/18 were Flu A (H3N2) and Flu B. All the vaccine offered to children and adults covered the Flu A (H3N2) strain. People over the age of 65 are slightly more likely to catch the Flu A H3N2 strain. Children in eligible groups received a quadrivalent vaccine as this group are more likely to be affected by Flu B. Protection against the Flu B strain “Yamagata” which circulated in 2017/18 was contained in the quadrivalent vaccine but not in the 2017/18 trivalent vaccine. However, children who had been immunised would have provided indirect protection to the adult population as they often pass on flu to other family members.

4.2 For the forthcoming flu season the Joint Committee on Vaccination and Immunisation (JCVI) has concluded that an adjuvanted trivalent vaccine (aTIV) is more effective and highly cost effective in those aged 65 and over compared to the vaccine used in the 2017/18 season for adults. JCVI also recommended that adult at risk groups under 65 receive the quadrivalent vaccine which will offer protection against 2 strains of Flu B rather than one seen in the trivalent vaccine. On average use of the quadrivalent vaccine is likely to lead to reduced activity in terms of GP consultations and hospitalisations. The aTIV vaccine will be delivered to providers in phases for the 18/19 only; this is to ensure the availability of the vaccine is

equitably distributed nationally. Therefore providers will need to prioritise within their over 65 population at the start of the flu season to protect the most vulnerable individuals.

5. MONITORING

5.1 Monitoring involved immunisers recording activity on the national IMMform system from 1st September until the official end of flu season March 2018. Practices are notified of any flu vaccinations administered by third parties such as local pharmacists, midwives and Intrahealth, the school programme provider. Throughout the flu season PHE publish a weekly flu report detailing levels of circulating flu strains.

5.2 Public Health England has provided summary data for the 2017/18 season across the North West. Laboratory detections (PHE NW laboratory data): from week 27 2017 to week 15 2018 found there for both influenza A and B, this was the highest number of detections seen since the 2010/11 season. In the North West most outbreaks were reported by care homes (87%). 61% of outbreaks were confirmed as Flu A and 42% confirmed as Flu B (4% of confirmed outbreaks had both A and B identified). Locally we had one confirmed flu outbreak in a care home.

6. COMMUNICATIONS AND PROMOTION

6.1 Excellent communications are pivotal to the successful promotion of the seasonal flu programme. The 2017/18 season delivered a comprehensive campaign locally and in partnership with GM Health and Social Care Partnership. The national "Stay Well this Winter" campaign was the overarching link to our communications plan that encompassed press releases, articles in the Citizen, a taxi wrap, bus adverts and banners as well as using social media, through all available channels. Messages were sent to convey the universal importance of good respiratory etiquette when coughing and sneezing; and target information to at risk groups. In addition, local flu clinic timings were advertised. The content was adapted to reflect the issues arising from the flu teleconferences held with stakeholders, as the season progressed. The local communications campaign has been reviewed and an updated communication plan is in progress for the forthcoming season.

6.2 Flu campaign material and training resources can be accessed on https://www.gov.uk/government/collections/annual-flu-programme

7. PERFORMANCE

7.1 Within GM there were 1,217,028 people eligible for the influenza (flu) vaccine in 2017/18 across the GM Health and Social Care Partnership (GMHSCP) area (according to provisional data), an increase of 82,646 people from the 2016/17 eligible cohort. GMHSCP was the highest ranked area (out of 25) in uptake among those individuals in at risk groups aged 6 months to 65 years, and the second highest performing amongst all pregnant women, and for those aged 65 or over. There has been significant improvement in the average (mean) uptake of the vaccine in school aged children across GM in comparison to 2016/17, with over 10% improvement demonstrated across all eligible age cohorts in all 10 GMHSCP Local Authorities (LAs).

7.2 Table 1 compares the Tameside and Glossop CCG performance for 2017/18 against our uptake position in 2016/17 with GM and national comparators (England). We achieved higher uptake in all risk groups compared to the GM and national average. We have improved our performance position locally for the over 65 age group and 2 and 3 year olds. The latter group was a key focus of our campaign. Our local position in 2017/18 has dipped for

pregnant women and under 65 clinical at risk groups and this has been discussed with stakeholders.

Table 1: Comparative National /GM ranking and flu vaccination uptake for 2016/17 and 2017/18

	2016/17	2017/18	Target/Ambition	National and GM uptake 2017/18	Tameside and Glossop CCG 2017/18 % uptake (2016/17 in brackets)
For those aged 65 or over					
National Rank*	18	29	75%	72.6%	75.9% (74.4%)
GM Rank	4	4		75.4%	
Clinical at risk groups aged 6 months to 65 yrs					
National Rank	11	11	55%	48.9%	54.7% (55.8%)
GM Rank	4	3		52.4%	
Pregnant Women					
National Rank	11	45	55%	47.2%	52.7% (54.4%)
GM Rank	2	4		52.1%	
2 year olds					
National Rank	144	92	40% -65%	42.8%	44.8% (38.5%)
GM Rank	6	4		43.5%	
3 year olds					
National Rank	92	99	40%-65%	44.2%	46.1% (43.7%)
GM Rank	6	4		45.1%	

• National ranking is out of 209 CCGs Data Source: HSCP.

7.3 **Tameside Schools Flu Programme Performance (Ambition 40%-65%)**
Tameside's local performance for the school based programme compares favourably to the GM and national average, as shown in Table 2. There has been a significant improvement in 2017/18 especially with children of reception age where the setting for delivery changed to schools. Glossop schools uptake is reported with Derbyshire data.

Table 2: Tameside schools performance 2017/18 and 2016/17 with comparative GM and national data.

	2017/2018						2016/2017			
Local Authority	**Reception**	**Year 1**	**Year 2**	**Year 3**	**Year 4**		***Reception**	**Year 1**	**Year 2**	**Year 3**
Tameside	68.6%	65.4%	63.9%	63.7%	60.2%		27.7%	56.6%	54.1%	50%
GM	63.2%	61.2%	60.8%	58.1%	56.9%		32.3%	51.9%	50.2%	47.5%
England	62.6%	60.9%	60.3%	57.5%	55.7%		33.9%	57.6%	55.3%	53.3%

*Reception age children were immunised by primary care in 2016/2017

7.4 **Frontline HealthCare Workers**

ICFT undertook a proactive campaign for staff vaccination with the quadrivalent vaccine. NHSE has published a 2 year CQUIN covering 17/18 and 18/19 which includes an indicator to improve the uptake of flu vaccinations for frontline healthcare staff within providers. The CQUIN target for 2017/18 (Year 1) was 70% and it is rising to 75% in the second year. The ICFT reported 67% which but fell short of the 70% CQUIN target in year 1. The ICFT were short 94 staff (out of a denominator of 2874) to hit the 70 % target. Uptake varied across staff groups. ICFT have reflected on the outcome and are using the learning from the 2017/18 campaign to devise their implementation plan for 2018/19.

7.5 **Performance improvement**

An annual flu debrief occurs at the conclusion of the season when PHE performance reports are released to localities. The essence of action for all stakeholders involved is effective continuous communication to promote awareness of the vaccination among at risk groups, their carers and frontline health and social care staff. Primary care colleagues have received information on performance at a practice, neighbourhood and locality level. A key strategy is to continue to improve the uptake in children as this will not only protect them but reduce the circulation of flu in families and the wider community. The earlier the vaccinations for children are delivered will facilitate a reduced risk of flu spreading. We will continue to improve our overall performance across all age groups. It needs to be noted that denominator populations are increasing for adults hence providers are working harder to deliver more vaccinations for an equivalent uptake. The National Institute for Clinical Effectiveness (NICE) is working on guidance for increasing uptake in and is expected to be published in July 2018. The local Flu Working Group will use the guidance to assess local arrangements.

8. GOVERNANCE

8.1 The Tameside Health Protection Group oversees the co-ordination of the local seasonal flu campaign. In addition the Flu Working Group holds a monthly teleconference/meeting with a wider range of stakeholders, including Public Health England to update on performance, national and local communications and agree key actions as the season unfolds. It also meets to hold an annual flu debrief which occurred in March 2018. Our first meeting of the 2018/19 season is in June 2018 as we enter the preparation phase. The GM SIT has also held its annual debrief with local flu leads in May 2018.

9. OUTBREAK CAPABILITIES PLAN

9.1 Maintaining and improving the health of our communities is at the heart of Health Protection and ensuring an effective response to outbreaks of disease is a crucial part of this. Whilst the response to outbreaks isn't new and our local health economy routinely demonstrates that it has effective arrangements in place, it is important that we review our arrangements with the organisations and people who need to work together, cognisant of each other's roles and responsibilities for a range of scenarios.

9.2 The Outbreak Capabilities Plan (OCP) plan has been developed to ensure clarity on operational roles and responsibilities for each responding organisation in the event of an outbreak. It is intended to act as a companion to the GM Multi-agency Outbreak Plan, providing operational detail helping responders quickly provide an effective and coordinated approach to outbreaks of communicable disease. It is important for participating organisations to support staff to engage in appropriate exercising to embed the multi-agency response to an outbreak and create familiarity over key tasks.

9.3 Responsibility for managing outbreaks is shared by all the organisations who are members of the Outbreak Control Team (OCT). This responsibility includes the provision of sufficient

financial and other resources necessary to bring the outbreak to a successful conclusion. The great majority of incidents and outbreaks are dealt with as part of normal service provision, and may not impact greatly on routine services or require an OCT to be convened. On occasion, outbreaks are of such magnitude that there may be significant implications for routine services and additional resources are required. In this instance the Director of Public Health may declare a major outbreak / incident and therefore the major incident plans of organisations affected will be invoked as appropriate.

9.4 The Tameside OCP has been to the Health Protection Group and the Tameside and Glossop Health Emergency Resilience Group (HERG). It has been forwarded to Civil Contingencies Resilience Unit (CCRU) as part of their suite of plans to ensure we have a resilient city region. The Local Heath Resilience Partnership (LHRP) has oversight of all the OCPs from the GM 10 boroughs.

