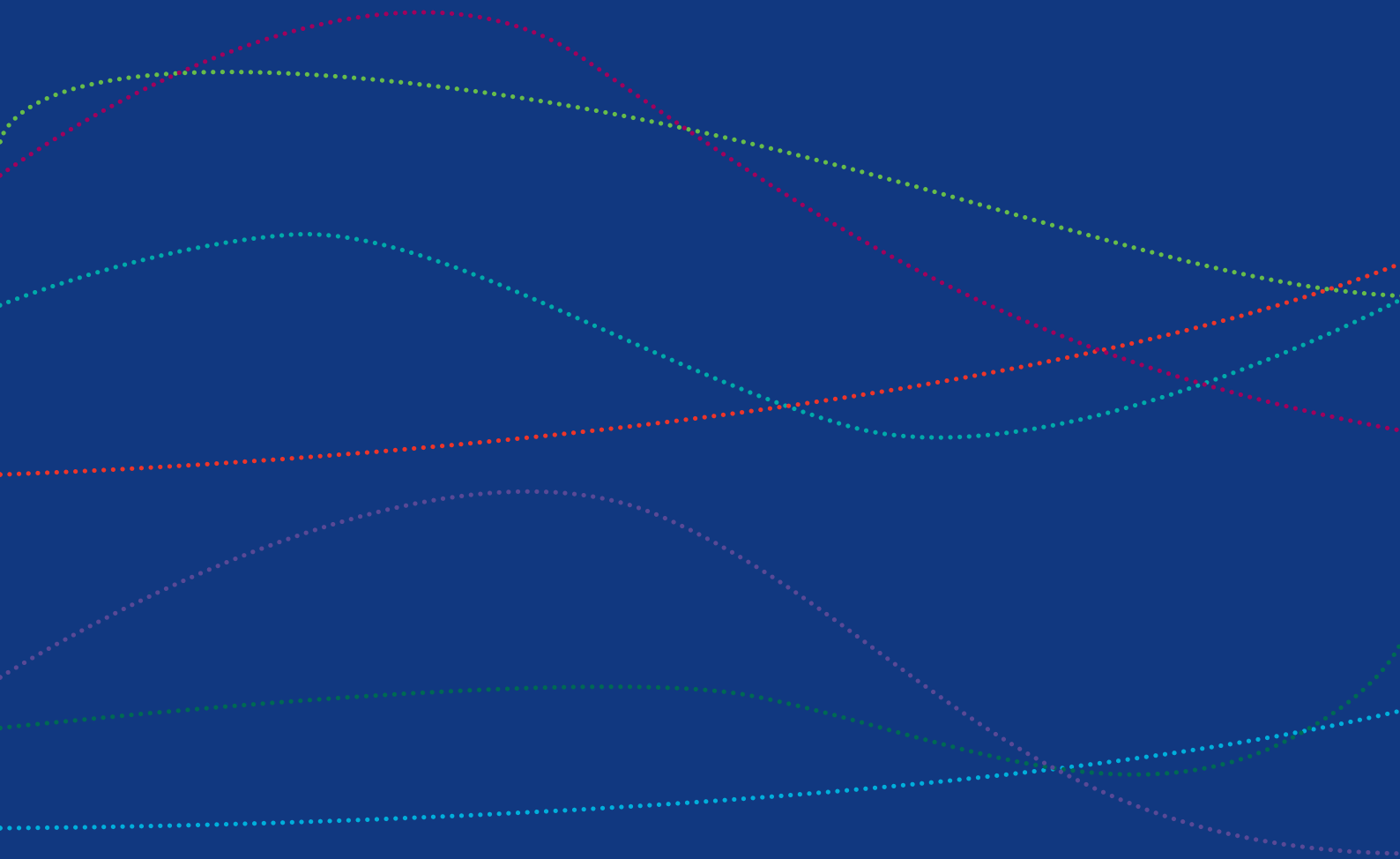
NHS

Tameside and Glossop Clinical Commissioning Group



NHS TAMESIDE & GLOSSOP CLINICAL COMMISSIONING GROUP

COMMISSIONING STRATEGY 2012-2017

Contents

Foreword

Outside our local hospital and outside every general practice you will find cigarette ends on the ground. Smoked sometimes by the people who have just received care for their smoking related illness. We have become accustomed to seeing overweight adults and children, sometimes so unfit they struggle with the normal activities of daily living. There is an unacceptable rise in the number of people with diabetes, which increases the risk of heart disease, blindness and poor physical fitness. The number of elderly people with multiple illnesses, often involving dementia, is increasing and they are becoming more isolated and reliant on social support.

These are the things we see. Mental and emotional health issues are often hidden but can have a huge impact on people's lives.

The way we live our lives affects the illnesses we have, and, as you will see in this strategy, the people of Tameside and Glossop have more than their fair share of serious life threatening illness. We live three years less than the national average. The roots of our local poor health are complex, and it is not just up to the individual to change, we have to help create a healthy community.

Of course people are allowed to make unhealthy choices, and most of us do some of the time. However, when those choices become the norm and lead to disabling illness we have a duty to support people in making better choices. We know that it hard to change how we live our lives but recognise that there are huge benefits both to individuals and communities as a whole when we do. This is especially important when the resources used to provide care for one person, take away our ability to offer a service to another.

This is the challenge which has been accepted by the new leaders of our local health services, Tameside and Glossop Clinical Commissioning Group (CCG). We are led by local GPs, supported by managers and have the job of getting the best quality health for our local people.

This 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 the current illnesses we have.

Doctors, nurses, therapists and everyone who works in health have a passion for getting things right for their patients. We see our patients' anguish when illness robs them of their independence and dashes their dreams. We see first hand how unhealthy living affects families and the wider society. Every day we are reminded that local people deserve the best we can offer.

We have £337 million to spend (£1,400 per local resident), but cannot do this work on our own. We can get better results if health services work closely with the Public Health, Local Authority, Police, Education and voluntary, community and faith groups. Most importantly we get the best outcomes if we work together with local people.

In our strategy we explain what is important to us, how we will work, and how we will set about spending our money to help the people of Tameside and Glossop live better lives. We make a lot of promises, and we are accountable to you, the people who live and work locally.

Dr Richard Bircher,
GP Board member and lead for strategic commissioning

Introduction

There are several chapters in this five year strategy. They describe what is important to us, and how we will go about using our own and other public sector resources, in partnership, to improve the health of the population and the medical services we provide.

We have consulted our public, local public sector organisations, GPs, the hospital and many other clinical partners in drawing the ideas for this strategy together. It reflects not just our own views but those of all interested parties.

In the first three chapters we tell you who the CCG are and what makes us different and the principles by which we intend to deliver our strategy. We talk about our attitudes to quality and our determination to deliver a health service which is compassionate and reliable.

Our vision states we will 'inspire' our partners to develop excellent, compassionate and cost effective care. This means that we want to be true leaders in all aspects of health and wellbeing, and that everything we do will focus on improving the services we commission for our population.

We cannot strive to continuously improve our care and services if we do not focus on the people who deliver that care and who work in the organisation. To be credible, we must deliver our vision and strategy through our values, style and behaviours. Put simply we need to get the best possible staff working in the best possible way. We shall lead by example.

In chapter four we outline our local health challenges and why there is such a strong argument to doing things differently to the past. This is our mandate to shake our local health systems up, and ask the people of Tameside and Glossop to take up healthier ways of living.

Chapter five focuses on seven priority areas of work. This presents how we intend to change local care services. Some of these changes are far reaching and will transform the way we deliver health and social care. We need to make savings in some areas (often without cutting services) to boost provision in others.

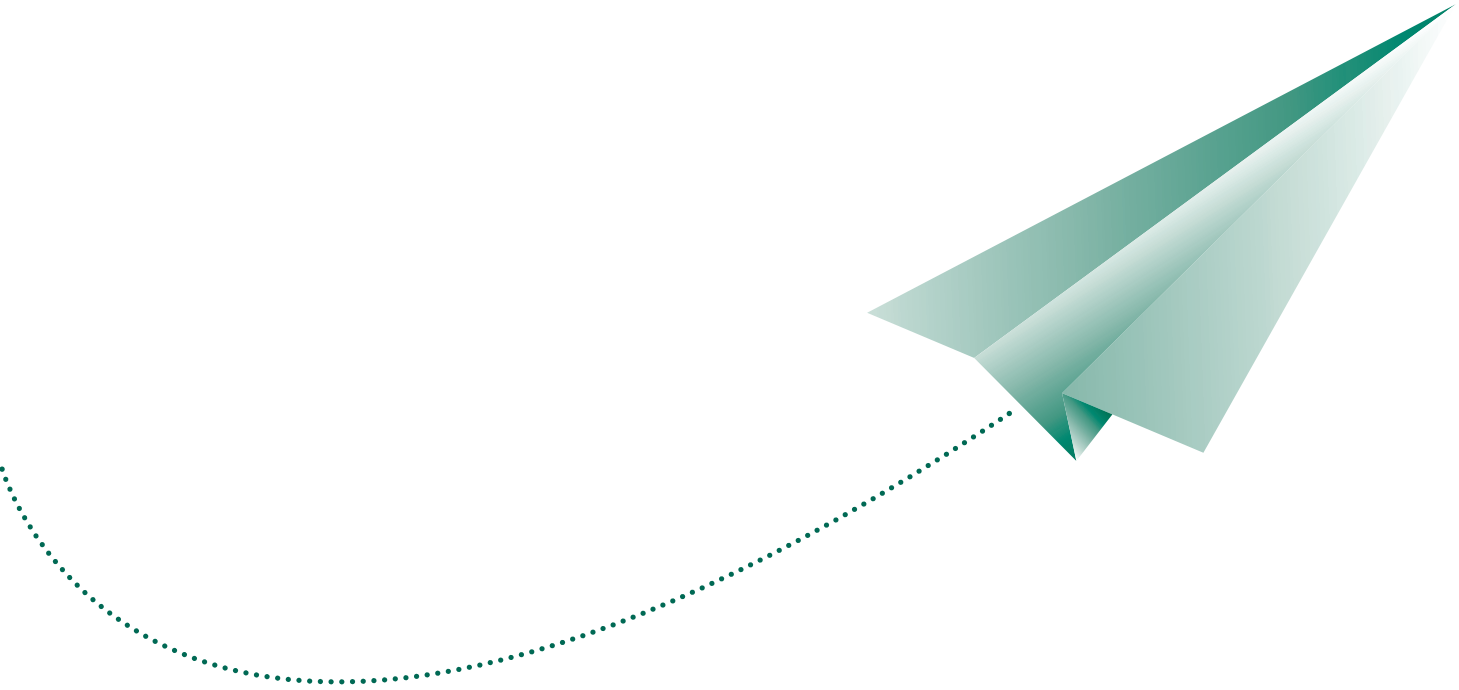
We describe how we will:

- Help children and young families to live secure and healthy lives
- Tackle the damaging effects of obesity, smoking and alcohol and other unhealthy lifestyles.
- Improve mental health and learning disability services, especially for people with dementia
- Provide more appropriate and cost effective services for people with long term conditions
- Provide appointments and treatments, especially for people with life threatening illnesses such as cancer
- Provide emergency and same day care for people who suddenly become unwell
- Make care for people who are approaching the end of their life more appropriate and compassionate.

