NHS Tameside and Glossop
2014/15- 2018/19 Five Year Strategic Plan
Key Lines of Enquiry Technical Appendix

1. Submission details

1.1. Which organisation(s) are completing this submission?

NHS Tameside andGlossop Clinical Commissioning Group

1.2. Contact name and contact details

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2. System vision

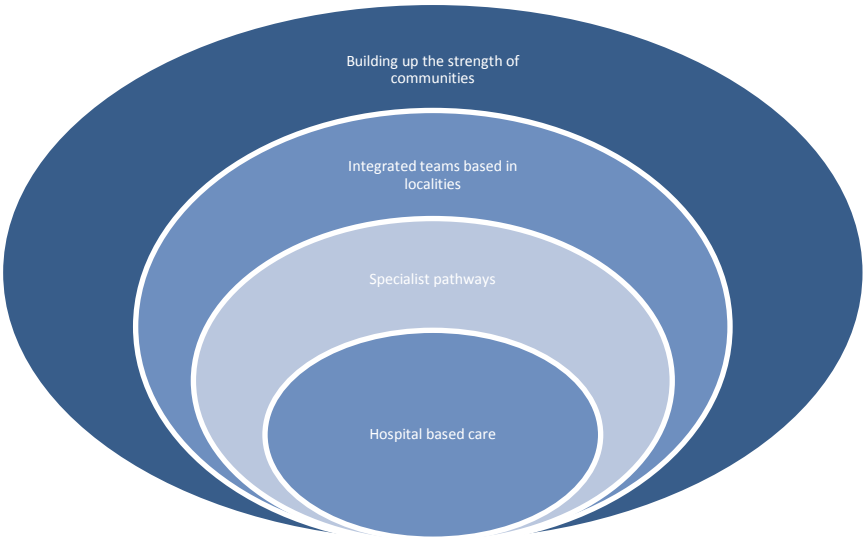
2.1. What is the vision for the system in five years' time?

NHS Tameside and Glossop, Tameside Metropolitan Borough Council, Derbyshire County Council and NHS England are all committed to reducing demand on more intensive health and social care services by focussing on community based prevention and early intervention initiatives.

As local commissioners we have come together to fundamentally address the health and social care challenges faced by our population. We have created a "Care Together Programme" to redesign and realign health and care services to provide joined up care to Tameside and Glossop citizens. This will ensure that people get the right care in the right place from the most appropriate professional and within the resources available.

Whilst commissioner led, this vision is partnership driven as only by working together can we ensure a sustainable care sector. Care Together aims to introduce a new form of provision into the care services market namely a fully Integrated Care Organisation spanning primary, community, mental health, social and local hospital based care. This will ensure Tameside and Glossop people receive holistic high quality health and social care that lines up to the principles of the 6 Cs (Care, Compassion, Competence, Communication, Courage and Commitment) and delivers the best possible health outcomes.

The care will be organised around four levels as shown in the diagram below and aims to promote self care whilst ensuring support is available when required coordinated by people who are able to consider the wider needs of the individual and plan their care accordingly.



Level 1 Building up the strength of individuals and communities

- Understanding the things already available to support people and ensuring people know about them
- Using technology and other equipment to help people be more independent
- Investing in community groups and the 3rd sector to provide low level support to others

Level 2 Integrated teams based in localities:

- Teams of multi skilled professionals based in the 5 geographical localities
- Identifying and proactively supporting "at risk" people
- Using integrated case management and care coordination
- Access to appropriate specialist resources and services when required
- Focused on better condition management, preventing admissions, and facilitating discharge

Level 3 Specialist pathways:

- Seamless continuity of care across specialist, community and primary care
- Recognising the need for specialist support in certain pathways and providing more flexible access
- Using the broader hospital network and thinking differently to deliver specialist care
- A consistent, high quality approach to discharge by proactive planning, involving the right people, when someone is admitted

Level 4 Hospital Based Care:

- The best health outcomes delivered 24 hours a day, 7 days a week
- Concentrated expertise in teams delivering the “once-in-a-lifetime” specialist care at a particular hospital

We, along with our Local Authorities, are committed to driving up healthy life expectancy and supporting people and communities to flourish through self care and independent living and right service right place and time. We will work with our public, patients and professionals to redesign the way services are organised and delivered shifting the locus of care away from hospital settings and eliminating the fragmentation they experience today.

2.2. How does the vision include:

2.2.1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care

The work on developing the integrated care vision started in 2012 with discussions with the public, members and partners about the need to focus on preventing ill health and organising care around the needs of the individual. People are aware of the financial pressures local authorities and health services are under and our recent consultations have shown local people expect us to work together to reduce waste and provide high quality care.

Our Care Together programme includes a Communications and Engagement workstream that aims to ensure plans are shaped by our local population. Our Service Redesign workstream enables patient experience to feed into the design of individual services.

We also use complaints and compliments to identify poor and good practice and to inform future commissioning. We will strengthen this further through our revised Patient Engagement Strategy to ensure the patient perspective is fundamental to our commissioning decisions.

We are developing the use of technology to make it easier for patient opinions to be gathered. In particular we are using software to analyse patient feedback that is fed into both local and national systems so we can use the learning to inform service development.

We encourage feedback from our most vulnerable patients and have developed easy to read questionnaires to make sure we gain their views on the care they have received. This along with developing our understanding of the needs of people who are seldom heard will enable us to make sure that our services are accessible to all those that need them.

We see the role of the lay representative in our governance structures as key and expect them to ensure patients have been consulted and involved in all our plans.

Our Patient and Public Impact Committee has representation from Tameside, Derbyshire and High Peak Overview and Scrutiny Committees, Healthwatch (Tameside and Derbyshire), Community Voluntary Action Tameside (CVAT), High Peak CVS, Tameside and Derbyshire's Health and Wellbeing Boards, Public and Patient Engagement/Customer Service Representation from Arriva, Tameside Foundation Trust, Stockport Foundation Trust and Pennine Care. It makes sure that public and patient involvement in Tameside and Glossop CCG:

- identifies the needs and aspirations of local people
- is being used to develop priorities, strategies and plans

- has influenced service delivery
- has helped to procure services
- is effectively monitoring services for key public and patient engagement quality outcomes and standards

The needs of our Protected Groups are discussed in our Consumer Advisory Panel which is a 'service user' advisory group representing the needs of vulnerable and protected groups to ensure fair access to healthcare services in Tameside and Glossop.

Our Care Together model starts with building the strengths of individuals and communities enabling individuals to take responsibility for their care. We have identified programmes for delivery in 2014/16 that will support this aim, including the development of our "Wellness Offer", redesign of services and support for carers, ensuring the engagement and development of our Third Sector providers, and the development of "advice and support" services.

