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Tameside Metropolitan Borough

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# HEALTH AND WELLBEING BOARD

**Day:** Thursday
**Date:** 22 September 2016
**Time:** 10.00 am
**Place:** Lesser Hall - Dukinfield Town Hall

| Item No. | AGENDA | Page No |
|---|---|---|
| 1. | **APOLOGIES FOR ABSENCE** | |
| 2. | **DECLARATIONS OF INTEREST**<br>To receive any declarations of interest from Members of the Health and Wellbeing Board. | |
| 3. | **MINUTES**<br>The Minutes of the meeting of the minutes of the previous meeting of the Health and Wellbeing Board held on 10 March 2016. | 1 - 6 |
| | ***ITEMS FOR DISCUSSION / DECISION*** | |
| 4. | **CARE TOGETHER ECONOMY MONITORING STATEMENT**<br>To receive the attached report of the Executive Member (Adult Social Care and Wellbeing) / Executive Member (Healthy & Working) / Executive Member (Children and Families) and the Director of Finance, Single Commissioning Team. | 7 - 50 |
| 5. | **CARE TOGETHER PROGRAMME UPDATE**<br>To receive the attached report of the Executive Member (Adult Social Care and Wellbeing) / Programme Director (Tameside and Glossop Care Together). | 51 - 70 |
| 6. | **HEALTH SKILLS AND HEALTH INTEGRATION**<br>To receive the attached report from the Deputy Chief Executive, New Charter Housing, and the Project Lead, Employment and Skills, Tameside MBC. | 71 - 80 |
| 7. | **SAFE AND WELL EVALUATION**<br>To receive the attached report of the Borough Commander, Greater Manchester Fire and Rescue Service. | 81 - 90 |
| | ***ITEMS FOR NOTING / INFORMATION*** | |
| 8. | **PUBLIC HEALTH ANNUAL REPORT**<br>To receive the attached report and accompanying presentation of the Executive Member (Healthy and Working) / Director of Public Health. | 91 - 138 |

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

**9. URGENT ITEMS**

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

**10. DATES OF NEXT MEETING**

To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 10 November 2016.

**TAMESIDE HEALTH AND WELLBEING BOARD**

**10 March 2016**

**Commenced: 10.00 am** **Terminated: 11.50 am**

**PRESENT:**
Councillor Kieran Quinn (Chair) – Tameside MBC
Councillor Brenda Warrington – Tameside MBC
Steve Allinson – Clinical Commissioning Group
Stephanie Butterworth – Tameside MBC
Judith Crosby – Pennine Care NHS Foundation Trust
Graham Curtis – Clinical Commissioning Group
Ben Gilchrist – CVAT
Angela Hardman – Tameside MBC
Karen James – Tameside Hospital NHS Foundation Trust
Penny King – Stockport NHS Foundation Trust
Steven Pleasant – Tameside MBC
Andy Searle – Chair, Adult Safeguarding Board
Dominic Tumelty – Tameside MBC

**IN ATTENDANCE:**
Chris Mellor – Independent Chair, Care Together Programme Board
Sandra Stewart – Tameside MBC
Peter Timmins – Tameside MBC
Clare Powell – Stanley Powell Associates
Chris Rendell – Care Quality Commission
Jennifer Good – Care Quality Commission

**APOLOGIES:**
Alan Dow – Clinical Commissioning Group
Councillor Gerald Cooney – Tameside MBC
Councillor Peter Robinson – Tameside MBC
Tony Powell – New Charter Housing Trust
Clare Watson – Clinical Commissioning Group

## 47. DECLARATIONS OF INTEREST

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

## 48. MINUTES OF PREVIOUS MEETING

The Minutes of the Health and Wellbeing Board held on 21 January 2016 were approved as a correct record.

## 49. QUALITY OF CARE IN A PLACE

The Chair welcomed Charles Rendell and Jennifer Good, Care Quality Commission (CQC), who gave a presentation on the work of Quality of Care in a Place and the pilot approach. Reporting on the quality of care in a place was the next step in understanding how the CQC could contribute to discussions about quality beyond individual providers. The health and care landscape was rapidly changing and the CQC was working hard to ensure that it was an enabler of progress. The prototype report for Tameside was one in a suite of three reports which aimed to inform an understanding of how CQC could build a picture of what care was like for people who used a range of different health and social care services in one area, rather than looking at individual care providers such as hospitals, care homes or GP services.

The presentation was accompanied by an initial data report and key findings using publically available information. Members of the Health and Wellbeing Board provided their initial views and observations on the recently provided data report and agreed to forward their detailed comments to the CQC.

**RESOLVED**
**That Charles Rendell and Jennifer Good be thanked for their presentation and members would forward their comments directly to the CQC.**

## 50. CARE TOGETHER PROGRAMME UPDATE

Consideration was given to a report of the Executive Member (Adult Social Care and Wellbeing) and the Programme Director, Tameside and Glossop Care Together, providing an update on the progress and developments within the Care Together programme since the last meeting.

It was explained that at the end of January a submission for GM Devolution transitional support was submitted to GM Devolution which set out the level of funding required over the next three years to transform the health and social care system across Tameside and Glossop. Further detail required regarding implementation plans and assurances around efficiency gains would be addressed by the next submission in March 2016.

A summary of operational progress in the following areas was also highlighted:

- Transfer of Community Services;
- Single Commissioning function and pooled budgets;
- Model of care; and
- Programme Support Office and Programme Development.

**RESOLVED**
**(i) That the progress of the Care Together Programme including the strategic and operational aspects be noted.**
**(ii) That a further update report be presented to the next meeting.**

## 51. DEVELOPING A SINGLE COMMISSIONING STRATEGY

The Chair welcomed Clare Powell, Consultant, Stanley Powell Associates, who gave a presentation providing an overview of the emerging commissioning strategy for the Tameside and Glossop single commission. It was based upon discussions with key members of staff from the single commission, Tameside Hospital Foundation Trust, councillors and GPs, two staff workshops and a review of existing plans and strategies.

It suggested an initial focus on 4 key commissioning priorities as follows:

- Wider determinants of health and wellbeing;
- Healthy lifestyle behaviours;
- Long term conditions; and
- Supporting positive mental health.

These had been identified as the areas that could have the biggest impact on improving health and wellbeing whilst reducing long term costs. It was a key component of the Care Together Programme and the local contribution to the GM Plan.

Members of the Health and Wellbeing Board noted the presentation and contributed comments / observations to the development of the emerging strategic aims.

**RESOLVED**
**That the content of the presentation on the emerging commissioning strategy for the Tameside and Glossop single commission be noted.**

## 52. IMPACT OF CUTS TO PUBLIC HEALTH GRANTS

The Executive Member (Healthy and Working) introduced a report which explained that on 4 November 2015, the Department of Health confirmed that it would reduce its spending on public health grants to local authorities by £200m this financial year, 2015-16. This 6.2% in year cut in public health grant for Tameside amounted to £942,928.

In the November 2015 Spending Review, additional cuts in the Public Health grant were announced, which would be an average real terms cut of 3.9% each year to 2020-21. This translated into a further cash reduction of 9.6% in addition to the £200m of savings announced early in the year. For Tameside Council this would mean a confirmed reduction of £363,180 for 2016-17 and another reduction of £387,000 in 2017-18 having a very significant impact on the commissioned Public Health services.

The Director of public Health made reference to the approach being taken to respond to the 2015-16 in year Public Health grant cut, and the reduction in grant funding that would continue to 2020-21. It was noted that 85% of the Public Health grant was commissioned through contracts and confirmation of these reductions would present enormous challenge to reduce, decommission or renegotiate contracts for April 2016/17. A prioritisation framework had been implemented and a review of the total budget available for 2015/16 had been undertaken. A set of proposals against current Public Health expenditure had been developed and a summary was detailed in the report relating to the following areas:

- Starting and Developing Well Programme – total saving £197,000;
- Living and Working Well Programme – total saving £441,000;
- Ageing Well Programme – total saving of £25,000;
- Reducing staff costs and IT consumables – total saving of £25,000;
- Review of all contracts commenced – target saving of £164,928; and
- Public Health staffing redesign – identified part year saving of £79,000.

A letter from the Director of Public Health was sent to all providers in November 2015 informing them of the proposed cuts to the Public Health budget and one to one meetings had taken place throughout November / December to start the process of consultation and possible renegotiation of contracts. In addition, Public Health commissioning leads had met with all providers to look at possible funding scenarios of reductions on current contracts.

Members of the Board heard that a public consultation on the Council's Big Conversation Website had taken place over a four week period commencing 4 December 2015 to 4 January 2016 where the proposals for the 2015/16 reductions were described and the public invited to comment. The structure of the consultation and responses were detailed in **Appendix 2** of the report.

In considering the proposals in the report, the Board expressed their deep concern and disappointment regarding the cuts to Public Health budgets and the detrimental impact these would have on many prevention and early intervention services. The Council had a statutory duty to provide mandatory functions such as tackling alcohol and drug misuse, smoking and obesity as well as generally promoting a healthier lifestyle. Investing in prevention ultimately saved money in other areas by reducing the demand for hospital, health and social care services. The Board also noted that the grant from 1 April 2016 would be included within the single commissioning pooled fund and would therefore be aligned and considered alongside the outcomes of the single commissioning strategy once the strategy was finalised and been approved.

**RESOLVED**
**That the approach being adopted in the report and response to the funding situation described be noted.**

## 53. CHILDREN'S SERVICES DEVOLUTION UPDATE AND THE REGIONAL ADOPTION AGENCY PROGRESS REPORT

Consideration was given to a report of the Executive Member (Children and Families) / Assistant Executive Director (Children Services), which explained that Devolution Manchester offered a number of opportunities for Children's Services to share resource and service transformation across Greater Manchester in order to maximise outcomes for children whilst potentially achieving significant savings for each Council.

Members were informed that there were seven work streams that had been set up and further detail of each was set out in the report. Each work stream was headed by a Director of Children's Services and there was evidence of significant and important buy-in from Councils, other Governmental departments and the Voluntary Sector. The Department for Education (DfE) was committed to three weekly meetings which would include other government departments as required.

In addition, following Central Government announcements regarding Regionalisation of Adoption, Tameside Children's Services had been collaborating extensively with colleagues and Tameside had joined a consortium bringing together several of the highest performers for Adoption which is proposed to be called the West Pennine Adoption Agency.

The Department of Education was keen for Health and Wellbeing Boards and Clinical Commissioning Group colleagues to be invited to consider the offer to the adoption service, both pre adoption (health assessments, CAMHS and support to planning) and for adoption support services.

It was explained that for all of the above there would be a need to bring more detail through Governance processes as that detail was developed and the implications for Tameside were better understood. As such, the report remained an update report rather than seeking permission for specific actions at this stage but in 2016/2017 there would be a number of reports coming to Board requesting authority to progress.

There had to date been some presentation to AGMA leaders of the work to date, dialogue had been started with the Departments of Education and Communities and partners from KPMG (management and accountant consultants) were assisting the process as commissioned.

**RESOLVED**

**(i) That the content of the report be noted and Tameside's involvement in the Devolution and Regional Adoption agendas continue to be supported.**

**(ii) That the views of the Department of Education that partners in the CCG were crucial to successful pre adoption planning and post adoption support be noted.**

**(iii) That it be noted that service progression on the 0-25 offer would not wait for devolution decisions to be made but would be progressed in order to avoid duplication and delay.**

## 54. OVERVIEW OF GREENSPACE ACTIVITIES AND POTENTIAL HEALTH AND WELLBEING OPPORTUNITIES

The Chief Executive introduced Nick Sayers, Head of Environmental Operations and Greenspace, and his colleague Nicola Marshall, Greenspace Development Manager, who gave a presentation

on the health benefits of greenspace supporting the improvement of health and wellbeing of the Borough's residents.

The health benefits of greenspace were well documented and evidence demonstrated a clear positive relationship between greenspace activities and health. The focus of the presentation was on additional opportunities available including volunteering undertaking operational tasks and walks, a partnership with Tameside College offering a horticultural course to students, Routes to Work with individuals working across operational teams, community growing plots and conservation days.

Members of the Board commented favourably on the content of the overview of greenspace activities and links which could be developed with Active Tameside and the healthy lives work stream. Consideration would also be given to how the activities could be communicated / promoted within primary care and other elements of the service as there was potential cost avoidance within the economy if greenspace opportunities were maximised.

**RESOLVED**
**That the content of the presentation and the possible benefits and opportunities that the Borough's greenspace could offer in terms of health and wellbeing of communities be noted.**

## 55. UNLOCKING TAMESIDE'S COMMUNITY ASSETS

Consideration was given to a report of the Chief Executive, Community and Voluntary Action Tameside (CVAT), which outlined proposals for how CVAT, Healthwatch and local voluntary and community organisations could be full and effective partners in Care Together and contribute to the Locality Plan's aim of transforming the relationship between the population and the health and social care system.

He stated that thanks to Care Together, Tameside was the perfect place to develop this innovation and showcase new approaches to demand reduction that also fostered community resilience and achieved better outcomes for patients. This was not intended as a fully costed proposal but to outline the areas that had the greatest potential to be enhanced through Care Together.

The proposals set out examples of how that could be achieved with investment focused on the following themes:

- Reducing demand and supporting empowerment;
- Improving health outcomes through co-production; and
- Connecting with the business sector.

CVAT and Healthwatch were keen to scale up the offer from the voluntary sector and develop its strategic role within Care Together to unlock the potential within Tameside's communities.

Board members commented favourably on the proposition and the practical examples provided to develop new approaches that would contribute to reducing demands on the health and social care system whilst also empowering local people to find their own solutions to their health and care needs.

**RESOLVED**
**That the proposals set out in the document be endorsed and developed further via the Care Together work streams.**

## 56. URGENT ITEMS

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

## 57. DATE OF NEXT MEETING

To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 30 June 2016 commencing at 10.00 am.

**CHAIR**

| | |
|---|---|
| **Report to:** | **HEALTH AND WELLBEING BOARD** |
| **Date:** | 22 September 2016 |
| **Executive Member / Reporting Officer:** | Councillor Jim Fitzpatrick – First Deputy (Performance and Finance)<br>Councillor Brenda Warrington – Executive Member (Adult Social Care & Wellbeing)<br>Councillor Gerald P. Cooney – Executive Member (Healthy & Working)<br>Councillor Peter Robinson – Executive Member (Children & Families)<br>Kathy Roe – Director Of Finance – Single Commissioning Team |
| **Subject:** | **TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2016/17 REVENUE MONITORING STATEMENT AT 31 JULY 2016 AND PROJECTED OUTTURN TO 31 MARCH 2017** |
| **Report Summary:** | This is a jointly prepared report of the Tameside & Glossop Care Together constituent organisations on the revenue financial position of the Economy.<br>The report provides a 2016/2017 financial year update on the month 4 financial position (at 31 July 2016) and the projected outturn (at 31 March 2017).<br>A summary of the Tameside Hospital 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 |
| **Recommendations:** | Health and Wellbeing Board Members are recommended :<br>To note the 2016/2017 financial year update on the month 4 financial position (at 31 July 2016) and the projected outturn (at 31 March 2017).<br>Acknowledge the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget.<br>Acknowledge the significant amount of financial risk in relation to achieving an economy balanced budget across this period.<br>To note the 2016/17 quarter one Better Care Fund monitoring statement **(Appendix D)** |
| **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:**<br>**(Authorised by the Section 151 Officer))** | This report provides the financial position statement of the 2016/17 Care Together Economy for the period ending 31 July 2016 (Month 4 – 2016/17) together with a projection to 31 March 2017 for each of the three partner organisations.<br>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.<br>Each constituent organisation will be responsible for the financing of their resulting deficit at 31 March 2017.<br>It should be noted that the Integrated Commissioning Fund for the partner Commissioner organisations will be bound by the terms within the existing Section 75 agreement and associated Financial Framework agreement which has been duly approved by both the Council and CCG.<br>Health and Wellbeing members should also note that the 2016/17 Better Care Fund allocation sum of £15.323m (detailed within section 6, table 7 of the report) is included within the Section 75 funding allocation of the Integrated Commissioning Fund as detailed in **Appendix C** as this is a revenue funding allocation**.** Actual expenditure is included with table 1. The Disabled Facilities Grant sum of £1.978m (detailed within section 6, table 7 of the report) is excluded from this total as it is a capital funding allocation. |
| **Legal Implications:**<br>**(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 :<br>Stephen Wilde, Head Of Resource Management, Tameside Metropolitan Borough Council<br>Telephone:0161 342 3726<br>e-mail: stephen.wilde@tameside.gov.uk<br>Tracey Simpson, Deputy Chief Finance Officer, Tameside and Glossop Clinical Commissioning Group<br>Telephone:0161 304 5449 |

e-mail: tracey.simpson@nhs.net

Ann Bracegirdle, Associate Director Of Finance, Tameside Hospital NHS Foundation Trust

Telephone:0161 922 5544

e-mail: Ann.Bracegirdle@tgh.nhs.uk

## 1. INTRODUCTION

1.1 This report aims to provide an update on the overall financial position of the economy as at Month 4 and to highlight the increased risk of achieving financial sustainability in the short term whilst we all acknowledge how much it will take to bridge the financial gap next year also.

1.2 The report includes the components of the Integrated Commissioning Fund (ICF) and the progress made in closing the financial gap for the 2016/17 financial year. The total ICF is £447.5m in value (**Appendix C**), however this value is subject to change throughout the year as new Inter Authority Transfers (IATs) are actioned and allocations are amended.

1.3 The Tameside & Glossop Care Together Single 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 The 2016/17 financial year is particularly challenging due to the significant financial gap and the risk of CCG QIPP schemes not being sufficiently developed to deliver the required level of efficiencies in year. A financial recovery plan was submitted to NHS England on 9 September following consideration by an extraordinary meeting of the Governing Body on 7 September. This report also considers the financial risks of the ICF in 2016/17. Please refer to section 7 for further details.

1.5 It should be noted that section 2 of the report includes details of the financial position of Tameside Hospital NHS Foundation Trust. This provides members with an awareness of the projected total financial challenge which the Tameside and Glossop economy is required to address during 2016/17.

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 Hospital NHS Foundation Trust
- NHS Tameside and Glossop CCG
- Tameside Metropolitan Borough Council

## 2. FINANCIAL SUMMARY

2.1 Table 1 details the 2016/17 budgets, expenditure and forecast outturn of the ICF and Tameside Hospital NHS Foundation Trust. However there are a number of key risks that have to be managed within the economy during the financial year:-

- Achievement of the original £21.5m projected commissioner financial gap (£13.5m T&G CCG and £8.0m TMBC);
- Delivery of the £17.3m projected financial deficit (i.e. agreed control total) of Tameside Hospital NHS Foundation Trust;
- Management of any potential over spend within Acute services. Any over spend would be an additional pressure over and above the financial gap stated above;
- Ensure Parity of Esteem is achieved in relation to Mental Health Services;
- Financial pressures as a result of national changes to the health contribution of funded nursing care payments (40% increase). This will generate an estimated increased liability to the CCG of approximately £0.6 million but this will be confirmed and reported at month 5.
- Management of Care Home placements due to the volatility in this area;
- Unexpected and complex dependency placements within Children's Services;
- Emergency In-year reductions to Central Government resource allocations;

- Pro-active management of Continuing Healthcare and Prescribing – both of which are subject to volatility;
- Remaining within the running cost allocation for 2016/17.

**Table 1 – Summary of the Tameside and Glossop Economy – 2016/17**

**Tameside & Glossop Integrated Commissioning Fund 2016/2017**

| | Year to Date (M4) | | | Year End | | | Movement | |
|---|---|---|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's |
| Description | Budget | Actual | Variance | Budget | Forecast | Variance | Previous Month | Movement in Month |
| Acute | 66,044 | 66,788 | (744) | 198,348 | 198,622 | (274) | (185) | (89) |
| Mental Health | 9,699 | 9,732 | (33) | 29,097 | 29,300 | (203) | (134) | (69) |
| Primary Care | 26,908 | 27,461 | (553) | 80,379 | 80,969 | (590) | (437) | (153) |
| Continuing Care | 4,864 | 4,927 | (63) | 14,236 | 14,442 | (206) | (207) | 1 |
| Community | 9,124 | 9,122 | 2 | 27,357 | 27,362 | (5) | 0 | (5) |
| Other | 9,194 | 7,686 | 1,508 | 23,471 | 22,688 | 783 | 557 | 226 |
| QIPP | 0 | 4,500 | (4,500) | 0 | 12,893 | (12,893) | (13,010) | 117 |
| CCG Running Costs | 1,497 | 1,614 | (117) | 5,162 | 4,737 | 425 | 406 | 19 |
| **CCG Sub Total **** | **127,330** | **131,830** | **(4,500)** | **378,050** | **391,013** | **(12,963)** | **(13,010)** | **47** |
| Adult Social Care& Early Intervention | 13,995 | 14,311 | (316) | 41,980 | 43,243 | (1,263) | (5,123) | 3,860 |
| Childrens Services, Strategy & Early Intervention | 8,635 | 8,712 | (77) | 25,877 | 26,185 | (308) | (1,594) | 1,286 |
| Public Health | (2,401) | (2,342) | (59) | 1,639 | 1,876 | (237) | (1,164) | 927 |
| **TMBC Sub Total *** | **20,229** | **20,681** | **(452)** | **69,496** | **71,304** | **(1,808)** | **(7,881)** | **6,073** |
| **GRAND TOTAL** | **147,559** | **152,511** | **(4,952)** | **447,546** | **462,317** | **(14,771)** | **(20,891)** | **6,120** |

**Tameside Hospital NHS Foundation Trust**

| | Year to Date (M4) | | | Year End | | | Movement | |
|---|---|---|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's |
| | Budget | Actual | Variance | Budget | Forecast | Variance | Previous Month | Movement in Month |
| **Net Surplus/(Deficit)** | (6,397) | (6,159) | 268 | (17,300) | (17,300) | 0 | (17,300) | 0 |

**Summary**

| | |
|---|---|
| **Tameside & Glossop Commissioner - Projected Gap - 31 March 2017** | **(14,771)** |
| **Tameside Hospital NHS Foundation Trust - Projected Gap - 31 March 2017** | **(17,300)** |
| **Tameside & Glossop Economy - Projected Gap - 31 March 2017** | **(32,071)** |

** Please note that accruals are included within the year end projections for the Council and not within the year to date totals. Projected expenditure and income within Council services is monitored on a monthly basis via data maintained within the respective service management information systems.*

*** The CCG figure quoted in table 1 differs from that reported to NHS England in the Non ISFE return, due to the treatment of QIPP. This is to ensure consistency of reporting across the Integrated Commissioning Fund, for both CCG and Local Authority. This is presentational only and does not affect the underlying position. It has been agreed at Single Commissioning Board, that all financial gaps (including QIPP) should be treated as a deficit until the savings have been achieved (ie, Reported as green in the QIPP table below)*

2.2 Assumptions included to deliver the Tameside Hospital NHS Foundation Trust projected deficit of £17.3m include:

- Savings of £7.8m (the FT's Cost Improvement Plan) are delivered (section 3.10 refers)
- £1.1m of additional income is received for the use of independent sector providers (this will finance associated expenditure incurred);
- There is a small over performance on PbR associate commissioner contracts;
- £6.9m Sustainability and Transformation funding is received (it should be noted that this is reliant on the condition that all financial and performance criteria is met);
- £17.3m working capital/loan is received to finance the projected year end deficit position;
- The Trust bed base is not increased;
- No significant unfunded additional expenditure materialises;

2.3 If these assumptions are not realised, sensitivity analysis suggests there is a risk that the projected year end deficit could increase by £1.4m (to a projected £18.7m deficit). It should be noted that by the end of 2016/17, the Trust will have £52m of repayable loans which have been borrowed to fund the deficit over the past 3 financial years. Repayment of this sum is scheduled to begin in 2018. However whilst it is anticipated the Department of Health will convert the loans into non repayable loans, the timescales and exact criteria required to facilitate this remains subject to confirmation.

## 3. FINANCIAL GAP

3.1 The Commissioner Financial Gap in 2016/17 for the ICF is £21.5m which includes £13.5m CCG QIPP target and an £8.0m TMBC financial savings target. It should be noted that this gap is a commissioner only gap. The economy wide position including the deficit at Tameside FT increases the scale of the challenge to £45.7m.

### Commissioner Financial Gap

3.2 Table 2 lists the schemes identified to address the commissioner financial challenge and meet the QIPP targets in 2016/17. Each scheme is summarised with an evaluation of the risk of achievement and delivery in 2016/17.

### Table 2 – Commissioner - Financial Gap Schemes (£'000) 2016/17

| Scheme | 16/17 Savings | | | Risk | Notes |
|---|---|---|---|---|---|
| | CCG | TMBC | Total | | |
| **SCHEMES WITH A QUANTIFIED FINANCIAL IMPACT IN 2016/17** | | | | | |
| Public Health - savings found | 0 | 217 | 217 | G | Planned reduction to the annual management fee payable to Active Tameside and additional incidental savings delivered within the service |
| Public Health - savings found | 0 | 169 | 169 | G | A reduction in the Community Services contract value has been agreed with Tameside FT |
| Public Health - additional resource (projected cost pressures) | 0 | 49 | 49 | G | |
| Public Health - reduction in estimated capital financing repayments (Active Tameside) | 0 | 514 | 514 | G | The capital financing figure in 16-17 has redeuced due to a rephasing of works to reconfigure the Active Tameside estate |
| Public Health - savings still to find | 0 | 432 | 432 | A | . |
| Adult Social Care - additional resource (projected cost pressures) | 0 | 3,908 | 3,908 | G | |
| Adult Social Care - savings still to find | 0 | 997 | 997 | R | The Council is currently in the process of identifying further options to address the projected financial gap that is expected to arise during 2016/17. Updates will be reported within future monitoring reports. |
| Childrens Social Care - savings found | 0 | 120 | 120 | G | Reduction to inflationary increases that were projected to materialise during 2016/17. |
| Childrens Social Care - additional resource (projected cost pressures | 0 | 1,215 | 1,215 | G | |
| Childrens Social Care - savings still to find | 0 | 379 | 379 | R | The Council is currently in the process of identifying further options to address the projected financial gap that is expected to arise during 2016/17. Updates will be reported within future monitoring reports. |
| Wheelchair Service | 230 | 0 | 230 | G | Contract now signed, guaranteeing 16/17 saving. Procurement exercise is on-going to determine scale of recurrent benefit. |
| ISCAN | 230 | 0 | 230 | G | Business case rejected at June PRG. Therefore money which was held in reserves is no longer required |
| RADAR | 32 | 0 | 32 | G | Money held in reserve in anticipation of additional spend with Greater Manchester West FT. No longer required. |
| MH Safer Staffing | 100 | 0 | 100 | A | Business case to PRG in August. Depending on outcome and subsequent negotiation with Pennine Care savings of upto £200k could be available. |
| Efficiency Savings: Admin Budgets | 115 | 0 | 115 | G | Confirmed savings made in 16/17 from running costs budgets. Chiefly driven by no longer having to fund salary of Chief Operating Officer. |
| Efficiency Savings: Admin Budgets | 385 | 0 | 385 | A | Further savings/slippage possible following budget holder review and in the event of any staff vacancies |
| Efficiency Savings: Programme Budgets | 500 | 0 | 500 | A | Individual budget holder review meetings already held as part of budget setting process. Therefore all of the obvious savings have already been captured. However further reviews to identify slippage and savings will be held in year. |
| Risk Stratification/Review of high risk patients | 1,000 | 0 | 1,000 | A | Review by Practices of high risk patients via risk-strat information - All practices and neighbourhoods to be supported to analyse their risk stratification data and identify where support can be optimised to prevent unnecessary urgent and planned care system demand. Data has been shared with practices and benefits are expected from September onwards |
| Integrated Elective Services | 800 | 0 | 800 | A | Bridging arrangements in place with Care UK / GM Primary Eye Care for 2016/17, with fully integrated service in place for MSK, ENT & ophthalmology through the ICO from April 2017. Based on budgets in place as part of the bridging service, 16/17 in year savings in the region of £800k are expected. Longer term recurrent savings will be made once new integrated services start in April 2017. |
| Referral Interceptor Scheme | 100 | 0 | 100 | A | Short term scheme while detail of the full RMS are developed and implemented. Will enable quick wins and reduce inapropriate referrals . Also supportive of EUR target below. |
| Effective Use of Resources | 500 | 0 | 500 | A | Non-payment of un-authorised EUR procedures. Significant potential savings based on benchmarking data across GM. Monitoring and financial challenge system being finalised and will go live at the end of July to challenge M3 data. THFT implementing internal processes to prevent listing |
| GP Prescribing | 1,000 | 0 | 1,000 | R | Challenging target to reduce prescribing costs, building on schemes implemented in 15/16. See separate schedule for detailed exploration of prescribing QIPP schemes. |
| **Total** | **4,992** | **8,000** | **12,992** | | |

| SCHEMES WITHOUT A QUANTIFIED FINANCIAL IMPACT IN 2016/17 - BUT WHERE WE ASPIRE TO REALISING SOME BENEFITS IN YEAR | | | | | |
|---|---|---|---|---|---|
| Neighbourhood Development | 0 | 0 | 0 | | Part of the transformational funding request from devolution. Joint savings claimed in the business case (from neighbourhood development, home care and healthy lives) to stop future years activity growth and maintain at 16/17 plan levels. Dependent upon GM funding in order to realise the benefits. While the business case does not assume any savings until 2017/18, we hope to be able to bring forward some of the benefits to address the 16/17 QIPP challenge. |
| Home Care | 0 | 0 | 0 | | Part of the transformational funding request from devolution. Joint savings claimed in the business case (from neighbourhood development, home care and healthy lives) to stop future years activity growth and maintain at 16/17 plan levels. Dependent upon GM funding in order to realise the benefits. While the business case does not assume any savings until 2017/18, we hope to be able to bring forward some of the benefits to address the 16/17 QIPP challenge. |
| Living Well - Self Care | 0 | 0 | 0 | | Part of the transformational funding request from devolution. Joint savings claimed in the business case (from neighbourhood development, home care and healthy lives) to stop future years activity growth and maintain at 16/17 plan levels. Dependent upon GM funding in order to realise the benefits. While the business case does not assume any savings until 2017/18, we hope to be able to bring forward some of the benefits to address the 16/17 QIPP challenge. |
| Referral Management System | 0 | 0 | 0 | | New referral management system reviewing all referrals. Will ensure availability of advice & guidance and appropriate use of diagnostics prior to consultation. Not part of the GM Devolution transformation fund bit but will require non-recurrent funding. Service design on-going and currently reviewing IM&T solution. Business case pushed back to allow for more work to be done on IM&T solution, but Referral Interceptor scheme above brought forward to ensure quick wins are achieved. |
| Digital Health | 0 | 0 | 0 | | Part of the transformational funding request from devolution. Digital Health Suite allowing care home residents/carers to consult on health conditions as they arise and allowing the person to be treated remotely which will reduce A&E attendances and emergency admissions. Savings dependent upon GM funding in order to realise the benefits. While the business case does not assume any savings until 2017/18, we hope to be able to bring forward some of the benefits to address the 16/17 QIPP challenge. |
| Home First | 0 | 0 | 0 | | Admission Avoidance & Discharge to Assess. Part of the transformational funding request from devolution which should reduce length of stay allowing the FT to close wards. Early implementation pilot on 2 wards from June but full realisation of benefits is dependent upon GM funding. |
| Flexible Community Beds | 0 | 0 | 0 | | Reconfiguration of intermediate care beds. Part of the transformational funding request from devolution. Savings dependent upon GM funding in order to realise the benefits. |
| Commissioning Improvement Scheme | 0 | 0 | 0 | | GP led schemes to manage demand, reduce inappropriate referrals and ensure value for money. Practices may be eligible to receive a payment under the scheme in 2017/18 based on achievement at both individual practice and neighbourhood |
| Anti Coag Review | 0 | 0 | 0 | | Work on-going in transformation directorate to standardise service across all providers and ensure appropriate level of follow up in secondary care |
| Estates | 0 | 0 | 0 | | Potential savings against the budgeted payments to Propco/CHP |
| **Total** | **0** | **0** | **0** | | |
| **SAVINGS TARGET** | **13,500** | **8,000** | **21,500** | | |
| **SAVINGS STILL TO FIND** | **8,508** | **1,808** | **10,316** | | |
| **SAVINGS STILL TO FIND FOLLOWING OPTIMISM BIAS ADJUSTMENT** | **11,201** | **1,592** | **12,793** | | **Assumes: 10% of red rated schemes will be realised in 2016/17.<br>50% of amber rated schemes will be realised in 2016/17.<br>100% of green rated schemes will be realised in 2016/17.** |

3.3 On a year to date basis £6.285m of savings have been achieved (the green rated schemes in the table), £0.607m of this relates to CCG schemes while £5.678m has been identified by TMBC to support the council services. For the council, this comprises additional budget that the Council has put into Care Together services to recognise the 2016-17 in-year cost pressures together with a reduction in Active Tameside borrowing requirements and reduction in the Community Services contract which Public Health holds with Tameside FT.

