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Tameside Metropolitan Borough

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HEALTH AND WELLBEING BOARD

Day: Thursday
Date: 19 January 2017
Time: 10.00 am
Place: Lesser Hall 2 - Dukinfield Town Hall

Item No.	AGENDA	Page No

GENERAL BUSINESS

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

To receive any declarations of interested from Members of the Health and Wellbeing Board.

3. MINUTES 1 - 4

The Minutes of the meeting of the Health and Wellbeing Board held on 10 November 2016 to be signed by the Chair as a correct record.

ITEMS FOR DISCUSSION / DECISION

4. MILITARY VETERANS 5 - 12

To consider the attached report from Dr Robin Jackson, Chair of the Armed Forces Network.

5. GM AGEING HUB: INTRODUCTIONS AND ENGAGEMENT 13 - 20

To receive a presentation from Paul McGarry, Strategic Lead for the GM Ageing Hub and Age-Friendly Manchester.

6. OFSTED INSPECTION OF SERVICES FOR CHILDREN IN NEED OF HELP AND PROTECTION, CHILDREN LOOKED AFTER AND CARE LEAVERS 21 - 34

To consider the attached report of the Executive Leader / Executive Member (Children and Families) / Chief Executive / Executive Director (People).

7. SEND REFORM UPDATE 35 - 40

To consider the attached report of Alan Ford, Commissioning Business Manager for Children, Young People & Families.

8. CARE TOGETHER ECONOMY FINANCIAL MONITORING STATEMENT 41 - 68

To consider the attached report of the Executive Member (Adult Social Care and Wellbeing) / Executive Member (Healthy and Working) / Executive Member (Children and Families) and the Director of Finance (Single Commissioning Team).

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.

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9.	**CARE TOGETHER PROGRAMME UPDATE**	69 - 72
	To consider the attached report of Jessica Williams, Programme Director.	
10.	**UPDATE ON HEALTHY NEIGHBOURHOOD PROGRAMME**	73 - 82
	To receive a presentation from Karen James, Chief Executive, Tameside Hospital NHS Foundation Trust.	
11.	**PRIMARY CARE UPDATE**	83 - 100
	To consider the attached report of Clare Watson, Director of Commissioning.	
12.	**ACTIVE TAMESIDE**	101 - 132
	To consider the attached report and accompanying presentation from Mark Tweedie, Chief Executive, Tameside Sports Trust. The Active Tameside Company Strategy: Inspiring People to Live Well and Feel Great, is also attached for information.	
13.	**HEALTH AND WELLBEING BOARD PRIORITIES 2017/18 AND FORWARD PLAN 2016/17**	133 - 138
	To receive the attached report of Angela Hardman, Director of Public Health and Performance.	

ITEMS FOR NOTING / INFORMATION

14. URGENT ITEMS

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

15. DATE OF NEXT MEETING

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

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.

TAMESIDE HEALTH AND WELLBEING BOARD

10 November 2016

Commenced: 10.00 am **Terminated: 11.35 am**

PRESENT:
Councillor Kieran Quinn (Chair) – Tameside MBC
Councillor Brenda Warrington – Tameside MBC
Councillor Peter Robinson – Tameside MBC
Councillor Gerald P Cooney – Tameside MBC
Graham Curtis – Clinical Commissioning Group
Christina Greenhough – Clinical Commissioning Group
Stephanie Butterworth – Tameside MBC
Anna Heinz – CVAT
Stan Boaler – Pennine Care NHS Trust
Angela Hardman – Tameside MBC
Karen James – Tameside Hospital NHS Foundation Trust
Steven Pleasant – Tameside MBC
Paul Starling – GM Fire and Rescue Service
Clare Watson – Clinical Commissioning Group

IN ATTENDANCE:
Sandra Stewart – Director of Governance, Resources & Pensions (Statutory Monitoring Officer)
Jessica Williams – Programme Director - Care Together
Julie Price – DWP
Lisa Pomfret - DWP

APOLOGIES:
Alan Dow – Chair Clinical Commissioning Group
Tony Powell – New Charter Group

67. DECLARATIONS OF INTEREST

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

68. MINUTES OF PREVIOUS MEETING

The Minutes of the Health and Wellbeing Board held on 22 September 2016 were approved as a correct record.

69. OVERVIEW OF THE DEPARTMENT OF WORK AND PENSIONS ACROSS GREATER MANCHESTER

The Chair welcomed Julie Price, Senior External Partnership Manager, and her colleague Lisa Pomfret, who provided an overview of the Department of Work and Pensions across Greater Manchester and including the new cluster configuration and rationale. Next steps for the DWP were outlined as follows:

- Build on UC rollout;
- Develop and resource the work coach role for health and disability;
- Work with employers – develop Disability Confident;
- Develop partnership working and joining up with local services;
- Engage with stakeholders on possible joint funding opportunities, and the Work and Health Programme.

RESOLVED
That the content of the presentation be noted.

70. DEVELOPING THE FUTURE ROLE AND PRIORITIES OF THE HEALTH AND WELLBEING BOARD / UPDATE ON HEALTH AND WELLBEING STRATEGY 2013/16

Consideration was given to a report of the Executive Member (Healthy and Working) and the Director of Public Health and Performance and accompanying presentation which explained that the Health and Wellbeing Board had recently held a development session to review its purpose as a place-based system-leader. The report brought forward the themes of the workshop with a set of recommendations around the future Forward Plan of the Board.

The key themes from the development session were outlined and Board Members felt that health and wellbeing boards provided a genuine opportunity to develop a place-based, preventative approach to commissioning health and care services, improving health and tackling health inequalities and the wider determinants of health. Systems leadership, clarity of purpose and function was the fundamental issue that arose from the session. Board Members felt that the primary role should be to provide macro-level system-leadership across the network of organisations and arrangements that made up the local health economy. A manageable number of issues should be explored, discussed and understood, for the purpose of the Board's time adding value to what happened in other parts of the system rather than to duplicate the efforts of partner organisations.

In terms of priority issues, although the priorities of the Joint Health and Wellbeing Strategy were upheld, there was a consensus that the Board should focus much more on public sector reform and the wider determinants of health.

The feedback from the development sessions were summarised in a number of key principles detailed in the report which would inform future Board priorities.

RESOLVED

(i) That the principles outlined in the paper be agreed.

(ii) That the Director of Public Health and Performance present an outline of the wider determinant priority focus areas for collective action moving into next year for consideration at the next meeting of the Board.

71. CARE TOGETHER 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 presentation in September 2016.

It was highlighted that on 30 September 2016, the Health and Social Care Partnership Strategic Partnership Board ratified the full transformational funding award of £23.226m to Tameside and Glossop economy over 4 financial years. Confirmation of the terms of the award was attached to the report at **Appendix 1**. The next step was to work with the Partnership to develop an investment agreement including implementation and delivery milestones to measure progress against the national 'must do's' and transformation priorities outlined in the Cost Benefit Analysis submission.

The operational progress relating to programme management, the Single Commissioning Function and the Integrated Care Organisation were highlighted.

In terms of next steps, the following work was highlighted:

- Finalisation of the Investment Agreement with the Partnership;
- Final implementation planning for the transformational schemes;

- Development of a comprehensive programme management plan to ensure delivery of schemes and the resulting improvements in healthy life expectancy and reductions in costs;
- Developing and implementing a measurement framework which accurately ensued planned transformational schemes were improving the healthy life expectancy of the Tameside and Glossop population;
- Finalising the financial sustainability plan for the economy;
- Developing the business case for the transaction of adult social care into the Integrated Care Organisation;
- Continued discussions to determine options for aligning primary care outcomes alongside those of the Integrated Care Organisation and therefore for the whole population.

RESOLVED
That the content of the update report be noted.

72. NORTH WEST SECTOR LED IMPROVEMENT: INFANT MORTALITY

Consideration was given to a report of the Executive Member (Children and Families) and the Director of Public Health and Performance which explained that this Sector Led Improvement review focused on child deaths aged under one year. This age range accounted for around two thirds of all child deaths both locally and nationally. In addition to the benchmark aspect of the review, the objective was to share evidence on actions, and assist each locality to adopt best practice, in order to reduce the number of child deaths under one year old.

In 2014/15 across the North West (23 local authorities) there were a total of 328 infant deaths that had been reviewed and closed. 37% were of infants from a BME background and 65% of deaths were of infants with a birth weight of less than 2500 grams. 43% of deaths were of infants whose mothers were from the most deprived quintile. Of the 328 infant deaths, 27 % had at least one modifiable issue implicated in the death. The most common modifiable issue identified across the North West was safeguarding consisting of abuse and neglect (62% of deaths with a modifiable issued identified). The next largest modifiable issue identified was smoking (59%). 33% of infant deaths where a modifiable issue had been identified were due to drugs or alcohol misuse and 23% through co-sleeping.

Although infant mortality both nationally and regionally had declined somewhat since 2002, it was important, if not essential, that work to reduce the number of modifiable factors in order to continue the downward trend in child mortality rates.

The report represented a significant amount of work undertaken over the past 12 months enabled with the support and contribution of a wide range of individuals with a passion for improving outcomes for children. The report brought together an important set of recommendations for improvements action across the North West and in individual localities. Delivery of this improvement would be reliant on the content of the report being firmly embedded within local improvement plans and delivery models.

RESOLVED
That the recommendations contained in the North West Sector Led Improvement Peer Review: Infant Mortality Report 2016 be endorsed and agreed.

73. TAMESIDE SAFEGUARDING CHILDREN BOARD ANNUAL REPORT

Consideration was given to the annual report of the Executive Member (Children and Families) and the Chair of the Tameside Safeguarding Children Board providing an overview of the Board's safeguarding activity against its 2015/16 priorities. It identified particular vulnerable groups, outlined emerging themes and provided details of the strategic priorities and actions for 2016/17. It also detailed the Board's resources both staffing and financial, structure and membership.

Regionally, there had been considerable work undertaken to prepare for the devolution of Greater Manchester and how Safeguarding would look in 2017 was still being worked on but Tameside was determined to maintain a local voice and make the best arrangements to ensure that the protection of children remained a high priority. Working with colleagues in all disciplines remained as important as ever and a recent joint development day with the Adult Safeguarding Board illustrated how crucial it was to cooperate on the overlap areas such as mental health, domestic abuse and substance abuse. In particular reference was made to the following:

- The Tameside Safeguarding Children Board team had been fully staffed since October 2016;
- The Threshold Guidance, Child in Need Policy and Children's Needs Framework had been revised;
- The Barnado's CSE 'Real Love Rocks' and 'Love or Lies' resource was available to all schools and other youth settings;
- A Safeguarding Youth Forum had been established, contributing towards changes to the Tameside Safeguarding Children Board website, publicity materials and safer social media messages;
- The Board had responded quickly and effectively to new statutory guidance in relation to Female Genital Mutilation and Preventing Radicalisation by delivering a comprehensive package of training;
- The Board made challenges in respect of the Public Service Hub Safeguarding arrangements, CAF data and resources and continued to monitor these;
- Robust verification process of partner agencies Section 11 Audits had been completed to ensure compliance with safeguarding standards;
- Serious Case Review Action Plans for Child M and N were signed off and two further reviews for Child Q and R were completed.

The Health and Wellbeing Board welcomed the annual report which clearly evidenced the progress that had been made to ensure that the safeguarding of children and young people remained a high priority for the Tameside Safeguarding Children Board and partner agencies across the borough. In addition, it outlined how the Board had positively responded to the challenges it had set itself in 2015/16.

RESOLVED
That the content of the Annual Report 2015/16 be noted.

74. HEALTH AND WELLBEING BOARD FORWARD PLAN 2016/17

Consideration was given to an outline forward plan designed to cover both the statutory responsibilities of the Health and Wellbeing Board and the key projects identified as priorities by the Board.

RESOLVED
That the forward plan be approved.

75. URGENT ITEMS

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

76. DATE OF NEXT MEETING

To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 19 January 2017 commencing at 10.00 am.

CHAIR

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	19 January 2017
Board Member/ Reporting Officer:	Dr Robin Jackson - Chairman of the NHS Armed Forces Network (North West).
Subject:	**IDENTIFICATION OF MILITARY VETERANS IN ORDER TO UNDERSTAND AND QUANTIFY THEIR HEALTH NEEDS**
Report Summary:	The report: • Explains the role of the NHS Armed Forces Network (North West). • Briefs the Board on the Report by the Forces in Mind Trust and its implications for the Board's Joint Strategic Needs Assessment (JSNA).
Recommendations:	That the Board agree that any commissioning and delivery of services should consider and take into account the following principles in order to improve the assessment of the mental and related health needs of veterans and their family members and ensure better wellbeing outcomes: 1. **Targeted and intelligent use of data and information** – veterans and their family members need to be routinely identified and included in health and social care data collection as part of a targeted and intelligent approach to assessment of their mental and related health needs. 2. **Appropriate and sensitive evidence based services** – responding to the needs of veterans and their family members requires services that are sensitive to their identity and culture and provide evidence based interventions as part of an appropriate care pathway. 3. **Involvement and participation of veterans and family members** – assessing and responding to the mental and related health needs of veterans and their family members should be done with their active involvement and participation. The three building blocks are interdependent and are proposed as key mechanisms for creating a sustainable and lasting framework for action that will improve the assessment of the mental and related health needs of veterans and their family members and inform the commissioning and delivery of services to meet those needs.
Links to Health and Wellbeing Strategy:	The health and wellbeing of military veterans links to the Living Well, Working Well and Ageing Well priorities in the Health and Wellbeing Strategy
Policy Implications:	The Armed Forces Network brief and the FiMT Report (http://www.fimtrust.org/wp-content/uploads/2015/10/CALL-TO-MIND-REPORT.pdf) outlines how JSNAs can be

	improved to incorporate the special health needs of Veterans and their families.
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications arising from the report at this stage.
Legal Implications: **(Authorised by the Borough Solicitor)**	This approach should go hand in hand and strengthen the legal requirements that all public bodies have to reduce inequalities and positively address health inequalities.
Risk Management :	There are no risks associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Helen Marshall, Bury CCG by: Telephone: 0161 762 3167 e-mail: helen.marshall@nhs.net

Presentation to Tameside Health & Well-being Board

Chair,

Thank you for this opportunity to report to the Board on behalf of Military Veterans in the Tameside area.
I am Dr Robin Jackson, a retired NHS GP, but still active as an Army GP in the Reserves.

In 2010, as Commanding Officer of 207 (Manchester) Field Hospital I took TA medical staff, including individuals from the Ashton Squadron, to Afghanistan to take over the British Military Hospital in Camp Bastion.

Commanding what was, and remained, the best trauma hospital in the world, ever, was the most challenging thing I have ever done, but for the many Servicemen whose "life-changing" injuries we treated, the challenge will be to cope with normal life every day.
I am determined to do whatever I can to make their challenge easier, hence my role as Chairman of the NHS Armed Forces Network (North West).

The AFN is one of nine NHS England bodies across England. We are supported by Bury CCG, in our role to oversee the provision of Healthcare to the Armed Forces Community in the North West, for Regulars, Reservists, Veterans and their families.

The nation recognises the debt that we owe to our Armed Forces in a document called the Armed Forces Covenant which lays down responsibilities for schools, Local Authorities, the NHS and employers to ensure that the Armed Forces including Veterans are not put at a disadvantage because of their military service.

We are fortunate in the North West in having excellent sources of Health Care for our Veterans. Dr Fergus Jepson at the Specialist Mobility Rehabilitation Centre in Preston is an international expert in the care of amputees, and he looks after approximately eighty Veterans who have lost limbs, and Pennine Care Foundation NHS Trust was the first in the country to set up a Mental Health service for Veterans.

The Armed Forces Network meets quarterly with CCGs, military charities and the Regular Forces including the Personnel Recovery Unit which helps Wounded Injured of Sick soldiers in the transition to civilian life.

We are a resource that CCGs and Health & Well-being Boards can call on for help with your JSNA.

The Forces in Mind Trust has produced a Report: "Call to Mind, a Framework for Action".

They reviewed every JSNA in the country to discover how Health & Well-being Boards assessed the Health needs of Veterans. They found that fewer than half mentioned them at all, and that of those that did, 82% simply included nothing more than the word "veteran".

Boards can have difficulty collecting data on Veterans for the following reasons:

1. Veteran status is not routinely recorded in Primary & Secondary healthcare statistics, and rarely features in social care statistics.
2. Veterans are dispersed across the country, and while there is some intelligence and data about their residence, this is not uniform or robust or sufficiently detailed at CCG or

Local Authority level.
3. Veterans themselves may be reluctant to identify themselves as Veterans even when offered the opportunity.
4. Veterans are a heterogeneous group, and assumptions about health need will not apply equally to all those classified as a Veteran.

The JSNA is a "Needs Assessment" which is why the Report believes that Veterans as a cohort should be identified as such:

1.**Targeted and Intelligent use of data and information**: Veterans and their family members need to be routinely identified and included in health and social care data collection as part of a targeted and intelligent approach to assessment of their mental and related health needs.
2. **Appropriate and evidence based services**: responding to the needs of Veterans and their families requires services that are sensitive to their identity and culture and provide evidence-based interventions as part of an appropriate care pathway.
3. Assessing and responding to the mental and related health needs of Veterans and their families should be done with their active involvement and participation.

The Press would have you believe that we Veterans are all "mad, bad or sad". Those of us who have witnessed the carnage of combat are forever marked and changed by that experience, but most of us adjust to normal life thereafter, however, the small number who struggle really do need special help.

Analysis by the Royal British Legion survey of 2014 and the Government's Annual Survey of Veterans 2015 looked at health effects on the "working age population, aged 16-64" with a subset of "early Service leavers aged 16-34, and the elderly Veterans.
Those aged 16-34 are significantly more likely to report hearing loss than non-Veterans of the same age (7.9% and 3.0% respectively). Veterans of all ages in the North West are significantly more likely than non-Veterans to report musculoskeletal problems (arms or hands: 30% v 18%, legs or feet: 42% v 29%, back or neck: 37% v 26%).
There is also a significant increase in alcohol abuse in young "early Service leavers".

The vast majority of Veterans make a satisfactory adjustment to civilian life, however, as noted previously, the small number who do not can have complex health needs that can also affect their families.

How can H&WBBs help?

We think there are possibly 560,000 veterans in the North West, of which two thirds will be aged 65 or over, and half will be aged over 75. An "average" GP Practice will have 384 Veterans as patients. These figures are only rough estimates.

I need your help firstly, to identify the true number of Veterans in order that your JSNA can be more accurate, and target Health resources, and secondly to increase the knowledge and awareness of all those who deal with the Health and Social Care needs of Veterans of how those needs present and can be addressed.

Health Education England has recently produced an excellent e learning programme[3] that provides training. to increase this knowledge.

I have written to all CCGs and LMCs in the North West (see Appendix A) asking GP Practices to record the status of Veterans with the relevant computer codes. These codes

can then searched and provide the numbers for your JSNA.

In conclusion:

I am not pleading a case for special treatment for Veterans, but the evidence shows that they can have particular health needs related to their previous military service. The better we are able to identify Veterans, the more accurately we are able to target Health and Social Care resources.

I ask that we all do our best to ensure that those who remain are not forgotten.

RG Jackson

RG Jackson TD VR
Chairman
NHS Armed Forces Network NW

Resources

1. This is the latest annual Government survey of the Health of Veterans:
https://www.gov.uk/government/statistics/annual-population-survey-uk-armed-forces-veterans-residing-in-great-britain-2015

2. This is the 2014 Royal British Legion survey:
https://www.britishlegion.org.uk/media/2275/2014householdsurveyreport.pdf

3. This is the Health Education England e Learning package:
http://www.e-lfh.org.uk/programmes/armedforces

4. This is the Forces in Mind Report Executive summary on JSNAs:
http://www.fim-trust.org/wp-content/uploads/2015/07/20150623-Call-to-MInd-Executive-Summary-23rd-June-20151.pdf

Appendix 1.: Letter to CCGs and LMCs

NHS
Bury Clinical Commissioning Group

Issued electronically to :

all Northwest LMCs
Lancashire CCGs
Greater Manchester CCGs Cheshire and Merseyside CCGs

Dear Colleague

HEALTH CARE FOR THE ARMED FORCES VETERANS: FINDING THE FORGOTTEN

I write as Chairman of the NHS Armed Forces Network (North West), one of ten regional bodies advising the NHS and others on delivering Health Care to the Armed Forces and Veterans.

Ex-Servicemen and women may have special needs due to physical or mental injuries and illness sustained in the line of duty. The Armed Forces Covenant acknowledges the Government's recognition of this, and requires the NHS and others to give Service personnel and Veterans priority, where their health has been affected by military duties. We believe there are approximately 526,000 Veterans in the NW, but we need accurate data.

As we approach Remembrance Sunday, and pay our respects to those who gave their lives for our nation, I need your help in ***Finding the Forgotten***. I want to find 10,000 additional Veterans by Christmas.

As a (retired) GP, I am wary of asking Practices to take on yet another task, but I feel this can be achieved by normal history taking and new patient registration. I would be grateful if GP Practice staff could complete the section on the GMS1 form for new patients, *"to be completed if you are returning from the Armed Forces"* when relevant. Everyone doing so, and all who are identified as a Veteran through, for instance, history taking in a consultation, should have the appropriate Read code for Veterans entered in their records (an average Practice of 8000 patients has around 384 Veterans).

The Read Codes for Military Veterans are as outlined below:

System 1 TPP clinical systems: use **XaX3N** (code for Military Veteran)
EMIS Web, Vision, Microtest clinical systems: use **13Ji** (code for Military Veteran)

This enables Health & Wellbeing Boards to collect anonymised figures on the number of Veterans, for their Joint Strategic Needs Assessments so that Health resources can be focused accordingly.

When Veterans are referred to hospital for treatment of illness or injury related to their military service, their status as Veterans should be noted in order that the Military Covenant can give them priority where appropriate.