The Integrated Locality Teams are the first line of support for patients who need more help. They will become partners with patients and carers in planning the care needed to keep people as well and independent as possible. Through effective risk stratification, integrated case management and care co-ordination they will prevent admissions to hospital and if someone does have to go to hospital they will enable them to be discharged as early as possible. The CCG and Local Authority commissioning partners will develop and implement plans for integrated locality teams for adults and for children during 2014/16.

2.2.2. Wider primary care, provided at scale

Part of our strategic reform of the local system is a changing Primary Care. Our 'Care Together' vision is for a fully joined up, high quality, sustainable, modern and accessible health and care system. Primary Care have a lead role in delivering this vision as providers of essential, additional and enhanced care, and of taking on increasing responsibility for an extended range of services. We will look to practices to co-deliver, working together more closely in larger units for some services, particularly in support of the frail elderly and urgent care services; and to offer improved access when needed.

We know that all providers of care need to change the way they deliver care for our changing population, and Primary Care will need to respond to the needs of its patients in today's society. It may need to change the way and time it delivers some of its services.

IT and IM&T solutions are key enablers to ensuring primary care can contribute to the integration of care, and the promotion of patient centred care. We are keen to explore solutions for integrated care records and patient focused creative technology.

We see Primary Care as a provider within the 'Care Together' Programme, yet recognise that general practice needs investment and support to deliver its core GMS/PMS/APMS contractual rquriements. We will therefore be developing our own local Primary Care plan, which complements the Greater Manchester strategy, and ensures that our practices have the right

capacity and capability to meet the demands within their existing contracts and to take on the additional responsibilities that our Care Together programme asks of them.

We will work with GM Local Area Team to ensure our practices are well placed and appropriately resourced to provide the best care, access and quality for our patients.

Primary Care, and general practice in particular, is at the heart of our new system wide transformation of care for Tameside & Glossop as part of our integration work. We know the importance of primary care as the cornerstone of plans to reform local health services and improve health and outcomes for local people Our service redesign new models of care are focused on delivering as much care as is safe and appropriate in primary and community care.

NHS Tameside and Glossop is working with Tameside Metropolitan Borough Council, Derbyshire County Council and NHS GM to reduce demand on more intensive health and social care services by focussing on community based prevention and early intervention initiatives. We are working together to address the health and social care challenges faced by our population. We know that if all other services fail, one does not - general practice. Primary Care is the safety net for our patients, and we need to ensure that we work with and develop our practices to ensure they can meet the needs of patients when demand rises, but also support them to sign post elsewhere, when their level of input is not appropriate or needed. We have created our 'Care Together' Programme to redesign and realign health and care services to provide joined up care to Tameside and Glossop citizens. This will ensure that people get the right care in the right place from the most appropriate professional and within the resources available. We want more care out of hospital, integrated pathways and services in an extended primary care.

Having the ability to plan and commission primary care services alongside the social care, hospital, community and mental health services will allow the local health economy to make faster progress on these plans and design services and contract mechanisms which work across the whole system of care.

We are working with our partners to ensure a sustainable care sector to ensure the people of Tameside and Glossop receive holistic high quality health and social care that lies up to the principles of the 6 Cs (Care, Compassion, Competence, Communication, Courage and Commitment) and delivers the best possible health outcomes. Primary Care can lead the way in the implementation of these principles, and we will look to build these into our general practice quality work through the LIG, and our local performance framework/balanced scorecard.

Our 'Care Together' model of delivery is organised around four levels and aims to promote self care whilst ensuring support is available when required coordinated by people who are able to consider the wider needs of the individual and plan their care accordingly. General practice is the focal point for these levels of care because the general practice primary health care teams already provide care and wellbeing services on a list based/micro basis, which we are looking to develop for a wider population based approach to care; putting patients first and wrapping care around them.

2.2.3. A modern model of integrated care

The interrelationship of health and social care requires that we commission as one. Integrated commissioning provides the only strong viable option to the pressures within Tameside and Glossop and it must be matched by integrated provision.

Our vision is an integrated provider that offers clinical viability and more importantly a safe and sustainable service that has patients and the wider population at its heart. The artificial barriers of primary, secondary and social care will be consigned to history as we develop a continuum of prevention, treatment and care that has the right person in the right place delivering the most appropriate interventions, service and care for the patients in their own home or very close to it.

As we move services into the community and wrap care around the patients, we will need staff to move with the patient and work in a new environment. There will be a need for training and support to enable this to happen. Staff will need to work together in an integrated way, crossing multi-professional boundaries to deliver care for the patient. Through the integrated delivery vehicle organisational boundaries will be blurred and removed, and therefore staff will work within one governance and delivery framework.

Our principles for integrated care are:

- Improve health and wellbeing outcomes
- Reduce health inequalities and improve healthy life expectancy
- Better experiences of using services
- Designing needs-led, evidence based services
- Focusing on wellness, maintaining good health and preventing illness including longer term health improvement
- High quality, safe, local treatment and support in planned and urgent situations
- Clear accountability for quality and safety across the whole system
- Getting good value for money for our taxpayers
- Managing our finances within the reducing available funding
- Making sure people don't have to give the same information lots of times
- Better access to care when and where people need it
- Making each contact count by identifying other things that are available and pointing people towards them
- Consistency of service quality across the localities
- Ensure delivery of statutory obligations
- Ensure delivery of services which meet safeguarding requirements
- Delivery of patient centred care plans and patient held records

We want a strong hospital based sector in our community that has outcomes that are amongst the best in the country. But it has to be safe, sustainable and affordable and that cannot be achieved by horizontal integration across GM hospitals alone. We must have vertical integration to enable only those conditions that require intensive support to take place in a hospital environment with the majority of care delivered within a patient's own community.

In 2014/15 we have developed joint commissioning intentions with Tameside Metropolitan Borough Council. These aligned our intentions for our commissioned spend relating to all health and social care services. During 2014/15 the two organisations will align their commissioning and look, over the next 2 years, to bring together the commissioning functions. Whilst we do not have any agreement with Derbyshire County Council to align any budgets we will be working in partnership to ensure the proportionate share of commissioning resources support this population. This supports the Better Care Fund approach to joint working.

During 2014/16 we will test and extend this way of working for the good of our population. Where providers feel unable to change and work with a newly integrated model, we will look to re-commission the care from an alternative provider.

2.2.4. Access to the highest quality urgent and emergency care

All levels of our Care Together programme support urgent care needs. We will ensure that when people need health or social care in an emergency they get prompt and effective support that gets them well again quickly.

Our integrated teams ensure that our most vulnerable patients are risk assessed and have comprehensive care plans in place that will reduce the risk of deterioration to the point when a need becomes very urgent or an emergency. Our use of technology will support early intervention and enable rapid responses to avoid emergency intervention. However, when such a need arises we will have the ability to mobilise an appropriate response through a single point of access. The aim will always to be support the person in their own home but where this is not possible community step up or acute facilities will provide the appropriate level of assessment and care.

