Tameside & Glossop Locality Plan

Tameside Metropolitan Borough

NHS Tameside and Glossop Clinical Commissioning Group

For everyone every day

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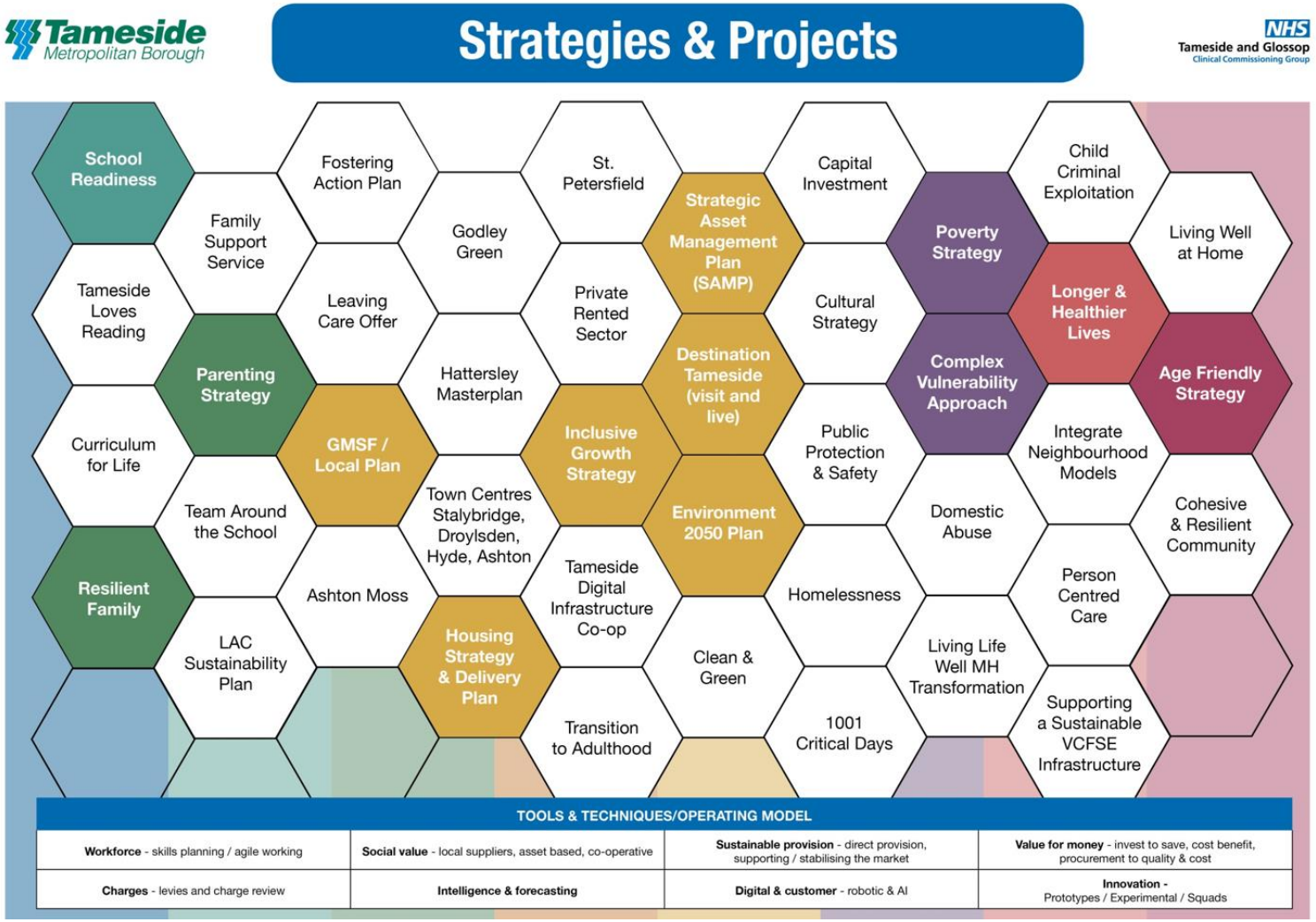
Section 1: Introduction

We have been on a challenging journey over recent years; significant financial challenges, poor health outcomes and a disconnected system all created a series of mounting pressures. Making the required improvements required **strong leadership** from people and organisations who have a sense of connection to Tameside and Glossop. We created integrated roles; the Chief Officer of the CCG is also the Chief Executive of the Local Authority and we have a Joint Director of Finance. We led the way nationally when we created a fully integrated commissioning fund between the CCG and Local Authority. This pioneering work has been enhanced by the co-production of one system-wide Corporate Plan with shared system-wide outcomes.

Real progress required **visible collaboration** - we knew we had to be brave, take calculated risks and identify short and long-term solutions to the challenges we faced. Innovative solutions included strong commitments to support the development of our Integrated Care Foundation Trust alongside a commitment to place-based provision by establishing integrated neighbourhood teams.

We view **health as an asset** to be protected and nurtured and we want our residents to share this view and feel confident in improving their own health and wellbeing. We know that some people find this easier than others and we want to work alongside them by developing a health creating system which empowers and supports our residents throughout their life.

Over the next 12 months we will continue to drive real change for our residents, with a particular focus on the key strategies and projects shown below.



Our story

- In Tameside, we're proud of where we've come from. From the canals that run through our towns, to the industrial cotton mills that make up our skyline, we're a place with a history and heritage that makes us, us. We're also proud of where we're going. Innovation is everywhere in Tameside and Glossop and our percentage of small to medium size businesses is higher than the North West average.

- While we're known for our graft, we're innovators too, our mill owners of the 19th century fought for women's suffrage and workers' rights, and their philanthropy gave the people of the borough libraries and public bath houses. Fast forward a couple of centuries and we're turning those Old Baths into state-of-the-art digital hubs for start-up businesses to prosper and grow.

- We've also been innovative in helping our future entrepreneurs. The multimillion pound Vision Tameside investment is transforming college education for our young people. Our three Advanced Learning Centres feature cutting edge laboratories and equipment to ensure our students are prepared to take on high skilled jobs in key growth sectors – from advanced manufacturing industries, to the fast developing digital and technology economy.

- We're a place where you can live a good life with easy access to our plethora of green space. We love where we are; just 12 minutes from Manchester City Centre with the Peak District on our doorstep; we're urban opportunity and rural tranquillity – with a host of Outstanding Primary and Secondary schools and a range of affordable housing to boot.

- Being part of the Greater Manchester family also means we understand the importance of collaboration. The Metrolink line connects us to neighbouring boroughs and devolution has allowed us to lead the way on health and social care integration and bring healthcare closer to home. We care about our people, and we take pride in knowing they're supported every step of the way.

Vision for Tameside and Glossop

Good quality healthcare is essential and we are fully committed to implementing the NHS Long Term Plan. We recognise however that healthcare provision only determines 15-25% of health outcomes. Despite significant progress improving our health outcomes, our population live an average of twenty years in poor health before they die. We view **health as an asset** and are committed to going further, faster and addressing these persistent inequalities.

Maintaining and improving quality is essential for the sustainability of our health and care economy. *"Quality without efficiency is unsustainable, but efficiency without quality would be unthinkable"*. The services we commission will provide good quality, joined up care which supports people to stay well, for longer, at home and have access to good quality advice and support in their community. When people do require hospital care, that care is safe and effective and they have a positive experience. Care homes are supported to provide good quality care which avoids people being admitted to hospital unnecessarily , including good quality end of life care. Children have a strong start in life; and maternity services are of high quality.

Our approach will incorporate proactive, predictive and personalised prevention and will recognise the substantial contribution from the wider determinants of health like education, housing, employment, environment and security. This Locality Plan intends to outline our ambition to address these wider determinants as part of our Corporate Plan commitment to transform health and wellbeing in Tameside and Glossop.

Our vision is to:

Significantly raise healthy life expectancy in Tameside and Glossop

through a place-based approach to better prosperity, health and wellbeing.

This means that the population of Tameside and Glossop will Start Well, Live Well and Age Well. People in Tameside and Glossop will get the very best start in life, they will grow, learn and move with confidence from childhood to adulthood as part of a resilient family. They will have access to a range of good employment and will have the confidence and skills to manage their health and live independently into older age. They will die with dignity in a place of their choosing. This ambition is recognised in our Corporate Plan 'Our People Our Place Our Plan'

Tameside Metropolitan Borough

Transforming Tameside & Glossop

Our People - Our Place - Our Plan

For everyone every day

NHS Tameside and Glossop Clinical Commissioning Group

Starting Well

Living Well

Ageing Well

Priorities

Very best start in life where children are ready to learn and encouraged to thrive and develop

- Reduce rate of smoking at time of delivery
- Reduce the number of children born with low birth weight
- Improve school readiness
- Children attending 'Good' and 'Outstanding' Early Years settings
- Take up nursery at 2yrs
- Promote good parent infant mental health

Aspiration and hope through learning and moving with confidence from childhood to adulthood

- Reading / writing / maths at Key Stage 2
- Attainment 8 and Progress 8 at Key Stage 4
- Young people going onto higher education
- Children attending 'Good' and 'Outstanding' schools
- Number of 16-19 year olds in employment or educated
- Increase the proportion of children with good reading skills
- Promote a whole system approach and improve wellbeing and resilience

Resilient families and supportive networks to protect and grow our young people

- Early Help Intervention
- Reduce the number of first time entrants into Youth Justice
- Increased levels of fostering and adoption
- Improve the quality of social care practice
- Improve the placement stability for our looked after children
- Reduce the impact of adverse childhood experiences

Opportunities for people to fulfil their potential through work, skills and enterprise

- Increase median resident earnings
- Increase the working age population in employment
- Increase the number of people earning above the Living Wage
- Increase number of enterprises / business start ups
- Working age population with at least Level 3 skills
- Increase the number of good quality apprenticeships delivered

Modern infrastructure and a sustainable environment that works for all generations and future generations

- Improve air quality
- Increase the number of net additional dwellings
- Increase the number of affordable homes
- Digital inclusion - average download speeds
- Reduce tonnes of waste sent to landfill and increase the proportion recycled
- Increase journeys by sustainable transport / non-car
- Increase access to public transport

Nurturing our communities and having pride in our people, our place and our shared heritage

- Increase participation in cultural events
- Reduce victims of domestic abuse
- Reduce the number of rough sleepers / homelessness
- Improve satisfaction with local community
- Victims of crime / fear of crime
- Reduce levels of anti social behaviour
- Increase access, choice and control in emotional and mental self-care and wellbeing

Longer and healthier lives with good mental health through better choices and reducing inequalities

- Increase physical and mental healthy life expectancy
- Improve the wellbeing for our population
- Decrease smoking prevalence
- Increase levels of physical activity
- 'Good' and 'Outstanding' GPs practices
- Reduce drug and alcohol related harm

Independence and activity in older age, and dignity and choice at end of life

- Increase the number of people helped to live at home
- Reduce hospital admissions due to falls
- Increase levels of self-care / social prescribing
- 'Good' and 'Outstanding' social care settings
- Prevention support outside the care system

Great Place
Inclusive Growth

Tameside and Glossop Corporate Plan: 'Our People Our Place Our Plan'

The first Tameside Strategic Commission Corporate Plan was agreed in early 2019 as the principal plan for the local system and has been endorsed by all our partners. 'Our People Our Place Our Plan' outlines our aims and aspirations for the area, its people and how we commit to work for everyone, every day. The plan is structured by life course; Starting Well, Living Well and Ageing Well, and underpinned by the concept that Tameside & Glossop is a Great Place, and has a Vibrant Economy. Within each life course we have identified a set of goals that set out what we want to achieve for people in the area throughout their life. A corporate plan dashboard allows us to monitor progress.

The Corporate Plan remains the primary document in Tameside and Glossop and drives the ambition of this Locality Plan which articulates how delivering the priorities of the Corporate Plan will support the people of Tameside and Glossop to live longer, healthier and happier lives.

The development of the Corporate Plan was informed by a range of information including feedback and views from local residents, stakeholders and partners. That included the outputs from large scale strategic activity such as the joint budget conversation and the Neighbourhood Summit.

Public services should be designed around the needs and expectations of people and communities and be relatable to personal experiences. The Corporate Plan is supported by a list of our Public Service Reform principles that define our way of working differently with our residents. These principles are articulated below and drive the ambition and further detail in Section 2 of this plan:

- A new relationship between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services. Do with, not to.
- An asset based approach that recognises and builds on the strengths of individuals, families and our communities rather than focussing on the deficits.
- Behaviour change in our communities that builds independence and supports residents to be in control
- A place based approach that redefines services and places individuals, families, communities at the heart
- A stronger prioritisation of wellbeing, prevention and early intervention
- An evidence led understanding of risk and impact to ensure the right intervention at the right time
- An approach that supports the development of new investment and resourcing models, enabling collaboration with a wide range of organisations.

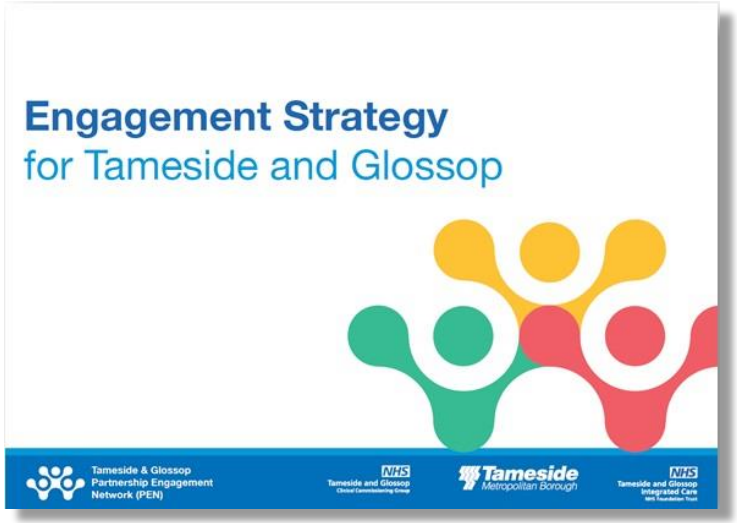
Section 2: A new relationship between public services, citizens and communities

Engaging people and communities in Tameside and Glossop

We are committed to putting the voice of the public, patients and our local communities at the heart of decisions about how we deliver local services. This is key to successful public service delivery and results in better services more appropriately tailored to people's needs. Our commitment to ensuring that the public, stakeholders, partners, and the voluntary, community and faith sectors are central in shaping the way we commission and deliver the best possible outcomes for our population is set out in the Tameside & Glossop Engagement Strategy.

