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AGENDA FOR

HEALTH AND WELLBEING BOARD

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To: All Members of Health and Wellbeing Board

Voting Members : Councillor J. Black, Dr. A. Gibson, Pat Jones-Greenhalgh (Vice Chair), Graham Atkinson, Dave Bevitt, M. Carriline, Lesley Jones, Mark Granby, Stuart North, Andrew Ramwell and Councillor R. Shori (Chair).

Non-Voting Members : Rob Bellingham

Dear Member/Colleague

Health and Wellbeing Board

You are invited to attend a meeting of the Health and Wellbeing Board which will be held as follows:-

Date:	Thursday, 6 March 2014
Place:	Rooms A&B Bury Town Hall
Time:	2.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members of the Health and Wellbeing Board are asked to consider whether they have an interest in any of the matters on the Agenda, and if so, to formally declare that interest.

3 MINUTES OF PREVIOUS MEETING *(Pages 1 - 6)*

The minutes of the last meeting held on the 30th January 2014 are attached.

4 MATTERS ARISING *(Pages 7 - 8)*

Action Log attached.

5 PUBLIC QUESTION TIME

Questions are invited from members of the public present at the meeting on any matters for which the Board is responsible.

Approximately 30 minutes will be set aside for Public Question Time, if required.

6 PHYSICAL ACTIVITY AND HEALTH

Dr William Bird will provide members of the Health and Wellbeing Board with a verbal update.

7 CLINICAL COMMISSIONING GROUP - STRATEGIC PLANNING *(Pages 9 - 32)*

Representatives from Bury's Clinical Commissioning Group will provide an update at the meeting.

8 REPORT ON THIRD SECTOR ACTIVITY *(Pages 33 - 44)*

The Chief Officer of the Citizens Advice Bureau will report at the meeting.

9 HEALTHIER TOGETHER UPDATE

Representatives from Bury's Clinical Commissioning Group will provide an update at the meeting.

10 COMMUNITY HEALTH AND WELLBEING ASSESSMENT

The Director of Public Health will report at the meeting.

11 HEALTH AND WELLBEING STRATEGY UPDATE *(Pages 45 - 48)*

The Director of Public Health will report at the meeting.

12 URGENT BUSINESS

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

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Minutes of: **HEALTH AND WELLBEING BOARD**

Date of Meeting: 30th January 2014.

Present: B3SDA, Dave Bevitt; Cabinet Member, Councillor Rishi Shori; Councillor Jane Black; Chief Officer, CCG, Stuart North; Community Safety Partnership, Superintendent Mark Granby; Executive Director of Adult Services, Pat Jones Greenhalgh (Chair); Executive Director, Communities and Neighbourhoods, Graham Atkinson; NHS England, Rob Bellingham; Dr A. Gibson; Chair, Healthwatch, Andrew Ramwell; Interim Director of Public Health, Lesley Jones; Executive Director of Children's Services, Mark Carriline

Also in attendance:

Julie Edwards – Democratic Services.
Julie Gonda - Assistant Director Commissioning and Procurement.
Dr. K. Patel – Chair CCG
Heather Crozier – Head of Customer Services, Adult Care services.

Apologies: There were no apologies.

Public attendance: 10 member of the public was in attendance

HWB.719 DECLARATIONS OF INTEREST

There were no declarations of interest.

HWB.720 MINUTES

Delegated decision:

That the Minutes of the meeting of the Health and Wellbeing Board held on Thursday 14th November 2013, be approved as a correct record and signed by the Chair.

HWB.721 MATTERS ARISING

Members of the Board reviewed the Health and Wellbeing Board Action Log.

Democratic Services reported that the Assistant Director of Legal Services had provided the Board with guidance in relation to the Pharmaceutical Needs Assessment. The current regulations (The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013) make provisions for the conduct of PNAs. Regulation 5 states that each HWB must publish its first PNA by April 1st 2015.

Regulation 4(2) requires each HWB in so far as is practicable; to keep up to date the map which includes in its pharmaceutical needs assessment pursuant to paragraph of Schedule 1 (without needing to republish the whole of the assessment or publish a supplementary statement) this map identifies the premises at which pharmaceutical services are provided in the are of the HWB.

The Interim Director of Public Health has requested that the Commissioning Support Unit provided the Board with an up to date assessment of the current pharmaceutical need in Bury.

Delegated decision:

The action log be noted.

HWB.722 PUBLIC QUESTION TIME

The Chair, Councillor R Shori, invited questions, comments and representations from members of the public present at the meeting.

Questions were asked and comments made on the issues detailed below.

In response to a question from Councillor Walker, with regards to the site formally occupied by the Peel Health Centre, the Chief Operating Officer, CCG reported that the NHS does not own the building and there is no further information to report with regards to the progression of a business case.

In response to a question from Councillor Walker, in relation to the membership of the Health and Wellbeing Board, Democratic Services reported that the Board's membership was constituted as defined in the Health and Social Care Act. The Council if it wishes may appoint additional members to the Board. Currently representatives from Pennine Care Foundation Trust and Pennine Acute NHS Trust would by invited to attend the Board meeting as required.

The Chief Operating Officer CCG, reported that it would be useful to review the membership of the Board.

HWB.723 BETTER CARE FUND

Stuart North Chief Operating Officer, CCG, Interim Director of Public Health, Lesley Jones and the Assistant Director of Commissioning and Procurement, Julie Gonda, gave a presentation providing an overview of the model for Bury's Integrated Health and Social Care and Better Care Fund. An accompanying report had been submitted to the Board providing an overview which included information relating to:

- Health and social care reform is part of a wider programme of Public Services Reform across Greater Manchester.
- Work has been on-going to progress new models of delivery.
- Integration of health and social care is complex and a medium to long term ambition. The new model of delivery is still developing and will

continue to evolve in the light of health reforms and neighbourhood initiatives.

- Shared vision and commitment to person centred and coordinated care, empowering and enabling, emphasis on prevention access to services 7 days a week.

- Better care fund - £3.8billion nationally - Local allocation £11.727m, £1billion directly is related to performance, which equates to £3m locally.

- Main aims of the better care fund is to protect adult social care services, invest in new and re-shaped services which help integration and benefit both health and social care.

Questions were invited from those present at the meeting and the following points were raised:-

Dave Bevitt, B3SDA, commented that the Better Care Fund must be linked to the Joint Strategic Needs Assessment.

The Executive Director of Adult Services reported that a large amount of data analysis has been undertaken in relation to different patient pathways, integrated models of care and data intelligence to inform the better care fund submission.

In response to a question from the Executive Director of Children's Services, the Chief Officer, CCG reported it will be necessary to reduce the demand at A&E by 15% over the next two years, this will require a change in emergency activity.

The Chair of the CCG reported that the CCG are looking at a number of measures to tackle the required reduction in funding and the requirement to reduce A&E attendance, these include short term measures as well as longer term preventative measures.

The Chief Officer of the CCG reported that the CCG's are in the process of developing an ambitious five year plan.

The Chair reported that he wanted to ensure that the assurance and oversight of the better care fund and associated funding would remain with the Health and Wellbeing Board.