NHS Health Education England's free e-learning pack for all Healthcare professionals, clinical and administrative (http://www.e-lfh.org.uk/programmes/armedforces) tells you all you need to know about health care for the Armed Forces Community.

A Press Release will be issued on 7 Nov 16, asking Veterans to make their status known; and in support of this, I am asking that you forward this letter to GP Practices within your locality as soon as possible so that they are aware of the campaign.

Yours sincerely,

RG Jackson

Dr Robin Jackson TD VR
Chairman, NHS Armed Forces Network North West NHS Bury Clinical Commissioning Group
21 Silver Street
Bury
Lancashire
BL9 0EN

Tel: 0161 762 3100
Email: **robin.jackson3@nhs.net**

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	19 January 2017
Board Member / Reporting Officer:	Paul McGarry, Strategic Lead, Greater Manchester Ageing Hub
Subject:	**GREATER MANCHESTER AGEING HUB**
Report Summary:	The attached presentation gives an update on the work programme of the Greater Manchester Ageing Hub. The Greater Manchester (GM) Ageing Hub has been created so that GM partners can coordinate a strategic response to the opportunities and challenges of an ageing population.
Recommendations:	The Health and Wellbeing Board are asked: • To note the presentation • To continue to engage with the GM Ageing Hub to ensure alignment of local priorities
Links to Health and Wellbeing Strategy:	The GM Ageing Hub Programme links to the Living and Ageing Well priorities of the Health and Wellbeing Strategy.
Policy Implications:	GM's ambition, as set out in the Greater Manchester Strategy (GMS), is to develop a new model of sustainable economic growth where all residents are able to contribute to and benefit from sustained prosperity and enjoy a good quality of life. The GM Strategy recognises the challenges we will face as the population ages – yet it will be increasingly important to recognise and address the opportunities.
Financial Implications: (Authorised by the Section 151 Officer)	There are no direct implications arising from this report at this stage.
Legal Implications: (Authorised by the Borough Solicitor)	It will be important that the Board receive regular assurance information to understand where resources may need to be focussed and to determine whether interventions are effective as well as understanding the impact of not addressing these issues in terms of finances and outcomes for health.
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 Gareth Williams, GM Public Service Reform Team. Telephone: 0161 219 6170 e-mail: g.williams3@manchester.gov.uk

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Paul McGarry
Strategic Lead
Greater Manchester Ageing Hub

GMCA BOLTON BURY MANCHESTER OLDHAM ROCHDALE SALFORD STOCKPORT TAMESIDE TRAFFORD WIGAN

GM AGEING HUB

Population Change in Four City Regions:

City Region	Population: 75+ ('000s)				% of population 75+	
			Change 2011 - 2036		2011	2036
	2011	2036	No.s	%		
Greater Manchester	**221**	**387**	**166**	**75**	**8.6**	**14.2**
Liverpool City Region	154	257	103	67	10.4	**17.3**
Leeds City Region	260	475	215	83	8.7	**14.3**
Sheffield City Region	171	290	119	69	9.5	**15.1**

Source: Buckner, L et al (2011) N8 Research Partnership

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

3

GM Ageing Hub Themes

- Age-friendly **neighbourhoods**
- Healthy **Lifestyles**
- **Innovation**, technology and design
- **Economy** and ageing
- **Culture**
- **Planning**, housing and transport

Next steps/ways of working

- GM Ageing Hub **Steering Group**
- **Centre for Ageing Better**
- 16th February **conference**
- **Partnership** Group **Foresight** and Policy Reports
- Local **consultation and engagement**
- On-line **platform**

THANKS FOR LISTENING

For more information:

p.mcgarry@manchester.gov.uk

0161 234 3503
@AgefriendlyMCR
@GMAgeingHub

Report to :	**HEALTH AND WELLBEING BOARD**
Date :	19 January 2017
Board Member / Reporting Officer:	Councillor Kieran Quinn – Executive Leader Councillor Peter Robinson – Executive Member for Children and Families Steven Pleasant – Chief Executive Stephanie Butterworth – Executive Director – People
Subject :	**OFSTED INSPECTION OF SERVICES FOR CHILDREN IN NEED OF HELP AND PROTECTION; CHILDREN LOOKED AFTER; AND CARE LEAVERS**
Report Summary :	This report updates the Health and Wellbeing Board on the recent Ofsted inspection of services for children in need of help and protection; children looked after; and care leavers. Ofsted also undertook a review of the Tameside Safeguarding Children Board (TCSB). Health and Wellbeing Board are provided with a summary of the Ofsted activity, Ofsted's judgements and findings about Tameside and the future work Ofsted will undertake as a result of them judging Tameside's Children's Services to be inadequate. The report also sets out an approach to a Tameside Children's Services Improvement Programme including the establishment of a Tameside Children's Services Improvement Board (TCSIB) to oversee the development and implementation of a Tameside Children's Services Improvement Plan (TCSIP).
Recommendations :	Health and Wellbeing Board are asked to note the content of the report and the following recommendations agreed by the Council's Executive Cabinet: • Approve the establishment of a Tameside Children's Services Improvement Board (TCSIB) – with an independent chair – on the basis of the terms of reference laid out at **Appendix 1**. • Approve the development of the Tameside Children's Services Improvement Plan (TCSIP) and Business Plan together with an Investment Plan based on the outline explained in this report.
Links to Community Strategy :	The Community Strategy and the Corporate Plan outline the priorities for improving the borough of Tameside including the quality of life for children and families, particularly those who are most vulnerable and in need of help. The improvement approach outlined in this report will be the key programme of work supporting the delivery of those priorities.
Financial Implications : (Authorised by the Section 151 Officer)	The financial implications of the Tameside Children's Services Improvement Plan per recommendation 2 will be included within the associated investment plan once the improvement plan is finalised. The investment plan will include the level and

	phasing of the additional investment required, the planned duration either as recurrent or non-recurrent and the expected efficiencies which will also be realised within the service. It should be noted that the initial phase of the investment plan requirement was approved by the Executive Cabinet of the Council on 14 December 2016. Approval was granted for the three invest to save initiatives: Family Group Conferencing, Edge Of Care Service and From Care To Success, transitional support for Care Leavers. The associated financial implications are contained within the Executive Cabinet report.
Legal Implications : (Authorised by the Borough Solicitor)	Whilst many do not recognise the judgment which has been given and the evidential basis upon which the decision made, it has been determined that it is in the best interests of all concerned that rather than challenge the Council will use its resources and efforts to turn the decision around.
Risk Management :	As set out in 'Putting Children First' all local authorities that are rated inadequate by Ofsted for their children's services will go into intervention. Failure to respond effectively will lead to escalation of the intervention. The Minister will write to Tameside when the report is published to inform us that the local authority is in intervention and will issue an Improvement Notice. For local authorities like Tameside that are not inadequate in every category ('systemic failure') and that haven't failed two Ofsted inspections in five years ('persistent failure'), the Department for Education expect that most will be able to turn themselves around with support and challenge from experts. To that end the Department will appoint an improvement adviser to work with us, do a diagnostic review of the underlying issues and potential solutions, help us to develop our improvement plan, and provide the longer-term challenge and support. The Department will review progress every six months and will expect to see evidence of good progress at each review point such that we would no longer be inadequate when Ofsted re-inspect after two years. If the progress isn't sufficient, that is when the Department would consider escalating the intervention, potentially appointing a children's services Commissioner to review whether services should be removed from council control.
Access to Information :	The background papers relating to this report can be inspected by contacting the report writer Simon Brunet: Telephone: 0161 342 3542 e-mail: simon.brunet@tameside.gov.uk

1. BACKGROUND

1.1 All local authorities in England are inspected by Ofsted within a three/four year period under the unannounced single inspection framework for children in need of help and protection; children looked after and care leavers. The inspection also includes a review of local safeguarding children boards. Her Majesty's Inspectors (HMI) carry out these inspections under section 136 (2) of the Education and Inspections Act 2006. When a local authority is judged to be inadequate for overall effectiveness, Ofsted will apply its arrangements for monitoring and re-inspection.

1.2 Ofsted undertook the Tameside inspection over a four week period from 26 September to 20 October 2016.

2. OFSTED INSPECTION ACTIVITY

2.1 Over the four week period the team of ten Ofsted inspectors:

- Evaluated and explored a sample of children's cases in order to judge the quality of front-line practice and management and the difference this makes to the lives of children, young people, their families and carers.
- Tested decision-making at all stages of a child's journey.
- Met with children, young people and carers.
- Shadowed staff in their day-to-day work, for example observing practice in the duty team, the work of social workers and the work of independent reviewing officers.
- Observed practice in multi-agency meetings such as child protection conferences, looked after children reviews and resource panels.
- Reviewed a wide range of specific information, such as data and reports, requested from the local authority.

2.2 Feedback was provided by the Ofsted inspection team to the Council on the last day of the inspection (20 October 2016). A draft report was shared with the Council on 18 November 2016 with 5 days for the Council to respond to this (i.e. by 24 November 2016).

2.3 The pre-publication report was issued to the Council on Wednesday 7 December 2016 and the final report was published on the Ofsted website on Friday 9 December 2016.

3. KEY FINDINGS AND FEEDBACK FROM OFSTED

3.1 Ofsted scored Tameside's Children's Services as below:

Judgement	Score
Overall Effectiveness	**Inadequate**
Children who need help and protection	Inadequate
Children looked after and achieving permanence	Requires Improvement
Adoption	*Good*

Experiences and progress of care leavers	*Requires Improvement*
Leadership, management and governance	Inadequate

Local safeguarding children board	Requires Improvement

3.2 Summarised below are some of the key themes of Ofsted's findings:

- Capacity & resources: Ofsted say there is insufficient capacity to meet increased levels of demand and that resources are not being used effectively. High staff turnover and the use of agency workers means the workforce is not suitably experienced. Social workers have too many cases meaning they don't have enough time with children to really get to know them and their needs.

- Management & oversight: Ofsted say over the summer and when they came to Tameside there were unacceptable delays in the hub (front door) before medium risk domestic abuse cases considered by qualified social worker. And that these issues were not known by managers. Poor oversight by managers means variable practice and quality are not being addressed, in particular the variability in decision making. Performance management information is often not fit for purpose and is not used effectively.

- Quality & practice & outcomes (incl. voice and experience of child): Poor application of thresholds means there are too many repeat contacts, services are provided at the wrong level of need and abuse is often not investigated. Most assessments for children needing help or protection don't sufficiently address risk. The use of the Common Assessment Framework (CAF) to prevent escalation is too limited. Assessments for children looked after are not routinely updated, and not all children looked after have effective permanence plans.

3.3 Ofsted acknowledged a number of areas of good practice and positive outcomes for children and families in Tameside. They praised our adoption and fostering service, the support given to disabled children, the work of the virtual school, the range of services available to families affected by domestic abuse, training opportunities for staff and the effectiveness of how we help care leavers transition into adult life.

4. OFSTED REQUIREMENTS OF TAMESIDE

4.1 When a local authority Children's Service is rated inadequate there is a clearly defined process that Ofsted and the Department for Education follow for action planning, ongoing monitoring and re-inspection. The table below summarises that process and associated requirements and milestones.

	Activity	By when	Dates
A	'Pre-publication Inspection Report' issued to Tameside	-	7 December 2016
B	'Inspection Report' published on Ofsted website	-	9 December 2016
C	'Action Planning Visit'	Within 25-35 days of (A)	24 January 2017

D	'Statement of Proposed Action' to be submitted	Within 70 days of (A)	20 March 2017
E	First 'Quarterly Monitoring Visit'	1st – within 4 weeks of (D) *(then quarterly thereafter)*	To be confirmed but expected w/c 20 or 27 April 2017 (*)
F	'Post-monitoring Single Inspection'	Within two years but not normally sooner than before the fourth 'Quarterly Monitoring Visit'	-

Please note:

- The outputs from the first 'Quarterly Monitoring Visit' (E) will not be published by Ofsted. Subsequent ones will be.
- 'Quarterly Monitoring Visits' are effectively short inspections and should be prepared for as such.

4.2 As set out in 'Putting Children First' all local authorities that are rated inadequate by Ofsted for their children's services will go into intervention. Failure to respond effectively will lead to escalation of the intervention. The Minister will write to Tameside when the report is published to inform us that the local authority is in intervention and will issue an Improvement Notice. For local authorities like Tameside that are not inadequate in every category ('systemic failure') and that haven't failed two Ofsted inspections in five years ('persistent failure'), the Department for Education expect that most will be able to turn themselves around with support and challenge from experts. To that end the Department will appoint an improvement adviser to work with us, do a diagnostic review of the underlying issues and potential solutions, help us to develop our improvement plan, and provide the longer-term challenge and support. The Department will review progress every six months and will expect to see evidence of good progress at each review point such that we would no longer be inadequate when Ofsted re-inspect after two years. If the progress isn't sufficient, that is when the Department would consider escalating the intervention, potentially appointing children's services Commissioner to review whether services should be removed from council control.

4.3 Tameside's response to the Ofsted inspection has already started, and well in advance of the Ofsted timetable. We are well positioned to show Ofsted at the first milestone – the action planning meeting on 24 January 2017 – both the pace and scale of our commitment to improvement.

5. TAMESIDE CHLDREN'S SERVICES IMPROVEMENT PROGRAMME

5.1 In response to the Ofsted inspection outcome a Tameside Children's Services Improvement Programme is being developed. The primary objective of the Tameside Children's Services Improvement Programme is for the Council and its partners to achieve sustainable improvements at scale and pace across the full range of services for children and families in Tameside. The focus on sustainable change will require new ways of working including careful analysis and tracking of performance to demonstrate effective improvement and tangible impact on outcomes for children and families.

5.2 The Tameside Improvement Programme will follow a number of guiding principles to ensure it is both effective and relevant. Strategic direction will be provided by a Tameside Children's Services Improvement Board (TCSIB) who will oversee a Tameside Children's Services Improvement Plan (TCSIP). Delivery of the Plan will come from the bottom up. The practical ideas and projects that will deliver the Board's vision and the Plan's objectives

are best developed by practitioners and the children and families they support. It is they who truly understand what will and won't work.

5.3 Extensive work, supported by independent practitioners and advisors, will need to be undertaken to identify the root causes of the problems identified by Ofsted. The findings from that work will inform the Tameside Children's Services Improvement Plan – which in turn will be supported by a performance scorecard. This plan will be the basis for implementing change and for driving through service redesign and delivery. New governance arrangements will be introduced to manage the Tameside Children's Services Improvement Programme and ensure delivery of the Tameside Children's Services Improvement Plan (TCSIP).

5.4 The two fundamental elements to the Tameside Improvement Programme that need to be addressed urgently to ensure rapid progress towards improvement are governance and improvement planning. The proposed approach to these is laid out in the following two sections of this report.

6. GOVERNANCE

6.1 The governance arrangements for the Tameside Children's Services Improvement Programme will comprise three main groups:

- Tameside Children's Services Improvement Board (TCSIB);
- Tameside Children's Services Improvement Executive (TCSIE);
- Tameside Children's Services Improvement Delivery Group (TCSIDG).

6.2 The scope of the three groups is explained in a little more detail in the table below. The full terms of reference (including proposed membership) for the Tameside Children's Services Improvement Board (TCSIB) can be found at **Appendix 1**.

Group	Chair	Members	Freq.
Improvement Board	Independent Chair	Elected Members Chair of LSCB Department for Education Officers – Tameside Council Officers – Partners	Monthly
Improvement Executive	Steven Pleasant	Officers – Tameside Council Officers – Partners	Monthly
Delivery Group	Steven Pleasant	Officers – Tameside Council	2-weekly

6.3 The Tameside Children's Services Strategic Improvement Board (TCSIB) will provide the strategic direction for delivering the required improvements. It will provide challenge and rigour to the process whilst collaborating to achieve and sustain continuous improvement in Children's Services and across the wider partnership in Tameside. The Board will have an independent chair to provide appropriate external challenge and rigour. The chair will not be accountable for improvement; that responsibility lies with the Council, working with partners.

6.4 The groups outlined at paragraph 6.2 will work effectively together to ensure that appropriate strategic and operational direction is provided and improvements are implemented on the ground. The groups will complement each other and ensure that the targets, outcomes and outputs are accurately identified and delivered.

6.5 The above approach will be supported by both the Children's Services Management Team and a Corporate Support Team – who together will drive the effective implementation of change. Both will work closely together to ensure progress is made and actions delivered. The Corporate Support Team will provide additional resource and internal assistance to the teams and workgroups in Children's Services to ensure they have sufficient capacity to deliver change and improvement.

7. IMPROVEMENT PLAN

7.1 The Tameside Children's Services Improvement Plan (TCSIP) will be a public document, agreed and owned by the Tameside Children's Services Improvement Board (TCSIB). It will set out the strategic direction, key milestones and positive outcomes the Board would expect to see over the next two years. The Board will provide independent scrutiny and challenge to the Council and partners against their delivery of the Plan.

7.2 To ensure the Plan is meaningful and effective it will include a series of tightly defined actions, each one with clear timescales and transparent accountability. A performance scorecard will underpin the action plan, providing measures of progress against outcomes as well as the achievement of milestones against actions. Detailed progress against the Plan (i.e. the action plan and scorecard) will be reported to each meeting of the Board. Alongside this a progress summary will be produced each quarter to update the public in a more accessible way on the work to that point.

7.3 The proposed structure of the Tameside Children's Services Improvement Plan (TCSIP) document is summarised below. The detailed action plan and scorecard sit within that Improvement Plan document, but will also be standalone products.

- Foreword / introduction (from Leader and Chief Executive)
- Tameside context – our journey and where we believe we are
- Children and families in Tameside (using infographics etc.)
- What's happened – Ofsted have undertaken the inspection, ratings, key findings / headlines
- Our response – Tameside Children's Services Improvement Programme. Strategic Improvement Board (with independent Chair), Tameside Improvement Plan, plus strategic summary of improvement work (e.g. workforce development, engagement with children etc.)
- What will good look like – where we expect to see the service, and outcomes for children, in 1, 2 and 5 years.
- Action Plan (detailed action plan for improvement)
    - Leadership, strategy and intelligence (including innovation, ideas and Public Service Reform)
    - Workforce development and skills
    - Capacity and resources (including staff, money, systems and processes)
    - Quality and practice (including oversight and challenge)

- Voice and experience of the child (i.e. the outcomes for children and families)
- Child in Need (including domestic abuse)
- Child Sexual Exploitation (CSE)
- Children looked after and care leavers (including fostering and adoption)

- Are we improving – performance scorecard

- Glossary

- Further information and contacts

7.4 The Council's Executive Cabinet agreed to develop the Tameside Children's Services Improvement Plan (TCSIP) on the outline above. Practitioners and children will be involved in this work to ensure the Plan hears and reflects their voice, concerns and ideas for improvement.

7.5 An action plan has to be submitted to Ofsted within 70 working days of receipt of the pre-publication report which is expected to be a deadline around mid-March.

8. IMPROVEMENT JOURNEY

8.1 Delivery of the Tameside Children's Services Improvement Plan (TCSIP) will be a journey that is underpinned by a number of other pieces of work, many of which have already commenced to support change and improvement within Children's Services.

- Workforce engagement & development – a number of staff engagement sessions have already been undertaken with further planned on an ongoing basis. These sessions are essential as two-way communication between practitioners and senior leaders. They also prove invaluable as workshops to hear the voice of practitioners in the Improvement Plan and develop the specific projects and changes that will deliver that plan.

- Quality of practice – a specialist Quality Assurance post is to be recruited to that will sit outside the service but act as an internal critical friend. This will ensure we have appropriate challenge to practice and decision making in a semi-independent and supportive environment. Alongside this a consultant social worker is to be recruited to work directly with social workers to help build further their confidence and skills particularly around decision making and recording.

- Performance scorecard – a performance framework is being developed that will enable a clear assessment of progress towards improved quality of life. The action plan within the Improvement Plan will have milestones that will measure and report progress towards implementation. But it is important to have the performance scorecard alongside this to assess achievement of tangible outcomes for children and families. The scorecard will not just be indicators it will include quantative and qualitative information such as outcomes from critical friend reviews of practice, service user feedback etc. The service is developing a new performance framework, team self-assessment process and improvement planning approach. This will be in place from early in the New Year and will be monitored through regular performance clinics (a two-way process between managers & staff)

- Review of systems and processes – all systems and processes will be reviewed to check they are still fit for purpose and are enablers not barriers. Fit for purpose is defined as helping practitioners to do their job and enabling the achievement of quality and practice standards. Alongside this the review will ensure systems and

processes provide meaningful data and information to managers and practitioners. Data and information for managers and help them understand flows and plan work, and help practitioners to manage and prioritise their caseloads.

9. SUPPORTING ACTIVITY

9.1 Wrap around supporting activity will be required in a number of areas to facilitate and enable the implementation of change and the delivery of the Improvement Plan.

9.2 A Corporate Support Team has been established to provide additional resource and advice to the teams and workgroups in Children's Services to ensure they have sufficient capacity to deliver change and improvement. The team includes specialists in programme support; systems / process re-design and mapping; workforce engagement and development; performance management; achieving quality in practice; investment models and finance; communications; legal.

9.3 A communications plan is being developed to effectively communicate to stakeholders our improvement work with a particular focus on outcomes for children and families using case studies and real life stories.

10. STAFF ENGAGEMENT AND DEVELOPMENT

10.1 Staff engagement and development will be an underpinning enabler of improvement. A series of staff engagement sessions are planned. These sessions are essential as two-way communication between practitioners and senior leaders. They also prove invaluable as workshops to hear the voice of practitioners in the Improvement Plan and develop the specific projects and changes that will deliver that plan.