The strategy is jointly facilitated by the Tameside & Glossop Strategic Commission and the Tameside & Glossop Integrated Care NHS Foundation Trust and guided by the Partnership Engagement Network (PEN). This provides a forum for ongoing two-way conversations with the public and stakeholders.

Work to date has covered a wide variety of themes including integrated neighbourhoods, intermediate care, patient voice, mental health, estates, air quality, homelessness, active ageing, supporting ex-service personnel, end of life care, digital skills and new ways to access General Practice. Additionally we have responded to well over 100 local, regional and national engagement and consultation exercises. All our engagement activity is thoroughly analysed and the outputs inform future decision making.



Tameside Co-operative Council and Tameside & Glossop Co-operative Community

Tameside Council became a member of the Co-operative Council Innovation Network (CCIN) in October 2019. CCIN was established to promote the delivery of local services in a co-operative or co-productive manner; our work will focus on a Tameside & Glossop Co-operative Community rather than just Tameside Council as a Co-operative Council.

Co-operative Councils aim to instigate collective action, co-operation, empowerment and enterprise. Although the precise model varies by service we believe that co-operative approaches can be applied to almost everything including community regeneration, economic development, youth services, housing, leisure, social services, health and education.

Co-operative values closely align with our Public Service Reform principles; the values and principles of co-operative working are social partnership, democratic engagement, co-production, enterprise and social economy, maximising social value, community leadership, new models of meeting priority need, innovation and learning.

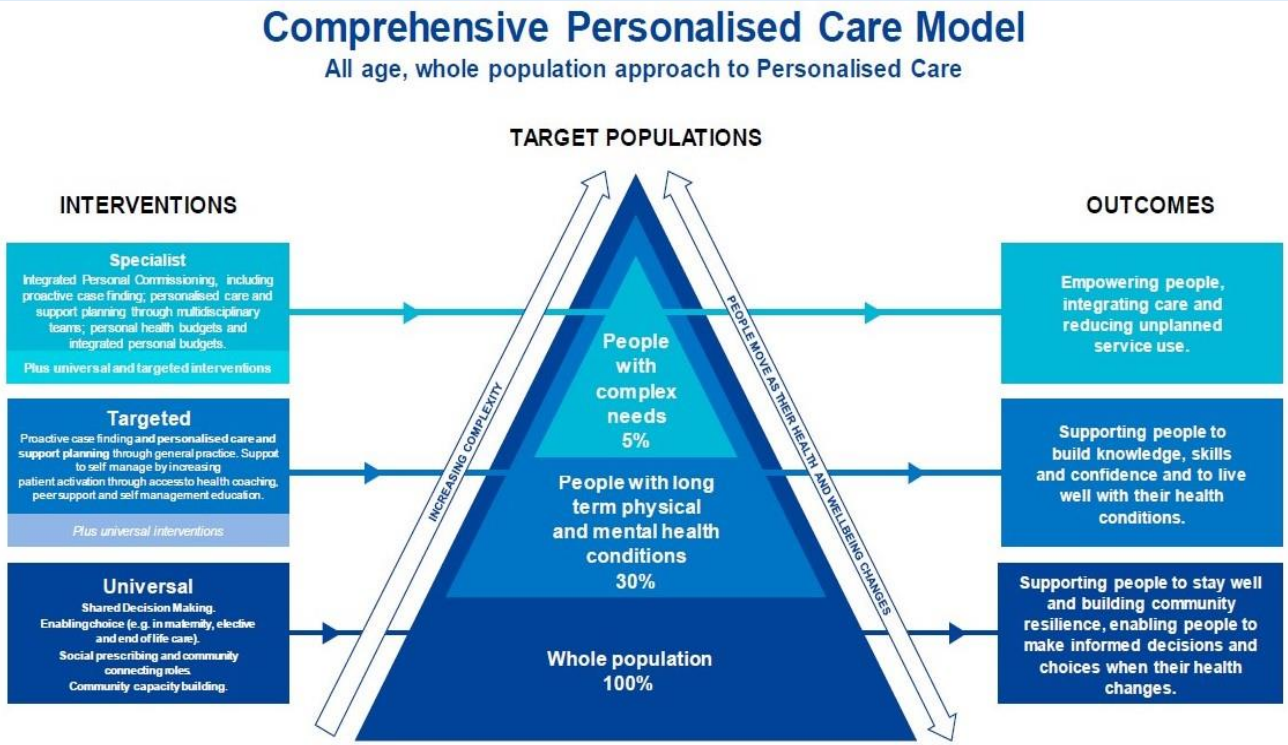
A Personalised Approach to Wellbeing

We recognise the requirement to support a more personalised approach to wellbeing to meet the increasingly complex demand of the health and care system. When people can actively shape their own care and support it often leads to better outcomes and experience. The primary purpose of the health and care system has been to provide periodic treatment for acute illness, it now needs to deliver joined-up support for growing numbers of older people & / or people living with multiple long term conditions.

The increasing prevalence of long term conditions, including people with multiple long term conditions represents a major challenge for how we provide care and support. We need a system that is better at addressing people's multiple health needs instead of channelling people down single condition pathways. In any health and care economy roughly 80% of all activity is generated by 20% of the population – yet even within this high usage group, people with long term health needs only spend a modest amount of time in receipt of direct support from the system. The vast majority of their time is spent at home, with their families and within their communities. This requires a shift in the way we support people with long term health and care needs harnessing and building upon community assets to work harmoniously across partnerships.

To achieve this, we need to be bold in our ambition. We have already made big strides in this area but recognise that we still have a long way to go. In Tameside and Glossop we will:

- Build comprehensive approaches across the public sector to assist people to access support with the wider determinants of health and wellbeing.
- Transform the way in which we support people with long term health and care needs in line with NHS England's Universal Model for Personalised Care.
- Work in partnership with our population and communities on new approaches that help improve health and wellbeing.
- Build an authentic and new relationship with the VCFSE sectors recognising their vital role as equal partners in the delivery of a place based, population health approach.



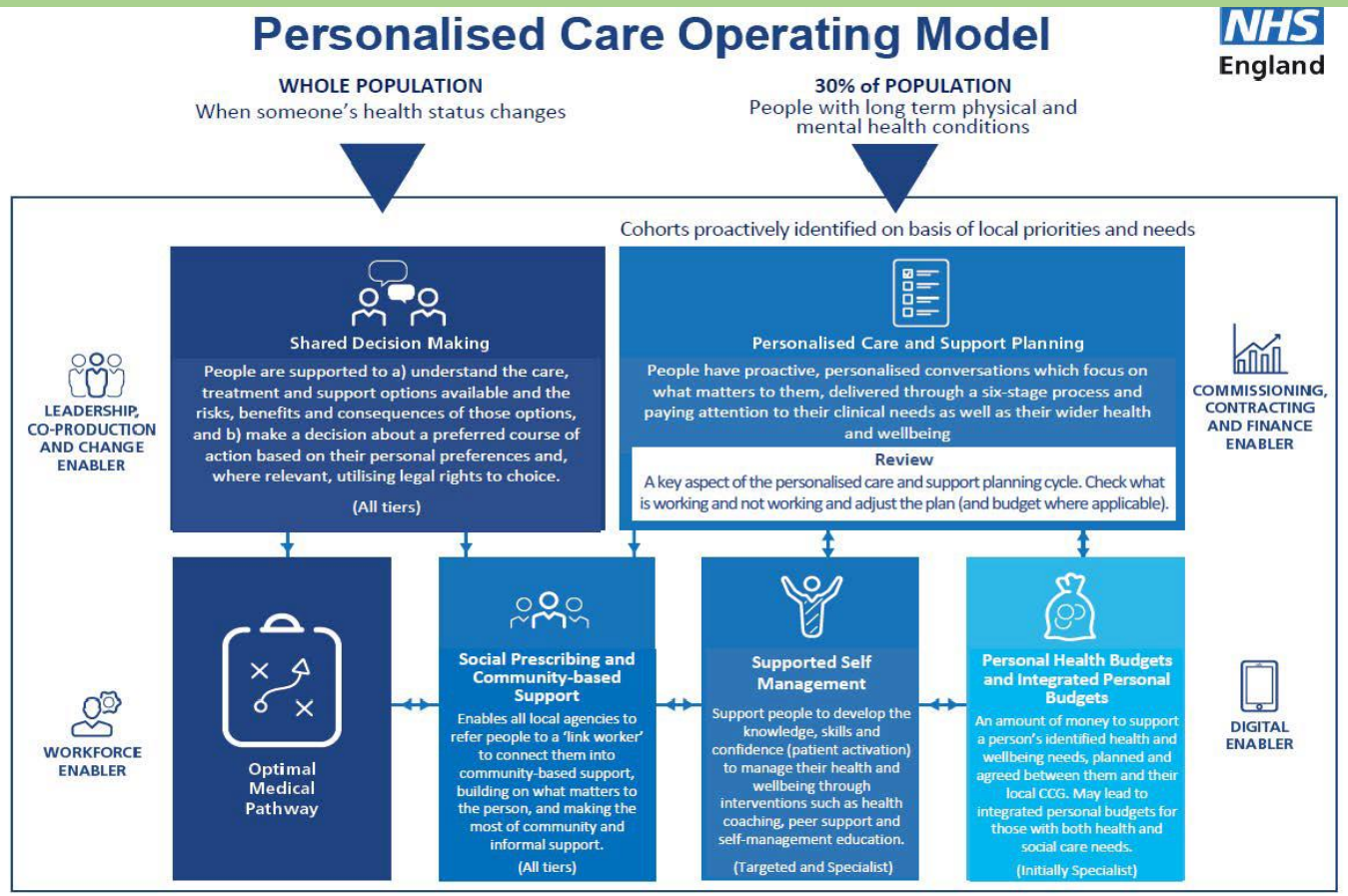
A Personalised Approach to Wellbeing

The Comprehensive Model for Universal Personalised Care (UPC) was published by NHS England in January 2019. It is a complementary document to the NHS Long Term Plan and comprises six, evidence-based standard components intended to improve health and wellbeing outcomes and quality of care, whilst also enhancing value for money. There are a number of key enablers to ensure that this model is effectively implemented which require consideration for successful delivery (see diagram).

This is a response which *must* cross organisational boundaries with senior, strategic ownership from all partners. It is not possible to respond to the system changes required to implement the spirit (and the letter), of the UPC from within any one organisation alone.

This approach of integrating around the person and making the most of the potential of people and their communities, cuts through organisational silos and provides a practical way for people themselves to be the best integrators of their care. This model puts personalised care at the core of the system's integration efforts.

For the past three years as part of our system transformation we have delivered a programme focusing on Person and Community Centred Approaches. This means we have made positive strides towards achieving the aims of the UPC. The impact of personalised care when embracing and delivering on the Universal Personalised Care Model in Tameside and Glossop would achieve a huge shift in people's experiences, their outcomes, the workforce and the system as a whole.



Next Steps for Building a Universal Model in Tameside and Glossop:

1. Establish a multi-agency programme board reaching across the health economy
2. Establish clear leadership and strategy for the programme with the Person & Community Centred Approaches team working on behalf of the economy
3. Develop an ambitious 10 year programme of work supported by a shorter term action plan
4. Co-produce and publish a local vision for Personalised Care with the public and staff.

An equal partnership with the Voluntary Community, Faith and Social Enterprise Sector

Putting people and communities genuinely in control of their health and wellbeing requires an integrated response that focusses on preventative approaches and a shift away from the medical model of illness towards a model of care which considers the expertise and resources of people and their communities. The VCFSE sector are vital delivery components of a modern public service. Anchored in 'place', VCSE sector organisations exist to support and enhance the lives of people and the environment. We are fortunate to have over 1000 organisations locally, each making a unique contribution to engaging citizens and communities in support of agreed place-based priorities.

The Tameside PACT sets out the joint commitment of the Public Sector and the VCFSE to improve the life chances of local people particularly those facing additional challenges, inequalities, and lack of opportunity. We want our local population to be with us on this change to ensure we take bold steps forward in the way we work together and achieve better outcomes as a result. The Pact is a visible, living pledge to our promise to working together differently. We are committed to developing a strategic commitment to partners in Glossopdale; this is complicated by different Local Authority arrangements. We will ensure parity for VCFSE partners in Glossopdale to those experienced in Tameside and will work to develop comparable Pact principles.

PACT Principle 1 – Hear diverse local voices more directly and more often: We want local people to have a meaningful opportunity to be involved in decision making, local priority setting and co-designing solutions. We are committed to working together to create the environment, support, and recognition for a range of diverse local voices to be heard.

PACT Principle 2 – An equal partnership built on trust: We know that VCFSE organisations and Public Sector Partners bring different strengths to and that we must harness all our assets to fully realise our shared potential. Relationships built on openness, honesty and integrity will be the key to our success. We are committed to finding ways for genuine partnership working where we can redress the power imbalances, respectfully challenge each other when needed and come together to achieve our shared ambitions.

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

An equal partnership with the Voluntary Community, Faith and Social Enterprise Sector

The Tameside Pact shows we have a strong commitment to the VCFSE sector, however we know we need to do more; we are committed to meeting the ambition of the GM VCFSE Commissioning Framework and implementing the 6 recommendations of the report as shown below.

1. Embed the importance of the VCFSE:

- We will ensure parity of treatment between the VCFSE sector and other service providers across the health and social care economy.

2. Better knowledge, understanding and access:

- We will recognise and value the diversity and strengths of the VCFSE.
- We will invest in a local infrastructure to connect, develop, strengthen and provide strategic influence

3. Nuanced approach to funding:

- We will use the most appropriate funding and tendering approaches that strengthen the VCFSE offer.
- We will create a strategic and sustainable VCFSE investment board which will acknowledge the value of grants of all sizes.

4. A core focus on co-design and Co-production:

- We will create spaces to co-design and co-produce new ways of working, rooted in relationships, power-sharing and equity.

5. Social Value:

- We will maximise the use of Social Value to consider and secure wider social, economic and environmental benefits from investment decisions.

6. Investing in strategies for building community capacity:

- We will recognise the expertise and strengths of the VCFSE sector as a key partner in the ongoing development of or local integrated systems.

Our neighbourhood model

Following the Place-based reform model developed with GM colleagues we intend to further connect services at the neighbourhood level, designed around the person and their needs. We currently have three distinct neighbourhood teams at different stages of development, these are Integrated Neighbourhood Health & Social Care teams which are coterminous with our Primary Care Networks, Integrated Neighbourhood Service Teams and Children's Neighbourhood teams.