Delegated decision:

- That the Health and Wellbeing Board:
  Sign off this first working draft of the Better Care Fund Plan to be submitted to NHS England 14 February 2014;
- Delegate authority for the sign off of the final plan, to be submitted to NHS England 4 April 2014, to Chair of Health & Wellbeing Board, Executive Director of Adult Care Services and Chief Officer, Bury CCG.
- The Health and Wellbeing Board continue to monitor the progress of the Better Care Fund.
- That the Clinical Commissioning Group' Five Year Strategy is brought to a future meeting of the Health and Wellbeing Board.

HWB.724 HEALTHIER TOGETHER

Members of the Board considered a verbal presentation from the Chair of the Clinical Commissioning Group Dr. Patel in relation to the Healthier Together conversation. The presentation contained the following information:

The CCG Chair reported that Healthier Together is initially a Community 'Conversation' about transforming health and social care across Greater Manchester.

The purpose of the conversation will be to update communities and gather views about; joining up health and social care services, enhancing GP and community services and transforming hospital services.

The CCG Chair reported that the service review will be about enhancing the level of care and will result in centres of excellence supported by local fit for purpose, smaller units.

The CCG Chair reported that no decisions have been made about the location of hospital services, the final decision will be made by the Association of Greater Manchester Clinical Commissioning Groups once the public conversation and consultation had been completed.

Questions were invited from those present at the meeting and the following points were raised:-

Dave Bevitt B3SDA commented that the CCG must ensure that public engagement in relation to the Healthy Together conversation is not just limited to Township Forums.

In response to a question from the Executive Director of Children's Services, the CCG Chair reported that in order to manage political fall out from any major service reconfiguration it would be necessary to build trust, be transparent and assure members that the service changes proposed are in the best interest of their area.

The Interim Director of Public Health reported that her department would liaise with representatives within the CCG to review how they may be able to support the conversation and public consultation.

Delegated decision:

Healthier Together would remain a standing agenda item.

HWB.725 PRIORITY SETTING AND THE HEALTH AND WELLBEING WORK PROGRAMME

Members of the Health and Wellbeing Board discussed the approach being taken to deliver the outcome measures and develop ways of reporting on the actions from the Health and Wellbeing Strategy.

The Interim Director of Public Health reported that the Board has a key role in provided oversight and assurance in relation to the Health and Wellbeing Strategy. The Board will gain assurance oversight through three related reports that will be present at future Board meetings; Performance against outcomes report; delivery plan and milestones report and a thematic report (focusing on a priority area).

The Head of Customer Services reported that a series of workshops focused on each of the Strategy key priority areas have been arranged. The key leads and groups identified for each priority area will then form a virtual network that will then be responsible for delivering the actions and measures of success for the priority.

Delegated decision:

The report be noted.

HWB.726 COMMUNITY HEALTH AND WELLBEING ASSESSMENT

The Interim Director of Public Health provided members of the Board with an update in relation to the Community Health and Wellbeing Assessment.

The Interim Director reported that the current Joint Strategic Needs Assessment provides high level data on a number of important health related issues which has informed the Health and Wellbeing Strategy.

The Interim Director reported that there is currently a lack of infrastructure and capacity in Bury to meet the JSNA requirements. The CHWA steering group has met and agreed the following:

- To commission research to understand what data is currently held by Team Bury partners, what use the data is currently put to, what intelligence and analytical capacity exists across agencies, what questions partners would most like the CHWA to answer

- To scope the options for a publically available platform where CHWA products can be shared and better utilised.

- To focus on capacity-building for the CHWA through development of an intelligence hub within the Adult Care Directorate, partnership working with intelligence and analytical specialists from partner agencies and investment in analytical tools.

Questions were invited from those present at the meeting and the following points were raised:-

The Executive Director of Children's Services reported that representatives from Ofsted and the Office of the Children's Commissioner had both made representations in relation to early help services and child exploitation, that the JSNA should contain information in relation to these matters.

The Interim Director reported that it is important for the Council to prioritise what population information and data intelligence information is contained with the JSNA.

The Interim Director reported that the JSNA should provide a detailed summary of the needs, assets and hold qualitative intelligence information.

The Chair of the Health and Wellbeing Board reported in order for the JSNA to be effective and have the required capacity it would be necessary for partners and stakeholders to invest financially in the JSNA data.

The Interim Director reported that there are currently vacancies for two data intelligence analysts post within public health.

Dr Gibson reported that it would be necessary to invest in a web platform facility that would allow people to access up to date quality information about local services and community assets.

The Head of Customer Services reported that a separate web platform had been identified that would meet this requirement.

Delegated decision:

The report be noted.

HWB.727 RETIREMENT OF SUPERINTENDENT MARK GRANBY

The Chair Councillor Shori informed the Board that Superintendent Mark Granby would retire in February 2014 and would cease to be a member of the Board.

Delegated Decision:

That Superintendent Mark Granby be thanked for his commitment and valuable contributions to the Health and Wellbeing Board during the last year.

Councillor Rishi Shori
Chair

(Note: The meeting started at 6pm and ended at 8pm)

Health & Wellbeing Board Action Plan

30th January 2014

Action No	Responsible	Action	Outcome
1	SN/KP	Healthier Together, A review of Health and Care in Greater Manchester would be a standing agenda item.	Standing agenda item
2	HC	To bring the proposal for the Virtual Network hub to a future meeting	Standing agenda item
3	DH	A Community Health and Wellbeing Assessment update would be given at the next meeting of the Health and Wellbeing Board.	Standing agenda item
4	LJ/HC	That a Health and Wellbeing Board working programme be developed.	Update re the workshops be provided at the March meeting.
5	IC	Ian Chambers/Mark Carriline would provide an update at a future meeting of the Joint Committee in relation to the work of the Children with Additional Needs and Disability Partnership Group.	Ongoing
6	RS/PJG/SN	Bury's Better Care Fund (Formally Integrated Care Strategy) would be considered at subsequent Board meetings.	• That the Health and Wellbeing Board: Sign off this first working draft of the Better Care Fund Plan to be submitted to NHS England 14 February 2014;

			• Delegate authority for the sign off of the final plan, to be submitted to NHS England 4 April 2014, to Chair of Health & Wellbeing Board, Executive Director of Adult Care Services and Chief Officer, Bury CCG. • The Health and Wellbeing Board continue to monitor the progress of the Better Care Fund.
7	JH/JE	A report providing information relating to the impact of the welfare reform on the health economy be presented to a future meeting of the Health and Wellbeing Board	Claire Jenkins (April meeting)
8	D/B	Report on Third Sector Activity in support of Health and Wellbeing priorities.	Dave Bevitt to report on behalf of Bury's 3SDA at the March Meeting.
9		A "Healthier Radcliffe" evaluation report will be considered at a future meeting of the HWB.	Date to be confirmed
10	RS/JE	Review the membership of the Hwb	Councillor Shori to meet with Democratic Services to discuss

REPORT FOR DECISION

Agenda Item	

DECISION OF:	**H&WB**
DATE:	**06/03/2014**
SUBJECT:	**CCG Operational and Strategic Plans**
REPORT FROM:	**Stuart North**
CONTACT OFFICER:	**Stuart North**
TYPE OF DECISION:	**For Decision by the Committee**
FREEDOM OF INFORMATION/STATUS:	This paper is within the public domain
SUMMARY:	The CCG wishes to share the work undertaken so far for review and approval
OPTIONS & RECOMMENDED OPTION	That the Health and Wellbeing Board: § Agree the draft operational plan submissions § Confirm a decision on the Local Quality Premium Metric in conjunction with the BCF Metrics – Dementia as the priority for Local Quality Premium (there is a financial penalty linked to this) § Delegate authority to S. North, P. Jones-Greenhalgh and Councillor Shori to sign off the measure of 'specified increased level of reporting of medication errors from specified local providers', to obtain a GM wide approach. § Support the work in developing the priority areas for inclusion within the strategic plan

IMPLICATIONS:	
Corporate Aims/Policy Framework:	Do the proposals accord with the Policy Framework?
Statement by the S151 Officer: Financial Implications and Risk Considerations:	Approval of plan submissions is a requirement in order to draw down funding from the "Better Care Fund".