3.4 In total £12.992m of savings have been identified, of which £2.376m have been risk rated red. £8.508m remains unidentified. We expect that some of this funding gap will be met by a combination of new schemes and proposals which are due to start or be actioned imminently, together with the implementation and acceleration of schemes which are included in the table but are not currently quantified. If we are unsuccessful at implementing the totality of these schemes, we will be facing substantial pressures resulting in a significant risk of the CCG moving into a deficit position and therefore non-delivery against the financial control target for 2016/17. It is therefore essential that this risk is widely understood across the economy and all efforts channelled in addressing this problem whilst ensuring the provision of clinically safe and sustainable services for our residents.

3.5 If we make an assumption that we will be unable to realise all of amber and red rated savings in 2016/17 and apply some optimism bias, the total savings which still need to be identified by the Commissioners increases to £12.793m.

3.6 Since last month the CCG has realised £0.115m of savings as a result of admin budget reviews, which have been categorised from amber into green, while integrated elective services and referral interceptor have moved from the unquantified portion of the report into amber rated schemes with expected savings of £0.800m and £0.100m respectively.

3.7 Options have been considered at previous finance committees to address the residual gap non-recurrently for 2016/17. However, it is important to recognise that some of the interventions would in effect be a form of financial support and the risk associated with this action would need to be fully evaluated.

3.8 The 2016/17 CCG QIPP target assumes that expenditure on secondary care, CHC, prescribing and other areas at risk of overspending against plan are assumed to perform in line with plan. If we have significant over spend in these areas we will have to review our options for addressing the gap.

3.9 The Councils position has improved significantly from the previous reporting period due to additional budget being allocated to fund in year cost pressures as outlined above. The Council is still in the process of identifying options to address the projected recurrent financial gap that is expected to arise during 2016/17. It is anticipated that the outcome be reported within future monitoring reports.

**Tameside Hospital NHS Foundation Trust Efficiency Savings**

3.10 Table 3 provides a summary of the Tameside Hospital NHS Foundation Trust efficiency savings for delivery in 2016/17

**Table 3 -Tameside Hospital NHS Foundation Trust: Efficiency Savings Programme 2016/17**

| | Month 4 - Year to Date | | | | Year End Forecast | | |
|---|---|---|---|---|---|---|---|
| | Plan (£'000) | Actual (£'000) | Variance (£'000) | | Plan (£'000) | Actual (£'000) | Variance (£'000) |
| In Year Total Savings | 2,482 | 2,224 | (258) | | 7,832 | 7,832 | 0 |
| Recurrent Savings | 2,482 | 561 | (1,921) | | 7,832 | 3,675 | (4,157) |

3.11 Although the savings are forecast to deliver in year, only 47% are recurrent which will result in a financial pressure in 2017/18 if recurrent savings are not identified.

3.12 £1.0m of the recurrent savings have a high risk of delivery. These schemes include reduction in use of medical agency by recruiting substantively and radiology reconfigurations.

3.13 Whilst the current priority of the economy is to deliver a balanced budget during the current financial year, it is essential that additional efficiency schemes are progressed at scale and with urgency to address the projected financial gap the economy will need to address in the next and subsequent financial years. A summary of the projected gap for each financial year to 2020/21 is provided within table 4. Please note that this is consistent with the existing Locality plan submission to GM Health and Social Care Partnership, which will be reviewed during the Autumn of 2016.

**Table 4 – Projected Tameside and Glossop Economy Financial Gap**

| T&G Projected Financial Gap | 2016-17 £'000 | 2017-18 £'000 | 2018-19 £'000 | 2019-20 £'000 | 2020-21 £'000 |
|---|---|---|---|---|---|
| Tameside MBC | 8,000 | 22,114 | 22,601 | 21,752 | 25,837 |
| Tameside & Glossop CCG | 13,500 | 22,485 | 22,083 | 22,209 | 18,547 |
| Tameside FT (after CIP) | *24,200 | 24,380 | 24,686 | 25,049 | 25,786 |
| **Economy Wide Gap** | **45,700** | **68,979** | **69,370** | **69,010** | **70,170** |

. * *This represents the underlying recurrent financial position at THFT. However, the Trust is in receipt of £6.9m sustainability funding in 2016/17 resulting in a planned deficit of £ 17.3 m (referred to in section 2.2)*

## 4. MONTH 4 UPDATE

4.1 **Acute** The overall Acute budgets are forecast to over spend by (£0.274m) at year end. It must be noted only 3 months of activity data has been received at the time of writing therefore there is an element of risk associated with these figures. Activity will be monitored closely on a month by month basis.

4.2 Table 5 below details the position of our main acute providers. The full year forecast position of the main acute providers is an under spend of £0.023m which is partially offsetting the overall overspend of (£0.274m).

**Table 5 - Main Acute Providers**

| Provider | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | Budget | Actual | Variance |
| | £000's | £000's | £000's | £000's | £000's | £000's |
| TFT | 42,450 | 43,167 | (717) | 127,075 | 127,075 | 0 |
| CMFT | 7,441 | 7,579 | (139) | 22,280 | 22,546 | (266) |
| SFT | 3,974 | 3,766 | 208 | 11,969 | 11,770 | 198 |
| UHSM | 2,150 | 2,258 | (108) | 6,568 | 6,664 | (96) |
| PAHT | 1,336 | 1,242 | 94 | 4,029 | 3,896 | 133 |
| SRFT | 1,072 | 1,126 | (54) | 3,226 | 3,340 | (114) |
| WWL | 464 | 386 | 78 | 1,409 | 1,263 | 146 |
| BOLT | 27 | 19 | 0 | 80 | 58 | 22 |
| **Total** | **58,914** | **59,544** | **(630)** | **176,635** | **176,612** | **23** |

4.3 **Tameside FT** – Contract is over spending by (£0.717m) on a year to date basis based on month 3 data. This excludes a cross year pressure of (£0.178m) for excess bed days which is to be resolved alongside the other risks within the TFT contract at a senior level. We continue to forecast a year end break even position on the basis that there will be acceleration of transformational schemes which we anticipate will reduce activity back into line with budget from M07.

4.4 The risk associated with the forecast position needs to be appreciated within the context of the risk/gain share agreed as part of the contract, where a floor/ceiling has been set at £0.500m above/below this contract value. In the eventuality that full year overspend is in excess of this ceiling, premium payments of 50% are triggered. Based on the current levels of overspend and if the final contract reconciliation point was today, this clause would be triggered and over performance of £1.075m would be payable. This is not captured within the current financial position and poses a significant financial risk to the CCG which has been recorded in the risk register. It is imperative that action is taken in the months to come to ensure that agreed transformation schemes are implemented to drive down activity to the contracted level. This is in the financial interests of both provider (who have a marginal cost in excess of tariff) and commissioner (who do not have the resource to fund this level of demand). Conversations are being progressed at director level in order to determine how to manage this risk in the best interests of the economy.

4.5 In addition to the direct PbR tariff cost and volume pressures covered in the narrative below and the cross year excess bed days pressure of (£0.178m), the FT have identified cost pressures related to premiums they are paying to the commercial sector (£0.141m).

4.6 In terms of the year to date position elective activity is overspent by (£0.189m) and this is driven by Trauma & Orthopaedics (£0.235m). In order to avoid the premium cost incurred by TFT when making secondary referrals to the private sector, GPs have been encouraged to refer directly to providers other than Tameside Hospital including private providers where appropriate. In line with this protocol we have seen a decrease in T&O referrals to TFT averaging 35 cases per month in quarter 1 and an increase in the independent sector which is overspent on T&O by (£0.108m) year to date. This planned movement of service was factored into the 2016/17 TFT contracting round and the budget allocation for the reduction of the 2016/17 TFT plan is currently sat within CCG reserves to offset the year to date overspend on the independent sector.

4.7 Emergency Care is over spent by (£0.202m) based on month 3 data which is mainly due to pressures within Ambulatory Care (£0.192m). However, it must be noted that there was an extreme overspend on non-elective emergency within month 1 which has significantly reduced in subsequent months. This was due to a one off "spike" within General Medicine for pneumonia which peaked at (£0.117m) overspent in April and dropped to (£0.040m) overspent in June. In addition, there is a second element to the excess bed days cross year pressure relating to the spells. This equates to an additional pressure of (£0.112m) which has not been removed from the year to date position. Furthermore, the Care Together service redesign focuses on higher utilisation of ambulatory care hence the movement of (£0.192m) mentioned earlier was as expected, however a corresponding reduction in high cost admissions has not yet emerged. In particular, DVTs and Pulmonary Embolism are over spending by (£0.072m) and (£0.088m) respectively. Investigation of the D-Dimer scheme during M03 was unable to verify with any certainty that this initiative has reduced DVTs presenting in the acute setting, however there were indications from the analysis that the scheme is possibly offsetting underlying growth and that the over spend would be significantly higher if the new protocol was not in use. An audit of test outcomes is underway with the commissioning team to measure the performance of the scheme.

4.8 Non-Emergency care is over spending by (£0.133m), which is due to elevated births during May and June. The marked increase in antenatal pathways reported at M3 was investigated and the outcome was the identification of a presentational issue within the monitoring data provided by the FT in terms of unit plan prices. This will be resolved for M5. In addition, maternity data has been validated to alleviate concerns raised regarding duplicate charging of pathways across providers.

4.9 Outpatients are over spending by (£0.134m) year to date, with particular emphasis around first attendances which is over spending by (£0.152m). This is particularly interesting in view of the new Elective Care Pathways around MSK, ENT and Ophthalmology as we would expect to be seeing a reduction in first attendees as GPs aim to only refer patients to the acute setting if surgery is required using the referral guidance criteria. In particular, ENT is and T&O are (£0.02m) and (£0.009m) over spent year to date. This is also true of other GM providers and as such an exercise is underway to provide further referral analysis around DNAs, inappropriate referrals and referral outcomes in order to understand this further for M5.

4.10 Direct Access is over spending by (£0.094m) year to date of which (£0.040m) relates to MRI scans during month 1. The MRI costs significantly dropped from month 2 onwards due to the closure of the mobile unit, however as the unit would have been standing empty for the remaining month of the contract it was utilised for other services, hence the (£0.027m) over spend for M2 on unbundled diagnostics.

4.11 Finally we have an over spend within the independent sector of (£0.240m) which covers a range of services including T&O and MRI scans. As discussed within the elective position, this was a planned movement of service between TFT and the private sector factored into the 2016/17 contract. The expectation for activity levels to reduce at TFT as activity increases with private providers has not yet materialised, hence we are incurring the costs of

both providers, plus the pass through premium cost when TFT are internally referring patients to the independent sector. This is clearly not a sustainable nor an affordable scenario for either party. Hence the importance of the Director level conversations to understand the rationale and factors influencing decisions which are driving the improvement of RTT levels at TFT and how this needs to be balanced with overall financial stability.

4.12 **Central Manchester FT** is overspent by (£0.139m) at M4. The forecast position to year end is an over spend of (0.266m). The main issues are:

- Macular activity continues to overspend having increased to (£0.140m) year to date. The forecast has been adjusted this month to take account of this over performance and to factor in an additional £0.090m for future months. The CCG has recently written to providers about adherence to EUR policies and as such we expect cataract activity to reduce in future months and to broadly come back in line with plan. It was also noted that due to the financial envelope the plan was negotiated down for 2016/17. This area of activity will continue to be closely monitored along with SpaMedica within the Independent Sector where macular activity continues to grow.
- Daycase activity is overspent by (£0.058m). This is largely due to Gastroenterology, and mainly endoscopies, as CMFT reduces the Waiting List backlog.
- Easy Go Renal Dialysis Patient Transport – The forecast has been increased by a further (£0.018m) which represents an additional month's service having been extended again and now due to cease on 30 September. The transfer date to NWAS is now expected to be 1 October 2016.
- The offset to the noted pressures is largely the under spend in drugs costs, currently stating a year to date £0.103m (27%) under plan. The main drivers are Adalimumab and Etanercept, which were drugs that reported significant over-performance in 2015-16, which we reflected in our 206/17 plan.

4.13 **Stockport FT –** Contract is currently under-spending by £0.208m on a year to date basis this is driven by large underspends in Elective Orthopaedics where we have seen underspends of £0.095m. This is currently being offset by bigger increases in activity at Tameside FT and private acute provider BMI. This trend at Stockport is expected to continue for the remainder of 2016/17.

4.14 The other main area where we are recognising a significant under performance of £0.066m is within the Stroke pathway where we have seen activity significantly below plan in Months 1 & 2 but assume this will return to expected levels at M3.
The forecast outturn for Stockport FT is an under performance £0.198m.

4.15 **University Hospital South Manchester –** Contract currently overspending year to date by (£0.108m) which is driven by over-performance in Critical Care and Day-cases but being partially off-set by a significant under performance in Non Elective of £0.093m.

4.16 Critical Care saw a significant over performance in the M2 position from a single patient who required organ support care and a significant stay in hospital equating to costs of (£0.070m). No activity was recorded in M3 so the decision to forecast the position back to plan for the remainder of 2016/17 is considered appropriate.

4.17 Long term ventilation support has seen a year to date overspend of (£0.021m) with the majority of this activity concentrated in M1 but M2 & M3 are still over-spending but with a lower cost impact. This trend is predicted to continue so has been reflected within the forecast position.

4.18 Implantation cardiac devices and stent procedures have been a key driver of increased day case costs. It is expected that these procedures will be in line with plan for the remainder of the year. Non elective procedures have reduced and particularly within Geriatric medicine for angiograms and angioplasty procedures.

4.19 **Salford Royal FT Contract** currently overspending by (£0.054m) in the year to date position which is mainly driven by Day cases and Non Elective activity. Neuro Rehab is under-spending against plan by £0.033m.

4.20 Overspends in Day cases are within pain management and clinical haematology. Further detail is being sought to try and understand the reason for this trend.
Non elective activity has seen increases in unplanned dermatology procedures and the provider is being contacted to gain a better understanding of what is driving this change. Stroke activity has increased also and these additional pressures are reflected in the forecast position.

4.21 There have been month on month reductions in neuro surgery and slow stream rehab but for prudence the forecast is reported to be in line with plan at this stage.

4.22 **Mental Health** budgets continue to forecast an overspend of (£0.135m) at year end. This is largely due to additional placements within the Non CHC service which were not included within the baseline budget. As with the CHC placements this continues to remain and area of volatility and risk. A patient level review has taken place between the Finance and CHC teams in July and work is continuing in August. A more robust methodology of data analysis is currently in development and this will ensure a much more streamlined process with more effective forecasting.

4.23 As notified to NHSE we continue to meet, if not exceed (due to additional costs being incurred within Non CHC) the 2016/17 Parity of Esteem. This continues to be one area that will be monitored on a monthly basis both internally and externally by NHSE.

4.24 **Primary Care** Month 4 Primary Care is forecast to overspend by (£0.590m) driven mainly from pressures in Prescribing.

4.25 The CCG also has a cross year pressure from Prescribing of £0.216m. At this early stage in the financial year, the PPA profile is used to estimate the forecast for the remainder of the year. The Medicines Management team are providing intense support to individual practices to reduce prescribing costs.

4.26 The CCG has a £1m QIPP target for prescribing in 2016/17. As referenced above, the Medicines Management team continue to work with GP practices in managing their prescribing costs, repeat orders and elimination of waste, but until a reduction in prescribing expenditure is reported in the Prescribing Monitoring Document (PMD), a forecast position of (£0.500m) overspend is felt to be realistic at this stage. Therefore, in order for the CCG to achieve the prescribing QIPP target in 2016/17 the CCG would need to implement schemes that actually achieve savings of £1.5m compared to the current forecast.

4.27 Delegated Co-Commissioning expenditure shows a forecast overspend of £0.059m compared to a previously reported underspend of £0.067m. This represents an adverse movement of £0.126m. This is attributable to three main areas:

- GMS – The national global sum rate is much higher than the 1% increase anticipated at budget setting. Furthermore, this overspend has increased by £0.073m in month following the adjustment to list sizes at quarter two. For prudence, a further increase based on 0.4% growth has been included for the remaining two quarters of the year. There is a possibility of some additional funding becoming available to CCGs which may mitigate this pressure however this has yet to be confirmed.
- QOF – The final achievement of the 2015/16 QOF is not available until formally signed off in July; this is then used to update the 2016/17 forecast. At month 3 an estimate of the 2015/16 position was used which together with the change in list size has seen a £0.067m increase in the estimated position for 2016/17.

- Premises Cost Reimbursement – The 2 pressures outlined above are offset slightly by a reduction in the forecast for premises cost reimbursement. This is the impact of a national recalculation of GP premises rateable values. Where practices have submitted invoices for reimbursement, any financial benefit has been reflected in the position reported, however where rates' invoices are still to be received this will be realised in future months.

4.28 The financial position in respect of Delegated Co- Commissioning budgets is discussed in in detail at the Primary Care Committee and the CCG and GMH&SCP colleagues work closely under the principles of the Memorandum of Understanding in place with NHS England.

4.29 **Continuing Care** The month 4 forecast outturn position for CHC remains an overspend of (£0.207m). A patient level review has taken place between the Finance and CHC teams in July and this review is continuing throughout August.

4.30 Initial findings from the review indicate that there has been an increase since last year on Long Term patients with a CHC care package. July 2015 reported 229 Long Term patients in the system compared with 245 patients in July 2016. This upward trend is an indication that more patients in T&G are requiring longer term CHC packages as people are living longer with more complex needs. On average each package of care costs the CCG £0.052m per annum.

4.31 The findings also confirm that there is a significant increase in Fast Track patients compared with last year. In July 2015 there was an average of 25 Fast Track patients in the system compared with an average of 47 in July 2016. Fast Track Patients have a shorter length of stay but the increase in demand could pose a risk to the financial position if this upward trend continues.

4.32 Detailed work in August will concentrate on the analysis of the invoicing for CHC. Currently patients are forecast to receive packages of care until the end of the financial year, unless they are clearly identified as a Fast Track patient. This detailed review will identify if there has been a cross year financial benefit from the accrual that was included at the end of 2015/16

4.33 **Funded Nursing Care.** In July the Department of Health announced an increase in Funded Nursing Care (FNC) rates payable by CCGs for 2016/17. The rate paid by the NHS to nursing homes for eligible patients will rise with effect from 1 April 2016 to £156.25 per week from the current standard rate of £112 per week. This equates to circa 40% increase but only a 2% increase was estimated in the budget setting process. This will generate an estimated financial pressure on the CCG of around £0.600m. This is currently being evaluated and will be confirmed and reflected in financial values at month 5.

4.34 **CCG Running Costs** The CCG running cost allocation has been reduced in 2016/17 by £0.040m in line with NHS England guidance. The annual budget in 2016/17 is £5.162m. The CCG is forecast to under spend on running costs by £0.425m at the year end. Table 6 below shows the running costs by directorate.

4.35 QIPP savings of £0.116m have been found within Running Costs due to natural attrition.

4.36 The cost of repairing the air conditioning unit in New Century House (£0.295m) is reflected in the Month 4 position. However, this pressure is partly off-set by a cross year benefit in telecommunications of £0.130m within the IM&T budget. The single commission's estates and legal team are currently reviewing the terms of the lease for New Century House to explore if this pressure could be mitigated.

**Table 6 – CCG Running Costs 2016/17**

| Directorate | WTE Estab | £000's Budget | £000's Forecast | £000's Variance |
|---|---|---|---|---|
| Commissioning | 15.36 | 747 | 757 | (10) |
| Finance | 13.03 | 750 | 673 | 77 |
| CEO / Board Office | 2.28 | 688 | 547 | 141 |
| Chair / Non Execs | 0.60 | 218 | 218 | 0 |
| Communication & PR | 5.00 | 233 | 184 | 49 |
| Corporate Governance | 9.80 | 455 | 449 | 6 |
| Human Resources | 1.50 | 45 | 38 | 7 |
| IM&T | 3.00 | 259 | 224 | 35 |
| IM&T Projects | 0.00 | 175 | 176 | (1) |
| Nursing Directorate | 2.00 | 115 | 113 | 2 |
| Contract Management | 4.40 | 323 | 251 | 72 |
| Estates | 0.00 | 430 | 430 | 0 |
| Corporate / Other | 1.00 | 724 | 696 | 28 |
| **TOTAL** | **57.97** | **5,162** | **4,756** | **406** |

4.37 **Tameside MBC** Additional Council resource of £5.172m to contribute to in year cost pressures is included in the month 4 figures. This was approved by the Executive Cabinet of the Council on 31 August 2016. The narrative below details additional service pressures.

**Adult Social Care (Including Early Intervention)**

4.38 **Better Care Fund** - Removal of payment for the performance element of BCF has resulted in changes to national conditions around NHS commissioned out of hospital services. There is a minimum requirement in 2016/17 to invest £4.4m of the overall BCF allocation into these services which represents an increase of £1.12m on the previous year's figure. Consequently this has resulted in a £1.12m reduction in the BCF resource available to fund Adult Social Care

4.39 **CCTV -** The service has a projected deficit of £0.060m. A service review is underway in this area to reduce expenditure where appropriate. Further updates will be provided in future reports.

4.40 **Residential & Nursing Care –** The current net cost of placements is projected to be £0.387m in excess of budget for the financial year. This is as a result of increased placement numbers and a reduction in client contributions due to individual financial circumstances. Changes to the FNC contribution rate will potentially reduce net expenditure in this area by approximately £0.600m. This will be confirmed and reported at month 5.

It should be noted that the Council are mid-range compared to other NW Local Authorities in terms of placement numbers into Residential & Nursing care for over 65s but will seek to improve the position to be top quartile performers as new models of care are implemented.

4.41 **Homecare** - The 2016/17 budget takes account of the increased fees payable to providers and was set based on March 2016 activity levels. Current data suggests that the number of commissioned hours has reduced therefore current projections are that spend for the year will be under budget by £0.195m.

4.42 There have been instances of provider failure over the last 18 months which has led to capacity concerns across the homecare market.

4.43 The Care Together Single Commissioning Board approved an increase to the hourly rate payable to providers on 7 June 2016 (backdated to 1 April 2016) as a result of the implementation of the National Living Wage from 1 April 2016.

4.44 The service continues to review existing commitments in line with statutory responsibilities to deliver a balanced budget by the end of the financial year. Associated progress will be included within further monitoring reports during 2016/17.

**Childrens' Services (including Strategy and Early Intervention)**

4.45 **Looked After Children (LAC) -** The current number of LAC supported by the Council is 445. This includes Fostering and Adoption placements as well residential care homes. Numbers have increased by 10 since April 2016 with some individual external residential placement costs in excess of £0.200m per annum. Current estimates are that spend will be in excess of budget by £0.401m by the end of the financial year. It should be noted that the service is exposed to the risk of further unexpected and complex needs placements.

**Public Health**

4.45 Current proposals to reduce the fee payable to Active Tameside for management and operation of the leisure estate will materialise during 2016/17. This will result in a cost saving to the Council of £0.350m per annum (as a minimum from 2017/18) as Active Tameside improves its financial self-sufficiency via capital investment by the Council in the estate.

4.46 The Directorate have negotiated a reduction of £0.169m in the Community Services contract with Tameside FT.

4.47 Temporary resourcing of the Active Tameside capital investment prudential borrowing repayments is currently under consideration. The temporary resourcing arrangements will be replaced in future years via the recurrent savings achieved from a significant reduction to the annual management fee payable. Currently a borrowing repayment of £0.186m is included within the month 4 projected outturn estimate.

## 5. ADDRESSING THE LOCAL HEALTH ECONOMY GAP

5.1 Considerable work is ongoing to ensure the Economy is investment ready by the end of August when the Greater Manchester Strategic Partnership Board will consider the Tameside and Glossop proposals for Transformational Funds. A revised sum of £23.2m has been requested over the period to 2019/20, £5.2m of which has been requested in 2016/17. It is envisaged a decision on the proposals will be known by 30 September 2016.

## 6. BETTER CARE FUND

6.1 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.

6.2 Table 7 provides details of the better care fund allocation for 2016/17 together with the actual expenditure to 30 June 2016 (Quarter 1) and the projected expenditure to 31 March 2017.

**Table 7 – Better Care Fund 2016/17**

| Allocation | Funding Category | 2016/17 Allocation | Actual Expenditure to 30 June 2016 | Projected Expenditure to 31 March 2017 | Projected Variation to 31 March 2017 |
|---|---|---|---|---|---|
| | | £'m | £'m | £'m | £'m |
| Better Care Fund | Revenue | 15.323 | 3.150 | 15.323 | 0.000 |
| Disabled Facilities Grant | Capital | 1.978 | 0.216 | 1.978 | 0.000 |
| Total | | 17.301 | 3.366 | 17.301 | 0.000 |

6.3 Health and Wellbeing members should note that the 2016/17 Better Care Fund allocation sum of £15.323m (detailed within table 7) is included within the Section 75 funding allocation of the Integrated Commissioning Fund as detailed in **Appendix C** as this is a revenue funding allocation**.** Actual expenditure is included with table 1. The Disabled Facilities Grant sum of £1.978m (again detailed within table 7) is excluded from this total as it is a capital funding allocation.

6.4 **Appendix D** provides supporting details of the 2016/17 quarter one (1 April 2016 to 30 June 2016) 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. Therefore, the remaining respective quarterly monitoring statements for 2016/17 will be included in future financial monitoring report agenda items as appropriate.

6.5 **Appendix E** provides confirmation for members that the 2016/17 Tameside Better Care Fund plan has been approved by NHS England.

## 7. RISKS

7.1 The key financial risks facing the Commissioners and THFT within the Economy at 31 July 2016 (month 4) are detailed in Table 8.

