SHADOW HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

16th January 2012

at 10.00 a.m.

in Committee Room 'B',
Civic Centre, Hartlepool

MEMBERS: SHADOW HEALTH AND WELLBEING BOARD

Voting Members (statutory members)

Directly Elected Mayor, Executive Members of the Local Authority, Chief Executive of Local Authority, Representative of Clinical Commissioning Group, Chief Executive/Director of the PCT (transitional arrangements until 2013), Director of Public Health, Director of Child and Adult Social Services, HealthWatch Board Member, Representative of the NHS Commissioning Board, Patient Representative.

Non-Voting Members (non-statutory members)

Director of Regeneration and Neighbourhoods, North Tees and Hartlepool NHS Foundation Trust, Tees Esk and Wear Valley NHS Trust, Voluntary Sector Representative(s), North East Ambulance NHS Trust.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST**

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 21st November 2011 *(attached)*

4. **MATTERS ARISING FROM MINUTES**

   4.1 Development of Immunisation Strategy- Verbal Update, Assistant Director, Health Improvement
   4.2 Health and Wellbeing Strategy - Verbal Update, Assistant Director, Health Improvement

5. **ITEM FOR INFORMATION**

5.1 Public Health Update – Verbal Update, Assistant Director, Health Improvement

5.2 Healthworks: Annual Health and Wellbeing Report – November 2011 (North Tees Foundation Trust) *(attached)*

5.3 Letter from David Behan, Director General for Social Care, Local Government and Care Partnerships at the Department of Health *(attached)*

6. **ITEMS REQUIRING DECISION**

None

7. ITEM FOR DISCUSSION

7.1 Presentation on the following:-
(i) Clinical Commissioning Group – Proposed Configuration *(attached)*
(ii) Clinical Commissioning Group – Good Health – Everybody's Business; A Clear and Credible Plan for Commissioning Health Services for the Populations of Hartlepool and Stockton-on-Tees (*attached)*

7.2 Excess Seasonal Deaths and Winter Warmth – Presentation, Assistant Director, Health Improvement and Cleveland Fire Authority Representative

8. FUTURE AGENDA ITEMS

27th February (1.00 p.m.)
(i) Reablement
(ii) Immunisation Strategy for approval

9. ANY OTHER BUSINESS

9.1 'Mind the Hunger Gap' – Assistant Director, Health Improvement
9.2 North East Leadership Academy – Assistant Director, Health Improvement

SHADOW HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

21st November 2011

The meeting commenced at 2.00 pm in the Civic Centre, Hartlepool

Present:

The Mayor, Stuart Drummond - In the Chair

Statutory Members

Councillors: Robbie Payne (Deputy Mayor) (Finance and Procurement Portfolio Holder),
Pam Hargreaves (Transport and Neighbourhoods Portfolio Holder),
Gerard Hall (Adult and Public Health Services Portfolio Holder).
Chris Simmons (Children's Services Portfolio Holder),

Nicola Bailey, Acting Chief Executive
Jill Harrison, Assistant Director, Adult Social Care
Louise Wallace, Assistant Director, Health Improvement

John Bentley, Hartlepool PCT
Christopher Akers-Belcher, Hartlepool LINKs Co-ordinator
Dr Paul Pagni, representing Clinical Commissioning Group

Non Statutory Members:

Carole Langrick, Deputy Chief Exec, North Tees and Hartlepool NHS Foundation Trust
Dave Stubbs, Director of Regeneration and Neighbourhoods

Also present representing North East Health Protection Unit:

Peter Acheson, Consultant in Health Protection
Paul Davison, Unit Director
Julia Waller, Senior Nurse

In attendance as Substitutes:

David Brown as substitute for Martin Barkley, Tees, Esk and Wear Valleys NHS Foundation Trust
Ron Foreman as substitute for Margaret Wrenn, Hartlepool LINK

Officers: Sarah Bowman, Speciality Registrar Public Health, NHS Tees
Catherine Frank, Partnerships Manager, HBC
Alison Wilson, Director of Health Systems Development, NHS Hartlepool
Amanda Whitaker, Democratic Services Team Manager, HBC

12. Apologies for Absence

Councillor Jonathan Brash (Housing and Transition Portfolio Holder), Councillor Peter Jackson (Regeneration and Economic Development and Skills Portfolio Holder), Councillor H Thompson (Performance Portfolio Holder),Martin Barkley, Tees, Esk and Wear Valley NHS Trust, Margaret Wrenn, Hartlepool LINK,

13. Declarations of interest by Members

None

14. Appointment of Vice Chair

Dr Pagni was appointed Vice-Chair of the Shadow Board

15. Presentation – North East Health Protection Unit including Immunisation

The Shadow Board received a comprehensive presentation by Peter Acheson, Consultant in Public Health and Paul Davison, Unit Director.
The presentation covered the core principles of health protection, the support and advice provided by the Health Protection Agency, known implications of 'Healthy Lives, Healthy People' and issues which were specific to Hartlepool Borough Council. Julia Waller, Senior Nurse also provided the Shadow Board with a comprehensive presentation which addressed issues associated with reducing the difference in immunisation uptake in Hartlepool. It was noted that Hartlepool currently fell short of the World Health Organisation target of 95% of children immunised by their first birthday and that Hartlepool was second worse performing Primary Care Trust (PCT) in the North East in terms of numbers of children completing a primary course of immunisation. Children and young people who were most at risk of not being immunised were detailed. Julia highlighted variations by GP practice and the consequences of not increasing uptake. The Board noted the benefits arising from the Immunisation Strategy which had been produced by Salford PCT.

The Shadow Board discussed issues arising from the presentations including the need for a child health information system to record immunisation details. The Board recognised that the immunisation data which had been provided, in terms of immunisations generally, was not acceptable. Grave concerns were expressed regarding the implications and

the risks associated with the data. Members of the Board agreed that the object of the Shadow Board was to 'make a difference' and commitment to address the issue of immunisation uptake was expressed by Board Members. The benefits of effective targeting whilst increasing awareness were recognised together with a role for the media. It was further recognised that it was important to recognise why immunisation levels were low and to consider the role which could be played by schools/school nurses. As a Local Authority, the Council had adopted a number of Strategies and it was acknowledged that the issue of immunisation should be included within the Council's Strategies whenever appropriate.

At the conclusion of discussions, it was agreed that this Shadow Board should have a Strategy or Work Plan which articulated the issues highlighted at the meeting and which fed back to the Board on a regular basis.

Decision

The Assistant Director, Health Improvement, undertook to liaise with all agencies with a view to producing a Strategy addressing the issues raised at the meeting and to arrange for related reports to be submitted to the Board quarterly.

16. Minutes

The minutes of the meeting held on 10th October 2011 were confirmed.

17. Matters Arising from Minutes

(i) Composition of Board – concerns which had been expressed at the previous meeting were reiterated, particularly in relation to community representation. It was agreed that the composition of the Shadow Board should be an issue to be regularly reviewed by the Board.

(ii) Member Development Needs – It was agreed that this issue should be kept on agenda in order that it could be pursued when/if appropriate.

(iii) HealthWatch – Key Messages – A document which had been prepared by the Hartlepool LINKs Co-ordinator had been circulated with the agenda and was noted by the Shadow Board.

(iv) Association of North East Councils – Improving Health Task and Finish Group Report - The report had been circulated with the agenda. The Shadow Board commended the report and discussed the salient issues which had been highlighted by the report. The Assistant Director, Health Improvement suggested that the recommendations included in the Board be revisited by the Shadow Board in approximately 3 months.

(v) Future Meeting Dates – Suggested future meeting dates for the Shadow Board had been circulated. It was agreed that the Board should continue to meet on a Monday, on dates which alternated with those when meetings of Cabinet were scheduled.

18. Operating Principles for Health and Wellbeing Board

A paper had been circulated which set out operating principles and accompanying narrative to support the effective establishment and functioning of health and wellbeing boards. The principles were intended to help board members consider how to create really effective partnerships across local government and the NHS.

Decision

The paper was noted.

19. Update of Public Health Transition

Nicola Bailey, Acting Chief Executive, advised the Shadow Board that a report would be submitted to the Council's Cabinet, at beginning of December, on public health transition arrangements. The report would address issues including the role and function of public health and options regarding the role of the Director of Public Health in the light of the Public Health White Paper 'Healthy People Healthy Lives'. This would include a transition plan for the transferring of responsibility for public health from Hartlepool Primary Care Trust (PCT) to Hartlepool Council. Transition Plans were required to be submitted to the Regional Director of Public Health by end 2012.

Following the update by the Acting Chief Executive, discussion took place on issues relating to public health budgets and resources and the provision of public health regionally. Communication issues were also highlighted for consideration in the context of the proposed arrangements.

Decision

The update was noted.

20. NHS Cold Weather Plan for England 2011/12 – Protecting Health and Reducing Harm from Severe Cold

The NHS Cold Weather Plan for England 2011/12 had been circulated. The document sets out the arrangements that will apply, and the actions that can be taken in advance of, and during, a spell of severe cold weather. It was noted that four levels of intervention had been identified depending on the risk of severe winter weather. Guidance was provided on how to reduce the impact that severe cold weather had upon health and, in doing so, save lives.

During the discussion which followed presentation of the report, reference was made to the Warm Homes, Healthy People fund which had been established for winter 2011/12. Board Members were assured that bids to access the fund would be submitted by the required deadline of December. The Assistant Director, Adult Social Care updated the Board on work that was being undertaken with Cleveland Fire Authority to address issues including fuel poverty, snow clearance and safe heating. It was hoped at the end of the programme that a report would be drafted to determine the success of the initiative and that a copy of that report could be submitted to a future meeting of this Shadow Board. In the meantime, it was agreed that a report be submitted to the next meeting of the Board to determine if there were any actions that Board Members could progress.

Decision
That a report be submitted to the next meeting of this Shadow Board to identify if any action needs to be taken by the Board in relation to this issue.

21. Framework – Draft Joint Health and Wellbeing Strategy (*Speciality Registrar in Public Health, NHS Tees*)

The Speciality Registrar in Public Health presented a report which proposed the draft framework for the Hartlepool Joint Health and Wellbeing Strategy. The proposed process for developing the Strategy had been agreed at the Shadow Board meeting held on 10th October 2011. A Task and Finish Group had subsequently met on 3rd November to discuss the framework, the content of which was set out in the report.

Board Members were anxious to ensure that tangible issues, which allowed the Board to 'make a difference', were identified in the document and that engagement with commissioners and providers were vital to the way forward. It was highlighted also that it was important that sufficient time was dedicated to exploring issues fully.

Decision

That further detailed consideration be given to the Strategy at the next meeting of the Shadow Board.

22. Any Other Business

(i) Future Meetings – Board Members were asked to consider venues for future meetings of the Board and were requested to advise Amanda Whitaker, Democratic Services Team, of any suggested venues.

(ii) Membership Forms – Forms had been tabled at the meeting. Board Members were requested to complete the forms and return to Amanda Whitaker, Democratic Services Team.

The meeting concluded at 4 p.m.

CHAIR

North Tees and Hartlepool NHS
NHS Foundation Trust

Healthworks

Annual Health and Wellbeing Report

November 2011

Contents

Foreword

While preventing ill health and promoting good health might have been seen as a function of primary care, hospitals have always had an important role in this area. Traditionally this role might have been secondary prevention; in other words offering patients the information and support they need to prevent a reoccurrence of the illness that brought them into our service in the first place. Obviously examples might be dietary advice for a person with heart disease or stop smoking information for a person with chest disease.

These activities of course are valuable, have their place and will continue. However the Trust, in line with government policy and working closely with its partners in health and social care, is more concerned about concentrating its activities where they can have the best effect. As our population and its needs change, we know that a reactive service and doing more of the same will not provide the solution needed. The founding principles of the NHS included preventing ill health and promoting good health as well as caring for those who are sick. Hospitals have been viewed as the sickness end of that continuum but in truth this has never been the sole purpose of hospitals and with the integrated acute and community service now provided at North Tees and Hartlepool NHS Foundation Trust we are now in the best position ever to offer a truly holistic health and wellbeing service alongside the vitally important job of caring for those who are sick.

Every contact with a patient is a health and wellbeing opportunity. We believe we have had a great deal of success in this area but we plan to ensure that every occasion is maximised.

There has been nothing short of a revolution in healthcare and, thanks to the vision and leadership of the clinicians in the Trust we are at the leading edge. To take one example the care of people with diabetes has undergone a radical transformation. Much work is directed into preventing people from developing diabetes and we support and educate many patients about this. But if a person is diagnosed then care, far from being concentrated in hospital with the patient a passive recipient of the care, is provided in the community with an education programme which puts the patient in the driving seat in terms of living with their condition.

This first Healthworks report is a summary of our activities in the past year. It provides a firm foundation for our future commitment to the health and wellbeing of the people we serve and our staff whose own health and wellbeing is a vital ingredient to their ability to continue to provide a first class service for local people.

I commend this report to you.

Carole Langrick
Deputy Chief Executive / Director of Strategic Development
North Tees and Hartlepool NHS Foundation Trust

Introduction

Welcome to our first edition of Healthworks.

Healthworks is the name we have given to North Tees & Hartlepool NHS Foundation Trust's Annual Report on Health & Wellbeing.

An annual report on our contribution to improving the health and wellbeing of the people to whom we provide services is entirely appropriate and long overdue because our role in health and wellbeing is multiple and the extent of it is not always fully recognised. We are truly a cradle to the grave service and provide care, help, support and treatment across the whole dimension of the health experience from health promotion, to preventing ill-health, to treating ill health and supporting people through long term conditions, right through to the end of life itself. More specifically:

- We actively promote healthy living and healthy lifestyles through specific services geared to this purpose and also through our hundreds and thousands of contacts with people concerning their health every day of every year.
- We detect early signs of ill health and identify where actions or behaviours or symptoms may result in illnesses developing at a later stage.
- We intervene and treat people across a wide range of specialities and conditions to return people to a state of optimum health and wellbeing.
- Where optimum functioning cannot be achieved we support people to manage their conditions to achieve the best possible functioning and to prevent deterioration.
- When our patients reach the end of their lives, we support them and their families and carers to ensure that this time is as comfortable as possible.

Within the Trust we recognise our contribution to the wider health agenda and with the increasing, and welcome, focus on health and wellbeing we thought that it would be timely to do a stocktake of our activities in this arena as well as set out our stall for our activities in the forthcoming year.

Healthworks is the result of this stocktake of our health and wellbeing activities, actions and contributions. In this inaugural edition we have followed closely the format and approach set out in previous versions of the Joint Strategic Needs Assessments (JSNA) by our Local Authorities and Primary Care Trusts. This approach reflects our sign-up to tackling the health needs of the area and our support of the approach that has been taken locally to improving health and wellbeing.

For us the purpose of Healthworks is fourfold:

- It is a stocktake of our contribution to the priority areas identified by our partners in terms of improving health and wellbeing in the area.
- It sets out how we already contribute but also draws attention to the potential for further contribution as part of the service commissioning and provision processes.
- It demonstrates our value as a partner working closely with our partner agencies, stakeholders and patients to deliver great achievements in this important area of work.
- It provides a visible profile within our organisation to all our staff and clinicians regarding our expectations that this area of work is given priority in the daily work of the organisation; in the business planning processes; and in the strategic planning of our services for the future.

This Annual Report is structured as follows:

Section One: Who are we and what do we do?

This section gives a brief summary of our Trust giving a flavour of where we are located, the services we provide and our strategic direction for the future.

Section Two: The Health & Wellbeing Needs of our area

This section summarises the extent of the health and wellbeing needs of this area that we are in a prime position to be able to tackle.

Section Three: Health & Wellbeing and North Tees & Hartlepool NHS Foundation Trust

This section gives an overview of the national policy direction in relation to health and wellbeing that sets the backdrop of the role that we can and do play in relation to this area and where we can add more.

Section Four: Health & Wellbeing Priority areas

Using the priority areas identified in previous Joint Strategic Needs Assessments, we have adapted the format to analyse the state of health and wellbeing as it applies to our populations; identified our contribution so far; and, highlighted our intentions for ongoing contribution that, subject to continued support from commissioners will be built in to our work programmes in the forthcoming year.

The University Hospital of Hartlepool

The University Hospital of North Tees

Section One:

Who we are and what do we do?

North Tees and Hartlepool NHS Foundation Trust was authorised as a NHS Foundation Trust in December 2007. We provide a wide range of health and healthcare services for approximately 400,000 people living in Hartlepool, Stockton on Tees, Sedgefield and parts of Easington in County Durham.

We have two hospitals:

- The University Hospital of Hartlepool; and
- The University Hospital of North Tees

We care for patients in over thirty community facilities including Peterlee Community Hospital and, One Life Hartlepool, which is the first of the integrated care centres to be created under the Momentum: Pathways to Healthcare programme. This programme is transforming the shape of health services in our area by moving services closer to people's homes; developing new integrated care facilities in community settings; and ultimately will lead to a new hospital to replace the existing two in Hartlepool and Stockton respectively.

The Trust employs in excess of 5,800 members of staff across the hospital and community services and has an income of over £260m (2010/11).

We were the first NHS Foundation Trust to become a combined acute and community Trust under the policy of Transforming Community Services; a move which has proved very successful in streamlining care for patients. Community staff have also seen benefits in having the resources of a successful acute NHS Foundation Trust to support their work.