	Plans have been developed jointly between Buy council and Bury CCG.
Statement by Executive Director of Resources:	
Equality/Diversity implications:	EIA will be undertaken on the operational and strategic plans prior to submission
Considered by Monitoring Officer:	Yes JH
Wards Affected:	All
Scrutiny Interest:	

TRACKING/PROCESS **DIRECTOR:**

Chief Executive/ Strategic Leadership Team	Executive Member/Chair	Ward Members	Partners
Scrutiny Committee	Committee	Council	

1.0 Purpose of the Report

Inclusion and collaboration with partner organisations

2.0 Background

National Requirements

NHS England has requested information from the CCG detailing a two year operational plan and a five year strategic plan in addition to the Better Care Fund (BCF) proposal. These should be integrated Health and Care Plans.

2.0 Issues

Operational Plan

The operational plan draft submission took place on the 14th February and consisted of a set of declarations, metrics and activity information. The metrics can be found in the accompanying document, Final Draft Narrative for Bury CCG Op Plan 2014, for review.

Metrics
The final submissions of the Operational Plan and the Better Care Fund are due on the 4th April 2014. A decision is required prior to submission on the Metrics to be included for the CCG Local Quality Premium and the Better Care Fund Metrics - Both Falls and Dementia are under consideration within the BCF which is under consideration at the Board as an independent item.

Measure
One aspect of the operational plan to highlight is the measures section:
"E.A.9 *Have you agreed (in conjunction with your Health and Wellbeing Board and NHS England area team) a specified increased level of reporting of medication errors from specified local providers between Q4,2013/14 and Q4, 2014/15?"*

At the time of draft submission it was expected that this would be worked up locally and brought to the H&WB on the 6th March, however work is still under way on developing this indicator and there has been a proposal that this should be agreed at a Greater Manchester level. A request is made therefore to have delegated responsibility for sign off from the board to; Stuart North, Pat Jones-Greenhalgh and Councillor Shori on this, in order to progress with the GM approach.

Strategic Plan

Guidance regarding the requirements for the Strategic plan can be found in the accompanying document 'NHS England Strategy Templates'. The CCG with intelligence and collaboration from Public Health, have identified the following six priority areas:

- Coronary Heart Disease and Stroke
- Cancer
- Chronic Obstructive Pulmonary Disease
- Mental Health and Learning Disability Mortality
- Liver Disease/Alcohol
- Reducing unplanned activity

These priorities were chosen as they are felt to be those that will best support achievement of the overall aims of reducing health inequalities and improving outcomes in Bury. This is work continues to progress and the CCG, Public Health and Local Authority wish to engage wider to ensure the most appropriate areas to focus are identified. Any contribution from the H&WB members would be welcomed.

3.0 Conclusion

The Board are requested to review and agree the Operational Plan - final submission date is 04/04/2014
A decision is also required on the Local Quality Premium
A request is also made for delegated authority for sign off from the Board to S. North, P. Jones-Greenhalgh and Councillor Shori, for the measure of 'specified increased level of reporting of medication errors from specified local providers', to obtain a GM wide approach.

Finally the Board are requested to consider the current 6 identified priority areas and support their further development.

List of Background Papers:-

H&WB Final Draft Narrative for Bury CCG Op Plan 2014
NHS England Strategy Templates

Contact Details:-

Maria Howard
Interim Strategic Planning Support Manager
Bury CCG
21 Silver Street,
Bury, BL9 0EN
0161 762 3150

Outcome Ambition	Overarching Indicator	Narrative	Measures and Rationale
Ambition 1 Securing additional years of life for people with treatable MH and physical health conditions	C1.1 Potential years of life lost to causes considered amenable to healthcare. Adults, children and young people (NHS OF 1ai & ii)	Premature deaths from circulatory disease continue to be the greatest contributor to the gap in life expectancy between Bury and the rest of England, followed by cancer and thirdly respiratory diseases. By improving the identification and management of patients with or at high risk of CVD the burden of this disease will be reduced in Bury. Health inequalities will be systematically addressed through the Better Together collaborative, driving up the quality of care and improving outcomes through the provision of quality data at practice level and support to reduce clinical variation. NHS Health Checks will be delivered by every member practice with prioritisation of those at highest risk of CVD and drive to continually improve uptake rates. Integrated services will be implemented for cardiology, diabetes and respiratory services with focus on greater uptake and completion of cardiac and pulmonary rehabilitation.	E.A.1 PYLL (Rate per 100,000 population) Baseline 2660.5 2014/15 2575.4 2015/16 2493.0 2016/17 2413.2 2017/18 2336.0 2018/19 2261.2 3.2% Year on year
Ambition 2 Improving the health related quality of life of the 15 million + people with one or more LTC including MH conditions	C 2.1 Improved health related quality of life for people with LTC	The CCG has identified a range of activities that will be operational in 2014/15 and beyond, these include: • Clinical Leadership: Bury CCG has invested in a Clinical Leadership model which provides experienced clinical leads for LTC and Mental Health with dedicated time to support developments within their respective agenda and often work closely together given many of the interdependencies. • Patient Engagement: Bury CCG is supported by a robust Patient Cabinet, which has identified leads across services areas, who link closely to clinical and managerial leads to help inform, develop and critic proposals. • LTC: Bury CCG is engaged in range of activities to support patients with LTC. The CCG is activity participating the LTC AQUA programme which sees the risk stratification of patients, the development of MDTs and the promotion of shared decision making. The CCG are also currently reviewing with PCNHSFT the impact of Care co-ordinators, Telelhealth. • Asthma: Asthma is a particular priority for the CCG in 2013/14 and beyond. 2013/14 focused on Asthma, cumulating in a training programme for all GP practice and Pharmacist on Asthma Inhaler Techniques. • Integrated Community Diabetes: Bury CCG has been working jointly with HMR CCG and	E.A.2 Average EQ-5D score for people reporting having one or more long-term condition Baseline 70.4 2014/15 71.4 2015/16 72.9 2016/17 73.1 2017/18 73.3 2018/19 73.5 Aim to achieve the England rate by 15/16 (stretch target in 2nd year) with the current England change rate of 0.2 applied each year thereafter.

