NHS
Tameside and Glossop
Clinical Commissioning Group

Summary of 2012-2017 Commissioning Strategy

Our five year strategy has two main themes running through it. How to prevent future illness and how to re-organise health services locally so that we can better deal with current illnesses. In it we set out what we will do to improve the health of the population.

Who we are

NHS Tameside & Glossop Clinical Commissioning group is a membership organisation of 128 GPs and is responsible for commissioning health services for 238,000 people. We work in five geographical localities; Ashton, Hyde, Stalybridge, Denton and Glossop the first four of which are within Tameside Metropolitan Borough and Glossop lies within Derbyshire being served by Derbyshire County Council and High Peak Borough Council.

Our vision is that **by inspiring all NHS colleagues, and working closely with partners, we will ensure the development of excellent, compassionate, cost effective care, leading to longer healthier lives**. And we operate by the principles of:

- Listening to patients,
- Developing innovative services closer to home,
- Increasing taxpayer value for money,
- Improving the health of the residents of Tameside and Glossop.

We consulted widely when developing our vision, principles and plan so our strategy includes views from the following:

Residents GP Members Tameside and Derbyshire LINks Tameside 3rd Sector Coalition
High Peak Volunteer Service Community Action for Tameside Seniors Network GALOP
BME Network The Funky Lizard Network Health and Social Care Network Tameside Voice
The Interfaith Network Economic Development Network GP Practice Staff Our Staff
Clinical Congress Our Consumer Advisory Panel Information Ambassadors from TMBC
Tameside Carers Centre Volunteer Centre Tameside Volunteer Centre Glossop High Peak BC
Tameside MBC Derbyshire CC Health and Wellbeing Board members
Tameside Hospital Foundation Trust Tameside & Glossop Community Healthcare Stockport NHS
Foundation Trust Pennine Care NHS Foundation Trust West Pennine Local Medical Committee
Local Pharmaceutical Committee Greater Manchester & Cheshire Cardiac and Stroke Network
Local Authority Overview Scrutiny Committees for Tameside, Derbyshire and the High Peak

How we will deliver our 5 year vision

We have four strategic tactics:

1. Putting our patients at the centre of everything we do

We believe good care is arranged to make things easier for the user not the service and we think how people are spoken to and dealt with is as important as the medical treatment they receive. So we will listen to patients in designing how health services work and put our population at the centre of our planning.

People see care which keeps them out of hospital as a success. So we will invest in prevention and early intervention services and aim to keep patients safe at home, helping them to manage their own health supported and cared for by professionals who respect and value the decisions and choices they make.

2. Clinical leadership

GPs provide care on a day to day basis, so know what needs to be done to improve outcomes for patients. We will use the relationships we have with our clinical colleagues to challenge performance, drive improvements and deliver change.

3. Working together in partnership

The challenges that lie ahead are too great for the CCG to manage on its own so we will work in partnership and collaboration with our stakeholders including:

- Patients, users and carers
- LINks (HealthWatch)
- TMBC, Derbyshire CC and High Peak Borough Council,
- Provider colleagues
- Voluntary, community and faith organisations
- Other Greater Manchester CCGs
- NHS Greater Manchester and NHS North of England

4. Integration and System transformation

To deliver our patient centred services we need to increase integration and we are working with TMBC and Derbyshire CC on a programme of integration and service improvement that transforms health and social care, improving quality and outcomes through a seamless patient centred journey.

As well as working with our local authorities we are working with colleagues across Greater Manchester to ensure that our patients along with those in the other CCGs have access to excellent services that deliver the best outcome for the patient. This programme is known as 'Healthier Together'

This will mean changes for our local hospital, Tameside NHS Hospital Foundation Trust as they recognise they cannot continue to provide everything they currently do. We we will work with them to ensure that they are able to offer excellent services that support integrated patient pathways.

How we will continuously improve

We will develop a culture of continuous improvement so that Tameside and Glossop is seen as a centre of excellence. We want the best services for our patients, and we want the best staff to deliver them. We will monitor and assure quality in terms of how successful and safe our care is and the experience patients have.

