AGENDA FOR

HEALTH SCRUTINY COMMITTEE

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To: All Members of Health Scrutiny Committee

Councillors: C Cummins, J Grimshaw, S Haroon, K Hussain, O Kersh, C Morris, S Nuttall, L Smith, S Smith (Chair), C Tegolo, R Walker and S Walmsley

Dear Member/Colleague

Health Scrutiny Committee

You are invited to attend a meeting of the Health Scrutiny Committee which will be held as follows:-

Date:	Wednesday, 26 June 2019
Place:	Meeting Rooms A&B, Bury Town Hall
Time:	7.00 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 Health Scrutiny Committee 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 PUBLIC QUESTION TIME

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

4 MINUTES *(Pages 1 - 6)*

The minutes of the meeting held on 25th April 2019 are attached.

5 HEALTH AND SOCIAL CARE REFORM *(Pages 7 - 44)*

- Geoff Little, Chief Executive Bury Council will provide an update on the One Commissioning Organisation
- Kath Wynne Jones, Chris O'Gorman and Julie Gonda will provide an update on the Locality Care Organisation

Presentations are attached.

6 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE *(Pages 45 - 82)*

Jon Hobday, Public Health Consultant to report at the meeting. Presentation is attached.

7 WORK PROGRAMME UPDATE *(Pages 83 - 88)*

A report from Julie Gallagher Principal Democratic Services Officer is attached.

8 URGENT BUSINESS

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

Agenda Item 4

Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 25th April 2019

Present: Councillor S Smith (in the Chair)
Councillors, S Haroon, L Smith, T Holt, J Grimshaw, Susan Southworth and R Walker

Also in attendance: Councillor Andrea Simpson, Cabinet Member, Health and Wellbeing.
Julie Gonda, Interim Executive Director, Communities and Wellbeing
Jon Hobday, Public Health Consultant
Cath Tickle, Commissioning Programme Manager
Howard Hughes, Clinical Director Bury CCG
Jo Stephens, Representing Pennine Care Foundation Trust
Marcus Connor, Corporate Policy Manager
Julie Gallagher, Principal Democratic Services Officer

Public Attendance: No members of the public were present at the meeting.

Apologies for Absence: Councillor N Jones

HSC.465 DECLARATIONS OF INTEREST

Councillor Joan Grimshaw declared a personal interest in all matters under consideration due to her membership of the Patient Cabinet.

HSC.466 PUBLIC QUESTION TIME

There were no questions received under this item.

HSC.467 MINUTES

It was agreed:

That the minutes of the meeting held on 5th March 2019 be approved as a correct record.

HSC.468 DEVELOPMENT OF THE NEURO REHABILITATION SERVICE IN BURY

Cath Tickle, Commissioning Programme Manager, Howard Hughes, Medical Director, Bury CCG and Jo Stephens, Representing Pennine Care Foundation Trust attended the meeting to provide members with an overview of the development of the community rehabilitation services

serving Stroke and Neuro patient groups. The presentation contained information with regards to the following areas:

- GM Community Neuro Rehab Provision Review
- GM Acute Service Reconfiguration
- Current GM Model of Neuro Rehab
- Proposed model of care – NHS CCG Commissioning intention
- Rationale for a Local Service, benefits and next steps.

The Commissioning Manager reported that at the October (2018) meeting of the Clinical Cabinet a business case was approved for the development of a Community Neuro Rehabilitation Service. Building on the existing well performing Bury Stroke Service, commissioned from Pennine Care Foundation Trust (PCFT). It was reported that an integrated Stroke and Neuro Rehabilitation Service will support, an initial target cohort of the most complex neuro patients from Floyd Unit Rochdale and those in an acute settings that require rehabilitation; this will be approximately 100 patients.

The Commissioning Manager reported that the capacity of the new local service will be enhanced over a period of time, based on levels of actual local need, as opposed to estimated levels of need.

Those present were invited to ask questions and the following issues were raised.

Responding to a Member's question in respect of how service delivery will be measured, the Commissioning Manager reported that quarterly performance monitoring reports will be provided to the GM operational delivery network as well as local internal monthly CCG reports. Examples of key performance indicators will include response time, and physiotherapy waiting times. It is envisaged that integrated services will enhanced outcomes for Bury Neurology patients, improve patient experience and drive up quality.

The Commissioning Manager reported that the data collected from the initial phase of delivery will be collated and will influence how subsequent services are developed. Data collated will include patient flow information, length of stays and waiting times.

Responding to concerns raised by members in respect of this cohort of highly complex patients receiving the right and appropriate support in the community; the Pennine Care representative acknowledged that previously there had been some issues with care in the community. These proposals will ensure that there is a co-ordinated timely and meaningful input from a specialist co-located MDT team that will now include a clinical psychologist.

The facilitated discharge from an inpatient unit would mean the patient could have a shorter and less intense care package with less likelihood of becoming institutionalised.

Responding to a Member's question, the Clinical Director, CCG reported that the third sector will be an important partner in the Locality Care

Organisation, service delivery will be devolved in its entirety to this organisation, this will result in an increased role from some of the third sector organisations that currently support and provide smaller scale projects.

The CCG Clinical Director reported that an additional 400,000 pounds has been made available to support the establishment of this service.

It was agreed:

Representatives from the CCG and Pennine Care be thanked for their attendance and a further update in respect of performance against key performance indicators, the impact of the new service and the role out of the service to a wider cohort be considered.

HSC.469 SUBSTANCE MISUSE SERVICE

Jon Hobday, Public Health Consultant attended the meeting to provide members of the committee with an update with regards to the Greater Manchester drug and alcohol strategy as well as the approach taken in the Borough to address the issues raised.

This will be the first ever Greater Manchester Drug and Alcohol Strategy setting out a collective ambition to significantly reduce the risks and harms caused by drugs and alcohol and help make Greater Manchester one of the best places in the world to grow up, get on and grow old.

The Public Health Consultant reported that it is estimated that expenditure on alcohol related crime, health, worklessness and social care costs amount to £1.3bn per annum - approaching £500 per resident.

Alcohol places a significant burden on public services, causes health problems such as cancer, liver cirrhosis and heart disease, affects the well-being of families, and is a major contributor to domestic abuse, violent crime and public disorder.

The Public Health Consultant reported that there has been a long term downward trend in drug and alcohol use amongst adults and young people. Locally treatment services are more recovery focused than they used to be and more people are successfully completing treatment, but the Public Health Consultant reported that there is much more to be done.

Questions were invited from those present and the following issues were raised:

Responding to a Member's question, the Public Health Consultant reported that the decision to progress to an all age delivery model for substance misuse service was following discussions with a range of stakeholders. It is envisaged that this will help service delivery, particularly supporting the service users transitioning from young people to adult services. In addition it will generate efficiency savings from the adoption of a single line management structure.

In response to a Member's question, the new model of service delivery is based on a neighbourhood approach, this approach will allow the service to be tailored to a range of a challenges that exist in the different townships in the Borough.

The Public Health Consultant reported that model will be based on building on existing capacity in the communities, looking at assets that already exist and building a model that is recovery focused.

This is not a stand-alone strategy and will form part of ongoing work with complex needs, child sexual exploitation and domestic violence.

Responding to a question with regards to the recently undertaken Borough wide Children and Young People Survey, the Public Health Consultant reported that the survey produced some interesting data with regards to young people's drug use and in particular young people purchasing legal prescription drugs from internet sites. This data from this survey is currently being analysed and will be used to inform future service planning.

It was agreed:

The Public Health Consultant be thanked for his attendance and the Substance misuse tender document be shared with members of the Committee.

HSC.470 ADULT CARE ANNUAL COMPLAINTS REPORT

Andrea Simpson, Cabinet Member for Health and Wellbeing, Interim Executive Director Communities and Wellbeing and Marcus Connor, Corporate Policy Manager attended the meeting to present the Adult Care Annual Complaints Report.

The report provided an overview with details of information relating to Adult Social Care Services. The report relates to the periods 2016/17 and 2017/18, and provides comparisons between the two years noted and previous years, as well as detailing the nature, scope and scale of some of the complaints received.

The total number of complaints received over the last two years has remained relatively static at 68 in 2016/17 and 67 in 2017/18. Although service pressures have increased for the department, the figures indicate that customers are generally happy with the services they have received.

The majority of complaints received are made by a family member, advocate or solicitor of service user, rather than the service user themselves. In 2016/17, this represented 50 (74%) of the 68 complaints received, and, in 2017/18, this represented 45 (67%) of the 67 complaints received.

Of the complaints received in 2016/17 and 2017/18, 26 (38%) and 36 (54%) respectively were not upheld, this compares to 32% in 2015/16. The

increasing proportion of complaints not upheld demonstrates the quality and accuracy with which services are initially delivered.

The number of complaints referred to the Local Government Ombudsman (LGO) has similarly remained stable, at 5 (7%) and 4 (6%) cases being considered.

In 2016/17 and 2017/18, 291 and 265 compliments were received respectively.

Members requested that complaints relating to Persona be considered by the Committee at the same time as the Adult Care Complaints report.

Councillors reported that they are receiving an increase in complaints in relation to charges for day care services. The Interim Executive Director reported that following the 2014 Care Act, the Council agreed to introduce charging for day care services, this is undertaken following a financial assessment. Bury was one of the last local authorities to introduce charging for fay care services.

It was agreed:

A briefing note will be circulated to Elected Members providing details of the charges introduced following implementation of the Care Act.

Councillor S Smith
In the Chair

(Note: The meeting started at 7pm and ended at 8.35pm)

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Health and Social Care Reform

The Bury Health and Social Care "One Commissioning Organisation"

NHS Bury Clinical Commissioning Group

Bury Council

Health and Social Care Reforms

Local Care Organisation (LCO)

One Commissioning Organisation (OCO)

Working with Bury people and communities

NHS
Bury
ical Commissioning Group

Bury
COUNCIL

Why are we doing this?

Bury population will continue to grow. Proportion of that larger population who are 65+ will also grow

Financial gap of £25m across CCG and Council this year

Despite amount of money being spent outcomes for Bury people not acceptable

Health life expectancy

- Bury men 58.5 vs 63 nationally
- Bury women 62.2 v 63.3
- Most deprived parts of Bury 53.1 men and 54.2 women

NHS Bury ical Commissioning Group

Bury COUNCIL

The Opportunities

To close financial gap and improve outcomes we need to re
balance:-

- From late intervention in hospitals and residential care
- To early intervention in communities

GM Devolution – a once in a generation opportunity to do th

£19m investment in transformation and freedoms to innova

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The Objectives

To empower Bury people:-

- To remain well for longer
- To make informed choices

To create a different model of services for Bury people

- A team instead of separate services
- A relationship based on understanding of whole people, families, carers

Overall control of the 'system' as a whole

NHS Bury ical Commissioning Group

Bury COUNCIL

Bury Health and Social Care "One Commissioning Organisation"

A single commissioner for health and social care in Bury, commissioning for outcomes, and commissioning against a wide ranging and dynamic local evidence base"

" ….bringing together the Health and Social Care Commissioning functions of Bury Council and Bury CCG into One Commissioning Organisation, with a pooled or aligned budget, a single commissioning strategy, a shared approach to maximising social value, and strategically commissioning for outcomes"

Bury Locality Plan for Health and Social Care Transformation April 2017

NHS Bury ical Commissioning Group

Bury COUNCIL

Bury "One Commissioning Organisation" Ultimate Ambition and Vision

Ultimately and over time the Bury "One Commissioning Organisation" will encompass all strategic commissioning from the Council and CCG and other public services where possible

NHS
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ical Commissioning Group

Bury
COUNCIL

Bury One Commissioning Organisation Deadlines

- **By 1 October 2019 -** Strategic Commissioning Board (health and social care)in place

- **By 1 April 2020 -** OCO staffing function (health and social care) fully operational

NHS Bury ical Commissioning Group

Bury COUNCIL

What this means

A single joint leadership and staffing, with a single approach and single budget, working as one, for common purpose

Initially (from 1 April 2020) the Bury OCO will include commissioners for:

- CCG
- Adult Social Care
- Public Health
- Children and Young People
    - SEND, Disability, Personal Budgets

NHS Bury ical Commissioning Group

Bury COUNCIL

What this means

Governance

A "Strategic Commissioning Board" providing leadership and governance of Health and Social Care Commissioning and promoting alignment with wider Council and Public services by inclusion of all Council functions on the "Strategic Commissioning Board"

Operations

A single commissioning function comprising integrated health and social care commissioning teams, supporting the Boards decision making and enacting its commissioning decisions and working with communities and wider Council and public service partners

NHS Bury ical Commissioning Group

Bury COUNCIL

BURY LOCAL CARE ORGANISATION

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Bury Overview and Scrutiny Committee- June 2019

Chris O'Gorman

| LCO Independent Chair |

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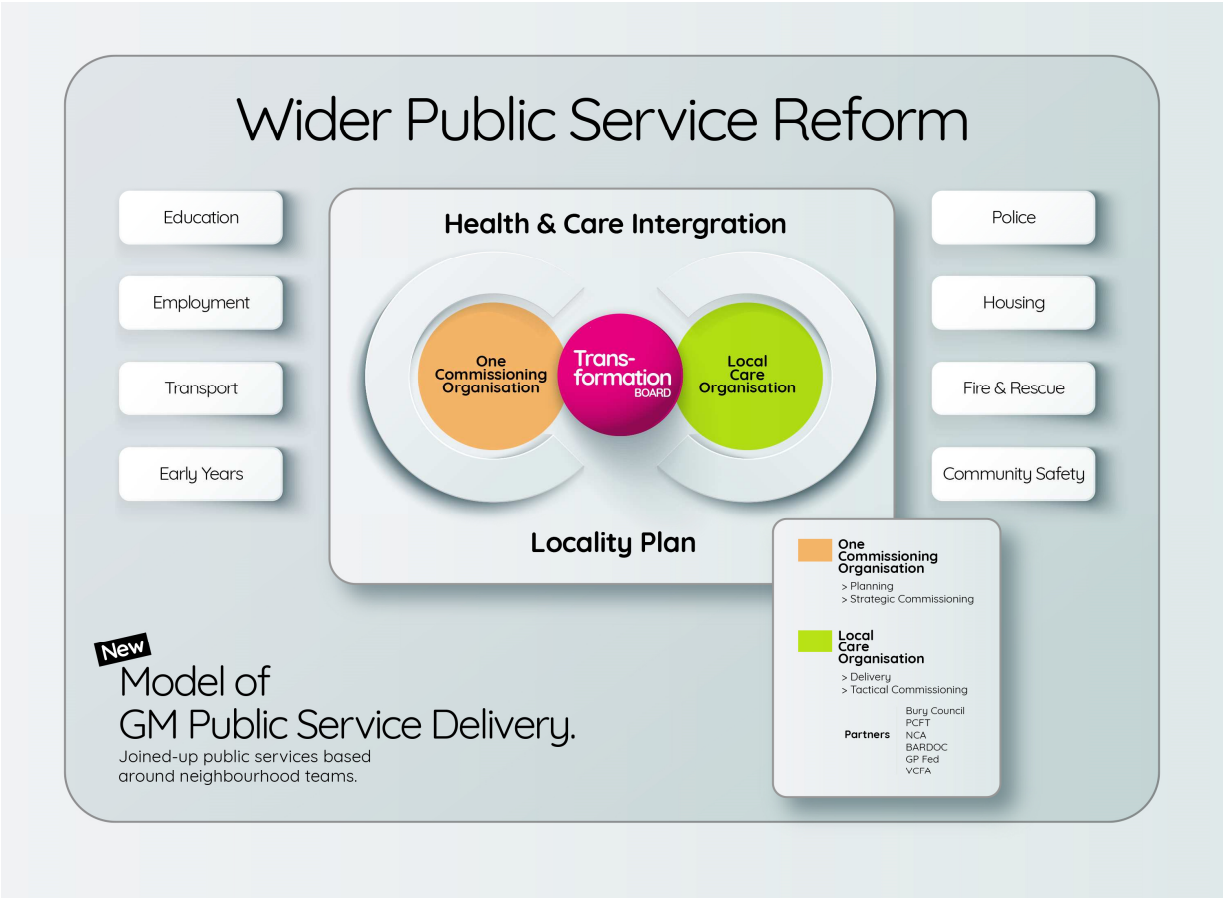
Link with Public Service Reform



BURY LOCAL CARE ORGANISATION

Improving lives in Bury

1st April LCO launch

Our Partners:

- **Bury Council**
- **Northern Care Alliance**
- **Pennine Care NHS Foundation Trust**
- **VCFA**
- **GP Federation**
- **BARDOC**
- **Persona**

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Our Vision

Overall Aims:

- Encourage everyone to work in a mutually beneficial and collaborative way
- Enable sharing of information between clinicians and health professionals
- Support people in becoming active participants in managing their own health
- Developing health and care services more in communities and homes
- Services will be developed around neighbourhoods and tailored for local areas with their own unique needs
- Patients will only have to 'tell their story' once

Our Vision:

- We want to find a way of capturing simply and clearly our vision for the future, one that everyone can relate to and be inspired by, and will be asking for your input…..