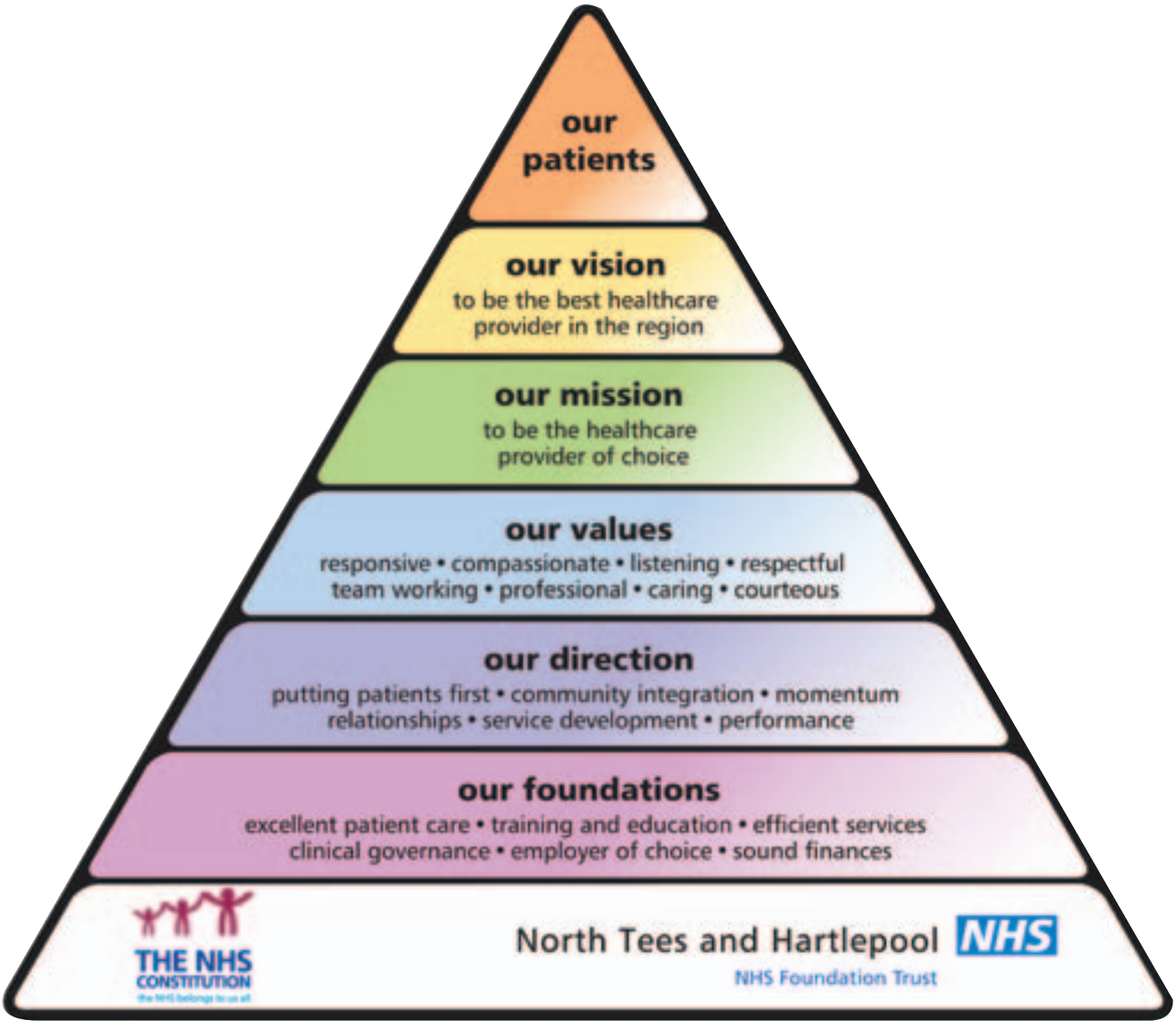
Our breast screening services cover Teesside (the local authority areas of Hartlepool, Stockton on Tees, Middlesbrough and Redcar and Cleveland), South Durham and parts of North Yorkshire and we are the referral centre for bowel screening for Teesside, South Durham and North Yorkshire.

We provide community musculoskeletal services and community dental services for the whole of Teesside. Patients from a wider catchment area, can and do, choose to use our services; our leading edge spinal services at the University Hospital of North Tees attract patients from other parts of the country, and women who live out of our area have chosen to use our midwife-led birthing centre in Hartlepool.

We have a relentless focus on patient safety and improving the quality of our services. The culture in the Trust is very much about team working from the domestic staff cleaning the wards to the consultant carrying out the World Health Organisation (WHO) checklist before an operation begins: every member of staff knows and understands their contribution to safety, outcomes and patient experience. This is reflected in the continued reductions in mortality; our track record with respect to hospital acquired infections and patient feedback through surveys.

We were one of the original partner Trusts to embrace LEAN methodology and this is now truly embedded within our Trust with a wide range of staff understanding and embracing the principles in their everyday work as well as particular and specific focused interventions to improve work flows, efficiency and waste reductions.

We have ambitious plans for the future to work with our healthcare partners to transform health and healthcare services under the Momentum: Pathways to Healthcare programme. This programme will help to keep people healthy, intervene early and provide care in or closer to people's homes by an infrastructure of integrated care centres with the final piece of the Momentum jigsaw of a newly built hospital.


our patients
our vision
to be the best healthcare provider in the region
our mission
to be the healthcare provider of choice
our values
responsive • compassionate • listening • respectful
team working • professional • caring • courteous
our direction
putting patients first • community integration • momentum
relationships • service development • performance
our foundations
excellent patient care • training and education • efficient services
clinical governance • employer of choice • sound finances
THE NHS CONSTITUTION
North Tees and Hartlepool NHS
NHS Foundation Trust

Our strategy can be summarised in the diagram opposite. Taking each of the areas in turn:

Our Patients

Our patients are at the pinnacle of our triangle. It is for our patients that we are here.

Our Vision

To be the best healthcare provider by delivering excellent services for our patients.

Our Mission

North Tees and Hartlepool NHS Foundation Trust will become the healthcare provider of choice by putting patients first, delivering efficient, safe and reliable services, enabling excellence, encouraging innovation, embracing learning, knowledge and change.

We will achieve this by operating a LEAN performance focussed organisation that thrives on change and provides:

- Good patient care through safe, modern high quality health services
- Efficient services by recognising that waste in one area compromises patient care in another
- A good place to work by being a good employer, working together and valuing people
- Education and training to enable staff to deliver individual, professional, team and organisational objectives.

Our Values

Healthcare is a people business and therefore we place great emphasis on all the people associated with our business, namely, patients, public and our staff. All are key to what we do. This is recognised in our People First Values which underpin our service delivery. We expect our People First Values to drive our behaviour when we are delivering care to our patients and their families as well as in our dealings with colleagues and people in our own and other organisations.

Our People First Values expect that we will:

- Be responsive to the needs of our patients as individuals
- Be responsive to the needs of our stakeholders
- Treat all people with compassion, care, courtesy and respect
- Respect each person's right to privacy, dignity and individuality
- Take time to be helpful
- Respond quickly and effectively
- Always give clear, concise explanations
- Practise good listening skills
- Develop and maintain an appropriate environment
- Look the part
- Deal effectively with difficult situations
- Perform as a team

Fundamentally, 'Putting Patients First' is what we stand for and believe in.

Our Direction

We have identified six key strategic themes for the organisation as follows:

- Putting Patients First
- Momentum: Pathways to Healthcare
- Community Integration
- Manage our Relationships
- Service Development
- Maintain Compliance and Performance

These have been translated into strategic aims as follows:

a. Putting Patients First

To create a patient centred organisational culture by engaging and enabling all staff to add value to the patient experience and demonstrated through patient safety, service quality and LEAN delivery.

b. Momentum: Pathways to Healthcare

To develop and implement a new healthcare system for the people of: Easington, Hartlepool, Sedgefield and Stockton.

c. Community Integration

To develop and expand the portfolio of services to provide healthcare services to our communities as close to home as possible.

d. Service Development

To improve and grow our healthcare services to better meet the needs of our patients, commissioners and the Trust.

e. Manage our Relationships

To ensure our services, and the way we provide them, meet the needs of our patients, commissioners and other partners by proactively engaging with all appropriate stakeholders, including our staff, through communications, engagement and partnership working.

f. Maintain Compliance and Performance

To maintain our performance and compliance with required standards and continually strive for excellence by good governance and operational effectiveness in all parts of our business.

Underpinning all of the strategic aims are strategic objectives which identify the outcomes to be delivered for the aims to be achieved. These in turn are underpinned by specific strategies and delivery plans.

Our Foundations

Our vision, mission, values and direction are built upon the firm foundations and track record of:

- Excellent patient care
- Training and education
- Provision of efficient services
- Clinical governance
- Being a good employer
- Sound finances

We will now go on to describe in more detail the health and wellbeing needs of the people in the area that we serve.

Section Two:

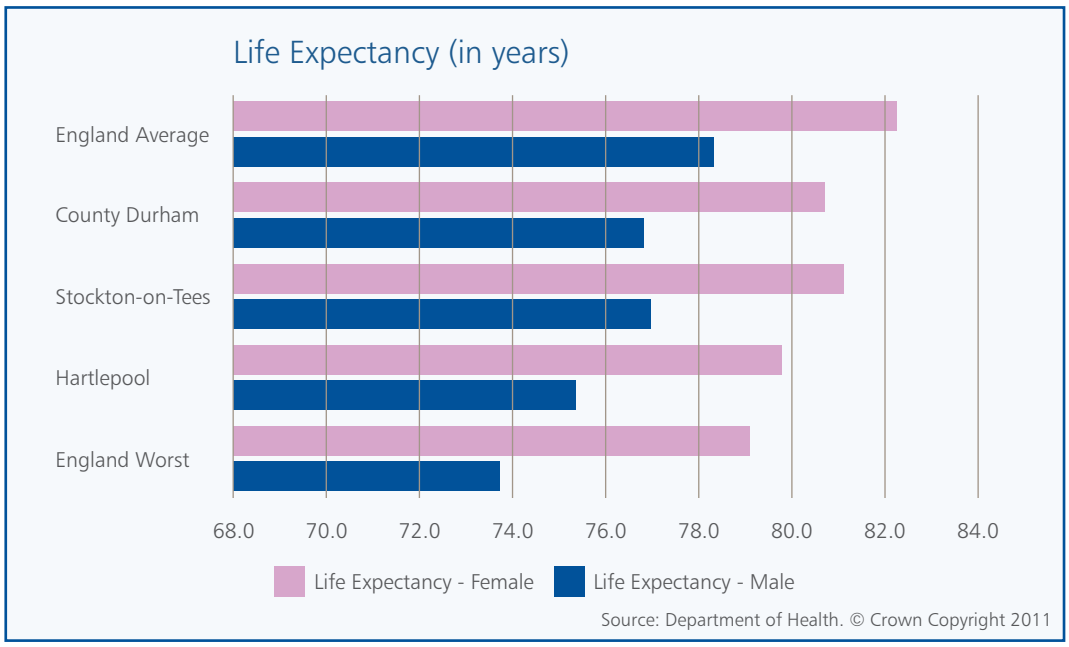
The Health & Wellbeing Needs of our area

The health and wellbeing of the people of the area that we serve, predominantly Hartlepool, Stockton-on-Tees and parts of Easington and Sedgefield in County Durham provides ample evidence of the need for investment not only in traditional health treatments, but in promoting healthy living and lifestyles and early detection of illness through to supporting the management of long term conditions and providing care at the end of a persons life.

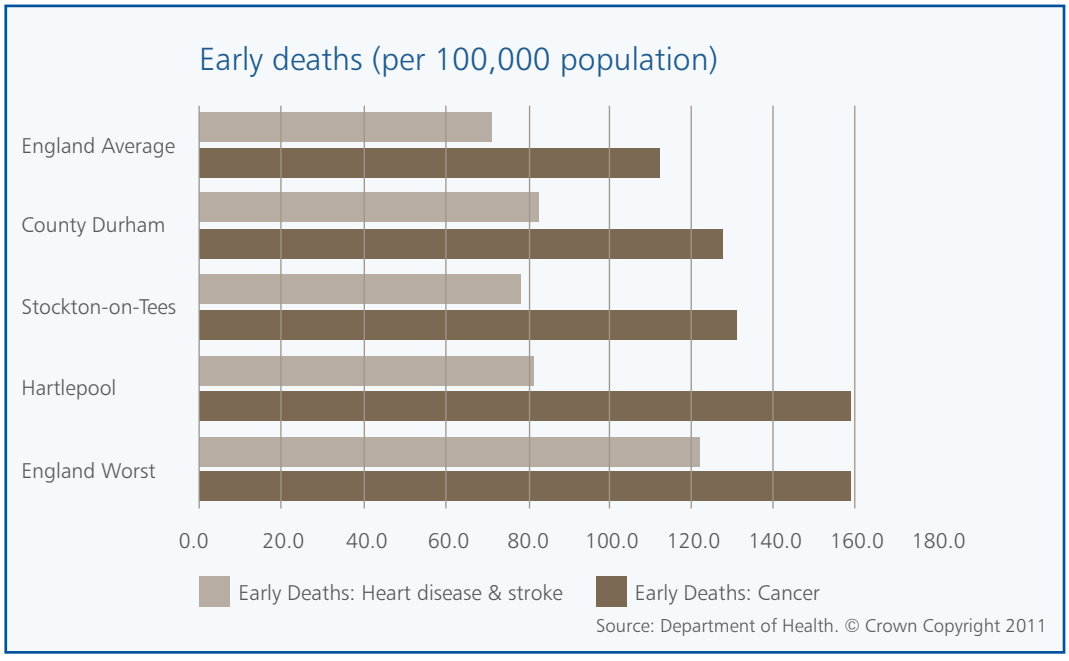
Historically, the local area has been highly dependent on heavy industry for employment and this has left a legacy of industrial illnesses and long term conditions. This, coupled with a more recent history of high unemployment as the traditional industries have retracted, has led to significant levels of deprivation that rank among the highest in the country.

Analysis of deprivation shows that out of 354 local authorities, the district of Easington, which will be partly served by the new hospital, is the 7th most deprived in England, Hartlepool the 23rd whilst Stockton is ranked 98th, however deprivation levels across Hartlepool and Stockton vary widely. The link between deprivation and ill-health is well recognised.

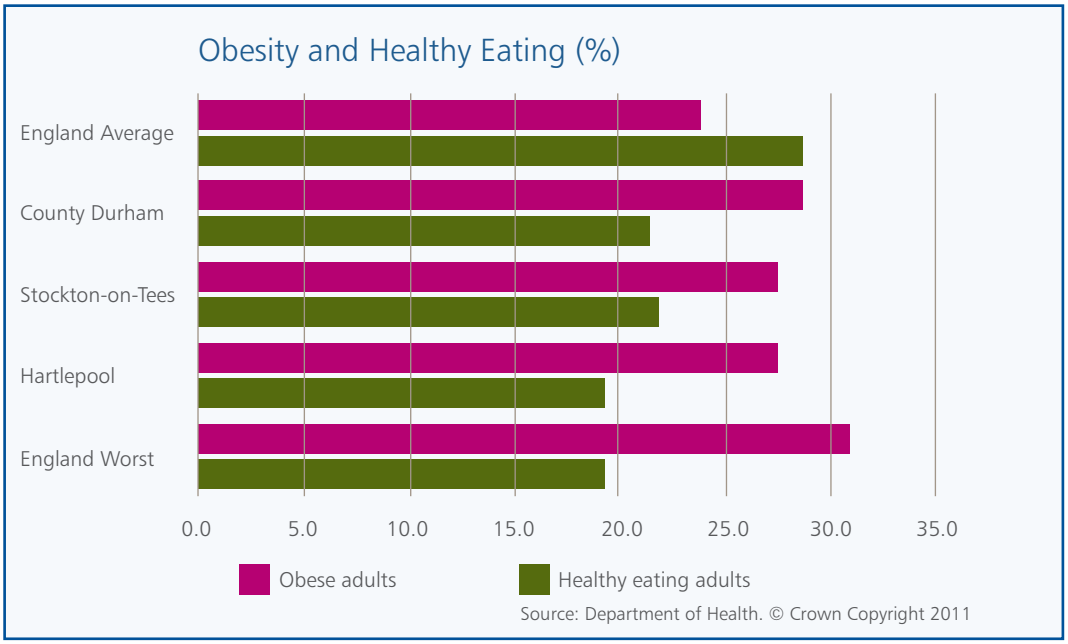
Key measures of health and wellbeing make for poor reading for our locality.



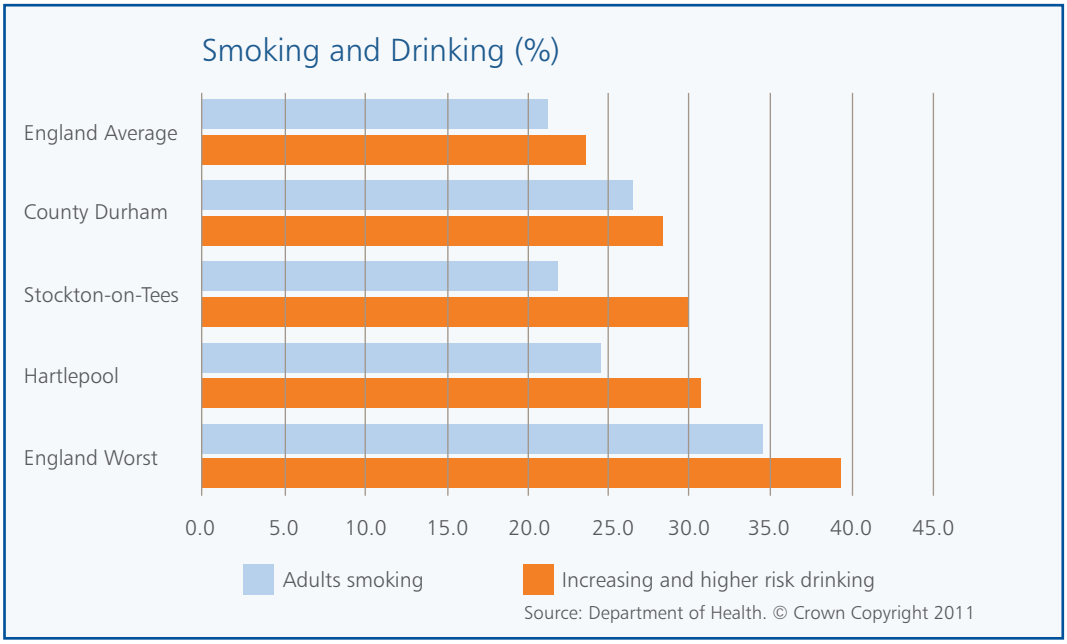
Whilst life expectancy continues to increase year-on-year, current life expectancy for both men and women in our local population is lower than the England average.



Mortality from common diseases is significantly greater than the England average. Deaths from lung cancer are 50% greater; deaths from colorectal cancer are 30% greater, deaths from circulatory disease are 16% greater, deaths from stroke are 12% greater and deaths from suicide and undetermined deaths are 42% greater than the England average.



Rates of obesity in both children and adults have increased in line with national trends, but there are a greater proportion of obese people in the local population compared to England. This is reflected in the lower than average consumption of five fruit or vegetable portions per day.