9.5 As the OCP contains confidential information, queries should be addressed to the report author.

10. RECOMMENDATIONS

10.1 As set out on the front of the report.

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	28 June 2018
Executive Member / Reporting Officer:	Jacqui Dorman Public Health Intelligence Manager
Subject:	**JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)**
Report Summary:	This report contains information about the new 'Life in Tameside and Glossop' website and the summary Joint Strategic Needs Assessment 2017/18.
Recommendations:	The Health and Wellbeing Board is aware of the new website that supports the Joint Strategic Needs Assessment process.
Links to Health and Wellbeing Strategy:	As previously reported the Health and Social Act (2012) requires that Health and Wellbeing Boards produce a Joint Strategic Needs Assessment for their area that is refreshed on an annual basis. The Joint Strategic Needs Assessment is now produced as an online tool, meaning we can keep the data more up to date than we could previously and is more accessible to all partners across Tameside and Glossop. An annual refresh summary is also produced and is available on the new portal.
Policy Implications:	From the 1 April 2013 every Health & Wellbeing Board in England has a statutory responsibility to publish and keep a up to date a Joint Strategic Needs Assessment
Financial Implications: (Authorised by the Section 151 Officer)	There are no immediate direct financial implications arising from the report. However, it is essential that the joint strategic needs assessment is considered when determining the prioritisation of locality resource allocations.
Legal Implications: (Authorised by the Borough Solicitor)	From the 1 April 2013 every Health and Wellbeing Board in England has a statutory responsibility to publish and keep an up to date Joint Strategic Needs Assessment. This new website supports the Joint Strategic Needs Assessment process.
Risk Management:	The Health and Wellbeing Board need to ensure the delivery of the Joint Strategic Needs Assessment, which is robust enough to inform local commissioning plans. The Health and Wellbeing Board must be able to demonstrate need within Tameside and Glossop to enable commissioners to make decisions about services and interventions delivered across the borough.
Access to Information:	All papers relating to this report can be obtained by contacting: Jacqui Dorman, Policy, Communication and Performance Telephone: 07813871010 e-mail: Jacqui.dorman@tameside.gov.uk

1. LIFE IN TAMESIDE & GLOSSOP (JSNA)

1.1 Local information is vital to us, our partners and our residents when making key evidenced based decisions. Advances in technology have resulted in new and advanced methods to support decision-making. For example, data observatories and web based information systems have enabled people to make better decisions. Emerging research into Decision Support Systems demonstrates that decision makers can operate in a more timely manner using real-time data, more accurately due to data mining and 'big data' methods, more strategically by considering a greater number of factors, more precisely and inclusively due to the availability of social networking data, and with a wider media reach with video and audio technology.

1.2 We need good information to effectively manage our health and social care system. Tameside's health and social care system faces a growing challenge: doing more and better with less. Good information is crucial to achieving a high-performing and sustainable health and social care system that is also safe and responsive to the needs of our residents.

1.3 The value of better information use for health and social care decision-making has never been stronger, nor has the time for concerted action been more appropriate. Working together toward a shared vision of *better information for improved health and wellbeing outcomes* can help us realise an important opportunity to achieve the best possible health, the highest-quality care and a sustainable, efficient health and social care system.

1.4 With the emergence of a fully Integrated Care Organisation for the borough, it is vital that commissioning decisions are based on timely and robust information and evidence. Traditional methodologies that highlight the needs of a population or how services are utilised are report based that are costly in both time and capacity.

1.5 Technology that enables all secondary use data and information to be stored in one place that is available to the fingertips of the commissioner at the point of need; that enables the commissioners for the Integrated Care Organisation to make effective and appropriate decisions is the strategic objective for making a difference to how we commission services in the future.

1.6 For our residents to make decisions about their own health and wellbeing and care, it is also important that information is available to them that is appropriate to them and where they live.

1.7 The provision of health information to patients and the public is now firmly embedded in health policy across the UK. There are powerful legal, moral, ethical and financial incentives for providing quality information to enable people to better manage their health and wellbeing and make fully informed decisions about their treatment and care. Providing access to good quality health information, and the support to use it, is the key to unlocking much sought after and much needed patient and public engagement.

2. THE TAMESIDE AND GLOSSOP JSNA (LIFE IN TAMESIDE AND GLOSSOP) WILL DO THIS A MORE

2.1 The JSNA website will bring data, intelligence and evidence from all health and social care partners into one easily accessible and useable website.

2.2 The home page has the key headliners for the borough and the most frequently asked for statistics, latest news, document releases and statistics for the area.

2.3 The web portal will also have a complete directory of data sets covering the whole life course and geodemographic information and more.

2.4 The website includes a 'Find Support' directory that will enable commissioners to audit current provision across the borough (Assets) and support social prescribing for our residents that is appropriate to their needs.

3. IN SUMMARY

3.1 In view of reduced capacity across the Tameside and Glossop health and social care economy, ensuring data and information is available to those who need it at the point of need is more important than ever. Holding the information in one place and creating a portal that is easy to use and accessible to all is a cost effective way of enabling everyone across Tameside and Glossop to access the knowledge and information they need. The website also supports our statutory responsibility to produce a JSNA.

3.2 The publics' ability to engage depends on finding and using information to increase their understanding, and being supported to develop the motivation, confidence and care skills needed to actively manage and improve their own health. There is clear evidence that more knowledgeable residents enjoy better health outcomes and incur lower costs. Investing in high quality consumer health information and support, therefore, is not only the right thing to do from an ethical standpoint as a crucial element of patient centred care; it is also a financial and clinical imperative.

3.3 The Life in Tameside & Glossop portal is accessible here:

https://www.lifeintamesideandglossop.org/

Please note we are still in the process of adding information into the 'Find Support' pages as the mapping of assets is still on going.

3.4 Attached is the JSNA summary of health and wellbeing for 2017/18

4. RECOMMENDATION

4.1 As set out on the front of the report.

Tameside Metropolitan Borough

NHS Tameside and Glossop Integrated Care NHS Foundation Trust

NHS Tameside and Glossop Clinical Commissioning Group

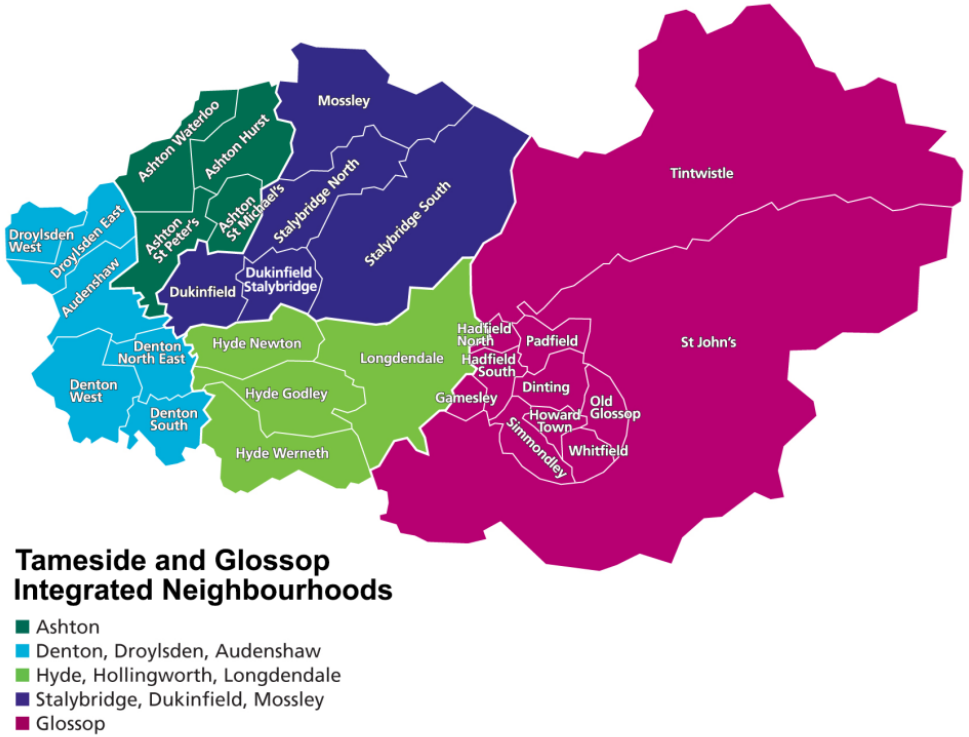
Joint Strategic Needs Assessment for Tameside

2017/18

TAMESIDE AND GLOSSOP Caretogether

SUMMARY OF HEALTH & WELLBEING

Due to the unique position of the local authority and local CCG, where a single commissioning function exists between the council and CCG for health and social care This JSNA summary of health and wellbeing is for Tameside but includes both Tameside only and Tameside and Glossop information, as the CCG commissions health services for both Tameside and Glossop. Therefore the information contained in this JSNA summary will cover both Tameside only and Tameside and Glossop. Please note that publicly available Public Health data is based at Local Authority level and not CCG level. Information in this summary is for Tameside only unless otherwise stated.



The local view of Health and Wellbeing in Tameside

The Tameside area of Greater Manchester sits on the edge of both the Pennines and the Peak District. Tameside is named after the river Tame which flows through the borough and spans the areas of Ashton-under-Lyne, Audenshaw, Denton, Droylsden, Dukinfield, Hyde, Longdendale, Mossley and Stalybridge. Tameside borough shares its border with Manchester, Stockport, Oldham and the borough of High Peak. Glossop is a market town in the High Peak, Derbyshire, about 15 miles (24 km) east of Manchester. Historically, the name Glossop refers to the small hamlet that gave its name to an ancient parish recorded in the Domesday Book of 1086.

The resident population of Tameside and Glossop is approximately 254,646, (13% Glossop, 87% Tameside) with the GP registered population currently being 245,511, meaning that the health economy of Tameside and Glossop doesn't serve all the residents of Tameside and Glossop, with around 4% receiving health and social care services outside the Tameside and Glossop boundaries..

Population

More people now live in Tameside than at any time in the past, with population projections estimating that this will continue to increase over the next 10 years.

The ethnic composition of the Tameside population is also changing, with the current Census (2011) showing that 15.8% of the local population are from an ethnic minority group; this is an increase from the last Census (2001) of 7.4%.

Health & Well-being

The issues for health & wellbeing in Tameside are complex and often lie outside the traditional health and care services. It is widely recognised that social and environmental determinants and their interdependencies influence the health and wellbeing outcomes of our population and communities.

As the population continues to grow, age and change, so too will the demand for health and social care services across the area, thus a need to enable our population to live as long as possible in good health, illness and disability free to ensure services can cope with increased demand and that health and social care are affordable to the local economy.

Changes in the ageing population now are currently contributing to the increased demand on health and social care services. The demands on these services will continue as people live longer and the dynamics of the ageing population changes. The number of carers will also increase as more people live longer and therefore it is important to have responsive flexible arrangements in place to support people caring for others and to support people who want to live independently; this will create an health and social care culture where the need for secondary hospital services are a last resort.

Demand for early years and school age children's services is also on the increase therefore children's service will need to adapt and respond to take into account the changing diversity of the population going forward.

Health and Well-being at a glance

- The health and well-being of people in Tameside is generally worse than the England average, with the exception of a few wards.
- Deprivation is higher in Tameside with over 10,560 children under 16 years living in low income families. A decrease from previous years.
- Life expectancy at birth for both males and females is lower than the England average (approx. 77.3 years males, 80.7 years females)

- Life expectancy locally is 10.4 years lower for men and 8 years lower for women in the most deprived areas of Tameside compared to the least deprived areas.
- Healthy life expectancy at birth is currently **56.4 years** for males in Tameside and **58.8 years** for females in Tameside. This is significantly lower than the England averages but an improvement on previous years.
- In year 6, 33.9% of children are classified in the excess weight category, an decrease on previous years, GCSE attainment, under 18 alcohol specific hospital admissions, hospital admissions for self-harm and injuries, breast feeding initiation and at 6 to 8 weeks and smoking in pregnancy are all significantly worse than the England average.
- Rates of smoking related deaths and hospital admissions for alcohol harm are significantly higher than the England average
- Deaths from Cardiovascular disease in 2014/16 show that 594 people (104.1/100,000) in Tameside died prematurely, higher than the England average (73.5/100,000).
- Deaths from Cancer in 2014/16 show that 894 people (156.5/100,000) in Tameside died prematurely, higher than the England average (136.8/100,000).
- Deaths from Respiratory disease in 2014/16 show that 248 people (43.7/100,000) in Tameside died prematurely, higher than the England average (33.8/100,000).