Admissions Avoidance is a key programme in our 2014/16 plans. The initial focus is on the frail elderly with future work planned on Long Term conditions, Ambulatory Care and Minor illness/injury. Our All Age Mental Health, All Age Learning Disabilities and Children programmes will ensure access to specialist support in an urgent or emergency situation.

Our work with North West Ambulance Service (NWAS) on our Paramedic Emergency Service (PES) will continue as they develop their changed role within an enhanced system of urgent care. Working together we will build on the development and implementation of initiatives such as the Urgent Care Desk, Paramedic Pathfinder, Referral Schemes into Primary Care, Targeting Frequent Callers, and increasing the percentages of patients that are treated by ‘See and Treat’ and ‘Hear and Treat’. To develop the role of “mobile urgent treatment centres” so conveyance to hospital will be only one of a range of clinical options open to ambulance service. PES will be key part of delivering safe care closer to home in Tameside and Glossop.

Our plans include developing our A&E and the Walk in Centre services so that people can be seen in the best place and by the most appropriate person.

The horizontal integration across GM hospitals through Healthier Together will support access to "once-in-a-lifetime" specialist care at a particular hospital e.g. Stroke Care. This will give patients the best possible health outcomes 24 hours a day, 7 days a week.

Our integrated case management and care co-ordination approach and intermediate care services will ensure that patients are discharged promptly and enabled to return home wherever possible.

2.2.5. A step-change in the productivity of elective care

Through our specialist pathways and in hospital care programmes we will deliver high quality elective care that is more convenient for our patients and reduces the length of time spent in a hospital bed.

We have a number of specialist pathway redesign programmes identified for 2014/16, nine of which will have a significant impact on the effectiveness of elective care

Cancer	Diagnostics	Musculoskeletal	Ophthalmology	Sexual Health
Specialist Long Term Conditions - Respiratory	Specialist Long Term Conditions - Cardiovascular	Stroke and Neurological Rehabilitation	General Surgical	

Our integrated services will enable a multidisciplinary approach that ensures the right person supports the patient in the right place through the most appropriate intervention.

Through seamless continuity of care across acute, specialist community and primary provision we will reduce duplication and waste and improve patient experience.

Our increased access to direct access diagnostics and Straight to Test pathways will reduce delays and avoid unnecessary appointments freeing up both patient and clinician time.

We will reshape provision at Tameside Hospital to that of predominately daycase and outpatient activity with diagnostic support. Retaining 64% of patient care locally and providing a clinically safe and viable platform from which to build a new model of health and social care provision.

We will support all our providers to build capacity and capability. We will also support the development of new providers. We want a vibrant, flourishing and competitive provider market place to meet the challenges of the new integrated service models. We will reward innovation in delivery, particularly focused on quality, safeguarding and social values.

2.2.6. Specialised services concentrated in centres of excellence (as relevant to the locality)

Working with partners in the South Sector of Greater Manchester and wider through Healthier Together we will build a model of specialist services that deliver excellent health outcomes. We will have 'centres of excellence' where the very best doctors, nurses and therapist are available 24 hours a day, 7 days a week.

Our plans are congruent with the Healthier Together proposition but for us, that is an enabling staging post not our end state. The reforms proposed in healthier together are about saving lives not money. Although there are some predicted savings to reinvest in care out of hospital they do not go far enough for us in addressing the gap of £74m. There is a clear direction though, consistent with findings from the foundation trust regulator (Monitor) that smaller hospitals need not only to work within new models of care (Care Together and Healthier Together) but share staffing etc. (what is called a single service model). Locally we have been talking to neighbouring hospitals about what needs to be done together across a partnership of hospitals. There has been a great deal of focus on how TGH would work with partners in a 'southern sector' but we know our patients also use other hospitals and so we continue to discuss how best hospital care should he organised.

2.3. How does the five year vision address the following aims:

2.3.1. Delivering a sustainable NHS for future generations

Our Care Together vision of an Integrated Care Organisation will address the clinical and financial pressures that have been subject to local and national scrutiny. We are planning a viable and sustainable local economy but those plans are predicated on support from the relevant regulatory bodies for:

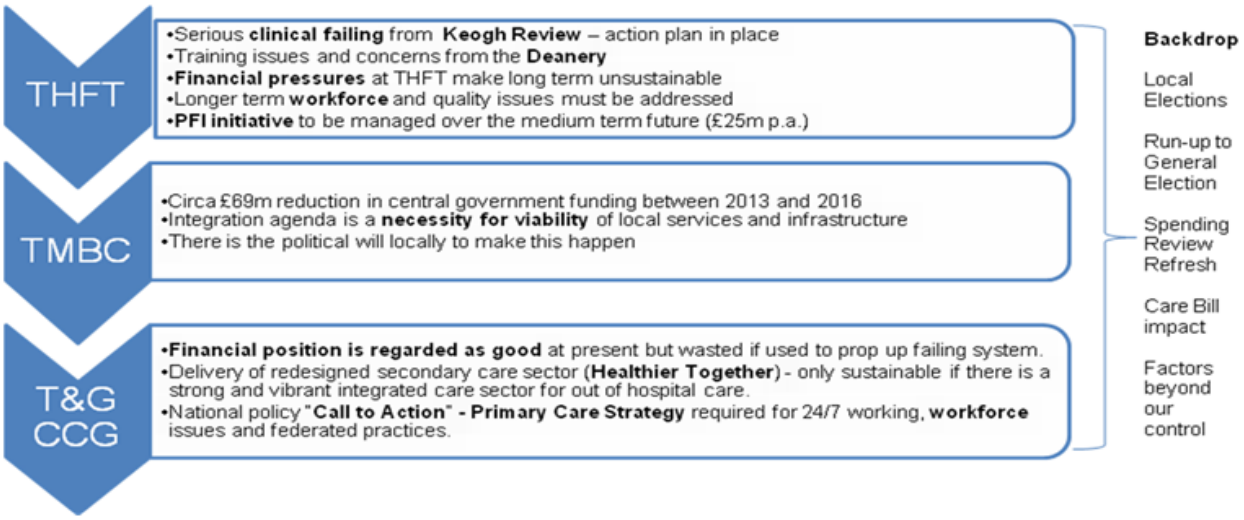
- The development of a new and innovative service delivery vehicle (the ICO); and
- Flexibility in the design of new procurement, payment and funding mechanisms.

This support is essential to the success of our approach to integrated care.