Despite recent efforts, in part successful, to tackle smoking and binge drinking, the prevalence of these lifestyle indicators are greater than the England average.

Furthermore, population changes forecast for the next decade and beyond, in particular the growth in the proportion of elderly people, will have a further impact on health and health services and necessitates the need for all partner agencies involved in health and social care to join forces to identify and meet the needs of the local population and to reduce health inequalities.

Section Four of this report provides more detailed analysis of the state of the health and wellbeing of our populations in priority areas, identifies our contribution so far and highlights our intentions for ongoing contribution that with continued commissioner support will underpin our work programmes in the forthcoming year.

Before this detail, we consider the national policy direction in relation to health and wellbeing that sets the backdrop of the role that we can and do play in relation to this area and where we can add more.

Section Three:

Health & Wellbeing and North Tees & Hartlepool NHS Foundation Trust

In July 2010, the National Health Service white paper 'Equity and Excellence: Liberating the NHS' set out a new direction for the NHS. The NHS white paper is radical and far reaching proposing significant changes to the current arrangements for commissioning, providing and performance managing NHS services. The white paper proposes establishing Clinical Commissioning Consortia and abolishing Primary Care Trusts (PCTs). It also proposes that responsibility for public health should transfer from PCTs to the Local Authority and a newly created national body 'Public Health England'. The white paper places a requirement on Local Authorities to assume new responsibilities in relation to health services, public health and health improvement and proposes a key vehicle for delivering this is through the creation of statutory Health and Wellbeing Boards.

In November 2010, the Government published 'Healthy Lives, Healthy People: Our Strategy for Public Health in England'.

This paper set out the vision for the future of public health moving forward under Local Authority leadership with a Director of Public Health jointly with Public Health England. This white paper also proposed that as part of the new public health system based on strong local and national leadership, that each Local Authority unitary or upper tier authority should establish a Health and Wellbeing Board.

The remit of the Health and Wellbeing Board as outlined in the public health white paper and subsequent Government response to the 'NHS Futures Forum' is as follows:-

- Statutory board bringing together the key NHS, public health and social care leaders to work in partnership to improve the health of the population.
- Establish a shared local view about the needs of the community based on the Joint Strategic Needs Assessment (JSNA) and support joint commissioning of NHS, social care and public health services.
- Develop a Health and Wellbeing Strategy and commissioning plans based on the JSNA for the area.
- Promote better use of resources across agencies and to further integrate health with adult social care, childrens' service and wider services.
- Have a "formal role in authorising clinical commissioning groups" and have input into annual assessments of the groups, which will be carried out by the NHS Commissioning Board.
- Be able to refer any commissioning plans they feel are not in line with local health and wellbeing strategies to the NHS Commissioning Board (but will not have the power of veto).
- Have a new duty to involve users and the public as part of the structure supporting the Health and Wellbeing Board.
- As the Health and Wellbeing Board "discharges executive functions of local authorities" it should operate as equivalent executive bodies do in local government. It will be for local authorities to determine the precise number of elected members on a Health and Wellbeing Board, and they will be free to insist upon having a majority of elected councillors.
- Be the vehicle for "lead commissioning" for particular services, for example social care for people with long-term conditions – with pooled budgets and joint commissioning arrangements where the relevant functions are delegated to them.

North Tees and Hartlepool NHS Foundation Trust is a key partner in delivering on this challenging public health agenda. We already provide many services that not only protect the health of the population; but also improve health. We have a key role in not only identifying need as illustrated in section 2 and detailed in section 4; but as a key strategic partner in meeting those needs and reducing inequalities.

In the next section we will outline our health and wellbeing priorities that will reflect the priorities of the Health and Wellbeing Boards and emerging Health and Wellbeing Strategies.

Section Four:

Health & Wellbeing Priority areas

We have studied the local 2010 Joint Strategic Needs Analyses and identified 9 key areas where we can have the most direct impact, illustrated in the diagram below.

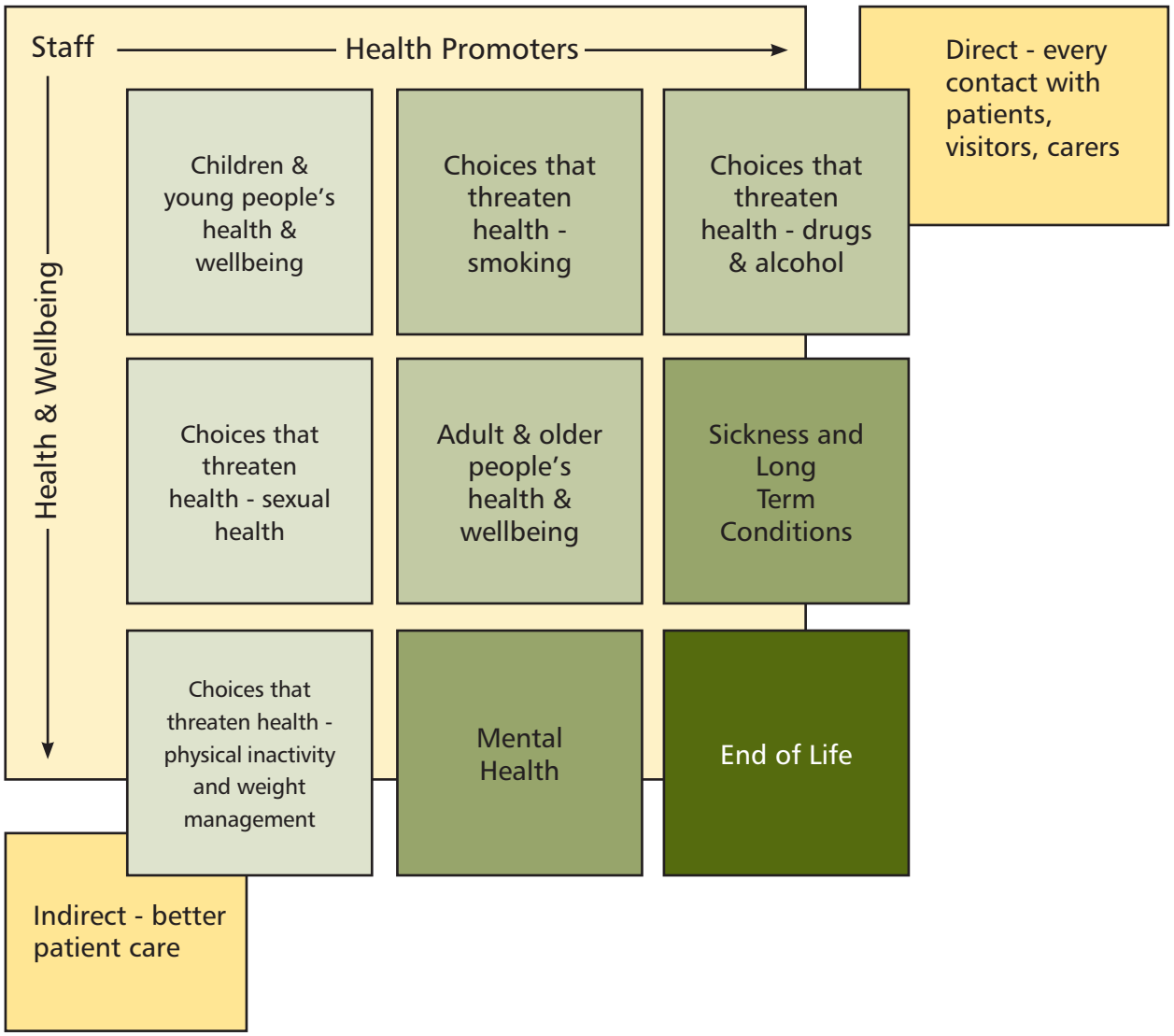
These nine areas cover all aspects of health and wellbeing, from preconception through to end of life. There are specific areas related to;

- The stages of a person's life
- Choices that individuals make that threaten their health
- Conditions that individuals live with that impact on their everyday health and wellbeing

They are considered in terms of the health and wellbeing of our staff which can affect the quality of the patient care delivered and the delivery of patient care itself through every direct contact with patients, visitors and carers.

With respect to the health and wellbeing of our staff, the Trust has a Health and Wellbeing charter which was launched in September 2011. The charter sets out 9 ways that the Trust will work to improve the health of our workplace and it is presented at Appendix A.

The types of health and wellbeing promotion that the Trust delivers can be categorised into three levels, those that concentrate on prevention (primary), those that return an individual to a state of good health and wellbeing following ill health (secondary) and those aimed at maximising health and wellbeing despite an underlying condition (tertiary).



The remainder of section 4 will expand on each of the 9 priority areas in turn, presented as a "Focus on…" summary, bringing together information, intelligence and action from across the health community, designed to tell you:

- What we know in general about the priority area.
- Facts and figures comparing the local position against the wider North East and England.
- What has been achieved in terms of progress made in recent years by partners across the health community.
- What we contribute as a Trust, at primary, secondary and tertiary level as appropriate, that has a direct impact on the priority area.

Focus on...Children & Young People's Health & Wellbeing

North Tees and Hartlepool NHS
NHS Foundation Trust

What we know

- The number of children living in poverty is higher than the England average
- Obesity in children and young people is above England average
- There is a need to promote positive sexual health, reduce teenage conceptions, improve breastfeeding rates and reduce smoking during pregnancy
- There is a need to reduce substance misuse by children and young people as well as the effects on children and young people
- Stockton have identified a need to improve the quality of hospital and community healthcare for all children, and Hartlepool have identified the need to improve access to support services.

Facts and Figures

Focus on...Children & Young People's Health & Wellbeing	Hartlepool	Stockton	North East	England
Smoking in pregnancy (% 2009/10)	26.9%	20.2%	22.8%	14.0%
Infant deaths (Rate / 1,000 live births)	5.12	4.32	4.76	4.71
Children in poverty (% 2008)	28.9%	21.3%	26.0%	20.9%
MMR Vaccination by 5th birthday (% 1st & 2nd dose)	84.8%	89.7%	89.0%	82.7%

- Smoking in pregnancy and deprivation are two issues that lead to a poor start to a child's life. We are worse than England on both of these measures and Hartlepool worse than the North East
- Infant deaths are worse than England and the North East in Hartlepool but better in Stockton
- Take up of childhood vaccinations is better than England, however Hartlepool is worse than the North East

What the health community has achieved

- Establishment of school based health services (including sexual health) in schools
- Appointed a breastfeeding co-ordinator to drive the implementation of the UNICEF baby friendly award and commissioned a media campaign to challenge the bottle feeding culture across the town in Hartlepool
- Schools in the area have achieved "Healthy School status"
- Golden Apple Healthy eating award for local businesses
- Parenting programme offered by Barnados

What we contribute

- A comprehensive maternal health service
- A neonatal service for premature babies requiring intensive, high dependency and special care
- Weaning programme for mothers of children 0-2 years
- School Nursing for the national child measurement programme, child protection and signposting to appropriate services
- Health Visiting contribute to a range of healthy child programmes and child protection matters
- Family nurse partnership supports teenage mothers
- A range of inpatient paediatric services

Focus on...Smoking

What we know

- Smoking prevalence is higher than the national average, with populations living in the lower socioeconomic having the highest prevalence rates and the least 4-week quit success rates
- Around three quarters of smokers say they would like to quit, less than half attempt to quit and less than 3% actually quit each year
- Smokers like stop smoking clinics in locations with easy access and at varied times
- Rates of smoking during pregnancy are high

Facts and Figures

Focus on...Smoking	Hartlepool	Stockton	North East	England
Smoking in Adults (% 2006-08)	26.9%	20.2%	22.8%	14.0%
4 Week Smoking Quitters (2009/10)	5.12	4.32	4.76	4.71
Smoking attributable hospital admissions (2008/09)	28.9%	21.3%	26.0%	20.9%
Deaths from Smoking (2006-2008)	84.8%	89.7%	89.0%	82.7%
Smoking in Pregnancy (% 2008/09)	24.0%	20.3%	22.8%	14.8%
Smoking in Pregnancy (% 2009/10)	26.6%	19.9%	n/a	n/a

- With the exception of 4-week smoking quitters, Hartlepool worse than North East and England average in all cases and Stockton better than North East and worse than England in all cases

What the health community has achieved

- Over the past 5 years achieved excellent results in 4 week quit rates
- Secured national funding to develop initiatives to work on tobacco control issues and smoking cessation
- Increased awareness of advice and support which is available to pregnant women and their families to help them quit smoking
- Variable performance in smoking during pregnancy

What we contribute

- Provide an extensive annual smoking cessation training programme to all health professionals and deliver health promotion events on the service and the dangers of smoking
- Offer smoking cessation advice to inpatients through a small team of advisors in the two hospitals and all health professionals offer advice during routine clinical contact across a range of specialties, e.g. respiratory and lung health, maternity and vascular plus opportunistic advice at every clinical contact
- Provide 20 weekly stop smoking drop-in clinics in the community & quality assure the service offered by 24 pharmacies
- Treat patients with conditions caused by smoking such as chronic obstructive pulmonary and coronary heart diseases

Focus on...Drugs & Alcohol

What we know

- Binge drinking levels and alcohol specific admission rates are amongst the highest in the country and rising
- There were over 7,500 admissions to hospital in 2009/10 attributable to alcohol
- There are estimated to be over 3,000 problem drug users using opiates and/or crack cocaine, with many more residents using a wide variety of drugs
- In addition to the harm caused to users and their families, drug and alcohol misuse leads to increased levels of crime, in particular violent crime

Facts and Figures

Focus on...Drugs & Alcohol	Hartlepool	Stockton	North East	England
Increasing and Higher Risk Drinking (% aged 16+, 2008)	30.6%	30.0%	27.0%	23.6%
Hospital stays for alcohol related harm (rate 100,000; 2009/10)	2,578	2,278	2,406	1,743
Drug Misuse (estimated problem drug users per 1000; 2008/09)	19.0	15.8	10.8	9.4

- Increasing and higher risk drinking levels are worse than the North East and England averages
- The rate of alcohol related admissions to hospital for Hartlepool is worse than the North East and England, Stockton is worse than England
- Rates of problem drug misuse are worse than the North East and England

What the health community has achieved

- HYPED is provided in Hartlepool and STASH is provided in Stockton by a voluntary organisation known as DISC, who deal with people up to the age of 21 years with substance misuse issues. They go into schools to deliver education sessions and also have specialist workers who work one to one with children and their families
- The Albert centre provides alcohol treatment to individuals with an audit score of 30 or above. Intra-health provide treatment and support to individuals with an audit score below 30.
- There are 2 transformational alcohol workers employed in Hartlepool and Stockton

What we contribute

- 2 Alcohol Specialist nurses are employed in the trust and are working with GPs and other services to target those individuals who are dependent upon alcohol or are at risk of becoming dependent to revise treatment plans. They encourage engagement in support services and provide brief interventions.
- We are implementing the NICE guidance on detoxification
- Alcohol specialist nurses have initiated multi-agency meetings to discuss individual cases and improve collaborative working
- 2 midwives for pregnant women with drug & alcohol problems
- We treat a growing number of people with drug and alcohol related chronic diseases.

Focus on...Sexual Health

What we know

- In Hartlepool there is a clear picture of an increasing trend in sexual risk taking behaviour with the resultant increase in STIs and pregnancy
- There is a need to increase the quality and availability of sexual health service information
- There is a need to increase the GUM / CASH clinic times and offer "walk in appointments" and "timed appointments"
- There is a need to provide better and more integrated services
- There is a need to reduce teenage pregnancies

Facts and Figures

Focus on...Sexual Health	Hartlepool	Stockton	North East	England
Teenage pregnancy (<18 years per 1,000, 2007-2009)	63.5	49.8	50.3	40.2
Fertility rate (2009 fertility rate, 11-49 years)	2.10	2.03	1.81	1.96
Abortion rate (as a % of potential fertility rate)	21.8%	19.5%	19.0%	21.2%
Acute STIs (per 100,000 population, 2010)	719.1	681.5	795.9	778.9

- Teenage pregnancy rates are higher than England. Rates for Hartlepool are significantly higher than the North East also.
- Fertility and abortion rates are higher than the North East average, Fertility is higher than England also, with abortion close to England, Hartlepool slightly higher, Stockton slightly lower.
- We have lower rates of sexually transmitted infections.

What the health community has achieved

- Provision of CASH and GUM clinics.
- Young persons clinic delivered in One Life.
- Drop in clinics provided in schools.
- There is multi agency delivery of sexual health education in schools as part of the personal, social and Health Education module.

What we contribute

- Midwives contribute to the public health agenda on sexual health on a continuous, opportunistic basis.
- Early pregnancy advisory clinic provides advice on pregnancy and contraception.
- Health visitors and school nurses advise on sexual health matters.

Focus on...Adult & Older People's Health & Wellbeing

North Tees and Hartlepool NHS
NHS Foundation Trust

What we know

- There is a need to reduce inequalities as the health of the local population is generally poorer than the rest of the country, but it varies between wards, with more affluent wards having better health and poorer wards having worse health.
- Levels of obesity, smoking and alcohol consumption are higher than the England average.
- The average life expectancy has increased therefore the incidence of age related conditions has increased such as dementia, with 1,200 patients currently on the dementia register.
- Increasing numbers of people are supported to live independently with the support of social care.

Facts and Figures

Focus on...Adult & Older People's Health & Wellbeing	Hartlepool	Stockton	North East	England
Years of Life Lost (/100,000 pop, all causes) MALE	736	635	668	539
Years of Life Lost (/100,000 pop, all causes) FEMALE	477	385	412	348
Prevalence of Dementia (% population)	0.41%	0.44%	0.53%	0.45%
Deprivation Index (Average Score / Rank out of 326)	33.68 / 24	23.46 / 100	n/a	n/a

- More years of life are lost to all causes than the England position. Hartlepool is worse than the North East and Stockton is better.
- Although rising, the prevalence of dementia is lower than North East and England.
- Deprivation is high which contributes to ill-health & wellbeing.

What the health community has achieved

- Rolled out direct payments and offered personalised budgets.
- Supported people to make changes to their lifestyles through the stop smoking service and health trainer service.
- Ensured all people have access to all of the national screening and immunisation programmes.
- Ensured the population who are at risk have access to the flu vaccine.
- Reablement Teams have been established in Stockton and Hartlepool.
- Provision of supported housing for older people.