10.2 The first all staff engagement session took place on 22 November 2016. Below is a summary of the main points of feedback:

- Need for better communication and active listening;
- Volume of work and staffing levels aren't balanced;
- Clarity needed around priorities;
- Greater opportunity to be involved in improvements;
- Recruitment doesn't bring experienced staff;
- Need to grow specialisms within services;
- Raised issues before and not acted on;
- Insufficient business support impacts on ability to do job;
- Allowing staff to work to full potential (level of decision making);
- Head space needed to reflect on the work.

10.3 Work has started already to address the concerns raised by staff and will be ongoing. Early activity includes:

- The duty team has been doubled in size.
- Additional agency staff has been brought in on a short term basis to provide space to start improvement work.
- Additional social workers will be recruited to reduce caseloads per staff member and allow a reduction in the reliance on agency.
- Appropriate caseload levels to ensure sufficient time with children and families.
- Recruited a psychologist with remit for looked after children as well as a worker in the Early Attachment Team.

- New dedicated head of service, reporting to improvement board, with a focus on quality, performance & practice.
- A new consultant social worker with a focus on practice.
- Currently reviewing the Quality Assurance Framework to ensure consistent / rigorous QA is embedded into service delivery. New head of service to lead and assure.
- Gathered information on salary and progression structures from across the region and will be bringing forward proposals as soon as possible to ensure our offer is strong and our staff stay with us longer.
- The workforce training strategy has been revised and is being implemented now. It includes an increased offer to all levels in the organisation.
- By the end of December we will have a reviewed and refreshed induction package for new staff.

10.4 A programme of workforce engagement sessions are planned in for the next year.

11. ACTION UNDERWAY / TAKEN TO DATE

11.1 The improvement work has started already with a number of quick wins implemented and early plans developed and ready to make live. These are summarised below:

11.2 Capacity & resources

- Additional agency staff has been brought in on a short term basis to provide space to start improvement work.
- Additional social workers will be recruited to reduce caseloads per staff member and allow a reduction in the reliance on agency.
- Appropriate caseload levels to ensure sufficient time with children and families.
- The duty team has been doubled in size.
- Recruited a psychologist with remit for looked after children as well as a worker in the Early Attachment Team.
- Gathered information on salary and progression structures from across the region and will be bringing forward proposals as soon as possible to ensure our offer is strong and our staff stay with us longer.
- The workforce training strategy has been revised and is being implemented now. It includes an increased offer to all levels in the organisation
- By the end of December we will have a reviewed and refreshed induction package for new staff.

11.3 Management & oversight

- Engagement of North West Employers to provide dedicated support and challenge to the leadership team, ensuring this is fit for purpose and has the capability and capacity to drive the improvements at scale and pace.
- Realignment of leadership structure to ensure sufficient capacity for improvement process.
- New dedicated head of service, reporting to improvement board, with a focus on quality, performance & practice.
- Hub issues addressed following summer spike. No backlog. Work tray cleared daily.
- Hub review complete. New sustainable model started from 28 November. Daily review of front door by senior manager to ensure daily clearance.
- New performance framework, team self-assessment and improvement planning process developed. In place by January. Monitored through regular performance clinics (managers & staff)

11.4 Quality & practice & outcomes (incl. voice and experience of child)

- A new consultant social worker with a focus on practice.
- Currently reviewing the Quality Assurance Framework to ensure consistent / rigorous QA is embedded into service delivery. New head of service to lead and assure.
- Completed a refresh of the Children in Care Council (2BeUs) with new independent coordinator and work plan. New pledge agreed at Full Council (29 November)
- Invest to save projects agreed. Edge of Care service; Family Group Conferencing; Care to Success (transitional support for care leavers).
- Review of systems for Domestic Abuse notifications with GMP under way to ensure a rapid response to notifications from the Safeguarding Partnership.

12. COMMUNICATIONS

12.1 A communications plan is being developed to effectively communicate to stakeholders our improvement work with a particular focus on outcomes for children and families using case studies and real life stories.

13. RECOMMENDATIONS

13.1 As set out on the front of the report.

14. APPENDICES

14.1 The following appendix is attached.

- **Appendix 1**: Terms of reference for the Tameside Children's Services Improvement Board (TCSIB).

APPENDIX 1

TERMS OF REFERENCE:

TAMESIDE CHILDREN'S SERVICES IMPROVEMENT BOARD (TCSIB)

The Tameside Children's Services Improvement Board (TCSIB) will provide the **strategic direction** for delivering the required improvements. It will provide challenge and rigour to the process whilst collaborating to achieve and sustain continuous improvement in Children's Services and across the wider partnership in Tameside.

The Independent Chair of the Board will oversee the effective functioning of the Board, providing appropriate external challenge and rigour. The Chair is not accountable for improvement; that responsibility lies with the Council, working with partners. The Chair will report on progress to Tameside Council, the local Health and Wellbeing Board and both Ofsted and the Department for Education.

The scope and objectives of the Tameside Children's Services Improvement Board (TCSIB) are:

- Develop and agree an Improvement Plan with clear and realistic milestones to carry out the actions and areas for improvement identified in the Ofsted inspection report of 9 December 2016.

- Agree a performance scorecard that underpins and evidences progress against the Improvement Plan.

- Oversee investment in improvement as delivered through the Improvement Framework

- Drive improvement and monitor progress against the requirements of the Improvement Plan. The Council and partners must regularly report to the Board on progress. Reporting should include an assessment of key milestones and performance trends. Where they are failing to meet targets and timescales the appropriate action to be taken should be explained.

- Review risk management and address issues that arise. This includes issues within the scope of the Improvement Plan and also other issues outside the plan which need to be brought to the Board's attention (e.g. flagging up constraints to the programme such as IT, financial or staffing issues, and non-compliance by partners with the Improvement Plan).

- Consider Council and other partner's reports on the wider improvement agenda in Children's Services and across the public sector in Tameside where appropriate.

- Commission and consider reports from bespoke reviews and challenge processes that assist in understanding root causes and thus informing progress against the Improvement Plan.

- Ensure that an assessment of progress is informed by the views of front-line practitioners and children, young people and carers.

- Work alongside existing strategic governance and accountability frameworks including the Tameside Safeguarding Children Board, the Health and Wellbeing Board, the Corporate Parenting Board and relevant scrutiny functions.

- The Board will commit to the Children in Care Council Pledge and oversee its implementation.

Membership:

The Tameside Children's Services Improvement Board (TCSIB) will have the following membership:

- Independent Chair – Jane Booth

- Executive Leader of Tameside Council
- First Deputy (Performance and Finance)
- Executive Member for Children's Services
- Chair of the Integrated Care and Wellbeing Scrutiny Panel

- Chair of the Tameside Safeguarding Children Board

- Chief Executive of Tameside Council
- Executive Director of Children's Services
- Assistant Executive Director for Children's Services
- Chair of Practitioners Improvement Group
- Representative of Corporate Parenting Group

- NHS Tameside & Glossop CCG
- Greater Manchester Police
- Tameside Integrated Care NHS Foundation Trust
- Primary School sector representative
- Secondary school sector representative
- Further education sector representative – Principal Tameside College
- RSL sector representative – New Charter
- VCF sector representative

- Local Government Association
- Grant Thornton

- Department for Education representative

In Attendance:

The following Tameside Council representatives will also be in attendance as required to support the board in carrying out its responsibilities:

- Representative from Resource Management
- Representative from Executive Support
- Representative from Policy and Communications
- Representative from Legal Services
- Representative From Workforce and Organisational Development
- Head of Performance and Development for People Service
- Improvement Board Executive Support

As each meeting will consider progress and make necessary decisions, it is essential that an appropriate representative who has decision-making powers attends in the place of an absent Board member.

Frequency:

The Tameside Children's Services Improvement Board (TCSIB) will meet monthly.

Format:

The agenda and papers will be made available 5 working days in advance of each meeting.

Reporting:

The Tameside Children's Services Improvement Board (TCSIB) will provide independent progress reports to:

- Executive Cabinet of Tameside Council
- Tameside Health and Wellbeing Board
- Ofsted's Regional Director and Senior HM Inspector (SHMI)
- Department for Education (DfE) Inspections and Intervention Team

Review:

The terms of reference, membership and frequency of meetings of the Tameside Children's Services Improvement Board (TCSIB) will be reviewed quarterly by the Board. Any changes must be agreed by the Executive Cabinet of Tameside Council.

Report to :	**HEALTH AND WELLBEING BOARD**
Date :	19 January 2017
Board Member / Reporting Officer:	Alan Ford – Commissioning Business Manager for Children, Young People and Families Catherine Moseley – Head of Access and Inclusion
Subject:	**SPECIAL EDUCATION NEEDS AND DISABILITY (SEND) REFORMS IMPLEMENTATION UPDATE**
Report Summary:	The report provides an update on the implementation of the Special Education Needs and Disability (SEND) reforms enshrined in Part 3 of the Children and Families Act 2014 in identifying and meeting the needs of Children and Young People with SEND in the local area. It asks Board members to consider their roles in contributing to Tameside's responsibility to these young people and how they can contribute to addressing the gap analysis. This area of work will be inspected by Ofsted and CQC at some point and will include the Local Authority, Clinical Commissioning Group and Public Health. This report is also being presented to the Education Attainment Improvement Board in January 2017.
Recommendations:	Members of the Health and Wellbeing Board are asked to note the contents of the report, and to consider their role in ensuring relevant steps are taken to progress arrangements to further the implementation of the SEND reforms:- • Ensure the co-production, development and delivery of a shared vision and strategy across the Local Area for children and young people with SEND; • Ensure that families, children and young people with SEND are at the centre of the development of the strategy and services; • Support the creation of a governance framework for the SEND Agenda, which ensures Executive oversight and reflects on performance report implications; • Ensure the establishment of a clear line of sight and accountability to the Health and Well Being Board; • Ensure the development of a performance matrix for SEND that includes prevalence and outcome information.
Links to Health and Wellbeing Strategy:	The Health and Wellbeing Strategy is due to be refreshed in 2017, which has held a strong focus on starting and developing well, supporting the most vulnerable in our communities and helping our children and families to reach their full potential. However, in the refresh there is clear need to ensure SEND is explicitly captured and articulated informing and shaping local plans.
Policy Implications:	A need has been identified to develop and deliver a shared vision and strategy across the Local Area for children and young people with SEND. In addition the Tameside JSNA needs to reflect SEND to ensure a shared process that brings challenge and innovation to commissioning and the decision making process for health and well-being.

Financial Implications: (Authorised by the Section 151 Officer)	There are no direct financial implications arising from this report. However, it should be noted that any associated expenditure which may subsequently arise would need to be funded from existing resources.
Legal Implications : (Authorised by the Borough Solicitor)	Special educational needs legislation has been reformed by the Government with effect from the 1 September 2014. The changes form Part 3 of the Children and Families Act 2014 which received Royal Assent on 13 March 2014. This is to improve outcomes for children and young people with complex needs and the experience of parents and carers. The three key changes are as follows: • *Production of a 'Tameside Local Offer'*: Placing a duty to set out clear and searchable information on services available to parents and carers, children and young people • *Education, Health and Care Plans (EHCP)* for children and young people with special educational needs from birth to age 25: Replacing Statements of Special Educational Needs, and Section 139a Learning Difficulty Assessments for post 16 education • *Personal Budgets:* For some families and young people with an EHCP to give greater independence, choice and control over their support. The Act also includes: • The need to involve children and young people and parents and carers at the heart of the process in a more person centred way • Places a requirement on local authorities and health services to jointly commission services for young people and families • Provides statutory protection for young people who are in education or training up to the age of 25 • That SEND duties will apply equally to all schools including Academies and Free Schools. It is therefore necessary that there is a clear strategy for delivery within the Borough cutting across organisational boundaries. It will also be important to ensure we learn from those organisations who have already been inspected and/or are regarded as being outstanding at delivery in this area.
Risk Management :	The assessment outlined in this paper highlight areas of SEND potential weakness/risk. The proposed recommendations and implementation of comprehensive self-evaluation framework (SEF) will mitigate the risks of poor outcomes and experiences for children and young with SEND and a potential poor inspection outcome.
Access to Information :	The background papers relating to this report can be inspected by contacting Alan Ford or Catherine Moseley by: Telephone: 07500 980612 / 07970 456012 e-mail: alan.ford4@nhs.net catherine.moseley@tameside.gov.uk

1 INTRODUCTION

1.1 The Special Educational Needs and Disability (SEND) Reforms, enshrined in Part 3 of the Children and Families Act 2014 came into force on 1 September 2014 and outlined the biggest transformation to special educational needs and disabilities support for 30 years. Local Areas now have responsibility for all children and young people with SEND aged 0 – 25. Through the Children and Families Act and the Code of Practice, responsibility for the development of SEND services lies with the Local Area rather than individual agencies or services. Local Area responsibilities under the Children and Families Act include:

- Ensuring appropriate services are in place which meet needs across the 0 - 25 age range;
- Embedding co-production with children, young people and their families / carers at both the strategic and individual level;
- Integration and joint commissioning of services across partners for example, the local authority and Clinical Commissioning Groups (CCG);
- The offer of a personal budget across education, health and / or social care;
- Clear improvements to the child/young person's life and education achieved through clearly articulated outcomes which match the child/young person's aspirations;
- Replacement of Statements of SEN and Learning Difficulty Assessments with Education, Health and Care (EHC) plans;
- Supporting young people over the age of 16 to exercise their right to make decisions about their lives/support (unless they lack the capacity to do so);
- The publishing of a 'local offer' (a one stop shop where information about all services and groups across the local area which support children and young people with SEND and their families can be found.);
- Supporting schools and colleges to embed the new SEN Support classification (replacement for School Action and School Action Plus) within their day to day practice to ensure improved outcomes for all children and you ng people with SEND.

1.2 A new framework for the inspection of local areas' effectiveness in meeting the needs of children and young people with (SEND) has been implemented. The new inspection programme began in May 2016, with potentially a Tameside assessment likely in 2017. It is important to note that this is a local area inspection, not a local authority inspection. The local area includes the Local Authority, CCGs and Public Health. The new joint inspection framework for SEND will seek to hold the local area to account and ensure that our plans are appropriate to meet local demand, and to ensure they have an effective relationship with the key providers to ensure effective arrangements for delivering completed and implemented EHC plans (*for further information on the inspection framework see Appendix*).

1.3 All areas in England will be inspected over the next 5 years. Two inspections have already taken place in Greater Manchester - Bolton and Rochdale. Derbyshire has also been inspected. Following inspection, the outcome letters are published by Ofsted and CQC and these can be accessed via https://www.gov.uk/government/publications/local-area-send-inspection-outcome-letters.

2. IMPLEMENTATION OF THE SEND REFORMS IN TAMESIDE – A GAP ANALYSIS

2.1 The local area has recognised that it needs to complete a comprehensive self-evaluation (SEF). The SEF will clearly document the local area's strengths and areas for improvement and lead to an area wide action plan in addition to individual organisation plans.

2.2 In order to complete the SEF, the local authority has used some of the SEND Implementation Grant to engage the services of an external consultant to give an objective assessment of where the local area currently stands. The CCG has undertaken a SEND

diagnostic audit and together with the robust external evaluation of the Local Area will assist the development of an accurate self-evaluation by the Local Area and ensure strategic ownership of the SEF and its outcomes. This work will assist the Local Area in developing a shared vision and strategy to answer three key questions:

- How effectively does the local area identify children and young people who have special educational needs and/or disabilities?
- How effectively does the local area assess and meet the needs of children and young people who have special educational needs and/or Disabilities?
- How does the local area improve the outcomes of children and young people who have special educational needs and/or disabilities?

2.3 The assessment has identified the following themes for improvement:

2.4 **Strategic Leadership**

- Greater oversight by strategic leaders of the SEND Agenda
- The development of a shared vision and strategy across the Local Area for children and young people with SEND
- Creation of a governance framework for the SEND Agenda;
- Establish a strategic steering group for SEND, to be tasked with setting the direction for all work relating to the SEND agenda across the Local Area and ensure accountability for delivery;
- Establish a clear line of sight and accountability to the Health and Well Being Board.

2.5 **Data and Intelligence**

- Develop a shared data suite/SEND Joint Strategic Needs Assessment across the Local Area to determine the prevalence of need across Tameside, identify gaps in services, inform improvements and drive commissioning decisions
- Use existing data sets more effectively so that the needs of children and young people at SEN support both in schools and colleges are better understood.
- Ensure that appropriate support is available to schools and colleges from all services to enable the identified needs to be met and to ensure that poor practice is challenged.

2.6 **Assessing Impact and Outcomes**

- Develop mechanisms by which the Local Area can measure the impact of services on improving the lives of children and young people with SEND and their families.
- Develop methods of tracking outcomes for individual children and young people with SEND across services so that the Local Area can be confident outcomes for children and young people with SEND in Tameside are improving.

2.7 **Local offer**

- Raise awareness of the Local Offer amongst parents, young people and settings.
- Review the Local Offer with parents and young people to ensure it contains the information which is most useful to them
- Ensure information contained on the Local Offer is timely, comprehensive, accurate and up to date.
- Develop a mechanism to ensure that usage can be monitored to help drive improvements
- Develop capacity to ensure the local offer is effectively managed and maintained.

2.8 **SEND Reforms**

- Through the formation of the SEND Steering group give direction to the ongoing implementation of the SEND reforms to ensure the focus is on the areas where less progress has been made for example, joint commissioning; preparation for adulthood; SEN support in schools.

3. NEXT STEPS

3.1 It is clear that there is much still to do in the Local Area to ensure that the reforms are fully embedded across all services to meet the needs of children and young people with SEND. In order to drive this agenda forward quickly, the following actions have been identified:

- Ensure the coproduction, development and delivery of a shared vision and strategy across the Local Area for children and young people with SEND;
- Ensure that families, children and young people with SEND are at the centre of the development of the strategy and services;
- Support the creation of a governance framework for the SEND Agenda, which ensures Executive oversight and reflects on performance report implications;
- Ensure the establishment of a clear line of sight and accountability to the Health and Well Being Board;
- Ensure the development of a performance matrix for SEND that includes prevalence and outcome information.

3.2 It is intended that SEND should regularly feature on the Health and Wellbeing Board Agenda as all partners have a role to contribute in either supporting, delivery or challenging the strategy and more importantly performance and outcomes for children and young people..

4. RECOMMENDATIONS

4.1 As set out on the front of the report.

APPENDIX

Hyperlink Guidance: Guidance: Local area SEND inspection: framework

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	19 January 2017
Executive Member / Reporting Officer:	Councillor Jim Fitzpatrick – First Deputy (Performance and Finance) Councillor Brenda Warrington – Executive Member (Adult Social Care & Wellbeing) Councillor Gerald P. Cooney – Executive Member (Healthy & Working) Councillor Peter Robinson – Executive Member (Children & Families) Kathy Roe – Director Of Finance – Single Commissioning Team
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2016/17 REVENUE MONITORING STATEMENT AT 30 NOVEMBER 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. The report provides a 2016/2017 financial year update on the month 8 financial position (at 30 November 2016) and the projected outturn (at 31 March 2017). 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 : To note the 2016/2017 financial year update on the month 8 financial position (at 30 November 2016) and the projected outturn (at 31 March 2017). Acknowledge the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget. Acknowledge the significant amount of financial risk in relation to achieving an economy balanced budget across this period. To note the 2016/17 quarter two Better Care Fund monitoring statement **(Appendix A)**
Links to Community Strategy:	The Sustainable Community Strategy and Local Area Agreement are key documents outlining the aims of the Council and its partners to improve the borough of Tameside (agreed in consultation with local residents).

	Within health the CCG's Commissioning Strategy and Primary Care Strategy are similarly aligned to these principles and objectives.
Policy Implications:	The Care Together resource allocations detailed within this report supports the strategic plan to integrate health and social care services across the Tameside and Glossop economy.
Financial Implications: **(Authorised by the Section 151 Officer))**	This report provides the financial position statement of the 2016/17 Care Together Economy for the period ending 30 November 2016 (Month 8 – 2016/17) together with a projection to 31 March 2017 for each of the three partner organisations. 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. Each constituent organisation will be responsible for the financing of their resulting deficit at 31 March 2017. 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. Health and Wellbeing members should also note that the 2016/17 Better Care Fund allocation sum of £15.323m (page 11 of the attached report) is included within the Section 75 funding allocation of the Integrated Commissioning Fund as this is a revenue funding allocation**.** Actual expenditure is included within section 1. The Disabled Facilities Grant sum of £1.978m (page 11 of the attached report) is excluded from this total as it is a capital funding allocation.
Legal Implications: **(Authorised by the Borough Solicitor)**	There is a need to deliver a balanced budget. Consequently, there are significant changes required to achieve this and reduce the current levels of spend which previously have been bailed out. This requires new models of working and relentless focus on budgets without compromising patient care and safety. Many of the new models are intended to achieve this rather than simply look to cut out waste.
Access to Information :	Any background papers relating to this report can be inspected by contacting : Stephen Wilde, Head Of Resource Management, Tameside Metropolitan Borough Council Telephone:0161 342 3726 e-mail: stephen.wilde@tameside.gov.uk Tracey Simpson, Deputy Chief Finance Officer, Tameside and Glossop Clinical Commissioning Group Telephone:0161 304 5449

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

Telephone:0161 922 5544

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TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position: M8

2016/17 Revenue & Capital Monitoring Statements at 30 November 2016 and projected outturn to 31 March 2017

15 December 2016

Stephen Wilde
Tracey Simpson
Ann Bracegirdle

NHS Tameside and Glossop Clinical Commissioning Group

NHS Tameside and Glossop Integrated Care NHS Foundation Trust

Tameside Metropolitan Borough

Section 1 - Care Together Economy Revenue Financial Position

Care Together Economy Revenue Financial Position

Organisation	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Tameside & Glossop CCG	250,941	251,641	(700)	377,978	380,495	(2,517)	(3,188)	671
Tameside MBC	46,043	48,290	(2,126)	69,272	72,643	(3,371)	(3,050)	(321)
Total Single Commissioner	**296,984**	**299,931**	**(2,826)**	**447,250**	**453,138**	**(5,888)**	**(6,238)**	**350**
ICFT Deficit	(11,356)	(11,476)	(120)	(17,300)	(17,300)	0	-	-
Total Whole Economy			**(2,946)**			**(5,888)**	**(6,238)**	**350**

The overall financial position of the Care Together Economy has improved by £350k month on month reducing the projected year end deficit to £5.89m or 1.3% of the full year budget. Key points to note are as follows:

Key Risks in Year End Forecast

- That the CCG QIPP doesn't deliver to current planned levels
- That the current level of Delayed Transfers of Care adversely impacts on the delivery of the Winter Plan with associated financial consequences

Planned Mitigations to Identified Risks

- Ownership of individual QIPP schemes together with rigorous monitoring will ensure delivery
- The Winter Plan reflects an integrated approach across the economy which is essential in managing delayed transfers of care (DTOCs) with implementation of the Home First transformation project critical to managing the level of DTOCs.