Our analysis clearly demonstrates that, if we do nothing, we will have an economy wide deficit of £74m by 2018/19. If we fail to address the issues at Tameside NHS Foundation Trust we will be paying an annual premium of c£20m over and above tariff for services locally, which is not sustainable or good stewardship of public finances. If we fail to tackle the larger issue of Tameside Metropolitan Borough Council's £44m deficit, this will impact massively on NHS services.

Integrated commissioning provides the only strong and viable option to the pressures within Tameside and Glossop, and it must be matched by integrated provision. Our Care Together programme makes this explicit and we look to Monitor, the Care Quality Commission and NHS England to be our partners in making this vision a reality.

The significant financial challenges facing the three principle public sector organisations within Tameside and Glossop have been labelled locally as the "perfect storm":



The above scenario provides a compelling case for change. This is a journey we commenced some 18 months ago and there have been several detailed pieces of work completed to help identify and quantify the scale of the problem facing the whole community. The most detailed pieces of work have been provided by Ernst and Young plus two further pieces of work led by McKinsey and Company.

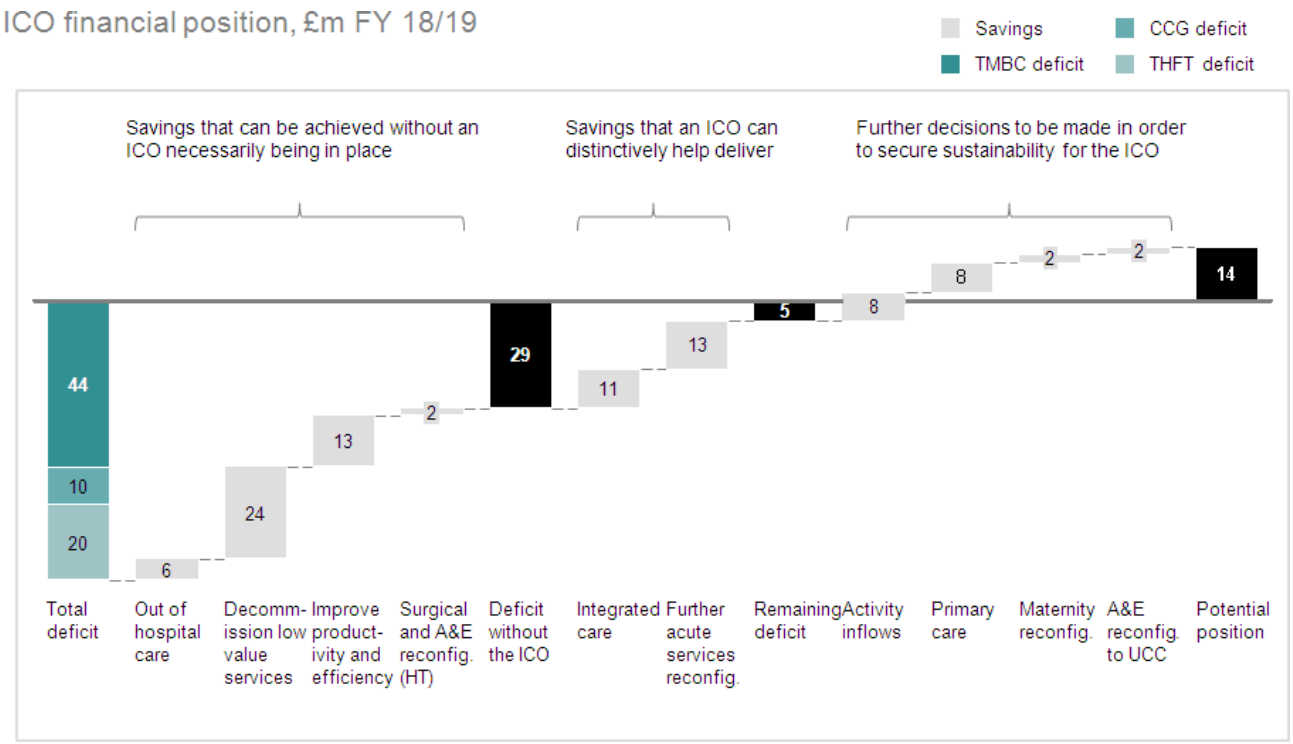
With a projected deficit of £74m we know we must be imaginative in addressing the needs of our community. Through joint working and jointly commissioning an integrated service that puts the needs of the patients first we can provide the highest quality of care by the right professional closer to the patients home, and support a hospital based system for those conditions that can only be and should only be provided in a high performing hospital.

We know our proposals are extremely ambitious but our situation is extremely challenging. When faced with the scale and impact of these competing pressures, tinkering at the margins of health and social care will not suffice. The scope of our Care Together programme is a minimum of £293m, providing us with the opportunity to make changes at a scale that can bridge the financial gap across the economy in a sustainable way.

The CCG has ensured the financial plans are congruent with the major national and regional service configurations and reforms taking place over this period. The CCG is working collaboratively with all partners, namely local authorities, Tameside FT with other providers and primary care to realise genuine savings from hospital based services in order to support the move to primary and community based services in an integrated model and therefore bridge the economic gap. Our vision for reconfiguration is based on the following six operational levers:

- Shift to out of hospital services
- Efficiency in out of hospital
- Decommission services
- Prevention and integrated care
- Estates consolidation
- Acute services reconfiguration

It is a combination of these six levers working within our proposed integrated model that we believe can secure clinical and financial sustainability for future generations. This achievement over the next five years can be succinctly demonstrated in the following waterfall diagram:



The ICO vehicle will be a new model of integrated service delivery; therefore we will look to develop a new contractual and payment regime that supports and strengthens our vision. We will be commissioning and paying for quality outcomes, health improvement and incentivising and rewarding excellent patient care and experience.

2.3.2. Improving health outcomes in alignment with the seven ambitions

As we enter the next years in our life as NHS Tameside and Glossop Clinical Commissioning Group we know they will be ones of significant challenge. However, we are confident that by working with our health, local authority, third sector partners and very importantly local people, we can live up to this challenge.

We have signed up to the Health and Wellbeing Strategies for both Tameside and Derbyshire which provide key direction for coordination of our shared aspirations to enable local people to live longier, happier lives and tackle health inequalities.