Useful Information:

Longer Lives: http://longerlives.phe.org.uk

Public Health Outcomes Framework: fingertips.phe.org.uk/profile/public-health-outcomes-framework

Tameside Health Profile: fingertips.phe.org.uk/profile/health-profiles

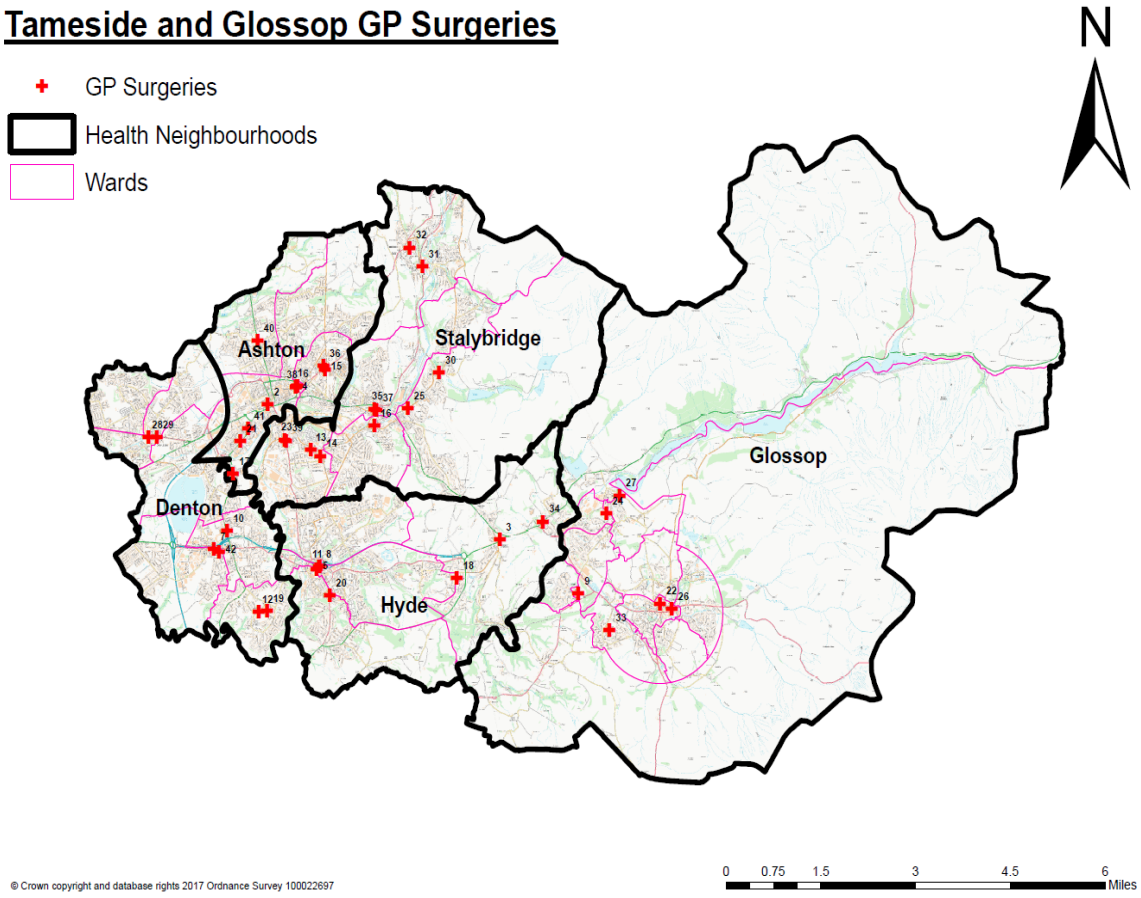
General Practice Profiles: finger tips practice profiles

Tameside Child Health Profile: fingertips.phe.org.uk/child-health/profile

Older Peoples Health & Wellbeing: https://fingertips.phe.org.uk/profile/older-people-health/

Inequalities

Tameside and Glossop is split into five neighbourhoods; Ashton, Denton, Glossop, Hyde and Stalybridge, with 40 general practices serving the five neighbourhoods in total. Of the 40 practices 34 practices (85%) are more deprived than the England avearges, with 21 practices (53%) being more deprived than the Tameside and Glossop average. There are five practices in Tameside and Glossop that fall into the 10% most deprived practices in the country. (Hattersley Group Parctice, Ashton GP services, West End medical centre, Cottage Lane surgery, Stamford House). These practices are in the neighbourhoods of Ashton, Glossop and Hyde.



Tameside and Glossop is also broken into to 30 wards. 19 within the Tameside boundary 11 within the Glossopdale boundary. Health and Wellbeing outcomes across these wards varies considerably with poor health outcomes such as disaese prevalence and premature mortality being significantly higher in the wards of St Peters, Gamesley and Hadfield North.

Health inequalities are the differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives.

Some differences, such as ethnicity, may be fixed. Others are caused by social or geographical factors (also known as 'health inequities') and can be avoided or mitigated.

In England, the cost of treating illness and disease arising from health inequalities has been estimated at £5.5 billion per year. In terms of the working-age population, it leads to productivity losses to industry of between £31–33 billion each year. Lost taxes and higher welfare payments resulting from health inequalities cost in the region of £28–32 billion. Estimating the costs of health inequalities: A report prepared for the Marmot review).

The following JSNA summary will enable commissioners and service providers to better understand the complexities and needs of the population served within the Tameside and Glossop health and social care economy. A wider set of statistics and information will be available on the Life in Tameside & Glossop JSNA website. www.lifeintamesideandglossop.org This summary takes the data that has been collected, collated and analysed and pulls out the key issues, challenges and improvements that effect our population across the life course.

Starting and Developing Well

EARLY YEARS and PRE SCHOOL

The early years are a key determinant of health. The Marmot Review recognised this in its priority policy objective - 'Give every child the best start in life' - which is crucial to reducing health inequalities across the life course, and other social and economic inequalities throughout life.

The foundations for virtually every aspect of human development - physical, intellectual and emotional - are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being - from obesity, heart disease and mental health, to educational achievement and economic status.

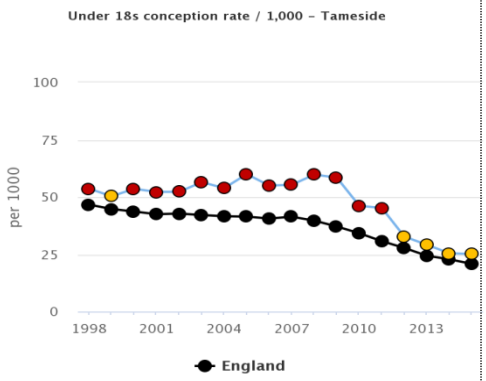
The following are key findings across Early Years. More information can be found here Overview of child health

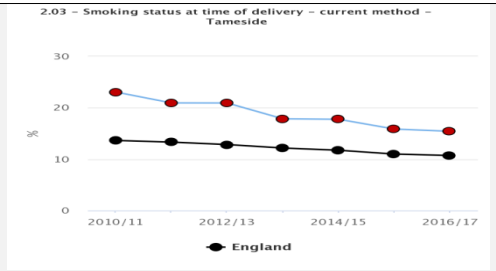
Population of children under 5 years

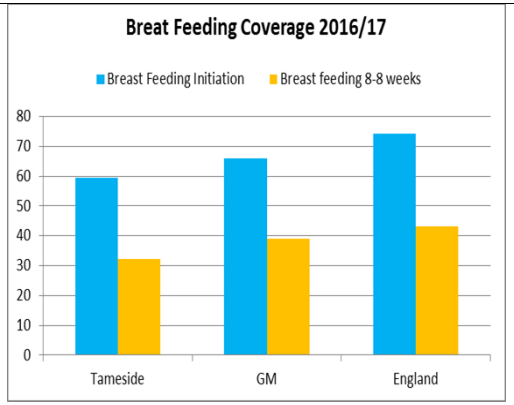
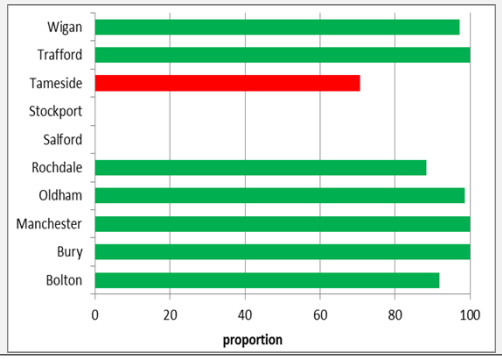
Across Tameside and Glossop there are approximately 14,847 children under the age of five years.

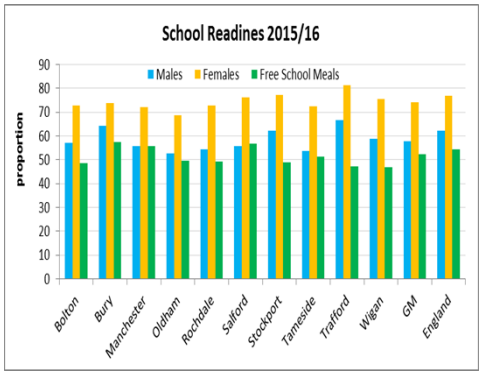
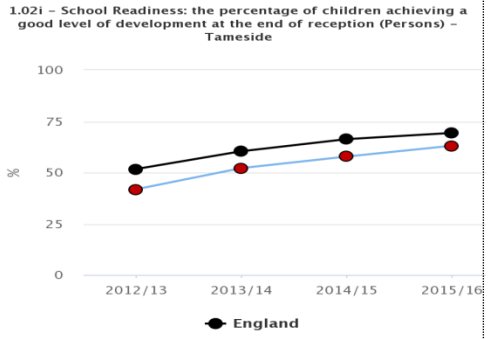
In 2016 there were 2,886 babies born in Tameside, with 21% of babies born in the most deprived quintile. 11% of babies were born with a low birth weight, with 7% being of very low birth weight (<1500 grams) and the highest proportion of births was born to mothers aged 25-34 years (61%). 1% of babies were born to women under 18 years; 10% 18 to 24 years and 29% to women over the age of 35 years.