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Our purpose

- **We are NOT**… an employer

We ARE…

- An over-arching organisation that sets vision, values, goals, ambitions across all delivery partners
- We work closely with the One Commissioning Organisation – single commissioning across the Council and CCG
- We are a common thread and a driver of transformational change
- We are a key part of joining up health and care in bury
- We have an agreed way of working – the 5 Ps

Our aim is to roll out and scale up all the good work and changes that are already happening, and introduce some new things too – and we need your help to do that.

Kath Wynne-Jones

| LCO Chief Officer |

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Our priorities

- Delivering transformational change for six priority areas:
    - **Integrated neighbourhood teams**
    - **The intermediate tier**
    - **End of life care**
    - **Community stroke/neurorehabilitation**
    - **The rapid response service**
    - **Urgent care and care home support**
- Overseeing the transfer of community services from PCFT to NCA
- Supporting the developing children's health and social care transformation programmes
- Developing the transformation programmes for other services not yet transformed across partners
- Building relationships and collaboration across partners
- Develop an infrastructure for April 2020 onwards

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Our Principles

BURY LOCAL CARE ORGANISATION

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Our Services

DIRECTLY MANAGED

All PCFT community services

75% of adult social care services

DIRECTLY INFLUENCED

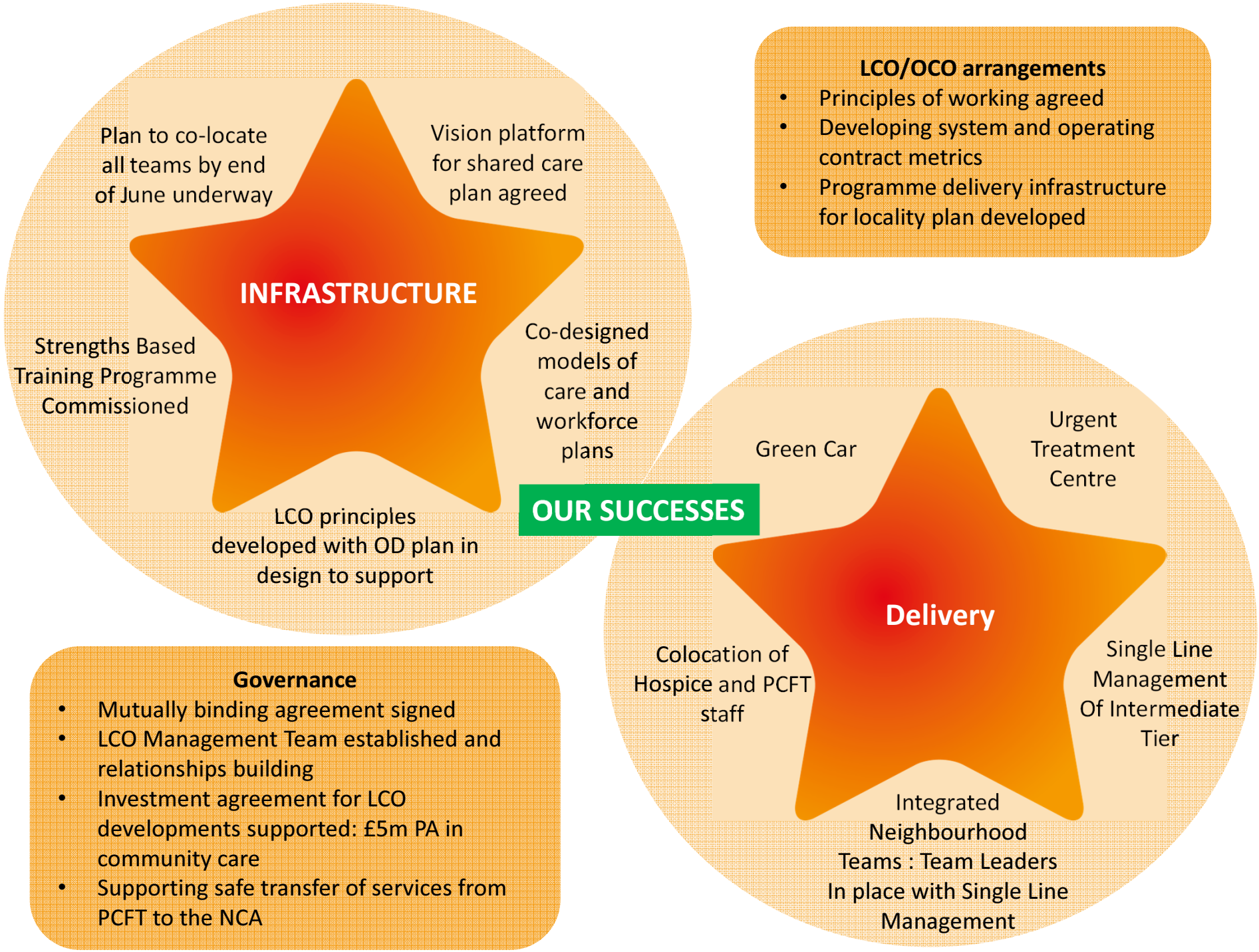
A&E and the medical wards

Local Bury Mental Health Services

Bardoc Services

Services provided by the GP Federation

Voluntary sector provision



LCO/OCO arrangements

- Principles of working agreed
- Developing system and operating contract metrics
- Programme delivery infrastructure for locality plan developed

Governance

- Mutually binding agreement signed
- LCO Management Team established and relationships building
- Investment agreement for LCO developments supported: £5m PA in community care
- Supporting safe transfer of services from PCFT to the NCA

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Green Car

"Big thumbs up, excellent service. No negatives".

"I think that this is the way forward to preventing unnecessary hospital admissions by providing accurate and effective and safe care to the patient. I would like to see this service extended to my main practice area".

"All positives no negatives".

"I had a very satisfactory consultation with the car paramedic who effectively was able to prevent a hospital admission, and assessed the patient very thoroughly and phoned me from the patient's house and we were able to formulate an effective plan for this patient's care".

"……. the GP was more than satisfied with the management plan instigated for the patient and the avoidance of a hospital A&E admission. We would definitely use the service again".

"the green car scheme had prevented an ambulance attendance".

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Joanne explains how Prestwich have been breaking down barriers in delivering person centred care through the multi-disciplinary team (MDT) meeting approach.

Joanne Cranham, a NHS Pennine Care District Nurse Team Leader has been involved in the MDT meetings since the start of the Pilot in Prestwich last year.

How long have you worked in the District Nursing team

I have worked for PCFT since 2013 I started as a band 5 community staff nurse, in February 2018 I was successful in 'stepping up to a band 6' team leader, after 3 weeks a full time post became available and I was successful and offered the post. Since then I have been a team leader at Prestwich district nurse team and have completed an in house band 6 development programme.

When did the District Nurses become involved in the MDT meetings

The district nurse team have been involved in the MDT since the beginning of the pilots last year, we have ensured District Nurse presence at all the meetings so far and been able to help with developing the processes and building relationships, staff have felt more empowered to help patients.

Can you give an example of where an MDT approach has significantly improved the outcome for a patient

Yes one particular patient was being managed already by both DNs and Social workers but separately until we began the MDT meetings, we did not do any joint working. DNs were visiting and raising concerns and safeguarding alerts.

The patient was bouncing in and out of hospital, Bardoc were being called and the daughter was being called out and was under increasing pressure from work about the time off she was needing.

Social workers had met the patient but not as frequently as the DNs so had not seen the very fluctuating capacity and understanding of the patient, DNs were able to give them a wider overall picture.

Once we started MDT we did a joint visit, then held a professionals meeting including the daughter and we put plans into place to look at providing a more safe and appropriate placement. By jointly working in this way we not only improved the outcome for the patient and daughter but also enabled a much quicker and timely response from all services involved.

How do you feel about moving into Integrated Neighbourhood teams

I am really excited by the upcoming re-location as I feel being based with other professionals will help us work together and share information easier on a day to day basis, not just at the MDT meetings.

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Operational updates

- Development of workforce plans for the intermediate tier and rapid response service
- Visit to Bealeys: positive feedback on relationships improving
- Support to the urgent care system following the implementation of rapid discharge protocol
- PCCC supported in principle 4 P/C networks :not aligned with the neighbourhoods but nieghbourhoods will be the delivery vehicle
- Participation in health and social care savings Board
- Engagement meeting with Bolton University regarding future training programmes
- Visit from Oldham Cares to start a learning journey together
- Recruitment of Divisional Nursing / Therapy Director to support community services
- OCO/LCO workshop held to gear up for new system management group from July
- Updated objectives and commenced 2:1 meetings with MT and Board members
- SEND inspection held with some gaps identified in services, which the LCO which contribute to suring up
- VCFA workshop to be held to understand the GM survey results and Bury opportunities

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The future of the LCO

- Understanding of the scope of services to be included from 20/21 is already inderway
- Alignment of LCO/OCO roadmap and associated activities is key
- Considering organsiational form options as part of the roadmap is vital: does this offer a route to efficiencies?
- Procurement timeline and ending of funding for LCO infrastructure do not align, which is a major risk
- Considering how we sustain the LCO infrastructure post March 20 ,assuming we need to be self funding

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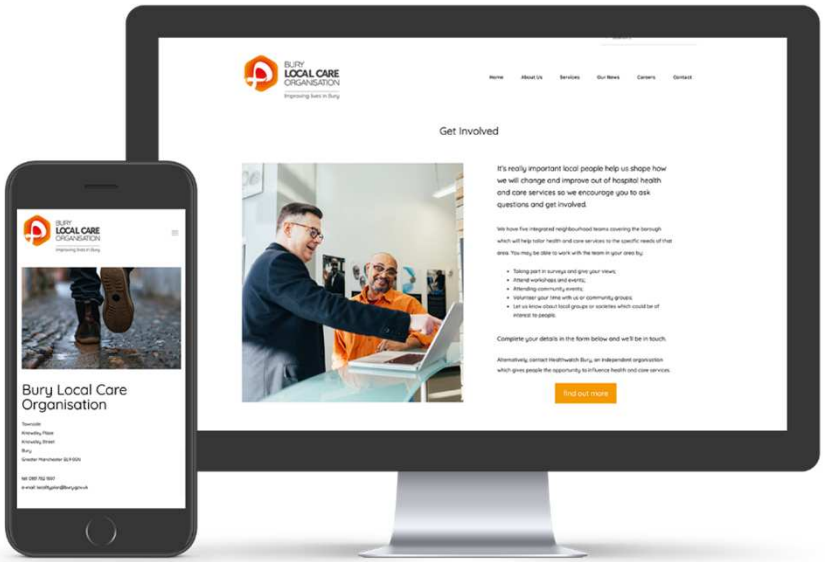
Our engagement

How we will share what we're doing

@Burylco
#Burylco

Twitter – **live**
Website – **nearly live!**



Burylco.org.uk

Julie Gonda

| Director of Adult Social Care |

VISION

Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.
Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities, DoH, 2009:

From a service user perspective this is expressed by NICE in the following terms:
Intermediate care services provide support for a short time to help you recover and increase your independence.This support is provided by a team of people who will work with you to achieve what you want to be able to do. Intermediate care may help you:
remain at home when you start to find things more difficult recover after a fall, an acute illness or an operation avoid going into hospital unnecessarily return home more quickly after a hospital stay.
Understanding intermediate care, including reablement: A quick guide for people using intermediate care services, NICE, 2018.

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Engagement

- Existing staff teams focused on vision, benefits, challenges, areas for development, building relationships
- Organisational stakeholders and subject matter experts
- NWAS Green Car paramedics and Urgent Care Team.
- CCG Senior Commissioning Manager and Clinical Lead for Mental Health, Programme Manager – Urgent Care, Clinical Lead for Medicines Management.
- LCO Clinical Lead
- FGH staff - Assistant Director of Nursing, Clinical Support Services, Consultant Physician in Acute Medicine/COTE Clinical Lead Persona Chief Officer
- Bury Community Mental Health Services, lead for AHP, Professional Lead for Nursing
- Bury VCFA.
- Bury Professional Congress.
- HMR Rapid Response and Intermediate Care Services.
- Choices for Living Well Customer Forum.

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Model

The PA review found:

- Current services are fragmented and provided inconsistently
- There is a disproportionately high level of bed-based care that is financially unsustainable
- There is a requirement to develop home-based intermediate care services
- The Rapid Community Response Service is struggling to meet the level of demand and does not have the ability to manage complex health cases.

The proposed delivery model will:

- bring together a **unified Bury-wide integrated team** under **single leadership**. The key deliverables are to:
- Introduce **home-based care** into Bury's intermediate care offering;
- Create **additional enhanced IMC beds** through dual registration of Killelea House;
- Relaunch **Rapid Community Response** with a broader multidisciplinary team.
- Focusing on acute admission avoidance by increasing step-up referrals
- Achieve higher bed occupancy
- Reduce average length of stay.