In the last chapter, we describe how we will know we have been successful and how we would like to be held to account.

We would be happy to respond to any questions of clarification. We are proud to present our five year strategy.

NHS Tameside & Glossop - Who We Are



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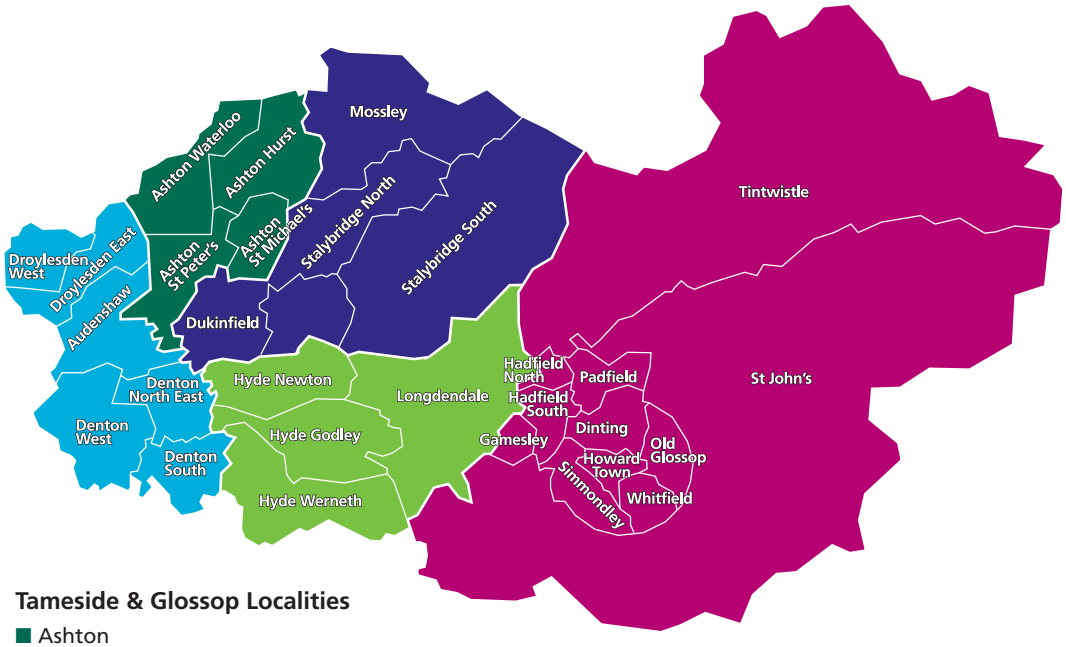
NHS Tameside & Glossop Clinical Commissioning group is responsible for commissioning health services for the 240,300 people registered with our 42 member GP practices. We work in five geographical localities; Ashton, Hyde, Stalybridge, Denton and Glossop. Four of our localities are within Tameside Metropolitan Borough and Glossop lies within Derbyshire being served by Derbyshire County Council and High Peak Borough Council. This gives us the challenge of working with three local authority partners to ensure the best healthcare for our patients.



Tameside & Glossop Localities

- Ashton
- Denton, Droylsden, Audenshaw
- Hyde, Hollingworth, Longdendale
- Stalybridge, Dukinfield, Mossley
- Glossop

The CCG is a membership organisation and is lead by all 128 local GPs, who have elected a board to carry out the work of improving local health and health services. The Board is made up of GPs, nurses, a hospital doctor, professional managers and local people.

Having such a wide membership means we are able to gather a lot of excellent opinion on the way our health services currently work well, and more importantly not so well. GPs know their staff and their patients well and represent the views of a very wide variety of people. We have ways of ensuring this wide opinion is focussed rapidly into meaningful change. Every report of excellent or poor local care and every new innovative idea are valued commodities within our CCG. This information continiously informs our plans.

We have the responsibility for deciding how healthcare monies are spent. GPs have always been responsible for providing best care for our patients, and that role remains. Alongside that we have the opportunity, and privilege, to use our expertise and passion for improving health and healthcare on behalf of the whole population of Tameside & Glossop. We will clinically lead changes and improvements locally, and influence the work of partners and others at a Greater Manchester and regional level through a range of strategic collaborations.

We have taken into account the views and opinions of our members, partners, stakeholders, and most importantly local people in developing our VISION, Our PRINCIPLES and our plans. (You can find further detail on the consulations and feedback in our 'Communication and Engagement Strategy'.

As a new organisation, it is important to define what we want to achieve and the behaviours that others can expect from us.

OUR VISION states:

Your CCG is led by local GPs. 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.

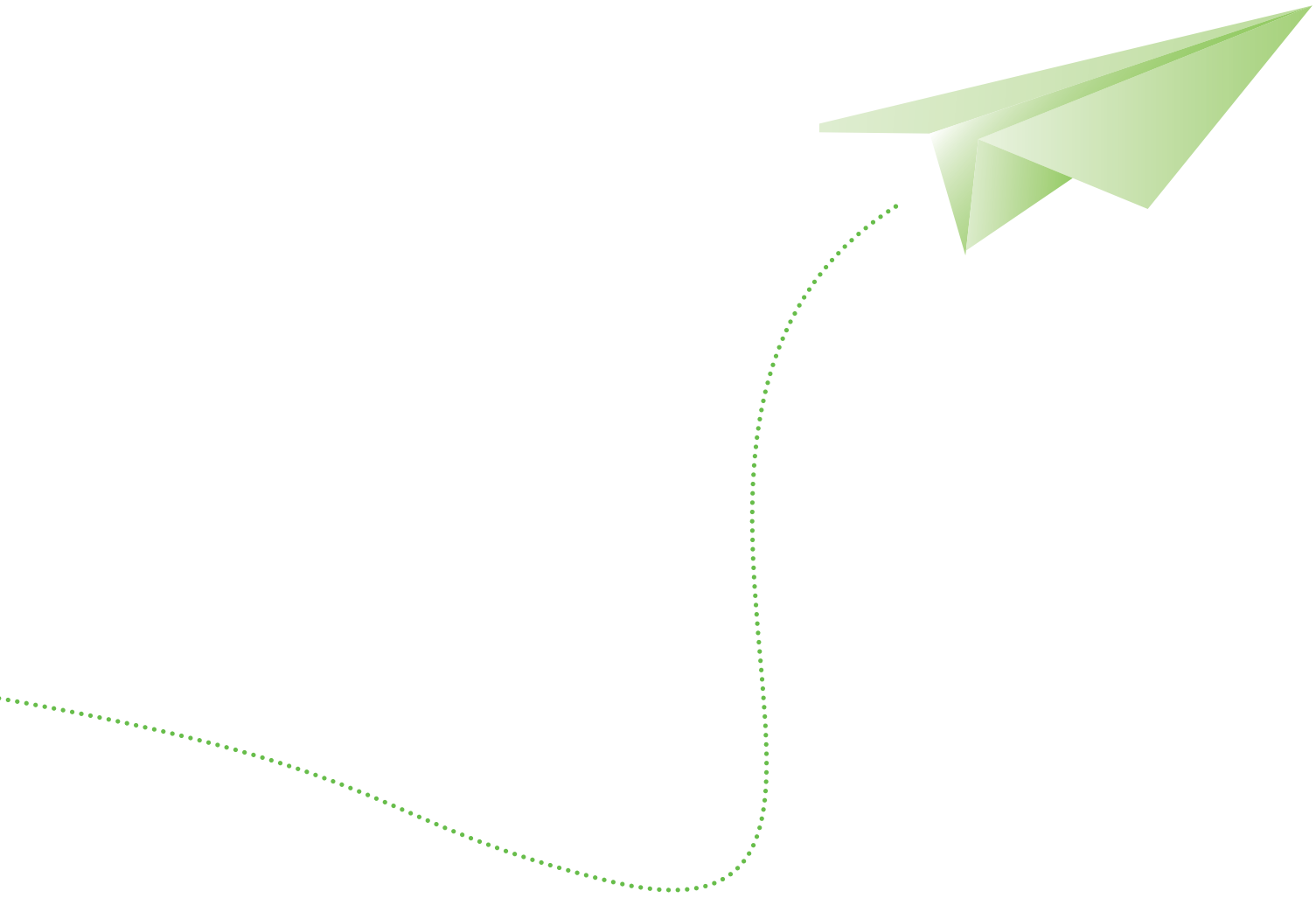
In everything we do we will operate by **OUR PRINCIPLES** of:

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

We have spoken to:

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
Volunteer Centre Tameside
Volunteer Centre Glossop
Tameside Carers Centre
Tameside Metropolitan Borough Council
Derbyshire County Council
High Peak Borough Council
Health and Wellbeing Board members
Tameside Hospital Foundation Trust
Hospital clinicians Stockport
NHS Foundation Trust
Pennine Care NHS Foundation Trust
Tameside and Glossop Community Healthcare
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

Our Strategy - How We Will Deliver Our 5 Year Vision



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We have four key strands to our strategic tactics that will ensure we deliver **OUR VISION** and remain true to **OUR PRINCIPLES.** These strands are linked, and rely on each other to deliver.