What we contribute

- Prambles exercise group for mothers of young babies and young children and healthy start programme for pregnant women with children under the age of 4 to improve their nutrition.
- Hartlepool Day hospital and Older Persons Team for people with integrated Needs (OPTIN), Falls Teams available for older people at risk, Osteoporosis specialist nurse.
- Occupational health for staff and good uptake of flu vaccination.
- Wide range of elective and emergency secondary care services.
- Memory clinics to aid early diagnosis of dementia.
- Wide range of community based services.

Focus on...Sickness & Long Term Conditions

North Tees and Hartlepool NHS
NHS Foundation Trust

What we know

- The historical dependency on heavy industry for employment has left a legacy of industrial ill health and long term conditions.
- As these industries have retracted over recent years unemployment levels and poverty now rank amongst the highest in the country.
- Uptake of cancer screening in Hartlepool is low.
- Life expectancy is lower than the England average and mortality from common diseases is significantly greater than the England average.
- Smoking and obesity levels are higher than the England average.

Facts and Figures

Focus on...Sickness & Long Term Conditions	Hartlepool	Stockton	North East	England
Standard of health rated "Not Good", %2001	12.0%	10.1%	11.8%	8.8%
Incidence of all cancers (per 100,000, 2006-2008)	331	309	312	296
Prevalence of COPD (%,2009/10)	2.59%	2.03%	2.43%	1.57%
Prevalence of CHD (%,2009/10)	4.71%	4.08%	4.70%	3.44%

- Over 10% of the local population rate their health has "not good". Higher than England and better than or close to North East.
- Incidence of all cancers is higher than England and higher than the North East for Hartlepool.
- Prevalence of COPD and CHD is higher than England.

What the health community has achieved

- GP provision has increased.
- Hartlepool has established a pilot programme to improve early detection of lung cancer and town wide GP and community vascular screening.
- Achievement of Quality Outcomes Framework (QOF) targets.
- Provision of well man and well woman clinics.
- Provision of supported housing.
- Provision of Flu vaccinations.
- Breath easy support group for people with COPD.

What we contribute

- DESMOND and HATTIE Education programmes for people with type 2 and newly diagnosed type 1 diabetes.
- Pulmonary rehabilitation programmes for patients with COPD.
- Cardiac rehabilitation delivered in the community.
- Health Trainers and dietetics services to support people in developing healthier lifestyles.
- Rapid access Transient Ischaemic Attack and chest pain clinics.
- Wide range of secondary care interventions.
- Wide range of community based provision, including telehealth.

Focus on...Physical Inactivity & Weight Management

North Tees and Hartlepool NHS
NHS Foundation Trust

What we know

- A greater percentage of local children and adults are obese compared to England and around the same percentage as the North East.
- Over one in three local children are overweight or obese and there is an indication of a large increase in childhood obesity between the ages of 5 and 11.
- Childhood obesity can lead to significant health problems later in life and can contribute to early death and health inequalities.
- Children and adults in Stockton are more physically active than their counterparts in Hartlepool, however the local population lags behind England for healthy eating.
- The clinical perception is that obese patients tend to be admitted more frequently and have longer lengths of stay.

Facts and Figures

Focus on...Physical inactivity & Weight Management	Hartlepool	Stockton	North East	England
Physically active children (% at least 3 hours PE/week)	51.0%	55.3%	57.0%	55.1%
Obese children (year 6) (% in 2009/10)	22.1%	20.1%	20.6%	18.7%
Healthy eating adults (% estimate HSfE* 2006-08)	19.3%	21.9%	21.5%	28.7%
Physically active adults (% aged 16+ 2009/10)	8.9%	12.3%	12.2%	11.5%
Obese adults (% estimate HSfE* 2006-08)	27.5%	27.7%	27.8%	24.2%

- Hartlepool significantly worse than England on all indicators.
- Stockton significantly worse than England for adult obesity and healthy eating.
- Stockton similar to England for obese children and physical activity.

What the health community has achieved

In Hartlepool

- Community weight management groups have been established as part of the Healthy Weight for Life Programme.
- Community fruit and veg bag schemes are available.
- All schools have achieved the Golden Apple Eating Award.
- The proportion of children who walk or cycle to school is above the England average.

Stockton

- Evaluation of weight management service is ongoing.

What we contribute

- The dietetics service assesses, diagnoses and treats diet and nutrition problems for patients with specific conditions.
- Health Trainer Service alleviates and reduces lifestyle related illness through the provision of health education, information, practical support and signposting to other agencies.
- Opportunistic advice during every clinical contact.
- Weight management support for those requiring elective surgery.
- Development of business case to provide bariatric surgery for those most obese and clinically appropriate patients.
- Healthy eating for staff and visitors in the hospital canteens.

Focus on...Mental Health

What we know

- 1 in 4 people in the UK will experience a mental health issue in their lifetime. Hartlepool has a 40% greater need than the national average in relation to serious mental illness and a 14% higher need for common mental health problems. Prevalence in males is higher than in females.
- Making sure people have care and protection when they need it is a major priority.
- We need to support people with mental health difficulties to live independently, and improve access to training and employment, benefits and supported living.
- There are around 30,000 patients on the depression register and 2,000 patients on the mental health register.

Facts and Figures

Focus on...Mental Health	Hartlepool	Stockton	North East	England
Suicide rate (100,000, All ages 2007-2009)	2.32	5.52	6.03	5.76
Hospital stays for self-harm (per 100,000, 2009-10)	344.9	320.2	nk	198.3
Prevalence of Depression (>18 years, %)	9.41%	15.75%	14.98%	10.90%
Prevalence of Psychoses (%)	0.69%	0.72%	0.78%	0.77%

- Suicide rates are lower than England and North East, however Stockton has double the rate of Hartlepool.
- Conversely, hospital stays for self-harm are higher than England, and higher in Hartlepool than in Stockton.
- Prevalence of depression and psychoses are higher in Stockton than in Hartlepool.

What the health community has achieved

- Developed a local dementia strategy.
- MIND provide services to adults with mental health issues.
- TEWV provide mental health services to adults and young people (CAMHS).
- Reforming of chronic pain pathways.
- Collaborative network wide development of level 2 training (NICE 2004) for staff working in Cancer and Palliative Care.
- The local Authority has rolled out personal budgets and provides a number of programmes, including an employment support service.

What we contribute

- The Trust employs a clinical psychology team who input into Stroke, Cancer and Cardiac services, Palliative care, Diabetes, and chronic pain. The Trust is leading on a Network Wide Anxiety Management in Stroke Services.
- The Trust employs a bereavement counsellor in family health and 2 across other acute services.
- Chaplaincy services for those who require spiritual support, regardless of faith.
- Occupational health services are available for staff who may be experiencing mental health issues, as a first point of contact.
- The Trust has a number of staff qualified in Cognitive Behavioural Therapy (CBT) to support patients with long term conditions.

Focus on...End of Life

North Tees and Hartlepool NHS
NHS Foundation Trust

What we know

- People in Hartlepool and Stockton die younger than the national average.
- Early deaths from heart disease, stroke and cancer are among the highest 25% in the country.
- The majority of deaths occur in hospital and around one fifth of deaths occur at home.
- Almost one in seven people die in a care home.

Facts and Figures

Focus on...End of Life	Hartlepool	Stockton	North East	England
Life expectancy - male (in years)	75.3	76.4	76.5	77.9
Life expectancy - female (in years)	79.0	80.9	80.6	82.0
Early deaths: heart disease & stroke (per 100,000 <75)	95.0	82.1	87.2	74.8
Early deaths: cancer (per 100,000 <75)	164.3	134.3	134.0	114.0
Deaths in hospital (%)	51%	61%	n/a	n/a
Deaths at home (%)	21%	19%	n/a	n/a
Deaths in hospice (%)	7%	4%	n/a	n/a

- Life expectancy is lower than the England average.
- Early deaths from certain conditions are higher than the England average.

What the health community has achieved

- Developed an End of Life strategy to ensure people experience a 'good death'.
- Promoted the North East Public Health Charter for "A Good Death".
- Worked with the University of Teesside to explore more compassionate human resource policies for people diagnosed with a life limiting illness and their carers.
- Taken a proactive approach to training of staff in care / nursing homes.

What we contribute

- Specialist Palliative Care Team operating in the community and hospital ensure that all people we care for at the end of their life experience a good death and their family receive appropriate support including the use of carers diaries and adoption of the Liverpool Care Pathway.
- Specialist palliative care clinical staff train and educate generic staff in providing palliative care services to support patients in the community and hospital. Consultant medical staff provide specialist support to Hartlepool and Butterwick Hospices.
- The Chaplaincy team supports the spiritual and emotional needs of patients, carers and staff, providing high standards of end of life care, and undertake funerals and support bereaved families.

Conclusion

In conclusion, this first publication of Healthworks, the Annual Health & Wellbeing Report of North Tees & Hartlepool NHS Foundation Trust sets out the challenge we face in order to improve the health and wellbeing of the people we serve and the people charged with meeting this challenge.

The challenge may be related to stages of an individual's life, whether it is the best possible start to life, a state of good health and wellbeing throughout life or ensuring a "good death".

The challenge may be related to choices that threaten health and wellbeing, such as publicising the dangers or treating the ill effects of smoking, excessive drinking, obesity, drug misuse and risky sexual behaviour.

The challenge may be to optimise the quality of everyday life for those persons living with permanent conditions, which have high levels of prevalence in the population that we serve.

Despite the magnitude of the challenge, we look forward to working with our partners through 2012 to rise to it.

Appendix A:
Health and Wellbeing Charter

North Tees and Hartlepool NHS Foundation Trust is fully committed to the health and wellbeing of all its employees. As the provider of health services, health and wellbeing applies as much to our staff as it does to our patients, and we want to do as much as possible to support our staff to be at their best, energised and motivated so that we can provide an excellent patient experience. We will work to improve the health of our workplace by:

1.Assessing the health needs of our workforce

2.Developing and implementing health policies as appropriate

3.Developing and providing health and wellbeing information, events and activities

4.Providing opportunities for advice, guidance and support on healthy lifestyle choices

5.Identifying health advocates to co-ordinate the health improvement activities and ensuring that they are given adequate time to fulfil their role

6.Ensuring that all employees have access to a range of services in order to influence behavioural change

7.Identifying health advocates to co-ordinate health improvement activities and ensuring they are given adequate time to fulfil their role

8.Demonstrating senior management commitment

9.Reviewing current working practices and management systems with a view to improving working conditions

Clare L Curran
Director of Human Resources and Organisational Development

John Rhodes
Chair of Staff Side

Department of Health

Department of Health
Room 213
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London
SW1A 2NS

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3 January 2012

Gateway reference: 17068

To:
Leaders of Local Authorities
Chief Executives of Local Authorities
Directors of Children's Services
Directors of Adult Social Services
Copy:
Local Involvement Networks
Healthwatch Programme Board and Advisory Group

Dear Colleague

Local Healthwatch

I am writing to let you know about the announcement made (today) by Secretary of State for Health, Andrew Lansley.

The announcement covers:

1. a new start date for Local Healthwatch
2. funding made available for the Healthwatch pathfinders
3. new funding of £3.2m for start up costs for Local Healthwatch; and

1. A new start date for Local Healthwatch in April 2013

Subject to parliamentary approval, Local Healthwatch will be the local consumer champion for patients, service users and the public. It will have an important role to champion the local consumer voice, not least through its seat on the local health and well being boards.

The new date for establishing Local Healthwatch in April 2013 will support the need to align this closer to the establishment of other new bodies such as the health and well being boards. The extension will also support preparations for implementation and enable Healthwatch England (which will be established in October 2012) to provide the leadership and support to Local Healthwatch organisations.

2. Funding made available for the HealthWatch pathfinders in Q4 of 2011/12

The funding being made available to each of the 75 Healthwatch pathfinders is in response to stakeholders seeking resources from the Department to support them in delivering their work. Whilst how this will be spent is for each pathfinder to agree with their delivery partners, there are three areas where value for money could be sought:

- demonstrate testing elements of proposed Healthwatch functions

- stakeholder events to involve local people
- develop wider community engagement
- rewarding and reimbursing volunteers (particularly from LINks) for their contribution
- contributing to their regional network to accelerate shared learning.

The funding for the pathfinders will be allocated through the local government Formula Grant route and we will be in contact with each pathfinder local authority to make them aware of this.

In addition to this, the Department will be funding expertise from the sector to draw together and share the learning and it will be important for the Healthwatch pathfinders to support this work to gather the information from them so to inform planning for the implementation stage in 2012/13.

3. New funding of £3.2m for Local HealthWatch in 2012/13

The new funding of £3.2m that will be made available in 2012/13 is for start up costs in setting up Local Healthwatch and includes costs such as staff recruitment/training, office set up costs, and branding; the funding will be allocated as part of the DH learning disabilities and health reform grant
in 2012/13.

Under the Local Government and Public Involvement in Health Act 2007, local authorities will need to continue to provide a Local Involvement Network (LINk) and funding for this continues to be allocated as part of the local government Formula Grant in 2012/13 and the £3.2m will be in addition to this.

The Department will provide further advice for planning purposes about funding for Local Healthwatch in 2013/14, as part of the Local Government allocations notifications at the end of 2012.

Yours sincerely,

David Behan
Director General for Social Care, Local Government and Care Partnerships

Hartlepool Shadow Health and Wellbeing Board (H&WBB)

January 2012

Clinical Commissioning Group – Proposed Configuration

1.0 Purpose

1.1 The purpose of this paper is to inform the H&WBB of the proposed final configuration of the Clinical Commissioning Group that will serve Hartlepool and to understand what assurances the H&WBB would need to ensure an effective and successful working relationship going forward.

2.0 Background

2.1 All Pathfinder Clinical Commissioning Groups (PCCGs) were required to confirm their proposed configuration by December 2011, in advance of an SHA risk assessment and shadow budget allocation. Currently, there are two CCG Pathfinders in the North of Tees. One in Hartlepool and one in Stockton.

2.2 The PCCGs on Teesside are aiming to achieve authorisation in October 2012. Confirmation of the proposed configuration is an essential milestone on the journey to full authorisation.

2.3 The running cost budgets for CCGs has been confirmed as £25 / head of practice registered population – considerably less than has been available to PCTs in the past. A significant proportion of the £25 / head will need to be set aside to fund commissioning support services provided by the NHS Commissioning Board (from April 1st 2013).

2.4 The CCG GP leads supported by the executive of the PCTs, have engaged with their constituent practices over the last months to consider the options for configuring the final CCG in light of the risks and challenges ahead (see 3.1 below).

3.0 Major Risks and Challenges

3.1 The major risks and challenges facing the clinical commissioners can be summarised as follows:

- To ensure a strong clinical focus on local patient experience
- To run the organisation with a modest running cost budget
- To secure strong clinical engagement
- To maximise local accountability (of GP commissioners to the H&WBBs and to the National Commissioning Board)

- To deliver QIPP[1] and manage significant financial risk to the commissioning budget
- To ensure strong collective commissioning and negotiating strength

4.0 Configuration Options

4.1 CCG Leads on Tees undertook a benefits and risks appraisal of a number of options, three of which were identified as having the greatest potential:

A. Four individual CCGs, co-terminous with each Local Authority
B. One CCG for Tees with localities co-terminous with each Local Authority
C. Two CCGs for Tees (one North, one South) but again with localities co-terminous with the respective Local Authorities

Option A). was discounted largely because it was the least cost effective in terms of the running cost budget and offered least financial risk sharing opportunity for the commissioning budget.

Option B). was rejected due to the risk of clinical dis-engagement in a very large CCG where the influence of clinicians could become diluted, the attention on local issues less focused and the incentives to achieve financial efficiencies lost.

Option C). was the preferred option of the majority of General Practices in Hartlepool (and across Tees) for the following reasons:

- Strong support of General Practices therefore a high probability of strong clinical engagement in future commissioning
- Significant administrative and general running cost savings (for example single set of executive officers, one set of audit fees and fewer non-executives)
- Stronger risk management arrangements especially for the commissioning budget
- Localities within the CCG for North of Tees (Hartlepool and Stockton) with very clear lines of accountability to their respective H&WBBs
- Opportunities to work collaboratively across the south of Tees on common pathways of care into and out of North of Tees Hospitals NHS Foundation Trust (NTHFT) and the Tees, Esk and Wear valley NHS Mental Health Trust (TEWV)

5.0 <u>Possible</u> Governance Model

5.1 Whilst the Locality areas (Hartlepool and Stockton) are expected to have a significant level of delegated authority, the CCG Board would retain certain statutory duties and functions and reserve certain decisions, in doing so, it would seek to maximise the clinical commissioning and financial management in each Locality and minimise duplication of some overarching functions which do not necessarily require detailed locality input. Exact governance arrangements and responsibilities of the localities and CCG Board are currently being developed. However these could look similar to below.

5.2 The CCG Board would delegate to the Localities :

[1] QIPP is the NHS Quality, Innovation, Productivity and Prevention programme with the aim of delivering the £20 billion savings across the NHS by 2015

- Commissioning and Service Development responsibilities
- JSNA/Health Needs Assessment/working with Health and Well Being Boards
- Budgets and their financial management
- Locality strategy and vision
- Requirement to nominate CCG Board and Committee members

5.3 The two CCGs (North - Stockton and Hartlepool, and South – Hartlepool, Redcar and Cleveland) may agree to work together in some areas, such as sharing policies which would allow for the possibility of joint committees between the two.

5.4 The CCG Board for North of Tees (Hartlepool and Stockton) would be established with membership from all of the Localities, for example:

- Chair (could be combined with another role)
- CCG Accountable Officer
- Chief Operating Officer
- CCG Chief Finance Officer
- Chief Nurse
- GP Locality members (3 if CCG with 3 Localities)
- Audit Non-Executive Director (NED)
- Patient / public engagement NED (alternatively could have an engagement NED in each Locality Committee)
- Consultant
- Executive Officers dependent upon final structures.

5.5 The CCG Locality Committees, whilst accountable to the CCG Board, would have significant delegated authority, supported by robust governance arrangements at Locality level. Membership of the Locality Committees could comprise for example of:

- Senior Medical Lead
- GPs/Other clinicians
- CCG Accountable Officer
- Chief Operating Officer
- CCG Chief Finance Officer
- Chief Nurse
- Other executives
- NED/lay membership/LINks/LA

5.6 On establishment (and in shadow operation), the CCG Board would set out a Scheme of Delegation to each Locality Committee and this would be the basis of the whole operation of the CCGs.