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New workforce

Intermediate Care	40.0 wte total
	10.0 Therapy
	11.0 Nursing
	4.0 Social Work
	10.0 Support Worker
	2.0 admin
Rapid Response	29.5 wte total
	11.0 Therapy
	2.0 Social Work
	9.8 nursing
	4.0 Support Workers
	2.0 admin
Across	6.0 wte total
	2.0 Pharmacy
	1.0 Drug /Alcohol
	3.0 Professional and managerial

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Mental Health and LD within the LCO

- Mental health strategy in development between PCFT and the OCO, taking into account the work undertaken by Niche
- LCO Board and MT session to be held led by PCFT to consider the future strategy and developments
- Mental Health Services will be integrated across all transformational points: small investment into intermediate tier and proposals in development for the primary care physchological offer
- LD services not yet in scope of the LCO
- Bury local MH services will be managed through single LCO/OCO contract arrangements

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Key risks summary

1. Financial sustainability of the economy in the short and long term
2. Workforce stability and availability
3. IM&T programme
4. Continuation of the LCO infrastructure post 2020
5. Alignment between neighbourhoods and networks

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Our Risks

Risk	Pre-mitigation score	Mitigation	Post-mitigation score
Lack of funding to support core and transformational models of care: primary care mental health services , UTC, reablement and OD team in the context of the system wide gap for 19/20	4 (L)*4(I) = 16	• System wide group established to bridge the gap for 19/20 • TF funding used to support continuation of schemes: review of all financial plans to commence to identify any slippage/support reprioritisation	4 (L)*4(I) = 16
Workforce stability and engagement	4 (L)*5(I) = 20	• Design of recruitment process/campaign underway via SWG • Considering opportunities for rotation of workforce across community, primary and acute care • Staff engagement sessions to support PCFT transaction to be extended to other LCO staff	4 (L)*4(I) = 16
Transaction risks: District nursing, clinical leadership and performance/waiting times	4 (L)*4(I) = 16	• Discussions held with OCO, but no agreements yet reached	4 (L)*4(I) = 16
Lack of clarity regarding leadership of enabling programmes – IM&T is a major risk, particularly with the retirement of the SRO	4 (L)*4(I) = 16	• LCO MT and IM&T group session being arranged	4 (L)*4(I) = 16

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Our Risks

Risk	Pre-mitigation score	Mitigation	Post-mitigation score
Ensuring we have the appropriate enabling infrastructure in place from the 1st April 2020	4 (L)*5(I) = 20	Agree process for determining: • In scope services for 20/21 • Target operating model • Organisational form • Future LCO infrastructure requirements	4 (L)*4(I) = 16
Cash ability assumptions and ambition to move resources across the across providers so not materialise	4 (L)*5(I) = 20	• Robust monitoring of process and impact measures as schemes mobilise • Recruit new roles on fixed term appointments where possible	4 (L)*4(I) = 16
No connection date yet agreed for Heathlands	4 (L)*4(I) = 16	• Issue been escalated via GMSS to Virgin	4 (L)*4(I) = 16
Decision making/risks for L4 services not managed in the context of the MBA	4 (L)*5(I) = 20	• Review of recent decision making processes, e.g. SEND, Heathlands,	4 (L)*4(I) = 16

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Our Risks

Risk	Pre-mitigation score	Mitigation	Post-mitigation score
Potential misalignment between neighbourhood and primary care network boundaries	4 (L)*4(I) = 16	• GP Federation leading conversations with LMC and practices regarding potential delivery models for new roles to support neighbourhood working. All applications needed to determine how they would support neighbourhood working	5 (L)*3(I) = 15
Full governance arrangements will not be fully operational from the 1st April 2019.	5 (L)*3(I) = 15	• We are aiming for the 1st July for new governance arrangements to be fully operational. • Workshops planned to engage back office support teams to face organisationally and to the LCO	4 (L)*3(I) = 15

Discussion

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JSNA update

Jon Hobday – Consultant in Public Health

Purpose

- To provide an overview of key health and well-being data for Bury
- To highlight the interventions which improve health and well-being over the life course
- To highlight the next steps

Definitions

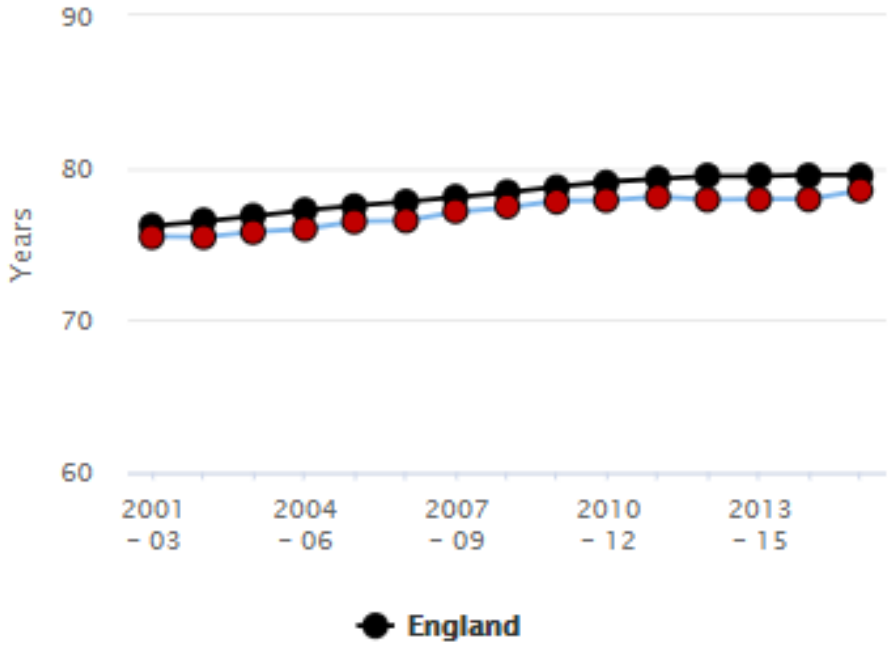
- Life Expectancy is the average number of years a newborn is expected to live if mortality patterns at the time of its **birth** remain constant in the future
- Healthy Life Expectancy a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.

Life Expectancy

0.1ii - Life expectancy at birth (Male) New data Bury

Life expectancy - Years

Export chart as image Show confidence intervals Export table as CSV file



Recent trend: –

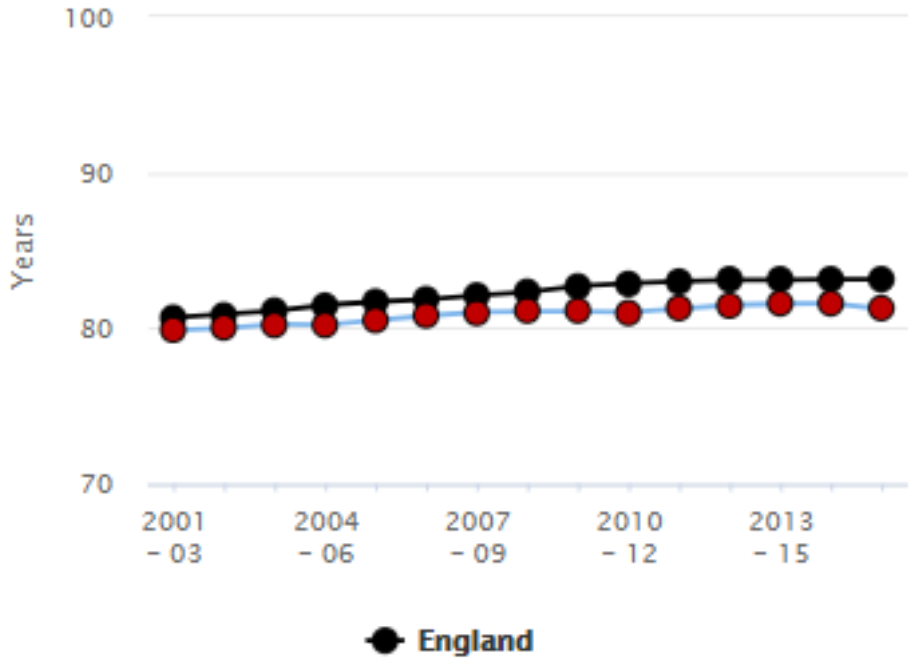
Period		Bury				North West region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03		-	75.5	75.0	76.0	74.8	76.2
2002 - 04		-	75.5	75.0	76.0	75.1	76.5
2003 - 05		-	75.8	75.3	76.3	75.4	76.8
2004 - 06		-	76.0	75.5	76.5	75.7	77.2
2005 - 07		-	76.5	76.0	77.0	76.0	77.5
2006 - 08		-	76.5	76.0	77.0	76.3	77.8
2007 - 09		-	77.1	76.6	77.6	76.6	78.1
2008 - 10		-	77.4	76.9	77.9	76.9	78.4
2009 - 11		-	77.8	77.3	78.3	77.3	78.8
2010 - 12		-	77.9	77.4	78.4	77.6	79.1
2011 - 13		-	78.1	77.6	78.6	77.9	79.3
2012 - 14		-	77.9	77.4	78.4	78.0	79.4
2013 - 15		-	78.0	77.5	78.5	78.1	79.5
2014 - 16		-	77.9	77.4	78.4	78.2	79.5
2015 - 17		-	78.5	78.0	79.0	78.2	79.6

Source:
Office for National Statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2015to2017)
Index of Multiple Deprivation 2010 and 2015 (IMD 2010 / IMD 2015) scores from the Department for Communities and Local Government.

0.1ii - Life expectancy at birth (Female) New data Bury

Life expectancy - Years

Export chart as image Show confidence intervals Export table as CSV file

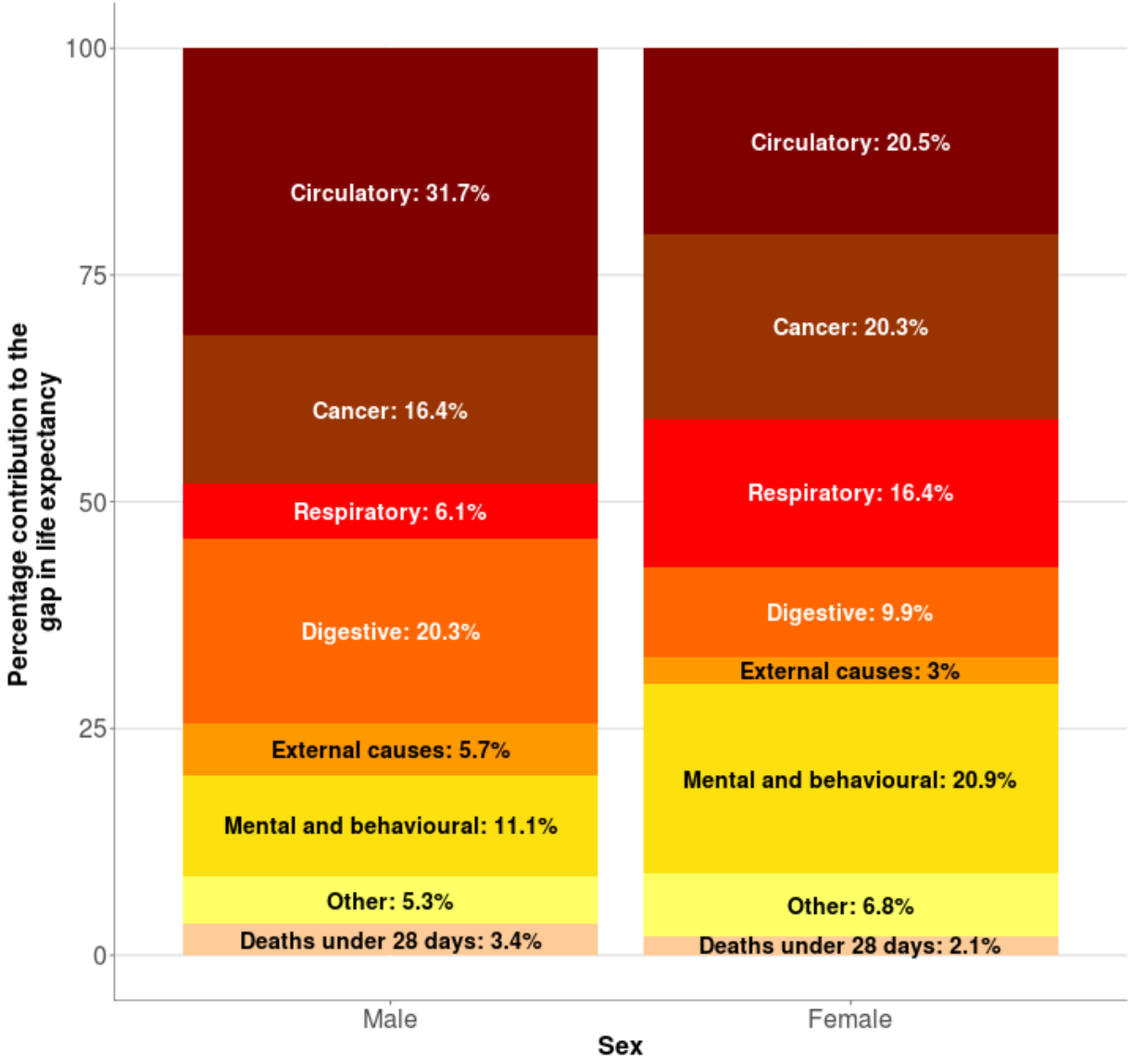


Recent trend: –

Period		Bury				North West region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03		-	79.9	79.4	80.4	79.5	80.7
2002 - 04		-	80.0	79.5	80.5	79.7	80.9
2003 - 05		-	80.2	79.8	80.7	79.9	81.1
2004 - 06		-	80.2	79.8	80.7	80.2	81.5
2005 - 07		-	80.5	80.0	81.0	80.4	81.7
2006 - 08		-	80.8	80.3	81.3	80.5	81.9
2007 - 09		-	81.0	80.6	81.5	80.7	82.1
2008 - 10		-	81.1	80.6	81.5	81.0	82.3
2009 - 11		-	81.1	80.6	81.5	81.4	82.7
2010 - 12		-	81.0	80.5	81.5	81.6	82.9
2011 - 13		-	81.2	80.8	81.7	81.7	83.0
2012 - 14		-	81.5	81.0	82.0	81.8	83.1
2013 - 15		-	81.6	81.1	82.0	81.8	83.1
2014 - 16		-	81.6	81.1	82.1	81.7	83.1
2015 - 17		-	81.2	80.8	81.7	81.8	83.1