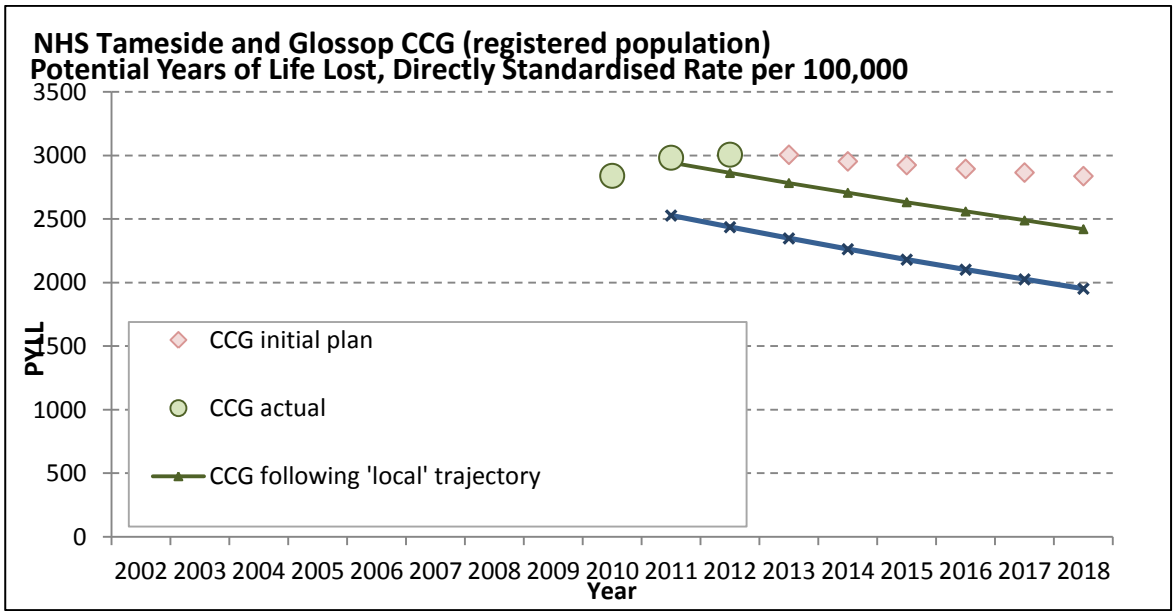
Through our four levels of care we will deliver the outcomes expected by the Department of Heath in 'Everyone Counts Planning for Patients 2014/15 to 2018/19' and achieve the health improvements people deserve.

Outcome Domain	Preventing people from dying prematurely	Enhancing Quality of life for people with longterm conditions	Helping people recover from episodes of ill health or following injury		Ensuring people have a positive experience of care		Treating and caring for people in a safe environment and protecting them from avoidable harm
Outcome Ambition	Securing additional years of life for people with treatable mental and physical conditions	Improving health related quality of life for people with long term conditions	Reducing avoidable time in hospital	Increasing elderly people living independently at home on discharge	Increasing positive experience of Care outside hospital	Hospital care	Significant progress on eliminating avoidable deaths
Building up the strength of individuals and Communities							
Locality Based Teams							
Specialist Pathways							
Hospital Based Care							

Ambition 1 Securing additional years of life for the people of England with treatable mental and physical health conditions.

Potential Years of Life Lost Trajectory

Baseline	14/15	15/16	16/17	17/18	18/19
3007.9	2955.7	2926.1	2896.9	2867.9	2839.2



We are committed to increasing life expectancy locally. Prevention and early identification are therefore at the centre of our plans. Through our level 1 and 2 programmes (2.2.1) and the specialist pathway programmes we will support people to manage their conditions and provide

prompt treatment when additional help is needed. The seven specialist pathways in 2014/16 that will have a significant impact on this ambition are:

All Age Mental Health	All Age Learning Disability	Dementia	
Specialist Long Term Conditions - Respiratory	Specialist Long Term Conditions - Cardiovascular	Cancer	Stroke and Neurological Rehabilitation

If people need hospital based services by sharing services across a number of hospitals we will concentrate expertise in teams delivering the "once-in-a-lifetime" specialist care at a particular hospital e.g. Stroke Care. This will reduce hospital mortality rates and ensure the best outcomes for patients.

Ambition 2 Improving the health related quality of life of people with one or more long-term condition, including mental health conditions.

Health Related Quality of Life Trajectory

Baseline	14/15	15/16	16/17	17/18	18/19
68.3	69.26	70.22	71.18	72.14	73.1

Alongside our commitment to increase life expectancy is one of improving Healthy Life Expectancy. As above, the care we will provide at all levels will support this. We will build on the success of our Diabetes service for all Long Term Conditions.

Our emphasis on increasing access to a greater range of psychological therapies especially Veterans, people in our BME communities and older people and the alignment of mental health support for people in the justice system with police and probation services will have a positive impact for a range of local people.

Ambition 3 Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

Composite Measure on Emergency Admissions Trajectory

Baseline	14/15	15/16	16/17	17/18	18/19
3195	3090	3074	3044	3013	2983

The underlying principle of our plans is to reduce the demand for intensive health and social care support. Our level 1 care focuses on wellbeing and will help people to help themselves and those close to them. Our level Integrated Locality Teams will enable people to be supported at home whenever possible and through an effective risk assessment process will we will get the right care in place early to reduce the need for hospital based care.

Many of the specialist pathways will deliver the majority of care out of hospital and the primary aim of our Admissions Avoidance pathway is to support people at home.

All our Mental Health specialist pathways aim to ensure that people remain healthy and out of hospital by providing excellent access to community based mental and physical health services.

Ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital.

When our older people are discharged from hospital we expect the majority will return to their home where they will be supported by our Integrated Locality Teams. Some may first receive reablement as part of the Intermediate Care specialist pathway.

By building up the strength of individuals and communities we hope that more people we be able to live in their own homes for their whole lives. We know Carer support is essential in maintaining people at home and this is a key programme for us in 2014/16.

Ambition 5 Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.

People Reporting Poor Experience of Inpatient Care Trajectory

Baseline	14/15	15/16	16/17	17/18	18/19
137.5	134.8	130.6	125.1	118.3	110

Our patients who do need hospital care will be treated as quickly as possible in a place that can most fully meet their needs. Overnight stays in hospital will be avoided wherever possible with more surgery being carried out in daycase facilities or in clinics. People who need specialist treatment will go to centres of excellence these may be within Greater Manchester or surrounding areas.

Working with other commissioner across the South Sector and Greater Manchester we will encourage a culture of continuous improvement in the hospitals serving our population.

Ambition 6 Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

People Reporting Poor Experience of GP and Out of Hours Services Trajectory

Baseline	14/15	15/16	16/17	17/18	18/19
5.5	5.39	5.23	5.01	4.73	4.4

Working with the LAT as Co commissioners we will deliver a programme of transformation across General practice, where we will work with our colleague practices to improve quality and reduce variations of care, and look where we can transform and increase the services delivered by primary care.

We will develop our Out of Hours GP services alongside other routes for accessing urgent care to ensure that patients get access to the most appropriate support as quickly as possible.

The range of services provided in primary and community settings will increase and our care planning should make sure services are wrapped around our patients.

Ambition 7 Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Eliminating avoidable deaths because of poor quality care is key to the work we are doing. Our work with Tameside Hospital Foundation Trust to address the clinical challenges identified through Keogh will continue.