		currently providers, PANHT and PCNHSFT to implement an Integrated Community Diabetes Service. The service goes live in April 2014 with a ramp up period to full delivery. The service has been designed around the 9 key care standards, see below, the need to move services closure to patients in the community, service delivery will be over 6 instead of 5 days a week, educational sessions for patients and clinicians are planned as is better communications across all parties. • Integration Agenda: With the greater access to primary care and the greater integration between stakeholders it is anticipated that LTC patients will notice the improvements and report these accordingly via the National Patient Survey. The CCG is currently developing its integration plans using its infrastructure of four sectors across the borough. Plans are well developed in the West Sector which was successful in obtaining National Demonstrator Site status. The five practices in the West Sector are already offering an enhanced primary care offer for the residents of Radcliffe, this offer includes 7 day working. • Care Homes LES: Whilst not targeting patients with LTC solely it is accepted that a large proportion of the patients covered by this arrangement do have one or more LTCs. Bury CCG is currently reviewing its Care Home LES. The LES started in 2013/14 and is set to continue for another year. Initial indications suggest a significant impact across several areas as a result of the LES. Home engaged in the LES are seeing reduced Non Elective Activity as a result of the additional support by GP practices. Longer Term the CCG is engaging a review of all community services with a view to redesign or re-procurement. In 2014/15 the CCG is establishing arrangements for an Integrated Community Respiratory Service and an Integrated Community Cardiology Service.	
	C 2.13 Estimated Diagnosis Rate for people with dementia	- Audit of GP Clinical Systems – working with the Data Quality Team and GPs to improve the recorded prevalence of dementia. - Dementia DES- Woking with Data Quality Team and GPs to search GP systems to identify patients at risk of Dementia who may not have a formal diagnosis - Dementia DES – Monitoring activity and promoting the DES with GPs. - Nursing Home LES (includes Dementia Screen) – Monitoring activity and promoting the LES with GPs - Promoting Dementia Pop Up Cafes in Bury - Support implementation of the National Dementia CQUIN (Indicator: Dementia - FIND, ASSESS, INVESTIGATE & REFER) - Membership of the Bury Dementia Action Alliance - Involvement in the discussions with Making Space re: Dementia Hub in Bury - Implementation of the Joint Dementia Strategy and Action Plan with the LA	ii) Dementia % Diagnosis 2014/15 - 0.67 2015/16 - 0.68 4. Quality Premium Local Indicator Dementia Diagnosis – Stretch Target 2014/15 0.68

	C 2.11 Recovery following talking therapies for people of all ages	- Working with IAPT service manager to promote the range of brief Cognitive Behavioural Therapy based interventions (super seminars, well being workshops) available to people of all ages, amongst GPs, pharmacist, and third sector organisations via posters, sector briefings and education. - Pharmacy pilot - IAPTS text service developed to allow people to opt into the service and to remind them about their appointment to encourage completion of treatment - Targeting of specific groups e.g. MUPS, LTC Work with LA and Public Health to develop referrals/signposting between IAPTS, Health Trainers, BEATS, Carers Centre etc Monthly meetings take place with the CCG and PCFT to monitor progress against the prevalence target and recovery target.	E.A.4 IAPT Proportion of people who receive therapies Q1 - 3.1% Q2 - 3.2% Q3 - 3.5% Q4 - 3.8% Aim to achieve the 15% target by Q4. 2015/16 - 15% E.A.S.2 IAPT Recovery 2014/15 - 45.6% 2015/16 - 50.0% Aim to achieve 50% by Q4 of 2014/15 and the full 50% in year 2015/16
Ambition 3 Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	C 3.1 Emergency admissions for acute conditions that should not usually require hospital admissions C 3.2 Emergency admissions within 30 days of discharge	The CCG has identified a range of activities that will be operational in 2014/15 and beyond, these include: • Manage the Urgent care Network. Bury CCG provide co-ordination for the NES Urgent Care Network Board. Participation in this network helps the NES CCGs to work collectively with PAHT and other stakeholders to address issues, manage and monitor the wider agenda. The co-ordination with other stakeholders such as Social Care, OHHs, NWAS, Mental Health, through this network is a key factor in helping to reduce emergency admissions. • Winter Planning: Each year the CCG develops its winter plans. Plans are mindful of the need to prioritise the co-ordination of services and ensure support for the elderly and frail and those with LTC's. Plans focus on communications to patients and the need for robust links between agencies to help facilitate safe discharge from hospital. Where pressures in the urgent care system are identified there are robust escalation procedures in place.	E.A.4 Emergency admissions composite indicator Baseline 2,931 2014/15 2,784 2015/16 2,345 2016/17 2,298 2017/18 2,252 2018/19 2,207 2013/14 projected outturn 2,173 (per 100,000) is an improvement

		• Clinical Leadership: Bury CCG has invested in a Clinical Leadership model which see experienced clinical leads for Urgent Care and Long Term Conditions. These clinical leads have dedicated time to support developments within their respective agenda and often work closely together given the obvious interdependencies. • Patient Engagement: Bury CCG is supported by a robust Patient Cabinet. The cabinet has identified leads across services areas who link closely to clinical and managerial leads to help inform, develop and critic proposals. • LTC: Bury CCG is engaged in range of activities to support patients with LTC. The CCG is activity participating the LTC AQUA programme which sees the risk stratification of patients, the development of MDTs and the promotion of shared decision making. The CCG are also currently reviewing with PCNHSFT the impact of Care co-ordinators, Telelhealth. A particular priority for the CCG in 2013/14 and beyond has been a focus on Asthma cumulating in a Training programme for all GP practice and Pharmacist on Asthma Inhaler Techniques. • Integrated Community Diabetes: Bury CCG has been working jointly with HMR CCG and currently providers, PANHT and PCNHSFT to implement an Integrated Community Diabetes Service. The service goes live in April 2014 with a ramp up period to full delivery. The service has been designed around the 9 key care standards, see below, the need to move services closure to patients in the community, service delivery will be over 6 instead of 5 days a week, educational sessions for patients and clinicians are planned as is better communications across all parties. • Integration Agenda: The CCG is currently developing its integration plans using its infrastructure of four sectors across the borough. Plans are well developed in the West Sector which was successful in obtaining National Demonstrator Site status. The five practices in the West Sector are already offering an enhanced primary care offer for the residents of Radcliffe, this offer included 7 day working. • Care Homes LES: Bury CCG is currently reviewing its Care Home LES. The LES started in 2013/14 and is set to continue for another year. Initial indications suggest a significant impact across several areas as a result of the LES. Home engaged in the LES are seeing reduced Non Elective Activity as a result of the additional support by GP practices. • Reablement: As plans are developed further with the Local Authority around the Better Care Fund, historical arrangements to support re-ablement will roll forward. These arrangements see the integration of staffing across PCNHSFT and the Local Authority	2014/15 target is a 5% reduction from baseline a reduction of 147 (5%) 2015/16 figure sees a further 15% reduction from baseline of 439 (15%) 2016 -19 set at rolling 2% reduction – work in continuing on this 4. Activity Measures A&E Attendances - all types Forecast Growth 14/15 -3% 15/16 -12% 16/17 - 2% 17/18 - 2% 18/19 - 2% 15% reduction in first 2 years in line with CCG direction and a further 2% for the years onward