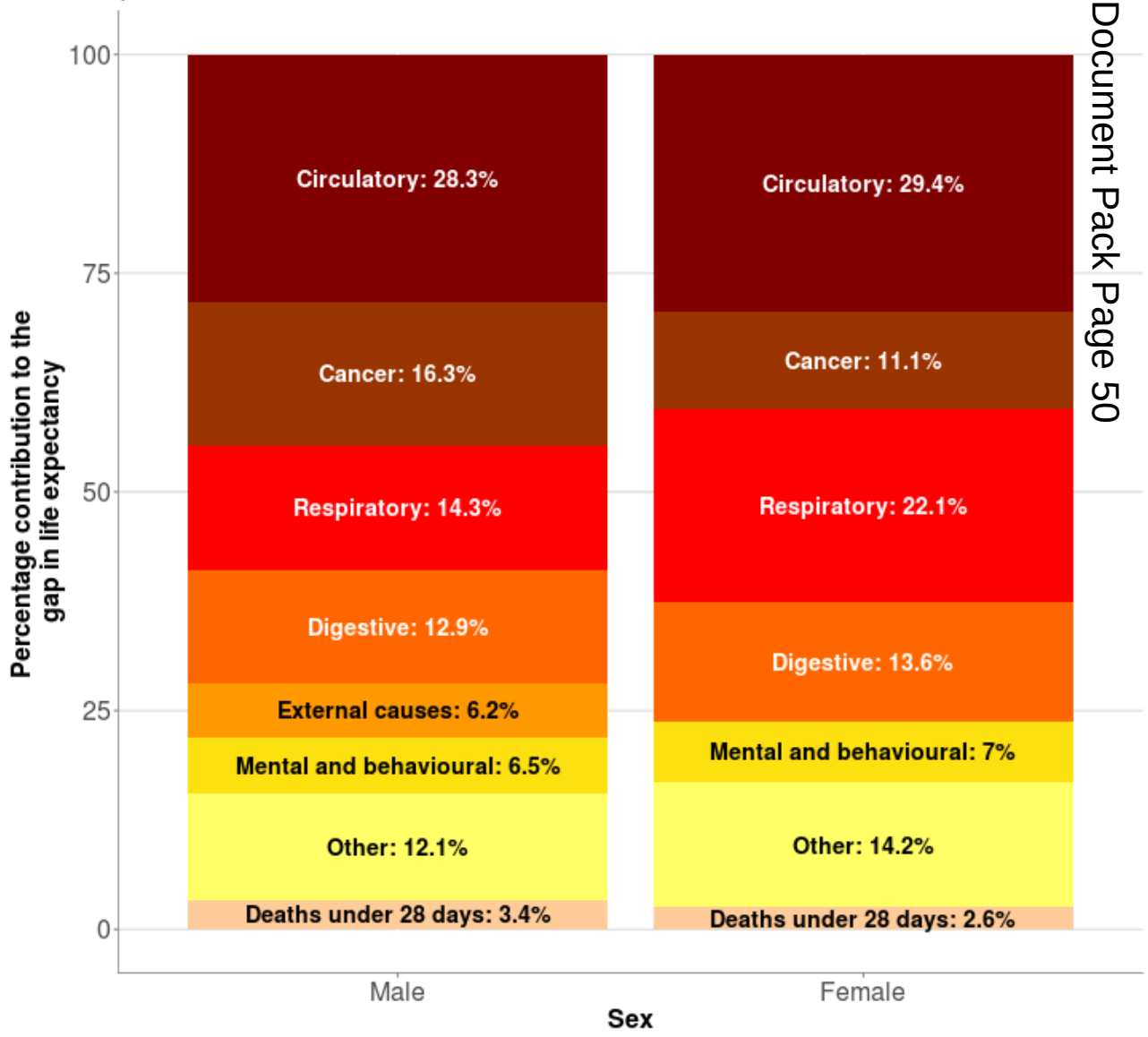
Source:
Office for National Statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2015to2017)
Index of Multiple Deprivation 2010 and 2015 (IMD 2010 / IMD 2015) scores from the Department for Communities and Local Government.

Scarf chart showing the breakdown of the life expectancy gap between Bury as a whole and England as a whole, by broad cause of death, 2015-17



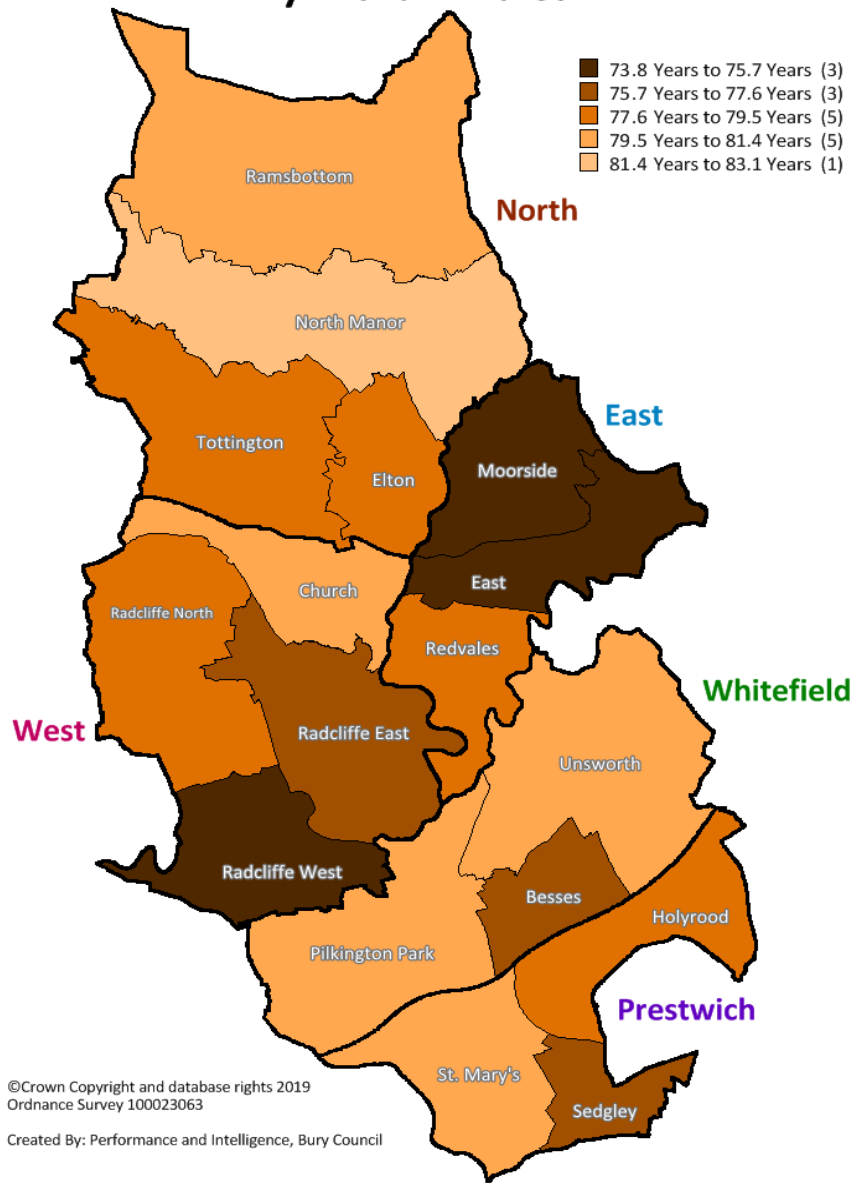
Source: Public Health England: Segment Tool

Scarf chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Bury, by broad cause of death, 2015-17



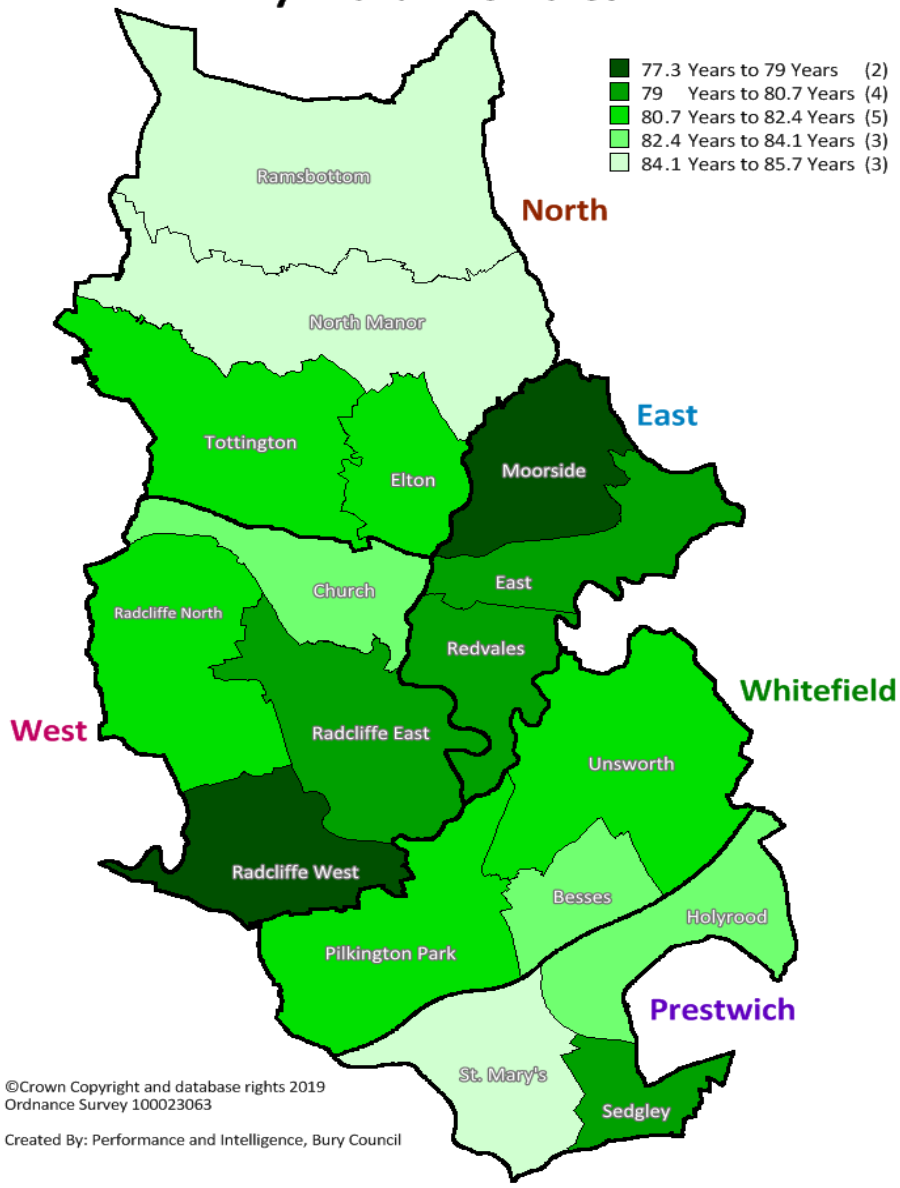
Source: Public Health England: Segment Tool

Life Expectancy 2013-2017
By Ward - Males



Created By: Performance and Intelligence, Bury Council

Life Expectancy 2013-2017
By Ward - Females

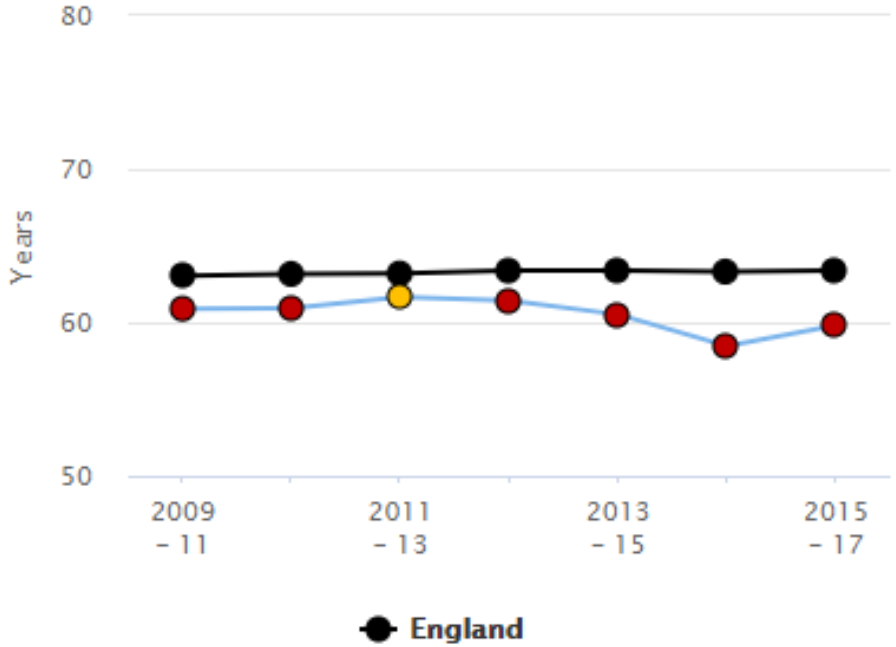


Created By: Performance and Intelligence, Bury Council

Healthy Life Expectancy

0.1i - Healthy life expectancy at birth (Male) New data Bury — Life expectancy - Years

Export chart as image Show confidence intervals Export table as CSV file



Recent trend: –

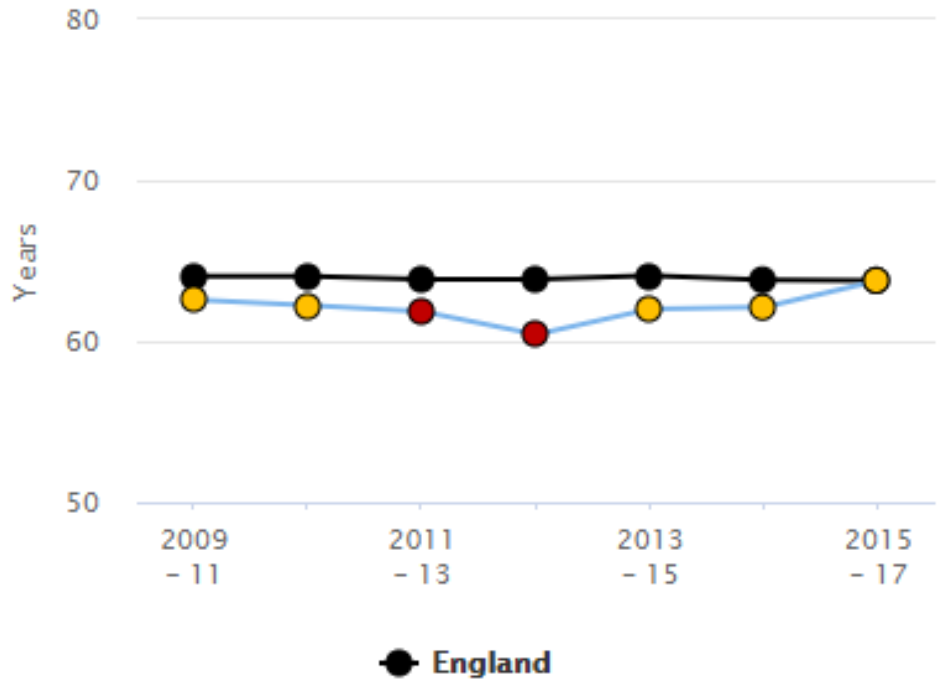
Period		Bury				North West region	England
		Count	Value	Lower CI	Upper CI		
2009 - 11	●	-	60.9	59.2	62.6	60.8	63.0
2010 - 12	●	-	60.9	59.2	62.6	61.0	63.2
2011 - 13	●	-	61.7	59.9	63.4	61.2	63.2
2012 - 14	●	-	61.4	59.6	63.3	61.0	63.4
2013 - 15	●	-	60.5	58.7	62.3	61.1	63.4
2014 - 16	●	-	58.5	56.5	60.4	60.9	63.3
2015 - 17	●	-	59.8	57.9	61.7	61.2	63.4

Source:
Office for National Statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2015to2017)