## Table 8 : Schedule of Key Financial Risks – Month 4 2016-17

| Risk | Probability | Impact | Risk | RAG | Detail of Risk | Mitigation |
|---|---|---|---|---|---|---|
| The achievement of meeting the Financial Gap recurrently. | 4 | 4 | 16 | R | £12.992m of savings have been identified, of which £7.499m have been risk rated red. £8.508m remains unidentified. We expect that some of this funding gap will be met by a combination of new schemes which will be brought forward, together with the implementation and acceleration of schemes which are included in the table but are not currently quantified. These schemes are unlikely to resolve the total gap meaning we have significant risk of non-delivery against the financial savings target in 2016/17. It is therefore essential that this risk is widely understood across the economy and all efforts channelled in addressing this problem to ensure the provision of clinically safe and sustainable services for our residents. | As part of the Commissioning Improvement Scheme (CIS), GP's along with Commissioners are developing schemes to improve care for patients and achieve the required financial gap in 2016/17. |
| Over Performance of Acute Contract | 3 | 4 | 12 | A | 3 months SLAM data is available for 2016/17, however based on historic data and trends this is one area that is potentially volatile and could therefore create an additional pressure on the ICF in 2016/17. Despite £0.7m of year to date overspend we are currently forecasting that the TFT contract will be in line with plan by year end. If there is an over performance on the TFT contract a 50% premium will be paid. | Both finance and activity data when available for 2016/17 will be monitored and challenged where necessary. The CCG has a 1% uncommitted reserve and a 0.5% contingency that have been set aside as per NHSE guidance. The initial plan would be to utilise this funding to offset such pressures, but confirmation from NHSE would be required. It is anticipated transformational funding will be received which will enable investment in areas to redesign services that will provide savings and better services for patients. |
| Not receiving Transformation funding | 2 | 4 | 8 | A | It is anticipated transformational funding will be received in 2016/17. A decision is anticipated by 31st August. | There is the potential to use some LA funding to bridge the gap temporarily with the remainder of the £49m to follow later. The CCG, TFT and TMBC are working closely with the GM Health and Social Care Partnership team and confirmation of how much funding will be received will be confirmed in August 2016. |
| Over spend against GP prescribing budgets | 3 | 5 | 15 | R | Despite a QIPP scheme of £1m being set for 2016/17 for prescribing, the costs in the final quarter of 2015/16 increased considerably more than planned. The CCG has incurred a cross year pressure of £216k on prescribing and is forecasting a year end over spend of £500k. Therefore there is a significant financial risk on prescribing in 2016/17. | A number of practices have or are looking to use a practice based pharmacist to review prescriptions, along with the ongoing work with the Medicines Management team. This will hopefully drive costs down and identify additional areas for savings. |
| Over spend against Continuing Health Care budgets | 2 | 3 | 6 | A | CHC was a cost pressure in 2015/16 to the CCG. Budgets have been set based on outturn plus a level of growth. | Budgets have been set at outturn plus and an element of growth and there is a provision on the balance sheet for potential restitution claims. A full detailed analysis of the Non CHC and CHC database is taking place in July 2016 between finance and the CHC team. This should ensure a robust forecast is produced and all known information recorded accurately. |

| | | | | | | |
|---|---|---|---|---|---|---|
| Operational risk between joint working. | 1 | 5 | 5 | A | The Integrated Commissioning Fund and integrated working is a new way of working and reporting, bringing together different cultures and different methods of accounting, which therefore bring with it an element of risk. | Working relationships between the CCG and TMBC are very good. There are numerous meetings, and committees which both members regularly attend, contribute and make decisions. Therefore this should mitigate any risk with joint working. |
| CCG Fail to maintain expenditure within the revenue resource limit and achieve a 1% surplus. | 4 | 4 | 16 | R | If the QIPP target and risks stated above are not mitigated the CCG would fail to achieve its mandated 1% surplus. | If all of the above risks are mitigated as explained then by default the CCG would achieve a 1% surplus and the ICF would have a balanced budget. |
| In year cuts to Council Grant Funding | 2 | 3 | 6 | A | In 2015/16 the Public Health grant was reduced by £1m part way through the financial year. The Council had to fund committed expenditure through use of existing reserves. | The Council maintains earmarked reserves, although these should not be viewed as a long term solution. Discussions are ongoing about more flexible contractual arrangements to enable easier withdrawal to mitigate the effect of similar reductions in the future. |
| Care Home placement costs are dependent on the current cohort of people in the system and can fluctuate throughout the year | 3 | 4 | 12 | A | Expenditure on Residential and Nursing care home placements accounts for a significant proportion of Adult Social Care spend. The Council aims to manage placement profiles by offering community based services as an alternative wherever possible. In some cases however this is not possible due to the complexity of individual needs. | Continued development of the community based offer and use of technology where appropriate to support self-management of care. It is accepted however that it is not possible to fully mitigate the risk of additional placements. |
| Looked After Children placement costs are volatile and can fluctuate throughout the year | 3 | 4 | 12 | A | The current number of LAC supported by the Council is 445. This includes Fostering and Adoption placements as well residential care homes. Numbers have increased by 10 since April 2016 with some individual placement costs in excess of £0.200m per year. The service is also exposed to the risk of unexpected and complex needs placements. | Multi-agency approach around Troubled families as part of GM approved model in order to intervene earlier in the child's life and prevent the need for costly interventions (such as care home placements). Incentives of the fostering service to increase placements via this route rather than costlier residential placements, |
| Unaccompanied Asylum Seekers | 4 | 3 | 12 | A | There will be a financial impact on the Tameside Economy as unaccompanied Asylum Seekers are accommodated within the borough. There is a risk that associated Central Government funding does not equate to related expenditure incurred by the Council and CCG. | Central Government funding will be received to support related expenditure. The economy will need to ensure services are delivered within resource allocations received. |
| Provider Market Failure | 2 | 5 | 10 | A | The economy commissions services from the private provider sector e.g. Homecare, Residential and Nursing Care, Children's Residential placements. Internal intelligence suggests that some providers are anticipating financial strain due to the impact of delivering services within commissioned payment rates (e.g. impact of national living wage etc). | A review is underway to reconfigure service delivery requirements from the private sector market to ensure it aligns with the strategic commissioning objectives of the Integrated Care Organisation. The associated fee structure aligned to the revised market provision will also be considered within this review to ensure stability within the market. |
| Underperformance on Trust Efficiency Savings programme | 4 | 5 | 20 | R | The Trust has a £7.8m savings programme, with c.£1.5m of high risk schemes. The Trust forecast assumes delivery of the total value of the savings. | There is a rolling programme of identification of new schemes. The Trust is also working with other GM organisations involved in the national NHS Financial Improvement Programme to identify further savings. |
| Independent sector | 3 | 4 | 12 | A | The Trust has incurred £480k of expenditure with the | The Trust is having ongoing discussions with the |

| | | | | | | |
|---|---|---|---|---|---|---|
| expenditure not funded by commissioners | | | | | independent sector to July 2016. The Trust does not have budget for this. The 2016/17 contract was reduced to enable commissioners to contract directly with the IS. If this expenditure continues at the same rate, it is estimated the full year expenditure will be £1.1m. | commissioners to agree a financial position with relation to use of the independent sector. Internally, there is ongoing review of the activity required to deliver the performance targets. The Trust Efficiency programme will also potentially support this. |
| Total proposed value of Sustainability and Transformation Funding (STF) not received | 3 | 5 | 15 | R | It is anticipated the £6.9m STF will be received in full. This is dependent on achieving the planned financial control total and delivering the trajectories for A&E, RTT and Cancer. | A number of action plans are in place to support delivery of the performance targets (A&E action plan, RTT/Cancer monitoring and mitigation in place). Performance is monitored and challenged at all levels of the organisation from operational teams to the Board. |
| Additional unplanned expenditure due to winter pressures | 4 | 4 | 16 | R | The Trust has traditionally incurred additional expenditure over the winter period due to unplanned for pressures. | Several prior year schemes to reduce the impact of winter pressures have been funded an implemented. The Trust's winter resilience plans are also continuously monitored through the SRG. The Trust also has a de-escalation plan in progress to free up bed capacity, and the IUCT workstream will also support winter resilience. |
| Additional investment decisions agreed without identified funding | 2 | 4 | 8 | G | All the Trust's budget is allocated against planned expenditure and there is no contingency funding available for new investments. | The Trust has enhanced the governance process for approving additional investment and financial control. The Executive Management Team have communicated the recognition of the organisation's financial deficit position, and commitment of all budgets in 2016/17. |
| Unmitigated divisional overspends. | 3 | 4 | 12 | G | There are several areas of overspend within the Trust. Currently these overspends are offset by benefits relating to vacancies. However, recruitment to the vacancies are ongoing so this is not a sustainable position for the remainder of the year. | The Trust Efficiency programme supports the delivery of cash releasing savings schemes, to reduce expenditure and bring into line with budget. The Divisions report against a divisional performance framework to monitor and challenge overspending areas. |

## 8 RECOMMENDATIONS

8.1 As stated on the report cover.

# APPENDIX A

## Summary of CCG Financial Position

| NHS Tameside & Glossop CCG 2016/17 Financial Position | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Year to Date (M4) | | | | Year End | | | Movement | |
| | £000's | £000's | £000's | | £000's | £000's | £000's | £000's | £000's |
| Description | Budget | Actual | Variance | | Budget | Forecast | Variance | Previous Month | Movement in Month |
| ***Funding*** | | | | | | | | | |
| Programme Allocation | 116,690 | 116,690 | 0 | | 345,457 | 345,457 | 0 | 0 | 0 |
| Admin Allocation | 1,497 | 1,497 | 0 | | 5,162 | 5,162 | 0 | 0 | 0 |
| PC Co-Commissioning Allocation | 10,307 | 10,307 | 0 | | 30,922 | 30,922 | 0 | 0 | 0 |
| **Total Allocation** | **128,494** | **128,494** | **0** | | **381,541** | **381,541** | **0** | **0** | **0** |
| ***Expenditure*** | | | | | | | | | |
| Acute | 66,044 | 66,788 | (744) | | 198,348 | 198,622 | (274) | (185) | (89) |
| Mental Health | 9,699 | 9,732 | (33) | | 29,096 | 29,300 | (203) | (134) | (69) |
| Primary Care | 26,908 | 27,461 | (553) | | 80,379 | 80,969 | (590) | (437) | (153) |
| Continuing Care | 4,864 | 4,927 | (63) | | 14,236 | 14,442 | (206) | (207) | 1 |
| Community | 9,125 | 9,122 | 2 | | 27,357 | 27,362 | (5) | 0 | (5) |
| Other | 9,194 | 7,686 | 1,508 | | 23,471 | 22,688 | 783 | 557 | 226 |
| QIPP | 0 | 4,500 | (4,500) | | 0 | 12,893 | (12,893) | (13,010) | 117 |
| **Total Programme Costs** | **125,833** | **130,216** | **(4,383)** | | **372,888** | **386,276** | **(13,388)** | **(13,416)** | **28** |
| **Running Costs** | **1,497** | **1,614** | **(117)** | | **5,162** | **4,737** | **425** | **406** | **19** |
| **Total Costs (Admin + Programme)** | **127,330** | **131,830** | **(4,500)** | | **378,050** | **391,013** | **(12,963)** | **(13,010)** | **47** |
| **Surplus / (Deficit)** | **1,164** | **(3,336)** | **(4,500)** | | **3,491** | **(9,472)** | **(12,963)** | **(13,010)** | **47** |

# APPENDIX B

## Summary of TMBC Financial Position (ICF Fund Only)

| Directorate | Work Group | Revenue Budget total | Actual | Projected outturn | Variance |
|---|---|---|---|---|---|
| | | £'000 | £'000 | £'000 | £'000 |
| Adult Social Care | Adults Budget Strategy | (12,614) | (3,477) | (11,062) | (1,552) |
| Adult Social Care | Adults Performance & Development | 1,326 | 357 | 1,226 | 100 |
| Adult Social Care | Adults Senior Management | 531 | 199 | 539 | (8) |
| Adult Social Care | Supporting People | 3,141 | 3,025 | 3,140 | 1 |
| Adult Social Care | Adults Transport | 335 | 92 | 333 | 2 |
| Adult Social Care | Assessment & Care Management Contracts | 742 | 279 | 714 | 28 |
| Adult Social Care | CCTV | 232 | 117 | 292 | (60) |
| Adult Social Care | CHC Funding | 27 | 19 | 27 | 0 |
| Adult Social Care | Community Support | 871 | (410) | 892 | (21) |
| Adult Social Care | Dowries | 169 | (14) | 169 | 0 |
| Adult Social Care | FNC | 0 | 148 | 18 | (18) |
| Adult Social Care | Homecare | 3,939 | 1,008 | 3,744 | 195 |
| Adult Social Care | Localities | 6,812 | 2,361 | 6,781 | 31 |
| Adult Social Care | Long Term Support | 3,818 | 1,040 | 4,017 | (199) |
| Adult Social Care | Mental Health | 2,290 | 712 | 2,233 | 57 |
| Adult Social Care | Residential & Nursing Care | 14,080 | 5,329 | 14,467 | (387) |
| Adult Social Care | Occupational Therapy & Sensory Services | 1,016 | 312 | 967 | 49 |
| Adult Social Care | Residential and Day Services - Day Services | 1,244 | 424 | 1,266 | (22) |
| Adult Social Care | Residential and Day Services - Homemakers | 5,049 | 1,016 | 4,890 | 159 |
| Adult Social Care | Supported Accommodation | 6,492 | 1,031 | 5,973 | 519 |
| Adult Social Care | Urgent Care | 2,480 | 743 | 2,617 | (137) |
| **Total** | | **41,980** | **14,311** | **43,243** | **(1,263)** |
| Public Health | Adult Pooled Treatment Budget | 0 | (27) | 0 | 0 |
| Public Health | Public Health Contracts | 0 | 1,933 | 0 | 0 |
| Public Health | Public Health Manager | (13,938) | (7,513) | (13,633) | (305) |
| Public Health | Public Health Non Prescribed | 12,254 | 2,212 | 11,983 | 271 |
| Public Health | Public Health Prescribed | 2,019 | 173 | 2,036 | (17) |
| Public Health | Sport | 1,304 | 880 | 1,490 | (186) |
| **Total** | | **1,639** | **(2,342)** | **1,876** | **(237)** |
| Childrens Social Care | Adoption | 1,060 | 432 | 1,056 | 4 |
| Childrens Social Care | Assistant Executive Director - Children's | 128 | 60 | 133 | (5) |
| Childrens Social Care | Children with Disabilities | 2,237 | 715 | 1,982 | 255 |
| Childrens Social Care | Childrens - Safeguarding | 448 | 76 | 479 | (31) |
| Childrens Social Care | Children's Centre Services | 0 | 168 | (39) | 39 |
| Childrens Social Care | Childrens Home | 1,181 | 462 | 1,390 | (209) |
| Childrens Social Care | Childrens Legal Fees | 228 | 88 | 227 | 1 |
| Childrens Social Care | Children's Services Administration | 1,004 | 273 | 894 | 110 |
| Childrens Social Care | Childrens Social Work | 2,416 | 832 | 2,603 | (187) |
| Childrens Social Care | Early Help Contracts | 130 | 46 | 106 | 24 |
| Childrens Social Care | Early Help Services | 1,081 | 498 | 1,010 | 71 |
| Childrens Social Care | Early Years Team | 160 | 53 | 160 | 0 |
| Childrens Social Care | Fostering Services | 600 | 189 | 587 | 13 |

| | | | | | |
|---|---|---|---|---|---|
| Childrens Social Care | LAC Support Teams | 1,089 | 329 | 1,054 | 35 |
| Childrens Social Care | Local Safeguarding Children's Board | 123 | 87 | 123 | 0 |
| Childrens Social Care | Participation and Partnerships | 47 | 0 | 24 | 23 |
| Childrens Social Care | Placements Costs | 13,322 | 4,677 | 13,723 | (401) |
| Childrens Social Care | Social Work Child In Need | 0 | 1 | 3 | (3) |
| Childrens Social Care | Strategy & Early Intervention Management | 374 | 85 | 340 | 34 |
| Childrens Social Care | Troubled Families | 0 | (599) | 0 | 0 |
| Childrens Social Care | Young Carers | 113 | 44 | 122 | (9) |
| Childrens Social Care | Youth Offending Team | 136 | 196 | 208 | (72) |
| **Total** | | **25,877** | **8,712** | **26,185** | **(308)** |
| **TMBC Total** | | **69,496** | **20,681** | **71,304** | **(1,808)** |

# APPENDIX C

**Reconciliation of the Integrated Commissioning Fund**

| Description | Value | Notes |
|---|---|---|
| | £000's | |
| | | |
| **Original ICF Value** | **435,519** | **Based on 8th February Submission** |
| Amendment to CCG Surplus | 1,239 | Reduce from £4,730k to £3,491k |
| TMBC Adjustment | 1,798 | Includes inclusion of CCTV Operations |
| Final Adjustments | 1,830 | Confirmation of final contract values and amendments to BCF values |
| **Month 1 ICF Budget** | **440,386** | **Based on Final 11th April Submission** |
| CCG Allocation Correction | (31) | Tier 3 Specialist Wheelchairs Correction |
| TMBC M2 Budget Adjustment | 175 | Additional HR Budget & CCTV Adjustments |
| **Month 2 ICF Budget** | **440,530** | **As per month 2 Integrated Single Finance Report** |
| CCG Allocation | 141 | Eating Disorder Service Q1 |
| CCG Allocation | 53 | Pain management immunosuppressants |
| CCG Allocation | 18 | Supporting Primary Care and LCPO development |
| CCG Allocation | 807 | 7 day access funding |
| CCG Allocation | (24) | GM Stroke risk share |
| CCG Allocation | (40) | GM CHC Risk share |
| CCG Allocation | 890 | MH Stocktake |
| **Month 3 ICF Budget** | **442,375** | **As per month 3 Integrated Single Finance Report** |
| TMBC Cost Pressures Funding | 5,172 | |
| **Month 4 ICF Budget** | **447,547** | **As per month 4 Integrated Single Finance Report** |

| ICF Budget Reference | ICF Budget | CCG Net Budget 2016/17 | TMBC Net Budget 2016/17 | Total Net Budget 2016/17 |
|---|---|---|---|---|
| | | £m | £m | £m |
| **A** | **Section 75 Services** | **190.216** | **42.244** | **232.460** |
| **B** | **Aligned Services** | **156.183** | **27.252** | **183.436** |
| **C** | **In Collaboration Services** | **31.650** | **0.000** | **31.650** |
| | | **378.05** | **69.496** | **447.547** |

# APPENDIX F

**Glossary**

| Abbreviation | Description |
|---|---|
| AQP | Any Qualifying Provider |
| BCF | Better Care Fund |
| CAMHS | Child and Adolescent Mental Health Service |
| CCG | Clinical Commissioning Group |
| CHC | Continuing Healthcare |
| CIP | Cost Improvement Programme |
| CIS | Commissioning Improvement Scheme |
| CQUIN | Commissioning for Quality and Innovation |
| CSU | Commissioning Support Unit |
| CT | Care Together |
| DC | Daycase |
| DDRB | Doctors and Dentists Review Body |
| DES | Direct Enhanced Service |
| EL | Elective |
| GM | Greater Manchester |
| GMSS | Greater Manchester Shared Service |
| GP | General Practitioner |
| IAT | Inter Authority Transfer |
| ICF | Integrated Commissioning Fund |
| ISFE | Integrated Single Financial Environment |
| MfA | Manual For Accounts |
| MH | Mental Health |
| MMC | Medicines Management Committee |
| NEL | Non Elective |
| NHSE | National Health Service England |
| NMP | Non Medical Prescribing |
| ODN | Operational Delivery Network |
| OP | Outpatient |
| PBR | Payment By Results |
| PES | Paramedic Emergency Services |
| PMD | Prescribing Monitoring Document |
| PPA | Prescription Pricing Authority |
| PRG | Professional Reference Group |
| QIPP | Quality, Innovation, Productivity, Prevention |
| QOF | Quality and Outcomes Framework |
| RADAR | Rapid Access Detoxification Acute Referral |
| SCB | Single Commissioning Board |
| SFT | Stockport Foundation Trust |
| SHMI | Summary Hospital Level Mortality Index |
| SLA | Service Level Agreement |
| SLAM | Service Level Agreement Monitoring |
| TFT | Tameside & Glossop Foundation Trust |
| UHSM | University Hospital South Manchester Foundation Trust |
| WTE | Whole Time Equivalent |
| WWL | Wrightington, Wigan and Leigh Foundation Trust |

# Quarterly Reporting Template - Guidance

## Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 9th September 2016.

## The BCF Q1 Data Collection

This Excel data collection template for Q1 2016-17 focuses on budget arrangements, the national conditions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

## Cell Colour Key

| |
|---|
| Data needs inputting in the cell |
| Pre-populated cells |
| Question not relevant to you |

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

## Content

The data collection template consists of 8 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
**1) Cover Sheet -** this includes basic details and tracks question completion.
**2) Budget arrangements -** this tracks whether Section 75 agreements are in place for pooling funds.
**3) National Conditions -** checklist against the national conditions as set out in the BCF Policy Framework 16-17 and BCF planning guidance.
**4) Income and Expenditure -** this tracks income into, and expenditure from, pooled budgets over the course of the year.
**5) Supporting Metrics -** this tracks performance against the two national metrics, a DTOC metric, a Non-Elective Admissions metric, locally set metric and locally defined patient experience metric in BCF plans.

**6) Additional Measures -** additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care.
**7) Narrative -** this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

## Checklist

This sheet contains all the validations for each question in the relevant sections.

All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

## 1) Cover Sheet

On the cover sheet please enter the following information:

**The Health and Well Being Board**
**Who has completed the report, email and contact number in case any queries arise**
**Please detail who has signed off the report on behalf of the Health and Well Being Board**

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 7 cells are green should the template be sent to england.bettercaresupport@nhs.net

## 2) Budget Arrangements

This section requires the Health & Wellbeing Board to confirm if funds have been pooled via a Section 75 agreement. Please answer as at the time of completion.

**Have the funds been pooled via a s.75 pooled budget?**
**If the answer to the above is 'No' please indicate when this will happen**

## 3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Policy Framework 16/17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) and Better Care Fund Planning Guidance 16/17 (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/) have been met through the delivery of your plan. Please answer as at the time of completion.

It sets out the eight conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an estimated date when condition will be met, an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

## 4) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

**Planned income into the pooled fund for each quarter of the 2016-17 financial year**
**Forecasted income into the pooled fund for each quarter of the 2016-17 financial year**
**Actual income into the pooled fund in Q1 2016-17**
**Planned expenditure from the pooled fund for each quarter of the 2016-17 financial year**
**Forecasted expenditure from the pooled fund for each quarter of the 2016-17 financial year**
**Actual expenditure from the pooled fund in Q1 2016-17**

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2016-17 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

## 5) Supporting Metrics

This tab tracks performance against the two national supporting metrics, a Delayed Transfers of Care metric, a Non-Elective Admissions metric, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:

**An update on indicative progress against the six metrics for Q1 2016-17**
**Commentary on progress against each metric**

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

## 6) Additional Measures

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 /Q3/Q4 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

## 7) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress, reflecting on performance in Q1 16/17.

## Better Care Fund Template Q1 2016/17

### Data Collection Question Completion Checklist

**1. Cover**

| Health and Well Being Board | completed by: | e-mail: | contact number: | Who has signed off the report on behalf of the Health and Well Being Board: |
|---|---|---|---|---|
| Yes | Yes | Yes | Yes | Yes |

**2. Budget Arrangements**

| Have funds been pooled via a S.75 pooled budget? If no, date provided? |
|---|
| Yes |

**3. National Conditions**

| | | | 7 day services | | |
|---|---|---|---|---|---|
| | 1) Are the plans still jointly agreed? | 2) Maintain provision of social care services | 3i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate | 3ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)? | 4i) Is the NHS Number being used as the consistent identifier for health and social care services? |
| Please Select (Yes, No or No - In Progress) | Yes | Yes | Yes | Yes | Yes |
| If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY) | Yes | Yes | Yes | Yes | Yes |
| If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter (in-line with signed off plan) and how this is being addressed? | Yes | Yes | Yes | Yes | Yes |

**4. I&E (2 parts)**

| | | Q1 2016/17 | Q2 2016/17 | Q3 2016/17 |
|---|---|---|---|---|
| Income to | Plan | Yes | Yes | Yes |
| | Forecast | Yes | Yes | Yes |
| | Actual | Yes | | |
| | Please comment if there is a difference between the annual totals and the pooled fund | Yes | | |
| Expenditure From | Plan | Yes | Yes | Yes |
| | Forecast | Yes | Yes | Yes |
| | Actual | Yes | | |
| | Please comment if there is a difference between the annual totals and the pooled fund | Yes | | |
| Commentary on progress against financial plan: | | Yes | | |

**5. Supporting Metrics**

| | | Please provide an update on indicative progress against the metric? | Commentary on progress |
|---|---|---|---|
| | NEA | Yes | Yes |
| | DTOC | Yes | Yes |
| | Local performance metric | Yes | Yes |
| | If no metric, please specify | | |
| Patient experience metric | | Yes | Yes |
| | Admissions to residential care | Yes | Yes |
| | Reablement | Yes | Yes |

**6. Additional Measures**

| | GP | Hospital | Social Care | Community | Mental health |
|---|---|---|---|---|---|
| NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual | Yes | Yes | Yes | Yes | Yes |
| Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number | Yes | Yes | Yes | Yes | Yes |

| | To GP | To Hospital | To Social Care | To Community | To Mental health |
|---|---|---|---|---|---|
| From GP | Yes | Yes | Yes | Yes | Yes |
| From Hospital | Yes | Yes | Yes | Yes | Yes |
| From Social Care | Yes | Yes | Yes | Yes | Yes |
| From Community | Yes | Yes | Yes | Yes | Yes |
| From Mental Health | Yes | Yes | Yes | Yes | Yes |
| From Specialised Palliative | Yes | Yes | Yes | Yes | Yes |

| | GP | Hospital | Social Care | Community | Mental health |
|---|---|---|---|---|---|
| Progress status | Yes | Yes | Yes | Yes | Yes |
| Projected 'go-live' date (mm/yy) | Yes | No | Yes | Yes | No |

| Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area? |
|---|
| Yes |

| | |
|---|---|
| Total number of PHBs in place at the end of the quarter | Yes |
| Number of new PHBs put in place during the quarter | Yes |
| Number of existing PHBs stopped during the quarter | Yes |

| | |
|---|---|
| Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%) | Yes |

| | |
|---|---|
| Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting? | Yes |
| Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting? | Yes |

**7. Narrative**

| | |
|---|---|
| Brief Narrative | Yes |

| Data sharing | | | |
|---|---|---|---|
| 4ii) Are you pursuing open APIs (i.e. systems that speak to each other)? | 4iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance? | 4iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights? | 5) Is there a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional |
| Yes | Yes | Yes | Yes |
| Yes | Yes | Yes | Yes |
| Yes | Yes | Yes | Yes |

| Q4 2016/17 |
|---|
| Yes |
| Yes |

| |
|---|
| Yes |
| Yes |

| Specialised palliative |
|---|
| Yes |
| Yes |

| To Specialised palliative |
|---|
| Yes |
| Yes |
| Yes |
| Yes |
| Yes |
| Yes |

| Specialised palliative |
|---|
| Yes |
| No |

# Cover

| Q1 2016/17 | |
|---|---|
| **Health and Well Being Board** | **Tameside** |
| **completed by:** | Ali Rehman |
| **E-Mail:** | ali.rehman@nhs.net |
| **Contact Number:** | 0161 366 3207 |
| **Who has signed off the report on behalf of the Health and Well Being Board:** | Members of the Health and Wellbeing Board |



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

| | No. of questions answered |
|---|---|
| 1. Cover | 5 |
| 2. Budget Arrangements | 2 |
| 3. National Conditions | 36 |
| 4. I&E | 21 |
| 5. Supporting Metrics | 13 |
| 6. Additional Measures | 64 |
| 7. Narrative | 1 |

# Budget Arrangements

| | |
|---|---|
| **Selected Health and Well Being Board:** | Tameside |

| | |
|---|---|
| Have the funds been pooled via a s.75 pooled budget? | Yes |
| If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY) | |

# National Conditions

**Selected Health and Well Being Board:** Tameside

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

| Condition (please refer to the detailed definition below) | Please Select ('Yes', 'No' or 'No - In Progress') | If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY) | If the answer is "No" or "No - In Progress" 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 | Yes | | |
| 2) Maintain provision of social care services | Yes | | |
| 3) In respect of 7 Day Services - please confirm: | | | |
| i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate | Yes | | |
| ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)? | Yes | | |
| 4) In respect of Data Sharing - please confirm: | | | |
| i) Is the NHS Number being used as the consistent identifier for health and social care services? | No - In Progress | 01/02/2017 | The fixed dark fibre connection between tameside MBC and Tameside Hospital Foundation Trust is now in place. Tameside are in the process of testing and ro |
| ii) Are you pursuing Open APIs (ie system that speak to each other)? | Yes | | |
| iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance? | Yes | | |
| iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights? | Yes | | |
| 5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional | Yes | | |
| 6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans | Yes | | |
| 7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care | Yes | | |
| 8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan | Yes | | |

**National conditions - detailed definitions**

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

**1) Plans to be jointly agreed**

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

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

**2) Maintain provision of social care services**

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

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

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

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

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

**3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.**

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

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

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



**4) Better data sharing between health and social care, based on the NHS number**

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

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

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

**5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional**

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

**6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans**

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

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

**7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care**

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

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

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

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

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

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

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

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

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

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

We would expect plans to:

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

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

**Selected Health and Well Being Board:** Tameside

**Income**

**Q1 2016/17 Amended Data:**

| | | Q1 2016/17 | Q2 2016/17 | Q3 2016/17 | Q4 2016/17 | Annual Total | Total BCF pooled budget for 2016-17 (Rounded) |
|---|---|---|---|---|---|---|---|
| Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund) | Plan | £3,855,000 | £3,855,000 | £4,795,000 | £4,795,756 | £17,300,756 | £17,300,756 |
| | Forecast | £3,855,000 | £3,855,000 | £4,795,000 | £4,795,756 | £17,300,756 | |
| | Actual* | £3,855,000 | | | | | |

| | |
|---|---|
| Please comment if one of the following applies:<br>- There is a difference between the planned / forecasted annual totals and the pooled fund<br>- The Q1 actual differs from the Q1 plan and / or Q1 forecast | |

**Expenditure**

**Q1 2016/17 Amended Data:**

| | | Q1 2016/17 | Q2 2016/17 | Q3 2016/17 | Q4 2016/17 | Annual Total | Total BCF pooled budget for 2016-17 (Rounded) |
|---|---|---|---|---|---|---|---|
| Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund) | Plan | £3,855,000 | £3,855,000 | £4,795,000 | £4,795,756 | £17,300,756 | £17,300,756 |
| | Forecast | £3,855,000 | £3,855,000 | £4,795,000 | £4,795,756 | £17,300,756 | |
| | Actual* | £3,365,751 | | | | | |

| | |
|---|---|
| Please comment if one of the following applies:<br>- There is a difference between the planned / forecasted annual totals and the pooled fund<br>- The Q1 actual differs from the Q1 plan and / or Q1 forecast | The variation between the actual spend at Q1 and the plan is due to timings of payments to providers by the Local Authority who do not operate on a monthly accruals basis. |

| | |
|---|---|
| Commentary on progress against financial plan: | The pooled fund is expected to operate within budget for the financial year 2016-17 with the total BCF allocation of £17.301m being fully utilised by the end of Q4. |

**Footnotes:**

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

## National and locally defined metrics

| **Selected Health and Well Being Board:** | Tameside |
|---|---|

| | |
|---|---|
| **Non-Elective Admissions** | Reduction in non-elective admissions |
| Please provide an update on indicative progress against the metric? | On track to meet target |
| Commentary on progress: | Our focus on Home First builds on our schemes to avoid Non-elective admissions. We have seen a 19% increase in Ambulatory Emergency Care and the Alternative to Transfer and Integrated Urgent Care Team are providing alternatives to A&E attendance and admissions. We are using practice level risk stratification information to focus on pro-active care with high risk patients to reduce demand through a care coordination approach across |

| | |
|---|---|
| **Delayed Transfers of Care** | Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+) |
| Please provide an update on indicative progress against the metric? | No improvement in performance |
| Commentary on progress: | Further analysis is being undertaken to identify if community beds are being recorded correctly as they may be included in the acute figures.<br>Our Home First model includes a Discharge to Assess process that will reduce DTOCs significantly. The early adopter wards are significantly reducing the time spent on the ward once medically fit with an increased number |

| | |
|---|---|
| **Local performance metric as described in your approved BCF plan** | Newly diagnosed patients on primary care dementia registers |
| Please provide an update on indicative progress against the metric? | On track to meet target |
| Commentary on progress: | Our Dementia Diagnosis rate for 16/17 is not yet available however our practices are continuing their work to identify new patients and provide appropriate support. |

| | |
|---|---|
| **Local defined patient experience metric as described in your approved BCF plan** | Overall satisfaction of people who use services with Their Care and Support.The original submission used financial years building on a baseline of 61.6 from 2012/13 and had a Q4 15/16 position of 64.6 |
| If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used. | |
| Please provide an update on indicative progress against the metric? | Data not available to assess progress |
| Commentary on progress: | Annual - Adult Social Care Survey<br>The information in the template needs to be amended, the 61.6 relates to 2013-14 out-turn and the 64.51 relates to 2014-15 out-turn. No further update will be available until the 2016-17 Adult Social Care Survey has been completed expected for 4th Quarter 2016-17. |

| | |
|---|---|
| **Admissions to residential care** | Rate of permanent admissions to residential care per 100,000 population (65+) |
| Please provide an update on indicative progress against the metric? | On track to meet target |
| Commentary on progress: | 1st Quarter 2016-17 permanent admissions to residential and nursing care 65+ currently stands at 83 for the three month period. |

# Additional Measures

**Selected Health and Well Being Board:** Tameside

**Improving Data Sharing: (Measures 1-3)**

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

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

**2. Proposed Measure: Availability of Open APIs across care settings**

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

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

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

| | GP | Hospital | Social Care | Community | Mental health | Specialised palliative |
|---|---|---|---|---|---|---|
| Progress status | Live | In development | In development | In development | Unavailable | Unavailable |
| Projected 'go-live' date (dd/mm/yy) | [redacted] | | 30/11/16 | 31/03/17 | | |

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

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

**Other Measures: Measures (4-5)**

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

| | |
|---|---|
| Total number of PHBs in place at the end of the quarter | 9 |
| Rate per 100,000 population | 4 |

| | |
|---|---|
| Number of new PHBs put in place during the quarter | 9 |
| Number of existing PHBs stopped during the quarter | 0 |
| Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%) | 100% |

| | |
|---|---|
| Population (Mid 2016) | 222,147 |



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

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

**Footnotes:**

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Q4 15/16 population figures onwards have been updated to the mid-year 2016 estimates as we have moved into the new calendar year.