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 and timing of the recovery plan. 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 (i.e., reported as green in QIPP/recovery plans). Please note that accruals are included within the year end projections for the Council and not within the year to date totals. The CCG projections include accruals with in both year to date and year end projection total.

Original commissioner financial gap £21.5m. Still need to close £5.9m of this gap which is dependent on a proportion of amber and red schemes delivering in accordance with the optimism bias applied.

Mitigations to adverse variances contained in Year to Date Position

- Continued work to deliver improvement on the CCG QIPP position following submission of recovery plan.
- Continued work to deliver and identify further savings as part of the TMBC QIPP.
- Diligent efforts in striving to deliver the savings target in full. Significant risk attached to this.

Tameside & Glossop CCG

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Acute	132,749	132,003	746	197,643	197,522	121	(20)	141
Mental Health	19,350	19,384	(34)	29,098	29,153	(55)	(97)	42
Primary Care	54,709	55,192	(483)	81,655	82,736	(1,081)	(249)	(832)
Continuing Care	7,568	7,729	(161)	12,251	12,637	(386)	(376)	(10)
Community	18,322	18,296	26	27,559	27,520	39	47	(8)
Other	15,350	16,001	(651)	24,610	23,852	758	69	689
QIPP					2,517	(2,517)	(3,188)	671
CCG Running Costs	2,893	3,036	(143)	5,162	4,558	604	627	(23)
CCG Total	**250,941**	**251,641**	**(700)**	**377,978**	**380,495**	**(2,517)**	**(3,188)**	**671**

Overall there has been an improvement to the CCG's projected year end financial position by just over £1m in the projected year end variance. It is important to note that the majority of this improvement is a result of non-recurrent means and includes:

- Green rated QIPP schemes have increased by £671k to £10,983
- Other changes in outturn position by directorate:
  - **Acute**: Detailed breakdown of movements in acute providers detailed separately
  - **Prescribing**: A full review of prescribing costs has now been completed. This has resulted in a pressure of £757k. The forecast includes an expectation around QIPP achievement and an adjustment relating to number of prescribing days. But the key driver of the underlying pressure is the fact that prescribing volumes in 16/17 have increased by 4.28% in T&G against a benchmark increase of 2.84% in GM and 2.08% nationally.
  - **Continuing Care**: Forecast in line with month 7 to account for overall economy pressure relating to FNC rate increase. Detailed work on value of 16/17 forecast and monitoring arrangements ongoing.
  - **Other:** QIPP findings as above.
  - **Running Costs**: The deterioration in the Running Costs is due to IT expenditure regarding the impending moves from NCH offset by reduction of the Hyperion licences which we no longer use.

- Significant improvement in the CCG QIPP position following submission of recovery plan.
- £10,983k of the £13,500k target is now fully achieved, leaving a residual gap of £2,517k.
- The CCG has a plan to close this residual gap and has reported a post mitigation risk of zero to NHSE at M8, but still work to do to implement this plan.
- Much of the gap is closed non recurrently therefore still work to close gap recurrently in future years.
- CCG planning to:
  - Deliver 1% surplus in 2016/17
  - Keep 1% of allocation uncommitted
  - Maintain Mental Health Investment Target (formerly parity of esteem)
  - Remain within running cost allocation

Recommendations

- Note the updated M8 YTD position and projected outturn
- Acknowledge significant savings required to close the long term financial gap

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 and timing of the recovery plan. 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 (i.e., reported as green in QIPP/recovery plans)

CCG – Provider Performance

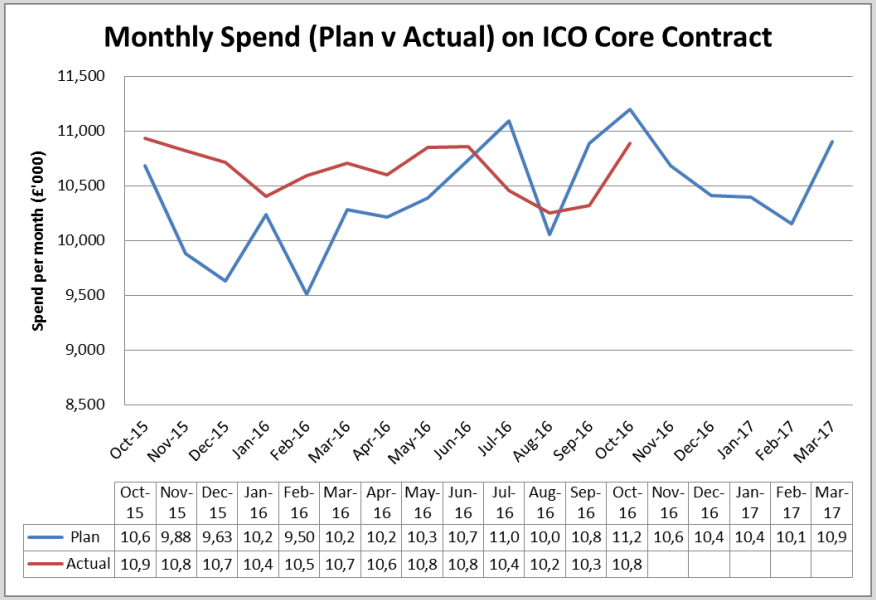
Acute Provider Drilldown

- **ICFT**: We are working towards agreeing a year end settlement with the ICFT which is anticipated to be an underspend against plan.
- Detailed below are the current areas underspending, however, these underspends should be considered in line with the budget profiling discussed under 'Acute TFT Movement' opposite:
  - **Non Elective:** General Surgery at £40k / T&O at £44k / General Medicine at £60k
  - **Critical Care:** £424k underspent YTD
  - **Drugs**: £191k underspent YTD
- **Central Manchester**: Adverse movement of full year forecast due to additional NEL activity - Cardiology (£35k), Nephrology (£44k), General Surgery (£35k) and Critical Care (£146k).
- **Pennine Acute:** Adverse movement of full year forecast due to one high cost patient incurring costs of (£43k) and Critical Care charges of (£12k).

Description	Year to Date			Year End Forecast		
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s
ICFT	85,193	84,442	751	126,575	126,575	0
Central Manchester	14,995	15,552	(557)	22,280	23,037	(757)
Stockport	7,985	7,396	589	11,969	11,114	855
South Manchester	4,344	4,570	(226)	6,568	6,830	(262)
Pennine Acute	2,697	2,623	74	4,029	3,871	158
Salford	2,159	2,259	(100)	3,226	3,478	(252)
WWL	929	798	131	1,409	1,259	150
Bolton	53	51	2	80	85	(5)
CCG Total	**118,355**	**117,691**	**664**	**176,136**	**176,249**	**(113)**

Acute TFT Movement

- The YTD position is underspent by £751k, of which £280k is non-recurrent and relates to cross year excess bed days.
- The graph below shows a spike in the profiling of the budget during July and September. Extending this to October, we have a further increase in budget contributing to the favourable YTD movement. It is expected that this will come back in line with plan over subsequent months so an element of forecast underspend as a year end settlement would seem a reasonable position.



Tameside MBC

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Adult Social Care & Early Intervention	28,052	28,943	(779)	41,995	43,331	(1,336)	(1,347)	11
Childrens Services, Strategy & Early Intervention	17,017	18,293	(1,276)	25,877	27,791	(1,914)	(1,582)	(332)
Public Health	973	1,054	(71)	1,400	1,521	(121)	(121)	-
TMBC Total	**46,043**	**48,290**	**(2,126)**	**69,272**	**72,643**	**(3,371)**	**(3,050)**	(321)

Overall the TMBC year end forecast position has deteriorated by £0.3m since period 7 increasing the projected year end variance to c.£3.4m, 7.3% on the current year's net budget. An explanation of the movements and other background is provided below:

Children's Social Care

- Additional temporary social workers recruited to address caseload capacity (£0.5m), additional external residential and foster care placements (£0.4m), planned savings initiatives yet to be realised (£0.9m), additional minor variations (£0.1m).

Public Health

- 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 projected outturn estimate. This is partial offset by underspends elsewhere within Public Health.

Adult Social Care

- Changes to the regulations associated with the Better Care Fund has created a pressure of £1.12m
- CCTV - The service has a projected deficit of £0.100m. A service review is underway in this area to reduce expenditure where appropriate. Updates will be provided in future reports.

Recommendations

- Note the updated M8 YTD position and projected outturn
- Acknowledge risk in relation to achieving balanced 2016/17 financial position

Tameside & Glossop Integrated Care NHS Foundation Trust (ICFT)

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Income	135,590	137,443	1,853	202,785	205,184	2,399	205,137	(47)
Expenditure	140,688	143,184	(2,496)	210,707	213,803	(3,096)	213,749	(54)
Earnings before interest, taxes, depreciation and amortisation	(5,098)	(5,741)	(643)	(7,922)	(8,619)	(697)	(8,612)	7
Net Deficit after Exceptional Costs	**(11,356)**	**(11,476)**	**(120)**	**(17,300)**	**(17,300)**	**-**	**(17,300)**	**-**

Financial Position

- For the 8 months to November 2016, the ICFT is delivering a deficit of £11.5m, broadly on line with plan.
- The year end forecast is for the planned £17.3m deficit, and assumes the following;
  - Delivery of the £7.8m Efficiency savings target
  - Delivery of the Tameside and Glossop CCG contract
  - Small over performance on all associate PbR contracts
  - Financial and performance criteria for receipt of £6.5m Sustainability and Transformation funding (STF) is achieved.
  - £17.3m working capital/loan is received to fund the deficit position.
  - Agency expenditure does not increase significantly

Key Risks to the Financial Position

- Under-performance of savings target – c.£1.8m of schemes are currently rag rated medium or high risk.
- Increased expenditure on agency staffing.
- Additional unplanned expenditure due to winter pressures.
- Savings relating to transformation schemes delayed.
- Performance targets requiring unplanned expenditure to use the independent sector.

Closing the Financial Gap

Establishing the Financial Gap

- Current financial gap across the health and social care economy in Tameside & Glossop is estimated to be £70.2m by 20/21.
- In 16/17 the opening gap was £45.7m. This is made of £13.5m CCG, £8m council and £24.2m ICO. Progress towards closing these gaps has been made throughout the year.
- The provider gap represents the 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 £17.3m.
- An updated position for 2017/18 and subsequent years will be presented after budget setting is completed in January 2017.

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**

Closing the Financial Gap - CCG

- CCG recovery plan submitted to NHS England which demonstrates initiatives which would allow the CCG to close the £13.5m 16/17 gap and deliver required surplus.

Summary of QIPP £'000s	2016/17 R	A	G	Total	2017/18 R	A	G	Total
PRIORITY 1 - Prescribing	1,449	0	0	**1,449**	1,123	1,393	0	**2,516**
PRIORITY 2 - Effective Use of Resources / Prior Approval	0	0	0	**0**	0	1,500	0	**1,500**
PRIORITY 3 - Demand Management	0	0	500	**500**	828	5,318	0	**6,146**
PRIORITY 4 - Single Commissioning Function Responsibilities	0	120	543	**663**	0	486	523	**1,009**
PRIORITY 5 - Back Office Functions and Enabling Schemes	250	0	0	**250**	500	1,000	0	**1,500**
PRIORITY 6 - Governance	0	30	0	**30**	0	100	0	**100**
Other Schemes in progress/achieved:								
Neighbourhoods	0	0	460	**460**	0	525	230	**755**
Primary Care	0	0	698	**698**	0	312	1,000	**1,312**
Mental Health	0	0	232	**232**	500	0	232	**732**
Acute Services - Elective	0	110	500	**610**	500	59	500	**1,059**
Enabling Schemes to facilitate QIPP	0	0	0	**0**	0	1,682	0	**1,682**
Technical Finance & Reserves	0	370	4,992	**5,362**	0	0	4,382	**4,382**
Other efficiencies	0	603	3,058	**3,661**	4,388	0	28	**4,416**
Grand Total:	1,699	1,233	10,983	**13,915**	7,839	12,374	6,895	**27,108**
Including adjustments for Optimum bias	170	617	10,983	**11,769**	784	6,187	6,895	**13,866**
10% of red rated schemes will be realised								
50% of amber rated schemes will be realised								
100% of green rated schemes will be realised								

- Savings identified exceed the target by £415k but after allowing for optimism bias, this becomes a shortfall of £1.731m.
- Analysis of recurrent vs. Non Recurrent savings:

Recurrent vs Non Recurrent	2016/17	2017/18
Recurrent Savings	**3,709**	**21,158**
Red	1,699	7,011
Amber	260	12,134
Green	1,750	2,013
Non Recurrent Savings	**10,206**	**5,950**
Red	0	828
Amber	973	240
Green	9,233	4,882
Total	**13,915**	**27,108**

Closing the Financial Gap - TMBC

Service	Savings Area	Detail	2016/17			
			R	A	G	Total
Public Health	Savings found	Planned Reduction to annual management fee payable to Active Tameside and other incidental savings			217	217
		Reduction in Community Services contract value - agreed with ICO			169	169
	Additional resource (projected cost pressures)				49	49
	Reduction in estimated capital financing repayments	Reduction in capital financing costs in 2016/17 due to rephasing of works to reconfigure Active Tameside estate			456	456
	Savings still to be found			490		490
	sub total Public Health		**-**	**490**	**891**	**1,381**
Adult Social Care	Additional resource (projected cost pressures)				3,908	3,908
	Savings still to be found	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.	997			997
	sub total Adult Social Care		**997**	**-**	**3,908**	**4,905**
Childrens Social Care	Savings found	Reduction to inflationary increases that were projected to materialise during 2016/17.			120	120
	Additional resource (projected cost pressures				1,215	1,215
	Savings still to be found	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.	379			379
	sub total Childrens Social Care		**379**	**-**	**1,335**	**1,714**
TOTAL			**1,376**	**490**	**6,134**	**8,000**
Including adjustment for Optimism Bias			138	245	6,134	**6,517**
	10% of red rated schemes will be realised					
	50% of amber rated schemes will be realised					
	100% of green rated schemes will be realised					
QIPP Target						**8,000**
Savings still to be found after accounting for optimism bias						**1,483**

Commissioner Financial Risk within the ICF

- Main financial risks within ICF are listed to the right
- Detailed registers which include further information about the risk and mitigating actions are reviewed by Audit Committee. Copies are available on request.
- Key changes to the financial risks since last month:
  - The probability of failing to close the financial gap has reduced in the current financial year, so the RAG has been reduced from Red to Amber.
  - There is an increased probability that the GP prescribing budgets will overspend, so the RAG has been increased from Amber to Red.
  - Due to the progress made in the CCG's recovery plan, the risk of not maintaining expenditure within the revenue resource limit and not achieving the 1% surplus has significantly reduced. The risk status has therefore been amended to Green.
  - Due to increased dependency levels of those placed in care homes and the associated cost pressures, the risk has been changed from Amber to Red.
  - Significant demand and associated financial pressures in the care home market nationally is resulting in an increased probability of provider failure.

Extracts From the Corporate Risk Registers	Probability	Impact	Risk	RAG
The achievement of meeting the Financial Gap recurrently.	3	4	12	A
Over Performance of Acute Contract	3	4	12	A
Not spending transformation money in a way which delivers required change	2	4	8	A
Over spend against GP prescribing budgets	4	4	16	R
Over spend against Continuing Health Care budgets	2	3	6	A
Operational risk between joint working.	1	5	5	A
CCG Fail to maintain expenditure within the revenue resource limit and achieve a 1% surplus.	1	4	4	G
In year cuts to Council Grant Funding	2	3	6	A
Care Home placement costs are dependent on the current cohort of people in the system and can fluctuate throughout the year	4	4	16	R
Looked After Children placement costs are volatile and can fluctuate throughout the year	3	4	12	A
Unaccompanied Asylum Seekers	4	3	12	A
Care Home Provider Market Failure	3	5	15	R
Funded Nursing Care – impact of national changes to contribution rates	4	3	12	A

Other Significant Issues

Tameside Better Care Fund

- Tameside Better Care Fund plan for 16/17 was approved by NHS England on 1 September 2016.
- Plan meets all requirements and funding has been released subject to spend being consistent with final approved plan.
- All spend is monitored through the Integrated Care Fund and is being spent in the following areas:

Scheme name	2016-17 budgets (£000's)		
	CCG	TMBC	Total
Urgent Integrated Care Service	**578**	**2,374**	**2,952**
IRIS	578	1,338	1,916
Early Supported Discharge Team		286	286
Community Occupational Therapists		750	1,974
Localities	**412**	**3,265**	**3,677**
Telecare/Telehealth	174	667	841
ICES (Joint Loan Store)	238	450	688
Reablement Services		2,148	2,148
Carers Support (in line with National Conditions of Care act related funding)	**412**	**-**	**412**
Carer Breaks (Adults)	412	-	412
Primary Care (£5 per head for over 75's)	**1,070**	**-**	**1,070**
Existing Grant - Disabled Facilities Grant	**-**	**1,978**	**1,978**
Impact of New Care Act Duties	**-**	**529**	**529**
Integration Pump Primimg	**982**	**-**	**982**
Maintaining Services	**-**	**4,801**	**4,801**
Mental health Services		2,450	2,450
Adult Social Care - Community based Services (Inc care Homes)		2,351	2,351
Contingency	**900**	**-**	**900**
Total	4,354	12,947	17,301
	Funded by (£000's)		
NHS Tameside & Glossop CCG			15,323
Central Funded Grants			1,978
Total BCF Fund			17,301

Derbyshire Better Care Fund

- Derbyshire Better Care Fund for 16/17 has also been approved by NHS England.
- Plan meets all requirements and funding has been released subject to spend being consistent with final approved plan.

Scheme name	Hosted by DCC/Other CCGs		
	CCG	CCGs	Total
	£000's		
Community Home & Hospital Enhanced care team	**-**	**23,138**	**23,138**
Reablement Services / Community services		18,287	18,287
CDM & Discharge Ward		2,877	2,877
Mental Health		1,974	1,974
Primary Care	**164**	**1,529**	**1,693**
Intergration Pump priming		**8,051**	**8,051**
Maintaining Services	**284**	**24,801**	**25,085**
Maintaining Eligibilty Criteria			-
LCCTS	284		284
Adult Social care		24,801	24,801
Demographic pressures			-
Total	448	57,519	57,967
	Funded by (£000's)		
NHS Tameside & Glossop CCG			2,212
Other CCGs and Central			55,755
Total BCF Fund			57,967

Other Significant Issues

Funded Nursing Care

- 40% increase in health contribution toward FNC cases has been agreed nationally. The assessment of the impact to the whole economy has been completed and the additional cost is estimated to be £189k.
- This is an interim change until December 2016 pending the outcome of a national review into FNC charges. There is an element of the rate for agency nursing staff (which could lead to a reduction of the rate in the future regional variation)

Transformation Funding

- Transformation funding of £23.2m has been approved by Greater Manchester Health & Social Care Partnership. The Investment Agreement that will support the release of the funding been developed and was signed on 16th December 2016. The year 1 funding of £5.2m has now been made available to the economy.