1 Putting our patients are the centre of everything we do

2 Clinical leadership

3 Working together in partnership

4 Integration and System transformation

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

TThe only way anyone can know what is important to local people is to listen to their comments, good and bad, and to canvass their opinion on what makes a good health service. We will listen to patients in designing how health services work and offer them a choice, where possible, of where they go to receive their care. We will put our population at the centre of planning the care needed. (More details can be found in Chapter 3 of our strategy, and in our 'Communications and Engagement Plan').

We want to provide the best possible health and social care services to people in Tameside and Glossop, and are adopting an ambitious and radically different approach to the care we commission.

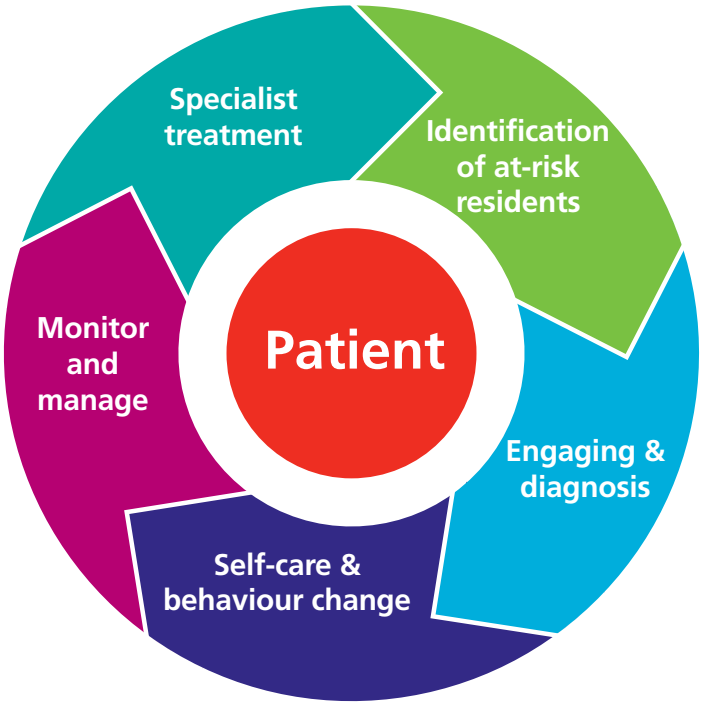
Patients should not have to experience health services which are difficult to use. Where there are cancellations, poor communication and long waiting times the service needs to change. Good care is arranged to make things easier for the user not the service, putting the patient at the centre of care.

We will promotethe NHS Constitution raising awareness amongst our population, our practices and our providers. So that everyone is more aware of what they can expect from the NHS and what their role is in helping it work effectively.

Often compliments and complaints made about our health service are to do with issues of compassion, politeness and respect. We have purposefully prioritised these issues. We believe how people are spoken to and dealt with is as important as the medical treatment they receive.

We have a management structure that ensures that the patient voice in heard in all aspects of our business.

People see care which keeps them out of hospital as a success. We will design our services to identify what help people need much earlier, and ensure we invest in prevention and early intervention services. We 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.



We will further develop the use of technology to support care and, when it is safe, keep patients at home. We will promote a more person centred, personalised approach to care working towards personal health budgets and recognise the challenges that this may bring.

In line with our joint strategy for carers with Tameside Metropolitan Borough Council (MBC) and Derbyshire County Council (CC) we will continue to respect the role of the carer in the services we commission and value the immense contribution they bring to the health and social care economy.

2.Clinical leadership

We are a new organisation, led by GPs; therefore we have a unique opportunity to lead the agenda across the health and social care economy. We are, and want to be, different from our predecessor organisations, and we want the public and our stakeholders to see the differences that having clinicians leading the way, can bring. We are passionate about improving care and the quality of services, and will use the relationships we have with our clinical colleagues to challenge performance, drive improvements and deliver change. GPs provide care on a day to day basis, so know what needs to be done to improve outcomes for our patients. As leaders of the organisation, we will now do this on behalf of our CCG population.

We will build on the increased willingness of primary, community and hospital clinicians to work together to improve the quality of services. Our desire is for excellent care for our patients provided by all providers. This is detailed in the following chapter.

As leaders within a clinical community we will ensure that our colleagues – our peers - understand that best clinical practice will be rewarded and poor clinical practice will not be accepted. As leaders within a health and social care economy, we will ensure that our members, partners and stakeholders understand that improved outcomes and high quality integrated care will become the norm, and that inefficiency, waste and duplication will not be tolerated or resourced.

We recognise that the health of our population is affected by climate change and environmental issues and aim to be a local leader in the area of sustainable development.

3.Working together

The challenges that lie ahead are too great for NHS Tameside and Glossop to manage on its own. Our governing body and the 128 members will therefore work in partnership and collaboration with our stakeholders including:

- Patients, users and carers
- LINks (HealthWatch)
- Tameside MBC, Derbyshire CC and High Peak Borough Council,
- Provider colleagues: Tameside, Stockport and Pennine Care Foundation Trusts and Independent Sector providers
- Voluntary, community and faith organisations
- Other Greater Manchester CCGs
- NHS Greater Manchester and NHS North of England

We have been leading a piece of work across Greater Manchester, with and on behalf of the other eleven CCGs, on collaborative working and the leadership of cross boundary commissioning issues. We will ensure that NHS Tameside and Glossop continues to be an active leader in this area, contributing to the wider conurbation health and social care service priorities.

We will work with NHSGM to jointly develop a framework to improve Primary Care performance. We know that by working together we are able to benefit from other's experience and knowledge.

4. Integration and System transformation

We aim to transform local services into something which gives us better outcomes and is more compassionate.

To deliver our patient centred services we need to increase integration. The added benefit of this is by ensuring we get the right services to people at the right time we save money. So we are working with Tameside MBC and Derbyshire CC on a programme of integration and service improvement that transforms health and social care.

We are reviewing the current community services, including mental health, looking at how best to link together health and social care services to deliver integrated teams, which improve quality and outcomes through a seamless patient centred journey. Our work will support and advise the national Community Budgets programme.

We are starting with dementia to test and develop new ways of joint working across Tameside and Glossop and aim to complete the development and planning phase of this whole systems integration by the end of 2012/13. We will then tender for the newly designed integrated health and social care pathways during 2013/14 to ensure we get the best outcome for patients and deliver improved value for money across the economy. Our local hospital will deliver care as part of these integrated services.

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 eleven CCGs have access to excellent services that deliver the best outcome for the patient. This programme is known as 'Healthier Together'

Integrated Patient Pathway for Planned Care Inpatient Stays

This will mean changes for our local hospital. Tameside NHS Hospital Foundation Trust (TFT) recognises that in order to provide high quality, senior professional led services 24 hours a day it cannot continue to provide everything it currently does. We and others across Greater Manchester agree with this. So we will work with TFT to ensure that its new service and business configuration means that is able to offer excellent services that support integrated patient pathways which involve alliances with other organisations.

We are committed to a local hospital with:

- An A&E, but with a re-focus that it should be for Accident and Emergency conditions only, not a gateway to other care (such as doctor-to-doctor admissions, social and psychological crisis and treatment of minor conditions). To support this we will have:

  - High quality easily accessible primary care alternatives to A&E

  - Same day consultant clinics for unplanned care, to provide an alternative to admission to hospital

- Less people staying overnight through:

  - Transformation of medical inpatients services to dramatically improve the quality of care, and the speed at which people are treated. This will include further integration of social and medical services for people whose illness makes it difficult to live independently at home

  - Development of acute medical treatments which can be delivered in the patients home (or care home) in order to make discharge from hospital faster or prevent the need for admission in the first place

- More accessible Planned Care through

  - outpatients services at different times of the day

  - the transfer of some routine outpatient follow ups into community clinics (or for the housebound in their home)

  - a greater range of specialist clinics

  - increased day case surgical treatments

  - accessibility of all test results to primary care, and for primary care tests to be accessible to hospital doctors

We are confident that the transformation we have planned will improve patient outcomes and experience and enhance the reputation of our local hospital and the health and social care economy.

Aiming For Excellence - How We Will Continuously Improve

[3]

We are committed to excellence in both the services we commission and they way our staff behave.

Culture

We will develop a culture of continuous improvement of ourselves and others who are involved in the health and wellbeing of local people. Everyone – clinicians and managers - will have their performance assessed, and participate in the assessment of others. We will encourage 360 degree peer review between clinical teams both within and across organisations and everyone will be challenged to improve their contribution to local services and be given support to do so.

We want the best services for our patients, and we want the best staff to deliver them. We want Tameside and Glossop to be seen as a centre of excellence, where health and social care staff are proud of the organisations they work for, and are proud of the care they give. We will build on the our excellent reputation as GP training practices working with the Deanery to promote Tameside and Glossop as a place of work for aspiring clinical leaders and champions across primary, community and secondary care. We all have a responsibility to improve our reputation and the CCG will lead developments through the Clinical Congress and a Skills Sharing Programme.

Working with our health and social partners we will aim to be a centre of excellence for dementia and care for the frail elderly, especially those approaching the end of their life. We are part of the National AQUA/Kings Fund Integrated Care Community project.

We recognise our corporate responsibility as an NHS organisation in tackling climate change and promoting sustainable development. And will look to reduce our own carbon emissions and operate in a sustainable way as well as encouraging sustainable develpment in our partners.

Continuous assessment

We have a 'Commissioning for Quality' strategy which describes in more detail how we will monitor and assure quality in the three key areas below:

- Effectiveness of Care (successfully our interventions are)
- Patients Experience (how patients rate the quality of our care)
- Patient Safety (how safe our services are)

We will use a wide range of measurements In order to judge the quality of our care such as:

- The Harm Free Care & Safety Thermometer (national set of indicators)
- Levels of Hospital Acquired Infections
- Clinical Audits
- Unannounced Visits
- Mystery Shopper
- Safeguarding
- Patient Feedback
- Professionals feedback on each others services

Our plan is to 'Listen and then to take a Look'.

We will use this information to produce our 'Quality Dashboard and Performance Reports' that will be discussed regularly by our Quality Committee, Planning Implementation & Quality Committee and CCG Board. We will benchmark ourselvers against national and regional targets for population health,access, outcomes and service costs and ensure that our population are receiving care in line with the NHS Constitution. In this way, the leaders of our health system, with the ability to change services, will be well informed about the quality of local care.