We have a robust incident management process in place to ensure that providers are effectively reporting and learning from patient safety incidents. Healthwatch representation is a fundamental component of our governance arrangements with representation on our Quality Committee and Public and Patient Impact committee.

We participate fully in both the GM and Regional Quality Surveillance Groups hosted by NHS England. We will also take an active part in the NHS England local safety improvement collaborative, once established, so that lessons learned, themes and trends arising from complaints and patient safety incidents can be shared.

We can only deliver our ambition of continuous improvement by working collaboratively. We have developed and agreed Community Based Care Standards across Greater Manchester that compliment the Hospital Based Care Standards being used in our Greater Manchester Hospitals.

As well as working with our Local Authority colleagues to agree and monitor the quality of our Care Together services we will work with NHS England to ensure that primary care works effectively as part of our integrated system and that our primary care services are of the highest quality.

We also expect our services to hold one another to account. The Commissioning for Quality and Innovation (CQUIN) payments in 2014/15 are dependent on our services working together to support our journey to integrated working. The process of developing the CQUINs started that approach with them being developed and agreed together. They will improve the health of our highest risk patients such as fail elderly and children with asthma.

Most importantly the opinions of our patients and partners across the health, social care, voluntary and independent sector on whether local services are delivering the standards we expect and how we can develop and improve them are essential. The strong patient and carer representation working alongside our clinicians and managers in our governance structures makes sure that we focus equally on all aspects of quality and safety. Our services deliver excellent, compassionate, cost effective care, leading to longer healthier lives.

2.3.3. Reducing health inequalities

The Care Together Programme focuses on risk stratification and support to individuals to enable them to maintain their health. Prompt access to specialist care both urgent and routine will help early diagnosis and fast recovery. The development of centres of excellence with teams delivering "once-in-a-lifetime" specialist care will ensure improved health outcomes for patients.

Through Integrated Locality Teams and a developed Primary Care offer care can be planned around the specific needs of the people living within the locality. This along with the ability to strengthen community assets including investment in community groups and the 3rd sector will help reduce the 13 year variation in life expectancy across Tameside and Glossop and bring the Healthy life expectancy to within two years of the English average.

There is now more of a focus on healthy life expectancy when looking at inequalities. Healthy life expectancy is an estimate of the years of life that will be spent in good health. There are important socio-demographic differences in healthy life expectancy. Not only can people from more deprived back grounds expect to live shorter lives, but a greater proportion of their life will be in poor health.

For the population of Tameside the healthy life expectancy for males is 57.5 years compared to the England average for males of 63.2 years. For females the healthy life expectancy in Tameside is 56.8 years compared to the England average of 64.2 years, a gap of 5.7 years for males and 7.4 years for females, which is significantly worse than the England average.

The length and quality of people's lives differ substantially. Some of these differences are unavoidable (e.g., genetic differences) or through accidents. However, factors that are amenable to change, such as socio-economic status, education and quality people's living environment, also play a significant part, leading to large inequalities in healthy life expectancy.

The gap in life expectancy between rich and poor persists. After some fluctuation, the gap is larger now than in the early 1970s. Men and women from the richest social class can on average expect to live more than seven years longer than those in the poorest social class.

To improve healthy life expectancy and reduce health inequalities, the causes of premature illness and death (deaths of people aged 75 or under) need to be tackled with a focus on those that have the greatest impact on our population relative to the rest of England and those that disproportionately affect particular communities. It is essential therefore that the causes and how to prevent them are understood. These will relate both to the environment in which people live and closely linked to that, their lifestyle and behaviour.

The key to ensuring a more healthy population is a significant investment and prioritisation in "wellness" services and flexible personalised services closer to home. This will mean a change in investment profiles and service redesign to ensure a preventative approach to improving health, increasing life expectancy and tackling health inequalities.

Early intervention and prevention is everyone's business and must:

- Facilitate access to universal services
- Build social capital within local communities
- Be embedded in primary and secondary care
- Ensure people have greater choice and control over meeting their needs

The fact poor mental health is associated with a greater risk of physical health problems, and poor physical health is associated with a greater risk of mental health problems is recognised and so we will develop the range of knowledge and skills within our services to ensure people with mental health conditions are able to access all wellness services and people with long term conditions or chronic illness have access to psychological therapies.

The community level work also supports our focus on the seldom heard and hard to reach individuals. We will continue to develop services for people with Learning Disabilities and Mental Health conditions working to ensure parity of esteem. We aim to increase the availability and uptake of health screening for people with Learning Disabilities so that 100% of people receive an annual health check and 75% take up invitations for routine screening. The range of psychological therapies available to older people, military veterans and BME groups will increase.

We will support vulnerable families and help parents with mental health issues so they are able to provide the best outcomes for their children. We will also be working with our schools, health and social care providers, and parents to develop the services available to families with children and young people with Special Educational Needs.

Our Dementia services will diagnose people early and ensure individuals and carers are supported to stay at home through advice and care. The ability of all professionals to treat dementia sufferers when they are ill will be increased and our Rapid Assessment Interface and Discharge (RAID) – Psychiatric liaison services that provide mental health care to people being treated for physical health conditions will continue to develop.

2.4. Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?

The integration plans have been developed over the last years through discussions with Tameside Metropolitan Borough Council and Derbyshire County Council and both Health and Wellbeing Boards have discussed plans and approved the way forward.

The plans align to the Health and Wellbeing Plans and formative versions of plans have been presented to various partners and the Health and Wellbeing boards and final versions will be formally approved through the integrated governance structures signoff will be gained.

Both Local authorities have worked with the CCG in developing the Better Care Fund plans which have been approved by the respective Health and Wellbeing Boards.

2.5. How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?

Working across two Local authorities and Health and Wellbeing Boards we are party to two Better Care Funds. Both demonstrate our commitment to reducing the demand for intensive health and social care support aiming to support people in their own homes and prevent the need for hospital admissions. The interventions described involved the integrated teams working at Care Together levels 1 to 3.

The Better Care Fund is a key enabler to take our integration agenda forward at scale and pace, acting as a significant catalyst for change. The statutory financial allocations available to invest in BCF are summarised in the following table:

	2014-15	2015-16
	£000s	£000s
CCG	3,673	17,318
Tameside MBC		1,801
Derbyshire County Council		224
Total	3,673	19,343

The Better Care Fund will support the aim of providing people with the right care, in the right place, at the right time, through a significant expansion of care in community settings and reablement services. It provides the opportunity to improve the lives of some of the most vulnerable people in our local economy by giving them control and placing them at the centre of their own care and support perhaps even giving them a personal budget to manage their care. This evidently provides them with a better service and a better quality of life.