In line with the GM ambition, we are committed to develop our neighbourhood teams to include the full range of partners and move to whole population all-age inclusion where appropriate. The work around adults is well embedded however the establishment of Children's Neighbourhood teams is currently evolving, with the ambition that multi-disciplinary neighbourhood teams will provide wraparound support for children and families to provide Early Help and prevent escalation.

Integrated Neighbourhood Service hubs: Our Integrated Neighbourhood Service Hubs became operational in May 2016 and act as an effective response to delivering front-line services with reduced resources. The Hubs bring together frontline service providers and focus resources where they are needed most. This approach has removed duplication and reduced pressure on service providers. Daily multi-agency meetings take place at the hubs to consider issues affecting residents and communities and to identify families and individuals that are not coping with the stresses of daily life and who are putting pressure onto frontline services. This approach identifies services and organisations that will improve the quality of life for these residents and prevent their personal situations from deteriorating to the point where further strain is placed on stretched resources.

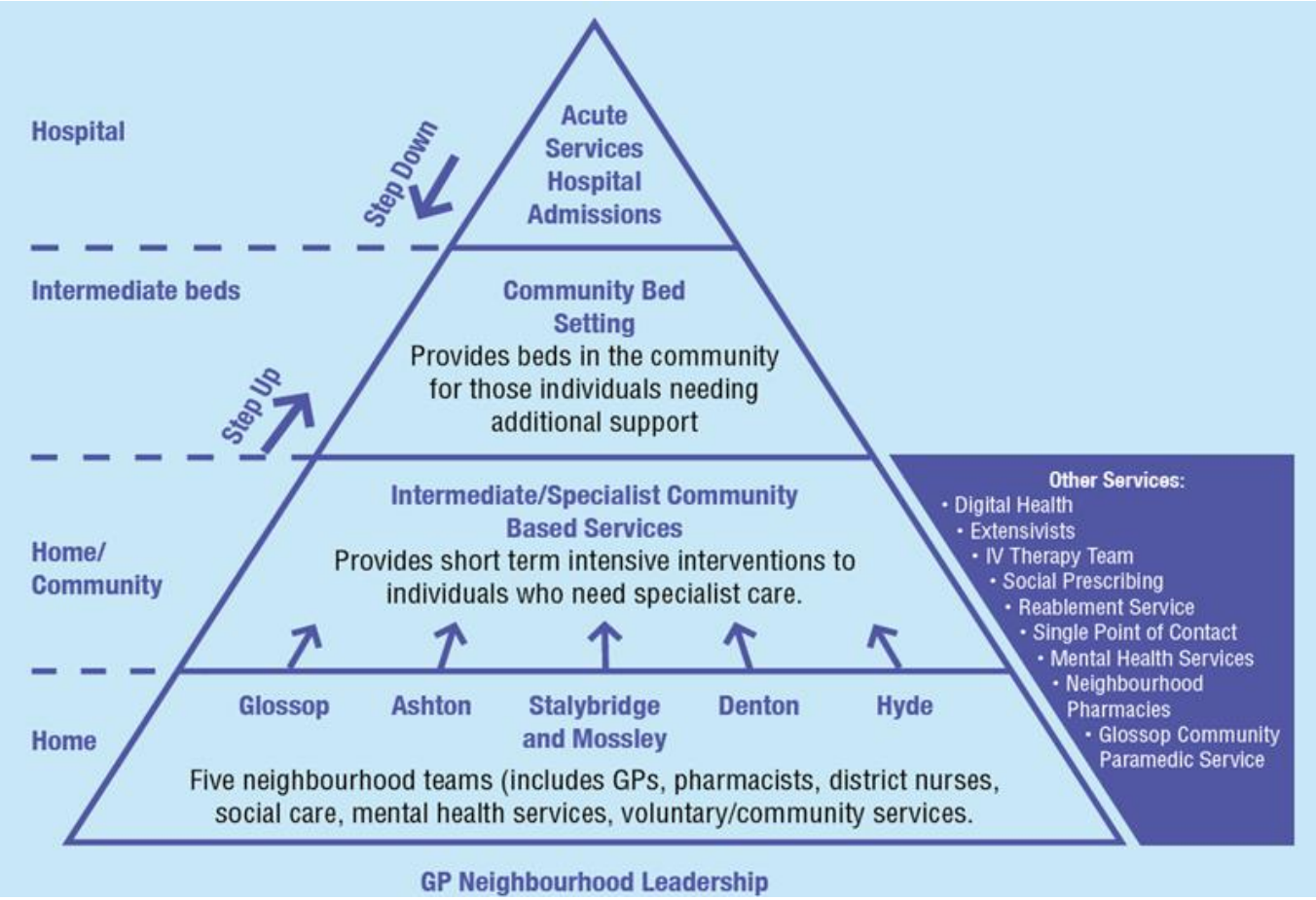
Better use of the public estate: To support our neighbourhood model and ambitions around health and care we will create an estate infrastructure that is geographically aligned to service the needs of a growing population. The infrastructure will meet the short-term priorities and long-term strategic objectives. Our estates model will ensure efficient use of resources and maximise the impact of digital technology and new ways of working.

Integrated Health and Social Care neighbourhood teams

Integrated Health and Social Care services closer to home: Our integrated health and social care model is shown here. We know that individuals have a better experience of care with improved outcomes when their care is integrated around their individual needs and provided as close to home as possible. We have integrated health and social care services within five integrated neighbourhood teams (INTs) made up of GPs and their practice staff, pharmacists, social workers, mental health workers, community nursing teams and community wellbeing co-ordinators.

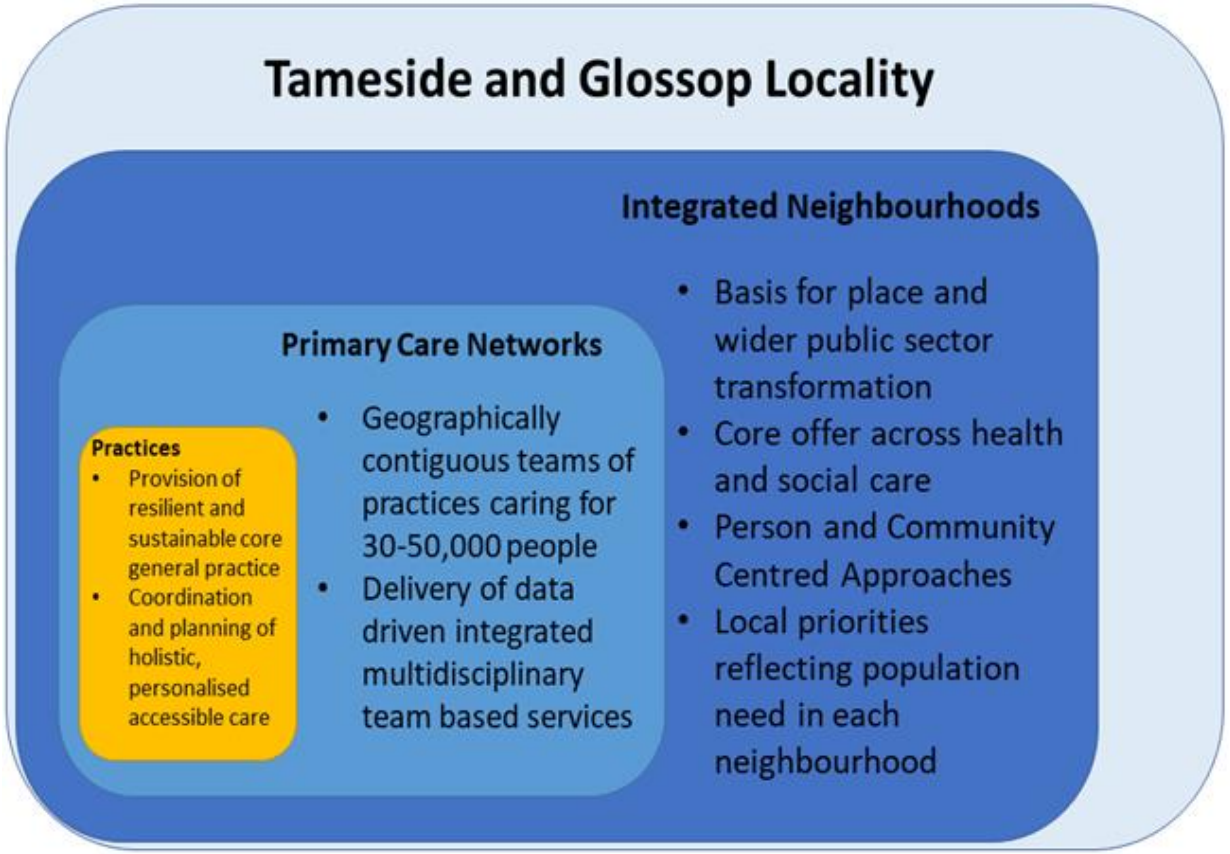
These teams provide a co-ordinated care and support service to people who live in their neighbourhood area who have long-term conditions, other ongoing care and support needs, or who are most at risk of unplanned admissions to hospital. We have developed a system that is holistic and bespoke and recognises that for some people we cannot prevent illness, however we can have flexible and responsive specialist services to wraparound individuals therefore only admitting patients to hospital by exception.

As well as supporting individuals to stay well and remain in control of their health and care, we are committed to providing the best possible care and support when people need it. Our approach to care operates on the “Home First” principle focused around meeting an individual’s needs in their home, or within the community – bringing services to people and avoiding unnecessary admissions to acute services.



Primary Care Networks: Progress so far

- The NHS Long Term Plan introduced the concept of Primary Care Networks (PCNs). PCNs involve the provision of coordinated care through integrated teams with GP practices at the centre. GP practices working together at scale will provide a wider range of primary care services to patients. They will increase access and make better use of collective resources across practices and other local health and care providers to allow greater resilience, more sustainable workload and access to a larger range of professional groups.
- Locally general practice is established within each Integrated Neighbourhood. PCNs will create another dynamic within these however with an opportunity to provide stability and efficiency for general practice through the economies of an increased footprint.
- We have already made significant strides to deliver integrated working practices within our 5 neighbourhoods via our Care Together programme and it was a key indicator of success that our PCNs match our current neighbourhoods. The PCN footprints were approved in Tameside and Glossop in May 2019.
- Our strong local partnerships will help us enter our next phase of PCN development with an increased focus on prevention of illness and personalised care which will allow the system to develop from reactively responding to ill health to proactively providing local leadership and support.
- PCNs will deliver a set of seven national service specifications; structured medication reviews, enhanced health in care homes, anticipatory care (with community services), personalised care and supporting early cancer diagnosis (by April 2020), cardiovascular disease case-finding and action to tackle inequalities (by 2021). To meet this challenge each PCN will receive additional funding to provide a wider range of primary care services to patients, involving a wider set of staff roles than would be possible in individual practices. Importantly, PCN will be tasked with taking a proactive approach to managing population health and, from 2020/21, assessing the needs of their local population to identify people who would benefit from targeted, proactive support.



Section 3: The journey so far
Development of the Strategic Commissioning Function

The development of the Strategic Commissioning Function (SCF) between Tameside MBC and Tameside and Glossop Clinical Commissioning Group (CCG) has been highly successful and required high levels of trust and commitment to partnership working. The SCF allows for a single place-based commissioner focused on wider Public Service Reform alongside key health outcomes. In early 2016 the SCF was established, initially taking the form of a shadow SCF with co-location of commissioning teams and an interim integrated senior management team. In late 2016 the Council Chief Executive was jointly appointed as CCG Accountable Officer with processes undertaken to reduce transaction costs across the SCF. In autumn 2017 a joint Chief Finance Officer was appointed alongside a substantive integrated management structure and The Strategic Commissioning Board was established incorporating Councillors, Governing Body GPs and Executive Directors.

The Integrated Commissioning Fund (ICF) was established in 2016 underpinned by a robust financial framework. Initially it included only Adult Social Care, Children's Services and Public Health budgets from the Council alongside the total T&G CCG allocation including delegated Primary Care co-commissioning budgets. The ICF expanded to include all TMBC and CCG commissioning allocations in 2018-19. The ICF has brought a range of benefits including streamlined governance and decision making, the rationalisation of joint funding arrangements, alignment to the single leadership structure and single budget reporting.

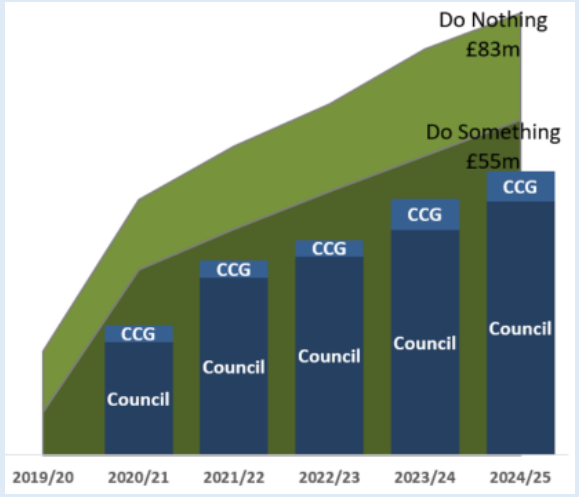
The ICF comprises of three separate funding allocations:

- Section 75 budgets relate to services that sit within the pooling arrangement under Section 75 of the NHS act 2006. The SCB can make binding decisions on behalf of TMBC and T&G CCG.
- Aligned budgets relate to services that the regulations specify cannot be pooled under Section 75, but which will be managed alongside the Pooled Fund. SCB can make recommendations on the spending of this funding which requires ratification by the relevant statutory organisation.
- In collaboration budgets relate to services that the regulations specify shall not be pooled under Section 75, where the CCG and Council have limited direct influence over the utilisation of these funds, or where expenditure is not directly related to service delivery. Budgets include delegated co-commissioning in Primary Care, Dedicated Schools Grant, levies payable to the GMCA, Housing Benefits Grant and Capital Financing costs. SCB can make recommendations on the spending of this funding which requires ratification by the relevant statutory organisation.