6.0 Authority

6.1 The Schemes of Delegation would set out very clearly where decisions would be made under the two CCG model. The level of decisions reserved to the CCG Board in either model would need to be discussed and agreed.

6.2 It is expected that the CCG Board would ratify/approve recommendations from the Locality Committees. The approval process would be based on criteria which were agreed by the Board in advance.

6.3 The emerging CCG governance guidance may provide information of the appointments process for the CCG Board.

7.0 Relationship with the Health and Well-Being Board

7.1 Critical to the success of this configuration of the CCG for Hartlepool is the opinion of the constituent GP practices. Without their backing, any proposed configuration would fail to pass the SHA risk assessment, would not be allocated a shadow budget and would therefore fail to be authorised in October 2012. Hartlepool GPs have given their strong support for a single CCG across North of Tees but with a condition. That is, each Locality must be clearly defined with a scheme of delegation and budgetary allocation that empowers and incentivises the clinicians to engage as commissioners in their local community.

7.2 However, it is also of great importance that the Local Authority and the HWBB are given the opportunity to seek their own assurances to ensure their priorities and objectives can be met. Consideration may be given to:

- How the Localities will be represented before the H&WBB?
- To what extent will the Localities be empowered to make commissioning decisions and allocate financial resource?
- How will the commissioning plan of the CCG reflect local health needs and priorities identified in the JSNA?

8.0 Recommendation

8.1 The Hartlepool Shadow H&WBB is requested to note the report on the final CCG configuration and to consider the assurances it would require to ensure successful delivery of its priorities and objectives in the future.

Ali Wilson
January 2012

Final Draft

Clinical Commissioning Group

Good Health - Everybody's business

A clear and credible plan for commissioning Health services for the populations of Hartlepool and Stockton-on-Tees

2012 - 2017

Draft 10 – 19th December

Further Actions to be completed

Content

Appendices:

1. Chairs' Foreword

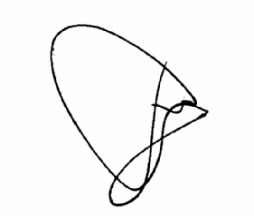
This is the first "clear and credible plan" that our CCG has produced that sets out our objectives over the next five years giving specific focus on the next three years.

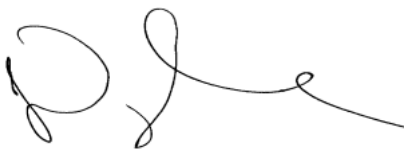
The aim is to become a fully authorised single body CCG in October 2012 responsible for commissioning health services for the populations of Hartlepool and Stockton-on-Tees as set out in the NHS Health Bill.

From 1st April 2012 a single shadow CCG Board will be in place focusing on the localities in preparation for full authorisation and we will establish a robust governance infrastructure building on the arrangements already in place. This arrangement will be supported by an Organisational Development plan to aid us in our transition and pathway to authorisation.

There have been three significant changes that have enabled the CCG to make solid progress towards becoming an authorised clinical commissioning group;

- Colleagues within general practice, both clinical and administrative have positively responded to the challenge that has been set before them and we have seen a significant increase in the level of engagement which has allowed the emerging CCG to meet this challenge.
- NHS Tees has from very early stages aligned its functions and workforce around the CCG allowing us to embed, understand and lead key functions that we will be required to carry forward from April 2013.
- Finally, the CCG has worked hard to develop its relationships with key stakeholders ranging from service providers to patient groups and these relationships will be critical in ensuring we commission high quality effective services.





Dr Boleslaw Posmyk
Chair (Hartlepool Locality)

Dr John O'Donoghue
Chair (Stockton-on-Tees Locality)

2. Executive Summary

This Clear and Credible Plan sets out the commissioning vision of the Clinical Commissioning Group which is to build 21st century health services for and with the Stockton and Hartlepool communities so that health inequalities reduce and wellbeing continuously improves.

To ensure services continue to be commissioned on a locality basis, the CCG will retain a strong individual locality focus with clear financial governance frameworks to allow them to deliver quality Health services to the populations of Hartlepool and Stockton-on-Tees in partnership with key stakeholders such as the Health & Well-being Boards, Local Authorities, community and voluntary organisations and the third sector.

- This plan will focus on addressing the quality needs of the local populations and will demonstrate how the CCG will improve the health outcomes for patients and the wider public through the efficient use of delegated resources.
- As such, it will focus on how the CCG intends to take forward identification of the key transformational developments that will be required to deliver QIPP
- The CCG will commission services to work towards nationally agreed outcomes and will use information and intelligence from the Joint Strategic Needs Assessment and Patient Engagement when commissioning services on behalf of the communities.

This document takes into account the key health challenges of the population of Hartlepool and Stockton-on-Tees in response to the JSNA which is developed in partnership Hartlepool Local Authority and Stockton Local Authority which focus on;

- Cardiovascular disease (diseases of the heart and circulatory system including strokes)
- Cancer
- Smoking-related illness e.g. Chronic obstructive pulmonary disease (diseases of the lungs)
- Alcohol related illness

In response to the JSNA and national requirements set out in both the operating framework and outcomes framework we have identified a number of key initiatives that enable to meet these challenges such as better outcomes and improved patient experience. These initiatives have clear measurable outcomes that will be monitored and supported by primary care

How the CCG will performance manage delivery of the above initiatives

3. CCG Vision

The vision of our Clinical Commissioning Group is;

> ***'To build 21st century health services for and with the Stockton on Tees and Hartlepool communities so that health inequalities reduce and wellbeing continuously improves'.***

In order to achieve this vision, the CCG has developed this clear and credible plan which sets out what we want to do and how we intend to do it. A measure of success of the plan will be that it reflects the needs and priorities of the local communities and all constituent members will understand and be able to promote the plan in their practices and more widely.

The CCG will work with our patients to promote and support healthy living and self care and, by involving service users, carers, staff, providers, partners and the public, we will develop services and reduce health inequalities. We will work in partnership to transform services and will ensure transparency through inclusion of all stakeholders to meet patient needs. We intend to commission sustainable services as close to the patient's home as possible and ensure these services are safe, high quality and cost effective. We shall plan and respond to the identified needs at a locality level for the residents of Hartlepool and Stockton-on-Tees.

4. Clinical Commissioning Group Overview

4.1 National Context

The Governments NHS reform proposals give accountability for commissioning the bulk of healthcare services in England to Clinical Commissioning Groups (CCGs), led by GPs. The national target date for the authorisation of CCGs as accountable commissioning bodies is April 2013.

The NHS Operating Framework and Outcomes set out the planning, performance and financial requirements for NHS organisations in 2012/13 and the basis on which they will be held to account. Further information can be found at www.dh.gov.uk.

As commissioners, we will develop and actively manage clear and credible commissioning plans which best meet the needs of our populations within available resources and ensure delivery of safe and high quality care.

Although responsibility for local commissioning will rest with the CCG, the National NHS Commissioning Board is accountable for the outcomes achieved by the NHS and will provide leadership for the new commissioning system.

The CCG will ensure that patients and the public are at the heart of everything our health and social care services do. **'HealthWatch England'** and a **'Local HealthWatch'** will be established to champion the views and experiences of patients, services users, carers and the wider public.

The CGG will work in partnership with Public Health, Social Care and representatives of LINKs and then subsequently Health-Watch to deliver integrated health and social care services to improve the health and wellbeing of people in our area. This function will be delivered through the further development of local Health & Wellbeing Boards and Partnerships.

4.2 Local Context

Early in 2011, both Hartlepool and Stockton-on-Tees established pathfinder CCGs. **The aim is to become a fully authorised single body CCG in October 2012** covering both populations. Until this time, the NHS Tees Board has delegated authority to both local Pathfinder Committees to discharge its duties. They have developed processes to ensure the delivery of commissioning initiatives within their respective locality area.

From 1st April 2012 a single shadow CCG Board will be in place focusing on the localities in preparation for full authorisation.

The CCG will establish a robust governance infrastructure building on the arrangements already in place to ensure the appropriate and effective delivery of the NHS agenda. (Appendix D – Governance Framework)

An Organisational Development plan has been developed to aid transition and pathway to authorisation. (Appendix F – Organisational Development Plan)

Stockton-on-Tees LINks statement;

'Stockton-on-Tees LINk agrees with the vision of reducing health inequalities and improvement of overall wellbeing of people in Stockton-on-Tees. The LINk consistently finds that one of the central elements that ultimately impacts on patient experience is effective communication: listening to patients and carers, keeping patients and carers informed and communicating well with all stakeholders.

Stockton-on-Tees LINk welcomes the commitment from the CCG to engage and consult with people in Stockton-on-Tees and to continue to develop the relationship with LINk as it evolves into local HealthWatch. The LINk hopes this will provide a good foundation for ensuring that the voices of all communities across the Borough are heard and reflected in the commissioning intentions of the CCG.'

Hartlepool LINks statement;

5. ***Needs* Assessment - The case for change**

The Joint Strategic Needs Assessment (JSNA) highlights the main health and wellbeing priorities for the residents of ***Stockton-on-Tees and Hartlepool*** taking account of data and information on inequalities within and between communities. A range of plans, strategies, and policies have been developed to help us work effectively in partnership to make a difference to the lives of residents.

The CCG has built on the work already carried out by NHS Tees in developing the Integrated Strategic Operating Plan and have consulted with key stakeholders including Patients, Health & Well-being Partnership and Local Authority Scrutiny Committee on how the CCG will take forward and complement current strategies.

The CCG has specific populations consisting of two localities; Stockton-on-Tees and Hartlepool.

		Hartlepool		Stockton-on-Tees		
		Number	%	Number	%	Total
Current	Population	94,500		191,100		285,600
	Under 16 years			36,900	19.7%	36,900
	Retirement age			33,000	17.3%	33,000
	BME			5,700	3.0%	5,700
Projected (2029)	Population			219,100		219,100
	Under 16 years			35,793	16.3%	53,460
	Retirement age			53,460	24.4%	
	Practices	15		26		41

One of the tools we are using is the predictive health outcome model which have been developed by the Association of Public Health Observatories. These consider trends in data and also risk factors for specific diseases and predicted changes in population structure. Knowledge from these is then applied to population projections to estimate likely levels of disease into the future. The further into the future the model predicts, the greater the uncertainty around the estimated value.

The JSNA states the health conditions that most affect people in Stockton-on-Tees and Hartlepool include:

- Cardiovascular disease
- Cancer
- Smoking-related illness
- Alcohol related illness

Prevalence predictions have been produced for chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), diabetes mellitus, hypertension and stroke. In 2010, a high-profile engagement campaign was undertaken with members of the public, one of the aims of which was to increase understanding of the local community's views on key priorities for investment. Overall, the views of 1883 people were recorded via telephone, street and campervan interviews.

Respondents identified the priority topics most likely to affect them and their families as being;

- Cancer (24%),
- Healthy heart (23%)
- Smoking (17%),

Health Inequalities are spread across the CCG and localities e.g. smoking prevalence varying from 16% to 48%, and emergency admissions for heart disease two and a half times more likely in the most deprived wards than in the least deprived.

Further information detailing the health profiles for Stockton on Tees and Hartlepool can be found in the Joint Strategic Needs Assessment which can be accessed at;

http://www.teespublichealth.nhs.uk/

In October and November 2011, views were sought from patients, carers, members of the public and stakeholders across Teesside in order to ensure that this plan reflects the views of local people. There was significant consensus from patients on a few key themes or topics, with the most popular being:

- Quality of care and of the patient experience;
- Ensuring services represent value for money and reducing waste;
- Focusing on timely access to care and on care closer to home;
- Listening to patients / carers, effective communication and supporting choice;
- Staying true to the core values of the NHS, including care available to all, free at the point of delivery;
- Equality of access and fairness in treatment;
- Meeting the needs of the local community and supporting health improvement initiatives.

One of the key issues that the CCG has identified relates to patient experience. Patients are consistently highlighting the issues on the complexity of what services to access and when to access them particularly Urgent Care.

One of the key priorities of the CCG is to tackle variation of health and treatment outcomes by ensuring all services follow agreed pathways determined by the most up to date evidence available.

5.1 Strategic analysis

Probably the greatest opportunity that clinical commissioning presents is for clinical engagement across the system, with shared goals and shared mechanisms to achieve change.

There are opportunities to be made through improved efficient pathways and better coordination of services, opportunities exist to treat patients in settings closer to home.

Clinical led commissioning provides primary care with the opportunity to ensure the most effective pathway is implemented at each patient contact.

We will utilise key processes as a shadow CCG Board developed in collaboration with the PCT to measure and manage the delivery of this commissioning plan. These include the;

- Integrated Strategic Operating Plan (ISOP)
- Joint Strategic Needs assessment (JSNA)
- Demand management strategy
- Organisational development plan
- Critical pathway for authorisation
- Communication and engagement strategy
- Performance meetings between CCG and PCT
- PCT support team performance framework for all constituent practices
- Financial and QIPP Plans

6. Commissioning Intentions - How the CCG will fulfil it's vision and what will change

6.1 Ways of working

We will continue to support groups of GP practices to build effective relationships and promote their active engagement with projects.

We will work with practices to identify issues, gaps & opportunities, develop action plans, and work closely with colleagues across the CCG to ensure both individual and strategic goals are monitored and achieved. This approach:

- Builds effective relationships with practice staff

- Supports active engagement and implementation of key commissioning work streams
- Improves communication
- Supports collaboration
- Minimises duplication & rework

The CCG and it's practice members review and respond to the GP Variation in Spend (GVIS) report. This highlights areas of spend at a GP practice level, particularly identifying areas of variation from average. Practices are supported to explore areas where they are an outlier, investigate the causes of this variation, develop and implement action plans to address any issues identified and encourage changes in the use of healthcare resources to improve care pathways, patient outcomes and ensure the best use of resources. The key principles that underpin this work are the need to:

- Generate a supportive rather than 'policing' environment
- Have an open minded and supportive approach
- Work in a systematic way
- Actively involve all GP's from every practice
- Adopt an understanding, sharing and educational approach enabled through constructive peer review
- Improve care pathways to deliver tangible benefits for patients whilst ensuring cost-effective use of resources.
- GP practices working together with the locality team to reduce variation in clinical practice within a best evidence framework

6.2 Key Workstreams

Within this framework several work streams have been identified for particular attention that reflect local needs and national priorities (Appendix B outlines the key projects and measure that will support delivery of the NHS outcome framework).

Health inequalities

To address the previously identified health needs our work will support interventions around the health conditions most affecting our population. The focus on systematic and scaled interventions is critical in addressing health inequalities to meet some of the short-term priorities but enable long term and wholesale change to the system. Building on the national work around health inequalities instigated by the National Support Team health inequalities needs to be addressed at 3 levels:

- Population health,
- Personal health, and
- Community health.

Urgent care

The CCG is using recent examples of best practice (Guidance for commissioning integrated Urgent and Emergency Care: A 'whole system' approach", Dr Agnelo Fernandes, August 2011, The Royal College of General Practitioners) to commission and improve Urgent Care Services

that are coherent and make sense to patients. To ensure the CCG is commissioning a fully integrated urgent care system the following initiatives are being taken forward;

- Work with Out Of Hours and Minor injury service providers to develop closer working with acute services
- Promote and support self management for a range of Long Term conditions e.g. COPD
- Develop case management across both health & social care with specific focus on Long Term Conditions, care homes and end of life care

The CCG are using the Urgent Care Clinical Dashboard which presents 'real-time' information on unscheduled care activity including A&E attendances, emergency admissions and GP Out of Hours attendances.

As part of effective demand-management, it is essential that patients have access to information about accessing local services to enable them to choose the appropriate service for their need. The CCG will support patients to make informed choices about which NHS service is most suitable for their illness or injury, and also promote self-care where this is most appropriate. A key enabler to support these plans is the national roll-out of the NHS 111 service and the Capacity Management System (directory of services). Plans are underway to implement the 111 service across Tees by April 2013.

Community services

The CCG recognises the importance of an effective community service to deliver patient outcomes. Outcomes have been developed in relation to service delivery with the community services provider. This will shape services to better enable General Practices to co-ordinate patient care particularly those with long term conditions. The CCG will work with North Tees and Hartlepool Foundation Trust to deliver “Momentum – Pathways to Care”, this will involve a strategic and operational shift of service provision from hospital to community based provision in anticipation of “New Hospital” developments.

Personal Health budgets

The development of PHBs has the support of the Coalition Government and is cited as having potential for increasing personalisation and putting patients in control. The CCG is committed to continuing the pilot and following completion of the evaluation in October 2012, implementing the identified recommendations.

Demand Management

Decisions on appropriate referrals should be made by clinicians in line with best clinical evidence. The CCG will ensure all patients are seen on the basis of clinical need. By taking a systematic approach to reviewing care pathways, the CCG will manage the demand for hospital treatment by using effective services and facilitating a more timely discharge back to services provided in the community, key schemes include;

New to Review activity – Improving Productivity

The CCG is monitoring the number of review appointments that are generated by each new referral. As part of previous commissioning intentions, the acute trusts were set targets to move to within the top decile (10%) of activity when compared to national rates. Clinicians from primary and secondary care will continue to collaborate across specialties to identify initiatives that will improve the patient pathway.

Alcohol

The CCG is focussing on reducing hospital admissions relating to alcohol. The approach will be to enable staff who work within the Drug and Alcohol Teams based within the hospital to identify and target multiple admissions resulting from alcohol misuse.

The following areas have been highlighted as priorities in response to the NHS operating framework 2012/2013. These are;

Military and Veterans health

The CCG will be actively involved in local network group (Tees Armed forces network) to ensure the principles of the Armed Forces Network Covenant are met for the armed forces and that the NHS locally plays an active part in this locally.

Health Visitors and Family Nurse Partnership

The CCG will work in partnership with local PCTs and Health and Wellbeing Board's to ensure the development of effective local health visiting services, with sufficient capacity to deliver the new service model set out in "Health Visitor Implementation Plan 2011 – 2015 – A Call to Action" : to deliver the Healthy Child Programme. The Family Nurse Partnership is currently being implemented across Stockton-on-Tees and Hartlepool.