We are currently designing a risk share arrangement with the key stakeholders to ensure there is a shared responsibility and impetus for managing the required changes in the delivery of care. It is essential that we achieve the required change in activity flows to more out of hospital services to ensure the providers are able to reduce their capacity and maintain a clinically safe and sustainable service.

The CCG wishes to extend the Better Care Fund to use this as the vehicle to take on the joint finance arrangements of our proposed integration model. This would result in the creation of a much larger Section 75 arrangement in 2015/16 of circa £293m to incorporate all the services "in-scope" for integration as identified by the Care Together Programme. Furthermore, this will be underpinned by Risk Share Principles which have been endorsed by the Joint Integration Board. The Section 75 agreement will be hosted by Tameside Metropolitan Borough Council and again reaffirms our commitment to acting in unison to address the challenges in our economy.

2.6. What key themes arose from the Call to Action engagement programme that have been used to shape the vision?

We have asked patients, carers, community groups and health and social care professionals what our services should look like. The main things people want are:

- Fast easy access to services including 24/7 access to advice and reassurance on the most appropriate place of treatment when urgent treatment is required
- High quality, continuity of care across Health and Social Care.
- Services available closer to where people live, especially when people rely on public transport. Although some people were happy to travel further for better quality and faster treatment.
- To know what services were available and how to access them. This included all Health and Social Care staff being able tell patients what services are available, how, where and when to access them.
- Patients and carers wanted to be listened too and treated with dignity and respect. They want to feel valued and be involved in the care they or their relatives receive. To be kept informed throughout their care and ensure that information is given to them in timely manner to minimise any distress.

Our five year plans will deliver these as:

- People will be supported to keep well through our 'Wellness' programme and have access to advice 24/7.
- The majority of our patients will be treated in the community by integrated teams of multi skilled health and social care professionals.
- Our patients who do need hospital care will be treated as quickly as possible in a place that can most fully meet their needs. Overnight stays in hospital will be avoided wherever possible with more surgery being carried out in daycase facilities or in clinics.
- People who need specialist treatment will go to centres of excellence these may be within Greater Manchester or surrounding areas.
- We will have a health and social care campus supported by satellite centres in our townships with effective transport links to reduce the need for patients to go to different places for different support.

2.7. Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included?

We have always committed to feedback how we have used what people said. Our strong links with Practice Participation Groups and Healthwatch has enabled us to get formative feedback on our plans and our documents describing those plans such as our prospectus. This has then enabled people to see their views reflected in the final versions.

At our most recent Listening2 Patients event the following were highlighted our plans already show how we have embraced the system wide aspects and we will demonstrate how we have used this information as the service design work progresses.

- Patients reported they liked many of the services they get from Primary, community and the hospital
- End of Life care was good and increased integration would be good with less 'red tape' in urgent situations
- Urgent care was thought to have a negative impact on planned care
- Patients felt involved in Long Term Conditions care and would like more community based services with shorter waiting times and professionals working together more.
- Local patients want to be treated with care and compassion. They wanted to be listened too and be involved in the care they or relatives receive.
- They wanted faster and easier access to the most appropriate service with advice available on where they should go when they want urgent treatment.
- Most patients were willing to travel to get faster support from specialists but did not want to travel too far and felt public transport was an issue.

Patients wanted:

- More 24/7 access to advice for children and family services
- Glossop people want more access to urgent care within Glossop.
- More access to local A&E and GP same day care
- More emotional support for carers and relatives
- More information on what services are available and how to access especially mental health
- More CBT
- Better promotion of memory services and carers support
- Access to domestic abuse staff and health visitors in walk in centre
- Children want to know that there is someone who is representing them to ensure that they matter when it comes to performance
- Teenagers want to be treated by people who understand the needs of their age group

The top priorities were:

- Everyone in Tameside and Glossop able to access high quality care wherever they live
- More tests available in GP surgeries rather than in hospital
- Health and Social Care professionals working together and only asking once
- Treated at home rather than having to stay in hospital
- Advice and guidance to stay healthy
- 7 day a week access to health and social care

A more formal 'You Said' 'We Did' will be part of our communications workstream.

3. Current position

We committed in our previous five year strategy to address our health challenges and maintain a strong financial position. This commitment remains as we start our programme of more radical change and build our Integrated Care Organisation.

Tameside and Glossop has a population of circa 240,300 people. The health of local people is generally worse than the England average. Deprivation is higher than average and about 10,500 children live in poverty. 32% of our population are living in areas that are within the 20% most deprived in England. There is growth in the over 65 year olds whilst the over 85 year olds are forecast to double adding additional challenges for services in these high user groups.

Healthy Life Expectancy is more than 3.5 years below the England average. Locally our men have a healthy life expectancy of 59.6 compared to 63.5 in England and women 61.2 compared to 64.8. Life expectancy between our most deprived and the least deprived areas is over 13 years.

Our need to reduce our use of intensive health and social care is recognised. The opportunities identified in our Right Care pack confirmed our understanding and our need to maintain our focus on programme budgeting investing in prevention and community services to reduce demand on hospital and emergency care especially around our four high impact diseases; Cardio-vascular disease; Respiratory disease; Cancer and Diabetes.

The other areas highlighted in our Right Care pack are Trauma and Injuries and Mental Health. Our work across Greater Manchester supports the Trauma agenda and Mental Health will be supported through several key programmes in 2014/16.

Our Care Together programme has been developed through analysis of our health outcomes, service activity and the financial challenges across the health and care economy. We have worked with strategic partners over the last 18 months to provide detailed analysis and benchmarking both nationally and internationally and identify opportunities for improvement.

All our Service Redesign programmes starts by using available data to benchmark existing services and health outcomes and identify opportunities for improvement. NHS Benchmarking is a key partner in our early service development work.

We are working to combine the risk stratification tool we've developed with the local authority Insight population data to enable us to take a holistic approach to identifying needs.

Both our local authorities have JSNAs and our plans reflect the needs described in them. Our plans for a joint Intelligence team with Tameside Metropolitan Borough Council will enable us to bring together expertise and information that supports our holistic approach to care. It will allow us to monitor a range of measures that will show us the difference we are making to the lives of local people.