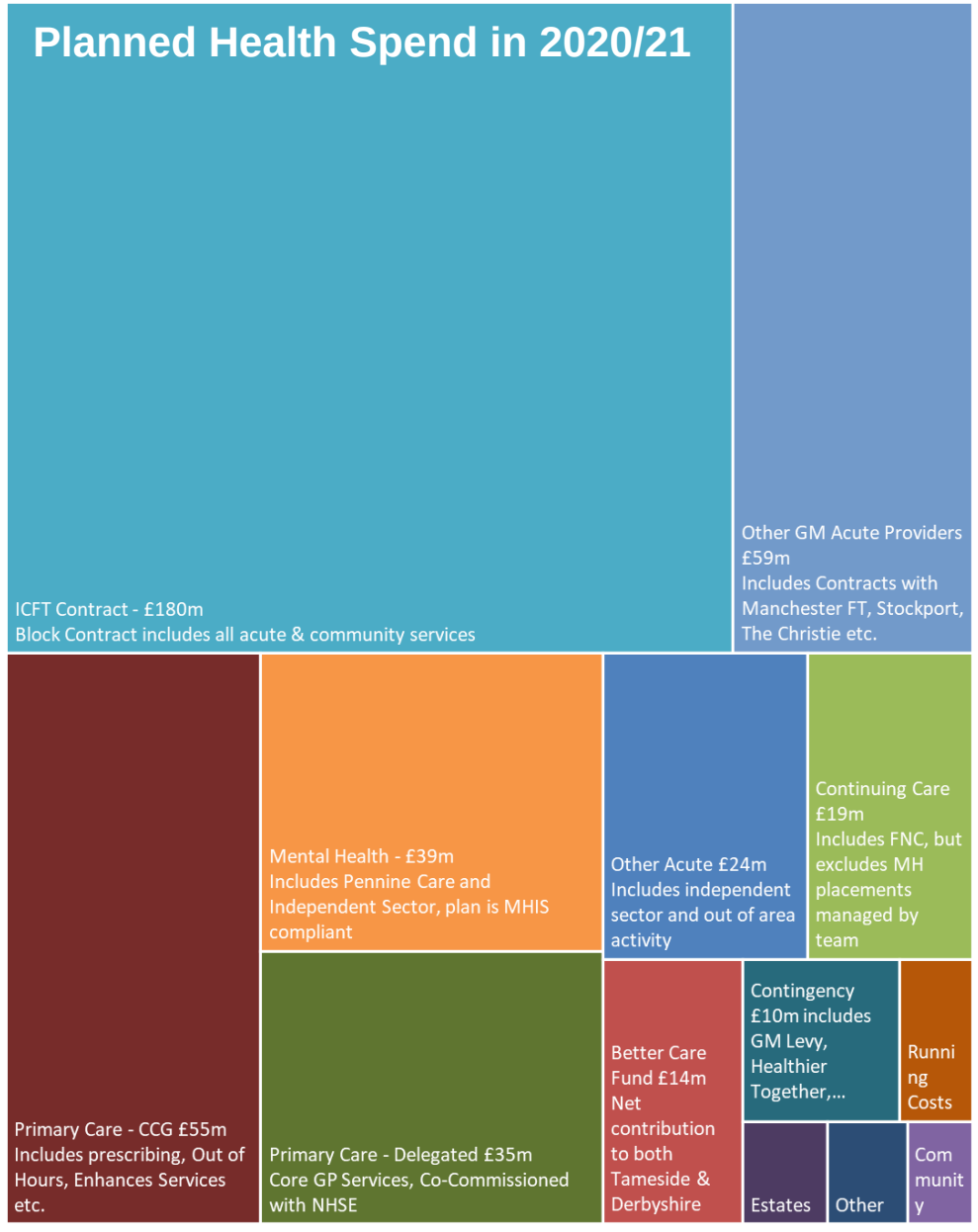
The SCF is developing a series of integrated contracting and funding mechanisms with its principle partners including T&GICFT, General Practice and Pennine Care NHS FT that incentivise the achievement of interconnected health and social care outcomes and meet the needs of the Tameside and Glossop population.

Financial position

- Since October 2017 Tameside & Glossop CCG and Tameside MBC have shared a single Chief Finance / S151 Officer. Under this single leadership we have created one integrated finance team managing a combined Integrated Commissioning Fund (ICF) of circa £1 billion. CCG, Council and ICFT are on track to deliver against financial control totals in 2019/20, this has been assisted by utilising various non-recurrent measures. Continued work is required to drive recurrent savings and efficiencies. Planned health spend in 2020/21 is £433m.
- We have developed 5-year financial plans to support our strategic objectives whilst achieving and maintaining financial stability. These plans look at expected future expenditure, incorporating demographic change, the requirements of the NHS Long Term Plan and other known and anticipated pressures. Under a "Do Nothing" scenario the financial gap across the ICF is expected to grow to £83m by 2024/25. Savings and efficiency plans are currently in place to address some of this gap and we expect that these plans will deliver savings of £28m p.a. by 2024/25. This leaves a residual financial gap of £55m p.a., which we must address. Amongst other things this will require us to reduce demand by further commitment to personalised preventative and proactive care.



- Our locality plans assume the financial gap will be closed and all financial control totals will be met. This incorporates a degree of risk, but as an economy we are committed to achieving operational financial balance; delivering a Council balanced budget and a 1% CCG surplus; compliance with the Mental Health Investment Standard, managing within cash limits and achieving the CCG running cost target.



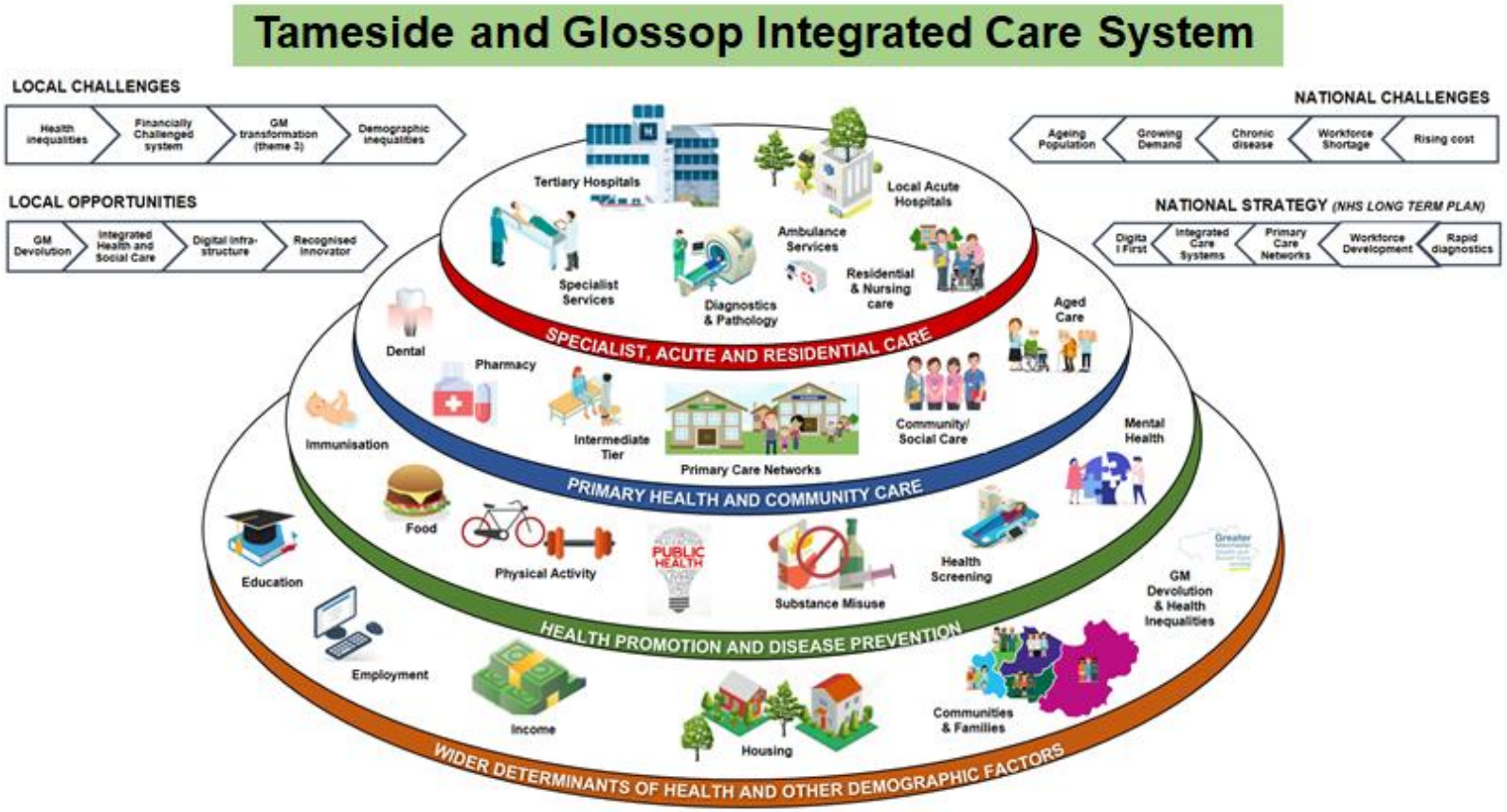
Development of an Integrated Care System

The ambition is to create a truly integrated care system for Tameside and Glossop. Our commitment to develop an Integrated care Organisation (ICO) began in 2013 when the system came together to respond to financial challenges in the CCG and clinical quality challenges at Tameside Hospital Foundation Trust which was placed in special measures. To improve outcomes, better manage demand and ensure long-term financial sustainability, plans were agreed in 2015 to a shift of emphasis for the hospital trust away from providing purely acute hospital services to becoming the lead provider for a range of integrated health and care services and a community-based model of care.

The system identified that key to the financial and clinical sustainability of the Tameside and Glossop Health and Care system is that care is provided as close to home as possible, avoiding high cost settings and hospital attendances where they are not necessary. In 2016 community health services for Tameside and Glossop became part of Tameside Hospital NHS Foundation Trust and the Trust became Tameside and Glossop Integrated Care NHS Foundation Trust (T&GICFT).

The transformed system committed to ensuring that services are responsive to people's needs, collaborate with communities to ensure people have the resources they need to stay well and ensure that the care provided puts people at the centre, recognises their expertise and maximises their potential to manage effectively.

The transformed model has a much stronger emphasis on ill-health prevention, supported self-care and better management of care for people with long-term conditions (which accounts for the bulk of NHS expenditure). This approach to care formed the basis of the Contingency Planning Team report, approved by the regulator Monitor in Sept and is in full alignment with the GMHSCP plans and the NHS Long Term Plan.



Transformational investment in Tameside and Glossop Integrated Care Foundation Trust (ICFT)

To support the transformation of our health and care services in Tameside and Glossop we successfully secured £23.2m of non-recurrent transformation funding from Greater Manchester Health and Social Care Partnership (GMH&SCP) over a three year period 2016 - 2019. This funding was invested into a number of schemes which support our vision of new models of care. Outlined on the next pages, these aim to better support people in their own homes, reducing the likelihood of hospital attendance and admissions, and to ensure that people are as well supported as possible to live healthy and independent lives. The impact of these programmes in 2018/19 are demonstrated in the table below.

All of these schemes aim to change behaviours or services within the Tameside and Glossop health and social care system, to contribute to delivery of the proposed system benefits, and impact on the successful delivery of the locality ambitions of financial sustainability and healthy life expectancy, support the transform local services, accelerate the integrated care model and provide better, more efficient care pathways for patients across health and social care.

The investment supported a range of transformational projects including enabling programmes of organisational development to support the development of new integrated teams, changes to the home care service model to focus on a personalised and outcome based service rather than the traditional depersonalised time and task model. Additionally, the establishment of five neighbourhood integrated teams incorporating Primary care networks, General Practice, pharmacists, social workers, support for mental health, community nursing teams and community wellbeing co-ordinators. These teams provide co-ordinated care and support to people who live in their neighbourhood area who have long-term conditions, other ongoing care and support needs, or who are most at risk of unplanned admissions to hospital.

To help bridge the gap between hospital and community services the ICFT have also brought together community services and developed a range of new specialist services into the Intermediate Tier Services directorate. These provide core community health and care services to support people to live healthy lives, as well as specialist, short term interventions in people's homes or within neighbourhoods, to allow people to be discharged from hospital and cared for in their home as early as possible or avoid a hospital admission all together.

ACTIVITY	BENEFIT IN 2018/19
Reduction in Emergency Department Attendances	**2,598** attendances
Emergency Admission reductions	circa **900** admissions
Bed days saved	**9,124** bed days saved
Number of acute Beds saved	**21** beds
GP care home visits saved	**2,114** visits
Care Home Hours saved (not spent at ED)	**6,552** hours
Outpatient Appointments saved	**327** saved
INDICATIVE SAVINGS FROM TRANSFORMATION SCHEMES	**£3,162,232**

ICFT New Models of Care: Reducing demand through transformation (1)

The **New Models of Care** programme included a number of specific transformational schemes to reduce demand in the system. These are described below**:**

- **The Integrated Neighbourhood Teams** provide a single point of contact for individuals using services and bring together resources to ensure that patients experience well-planned and well-coordinated care which is embedded within wider community support. Adult Social Care functions and staff are scheduled to transfer from Tameside TMBC to ICFT in 2020. This will further integrate care for our population and ensure that we are eliminating organisational and professional boundaries to achieve high quality and effective care.
- **Integrated Urgent Care Team (IUCT)** includes therapists, nurses, social workers and wider support staff. The team works between the hospital and the community, supporting people who are experiencing difficulties within their own home who have been discharged from hospital, intermediate care or other health and social care environments. The team respond to people with urgent care needs to ensure that they receive the help they need and avoid unnecessary admissions to hospital. Since April 2017 this initiative has reduced pressures on the Emergency Department and saved 7500 bed days and showing indicative savings of £1.1m.
- **Community Intravenous (IV) Therapy** 7 days per week; this supports patients needing IV therapy to be discharged from hospital earlier and receive safe and effective care in their own home. Since August 2017 this service has saved 5000 bed days with savings of £365k.
- **Neighbourhood Pharmacists** work closely with individuals in need of additional support to optimise patient outcomes through effective use of medicines. This helps individuals to live independently in the community with reduced need for unplanned and emergency admissions.
- **Digital Health** uses new digital technologies to help deliver the healthcare needs of people living in care homes, by providing a platform for people to have a ‘virtual consultation’ with the digital health nurse where clinically appropriate. This programme ensures that an individual’s needs are accurately assessed and met as swiftly as possible while individuals remain in their own home. This improves care, prevents health conditions escalating and reduces unnecessary admissions. Since April 2017 this service has received 12200 calls, prevented over 3500 Emergency attendances, 1270 GP visits and saved 9016 care home hours spent in ED.
- The **Extensivist Service** supports individuals with complex needs to help them manage their conditions and reduce the number of times they need to come into hospital in a crisis. This has saved 186 bed days, prevented 323 outpatient appointments and 670 emergency attendances with a net saving of £110k.