# Narrative

| **Selected Health and Well Being Board:** | Tameside |
|---|---|

| Remaining Characters | 32,221 |
|---|---|

| Please provide a brief narrative on overall progress, reflecting on performance in Q1 16/17. Please also make reference to performance across any other relevant areas that are not directly reported on within this template. |
|---|
| Our Transformation Plans are being implemented at both commissioner and provider levels.<br><br>The Single Commission comprising NHS Tameside and Glossop CCG and TMBC has been operational since April 2016. The Tameside and Glossop Integrated Care NHS Foundation Trust remains in shadow form until April 2017.<br><br>Our Integrated Neighbourhood and Home First plans are providing a strong foundation for improving the health and wellbeing of our local population and supporting people who need additional care to remain at home for as long as possible.' |

NHS England
Skipton House
80 London Road
London,
SE1 6LH
E-mail: Andrew.ridley1@nhs.net

To: *(by email)*

| | |
|---|---|
| Councillor Kieran Quinn | Chair, Tameside Health and Wellbeing Board |
| Steven Pleasant | Chief Executive, Tameside Metropolitan Borough Council & Interim Accountable Officer, NHS Tameside & Glossop Clinical Commissioning Group |

1 September 2016

Dear colleagues

**BETTER CARE FUND 2016-17**

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance. We know that the BCF has again presented challenges in preparing plans at pace and we are grateful for your commitment in providing your agreed plan. As you will be aware the Spending Review in November 2015, reaffirmed the Government's commitment to the integration of health and social care and the continuation of the BCF itself.

I am delighted to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. Essentially, your plan meets all requirements and the focus should now be on delivery.

Your BCF funding can therefore now be released subject to the funding being used in accordance with your final approved plan, which has demonstrated compliance with the conditions set out in the BCF policy framework for 2016-17 and the BCF planning guidance for 2016-17, and which include the funding being transferred into pooled funds under a section 75 agreement.

These conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG in your Health and

Wellbeing Board area as to the use of the funding.

You should now progress with your plans for implementation. Ongoing support and oversight with your BCF plan will be led by your local Better Care Manager.

Once again, thank you for your work and best wishes with implementation and delivery.

Yours sincerely,

Andrew Ridley
Regional Director, South of England, and SRO for the Better Care Fund

**NHS England**

Copy (by email) to:

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| Richard Barker | Regional Director, North of England, NHS England |
| Anthony Kealy | Programme Director, Better Care Support Team, NHS England |
| Tim Barton | Regional Better Care Lead, NHS England North |
| Justine Howe | Better Care Manager, NHS England North |

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| **Report to:** | **HEALTH AND WELLBEING BOARD** |
| **Date:** | 22 September 2016 |
| **Executive Member / Reporting Officer:** | Cllr Brenda Warrington, Executive Member, Adult Social Care and Wellbeing<br>Jessica Williams, Programme Director, Tameside & Glossop Care Together |
| **Subject:** | **INTEGRATION REPORT - UPDATE** |
| **Report Summary:** | This report provides an update to the Tameside Health and Wellbeing Board on the progress and developments within the Care Together Programme since the last presentation in March 2016. |
| **Recommendations:** | The Health and Wellbeing Board is asked:-<br>1. To note the progress of the Care Together Programme including the strategic and operational aspects; and<br>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 which will help to achieve the priorities identified in the Health and Wellbeing Strategy. |
| **Policy Implications:** | One of the main functions of the Health and Wellbeing Board is to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate. This meets the requirements of the NHS Constitution. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | The Care Together Economy has a projected year end deficit of £32.1m at the period ending 31 July 2016 (£14.8m within the Integrated Commissioning Fund and £17.3m Tameside Hospital Foundation Trust) – agenda item 4 provides the associated details.<br>There is therefore a clear urgency to implement associated strategies to ensure the current year projected funding gap is addressed and closed on a recurrent basis across the whole economy.<br>It should be noted that each constituent organisation will be responsible for the financing of their resulting deficit at 31 March 2017<br>It is also essential for the economy that the GM Health and Social Care Partnership funding bid referred to in section 2 of the report is approved, as this funding will support transformational initiatives which will deliver recurrent efficiency savings across the economy. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | It is important to recognise that the Integration agenda, under the auspices of the 'Care Together' banner, is a set of projects delivered within each organisation's governance model and now to be delivered jointly under the Single Commissioning Board together with the Hospital. 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 report is to provide confidence and oversight of delivery.

**Risk Management :**

The Care Together Programme has an agreed governance structure with a shared approach to risk, supported through a project support office.

**Access to Information :**

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

 Telephone: 0161 304 5342

 e-mail: jessicawilliams1@nhs.net

## 1. INTRODUCTION

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

1.2 The report covers:

- GM Health and Social Care Partnership (previously GM Devolution);
- Operational Progress;
- Next Steps;
- Recommendation.

## 2. GM HEALTH AND SOCIAL CARE PARTNERSHIP

2.1 Following our submission for transformational funds in January 2016, the GM Devolution instigated a process to ensure transparency and rigour of funding decisions. This process determined in May 2016 that Tameside and Glossop alongside Salford and Stockport would be invited to submit the initial funding applications for consideration by the GM Health and Social Care Partnership Strategic Programme Board Executive.

2.2 Tameside and Glossop therefore submitted a comprehensive application on 15 June 2016. This included:

- Summary of descriptor of transformational schemes **(Appendix 1)**
- Cost benefit analysis
- Financial Roll Up (summary of the whole financial challenge to the economy by 20/21)
- Narrative to support this.

The financial request was for £30.068M over 3 years.

2.3 Our submission was independently reviewed by CarnallFarrar and PwC and their feedback was presented to the GM Health and Social Care Partnership Transformational Funding Oversight Group (TFOG). The recommendation which subsequently came out of this meeting was an offer of £1M to help us develop our plans further and return for future consideration at TFOG in the autumn. This offer was rejected on the basis of incomplete understanding of our economy financial position and the overriding need to move into the delivery stage.

2.4 Since this time, considerable work has taken place between the economy finance team and the GM Health and Social Care Partnership team to ensure that the plans within Tameside and Glossop are widely understood and will satisfy TFOG at the next iteration. We resubmitted our application for funding on 18 August 2016 and look forward to hearing a favourable result in the near future.

2.5 In the meantime, we continue to develop the implementation plans for the schemes and work up a draft “Investment Agreement” which will be required between the economy and GM Health and Social Care Partnership. This is a detailed document which will describe the key milestones for the economy including national requirements and delivery of standards. Our aim is to ensure this is signed by the end of September which would then bring us back into the same trajectory as Salford and Stockport.

2.6 GM Health and Social Care Partnership continues to receive invitations to and attend the Care Together Programme Board.

## 3. OPERATIONAL PROGRESS

**Transfer of Community Services**

3.1 The transfer of community services from Stockport Foundation Trust into Tameside Hospital Foundation Trust (THT) successfully occurred on 1 April 2016. 734 staff and approximately £24M moved into THT which is the first important step of towards and Integrated care Organisation and enables closer working between core health and social care services.

3.2 Work is developing at pace to design a new and integrated community offer and change ways of working to ensure a focus on prevention and increasing independence. As part of this and to signify the changing nature of the Foundation Trust, the name of the Trust will change to Tameside and Glossop Integrated Care NHS Foundation Trust on 1 September 2016.

**Single Commissioning Function**

3.2 On 1 April 2016, the two commissioning teams came together under one single leadership, governance and management structure. Commissioning staff have been co-located in the CCG building, one medium term strategy has been agreed and team building continues. Steven Pleasant, Chief Executive, Tameside MBC has been appointed on an interim basis, the Single Accountable Officer for this single commissioning function.

3.3 A jointly managed budget of £442M has been developed to enable money to flow according to strategic commissioning decisions.

3.4 A substantive management structure to deliver strategic health and social care commissioning. The senior level of this has now been agreed following an independent review (Deloitte) and the next steps for this will be to understand the role of commissioning going forwards and develop a organisational structure to ensure this is delivered.

3.5 The Single Commissioning Board is operational, meets monthly and is chaired by Dr. Alan Dow, Chair, CCG. This is supported by a professional reference group made up of a wide range of health and social care clinical and professional colleagues to ensure the delivery of high quality services is optimised at all times.

**Model of Care**

3.6 The Model of Care Steering Group continues to work at pace to agree the process for determining the detailed model of integrated care under the leadership of Karen James, Chief Executive, Tameside Hospital Trust. This work has focussed on the development of the transformational schemes and ensuring emerging plans in all work stream areas meet the needs for Tameside and Glossop and also, are widely understood and supported.

3.11 Work also continues apace in many of the enabling task and finish groups to support the model of integrated care. This includes a strategic estates plan, a comprehensive programme to radically overhaul current IM&T and drive benefits in the future, the organisational development programme and development of the organisational governance arrangements.

**Programme Support Office and Programme Development**

3.12 A high level programme plan has been created and is summarised by the Care Together Programme Board Forward Plan (attached as **Appendix 2**). The Programme Support Office will be working with the identified leads to ensure they receive the support they need to hit these milestones.

## 4. NEXT STEPS

4.1 As well as the continuation of all work above and especially the focus on the model of care, notable next steps are as follows:

- Securing the transformational funding and moving rapidly to the delivery of schemes;

- Creating a plan to deliver financial sustainability for the economy;
- Determining scope and potential milestones for the transfer of social care into the ICO;
- Aligning primary care outcomes alongside the ICO;
- Developing and implementing a measurement framework which accurately ensures our planned transformational schemes are improving the healthy life expectancy of the T&G population.

4.2 In order to ensure timeliness of information provided to Health and Wellbeing Board, the next steps will be expanded in the presentation provided for discussion.

## 5. RECOMMENDATIONS

5.1 The Health and Wellbeing Board is asked:-

- note the progress of the Care Together Programme including the strategic and operational aspects; and
- To receive a further update at the next meeting.

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**GM TRANSFORMATION FUND FULL PROPOSAL FORM**
**RESUBMISSION**

| **SECTION 1: INFORMATION ABOUT THE LOCALITY/GM INITIATIVE LEAD** | | |
|---|---|---|
| **1.1** | **Lead organisation name** | Tameside and Glossop Health and Social Care Economy |
| **1.2** | **Primary contact details** | Name: Jessica Williams<br>Position: Programme Director, Care Together<br>Email: jessicawilliams1@nhs.net<br>Tel: 07985 276263 |

| **SECTION 2: INVESTMENT CASE INFORMATION** | | |
|---|---|---|
| **2.1** | **Programme title** | Driving up health, wellbeing and prosperity across Tameside & Glossop and creating a financially and clinically sustainable health and social care economy. |
| **2.2** | **Duration of fund request** (*months*) | 40 months incorporating the phasing of different elements of the schemes. |
| **2.3** | **Anticipated Programme start date** (*month and year)* | Already commenced.<br>Increases in scale and pace dependent on investment levels and timing. |
| **2.4** | **Total programme budget?** | The whole programme budget will be a mix of revenue (£23.2m from GM, £6m from the local economy) and capital funds (£48m although still to be finalised). |
| **2.5** | **How much funding are you requesting from the GM transformation fund?** | 2016/17 £5.174m<br>2017/18 £7.928m<br>2018/19 £6.880m<br>2019/20 £3.224m<br>**Total Funding Request £23.226m**<br>**Including revenue for enabling schemes of £2.1m** |
| **2.6** | **What other sources of financing are you requesting?** | Additional support has been sought through;<br>• £6M Transformation programme pump priming received in 2015/16 from TMBC/CCG (£1.3m remaining in 2016/17)<br>• NHS England licences to deliver the Patient Activation Measure. Awarded.<br>• Part of NHS England Health as a Social Movement Programme with Stockport and Oldham. Awarded.<br>• £500,000 from Health Foundation to fund evaluation research. Application in progress |

**SECTION 3: INVESTMENT CASE OUTLINE**

**3.1** **What is the proposed programme and vision?**

*Please keep your answer to 500 words or less*

*Please cover the following topics:*

- *Type of scheme(s)*
- *Programme vision (population served and programme objectives)*
- *Alignment with at least one of the GM transformation initiatives*

**3.1.1 Overview**

Care Together is our transformational approach to significantly improving the health and wellbeing of the 250,000 residents of Tameside and Glossop. The programme comprises three key elements:

- Establishment of a Single Commissioning Function to ensure resources are aligned and distributed in a way which facilitates integration and most effectively meets need;
- Development of an Integrated Care Organisation to eliminate traditional organisational silos and boundaries;
- A new model of care to drive forwards at pace and scale the changes to achieve our ambitions in terms of improved outcomes for our population and a financially and clinically sustainable health and care system.

We aim to develop a sustainable economy by improving the healthy life expectancy (HLE) of our population. In doing this, our programme has three key ambitions which are wholly in line with both GM and national policy:

1. To support local people to remain well by tackling the causes of ill health, supporting behaviour and lifestyle change and maximising the role played by local communities;
2. To ensure that those receiving support are equipped with the knowledge, skills and confidence to enable them to take greater control over their own care needs and the services they receive;
3. When illness or crisis occurs, to provide high quality, integrated services designed around the needs of the individual and, where appropriate, provided as close to home as possible.

We have the economy wide leadership in place to deliver our integration agenda. We have a coherent and ambitious strategy, comprehensive governance arrangements and have already delivered a single commissioning function and shadow Integrated Care Organisation. Implementation plans are developed to move at pace to transform to our new model of care and start to deliver the significant financial savings required.

This transformation funding proposition comprises 6 interdependent transformation schemes to drive down cost across our health and social care economy by reducing acute activity and stemming the growth in demand for health and social care services. Funding is required over three years to enable the double running of services to safely transition to the new model of care for Tameside and Glossop.

A separate funding request for capital is being prepared for submission to the Department of Health / NHSI to facilitate key enabling schemes. These enabling schemes together with current financial management programmes, GM programmes and the proposed transformational funding schemes, will deliver a financially sustainable economy.

**3.1.2 Background**

Tameside and Glossop economy has experienced significant clinical and financially sustainability challenges for a number of years. Three significant external reviews have been conducted (Ernst & Young 2012, McKinsey 2013/4 and PwC via Monitor's CBT process in 2015) and all concluded that improved population outcomes at reduced cost could be achieved through integration of health and social care services. As the financial challenge continues, we have continued to develop and implement plans to maintain/increase service provision but at reduced cost.

In November 2014, Monitor appointed Price Waterhouse Cooper (PwC) as a Contingency Planning Team (CPT) to test the financial and clinical sustainability of Tameside Hospital NHS Foundation Trust (THFT) following a number of critical reports. The CPT report was supported and published by Monitor in September 2015 and fed directly into the on-going work across the economy. The CPT process provided considerable assurance on our plans as it concluded that THFT should become an Integrated Care Organisation (ICO) as the delivery vehicle for providing an integrated health and social care system.

The CPT however, did not provide a solution for the whole economy financial challenge due to being primarily focussed on the financial sustainability of the acute Trust. It outlined a potential saving of £28m per annum once integration had occurred but that substantial transformational revenue and capital funding would be required to ensure delivery. Since the publication of the CPT report, the focus has been on developing an economy solution, including the creation of an ICO, to the whole £70m financial challenge. The detail of this can be found within the Tameside and Glossop Locality Plan and subsequent implementation plans (See Section 5) and this transformational funding application to GM Health and Social Care Partnership is the result of this process. Details of the funding request are contained in section 4.3 of this document.

On the basis of the Locality Plan which shows a balanced NHS Foundation Trust and whole economy by 2020/21, Tameside FT has secured significant cash support from NHSI (PDC distress support). This is effectively a cash loan. Upon delivery of the 20/21 plan, this is likely to be converted into a non-repayable loan. Although funding is only confirmed by NHSI annually, its receipt until 20/21 is believed to be low risk. It should be noted that the requirement for PDC support will be greater than currently planned should the ICO proposal not be implemented.

**3.1.3 Transforming our model of care**

Transformational funding is required in Tameside and Glossop to enable the development of a new model of care, largely based on the development of neighbourhood based services. New services need to be safe and operational before significant funds can be released from the traditional model of health and social care.

6 specific schemes have been developed for the economy to stem the growth in demand for all health and social care services and also to reduce acute activity. These schemes are complimentary both to the NHS Standards and the GM wide programmes e.g.; Healthier Together as shown in Diagram 1 (at the end of this section).

The resources required to implement these schemes at scale form the majority of the input into the CBA Model and therefore only the benefits expected from these schemes have been included within the outputs. This is to ensure transparency for GM H&SCP and guard against the inflating financial

benefits across the economy.

The schemes broadly fall into two categories; demand reduction/absorbing growth and reduction in acute activity. The reduction in acute non-elective activity is approximately 35% when compared against a Do Nothing option. The schemes are described in brief below.

## Demand Reduction/Absorbing Growth

**1) Development of Integrated Neighbourhoods (INs)**
Building upon the introduction of place based public sector hubs in Tameside, we will develop health and social care teams to deliver a wide range of services that not only treat illness but promote wellness and behaviour change. This will involve a comprehensive response from community services, social and primary care, outreach from hospital specialists, mental health and support from public health and preventative services.

Input from the voluntary and community sector will be central to the success of this approach.

There will be five INs across the Tameside and Glossop CCG footprint.

**2) A System Wide Approach to Self-Care**
One of the key approaches to creating a sustainable economy will be supporting the population to manage their health more effectively, adopt healthier behaviours and choose appropriately when accessing support from health and social care. We will adopt a system wide approach to self-care and supported self-management, where self-care becomes our default and something promoted by all parts of the health system.

Underpinned by a proactive risk stratification approach and the use of the Patient Activation Measure, we will identify people who are at greatest risk of poor health and high levels of unplanned activity. We will focus on the development of social prescribing at scale and combine it with an asset based community development approach seeking to unlock the potential of communities and individuals.

**3) Help to support people at home service**
Using a holistic approach to service delivery, we will redesign the current homecare model to ensure it is focused on individual strengths and capabilities. The workforce and providers delivering this service will form an integral part of the INs. We will place an emphasis on moving away from time and task, to high quality contact with people that utilises a wide range of community assets, technology and the range of community and primary health available to remain safe, secure and independent at home.

The new service will deliver a sustainable care home market with significant more capacity and which pays its staff at levels commensurate with the expected role.

## Acute Activity Reduction

**4) Home First**

'Home First' is the urgent care response to ensuring that wherever possible, people can receive care in their own home. Home First will ensure that people, over the age of 18, are supported in the environment most appropriate for them and most likely to achieve the best outcomes.

The Integrated Urgent Care Team (IUCT) is the operational team that underpins the delivery of the model. The team will consist of a range of integrated health, social care and voluntary and community sector professionals to support people through their journey to recovery.

**5) Flexible Community Bed Base**

When people cannot be supported at home, the flexible community beds base will offer:

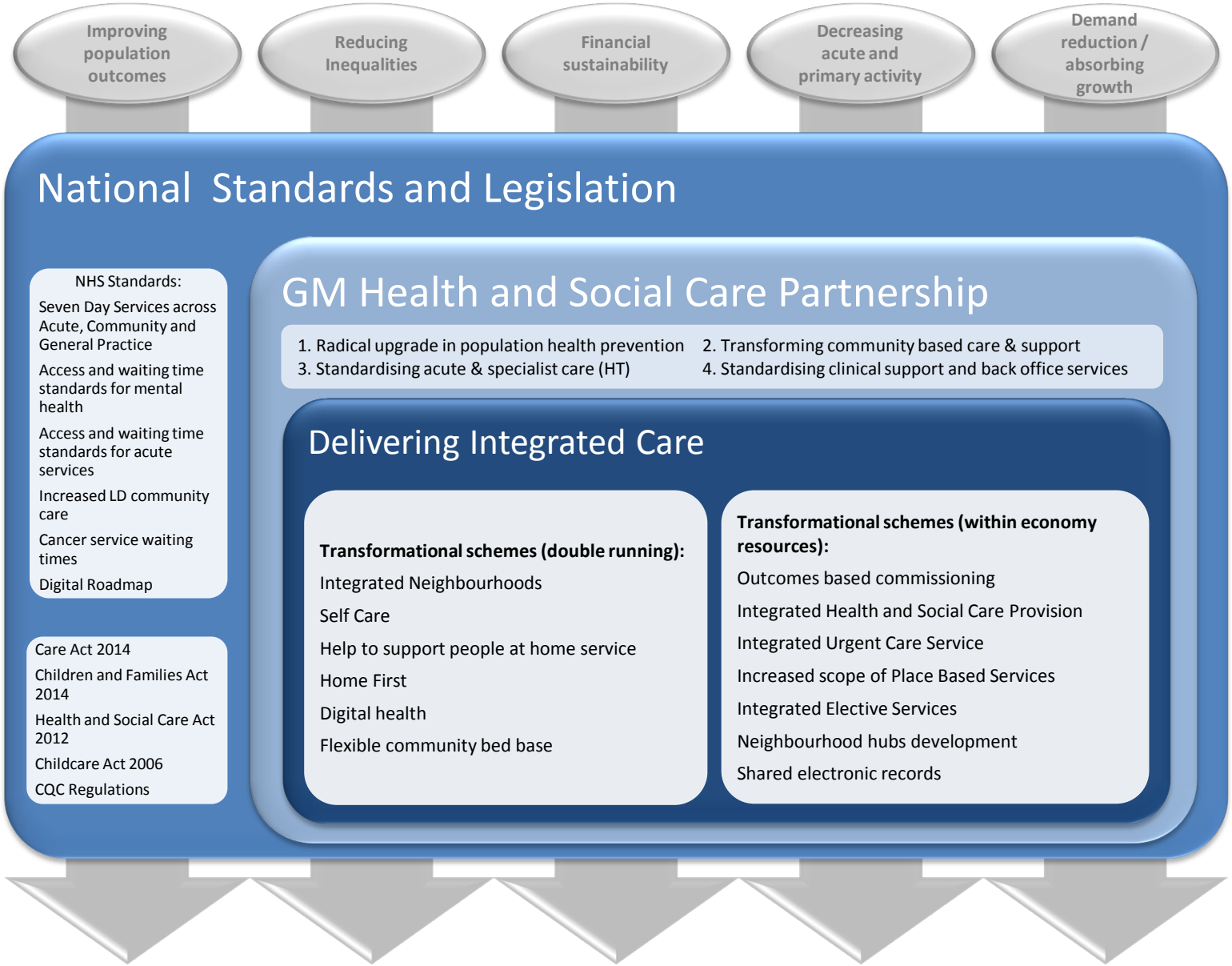
- Step down capacity for discharge to assess (including complex assessments)
- Step up capacity
- Intermediate care capacity
- Recuperation beds that offer an opportunity to re-stabilise prior to undertaking rehab
- Specialist assessment and rehab for people who have dementia or delirium

**6) Digital Health**

Enhancing technology in care homes will offer the ability alongside a highly skilled workforce to deliver clinical consultations to occur in the person's place of residence without the need to transfer a resident to hospital. It will support both residents and care home professionals to engage in "skype" conversation with health and social care professionals leading to a personalised response with "home" as the default position.

All these specific schemes within our overall programme of health and social care reform support the GM Transformation themes. This is explored in more detail in Section 4.1 below.

Diagram 1


Improving population outcomes
Reducing Inequalities
Financial sustainability
Decreasing acute and primary activity
Demand reduction / absorbing growth
National Standards and Legislation
NHS Standards:
Seven Day Services across Acute, Community and General Practice
Access and waiting time standards for mental health
Access and waiting time standards for acute services
Increased LD community care
Cancer service waiting times
Digital Roadmap
Care Act 2014
Children and Families Act 2014
Health and Social Care Act 2012
Childcare Act 2006
CQC Regulations
GM Health and Social Care Partnership
1. Radical upgrade in population health prevention
2. Transforming community based care & support
3. Standardising acute & specialist care (HT)
4. Standardising clinical support and back office services
Delivering Integrated Care
Transformational schemes (double running):
Integrated Neighbourhoods
Self Care
Help to support people at home service
Home First
Digital health
Flexible community bed base
Transformational schemes (within economy resources):
Outcomes based commissioning
Integrated Health and Social Care Provision
Integrated Urgent Care Service
Increased scope of Place Based Services
Integrated Elective Services
Neighbourhood hubs development
Shared electronic records

**SECTION 4: ALIGNMENT TO TRANSFORMATION FUND CRITERIA**

*Please keep your answer to section 4 to 4-5 pages or less or attach relevant documents (where possible, you should highlight where this information can be found in existing documents such as your Locality Plan or CBA output)*

**4.1** **How will the proposal align to the GM strategy?**

*Please cover the following topics:*

- *How does the programme and your Locality Plan align to the short and long term GM vision & strategy? In particular, discuss how your programme will deliver part of the how your plan will help to close the financial gap by improving outcomes for the locality population, increase independence and reduce demand on public services.*
- *Which of the transformation initiatives does it align to and why?*
- *How will the programme contribute to wider transformation across GM?*
- *Is there any cross-collaboration with other localities or GM transformation initiatives?*

Our Locality Plan describes how health and social care services will contribute towards our whole system ambition of improving health, wellbeing and prosperity. This is congruent with the aims for Greater Manchester Health and Social Care Partnership.

Through strong leadership, pooling our resources and redesigning how our health and social care provision works collectively, Tameside and Glossop aim to deliver financial sustainability within five years. This will be achieved by a simultaneous focus on:

- Reducing growth in health and social care demand;
- Avoiding unplanned admissions;
- Efficiency and unlocking the potential of enabling workstreams.