		under a single management arrangement. A key component to plans is the configuration of Crisis Response services. • Crisis Response: The Crisis Response Team (CRT) is a multi-disciplinary team consisting of health & social care professionals, OT and night sitter support for Bury patients over the age of 18 (although the average age of referrals is 81) who are in crisis although medically stable. The service runs between 8.00am – 10.00pm 7 days per week. Referrals can be made by any Bury clinician. The CRT respond to the referral within 2 hours and the patient receives a comprehensive assessment and a package of care is wrapped around the patient for up to 72 hours to allow the patient to recover in their own home. If the patient requires additional support then the CR Team can place the patient into a 72 hour assessment bed, however the overall ethos of the team is to keep the patient within their own home whilst they recuperate from their illness. The service is committed to work with the reablement service around readmissions and post discharge support. Longer Term the CCG is engaging a review of all community services with a view to redesign or re-procurement. In 2014/15 the CCG is establishing arrangements for an Integrated Community Respiratory Service and an Integrated Community Cardiology Service.	
Ambition 5 Increasing the number of people who have a positive experience of hospital care. **Ambition 6** Increasing the number of people with MH and Physical conditions having a positive experience of care outside of	C 4.1 Patient experience of GP Out of Hours	The most recent data for January 2013 to September 2013 gives patient experience ratings of: Bury – 69% Greater Manchester – 71% England – 68%. The rate for Bury OOH has dropped from 72% for the 9 month period to June 2012. The Greater Manchester (GM) rate has dropped from 73% over the same period. The GM CSU have finalised a new performance & quality report for all OOH providers, which will be circulated to CCGs following internal sign-off on Friday 17th Jan. The CSU will then coordinate monthly quality and performance meetings – likely to be held jointly for both Bury and HMR CCGs. Patient experience of OOH services will be a standing agenda item with the CCGs seeking assurances around the capture patient experience data and the use of the information to inform service delivery. Pennine Acute Hospital Trust (PAHT) The most recent available data for 2011/12 shows that for PAHT the overall patient experience score is 75% versus 78% at the '80th percentile' nationally. The most significant variance was in 'access and waiting' and 'better information, more choice'.	E.A.7 The proportion of people reporting poor experience of General Practice and Out-of-Ours Services Baseline 6.2 2014/15 5.9 2015/16 5.6 2016/17 5.3 2017/18 4.0 2018/19 4.7

hospital, in General Practice and in the community	C 4.2 Patient Experience of hospital care	PAHT capture patient experience via a number of different channels including: • Ward level – 'techno huddle' data, which gives real-time patient feedback • The Friends and Family Test • Local Patient Surveys This gives patient experience feedback across the 5 key domains: • Access and Waiting • Safe, high quality, coordinated care • Better information, more choice • Building closer relationships • Clean, comfortable friendly place to be Information resulting from these channels is discussed at the monthly NE Sector Clinical Quality Leads Meetings – with CCG assurance sought around data capture, use of the information to inform service change, and future ambition. Patient experience information is also used to information the CCG's Service Walkaround Schedule. PAHT have recently refreshed their quality strategy. Pennine Care Foundation Trust (PCFT) The most recent available data for 2006/07 shows that for PCFT the overall patient experience score is 76% versus 77% at the '80th percentile' nationally. The trust captures patient experience via a number of different channels including: • By using 'Elephant kiosks', which gives information around care quality. • Feedback captured by giving email and telephone number on the reverse of appointment cards. • PALS • Complaints • CJ to add information from CQL in September The trust are in the process of completing a review to triangulate PALS, patient experience	E.A.5 The proportion of people reporting poor patient experience of inpatient care Baseline 124 2014/15 121 2015/16 118 2016/17 115 2017/18 112 2018/19 110

	C4.3 Friends and Family Test for acute inpatient care and A&E	and complaints data – looking across the breadth of patient experience information to give a broader understanding of experience by service. As above - Information resulting from these channels is discussed at the monthly NE Sector Clinical Quality Leads Meetings – with CCG assurance sought around data capture, use of the information to inform service change, and future ambition. Patient experience information is also used to information the CCG's Service Walkaround Schedule. Analysis of the first 6 months of FFT implementation is being completed nationally and due for imminent release. The GM LAT intends to schedule Workshops, following these and the release of national guidance, a trajectory can be agreed with the providers, which will be split into two measures - the response rate and the net promoter score.	E.A.6 Do you plan to meet the nationally set objective for the Friends and Family Test in 2014-15 and 2015/16? Yes
Ambition 7 Making Significant progress towards avoidable deaths in our hospitals caused by problems in care.	C5.1 Patient safety incidents	Pennine Acute Hospital Trust During 1ST October 2012 to 31st March 2013 there were 5192 reported incidents, equating to 4.8 per 100 admissions. The average number of incidents for 'large acute trusts' is in the region of 7 incidents per 1000 admissions. Bolton – 2600, 6.3 per 100 admissions. Salford – 3874, 9.4 per 100 admissions. CMFT – 11,495, 13.7 per 100 admissions. In response to their position as a relatively low reporter of incidents, Pennine Acute Trust has recently completed an incident reporting review – the results of which will be presented internally to the PAHT board in February and to the NE Sector Clinical Quality Leads in March. Catherine Jackson has requested a position statement ahead of the formal report. Serious Incidents The NE sector CCGs have established an incident review management process for PAHT and each CCG takes a lead role – Bury (community services); HMR (mental health) and Oldham (PAHT). The CCGs meet monthly to review the incidents reported on the STEIS system, discuss the root cause analysis and understand any lessons learned. Pennine Care Foundation Trust PCFT are a relatively high reporter of patient safety incidents – during October to March 2013, PCFT reported 25 incidents per 1000 bed days versus 18 for Greater Manchester West, and 8 for Manchester Mental Health. Reported incidents are analysed by the CSU and	E.A.9 Have you agreed (in conjunction with your Health and Wellbeing Board and NHS England area team) a specified increased level of reporting of medication errors from specified local providers between Q4,2013/14 and Q4, 2014/15? No To go to H&WB board for discussion on the 6th March 2014 E.A.S 5. C.Difficile infection rates set at 2013/14 rates as per direction from the LAT.

		reviewed at the monthly NE Sector Clinical Quality Review Meetings – to discuss root cause analyses and to seek assurances around lesson learned.	

NHS England

Strategy templates

2014/15 – 2018/19

THE NHS CONSTITUTION
the NHS belongs to us all

Strategy templates

Part of the set of templates that support Everyone counts: Planning for patients 2014/15 – 2018/19

First published: 19 December 2013

Introduction:

A strategic plan differs from an operational plan in many ways; it should be short, focussed and describe in a motivational way the direction of the organisation (s) that have signed up to it. It describes to those outside the system what the system plans to achieve in a way that informs and engages. It provides the basis for further detailed planning and should stimulate change in a system. That said, the strategic plan must also be realistic and attainable, to allow those within the system to understand and align with the strategic vision whilst working at all operational levels.

It is essential for these plans to be at the forefront of the planning process; they set the vision, ambitions and framework against which the two year detailed operational plans will be set. To help the submission of attainable and ambitious plans, templates have been developed that we hope are simplistic, flexible and helpful to commissioners and health systems generally.

What are we asking for?

Strategic planning should include the following elements:

- A long term strategic vision
- An assessment of the current state and current opportunities and challenges facing the system
- A clear set of objectives, that include the locally set outcome ambition metrics
- A series of interventions that when implemented move the health system from the current position to achieving the objectives and implementing the vision

Each strategic plan needs to be tested against the six characteristics of a sustainable health and care system (outlined below and from page 10 of *Everyone Counts*) ensuring that it reflects the needs of local citizens, the conclusions of local Call to Action conversations and informed by modelling tools such as Any town.

The structure of the submission has two core sections that we are asking to be completed and returned to us, in accordance with the timelines issued separately. These sections are a plan on a page and a key lines of enquiry submission – the strategic template will be deemed incomplete unless both sections are returned.

1. A *system* wide description of what the health economy should look like in five years. This system vision should identify how the health system will shape itself to meet future health demands without compromising quality outcomes or financial sustainability –the plan on a page is a helpful approach to describing this vision and a draft guide has been included in Appendix A.