ICFT New Models of Care: Reducing demand through transformation (2)

- **Flexible Community Beds** provides both “step up” capacity to avoid unnecessary acute admissions and “step-down” capacity to support the efficient discharge of patients. This provides temporary intermediate care for individuals to enable them to undertake rehabilitation and return home where possible. This service has allowed for a reduction of 12 community beds and recurrent savings of £979k.
- We have delivered a **Person and Community Centred Approaches Programme** which has been delivered at scale across each of our five neighbourhoods. We have embedded a comprehensive model of social prescribing now attracting 2,000 referrals a year, have worked to implement self-management approaches, including the use of the Patient Activation Measure and have built a programme of volunteering across 8 practices in Tameside and Glossop. This programme has also worked to grow capacity in the voluntary and community sector.
- **Connecting Care for Children** provides additional resource within neighbourhoods with primary and community care services having access to specialist Paediatric Consultants through monthly multi-disciplinary clinics held in the community to provide education and intensive support to children and families with complex health and care needs.

The Strategic Commission is committed to continue investment into the schemes which have shown significant benefits to patients and the system. All of the schemes are subject to a rigorous evaluation via our partnership with the University of Manchester which is due for completion late 2020.

Alongside the schemes that have benefited from transformational funding, the ICFT and system partners have also implemented a series of programmes to transform and develop existing services within the integrated model of care to improve outcomes, this includes:

- **Advice and Guidance** allows GPs to obtain urgent advice from hospital consultants, to safely managing patients in primary care. This supports GPs to ensure a patient’s condition is treated appropriately and reduces unnecessary referrals.
- **E-referrals** ensure that there is a single method of referring in to the ICFT for consultant led out-patient services. This more efficient referral system eliminates much of the paperwork and time lag associated with non-electronic referrals, and will help ensure that patients are seen in a timely and efficient manner.
- **Urgent Care Treatment Centre:** Tameside and Glossop are committed to ensuring patients with an urgent need are seen by the right professional in the right place first time through an effective Urgent Care offer. A new Urgent Care Treatment Centre has been located on the hospital site next to A&E to ensure that patients are treated in a timely manner by the most appropriate healthcare professionals.

ICFT New Models of Care: Tackling Health Inequalities

The ICFT recognises the impact of health inequality on the local population and has developed a set of system-wide partnership health inequality programmes as part of the implementation of the integrated model of care to tackle inequality and improve outcomes for major health conditions. These include:

- Frailty & falls
- End of Life and Palliative care
- Cancer
- Targeted Lung Health Checks
- Respiratory
- Heart Disease
- Diabetes
- Stroke care

This comprehensive transformation programme has reduced demand on a stretched system and improved efficiency:

- 19% reduction in Delayed Transfers of Care
- 2.1% increase in Emergency Department attends in Tameside compared to 4.1% Nationally
- Average non-elective length of stay reduced by 0.5 days *(allowing the Trust to manage growth without increasing beds)*
- Increased % of T&G residents being admitted at the Trust instead of other hospitals *for* non elective admissions.

ICFT New Models of Care: Integrated Care for Population Health

Recognising that population health and wellbeing is about more than high quality healthcare services and the expanded role an integrated care organisation plays in the health and care system, the ICFT have developed a five year strategy **'Beyond Patient Care to Population Health'** with a bold vision to:

"Improve health outcomes for our population and influence the wider determinants of health, through collaboration with the people of Tameside and Glossop and our health and care partners".

To deliver this vision the ICFT aims to:

- Support local people to remain well by tackling the causes of ill health, supporting behaviour and lifestyle change, and maximising the role played by local communities to enable people to take greater control over their own care needs and the services they receive.
- When illness or crisis occur, provide high quality integrated services that are designed around the needs of the individual and are provided in the most appropriate setting, including in people's own homes.
- Develop and retain a workforce that is fit for the future needs of the organisation; Reward talent; and instill pride in the workforce which demonstrates our Values and Behaviours and has the skill and ambition for continuous improvement
- Work with partners to innovate, transform and integrate care provision in Tameside and Glossop and in doing so contribute to the delivery of financial sustainability.

Transformational investment: Digital Health Service

The **Digital Health Service (DHS)** is a team of Nurse Assessors based in the Digital Health Centre at Tameside Hospital who undertake remote, visual consultations on urgent health needs as they arise using SKYPE. The service works with NW Ambulance Service to identify patients.

The service commenced March 2017 in 4 care homes and is now operational in 46 of 47 homes in Tameside and Glossop as well as within the community response service and with individuals and their carers in their own homes.

Before Digital Health:

- An ambulance would have attended and Mary would have been conveyed to Accident & Emergency
- Admitted for rehydration and social care assessment
- Potentially extended length of stay
- Discharged back to care facility for rehabilitation (potentially long term).

Case study 1:

Mary is 82 and lives in a ground floor flat. She has a care package with 4 visits a day. On this occasion when the carer arrived she found Mary on the floor. The carer called an ambulance as she could not get Mary safely from the floor. The DHS saw the incident on the 111 / 999 call stack and contacted the carer who clarified that Mary appeared to be in no pain moving all limbs. Once the DHS had completed the triage and ruled out any obvious injury and Red flags, they contacted the Community response service (CRS) to request assistance at the scene.

The CRS attended and skyped her into the DHS, recorded her observations and examined her under the supervision and guidance of the DHS Nurse. Following this assessment the CRS stated that they felt it would be safer if the DHS Nurse could meet them at Mary's flat to assist her from the floor. They worked together to assist Mary back to her feet. As she remained a little unsteady they helped her back to bed and ensured she had access to a commode, drinks and sandwiches. After a general chat, Mary agreed that the team could refer her to social prescribing as she felt lonely and isolated. Finally a GP visit was arranged for the following day alongside a Multi-disciplinary team meeting. All these interventions were put into place in one visit and supported Mary to remain at home.

With Digital Health:

- Mary falls - Pendant alarm pressed
- CRS on the scene with Skype in to a DHS assessment confirming patient safe to be moved
- CRS use lifting equipment to move patient safely
- Patient unsteady on feet DHS refer to Integrated Urgent Care Team for physio assessment
- Observations recorded and drink given
- GP review requested by DHS
- Patient recognised as socially isolated and referred to social prescribing
- Mary remained safely at home.

Health Indicators: Progress

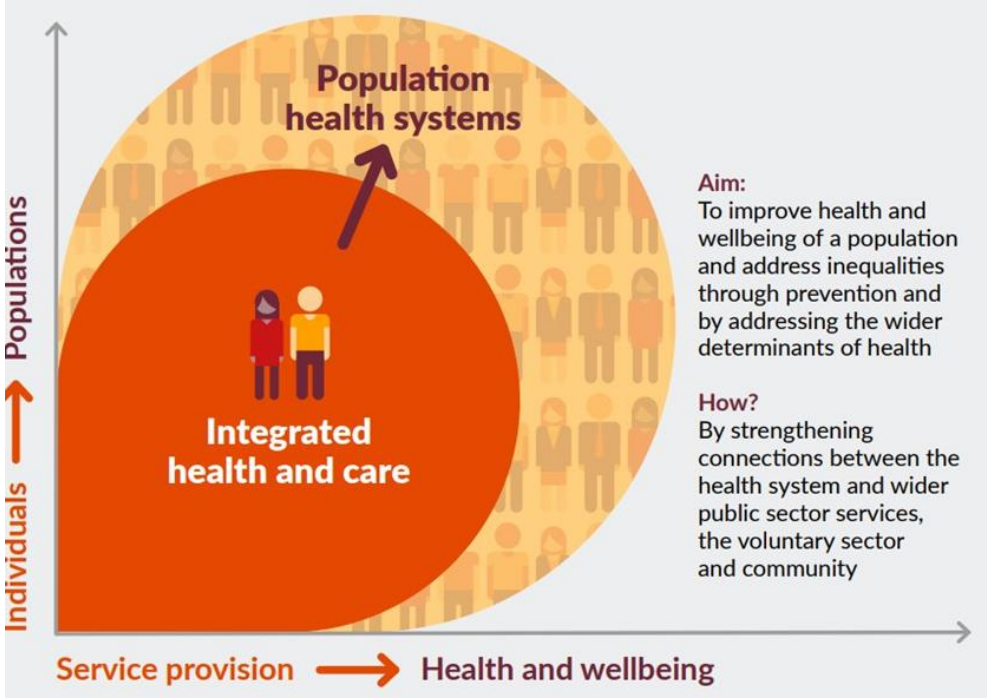
The previous locality plan written in 2015 committed to improve health outcomes with progress monitored via a range of indicators. Whilst many health outcomes will take a longer-time period to influence it is encouraging that 61% of the measures have improved with 6% staying the same. A summary of progress in key areas is outlined below.

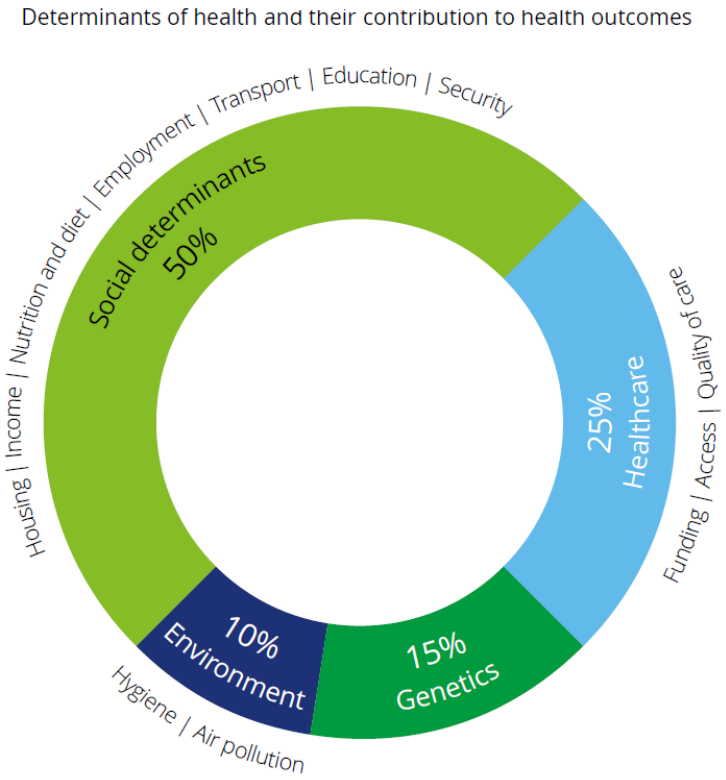
- **Premature mortality** from all causes (-4.1%), cancer (-7.7%) and cardiovascular disease (-11.5%) has seen a marked decrease with the gap narrowing by 35% from GM and 11% from England. Although we are seeing an overall reduction in premature mortality the gap for respiratory conditions remains a concern, this is likely to be driven by high historical rates of smoking, additionally infant mortality has increased, deaths from causes considered preventable have slowed and deaths from suicide and drug and alcohol misuse are on the increase.
- **Life expectancy** is a key proxy measure of the overall health of the population and we have seen no significant change in this figure. **Healthy life expectancy** indicates the number of years a person will live in good health, it is of concern that currently there is a 19.4 year gap for males and a 22.7 year gap for females between life expectancy and healthy life expectancy.
- **Smoking rates at time of delivery** are now considerably lower than they were 10 years ago although we have made limited progress since 2015/16 (-0.6%). **Adult smoking prevalence** has reduced considerably since 2015, with 7,719 less people aged 18 years and over now not smoking; the gap between Tameside and England has closed by nearly half (4.8% in 2015 to 2.6%).
- **School readiness** has improved by 4.5% since 2015/16 with 66% of children reaching a good level of development at 5 years. School readiness for children in receipt of free school meal status has improved (51.9%) but the attainment gap remains substantial.
- **Excess weight in reception year children** has seen a slight reduction but it is concerning that **excess weight in year 6 children** continues to increase. We have the 3rd highest level of excess weight in this age group in GM, with 37% of year 6 children overweight or obese. **Overweight and obesity** in adults has reduced slightly but 65.5% of the adult population are carrying excess weight and we remain behind England and GM.
- **Hospital admissions for unintentional and deliberate injuries in children** have decreased significantly and we are now similar to England for 15-24 year olds but worse for children aged 0-14 years. **Alcohol related hospital admissions** have been reducing year on year and although still significantly worse than the England average, the gap between Tameside and England has closed significantly.
- **Falls in older people aged 65 years and over** have reduced across all age ranges and we have a lower rate than GM and England.
- **Deaths in usual place of residence** has seen nearly an 8% increase since 2015; this is the biggest increase in England.
- **Dementia** is now slightly higher than it was in 2015, this rise was anticipated due to our ageing population. Dementia is now one of the biggest causes of death in people over 75 years in Tameside & Glossop.

Section 4: Delivering our ambition
Health Indicators: Wider determinants

We know that the health of our population is improving, however it is also clear that we need to do more. Our health system is high performing with the CCG rated as outstanding, the ICFT rated as Good with outstanding elements and 97.4% of GPs rated as Good or Outstanding.

The primary purpose of the health and care system has been to provide periodic treatment for acute illness, to be successful we need to further develop a population health system which reduces the demand on health services. This will be done by the delivery of joined-up support for growing numbers of older people & / or people living with multiple long-term conditions alongside a greater focus on proactive, predictive, and personalised Early Intervention and prevention.





We recognise that delivery of health services only accounts for approximately 20% of health outcomes and to make a significant improvement we need to strengthen connections across the system to address the wider determinants of health and empower our communities to feel confident in managing their own wellbeing. This approach is evidenced in our Corporate Plan and associated dashboard.

A modern, progressive and inclusive workforce for Tameside and Glossop

Attracting, developing and retaining a resilient multi sector workforce is a key requirement for supporting the system wide aspirations of this plan. We are committed to meeting the ambition of the GM Workforce Charter as part of our own workforce and those of commissioned partners.

In order to meet the vision for the workforce, colleagues from the HR and Organisational Development community across health and social care have worked collaboratively for many years on a number of key workforce initiatives. Programmes of delivery achieved to date include:

- The establishment of co-located integrated neighbourhood teams.
- Whole system engagement events enabling staff to shape service development and improvement activities designed to enhance service provision.
- The creation of the 16th standard of the Care Certificate programme, this is unique to Tameside & Glossop and is focused around Self-care. This is now fully embedded within the ICFT and Home Care providers and we aspire to introduce it to the private care home sector.
- The establishment of an active forum made up of colleagues from primary care, secondary care, CCG and the Council which identifies workforce challenges inherent in the system and endeavours to address these by developing innovative and sustainable solutions.