Whilst having an impact across all four GM objectives, the transformation schemes detailed in this proposition place a particular emphasis on:

- Radical upgrade in population health prevention
- Transforming community based care and support
- Standardising acute and specialist care

## GM Health and Social Care Partnership Objective 1 - Radical upgrade in population health prevention

**More people managing health, looking after themselves and each other**

Self-care and supported self-management are key to our transformational plans. In any health and social care economy, approximately 20% of the population uses approximately 80% of the available resource. Key to financial and clinical sustainability is supporting people to avoid illness by adopting healthy lifestyle choices, and when they do experience a long term condition(s) to manage them as effectively as possible.

We don't believe that self-care is driven by a series of interventions, but instead is likely to be promoted by developing a system where self-care becomes our system default and we create a paradigm shift moving away from medical model treatment of disease towards a system that recognises, promotes and utilises the assets of individuals and communities. We will implement the

Patient Activation Measure (a validated measure of people's knowledge, skills and confidence to manage their long term condition) with 12,000 people in Tameside and Glossop, aligning traditional risk stratification approaches with an understanding of people's knowledge, skills and confidence and tailor self-management approaches to address this.

In addition to this, our work developing asset based approaches in communities and our partnership with Stockport and Oldham on the delivery of the Health as a Social Movement Programme will contribute significantly to supporting the development of communities, empowered to look after their own health and to support people around them.

**Increasing early intervention, finding the missing thousands**

The Integrated Neighbourhood approach is predicated on proactive risk identification and alignment with public health approaches and emphasis on the wider determinants of health. By combining proactive risk stratification with the adoption of a place based approach, we will identify people at risk of ill health and work with agencies across the population to intervene early and holistically.

**Ageing well**

Supporting people to age well is a theme that traverses all our transformational programmes. We will place an emphasis on supporting people to remain at home and independent as possible for as long as possible. When people do need support, our default will be for this to be at home, or at their place of residence. At end of life, we will support people to die in the place of their choice.

## GM Health and Social Care Partnership Objective 2 - Transforming Community Based Support

**Enable conditions to be managed at home and in the community**

- INs will ensure that where people have ongoing care and support needs, they are proactively and holistically cared for and managed in the community. Through risk stratification and proactive case management, we will prevent as many people as possible from experiencing unplanned care, and ensure they are supported at home, or as close to home as possible when additional support is required.
- Home First will ensure that individuals who attend A&E but can be managed outside acute secondary care provision are discharged back home, with wrap around care as required.
- The links with Integrated Neighbourhoods will ensure that wherever possible, people at risk of A&E attendance are proactively identified and supported to avoid admission where clinically appropriate. Where admission is necessary, they will be safely transferred back into the care of INs who will then resume proactive and ongoing management and support.

**Provide alternatives to A&E when crises occur**

Home First will provide the following alternatives to A&E when a crisis occurs:

- Co-ordinated health and social care support including access to equipment around an individual at home;
- A flexible community bed base whereby individuals can be stepped up to community capacity rather than attending A&E;
- Digital Health in care home will provide an alternative to attendance at A&E through the use of technology to complete virtual clinical consultations and monitor the person remotely.

**Support effective discharge from hospital**
Home First through the integration of health and social care team's assessment of peoples' needs in their place of residence negates the need for assessment under the Care Act 2014 to be carried out in the hospital setting. The ambition is to discharge people as soon as they are medically stable through a personalised plan of care in their own place of residence. The flexible community bed base will provide an alternative setting to step down for assessment when home is not deemed safe.

## GM Health and Social Care Partnership Objective 3 – Standardising Acute and Specialist Care

All our plans aim to standardise acute and specialist care. By supporting more people to receive care closer to home and outside the hospital environment, we will deliver efficiency savings. Our transformation schemes will reduce unplanned admissions, support more efficient and effective delivery of planned care services, which will in turn relieve pressure on acute capacity. We are also actively engaged in the GM programme of work associated with Healthier Together.

## Contribution to Wider Transformation Across GM

The projects proposed within this business case will be delivered at both pace and scale and be backed up with the organisational infrastructure to remove many of the traditional barriers to integration. The combination of a single commissioning function with an integrated care organisation will accelerate an integrated approach and provide learning for other areas.

All our programmes will be robustly evaluated and learning shared across GM. However specifically we are in the process of forming a bid to the Health Foundation to investigate the economic impact of improving the population of people with long term conditions to manage their health more effectively – using the Patient Activation Measure as a key metric.

## Cross GM Working

We are working collaboratively with colleagues in Stockport and Tameside to share resources on our combined investment. We have identified together the following areas as those where collaboration could both reduce costs and provide specific support to the GM system more broadly.

- Outcomes Framework and Population health analytics (segmentation and stratification)
- Development of our IM&T solutions
- Capitation and funding models
- Evaluation
- Replication (supporting spread across GM through the development of tools and 'how to')

We continue to share our learning with NHS England New Care Models Team and National Vanguards sites. We are also working closely with the Stockport Vanguard and Oldham on the development of social movements in health as part of the NHS England national programme. This is also backed up by additional resource from NESTA.

We aim to link with Salford University on a large scale research programme linked to the economic impact of a system wide approach to self-care pending the outcome of a bid to the Health Foundation.

| | |
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| **4.5** | **Does the proposal provide a foundation for further transformation?**<br>*Please cover the following topics:*<br>• *How will progress be evaluated and learning provided to other localities?*<br>• *How will this programme build on or support other elements of your Locality Plan?* |
| | Our Care Together will deliver transformation of the whole health and social care economy over the next five years. The overall approach lays the foundation for us to deliver our overarching vision for care in Tameside and Glossop. The key development of INs provides the basis of place-based, integrated care as set out in our Locality Plan. This will act as the catalyst and bedrock of movement of resource from acute setting into the community, providing the basis for further transformation.<br><br>We are developing an economy wide Quality and Outcomes Framework to transform the way we measure success and be more congruous with an integrated approach. It will also place an emphasis on measuring our success based on the things that matter most to people. Monitoring, evaluation and, where necessary, modification of the model is essential not only to ensure that the key strategic aims of improving outcomes for the population are delivered, but also that the shift and reduction in funding is achieved. The local indicators will be transferrable to other local economies, enabling comparisons and benchmarking to ensure maximum impact from the integrated system.<br><br>The Plan, Do, Study, Act (PDSA) methodology will be used to capture all learning from the operational roll out of Home First. This methodology will enable us to be responsive as a system by continually monitoring the change process and assess the impact to ensure that we deliver against our objectives.<br><br>The Locality is fully committed to the wider GM transformation programme and will provide regular feedback into the wider economy to show learning and support the development of wider programmes of reform. Our programme will be fully evaluated, using mixed methodology, with key 'check points' to assess trajectory and effectiveness. This will enable us to build upon what works, and also to share learning with GM more widely and further afield. |

## 5 Appendices

The following documents **are available on request** to support the information within this business case but have not been embedded in the document given their size.

| Document | Description | Approval Process |
|---|---|---|
| Business Propositions | Detailed business propositions for each of the transformation schemes detailed in this business case:<br>• Integrated Neighbourhoods;<br>• Self-Care<br>• Supporting people at home<br>• Home First<br>• Digital Health<br>• Intermediate Care (Flexible Community Bed Base) | Approved by:<br>Care Together Programme Board Independent Chairman, Chris Mellor<br><br>Date:<br>9th June 2016 |
| Enabler Schemes | Detailed proposals to cover:<br>• IM&T<br>• Estates<br>• Organisational Development<br>• Medium term Single Commissioning Strategy | Approved by:<br>Care Together Programme Board Independent Chairman, Chris Mellor<br><br>Dates:<br>• IM&T: 11th February 2016<br>• Estates: 14th April 2016<br>• Organisational Development: 12th May 2016 |
| Participation and Engagement | • Communication and Engagement Plan<br>• Engagement Toolkit<br>• Care Together Engagement Reports<br>• Equality and Diversity | Approved by:<br>Care Together Programme Board Independent Chairman, Chris Mellor<br><br>Date:<br>• Plan and Toolkit: 12th May 2016<br>• E&D: 9th June 2016 |
| Governance Documents | • Memorandum of Understanding outlining partnership between Tameside MBC, Tameside and Glossop CCG and Tameside Hospital NHS Foundation Trust<br>• Terms of reference for Programme Board and key workstreams<br>• Locality Plan<br>• Programme plan (implementation proposals) | Approved by:<br>Care Together Programme Board Independent Chairman, Chris Mellor<br><br>• Memorandum of Understanding: 13th October 2016<br>• Terms of Referenced (revised & updated): 14th April 2016<br>• Locality Plan approved by: Health & Wellbeing Board 12th November 2015 |

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TAMESIDE AND GLOSSOP Caretogether

# Care Together Programme Board
# Forward Plan 2016-17 summary

| 8th September | 6th October | 10th November |
|---|---|---|
| • Proposed whole system metrics and dashboard<br>• Proposed Integrated Neighbourhood model of care<br>• Options appraisal for raising capital to develop integrated neighbourhood hubs<br>• Establishment of local workforce transformation group<br>• Update on financial challenge | • T&G Financial Sustainability Plan<br>• Identifying scope and responsibilities of ICO<br>• Identifying scope and responsibilities of Single Commissioning Function<br>• Care Together priorities and objectives 16/17 & 17/18<br>• Investment agreement and governance arrangements for transformational funds<br>• Pre-consultation engagement report<br>• Adult Social Care Options Appraisal<br>• IM&T business case for community services hardware | • Care Together Risk Register<br>• Financial Progress / Tracking<br>• Update on financial challenge<br>• Review of Care Together Programme governance arrangements<br>• Proposed functions moving from Commissioning to ICO (options/due diligence process) |
| **8th December** | **TBC January 2017** | **TBC February** |
| • Consultation<br>• Update on financial challenge | • Transfer of community services review<br>• Update on financial challenge | • Financial Progress / Tracking<br>• Care Together Risk Register<br>• Update on financial challenge |

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| **Report to:** | **HEALTH AND WELLBEING BOARD** |
| **Date:** | 22 September 2016 |
| **Executive Member / Reporting Officer:** | Tony Powell, Deputy Chief Executive, New Charter Housing<br>David Berry, Project Lead (Employment and Skills), Tameside MBC |
| **Subject:** | **WORK, SKILLS AND HEALTH INTEGRATION** |
| **Report Summary:** | Devolution has presented Greater Manchester with the opportunity and ability to deliver improved health outcomes by supporting people to contribute and connect to growth. This report provides the Health and Wellbeing Board (HWBB) with an outline of the major employment initiatives in Tameside and the current progress and opportunities to integrate with health services. |
| **Recommendations:** | The HWBB are requested to:<br>1. Note the employment initiatives taking place in GM and Tameside recognising the work that has taken place to date to integrate work, skills and health services.<br>2. Actively promote and support the development and success of Pilots, Programmes and Approaches detailed in the report to deliver work, skills and health integration in Tameside developed alongside GM Models.<br>3. Review the progress of work, skills and health integration in Tameside on a 6 monthly basis to inform Policy and Commissioning decision making.<br>**4.** Respond to the contents of this report with regards to understanding how the knowledge and skills available in Tameside can best be utilised. |
| **Links to Health and Wellbeing Strategy:** | This report delivers specifically to the working well strand of the strategy. |
| **Policy Implications:** | This work has implications for the longer term health and work system economies in reducing demand through improved levels of health. This work is also designed to provide improved patient experience and access. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | Whilst there are no direct financial implications arising from the report, it should be recognised that initiatives contained to improve health, work and skills opportunities for residents of the borough will potentially lead to the reduced demand on public sector services and associated costs incurred. This will therefore contribute towards the delivery of future year efficiency savings alongside reduced resource allocations within the economy.<br>It is essential these initiatives are stringently monitored to ensure efficiencies are realised. |

| | |
|---|---|
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | The successful integration of work, skills and health services is essential to achieving the Greater Manchester Growth Strategy and reform of Health and Social Care. Effective integration will improve services for residents and reduce public spend on high demand provision therefore reducing longer term risk of affordable and quality services. |
| **Risk Management:** | Failure to deliver programme will impact negatively on future investment models and programmes of this type being agreed and implemented at the Greater Manchester level. |
| **Access to Information:** | The background papers relating to this report can be inspected by contacting<br>Telephone:0161 342 2246<br>e-mail: david.berry@tameside.gov.uk |

## 1. INTRODUCTION

1.1 Devolution has presented Greater Manchester with the opportunity and ability to deliver improved health outcomes by supporting people to contribute and connect to growth. This report provides the Health and Wellbeing Board (HWBB) with an outline of the major employment initiatives in Tameside and the current progress and opportunities to integrate with health services.

1.2 The Tameside Partnership has endeavoured to create and maximise opportunities to integrate work and health services, this work is captured within this report alongside intentions to shape existing and future service models and commissioning strategies.

1.3 In many of the programmes the minimum level of integration is set at a National or Greater Manchester level through the commissioning process. Tameside has consistently aimed to maximise operational integration and works with commissioners such as the Department for Work and Pensions (DWP) and GMCA to lobby for a fully integrated employment and health system.

1.4 The HWBB are asked to note the progress achieved and consider the plans and opportunities to deliver further integrated work and health services.

## 2. HEALTH, WORK AND SKILLS

2.1 There is a strong evidence base that work is generally good for physical and mental health and well-being, and that unemployment and worklessness is associated with poorer physical and mental health and well-being, contributing to health inequalities.

2.2 Unemployment is one of the most significant contributors to social and health inequalities, leading to increased:

- consumption of tobacco and alcohol
- use of GP services and medication
- admissions to psychiatric hospital.

2.3 With unemployed people having:

- Twice the rate of depression and three times the rate of anxiety than the general population
- Increased rates of obesity
- Increased cardiovascular morbidity and mortality.

2.4 In addition, the 2011 North West Health and Wellbeing Survey revealed that there is a strong correlation between levels of qualifications held by individuals and mental wellbeing. This correlation is stronger than the relationship between individual wealth and mental wellbeing. This is important because higher levels of mental wellbeing are associated with greater personal resilience and lower levels of poor health.

2.5 It is therefore essential that we enable and support local people to obtain skills and qualifications throughout their lives: not just because of their importance to economic growth but because it will make for a population that is mentally resilient and better able to cope with changes to their personal circumstances, such as a change in employment, poor health or unexpected bereavement.

2.6 Recent evidence suggests that work can be good for health, and has a role to play in reversing the harmful effects of long-term unemployment and prolonged sickness absence.

2.7 Nevertheless, the benefit of working is true for healthy people of working age, for many disabled people, for most people with common health problems and for people in receipt of benefits. Work for sick and disabled people:

- is therapeutic and helps to promote recovery and rehabilitation;
- improves quality of life and leads to better health and wellbeing outcomes;
- minimises the harmful physical, mental and social effects of long-term sickness absence;
- reduces the risk of long-term incapacity;
- promotes full participation in society, independence and human rights;
- reduces poverty.

2.8 Yet much of the current approach to the treatment of people of working age, including the sickness certification process, reflects an assumption that illness is incompatible with being in work.

2.9 However, there are provisos regarding the nature and quality of work and its social context, as there can be health damage resulting from poor quality work. Marmot identifies that good work and employment supports individuals to have good health.

2.10 Good work is characterised by having control over work, in-work development, flexibility, protection from adverse working conditions, a living wage, ill health prevention and stress management strategies and support for sick and disabled people that facilitates a return to work. Both the psychosocial and physical environments at work are important.

## 3. OUTLINE OF EMPLOYMENT INITIATIVES

3.1 The table below sets out a simple guide to the major work and skills initiatives to increase employment, earnings and skill levels. Our efforts have focused on integrating these initiatives with health services to maximise use of resource (people/skills/locations/funding). Several innovative pieces of work are being developed from this approach including the Healthy Hattersley GP Pilot and a joint Mental Health Employment Post within Working Well.

| Employment Initiative | Description | Volume Tameside Residents (GM in brackets) | Integration with health | Commissioner | Provider (Tameside) | Delivery timescale | Ask |
|---|---|---|---|---|---|---|---|
| Working Well Pilot | 2 year tailored key worker support for residents on ill health benefit (ESA). Referred from Jobcentre | 441 (4,985) | All participants have a health condition (67% physical, 64% mental - or multiple), integration has been area led (GM Health Protocol agreed by HWBB 2014) | DWP and GMCA (Salford MBC) | Ingeus | 2014-2019 | Continued integration of existing services |
| Working Well Expansion (including GP referral route and Talking Therapies Service) | 2 year tailored key worker support for residents on various benefit groups (JSA, ESA, UC, LPIS) Referred from Jobcentre and selected GPs | 1,100 (15,000) | Majority of participants have health condition, some integration is established within the model (Talking Therapies/GP pilot referral), local areas required to lead on whole system integration | DWP and GMCA (Trafford MBC) | Ingeus | 2016-2020 | Review of new claimant group barriers and access, integration and development with Integrated Neighbourhood Teams to co-case manage as appropriate |
| Building Better Opportunities | 3 year tailored key worker support for residents who are most excluded from the job market. Identified by | Estimated 390 (3,990) | High number of participants likely to have a health condition | Big Lottery and European Social Fund | Announced 25th August | 2016-19 | Review of claimant group barriers and referral access, integration and development with Integrated |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Registered Social Landlords | | | | | | Neighbourhood Teams to co-case manage as appropriate |
| Work and Health Programme | This programme is currently in design to replace the outgoing Work Programme. | TBC (Intention to bring total resident supported to 50,000) | In design – intention to focus support on residents with health conditions. | In design DWP/GMCA | Procurement not yet started | TBC | Joint commissioning at a GM level to deliver a programme that is underpinned by health and work outcomes. Universal GP referrals routes to access the programme. |
| Healthy Hattersley Pilot | GP Referral pilot to support Hattersley residents with health conditions | Upto 145 | Pilot to provide evidence base for further integration of GP and work and skill services | Tameside MBC | Procurement ongoing | 2016-17 | Following learning and evaluation establish evidence base through proof of concept to roll out GP referral route to practices across Tameside. |
| Skills for Employment | Tailored key worker skills support (Working Well Expansion and Pilot participants have priority access) | No locality breakdowns (6,000) | Majority of Working Well Participants have a health condition. | Skills Funding Agency | Manchester Growth Company (Prime) Inspire to Independence (Sub contractor) | 2016-2019 | Review of new claimant group barriers and access, integration and development with Integrated Neighbourhood Teams to co-case manage service as appropriate |
| Great Opportunities | Work Club provision to support residents into work, education and training | 435 | Lifeline (substance misuse) project is an integrated partner | New Charter | New Charter | Ongoing | Review of claimant group barriers and access, integration and development with Integrated Neighbourhood Teams to co-case manage service as appropriate |
| Troubled Families | Support programme for families (some members of the family may be out of work) | 600-1000 | The Troubled Families approach is rooted within the Public Service Hub with wrap around support from health agencies. | Department for Communities and Local Government | Tameside Council (Commissioner and Provider) and New Charter (Provider) | Ongoing | Review of claimant group barriers and access, integration and development with Integrated Neighbourhood Teams to co-case manage service as appropriate |

## 4. SERVICE APPROACHES

4.1 There are a series of approaches that can be described as cross cutting. These approaches are at varying stages of design, implementation and development and support the delivery of employment, skills and health in Tameside. The approaches are interlinked with the Policy Changes set out in section 3.

4.2 The Health and Wellbeing Board can be assured that the development of the three approaches is being taken forward in an integrated way. Lead officer representatives (Alison Lewin NHS T&G CCG, David Berry Tameside MBC Employment and Skills, Emma Varnam Tameside MBC Integrated Neighbourhood Services) are actively engaged in design and review processes to enhance offers.

4.3 It is vital that the approaches integrate with the Initiatives set out in section 2 so as to maximise the use of resource and ensure integrated provision.

- Integrated Neighbourhood Service/Teams (Community) – Launched in May 2016 - these teams will be operating from 2 bases; North (Ashton Police Station) and South (Hyde Police Station). The teams will be focusing on providing support to residents requiring lower level complexity of support with a focus on enforcement issues. The approach will provide a model to draw in wider support around issues such as employment, skills and health needs following diagnosis of additional needs. Options for integrating employment and skills specialist support in the model are currently being explored.
- Integrated Neighbourhood Teams (Health) – Currently in design – This approach is in the design phase and will be based on 4 neighbourhoods within Tameside. The objectives currently under consideration include proactively identifying people at high risk of requiring access to services, help people live independently, co-ordinate delivery of services from all providers, optimise self-care and family/carer support, focus on improved condition management and help prevent people from having to move to a residential or nursing home. The inter-relationship (referral and co-case management pathway) with employment and skills has been included within the delivery model.
- Public Service Hub – Launched in 2014 the Public Service Hub has successfully brought together Public and Voluntary Sector agencies to provide a new resident centred approach to service delivery. The Hub aimed to integrate insight, intelligence and organisational responses to complex dependency within a Troubled Families/Early Help/Children Safeguarding context. The Hub has successfully integrated Mental Health, Jobcentre Plus, Police, Probation and Welfare Rights in this setting. The Hub is currently under review lead by a focus to improve processes and deliver a reduction in demand for children's social care. The Hub could provide a focal point to develop enhanced insight and intelligence of complex cases requiring health, work and skills interventions beyond traditional children's/early help services aimed at action planning to support children and to a lesser extent parents.

## 5. PROGRAMMES/POLICY CHANGES

5.1 In this section three key policy areas are set out that need to be considered alongside the development of local work.

5.2 Health Devolution - The Health Devolution Memorandum of Understanding sets out that the parties share the following objectives:

- To improve the health and wellbeing of all of the residents of Greater Manchester (GM) from early age to the elderly, recognising that this will only be achieved with a focus on prevention of ill health and the promotion of wellbeing. We want to move from having some of the worst health outcomes to having some of the best;
- To close the health inequalities gap within GM and between GM and the rest of the UK faster;
- To deliver effective integrated health and social care across GM;
- To continue to redress the balance of care to move it closer to home where possible;
- To strengthen the focus on wellbeing, including greater focus on prevention and public health;
- To contribute to growth and to connect people to growth, e.g. supporting employment and early years services; and
- To forge a partnership between the NHS, social care, universities and science and knowledge industries for the benefit of the population.

5.3 Universal Credit – Following pathfinders for limited claimant types UC is now in operation across the whole of GM. In March 2016 all benefit types (increased levels of vulnerability and complexity of claimant) were migrated into UC in 5 areas only across the UK. The development of UC is of major significance as it promotes online claims, monthly payments and work allowances to support claimants to enter lower earning employment before increasing hours. Many claimants in Tameside who have low or no contact with the

Jobcentre/Public Sector will need to adapt to change in the way they claim benefits and search for work. The key risk factor for GM/Tameside is to see the successful implementation of UC through a strong local partnership approach. Poor implementation will have a negative impact on residents and could increase key factors such as increased rent arrears, increased prevalence of health conditions exacerbated by loss of income.

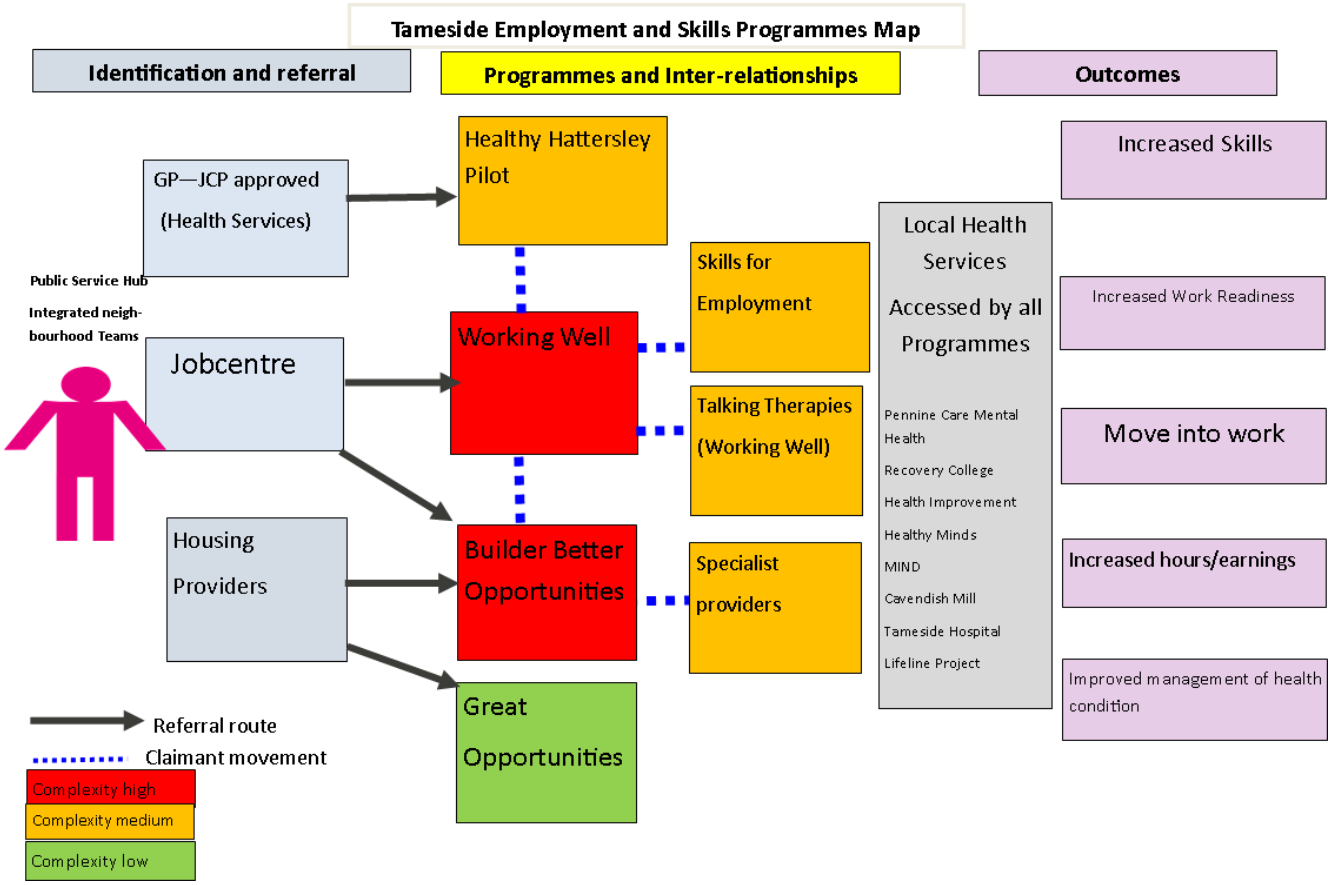
5.4 Universal Support Delivered Locally (USDL) – USDL approaches were trialled successfully in GM in 2015 (along with 11 other sites across the UK). USDL focuses on partnerships to support vulnerable UC claimants who will not have an effective claimant journey. Increasing budgeting and digital skills are at the centre of USDL. GM trialled a holistic claimant centred approach which focused on resolving root cause issues rather than budgeting and digital in isolation. The GM Trial was successful and has developed into a GM level joint programme with DWP called Universal Support Greater Manchester (USGM). USGM is aimed at integrating Jobcentre Plus and Partnership (including health) services with regards to data sharing, use of intelligence to target resources, co-case management through co-location.

## 6. INTEGRATION AT A TAMESIDE LEVEL

6.1 The diagram below sets out the relationship between the current employment programmes in Tameside. The main policy and commissioning aim is to enable a wide variety of health services to refer into employment programmes with co-case management available as a tool for practioners as appropriate.

6.2 The diagram shows the complexity of claimants within each programme and how relationships exist through Working Well to create a co-ordinated approach within the borough to move patients through the system to different types of support. For example Working Well Pilot completers could continue to receive support through BBO or Working Well Expansion non-attachments could be signposted to BBO as an alternative programme. Currently local health services are accessed by programmes via one way referrals or signposting, this could be enhanced by identifying patients via Integrated Neighbourhood Teams and GPs with an ongoing co-case management approach.

6.3 The GM Eco-system approach is attached as **Appendix A**, Tameside is aligned to the GM approach and actively works with the GM team to design new services and develop existing approaches.




## 7. GOVERNANCE

7.1 The development of Tameside work and health integration will be strategically and operationally taken forward in the following governance groups.

**Strategic**

- Health and Wellbeing Board
- Prosperous Board

**Operational**

- Healthy Lives Workstream
- Care Together Locality Workstream
- Working Well Steering Group
- Complex Dependency Steering Group

7.2 At GM level the Public Service Reform Team and Health and Social Care Devolution Team are taking forward integration plans in conjunction with local areas. The development of a Work and Health Programme (replacing the Work Programme) on a GM package area footprint.