0.1i - Healthy life expectancy at birth (Female) New data Bury

Life expectancy - Years

Export chart as image Show confidence intervals Export table as CSV file



Recent trend: –

Period		Bury				North West region	England
		Count	Value	Lower CI	Upper CI		
2009 - 11	●	-	62.6	60.8	64.3	61.6	64.0
2010 - 12	●	-	62.2	60.4	64.1	61.7	64.2
2011 - 13	●	-	61.9	59.9	63.8	62.0	63.8
2012 - 14	●	-	60.4	58.3	62.5	61.7	63.9
2013 - 15	●	-	62.0	59.9	64.1	61.9	64.1
2014 - 16	●	-	62.1	60.2	64.0	61.9	63.8
2015 - 17	●	-	63.8	61.9	65.6	62.3	63.8

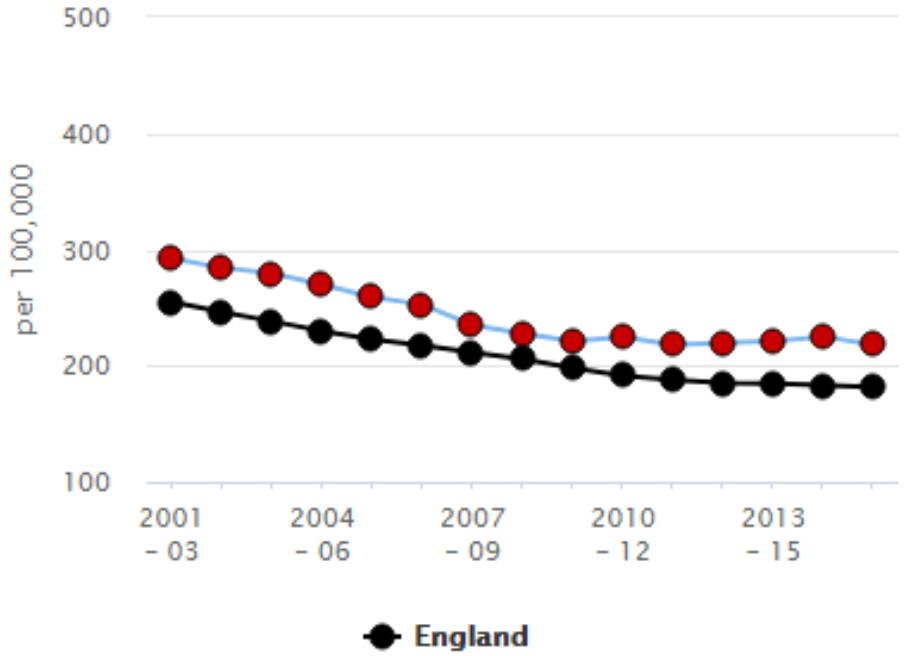
Source:
Office for National Statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2015to2017)

Mortality from preventable causes

4.03 - Mortality rate from causes considered preventable Bury

Directly standardised rate - per 100,000

Export chart as image Show confidence intervals Export table as CSV file



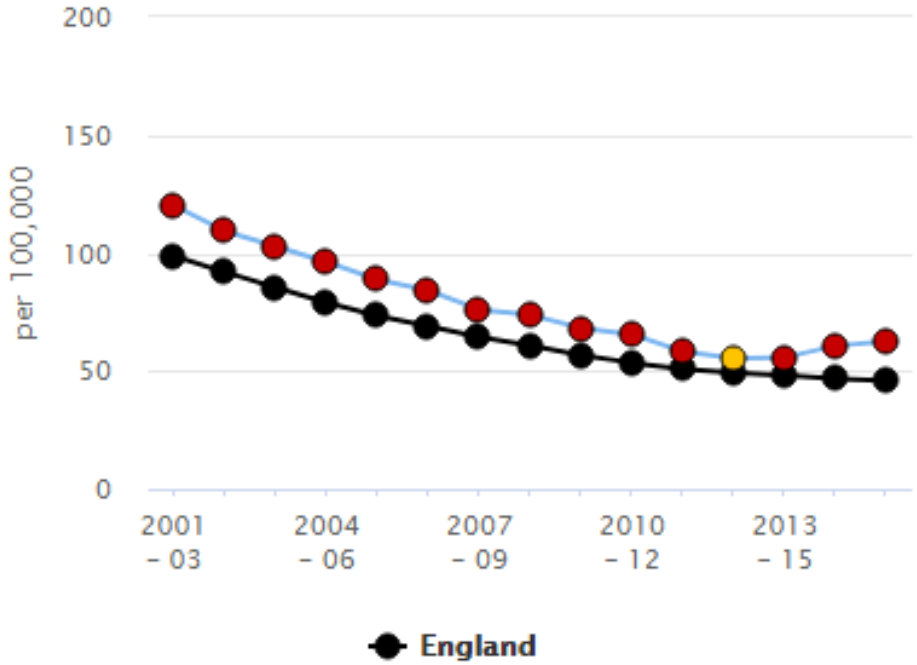
Recent trend: –

Period		Bury				North West region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03	●	1,321	292.4	276.7	308.8	304.9	254.7
2002 - 04	●	1,303	284.4	269.0	300.4	293.1	246.0
2003 - 05	●	1,285	279.3	264.1	295.1	285.2	238.2
2004 - 06	●	1,252	269.7	254.9	285.2	275.3	229.5
2005 - 07	●	1,213	259.1	244.6	274.2	268.4	222.7
2006 - 08	●	1,192	252.6	238.3	267.5	263.7	217.6
2007 - 09	●	1,125	234.8	221.2	249.1	258.8	211.5
2008 - 10	●	1,106	227.7	214.4	241.7	251.9	205.8
2009 - 11	●	1,093	221.2	208.2	234.8	242.2	197.7
2010 - 12	●	1,130	224.5	211.5	238.0	233.5	191.4
2011 - 13	●	1,112	218.1	205.4	231.4	228.6	187.4
2012 - 14	●	1,137	219.5	206.8	232.7	226.0	185.1
2013 - 15	●	1,154	221.0	208.4	234.2	224.9	184.5
2014 - 16	●	1,191	224.9	212.2	238.1	223.0	182.8
2015 - 17	●	1,169	218.1	205.7	231.0	220.4	181.5

Source: Public Health England (based on ONS source data)

4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable Bury Directly standardised rate - per 100,000

Export chart as image Show confidence intervals Export table as CSV file



Recent trend: –

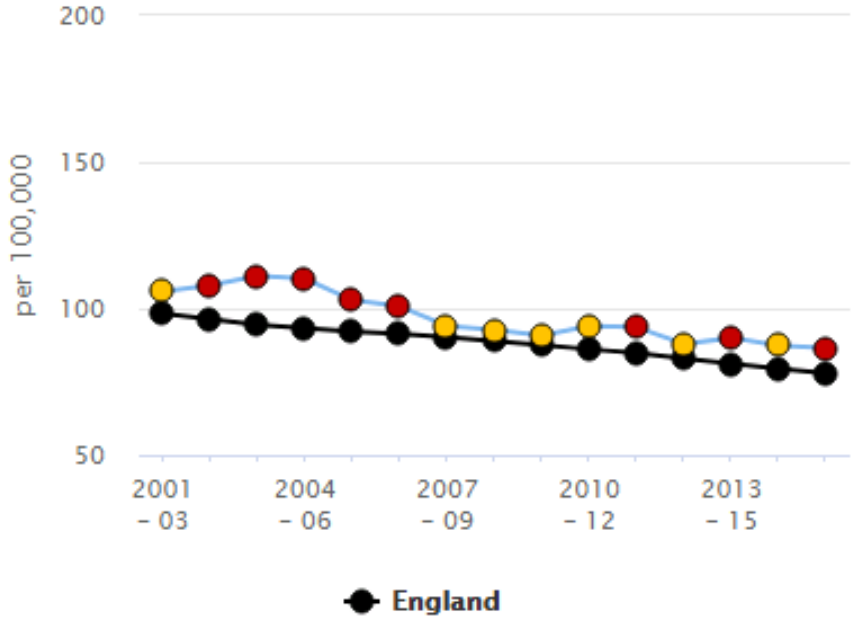
Period		Bury				North West region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03	●	481	120.1	109.6	131.4	118.2	98.6
2002 - 04	●	446	109.3	99.3	120.0	110.7	91.9
2003 - 05	●	422	102.8	93.1	113.2	103.3	85.3
2004 - 06	●	399	96.2	86.9	106.1	97.3	78.9
2005 - 07	●	373	88.8	79.9	98.3	90.4	73.4
2006 - 08	●	357	84.1	75.5	93.4	84.6	68.9
2007 - 09	●	325	76.0	67.9	84.7	79.1	64.3
2008 - 10	●	321	73.7	65.8	82.3	74.9	60.7
2009 - 11	●	301	68.1	60.6	76.3	70.0	56.6
2010 - 12	●	298	65.5	58.2	73.4	65.1	53.5
2011 - 13	●	266	58.1	51.3	65.6	61.4	50.9
2012 - 14	●	260	55.4	48.8	62.6	59.4	49.2
2013 - 15	●	265	55.8	49.2	63.0	58.2	48.1
2014 - 16	●	294	60.6	53.9	68.0	57.2	46.7
2015 - 17	●	307	62.6	55.8	70.1	57.0	45.9

Source: Public Health England (based on ONS source data)

4.05ii - Under 75 mortality rate from cancer considered preventable Bury

Directly standardised rate - per 100,000

Export chart as image Show confidence intervals Export table as CSV file



Recent trend: –

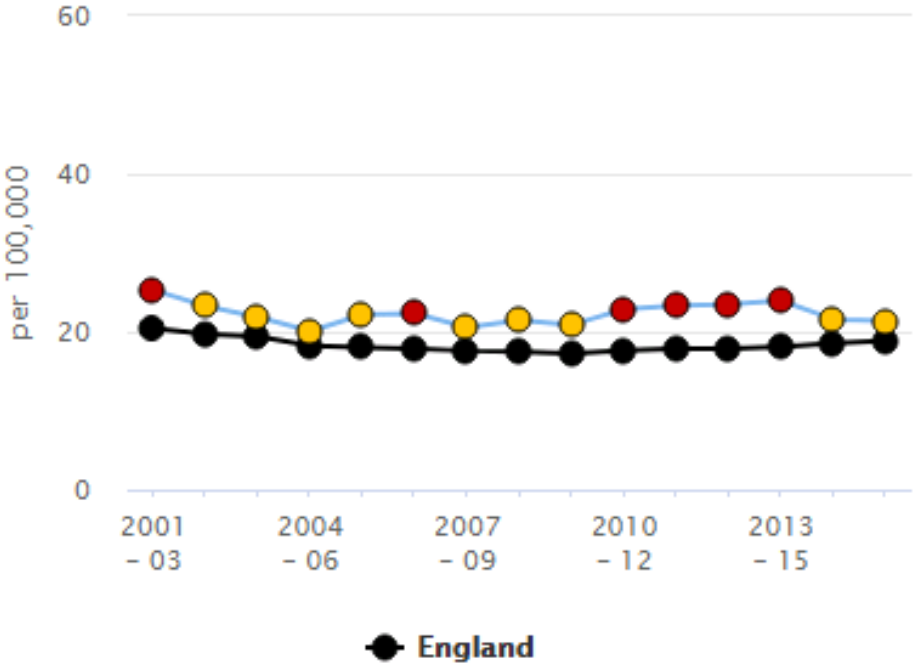
Period		Bury				North West region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03	●	436	105.8	96.1	116.3	114.9	98.3
2002 - 04	●	450	107.9	98.1	118.4	111.0	96.4
2003 - 05	●	466	111.1	101.1	121.7	109.5	94.5
2004 - 06	●	469	110.2	100.4	120.7	108.0	93.2
2005 - 07	●	442	102.8	93.4	113.0	107.1	92.1
2006 - 08	●	436	100.7	91.4	110.7	106.1	91.3
2007 - 09	●	409	94.0	85.1	103.7	104.9	90.3
2008 - 10	●	411	92.6	83.8	102.1	103.6	88.9
2009 - 11	●	410	90.8	82.1	100.1	101.4	87.4
2010 - 12	●	433	94.0	85.3	103.4	99.5	86.1
2011 - 13	●	437	93.6	85.0	102.9	98.0	84.8
2012 - 14	●	416	87.9	79.6	96.9	96.3	83.0
2013 - 15	●	429	89.9	81.6	98.9	94.7	81.1
2014 - 16	●	423	87.3	79.2	96.1	92.0	79.4
2015 - 17	●	424	86.5	78.4	95.1	89.7	78.0

Source: Public Health England (based on ONS source data)

4.07ii - Under 75 mortality rate from respiratory disease considered preventable Bury

Directly standardised rate - per 100,000

Export chart as image Show confidence intervals Export table as CSV file



Recent trend: –

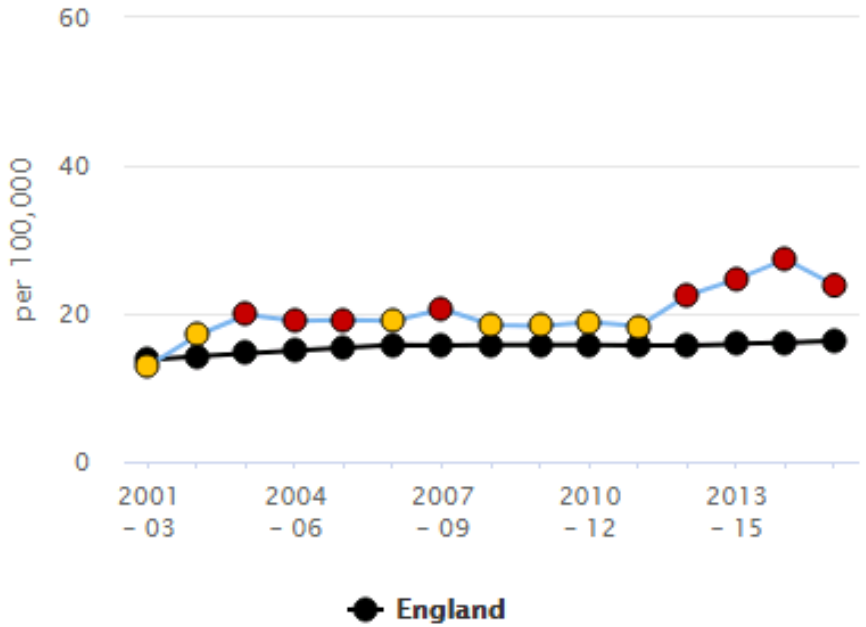
Period		Bury				North West region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03	●	98	25.3	20.5	30.8	26.9	20.4
2002 - 04	●	91	23.3	18.7	28.6	25.9	19.7
2003 - 05	●	87	21.8	17.5	27.0	25.4	19.4
2004 - 06	●	81	20.1	15.9	25.0	23.4	18.2
2005 - 07	●	90	22.2	17.8	27.3	23.3	18.0
2006 - 08	●	92	22.3	18.0	27.4	23.6	17.9
2007 - 09	●	87	20.6	16.5	25.4	23.6	17.6
2008 - 10	●	94	21.5	17.3	26.3	23.9	17.4
2009 - 11	●	93	20.9	16.8	25.6	23.6	17.2
2010 - 12	●	103	22.8	18.6	27.7	23.9	17.6
2011 - 13	●	108	23.3	19.1	28.1	24.0	17.9
2012 - 14	●	110	23.5	19.3	28.3	23.8	17.8
2013 - 15	●	113	23.9	19.7	28.8	24.4	18.1
2014 - 16	●	102	21.6	17.6	26.2	25.6	18.6
2015 - 17	●	104	21.4	17.4	25.9	25.7	18.9