The **Primary Care workforce** is a key priority locally. We will create a sustainable primary care workforce, delivering our neighbourhood model of care that is wrapped around the needs of people and their communities while improving population health outcomes. To support this we will develop a Primary Care Workforce Academy as well as committing to the key themes of the GM Primary Care Workforce Plan, specifically:

- Focus on recruitment and retention
- Grow our own
- Career development opportunities
- Training and Education

This work programme will improve recruitment and retention, have a robust training and development infrastructure and enable a workforce that is:

- Diverse, with a skill mix that is able to respond proactively to local population needs.
- Responsive to the changing needs of staff.
- Able to interface across the wider health and care system.
- Able to make a clear contribution to improving population health outcomes.
- Able to maximise the opportunities to work to their full potential.
- Motivated, resilient and stable to ensure high quality service delivery.
- Empowered to lead or engage in service improvement
- Flexible to respond to changing needs in a dynamic system
- Digitally enabled to keep pace with new technology

Living Life Well: Mental Health Transformation

We are committed to improving child and adult mental health, narrowing the gap in life expectancy, and ensuring parity of esteem with physical health. Mental Health is a cross-cutting theme of all the programmes of work within this Locality Plan. We are committed to shifting the focus of care to prevention, early intervention and resilience and delivering a sustainable mental health system in GM requires simplified and strengthened leadership and accountability across the whole system.

The Tameside and Glossop Mental Health Strategy has been developed to meet the challenges of the Five Year Forward View for Mental Health, the NHS Long Term Plan and our Corporate Plan. Co-produced within our Living life Well Programme, the strategy is based on a shared vision for Mental Health services and commits significant additional investment to achieve the outcomes below:

Mental Health Strategy outcomes

1. People are connected and able to participate equally in society
2. People are able to recover and live life well
3. People have control over their lives

These outcomes will be achieved by delivering on our three priorities:

1. Increase opportunities for people to stay well in the community
2. Increase opportunities to get help before / during a crisis
3. Make effective use of secondary care

1. Increase opportunities for people to stay well in the community

At the heart of our Living Well Programme is neighbourhood mental health development, focused on supporting people with multi-faceted needs who have not always received co-ordinated support in the past. This includes significant additional investment into a new multiagency Neighbourhood Mental Health Team who use asset based coaching to support people to improve their mental health. We will also improve physical health by increasing the uptake of NHS health checks for people with learning disabilities and those with serious mental illness and dementia.

We have committed additional investment to expanding capacity to deliver the access and waiting time standards for psychological therapy (IAPT) and the quality and capacity of our early intervention in psychosis provision. The ambition is to embed psychological therapies into long-term condition services to integrate mental healthcare with physical healthcare.

We are developing an Integrated Dementia Pathway and increasing support in the community. Dementia practitioners and Alzheimer's Society Dementia Support Workers are co-located in each neighbourhood.

Neurodevelopmental provision: We have committed additional investment for the autism and Attention Deficit Hyperactivity Disorder (ADHD) teams to reduce waiting times and increase support including extra resource within the neighbourhood mental health team.

Living Life Well: Mental Health Transformation

2. Increase opportunities to get help before / during a crisis

The Neighbourhood Mental Health Team offers easy access to support through drop-ins in each neighbourhood, including in the Anthony Seddon Centre. The Team deliver a STORM pathway, offering suicide assessment and proactive intervention. The Community Mental Health Teams support people with serious mental illness and are vital to keep people well in the community. The development of a new model of care is underway in Pennine Care Foundation Trust and, in time further integration is planned, in line with the national proposal to develop new models of integrated primary and community care for people with serious mental illness. We have committed additional investment to:

- Expand the Liaison Mental Health Teams that work in the Emergency Department and on the inpatient wards in the hospital.
- Expand the capacity and interventions offered by the Home Treatment Team and integrate this with the new safe haven, providing community crisis services 24/7.
- Establish a new overnight safe haven on the hospital site providing opportunity for extended assessment, short term crisis support and intervention for people in crisis who have had a mental health assessment.

3. Make effective use of secondary care (in-patient beds and specialist community home treatment teams)

Efforts to promote timely discharge and reduce Delayed Transfers of Care (DTOC) through proactive in-reach from the CCG and Social Care in Tameside and Derbyshire has had a very positive impact on reducing delays. The safe haven and the expanded Home Treatment Team will reduce the number of short stay admissions to the mental health wards and also support early discharge.

The requirements to improve the in-patient offer through meeting safer staffing and increasing the therapeutic offer are being explored as part of the Pennine Care Sustainability and Transformation review. Opportunities to develop specialist provision are being explored with other CCGs with a view to improve patient experience, reduce costs and provide care closer to home.

Learning Disabilities and Autism: We are committed to reducing health inequalities and will focus on “Building the Right Support” for people with a learning disability. Transforming Care remains a priority for our locality and we continue to work with partners to develop support to prevent admission including developing specialist provision closer to home. The Learning Disability Partnership and Autism Strategy Group are working to deliver the GM Strategies and ensure we progress towards meeting the national learning disability improvement standards over the next five years. This will include identifying requirements to reduce waiting times for access to specialist services for diagnosis and also ongoing support.

Living Life Well: Mental Health Transformation

The Very Best Start in Life for Children and Young People

- All partners are working together to integrate services that support families within Tameside neighbourhoods. This includes co-locating teams and integrating services around the presenting needs of the family, working to the Signs of Safety model. By 2021, an additional 1920 children and young people will have access to specialist mental health services. This will equate to 35% of those children and young people with a diagnosable mental health condition.
- The inclusion of psychological approaches within the integrated **Family Intervention Service** will improve outcomes and reduce the numbers of children who become looked after by providing comprehensive support to families early and to those on the edge of care. This service will also support the young people and their families on the Transforming Care Dynamic Support Database, in line with the Ealing model.
- Local pathways are being developed to ensure effective integrated working with the new GM Children and Young People Crisis Care developments. 80% of children with an eating disorder will receive treatment within one week in urgent cases and four weeks for non-urgent cases, supported by the community eating disorder team.
- **Integrated Perinatal / Parent Infant Mental Health Pathway:** We plan to develop an integrated service by bringing together our long-established parent infant mental health pathway, with the new specialist GM Perinatal Community Mental Health Team to achieve ambitious local and national targets.
- **Special Educational Needs and Disability (SEND): Neurodevelopmental pathways** – following a review of the autism and attention deficit hyperactivity disorder pathways waiting times to support and diagnosis should be reduced. Plans are being developed to explore options for developing a **0-25 integrated service** including education, health and social care.
- A new service, Helping at Home, is being mobilised to provide support to families with a child with learning disability and / or autism aged under five where the families are looking for support regarding behaviour. We are establishing a specialist intensive support team to support children and young people with a Learning Disability and / or Autism whose behaviour challenges and puts them at risk of needing residential care or hospital admission.
- We plan to establish a single point of entry into services that support families; this will include access to Early Help and CAMHS, as well as VCFSE support. This will work with the Team Around the School approach.

STARTING WELL

Case study 2:

Tameside loves reading is a three-year programme that acts as an umbrella to a range of services, projects, initiatives and strategies being delivered to children, young people and adults across the borough, harnessing a love and enjoyment of reading and improving literacy skills.

Aims:

- To encourage a love of reading
- To improve reading skills and wider educational achievement in children and young people to help them secure better work and life opportunities.
- To offer a wider range of reading choices and broaden views to develop and extend the reading experience by using reading to inspire creativity and imagination
- Promote literacy skills and raise educational standards
- Promote social interaction, conversation and community experiences through reading
- Encourage more parents, grandparents and carers to read with their children, supporting the home learning environment
- Inspire a wider love and enthusiasm for books and reading among Tameside families
- Recognise the importance of speech, language and communication for the development of children's reading skills.
- Work with partners and businesses across the borough to raise the profile of reading.

Tameside READING

Projects delivered so far via this initiative include working with Tameside Hospital with 1450 visitors attending a pop-up library and the distribution of over 2000 'Books for Babies' to new families.

Tameside Loves Reading also encompasses Tameside Reading Volunteers and has been working with partners across the borough to raise the profile of reading, ensuring that it is enjoyed by all, as well as being made a priority, supporting literacy development and is embedded in the home.

In 2018/19 Tameside Reading Volunteers were responsible for generating an extra 1000 reading hours as 200 children were supported. Each child received ½ hour reading for 10 weeks from 91 volunteers working across the public sector in Tameside and Glossop. Currently 80 volunteers are working at 46 schools to read with another 160 children.

A GREAT PLACE TO BE BORN
Priority 1: Very best start in life where children are ready to learn and encouraged to thrive and develop

The Starting Well work programmes are overseen by the Tameside Starting Well Partnership. We want all children, young people and their families to be healthy, safe from harm and have the confidence to be ambitious and achieve their aspirations. We know that vulnerable children become vulnerable adults. We want every child to have the best start in life which is crucial to closing the gap in health, education and social inequalities.

The foundations for virtually every aspect of development – physical, intellectual and emotional – are laid in early childhood. The earliest experiences have a lifelong impact on physical, mental and emotional health. Evidence shows that when a baby's development falls behind during the first year of life, it is then much more likely to fall even further behind in subsequent years, than to catch up with those who have had a better start. Pregnancy and the birth of a child is a critical window of opportunity when parents are especially receptive to support and guidance. We want to address the social gradient in children's access to positive early experiences; later interventions, although important, are considerably less effective when good early foundations are deficient. We will continue to promote uptake of free funded early education and will maintain or improve the number of good and outstanding education settings

We are committed to promoting good maternal and infant health and will reduce the number of children born with a low birth weight. We will do this through a variety of methods including implementing best practice in maternity services as outlined in the Better Births Review this will include implementing the Saving Babies Lives Care Bundle 2.

We are also committed to prioritising preventative healthcare with a focus on reducing rates of smoking and alcohol use during pregnancy. We have implemented the Babyclear smoke-free pregnancy programme in partnership with GMHSCP. Through this programme we will reduce the number of women (and their partners or significant other) who smoke during pregnancy. We will deliver the GM Alcohol Exposed Pregnancies Programme and aim to reduce the number of alcohol exposed pregnancies locally. The programme will raise awareness of the risks of drinking alcohol during pregnancy and increase the awareness, diagnosis and support around Foetal Alcohol Spectrum Disorder, currently estimated to effect 120 babies born in Tameside and Glossop each year.

Children and young people account for 25% of emergency department attendances and 40% of emergency admissions across Greater Manchester, around 39% of Accident and emergency visits are non-urgent and could be seen in the community. We have developed an avoiding Paediatric admissions workstream and a range of initiatives to better support children in the community including the Paediatric Advice & Guidance Service delivered by the ICFT in partnership with Primary Care and wider partners.

A GREAT PLACE TO LEARN

Priority 2: Aspiration and hope through learning and moving with confidence from childhood to adulthood

- We want children and their families in Tameside to be **successful**.
- We will work to ensure that **positive opportunities and effective help** are available at the **earliest opportunity** – enabling children and their families to make the **choices** that mean they can thrive and achieve.
- Where children and families do need to access support, services will be **responsive**, of a **high quality** and focused on achieving **self reliance**.
- We will seek to break the cycle of dependence on services, and support children and young people to grow in a **stable and settled** environment.
- Children will be supported to realise their **aspirations.**

Core Values & Principles: •Child centred •Honest and respectful •Services based on effective relationships •Commitment to continual improvement •A culture of public service.

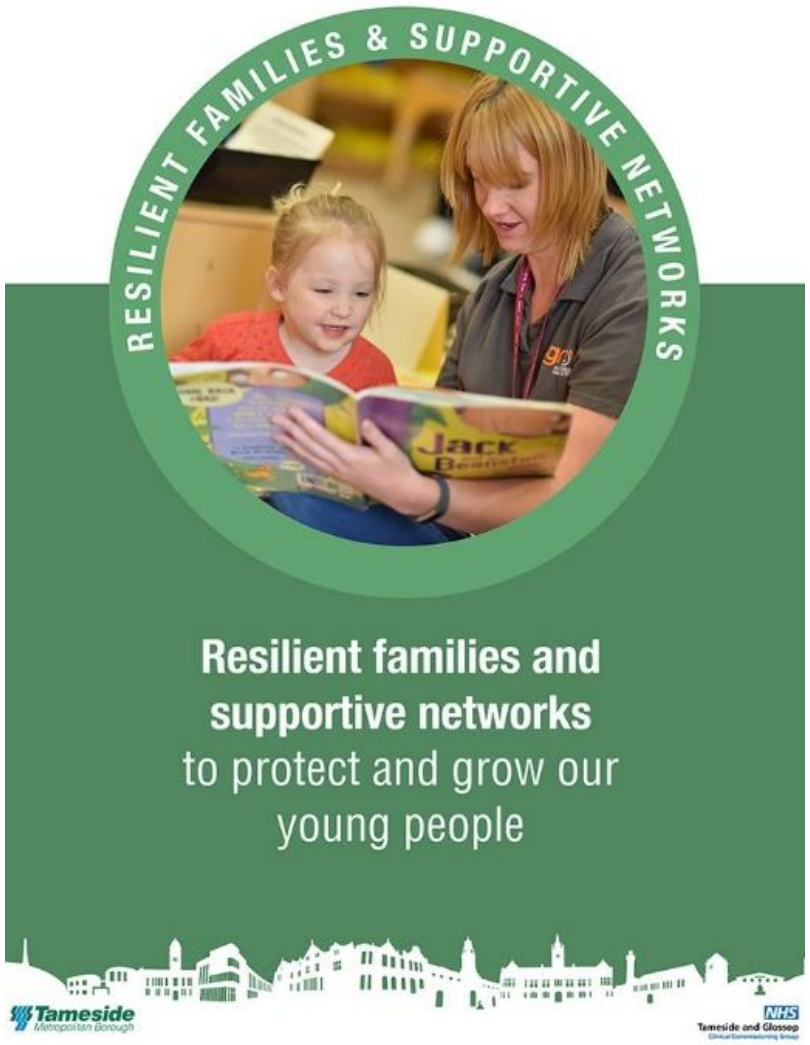
Learning: The Local Authority team has implemented a rigorous approach to School Improvement with a small central team working with all schools on a targeted and differentiated basis. A clear set of borough wide priorities (Reading, Attendance, SEN support, progression to Adulthood) are well understood which define and bring clarity to the role of the Local Authority.