## 8. RECOMMENDATIONS

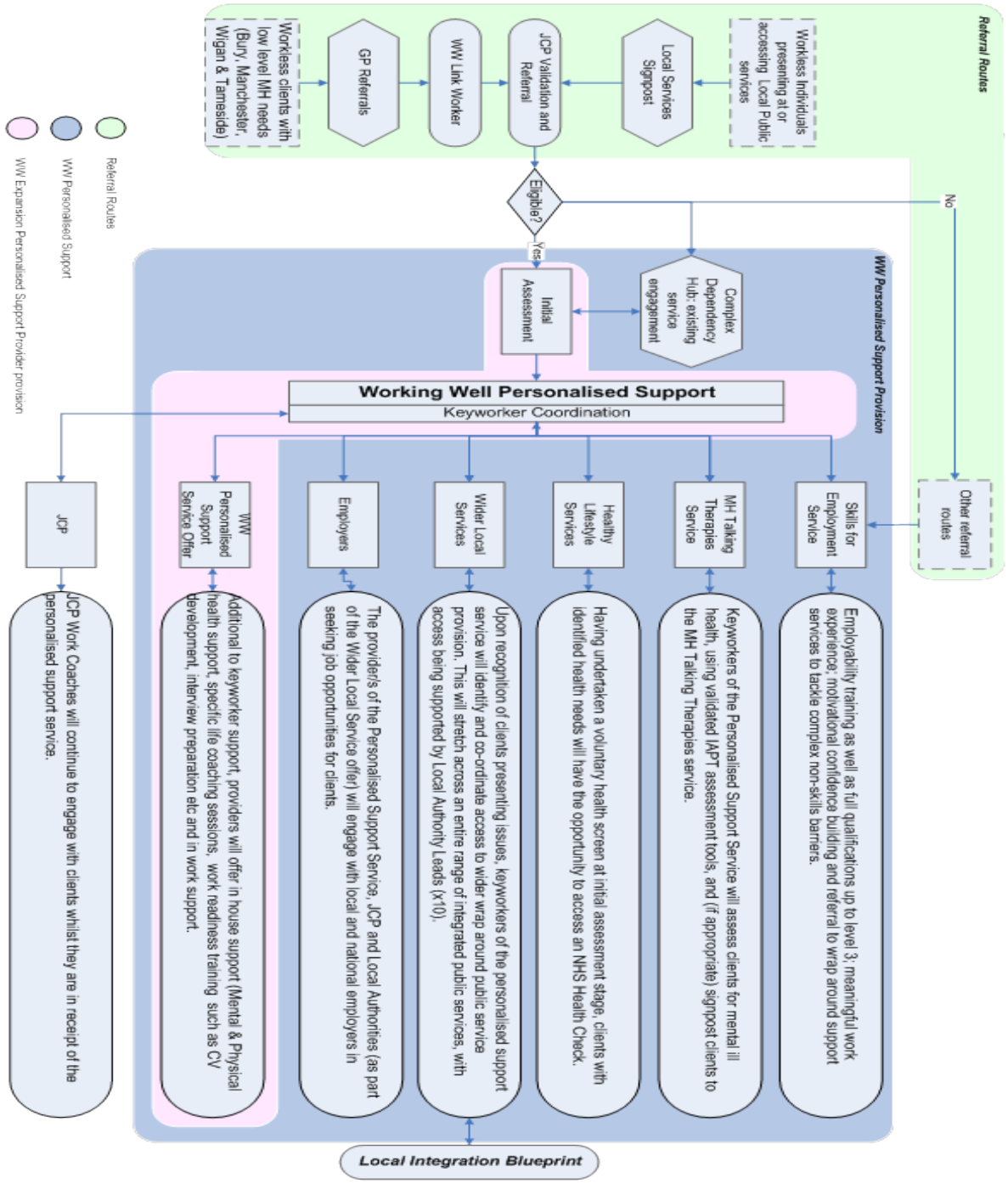
8.1 The HWBB are requested to:

1. Note the employment initiatives taking place in GM and Tameside recognising the work that has taken place to date to integrate work, skills and health services.
2. Actively promote and support the development and success of Pilots, Programmes and Approaches detailed in the report to deliver work, skills and health integration in Tameside developed alongside GM Models.

3. Review the progress of work, skills and health integration in Tameside on a 6 monthly basis to inform Policy and Commissioning decision making.
4. Respond to the contents of this report with regards to understanding how the knowledge and skills available in Tameside can best be utilised.

# APPENDIX A

Greater Manchester Eco-system



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|---|---|
| **Report to:** | **HEALTH AND WELLBEING BOARD** |
| **Date:** | 22 September 2016 |
| **Executive Member / Reporting Officer:** | Paul Starling, Borough Commander, Greater Manchester Fire and Rescue Service |
| **Subject:** | **SAFE AND WELL INITIAL EVALUATION** |
| **Report Summary:** | The purpose of this report is to inform the Health and Wellbeing Board of New Economy's initial cost benefit analysis (CBA) of Greater Manchester Fire and Rescue Service's (GMFRS) primary early intervention and prevention tool; the Safe and Well visit and to seek support to further develop closer working to improve fire and health and social care outcomes. |
| **Recommendations:** | The Health and Wellbeing Board are asked to:<br>• Note the Content of the report.<br>• Consider areas where closer joint working would improve the opportunity for more collaboration and improved outcomes as set out in paragraph 26 of this report. |
| **Links to Health and Wellbeing Strategy:** | Supportive Tameside and Healthy Tameside. |
| **Policy Implications:** | There are no policy implications relating to this report. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | Whilst there are no direct financial implications arising from the report, it should be recognised that the prevention and early intervention initiatives delivered by the Greater Manchester Fire and Rescue Service will potentially lead to a reduced demand on health and social care services and associated costs incurred. This will therefore contribute towards the delivery of future year efficiency savings alongside reduced resource allocations within the economy.<br>It is essential these initiatives are stringently monitored to ensure efficiencies are realised. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | This report sets out a clear rationale for invest to save approach to integrated working. Every proposition will have a clear business case and monitoring of the savings achieved for the whole economy so we are clear where reduction in budget is being achieved. |
| **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 Paul Starling, Borough Commander, by:

 e-mail: starlins@manchesterfire.gov.uk

## 1. PURPOSE OF REPORT

1.1 The purpose of this report is to inform the Health and Wellbeing Board of New Economy's initial cost benefit analysis (CBA) of Greater Manchester Fire and Rescue Service's (GMFRS) primary early intervention and prevention tool; the Safe and Well visit and to seek support to further develop closer working to improve fire and health and social care outcomes.

## 2. BACKGROUND

2.1 GMFRS has a long and successful history of prevention and early intervention. The service's primary tool to change behaviours relating to; and prevent fires in the home has been the Home Safety Check (HSC). When first introduced in 2005/06 GMFRS delivered less than 600 HSCs, rising to a peak of over 96,000 HSCs in 2009/10 (delivered by GMFRS and partners). In 2015/16 the service was still able to deliver over 42,000.

2.2 This approach has resulted in a 50% reduction in fatal fires in Greater Manchester (GM) over the last eight years[1]. With the number of fires and other incidents attended by GMFRS also falling by over 40% in the last ten years. More recently we have begun to see some of these trends reverse in the wake of austerity.

2.3 A HSC focused on risks and hazards in the home that may lead to a fire e.g. distraction whilst cooking or clothing left to dry too close to a heater; and ensuring that homes had a working smoke alarm and that occupiers knew what to do in the event of a fire.

2.4 Since 2007 GMFRS dedicated fire investigators have carried out in depth investigations into the cause of, and circumstances surrounding every fatal fire in Greater Manchester (166 in total). The findings from these detailed investigations has shown that whilst many fatal fires result from distraction or carelessness, the underlying causes leading to them include;

- Age
- Alcohol
- Recreational drugs
- Smoking materials
- Living alone
- In receipt of social service/agency support
- Physical disability including lack of mobility
- Mental health
- Prescribed medication

2.5 For GMFRS to continue to evolve its approach to preventing fires it needed to focus on early intervention, prevention and behaviour change relating to these and other underlying risk factors. Our discussion with colleagues in health and social care clarified that many of the underlying risk factors for fire are also the determinants of health and that any approach to early intervention, prevention and behaviour change relating to them, delivered by a fire and rescue service, could also assist in reducing current and future demand for health and social care services.

2.6 As part of its approach to learning and developing new interventions to reduce risk from fire and improve health and wellbeing, GMFRS introduced Community Risk Intervention Teams

[1] Greater Manchester Fire and Rescue Service 'Learning from Fatal Fires Report 2007-2015'

(CRIT) in January 2015. The teams were funded through DCLG Fire Transformation Funds and introduced the principles of responding to defined life saving incidents alongside NWAS, responding to high volume, low risk incidents on behalf of NWAS and GMP; and widening the service's approach to safety and delivery of brief interventions in the home.

2.7 The success of CRIT has been reported previously across Greater Manchester and having proved the concept, GMFRS has now moved to embed the principles of Community Risk Intervention across the service; enabling delivery at a scale that was previously not possible.

## 3. THE EMERGING PREVENTION ROLE OF THE FIRE AND RESUCE SERVICE

3.1 The recognition of the potential for a wider role for Fire and Rescue Services (FRS) has been endorsed by a range of national and local bodies. In October 2015 NHS England, the Chief Fire Officers Association, the Local Government Association, Public Health England and Age UK published a joint consensus statement setting out a national commitment to work together to improve health and wellbeing and reduce demand on a range of public services including health and social care consensus statement (**Appendix 1**).

3.2 The consensus statement was complemented by the publication of 'Design Principles for a Safe and Well Visit', which set out a basis on which FRSs could engage with health and social care partners locally to design a Safe and Well intervention that meets the needs of all partners. Safe and Well can include the following interventions;

- Fire
  - Cooking
  - Candles
  - Electrical Equipment
  - Portable heaters and open fires
  - Provision of risk appropriate domestic fire detection and warning
  - Escape plans
- Health
  - Weight
  - Mobility
  - Falls
  - Frailty
  - Burns and scalds
  - Provision of clinical and other equipment in the home that could increase fire risk
- Mental Health
- Learning disability
- Sensory impairment
- Loneliness/Social Isolation
- Smoking
- E-Cigarettes
- Alcohol
- Drugs
- Prescription medicines
- Hoarding
- Safety of under 5s
- Employment
- Home security
- Consent to share information

3.3 This collaborative approach enables FRSs to complement or provide for early intervention and prevention approaches locally. Based on the evidence from our fire investigations and the endorsement of partners nationally, GMFRS has developed its HSC into a holistic Safe and Well visit incorporating all aspects of Safe and Well identified above.

3.4 As part of an integrated response it has the potential to reduce current and future demand for fire and health and care services by equipping those in need; and those not yet in need with access to information and support to change behaviours and promote independence. However the opportunity to maximise the prevention capabilities of GMFRS will only be achieved if this approach is seen as part of an integrated place based health and social care system that is based upon the following:

- An ongoing commitment to a comprehensive prevention strategy.
- Recognition of common risk factors for health and fire by all partners.
- Understanding the opportunity to add value to and not replace existing health and social care roles.

3.5 In July 2015 the Public Health Devolution Memorandum of Understanding (MoU) for Greater Manchester was signed. As signatories to the agreement GMFRS have worked with Greater Manchester partners to support a focus on early intervention, prevention and population health. As part of the MoU, GMFRS undertook to introduce Safe and Well across Greater Manchester.

3.6 In October 2015 GMFRS formally replaced HSCs with a Safe and Well visit. All of its community safety teams have been trained to deliver all aspects of Safe and Well. Firefighters have been trained in some aspects, principally falls, frailty, social isolation and warm homes; and will receive training on all other aspects of Safe and Well over the next two years.

3.7 Due to its holistic nature Safe and Well visits inevitably take longer to deliver than traditional HSCs. As a consequence it is no longer practical to retain our previous target of 60,000 home safety interventions. The service will aim to deliver 30,000 targeted Safe and Well visits annually.

3.8 Our experience to date highlights the potential to significantly improve Safe and Well visits by improving training that could be jointly designed and delivered with partners; simplifying referral pathways between complementary organisations, improving data sharing and improving use of estates to enable closer partnership working.

3.9 Although still in its early stages, GMFRS commissioned New Economy to carry out an independent cost benefit analysis (CBA) of Safe and Well visits in Greater Manchester.

3.10 Their CBA concluded:

- The Safe and Well programme is viable fiscally and valuable economically.
- For every £1 spent on Safe and Well, partners as a minimum are set to save the fiscal equivalent of £2.52 in benefits ( in year and recurrent).
- Over 5 years the gross fiscal benefits to various partners is estimated at £5.3M.
- £4.3M relates to increased benefits to the NHS.
- Immediately accessible benefits to the NHS amount to £852K over the 5 year period.
- The estimated benefits could increase by as much as 250% over time and given the involvement of partners in service redesign.

3.11 The full CBA document is attached.

3.12 Building upon these encouraging findings GMFRS are committed to working with partners to increase the understanding of the potential benefit of the services early intervention and prevention activities to the wider public purse and local residents.

## 4. GREATER MANCHESTER DEVOLUTION AND GMFRS

4.1 There now exists an opportunity to identify how GMFRS can further support wider early intervention and prevention work and complement the work of health, social care and wider public sector services; whilst maintaining its primary function to prevent and fight fire. As part of its transfer to the GMCA the service recognises the opportunity to work as part of an even more integrated system both at a Greater Manchester and at a local level.

4.2 Through its membership of key strategic partnerships GMFRS has already contributed, at a strategic level to the Public Health Devolution MoU and the health and social care devolution plan 'Taking Charge of our Health and Social Care'.

4.3 Its involvement as part of the GM Reform Board and the GM PSR & HSC Task and Finish Group, will ensure that it continues to complement the services of others and assist the development of more integrated approaches.

4.4 At a local level our Area management teams have been contributing to the development of locality plans, the development of place based pilots and the roll out of place based teams. Much of this has been through local relationships rather than membership of key local strategic partnerships. The opportunity exists to strengthen this approach through GMFRS contributing directly as part of local Health and Wellbeing Boards (HWBB); strengthening place based planning and building on recent Greater Manchester guidance for HWBBs to be the vehicle within a locality to agree the Locality Plan and monitor delivery.

## 5. STRENGTHENING PARTNERSHIP WORKING

5.1 GMFRS recognises that by working in partnership in the wider health and wellbeing context, fire and rescue services can help to enhance and improve shared outcomes beyond those that could be achieved in isolation. As part of the GMFRS offer to work with localities there are a number of areas where closer working would improve the opportunity for more collaboration and improved outcomes:

- Governance and Strategic Partnering – The inclusion of GMFRS Managers on local HWBBs and the inclusion of GMFRS on local governance and planning structures to support the development and implementation of locality plans.
- Co-design and production – Adopting the principle that all prevention interventions where GMFRS are leading, or are included are designed in partnership to ensure the best fit of City region programmes such as Safe and Well at a local area level.
- Improved data sharing – An undertaking to explore enhanced data sharing at a Greater Manchester level and the inclusion of GMFRS capacity in locality planning including the Joint Strategic Needs Analysis process and other processes supporting locality planning.
- Integrated workforce training and development – A commitment by partners and GMFRS to explore integrated and aligned training and workforce development to support Making Every Contact Count (MECC) and investing in the wider public health workforce .
- An enhanced place based offer – An agreement to explore the feasibility for each local area to:

- Adopt the Safe and Well visit as part of the local risk assessment of health and social care needs;
- Use fire stations as community assets to support healthy lifestyles in local communities;
- Work with GMFRS to understand the links between mental health and fire risk and to strengthen the community response;
- Consider the role of fire services in the use of assistive technology and Telecare.

## 6. CONCLUSIONS

6.1 GMFRS has a long and successful history of prevention and early intervention. By working in partnership with other organisations, the expertise and experience of GMFRS in early intervention and prevention can contribute to the GM aspiration for a radical uplift in population health.

6.2 Along with health, social care and voluntary groups GMFRS are at the heart of their communities. However the potential to maximise the prevention capability of GMFRS has not been fully realised at a locality level.

6.3 The consideration by partners of the opportunities outlined in paragraph 26 of this report and their adoption will assist in further realising the contribution that GMFRS can make to place prevention at the centre of all that we do to reduce risk to and improve the health and wellbeing of the GM population.

# Appendix 1

Public Health England

NHS England

**Consensus Statement on Improving Health and Wellbeing between NHS England, Public Health England, Local Government Association Chief Fire Officers Association and Age UK**

**This consensus statement describes our intent to work together to encourage joint strategies for intelligence-led early intervention and prevention; ensuring people with complex needs get the personalised, integrated care and support they need to live full lives, sustain their independence for longer and in doing so reduce preventable hospital admissions and avoidable winter pressures/deaths.**

**Headline consensus statement**

We will work together to use our collective capabilities and resources more effectively to enhance the lives of the people we work with and we will support and encourage our local networks to do the same in their communities.

**Introduction**

Demand for health and social care is rising as a result of an increase in the numbers of children and adults with long term conditions, alongside an ageing population. The NHS Five Year Forward View highlights the need for an increased focus on integration and prevention so that resources are utilised more effectively, outcomes are improved and demand is reduced. It also recognises the need to broaden and deepen the involvement of the third sector in developing solutions. At the same time the number of fires has decreased due to preventative work by Fire and Rescue Services (FRS) and regulatory measures. This has resulted in new opportunities for the FRSs to complement and further support the health and social care sector.

Representatives from NHS England, Public Health England (PHE), the Local Government Association (LGA), Age UK and Chief Fire Officers Association (CFOA) met on 14 April 2015 to agree to develop a new working relationship with the shared aim of identifying and improving the quality of life of those who could benefit the most from early engagement with local services; for example, older people and people with multiple long term conditions and complex needs. This consensus statement represents a joined-up multi-agency approach to put into practice the national commitment to more integrated care, closer to people's home. Its emphasis is on local initiatives to deliver preventive interventions to our people who would benefit most in their own homes and supports local action to deliver better health and well-being outcomes.

Local Government Association

age UK Love later life

CFOA Chief Fire Officers Association

**Shared purpose**

There are common underlying risk factors which increase demands on both fire and health services, such as the number of long-term conditions, cognitive impairment, smoking, drugs or substance misuse, physical inactivity, poor diet, obesity, loneliness and/or social isolation, cold homes and frailty. By identifying people with these risk factors and taking a whole system approach to interventions which are centred on peoples' needs, we intend to make every contact count, irrespective of which service it is from.

**Our individual and collective strengths**

**FRS:** The 670,000 home visits carried out by the FRS in England provide an opportunity to deliver improved proactive support that delivers improved integrated care between the relevant organisations.

**NHS, Public Health and local government:** Equally health and local government staff have opportunities to identify households with complex conditions/needs and who are at an increased risk of fire

**Age UK:** with and through our network of 165 independent local Age UKs we provide, coordinate and signpost to a range of services for individuals, their families and carers, and with groups of older people in their own homes and in the community to help them to manage their long-term conditions, while improving their health and wellbeing.

**Collectively we can offer** an integrated approach to targeting through the better co-ordination, prevention and early intervention that has been demonstrated to increase the reach and impact of all services. For instance, in areas of best practice, health services have commissioned the fire and rescue service in collaboration with Age UK (and other voluntary sector organisations) to make interventions in people's homes that have resulted in improved health and reduced risk. Early results have been positive, with a measurable significant impact on improving outcomes. This work could be expanded with the fire and rescue service working with a number of local commissioners.

**Supporting local action and flexibility**

We encourage local organisations to work together more effectively in partnership and to consider seeking greater integration of services where possible, while supporting meaningful local flexibility in the way this happens. FRSs, by working in an integrated way as part of a whole systems approach, can add even greater value and resilience to communities by understanding and responding to local needs and drivers.

Local areas, and the organisations we represent, are too diverse for a 'one size fits all approach'. However, there are some key actions which we will take nationally to support local action.

- Producing this consensus statement between NHS England, CFOA, PHE, Age UK and LGA that sets out how health, public health, the fire and rescue service and the Age UK can work together to encourage local action to prevent and minimise service demand and improve the quality of life of older people and children and adults with long term conditions.
- Developing the design principles for a Safe and Well Visit that is informed by existing good practice within the FRS and Age UK network. The visit aims to identify and tackle risk factors that

impact on health and wellbeing and which can lead to an increase in demand for health and local authority services. Wider health impacts are also addressed during the visit, such as the identification of frailty, promotion and support of healthy aging, help to avoid trips and falls; and signposting to relevant services through making every contact count and sources of help.

- Identifying and exploring opportunities to improve local services, making them more efficient and effective by working more closely together and where appropriate integrating services through measures such as better information sharing, the promotion of existing guidance and initiatives, access to inclusion to improvement support programmes and joint communications.
- Investigating the opportunities for more effective and appropriate information sharing across NHS England, PHE, Age UK and FRS.
- Developing shared communications for our collective networks, the public, professionals, partners and other stakeholders to raise awareness of the benefits of a more connected approach and to provide reassurance about skills and knowledge, appropriate information sharing and joined up pathways.
- Promoting and encouraging local collaboration through Health and Wellbeing Boards, Joint Strategic Needs Assessments, System Resilience Groups as well as through the commissioning of collaborative approaches.

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| **Report to:** | **HEALTH AND WELLBEING BOARD** |
| **Date:** | 22 September 2016 |
| **Executive Member / Reporting Officer:** | Councillor Gerald P Cooney – Executive Member (Healthy and Working)<br>Angela Hardman – Director of Public Health |
| **Subject:** | **PUBLIC HEALTH ANNUAL REPORT 2015-16** |
| **Report Summary:** | The Director of Public Health's Annual Report 2015-16 is themed around Self-Care.<br>The Report emphasises that by focusing on self-care we can help to increase people's confidence to live well, improve their quality of life and improve the patient experience. Together we can create an environment which promotes self-care through healthy lifestyle choices, based on local leadership within communities. We can see a fundamentally different relationship between public services, residents and local communities by working locally to enable people to build their skills and confidence and improve self-care in all its forms.<br>The Report highlights our existing programmes of work and shows where real opportunities exist as a result of the restructure brought about by Care Together and Greater Manchester Devolution.<br>The Report concludes that through self-care we can realise these bold ambitions of the Tameside and Glossop 'Care Together' Programme:<br>- "We aim to raise healthy life expectancy to the North West average within five years."<br>- "We then will continue to drive our ambition to achieve the England average within the subsequent five years." |
| **Recommendations:** | This report is for information only. |
| **Links to Sustainable Community Strategy:** | This Public Health Annual Report is relevant to all aspects of the Community strategy, but health most specifically. Although an independent report, it also contributes to the delivery of the corporate vision: The Council, as a representative body, exists to maximise the wellbeing of the people of the borough. |
| **Policy Implications:** | The report does not have any policy implications, however, it presents a challenge to the Council and partners to embed principles within their policies that promote health and reduce inequalities. |

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| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | Whilst there are no direct financial implications arising from the report, it should be recognised that initiatives to improve the health and wellbeing of residents of the borough will potentially lead to a reduced demand on health and social care services and associated costs incurred. This will therefore contribute towards the delivery of future year efficiency savings alongside reduced resource allocations within the economy.<br><br>It is essential these initiatives are stringently monitored to ensure efficiencies are realised. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | The publication of this report fulfils a statutory requirement of Tameside's Director of Public Health and sets out an approach to meet our Health and Wellbeing Strategy. |
| **Risk Management :** | The annual report of the Director of Public Health is being presented to Board for their information. |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting Gideon Smith – Consultant in Public Health Medicine<br><br>Telephone:0161 342 4251<br><br>e-mail: gideon.smith@tameside.gov.uk |

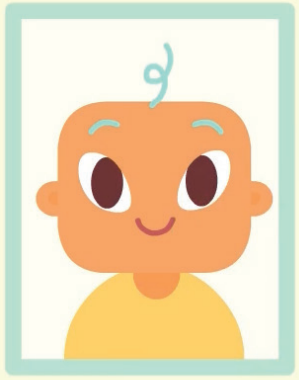
# SELF-CARE FOR LIFE

## ANNUAL REPORT FROM THE DIRECTOR OF PUBLIC HEALTH FOR TAMESIDE 2015-16

# CONTENTS







# FOREWORD

Angela Hardman
Director of Public Health, Tameside Council

Welcome to my third annual report as Director of Public Health in Tameside. This year's report brings an important focus on self-care.

Self-care is everybody's business. It's about creating a culture where we work together to be the best that we can. That's not just about self-care for us as individuals, it's also about self-care in our families and communities and in our health and care services.

By giving people and communities the power and control to make good choices, to look after themselves and their families and use the right services at the right time, we can start to make a real difference to health and well-being.

My hope is that by focusing on self care we can help to increase people's confidence to live well and improve the quality of their life. The report shares examples of the great work already in place to support people to be the best they can and shows where real opportunities exist to embed self care into all that we do.

Together we can create an environment which promotes self-care through healthy lifestyle choices, based on local leadership within communities.

We can see a fundamentally different relationship between public services, residents and local communities by working locally to enable people to build their skills and confidence and improve self-care in all its forms.

My ask of you in reading this report, is that you take the opportunity to reflect and consider self care firstly from your own personal perspective and secondly, in terms of how you can champion self care to others - members of your family, friends, neighbours, work colleagues; and if you are in a position to influence self care in your business endeavours how you can take this forward. Myself and my team would be more than happy to explore ideas and opportunities to encourage self care across the workforce and wider community.

Thank you to everyone involved in planning and delivering self care.

SELF-CARE SUPPORTING EACH OTHER TO GOOD HEALTH AND WELLBEING.

# EXECUTIVE SUMMARY

A lot of people in Tameside get sick earlier in life than in other places in the UK, and some of us will die younger than we should. The picture is similar across Greater Manchester. This is unfair and we want to change it. Self-care is one of the ways we can do that.

Self-care is the key to better health. By focusing on self-care, we can increase people's confidence to live well and improve their quality of life and experiences.

Most of the time, most of us are able to take care of ourselves and our families. From the start of life through our working years and into old age, we use our skills and knowledge to maintain good health, prevent illness and manage long-term conditions.

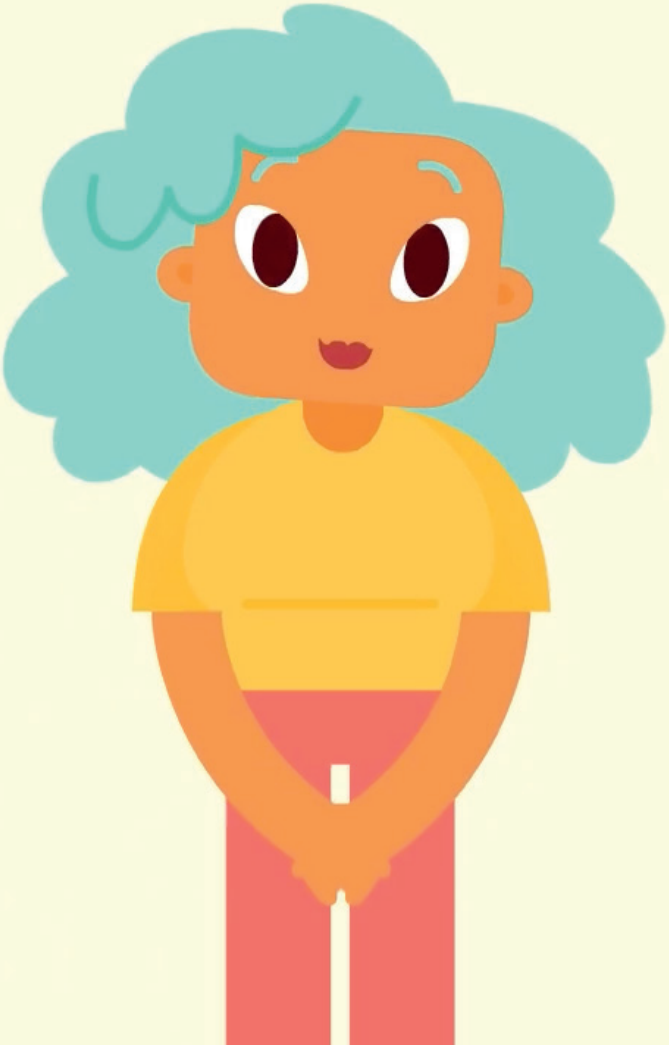
Self-care focuses on the things that matter to us, like being independent or staying in work, as well as clinical issues. It is also about being empowered to make changes in our lives, and be in control of our health. When we take care of ourselves, we understand better our strengths and abilities, and that enables us to reach our goals and stay healthy and well.

The more of us who take charge of our health early, the fewer of us will need 'big help' later in life, like an unplanned operation or long-term medication. That's good news for individuals, families and health services.

Our health and social care services are under a lot of pressure. People are living longer, but often with more health problems, and there is less money to spend on services. Focusing on self-care means that over time, the money saved when people stay well, rather than becoming ill, can be spent elsewhere.







The key to a healthier Tameside is to get as many people feeling confident to manage their own health as possible. We want people in our communities to know how to look after their body and mind, and to know the people and places that can support them to be happy and healthy for life.

We are going to do that by making the most of the changes happening through the Tameside & Glossop Care Together programme and Greater Manchester Devolution. We have developed a new model of care, that will champion self-care as an integral part of all our lives.

We will change the relationship between people and their health, and between people and health and care services, by using an asset based approach. This means helping people and communities to develop resilience and become more capable of looking after themselves.

The focus is on preventing ill health, rather than treating illness. That means looking at mental as well as physical health, and managing long-term conditions as well as promoting healthy lifestyles.

Changing our focus is going to mean a fundamental shift in our thinking; blending evidence-based public health approaches and interventions, developing our staff and adopting place-based community approaches. We need to provide a range of options that can respond flexibly to the needs of different people, in different places, at different stages of life.

We have some bold ambitions for the Tameside and Glossop 'Care Together' Programme. We want to raise healthy life expectancy to the North West average within five years. In the subsequent five years we aim to reach the average England life expectancy.



# PROMOTING SELF-CARE IS AT THE HEART OF THIS AMBITION

# RECOMMENDATIONS

We already focus on self-care, but we want, and need, to do more.

An important part of our Care Together Programme is about changing the relationship between individuals and their health, and between people and their health and care services. Our recommendations for future work centre around this. To begin this work in earnest, there are two important foundations to lay down. Firstly, using asset based approaches, which identify and utilise the strengths, skills, capacities and resources which individuals and communities have. Secondly, we must do more to involve residents, co-producing our services with the people who use them.

**Changing relationships between people and their health, and between people and services, will also mean:**



**1. Developing the skills, knowledge and confidence that individuals need in self-care.**

**Our focus should be on:**

- providing local self-management programmes for people with long-term health conditions.
- developing a Patient Activation Measure (PAM) based evaluation and research programme, which will encourage people to become more engaged in their health and wellbeing.

**2. Creating effective peer support and building strong and resilient communities.**

**Through Care Together we will continue to develop:**

- A broad wellbeing service, which focuses on mental as well as physical health.
- Asset-based approaches.
- Social prescribing and risk stratification; identifying and supporting those who use services most, or are likely to use services a lot in future.
- 'Good work' programmes that support employers and employees to promote and adopt healthier lifestyles and better self-care.
- A 'find and treat' programme to find people with serious but unidentified health problems.