CCG
Responsible for safe and sustainable service

- Sharing Best Practice
- Peer Review
- Joint Working with Hospital & Community Colleagues
- Locality Working
- Innovation

- The Patient's Leader
- Member of Health & Wellbeing Board
- Influences other Commissioners
- Joint Reviews of Quality and Service Development Plans
- Joint Education

GPs
Responsible for the care of patients

- Services Used Appropriately
- Feedback on Experience
- Patient Support Group
- Exercising Choice on Services

Providers
Responsible for th care they provide

- IT Systems Supporting Patients Through Services
- Patient Centred Information and Advice
- Joint Clinical Guidelines
- GPs and other Clinicians Working Together
- Strong Patient Feedback

Patients
Responsible for their own health

We will meet regularly with the providers of our services to discuss quality and to ensure they have systems to manage and monitor quality including clinical audits. We will support the use of incentive schemes that reward services when local people are receiving high quality care.

When planning services we will use patient feedback and guidance from the National Institute of Clinical Excellence (NICE) to inform our decisions. Through our Patient Experience Group, we will include patients as essential members of any service redesign team and involve them in assessing potential new providers through community groups, our Consumer Advisory Panel and General Practice patient participation groups.

We will insist that any new service is judged for its ability to treat people with dignity and respect as well as deliver good health outcomes.

Our population is diverse and the health needs challenging so we will develop a programme of health equity audits to ensure we achieve equitable outcomes for our different population groups.

We spend around £42.5 million a year on medicines and ensure that money is well spent through our Medicines Management Committee. They consider the impact of NICE decisions on what all our local doctors (and specialist nurses) prescribe as well as which medicines are most cost effective. They advise us on what new medicines may become available in the next five years. They will also continue to work with our local Pharmacists to help them to deliver services such as Needle Exchange, Supervised Consumption of Methadone, COPD inhaler Techniques and Smoking Cessation.

We will support our GP members in their prescribing through advice, audits and education. Partnership working is key to effective use of medicines and we will continue to work closely with our members, colleagues at Tameside FT and across Greater Manchester to agree what medicines we will provide patients so that we can ensure that cost effectiveness, quality and outcomes are maximised.

Skills sharing and education and training

We will lead by example working towards becoming an Investor In People. Developing the skills and knowledge of our staff and members and ensuring learning is central to the way we work. We will develop systems that encourage innovation and best practice and local performance indicators that demonstrate excellence and reward successful innovation and practice such as:

- Skills and knowledge swaps, with primary care GPs, Nurses and Admin working within community or secondary care (and vice versa).
- An innovation fund to improve patient care across organisations, and develop an annual awards event for both primary and secondary care linked to **Our VISION**

We will strengthen our pathways and integration and facilitate co-operative working through:

- Joint training sessions for established clinicians, in 'mandatory or essential' updates such as communication skills
- Joint induction for all new consultants and GPs employed in our area, which focuses on joint working, leadership and public health challenges
- A joint leadership skills training programme
- Developing the skills of Primary and Secondary Care clinicians to support care closer to home

We will support our patients to become very knowledgeable about their own illnesses through our Expert Patient Programmes and use support groups to feedback their experiences through, surveys (Patient Reported Outcome Measures) and complaints systems.

Dealing with poor practice

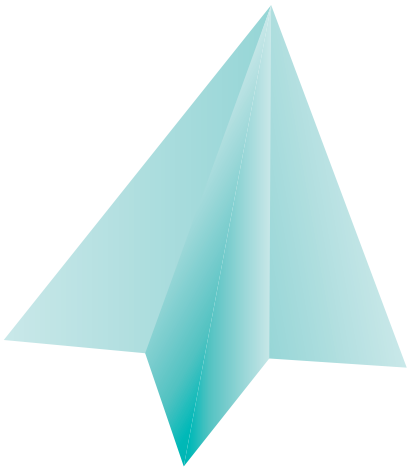
Our patients deserve the same high quality primary care services wherever they live. They deserve the same quality community, secondary and mental health services living in Tameside and Glossop as they would living in another part of the country. We will not accept poor practice from any of our providers (including our member general practices), and any variations in quality which falls below acceptable levels will be investigated promptly and the provider supported to change. Where improvements are not made we will decommission the failing services and provide alternatives. We shall do this more promptly than in the past.

Our providers will be aware of our zero tolerance approach to poor practice. The care we commission on behalf of our population will be of the same standard and quality as that we would all want to see for our loved ones. We will not accept any provider who continuously delivers below the average and who will not engage with us on improvements in their performance.

Co-ordinated through our Patient Experience Group, we will include patients, users and carers as essential members of our performance monitoring team, and working with Healthwatch (and its predecessor LINks) to monitor and assess the services we commission. We will make sure patient compliments and complaints are fed back directly to the person in charge.

We will look to our population as stakeholders who not only support the management of performance, but who act as a 'common sense' committee to deliver strategic system transformation.

Our Local Status - Why We Need To Change



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Our VISION includes living longer healthier lives; and we do need to change our health and social care services if we want achieve this.

Worse than England average

Smoking in pregnancy; Breastfeeding initiation; Alcohol attributable and specific hospital admissions and mortality; Alcohol-specific hospital stays (under 18s); Teenage pregnancy (under 18); Adult smoking; Healthy eating adults; Obesity in adults; Hospital stays for self-harm; Drug misuse; People diagnosed with diabetes; Life expectancy; Smoking related deaths; Early deaths from cancer, heart disease & stroke; All cause mortality in under 75; Binge drinking; Deprivation; Proportion of children in poverty; Educational achievement; Violent crime; Long term unemployment.

Close to England average

Levels of obesity in children; Increasing and higher risk drinking; Physically active adults; New cases of tuberculosis; Hip fracture in 65s and over; Excess winter deaths; Infant deaths; Children and young people smoking

Better than England average

Childhood immunisation uptake; Incidence of malignant melanoma; Road injuries and deaths; Statutory homelessness

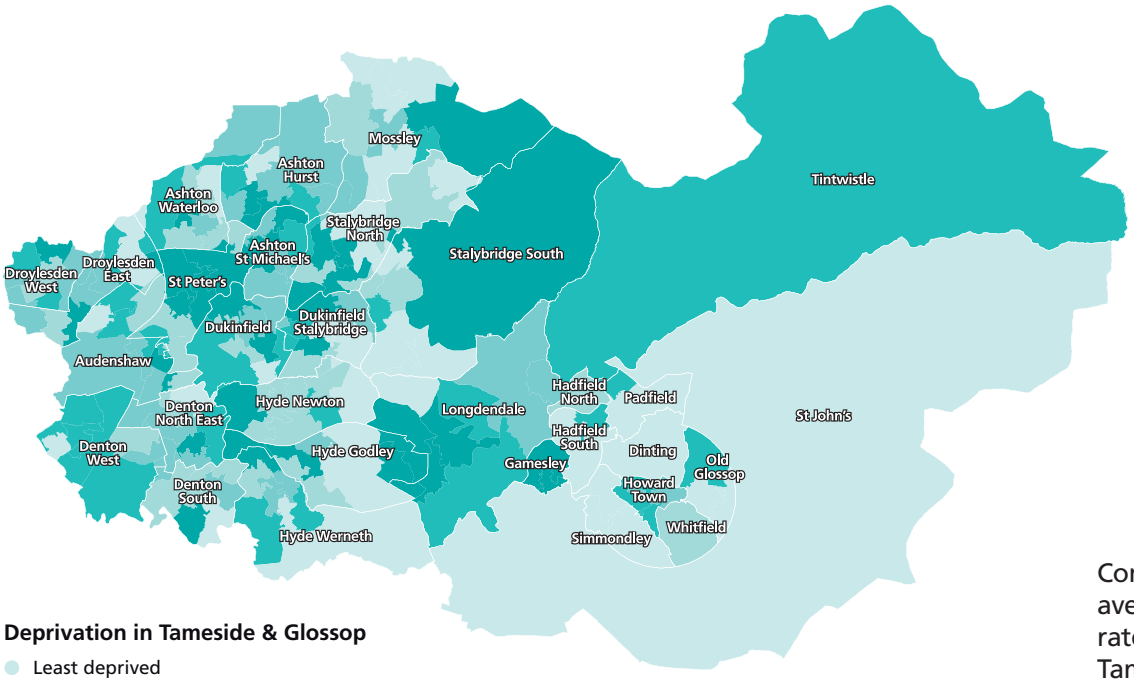
We need to change to meet the current health needs of our population

Our Joint Strategic Needs Assessment (JSNA), which we developed with the Tameside and Derbyshire Health and Wellbeing Boards, describes in detail the health and social care needs of our local people. It points us towards four diseases which have the biggest impact currently in Tameside and Glossop:

- Cardio-vascular disease (heart disease and stroke)
- Respiratory disease (Chronic Obstructive Airways Disease)
- Cancer
- Diabetes

It also highlights the main causes of these diseases which will continue to impact on us in future:

- Alcohol related ill health
- Obesity related illness
- Smoking related ill health
- Age related health issues such as general frailty and dementia



Deprivation in Tameside & Glossop

- Least deprived
- 4
- 3
- 2
- Most deprived

Key Facts which show our health problems

Local life expectancy is lower than the national average with men at 76.1 years compared to 78.6 in England and women at 80.3 years compared to 82.6. It has been increasing in both deprived and affluent areas but the rate of improvement is slower in more deprived areas.

For the period 2008–10, the difference in life expectancy between the most deprived and the least deprived areas was over 13 years: 72.4 years in Hadfield North compared to 85.8 years in Old Glossop. This gap has got bigger over recent years and we urgently need to narrow it.

We have 32% of our patients living in areas that are within the 20% most deprived in England.

By deprived we mean people lack social support, have financial worries, low self esteem and make unhealthy lifestyle choices.

The majority of the gap in life expectancy between Tameside and Glossop and England is caused by higher than expected levels of death before age 75. In 2008 -10 the main causes of these premature deaths were: Cancer (35%), Cardio-vascular disease (including heart disease and stroke) (29%) and respiratory disease (including COPD) (10%).