The impact of targeted work is strong with rapid and significant improvement for those schools with the greatest challenges. We have seen significant reductions in exclusions, improvements in reading progress, outcomes for children with SEN, attainment at Key Stage 4 and Good Level of Development at age 5. However, more work needs to be done and improvement needs to accelerate particularly in secondary schools. Our approach and priorities remain unchanged with a focus on disadvantage, boys and targeted work in the Early Years, in evidence informed practice and brokered school to school support.

Moving with confidence from childhood to adulthood: Preparation for adulthood is a key area for development to help young people achieve future aspirations and reduce increasing demand on the care system. We will develop a cross-partnership strategy to support young people at this crucial point in their lives. A priority area of focus is children and young people with Special Education Needs and Disability (SEND).

A GREAT PLACE TO RAISE A FAMILY

Priority 3: Resilient families and supportive networks to protect and grow our young people



We recognise the need to improve our levels of support to our most vulnerable families, reduce demand in the system and prevent escalation. To achieve this ambition we plan to further develop many current initiatives and implement new ways of working including:

- Creating multi-disciplinary neighbourhood teams to provide wrap around support for children and families.
- Establish a Family Support Service to provide practical support and diversionary work to prevent admissions – de-escalating risk, across the continuum of need
- Speed up and enhance the implementation of the current ‘Team Around the School’ model to all schools, colleges and nurseries (including PVIs)
- Restructure the duty and locality teams to remove a step in the process Stage 2. Move to true locality working with teams based in each of our neighbourhoods holding a neighbourhood based cohort / caseload
- Deliver a respite / short break facility, and a residential assessment unit with an emergency provision which is supported by an outreach team/key workers. To prevent placement breakdown, and to allow children to safely remain at home with their family.
- We will review all placements to ensure children are in the right placement for the shortest possible time. We will keep more Tameside children in Tameside by introducing a modernised, fit for purpose fostering offer which will increase the number of foster carers through a new model tailored to current need, cohort demographics and an enhanced payment and support model.

LIVING WELL

Priority 4: Opportunities for people to fulfil their potential through work, skills and enterprise

A GREAT PLACE TO WORK

Case study 3:

Integrating Health & Employment

Over the last 5 years we have strategically created and developed an integrated offer between our employment, skills and health services. This has delivered more operational capacity in frontline services for people with health conditions both physical and mental to fulfil their potential through employment.

We have understood our challenges to employment and built a strong case to commissioners to increase investment turning small pilots to scaled universal services.

Through the Living Life Well programme we created 2 Employment Coaches dedicated to supporting residents with mental health conditions working within a holistic model of support. This represents a system change in building employment and skills services within a health model, this is essential to tackle the key barriers to employment (health, housing, confidence and sequenced holistic support). This local innovation compliments the successful integration and delivery of the Greater Manchester Working Well programmes that have seen 400+ vulnerable Tameside residents with health conditions access employment.

We want to increase the skill levels of our population to enable them to access good employment that is sustainable and increases their earnings. This will be delivered through:

- Good quality Careers Advice and Guidance at any age.
- A focus on how mental health impacts on employment, education and training between the ages of 16 and 17.
- Increase apprenticeship and youth employment through the use of targeted grants and schemes to encourage local employers to employ and train our young people.
- Increasing disability employment outcomes through engagement of the business community in the disability confident agenda.

Where residents have health conditions we want to support them and our employers to manage those conditions to support people to enter and remain in employment by engaging vulnerable residents with health conditions in holistic employment programmes including the Working Well suite of programmes:

- Work and Health Programme – Holistic service for residents with health conditions to get back to work.
- Early Help Programme - GP led referrals to keep people with a health condition in work.
- Specialist Employment Service – Additional capacity to support residents with learning disabilities and severe mental illness.

Priority 4: Opportunities for people to fulfil their potential through work, skills and enterprise

Poverty is the single biggest determinant of health, Tameside is now ranked as the 28th most deprived local authority in England and 26% of children in Tameside are estimated to live in poverty. Poverty is not just experienced by those out of work in fact the biggest increase in rates of poverty is amongst working families. A programme of work has been launched to engrain poverty prevention and mitigation across our system. Central to this is a commitment that interventions are informed and co-designed by residents.

Economic Growth and Health: Being economically active and engaged in some form of good work has clear physical and mental health benefits for our residents. It is therefore vitally important that the borough is able to grow its economy to provide residents with good work in rewarding jobs, based in locations that are reachable by walking, cycling and public transport, providing a good work / life balance and reducing the environmental impact of commuting.

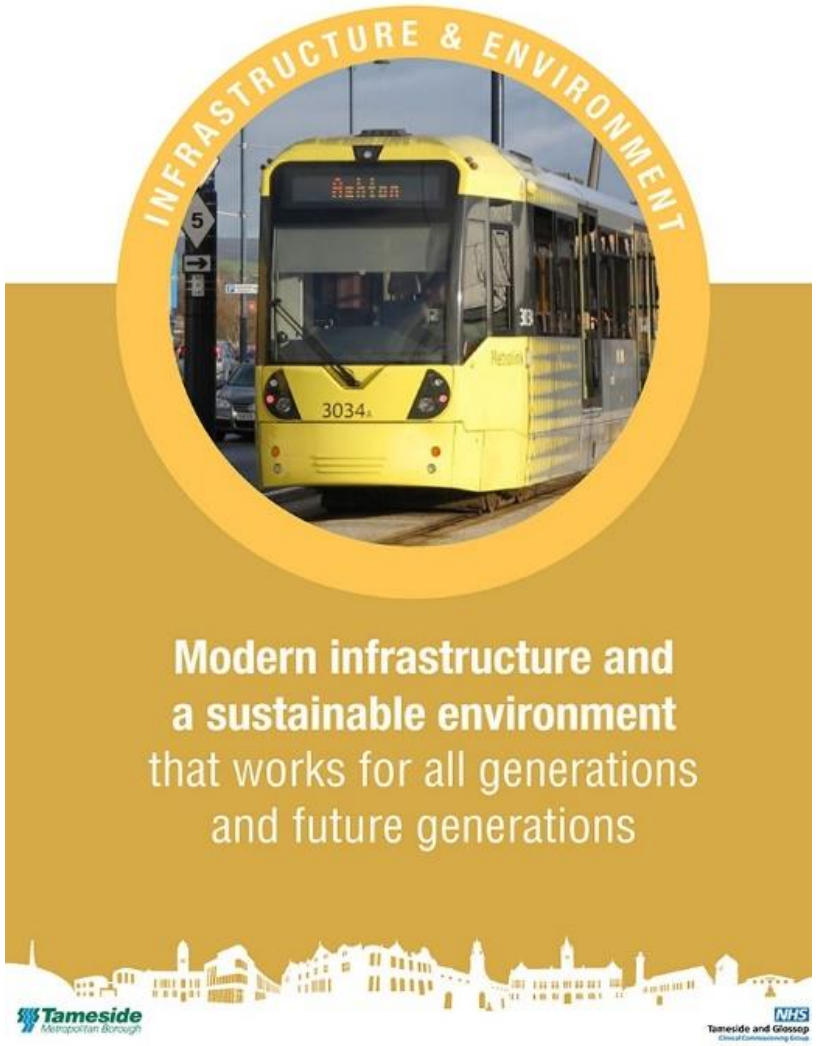
The emerging Tameside Inclusive Growth Strategy is building on work by GM to identify areas of our economy in which we have strengths, and then building on these, both through physical development and the development of the right skills base in the borough. The Strategy will also be focusing on the vital role that our six Town Centres will play as both economic drivers and as vibrant diverse places where residents can work, shop and access a broad range of public services. As traditional community hubs, which are often the centres of public transport infrastructure, the high street and immediate surrounds are natural locations for us to build a more inclusive economy.

We are working with the business community to create a thriving business network that supports increased start ups, encourages sector collaboration and overall productivity. This network will enable us to engage with businesses more effectively in our work to improve health and employment across our population.

The new **Tameside Digital Strategy** aims to be a catalyst for innovation with the on-going investment into the development of a world class digital infrastructure across the borough which will provide next generation connectivity for local health sector partners across the locality and beyond. Digital technology can radically transform how we do things; delivering fibre speed services will enable almost instantaneous transfer of high density images from CT Scans and X-rays to healthcare professionals in our neighbourhoods. Harnessing the potential of artificial intelligence (AI) can transform the speed and accuracy of diagnosis in the NHS. Delivering fast, affordable, reliable and secure connectivity for the economy will provide the foundations to share information, share services and improve resident access to digitally enabled services.

A GREAT PLACE TO LIVE

Priority 5: Modern infrastructure & a sustainable environment that works for all generations & future generations



Healthy Spaces: The environment in which we live plays a pivotal role in our lives. The quality of our streets, green spaces, air, and the commercial and transport infrastructure around us impacts on how we interact with our space and get enjoyment from it. This, in turn, has a major impact on our physical and mental wellbeing.

The importance of improving air quality is a key priority for us with poor air quality, mainly due to use of motor vehicles, shortening lives and contributing to chronic illness and 1200 deaths each year in Greater Manchester. The impact of this is not felt equally throughout society as it particularly affects the most vulnerable in society: children and older people, those with heart and lung conditions and less affluent communities. We are committed to meeting the ambition of the GM Clean Air plan and support the GM commitments to cut air pollutants and to ensure that at least 90% of the NHS fleet uses low-emissions engines (including 25% ultra-low emissions) by 2028/29. It is our aim to reduce NO^2 levels below the EU Limit Value in the shortest possible time, not only to comply with our legal obligations but also as a recognition of the benefits of improved air quality for reasons of public health, environmental protection and economic benefit.

We have undertaken a Clean Air peer review to understand the local challenges, opportunities, and drivers for change. Interviews with senior system leaders were conducted, and recommendations made on how to harness the existing local enthusiasm and strong engagement in this area. The findings from this review will be used to develop a comprehensive action plan for system-wide action.

Active Neighbourhoods: We have a wealth of options for physical activity across the borough from great green and blue spaces, many sports clubs and facilities. 6% of premature mortality is directly attributable to inactivity yet around 28% of adults in Tameside are inactive, and 37.5% of children are classed as less active. Our ambition is to normalise movement for work rest and play, and to increase the volumes of people visibly participating in activity and methods of active travel including walking and cycling.

Priority 5: Modern infrastructure & a sustainable environment that works for all generations & future generations

Housing:

Good housing influences people's wellbeing, quality of life and the economic and social opportunities available to them. It is often said you cannot have good health without good housing and it is estimated that poor housing costs the NHS in England up to £2billon each year. Housing supports good health and wellbeing if it is affordable and provides a stable base where we feel safe and connected to community, work, education and services.

We will adopt a broader approach to our housing agenda; following completion of the Tameside Housing Needs Study and the recently adopted GM Housing Strategy we are planning to develop a Housing Strategy & Delivery Plan. This plan will meet the ambition of our corporate plan to build successful lives, strong and resilient new communities, invest in a local and vibrant economy and promote healthy lives.

For our neighbourhoods to be attractive places to live, work and invest, an integrated and connected approach is essential to ensure better outcomes are delivered for local people. Access to a safe, decent affordable home is a key component of our work around Public Service Reform; health and healthy spaces with accessibility, choice and quality of design will sit at the heart of this wider agenda.

We are committed to undertaking further analysis, development and work to ensure our housing provision supports good health and is inclusive of the following priority areas:

(1) how good housing can help prevent people from being admitted to hospital

(2) how good housing can help people be safely discharged from hospital

(3) how good housing can support people to safely remain in their own home and independently live in the community.

A safe, stable home is the foundation on which individuals, families and communities develop a sense of wellbeing, secure a better quality of life, access services, stay health and retain independence.

A GREAT PLACE TO VISIT

Priority 6: Nurturing our communities and having pride in our people, our place and our shared heritage.

We will work in partnership with internal and external partners to develop and deliver high quality programmes of events, activities and services that develop skills and learning and contribute to health and wellbeing.

Homelessness and rough sleeping: We have adopted an innovative approach to tackling rough sleeping across the borough. Recognising that the drivers for rough sleeping are complex & wide-ranging, the Homelessness Team have worked hard to develop a flexible & individualised service which looks to address the issues for each service user, rather than provide a universal service for all. The principle of individualisation means that very specific problems can be addressed as part of a package of measures for each service user, who is then given the correct support prior to – and also after – being moved on to more permanent accommodation. The service has seen significant successes in reducing rough sleeping in a short space of time. 42 individuals were rough sleeping across the borough in October 2018. In November 2019 this figure had dropped to 2.

Domestic Abuse: There has been a large increase in people requiring support around Domestic Abuse and reducing the number of victims is a key objective locally. The local direct costs associated with the impacts of Domestic Abuse in terms of health services, housing and criminal justice have been estimated at £22.3m per year but the wider indirect costs have been modelled by the Home Office as being as high as £250m per year.

Services are commissioned across the borough to tackle the harm caused by Domestic Abuse, however the complexity requires a whole-system approach. It is an issue that affects people of all ages and in different communities across our borough with children particularly vulnerable to the impact of abuse. A Domestic Abuse peer review has been completed and a strategy and delivery plan are currently under development. These recognise that, as well as a short-term strategy to reduce incidence, there is a requirement for a much longer term, generational strategy which promotes good relationships & creates a culture which is opposed to abusive behaviour.

A GREAT PLACE TO LIVE A HEALTHY LIFE

Priority 7: Longer & healthier lives with good mental health through better choices & reducing inequalities

We will work with our partners locally and across Greater Manchester to deliver the ambition of the NHS Long Term Plan. Our focus remains on early identification and prevention whilst ensuring prompt access to diagnostics and effective treatment. This along with effective recovery and self-care will help ensure our urgent and emergency services are only seeing people with an unavoidable urgent or emergency need.

Early Identification

Neighbourhood profiles and risk stratification support the identification of our more vulnerable population and helps ensure our plans reduce health inequalities.

Working with partners including CRUK and Macmillan we are supporting professionals to improve uptake to national screening programmes as well as developing their skill in identifying cancers earlier and increased numbers of GPs are completing relevant modules within the national online training programme, Gateway C. We will expand our Cancer Champions further to ensure delivery across all neighbourhoods. We will work with GMHSCP to implement HPV vaccinations for boys and implement alternative delivery mechanisms for cervical screening. Our involvement in the National Lung Health Checks programme, means our population will be invited for screening during 2020. A key facet of this programme are connecting with our prevention services supporting people to develop healthier lifestyles.

All 37 General Practices are delivering our Long Term Conditions Locally Commissioned Services which are designed to achieve better health and care outcomes for people living in Tameside & Glossop with a Long Term Condition. Ensuring the registered population have access to the NHS Health Check and Smoking Cessation services with additional focus on Diabetes, Respiratory Disease and Cardiovascular Disease. This supports increased identification, reported prevalence and reduced unwarranted variation as well as promoting uptake of preventative activities.