2. A unit of planning[1] specific narrative describing how each organisation would reach this desired state through a high level road map that captures the high impact interventions planned within the health economy. This narrative takes the form of a key lines of enquiry submission. While this Strategy template looks for a narrative, this narrative must relate to, and underpin, the five year plans submitted in the related templates covering finance, activity and outcomes. To reduce duplication we have not asked for this material to be repeated in this document. In addition, the two year operational plans need to be consistent with the strategic direction set out here and triangulation across these various elements will be part of the assurance process.

This template contains the requirements of both sections of the template.

[1] The unit of planning will be determined by CCGs in accordance with letter issued on 04 November 2013

Section one | System narrative plan on a page

The plan on a page should have stakeholder sign up to its goals at a local health economy level. It should include the following characteristics:

Segment	Covering:	Supported by:
1. System vision	A statement describing what the desired state would be for the health economy in 2018/19 – this should ideally describe the health and care system rather than an individual organisation view – and which accounts for the six characteristics of a high quality, sustainable health and care system	Stakeholder sign up Individual organisation visions
2. Improving quality and outcomes	A) Looking at the seven improving outcome ambitions identified in *Everyone Counts*: planning for patients, how does the health economy plan to improve these and where appropriate, what level of improvement does it expect?	Detailed metrics will be provided in the operational template for years 3 - 5
	B) What other local quality improvement plans are in place and how do these align with the local strategic needs assessments?	Sign up from key stakeholders such as Health and Well-being Boards
3. Sustainability	In five years, what are the health economy goals for sustainability including reference to financial position, other resources and points of service delivery. This work should reference the do nothing gap calculated for the system by 2018/19 that aligns to the challenges identified in A Call to Action[2]	Detailed metrics supplied in the financial templates for each component organisation
4. Improvement interventions	To achieve the desired end state what are the key improvement interventions planned at an organisational level and how will these deliver the quality and sustainability outcomes required?	Contract expectations included in the financial template
5. Governance overview	A summary of the governance processes in place to oversee the delivery of the plans, including high level description of what success looks like and who is responsible for measuring it	
6. Key values and principles	A summary of the agreed values and principles that underpin the system wide working required to deliver the vision	

As part of the assurance process, the plans on a page will be reviewed to understand alignment to detailed organisational metrics submitted through the operational and financial templates.

Examples of plans on a page are available separately

[2] http://www.england.nhs.uk/2013/07/11/call-to-action/

Section Two | Key lines of enquiry (KLOE)

The following table template asks key lines of enquiry and contains space for the organisation to add their responses.

Segment	Key Line of Enquiry	Organisation response	Supported by:
Submission details	Which organisation(s) are completing this submission?	[*Please provide the names of the organisation(s) who are completing this template*]	
	In case of enquiry, please provide a contact name and contact details	[*Please provide a names lead and contact details in case of enquiry*]	
a) System vision	What is the vision for the system in five years' time?	[*Please provide the overall system vision which should tie back to the plan on a page. How will the system look and feel from a patient's perspective?*]	*The plan on a page*
	How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically: 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 2. Wider primary care, provided at scale 3. A modern model of integrated care 4. Access to the highest quality urgent and emergency care 5. A step-change in the productivity of elective care 6. Specialised services concentrated in centres of excellence (as relevant to the locality)	[*Please provide details of how these models and characteristics have been embedded into the five year plans, including referencing the activity and finance projections impacted by the characteristics. The activity and financial projections should be provided in the specific operational and financial templates.*]	*Details provided within the activity and financial templates which will be triangulated.*

Segment	Key Line of Enquiry	Organisation response	Supported by:
	How does the five year vision address the following aims: a) Delivering a sustainable NHS for future generations? b) Improving health outcomes in alignment with the seven ambitions c) Reducing health inequalities?	[*Please add your response to the key lines of enquiry here.* *A) From a resources perspective, what will the position be in five years' time? Is this position risk assessed?* B) *You should explain how your five year strategic plan will improve outcomes in the seven areas identified, within the context of the needs of your local population and what quantifiable level of improvement you are aiming to achieve*]	[*Please reference additional supporting documentation you feel is helpful*]
	Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?	[*Please provide details of the organisations who have signed up to this vision and the process by which sign up was obtained*]	
	How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?		
	What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	[*Please provide details of key feedback from any call to action engagement and confirm how these have been incorporated into the strategic vision?]*	
	Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included?		
a) Current position	Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?		
	Do the objectives and interventions identified below take into consideration the current state?		

<table>
<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr><td></td><td>Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?</td><td></td><td></td></tr>
<tr><td>b) Improving quality and outcomes</td><td>At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?</td><td>
<table>
<tr><th>Ambition area</th><th>Metric</th><th>Proposed attainment in 18/19</th></tr>
<tr><td>1</td><td></td><td></td></tr>
<tr><td>2</td><td></td><td></td></tr>
<tr><td>3</td><td></td><td></td></tr>
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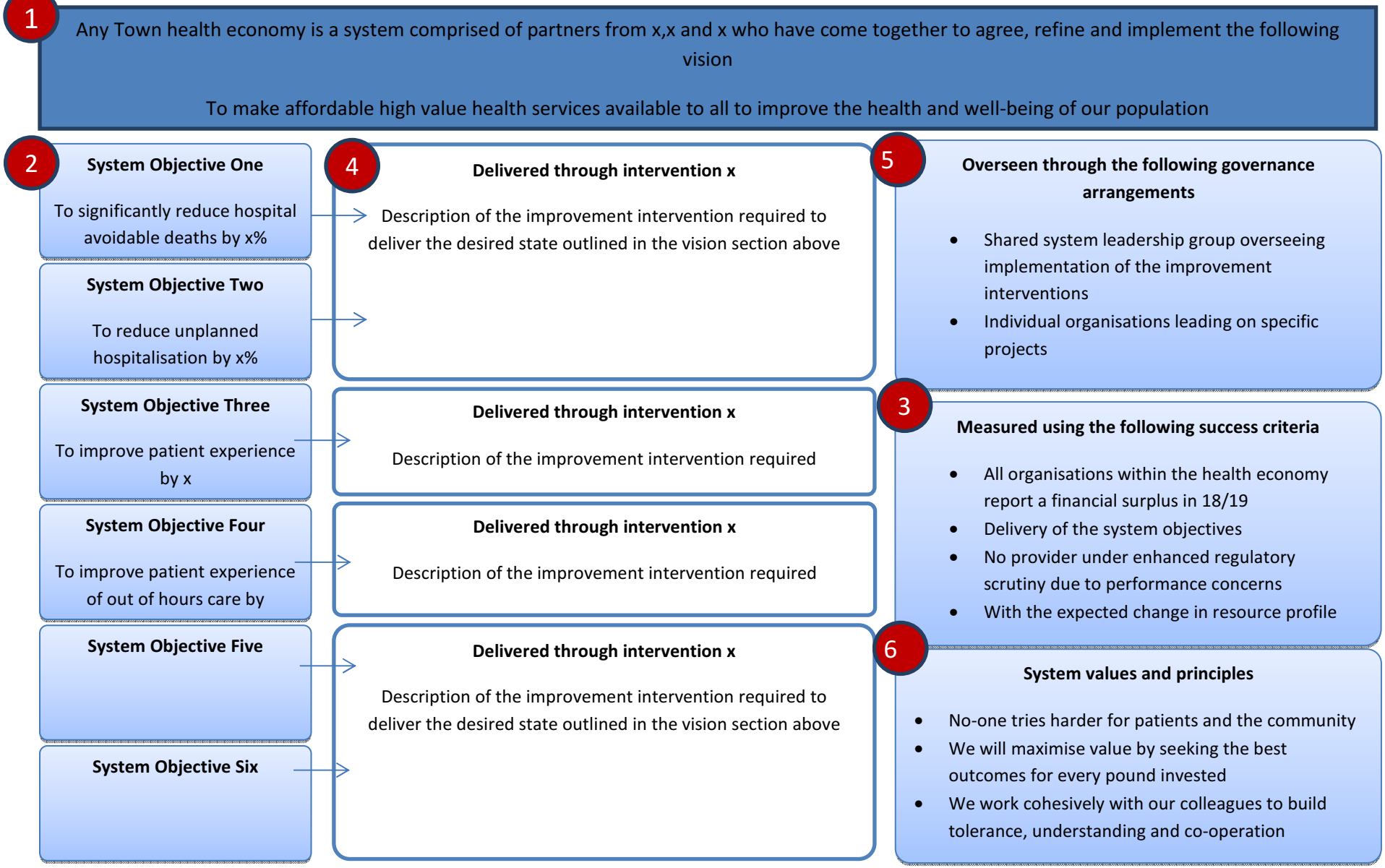
<tr><td>6</td><td></td><td></td></tr>
<tr><td>7</td><td></td><td></td></tr>
</table>
</td><td></td></tr>
<tr><td></td><td>How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?</td><td></td><td></td></tr>
<tr><td></td><td>What data, intelligence and local analysis was explored to support the development of plans for improving outcomes and quantifiable ambitions?</td><td></td><td></td></tr>
<tr><td></td><td>How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?</td><td></td><td></td></tr>
<tr><td></td><td>How have the Health and well-being boards been involved in setting the plans for improving outcomes?</td><td></td><td></td></tr>
<tr><td>c) Sustainability</td><td>Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?</td><td></td><td></td></tr>
</table>