Deaths from smoking are greater than the combined total of the six next greatest causes of preventable deaths. The incidence of ill health in women caused by smoking has risen. For example, female death rates from lung cancer rose by 12% between 2002 and 2010.

Compared to the national average, there is a higher rate of binge drinking in Tameside and Glossop, which impacts on the number of hospital admissions. From 2002/03 to 2010/11 the number of alcohol related hospital admissions increased by 200%.

Compared to national average we have less people aged 65 and over; 15.6% compared to 16.5% across England. However, we expect a 50% increase in the number of people aged 65 and over living in Tameside and Glossop by 2029. By the same year, we also expect the number of people aged over 85 to double.

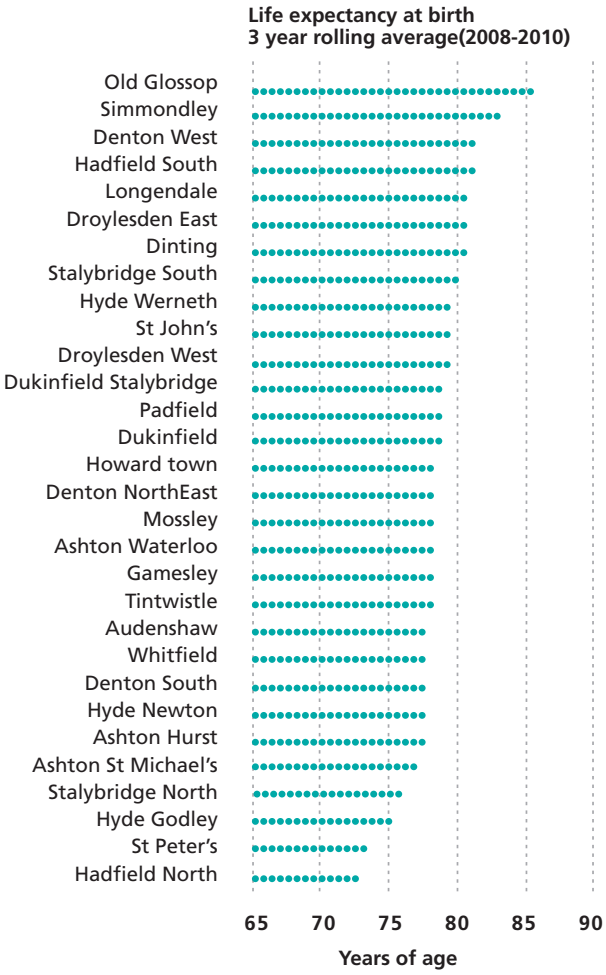
Research suggests that two-thirds of people would prefer to die at home, but the majority still die in hospital. Locally, the proportion of people dying in hospital is significantly higher than the England average: 62.6% compared to 54.5%.

Locally, emergency care costs around £47 million a year, with 20,000 admissions.

Health Inequalities

Differences in health outcomes such as life expectancy are called health inequalities. They can exist between different genders, ethnic groups, socioeconomic groups, age groups and often exist amongst vulnerable groups such as the elderly and people with mental health issues. The reasons for them are complex and include things like lifestyle, poverty, housing and access to healthcare. We have high levels of health inequality with the people living in our areas of highest deprivation more likely to experience poor health and death at a younger age, as can be seen in the 13 year difference in life expectancy highlighted earlier.

Reducing health inequalities is important to us and we know from research that it is not enough to focus solely on the most disadvantaged. To really improve the health and wellbeing of local people and reduce health inequalities we need to ensure we all promote health and wellbeing with everyone we work with. As you read Chapter 5 you will be able to see some of the ways we will be doing this.



We need to change to meet future demand for health services

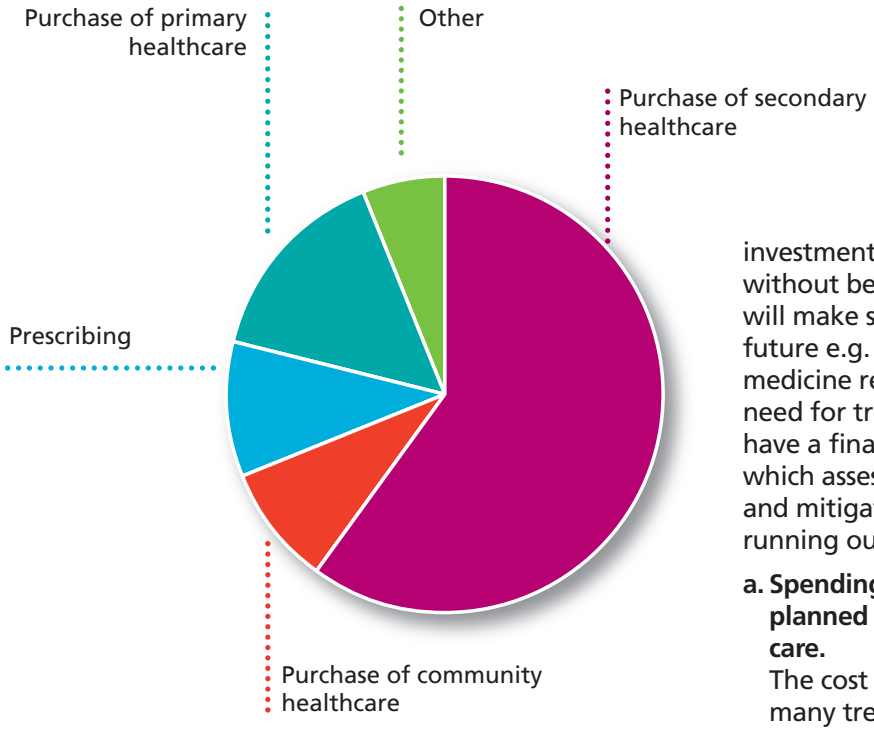
Many things affect the demand for services. Four key things locally are:

a. **The increasing number of older people living in Tameside and Glossop.** We need to work with social care providers to jointly commission and deliver services which support older people. Particularly those which aim to keep older people healthy and living independently in their own home and help them avoid hospital admissions. Currently three quarters of adult hospital beds (not surgical) are treating an elderly patient with dementia.

b. **The increasing number of people with debilitating long term conditions such as diabetes.** We need to help people manage their conditions so they stay well and out of hospital. We want to increase the early identification of illness as well as working with the population as a whole to reduce their risks of developing long term conditions.

c. **Patients having higher expectations of the NHS.** We need to develop a greater partnership with people providing them with the information they need to make choices around their health and treatment, promoting healthier lifestyles and self care. We need to find ways of meeting the challenges that the consumer age brings with people expecting access to the latest drugs and technology. If patients are to use scarse health resources appropriately they will need to know what is most suitable. This involves a lot of public consultation and education.

d. **The impact of the recession on the determinants of health.** We need to work with local partners to try and reduce any negative impact that may result from changes to the economy and local services and systems. We know that the mental and physical health of our population is being affected by a lack of jobs, changes to the benefits system and increasing fuel prices. We need to ensure people get the help they need.



Expenditure 2011/2102

We need to change to be prepared for less NHS funding in the future.

We have a duty to make every pound we spend give the maximum return possible for our population. We expect public finances to get even tighter in the next few years.

Our Financial Position

We have an annual budget of £337m in 2012-13 with which to invest wisely and appropriately. We plan to spend it as follows:

We have been through three years of financial challenge, but by careful management we have reduced our costs by approximately £50m to achieve all the targets we were set. We have done this without cutting clinical services.

We do not know exactly how much money we will get in the future and this means we can not commit to too many expensive investment projects without being sure they will make savings in the future e.g. preventative medicine reducing the need for treatment. We have a financial plan which assesses, manages and mitigates our risk of running out of money:

a. **Spending more than planned on hospital care.**
The cost (tariff) for many treatments is set nationally so if this changes we could end up paying more. Also if we have more people needing hospital care it will cost us more. A 2% growth in activity could present us with a bill for £2m more than we expected.

b. **Paying for Long term residential Care**
The numbers of people who have very complex illnesses and need 'round the clock' care can vary greatly and so it is difficult to be sure what we will have to spend.

c. **Variable Cost of medicines**
As new drugs are released and others come off patent the amount we will have to spend changes.

d. **Achieving the Changes we have Planned**
If we are too slow in implementing our plans we may not see the benefits we were expecting. There is a lot of change and less resource. We have to make sure we plan and prioritise the most important changes first.

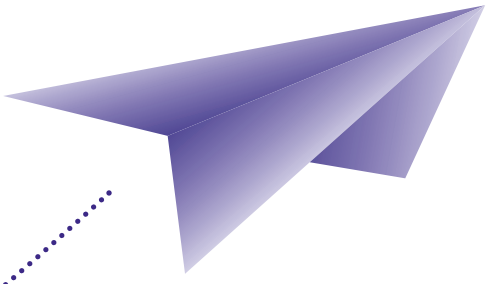
e. **The impact of the NHS changes**
We are always aware of the changes to the NHS as part of government policy. We have to plan for uncertainty and also the impact of reductions to the income of our strategic partners, for example, our local authority partners.

Our financial priority is to invest wisely in our plans to successfully improve health and wellbeing of our population, working in partnership, whilst achieving all our statutory financial targets and requirements. And we will use prioritisation tools to inform our decision making on investment and disinvestment decisions and to help us manage competing priorities.

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

Our financial strategy is to ensure that we manage resources appropriately so we can achieve **Our VISION**.

Our Seven Clinical Challenges - What Changes You Will See



[5]

We will achieve Our VISION and have the greatest impact on health and reducing health inequalities by focusing on seven clinical areas.