Carers

The CCG has recognised the need to develop a joint Carers Strategy with the Local Authority by September 2012 it will at a minimum reflect:

- Supporting those with caring responsibilities (Young People and Adults) to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages (short breaks)
- Enabling those with caring responsibilities to fulfil their educational and employment potential
- Personalised support both for carers and those they support, enabling them to have a family and community life
- Supporting carers to remain mentally and physically well

Patient experience

The CCG will seek assurance from providers as to the steps they are taking to record and improve the patient experience. This will include

monitoring collection of data and actions taken to address identified areas for improvement.

In addition, patients' experiences of services, will be used by the CCG to inform decision-making processes, such as that from LINks/Healthwatch, GP Practice Patient Participation Groups and MY NHS, will be used by the CCG, both as direct sources of information about the patient experience and as a tool for capturing the views of the wider Practice population. Further information on the communication and engagement framework can be found in (appendix C)

7. CCG Finance

Although we are a single CCG, outlined in the financial governance sections (appendix D) budgets will be set and managed at a locality level.

The financial outlook for the North Tees Health Economy is more challenging than in recent years, with average growth in 2011/12 of 2.1% across Tees, compared with uplifts of c.5.5% in the preceding years. In the context of continuously rising demand and an ambitious national reform programme, The CCG will become increasingly reliant on efficiency savings as a means of generating resource to fund future growth and investment. (See appendix E and F)

The expected allocations for the CCG will be c£351m with growth for 2012/13 at 2.8% this equates to £9.8m additional funding

Current planned commitments including inflation, increase in CQUIN payments, as well as demand and demographic growth will commit c£23m.

Further investments will be required to meet the operating framework as well as investing in developing the commissioning plan, it is estimated these will be c£7m

This leaves a QIPP challenge of c£20m.

7.1 Delivering QIPP

The CCG has accepted this challenge and has recognised the need to take decisive action to address the problems in order to ensure the contracts which it can influence are in recurrent affordable balance by 31st March 2013.

Initiatives have been implemented with our major providers, in the current financial year, a number of which have been materially relevant in terms of ensuring QIPP targets are achieved. The next steps are to further progress these initiatives with our service providers.

The key themes around delivering the QIPP challenge are

- Provider/Tariff Efficiency £13.0m
- Urgent Care £ 3.0m

- Planned care £ 1.3m
- Prescribing £ 2.5m
- Joint Commissioning £ 1.0m

Further information on the financial framework for both localities can be found in appendix E and F.

7.2 Provider Management

The CGG currently has 42 major contracts across the NHS Tees Provider base. The majority of contracts are now covered by the nationally mandated standard contracts, they include;

- NHS Standard Acute Contract; covering providers such as NTHFT, STHFT, Nuffield, Ramsay etc.
- NHS Standard Community Contract; covering providers such as the North Tees Community Provider, MRCCS, Hospices etc.
- NHS Standard Mental Health Contract; covering providers such as TEWV, Alliance, MIND etc.

The CCG is committed to supporting and taking forward the key contracting meetings required to manage the performance and outcomes of its commissioned providers, these include;

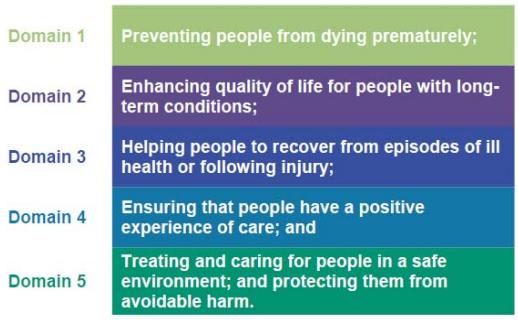
- Contract Compliance Committee
- Corporate Contract
- Data Quality and Information Group
- Clinical Quality Review Group

9. Outcomes and Performance. (How we will measure and know we are achieving desired outcomes and vision)

9.1 Ensuring High Quality Care

Improving the quality of services is one of our overarching strategic objectives and incorporates national best practice, regional work through the clinical networks and our local initiatives. The 2010 Strategy set out the "Quality Story" across the three domains: clinical outcomes, patient safety and patient experience.

Evidence Based Practice has been incorporated into the development of the **CQUIN** work and **Quality Outcome Schedule** for 2012/13. The CCG will drive a change in the focus of the contracting and procurement discussions towards a more holistic approach focusing on **improved outcomes** for patients as set out in the domains identified below. The CCG will be use CQUIN to drive up quality.



9.3 Patient Safety

The CCG will embed key clinical themes identified in the Safer Care North East (SCNE) framework (e.g. the deteriorating patient). We will work collaboratively with all of our provider organisations in driving forward national, regional and local initiatives to improve patient safety.

The CCG will continue to promote clinical engagement and collective working in the areas of HCAI which in more recent years has seen the reductions in the numbers of cases of MRSA and C.difficile. Through Clinical Quality Review Groups (CQRG), we will ensure that robust clinical challenge occurs between providers and commissioners as we strive to commission safe, effective quality services for our patients.

9.4 Safeguarding

Systems and processes will be continually reviewed and refined to support quality improvement and to evidence outcomes. We will ensure that we discharge our statutory functions accordingly and build upon improvements to date in this area for children and adults.

9.4 Measuring Performance

In order to provide assurance that the CGG continues to deliver against the requirements in the operating framework, and to provide the opportunity for robust challenge a Performance Management Process has been implemented throughout 11/12 and will continue into 12/13;

A single “ISOP Performance Report” is produced on a monthly basis. This process is intended to ensure, as far as is possible, that all information in relation to current performance and any mitigating actions captured.

In 12/13 the CCG focus will continue in line with national requirements and local priorities relating to the three key performance categories of;

- Quality
- Resources
- Reform around outcomes frameworks

This plan outlines how we will locally deliver the requirements of the 12/13 NHS Operating Framework together with identifying how we will meet the challenges associated with QIPP, finance, activity, workforce, informatics and transition to new structures.

Appendix A - Glossary

Abbreviation	Explanation
A&E	Accident & Emergency
APMS	Alternative Personal Medical Services
BME	Black, Minority, Ethnic
CCG	Clinical Commissioning Groups
CCP	Clear and Credible Plan
CDIFF	Clostrium Difficile
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
CVD	Cardiovascular Disease
GMS	General Medical Services
GVIS	GP Variation in Spend
ISOP	Intergrated Strategic Operating Plan
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LINKs	Local Involvement Networks
LOS	Length of Stay
LTC	Long term Conditions
MRSA	Methicillin-resistant Staphylococcus aureus
NHSCB	National Health Service Commissioning Board
OOH	Out of Hours
PCT	Primary Care Trust
PMS	Personal Medical Services
QIPP	Quality, Innovation, Productivity and Prevention
QOS	Quality Outcome Scheme
SCNE	Safer Care North East

Appendix B – Commissioning Plan Overview

To build 21st century health services for and with the Stockton and Hartlepool communities so that health inequalities reduce and wellbeing continuously improves

Domain	Rationale	Themes	Projects/Initiatives	Outcome measures
Preventing people from dying prematurely	Significant lifestyle issues of smoking, excessive alcohol use and maintaining a healthy weight are significant contributing factors to the big killers of Cancer, CHD and respiratory disease	• Staying Healthy • Planned Care • Unplanned Care • Social Care & Integrated Working	• Healthy Heart programme • Smoking Cessation • Alcohol Pathway redesign • Weight management • Bowel Cancer Screening Programme	▪ Rate of hospital admissions ▪ Mortality rates ▪ Smoking quit rates ▪ Smoking in pregnancy rates ▪ Weight management activity ▪ National Childhood Measurement Programme
Enhancing quality of life for people with long-term conditions	• High levels of urgent admissions and re-admissions • Unsustainable levels of hospital activity - year on year increase in admissions and attendance at A&E • Patients can be treated closer to home • Autistic Spectrum conditions do not have access to diagnosis and appropriate support Access to high quality, early diagnosis and appropriate support improves outcomes for people with dementia	• Staying Healthy • Planned Care • Unplanned Care • Mental Health & LD • Social Care & Integrated Working	• Healthy Heart programme • Development of community services • Telehealth/Telecare • IBD Pathway • Self Management projects • Personal Health Budgets • Care Home Management • Medicines Management • IAPT • LD annual health check and action plan • Diabetes Pathway • Primary Care Training Project	▪ Reduction in unplanned admissions/readmissions ▪ Reduced number of delayed discharges ▪ Number of people with self-care/health installations ▪ 100% of those with LD to be offered an annual health check and health action plan ▪ No. of people with MH problems in settled accommodation ▪ No. of people with common MH problems claiming
Helping people to recover from episodes of ill health or following injury	• High levels of urgent admissions and re-admissions • Better co-ordination of NHS and social care needed to keep people independent and reduce avoidable admissions	• Staying Healthy • Planned Care • Unplanned Care • Social Care & Integrated Working	• Re-ablement • Development of community services • Enhanced discharge support • Ambulatory Care pathways	▪ Number of patients with a re-ablement plan in place ▪ Reduction in unplanned admissions/readmissions
Ensuring that people have a positive experience of care	• Quality of care is generally high but there is variation in utilisation and outcomes of care across the health economy • Patients can be treated closer to home	• Social Care & Integrated Working • Staying Healthy	• End of Life Pathway • Single point of Access (111) • Dementia Pathways • Autism Pathways • Consultant to consultant • New to review pathways • Carers project • Military & Veterans Health	▪ C2C referral rates. ▪ Outpatient procedure rates ▪ Reduce variation across General Practice ▪ Quality, cost and volume prescribing ▪ Patient satisfaction surveys
Treating and caring for people in a safe environment and protecting them from avoidable harm	• Patients can be treated closer to home • High levels of urgent admissions and re-admissions	• Staying Healthy • Planned Care • Unplanned Care • Social Care & Integrated Working	• Peadiatric Pathways • Alcohol Pathways • Dementia Pathways • Ambulatory care project • Health Visitor & Family Nurse Project	▪ MH – numbers retained in employment ▪ No. of people with MH problems in settled accommodation ▪ No. of people with common MH problems claiming sickness-related benefits

Cross Cutting Initiatives

- Ensure commissed serivces focus on outcome delivery e.g. Transformational not transactional
- Co-ordination of commissioning support to CCG
- Demand management through effective use of business intelligence tools e.g. urgent care dashboard, CAAS
- Engagement and relationships with key stakeholders e.g. Providers, public, primary care

Appendix C – Communication, Consultation and Engagement Framework

The CCG are determined to demonstrate how it will ensure inclusion of patients, public, communities of interest and geography, health and wellbeing boards and local authorities in everything they do, especially in out commissioning decisions. A comprehensive Communication and Engagement Strategy will be developed to allow us to gain a broad range of views, analysing and acting on these. It will be evident how the views of individual patients from the consulting room are translated into commissioning decisions and how the voice of each partner organisation will be sought and acted on.

Stakeholders
In order to ensure that communication and engagement activity is tailored to the needs of stakeholders a stakeholder analysis will be undertaken. Broadly speaking, stakeholders will include:

- Patients and Carers
- Public
- Community Interest Groups
- Primary Care
- Secondary Care
- Public Partners (e.g. Local Authorities, Voluntary Sector, Health & Wellbeing Board)
- Local Healthwatch (LINks)
- Political Partners (e.g. MP's, councillors)
- Media

Patient, Carers and Public Engagement
The CCG will build upon these existing mechanisms to maximise opportunities to engage with and seek the views of patients, carers and the local population.

Many GP Practices across the area have Patient Participation Groups (PPG's) which provide feedback to individual practices and contribute to operational decision- making. This mechanism will be strengthened and Practices will be supported to develop PPGs to enable the CCG to gauge the views of their collective Practice population as well as gather intelligence at individual Practice level. This will include the development of "virtual" participation groups.

NHS Tees has been engaging with patients, public and stakeholders through a variety of mechanisms to solicit views and influence commissioning decisions. The CCG will capitalise on this work and develop existing mechanisms for engagement which will include patients, carers, stakeholders and wider community interest representatives. This will provide the CCG with a platform to:

- Communicate key messages

- Engage and consult with patients, carers and stakeholders on service and pathway design (e.g. promote involvement opportunities)
- Capture the views of patients, carers and stakeholders of NHS services (e.g. online surveys)
- Engage with “hard to reach” or “seldom heard” groups
- Feedback to patients, carers and stakeholders on the outcomes of activity

This mechanism will include partner agencies such as Local Authorities, other NHS organisations, Local Health Watch (LINks) and Voluntary and Community Sector (VCS) Organisations to capitalise on network and engagement opportunities.

Patient Experience
The measurement of patient experience will be integral to decision making. We will work closely with all providers of NHS services to receive feedback and will ensure that patient experience is embedded into commissioning and contracting arrangements. This will allow the CCG to seek assurances from Providers and identify any “hotspots”.

We will create a picture of local patient experience using data from a variety of sources including patient experience surveys (GP practices, secondary and primary care), PALS and complaints.

Patient experience data will be reported to CCG Board.

In order to support the “Information Revolution” and promote patient choice, patient experience information will be published in an easy to understand meaningful format on the CCG website. (www.northteesccg.org.uk)

Partner Agency Engagement
We will work closely with partner agencies, including Local Authorities and Voluntary Sector organisations to identify opportunities for collaboration and to share intelligence across the local health economy.

The CCG will build upon the good relationship between LINks (LHW) and the local NHS and will continue to proactively engage with LHW to ensure that the work of LHW feeds into the CCG Board.

A mechanism will be developed to ensure a systematic approach to engaging with LHW and will ensure that *CCG is best placed to receive intelligence from LHW, is accountable and can respond to recommendations in a timely, meaningful manner.

We will actively participate in the Health and Well Being Board (HWBB) and will contribute to the JSNA which will form the baseline for commissioning decisions.

Use of technology

The use of web and new technologies will be instrumental in ensuring that the CCG is transparent and accountable to the public in its decision making and will provide platforms for publication of information and instant public feedback.

NHS Tees has been using new media platforms to engage with the local population for the past 2 years and has established a presence on Twitter and Face Book. The CCG will consider how it will develop the existing platforms already used to further embed the use of new media into their engagement strategy.

Appendix D - Governance Framework

Governance Infrastructure

The CCG will establish a robust governance infrastructure building on the arrangements already in place to ensure the appropriate and effective conduct of business.

As a statutory organisation the CCG will adhere to standing orders and standing financial instructions with a clear scheme of delegation clarifying the delegated responsibilities of the CCG Board's sub-committees who will support the Board in discharging its duties.

Clear Terms of Reference will be established for the Board in line with published best practice such as The Healthy NHS Board: Principles for Good Governance. The terms of reference for the Board and its sub-committees will explicitly make reference to the statutory duties and other requirements of the Committee as well as set out processes to ensure probity in the conduct of business including decisions taken to vote and settling disputes in such circumstances.

The CCG Board will hold these committees to account through the scrutiny of their minutes.

Furthermore, to enable the Board and each Committee to effectively plan and deliver their terms of reference and associated statutory duties an annual cycle of business will be established. For the Board, this will include as a minimum

- Receipt of assurance information/reports in line with statutory requirements including relevant annual reports
- Regular review of strategic and operational risks to the deliver of CCG business/plans including Annual statement on Internal Control
- Regular review of performance against commissioning plans and ISOP
- Regular review of financial performance and risks
- Receipt of minutes from sub-committees
- Annual report from Audit Committee Chair
- Regular review of terms of reference

Annual cycle of business will be established in line with nationally published relevant guidance such as the Integrated Governance Handbook and the Audit Committee Handbook.

Risk Management Framework

Managing risk is considered to be integral to the everyday running of CCG business and specific risk management responsibilities will be agreed and documented in a risk management strategy and associated policies.

The CCG Board will be responsible for the management of key risks as defined within an Assurance Framework and corporate risk register. The governance infrastructure and scheme of delegation further embed risk management responsibilities throughout the organisation to ensure management of risk is appropriately delegated to CCG leads, clinicians, directors, assistant directors and managers although all staff will be aware they have a responsibility for the management of risk.

Assurances of the effectiveness of the processes in place to manage risk will be sought and reviewed by the committee reporting structures but principally by the Governance Committee, Audit Committee and ultimately the CCG Board.

The CGG has establish a corporate risk register and risk assessment process whereby risks are graded according to their level of severity and all risks submitted are allocated to a responsible officer and have an action plan to support the risk. The risk register will be accessible to all staff and will be supported by a risk assessment process. This will enable operational risks to be identified, escalated and managed at a local level and will be complemented by an Assurance Framework which identifies and articulates the organisation's strategic risks. Risks will be escalated to the Board where appropriate.

Risk management is not however limited to the CCG's internal risks and will also include partnership risks and a register of all partnership arrangements to enable robust recording of such risks.

CCGs have currently established a risk register whish describes the risk currently faced by the CCG as they work through authorisation and the development and implementation of the CCP. CCG staff will receive training and support from NHS Tees staff to ensure the effective identification, ownership and management of risk and will be provided with access to NHS Tees executive information system MIDAS which facilities the electronic capturing an automated monitoring of all risks. This will also enable risk sharing between the PCTs and the CCGs until autonomy is achieved.

In accordance with statutory requirements, the CCG will publish an Annual Statement on Internal Control informed by the Head of Internal Audit Opinion.

Ensuring Probity

Members of the CCG Board will adhere to the seven (Nolan) principles established by the Committee for Standards in Public Life and published codes of conduct for NHS staff. To ensure these principles are embedded within the CGG and ensure delivery of standing orders, processes will be established that regularly capture and review any declarations of interest that may impact upon the conduct of CCG business. In addition, a corporate register of gifts and hospitality will be maintained. This information will be made available to the public in accordance with the corporate publication scheme and statutory requirements.

Committee meetings currently, and will continue to explicitly seek declaration of interest in the conduct of CCG business to enable action to be taken to ensure interests are managed appropriately and business is not compromised or adversely impacted as a consequence.

Financial control

Delegated budgets and authority

CCG allocations will mirror recurrent PCT revenue resource limits less funding for services to be commissioned by Local Authorities and the NHS Commissioning Board (e.g. specialist services, primary care, public health etc). Under this assumption, locality budgets will be set to reflect this arrangement and ring fenced on this basis.

Allocation of Growth

Growth will be allocated to the localities based on a minimum uplift plus a % dependant on distance from target. For example if the national uplift was 2.5%, then 2% would be applied to all localities, with the remaining 0.5% allocated proportionately to those localities under target.