	Outcome	Challenge	Implications	Recommendations
1.	Children in low income families	There are nearly a quarter of under 16s living in low income families across Tameside and Glossop (23.7%), this equates to around 10,473 children compared to 20.1% in England. The highest proportions of these children live in the wards of Gamesley, St Peters, Ashton St Michaels and Hyde Newton.	The Marmot Review (2010) suggests that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy. Children born in the poorest areas of the UK weigh, on average, 200 grams less at birth than those born in the richest areas. Children from low income families are more likely to die at birth or in infancy than children born into richer families.	Increase opportunities for parents to work and to work in well paid employment. Support parents from more deprived backgrounds at the pre-birth stage more. Reduce smoking in pregnancy, increase pre-birth health visiting visits to parents to be from the most deprived backgrounds to ensure they are fully prepared for birth.

			They are more likely to suffer chronic illness during childhood or to have a disability.	
2.	< 18 Conceptions	The under 18 conception rate for Tameside in 2015 was 25.1 per 1,000 15 to 17 year olds a 1% decrease from 2014 and now similar to the England average of 20.8  	Poverty and deprivation are strongly associated with teenage conceptions and hence teenage pregnancy is still a significant public health priority. There are a number of associated issues with teenage parents for both the parents and the child that include, poor emotional health, poor physical health, poverty, low educational attainment and unemployment.	Enhanced sexual health education in schools where rates of teenage conceptions are highest. Women under the age of 19 years who are admitted to maternity units or who attend sexual health clinics should receive extensive information and advice on the full range of contraceptive methods available to them. All health and social care professional working with vulnerable young people should be trained to provide standard contraceptive advice or able to sign post to services
3.	Smoking at Time of Delivery (SATOD)	Smoking in pregnancy in 2016/17 is still on the decrease. However, Tameside is still significantly higher than the England average with 15.4% of women smoking throughout their pregnancy. (10.7% for England and 12.5% Greater Manchester average).	Smoking during pregnancy is related to many effects on health and reproduction, in addition to the general health effects of tobacco. A number of studies have shown that tobacco use is a significant factor in miscarriages among pregnant smokers, and that it contributes to a number of other threats to the health of the foetus, such as premature birth, complications in birth, still birth, low birth weight, asthma and other	Identify pregnant women who smoke at the earliest opportunity. Ensure clear advice to smoking pregnant women is clear about the danger of continuing smoking. Use Nicotine Replacement Therapy (NRT) or other pharmacological support. Work with the whole family re stop smoking through relevant interventions.

			respiratory conditions and sudden infant death.	
4.	Breast Feeding	[Infant feeding profile Tameside] New mums initiating breast feeding in Tameside (2014/15) was 59.6%. This is lower than both the Greater Manchester and England averages (65.9% and 74.3% respectively) and has not increased over the last 5 years. At 6 to 8 weeks breast feeding decreases further with 32.2% of babies still being breast fed (a 27.4% reduction/drop-off). For Greater Manchester 6-8 week breast feeding was 39% and for England 43.2%.	Evidence is clear on the benefits to health of breast feeding for both mother and infant. In the short term babies who are not breast fed are more likely to have infections such as gastroenteritis, respiratory and ear infections and are at particular risk of hospitalisation. The infant feeding profile for Tameside supports this as emergency hospital admissions for gastroenteritis and respiratory infections is significantly higher than the England average. In the long term, evidence shows that non-breast fed babies are more likely to be overweight or obese-this can then lead to type 2 Diabetes, higher blood pressure and cholesterol.	NICE guidance to improve breast feeding rates recommends commissioners to: Adopt a multi-faceted approach or a coordinated programme of interventions across different settings Activities to raise awareness of the benefits of, and how to overcome the barriers to, breastfeeding Training for health professionals Breastfeeding peer-support programmes Joint working between health professionals and peer supporters Education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period Work with local partners to ensure mothers can feed their babies in public areas.

				
5	Child Development at 2 to 21/2 yrs.	The proportion of children aged 2 to 21/2 yrs. offered ASQ-3 as part of the healthy child programmes (2015/16) was 70.6% (Tameside), 93.9% (GM) and 81.3 % (England). This is a new outcome measure and therefore these results are for an aggregate of 3 quarters of annual data (Q4 missing) 	Children aged 2 to 2.5 years should be offered ASQ-3 as part of the healthy child programme. This measure is important to help monitor child development in order to observe and track changes in outcomes over time. This measure will also help assess the effectiveness and impact of services for 0-2 year olds. The ASQ-3 health and development review is an important way to see how children have developed at this stage of childhood and is a good indicator of potential outcomes later on in childhood such as school readiness.	The ASQ-3 should now be an integral part of the healthy child programme and health visiting services locally. All children should be assessed and health visitors should encourage parents to complete the assessment and offer support to parents who need help to complete the assessment. The results of ASQ-3 assessment should be used to improve outcomes for children. Locally services to improve child development should be available to support parents and children to improve the areas within ASQ-3 (communication, fine & gross motor skills, personal/social skills and problem solving)
6	School Readiness	School readiness: The percentage of children achieving a good level of development at the end of reception	why school readiness is important 94% of children who achieve a good level of development at age 5 go on to	There is not one enabler to improve school readiness at age 5 years but many. 3 main enablers to improve outcomes at

		results for 2015/16. Show that for the 5th year running Tameside results for all children are improving year on year. 2015/16 results show that 63% of children were school ready, for GM and England the results were 65.7% and 69.3% respectively. Although Tameside is still significantly below the England average, the gap between Tameside and England as closed by 36% in 4 years.  	achieve the expected level of achievement at key stage 1 and 5 times more likely to achieve the highest level[1]. Children who start off in the bottom 20% of development at 5 years are 6 times more likely to be in the bottom 20% at key stage 1.  	age 5 for children include • A good early years home learning environment • Access to good quality pre-schools • Access to effective primary schools *What parents DO is more important than who parents are* measuring what matters_ Marmot

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/180884/DFE-00274-2011.pdf

Starting and Developing Well

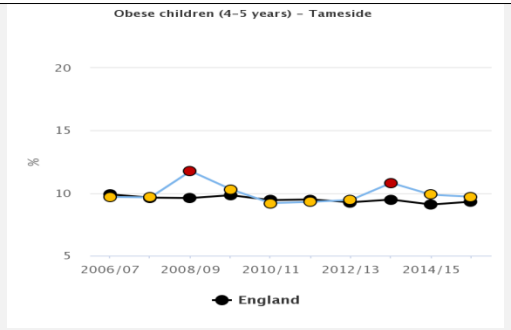
CHILDREN and YOUNG PEOPLE

Children and young people are rightly a target for population health programmes and services. The fact of their youth means there is time to prevent damaging behaviours and attitudes developing and time to help them establish good patterns of manageing their health and wellbeing for the rest of their lives.

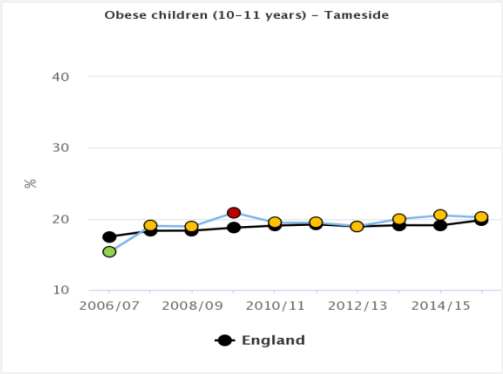
The following are key issues for children and young people in Tameside and Glossop

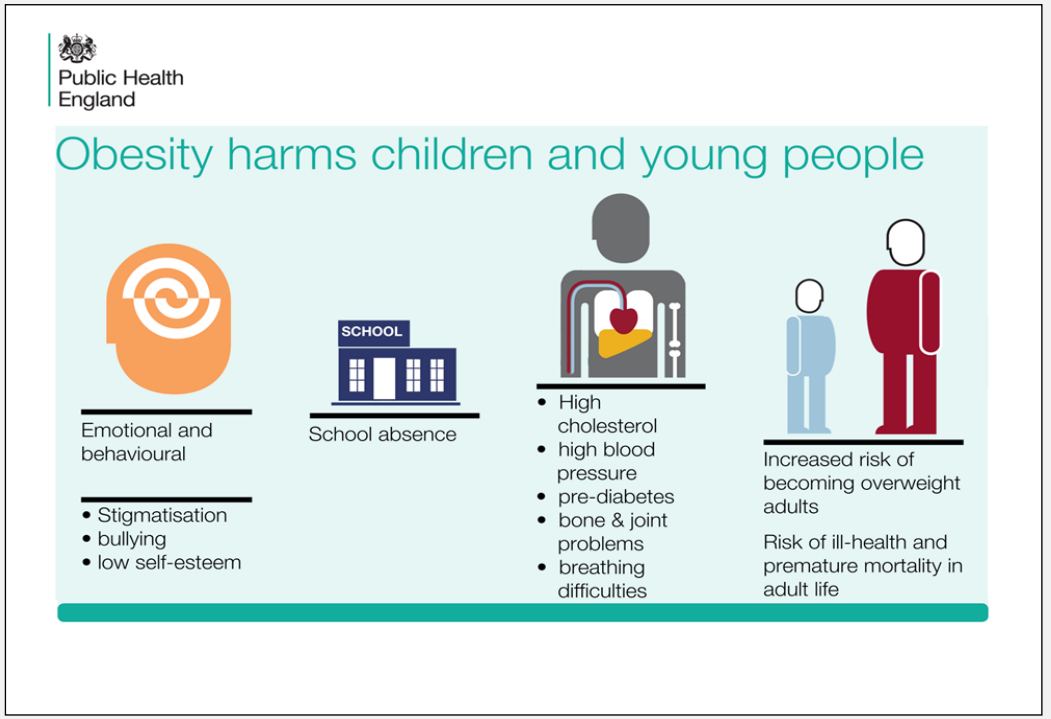
	Outcome	Challenge	Implications	Recommendations
1.	Over weight and Obesity in children and young people	The proportion of 4 to 5 year olds in Tameside that are overweight or obese in 2015/16 was 9.7% (9.7% (GM) & 9.3% (Eng.)) For year 6 children (10-11 yrs.) the proportion more than doubles to 20.2% (21.1% (GM) & 19.8% (Eng.)) Although Tameside is higher than England for both year groups, the difference is not significant. Trend for reception children	Childhood obesity, and excess weight, are significant health issues for individual children, their families and public health. It can have serious implications for the physical and mental health of a child, which can then follow on into adulthood.[2] The numbers of children, who continue to have an unhealthy, and potentially dangerous, weight, is a national public health concern.	There are many interventions to help promote healthy outcomes for children that are both individual and population based. The following link takes you to Childhood obesity: applying All Our Health It gives facts and figures on childhood obesity and principles and interventions that support individuals, professionals, communities and populations to remain a healthy weight. childhood-obesity-applying-all-our-health

https://www.gov.uk/government/publications/childhood-obesity-applying-all-our-health/childhood-obesity-applying-all-our-health