CHILDREN AND FAMILIES
(HELPING CHILDREN AND YOUNG FAMILIES LIVE SECURE HEALTHY LIVES)

LIFESTYLE CHOICES
(TACKLING THE DAMAGING EFFECTS OF OBESITY, SMOKING AND ALCOHOL AND OTHER UNHEALTHY LIFESTYLES)

MENTAL HEALTH
(IMPROVING MENTAL HEALTH AND LEARNING DISABILITY SERVICES, ESPECIALLY FOR PATIENTS WITH DEMENTIA)

LONG TERM CONDITIONS
(PROVIDING MORE APPROPRIATE AND COST EFFECTIVE SERVICES FOR PEOPLE LIVING WITH LONG TERM CONDITIONS)

PLANNED CARE AND CANCER
(PROVIDING APPOINTMENTS AND TREATMENTS ESPECIALLY FOR PEOPLE WITH LIFE THREATENING ILLNESSES)

URGENT CARE
(PROVIDING EMERGENCY AND SAME DAY CARE FOR PEOPLE WHO SUDDENLY BECOME UNWELL)

END OF LIFE
(MAKING CARE FOR PEOPLE WHO APPROACHING THE END OF THEIR LIFE MORE APPROPRIATE AND COMPASSIONATE)

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. These are also our major Quality Innovation Productivity Prevention Partnership (QIPPP) priorities and align with the NHS Outcomes Framework.

Our local work reflects and delivers key national and regional strategies and frameworks.

Our work also reflects the fact that to achieve **Our VISION** our plans must fit with those of our partners across Tameside & Glossop, Greater Manchester and the North West. We are committed to working with Tameside Hospital NHS Foundation Trust, Pennine Care Foundation Trust, Stockport Foundation Trust, Tameside Metropolitan Borough Council and Derbyshire County Council to jointly get the best value from every pound spent on health (and social) care services.

We do this through being active members of the Tameside and Derbyshire Health & Wellbeing Boards. This is where large scale decisions on how we all spend our resources are discussed and agreed. Each Board has developed a joint Health and Wellbeing Strategy for their area with key priorities to promote good health and wellbeing for all.

Tameside Health and Wellbeing Board Strategic priorities are to:

- **Improve the health and wellbeing of local residents throughout life**
- **Give targeted support to those with poor health to enable their health to improve faster**
- **Develop cost effective solutions and innovative services, through improved efficiency**
- **Focus on prevention and early intervention**
- **Emphasise local action and responsibility for everyone**
- **Deliver more joined up services that meet local need**
- **Enable and ensure public involvement in improving health and wellbeing**

Derbyshire Health and Wellbeing Board Strategic priorities are to:

- **Improve health and wellbeing in early years**
- **Promote healthy lifestyles**
- **Improve emotional and mental health**
- **Promote the independence of people living with long term conditions and their carers**
- **Improve health and wellbeing of older people**

Our plans to meet our seven challenges are fully aligned with those of our partner Health and Wellbeing Boards.

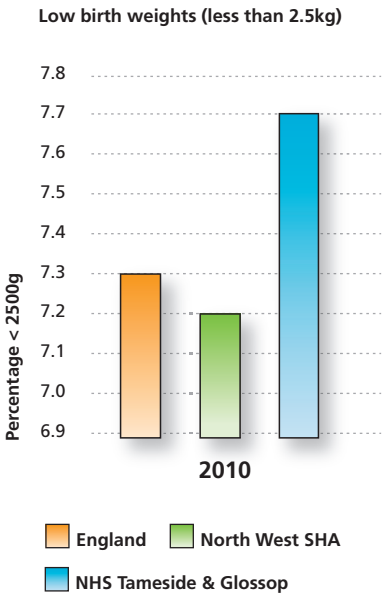
Tameside Health & Wellbeing	NHS Tameside & Glossop	Derbyshire Health & Wellbeing
STARTING WELL	CHILDREN AND FAMILIES	HEALTH & WELLBEING IN EARLY YEARS
DEVELOPING WELL	LIFESTYLE CHOICES	HEALTHY LIFESTYLES
LIVING WELL	MENTAL HEALTH	MENTAL HEALTH & WELLBEING
WORKING WELL	LONG TERM CONDITIONS	PEOPLE WITH LONG TERM CONDITIONS & THEIR CARERS
AGEING WELL	PLANNED CARE AND CANCER	OLDER PEOPLE'S HEALTH & WELLBEING
DYING WELL	URGENT CARE	
	END OF LIFE	

CHILDREN AND FAMILIES
(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.

Now

We have more babies with a low birth weight than in the North West and England. Low birth weight reflects the health of mothers and babies and is associated with poor outcomes for babies usually including increased infant mortality. However, for us even though we have low birth weight babies this is not associated with higher infant mortality, which is consistently below the North West and England averages.



Our rates of breastfeeding at 6 – 8 weeks are improving, but are still below national average. This means our mums and babies are missing out on the benefits such as reduced diarrhoea and respiratory infections in infants; reduced risk of obesity in children; reduced risk of developing coronary heart disease and diabetes in later life and reduced risk of ovarian and breast cancer in mothers.

Our children have more hospital admissions because of injuries than across England with 1.5 in 100 ending up at hospital compared to 1.2 in 100 nationally . It has reduced since 2007/08 but still we have too many especially in our 0-4 year olds. More of our children also end up in hospital because of asthma, epilepsy and diabetes than the national average.

Not enough of our 4 year olds are school ready compared to the national average and we also have a higher number of Children in Need than nationally whom are due to parental mental health.

In 2017

Health Outcomes

- **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**

"Families will become strong and healthy enough to give their children the best start'"

Dr Tina Greenhough, Clinical Lead for Children and Families

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.

Safeguarding

COMMUNITY SETTING

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.

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.

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.

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.

HOSPITAL SETTING

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.

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.

WHAT WILL THE CHANGES MEAN?

SERVICES	PARTNERS	CHILDREN AND FAMILIES
Support for children and families is integral to all services	Staff are equipped across all sectors to deliver whole system approaches, such as brief interventions, active support to stay healthy, to meet key priorities	Active support to stay healthy Reduced dependency on services
Preventative and early intervention	Staff are able to screen for early indicators of emerging needs and empower families to find solutions	Able to access appropriate support early on and nearer home
Work together to deliver evidenced based patient centred pathways	Work together to meet agreed priorities for children and families Targeted provision shaped through the engagement of parents and children	Access to and confidence in effective services
Programmes in place to build community capacity	Services work with strong community support groups	More peer support and local groups helping other families
More psychological support	Mental team specialists will work within children's services	Children and parents will be able to get help on mental health when required

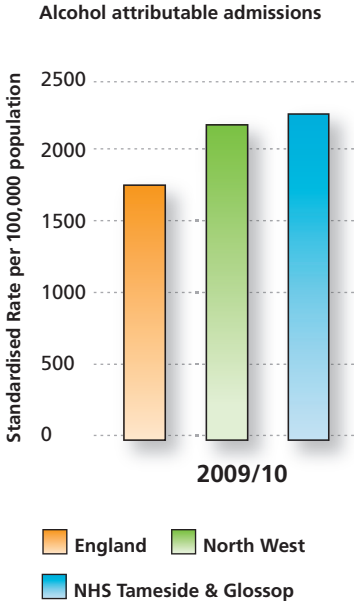
LIFESTYLE CHOICES

(TACKLING THE DAMAGING EFFESCTS 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.

Now

Around 23% of our population drink at a level that is hazardous and puts their health at risk and 7% are already harming their health through the amount they drink. In 2010/11 we had 2.4 admissions for every 100 people in our population because of alcohol compared to a national average of 1.9. We also have more people dying because of alcohol compared to national figures. Binge drinking is prevalent with high rates of admissions for acute intoxications especially for 20-25 year olds. We have boys as young as 15 and girls younger than 14 being admitted as well as all ranges of adults. The people who are being admitted live in our more deprived areas.



Over 24% of our adults smoke which is higher than the 21% average across England. We have seen a year on year decrease since 2009 when we had over 30% of adults smoking but this is starting to level off. Last year our stop smoking support services helped 2,110 people quit.

In 2010/11 23% of our pregnant women smoked at the time of giving birth. This was the highest rate in Greatest Manchester and much higher than England (14%). Our levels have decreased but the gap between us and the regional and England average is no closer. Children exposed to second hand smoke are at much greater risk of cot death, meningitis, lung infections and ear disease and when both parents smoke children are four times more likely to start smoking than if neither parent smokes.

People who are overweight or obese are at a greater risk of diabetes, coronary heart disease and cancer. On average obesity reduces life expectancy by 11 years. Amongst adults, levels of obesity are significantly higher than the England averages: 26.5% compared to 24.2%.

The proportion of overweight children in Reception Year and Year 6 is similar to regional and national figures. With regard to obesity however, although there are lower levels amongst Reception year children compared to regional and England averages, levels amongst Year 6 children are lower than regional averages, but higher than national averages.

In 2017

Health Outcomes

- **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**

"We help individuals realise their power to make positive choices"

Dr Tina Greenhough, Clinical Lead for Lifestyle Choices

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

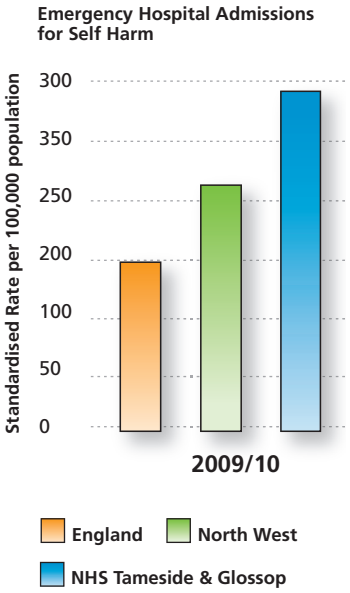
WHAT WILL THE CHANGES MEAN?