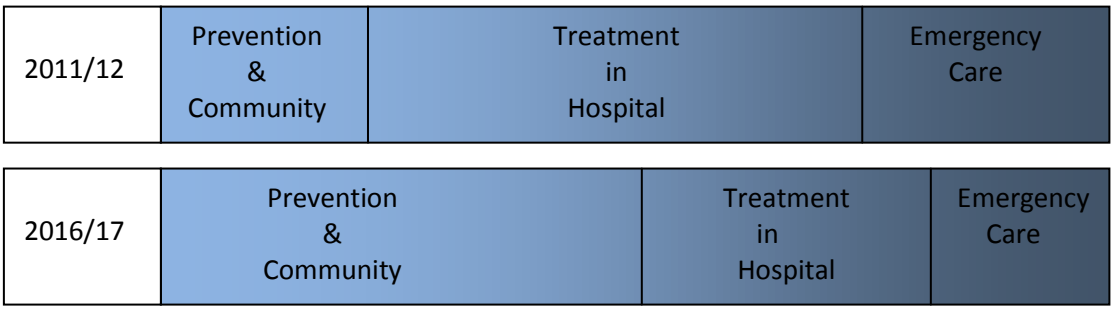
We will ensure learning is central to the way we work having systems and local performance indicators that encourage and reward excellence and innovation. We will include patients, users and carers as essential members of our performance monitoring team, and work with HealthWatch to monitor and assess services.

Why we need to change

Our Joint Strategic Needs Assessments detail the areas were the health of our population is below average and where we have the greatest health inequalities both of which we aim to address through our strategy. At the same time we have planned to meet future demands such as increased numbers of older people, more patients with long term conditions and increased expectations of the NHS.

Our financial priority is to invest wisely, working in partnership, whilst achieving all our statutory financial targets and requirements. So we have prepared for less NHS funding in the future as well as increased costs for hospital and 'round the clock' care.

We will see a change in how we spend our money as we increase our investment in preventative and community care.

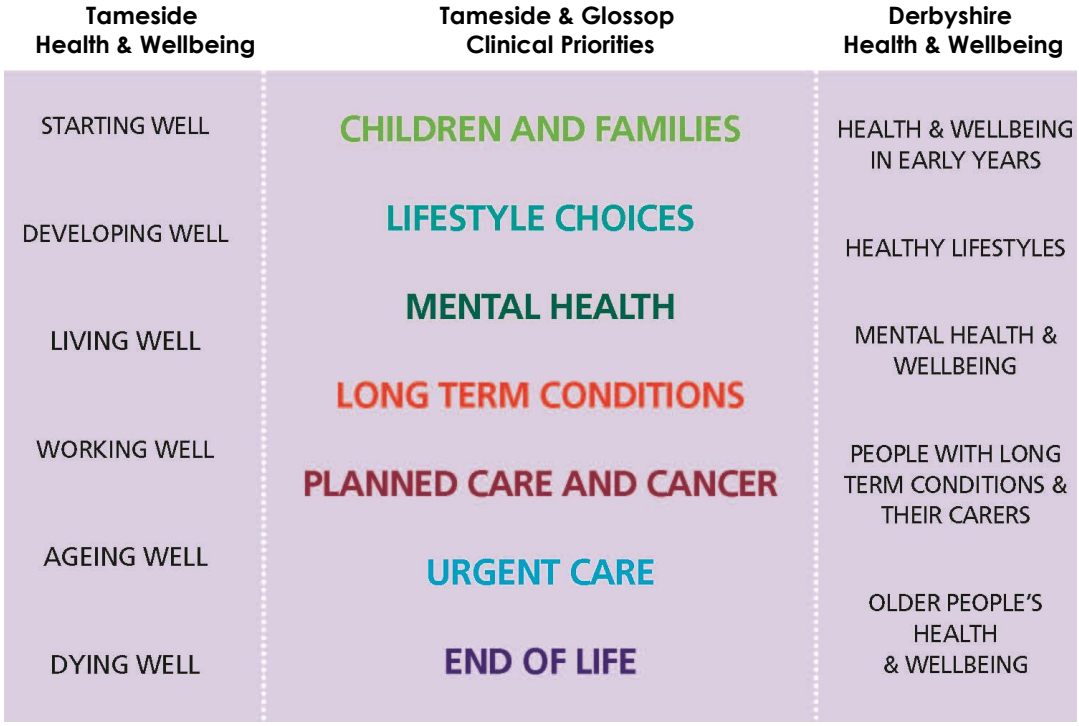


What changes will you see

We will have the greatest impact on health and reducing health inequalities by focusing on the following seven clinical areas. We chose these based on the needs of our population, views of our member GPs and other clinicians, and the responses we have had from partners, the general public and local community groups.