You can read more about these approaches, and how they are working in Tameside, in Chapter 3 of the report.

**3. Creating a skilled and knowledgeable workforce** both now and in the future, so that self-care becomes a golden thread running throughout all our prevention, treatment and care services.

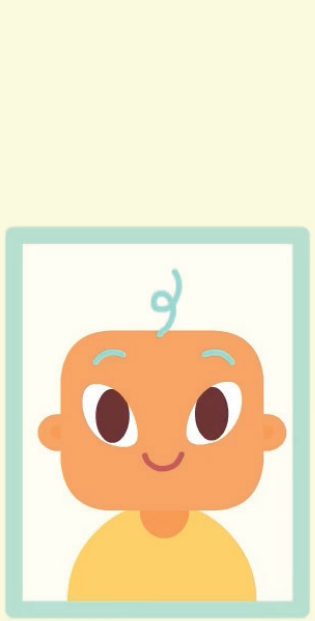
# CALL TO ACTION

Self-care is at the heart of what we do. Across Tameside, organisations are already working together to deliver effective self-care programmes and strategies. Tameside residents are playing their part too, embracing self-management and prevention and adopting healthier lifestyles.

But we want to do more. We all have a responsibility to take care of ourselves and our communities.

- We want to build on our success so far, expanding and improving what we do to reach more people.
- We want to create a social movement for behaviour change, self-care and self-management, where we fundamentally change the relationship between people and health and social care services.
- We want to build strong and resilient communities, where people are well supported and motivated to make lifelong changes to their health and wellbeing.
- We want to increase the life expectancy of people in Tameside, and create fair and responsive services that drive progress and improve both quality of life and health.





# 1 CHAPTER 1: ABOUT SELF-CARE

"Self-care is a deliberate action that individuals, family members and the community should engage in to maintain good health. Ability to perform self-care varies according to many social determinants and health conditions"

**World Health Organisation**

Although we might sometimes use health services, such as our GP or local hospital, most of the time, most of us are able to take care of ourselves and our families. We clean our teeth, we treat coughs and colds with medicines from the pharmacy, take regular exercise, choose healthy eating options and we ensure we get enough sleep.  This is called self-care, and it's by far the best way to stay healthy, prevent illness and live a long life.

Self-care is about individuals, family members and their communities doing all the things that help us to maintain good health. The services we use can help too; by providing us with good information, by encouraging and motivating us and by making it as easy as possible to choose the healthy options.  Self-care is a life-long activity, because we look after ourselves and our families from the start of life, through our working years, right into old age.

Whether you're able to look after yourself in this way, and how well you're able to it, is affected by many things. These include where you're born, whether you have a job or are disabled, and even whether you are managing long-term health problems.



**This is what else we know about self-care:**

- **There is a lot of it happening already**. In fact, around 80% of all health care is self-care.
- **Most of us are already doing it.** Most of the time, people manage their own health and wellbeing, rather than seeing a health professional or using a health service. Most of us feel comfortable managing everyday minor illnesses like coughs and colds; particularly when we're confident about the symptoms and treatments.
- **It focuses on the things that matter to us,** like being independent or staying in work, as well as clinical issues.
- **It's about empowering people to make changes in their lives,** and to be in control of their health. When we take care of ourselves, we understand better our strengths and abilities, and that enables us to reach our goals and stay healthy and well.

# THE BEST PERSON TO LOOK AFTER OUR HEALTH IS US

**There are four main features of self-care:**

1. **Regulatory self-care** is about the basic things we do, like making sure we eat well and get enough sleep.

2. **Preventative self-care** is stopping health problems before they start, like our brushing teeth to prevent decay, or being active to build our strength.

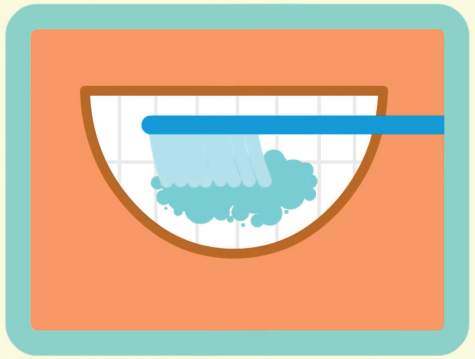
3. **Reactive self-care** is about taking care of ourselves when we get sick, for example, buying cough medicine from the chemist or visiting NHS Choices to look for health information.

4. **Restorative self-care** means managing any long-term health problems so that we stay well, like taking medications as prescribed, or quitting smoking.

You can find out more about what we're doing in Tameside in these four areas on page 26 of the report.

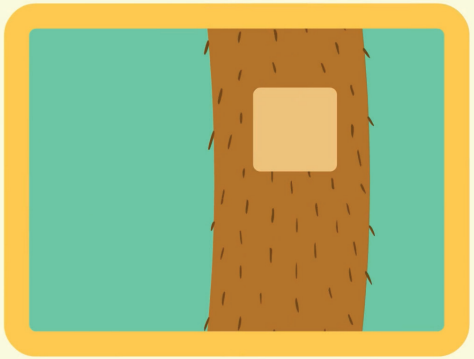


REGULATORY



PREVENTATIVE


REACTIVE



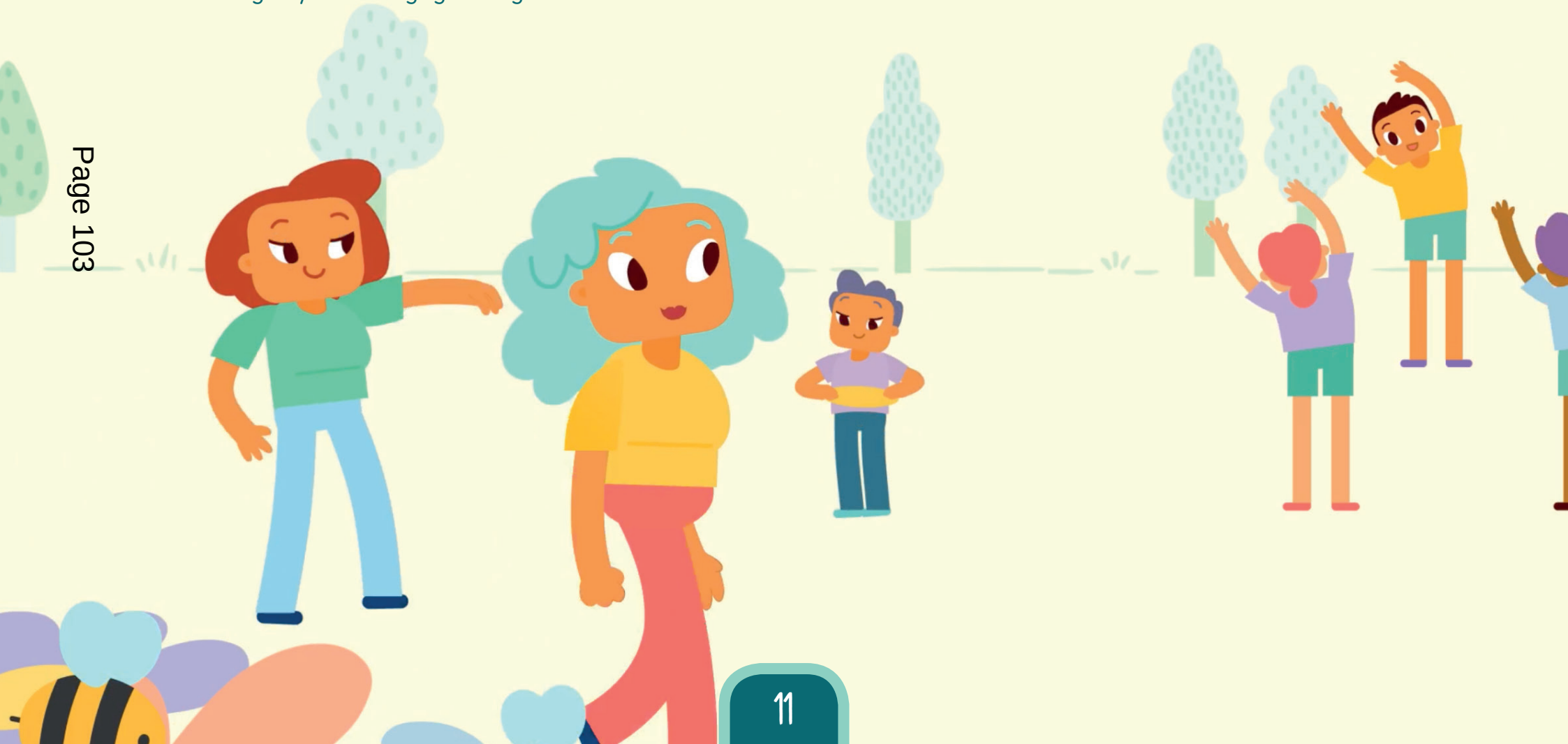
RESTORATIVE

# WHY IS SELF-CARE SO IMPORTANT?

The more of us who take charge of our health early, the fewer of us will need 'big help' later in life, like an unplanned operation or long-term medication.  That's good news for individuals, families and health services.

Self-care can lead to better health and a better quality of life. So, for example, good self-care by taking medicines correctly can mean long-term conditions like asthma are better controlled.  That in turn means fewer visits to accident and emergency when things go wrong.

Our health and social care services are under a lot of pressure. People are living longer, but often with more health problems, and there is less money to spend on health services. Focusing on self-care means that over time, the money saved when people stay well, rather than becoming ill, can be spent elsewhere. This means more money to spend on new medicines and technology, and improving the experience for those who have to be in hospital or care.



# 2 CHAPTER 2: REALISING OUR AMBITION - EXPANDING SELF-CARE THROUGH DEVOLUTION AND INTEGRATION

A lot of people in Tameside get sick earlier in life than in other places in the UK, and some of us will die younger than we should. The picture is similar across Greater Manchester. That isn't fair, and we want to change that. Self-care is one of the ways we can to do it.

The key to a healthier Tameside is to get as many people feeling confident to manage their own health as possible. We want you to be know how to look after your body and mind, and to know the people and places within your community that can support you to be happy and healthy for life.

Our mission is to make a trip to the GP something you rarely have to do, and a stay in hospital even rarer.

How are we going to do that? By making the most of change.

Tameside is going through a significant and wide-ranging restructure of services and organisations. So, now is a great time to make changes. Decisions about our health and care can now be made in a different way, through the Care Together programme and Greater Manchester Devolution.



"We believe everyone living in Tameside and Glossop should be supported to live a long, healthy and fulfilling life. We are committed to changing the way we organise, provide and fund public services to ensure we achieve this aim." Also, "Our ambition for the public sector across Tameside and Glossop is bold. We aim to raise healthy life expectancy to the North West average within five years. By 2020, a male in Tameside and Glossop can expect to have an additional 3.3 years of healthy life expectancy and women an additional 3.2 years. We then will continue to drive our ambition to achieve the England average within the subsequent five years."

**A Place-Based Approach to Better Prosperity, Health and Wellbeing: Tameside and Glossop Locality Plan, November 2015**

# TAMESIDE AND GLOSSOP CARE TOGETHER PROGRAMME

This programme is bringing about integrated health and social care. That means bringing together hospital and community care, as well as health and social care. By doing this, we have an opportunity to change the way health services are delivered and encourage self-care by bringing health and well-being into homes and communities.

**Our focus is on:**

- Empowering individuals to stay healthy, by giving individuals confidence and skills.
- Providing self-care courses for people diagnosed with a long-term condition.
- Giving individuals the right information and support to manage their own health and seek the best help when needed.
- Developing effective community leadership, which promotes a 'bottom up' approach to encouraging us to make healthy lifestyle choices.
- Building strong communities, led and influenced by their members.
- Creating a website that Tameside residents can use to find information about health and wellbeing services in their local area.

**More broadly, we are changing the way we plan and deliver services. We will:**

- Use an asset based approach. This means helping people and communities to develop resilience and become more capable of looking after themselves.
- Build and support a thriving voluntary, community and faith sector.
- Put co-production with service users at the heart of developing services.
- Change the way we commission services, for example by using the Joint Strategic Needs Assessments (JSNA) to underpin our decisions.
- Train and develop the skills of our staff so that they can support self-care.

We will use risk stratification to identify people who are high intensity users of health and social care services, or who have the potential to have high level needs in future. This will enable us to improve quality of life by effectively targeting our services, and supporting people to manage their conditions better through self-care.

# THE HEALTHY LIVES WORK STREAM

The Healthy Lives work stream is part of the Care Together strategy. It aims to improve healthy life expectancy for the people of Tameside and Glossop, by working across all health and social care organisations and services to embed preventative thinking and practice.

The focus is on preventing ill health, rather than treating illness. That means looking at mental as well as physical health, and managing long-term conditions as well as promoting healthy lifestyles.

Changing our focus is going to mean a fundamental shift in our thinking; blending evidence-based public health approaches and interventions, developing our staff and adopting place-based community approaches. We need to provide a range of options that can respond flexibly to the needs of different people, in different places, at different stages of life.

As part of this work we can look for opportunities to encourage self-care and prevent ill health in all of our contacts with individuals and their families. We will create prevention pathways and link these to existing care pathways. As and when new models of care develop, prevention will be built into these new care pathways too.

We are exploring the use of social prescribing, which links people with health problems with non-medical support and services in their community. Last year, Tameside and Glossop CCG funded a pilot project of social prescribing involving 8 GP practices. The project had a significant impact on those who took part, with almost half saying they felt safer and more positive as a result, and a quarter feeling more able to look after themselves. It was so well received, that we will be extending it out to neighbourhood teams.

**If we are going to provide services differently, then communities need to grow and develop at the same time. We will ensure that local communities are supported and nurtured by:**

- increasing and improving the participation of local people in shaping their services
- developing new peer support mechanisms, focused on managing long-term conditions
- creating resources to help people self-care
- addressing low health literacy.

# GREATER MANCHESTER DEVOLUTION

As well as changes to local health and social care services, devolution across Greater Manchester also creates opportunities for us to work together and innovate.

The Greater Manchester Health and Social Care Devolution Strategy 'Taking charge of our health and social care in Greater Manchester' includes a commitment to upgrade prevention and self-care.

As with the changes happening in Tameside, the strategy is proposing to change the way you, the people of Greater Manchester, view and use public services; creating a new relationship between people and the care system. Part of this vision will see the development of population wide Find and Treat programmes aimed at finding the 'missing thousands' who have diseases, but don't yet know it.



**Other elements of the strategy include:**

- Working with Health Innovation Manchester to develop digital technologies that allow people to track and analyse their own health data and to share this with others. This can help people to manage long-term conditions and stay healthy and well.

- Social marketing programmes. These use insights into people's behaviour to engage them to become active participants their own and others' health.

- Developing a Greater Manchester framework for 'patient activation' - motivating people to take control of their health and supporting work places to tackle health inequalities.

- Increasing the range and profile of self-care support programmes, and training our staff to deliver them.

- Working with Health Education England to give our public sector staff more skills in self-management education, shared decision making, health coaching and patient activation.

"60-70% of premature deaths are caused by behaviours that could be changed, and around 70-80% of all people with long-term conditions can be supported to manage their own condition."

**Taking charge of our health and social care in Greater Manchester**

# 3 CHAPTER 3: SELF-CARE PROGRAMMES AND INTERVENTIONS IN TAMESIDE

There is a great deal of self-care already happening in Tameside. This part of the report highlights some of the amazing work being led by Public Health, working collaboratively with partners, community groups, local agencies and organisations.

# A SELF-CARE AT INDIVIDUAL, FAMILY, GROUP, COMMUNITY AND SERVICE LEVEL

## INDIVIDUAL SELF-CARE: ONE YOU

By the time we reach our 40s and 50s, many of us will have dramatically increased our chances of becoming ill later in life. Whether we are eating the wrong things, drinking too much alcohol, smoking or not being active enough, all of these small things can add up. Making better choices now can have a huge influence on our health; it could prevent diseases such as type 2 diabetes and it could help us to stay independent in later life.



'One You', is the first nationwide campaign aimed at preventing health problems in adults. Set up by Public Health England, the campaign encourages adults, particularly those in middle age, to take control of their health by supporting them to make simple changes.

One You provides tools, support and encouragement, to help adults to move more, eat well, drink less and be smoke free. One You also provides information on how people can reduce their stress levels and sleep better. In Tameside Be Well Tameside, Active Tameside, Tameside and Glossop CCG, Tameside Council and Tameside Hospital all promote the 'One You' initiative.

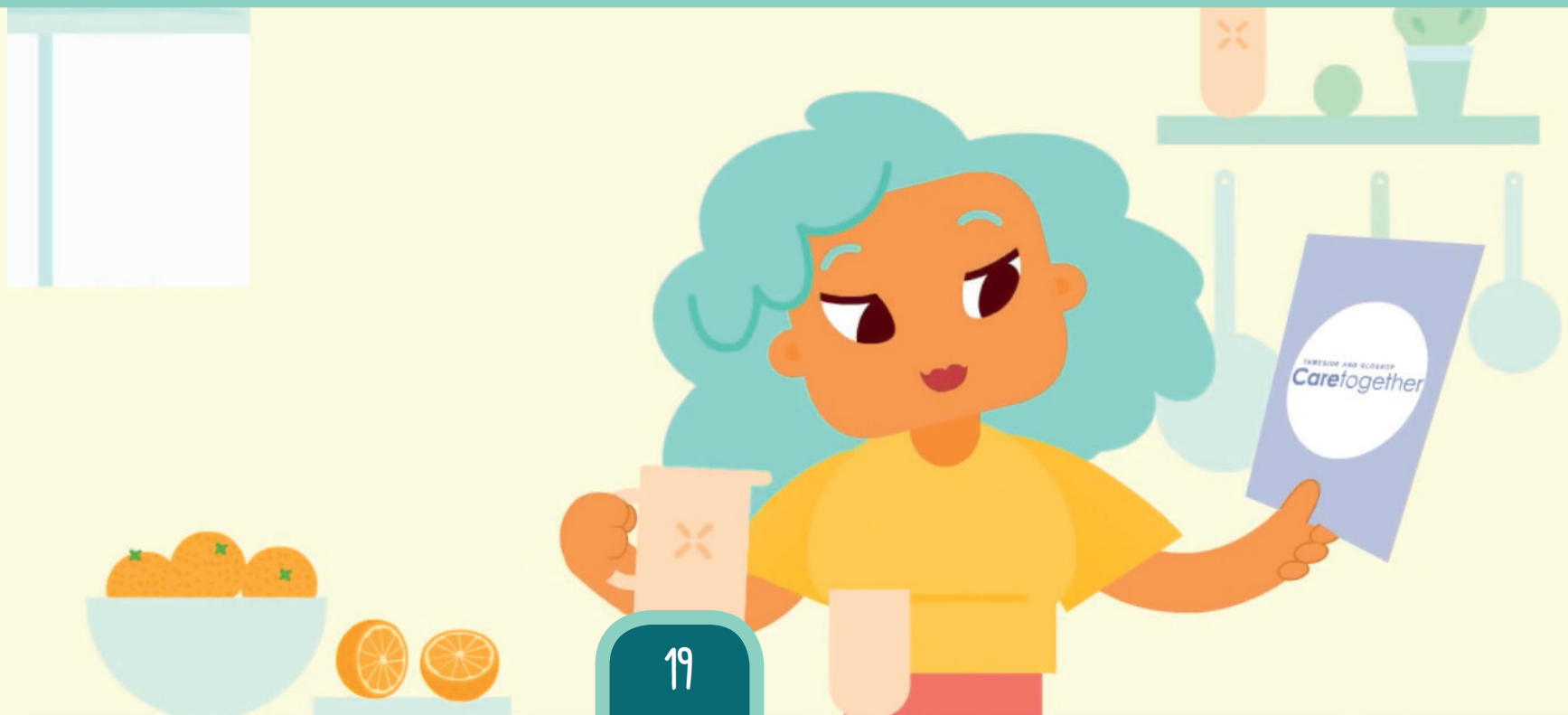
**www.nhs.uk/oneyou**

# CASE STUDY: ONE YOU IN TAMESIDE

One You was launched at our popular Grafton Centre in Hyde. We ran sessions for their middle-aged membership, including an aerobics class and an outdoor walk in a local park, while a team of health professionals held a small marketplace in the community centre's bistro. Representatives from our local sports trust, Active Tameside, were on hand to talk about physical activity and the programme for people with long-term conditions. Our 'Be Well' Service did blood pressure checks, and offered advice on maintaining a healthy weight and stopping smoking. Staff from our local alcohol service were also on hand to talk about sensible drinking.

Following on from this successful local launch, Be Well Tameside, Active Tameside, Tameside and Glossop CCG, Tameside Council and Tameside Hospital will all be promoting 'One You' as an effective tool for local people to use to take control of their health.





# INDIVIDUAL SELF-CARE: SELF-CARE WEEK

Self-care week is a national campaign that runs every November and focuses on embedding support for self-care across communities, families and generations. The campaign is run by the Self Care Forum, a group of organisations dedicated to embedding self-care into everyday life. They include the NHS Alliance, Royal College of Nursing, National Association of Primary Care, National Association of Patient Participation and the Proprietary Association of Great Britain (PAGB).

In 2015, Self-Care week focused on the broad topic of 'Self Care for Life'.

In Tameside, we supported and promoted the campaign through our social media, websites and services. Haughton Thornley Patient Participation Group held an event to highlight medication passports, and there was also an open introduction to the local self management course programme for people with long term health conditions held in Ashton Library.

By engaging health and social care providers, community organisations and individuals locally and across the country, Self-Care Week is making an important contribution to enabling a self-care culture in families and communities.

**www.england.nhs.uk/2015/09/self-care-week/**

# FAMILY SELF-CARE: EARLY YEARS NEW DELIVERY MODEL

Our vision is that all children and young people in the borough are happy, safe and healthy, inspired and enabled to succeed and ready to learn at school and beyond.

Sadly, inequalities in learning can start early, with the gap between those from deprived and less deprived homes opening up in the first two years of a child's life. So, early help and early intervention is vital in preventing poor health, social, emotional and educational outcomes.

We want every child to achieve their full potential. In Tameside we are creating high quality, child focused services that target those most in need.

We are working to train our early years staff and develop their skills. Our early years services will be integrated and delivered by health, education, social care, private and voluntary service partnerships.

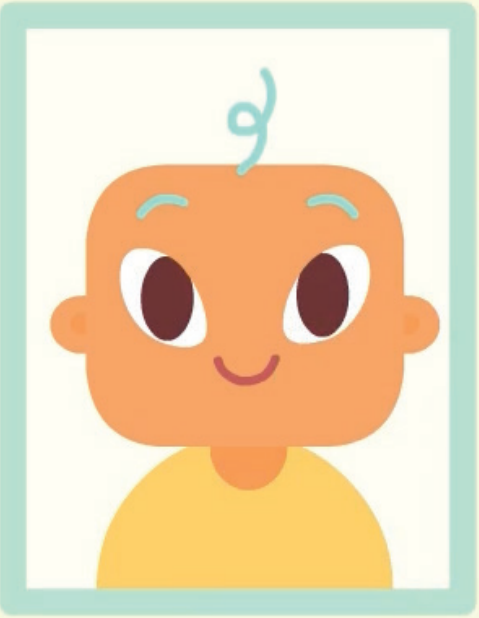
Joined-up services make it easier to provide the right information and support at the right time. That in turn helps parents and carers feel confident, competent, well-informed and secure in their role. By doing that, we enable children to thrive in an environment where they are encouraged and supported to reach their potential.

- The Health Visiting Service delivers the full Healthy Child Programme (HCP) to every child (0 to 5 years) and their family in Tameside, supporting self-care.

- The Tameside 'Babies Can't Wait' agreement means that all pregnant women or those with children under the age of two years and their partners can access the adult Healthy Minds service directly following referral, avoiding any wait. This has meant it is possible for parents to receive support for their own mental health.

- Parenting courses for families with children aged 0-5 are focused on relationship building between parent/carer and child, enabling parents to support and care effectively. We utilise the Solihull Approach and Solihull Parenting course to meet the needs of our families. A further parenting course called Mellow Parenting is now being introduced specifically to support parents and children with a higher level of need.

- A network of partners and organisations in Tameside are working hard to support new and expecting mother to initiate breastfeeding, and to keep it up for as long as possible.



# PEER GROUP SELF-CARE: YOUTH FORUM: L.G.B.T. OUTLOUD TAMESIDE YOUTH SERVICE

If you're misunderstood or stigmatised, it can affect your confidence and self-esteem, and this can stop you getting the support you need. If you feel like this, you're also much less likely to take care of yourself.

If you're young and lesbian, gay, bisexual or transgender (LGBT) then you're also more likely to be depressed or anxious. This can lead young people to consider suicide or to self-harm.

To provide some much needed support, Tameside Youth Service set up and are running a project called L.G.B.T OUTLOUD, which creates a safe, friendly and confidential environment for young people. It's a place where they can meet new friends, be themselves, get involved in projects, get support and advice, and most importantly have fun.

**www.tameside.gov.uk/youthservices/boroughwideactivities**



## CASE STUDY: ADAM

Adam [not his real name] is 14 years old, struggling with his sexuality and gender identity and suffering severe bullying at school. He feels isolated, worthless, alone and in desperate need of love and affection. He can't find support at school and his one friend isn't welcome in his home.

Adam decides to look for friends online, and he soon connects with lots of people who he talks to about his inner self and feelings. He arranges to meet one of his new friends in Manchester, but they turn out not to be who they say they are. Adam ends up being sexually assaulted.

A year on from that, Adam regularly attends the LGBT OUTLOUD support group. His confidence has grown and he is rebuilding his self-respect. He has settled well at college, he no longer puts himself in such risky situations and he has developed healthy relationships with friends his own age.

# COMMUNITY SELF-CARE: ASSET BASED COMMUNITY DEVELOPMENT

Traditionally, health and social care have used a deficit model approach to planning services. This means we have focused on problems and how to fix them. This can lead to a 'top down', professional led approach, which doesn't always encourage or enable people to look after themselves.

An asset based approach does the opposite.  It focuses on the strengths, skills, capacities and resources which individuals and communities have, and how these can enhance their capability and capacity to sustain health and wellbeing. By using this approach, we can bring about effective and sustainable improvements in mental and physical wellbeing.

Over the past eighteen months, we have been working in partnership with neighbourhood services and Community and Voluntary Action Tameside (CVAT) on an Asset Based Community Development (ABCD) programme.



**These are some of the partnership's achievements:**

- Collating good practice to help us deliver an ABCD programme in Tameside.
- Establishing a network for community development practitioners, including volunteers, working directly with local people and groups.
- Delivering ABCD Training for managers and front-line staff.
- Engaging community members in deciding how to spend part of a public budget.
- Researching how best to identify changes in community resilience and social value and developing an evaluation framework.

**The concepts that underpin all of our work are:**

- Voice and control. This means shifting power and enabling participation at an individual and collective level.
- Making health and access to services fairer and reducing avoidable inequalities.
- Social connectedness, which is leading to healthier and more cohesive communities.

# COMMUNITY SELF-CARE: TIME TO CHANGE

One in four of us will be affected by mental illness in any year. The effects are as real as a broken arm, even though there isn't a sling or plaster cast to show for it. Yet mental illness is still surrounded by prejudice, ignorance and fear. The attitudes people have towards those of us with mental health problems can mean it is harder for them to work, make friends and in short, live a normal life. Nine out of ten people with mental health problems say that stigma and discrimination has a negative effect on their lives.

Time to Change is a national campaign run by Mind and Rethink Mental Illness, which aims to end the stigma and discrimination faced by people who experience mental health problems.



The campaign is working with organisations, young people and African and Caribbean communities; to set up a network of grassroots activists combating discrimination and is running a pilot scheme working with mental health professionals and attitudes towards mental health.

Residents, community groups, schools and other organisations in Tameside are making a difference, by giving pledges about mental health and stigma.

Reducing stigma makes a key contribution to enabling the confidence and skills for self-care.

Residents, community groups, schools and other organisations in Tameside are making a difference, by giving pledges about mental health and stigma. Nearly 100,000 people across the country have made a pledge to date.

You can do this at: **www.time-to-change.org.uk**

time to change

let's end mental health discrimination

# SELF-CARE WITHIN SERVICES: MAKING EVERY CONTACT COUNT

Making Every Contact Count (MECC) is a national initiative, which is also running in Tameside.

MECC is about making the best of every opportunity we have to raise the issue of healthy lifestyles, by talking to people about their lifestyle choices and offering appropriate information or support. The aim is to improve lifestyles and reduce inequalities in health.

MECC offers lifestyle advice and support around alcohol, healthy eating, physical activity, smoking and mental wellbeing. This kind of approach can be a challenge though. Some people have difficult and complex lives, and finding space to talk about and makes changes to lifestyle can be hard. Our staff also need to have the right training and support.

In Tameside, the Council, hospital, primary care, community health and third sector providers and volunteers all provide MECC advice. Health and Wellbeing Board partners signed up to a MECC Pledge in 2013, and the programme has been building year on year since, with over 30 local organisations now involved.



## CASE STUDY: SARAH

Sarah (not her real name) had been homeless in the North of England after escaping domestic violence in 2011. On returning to the Tameside area, she was assessed and supported by Foundation, and other various agencies, to help her deal with alcohol and drug addiction. This support was at a high level of intervention and Sarah needed on-going support.

Throughout her support for drug and alcohol addiction, the Foundation staff continued to see Sarah as someone who would benefit from general information about healthy living.

By taking a holistic attitude and putting into practice the MECC approach, Foundation have been successful in supporting Sarah to begin to turn her life around for the better – she has successfully completed detox and is now engaging well in a rehabilitation program. MECC is a stepping stone on the road to helping people to consider their own lifestyles, and the risks they may be taking.