SERVICES	PARTNERS	RESIDENTS
All local services support improvements in lifestyle	Licensing, trading standards, the police as well as others will help reduce underage sales and access to illicit tobacco and enforce smoke free public spaces. Active travel and access to leisure facilities and green space for all our residents will be encouraged	Support to live healthy lifestyles and reduce the risk of developing ill health
Local social marketing programmes focussed on young people in Tameside and Glossop which will be built to address their concerns, using their language and preferred media	Front line staff trained to have conversations with every patient about their lifestyle choices and providing patient Information/ literature	Targeted information on lifestyle
More prevention and health promotion with healthy individuals as well as people who are already ill. General practices to be experts at signposting patients to the best local resources to improve their health	Will actively find people who are at risk	Will be asked about your smoking, alcohol use and diet more often and provided information on staying healthy
Maternity and Children and Family services will encourage changes in the home across the whole family	Extending case finding and brief advice about lifestyle to partners, including Children's Centres and schools. Schools will promote healthy growth and healthy weight in children and focus on promoting healthy eating in children	Will be supported to make changes as a family
Primary, community, hospital and social care working closer together along with other local services to offer a flexible range of options for lifestyle behaviour change support	Staff across health, social care, emergency services, probation and the voluntary sector will offer people a full range of different evidence-based lifestyle behaviour change services that can support behaviour change	If you smoke you will be encouraged to quit, and if you agree to try you will be referred to NHS Stop Smoking Services. If you drink above sensible levels you will be encouraged to cut down. If you are overweight you will be helped to lose weight
Every opportunity is taken to link lifestyle to acute and long term conditions that present to primary and secondary care	All clinicians addressing the determinates of ill health and linking patients to further support	Understand the links between lifestyle and illnesses and offered behaviour change support as a routine part of care to support and better recovery from acute conditions and better prognosis for long term conditions
Specialist behaviour change services that support recovery and reintegration	Range of specialist evidence-based community behaviour change services. Specialist support for protected groups	Accessible support in a wide range of locations, times and delivery models. Better prognosis, less risk of premature death and disability from cardiovascular, respiratory and liver disease

MENTAL HEALTH

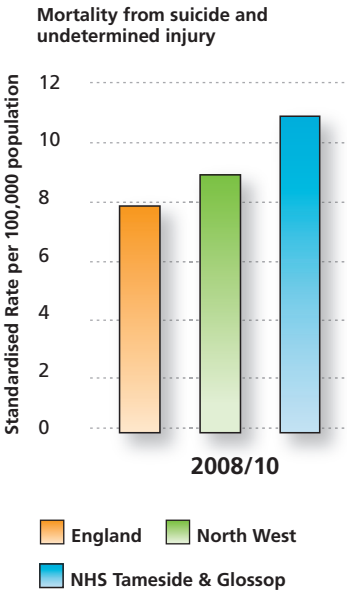
(IMPROVING MENTAL HEALTH SERVICES AND LEARNING DISABILITY SERVICES, ESPECIALLY FOR PATIENTS WITH DEMENTIA)

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.



Now

Only 0.2% of our older people access Primary Care Mental Health Services which is less than we would expect given our population. Our level of diagnosed dementia is 201 (48%) compared to a national average of 41%. Our Home Intervention Team team support the timely and safe discharge of patients. They also work with older people at home to avoid them being admitted to hospital. We have less of our Black and Minority Ethnic (BME) population accessing services and less of our 18,000 military veterans



"Mental Health problems will be talked about and treated in the same proactive way as physical problems

Dr Tina Greenhough, Clinical Lead for Mental Health

receive help from our services than we would expect.

Our Primary Care Mental Health service achieves a 50% recovery rate which is better than the national average of 40%. And whilst our local psychological therapy services provide CBT, CATS therapy and EMDR, they do not meet the full range of needs such as eating disorders and couples who need therapy.

Local people with Learning Disabilities are not supported are well as we would like with only 25% being offered an annual health check and around 1 in 5 taking up routine screening invitations.

We have too many people who repeatedly end up in hospital because of their mental health and we have more people who die from suicide than the national average

In 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

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

WHAT WILL THE CHANGES MEAN?

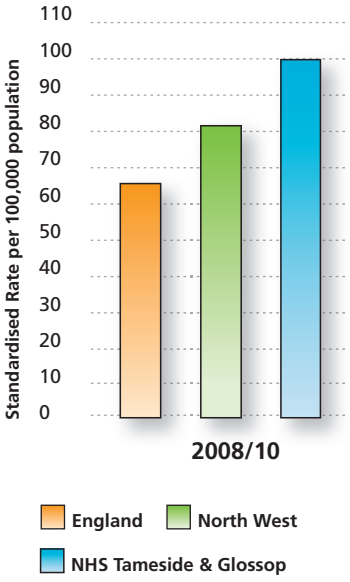
SERVICES	PARTNERS	RESIDENTS
More prevention and health promotion More involvement of 3rd sector/voluntary organisations	Active Case finding Providing Patient Information/ literature Awareness raising	Active support to stay healthy
Primary and community care and GPs working closer together and connecting more with social care and community services	Strong links between Health and Social care to avoid admissions 24/7	Round the clock services to help people stay at home rather than hospital
A range of self help resources	Awareness raising and ensuring appropriate guided self help	Take more responsibility for own mental health
A broad base of interventions available	Developing the workforce to ensure effective service delivery	More personalised approach
Use of telecare and rapid response teams without the need for significant amounts of specialist hospital care	Community services supporting telecare Rapid response teams in community providers	More independence with their care managed in the community using integrated care models to support
Primary, secondary and acute services working closer together	Strong pathway development	Seamless services, getting the right treatment in the right place at the right time

LONG TERM CONDITIONS

(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.

Mortality from all circulatory diseases (under 75 yrs)

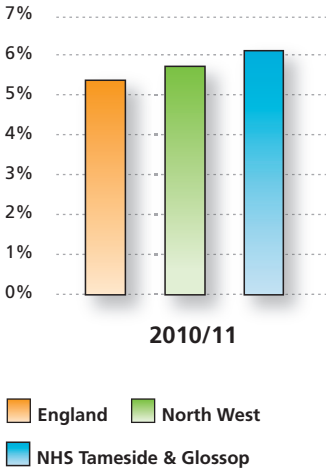


Now

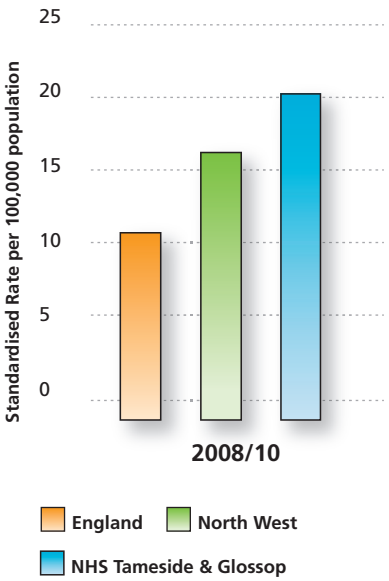
We have large numbers of people suffering from cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD) and diabetes.

We have reduced the number of people under 75 years old who are dying from CVD by 55.2% since 1995 but we still have significantly higher rates than the national rate.

Diabetes Prevalance (17 years and over)



Mortality from bronchitis, emphysema and other COPD (under 75 yrs)



We have more people being admitted as an emergency for heart disease than the national rate. However our mortality rate within 30 days of a heart attack is similar to the national rate. The quality of our Stroke care is not as good as other local areas.

We have one of the highest rates of mortality for COPD in Greater Manchester and much higher than nationally.

Our patients with Diabetes have a higher than average mortality rate. Over the last three years we have increased the number of patients on GP diabetes registers as we are identifying people more effectively. We currently have 12,326 people identified as having diabetes.

In 2017

Health Outcomes

- **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**

"I see a different Primary Care with GPs, Pharmacists, Dentists and Opticians offering much more; delivering that which used to be only available in the hospital while not becoming too big to care and remaining personal and compassionate."

Dr Alan Dow, Clinical Lead for Long Term Conditions

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

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, formal self management programmes, and telehealth

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

Specialist Primary Care

More specialist consultations, diagnostic tests and care, delivered within general practice prior to / as an alternative to referral to hospital

Specialist Community Care

Increased provision of care in community settings as an alternative to referral to hospital

HOSPITAL SETTING

Specialist Local Hospital Care

More specialist and intensive care delivered in local hospitals

Specialist/Tertiary Hospital Care

The most specialist and intensive care

WHAT WILL THE CHANGES MEAN?

SERVICES	PARTNERS	RESIDENTS
More prevention and health promotion	Active Case finding providing Patient Information/ literature Identifying "at risk" patients / populations	Active support to stay healthy Encouragement to have an NHS Health Check when invited to do so
Primary and community care and GPs working closer together and connecting more with social care and community services	Working together to support patients with long term conditions – move towards "integrated care teams". Strong links between Health and Social care to avoid admissions 24/7	Single point of contact to manage your care A named person who is responsible for making sure you get the care you need
More services delivered in the community and primary care	Delivery of services in alternative settings to traditional hospital outpatient setting. Integrated services across secondary care and community settings	Less appointments in hospital - more in the community
Use of technology to support patients with long term conditions	Supporting patients with long term conditions to use telehealth equipment to monitor their condition. Change own working practice to encompass remote monitoring and clinical triage	More independence to manage conditions at home. Learning how to monitor conditions such as COPD using telehealth equipment at home
Increased range of diagnostics delivered in primary care	Carry out an increased range of diagnostic tests prior to referral or as alternative to referral to secondary care for specialist advice and management	Having more tests done in local GP surgeries before being referred to the hospital
Increased range of self care support available to patients and professionals	Include self care in the range of support made available to patients. Increase staff understanding and uptake of formal self care programmes to support patients and carers	Taking part in self care programmes to teach people how to manage living with/caring for someone who lives with a long term condition
Development of models of care across Greater Manchester, with specialist care being provided at specialist centres, and patients being transferred back to their local area for ongoing medical care and rehabilitation. Development of hyper acute Outpatients clinics for patients to be seen rapidly by a specialist when their condition deteriorates or the use of hospital at home treatments (ie ambulatory care) Also development of professional advice lines to experts to discuss LTC treatments. The development of patient support groups and education programmes (ie Expert Patients) for people with Long term conditions.	Redesign of service provision to meet Greater Manchester wide service models	Travel for specialist intervention to other areas of Greater Manchester and return to local areas for ongoing medical care and rehabilitation

PLANNED CARE AND CANCER

(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.

Now

On average 153,600 patients ever year have planned treatment through our services ranging from physiotherapy to major surgery. We use an average of 10,000 outpatient appointments and 2,700 bed nights a month and carry out 7,300 procedures on Tameside & Glossop patients. Our patients can choose where or when they are treated for the majority of planned care and for services like adult hearing we have five different organisations delivering services all over the area.

93 % of the people who had booked appointments in hospital care attended them and over 94% of people waited less than 18 weeks for their hospital treatment. But we could be better.