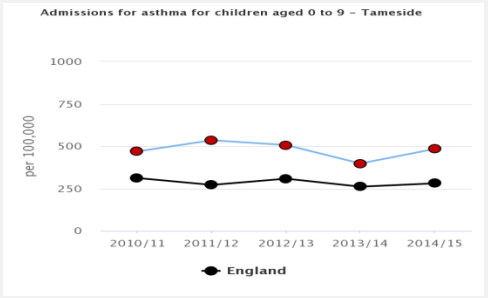
Trend for year 6 children

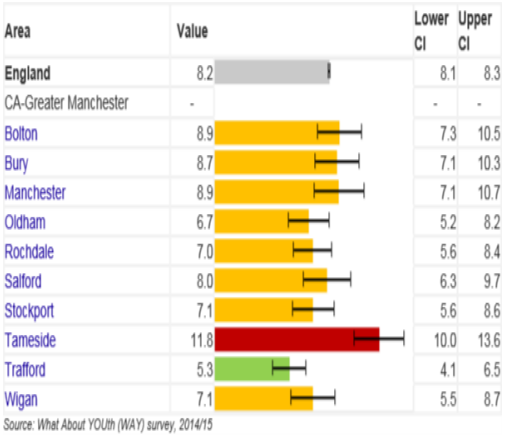




2.	Children in Care	The number and proportion of children who are looked after in Tameside in 2017 is 515 or 105 per 10,000. This is significantly higher than both the North West and England averages of 86/10,000 and 62/10,000 respectively. The rate of looked after children in Tameside is an increase on previous years and an 18% increase since 2016.[3] The following link takes you to more	Children in care are 4 times more likely than their peers to have a mental health difficulty. Children in care do less well in school than their peers. Care leavers are less likely to be in Employment, Education or Training than their peers. A disproportionate number of children and young people in care are from black and minority ethnic	Recommendations for commissioning and delivering services for looked after children should enable organisations, professionals and carers to work together to deliver high quality care, stable placements and nurturing relationships for looked-after children and young people. The National Institute for Health and Care Excellence (NICE) has produced a set of

[3] https://www.gov.uk/government/publications/local-authority-interactive-tool-lait

		information/statistics on vulnerable children and young people in Tameside. fingertips.phe.org.uk/child-health-vulnerable children and young people	backgrounds and have particular needs. Approximately 1 in 10 children in care have to move more than 3 times. 1 in 4 homeless people have been in care at some point Children who are looked after are 4 times more likely to have mental health problems I in 5 females in care become teenage parents (<18 years) www.nao.org.uk-Children-and-young-people-in-care-and-leaving-care.A.pdf	principles, guidance and recommendations to achieve better outcomes for looked after children https://www.nice.org.uk/guidance/ph28/chapter/1-Recommendations
3.	Emergency Hospital admissions for Asthma (<10 yrs.)	The rate of emergency hospital admissions for asthma is significantly worse than the England average at 483.4/100,000 0-9 year olds. But less than the GM average of 505.5/100,000 (England=280.1/100,000) 	Children account for the largest proportion of hospital admissions for asthma with higher admissions usually occurring over the autumn/winter periods. A stay in the hospital can be difficult for any child at any age. Illness and hospital stays are both stressful. They disrupt a child's life and can interfere with normal development. While children are in hospital, they may suffer from emotional distress because they are away from their family and friends. It also impacts on their education due to missed days away from school. A hospital stay for	To avoid asthma symptoms children should avoid tobacco smoke; however smoking prevalence is significantly higher than the England average and so makes it difficult for children to avoid. Therefore intervention to reduce population smoking prevalence needs to increase at pace. Air pollution is another major factor for manageing symptoms in children with asthma. Therefore measures to reduce air pollution in the borough are key in reducing hospital admissions. Good treatment and care that involves the use of prescribed inhalers and regular reviews of symptoms in primary care can

			children also impacts on the parent/carer as it means time away from work or other family members, this therefore as wider implications on the economy and population wellbeing.	prevent unnecessary hospital admissions. Care plans need to be in place for all children with diagnosed asthma to support both the child and parent/carer. Care plans should be available to school nurses so school nurses are able to identify all children in their care with asthma.
4.	Smoking at 15 years	The proportion of current and regular 15 year old smokers in Tameside is significantly worse than the England average. Current smokers at 15 yrs. 11.8% (8.2% Eng.) Regular smokers at 15 yrs. 8.9% (5.5% Eng.)  Source: What About YOUth (WAY) survey, 2014/15	Smoking at 15 years is an indication of the future prevalence of adult smokers. Smoking is still the biggest cause of premature death and morbidity. With 80% of all lung cancers, 14% of all cardiovascular conditions, 80% of chronic respiratory conditions such as COPD and 25% of all cancers being attributed to smoking. It is estimated that among children who try smoking around a third are likely to become regular smokers. Smoking initiations is associated with a wide range of factors including parental and sibling smoking, ease of obtaining tobacco products, peer pressure and peer group smoking and socio-economic status.	Children who live with smokers are up to 3 times more likely to become smokers themselves. [4] Therefore it is important to continue to reduce the adult smoking population. Research suggests that knowledge and education about smoking is a necessary component of anti-smoking campaigns, but by itself does not affect smoking rates. Price can deter children from smoking as can ease of access to tobacco products. National policy and law are one of the ways to reduce children smoking. Since 2007 the legal age for purchasing tobacco products was raised from 16-18 years, with the intention for making it more difficult for young people to buy cigarettes. A ban on the sale of cigarettes from vending machines in 2011 and a ban on displaying tobacco products will also help to deter young people from purchasing tobacco products. However, legislation alone is not sufficient, both enforcement and local community policies will improve

[4] http://ash.org.uk/category/information-and-resources/fact-sheets/

				compliance by retailers.
5	GCSE Achievement including English and maths	GCSE attainment in Tameside is similar to the England average and better than the GM average. 57.7% (Tameside), 56.1% (GM), 57.8% (Eng.) For children in care inequalities exist in achieving 5 good GCSEs with only 22% of children in care in Tameside achieving this. However Tameside fair better than both GM and England for children in care with 14.8% (GM) and 13.8% (Eng.), so the gap between all children and children in care is much narrower. https://fingertips.phe.org.uk/school age pupil outcomes	A good level of education gives young people the opportunity to earn more and be in more fulfilling careers/jobs. Ensuring children and young people are literate and numerate will also enable them to navigate their way through adulthood better, In the competitive job market, academic and vocational qualifications are increasingly important. Those without qualifications are at higher risk of unemployment and low incomes. More generally, success in acquiring formal qualifications strengthens children's self-esteem and enhances development of identity.[5]	Access to good quality educational establishments and educational teaching is key. So ensuring all Tameside schools are Ofsted rated 'Good' or above is important. Reducing the gap between all pupil attainment and those children in care is also important to improving overall standards. Improved access to high quality early years provision for looked after children is essential in ensuring children in care start their formal education on a level platform with non-looked after children. Ensuring children are ready for school at age 5 will ensure no children are disadvantages or left behind and ensuring all children with special educational needs receive the support needed to enable them to learn will also impact on overall educational outcomes for children.
6	Emergency Hospital admissions for self-harm (10-24 yrs.)	Tameside has significant levels of self-harm compared to the England average, with 609.8/100,000 (n=234) being admitted for self-harm in 2015/16. (Eng. average ~~430~~.5/100,000). Tameside has the 2nd	There are many different ways people can intentionally harm themselves, such as: •cutting or burning their skin, punching or hitting themselves, poisoning themselves with tablets or toxic chemicals, misusing alcohol or drugs, deliberately starving	When someone presents with self-harm they should be risk assessed for physical risk, emotional and mental state. The quality of care for those who self-harm depends on the quality of joint working between the A&E and hospital

[5] Machines, S in Exclusion, employment and opportunity, Case Paper No 4, Atkinson. A and Hills J, (eds), 1998, page 61. ↩

highest level of self-harm in Greater Manchester and has been increasing year on year for the last 5 years

Area	Value	Lower CI	Upper CI
England	430.5	426.5	434.7
CA-Greater Manchester	-	-	-
Bolton	524.5	464.2	590.6
Bury	398.5	332.3	474.0
Manchester	296.2	265.4	329.5
Oldham	327.4	276.0	385.6
Rochdale	269.8	221.3	325.8
Salford	523.9	460.1	594.1
Stockport	494.8	432.9	563.0
Tameside	609.8	534.1	693.1
Trafford	313.7	260.0	375.1
Wigan	700.0	631.6	773.8

themselves or binge eating or excessively exercising.
There are many reasons for self-harming such as social problems, emotional problems, trauma or psychological problems.

High levels of self-harm in the population are an indication of the level of population mental well-being.

Self-harm increases the risk of suicide and therefore needs to be treated seriously.

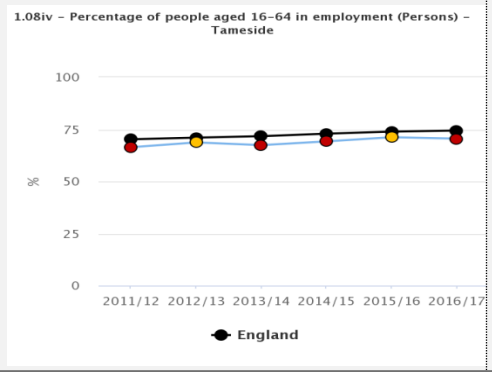
Self-harm is usually an expression of personal distress.

trust and mental health services.
It is important to understand the causes of distress and therefore improving access to talking therapies and other psychotherapy services and improving referral pathways is important.
As self-harm is related to the general mental health of the populations, improvements to overall population mental wellbeing is important.
Schools need to identify and highlight triggers to self-harm such as cyber bulling, body image and self-esteem.
Building resilient people and communities enables people and communities to deal with the challenges of daily life.

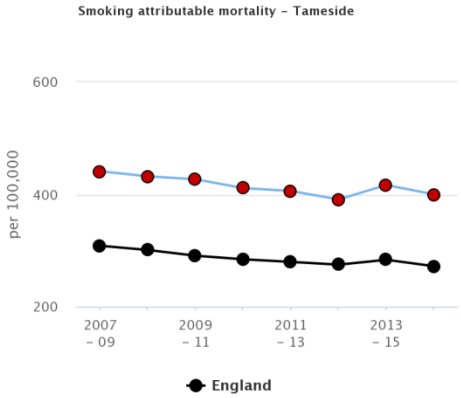
Living and Working Well

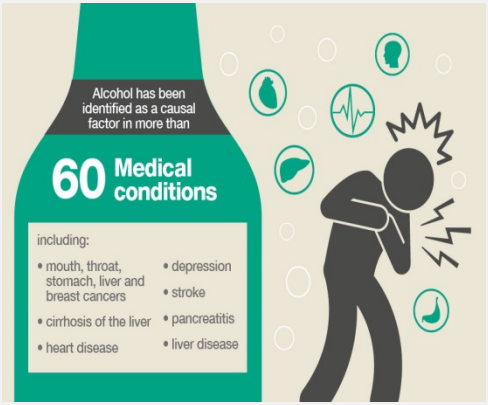
Great strides have been made in improving health and wellbeing in recent years. As an area we are living longer than ever before. However in spite of this progress we still lag behind other areas of the country and Greater Manchester. Too many people are dying too young. In Tameside and Glossop we want people to live longer in good health and able to have fulfilling lives at work and at home.