On this basis, all localities would receive a minimum level of growth, with those under target receiving a marginally higher sum i.e. no locality would receive negative growth. This is in line with current national policy.

Financial Plan

Each locality will be required to produce a balanced and affordable financial plan, in line with agreed control totals. Control totals will be set for each locality, mirroring current arrangements which will avoid the potential to accumulate significant surpluses at locality level.

Financial plans must detail investment and disinvestment proposals in line with available resource. This must clearly demonstrate that only 98% of resources have been committed recurrently in line with national policy. This also reflects sound financial practice.

Proposals for the remaining 2% should be included in this plan but must be non recurrent in nature. Profiling of spend must be towards the latter part of the financial year in order to ensure flexibility in year in the event of unplanned financial pressures.

Locality financial plans should explore a minimum of three scenarios including best, worst and likely case. Contingency arrangements and actions to manage in year pressures under the worst case scenario must be explicit (i.e. the locality must prepare an outline financial recovery plan).

Locality financial plans must demonstrate the achievement of national targets, operating framework commitments and strategic local priorities. On the proviso that these conditions are met, individual locality plans will be consolidated into a single CCG plan to be presented to and formally ratified by the CCG Board in March in advance of the new financial year.

This will ensure synergy in plans at CCG level and feed the corporate business and performance plan with a set of clearly identifiable performance measures as necessary to comply with national reporting requirements.

Risk share arrangements
CCGs will continue to be required to commit only 98% of resource recurrently. The remaining 2% will be held on behalf of the Locality at CCG level. Outline plans for commitment of this resource must be identified at the start of the financial year by Localities, however as mentioned above profiling of spend must be towards the latter part of the financial year in order to ensure flexibility in year in the event of unplanned financial pressures.

Localities may expand the range of specific risk share arrangements in place to include for example critical care, however Locality financial plans must contain adequate provision for all potential local pressures.

Routine performance management will identify a CCG in financial difficulty. If financial concerns are raised then the CCG will be asked to invoke its 'worst case financial recovery plan' and this must be formally raised with and presented to the CCG Board.

To the extent that the in year and / or recurrent financial position cannot be managed and the requirement for financial support becomes necessary then a formal application must be made to the Board.

Requirement for additional support
Any locality requiring additional financial support must present a detailed financial recovery plan to the Board, identifying how recurrent balance will be secured alongside the plans to repay any financial support the following financial year.

The Board will consider how it will resource any support. The first call will clearly be any slippage from the specific locality share of the 2% non recurrent top slice resource. If this is insufficient the Board will determine how this may be resourced utilising slippage from other locality top sliced resources.

Protection of underspends / repayment of overspends
To the extent that all localities manage to their respective financial control totals, the carry forward of underspends will be consistent with national policy. Localities may not accrue surpluses beyond agreed control totals.

Where a locality overspends in year and receives financial support, then brokerage must be re-paid in accordance with the approved recovery plan. This cannot be funded through the 2% top slice.

Capital
The requirement for capital resources will be minimal for future CCG's. Should there be a capital programme this would be better managed at CCG rather than locality level, however Locality groups would be able to access this through submission of business cases.

Appendix E – Financial Framework (Stockton-on-Tees)

Context
The financial outlook for the Stockton CCG Health Economy is significantly more challenging than in recent years, with average growth in 2011/12 of 2.1% across Tees, compared with uplifts of c.5.5% in the preceding years. In the context of continuously rising demand and an ambitious national reform programme, Stockton CCG will become increasingly reliant on efficiency savings as a means of generating resource to fund future growth and investment.

Requirement for funding in 2012/13
Expenditure commitments across the CCG for 2012/13 total c£19.7m, which includes shortfalls on QIPP, the impact of contract over performance and other financial pressures which have developed throughout the course of 2011/12.

Growth for 2012/13, allocated through the Comprehensive Spending Review, totals £6.3m (2.8%). This will require efficiency savings in the region of £13.3m to be delivered recurrently, to ensure financial balance is maintained and contingency funds are protected in line with DH requirements.

This represents an efficiency requirement of c.5.8%.

Expenditure commitments:

Inflation requirements	2.1%
CQUIN uplift (on provider contracts)	0.9%
Demographic and demand growth	2.6%
QIPP shortfall and over performance	0.9%
Pre-commitments	0.6%
National policy developments	1.1%
Local Developments	0.4%
Total	**8.6%**

Funded by:

Growth	2.8%
Efficiency programme	5.8%
	8.6%

Expenditure commitments

Inflation requirements £4.8m
Inflation uplifts for healthcare providers are set through national tariff arrangements. Local discretion is applied to other areas of spend.

CQUIN increase £2.0m

An increase of 1% on the provider contracts equates to c 0.9% uplift on the baseline budget.

Demographic and demand growth £5.9m
Growth on acute contracts is estimated at c2.8% on contract baselines equating to £3.6m. In addition to this, substantial demand growth in specialist commissioning, continuing healthcare and prescribing has also been reflected.

Contract pressures and over performance c£2.0m
Throughout 2011/12 a number of pressures have been absorbed non recurrently. Most significantly pressures on acute contracts reached c. £3.6m as a result of increased demand above expectations and shortfalls in demand management initiatives. Additional pressures on primary care prescribing, specialist commissioning were also a factor.

Pre-commitments £1.4m
PCT commitments in this area have reduced in the last few years as resources have reduced, the remaining pre commitment relates to the expansion of Radiotherapy. Also the reinstating the public health QIPP delivered in 2011/12

Local and national priority developments £3.5m
The annual operating framework identifies a range of policy initiatives, including reablement funding, cancer developments, and specialist commissioning, a previous commitment to fund carers support is also required. A general reserve has also been set for the new operating framework due end of November, following which financial plans will subsequently be refined in more detail. Local developments, due to the economic picture are minimal.

Funding for these commitments is clearly reliant upon delivery of efficiency savings. Given the inherent risk within this strategy, investment funding can only be released on delivery of the QIPP programme.

Funding Sources

Growth
Growth at £6.3m, will fund approximately one third of the total requirement for resource across Stockton, leaving the balance of £13.3m to be generated through efficiency savings.

Efficiency savings identified within Quality, Innovation, Productivity and Prevention (QIPP) Programme

The requirement for efficiency savings has been assessed at 5.8% equating to £13.3m.

Contributing to this are price efficiencies generated through the application of the nationally set tariff uplift for all NHS and Foundation Trust contracts, estimated at c£6.0m.

In order to address the remaining balance of £7.3m, a range of efficiency schemes have been identified as follows:

Programme	£m
Acute – unplanned care	£ 3.4
Acute – planned care	£ 1.3
Joint Commissioning	£ 0.7
Prescribing	£ 1.9
Sub total	£ 7.3
Price efficiencies	£ 6.0
Total	**£13.3**

The level of acute savings required is considerable, particularly in the context of a payment by results framework which relies on effective demand management arrangements being in place.

Contract negotiations will understandably focus on the detail of PCT/CCG plans to deliver the savings required. Whilst the level of savings required from acute providers is significant, this must be seen in the context of substantial investment in contract growth and over performance in recent years.

However, delivering savings of this magnitude is a challenge and requires real acceptance from all parties that current levels of growth cannot be sustained. Expenditure must be reduced across all parts of the economy to deliver a sustainable solution and healthcare providers on Tees have expressed a genuine desire to work with commissioners to streamline pathways in order to reduce costs.

Negotiation of savings at this level however will be extremely challenging for both commissioners and providers. In recognition of the need to ensure that all parts of the health economy remain viable, we are working on a collaborative basis with local providers, involving clinician to clinician discussion on the detail of individual scheme proposals and the impact on specialty level activity and costs.

It is key that changes in pathways and reduction in cost is managed in a sustainable way and that the inherent risks for both providers and commissioners are mitigated appropriately. All parties must be inextricably linked and jointly responsible for delivery of this programme and contract offers have been structured in such a way as to recognise the need to share the management of risk through this uncertain period.

Risks in relation to in year over performance will be mitigated through contractual frameworks currently being agreed.

Plans for 2013/14 and beyond

Plans for 2013/14 and beyond are based on the assumption that the measures taken as part of the QIPP programme will serve to prevent the acute contract pressures which have become an issue in recent years and provide a stable platform on which to determine how resources should be deployed in future to achieve maximum health benefit.

Key assumptions in future year plans are as follows:

- Growth reduces to 2011/12 levels c2.2%
- Inflation uplifts are static for two years and then begin to rise
- Acute contract growth is provided for at 3%
- Tariff efficiencies deliver 4% in real terms from 2013/14 onwards at local level
- QIPP efficiencies are generated in full on a recurrent basis

NHS Tees	**2012/13** £m	**2013/14** £m	**2014/15** £m	**2015/16** £m
Sources				
Growth	6.3	5.2	5.3	5.4
Efficiencies	7.3	8.3	7.3	7.3
Tariff efficiencies	6.0	5.8	5.9	6.0
Total efficiencies	***13.3***	***14.1***	***13.2***	***13.3***
Total resource available	**19.6**	**19.3**	**18.5**	**18.7**
Applications				
Uplift inc CQUIN	6.8	6.8	8.1	8.3
Contract pressures	2.0	0.0	0.0	0.0
Demo/demand growth	5.9	6.1	6.8	6.9
Investment	4.9	6.4	3.6	3.5
Total commitment	**19.6**	**19.3**	**18.5**	**18.7**

Future year efficiency requirements

Provided growth on acute contracts, prescribing and continuing healthcare can be maintained at an affordable level, the requirement for future QIPP savings will remain at similar levels to 2012/13 in future years.

The CCG is already fully engaged in reviewing current QIPP schemes and identifying and agreeing additional schemes which will support management of demand.

The four year QIPP plan is identified below.

QIPP plan	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	Total £m
Acute – unplanned care	3.4	3.0	3.0	3.0	12.4
Acute – planned care	1.3	1.0	1.0	1.0	4.3
Prescribing	1.9	0.9	0.9	1.0	4.7
MH/LD	0.0	1.4	0.8	0.8	3.0
Support functions	0.0	0.3	0.0	0.0	0.3
Primary & community services	0.0	0.5	0.5	0.5	1.5
Other schemes	0.7	1.1	1.0	1.0	3.8
Sub total	7.3	8.2	7.2	7.3	30.0
Price efficiencies	6.0	5.8	5.9	6.0	23.7
Total	13.3	14.0	13.1	13.3	53.7

Appendix F – Financial Framework (Hartlepool)

Context
The financial outlook for the Hartlepool CCG Health Economy is significantly more challenging than in recent years, with average growth in 2011/12 of 2.1% across Tees, compared with uplifts of c.5.5% in the preceding years. In the context of continuously rising demand and an ambitious national reform programme, Hartlepool CCG will become increasingly reliant on efficiency savings as a means of generating resource to fund future growth and investment.

Requirement for funding in 2012/13
Expenditure commitments across the CCG for 2012/13 total c£6.9m, which includes shortfalls on QIPP, the impact of contract over performance and other financial pressures which have developed throughout the course of 2011/12.

Growth for 2012/13, allocated through the Comprehensive Spending Review, totals £3.5m (2.8%). This will require efficiency savings in the region of £3.4m to be delivered recurrently, to ensure financial balance is maintained and contingency funds are protected in line with DH requirements.

This represents an efficiency requirement of c.2.5%.

Expenditure commitments:

Inflation requirements	2.1%
CQUIN uplift (on provider contracts)	0.9%
Demographic and demand growth	2.6%
QIPP shortfall and under performance	(2.2)%
Pre-commitments	0.3%
National policy developments	1.2%
Local Developments	0.4%
Total	**5.3%**

Funded by:

Growth	2.8%
Efficiency programme	2.5%
	5.3%

Expenditure commitments

Inflation requirements £2.7m
Inflation uplifts for healthcare providers are set through national tariff arrangements. Local discretion is applied to other areas of spend.

CQUIN increase £1.1m

An increase of 1% on the provider contracts equates to c 0.9% uplift on the baseline budget.

Demographic and demand growth £3.3m

Growth on acute contracts is estimated at c2.8% on contract baselines equating to £1.9m. In addition to this, substantial demand growth in specialist commissioning, continuing healthcare and prescribing has also been reflected.

Contract pressures and over performance c(£2.7)m
The delivery of QIPP in 2011/12 and contract under performance has led to an over achievement of the QIPP target which has significantly contributed to the 2012/13 baseline QIPP delivery and thus shows a reduction of c£2.7m.

Pre-commitments £0.5m
PCT commitments in this area have reduced in the last few years as resources have reduced, the remaining pre commitment relates to the expansion of Radiotherapy. Also the reinstating the public health QIPP delivered in 2011/12

Local and national priority developments £2.1m
The annual operating framework identifies a range of policy initiatives, including reablement funding, cancer developments, and specialist commissioning, a previous commitment to fund carers support is also required. A general reserve has also been set for the new operating framework due end of November, following which financial plans will subsequently be refined in more detail. Local developments, due to the economic picture are minimal.

Funding for these commitments is clearly reliant upon delivery of efficiency savings. Given the inherent risk within this strategy, investment funding can only be released on delivery of the QIPP programme.

Funding Sources

Growth
Growth at £3.5m, will fund approximately 50% of the total requirement for resource across Hartlepool, leaving the balance of £3.4m to be generated through efficiency savings.

Efficiency savings identified within Quality, Innovation, Productivity and Prevention (QIPP) Programme
The requirement for efficiency savings has been assessed at 2.6% equating to £4.7m.

Contributing to this are price efficiencies generated through the application of the nationally set tariff uplift for all NHS and Foundation Trust contracts, estimated at c£3.4m.

This means that there is no need for an allocative QIPP target, although there are still areas of efficiency that have been identified as per below which will allo further investment and to contribute to future years QIPP requirements

Programme	£m
Joint Commissioning	£ 0.3
Prescribing	£ 0.6
Sub total	£ 0.9
Price efficiencies	£ 3.4
Total	**£ 4.3**

It is key that changes in pathways and reduction in cost is managed in a sustainable way and that the inherent risks for both providers and commissioners are mitigated appropriately. All parties must be inextricably linked and jointly responsible for delivery of this programme and contract offers have been structured in such a way as to recognise the need to share the management of risk through this uncertain period.

Risks in relation to in year over performance will be mitigated through contractual frameworks currently being agreed.

Plans for 2013/14 and beyond

Plans for 2013/14 and beyond are based on the assumption that the measures taken as part of the QIPP programme will serve to prevent the acute contract pressures which have become an issue in recent years and provide a stable platform on which to determine how resources should be deployed in future to achieve maximum health benefit.

Key assumptions in future year plans are as follows:

- Growth reduces to 2011/12 levels c2.2%
- Inflation uplifts are static for two years and then begin to rise
- Acute contract growth is provided for at 3%
- Tariff efficiencies deliver 4% in real terms from 2013/14 onwards at local level
- QIPP efficiencies are generated in full on a recurrent basis

NHS Tees	**2012/13**	**2013/14**	**2014/15**	**2015/16**
	£m	£m	£m	£m
Sources				
Growth	3.5	2.9	2.9	3.0
Efficiencies	0.0	2.7	4.1	4.2
Tariff efficiencies	3.4	3.3	3.5	3.5
Total efficiencies	***3.4***	***6.0***	***7.6***	***7.7***
Total resource	**6.9**	**8.9**	**10.5**	**10.7**

available				
Applications				
Uplift inc CQUIN	3.8	3.8	4.5	4.6
Contract pressures	-2.7	0.0	0.0	0.0
Demo/demand growth	3.3	3.5	3.8	3.9
Investment	2.5	1.6	2.2	2.2
Total commitment	**6.9**	**8.9**	**10.5**	**10.7**

Future year efficiency requirements
Provided growth on acute contracts, prescribing and continuing healthcare can be maintained at an affordable level, the requirement for future QIPP savings will remain at similar levels to 2012/13 in future years.

The CCG is already fully engaged in reviewing current QIPP schemes and identifying and agreeing additional schemes which will support management of demand.

The four year QIPP plan is identified below.

QIPP plan	**2012/13** £m	**2013/14** £m	**2014/15** £m	**2015/16** £m	**Total** £m
Acute – unplanned care	0.0	0.8	2.0	2.0	4.8
Acute – planned care	0.0	0.0	0.3	0.3	0.6
Prescribing	0.6	0.4	0.4	0.4	1.8
MH/LD	0.0	0.4	0.4	0.4	1.2
Support functions	0.0	0.2	0.0	0.0	0.2
Primary & community services	0.0	0.3	0.4	0.4	1.1
Joint Commissioning	0.3	0.6	0.6	0.7	2.2
Sub total	0.9	2.7	4.1	4.2	11.9
Price efficiencies	3.4	3.3	3.5	3.5	13.7
Total	4.3	6.0	7.6	7.7	25.6

Appendix G - Organisational Development Plan

Introduction
This plan represents the first iteration of the development plan for the emerging Clinical Commissioning Group (CCG).

North Tees CCG is a new organisation with elected members driving clinical change.

North Tees CCG aspires to be amongst the top 10% best performing CCGs nationally, providing high quality care for its patients in a sustainable and value for money manner.

All executive members fully appreciate the steep learning cure they now face and the unprecedented level of ambiguity the NHS faces, however it is clear that there is both common purpose across the Executive and its membership and an enthusiasm to learn through delivering change for our local population.

Process
In identifying areas for development and proposing potential solutions the following steps have been carried out:

- Members of CCG Sub-Committee completed diagnostic tool
- Analysis of the results and discussion to agree baseline measurement
- Discussions with individual members of the Executive Team regarding development needs

The plan is based upon the six main areas of competency described in the diagnostic tool, namely:

- Clinical focus and added value
- Organisational capacity and capability (including governance)
- Engagement with patients and communities
- Clear and credible plan
- Capacity and capability
- Collaborative arrangements
- Leadership capacity and capability

Although the plan concentrates on the development needs of North Tees CCG it is recognised that many of the gaps in knowledge and skills will be addressed through a local, regional and national events.

The plan is also a working document, which will change as guidance around the development of emerging CCGs becomes available.
The diagnostic tool upon which this Organisational Development is based will be repeated on a quarterly basis to assess progress against agreed actions.

