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