Segment	Key Line of Enquiry	Organisation response	Supported by:
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?		
	Can the plan on a page elements be identified through examining the activity and financial projections covered in operational and financial templates?		
d) Improvement interventions	Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the : • Overall aims of the intervention and who is likely to be impacted by the intervention • Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have • Investment costs (time, money, workforce) • Implementation timeline • Enablers required for example medicines optimisation • Barriers to success • Confidence levels of implementation The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit.	**Intervention One** Overall description [CCG to comment] Expected Outcome [CCG to comment with particular emphasis on the impact on the outcome ambitions or the six characteristics] Investment costs • Financial costs [CCG to comment] • Non-Financial costs [CCG to comment] Implementation timeline [CCG to comment] Enablers required [CCG to comment] Barriers to success [CCG to comment] Confidence levels of implementation [CCG to comment]	

Segment	Key Line of Enquiry	Organisation response	Supported by:
e) Governance overview	What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?		
f) Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions		

Appendix A: One potential approach to developing a system plan on a page



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What is the Third Sector?

Anything that is not the private or public sector!

Community, voluntary and faith groups, charities, co-operatives, sports and social clubs

Community Interest Companies, Companies Limited by Guarantee, mutuals.

Sector is very Diverse

Approx 820 groups operating in the borough.

Small community based groups, sports and social clubs - to multi-million pound, national award winning organisations.
An estimate for Bury is that some 75-78% of the groups are ‘micro’ organisation i.e. under £10000 income (in reality less than circa £2500)

Most of the income that comes is accounted for by the other 25-22%

Strength of the Sector

Bury - it is estimated that

Population: 181300

Groups: 820

FTE Employees: 1000

Total income from all sources: £40m

Number of volunteers: 18000

Number of hours per week: 54,000

Strengths (cont)

Access to vulnerable groups

Flexible and Responsive

Accountable to users and local people

Partnerships and Networks

Experience of recruiting, supporting and training volunteers

Access to other funds – lottery, charitable trusts etc leverage for funding

Case Studies – CAB

- S. moved from Openshaw to Bury claiming Employment Support Allowance has heart condition. Informed DWP
- Told to not attend Openshaw and that Bury Job Centre would offer appointment. Never occurred benefit sanctioned payment stopped. S. hasn't eaten , lost 2.5 stones in weight and admitted to hospital by GP. S. had no electricity in the flat and couldn't use a kettle or heat food form food parcel.

Case studies (cont)

- S. walked 4 miles to CAB seen by volunteer at Gateway interview and immediately referred for specialist benefit help (paid).
- Payment reinstated after 6 weeks
- Client referred to Debt Specialist clinic for help with managing rent arrears and financial and budgeting advice with a view to being able to take control of finances.

Case Study – Home Start

- K lone parent 3 boys moved to the area escaping domestic violence supported by Womens Aid.
- Head teacher identified attendance and other issues at school
- Referred to Home Start after discussion with K.
- K. tearful and anxious re state of the house
- Knew needed to see GP but no one to look after children
- Volunteer worked to build relationship

Case study (cont)

- Action plan drawn up to include tea time routine established with volunteer support
- Visits to Childrens centre
- GP appt with volunteer watching children
- After several visits K. opened up about her experiences, guilt and doubt about her abilities as a mother to protect the children
- School attendance at 100% in K.s own words
- ‘When I look back I don’t recognise the old me from last year, Pam has helped so much I actually look forward to going to school now and love helping in the nursery class ..who knows.. Perhaps I might be a teacher one day!’

Other Examples

- Age UK – Newquay Pathfinder Managing Long Term Conditions
- Using Age UK staff and volunteers to act as key link –
- Managing director of NHS Kernow ‘about listening to the person’s story and making everything fit around the person to live the life they want’
- Impact 27% increase in self described quality of life, confidence and wellbeing
- 35% reduction in hospital admissions (£4.40 return for every pound invested.

Other Examples

- Crossroads – supporting 200 carers per week
- Paid staff and volunteers
- Individuals and group work
- Musical Memories - dementia group
- ‘there were other carers at the session, with similar problems, which we discussed and for once I didn’t feel alone’ A.P.
- ‘I honestly don’t know what I would have done without Crossroads and Musical Memories and often wonder what would happen to people like myself without the care and understanding of it’s staff’ A.P.

Issues

- Pressure on external funders (in particular local authority funding going forward) e.g. Pressure to reduce the £800,000 available from Bury LA Commissioning Fund
- Digital Agenda – digital by default volunteer roles in developing skill and access for clients
- Commissioning – social value and localism can be part of the commissioning process lets be bold in supporting local groups.
- Partnership – well developed lets use them.
- The sector needs to work better together and be more entrepreneurial. Help us to achieve this – help in kind can be valuable
- Data sharing JSNA use the sector as a resource

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Health and Wellbeing Report (For information)

Bury COUNCIL

Agenda Item	

MEETING:

DATE:

SUBJECT: Health & Wellbeing Strategy Dashboard

REPORT FROM: Anna Barclay (Public Health Analyst, Bury Council)

CONTACT OFFICER: Anna Barclay

1.0 Purpose of the Report

This is a draft of a dashboard to monitor the measures described in the Health & Wellbeing Strategy. It is brought to the board for comments.