Cancer is the commonest cause of premature death in people under 75 in Tameside and Glossop, and England as a whole. Deaths from cancer make up 22% of the difference between local and national life expectancy for men, and 20% for women. Our death rates for lung, bowel and breast cancer are above the national average and our 5 year survival for bowel cancer is currently the lowest in Greater Manchester. We also have significant variation in death rates from lung cancer between wards in Tameside & Glossop. Not everyone takes up their invitations to cancer screening and we have variation across practice populations.

In 2017

Health Outcomes

- **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**

"Our patients will receive care at least as good as that found in the best 25% of hospitals"

Dr Guy Wilkinson, Clinical Lead for Planned Care

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

WHAT WILL THE CHANGES MEAN?

SERVICES	PARTNERS	RESIDENTS
Invitations and reminder letters when cancer screening is due. Further reminders of booked appointments and for those who do not attend, to re-book	Actively encouraging people to attend screening	Reminders of why screening can save lives
Most diagnostics delivered out of hospital	More providers using health clinics/Primary Care Centres Increased use of mobile diagnostics	Less distance to travel and or more choice on where and when tests are carried out
More treatments available in the GP practice	Hospitals and GPs working more closely, sharing best practice and providing advice and guidance electronically or by telephone Development of more specialist skills within general practice	Routine treatment available close to home
Nurse led care for appropriate conditions	Using Specialist Nurses more appropriately to deliver care	You will receive high quality care directly from nurses
A movement of outpatients and consultations in the local community	Acute consultants and clinical assistants working from health clinics/PCCs/Practices	Able to find nurses, therapists and social care staff working together in local teams, often based in GPs
More day cases and shorter length of stay by using the most up to date techniques to help people recover quickly and need less time in hospital More use of Office based investigations and one stop clinics at the local hospital	GPs promoting Day cases and Enhanced Recovery. Acute Day Case procedures leading to different use of wards and less hospital beds Enhanced Recovery increasing therapy on day of operations and reducing beds	Less stays or shorter length of stay in hospital
Highly complex and specialist care located in Greater Manchester centres of excellence	Changes in services delivered form hospitals and more Greater Manchester pathways	You will receive excellent care but may have to travel further for it

URGENT 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.

Now

We spent around £47 million in 2011/12 on emergency care. Around 80,000 people attended A&E 25% of which were admitted. Our local hospital A&E department sees on average 210 patients a day and does a good job to look after an increasingly large number of unwell people, but the strain on services is showing.

General practices across Tameside and Glossop provide on average 5000 same day appointments for patients a week. However; some patients still use A&E and the Ashton Walk in Centre when they could have had an appointment with their GP. Approximately 20% of A&E patients could be more appropriately seen by other parts of the NHS. Even many of the patients admitted to hospital for 24 hours could have been avoided.

> "'When we have a health emergency we will have clinicians with exceptional skills who are able to treat us promptly and help us when we have difficult decisions to make'"
>
> **Dr Richard Bircher, Clinical Lead for Urgent Care**

Some of our emergency or same day admissions to hospital are for our elderly patients yet we know that if they are particularly frail it may be more appropriate to care for them in their own homes.

Attendences and admissions are increasing at the same time as everyone struggles to ensure patients are discharged promptly when they are well. This puts increasing pressure on the number of hospital beds we have. The current health and social care system is not sufficiently co-ordinated to prevent this happening on a regular basis.

In 2017

Health Outcomes

- **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**

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 and better choice

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

WHAT WILL THE CHANGES MEAN?

SERVICES	PARTNERS	RESIDENTS
Better same day access to general practice/primary care	A&E directing patients back to primary care for same day appointments providing consistent messages to our patients. Expert Patient Groups working with GP practices and PPGs to improve knowledge and signposting for staff and patients in the community	Attend GP and/or other primary care provider for appropriate service, and not attending A&E for routine care
Primary care and GPs working closer together and integrating with social care and community services	Working together to offer patients an alternative to A&E and the hospital, managing acute exacerbations at place of residence. Wrapping care around the patient 24/7 to reduce emergency admission to care home and/or admission via A&E	More acute conditions managed at home, which is seen as the preferred location for patients A named person who is responsible for making sure you get the care you need
Use of 111 and local Directory of Service	Signposting to the available services Understanding of appropriate/alternative services and referral patterns in Delivery of services in alternative settings to traditional hospital outpatient setting Integrated services across secondary care and community settings	Increased and more appropriate use of local services by using advice and self management Being aware of alternative services to those in a hospital setting – giving people 'Choice'
Better management in care homes to ensure patients are not admitted to hospital	Supporting patients with acute exacerbations, falls, dehydration to stay out of hospital. Working with ambulance service on new pathways and models of care, to reduce conveyance from care homes to hospital	More independence to manage conditions at home Understanding of care alternatives to hospital admission for relatives and carers
Increased range of community services, incl. diagnostics delivered in primary care setting, and ambulatory services	Carry out an increased range of diagnostic tests to prevent attendance at A&E, and/or admission for e.g. dehydration, and/or DVT	Having more tests done in local GP surgeries and/or community setting before being referred to the hospital
Integrated discharge planning in place once a patient is admitted to hospital	Joined up services, improved pathways, earlier discharge	Patients being managed and supported through the system, to ensure their return to their home asap
Increased access to step-up and step-down Intermediate Care Services	24/7 care through integrated service provision; co-location and joint management structures. Streamlined systems and processes to cut waste in the system and duplicate assessment	24/7 Care at home, promoted through early discharge; access to rehabilitation and recuperation enabling return to daily living.
Fewer A&E departments – establishment of Trauma Centres/trauma networks	Ambulatory focus and emergency/acute medicine becomes core business	Receiving care in 'Centre of Excellence' for major accident and/or emergency

END OF LIFE

(MAKING CARE FOR PEOPLE WHO APPROACHING THE END OF THEIR LIFE MORE APPROPRIATE AND COMPASSIONATE)

Over half of us want to die at home, and as we become more frail and elderly this proportion increases. 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.

Now

In 2010 30.9% of deaths in Tameside & Glossop occurred at 'home' compared with 50.5% in some areas of England. Unfortunately some patients do not have their end of life identified in advance which means we are not able to make sure they are supported to be cared for and to die in the place of their choice

"People who are approaching the end of their life will be helped to plan for a good death, where everything possible is done to reduce pain, distress and emergency situations"

Dr Richard Bircher, Clinical Lead for End of Life

In 2017

Health Outcomes

- **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 delivering high quality end of life care**
- **The development of specialist services for patients with dementia who are approaching the end of life**

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

WHAT WILL THE CHANGES MEAN?

SERVICES	PARTNERS	RESIDENTS
Increased identification of patients at end of life	Increase use of formal EOLC tools such as Gold Standards Framework, Liverpool Care Pathway, Advance Care Planning	Better support for patients at end of life to be cared for and to die in the place of their choice
Improved communication with patients and carers about death and end of life care	Training requirements for health & social care professionals in Advance Care Planning and communication skills	Health and social care professionals holding conversations to identify where patients want to be cared for and their wishes for care at end of life
Reduction of deaths in hospital	Rapid discharge for patients identified as end of life patients Increase in support available in the community for patients at end of life Increase in specialist end of life care staff to support identification of patients at end of life, and discharge of patients into their preferred place of care	Ability to be discharged and cared for at home, if this is the wish of patients and carers Services in place to provide the necessary support for people to be cared for and die at home if this is their wish

How We Will Know We Have Been Successful – Ensuring We Get It Right

[6]

"I get the best care possible locally"

"I am involved in all decisions about my care"

The People of Tameside and Glossop

"Our CCG works with us to benefit the people of Tameside & Glossop"

"The health of people in Tameside & Glossop has improved"

Our Partners

"My work in the CCG makes a difference to people's health"

"I believe the CCG is a great place to work'"

Our Staff

"The needs of protected groups are always considered"

"The CCG has helped us get other organisations to meet our needs'"

Our Representative Bodies

We will be successful if we deliver : **OUR VISION**

Your CCG is led by local GPs. 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 live up to **OUR PRINCIPLES**:

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

We have made a lot of promises and see ourselves as accountable to you, the people who live and work locally. So we will look to you to judge our success. In 2017 you will see:

- The overall health of the population is better as we will have achieved the health outcomes we promise in Chapter 5
- 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

"I know I influence local health services"

"Health care is less fragmented"

Our Member GPs

"What our GPs want is important to us"

"We feel part of a team which works together for the benefit of patients"

Our Health Colleagues

Appendix 1 - References & Related Documents

Data references

Life Expectancy – Public Health NHS Tameside & Glossop 2012

Deprivation – Public Health NHS Tameside & Glossop 2012

DSR - Directly age-standardised rate -a method of adjusting the basic rate to allow for differences in age structures that may exist between different populations.

Birth Weight - The NHS Information Centre for health and social care. Compendium of Population Health Indicators 2012

Injury Admissions- Inpatient Hospital Episode Statistics (HES) 2009/10 accessed from South West Public Health Observatory

Alcohol Admissions - http://www.lape.org.uk/downloads/LapePCTDatasetNWPHO07092011.xls

Obesity Levels - Health Profiles, APHO, 2012

Self Harm Admissions - http://www.apho.org.uk/resource/view.aspx?RID=105586

Suicide Mortality - The NHS Information Centre for health and social care. Compendium of Population Health Indicators 2012

CVD Mortality – The NHS Information Centre for health and social care. Compendium of Population Health Indicators 2012

COPD Mortality – The NHS Information Centre for health and social care. Compendium of Population Health Indicators 2012

Prevelence of Diabetes - The NHS Information Centre for health and social care. Compendium of Population Health Indicators 2012

Research References

[1]Marmot, M. Fair Society, Health Lives: The Marmot review. The Marmot Review, 2010.

Related Documents

Communication and Engagement strategy

Commissioning for Quality Strategy

Tameside Health and Wellbeing Strategy

Derbyshire Health and Wellbeing Strategy

'PREVENTABLE and TREATABLE: A Cancer Prevention, Early Detection and Inequalities Strategy for NHS Tameside and Glossop'

Tameside and Glossop Joint Strategic Needs Assessment

Joint Strategy for Carers 2011-14

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