Social Prescribing

Our social prescribing programme is delivered by the Voluntary Sector; Action Together and The Bureau work in partnership with the system-wide Person and Community Centred Approaches team based within the ICFT. Social prescribing is fundamentally about demand reduction; early analysis is encouraging with a 19% reduction in GP contact (using data 6 months pre and post referral) and the potential to save 4,280 GP appointments per annum (based on 1600 referrals).

Priority 7: Longer & healthier lives with good mental health through better choices & reducing inequalities

Prevention

Tobacco: Our Tobacco-free multi-agency partnership has developed extensive work programmes to address the health inequality challenges associated with smoking by addressing both treatment and prevention. We have specialist stop smoking / tobacco addiction advisors in the community, GPs, pharmacies and in maternity. We will implement the CURE Smoking cessation programme within NHS T&G ICFT in April 2020 initially focussing on admitted patients with plans to expand into mental health and non-admitting services. We will protect our children and young people from the effect of tobacco by de-normalising tobacco smoking. Our programme includes smokefree events, sports, and school gates. Our leisure provider has recently gone smokefree outdoors across its estate.

Substance misuse: The local health burden related to the impact of alcohol consumption is significant with the highest rate of alcohol-specific mortality and dependent drinkers of all statistical peers, higher rates of alcohol specific admissions of young people than the England average and significantly higher numbers of people who are not in employment as a result of alcohol than the national average. Our levels of drug use are high with almost 1400 opiate users and a high proportion of adults with drug dependency living with children. Due to the scale of the challenge and following an independent peer review around substance misuse in late 2018 we have developed a local Strategic Substance Misuse Partnership with senior leaders from the local authority, CCG, ICFT, police and voluntary sector. This partnership oversees the local work programme with specialist treatment services, hospital alcohol liaison service, proactive work with licensing colleagues to reduce harms of alcohol availability across the community, the Alcohol Exposed Pregnancies work programme and dedicated work around the hidden harm to children.

Prompt Access to Diagnostics and Effective Treatment

- We are committed to ensuring that each patient is seen by the most appropriate clinician(s) to meet their need, closer to home where possible including via virtual consultation, in a holistic and efficient way.
- We are improving access to services to ensure people receive timely access to diagnostics, receive a faster definitive diagnosis and treatment. Our use of Advice and Guidance helps ensure only people who need to be assessed within secondary care are referred and working with the ICFT we are building on our Dermatascope Local Commissioned Service to enable consultant review of images. Alongside learning from GM pilots it is hoped that this will help reduce pre-surgery Outpatient appointments.
- We will continue to develop our Primary Care delivered LCSs to increase opportunities for people to be assessed and supported within Primary Care to ensure improved access for people and reduce unnecessary outpatient appointments in hospital settings.
- Building on the learning from the breast service we will increase opportunities for patients to be directly referred to services without the need for a GP appointment as well as considering how self referral for hearing loss could reduce demand on GPs.

Priority 7: Longer & healthier lives with good mental health through better choices & reducing inequalities

- We will develop the use of virtual Multi Disciplinary Teams (MDTs), initially focussing on Chronic Obstructive Pulmonary Disorder (COPD) but extending to other conditions and specialities from 2020/21 onwards.
- We will work with the GM Elective Care Reform Board and Improving Specialist Services Programme to reduce the demand on hospitals, standardise our approach to referral and make more efficient use of the available capacity including the potential for capacity to be shared.

Recovery and ongoing Self Care

- The Universal Personalised Care Model underpins our services; through this we aim to encourage people to be active participants in their recovery with ongoing self-care. In 2020 we will work with referrers and providers to ensure shared decision making is at the centre of pathways.
- We will explore more opportunities to introduce 'prehabilitation' building on the experience of the cancer work.
- We will encourage our providers to use Patient Initiated Follow Ups.
- We are continuing to invest resources to support people to live with and beyond cancer and support the delivery of the 'Recovery Package'.

Urgent and Emergency Services

- We are committed to the GM Urgent and Emergency Care Improvement and Transformation Programme and have developed our services to reduce the need for an admission and ensure people who do not need acute care are not remaining in acute beds unnecessarily.
- Urgent and Emergency Care is overseen by the multi-agency locality Accident and Emergency Delivery Board and a fully integrated approach is taken to assigning funding irrespective of whether it is accounted for as Health or Social Care.
- 2019 saw the co-location of The Urgent Treatment Centre (UTC) alongside the Accident & Emergency department. Through the UTC we will develop a culture of 'ring before you go' to maximise opportunities to manage demand and fully utilise other community alternatives or self-care. We will develop our existing Same Day Emergency Care model (SDEC) further maximising opportunities to support people in medicine, surgery and pregnancy without the need for an admission and operating 7 days a week.
- We will develop our Digital Health offer and our Integrated Urgent Care Team are developing pathways with other partners to increase the usage from NHS 111, 999 as well local services. This will support even more people who require urgent care to remain in their own home and avoid the need for an Emergency attendance or admission.

Developing Primary Care as a key component of community care

Recognising local pressures, the NHS LTP has committed that funding for Primary Care and Community Health Services will grow at a faster rate than for the rest of the NHS. Each Primary Care Network (PCN) will receive additional funding to provide a wider range of services to patients. PCNs will be the key delivery vehicle for a different model of General Practice as outlined in Section 3.

Primary Care ambition: The traditional model of Primary Care will evolve, with more focus on digitally enabled, multidisciplinary, integrated and preventative support, based in the right place for local populations. This will not only improve the quality of primary care delivery and improved population health outcomes, it will also ensure its future sustainability. Primary Care is at the heart of the integrated care neighbourhood model; our people and communities will have access to high quality, fully integrated, place-based care within our neighbourhoods. We will continue to strengthen relationships between General Practice and the wider primary care workforce of community pharmacy, dentistry and optometry.

We will make it easier for people to access non-clinical support that gives them the skills, knowledge and confidence to improve their health and wellbeing. This includes non-clinical frontline staff as care navigators supporting and signposting patients to choose well and consider self-care options where appropriate. We will maximise the use of Person and Community-Centred Approaches through our model of 'Wellbeing in Practice'. This approach engages General Practice and their patient community to work together to provide solutions and support for patients whose needs are not currently being met by a medical model of care.

Locally Commissioned Services: We have a long history of Locally Commissioned Services (LCS) supporting delivery by Primary Care and will continue to build on our contracts with Pharmacies and Opticians maximising the support available to our population. Alongside national direction, In 2019/20 we launched a framework with General Practice that builds a number of 'bundles', each with a set of outcomes for an area of care. This approach was designed with the intention of continually increasing the level and transparency of investment in general practice and to focus on collective delivery priorities. Additional bundles are planned for 2020/21, including commissioning from PCNs. We will continue to evolve the framework with additional investment to improve health provision, and address unwarranted variation, across general practices for patients.

Improving Access: We will continue to expand patient access, routinely offering general practice appointments during evenings and weekends. As part of our Digital Strategy we will provide full population coverage of online consultations by April 2020 and video consultations by April 2021.

We implemented a **Veteran Friendly Approach to Primary Care** project to increase the identification of military service in Primary Care records. Military veterans often have different medical needs to other members of the public. Keeping accurate records of military service in Primary Care can therefore help healthcare providers offer better quality care. Over nine months the project increased the numbers of patients with records identifying military service from 90 to over 1300. The success of our model is influencing planning with GM and national colleagues. We intend to widen the scope to include other Primary Care settings including pharmacists, dentists and opticians.

AGEING WELL – A GREAT PLACE TO GROW OLD WITH INDEPENDENCE

Living Well at Home transformation and innovation case studies

Case study 4 - Blended Roles: We are aware that residents that rely on health and social care experience multiple visits by different agencies, each delivering separate components of care in a disjointed way. Alongside this, there are frequent challenges in attracting and retaining homecare staff. To combat this we developed a more integrated approach between home care providers and District Nurses as part of the neighbourhood model.

We identified how a homecare worker as part of a shared care approach plays a key role in keeping people living well at home. This included training homecare workers to deliver lower complexity health care tasks (also see case study 6), which would normally have been delivered by the District Nursing team. Initially we identified 40 high intensity users and undertook joint assessments and joint care planning.

Individuals received more timely care interventions provided by care workers who are trained in particular issues suited to the individual. They received fewer visits from less agencies whilst continuing to receive care and support that helps them live well at home. Individuals have more choice regarding the time of their visit. Importantly home care staff feel valued as part of a wider team and it is anticipated that this will improve recruitment and retention. There was an overall saving of 21.4% District Nursing time in the first cohort of 40 individuals, with a future potential to support more people with complex health needs at home and more importantly **ONE LESS KNOCK AT THE DOOR** for individuals.

Case study 5 - Personalised Care and support: We identified that the system was organised in a way that caused different organisations to plan and provide support independently of each other. This meant that the overall package of care often felt disjointed to the individual and led to too many visits for residents. To respond to this we developed an integrated approach between neighbourhood teams, GPs and home care providers. This included information sharing, joint planning and reviews. Home care teams are now an integral part of neighbourhood working and we have developed opportunities via social prescribing.

This has worked well for residents as they no longer have to tell their story over and over. The flexible approach to planning care ensures providers can work with individuals to make changes to support plan. Home care staff are valued as playing a key role in supporting people to live well at home. This approach builds resilience amongst communities by strengthening the role of voluntary sector in supporting people where they live and is **ONE LESS KNOCK AT THE DOOR** for individuals.

*(follow link **Living Well at Home** for video case study)*

Case study 6: The **insulin in care homes project** was a collaboration with local care homes, the Neighbourhood Team and the ICFT in 5 care homes in Hyde. Care home staff administered insulin instead of District Nurses for existing insulin dependent patients within care homes. Because the residents are able to have their insulin in a more flexible way, their diabetes has stabilized.

District Nurses reduced their activity in the care homes by 85% (438 minutes per week). This is the equivalent of almost a full day back into the service. This will release time for the District Nurses to focus on high dependency patients.

Tameside Age Friendly Communities

We recognise that our population is ageing, currently the 70-74 years age group is growing at the fastest rate and the biggest rise in the coming years will be in those over the age of 85 years. We are working hard to meet the future needs of our ageing population and will continue to increase our focus on age friendly communities in the borough. We will work with the local community and other organisations to enhance the lives of older people, with a focus on people ageing healthily by increasing healthy life expectancy. This includes increasing opportunities for leading healthier lifestyles and supporting our residents to actively age, and be socially active, less socially isolated, reduce falls and frailty, and increase accessibility to both green and blue spaces with increased transport modes that are sustainable.

The **Tameside Age Friendly Communities Strategy and Action Plan** is currently being written with key partners including with Tameside Council, Tameside CCG, ICFT, Active Tameside, Age UK, Transport for Greater Manchester, Housing Providers, community groups and residents. We will engage with local residents to ensure that we incorporate their needs and make Tameside a great place to grow old in.

The strategy has a scheduled publication date of March 2020 and focuses on prevention and improvement, whilst providing for those in need. The action plan required cross-sector working with key partners over the next two years and focuses on tackling social isolation, active ageing, reducing frailty and falls risk, early identification and identifying those at potential future risk. It also addresses housing issues, accessibility and safety issues (with a focus on transport), increasing age awareness and the Ageing in Place project.

These actions and future work will contribute to '**Age Friendly Tameside**'.

Ageing in Place is a local programme as part of the GM Ageing Hub, which asks each of the 10 GM boroughs to choose a town to take part in creating homes and neighbourhoods where people can age safely and independently. This centres around people being healthy and happy in their homes and neighbourhoods, preparing for older age with home modifications, increasing accessibility to the local area and beyond and having options to socialise and be active. It seeks to prevent the need for individuals to move into residential or care accommodation and can reduce healthcare demand, thus decreasing costs to the state. Stalybridge has been chosen as our Ageing in Place neighbourhood and the project will launch in 2020.

Age Friendly Neighbourhoods: we are working with the Greater Manchester Mayor Around the recently launched Age Friendly Challenge. This involves identifying neighbourhoods to find practical examples of what age friendly means and to share best practice across the city region. Successful areas will be awarded with accreditation, which involves official recognition from the Mayor and Combined Authority that your neighbourhood is age-friendly. Several areas locally have committed to this imitative including Mottram, Denton (North, South and West End), Hyde Newton and Ashton Waterloo, Dukinfield and Droylsden.

Priority 8: Independence and activity in older age, and dignity and choice at the end of life

- Our Age Friendly Communities Tameside strategy underpins our approach to ensuring people are valued for who they are and are able to live the lives they want. We want Tameside and Glossop to be known as a place where everybody can experience a positive older age.
- The multi agency Frailty Programme Board and Palliative and End of Life Care Board will continue to oversee development of services to ensure alignment with GM commitments and standards.
- Our Neighbourhoods and Urgent Care services are key to ensuring we identify those in our population who may need additional support to stay well and independent and develop personalised care plans in partnership with individuals and their family/carers.
- In 2019/20 many neighbourhoods have developed their MDT approach to identification and care planning. We will further develop the MDT model in 2020 to ensure we consistently identify people living with frailty or approaching the end of life and develop plans that enable them to experience improved outcomes through better access to appropriate interventions at the right time and in the right place. Our use of the Electronic Palliative Care Co-ordination System (EPaCCs) and development of our Local Health Care Record Exemplar (LHCRE) will underpin the communication and sharing of information that supports effective planning and decision making.
- We will develop our diagnostic capacity, fracture liaison service and falls service ensuring a system approach across primary, community and acute using case finding approaches to reduce the likelihood of falls. We are also working to identify people at risk of future frailty and falls much earlier with a greater focus on prevention of falls in younger cohorts (<65 years).
- Following the colocation of the community Palliative and End of Life Team with the local Hospice we will identify further opportunities to ensure seamless support for people in their last year of life including supporting families through bereavement.
- Our Urgent Care services are designed to minimise the need to admit people to hospital overnight and their integrated nature ensures a holistic approach is taken considering both health and social care needs. Our Digital Health Offer provides skype based consultations with a clinician to Care Homes and to the Community Response Service when caring for individuals in the community. Building on the success of the support Digital Health provides to NWAS to avoid ambulance transfers, linkages will be developed with the Clinical Assessment Service to avoid unnecessary A&E attendances and admissions. Our SDEC, Digital Health support to GPs and acute frailty offer will expand to increase the opportunities to support people with an acute need without a prolonged admission working alongside the community based support provided by IUCT.