1. **Children and Families**
   (Helping children and young families live secure healthy lives)
2. **Lifestyle Choices**
   (Tackling the damaging effects of obesity, smoking and alcohol and other unhealthy lifestyles)
3. **Mental Health**
   (Improving mental health and learning disability services, especially for patients with dementia)
4. **Long Term Conditions**
   (Providing more appropriate and cost effective services for people living with long term conditions)
5. **Planned Care and Cancer**
   (Providing appointments and treatments especially for people with life threatening illnesses)
6. **Urgent Care**
   (Providing emergency and same day care for people who suddenly become unwell)
7. **End of Life**
   (Making care for people who approaching the end of their life more appropriate and compassionate)

These challenges are aligned with those of our partner Health and Wellbeing Boards.



We have considered how services will change along the patient pathway, as shown in the next seven pages, and will be developing detailed plans each year as we implement our strategy.

How we will know we have been successful

We have made a lot of promises and see ourselves as accountable to the people who live and work locally who will see:

- The overall health of the population is better as we will have achieved the health outcomes we promise
- The levels of health inequalities between wards is reduced. Average life expectancy will be no more than 2 years below the national average and the difference between areas will be less than 13 years
- The satisfaction rates of patient care and experience of local health services, as reported in the GP Patient Survey and the Foundation Trusts' Patient Experience Surveys, has increased by 20%
- We have met our financial targets, not be overspent and be spending more on prevention
- We are in the top 10% of best performing CCGs in Greater Manchester and top 25% in the North of England against the nationally published CCG KPIs
- Our health providers are in the top 10% of best performing CCGs in Greater Manchester and top 25% in the North of England against the nationally published FT KPIs
- There is an over-subscription of training and junior clinicians who want to come and work in Tameside & Glossop

Helping children and young families live secure healthy lives

We want our children to have the best start they can in life and to support parents to build strong and healthy families.

Health Outcomes for 2017

- No more than 7.3% of our babies will have a low birth weight
- 42.5% of our babies will be breastfeeding at 6-8 weeks
- Our admissions because of injuries will be less than 1.5 in 100
- Our rate of admissions for children with asthma, epilepsy and diabetes will be in line with the national average
- The number of Children in Need whose parents have a mental health problem will be in line with the national level

Patient Pathways

<table>
<tr>
<td rowspan="8">Prevention and Health Promotion
Families are engaged, in a range of ways, to take responsibility for their own lifelong health outcomes through a relentless approach against our key health priorities.</td>
<td rowspan="8">Safeguarding</td>
<td>Community Setting</td>
</tr>
<tr>
<td>Self Care/Care at Home
Self help in families, schools and communities is promoted by all staff, trained to empower, reduce dependency, promote resilience and identify those at risk of poorer outcomes.</td>
</tr>
<tr>
<td>Primary/Neighbourhood Care
More training and support within Primary Care to identify needs and manage acute conditions in children.
Providers will build community capacity to reduce dependency and promote autonomy.</td>
</tr>
<tr>
<td>Specialist Primary Care
Opportunities to develop primary care based solutions to the management of long term conditions in children will be taken, building in children's practitioners where required.</td>
</tr>
<tr>
<td>Specialist Community Care
Evidence based specialist support for children and families for e.g. mental health, disabilities, long term conditions and children in need, will be commissioned within integrated teams, focussed on early intervention.</td>
</tr>
<tr>
<td>Hospital setting</td>
</tr>
<tr>
<td>Specialist Local Hospital Care
Swift and easy access to specialist healthcare for children with both urgent and elective needs from skilled paediatric practitioners working to agreed pathways in partnership with primary care and community services.</td>
</tr>
<tr>
<td>Specialist/Tertiary Hospital Care
The most specialist and intensive care for children with complex needs, working within care pathway for step up and step down.</td>
</tr>
</table>

Tackling the damaging effects of obesity, smoking and alcohol and other unhealthy lifestyles.

The way we live our lives especially smoking, harmful alcohol consumption, poor diet and lack of exercise contribute to the levels of ill health and premature death we see locally. We want to help people to understand the risks of their lifestyle choices and support them if they want to change. Making an impact on long term health of an area requires long term planning so a five year plan can only provide a starting point. We will work with all local bodies and the public to developed and be putting into practice a 20 year strategy for smoking, alcohol and obesity related ill health.