Source: Public Health England (based on ONS source data)

4.06ii - Under 75 mortality rate from liver disease considered preventable Bury

Directly standardised rate - per 100,000

Export chart as image Show confidence intervals Export table as CSV file



Recent trend: –

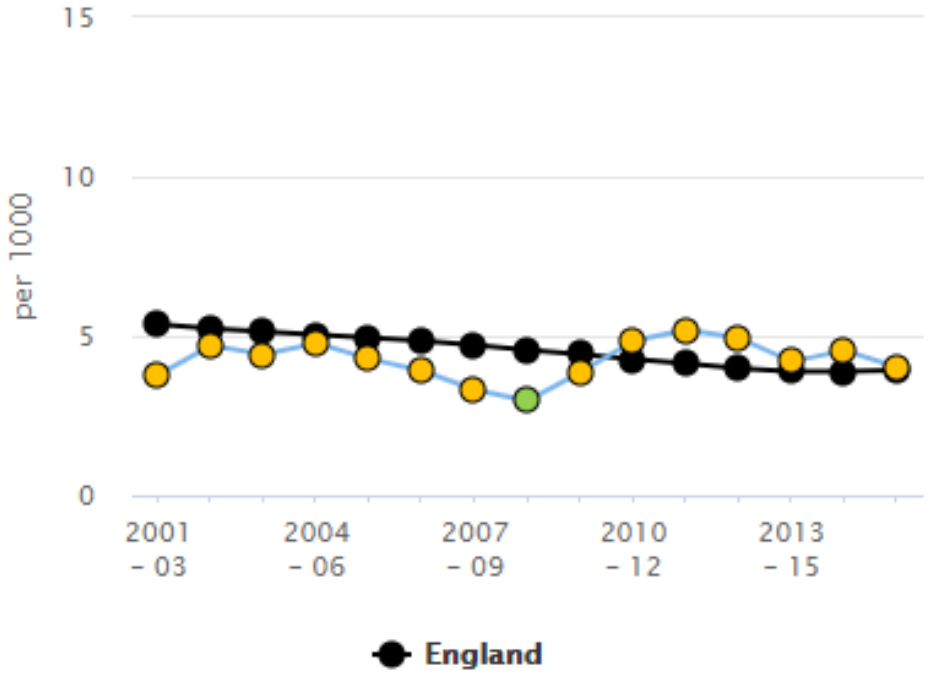
Period		Bury				North West region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03	●	61	13.0	9.9	16.7	18.9	13.8
2002 - 04	●	80	17.1	13.5	21.3	19.5	14.3
2003 - 05	●	91	19.9	16.0	24.4	19.9	14.6
2004 - 06	●	87	19.0	15.2	23.5	20.4	15.0
2005 - 07	●	89	19.2	15.4	23.6	21.3	15.4
2006 - 08	●	90	19.0	15.3	23.4	22.4	15.8
2007 - 09	●	99	20.6	16.7	25.1	22.6	15.7
2008 - 10	●	89	18.5	14.8	22.8	22.2	15.7
2009 - 11	●	88	18.3	14.7	22.6	22.0	15.8
2010 - 12	●	91	18.8	15.2	23.2	22.0	15.8
2011 - 13	●	90	18.3	14.7	22.5	22.0	15.7
2012 - 14	●	110	22.5	18.5	27.1	22.3	15.7
2013 - 15	●	121	24.6	20.4	29.5	22.7	15.9
2014 - 16	●	135	27.3	22.9	32.4	23.1	16.1
2015 - 17	●	119	23.8	19.7	28.5	22.9	16.3

Source: Public Health England (based on ONS source data)

4.01 - Infant mortality Bury

Crude rate - per 1000

Export chart as image Show confidence intervals Export table as CSV file



Recent trend: –

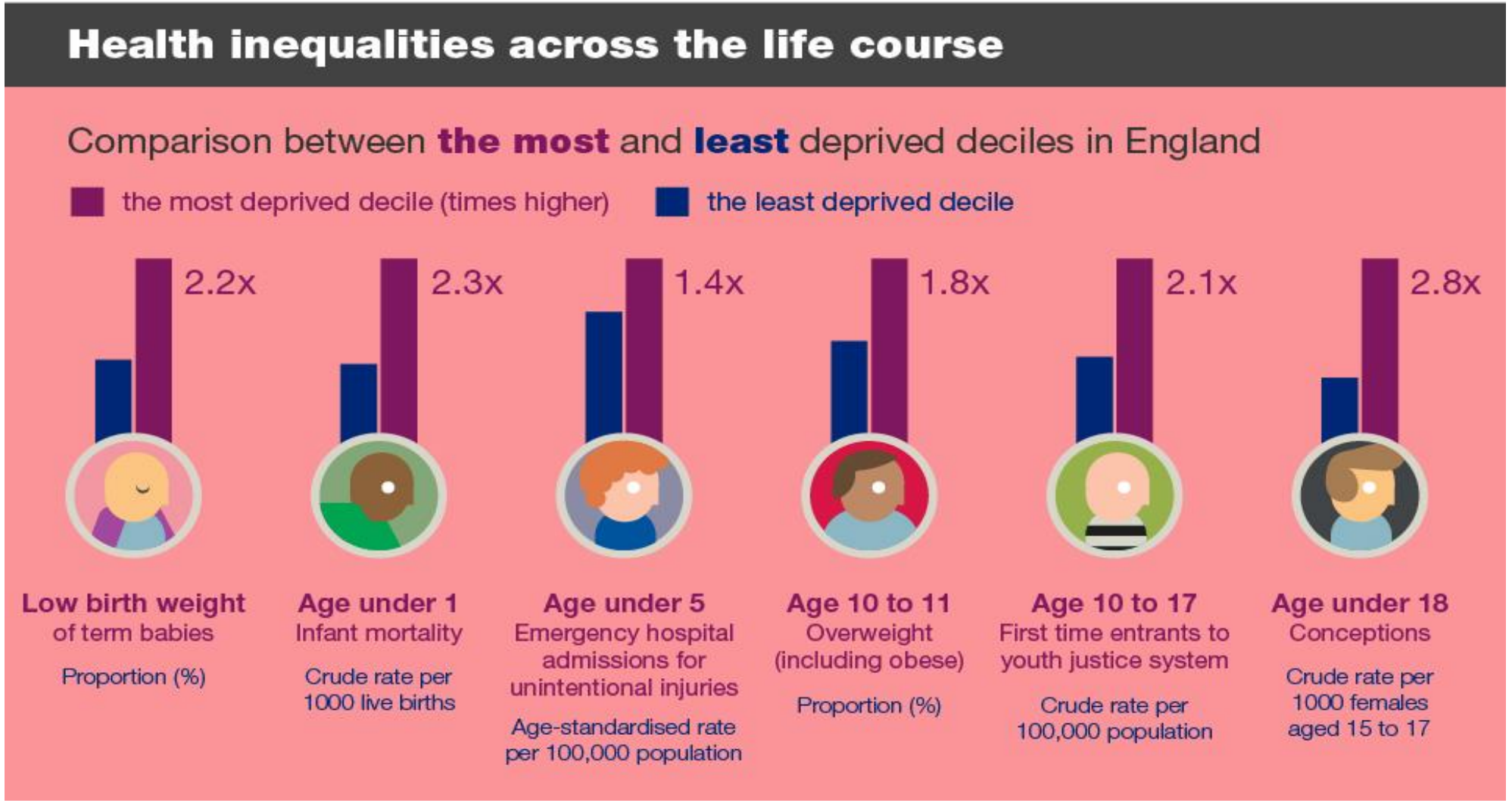
Period		Bury				North West region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03	●	24	3.8	2.4	5.6	5.7	5.4
2002 - 04	●	31	4.7	3.2	6.7	5.6	5.2
2003 - 05	●	30	4.4	3.0	6.3	5.7	5.1
2004 - 06	●	33	4.8	3.3	6.7	5.6	5.0
2005 - 07	●	30	4.3	2.9	6.1	5.5	4.9
2006 - 08	●	28	3.9	2.6	5.6	5.3	4.8
2007 - 09	●	24	3.3	2.1	4.9	5.0	4.7
2008 - 10	●	22	3.0	1.9	4.5	4.9	4.6
2009 - 11	●	29	3.9	2.6	5.5	4.7	4.4
2010 - 12	●	37	4.8	3.4	6.7	4.6	4.3
2011 - 13	●	39	5.2	3.7	7.1	4.4	4.1
2012 - 14	●	36	4.9	3.5	6.8	4.3	4.0
2013 - 15	●	30	4.2	2.8	6.0	4.2	3.9
2014 - 16	●	32	4.5	3.1	6.4	4.5	3.9
2015 - 17	●	28	4.0	2.7	5.8	4.6	3.9

Source: Office for National Statistics (ONS)

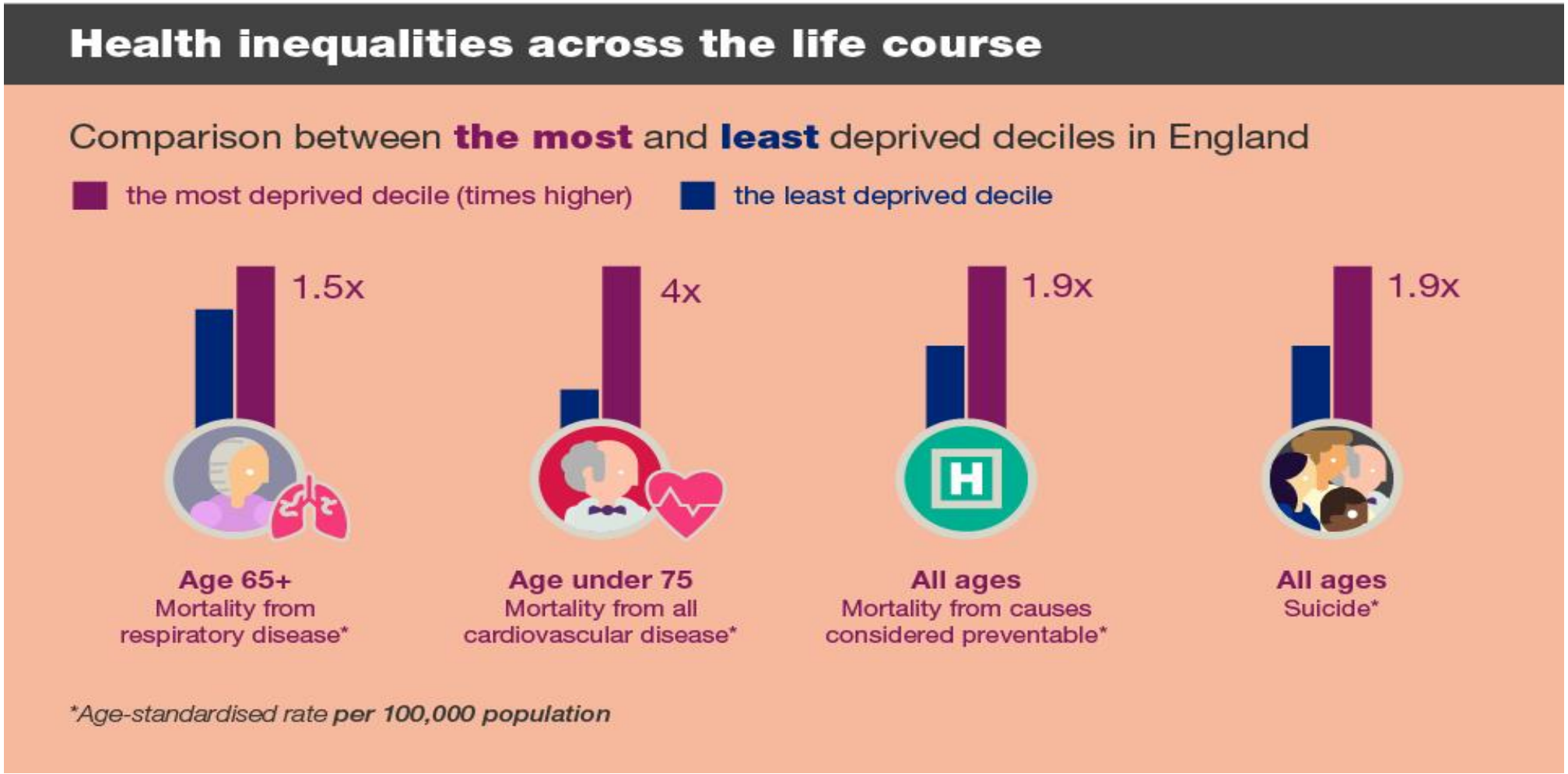
Impact of health inequalities across the life course

Public Health England

Health Matters



Impact of health inequalities across the life course



Cycle of Inequality

Breaking the Inter-Generational Cycle of Inequality in Bury

For more information please contact
Performance & Intelligence Team
Bury Council
PI.SDU@bury.gov.uk

BIRTH

2400 average number of babies born in Bury each year

408 (17.1%) babies are born into poverty

686 (28.6%) babies are bottle fed from birth

278 (11.6%) babies are born to mothers who smoke

59 (2.4%) babies are born with a low birth weight

CHILDHOOD

More Likely
- to be admitted to hospital
- fed nutritionally poor food
- Be known to Children's Social Care

Less Likely
- to achieve developmental milestones

574 (23.9%) children will be overweight or obese by reception (age 4-5)

5 children will be on a child protection plan

9 children will be place classified as a child in need

866 (36.1%) children will be overweight or obese by Year 6 (age 10-11)

751 (31.3%) children will not be school ready when starting school

ADOLESCENCE

More Likely
- to be overweight or obese
- have contact with the criminal justice system
- to have poor health/mental health
- Become a Looked After Child
- Misuse substances

Less Likely
- to achieve good educational outcomes
- Be physically active

118 (4.9%) children will be in the justice system

97 (3.9%) aged between 16 and 17 will not be in education, employment, training or activity will not be known

19 young people (between 15-24) will be admitted to hospital for substance misuse

216 (9%) children will have a mental health disorder between the age of 5 and 16 years

19 (0.8%) will become pregnant whilst a teenager

10 (0.42%) young people (between 16-24) will become homeless

ADULTHOOD

More Likely
- to live in poverty
- eat nutritionally poor food
- Have a Long Term Condition
- Suffer with poor mental health
- Die from a preventable condition

Less Likely
- to be employed
- exercise
- to achieve a good life expectancy
- to seek treatment for conditions early

9 (0.37%) will be long term unemployed as an adult (aged 16-64)