Integrated Commissioning Fund 2016/17

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Acute	132,749	132,003	746	197,643	197,522	121	(20)	141
Mental Health	19,350	19,384	(34)	29,098	29,153	(55)	(97)	42
Primary Care	54,709	55,192	(483)	81,655	82,736	(1,081)	(249)	(832)
Continuing Care	7,568	7,729	(161)	12,251	12,637	(386)	(376)	(10)
Community	18,322	18,296	26	27,559	27,520	39	47	(8)
Other	15,350	16,001	(651)	24,610	23,852	758	69	689
QIPP	0	0		-	2,517	(2,517)	(3,188)	671
CCG Running Costs	2,893	3,036	(143)	5,162	4,558	604	627	(23)
CCG sub-total	**250,941**	**251,641**	**(700)**	**377,978**	**380,495**	**(2,517)**	**(3,188)**	**671**
Adult Social Care & Early Intervention	28,052	28,943	(891)	41,995	43,331	(1,336)	(1,347)	11
Childrens Services, Strategy & Early Intervention	17,017	18,293	(1,276)	25,877	27,791	(1,914)	(1,582)	(332)
Public Health	973	1,054	(81)	1,400	1,521	(121)	(121)	-
TMBC sub-total	**46,043**	**48,290**	**(2,247)**	**69,272**	**72,643**	**(3,371)**	**(3,050)**	**(321)**
Grand Total	**296,984**	**299,931**	**(2,947)**	**447,250**	**453,138**	**(5,888)**	**(6,238)**	**350**
A: Section 75 Services	**154,253**	**155,323**	**(1,069)**	**232,295**	**234,629**	**(2,334)**		
CCG	126,324	126,030	294	190,275	190,565	(290)		
TMBC	27,929	29,292	(1,363)	42,020	44,065	(2,045)		
B: Aligned Services	**121,767**	**123,440**	**(1,672)**	**183,380**	**186,500**	**(3,120)**		
CCG	103,654	104,442	(788)	156,128	157,922	(1,794)		
TMBC	18,113	18,998	(884)	27,252	28,578	(1,326)		
C: In Collaboration Services	**20,962**	**21,169**	**(207)**	**31,574**	**32,009**	**(434)**		
CCG	20,962	21,169	(207)	31,574	32,009	(434)		
TMBC	-	-	-	-		-		

Section 2 - Care Together Economy Capital Financial Position

Tameside MBC

Scheme	Approved Capital Programme Total £'000s	Approved 2016/2017 Allocation £'000s	Expenditure to Month 8 £'000s	Projected Expenditure to 31 March 2017 £'000s	2016/2017 Projected Outturn Variation £'000s	Comments
Childrens Services - In Borough Residential Properties	912	912	618	750	162	Purchase of 2 additional in-borough properties including associated property adaptations. An Edge of Care establishment is yet to be purchased
Public Health - Leisure Estate Reconfiguration	20,268	5,203	3,174	4,064	1,139	Active Dukinfield - The scheme is on budget with an anticipated opening date of 9th January 2017. Active Longendale (Total Adrenaline) - The scheme is on budget and opened on 19th November 2016. Active Hyde – Work due to start on site on February/March 2017 with completion scheduled for November/ December 2017. Denton Wellness Centre – Layout plans and development agreement being established. Facility to be completed late 2018. The programme total of all schemes includes the sum of £ 2.650 million which will be wholly financed by Active Tameside.
Adult Services - Disabled Facilities Grant - Adaptations	1,978	1,978	749	1,978	0	
Total	**23,158**	**8,093**	**4,541**	**6,792**	**1,301**	

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Cover

Q2 2016/17

Health and	**Tameside**

completed	Ali Rehman
E-Mail:	ali.rehman@nhs.net
Contact Nu	0161 366 3207
Who has si	Members of the Health and Wellbeing Board

Question Completion - when all questions have been answered and the

	No. of questions answered
1. Cover	**5**
2. Budget A	**1**
3. National	**36**
4. I&E	**15**
5. Supporti	**13**
6. Addition	**63**
7. Narrativ	**1**

Budget Arrangements

Selected Health and Well Being Board:	Tameside

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

Footnotes:

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

National Conditions

Selected Health and Well Being Board: Tameside

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

Condition (please refer to the detailed definitio	Q1 Submission Response	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	Yes			1
2) Maintain provision of social care services	Yes	Yes			1
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes			1
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	Yes			1
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	No - In Progress	No - In Progress	01/02/2017	The fixed dark fibre connection between tameside MBC and Tameside Hospital Foun	1
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes			1
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes			1
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes			1
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes			1
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes			1
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes			1
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes			1

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.

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.

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:

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

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,

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.

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:

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.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in

Selected Health and Well Being Board: Tameside

Income

Previously returned data:

51 52 53 54
55 56 57 58
59

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

Q2 2016/17 Amended Data:

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

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	

Expenditure

Previously returned data:

61 62 63 64
65 66 67 68
69

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

Q2 2016/17 Amended Data:

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

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	The Council do not enter monthly accruals, on this basis the timing of spend differs slightly between quarters, this is simply a phasing issue and will resolve itself in subsequent quarters.

Commentary on progress against financial plan:	It is expected that the allocation will be fully utilised by the end of March 2017

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. Pre-populated Plan, Forecast and Q1 Actual figures are sourced

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 9% increase against plan in regards to Ambulatory Emergency Care and the Alternative to Transfer and Integrated Urgent Care Team are providing alternatives to A&E attendance

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:	Work is taking place to clarify the reporting and establish if the figure includes the community beds being managed by the ICFT Our Home First model includes a Discharge to Assess process that will reduce DTOCs significantly. The early adopter wards are significantly

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	
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	Annual - Adult Social Care Survey The information in the template needs to be amended, the 61.6 relates to 2013-14 out-turn and the 64.51 relates to 2014-15 out-turn. No

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.

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	This indicator is an annual indicator and no further data is available, the measure captures all service users 65+ who have been discharged from hospital into reablement / rehabilitation service for the period October 2016 - December 2016 and then a follow up review is

Footnotes:

For the local performance metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB.
For the local defined patient experience metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB, except in cases where HWBs provided a

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	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution

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

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Live	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable
Projected 'go-live' date (dd/mm/yy)				31/07/17		

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	4.1
Number of new PHBs put in place during the quarter	3
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?	No - nowhere in 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?	No - nowhere in 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
Population figures were updated to the mid-year 2016 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Boa	Tameside

Remaining Characters	32,222

Please provide a brief narrative on overall progress, reflecting on performance in Q2 16/17. A recommendation would be to offer a narrative around the stocktake themes as below:
Our Transformation Plans are being implemented at both commissioner and provider levels. 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. 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.'

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	19 January 2017
Board Member / Reporting Officer:	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 November 2016
Recommendations:	The Health and Wellbeing Board is asked to note the progress of the Care Together Programme including the strategic and operational aspects; and receive a further update at the next meeting.
Links to Community 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. The healthcare system in Tameside & Glossop has a projected £70m financial gap by 2020/21 which the Care Together Programme is designed to address.
Financial Implications: **(Authorised by the Section 151 Officer))**	The Finance Economy Wide Group meets fortnightly to ensure effective tracking of the locality finances and projections, reporting through to the Care Together Programme Board for further review. It is essential that the approved GM Health and Social Care Partnership funding is expended in accordance with the investment agreement and recurrent efficiency savings are subsequently realised across the economy.
Legal Implications: **(Authorised by the Borough Solicitor)**	It is important to recognise that the Integration agenda, under the auspices of the 'Care Together' banner, is a set of projects delivered within each organisation's governance model and now to be delivered jointly under the Single Commissioning Board together with the Integrated Care Organisation FT. 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.
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:
- Greater Manchester Health and Social Care Partnership;
- Operational Progress;
- Organisational updates;
- Recommendations.

2. GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP

2.1 On 30 September, the Partnership Strategic Partnership Board ratified the full transformational funding award of £23.226m to Tameside and Glossop economy over four financial years.

2.2 Work commenced with the Greater Manchester Health and Social Care Partnership (GMHCP) thereafter to develop our investment agreement. Inclusion in this was implementation and delivery milestones to measure progress against the national "must do's" and our transformation priorities as outlined in the Cost Benefit Analysis submission.

2.3 The full suite of documentation for the Investment Agreement was submitted, reviewed and refined over three weeks, with final submission taking place on 2 December.

2.4 The Investment Agreement was formally signed on 16 December by:
- Councillor Kieran Quinn - Executive Leader – TMBC
- Karen James - Chief Executive – Tameside and Glossop Integrated Care Foundation Trust)
- Lord Peter Smith - Chair – Greater Manchester Health and Social Care Strategic Partnership Board)
- Dr Alan Dow - Chair – Tameside and Glossop Single Commissioning Board
- Steven Pleasant - Chief Executive – Tameside MBC and Accountable Officer of Tameside and Glossop CCG.

2.5 Of the full £23.226m awarded, £5.2m is allocated to this financial year. £2.6m will be released for Q3 by NHS England to the CCG, and subject to further clarity on milestones and progress towards achieving the national must do's, the £2.6m for Q4 will be released in February 2017.

2.6 Monitoring of the Investment Agreement within the locality will take place on a monthly basis, with progress updates provided to Greater Manchester on a quarterly basis.

2.7 The transformational funding award unfortunately does not include any capital for IM&T and Estates. The Programme Support Office continues to liaise with Greater Manchester Health and Social Care Partnership, and NHS Improvement to understand the potential for funding bids and progress will be continually provided to this Board.

3. OPERATIONAL PROGRESS

Programme Management

3.1 The new Care Together (CT) programme structure will be implemented from January 2017 and will see the CT Programme Board move to quarterly meetings instead of monthly.

3.2 Priority programmes of work, such as the potential transfer of Adult Social Care services into the Integrated Care Organisation Foundation Trust (ICFT) require dedicated

resources, and as such, resources from the Care Together Programme have been deployed to work on this.

3.3 In addition, as the programme moves towards implementation phase, the Care Together Programme Support Office will need to be enhanced to provide the necessary system assurance. As this is needed quickly, it was proposed to procure some management consultancy support to set up the necessary systems which inspire confidence across the system.

3.4 A specification for acquiring additional support for the Care Together Programme has been developed and agreed, and the procurement process will formally commence towards the end of December.

Adult Social Care Transaction

3.5 The Adult Social Care Transaction Board continues to meet monthly, a full business case and due diligence process is being developed to ensure organisational and regulatory approval for the transfer. The business case is due to be signed off in February.

3.6 Workstreams have been agreed and will be established by mid-January.

Integrated Neighbourhoods

3.7 Three Integrated Neighbourhood managers have now been appointed. This is a significant milestone towards achieving our vision for the neighbourhoods, overseeing multi-disciplinary teams working jointly across health and social care to ensure the best possible outcomes for our local people.

3.8 The Integrated Neighbourhood Managers will be taking up post (dates to be agreed) in the first three months of 2017.

Savings Assurance

3.9 In November, the Locality Executive Group (LEG) discussed the importance of aligning the financial work across the locality to provide a holistic view of progress against the financial gap.

3.10 To facilitate the in-depth support and challenge required, it was agreed to set up 2-3 half day sessions in January to test the robustness of action plans in each scheme. It is anticipated that these sessions will:

- Confirm the Senior Responsible Officer and accountability for each scheme, key team leads and savings target for 17/18 and out to 20/21;
- Review the action plans of each scheme;
- Agree on the level of savings achievable in 17/18;
- Confirm if any additional support is required to ensure delivery of targets.

Operational plans and new contract

3.11 The contract for the Integrated Care Foundation Trust has now been agreed, and is due to be submitted to NHS England on 23 December, along with finalised Operational and Activity plans for the next two years.

4. ORGANISATIONAL UPDATE

Single Commissioning Function

4.1 As part of the drive to improve efficiency and reduce the costs of commissioning, New Century House is on track to be vacated at the end of the financial year. Plans are in place to move the whole Single Commissioning team to a new Council owned location(s).

4.2 Regular briefings have been scheduled to support staff through the process, with an indication of where they may be re-located to, and the ability to ask any questions to the Directors face to face, as well as full FAQ's on the intranet.

Integrated Care Organisation

4.3 The governance of the models of care is currently being reviewed and revised within the Integrated Care Foundation Trust to take into account a move towards implementation phase.

4.4 As such, a new Joint Management Team has been established in Tameside and Glossop Integrated Care NHS Foundation Trust to lead the implementation work, standing down the Models of Care Steering Group. It met for the first time on 21 December. Chaired by the Trust's Chief Executive, Karen James, it will bring together the Trust's executive team and clinical directors with the clinical GP leads for the five neighbourhoods and the lead directors for public health and social services.

5. NEXT STEPS

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

- Monitoring and reporting of the Investment Agreement;
- Agree financial sustainability plan for the economy;
- Procurement of additional Programme Support
- Development and sign off of the business case for the transaction of adult social care into the Integrated Care Organisation;
- First round of savings assurance meetings held in January;
- Continued discussions to determine options for aligning primary care outcomes alongside those of the Integrated Care Organisation and therefore for the whole population;
- Continue review of Mental Health Contract for the locality, to be completed by the end of the financial year.
- Developing and implementing a measurement framework which accurately ensures our planned transformational schemes are improving the healthy life expectancy of the Tameside and Glossop population.

6. RECOMMENDATIONS

6.1 As set out on the front of the report.

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	19 January 2017
Board Member/ Reporting Officer:	Karen James, Chief Executive – Tameside and Glossop Integrated Care Foundation Trust
Subject:	**UPDATE ON HEALTHY NEIGHBOURHOOD PROGRAMME**
Report Summary:	The attached presentation gives Board members an update on the development of the Healthy Neighbourhood Model and implementation in Tameside and Glossop.
Recommendations:	The Health and Wellbeing Board are asked to note the presentation.
Links to Health and Wellbeing Strategy:	The Healthy Neighbourhoods Model links to all the life course priorities of the Health and wellbeing Strategy in particular Living and Ageing Well.
Policy Implications:	There are no policy implications relating to this presentation.
Financial Implications: **(Authorised by the Borough Treasurer)**	The financial position underpinning the Neighbourhood approach and how it will assist in achieving a sustainable health & social care financial economy is set out in the economy wide finance report previously considered on the agenda at item 8.
Legal Implications: **(Authorised by the Borough Solicitor)**	The Integrated Neighbourhood model is our agreed approach for the neighbourhoods, overseeing multi-disciplinary teams working jointly across health and social care to ensure the best possible outcomes for our local people. It is our key approach to reducing costs significantly and improving outcomes for Tameside & Glossop. It is critical that expedient progress is made to deliver the step change in service delivery, reduce health inequality and deliver a sustainable financial health & social care economy.
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 Janice Douglas: Telephone: 0161 922 6002 e-mail: Janice.douglas@tgh.nhs.uk

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Healthy Neighbourhoods

Karen James
CEO, Tameside & Glossop Integrated Care NHS Foundation Trust

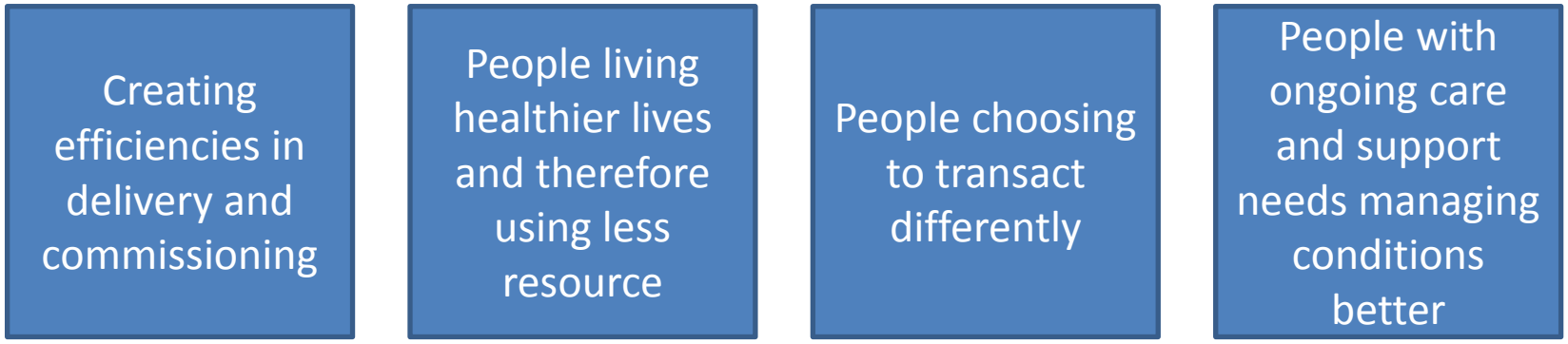
January 2017

NHS Tameside and Glossop Clinical Commissioning Group

NHS Tameside and Glossop Integrated Care NHS Foundation Trust

Tameside Metropolitan Borough

System savings can be derived in four ways



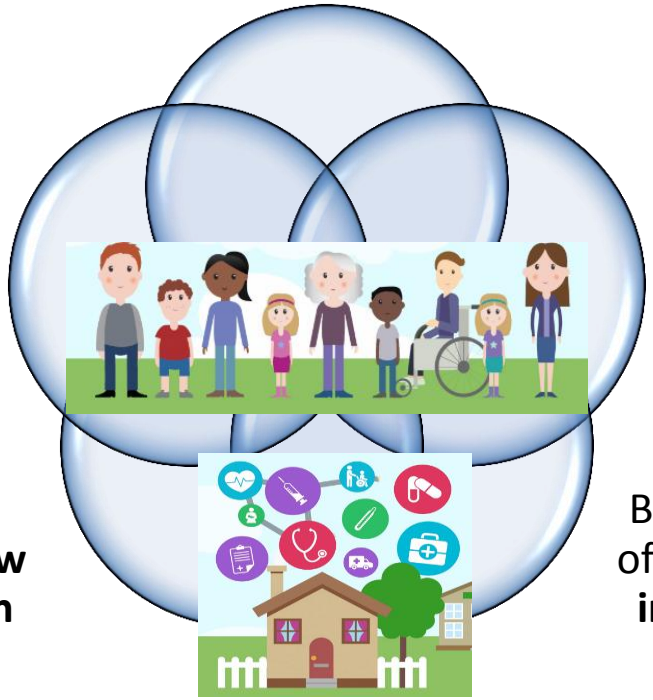
- Three out of the four areas identified above are not rooted in the system, but in people's homes, their lives and their communities.
- Our focus must therefore be on delivering integrated neighbourhood care and support for people that builds on the assets in our communities.

Principles of Integrated Neighbourhood working

Tameside and Glossop Integrated Care NHS Foundation Trust

Person centred approach within the context of family & community

Within the community, **close to home** from a flexible asset base



Local services **responsive** to local need

Services that **know their area & each other**

Build on the assets of the community & **intervene early** in an emerging problem

The Neighbourhood Approach

NHS
Tameside and Glossop Integrated Care
NHS Foundation Trust

5 Neighbourhoods
- North , South, East, West Tameside & Glossop

Multi-disciplinary teams: Primary care, community, social care, MH, voluntary/community sector

Linked to planned and urgent care systems & "intermediate" tier

Linked to wider Public Service Reform Hubs involving Police, Fire & Rescue, housing, education, work & health etc

New Neighbourhood Director, senior managers and administrative support for neighbourhoods as part of the ICO FT

Core offer across all five neighbourhoods with scope for local prioritisation once established and operating effectively

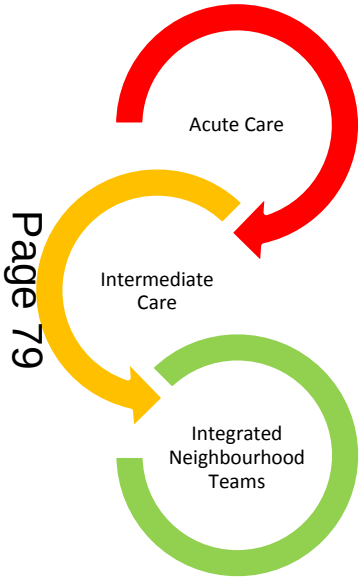
Pro-active, risk based approach focused on frequent service users

Adopt biopsychosocial model of care – look at person's whole care and support needs

Everyone Matters

Intermediate Tier

Tameside and Glossop Integrated Care NHS Foundation Trust



Intermediate Care Services

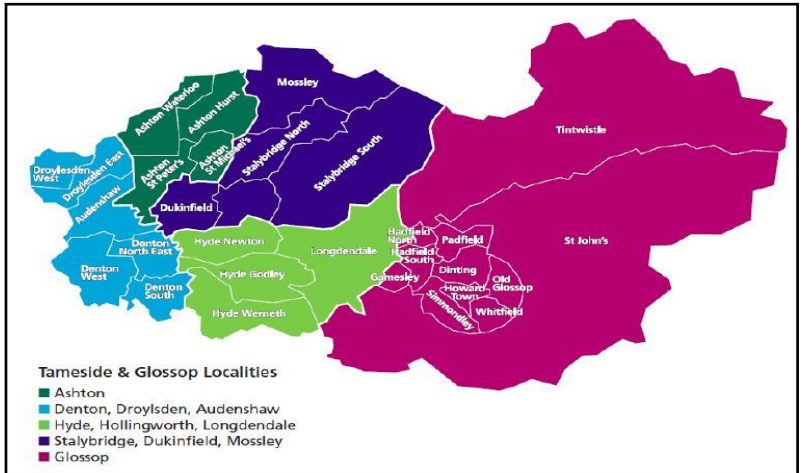
- Integrated Urgent Care Team
- *Re-ablement*
- *Community bed base*
- *Intermediate care at home*
- *IV Therapy Services*
- *Long Term Conditions Team*
- *Extensive Care Service*
- *End of Life Teams*
- *Mental Health*
- *Pharmacy*

Everyone Matters

Extensive Care

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

- The Extensive Care Service is part of the Neighbourhood ***core*** offer.
- This will be a targeted wrap-around tailored service to provide care for a risk stratified cohort of patients to reduce unnecessary crisis admissions and hospital attendances.



System Wide Self Care

Tameside and Glossop Integrated Care NHS Foundation Trust

- **Common areas of social prescribing;**
  - Peer Support
  - Self management education
  - Health coaching
  - Advocacy
  - Support with debt and housing issues
  - Information and advice
  - Community activities
  - Befriending
  - Community transport
  - Complementary therapies
  - Carers' respite

Questions & Discussion

NHS
Tameside and Glossop
Clinical Commissioning Group

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Tameside
Metropolitan Borough

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	19 January 2017
Board Member / Reporting Officer:	Clare Watson, Director of Commissioning
Subject:	**PRIMARY CARE BRIEFING – PRIORITIES AND SCOPE 2017-2021**
Report Summary:	This report provides a briefing on the priorities and scope for primary care over the next two to five year based on the national and regional strategies set out through the Five Year Forward View, General Practice Forward View, New Models of Care: The new models of care and contract framework, NHS Operational Planning and Contracting Guidance 2017-19 and Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021.
Recommendations:	1. Note the scale of the ambition for Primary Care nationally. 2. Support the delivery of this ambition through our local implementation, development of neighbourhoods and progression of new models of working and through the refresh of the Primary Care Quality Scheme. 3. Acknowledge the competing priorities on scarce financial resource and the CCG investment already in place as part of the Primary Care Quality Scheme, noting the refresh of this aligned to national policy and GM standards, and the investment in respect of neighbourhoods through Transformation Fund.
Links to Health and Wellbeing Strategy:	Improved care and outcomes, a focus on early intervention and prevention for all patients are priorities of the H&W Strategy.
Policy Implications:	Mets the legal policy framework.
Financial Implications: **(Authorised by the Section 151 Officer)**	Primary Care expenditure can fall into all three elements of the Integrated Commissioning Fund but this is predominantly in the Aligned and In Collaboration Budget areas. Although this briefing identifies potential funding streams for primary care collated from various operational planning guidance, this must be treated with caution. Clarity is required but it would be prudent to expect little, if any, additional resource and assume this resource inherent within CCG Baselines or Transformation Funds which are already significantly over subscribed with other clinical priorities. The CCG has committed £1.5m to the Primary Care Quality Scheme which will be refreshed with alignment to the priorities of the GP Forward View, planning guidance and GM standards to deliver optimum use of this resource.