Health Outcomes for 2017

- Only 21% of our adults will smoke
- Only 14% of women will be smoking at the time of giving birth
- Alcohol Related Admissions will be no more than 20% above National levels
- Adult and Child obesity rates will be lower than national levels
- The difference between our average life expectancy and England's will be no more than two years

Patient Pathways

Prevention and Health Promotion Engaging people in maintaining wellbeing through healthy lifestyles, based on information they trust and skills to care for themselves	**Community Setting**
	Self Care/Care at Home People can easily find resources and services they need to make and sustain positive lifestyle changes individually and collectively in community-based self-help groups
	Primary/Neighbourhood Care The principles of Make Every Contact Count will be embedded into every frontline service so that every opportunity is taken to offer people support to change their lifestyle to improve their health
	Specialist Primary Care Everyone who wants to make a positive behaviour change is offered evidence-based specialist support to achieve a healthier lifestyle
	Specialist Community Care As well as primary care based services the offer of support will include other community-based services so that every person gets a full choice of services and can access the service model best suited to their individual needs
	Hospital setting
	Specialist Local Hospital Care The principles of Make Every Contact Count will be embedded into all hospital services, taking the opportunities to link behaviour change to improved clinical outcomes of both acute and long term conditions
	Specialist/Tertiary Hospital Care Lifestyle behaviour change is an integral component of treating long term conditions even in the late stages or in severe disease

Improving mental health services and learning disability services, especially for patients with dementia

We are committed to improving the mental health and wellbeing of all our population and want to reduce the stigma around mental health and learning disability so that more people are willing to seek the help that would make a big difference to their lives.

Health Outcomes for 2017

- Uptake of services in our BME population will be in line with national averages
- 12% of our older people will be accessing mental health services
- We will be supporting the recovery of a greater range of people by offering an increased range of psychological therapies
- We will have a psychiatric service that meets the specific needs of people with learning disabilities
- We will work with local groups to increase awareness of the support available to military veterans so we increase the number of veterans accessing services
- We improve our recovery rates for psychological therapies
- We will have a local eating disorder service in place that supports children and adults
- 100% of our people with Learning Disabilities will receive an annual health check
- 75% of our people with Learning Disabilities will take up their invitations to routine screening services

Patient Pathways

Prevention and Health Promotion The 5 ways to wellbeing are firmly embedded in people's day to day life	**Community Setting**
	Self Care/Care at Home Self help resources are readily available in a variety of formats and are accessible to all
	Primary/Neighbourhood Care A range of health and social care services delivered in the community from accessible venues close to work or home, focusing on mental health
	Specialist Primary Care More specialist consultations, with staff trained in a broad range of interventions to ensure treatment stays in Primary Care
	Specialist Community Care Treatment provided by teams who can meet mental health needs in the community appropriately reducing hospital admissions
	Hospital setting
	Specialist Local Hospital Care More specialist and intensive care
	Specialist/Tertiary Hospital Care The most specialist and intensive care

Providing more appropriate and cost effective services for people with long term conditions

We want to help people with illnesses like Cardiovascular Disease, Respiratory disease and diabetes to manage their long-term conditions to limit the impact they have on their lifestyles.

Health Outcomes for 2017

- Reduce deaths in people under 75 years old from CVD including Stroke to the national average
- Reduce deaths in people under 75 years old from Diabetes to the national average
- Less people being admitted as an emergency for COPD

Patient Pathways

<table>
<tr><td rowspan="7">Prevention and Health Promotion
Engaging people in preventing illness and maintaining well being through healthy lifestyles, based on information they trust and skills to care for themselves</td><td>Community Setting</td></tr>
<tr><td>Self Care/Care at Home
Helping service users to stay at home, managing their own conditions with support from specialist staff where required, formal self management programmes, and telehealth</td></tr>
<tr><td>Primary/Neighbourhood Care
A range of health and social care services delivered in the community from local health centres, focusing on managing long-term conditions and first-line care</td></tr>
<tr><td>Specialist Primary Care
More specialist consultations, diagnostic tests and care, delivered within general practice prior to / as an alternative to referral to hospital</td></tr>
<tr><td>Specialist Community Care
Increased provision of care in community settings as an alternative to referral to hospital</td></tr>
<tr><td>Hospital setting</td></tr>
<tr><td>Specialist Local Hospital Care
More specialist and intensive care delivered in local hospitals</td></tr>
<tr><td>Specialist/Tertiary Hospital Care
The most specialist and intensive care</td></tr>
</table>

Providing appointments and treatments especially for people with life threatening illnesses

There are times when we need pre-arranged treatment for illnesses such as cancer, conditions like eczema or hearing problems or for treatment of arthritis. Ensuring this planned care is available when people need it is an important part of our work.