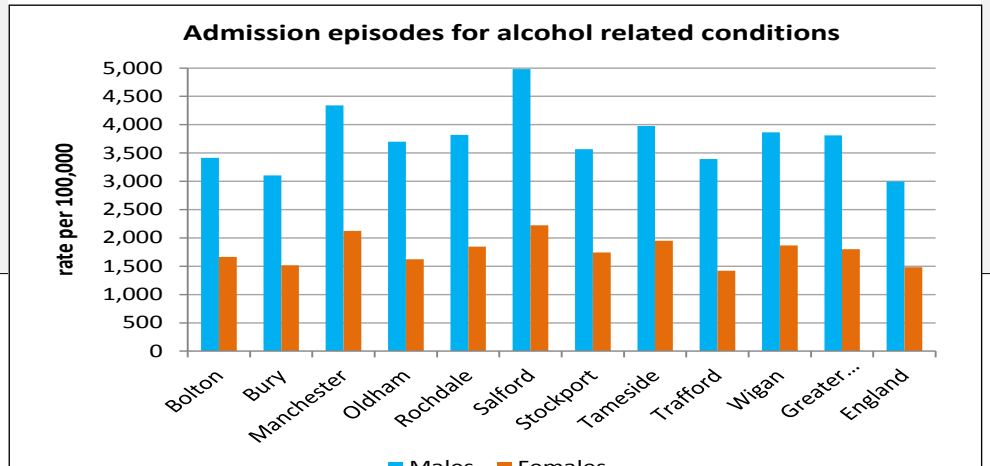
The following are key issues for Tameside and Glossop residents in relation to living and working well

	Outcome	Challenge	Implications	Recommendations
1.	People aged 16-64 years in employment (%)	Across Tameside there was 70.5% employment rate which is similar to the rest of GM (70.6%) bit less than the England average. (74.4%) The Tameside rate of employment in 2016/17 was a slight decrease on 2015/16, but an increase over previous years. Increasing employment and supporting people into work are key elements of the UK governments Public Health and welfare reform agendas. 	Evidence shows that there are economic, social and moral reasons that work is a good way to improve the wellbeing of individuals.[6] Worklessness is harmful to physical and mental health. Work is the most adequate means of obtaining economic resources and meets psychosocial needs in communities. Work is central to individual identity, social roles and social status, with employment and socio-economic status being the main drivers of social gradients in physical and mental health and mortality.	We can influence people's employment opportunities in many ways. Through adopting 'good' employment practices with our own organisations. Using the 'Social Value Act' to maximise equitable employment opportunities. Social Value Act Focusing on young people classed as NEET and those least likely bale to access the job market. Improve the health of direct employees. Champion and improve the take up of 'supported employment' and job retention schemes for people with learning disabilities and mental health issues. Champion employment issues within Health & Wellbeing Boards. Support and challenge local businesses through business in the community and other schemes. Help more people be 'Fit for Work'

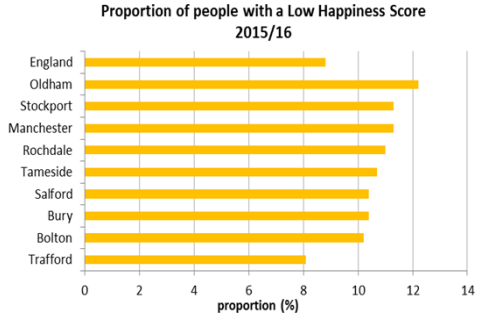
[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf

2.	Adult smokers	Smoking prevalence in adults across Tameside is significantly worse than the England averages. Adult smoking prevalence in 2016 was 22.1% (Tameside); 18.4% (GM); 15.5% (Eng.) For adults from routine manual workers smoking prevalence is higher at 35.6% (Tameside); 27.5% (GM); 26.5% (Eng.) Smoking in pregnancy was 15.4% (Tameside), 12.5% (GM), 10.7% (Eng.) Smoking attributable mortality in Tameside is also significantly higher than the England average at 399.9/100,000 versus 272.100,000 (Eng.) This equates to approximately 460 deaths a year relating to smoking. 	The cost of smoking related admissions to hospital for Tameside and Glossop is approximately £6.7million/year. Smoking equates to around 6,828 years of life lost through early death and illness. Smoking causes 80% of all lung cancers and respiratory diseases and is responsible for around 25% of all cancers. Smoking and the harm it causes aren't evenly distributed. People in more deprived areas are more likely to smoke and are less likely to quit. Smoking is increasingly concentrated in more disadvantaged groups and is the main contributor to health inequalities in England. Men and women from the most deprived groups have more than double the death rate from lung cancer compared with those from the least deprived. Smoking is twice as common in people with longstanding mental health problems.	Helping smokers to quit is one strand of the government's tobacco control plan for England. The other elements are: • making tobacco less affordable • preventing the promotion of tobacco • effective regulation of tobacco products • improving awareness of the harm • reducing exposure to second hand smoke These actions need to take account of the wider issues people face in their lives. Many factors, from lack of opportunity to social isolation, can increase the risks of unhealthy behaviours in particular smoking. Most smokers want to stop but quitting is hard. Many people make several attempts before they succeed. It's even harder when people are dealing with stress in their lives. To improve the chances of quitting, all smokers need: • effective services and therapies • supportive social networks • smokefree environments

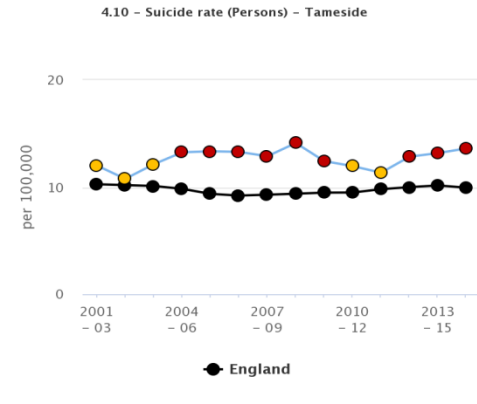
3.	Emergency (%) Admissions relating to alcohol (rate/100,000)	Emergency hospital admissions for alcohol related conditions are a major burden for the health and social care economy. With over 6,000 admissions occurring in 2015/16; (2,892/100,000); 2,737/100,00 (GM) and 2,179/100,000 (Eng.) Between 2014 and 2016 there were 97 (66.3/100,000) admissions for alcohol related conditions in young people under 18 years: This is significantly higher than the England average (37.4/100,000) and the GM average (52.9/100,000) Hospital admissions for alcohol related conditions impact on life chances and alcohol harm contributes to around 120 deaths each year in Tameside and approximately 1,442 years of life lost.	An analysis of 67 risk factors and risk factor clusters for death and disability found that alcohol is the third leading risk factor for death and disability after smoking and obesity.  Alcohol misuse, binge and chronic drinking are associated with a wide range of problems including personal impairment of physical and mental health and problems at a community level such as anti-social behaviour.	Responding to the needs of harmful and alcohol dependent drinkers. Not all people estimated to have some level of alcohol dependence will need specialist alcohol treatment. Some will benefit from a brief intervention consisting of a short alcohol health risk check in a range of health and social care settings. Assessing need, planning and commissioning alcohol treatment systems Local councils and health and wellbeing boards are involved in planning: • social care • housing strategy • public health • clinical treatment services • environmental health • licensing and trading standards This puts them at the heart of the partnership needed to tackle this complex issue. Alcohol treatment for harmful and dependent drinkers is an essential element in the broader range of alcohol policies and interventions that a council will need to plan and deliver. This is under the conditions of their public health grant.



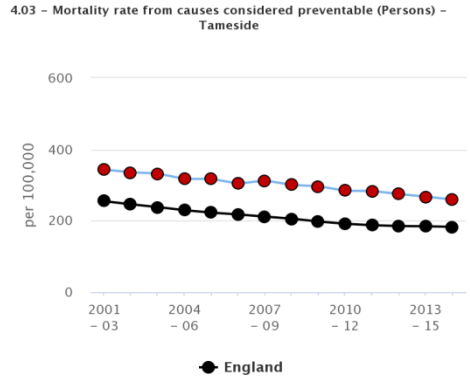
				Health and wellbeing boards are in the best position to consider: • how specialist alcohol services within hospitals integrate with the treatment system • potential joint funding arrangements across health and public health quality-governance-guidance-for-local-authority-commissioners-of-alcohol-and-drug-services.pdf
4.	Self-reported wellbeing – Low Happiness score	The Annual Population Survey (APS); asks a number of questions relating to wellbeing. 1. Overall, how satisfied are you with your life nowadays? 2. Overall, how happy did you feel yesterday? 3. Overall, how anxious did you feel yesterday? 4. Overall, to what extent do you feel the things you do in your life are worthwhile? The Low happiness score gives an overall indication of how people are feeling about their life. For Tameside	Well-being is a key issue for the Government. People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health. Happiness and good wellbeing contribute to overall life expectancy and in particular health life expectancy. Research evidence demonstrates that there are other benefits to being happy: • positive affect and well-being lead to sociability	Happiness is intertwined with the wellbeing of our local community. Being connected in a community helps people feel like they belong and this has a big impact on their happiness, that of their family, and the community as a whole. Strong neighbourhoods and social networks can have a significant impact on people's quality of life and well-being as they provide something which is vital for everyone - a sense of belonging. There is a clear relationship between the levels of wellbeing and inequality. Wellbeing and happiness, tend to be lower in areas with higher inequality of income

		in 2015/16, 10.7% of people had <u>low</u> happiness; this is higher than the England average of 8.8%.  	• better health, • success • self-regulation and, • Helping behaviour There is significant scientific evidence showing the positive benefits that come when we connect with people locally. These can include reducing the risk of depression, lowering the risk of heart disease and increasing how long we live[7],[8]	and wealth. Therefore, ensuring people have access to the same opportunities to education, employment, income, housing, transport, green spaces and resilient communities etc. will help to improve happiness in Tameside.

[7] Social capital: A review of the literature, Office for National Statistics (ONS) (2001)
[8] Maisel, N.C. & Gable, S.L. (2009) For richer…in good times…and in health: positive processes in relationships. In S.J. Lopez & C.R. Snyder (Eds.) Oxford Handbook of Positive Psychology. NY: Oxford University Press.