Legal Implications: **(Authorised by the Borough Solicitor)**	The statutory requirements for submission of CCG plans and GP Forward View plans are detailed.
Risk Management :	None, this is a briefing report only as any specific issues will be addressed in subsequent detail.
Access to Information :	The background papers relating to this report can be inspected by contacting Janna Rigby, Head of Primary Care Telephone: 07342 056001 e-mail: janna.rigby@nhs.net

1. INTRODUCTION

1.1. The strategy for Primary Care over the next two to five years is outlined throughout a number of national and regional documents, with links to each included at **Appendix 1**;

- The Five Year Forward View, published October 2014.
- The General Practice Forward View, published April 2016.
- New Care Models: The multispecialty community provider emerging care model and contract framework, published July 2016.
- NHS Operational Planning and Contracting Guidance 2017-2019, published September 2016.
- Greater Manchester Primary Care Strategy (Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021), published September 2016.

1.2. These documents are closely aligned and interlinked and all outline the need for system wide changes to ensure the NHS can deliver the right care, in the right place, with optimal value. The framework was first outlined in the Five Year Forward View with the clear task to "drive improvements in health and care; restore and maintain financial balance; and deliver core access and quality standards". This is translated to describe localities position in their Sustainability and Transformation Plans.

2. CONTEXT

2.2. Primary Care – whether provided by doctors, dentists, optometrists, pharmacists or other health and care practitioners who support people outside hospital – already benefits our local population. It offers easy access, high quality care from professionals who know their patients and can make a big difference to health outcomes.

2.3. There are many health and care related issues that could be addressed by improvements both to primary care generally and to specific services, in particular by ensuring we all work together and make the most of every opportunity to give people the right support close to where they live. How people use, or do not use, primary care is an indication of the scale of the challenge; this is alongside an ageing population, an increasing number of people with more than one long term condition and health inequalities.

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

Locality	Population (TBC)	General medical services contract	Personal medical services contract	Alternative provider medical services contract
Ashton	56,481	7	1	1* registered and WIC
Glossop	31,912	6	1	0
Stalybridge	43,545	9	0	1
Denton	49,594	5	0	2
Hyde	62,392	6	2	0
Total	243,624	33	4	4

2.5 We have a mixed economy of contracts, although the majority are general medical services.

- General medical services contract is the standard national general practice contract.
- Personal medical services contracts are locally contracted, specified and priced.
- Alternative provider medical services contracts locally were for the new practices that were commissioned to increase the number of GPs in an under-doctored locality.

This was a national initiative, with the make-up of the contracts determined locally based on the needs of the population served.

- General medical services contracts are nationally negotiated and run in perpetuity (subject to quality, performance etc.).
- Personal medical services contracts, although locally specified and priced, have recently undergone a nationally imposed review to bring the contract value more in line with general medical services.
- Alternative provider medical services contracts are for a 7 year term, and we are about to start a consultation and engagement exercise with the practice populations before we go through a formal procurement exercise and re-let the contracts. This is a national requirement for all alternative provider medical services contracts

Through its contract, a practice income is made up of Core, Additional and Enhanced elements. The majority of which are nationally prescribed. The Primary Care Trust/Clinical Commissioning Group has invested in locally commissioned services which have allowed practices to develop and deliver enhanced care services for our practice population.

2.6 This can be summarised by the two key principles of the GM Primary Care Strategy:

- **People-powered change** – making sure people receive the right support to take more control of their own health and behaviours;
- **Care delivered by population based models** – making the best possible use of resources available within localities and neighbourhoods.

2.7 Strengthening and transforming general practice will play a crucial role in the delivery of Sustainability and Transformation Plans and in integrating the aims of the GP Forward View into these plans. CCGs will need to document the aims and key local elements of the GP Forward Plan into more detailed local operational plans and submit one GP Forward Plan to NHS England on 23 December 2016; plans need to reflect local circumstances but must, as a minimum, set out:

- How access to general practice will be improved;
- How funds for practice transformational support will be created and deployed to support general practice;
- How ring fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed.

3 OPERATIONAL PLANNING GUIDANCE 'MUST DOS' AMD THE GOVERNMENT'S MANDATE TO NHSE

3.1. The operational planning guidance identifies 9 key 'must dos' for 2017-19, and primary care is a running theme throughout a number these. Primary care is also specified as a 'must do' under its own heading in the form of:

- Ensure the sustainability of general practice in your area by implementing the GP Forward View, including the plans for Practice Transformational Support, and the ten high impact changes.
- Ensure local investment meets or exceeds minimum required levels.
- Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of Improving Access to Psychological Therapies in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems.
- By no later than March 2019, extend and improve access in line with requirements for new national funding.

- Support general practice at scale, the expansion of Multi-speciality Community Provider or Primary and Acute Care System, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.

3.2 Alongside the documents outlined above NHS England are publishing a revised NHS Standard Contract for consultation. This refresh addresses ambition set out in the GP Forward View to enable more seamless care for patients, this includes the requirement for transmitting letter to GPs following clinic attendance in a progressively reducing timescale and also mandates, from April 2017, use of the e-Referral system with acknowledgement of the need to resolve practical issues which currently hinders the use and uptake of e-Referral system in general practice.

3.3 The planning guidance details the government's mandate to NHS England setting the 2020 goals, as with the 'must dos', primary care is a theme through these and is also specifically referenced in the following:

- Patient Experience – measured by the Friends and Family Test, alongside other sources of feedback to improve services.
- New Models of Care – including 100% of population having access to weekend/evening routine GP appointments and 5,000 extra doctors in general practice nationally.
- Technology – 95% of GP patients being offered e-consultation and other digital services and 95% of tests to be digitally transferred between organisations.

3.4 Primary Care, across the whole workforce within General Practice, Pharmacy, Optometry and Dental, has a key role in preventative intervention and signposting to support in the delivery of, for example but not limited to, cancer, obesity and diabetes, dementia, health and social care integration and mental health, learning development and autism targets.

4. NEW MODELS OF CARE

4.1. The theme throughout all the documentation is around system wide changes and transformation of services to change the way patients access care, self-care and benefit from population based care models. This place based approach of new models of care will break down the boundaries between different types of provider and foster stronger collaboration across services. This starts with Primary Care at Scale and grows to centre around a Multi-specialty Community Provider. This is not a new form of practice based commissioning or the recreation of a Primary Care Trust but is the delivery of primary and community based health and care services – not just planning and budgets.

4.2. The local view is that a new model of care would provide the required form in order to formalise and be an enabler for the desired function. Elements of the Multi-speciality Community Provider and/ or Primary and Acute Care System model may be used to ensure local arrangements align to the national principles of these models, however the presence of the Integrated Care Foundation Trust means that a different approach is needed in Tameside and Glossop to ensure the commissioning and provision of health and social care services is cohesive. Any new contract will be outcomes-based and the delivery model of this contract will be designed by the provider(s) alongside the Commissioner.

4.3. The building blocks of a Multi-speciality Community Provider or equivalent are the 'care hubs' of integrated teams, each typically serving a community of around 30-50,000 people. A Multi-speciality Community Provider is a place based model of care, it serves the whole population and covers the sum of the registered lists of the participating practices. It is designed to strengthen wider primary care provision and deliver transformed care provision out of hospital to pro-actively manage patients in the community and see a shift in people attending hospital who could be better supported in the community.

4.4. The work of the five Integrated Neighbourhoods across Tameside and Glossop will continue to implement areas of work for their populations. Details of this are included within **Appendix 2.**

4.5. The development of the Integrated Neighbourhoods will be led by Tameside and Glossop Integrated Care Foundation Trust, along with the Commissioning Business Managers and the Neighbourhood Clinical Leads from the CCG, to ensure that this model of care is fully integrated and embedded within the health and social care within Tameside and Glossop.

5. ENHANCED PRIMARY CARE AND EXTENSIVIST MODELS

5.1. A Multi-speciality Community Provider offers an enhanced primary care model which provides a broader range of services in the community integrating primary, community, social and acute care services and aims to improve the physical, mental and social health and wellbeing of the local population. They encourage diverse communities to look after themselves by supporting self-care and connecting people to community assets and resources. They support staff to work in different ways with a focus on team based care and harness digital technology to achieve their goals.

5.2. The extensivist model provides additional support for a small group of patients with high needs and high cost. This model uses risk stratification supported by trigger tools and case finding to identify patients which would benefit and works to provide targeted out of hospital care, fewer unplanned admissions, shorter lengths of stay and few unplanned readmissions.

6. TECHNOLOGY

6.1. The mandate for technology is for 95% of GP patients to be offered e- consultation and digital services and that 95% of tests be digitally transferred between organisations. The GM strategy takes forward the innovative practice taking place across localities and provides links to the new Health Innovation Manchester partnership to accelerate the discovery, development and implementation of new treatments and approaches with a focus on improving health outcomes. This includes the use of digital technology to improve how people access care, how records are shared with the ambition of becoming paper free at the point of care to strengthen primary care to create easier access to services that fit around the patient's family and work life. In line with the self-care culture of people powered change this also offers opportunities to improve access to advice and treatment through technology such as online, real-time video consultation.

7. PRIMARY CARE QUALITY

7.1. The Five Year Forward View, NHS Planning Guidance and Sustainability and Transformation Plans are all driven by the pursuit of the "triple aim":

- Improving the health and wellbeing of the whole population;
- Better quality for all patients through care redesign; and
- Better value for taxpayers in a financially sustainable system.

7.2. To this aim NHS England have introduced a new Improvement and Assessment Framework for CCGs and NHS Improvement have published the Single Oversight Framework. The key themes of the latter include quality of care; assessing whether a provider's care is safe, effective, caring and responsive.

8. GREATER MANCHESTER PRIMARY CARE MEDICAL STANDARDS

8.1. A suite of standards have been co-designed and agreed with the aim of transforming the delivery of primary care to reduce unwarranted variation, adopt a more pro-active approach to health improvement and early detection in order to improve health outcomes for the patient population. These standards are to be implemented by 2017, with similar standards also being developed in dental, optometry and pharmacy, all of which will contribute to the earlier detection of disease, proactive management within the community and supporting patients to self-care. The nine GM medical standards are:

1) Improving access to general practice;
2) Improving health outcomes for patients with mental illness;
3) Improving cancer survival rates and earlier diagnosis;
4) Ensuring a proactive approach to health improvement and early detection;
5) Improving the health and wellbeing of carers;
6) Improving outcomes for people with long term conditions;
7) Embedding a culture of medication safety;
8) Improving outcomes in childhood asthma;
9) Proactive disease management to improve outcomes.

8.2. Locally, proactive engagement around quality and assurance, aligned to the Care Quality Commission work programme will dovetail the delivery of national and regional directives. Utilisation of risk stratification data to understand the needs of specific cohorts of patients and how services and care models can be used to better support these patients is also in place, linked also to the enhanced primary care and extensivist models outlined above.

9. WORKLOAD

9.1. There is pressure on primary care from other parts of the health system resulting in increased workload, problems recruiting and retaining GPs therefore creates further workforce difficulties. The GM strategy illustrates that between 2002 and 2013 GP numbers only increased by 14% compared with a 48% rise in hospital consultants. A third of GPs hope to retire within the next five years and a fifth of current GP trainees plan to move abroad. Other parts of the primary care workforce face similar challenges, for example in practice nursing over 64% of nurses are over 50 and only 3% are under 40. A baseline collection of the current workforce, workload demands will form one element of our GP Forward View plan.

9.2. The potential for clinical pharmacists to reduce the burden on GPs and increase capacity within primary care is already being demonstrated. Locally there are success stories and feedback on the benefits being realised in our practices, resolving day to day medicine issues and requests from pharmacies, providing extra help for patients to manage long term conditions, advice to those on multiple medication and better access to health checks.

9.3. In GP Forward View plans CCGs will want to include a general practice workforce strategy that links to their service redesign plans. These should be clear about the current position, areas of greatest stress, examples of innovative workforce practices, the planned future model and actions to get there, building on the 10 high impact actions to release capacity described in the GP Forward View.

9.4. Improving the way different health and care professionals work together to get the most from what each profession brings to primary care services and individual patient care will help embed best practice in all services and will contribution to delivering the GM vision focusing on place and people rather than specific organisations and professional groups.

10. PRIMARY CARE ESTATES

10.1. The primary care estate varies significantly in terms of quality, condition and suitability and needs to cope with increasing patient activity as more services are developed out of hospital. Vision and direction for primary care estate needs to enable the delivery of place based services across neighbourhoods and make full use of buildings currently available, including patients' own homes, local community services, traditional primary care facilities and other public sector premises. Locally this agenda is being taken forward in a separate workstream.

11. FINANCE

11.1. Under delegated commissioning arrangements the CCG receives an allocation for core primary care commitments; the value of this for 16/17 to 20/21 is detailed below:

• 2016/17	• £30.922m
• 2017/18	• £32.075m
• 2018/19	• £33.041m
• 2019/20	• £34.108m
• 2020/21	• £35.485m

11.2. Although this outlines increases in allocation year on year, this must be measured against unknowns around increased in global sum, changes to the quality and outcomes framework and premises reimbursement regulations and changes in list size, though an element of list size growth is incorporated in allocation uplifts. It would be therefore be prudent to assume these allocation fully committed and any slippage be dealt with on an in year basis.

11.3. In addition to this allocation other primary care funding is potentially available as part of the £500m plus sustainability and transformation package announced in the GP Forward View including potential funding to support improvements. in access to general practice and improvements in estates and technology. As yet, GM Health and Social Care Partnership are seeking clarity on these resources, with particular reference to whether these are genuinely additional resources which GM can access, or whether these are either inherent in the GM Transformation Fund or already in CCG Primary Care baselines. Experience leads us to believe the latter two scenarios are the more likely and if so these resources are already significantly over-subscribed with other "must do" clinical priorities. It is therefore crucial that the whole health and social care economy work collaboratively to achieve optimal outcomes with the scare resources we have.

11.4. The different funding streams reported in various publications have been collated and are summarised in the table below. The third column reports the perceived reality of whether this is genuinely new funding and how this compares to CCG investment:

Operational Planning Guidance Headline	Policy Description	Detail/Tameside and Glossop translation
Transformational support 17/18 and 18/19 from CCG allocations	"CCGs should plan to spend a total of £3 per head of population as a one off non recurrent investment commencing in 2017/18 for practice transformation support as set out in the GP Forward View and can take place over two years, £3 per head in 17/18 or 18/19 or split over the two years. This	This funding is included within CCG core allocations. For Tameside and Glossop, based on list size information at 1 July 2016 this would equate £735,750. The CCG has already committed £1.5m to the Primary Care Quality Scheme which more than

	investment is designed to stimulate development of at scale providers for improved access, stimulate implementation of the 10 high impact actions to free up GP time and secure sustainability of general practice."	adequately addresses this requirement and others noted below. In addition there may be a possibility to address this requirement with links to the Primary Care investment via the GM Transformation Fund.
Online General Practice consultation software systems	This was announced in the GP Forward View with £45m funding for this programme with £15m to be deployed in 2017/18 along with the rules, specification and monitoring arrangements and a further £20m in 2018/19.	For Tameside and Glossop, based on nationally estimated registered populations this will equate to £63,595 in 2017/18 and £84,672 in 2018/19. GM Health and Social Care Partnership are seeking clarity on whether this is genuinely new funding and not already included in the GM Transformation Fund, or the CCG baseline.
Training Care Navigators and Medical Assistants	The £45m, over five years, announced in the GP Forward View for the Training Care Navigators and Medical Assistants programme totals £10m in each of 2017/18 and 2018/19 with £5m allocated in 2016/17.	Locally this allocation equates to, based on estimated registered populations, £21,229 in the current year, £42,402 in 2017/18 and £42,336 in 2018/19. GM Health and Social Care Partnership are seeking clarity on whether this is genuinely new funding and not already included in the GM Transformation Fund, or the CCG baseline.
General Practice Resilience Programme	The £40m non recurrent funding announced in the GP Forward View to be deployed over four years; £16m of which is being allocated in 2016/17. This resource will be delegated to NHS England local area teams on a fair share basis with a number of elements of the package being held centrally pending further information.	This resource will be held by the GM Partnership, detail of how this is to be allocated, including whether or not (and how) practices can self-refer is still unknown and requires confirmation.
Funding to improve access to general practice services	This funding stream allocates £6 per head to those CCGs who had Prime Minister's Challenge Fund pilot sites. The programme expands and includes £3.34 per head of population for remaining CCGs to provide access to pre-bookable and same day appointments to general practice services in evenings, 1.5 hours per day and provision of weekend provision on both Saturday and Sunday to meet local population need.	This should total a minimum additional 30 minutes capacity per 1000 population, rising to 45 minutes per 1000 population. For Tameside and Glossop this equates to £807k of which a recurrent allocation has been received in 16/17 are is therefore now within the CCG baseline with other competing priorities.
Estates and	CCGs were invited to bid for funding	Tameside and Glossop are

Technology Transformation Fund (ETTF)	from 2016/17 onwards.	understood to have been successful in securing capital funding for Union Street Hyde and Hattersley integrated Hub. The details have yet to be verified and account taken of the the additional revenue costs associated with capital funding.

11.5 There is also the potential for some non-recurrent funding which is being held nationally to support GPFV commitments in a number of areas including growing the general practice workforce, premises and the national development programme. In addition there will be potential increases in a number of national lines to support the promised increase in investment for general practice, this includes:

- Increases in funding for GP trainees funded by Health Education England;
- Increases in funding for nationally procured GP IT systems;
- Increases in the section 7A funding for public health services, which support payments to GPs for screening and immunisation services; and
- 3000 new fully funded practice-based mental health therapist to help transform the way mental health services are delivered.

11.6 NHS England has retained some national funds to support workforce developments including international recruitment and clinical pharmacists and Health Education England and NHS England will produce frameworks and models to support the expansion of physician associates, medical assistants and physiotherapists.

11.7 Primary Care is a significant partner in the neighbourhoods for which Transformation Funding has been received of circa £8m and plans are being developed collaboratively with primary care colleagues to deliver holistic services in neighbourhoods.

12. LOCAL IMPLEMENTATION

12.1. Although the neighbourhood model of peer support has been in place for a number of years more recently this has developed and expanded to promote new ways of working across, and by, neighbourhoods. The ambition of this is to improve efficiency and achieve the care delivered by population based models approach. Further alignment of commissioning staff to neighbourhoods has strengthened the support offer and work programme with practices. The review of risk stratification patients, as outlined in the description of the extensivist model, is being implemented locally through this extended support and it is anticipated that this will become embedded in practice culture.

12.2. Following the GM New Models of Care event in early October, a local session was held on 20 October. The national direction of new models of care described through national strategy, although in its infancy in Tameside and Glossop, is moving forward and will further develop through the coming years. We have already seen a change in the way practices are working together; this has further been reflected in the alignment of practices, both formally and informally.

12.3. Neighbourhoods are designing care models for their populations based on local need, fostering relationships between providers to deliver the best outcomes. These Integrated Neighbourhoods have been formed across all neighbourhoods bringing together providers to work in collaboration.

12.4. Different models of working and widening the range of professionals within the primary care workforce is a key strand throughout all the national documentation and this is being taken forward locally. This expansion of the primary care workforce, could comprise models such as for example: the use of community paramedics and pharmacists. These are currently in operation and may continue through 2017/18 and inform the further development of integrated neighbourhoods.

12.5. New models of care and the direction of the GP Forward View and GM strategy has been fully reflected in the documentation for the Alternative Provider Medical Services re-procurement. Although a new contract model is not yet available, the context in which the contracts are being re-procured and the future vision for these practices has been outlined and will form part of the assessment of bids.

12.6. The Greater Manchester Health and Social Care Partnership have recently been able to access to the national GP Development Programme and invited practices, through their CCG, to express interest in the Productive General Practice Programme. This programme offers dedicated support to practices to help them plan and implement rapid changes to release time, remove waste and create headspace to work through current and future pressures and implement a means to approach and manage these. We have been able to secure funding to support cohorts of practices through this programme and will communicate this to practices in the coming weeks ahead of the programme launch mid December. Alongside this a Quality Improvement champion workshop session is being held in December. This is the first session of a two part programme which is being facilitated locally as part of the learning from year one of the Primary Care Quality Scheme and will further support practices to understand their own practice and population need and how changes can be implemented to address both the direction of national and regional strategy but also to ensure sustainable general practice locally.

12.7. The Primary Care Quality Scheme refresh required for 2017/18 must reflect the current landscape, both financially and policy. This is best summarised as the Primary Care Quality Scheme refresh must deliver the primary care quality “triple aim”. This redesign must therefore address the direction for primary care outlined through the documentation to support the formation of new models of care and deliver people powered care and place based, population based models. This redesign will address the ‘must do’s’ and mandates from the planning guidance outlined above as well as ensure Tameside and Glossop fulfils its commitment to the delivery of the GM standards. The drive to improve use of technology and change the way people access services will also be reflected, ensuring people powered change can be achieved. This refresh is underway and will go through a period of patient and practice consultation.