2.0 Background

I was asked to create a draft dashboard to enable monitoring of the measures described in the Health & Wellbeing Strategy. This first draft is to stimulate discussion and feedback; the first tranche of data included here are the PHOF indicators that could easily be matched to the Health & Wellbeing Strategy measures. It is intended that more indicators (including those from different sources) will be included over time.

3.0 Issues

Feedback from the Board on the layout and content is required to develop the dashboard further.

- *Are 'statistical neighbours' the correct benchmark (if not, what is preferable)?*
- *What questions does the dashboard need to answer? Are there any it doesn't address?*
- *Are the Board familiar with spine charts? Would the Board be interested in a brief session on how to interpret them?*

4.0 Conclusion

Please send all feedback to Anna Barclay using the contact details below.

List of Background Papers:-

1) HWB Dashboard – draft v1 Feb14.pdf

CONTACT DETAILS:

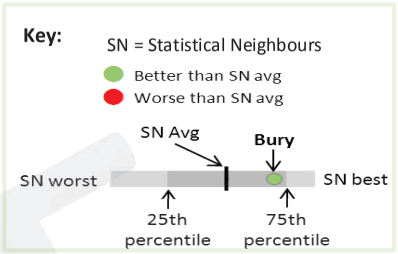
Contact Officer: Anna Barclay
Telephone number: (0161) 253 6910
E-mail address: anna.barclay@bury.gov.uk
Date: 25/02/14

Health & Wellbeing Strategy Measures Dashboard - February 2014 (draft v1)

The data below are PHOF indicators that can be matched to the Strategy measures at the end of each chapter. More indicators (including those from different sources) will be added following discussions and development. Indicators shown here are to demonstrate what the dashboard might look like and to stimulate discussion.

Please feedback your comments and suggestions to Anna Barclay: anna.barclay@bury.gov.uk or (0161) 253 6910.

This space will usually be used for the current report's headlines.



= Bury is in lowest quartile

NB: No significance implied

Strategy Measure Number and Indicator (See Table 2 on next tab for Measures)	Bury	SN Avg	SN Worst	Statistical Neighbours range	SN Best	Time Frame	Bury Rank 1= best, 11=worst	Description	Latest PHOF Update
Priority 1 - Ensuring a positive start to life for children, young people and families									
1 % achieving good level of development at end of reception	**51.2**	47.9	37.7		57.1	*2012/13*	4	% of children eligible for the EYFS Profile	**Feb-14**
2 Breastfeeding prevalence at 6-8 weeks after birth	**41.0**	34.3	22.1		47.2	*2012/13*	2	% of infants due a 6-8 week check	**Feb-14**
3 Smoking status at time of delivery	**15.3**	17.7	22.4		12.6	*2012/13*	3	% of maternities	**Feb-14**
Priority 2 - Encouraging healthy lifestyle and behaviours in all actions and activities									
4i Smoking Prevalence	**20.9**	22.6	25.6		19.5	*2012*	2	% of people aged 18+	**Feb-14**
4ii % inactive adults	**27.9**	30.0	33.2		25.9	*2012*	2	% of people aged 16+ classified as "inactive"	Aug-13
4iii Excess weight in 4-5 year olds	**19.5**	22.2	24.6		19.5	*2012/13*	1	% aged 4-5 classified as overweight or obese	**Feb-14**
4iv Excess weight in 10-11 year olds	**33.2**	33.5	36.1		31.1	*2012/13*	6	% aged 10-11 classified as overweight or obese	**Feb-14**
4v Excess Weight in Adults	**68.2**	65.9	70.2		60.1	*2012*	9	% aged 16+ classified as overweight or obese	**Feb-14**
5 Under 18 conceptions	**32.9**	37.4	45.4		28.4	*2011*	2	rate per 1,000 females aged 15-17	May-13
6i Under 75 mortality rate from all CVD	**102**	96	119		77	*2010-12*	8	Age-standardised rate per 100,000 under 75	**Feb-14**
6ii Under 75 mortality rate from cancer	**162**	163	177		148	*2010-12*	5	Age-standardised rate per 100,000 under 75	**Feb-14**
6iii Under 75 mortality rate from liver disease	**23.5**	23.4	30.9		17.0	*2010-12*	7	Age-standardised rate per 100,000 under 75	**Feb-14**
6iv Under 75 mortality rate from respiratory disease	**42.1**	41.2	48.8		27.6	*2010-12*	6	Age-standardised rate per 100,000 under 75	**Feb-14**
Priority 3 - Helping to build strong communities, wellbeing and mental health									
7 First time entrants to the youth justice system	**362**	528	1244		238	*2012*	2	rate per 100,000 10-17 year olds	Aug-13
8 Domestic Abuse	**23.0**	23.8	34.4		16.9	*2011/12*	8	rate per 1,000 population	**Feb-14**
9i Homelessness acceptances	**2.2**	1.5	2.5		0.3	*2011/12*	9	rate per 1,000 households	May-13
9ii Households in temporary accommodation	**0.2**	0.4	1.0		0.0	*2011/12*	3	rate per 1,000 households	May-13
Priority 4 - Promoting independence of people living with LTCs and their carers									
Priority 5 - Supporting older people to be safe, independent and well									
10 Injuries due to falls in people aged 65 and over	**1786**	1808	2749		1082	*2011/12*	5	age-sex standardised rate per 100,000 65+	May-13
11 Excess Winter Deaths Index (3 years, all ages)	**16.3**	15.2	17.9		12.4	*Aug 09 - Jul 12*	8	% of deaths	**Feb-14**

Please see next page for more details

Table 2: Health and Wellbeing Strategy Measures

H&WB Strategy Priority		Measures of success (number matches to indicators above)
Priority 1 - Ensuring a positive start to life for children, young people and families	1	An increase in the number of children achieving a good level of development at age 5
	2	Increases in breastfeeding initiation and maintenance at 6-8 weeks after birth
	3	A reduction in the number of mothers who smoking during pregnancy
Priority 2 - Encouraging healthy lifestyle and behaviours in all actions and activities	4	Reductions in the levels of smoking, physical inactivity, excess weight and harmful alcohol consumption in adults, children and young people
	5	A reduction in under 18s conception
	6	Reductions in early deaths from cancer and cardiovascular, liver and respiratory diseases
Priority 3 - Helping to build strong communities, wellbeing and mental health	7	A decrease in first time entrants to the youth justice system
	8	A reduction in domestic violence
	9	A reduction in homelessness
Priority 4 - Promoting independence of people living with long term conditions and their carers		*Indicators under discussion*
Priority 5 - Supporting older people to be safe, independent and well	10	A reduction in injuries and hip fractures due to falls in the over 65s
	11	A reduction in excess winter deaths

Table 3: Bury's Statistical Neighbours

Statistical Neighbours
Bolton
Calderdale
Darlington
Medway
St. Helens
Stockport
Stockton-on-Tees
Tameside
Telford and Wrekin
Wigan

Bury's 'Statistical Neighbours' are areas thought to be similar to Bury, calculated using CIPFA's 'Nearest Neighbours' online tool.

The comparator classes selected were Metropolitan Districts and Unitary Authorities. The indicators selected were the default CIPFA indicators plus '% Ethnic' and 'Index of Multiple Deprivation'.

More information on the tool can be found here:
http://www.cipfastats.net/resources/nearestneighbours/

Other info:

This is an adaptation of WMPHO's spine chart creator: http://www.wmpho.org.uk/tools/

Questions or suggestions? Please contact:

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