5	Suicide	Nationally suicide rates have remained fairly static over the last 10 to 15 years; where as in Tameside, suicide rates have fluctuated somewhat and for the most time remain significantly higher than the England averages. The rise in suicide and the significance for Tameside is in the male population, where current male suicide rates are 34% higher than the England average  	Suicide is a significant cause of death in young adults, and is seen as an indicator of underlying rates of mental ill-health. The suicide prevention outcomes strategy for England has the overall aim of reducing the suicide rate in the general population in England. Suicide prevention strategy for England 2017 update Suicide is preventable, yet suicide in Tameside has increased since 2007. On average in England 13 people take their own life every day. In Tameside someone takes their own life every 3 weeks. Suicide is a significant public health concern with widespread effect on communities. Suicide impacts the most on vulnerable communities and places a larger burden on low to middle income populations. [9]	While factors contributing to suicide vary; the most vulnerable in society, such as the young, the elderly, those with mental health issues and the socially isolated are at the greatest risk. • We need to strengthen our focus on men • We need to raise awareness of support for people who are struggling-in particular to those who are most vulnerable to the risk of suicide. • We need to ensure transport staff and those working in hotspot areas have appropriate suicide prevention training. • We need to tailor approaches to improve mental health and wellbeing in specific groups and make communities more resilient. • Increase access to taking therapies in areas where high risk populations live. • We need to reduce access to means of suicide
6	< 75 mortality rate from preventable causes	Under 75 mortality from preventable causes is considerably higher in Tameside than the national average. 259.4/100,000 versus	Despite the great strides that have been made in improving the health of the nation in recent decades, far too many people are dying too young from	Avoiding early deaths in our population is challenging. However the main areas of focus should be to • Reduce inequalities across all areas,

[9] http://apps.who.int/iris/bitstream/10665/75166/1/9789241503570_eng.pdf

		182.8/100,00. This equates to approximately 113 more death each year than the rest of England.  More males than females die early from preventable causes. (41% more)	diseases that are largely preventable. "Living Well for Longer" is an ambition for Tameside by decreasing early death and increasing healthy life expectancy. Early preventable deaths can be avoided through *Prevention* of illness, *earlier diagnosis,* and *high quality* treatment and care. Higher early preventable death rates are mostly seen in more deprived neighbourhoods. This creates wide inequality gaps for people who live in more geographically challenges areas of Tameside. Most causes of preventable death are from Cancer, CVD, respiratory disease, liver disease and suicide. These conditions are all related to poverty, education, life style and mental wellbeing.	in particular health inequalities • Tackle the wider determinants of health • Boost the local economy so that everyone as access to good quality employment and decent incomes • Adopt a population wide approach to tackling premature mortality • Prevent, detect early and mange effectively infectious and chronic conditions more effectively https://www.nice.org.uk/guidance/tackling-the-causes-of-premature-mortality www.nice.org.uk/Introduction#health-inequalities-impact-on-people-and-communities www.gov.uk/government/living-well-for-longer-a-call-to-action-to-reduce-avoidable-premature-mortality

Ageing and Dying Well

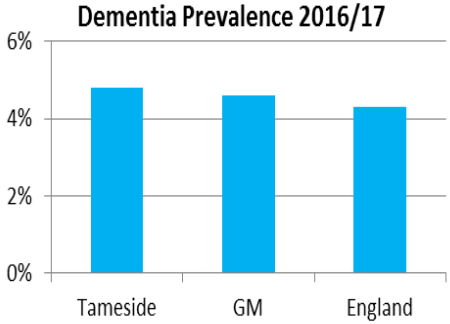
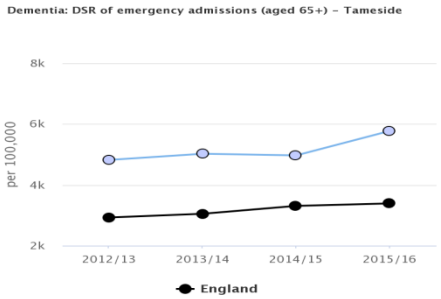
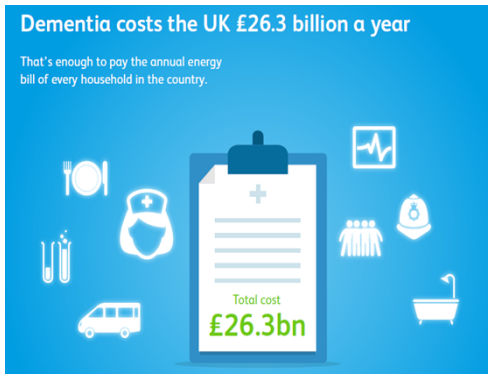
Ageing is a natural process and although advancing age is associated with physical and cognitive decline, wellbeing among older people is consistently found to be higher in later life than among young and middle aged adults. The population in Tameside and Glossop is ageing and the older age group is our fastest growing population. Ageing well is thus important, particularly in relation to health and social care costs. The absence of physical disease and disability are common criteria for successful ageing especially for health professionals but for older people themselves, contentment with life, independent living, being socially connected and ability to pursue interests are equally important.

The following are key issues for Tameside and Glossop in relation to ageing well.

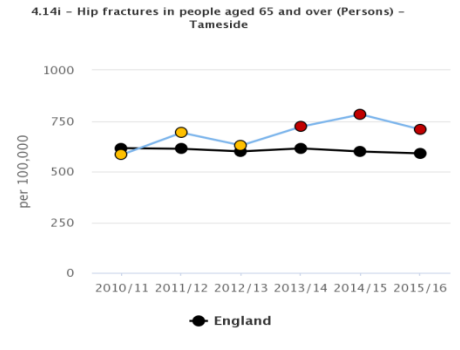
	Outcome	Challenge	Implications	Recommendations
1.	The ageing population	In 2016 there were 38,951 people aged 65 years and over (17% of the whole population) 6,500 more over 65s that 10 years ago (2006). Of this population 54% are female and 46% male and this gap widens at each five year interval increase. Healthy life expectancy is currently 56.4 years for males and 58.8 years for females. This means that a high proportion of our over 65 year population will be living with a long term condition or disability. Around 20% of older people in Tameside live on a low income.	The combination of extending life expectancy and the ageing of those born just after the 2nd world war, means that the population aged over 65 years is growing at a much faster rate than those under 65. Men and women from the highest socio-economic class on average expect to live 7 years longer than those from the lowest socio-economic class and more of those years will be disability free. So health inequalities will persist. Older people could be the driver of economic growth and social wellbeing or place a significant burden on the	Ensuring we keep out population well and illness and disability free for as long as possible is key to ensuring age does not put a burden on people and communities. When long term conditions and disability do become an issue, integrated multidisciplinary health and care teams are the most beneficial to individuals and the most cost effective way to manage people and long term conditions. Implementation of programmes that support 'Healthy Ageing', such as 'Men in Sheds', physical activity programmes aimed at older people, community cafes and neighbourhood schemes. Development of a society/communities

			younger population. The number of older people living on their own is also set to rise, which increases the risk of people experiencing loneliness and isolation. The impact of the ageing population will be felt the most by health and social care services, as the cost of health and social care are significantly greater for older people. The number of older people with care needs is expected to rise by more than 60% in the next 20 years. [10]	that are age friendly such as age friendly transport, housing, outdoor spaces, community support and activities.
2.	Dementia	There are an increasing number of people over 65 years with a diagnosis of dementia. Currently 1,843 (4.8%) of the over 65 population (2016/17). This has been increasing year on year for the past 10 years	Dementia is an umbrella term used to describe a range of progressive neurological disorders, that is, conditions affecting the brain. There are many different types of dementia, of which Alzheimer's disease is the most common. Some people may have a combination of types of dementia. Regardless of which type is diagnosed, each person will experience their dementia in their own unique way.[11] Symptoms of dementia include memory problems, communication issues and cognitive ability	Dementia affects both men and women, with women more likely to develop Alzheimer's and men more likely to develop vascular dementia. We can't rule out the risk of developing dementia entirely, but we can develop a healthy lifestyle which reduces some of that risk. Especially vascular dementia risk. Ageing is the biggest risk factor to Dementia so ensuring people are ageing well (active ageing) is important in preventing Dementia. Having a healthy younger life can reduce the risk of dementia so choosing healthier lifestyles

[10] https://www.kingsfund.org.uk/projects/time-think-differently/trends-demography
[11] https://www.dementiauk.org/understanding-dementia/about-dementia/

		 Emergency hospital admissions for dementia have also increased and in 2015/16 there were 2,017 emergency admissions compared to 1,709 in 2014/15. Dementia profile 	deterioration.  https://www.alzheimers.org.uk/info/20025/policy_and_influencing/251/dementia_uk/2	such as not smoking, being physically active and eating well are key. Dementia in England is under diagnosed and this is important in reducing emergency hospital admissions, so diagnosing Dementia at the earliest opportunity is key to improving dementia care and outcomes.
3.	Hip fractures in people aged 65 years and over	Hip fractures for Tameside residents over 65 years pose a real risk to health. Tameside have the 2nd	Fractures are an important cause of disability in the elderly. Due to decreased bone mass among this age	Hip fractures contribute to significant loss in productive years among the elderly. Changing modifiable risk factors such as

highest emergency admission rate for hip fractures in Greater Manchester and significantly higher than the England average. 708/100,000 compared to 589/100,00 (Eng.)
The rate of hip fractures has been increasing year on year up until 2015/16 where we have seen a sharp decline.



Older people who die because of a hip fracture is also a concern. Between 2014 and 2016 there were 57 deaths relating to hip fractures in people over 65 years in Tameside.

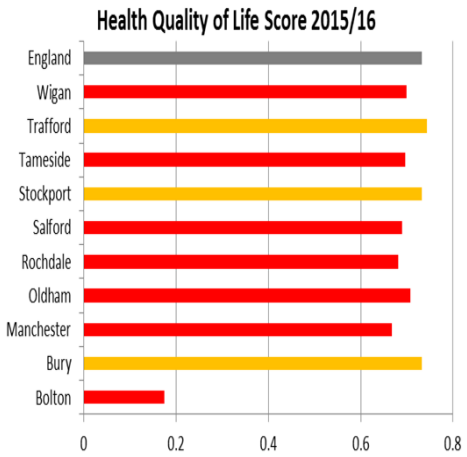
group, fractures are more common and tend to have a profound effect on ability to perform activities of daily living.
Falls and fall-related injuries are a major challenge to health and care systems and to the older people who suffer them. Around one in three people over 65 and one in two people over 80 fall at least once each year. Falls account for around 40 per cent of all ambulance call-outs to the homes of people over 65 and are a leading cause of older people's use of hospital beds. Each year there are around twice as many fractures resulting from falls as there are strokes in the over 65s.[12]
In addition to broken bones, falls may lead to prolonged lies on the floor, with resulting complications, and they are a common precipitant for people moving into long-term care, or needing more help at home.
Hip fractures are associated with significant morbidity, mortality, loss of independence, and financial burden. In usual care, the reported 1-year mortality after sustaining a hip

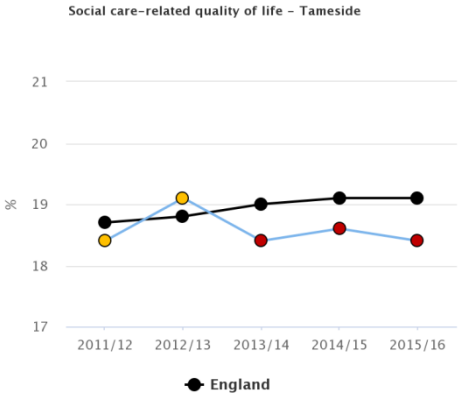
smoking and physical inactivity may help in reducing DALYs lost after hip fracture. Programs and measures which prevent the incidence of hip fractures among this age group may also help improve quality of life.
Preventing falls in older people is key to preventing hip fractures and reducing emergency hospital admissions.
NICE guidelines covers assessment of fall risk and interventions to prevent falls in people aged 65 and over. It aims to reduce the risk and incidence of falls and the associated distress, pain, injury, loss of confidence, loss of independence and mortality.
https://pathways.nice.org.uk/pathways/preventing-falls-in-older-people