13. RECOMMENDATIONS

13.1. As set out on the front of the report.

APPENDIX 1

Five Year Forward View

https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

General Practice Forward View

https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

New Care Models: The multispecialty community provider (MCP) emerging care model and contract framework

https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf

NHS Operational Planning and Contracting Guidance 2017-2019

https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

Greater Manchester Primary Care Strategy (Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021)

http://www.gmhsc.org.uk/assets/GMHSC-Partnership-Primary-Care-Strategy.pdf

APPENDIX 2

INTEGRATED NEIGHBOURHOOD ACTIVITIES - UPDATE

1. BACKGROUND

1.1. The Integrated Neighbourhood model has been developed with significant input from a range of stakeholders, and the implementation of the model is now being led by Tameside & Glossop Integrated Care NHS Foundation Trust.

1.2. The CCG Commissioning Business Managers and Neighbourhood Clinical Leads continue to support the further development and implementation of the IN model with a number of activities and projects across the neighbourhoods. This briefing paper has been produced with the intention (in the first instance) of sharing (informally) the work which is ongoing and which has been initiated and led by the Single Commissioning Function.

2. STANDARD ACTIVITIES ACROSS THE LOCALITY

2.1. Each of the neighbourhoods offer the following as standard:

2.2. Neighbourhood Business Meetings: These are held monthly, chaired by the clinical lead, and involve a range of General Practice staff (GPs, Practice Managers and Practice Nurses). The monthly Neighbourhood business meetings discuss and address any locality based issues and challenges. Also a platform to share key messages that will impact on Primary Care services within the Neighbourhood.

2.3. Practice Monthly Packs: facilitate monthly lock-in sessions (with Medicines Management, Business Intelligence, Finance colleagues) to review Practice data packs. Identify key trends and themes that the Practice may wish to focus on to reduce overspend and or deliver their referral Pathways differently so they fall in line with identified Good Practice.

2.4. Risk Strat data – Support Practices to review their cohort of 'Risk' clients identified through the monthly Risk Stratification report. Encourage Practices to link in with the LTC colleagues to undertake reviews of their patients with a view to ensuring all appropriate patients are on the right pathways and receive the best interventions at the right time.

2.5. Practice Visits – Undertaken Practice Visits with Clinical leads. Following the Visits, facilitated the sharing the granular breakdowns of activity as discussed/identified during conversation with the Practice staff. Maintain follow up conversations with Practices once breakdowns have been shared with the offer of continuous support to identify and resolve any concerning trends/themes as well as sharing with Peers any identified Best Practice.

2.6. Integrated Neighbourhood Meetings – CCG organise and facilitate / support Monthly Integrated Neighbourhood Team meetings attended by Adult Care, Social Services, Young People Services, Community Nursing (Tameside and Glossop Integrated Care Foundation Trust), 3rd Sector/Voluntary services, mental health and Primary Care colleagues. Key aim of the Group is to bring together all major departments to develop and deliver a system that will support the robust and integrated management of peoples Health and Social Care needs. This is building on the development phase of the Integrated Neighbourhood model, which for Glossopdale was supplemented with separate discussions to ensure the Derbyshire County Council stakeholders were involved.

2.7. Input to ongoing development, design and implementation of Integrated Neighbourhoods – the Single Commissioning Fund continue to engage at every opportunity in the development

and implementation of Integrated Neighbourhoods, with the Deputy Director of Transformation and the Heads of Primary Care meeting on a regular basis with the Director of Strategy from the Integrated Care Foundation Trust.

2.8. Pharmacy Support - The Single Commissioning Fund are currently leading the design of the integrated neighbourhood pharmacy model and are looking to take this through the required Integrated Care Foundation Trust governance, with support from the Trust to confirm the details required to enable this.

3. ASHTON – NORTH NEIGHBOURHOOD: Clinical Lead – Dr Nav Riyaz, Commissioning Business Manager – Christopher Martin

3.1. In addition to the monthly Neighbourhood Business Meetings, to take forward the Integrated Neighbourhood model, Ashton is holding the following meetings:

- An additional evening meeting for the neighbourhood to further discuss development of an integrated neighbourhood – this is proposed for 17 December (venue permitting).
- A meeting to discuss the children and young families area with primary care staff, school nurses, safeguarding, paediatricians and paediatrics community nursing – this will be in March 2017 after the children multi-disciplinary team model has been established by the children's commissioner.
- A meeting to discuss vulnerable / heavy acute system users with police, fire service, social care, third sector, mental health and the North West Ambulance Service.
- A "market" event where third sector and social prescribing providers can introduce themselves to the Ashton neighbourhood so GPs have a more robust idea of what is available, which will take place in the New Year. This has been discussed with Action Together, as best placed to provide support. Pete Forrester, one of the patient representatives attending the Ashton Neighbourhood will also support as it links in to work he is already undertaking for Ashton patient groups.
- Paediatrics advice and guidance pilot scheme, with Bedford House participating during the pilot.

3.2. Priority Projects - To look at over-referring areas as a neighbourhood, compare with other neighbourhoods and consider what can be done to reduce those areas of over-referral.

4. DENTON – WEST NEIGHBOURHOOD: Clinical Lead – Dr Asad Ali, Commissioning Business Manager – Heather Palmer

4.1. All practices are well engaged in the neighbourhood discussions and are willing to take part in integrated working. Examples of work to date includes:

- Denton Huddle – practices/social/community healthcare etc. met twice with really good attendance – another meeting arranged for January to take forward integrated agenda.
- Denton HRV (High Risk Vulnerable) – meetings on a quarterly basis – practices/social/community health/Pennine care/police to discuss individual cases again really well attended.
- Denton GSF (Gold Standards Framework) Meeting – held 1 integrated GSF meeting which was very well attended by social/community health/district nurses/police etc. but it was felt to take forward this forum as a HRV meeting and continue with GSF on a practice based approach.
- Practice based GSF meetings at all practices attended by social/district nurses.
- We have exchanged contact numbers practices AUA by pass numbers/social care/DNs/LTC on call as following discussions they had previously been issues contacting the teams.

4.2. Pilot projects in the Denton / East Neighbourhood include:

- 3 practices Nasal High Flow pilot with Catharine Thomas at Tameside Hospital NHS Foundation Trust to reduce Chronic Obstructive Pulmonary Disease re-admissions commencing December 2017;
- 3 practices paediatric outreach pilot commencing January 2017;
- 6 separate practices involved in the pilots out of 7 in the neighbourhood;
- The other practice has taken on 24 hr ECGs for the neighbourhood.

4.3. Priority areas for the further development of the Integrated Neighbourhood in Denton / East are:

- Practices are doing a retrospective peer review of 1 month's referrals to generate areas to focus on and identify trends and organise some consultant teaching sessions in these areas.
- Looking at the possibility of piloting a neighbourhood wide afternoon visiting service.
- Neighbourhood awaiting Transformation funds to run a Neighbourhood-wide telehealth project.
- Holding separate Multi-speciality Community Provider evening meetings to take forward as a neighbourhood.
- All practices taking part in Restricted Pharmacy ordering and looking at care home alignment.

5. HYDE – SOUTH NEIGHBOURHOOD: Clinical Lead – Dr Andy Hershon (to 31 December 2016 then Drs Jane Harvey and Lisa Gutteridge), Commissioning Business Manager – Louise Roberts

5.1. The Hyde Integrated Neighbourhood Team Steering group meet on a monthly basis and will continue to do so however but will from January take on a more operational role and we now also hold twice monthly strategic meetings. Ongoing work includes:

- The Hyde neighbourhood utilise the 'Clean Room' for a multi-disciplinary team assessment of medium/high risk patients and the intention is to utilise the operational INT meetings to discuss other cases (that fall outside the criteria for the clean room).
- Hyde Neighbourhood are involved in the Paediatric pilot project with Tameside and Glossop Integrated Care Foundation Trust, initially this will involve access to advice and guidance with a named consultant.
- Hyde practices have multi-disciplinary team /gold standard framework meeting in house to include a range of professionals i.e. Macmillan nurses, LTC team, district nurses and health visitors.
- Last year as part of the Commissioning Improvement Scheme (CIS) practices started to internally review / peer review referrals (and the more difficult cases were reviewed at the neighbourhood meeting).
- Hyde Practice Managers meet up on a regular basis and I am aware of several other meetings/inductions etc that take place to progress INT development.

5.2. Asset based Training: The Hyde neighbourhood was one of only 5 areas in Greater Manchester that was successful in securing this training, which forms part of the Greater Manchester Health and Social Care Devolution programme and refresh of the Greater Manchester Primary Care Strategy. It was decided that Hyde would be best placed as they already had experience in asset based approaches via their over 75s work. It was an opportunity to spread the message to other parts of the Primary Care system in Hyde.

The training has been developed in association with Skills for Health and Skills for Care and complements the Tameside Health & Wellbeing Strategy as well as the Tameside & Glossop Care Together programme, Locality Plan and work streams. The training was funded by NHS England.

5.3. Social support for practices: Developed with the support of Tameside MBC Adult Social Care teams, the worker will link into the Hyde Healthy Living workers and support patients across the neighbourhood.

5.4. Lifeline: Thornley House Medical Practice (along with Mossley) are currently piloting the redesign of the Drugs and alcohol primary care model of working within the community.

6. STALYBRIDGE – EAST NEIGHBOURHOOD: Clinical Lead – Dr Saif Ahmed, Commissioning Business Manager – Heather Palmer

6.1. All practices are engaged and willing to be involved in integrated working in the neighbourhood:

- Practice based GSF meetings held and increasing the numbers of social/community health care representatives at these meetings.
- We have exchanged contact numbers, practices' AUA by pass numbers/social care/district nurses/LTC on call as following discussions there had previously been issues contacting the teams.

6.2. Pilot projects in Stalybridge / East Neighbourhood:

- 1 practice paediatric outreach pilot commencing January 2017
- 2 practices long term conditions/mental health pilot – awaiting commencement date from Pennine Care

6.3. Priority areas for the Neighbourhood are:

- Established Stalybridge Peer Review Group to reduce inappropriate referrals for 2 outlying practices with an educational element for the GPs – starting w/c 5th December 2016.
- Care Homes – Task and Finish group met (practices/DN representatives) and putting together pilot of Integrated Care Home Ward Round led by Dr J Shilhan (Staveleigh) hoping to involve social care and community physio input to these ward rounds – hope to commence January 2017 for 3 months. Group to meet again during January 2017.
- Children's' and Families – Task and Finish Group led by Dr Tina Greenhough – met with practices/public health early years/social care – to include on all the Neighbourhood agendas each month 'what's new section relating to children's and families'. Number of actions as a result of first meeting including pulling together list of 'what's available in Stalybridge neighbourhood for children and families'.
- Meeting with Live Active on 13 December to organise a childrens' and families 'fun run/walk' with input from local practices/Live Active and Stalybridge schools in the New Year.
- Neighbourhood encouraging NMPs, and 3 new NMPs enrolled for training in the New Year
- All practices taking part in restricted pharmacy ordering and also now looking at care home alignment taken forward by the Care Home Task and Finish Group.

7. GLOSSOPDALE: Clinical Lead – Dr Alan Dow, Commissioning Business Manager – Wassiem Rafique

7.1. The Glossop Neighbourhood are all engaged in integrated working, with the following activities currently being undertaken:

- Link between Derbyshire County Council and Tameside MBC: liaise with Derbyshire CC and Tameside MBC to ensure parity between services offered to Glossop residents that are being offered to both Derbyshire and Tameside residents. Examples of recent work include agreements made around Sharp Bins collections, Larcs and IUDs, NHS Health Checks and Enuresis services.

- Community Specialist Paramedic – work closely with the Glossop CSP in the development of their role to support Glossop Practices. Ensure all identified Good/Best Practice is shared with all Primary Care colleagues.
- Re-zoning of Care Homes – due to the opening of Regency House, undertaking an exercise to re-zone all Glossop Care Homes to ensure process of management is as efficient as possible and no Practice has too much pressure on it in the management of this cohort of patients.
- Over 75 Schemes - Glossop Practices have been successfully running a range of Over 75 schemes that have made a positive impact in a range of areas. Such schemes include an Elderly Care Engagement Champion and a Practice Based Pharmacist.
- Minor Injuries Clinic - Glossop Practices undertook a pilot to deliver a Minor Injuries clinic from the Neighbourhood and has been working successfully to deflect potential attendances/admission in to hospital.
- Glossop MDT/GSF meetings - All meetings take place monthly All Glossop practices hold MDT/GSF meeting with a range of professionals i.e. Macmillan nurses, LTC team, DNs and HVs in attendance.

7.2. Potential pilots to be considered in Glossop include:

- Improved E-referral use - Peer led training to Practices to encourage/improve use of the E-referral system.
- Care Home Zoning (i) – Group of staff to work up the model i.e. GP, nursing expertise practice and community, Community Specialist Paramedic, social care, Care home rep. To ensure any offer covers preventative, proactive and urgent support which reduces demand on all partners and keeps more people in the homes rather than hospital.
- Care Home Zoning (ii) – following completion of the re-zoning exercise, a representative group (i.e. GP, Nurse, PM) visiting all Care Homes and Patients to hold information sessions and alleviate concerns related to the potential changes.
- Bridging the Gap – Young People Mental Health Service to be delivered locally in Glossop.

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	19 January 2017
Board Member / Reporting Officer:	Mark Tweedie, Chief Executive, Active Tameside
Subject:	**ACTIVE TAMESIDE – STRATEGY, GROWTH AND DEVELOPMENT**
Report Summary:	The presentation and attached papers aim to update Board members on the development of Active Tameside facilities, programmes and strategic vision, in particular the Live Active Programme. The presentation seeks to identify opportunities to deliver on the ambitions of the Locality Plan and Commissioning Strategy by reducing levels of inactivity in Tameside.
Recommendations:	The Health and Wellbeing Board are asked to note the update provided and consider how the opportunities to improve levels of activity in Tameside can be maximised.
Links to Health and Wellbeing Strategy:	Increasing physical activity cuts across all life course priorities in the Health and Wellbeing Strategy.
Policy Implications:	The Physical Activity Strategy for Tameside is currently being refreshed by the Tameside Activity Alliance – a multi-agency partnership with the joint aim to support Tameside residents to become more active. The programmes and services delivered by Active Tameside contribute to delivering this strategy.
Financial Implications: **(Authorised by the Section 151 Officer)**	It should be noted that on 24 March 2016 the Executive Cabinet of the Council approved capital investment within the Active Tameside estate of £20.4 million. The Council liability being £17.55 million with £2.85 million (plus interest) wholly financed by Active Tameside via unsupported borrowing facilitated by the Council. In addition a long term revenue funding agreement (with indicative annual values) was also approved commensurate with the remaining lease of the Active Tameside estate. The indicative revenue funding values are subject to annual agreement within the core Council budget setting process and are available within table 1, section 14.2 of the Executive Cabinet report.
Legal Implications: **(Authorised by the Borough Solicitor)**	The Council has/is investing heavily within its Sports & Leisure Estate, which are delivered by Tameside active. It is important that there is a clear performance and assurance framework in place so we can measure the success of that investment to ensure that we are reducing health inequalities and providing and reaching those groups that the normal competitive leisure market is not engaging with. The Council is required to show it is achieving value for money particularly where services are discretionary such as this and it clear needs to be supporting our statutory duties in respect of health and wellbeing in a measurable and

	targeted way over and above those people who would be using any available leisure facilities as they are already and would be engaged in such activities.
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 Mark Tweedie  Telephone: 0161 393 2204  e-mail: mark.tweedie@activetameside.com

1. INTRODUCTION

1.1 The Active Tameside Live Active service has achieved exceptional success over a relatively short period of time, this evidenced by the performance metrics shown on page 3. The service is working to accommodate a wide range of long term conditions within the same pathway, whilst offering a diverse exercise therapy offer and exit routes into long term activity. Chronic obstructive pulmonary disease, falls, mental health, musculoskeletal conditions and stroke are some of the main conditions that incur significant and escalating costs to the NHS through hospital and NHS service visits. It is well evidenced that by offering a specific physical therapy intervention, patient outcomes are not only improved but can produce significant demand and therefore cost reductions to the health and social care system.

2. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

2.1. Hospital based pulmonary rehabilitation has shown a cost reduction of £1835 per person per year (Chakravorty et al., 2011), with other evidence showing this to be as effective as community based programmes.

2.2. Individuals with chronic obstructive pulmonary disease (COPD) who are regularly active have fewer hospital admissions for exacerbations than those who are physically active (Esteban *et al.,* 2014), and spend fewer days in hospital when admitted. They are also more likely to attend primary care consultations as opposed to requiring home visits (Griffith*s et al.,* 2000). A hospital admission for COPD is estimated to cost the NHS at least £1960 (NICE, 2011).

2.3. Initiating an aerobic exercise program acutely after an exacerbation can significantly increase the aerobic fitness which was lost during the exacerbation, and is associated with an improved mortality risk and a reduced number of hospital admissions over the forthcoming year (Pitta *et al.,* 2006; Puhan *et al.,* 2005; Revitt *et al.,* 2013).

2.4. Providing pulmonary rehabilitation after discharge from hospital can reduce readmissions within three months from a third to just 7% of patients (Seymour et al., 2010).

2.5. Physical activity is associated with an improvement in depressive symptoms, which predicts fewer hospital readmissions in individuals with COPD (Coventry *et al.,* 2011).

3. FALLS PREVENTION

3.1. Falls prevention exercise (Stubbs et al., 2015) and/or regular independent physical activity (Heeschet al., 2008) is associated with a lower risk and incidence of falls.

3.2. The cost of falls to the NHS is £2 billion per year, with indirect costs to work absence and carer time required. Evidence suggests that the cost of continuing care in the 12 months following a fall is 4x the cost of the acute care for a fall (Tian et al., 2013).

3.3. Ambulance services respond to 700,000 calls for people who have fallen, costing £115 per call out (Newton et al., 2006).

4. MENTAL HEALTH

4.1. Exercise has also been associated with remission of depression. The cost of treating depression to the NHS in England is around £1.7 billion per year, with lost employment costing the economy £5.8 billion. Prevalence of depression is rising therefore these costs

are expected to rise, and the NHS costs only reflect the individuals who are in contact with NHS services (McCrone et al., 2008).

4.2. The NHS prescribes around 47 million antidepressants per year at a cost of around £270 million (HSCIC, 2012). Exercise has been shown to be as effective as medication for improving symptoms of depression.

5. MUSCULOSKELETAL

5.1. For people who have already developed a painful musculoskeletal condition engaging in appropriate physical activity actively reduces pain intensity, improves quality of life and prevents further disability and increased hospital visits.

6. STROKE

6.1. There are beneficial effects of physical activity on regaining function, independence and quality of life. Aerobic and combined programmes are effective at improving cardiorespiratory fitness and strength, which translates into an improved mobility, walking speed, walking capacity and balance, which are often important goals of stroke survivors (Saunders et al., 2013).

6.2. Individuals accessing regular physical activity interventions are more able to complete activities of daily living independently, at a pre-stroke level, improving quality of life (Billinger et al., 2014).

7. FUTURE OPPORTUNITIES

7.1. In 2016/17 the Live Active service will receive over 1400 referrals. There is further scope and local need within Tameside to fully expand the programme however currently at 1400 referrals and only 4 full time equivalent team members, the service is at maximum capacity to process and work with each client. Service costs and opportunities to scale up the current service provision to meet demand are as follows:

- 2,000 Inactive Tameside Residents with long term conditions - £214,000;
- 5,000 Inactive Tameside residents with long term conditions - £535,000;
- 10,000 Inactive Tameside residents with long Term Conditions - £1,070,000.

7.2. With the above models the service will be in a position to further maximise the outreach and engagement of the service to directly target and provide specific pathways of exercise therapy to some of the conditions mentioned above to include but not exclusive to:

- A full evidence based Fall Prevention programme;
- In House Cardiac Rehab Phase IV programme with sustainable exit routes into long term activities;
- Full Stroke rehabilitation programme;
- Complementary respiratory education and activity programme for COPD sufferers.

7.3. There is also an opportunity to have a single multidisciplinary team delivering targeted health and wellbeing interventions from Tier three to Tier zero. This would facilitate a more seamless pathway into support for the service recipient, create improved holistic workforce development opportunities and also yield potential efficiency savings.