4. Sustainability

Our improvements in health and social care services and Better Care Fund plans must deliver real efficiency improvements on a scale never seen before. The estimated funding gap for the economy over the next five years is:

	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m
CCG	5.1	7.9	9.8	10.0	9.9
Local Authority	4.5	16.8	27.0	36.0	44.2
TOTAL COMMISSIONING	9.6	24.7	36.8	46.0	54.1
Tameside FT	17.5	22.6	21.1	20.6	20.0
TOTAL ECONOMY GAP	**27.1**	**47.3**	**57.9**	**66.6**	**74.1**

Each year, we will set aside funds to carry forward for investment in the Care Together Programme. In 2014/15, £5m non recurrent funding has been identified for a Commissioning Development Fund to pump prime the re-design of pathways aligned to our integration programme. Beyond that, we will set aside approximately 1% p.a. of our allocation for future year investments whilst ensuring our intentions are congruent with the Greater Manchester Healthier Together and South Sector plans. There is significant risk associated with the accelerated pace of delivery of the Care Together Programme and the return of our cumulative £9.8m surplus (including the historic lodgement of £6.7m) held by NHS England is critical to the successful delivery of our integration programme over the course of the next two years. Any delays in implementation will have detrimental consequences to the whole system of change across the economy and will particularly impact the clinical and financial sustainability of the local provider.

Our plans assume Quality, Innovation, Productivity and Prevention (QIPP) efficiencies increasing each year, with a target of £5.1m in 2014/15 increasing to £7.9m in 2015/16 and just under £10m p.a. by 2018/19.

The table below summarises our 5-year financial plan.

	2014-15 £000s	**2015-16** £000s	**2016-17** £000s	**2017-18** £000s	**2018-19** £000s
Allocations	326,152.0	337,049.5	336,208.5	341,765.1	347,480.7
Total Spend	316,153.5	333,679.0	332,846.4	338,347.4	344,005.8
Investment Fund c/f	**9,998.5**	**3,370.5**	**3,362.1**	**3,417.7**	**3,474.8**
QIPP Target	5,141.0	7,897.2	9,870.7	9,957.2	9,931.1

The figures are, for the most part, based on our forecast 2013-14 performance, uplifted with the assumptions re:

- Inflation
- Efficiency
- Growth

Adjustments have then been made to incorporate:

- Investment plans
- Quality, Innovation, Productivity and Prevention (QIPP) plans
- Other known changes (e.g. revised contractual commitments)

These financial plans have been stress-tested to see how sensitive they are to changes such as increased hospital activity, higher drug costs, etc. More importantly this highlights the main areas of financial risk and enables the CCG to develop ways to mitigate them.

QIPP Plans

Our QIPP targets are summarised in the table above.

The QIPP plans are being developed in order to support our commissioning strategy, to deliver the efficiencies required to live within the planning assumptions and to enable the investments required to deliver the Care Together Programme.

Payment Mechanisms

It is widely recognised that current payment and contractual mechanisms can sometimes be a barrier to developing and implementing effective and efficient integrated care pathways

The CCG will develop alternative payment mechanisms, giving consideration to:

- What behaviours do different payment systems incentivise?
- Are the preferred options suitable and implementable in the NHS?
- How can we transition to the preferred options?

The CCG will also develop the use of personal health and social care budgets.

5. Improvement interventions

We are now turning our attention to the 'doing' aspects, sharpening the description of the 'ICO' but crucially accelerating service reform discussions with full engagement of patients and the professional community. The Care Together programme has eight workstreams which are supported through a Programme Management Office with a jointly appointed Programme Director.

Communication and Engagement - To ensure plans are shaped by our local populations and partners through effective communication and engagement.

Service Redesign and Primary Care - To develop a service model for integration in Tameside and Glossop taking into account the resources and services in scope.

Finance - To provide financial advice and guidance in the development of the service transformation.

Estates and Transport - To ensure that estates and transport needs are considered to deliver accessible services.

Governance and Legal - To ensure the programme operates within each organisation's governance structure.

IM & T – to ensure safe and appropriate sharing of information and the use of modern technology to underpin effective care.

Workforce and OD –Robust workforce planning will be required to ensure that the new system is able to provide the right numbers of staff, with the right skills at the right time. Additionally, significant work will be required to develop an organisational culture that underpins the objectives of the ICO including developing shared values and behaviours to support delivery of quality care in every setting.

Our key next steps are to build the out of hospital care services and support for healthy communities. Central to this is drawing the intelligence base together in terms of patient risk stratification: that way we can be assured we are targeting the right interventions at the right people.

Our Service Redesign workstream has identified a number of projects, named earlier, across the four levels of care for 2014/16 all of which work to the principles of

- Self-management
- Early detection and diagnosis
- Case management and coordinated care
- Keeping people at home

Our work with Healthier Together and the South Sector on hospital based care will supplement these programmes to ensure we deliver the health outcomes we need for our local population.

Our commitment to quality and continuous improvement will be reinforced through Care Together. Simplifying care is a cornerstone of our quality strategy as it will make it easier to ensure whole pathway quality.

Four key aspects of our quality plans are to:

- Monitor the quality of services, by measuring what they do and by inviting comment from users and use this information to guide all quality improvements
- Coordinate remedial action should things fall below an acceptable level.
- Protect the most vulnerable in our society
- Encourage continuous quality improvement at all levels in the organisation

We are fostering a culture of 'devolved' leadership where everyone, who comes across something which could be better, recognises it and works with others to make it right with the support of

their seniors to facilitate and respect these views. Care Together will encourage this and make complacency and a 'make do' culture a thing of the past.

6. Governance overview

The governance arrangements reflect the fact that our plans are being developed in partnership but partners still retain their individual statutory responsibilities.

The Care Together programme has its own governance structure as it needs clear lines of accountability and decision making due to the joint financial and clinical implications. However the work it is doing also fits within the governance structures of the partner organisations that retain overall responsibility for delivery as it is the alignment of existing resources that will underpin the programme.

The Tameside and Glossop Commissioning Executive ensures the programme remains consistent with the strategic needs of the population. It provides a Board level forum for discussion and agreement to take place. Each organisation retains overall accountability for their respective decisions having agreed the common ground and direction of travel. Initially the membership is restricted to commissioners but this may change as the work develops.

The Integration Board will oversee the implementation and system reform. It involves the CCG Chief Executive along with Tameside Metropolitan Borough Council Chief Executive are Care Together Executive Sponsors with the CCG Chief Finance Officer and Deputy Chief Executive as Programme Sponsor.

Care Together forms part of the agenda of our Health and Wellbeing Boards which will ensure it is subject to wider scrutiny.

The Care Together Programme has a Clinical and Professional Reference Group to act as a strategic sounding board for the work and to manage the interdependencies of the individual projects within the programme. The group provides clinical and professional insight to the programme and ensures engagement with frontline staff.

7. Values and principles

We continue to work to our CCG principles of

- Listening to patients
- Developing innovative services closer to home
- Increasing taxpayer value for money
- Improving health indicators

These have been developed and adopted into our integration agenda where:

- The needs of the community come before any one organisation's sovereignty
- Citizens will be supported in the right place with the right health and social care provided by the right professional

- Care designed people's needs enabling them to lead an independent life within own homes and local community
- We will maximise value by seeking the best outcomes for every pound invested
- We work cohesively as commissioners and providers