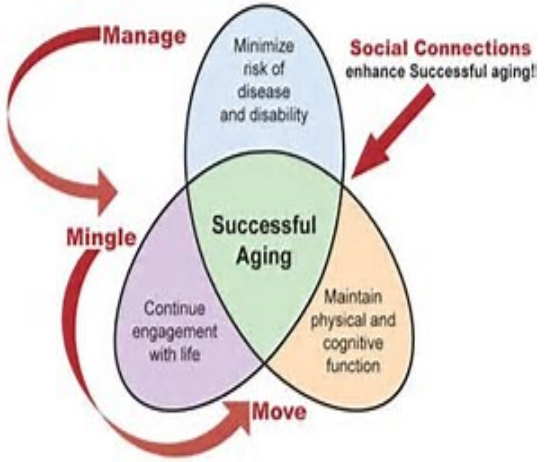
[12] https://www.kingsfund.org.uk/blog/2013/09/what-are-real-costs-falls-and-fractures

			fracture has been estimated to be 14% to 58%.	
4.	Health related quality of life for older people	The health related quality of life is a score of average health status in adults aged 65 years and over. The health related Quality of Life score provides a greater focus on preventing ill health, preserving independence and promoting well-being in older people. This is key to keeping systems functioning and in ensuring that the needs of this large population group are addressed. Average health scores are measured using EQ-5D scale from the GP Patient survey. https://www.gp-patient.co.uk/SurveysAndReports It asks questions on mobility, self-care, usual activities, pain/discomfort, anxiety and depression. Tameside residents aged 65 years and over had a combined average score of 0.696 which is lower than the England average of 0.733.	Older people are the biggest and costliest users of health and social care services and those with complex needs, long term conditions, functional issues, sensory or cognitive impairment are the highest cost and volume group of service users. However, although advancing age is associated with physical and cognitive decline; wellbeing is constantly found to be higher in older people than among young or middle aged adults. The influence of social relationships on the risk of death is strong in older people and is comparable with other established mortality risks such as smoking and alcohol.[13] Survival over an average of more than 9 years was associated with greater enjoyment of life. When older people are asked e=what successful ageing is, they usually say things like 'contentment with life', 'being socially connected' and 'able to pursue their interests'.[14]	Ageing well prevention programmes are evidenced based programmes that support people to age healthy and well and thus prevent social isolation, falls, improve physical health, and mental health. Physical activity is key to falls prevention, improving bone health and mental health in older people. NHS England has published a new Practical Guide to Practical Guide to Healthy Ageing with Age UK, to help people improve their health and general fitness, particularly those aged 70 or over with 'mild frailty'. The evidence-based guide covers key areas that have been identified as the main risk factors for older people living at home, but if they are proactively managed, they can help people stay well for longer and improve their quality of life. making our health system fit for ageing

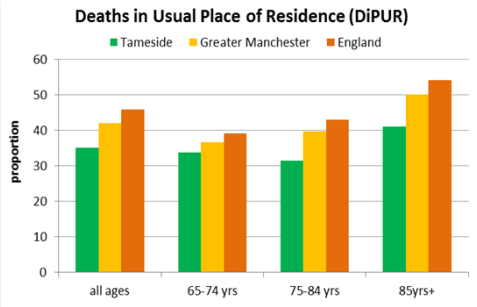
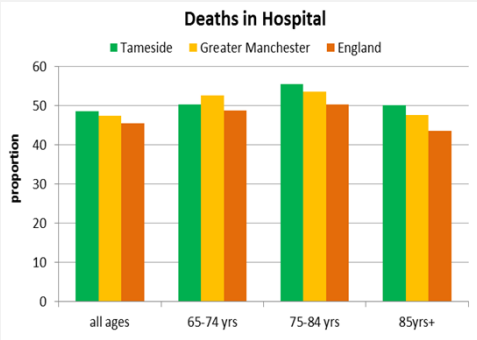
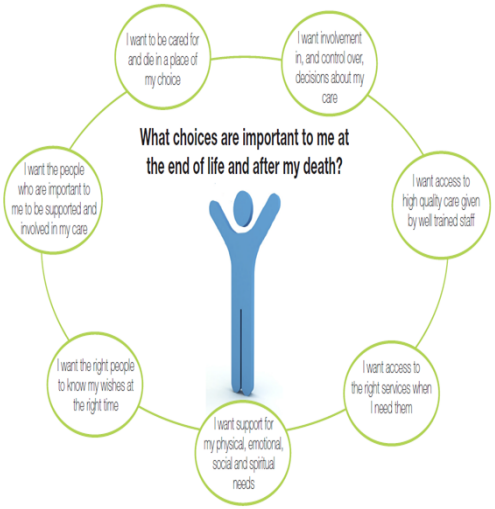
[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277584/Ageing_Well.pdf
[14] Friedman (2012). Wellbeing, ageing and immunity in Sergerstom (Ed. The Oxford handbook of Psychoneuroimmunology. Oxford University Press. New York







5	Deaths in Usual place of residence	Deaths in usual place of residence refer to deaths at home or in a care home if that was where the person permanently lived. Statistics for 2015 show that Tameside as a lower number of people at different age bands dying in their usual place of residence and a higher proportion of people dying in hospital.	Providing care at the end of life often involves the interaction of many different care agencies. Although many people may have a different ideas of what constitutes a 'Good Death', for many being treated as an individual, with dignity and respect, being without pain or symptoms, being in familiar surroundings and around close family and friends are the main needs. Some people do get to make a choice but many don't. Some people experience great care but too many people experience unnecessary pain and discomfort, are left alone or in public view. Some people do not get	Good palliative and end of life care should focus on the perspective of the dying person and the people closest to them and should be at the heart of our commitment to everyone at the end of life. Efforts should focus on improving care co-ordination, sharing data and information and building exemplar care pathways and innovative hospice led interventions. The 'Choice' review was a product of extensive public consultation and engagement that set out elements of end of life care that people most cared about. https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-response

		  [End of life profile for Tameside]	treated with dignity and respect and many people do not die where they wish to.[15] The National Care of the Dying Audit for Hospitals (NCDAH), England, found significant variations in care across hospitals in England. The audit showed that major improvements need to be made to ensure better care for dying people, and better support for their families, carers, friends and those important to them.	
6	Flu vaccination coverage for people aged 65 years plus	Flu vaccination coverage for people aged 65 years and over in Tameside and Glossop was 74.5% (2016/17). This is below the national target of 75% and is a continual concerning decline that has been occurring over the last 5 years.	Seasonal flu occurs every year, usually in the winter. It's a highly infectious disease caused by a number of flu viruses. The most likely viruses that will cause flu each year are identified in advance and vaccines are then produced to closely match them. Some people are more susceptible to the effects of seasonal flu. For them it can increase the risk of developing	The national flu immunisation programme is a key part of wnter planning. The flu programme is there to offer protection to those who are most at risk from the consequences of the flu virus. To increase uptake of flu vaccination across all eligible groups including those aged 65 years and over. It is important to • Make access to the flu vaccination as accessible as

[15] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf

Period	Tameside & Glossop		Greater Manchester	England
	Count	%		
2010/11	25,295	74.1	74.3*	72.8*
2011/12	27,160	77.2	76.4*	74.0*
2012/13	27,636	77.1	75.3*	73.4*
2013/14	28,444	76.2	75.2*	73.2
2014/15	28,688	75.3	75.0*	72.7
2015/16	28,237	73.8	73.9*	71
2016/17	28,023	73.5	72.2*	70.5

Across Tameside & Glossop there is also wide variation in coverage at GP Practice level.

There were more than a thousand emergency admissions for influenza, bronchitis and pneumonia in 2016/17 for people aged 65 years and over.

more serious illnesses such as bronchitis and pneumonia, or can make existing conditions worse. In the worst cases, seasonal flu can result in a stay in hospital, or even death. Complications of flu mostly affect people in high-risk groups, such as the elderly, pregnant women and those who have a long-term medical condition or weakened immune system.

possible

- Implement clear and timely communications especially those involved in manageing flu so that understand their roles and responsibilities.
- General flu awareness through flu campaigns and communication plans so the messages get through to the population. For example the National Flu marketing campaign.
- Support to general practice to encourage take up of flu vaccination and to practices that need support in improving take up rates.

Links to other useful Information:

Cardiovascular disease profiles: https://fingertips.phe.org.uk/profile/cardiovascular/
Cancer Service profiles: https://fingertips.phe.org.uk/profile/cancerservices/
Health Protection Profiles: https://fingertips.phe.org.uk/profile/health-protection/
Diabetes Profile: https://fingertips.phe.org.uk/profile/diabetes-ft/
Health Assets Profile: https://fingertips.phe.org.uk/profile/comm-assets/
Wider Determinants Profile: https://fingertips.phe.org.uk/profile/wider-determinants/

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	28 June 2018
Executive Member / Reporting Officer:	Debbie Watson – Interim Assistant Director (Population Health)
Subject:	**HEALTH AND WELLBEING FORWARD PLAN 2018/19**
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 2018/19.
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, Interim Assistant Director of Population Health by: Telephone:0161 342 3358 e-mail: debbie.watson@tameside.gov.uk

TAMESIDE HEALTH AND WELLBEING BOARD FORWARD PLAN 2018/19

	Strategy / policy and Board process	Priorities and performance	Integration	Other

28 June 2018	• PACT Endorsement and Update
	• JSNA – Our Life in Tameside and Glossop
		• Health Protection Update
		  ○ Influenza
		  ○ Outbreak Capability Plan
			• Care Together Update
			• Care Together 2017/18 Year End Financial Monitoring Statement and BCF Quarter 4
				• Forward plan

20 September 2018	• GM Public Health Outcomes Framework and Dashboard • Governance review – improving Children and Families	• Health and Employment Update • Food and Health in Tameside	• Care Together Update • Care Together 18/19 Monitoring Statement Q1	• Forward Plan
15 November 2018	Health and Wellbeing Board Development Session			
24 January 2019	• Tameside Safeguarding Children Annual Report • Tameside Adult Safeguarding Partnership Annual Report	• Public Health Annual Report	• Care Together Update • Care Together 18/19 Monitoring Statement Q2	• Forward Plan
7 March 2019		• System Wide Self Care programme in Tameside & Glossop – achievements and next steps	• Care Together Update • Care Together 18/19 Monitoring Statement Q3	• Forward Plan

	Strategy / policy and Board process	Priorities and performance	Integration	Other
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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