8. LIVE ACTIVE PERFORMANCE AND METRICS TO DATE

600 referralls within initial 8 months 1400 in Year 2	Majority of patients have 3+ co-morbidities	83% uptake rate (66% national average)
79% 12 week adherance rate (46% national average)	Majority of participants from Q1 & Q2 communities (Known risk factor to poor uptake and adherance)	Top 3 self- reported benefits Improved wellbeing, Weight loss, Improved confidence

No.	ELEMENT	WEEK 12 & 24 RESULTS
1	BEHAVIOUR CHANGE	Majority move from contemplation to action
2	PHYSICAL INACTIVITY	Inactive to 200 Metabolic mins walking or 165 moderate intensity activity
3	BEST IMAGINABLE HEALTH SCORE	Average 15 point increase
4	WEMWBS	Average 3 point increase
5	BLOOD PRESSURE	Progressive decline in BP across time points
6	SHORT TERM GOALS	85.4% achieved
7	MEDIUM TERM GOALS	72.2% achieved
8	FITNESS LEVELS	79% reported good improvements to functional fitness and ability
9	QUALITY OF LIFE	85% Improved

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TOTAL ADRENALINE

ACTIVE TAMESIDE

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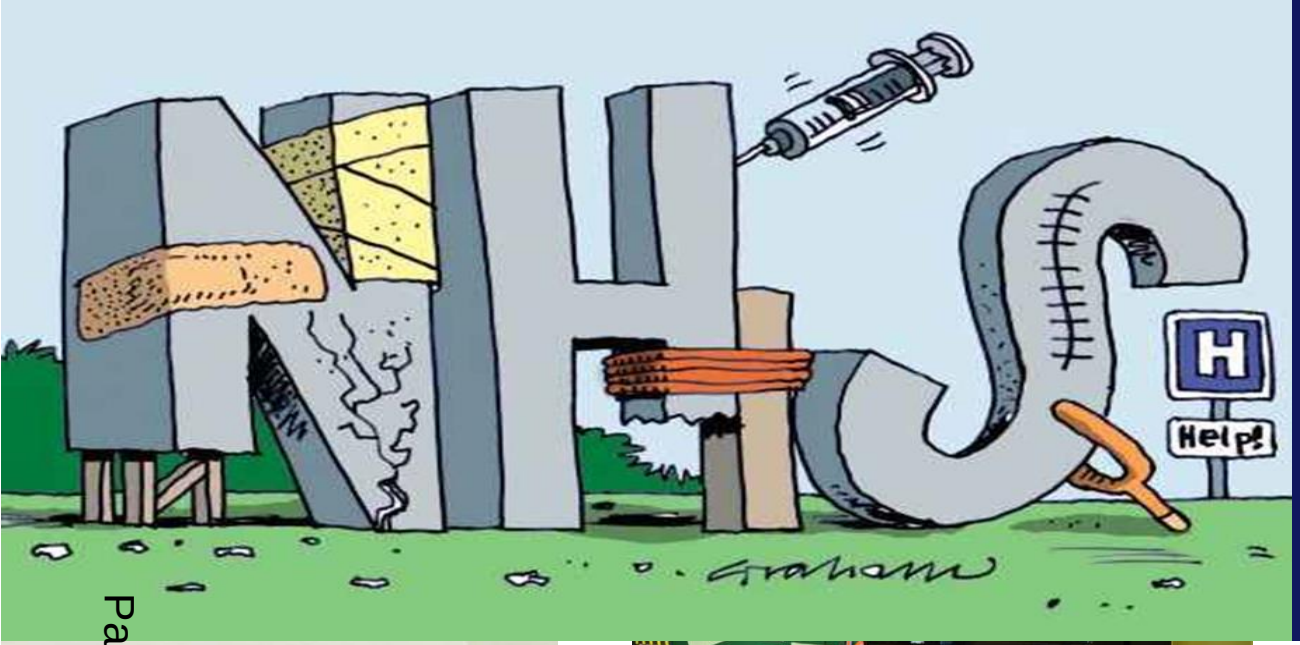

If being active was a pill we would be rushing to prescribe it. Physical activity is essential for health and reduces the risk of many preventable diseases and conditions from cancer to depression

Public Health England

Everybody Active, Every Day

Cross sector approach for national and local action

Supply & Demand Relationship

Live Well Services

LIVEWELL TAMESIDE

Web: **www.livewelltameside.com**
Email us: **liveactive@activetameside.com**
Call us: **0161 366 4860**

LIVE WELL, FEEL GREAT!

Active Tameside's vision for local people

ACTIVE TAMESIDE
Inspiring stories for healthy lives

These women can

A GROUP of women from Ashton are showing that 'this girl can' in Tameside.

Between eight and 10 women who attend the Women's Centre in Cavendish Mill, Ashton, have been going to Active Oxford Park every week since last September, as part of a free programme run by Active Tameside.

And a number of the women have enjoyed the sessions so much that they've joined Active Oxford Park and now visit several times a week.

Hayley Silcock, aged 26, from Ashton, who hated PE at school, works out at Active Oxford Park regularly.

She said: "I absolutely love it. If Active Tameside and the women's centre hadn't offered us the chance to go to the exercise sessions, I would never have gone to the gym on my own.

"But now it's given me confidence. It's the place where I can go and be myself and get all my frustrations out if I need to."

Mum-of-four, Emma Rabbanska, aged 34, another of the Active Oxford Park regulars, said: "It's a great stress reliever and going as a group has helped me to make friends."

HAVING a ball...Hayley and Emma with other members of the women's group at Active Oxford Park.

Feel great facts

WOMEN account for 63 per cent of all Active Tameside's memberships and the number is growing.

Dementia sessions a hit at Medlock

A DROYLSDEN couple coping with dementia say a new scheme at Active Medlock has thrown them a life-line.

Eric Kenny, aged 70, and his wife Carole who has vascular dementia, attend the two-hour lifestyle sessions for dementia sufferers and their carers at Active Medlock on Wednesday afternoons.

The lifestyle sessions include use of the gym, a zumba-style dance class, use of the swimming pool and tea, coffee and cakes.

And Eric, who is Carole's carer, says the sessions have given him and Carole, aged 70, new friends and a great way to stay healthy.

The sessions were launched by Active Medlock, with the Alzheimer's Society, and are open to dementia sufferers and their carers.

Said Eric: "It's a good way to meet people, and it's good to talk to other people who know what you're going through."

And he added: "I do a lot of walking but it's good to be able to use the gym at Active Medlock and both Carole and I enjoy the swimming sessions."

TEA for two... Eric and Carole Kenny enjoy a cuppa and a break at Active Medlock.

Live well tips

THE Alzheimer's Society says that, for many dementia suffers, leading a healthy, active lifestyle can have many benefits, including maintaining strong muscles and flexible joints and improving cognition which support independent living. Recent studies have shown that exercise may improve memory and slow down mental decline, reduce the risk of falls by improving strength and balance, and improve confidence and mood.

Tell us your inspirational health and exercise stories - hello@activetameside.com

Mum's a trailer blazer

A SINGLE mum is a prime example of Sport England's #thisgirlcan campaign despite having to look after four-year-old twins who are on the autistic spectrum.

Wendy Porritt, who received a grant from the Tameside charity Believe and Achieve Trust, is a keen cyclist.

She received a £2,000 grant to buy a trailer to attach to the front of her bike so that her twins, Hannah and Alfie, could go out cycling with her and the family.

Wendy was keen to give her young twins the experience of cycling along with her other children.

She said: "Cycling is a great way to exercise and it's a great way for all the family to stay active together."

And the former care worker added: "Children with disabilities should have no barriers to access sports and activities of their choice and they shouldn't have to jump through hoops to get access to them.

"Sport gives children confidence, a sense of achievement and self esteem, and being able to cycle with the family is helping Hannah and Alfie to gain those things."

BICYCLE made for three...mum Wendy Porritt with Hannah and Alfie in the new trailer that attaches to the front of her bicycle.

Nominate a sports star

Have you nominated anyone for the Pride of Tameside Sports Awards yet? The closing date is July 31, 2016. Find out more at www.activetameside.com

Need a hero?

MEET Mighty Mike.

He's the fifth of Tameside's new super sports heroes and he's a wizard in the pool. This summer, there's a range of activities and sessions in Active Tameside's pools, including Learn to Swim crash courses for children, beginners' courses for children over four years old who haven't yet achieved their 10 metre badge, and the bronze silver and gold challenge awards. For further information, contact your local Active centre or email hello@activetameside.com

LIVEWELL TAMESIDE

Opportunities

- **Alignment** of Plans
- **Access** to Services
- **Adaptability** to support PSR
- **Ability** to Lead

Commissioning for reform

ACTIVE TAMESIDE

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Inspiring People to Live Well & Feel Great

Active Tameside Company Strategy

Active Champion Together Integrity Value Enthusiasm

DRAFT 22/09/2016

Introduction

I am delighted and privileged to lead a Charity that delivers great outcomes for our communities, and that is underpinned by a socially inclusive ethos and commitment to address inequalities. Active Tameside is a great business employing fantastic people with a track record of providing high quality, leading-edge, value for money leisure, sport, physical activity and wellbeing services for people of any age or ability in Tameside.

Physical inactivity is recognised as the fourth greatest cause of ill health globally and, tragically, evidence suggests the tide of inactivity is worsening. Consequently, our society is facing the major challenge of increased avoidable health conditions associated with inactivity, and urgent, radical, and new solutions are required to meet this challenge. Evidence also suggests that the provision of high quality leisure facilities play a significant role in encouraging and sustaining the take-up of physical activity and, perhaps surprisingly, more so than green spaces. Our Strategy involves adopting innovative people and community-centred approaches to build new relationships that will empower more people and communities to take charge of their own health to live well and feel great.

Councils across the country are under great financial pressure to maintain their leisure facilities and associated services. Implicit to this Strategy and its action plan is the development of an even better, exciting and secure business that does not depend on public funding, and a business that is benchmarked to evidence performance excellence. To achieve this, we will continue to invest in exciting, new services so that we can generate financial surplus to reinvest into our charitable objectives. This will allow us to improve the quality and range of our services, become self-sustaining and extend our reach and impact to conquer inactivity and improve wider social and economic outcomes in our communities.

It gives me great pleasure to endorse this Strategy as Active Tameside's manifesto to conquer the challenge of inactivity, and to deliver a sustainable improvement to the healthy life expectancy of Tameside's people.

Mark Tweedie Chief Executive – Active Tameside

Foreword

I became Chair of Active Tameside in 2010, and I am delighted to have seen the Board of Directors, leadership team and wider workforce go from strength to strength during this time. Together, we have overcome huge financial and service development challenges, which is why I am confident that we have the best team in place to deliver this exciting new Strategy.

Tameside Council continues to successfully deal with the consequences of reductions in Government spending, coupled with rising costs due to increasing demands on health and social care services; a large proportion of which are due to society becoming increasingly more inactive.

Tameside commissioners, providers and stakeholders are working closely together to co-design, innovate and invest in services to successfully respond to these challenges. This response includes radical new approaches to upgrade and sustain early intervention and preventative services that are necessary to conquer the tide of inactivity and deliver sustainable improvement to healthy life expectancy.

Physical activity and sports participation is also closely linked to better economy, employment levels, community safety and educational outcomes for our communities. This is why Tameside Council is investing over £20million (period 2016-18) to improve its leisure facility estate to support Active Tameside in delivering this Strategy.

I am proud to state that this investment and innovative approach will ensure we can continue to provide leading-edge leisure, sport, physical activity and wellbeing services for this generation of Tameside people, and the next.

John Taylor Chair Active Tameside Board of Directors

Background

- Active Tameside is a registered charity which means our fundamental purpose is to deliver public benefit, and in keeping with this, all our surplus revenue is reinvested into our services.
- Active Tameside is the operating name of Tameside Sports Trust established in 1999 with a Board of 11 voluntary Directors; each Director provides unique expertise and experience to help run our business.
- Active Tameside delivers a wide range of leisure-facility and community-based services that generate participation in physical activity and sport to improve health and wellbeing, predominantly in the Tameside area but also with our partners across Greater Manchester.
- Active Tameside employs 300 people and has a turnover which has grown to £9 million (2016-17). Income is generated from an annual management fee from Tameside Council, specific commissioned work, grants plus income from schools and paying customers.

Factors Driving our Strategy

1. Address the barriers to physical activity, health and wellbeing.
2. Stimulate population level demand to be physically active.
3. Create services that meet people's health and wellbeing goals.
4. Develop new relationships with our communities and stakeholders.
5. Deliver high levels of social return on investment.
6. Generate surplus revenue to reinvest in great services.
7. Exceed our clients', customers' and partners' expectations.
8. Ensure a sustainable business against public sector spending reductions.

What we do and where we want to get to

Strategy Overview

Leading Provider

Service Innovation & Customer Service Excellence

Sustainable with an Asset-Based Development Focus

Behaviour Change Start - Stay & Succeed Model

Highly Skilled & Competent Workforce

High Quality Learning & Development Values-Based Culture

Appropriate Scope with an Inequalities Focus

Life Course Start Well - Develop Well - Live Well & Age Well Model

Place-Based Partnership Focus

High Quality Community Facilities

Our Goals

1. **To undertake a lead role working with our partners and stakeholders to:**
   I. *Achieve a sustainable population scale reduction in physical inactivity and*
   II. *deliver a sustainable improvement to healthy life expectancy.*

2. **To undertake a key role working with our partners and stakeholders to:**
   I. *Address health inequalities and create a system that focusses on improving health and wellbeing and*
   II. *improve social and economic outcomes in our communities.*

3. **To design and deliver the appropriate scope of innovative leading-edge services.**
4. **To develop and maintain the best partnerships.**
5. **To develop, attract and retain the best people.**
6. **To achieve the highest levels of service excellence.**
7. **To grow financial returns to invest more in our communities.**

Best Services

That are evidence-based, sustainable and have an asset-based development focus that recognise and build upon existing local community resources, and that use behavioural insight methodology to ensure barriers are removed to allow people to ***start, stay and succeed*** in an active healthy lifestyle.

Best Services – Easy to make a start…

We will empower **people** to **start** an active and healthy lifestyle by:

- Raising **'awareness'** of the opportunities to take part in physical activity and by simplifying the messages around the benefits to health and wellbeing.
- Providing easy access to **'try out'** physical activity in an appropriate and welcoming environment.
- Providing **'convenience'** to access physical activity opportunities at a suitable location and time.

Best Services – Easy to form a habit…

We will empower **people** to **maintain** an active and healthy lifestyle by:

- Providing **'positive experiences with rewards'** to increase the likelihood of continued participation.
- Providing a wide **'choice and variety'** of opportunities to maintain interest and to encourage progress.
- Providing opportunities to make friends and become part of a social network to develop a sense of **'belonging and commitment to others'**.

Best Services – Routes to achieve and succeed…

We will empower **people** to **achieve** results by:

- Providing access to specific, and when relevant, specialist **'support, guidance and coaching'**.
- Providing services that allow individuals to reach their **'personal best'** by achieving suitable and meaningful **'goals'.**
- Encouraging experience in appropriate personal **'challenges'** and **'competitive'** opportunities.

For Everyone

Services with the appropriate scope that support and empower people to meet their desired state of health and wellbeing for a lifetime, that eliminate the boundaries of inequality and meet the needs of all people across the ***start well, develop well, live well and age well*** components of the life course.

In the Best Places

Services that are underpinned by strong new relationships with our communities and partners, that adopt place-based community-centred approaches emanating out of high quality wellness, leisure and sports facilities.

Delivered by the Best People

Who are highly motivated, dynamic and responsive to new opportunities, and work within a strong ***values-based culture*** underpinned by access to the highest quality learning and development opportunities.

With a Great Brand

That is locally credible, recognisable as a leading-edge social enterprise, that delivers the highest standards of customer service excellence, evidenced by accredited industry quality standards.

Our Values Based Organisational Culture

Active

We encourage everyone to be healthy and active. Whatever your current health and wellness situation, we are here to support you to improve your lifestyle and live well for longer.

Champion

We work and adapt so that we can be the best. We will always support you to achieve your maximum potential and achieve your dream.

Together

We are there for people that need our help. If you are struggling, and need advice along your life-changing journey, we are here to help!

Integrity

We are genuine and honest with people. We will never mislead you and always give you the best advice possible to support your health improvement pathway.

Value

We respect people's opinions and differences. We will always listen to your thoughts and feelings to help support you on your life-changing journey.

Enthusiasm

We enjoy what we do and act positively; our enthusiasm influences others.

Putting our Strategy into Action with our Corporate Growth Plan

Our Corporate Growth Plan contains three business development strands each with specific objectives and measures to ensure we effectively deliver our goals and successfully monitor, evaluate and continually improve.

1. **Services and Business Development**
2. **Operations and Asset Development**
3. **Resource and Business Management**

ACTIVE TAMESIDE

TOTAL ADRENALINE

For more details contact

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iTRAIN 24seven FITNESS
www.itraingym.com

LIVEWELL TAMESIDE

HYDE LEISURE POOL

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	19 January 2017
Board Member / Reporting Officer:	Angela Hardman – Director of Public Health Debbie Watson – Head of Health and Wellbeing
Subject:	**HEALTH AND WELLBEING BOARD PRIORITIES 2017/18 AND FORWARD PLAN 2016/17**
Report Summary:	This report provides an outline of the priority focus areas and forward plan for consideration by the Board
Recommendations:	The Board is asked to agree the draft priority focus areas 2017/18 and forward plan for 2016/17.
Links to Health and Wellbeing Strategy:	The Health and Wellbeing Strategy to address needs, which commissioners will need to have regard of in developing commissioning plans for health care, social care and public health. The priority focus area and forward plan ensures coverage of key issues associated with the Board's duties to deliver improved outcomes through the strategy
Policy Implications:	The priority focus areas and forward plan have been designed to cover both the statutory responsibilities of the Health and Wellbeing Board and the key projects that have been identified as priorities by the Board.
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications for the Council relating to this report.
Legal Implications: **(Authorised by the Borough Solicitor)**	Local Authorities are obliged to publish a forward plan setting out the key decisions and matters they will consider over a rolling 4 months.
Risk Management :	There are no risks associated with this report**.**
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson, Head of Health and Wellbeing by: Telephone:0161 342 3358 e-mail: debbie.watson@tameside.gov.uk

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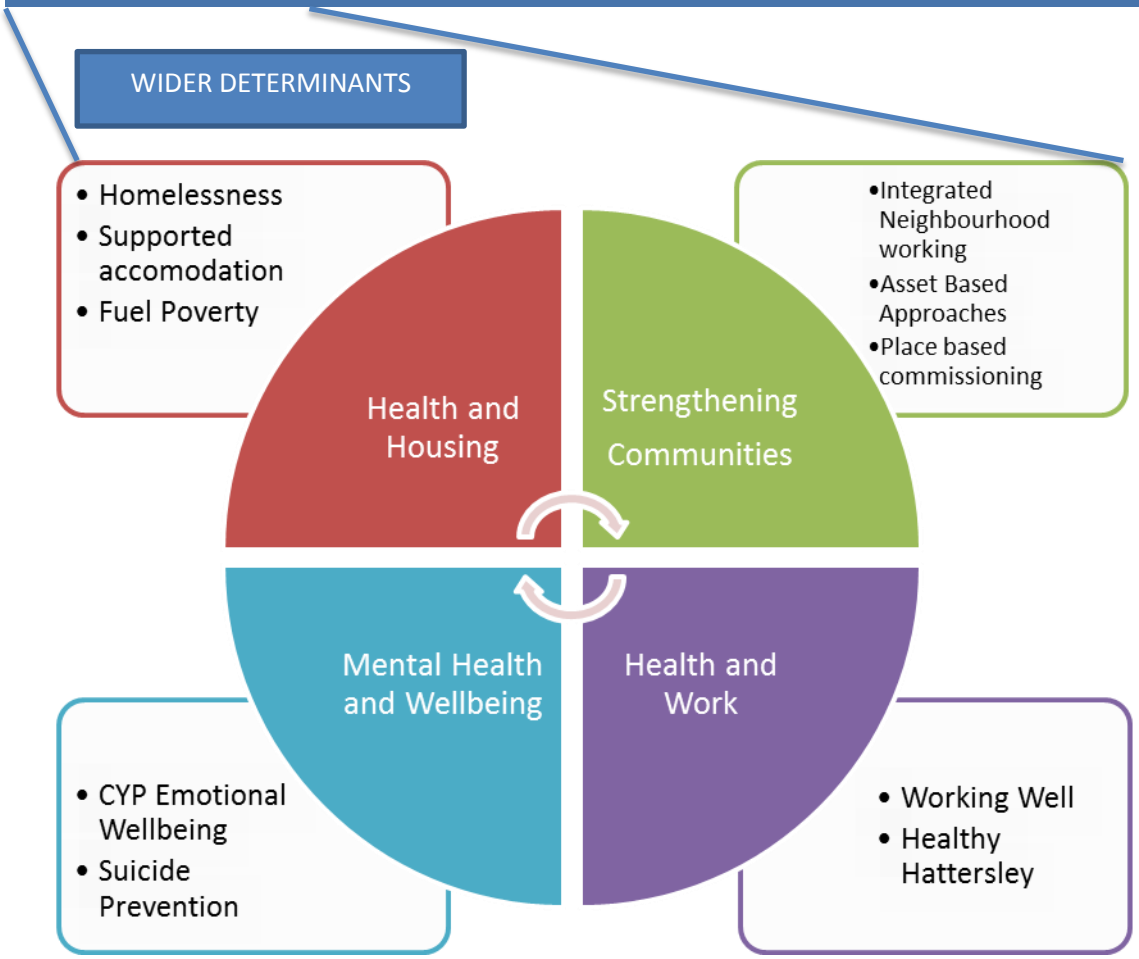
HEALTH AND WELLBEING BOARD PRIORITY FOCUS AREAS – 17/18

COMMISSIONING STRATEGY VISION : To significantly raise healthy life expectancy (HLE) in Tameside and Glossop through a place based approach to better prosperity, health and wellbeing and to deliver a clinically and financially sustainable local health and social care economy within five years.			
A focus on the wider determinants of health and wellbeing, in particular giving children the best start in life and helping people to stay in and return to work, thereby improving their own prosperity.	Early intervention and prevention across the life course to encourage healthy lifestyles and promote, improve and sustain population health.	Creating the right care model so that people with long term conditions are better supported and equipped with the right skills to look after themselves and manage their conditions more effectively, reducing dependency on the health and social care system by promoting independence.	Supporting positive mental health in all that we do.



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	Strategy / policy and Board process	Priorities and performance	Integration	Other
9 March 2017	• Theme 1 Population Health Plan • Tameside Adult Safeguarding Partnership Annual Report 2015/2016 • Realising the Value	• Mental Health and Wellbeing • Health and Housing • CAMHS Transformation Plan update	• Care Together Update	• Forward plan
NOTE: AGENDA ITEMS ARE SUBJECT TO CHANGE				
	Items to include: • JHWS – approval, alignment with other strategies • JSNA – updates and approval of arrangements • GM HWB and other strategy updates • National policy updates • Updates from linked governance processes – eg Health Protection Forum, Healthwatch,	Items to include: • JHWS Performance monitoring (outcomes) • JSNA updates • PH annual report • HWB performance	Items to include: • Regular public service reform updates • Integrated Commissioning Programme – Care Together • Partner member business planning updates (including CCG operating plan)	Items to include: • Forward Plan • Consultation on key issues and developments

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