610 (25.4%) as adults aged 19+ will be physically inactive

269 (11.2%) will live in fuel poverty

62 (2.6%) will provide substantial (50+ hours) of unpaid care

1183 (49.3%) will not eat the recommended '5 a day' portions of fruit and veg

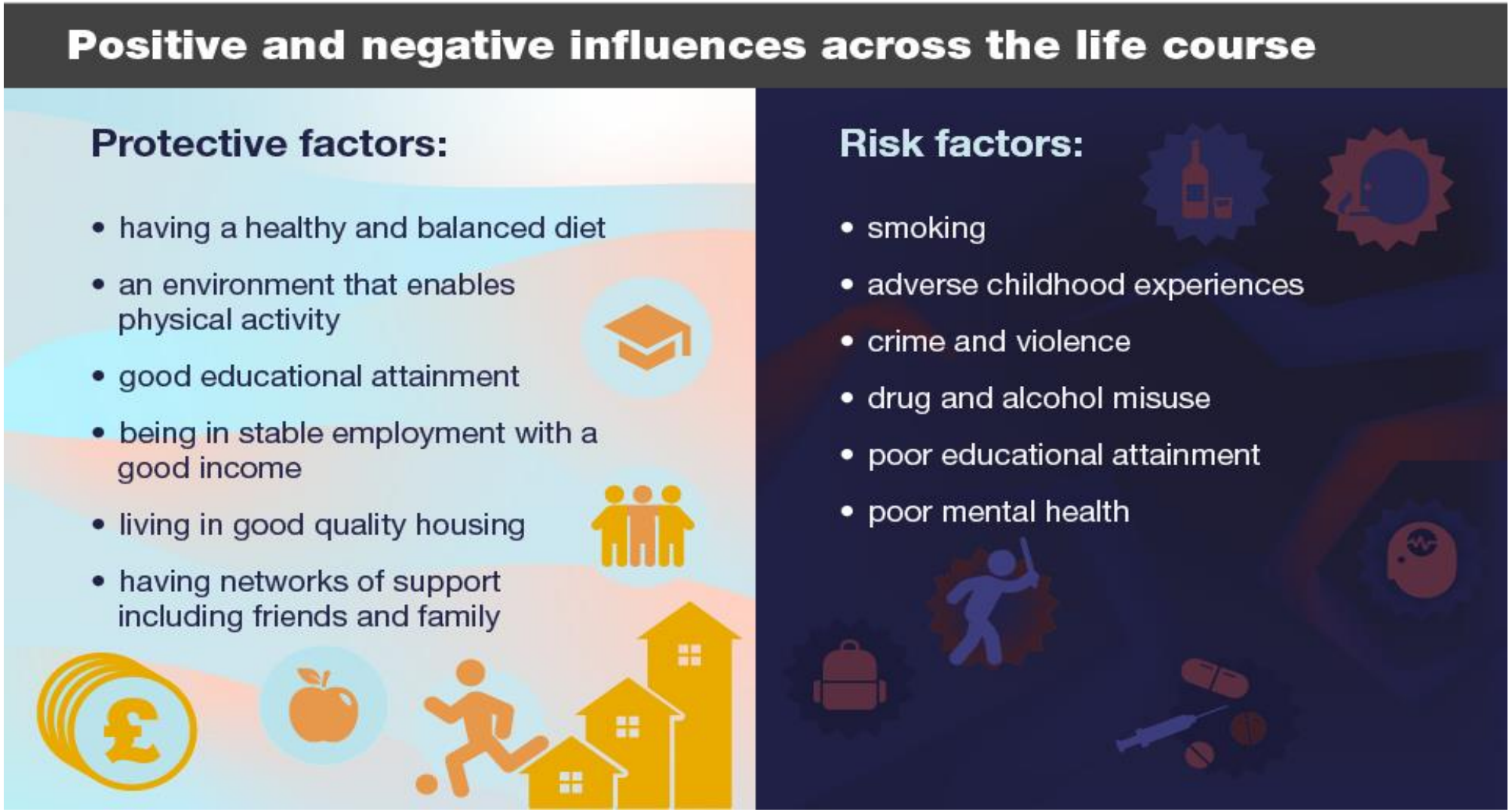
499 (20.8%) will have a long term health problem or disability

149 (6.2%) will report a long-term mental health condition

Influences on LE and HLE

Public Health England

Health Matters



What works in pre conception

- Being aware of screening before or during pregnancy
- Being up to date with all vaccinations before and during pregnancy
- Taking folic acid supplements
- Eating a healthy diet
- Being physically active
- Giving up smoking
- Not consuming alcohol

What Works In Pre Conception

O Healthy Lifestyle Factors	Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
I LM Percentage of adults drinking over 14 units of alcohol a week	LM 2014	26.3%	25.7%	–	→ 0	0% →
I A PHOF 2.03 - Smoking Status at time of delivery (SATOD) - Current Method	FY 2017/18	12.0%	10.8%	–	↗ 2	-28% ↓
I A PHOF 2.14 - Smoking prevalence in adults - current smokers (APS)	2017	16.3%	14.9%	–	↘ 2	-22% ↓
I A PHOF 2.13i Percentage of physically active adults	2017	63.6%	66.0%	–	↘ 1	-2% ↓
I BE PHOF 2.12 - Percentage of adults classified as overweight or obese	2018	64.3%	63.3%	–	→ 1	-3% ↓
I A PHOF 2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	FY 2017/18	46.4%	54.8%	–	↘ 2	-17% ↓
I A General fertility rate	2016	68.1%	62.5%	–	↗ 2	-3% ↓

Up to date with all Immunisations, Vaccinations and Screening	Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
PHOF 3.03iii - Population vaccination cover - Dtap/IPV/Hib (1 year old)	FY 2017/18	91.5%	93.1%	–	↘ 1	-1% ↓
PHOF 3.03iii - Population vaccination cover - Dtap/IPV/Hib (2 years old)	FY 2017/18	92.5%	95.1%	–	↘ 1	-3% ↓
PHOF 3.03i - Population vaccination cover age - Hepatitis B (1 year old)	FY 2017/18	39.0%	–	–	↘ 3	187% ↑
PHOF 3.03i - Population vaccination cover age - Hepatitis B (2 years old)	FY 2017/18	11.3%	–	–	↘ 3	18% ↑
PHOF 3.03iv - Population vaccination coverage - MenC	FY 2015/16	95.2%	1.0%	–	↗ 3	4% ↑
PHOF 3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	FY 2017/18	96.5%	94.9%	–	↗ 1	3% ↑
PHOF 3.03v - Population vaccination coverage - PCV	FY 2017/18	93.2%	93.3%	–	↘ 1	2% ↑
PHOF 3.03vi - Population vaccination coverage - Hib/MenC booster (2 years old)	FY 2017/18	91.5%	91.2%	–	↗ 1	1% ↑
PHOF 3.03vi - Population vaccination coverage - Hib/MenC booster (5 years old)	FY 2017/18	92.2%	92.4%	–	↗ 1	1% ↑
PHOF 3.03vii - Population vaccination coverage - PCV booster	FY 2017/18	87.9%	91.0%	–	↘ 4	-2% ↓
PHOF 3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	FY 2017/18	92.0%	91.2%	–	↗ 1	3% ↑
PHOF 3.03x - Population vaccination coverage - MMR for two doses (5 years old)	FY 2017/18	88.3%	87.2%	–	↘ 3	7% ↑
PHOF 2.20xii - Newborn Hearing Screening - Coverage	FY 2017/18	98.3%	98.9%	–	↗ 3	3% ↑
PHOF 2.20xi - Newborn Blood Spot Screening - Coverage	FY 2015/16	98.8%	95.6%	–	↘ 1	0% →
3.03xii - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old)	FY 2017/18	79.4%	86.9%	–	↗ 1	-11% ↓
3.03xvi - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old)	FY 2017/18	78.7%	83.8%	–	↘ 2	-4% ↓
3.03xv - Population vaccination coverage - Flu (at risk individuals)	FY 2017/18	50.1%	50.4%	–	↘ 1	10% ↑

What works in infancy

Investment in early childhood, child and adolescent health and development, and preconception, pregnancy and childbirth care can yield a 10-to-1 benefit to cost ratio in health, social and economic benefits. It can also reduce rates of mental health disorders and non-communicable diseases in later life.

Early language impacts on many areas of child development; it contributes to children's ability to:

- manage emotions and communicate feelings
- establish and maintain relationships
- think symbolically
- learn to read and write

Almost all children learn to communicate through language, yet there are strong and persistent differences in their ability to do so, with a pronounced social gradient in early language acquisition. The link between language and other social, emotional and learning outcomes makes early language a primary indicator of child wellbeing.

What Works In Infancy Scorecard

O Ages and Stages Questionnaire 3 (2 - 2 1/2 Year Check)	Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
I A Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	FY 2017/18	68.2%	90.2%	–	↘ 1	-32% ↓
I A Percentage of children at or above expected level of development in all five areas of development at 2-2½ years	FY 2017/18	76.7%	83.3%	–	→ 0	0% →
I A Percentage of children at or above expected level of development in communication skills at 2-2½ years	FY 2017/18	91.6%	88.8%	–	→ 0	0% →
I A Percentage of children at or above expected level of development in gross motor skills at 2-2½ years	FY 2017/18	88.1%	91.5%	–	→ 0	0% →
I A Percentage of children at or above expected level of development in fine motor skills at 2-2½ years	FY 2017/18	90.8%	92.0%	–	→ 0	0% →
I A Percentage of children at or above expected level of development in problem solving skills at 2-2½ years	FY 2017/18	93.7%	91.9%	–	→ 0	0% →
I A Percentage of children at or above expected level of development in personal-social skills at 2-2½ years	FY 2017/18	94.7%	91.3%	–	→ 0	0% →

Good Level of Development at the End of Reception/EYFS	Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
PHOF 1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception (Female)	FY 2017/18	75.7%	78.4%	–	↘ 1	28% ↑
PHOF 1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception (Male)	FY 2017/18	66.3%	65.0%	–	↗ 1	52% ↑
PHOF 1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception (Persons)	FY 2017/18	70.9%	71.5%	–	↗ 1	38% ↑
PHOF 1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Female)	FY 2017/18	58.5%	65.0%	–	↘ 1	51% ↑
PHOF 1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Male)	FY 2017/18	53.2%	48.6%	–	↘ 1	117% ↑
PHOF 1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception (Persons)	FY 2017/18	55.9%	56.6%	–	↘ 1	76% ↑

Foundation Stage Profile	Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
% Good level of development achieved - Pupils with SEN, without statement	2018	32.0%	28.0%	–	↗ 2	191% ↑
% of children achieving at least the expected level in FSP - Communication and Language	2018	85.2%	82.4%	–	↗ 5	23% ↑
% of children achieving at least the expected level in FSP - Personal, social and emotional development	2018	87.2%	85.2%	–	↗ 1	22% ↑

What works for 5-19

- Tackling vulnerabilities and adverse childhood experiences
- Supporting young peoples mental health and wellbeing
- Improving educational attainment
- Tackling tobacco, alcohol and drug use
- Reducing teenage pregnancies
- Increasing uptake of vaccination programme

What Works for 5-19

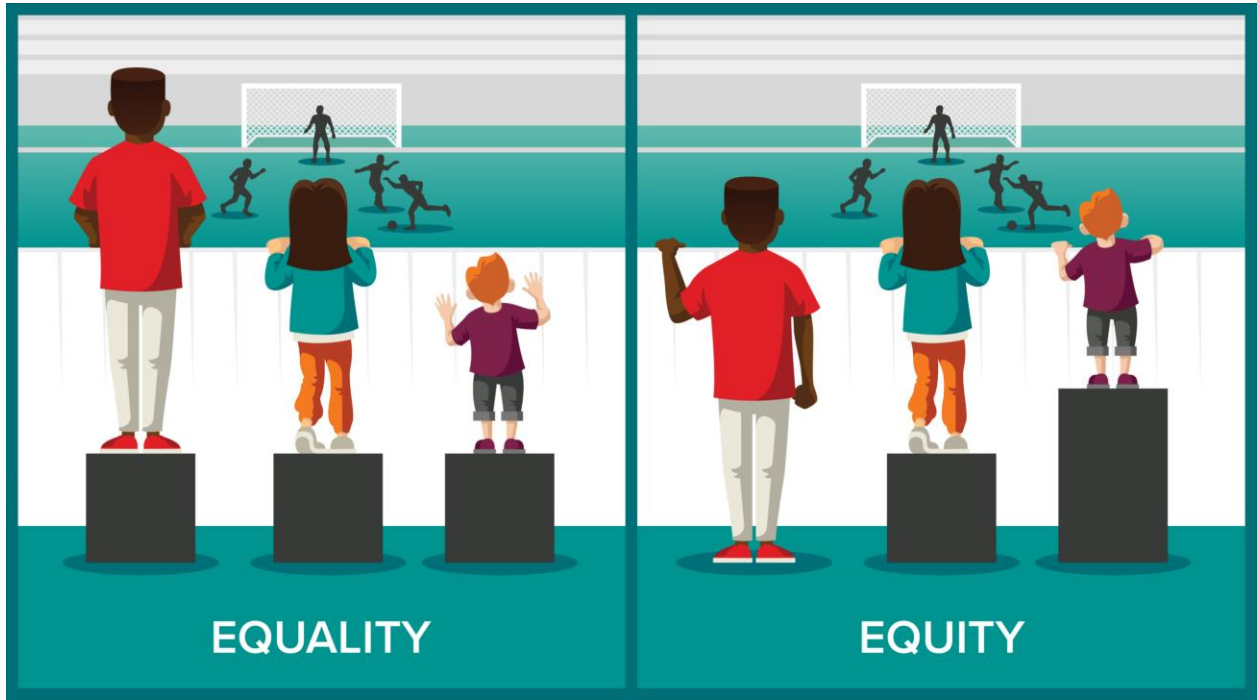
Good Mental and Physical, Health and Wellbeing	Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
PHOF 2.04 - Under 16s conception rate	2017	4.3	2.7	–	↗ 1	-35% ↓
PHOF 2.04 - Under 18 conception rate	2017	17.0	17.8	–	↘ 2	-69% ↓
PHOF 2.07i - Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years	FY 2015/16	132.1	104.2	–	↗ 1	-7% ↓
Estimated prevalence of mental health disorders in children and young people: % population aged 5-16	2015	9.0%	9.2%	–	↘ 1	0% →
Estimated prevalence of emotional disorders: % population aged 5-16	2015	3.5%	3.6%	–	↘ 1	-1% ↓
Estimated prevalence of conduct disorders: % population aged 5-16	2015	5.4%	5.6%	–	↘ 1	0% →
PHOF 2.09i Smoking prevalence at age 15 - current smokers (WAY survey)	FY 2014/15	8.7%	8.2%	–	→ 0	0% →
Percentage who have tried e-cigarettes at age 15	FY 2014/15	24.2%	18.4%	–	→ 0	0% →
Percentage of regular drinkers at age 15	FY 2014/15	7.1%	6.2%	–	→ 0	0% →
Percentage who have taken cannabis in the last month at age 15	FY 2014/15	4.8%	4.6%	–	→ 0	0% →
Percentage who have taken drugs (excluding cannabis) in the last month at age 15	FY 2014/15	0.7%	0.9%	–	→ 0	0% →
Percentage reporting low life satisfaction at age 15	FY 2014/15	12.7%	13.7%	–	→ 0	0% →