Health Outcomes for 2017

- 95% of people wait less than 18 weeks for their hospital treatment
- Patients will be able to choose care closer to home for most non complex treatments
- 95% of patients will attend their planned care appointments
- People will have to spend fewer nights in hospital when they have operations
- Our death rates from cancer are in line with national average
- 80% of invited women attend breast and cervical cancer screening
- 70% of patient invited for bowel cancer screening take up the offer

Patient Pathways

Prevention and Health Promotion Engaging people in preventing illness and maintaining wellbeing through healthy lifestyles, based on information they trust and skills to care for themselves	**Community setting**
	Self Care/Care at Home Helping service users to stay at home, managing their own conditions with support from specialist staff where required
	Primary/Neighbourhood Care Diagnosing problems and providing routine treatment, identifying when further support is required and supporting people after treatment in hospital
	Specialist Primary Care More specialist consultations, diagnostic tests and care, delivered within general practice as an alternative to referral to hospital
	Specialist Community Care Increased provision of diagnostics and care in community settings as an alternative to attending a hospital
	Hospital setting
	Specialist Local Hospital Care Treatment that requires more specialist facilities or for more complex conditions or patients
	Specialist/Tertiary Hospital Care The most specialist and intensive care

Providing emergency and same day care for people who suddenly become unwell

Emergency admissions to hospital are distressing, so we want to keep people well and out of hospital. We also want to ensure we use our A&E department wisely so that people can be seen promptly.

Health Outcomes for 2017

- Increased access to primary care consultations
- Reduce the number of A&E patients who could have been seen more appropriately elsewhere by at least 5%
- Less elderly patients placed on 'outlying' wards during acute admissions
- A 50% reduction in the number of people who are re-admitted within 30 days of discharge
- More elderly patients supported in their homes (including care homes) rather than attending A&E
- Elderly patients who are too frail to be treated at home, where hospital admission would be detrimental, or who are ready for discharge but need extra time to rehabilitate will be supported in intermediate care services
- Improved 'dignity scores' from patienst admitted to hospital
- Increased numbers of patients and their carers understanding how they can care for themselves or their relatives at home through expert patient knowledge in their communities

Patient Pathways

Prevention and Health Promotion Engaging people in preventing illness and maintaining well being through healthy lifestyles, based on information they trust and skills to care for themselves. Public engagement campaigns to improve knowledge of services in the system	**Community Setting**
	Self Care/Care at Home People managing their care at home, advice from NHS Direct/111, going to the pharmacy for advice and over the counter medication. Expert patient groups providing information and signposting to their communities
	Primary/Neighbourhood Care Increased and Improved access to primary care service, through system change in GP surgeries, increase in tele-consultations and appropriate surgery visits Walk in Centre, OOHs, expert patient groups, targeted clinics for, e.g. children, after school, integrated health and social care services managing people at home
	Specialist Primary Care Ambulatory pathways, More specialist consultations, diagnostic tests and care, delivered within general practice prior to / as an alternative to referral to hospital
	Specialist Community Care Intermediate care step up and down care, CARA, increased provision of care in community settings as an alternative to attendance at A&E and admission to hospital, ambulatory care pathways
	Hospital setting
	Specialist Local Hospital Care A&E, MAU and Short Stay Intervention Unit
	Specialist/Tertiary Hospital Care Trauma units, NWAS

Making care for people who approaching the end of their life more appropriate and compassionate

Patients and their relatives look to health services for guidance on when the end of life is likely and how to ensure that people can die in comfort and with dignity. Ensuring this support is availble is very important to us.

Health Outcomes for 2017

- Identification of people approaching the end of their life and direction into appropriate specialist care which can prioritise comfort and dignity over active treatment
- Patients will be supported to set on record their choices about their care and treatment at end of life through advance care plans.
- All carers will be able to access support during and after end of life care
- All our care homes accredited to deliver high quality end of life care
- 10% reduction in hospital deaths
- All our GPs deliverying high quality end of life care
- The development of specialist services for patients with dementia who are approaching the end of life

Patient Pathways

Prevention and Health Promotion Range of services available to support patients and carers to be cared for in their place of choice, with secondary prevention and health promotion services available where required	**Community Setting**
	Self Care/Care at Home Helping service users to be cared for and to die at home with support from specialist staff where required
	Primary/Neighbourhood Care GPs and other health and social care professionals more able to identify and manage patients at end of life, referring to specialist services where required
	Specialist Primary Care Increased training and support to enable primary care to carry out advance care planning and identify and support patients at end of life
	Specialist Community Care A range of specialist end of life care services available to support patients and carers to be cared for at home
	Hospital setting
	Specialist Local Hospital Care Specialist staff in place to identify patients at end of life, and facilitate care in the patients' place of choice
	Specialist/Tertiary Hospital Care The most specialist and intensive care