**www.foundationuk.org**

# B THE FOUR ASPECTS OF SELF-CARE

## REGULATORY OR BASIC SELF-CARE: FIVE WAYS TO WELLBEING

The Five Ways to Wellbeing are a set of simple actions that people can do to improve their health and wellbeing. In Tameside, our health organisations, schools and community projects are using them to help people take action to improve their wellbeing.

**These are the Five Ways:**

| | |
|---|---|
| **Connect** | Feeling close to, and valued by, other people is important to all of us. Social relationships are essential for our wellbeing, and act as a buffer against physical and mental ill health for people of all ages. |
| **Be active** | Being active regularly is linked with lower rates of depression and anxiety for all of us. |
| **Take notice** | Reminding ourselves to 'take notice' can strengthen and broaden awareness. Being aware of what is taking place in the present directly improves our wellbeing, and savoring 'the moment' can allow us to make positive choices based on our own values and motivations. |
| **Keep Learning** | Learning through life boosts self-esteem and encourages our social interaction and a more active life. |
| **Give** | Giving and participating with others makes us feel happy, which is good for our health. The smallest act of 'giving' can count; even giving a smile to someone can make a big difference. |



**In Tameside, our local organisations and services have been supporting people and communities to embrace the five ways to wellbeing:**

- Action Together offer volunteering opportunities, and help people teach their skills to others. For example, they manage the Volunteer Centre Tameside on Penny Meadow in Ashton that promotes volunteering opportunities, recruits and places volunteers and supports organisations that would like to involve volunteers in their work.

- Tameside, Oldham and Glossop Mind have been helping people to connect, feel less isolated and learn mindfulness. For example: volunteers can get active in the kitchen garden that provides produce for the café and helps to connect with others; or learn new skills to maintain resilience and/or learn how to teach others to do the same.

- Tameside Metropolitan Borough Council and community groups run a wide range of sports and activities for all ages, and for all abilities. For example:
  - led walks in the borough, whether it is a 30 minute walk and talk, a health walk which could last up to 90 minutes or a longer walk with the Tameside ramblers.
  - learn to run with 'couch to 5k', either through the NHS website or with Active Tameside and then take part in the weekly Parkrun at Stamford Park.
  - Tai Chi or walking football session.
  - for the currently inactive who also suffer from a long term condition, the live Active Service designed to get active safely.
  - For more information on all these activities go to **livewelltameside.com.**

# PREVENTATIVE SELF-CARE: TURNING THE CURVE

Some health problems in Tameside are going in the wrong direction; the number of people with them is going up, rather than down. So, we want to 'turn the curve' on these problems.

**Tameside Health and Wellbeing Board identified three priorities that will have the biggest impact on local health inequalities;**

- reducing smoking
- increasing physical activity
- controlling high blood pressure.

# SMOKING

Around one in four Tameside adults smoke. This is significantly higher than the national rate of just under one in five (19.5%). We also have the highest rate of smoking in pregnancy in Greater Manchester.

Tameside Tobacco Strategy is delivered via the Tameside Tobacco Alliance partnership. Our partnership is made up of staff from Public Health, Tameside Metropolitan Borough Council, Community for Voluntary Action Tameside, Pennine Care NHS Foundation Trust, Stockport NHS Foundation Trust, NHS Tameside and Glossop Clinical Commissioning Group and Greater Manchester Fire and Rescue Service.

**Over the last year, Tameside residents have been able to access services and support to stop smoking in a number of ways, including:**

- A local Stop Smoking Service and enhanced services available at pharmacies and GP surgeries
- Smoking cessation support in workplace.
- A 'Stop Smoking in Pregnancy' midwife.
- A smoke free playground campaign.

Every year, the number of people who smoke in Tameside goes down. Compared to the rest of England, we are seeing faster reductions in the number of women smoking in pregnancy and the overall percentage of people smoking.

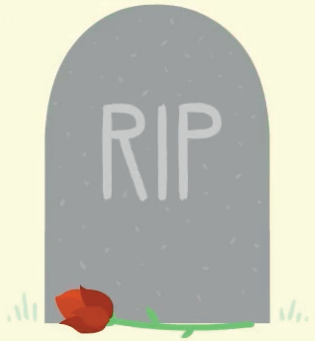
We also run a national campaign in our local area, called 7 Steps Out.

The campaign focuses on second-hand smoke, and the harm it causes to babies and children when adults smoke indoors. The campaign encourages parents, grandparents and carers to 'Take 7 Steps Out' right outside the home before smoking.

For more information about 7 Steps Out, please visit -

**www.take7stepsout.co.uk/**

Or if you would like support to quit smoking, please call the Health and Wellbeing Service on 0161 716 2000



# PHYSICAL INACTIVITY

Here in Tameside we have one of the worst levels of physical activity in the country. In fact, about one third of us is inactive. That lack of activity has a high cost; in terms of individual health and wellbeing, as well as the cost to health services and society generally.

Across Tameside there is a now a Physical Activity Strategy, which is focused on reducing the number of people who are physically inactive.

We want to be better than the national activity average by 2020. It is an ambitious target.

But by working together and by offering a range of different approaches, we are confident that we can increase healthy life expectancy, reduce health inequalities and improve overall quality of life in Tameside.



"If exercise were a pill, it would be one of the most cost-effective drugs ever invented"

**Dr N Cavill, health promotion consultant**

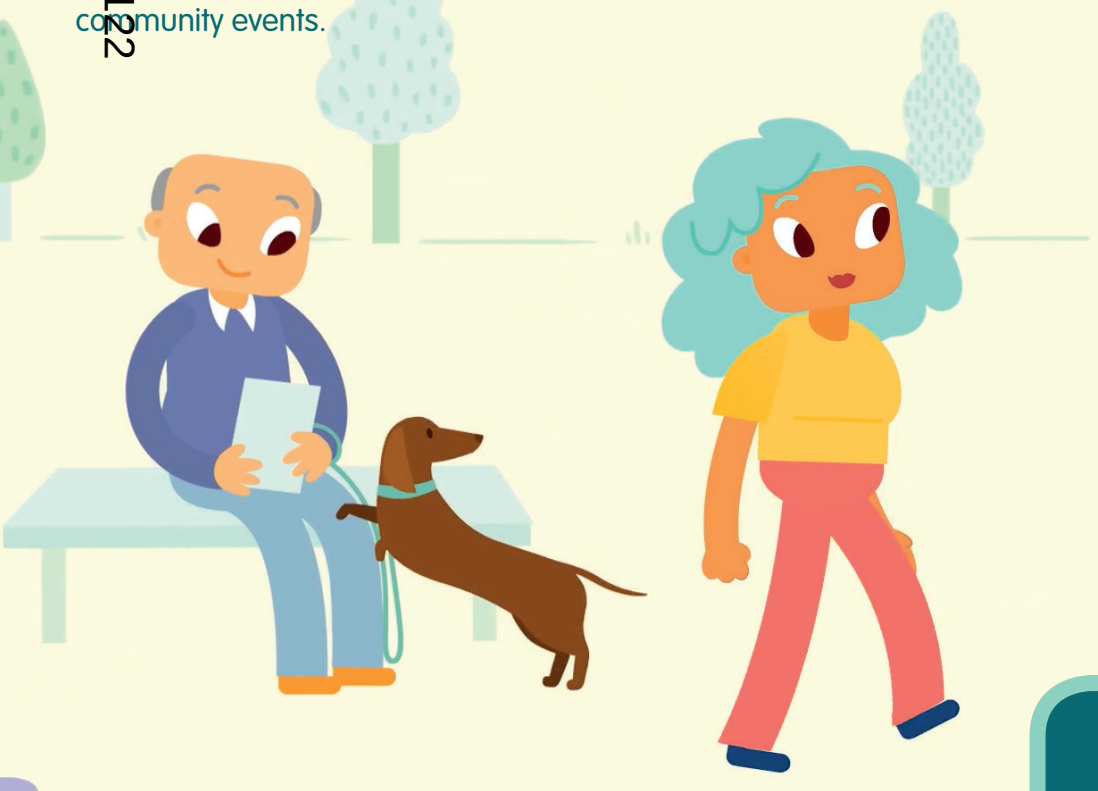
# HIGH BLOOD PRESSURE

Tameside has one of the highest levels of heart disease in England. One way to prevent heart disease and stroke is by controlling blood pressure.

Around one in three people in Tameside have raised blood pressure. However, high blood pressure often has no symptoms, so without a blood pressure check, many people won't know that they have it. High blood pressure is treatable, but in Tameside we estimate that four in every 10 people with it have not yet been identified. We know that if the number of people with high blood pressure in Tameside was on a par with the national average, we would see 30 fewer deaths from related illnesses each year.

The 'Check it!' social marketing programme has been drawing attention to the importance of blood pressure this year, and the Tameside and Glossop Health Improvement Team have been offering opportunities for checks at community events.





**You can now get a blood pressure check at a:**

- leisure centre
- pharmacy
- GP practice
- 'Check it!' programme event

More than 1300 people had a blood pressure check over a three-month period, and 100 of these were recommended to see their GP. A survey after the campaign showed that 40% of local people recognised the campaign.

Building on this success we are planning to continue the 'Check it!' programme because it so important that local people understand the risks from high blood pressure, get themselves checked and take action if they need to.

# REACTIVE SELF-CARE: PATIENT ACTIVATION

The Tameside and Glossop Care Together Programme and the Greater Manchester Devolution 'Taking Control' strategy, both encourage the development of patient activation.

To successfully self-care, and to manage our health well, we need to be active about it. We need knowledge, we need to develop new skills and we need to be confident about what we're doing. This is patient activation.

Helping people to be more active about self-care, and to develop the knowledge and skills they need, improves their engagement and health outcomes. By tailoring the way our services are delivered, according to how engaged someone is and what their patient activation level is, ensures that the level of support given matches the needs of the individual. That makes our services more efficient, productive and effective.



**For example, we know that:**

- Patient activation is a better predictor of health outcomes than socio-demographic factors such as ethnicity and age.
- People who are active and engaged are significantly more likely to attend screenings, check-ups and immunisations. They are also more likely to adopt positive, healthy behaviours and have body mass index, blood sugar levels, blood pressure and cholesterol in the normal range.
- Studies of interventions to improve activation show that people who start with the lowest activation scores tend to increase their scores the most, suggesting that effective interventions can help engage even the most disengaged. This is a great opportunity to achieve behaviour change and champion healthy lifestyle choices and direct support.

Within Care Together we will be promoting patient activation and making use of a Patient Activation Measure provided by NHS England to enable service providers and users to enhance confidence and skills for self care.

# REACTIVE SELF-CARE: DRUG AND ALCOHOL SERVICE TRANSFORMATION

**Our Alcohol Strategy for 2015 – 2020 aims to reduce alcohol related harm in Tameside. It has is a programme of activity that covers four strategic priorities, which include:**

- challenging local attitudes towards alcohol
- providing exceptional Drug and Alcohol services, which maximise the chances of long-term recovery.

Our local substance misuse services have been recommissioned, and the new provider, Lifeline, will focus on a recovery model of care and provide a more substantial service to alcohol users. The new service is organised around three teams: Early Intervention and Prevention; Recovery and Aftercare.

It includes services for Under 19s, 18 to 28 year olds, family support, and a range of group work, as well as one to one counselling, support and clinical services.

Through the focus on prevention and treatment we expect to see fewer people needing treatment, and fewer people needing treatment for long periods. And at the same time seeing less alcohol harm to the lives of everyone in Tameside.

**Advice and support around drugs or alcohol, please visit LifeLine Tameside at:**

Katherine Cavendish House
Katherine Street,
Ashton-under-Lyne
OL6 7DB

Phone: 0161 672 9420


REACTIVE

# RESTORATIVE SELF-CARE: EXPERT PATIENT

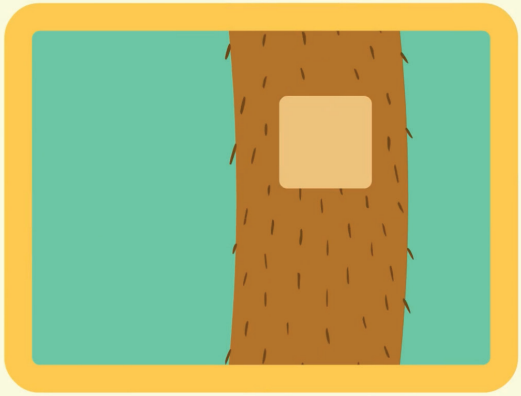
Tameside and Glossop Clinical Commissioning Group (CCG) commission Self-Management UK to deliver 'Self-Management for Life' courses for local people with long-term conditions. The courses help people to become confident, knowledgeable and skilled in managing their condition.

To get on one of the courses, people can ask their GP for a referral or can sign themselves up. The courses run once a week for three hours, over a period of six weeks. Participants include people with conditions such as diabetes, arthritis and heart disease.

Since 2012, there have been four courses a year. Five courses have been commissioned for 2016/17, to be run in each of the five areas of the CCG.

This year we will be focusing on high blood pressure, to fit with local initiatives.





RESTORATIVE

## CASE STUDY:

Self Management UK Course hosted at Ingeus Tameside as part of the Working Well Programme: – feedback from two participants who now have the confidence to find the right job whilst living with chronic fatigue and arthritis.

### KAREN

"I attended the Self Management Course in June. It was very informative and extremely helpful. I learnt a helpful breathing technique that helps with relaxation. Each session was on different subjects that I found really interesting e.g. Goal setting, exercise and healthy eating. A lot of people started the course and there was still a lot at the end. We all received a certificate which I thought was very nice. If there was another I would definitely attend."

### HELEN

"The group sessions were excellent. A non- pressured environment which helped open up my thinking, bringing calm redirection. Looking at the group reactions, people were uplifted, not hounded. It disentangled a lot of fear and presumptions I had because of a long term illness. It also reinforced realistic expectations rather than self-pity. Thank you Ingeus for arranging."

# STARTING WELL: SCHOOL RESILIENCE WORKSHOPS

Mental health disorders in young people, such as anxiety and depression, are surprisingly common. Poor mental health has an impact on every aspect of a young person's life including their ability to engage with education, make and keep friends and participate in family life.

Resilience is a self-care skill that young people need to help them overcome challenges. In Tameside, we have commissioned Mind to deliver a resilience programme in primary and secondary schools, working with teachers, young people and their parents.



**This programme includes:**

- mental health and emotional wellbeing assemblies
- resilience workshops for pupils
- staff training sessions
- parent training sessions.

A total of 30 primary and secondary schools have been involved, over a thousand pupils have attended resilience workshops and nearly 12,000 attended a resilience themed assembly. Feedback from young people who have attended the sessions has been positive. They felt generally better after sessions and felt they would be better able to cope if problems did arise.

For more information and mental health support for young people, please visit - **www.mind.org.uk**

## CASE STUDY: FEEDBACK FROM SCHOOL/ PUPILS

### SECONDARY PUPIL FEEDBACK

- "I can now cope better with my problems"
- "I feel a lot better and less stressed than I was before"
- "It taught me to be calm when I go through problems which stress me out"

### PRIMARY PUPIL FEEDBACK

- "Really helpful at teaching us to deal with our feelings"
- "It gives you ways to cope and help others"
- "It was brilliant because I know how to calm myself down so I can now handle issues in my life"

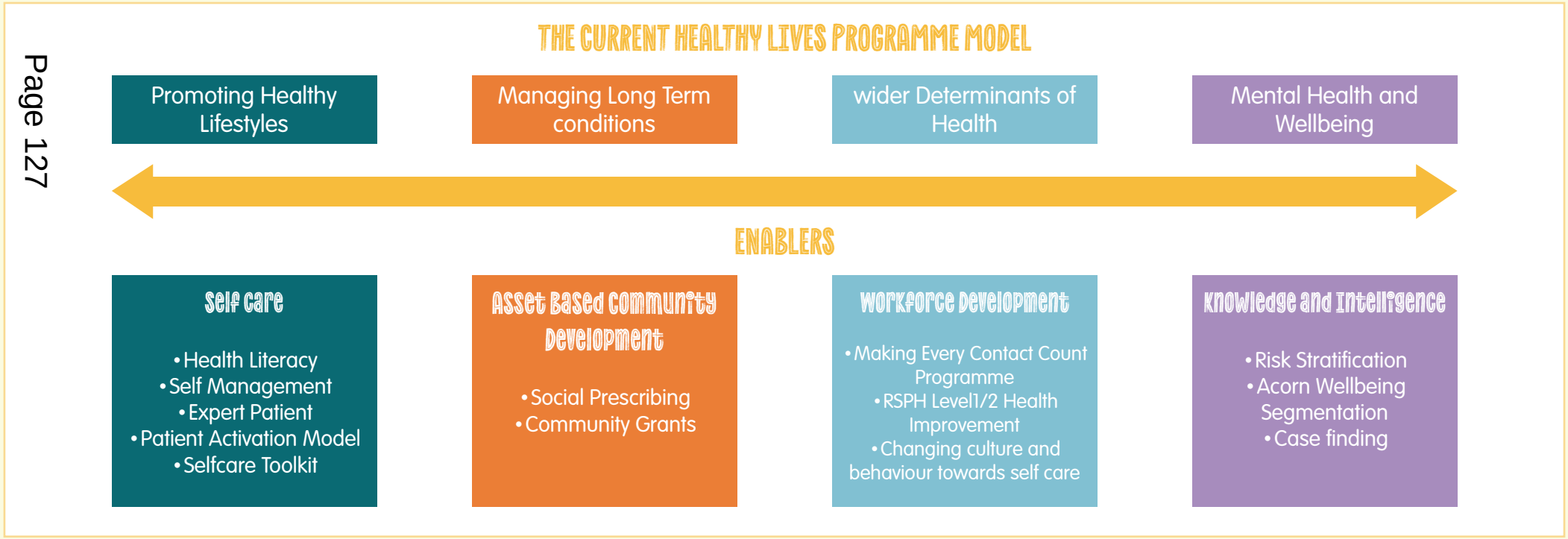
# LIVING WELL: WELLNESS OFFER

**Tameside Wellness Offer supports people to live well, by:**

- addressing the factors that influence their health
- enabling them to be independent and resilient
- helping people to support themselves and those around them.

The Tameside Wellness Offer goes beyond looking at single issue, healthy lifestyle services with a focus on illness, and instead, it aims to take a whole person, family and community approach to improving health.

Our vision is a person centred, not programme focused approach. We want to develop support based on a community approach, building your capacity to self-care and live healthy lives by addressing the factors that influence your health and wellbeing.



**That means providing integrated services that promote self-care through;**

- coaching
- structured decision making
- skilled, knowledgeable and confident staff who can to support individual self-care and community level self-care by building relationships and capacity within communities.

Consultation with the people of Tameside showed us clearly that most people want support with diet and activity. Support for mental health issues such as anxiety and mild depression was popular too; residents described lack of confidence as a huge barrier to accessing health and social opportunities.



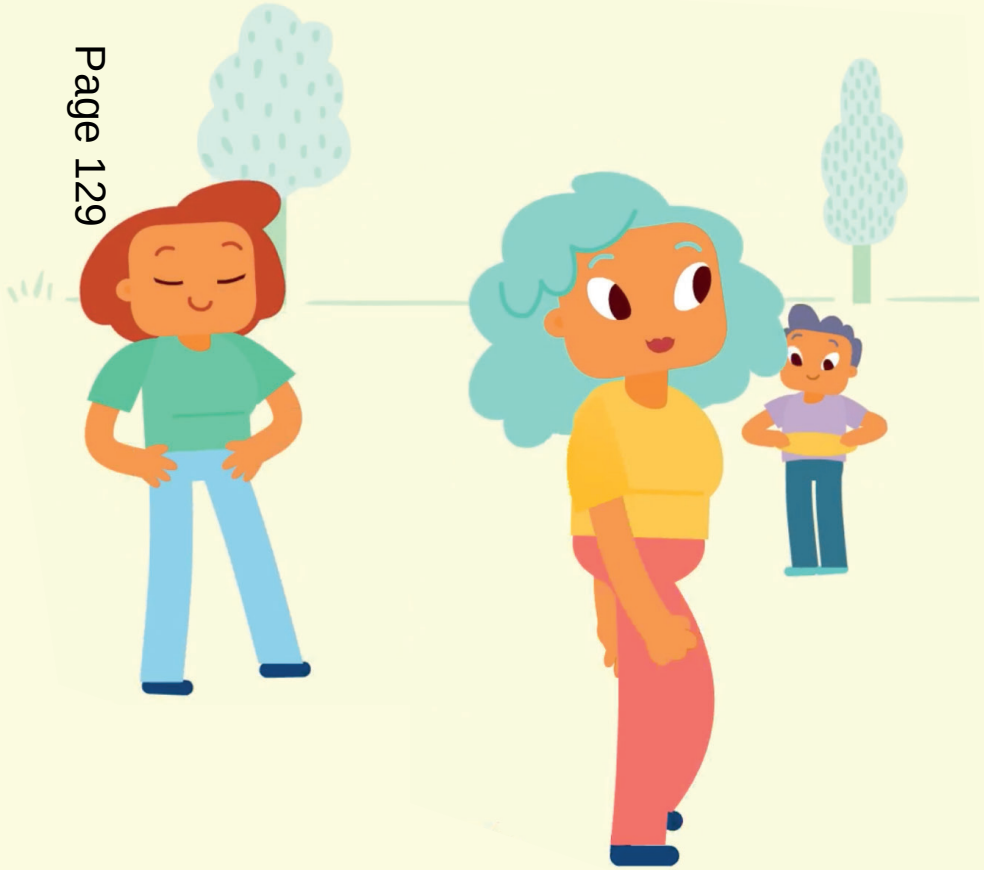
However, the consultation also showed us that people are confident in their ability to self-care, and to support each other and your community. There is support too for integrated services and a single place to go to, where people can get the help they need.

The Tameside Wellness Offer will also be accessed through the Healthy Lives programme of Care Together.

# WORKING WELL: 'GOOD WORK' PROGRAMME

We know that healthy staff are vital for a strong economy, and a strong economy is better able to provide good work for people. Having a strong economy supports self-care, as it increases employment and incomes and widens people's opportunities and choices.

Whether its paid or unpaid, full-time or a few hours a week, being at work can help you on the road to recovery after being off. Working can also be a good way to keep well if people have a long-term condition like diabetes, COPD, heart disease, depression, stress, asthma or back pain.





In Tameside, there are a range of programmes that support employers and employees to promote and take up more healthy lifestyles and better self-care. One of these is the Workplace Wellbeing Charter. Any organisation can use the charter and it provides an easy and clear guide on how to make workplaces a supportive and productive environment in which employees can flourish.

Healthy Hattersley  is a pilot programme building on the success of the Working Well programme, which supports the long term unemployed back into the workforce. In Hattersley, GPs are able to refer patents  that are unemployed and have health issues for additional support to address mental and physical health needs and skills development.

Skills for Employment is another form of support that is available to local people to help them return to work. The focus is on developing the skills needed to return to work such as confidence, literacy, customer services etc.

Please visit **www.wellbeingcharter.org.uk** for more information.

# AGING WELL:
## SMALL THINGS STORYBOX AND MANCHESTER CAMERATA

There are currently 85,000 people in the UK living with dementia. It can be a difficult condition to live with and manage, particularly if the person with dementia develops challenging behaviour. This is made more problematic by the lack of really effective treatment. Many people take anti-psychotic medicines to control behaviour, and these come with the risk of serious side-effects.

Small Things and Manchester Camerata provide an alternative approach, which helps to reduce the over prescribing of anti-psychotic drugs. The projects have brought music, literature and art to people with dementia and their carers, reducing their feelings of isolation.

Small Things run a project called StoryBox, which engages and communicates with people with dementia by using collaborative story making.  It provides sensory and fun experiences where games are played and stories are made up to encourage togetherness, improve concentration and lift mood.

Manchester Camerata brings together trained music therapists and musicians to work with individuals and groups through music therapy. Their local project, Tameside Opera group for older people, has proved a great success, and we are keen to build further similar projects local on this innovative programme.

# CASE STUDY: DONALD

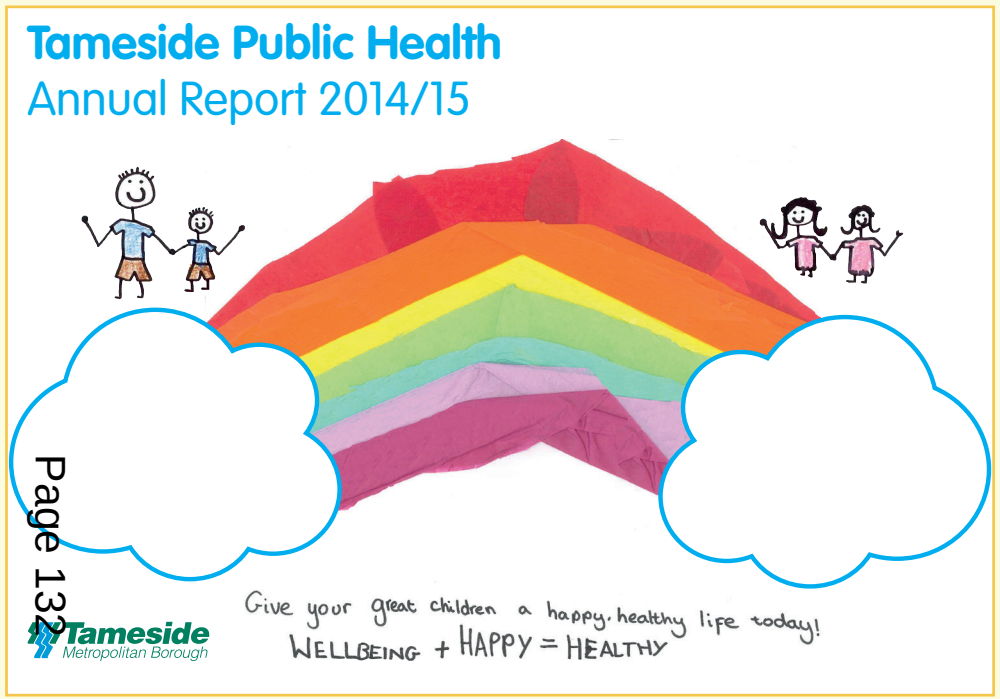
Donald took part in the Tameside Opera. He has a learning disability and dementia which affects his social skills and his confidence.  Donald gradually spent less and less time with other people, he stopped making eye contact and in the end would barely speak or take part in a conversation.

Joining the Tameside opera group has changed everything. Since he started music sessions, Donald now actively takes part, enjoys being in the group and has the confidence to help others to take part in different sessions within the scheme.  Donald now has a girlfriend, and both enjoy music sessions together.



For more information about Dementia, please visit - **www.alzheimers.org.uk**
To become a Dementia Friend, please visit - **www.dementiafriends.org.uk/**
**http://www.manchestercamerata.co.uk/learning/health/dementia**
**https://smallthings.org.uk/public-projects/storybox/**

# UPDATE FROM THE 2014/15 ANNUAL REPORT: HANDS UP FOR HEALTH!




Last year the Public Health Annual Report put the spotlight on Children and Young People, emphasising the important foundations for development that are laid down in childhood.

**The report made a number of recommendations. This is what we achieved:**

## SCHOOL READY

- The number of children who are 'school ready' in Tameside has increased from 52% in 2014 to 58% in 2015.
- Health Visiting teams and private day-care providers now use an evidence-based developmental screening tool called ASQ 3 for our 0-3 year olds. This helps us to identify any developmental delay early.
- Mellow Parenting has started, in partnership with Early Attachment Service, Health Visiting, HomeStart and Children's Centres.
- New learning classes have been introduced in the Children's Centres.
- Working with Future Gov, we have talked to parents who find it hardest to find and use our services, to find out how we can make them more accessible.

## YOUNG MOTHERS

- The Family Nurse Partnership is working with teenage parents.
- We developed a young parent pathway to make sure the needs of all our young parents are met.

## ACTIVE TAMESIDE

- Lifestyle advisors have been trained in pre/post-natal exercise. They will offer support to any woman who wants to be active during pregnancy.
- We are testing and evaluating the Active Mama course.

## BREASTFEEDING

- Our maternity, community health visiting and children's centres settings have the Baby Friendly Accreditation.
- HomeStart is providing a peer support breastfeeding programme.

## EMOTIONAL WELLBEING

- We are developing a Transformation Plan for Children and Young People's emotional health and wellbeing.
- Young MIND are providing mental health awareness assemblies, resilience workshops and one to ones in every secondary school.

## SCHOOLS

- Half of Tameside's Schools have been supported to complete a School Online Health Check.
- A Sex and Relationship Education (SRE) Group is looking at the issues surrounding SRE in Tameside Schools.
- A local Learning Mentor has produced a video explaining her journey of delivering SRE - **www.youtube.com/watch?v=ZUzh9FLfnWA**
- A 'Let's Talk About Sex' workshop in the summer will build on our assets and provide the much needed resource to enable schools to engage more effectively with sexual health issues.
- We are supporting young people to gain skills and enter the workplace.

# ACKNOWLEDGMENTS

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# GLOSSARY

**JSNA (Joint Strategic Needs Assessment):** a comprehensive description of the current health and wellbeing of the population of Tameside and recommendations for action that will lead to improvements. **www.tameside.gov.uk/puplichealthreports/JSNA-Report-201516.pdf**

**Patient Activation Measure (PAM):** a short questionnaire that measures an individual's knowledge, skill, and confidence for self-management.

**Risk Stratification:** aims to identify individuals in, or segments of, the population, who are high intensity users of health and social care services, or have the potential to have high level needs in the future. This can enable the targeting of services to improve health and wellbeing and to support people to manage their conditions better through self-care enabling them to have a better quality of life.

**Social Prescribing:** identifying and addressing social needs of health service users.

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