O Good Educational Attainment	Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
I A Percentage of Pupils achieving the expected level in Phonics decoding	2018	82.0%	82.0%	–	↗ 1	44% ↑
I A Key Stage 2 - Expected Standard in Reading, Writing and Mathematics	2018	64%	64%	–	↗ 2	16% ↑
I A % pupils achieving 5 GCSEs at grades A*-C including English and maths	2016	57.3 %	54.9 %	–	↗ 1	-9% ↓
I A Average Attainment 8 score per pupil	2018	45.2	44.5	–	↘ 2	-9% ↓
I A PHOF 1.05 - % of 16-17 year olds not in education, employment or training (NEET)	2017	4.0%	6.0%	–	↗ 2	-39% ↓
I A Level 3 Qualification By The Age of 19	2018	60%	57%	–	↘ 1	22% ↑

What works for 16-64

- Using Making Every Contact Count (MECC) at scale
- Increasing health check uptake
- Improving employment opportunities, earnings and workplace health
- Improving mental wellbeing and mental health
- Improving musculoskeletal health
- Increasing screening uptake

[What Works for 16-64]



		Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
O	Quality Skills, Employment and Workplace Health and Wellbeing						
I A	PHOF 1.09ii - Sickness absence - the percentage of employees who had at least one day off in the previous week	3YC 2017	1.5%	2.1%	–	↘ 2	-40% ↓
I A	% of working age residents aged 16-64, who have obtained qualifications equivalent to NVQ4 and above	2016	39.1%	38.2%	–	↗ 2	52% ↑
I Q	Employment rate 16-64	Q3 2017/18	73.4%	74.9%	–	↗ 1	2% ↑
I A	Percentage of employees over the age of 50	2016	35.7%	–	–	→ 0	0% →
I A	PHOF 1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	FY 2015/16	11.5%	8.6%	–	↗ 1	6% ↑
I A	ASCOF 1F - Proportion of adults in contact with secondary mental health services in paid employment	FY 2017/18	4.0%	7.0%	–	↗ 2	43% ↑
I A	PHOF 1.08iii - The percentage point gap between the employment rate for those in contact with secondary mental health services and the overall employment rate (persons)	FY 2014/15	72.3%	66.1%	–	↗ 1	5% ↑
I A	Median earnings of Bury residents	2018	£27,466	£28,751	–	↗ 1	26% ↑
I A	PHOF 2.14 - Smoking prevalence in adults - current smokers (APS)	2017	16.3%	14.9%	–	↘ 2	-22% ↓
I A	Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers (APS)	2017	29.4%	25.7%	–	↘ 4	-25% ↓
O	Good Musculoskeletal Health						
I A	% reporting a long term MSK problem	FY 2017/18	19.1%	17.0%	–	↗ 1	8% ↑
I A	PHOF 2.13i Percentage of physically active adults	2017	63.6%	66.0%	–	↘ 1	-2% ↓
I A	PHOF 2.12 - Percentage of adults classified as overweight or obese	2018	64.3%	63.3%	–	→ 1	-3% ↓

		Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
O	**High Mental Health and Wellbeing**						
I A	ASCOF 1H - Proportion of adults in contact with secondary mental health services living independently, with or without support	FY 2017/18	63.0%	57.0%	–	↗ 2	34% ↑
I A	Long-term mental health problems (GP Patient Survey): % of respondents (aged 18+)	FY 2017/18	9.7%	9.1%	–	↗ 1	162% ↑
I A	2.23i - Self-reported wellbeing - people with a low satisfaction score	FY 2017/18	4.7%	4.4%	–	↘ 1	-37% ↓
I A	2.23ii - Self-reported wellbeing - people with a low worthwhile score	FY 2016/17	5.3%	3.6%	–	↗ 2	-10% ↓
I A	2.23iii - Self-reported wellbeing - people with a low happiness score	FY 2017/18	8.1%	8.2%	–	↘ 1	-31% ↓
I A	2.23iv - Self-reported wellbeing - people with a high anxiety score	FY 2017/18	22.7%	20.0%	–	↘ 2	-1% ↓
O	**Increased uptake for Screening and NHS Health Checks**	Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
I A	2.20i - Cancer screening coverage - breast cancer	2018	76.1%	74.9%	–	↘ 1	-2% ↓
I A	2.20ii - Cancer screening coverage - cervical cancer	2018	72.7%	71.4%	–	↘ 7	-2% ↓
I A	2.20iii Cancer screening coverage - bowel cancer	2018	59.7%	59.0%	–	↗ 3	9% ↑
I A	2.20iv - Abdominal Aortic Aneurysm Screening - Coverage	FY 2017/18	80.8%	80.8%	–	↗ 1	1% ↑
I A	2.22iv - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	QM 2018	72.6%	48.7%	–	→ 0	0% →

Good Uptake for Vaccinations	Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
PHOF 3.03i - Population vaccination cover age - Hepatitis B (1 year old)	FY 2017/18	39.0%	–	–	↘ 3	187% ↑
PHOF 3.03i - Population vaccination cover age - Hepatitis B (2 years old)	FY 2017/18	11.3%	–	–	↘ 3	18% ↑
PHOF 3.03iii - Population vaccination cover - Dtap/IPV/Hib (1 year old)	FY 2017/18	91.5%	93.1%	–	↘ 1	-1% ↓
PHOF 3.03iii - Population vaccination cover - Dtap/IPV/Hib (2 years old)	FY 2017/18	92.5%	95.1%	–	↘ 1	-3% ↓
PHOF 3.03iv - Population vaccination coverage - MenC	FY 2015/16	95.2%	1.0%	–	↗ 3	4% ↑
PHOF 3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	FY 2017/18	96.5%	94.9%	–	↗ 1	3% ↑
PHOF 3.03v - Population vaccination coverage - PCV	FY 2017/18	93.2%	93.3%	–	↘ 1	2% ↑
PHOF 3.03vi - Population vaccination coverage - Hib/MenC booster (2 years old)	FY 2017/18	91.5%	91.2%	–	↗ 1	1% ↑
PHOF 3.03vi - Population vaccination coverage - Hib/MenC booster (5 years old)	FY 2017/18	92.2%	92.4%	–	↗ 1	1% ↑
PHOF 3.03vii - Population vaccination coverage - PCV booster	FY 2017/18	87.9%	91.0%	–	↘ 4	-2% ↓
PHOF 3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	FY 2017/18	92.0%	91.2%	–	↗ 1	3% ↑
PHOF 3.03x - Population vaccination coverage - MMR for two doses (5 years old)	FY 2017/18	88.3%	87.2%	–	↘ 3	7% ↑
3.03xii - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old)	FY 2017/18	79.4%	86.9%	–	↗ 1	-11% ↓
3.03xvi - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old)	FY 2017/18	78.7%	83.8%	–	↘ 2	-4% ↓

What works for the over 65

- Access to good employment
- Reduced crime and perceptions of crime
- Suitable housing and built environment
- Good uptake of vaccination
- Maintaining functional ability: brain and body
- Good falls prevention programme
- Preventing loneliness and isolation

What Works for the Over 65

			Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
O		Good Uptake for Age Specific Vaccinations						
I	A	3.03xiii - Population vaccination coverage - PPV (pneumococcal infection)	FY 2017/18	66.3%	69.5%	–	↘ 2	6% ↑
I	A	3.03xiv - Population vaccination coverage - Flu (aged 65+)	FY 2017/18	76.8%	72.6%	–	↗ 1	7% ↑
I	A	3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old)	FY 2017/18	41.5%	44.4%	–	→ 0	0% →
O		Access to good quality suitable Housing						
I	M	Number of housing units completed in the Borough that are affordable	FY 2016/17	385	–	–	→ 0	0% →
I	GMOF	Percentage of (all) housing stock empty for over 6 months	2018	1.49%	0.86%	–	→ 0	0% →
I	A	The number of affordable housing units proposed to be built on sites that have detailed planning permissions	2016	327	–	–	→ 0	0% →
O		Prevention of Premature Mortality						
I	A	PHOF 3.01 - Fraction of mortality attributable to particulate air pollution	2016	4.9%	5.3%	–	↗ 1	-11% ↓
I	A	PHOF 1.16 - Utilisation of outdoor space for exercise/health reasons	2016	17.9%	17.9%	–	↘ 1	46% ↑
I	A	Emissions of Carbon Dioxide (ktonnes per capita)	2016	4.8 kTpC	4.6 kTpC	–	↘ 4	-34% ↓

		Most Recent Period	Current Actual Value	Current Target Value	Next Period Forecast Value	Current Trend	Baseline % Change
O	**Maintaining good Functional Ability**						
I A	% reporting a long term MSK problem	FY 2017/18	19.1%	17.0%	–	↗ 1	8% ↑
I A	PHOF 4.16 - Estimated dementia diagnosis rate (aged 65+)	2017	85	68	–	→ 0	0% →
O	**Reduction in Loneliness and Isolation**						
I A	PHOF 1.18i - Social isolation: percentage of adult social care users who have much social contact as they would like	FY 2016/17	45.7%	45.4%	–	↘ 1	5% ↑
I BE	PHOF 1.18ii - Social Isolation: Percentage of adult carers who have as much social contact as they would like	FY 2016/17	26.2%	35.5%	–	↘ 2	-44% ↓
I A	Older people living alone: % of households occupied by a single person aged 65 or over	2011	12.4%	12.4%	–	→ 0	0% →
O	**Prevention and Reduction of Falls**						
I A	PHOF 2.24i - Emergency hospital admissions due to falls in people aged 65 and over (per 100,000 population)	2018	2,170	2,178	–	↗ 1	-2% ↓
I A	PHOF 4.14i - Hip fractures in people aged 65 and over	FY 2016/17	594	575	–	↘ 1	-13% ↓
I A	Osteoporosis: QOF prevalence (50+)	FY 2017/18	0.6%	0.6%	–	↗ 3	200% ↑

Actions to promote **health equity** and tackle **health inequalities** across **the life course**

1. Build healthy and resilient communities
2. Adopt a place-based approach to health
3. Tackle housing and fuel poverty
4. Take action on poverty and health
5. Take action on health and justice

Next steps

- Neighbourhood profiles
- Widening of the data sets included
- Improved granularity of data
- Automation

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Scrutiny Report

Agenda Item	

MEETING: HEALTH AND OVERVIEW AND SCRUTINY COMMITTEE

DATE: June 2019

SUBJECT: DEVELOPMENT OF A WORK PROGRAMME FOR 2019/2020

REPORT FROM: Principal Democratic Services Officer

CONTACT OFFICER: Julie Gallagher

1.0 SUMMARY

This report sets out details of potential items to assist in the development of a Work Programme for 2019/2020.

2.0 MATTERS FOR CONSIDERATION/DECISION

Members of the Health Scrutiny Committee are requested to:

Agree and set an Annual Work Programme for the 2019/20 Municipal year.

3.0 HEALTH OVERVIEW AND SCRUTINY COMMITTEE – TERMS OF REFERENCE.

The terms of reference state that the primary purpose of the Health Scrutiny Committee is:

- To carry out the Council's statutory obligations in relation to reviewing and scrutinising any matters relating to the planning provision and operation of health services in the area of the Council.
- To oversee the health and wellbeing of the Borough's population.
- To Scrutinise the provision, planning and management of Adult Care Services.
- To monitor the implementation of any scrutiny recommendations accepted by the Cabinet.

4.0 WORK PROGRAMME 2019/2020

4.1 The Health Scrutiny Committee is required to set a work programme for 2019/2020 which it will monitor throughout the year.

4.2 The Work Programme of the Health Scrutiny Committee will need careful consideration, bearing in mind the resources available, time constraints of Members and also the interests of the local community.

4.3 Work undertaken in the municipal year 2018/19

- Proposed Changes to In-vetro fertilisation
- Transformation
- Autism Spectrum Disorder
- Persona Care
- Delayed Discharge
- Urgent Care Redesign
- Transformation
- North east sector clinical transformation
- GP extended hours service

5.0 TOPICS IDENTIFIED

The topics identified have been split into two categories:

1. Topics that the Health O&S Committee may wish to re-visit
2. Topics not previously scrutinised by the Health O&S Committee

Suggested item	Context	Methodology	Outcome
Topics to be revisited or for further consideration:			
Delayed Discharge	• Monitor Bury's Performance against GM performance criteria.	Interview representatives from the Local Authority and the Acute Trust – Julie Gonda to lead	
North East Sector Clinical Transformation Update	• Implementation of the proposals • Proposals paused once re-started, report to scrutiny	Interview Representatives from the CCG/Acute Trust/GM Margaret O'Dwyer/Geoff Little to lead	Receive assurance in respect of the changes
Residential Care Top Up Fees	• Following discussions in respect of changes as a Result of the Care Act, Members raised concerns with regards to the impact of the introduction of top up fees	Interview representatives from LA - Julie Gonda to lead	Receive assurances in respect of casework concerns members have raised.
Neuro Rehabilitation Update	• Following discussions at a previous meeting in respect of a new proposals for service delivery, members wanted further information in respect of how the service has been embedded, performance against KPIs	Interview representatives from the CCG – Cath Tickle, Commissioning Programme Manager Howard Hughes, Clinical Director Bury CCG	Review KPIs
Additional items for consideration....	**1. Adults Complaints Report** **2. Items as identified on the Cabinet forward plan/HWB**		

New topics			
Health and Social Care reform • **OCO** • **LCA** • **JSNA**	Will be proposed that this is a standing agenda item for this year in light of the large scale proposed changes.	Present at the first meeting will be: Geoff Little Kath Wynne Jones Chris O'Gorman Lesley Jones	Standing agenda item, members will need to be regularly updated
Update from the CCG in respect of the Pennine Care Foundation Trust (September 2019)	Update from the CCG in respect of the Trust	Interview representatives from the CCG and the Trust – Margret O'Dwyer to lead	Members to receive assurances in respect of the commissioning and the provision of Community and mental health services
Health Visitors (September 2019)	Update on transfer into LA	Lesley Jones and Petra Hayes Bower to present.	Inform Councillors of the implications and changes of the transfer of Health visitors into the LA
GP Extended Hours and Access to Primary Care – GP Contract Changes (TBC)	Roll out of the extended access to primary care and changes to the GP contracts	Clinical Representatives (GP) (Martin Clayton) CCG representative (Marie Clayton)	Members to receive assurances that the extended hours align with the urgent care proposals and the development of the LCO.
Persona Update (September 2019)	Update following the transfer of staff from the LA to new company. Members have asked for further information in respect of complaints and also staff sickness levels	Invite representatives from Persona and the LA to update – Kat Sowden to lead	Members to receive assurance with regards to the progress and performance since the establishment of Persona.
Carers Update (TBC)	Update members on the services and support currently provided and future plans	Julie Gonda to lead with other officers	
Mental Health Update (TBC)	Inform members of the joint work been undertaken with the OCO	Julie Gonda to lead with other officers	

Improving Specialist Care Programme (TBC)	Inform members of the work been undertaken	Margaret O'Dwyer to lead	
Learning Disability (TBC)	Update regarding the Bury Plan and local delivery	Julie Gonda to lead with other officers	

6.0 CONCLUSION

A well thought out and effective Work Programme, focused on outcomes will strengthen the role of Health Scrutiny within the Council and more widely with partners and stakeholders.

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