North Tees Clinical Commissioning Group
Development Plan draft 1 – October 2011

Area for action	Current Position	Identified Gap	Agreed Development Need	Proposed Method to address	Diagnostic rating September 2011	Owner/Lead	Timescales
Domain 1. CLINICAL FOCUS AND ADDED VALUE				**Overall rating**			
The CCG has clinical leaders that are able to influence and lead others to deliver on the CCG's objectives of improving the health of the population and using the budget most wisely		Insufficient or underdeveloped clinical leadership capacity across the CCG; only 1 executive GP has undertaken Clinical Leadership training. No formal mechanism to identify new talent. No formal mechanism for succession planning.	Develop additional clinical leadership capacity across the CCG – not just GPs on the Sub-Committee. Provide access to a range of different learning opportunities eg formal leadership coaching, shadowing. Establish a formal process for succession planning. Establish a formal process for talent spotting.	External support via National Leadership Academy, National Institute of Innovation and Improvement. Locally run programmes eg Learning Academy, local university. Protected learning time sessions for clinical staff Procure external expertise to work directly with the CCG.		NHS Tees	

		Limited expertise in a range of change management techniques. Limited knowledge within the existing team in respect of corporate functions eg corporate governance.	Provide a range of training across CCG in respect of change management eg LEAN methodology, pathway planning. Provide access to the principles of project management training for clinical leaders.				
The CCG has a comprehensive, up to date understanding of the needs of its population now and over the next 5 years, that enables the CCG and its constituent Practices to describe the		Ensuring Practices have access to practice specific information. Skills to truly segment the population. Fully using this level of information to further refine	Increase analytical expertise and capacity within the CCG. Work more closely Public Health and Local Authority to ensure robust Health Needs Assessment process in place. Develop prioritisation methodology.	Utilise NHS/LCC expertise is developing HNA expertise. Consider external support where appropriate – learning from other local authorities.			

main health issues for their population.		prioritisation. No robust methodology for prioritising objectives. The skills to undertake detailed analysis e.g. whole system modelling. The capacity to provide detailed and meaningful reports at Practice level which are fully analysed and understandable to practices their own planning.	Agree process to undertake future JSNA to ensure full engagement across the CCG area.				
The CCG understands how healthcare services and healthcare providers can		The need to develop market management skills to ensure services are delivered to meet	Gaining knowledge/skills to manage and develop the local market more effectively.	Utilise a range of internal and external learning opportunities; formal training programmes, action learning sets, taking areas of good			

meet the needs of the population and the constraints on this.		the needs of the identified needs of the population. The capacity to dedicate to work with providers on a wider range of service developments/changes. Need to use performance information better to identify when providers are not delivering services as agreed.	Identify key contracting leads and support them to gain the level of knowledge required to fully engage in this work. Skills to analyse performance information from local providers to identify when services are not delivering.	practice across the region/country.			
Values and behaviours are agreed by all the constituent practices within the CCG. Through the way that the CCG works, behaviours that		More robust methods of identifying and accounting for equity and diversity issues. Ensuring the CCG strives to engage 'hard to	Training for key CCG team members in respect of Equity & Diversity. Developing a clear policy and action to address identified areas of inequity.	Work with current expertise within Tees to address these areas of development. To consider as a potential for a CSU type support model.			

support its values are promoted and strengthened whilst those behaviours that do not promote its values are sanctioned.		reach' groups. Development of first class communications to ensure openness and transparency in the CCG's work.	Working with LA via Public Health to identify a plan services for Hard to Reach Groups. Development of a communications strategy and associated methods of communication.				
There is conscious and promoted culture in the CCG of systematically and continuously improving the quality of clinical care to improve health outcomes within the given budget.		The need to develop further capacity to support practices and other teams to undertake change. The need to significantly strengthen the evaluation methods for projects to ensure impact can be identified.	A range of training and development in respect of Change Management, and Leading large scale change projects which is available to a wide range of individuals within a CCG. Support to develop robust evaluation mechanisms for on-going change projects using appropriate metrics and appropriate data	Both internal and external; programmes and courses; access SHA and National offerings for development. To use the expertise in establishing performance frameworks and indicators eg NICE, Institute for Innovation.			

			collection.				

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2. ORGANISATINOAL CAPACITY AND CAPABILITY (INCLUDING GOVERNANCE) Overall score -							
Key elements of a structural and cultural change (transition) plan are in place with the skills required to support this including project management and monitoring success.		Finalise OD plan. Develop CCG specific clinical improvement strategy. Alignment/assignment of staff to support operation of CCG. Policies & processes documentation to support change/ programme management. Clear process for regular review of approach to change/programme management to support continuous	Training for staff in their new roles: • Change Management • Project & Programme management • Lean methodology • Communications • Development of processes and policies for change/programme management. • Development of processes and policies for continuous improvement.	• Utilisation of Tees expertise and experience. • Collaborative approach with other Tees CCGs. • Eternal training support required in respect of key change management methodologies.			

		improvement.					
The CCG has the clinical, commercial, legal and other skills and capacity to negotiate, write and manage contracts for the provision of health services.		Capacity to undertake contract management within CCG. Lack of knowledge, skills and capacity regarding contracting/procurement /contract management within executive members. Robust methodology to assure for value for money contracts. Provision of timely & robust information on provider services & development of KPIs. Agreed approach to federation.	Capacity to undertake robust contract management of provider services. Identification & agreement of key Performance Indicators. Review of skills & knowledge once staff are in place. Access to robust and timely information on provider services. Basic understanding of:- Commissioning cycle and contracting processes. Governance requirements associated with contracting. The importance of supplier relationships. Information flows & analysis.	It is anticipated that this area of work will be a confederated function and the expertise will be drawn from TEES. Possible use if external training and development to support Executive members gain appropriate level of knowledge eg Action Learning Sets, e-learning, taught programmes.			
The necessary administrative functions are in		Gaps in its administrative understanding, skills	Complete alignment & assignment of staff. Training for staff in their new roles	Utilisation of Tees expertise and appropriate			

place to run the organisation.		and capacity, including with regard to the provision and manipulation of data.	including:- • Change management • Project & Programme management • Lean methodology • Communications • Finalise agreement on CCG's & CSUs • Develop policy on information Governance • Basic training in Information Governance	utilisation of training & development. Utilisation of existing policies and procedures adapting for consortium's use. To consider potential benefits of external CSU type functions for "back office functions".			
Systems are in place to effectively monitor and track quality and safety so CCG has early warning of problems and there are clear processes for acting when problems are detected.		Clear & robust policy & processes for incorporating clinical competence into decision making including:- • Quality and outcomes, • Allocation of budgets • Policies & procedures for identification for	Basic training on the role of CQC, Monitor, Health & Wellbeing Board & Health Watch. Training for identified Quality & outcome lead Development of Policies & Procedures for:- • Identification and proactive management of potential quality issues.	Utilisation of existing Tees expertise to support this area of development. Potential federated approach to share expertise in quality and monitoring and responding to regulators.			

		identification and proactive management of potential quality issues. • Identified lead for management of quality & outcomes.	• Development of a decision making process that explicitly incorporates quality & outcomes.	Possible e-learning taught programmes if necessary.			
The CCG has or is able to assemble the right commissioning skills and build the best operating model to most effectively commission services.		Need to finalise functions of CCGs & what will be confederated. Currently no workforce plan setting out skills & competencies required, recruitment policy and associated training & development plan. Second phase of assignment /alignment will provide very limited workforce.	Development of:- • Detailed workforce plan to ensure an appropriately skilled workforce is available to the Consortium to ensure high quality commissioning is undertaken. • Next phase of assignment to be developed with Tees.	Requires joint plan with Tees and the CCGs.			
Effective integrated corporate governance systems of		Need to develop policies, process & procedures for robust decision making and communications	Development policies, processes and procedures as list. Training in development of a	Utilise where appropriate, existing Tees policies and procedures.			

finance, probity, statutory duties and clinical quality are not in place.		decisions. Need monitoring progress & delivery of the Outcomes Framework. Managing Risk. Providing Board Assurance. Delivering continuous improvement. Stakeholder engagement Balance scorecard to be developed to monitor progress against objectives overtime.	balanced scorecard.	Seek external support for balance score card development – leaning from good practice elsewhere.			
There is capacity and capability in the organisation for robust financial management of budgets.		Timeliness of financial information. Limited capacity for financial support.	Basic introduction to NHS Financial Management, system's & processes. Increased financial capacity and capability. Scheme of delegation for identified budgets.	Utilisation of internal Tees expertise and capacity. Possible action learning sets with other CCGs approach for Exec Team to learn key			

				elements of financial management. Through phase 3 or 4 of assign and align.			
The CCG has a financial planning process that allows prioritisation of resource for commissioning services for its population and ensures that the funds are spent only as intended.		Currently there are no CCG specific policies, processes & procedures for Financial management, Prioritisation & Planning at CCG. Tees processes perceived as slow and bureaucratic by some stakeholders.	Development of policies, processes and procedures as list. Develop an understating of the need for robust project management principles. Basic understanding of:- Prioritisation processes. Understanding skills and capacity about financial planning control	Utilisation of internal TEES expertise and capacity. Possible action learning sets with other CCGs approach for Exec team to learn key elements of financial management. Development of "learner" business case processes as part of scheme of delegation. Through phase 3 or 4 of assign and align.			

The CCG can stand up to public scrutiny regarding its spending of public funds.		The CCG has not been responsible for this up to this point it does not have its own systems and processes in place currently. CCG needs to fully understand it's budgets and the outcomes these deliver.	There is a need for the CCG Executive Team to ensure robust systems and processes are in place to enable scrutiny of all its decisions as to how funding is spent. There is a need to take CCG executive board through ownership of budgets. The CCG needs to understand how performance on expenditure and outcomes matches.	Utilisation of current Tees expertise. Use of various publications/guidance regarding effective Boards, etc. Learn from other CCGs. Understand the benchmarking process.			

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CLEAR AND CREDIBLE PLAN Overall score							
There is a practical implementable strategy developed collaboratively that clearly sets out the priorities for the CCG and why those priorities are likely to lead to greatest health gain taking account of anticipated future changes.		At present the CCG does not have a dedicated Strategic Plan that has been developed by all its stakeholders. The ability to robustly prioritise objectives is required. Historical PBC plan excellent in depth but scope too limited. No overt process to ensure the CCG's strategic plan will, in the future link to other key planning processes e.g Local Authority.	Production of a single Clear and Credible Plan for the CCG by end December 2011 identifying delivery of QIPP objectives. Skills to undertake excellent strategic planning. Processes to identify and involve key stakeholders appropriately. Processes to robustly prioritise objectives. Develop and strengthen relationship management skills. Develop a federated partnership board with County	Utilisation of existing planning skills within Tees. Procurement of external support to ensure excellent stakeholder engagement. Utilisation of best practice/methodologies for prioritisation. Learn from best practice integrated communities.			

			Council and other CCGs to manage the interface and decision making.				
The CCG is equipped to ensure that the needs of the population are met by the provider of healthcare services. The CCG has prioritised what it needs to do to achieve these outcomes within resources.		Biggest Gap is analytical and modelling capacity to support more detailed scenarios to support planning – "what if". The need for skills such as systems dynamics or discrete event modelling to support commissioning decisions and to understand impact/unintended consequences. The inability, at present, to cost and analyse activity along a whole pathway to enable prioritisation within a pathway. Providing Practices with access to such skills to interpret the information in a practical and accessible way.	Need to ensure, expert, analysis capacity and capability is available to the CCG team. Need to ensure the support to practices to enable improves use of information and to make change accordingly. As above, need to ensure effective prioritisation process. Development of an accessible and focussed performance framework such as a balance scorecard.	Possible procurement of external analytical expertise and support. Combination of additional access to change management support at practice level both from Tees and external procurement for specific projects eg talking variation. Potential CSU area for exploration of alternative models of provision. Addressed through Phase 4			

		Sufficient change management capacity to support at Practice level and within wider health & social care teams.		onward of assignment.			
There is a clear vision (narrative) of what the CCG's purpose is and how it will achieve better patient outcomes within available resources and discharge its statutory duties.		No overarching strategic plan with pulls the various elements of action together. No formal policy to ensure robust Public and Patient Engagement. The need to further work with practices at practice level remains.	Excellent strategic planning skills. Policy to ensure robust and innovative PPI involvement in all aspects of the CCGs work. A clear plan to set out how Practices will be engaged and supported in the change required to deliver the key objectives of the CCG.	Possible procurement of external and analytical expertise and support. Combination of additional access to change management support at practice level both from Tees and external procurement for specific projects eg tackling variation. Potential CSU area for exploration of			

				models of provision. Addressed through Phase 3 onward of assignment.			
There are clear, consistent and communicated reasons for the things that the Consortium is going to do and how success will be tracked. These reasons are understood and accepted by practices and providers.		No clear communication strategy. Limited User and Carer involvement in the planning process. No comprehensive strategic plan currently in place. Prioritisation processes needs to be developed.	Ensure CCG Executive Team have a range of communication skills and techniques available to team. Ensure an excellent communication strategy. Develop a range of different skills and methods to communicate with Practices eg web based/face/media.	Currently working with Tees communication team and PPI team with other CCGs.			

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4. ENGAGEMENT WITH PATIENTS / COMMUNITIES							
Patients and public engagement is embedded into the organisation and the full commissioning process.		Historical lack of consistent engagement throughout all commissioning processes. Good engagement in planning and gap analysis but needs embedding in both procurement and evaluation.	Ensure engagement strategy in place for commissioning.	Currently working with Tees PPI team and communication teams to support this work.			
To definite and deliver on its purpose, the consortium has engaged with the different communities in the geographical area it covers.		Some sectors of the public are not currently reached within certain localities and work is being undertaken through this approach to identify these.	Ensure engagement throughout the commissioning cycle Hard to reach communities are confident their voices are heard.	To be developed with Tees communication and PPI team.			

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5 LEADERSHIP CAPABIITY & CAPACITY							
Leadership motivates individuals within the organisation to make changes in what they do.		The leadership team needs change leadership skills and capacity to excel in leading change in the wider health/social care community. The leadership of the CCG has mechanisms in place to assure itself of this, and of improvement.	Support to develop the following skills and knowledge both within the Executive team and across the CCG: Change leadership knowledge & skills. Review and monitoring skills. Motivational Interviewing Techniques. Appreciative enquiry.	A mixture of local provision of this training commissioned jointly through the federation. External training and development: National Institute for Innovation & improvement.			
The right reporting mechanisms exist so the CCG leadership is aware of progress in delivering the strategy.		Gaps in understanding, skills and capacity about reporting. Gaps in assurance process and robustness of the information it receives and provides, and of the CCGs continuous	Develop business knowledge and reporting skills and capacity. Basic understanding of performance & quality management & systems. Ability to ensure information is delivered on time.	Through accountability agreement for services with Tees. Potentially a CSU type service to be provided.			

		improvement.					
The CCG is clear about how it makes decisions. The delegation making is clear. The appropriate distribution of power, responsibility and accountability amongst practices.		Universal Clarity regarding the decision-making processes in, and for, the Consortium and consistent used. Clear and robust feedback mechanisms to practices, including the consequences of decisions.	Understanding of Nolan principle. Understanding of Public sector Board functions, systems and governance, including:- Risk Management Financial Stewardship Decision making Quality Assurance Probity Legality Role of corporate trustee	To be considered as part of federation and CSU options.			
There is leadership team in place with sufficient knowledge of commissioning processes to be able to ensure effective delivery. This knowledge includes how and		Gaps exist in the commissioning process knowledge/ skills of some of the leadership. These need to be identified and costed. Lack of mechanisms in place to assure itself of this, and of the	Understanding to be able to interpret information from experts and to apply this in making decisions. Capabilities across governance and finance, planning, negotiating and contract/performance management and relationship managements in innovation	To be considered as part of federation and CSU options.			

where to acquire additional knowledge and skills and to enable sufficient challenge advice provided, if required.		Consortium's continuous improvement.	and quality improvement. Contract and manage contracts to achieve optimal performance in these.				
The roles and responsibility of individual leaders, CCG leadership, the CCG and the constituent practices are clear and aligned to the Vision, Values & Strategy.		Personal development plans need to be in place. The leadership roles, responsibilities are not universally understood & accepted. Skills need to be acquired for "different conversations" with peers.	Personal Development plans required for each member, resulting in some individual specific training. Communication skills.	Use support from within Tees or other regional offerings.			
The leadership of the CCG is to make transparent, defensible, informed, robust and sustainable		CCG had agreed to adopt Tees SFIs as part of scheme of delegation; this will enable learning. Feedback on consequences of	Basic understanding of NHS financial systems. Operation of SFIs as part of delegated budgets as a subcommittee of Tees.	To be agreed with Tees Board.			

decisions about the allocation of public funds on the basis of systems that are compliant with legal, statutory and regulatory requirements and national governance policies.		decision making is slow and not always transparent.	Basic understanding of NHS specific costing processes. Appointment of dedicated qualified financial support. Improved availability of timely financial information.				
The CCG leadership understands how to involve those who will actually make things different so that the successes of the changes that are brought about are more likely.		Documented and communicated plan for engagement and managing stakeholders in the changes which are universally agreed and or consistently applied.	Comprehensive stakeholder Communication & Engagement Plan.	As outlined in engagement section.			

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6. COLLABORATIVE ARRANGEMENTS							
The CCG has the skills to understand the relationships they as an organisation, need as good commissioners and how to get the most out of these relationships,		Segmentation and prioritisation of relationships has not been undertaken.	Stakeholder management processes to identify prioritisation of relationship in context of consortium delivery priorities.	Take part in account management activities organised by Tees in Dec 2011.			
The CCG has formed and maintains relationships with other commissioners including the National Commissioning Board, other		Identification of functions, services and risk to be federated needs completion. Lead contracting arrangements to be finalised. Consortium does not	To identify and work with other consortia to develop objectives for co-ordinated commissioning. Agreeing how the consortia will make, share, buy the various functions/services. Relationship Management training	Agree federated functions by Sept 2011. Agree lead contract arrangements by Oct 2011. National guidance is expected			

Consortia and Commissioning Support Services.		have clear relationships with Deaneries' Higher Education etc.		regarding working with Deaneries' and high education. Relationship management training.			
There is access to the specialist and capacity to actively manage supplier and clinical engagement.		Identification of specific progresses for individual groups. Identification of process for systematic clinical out of county providers.	To work more consistently with clinical groups which have clear and agreed objectives. Supported by managers the clinical groups need to have a sense of achievement and delivery for the consortium priorities. Federated approach to be developed to enable access to highly specialist skills locally. Access through CSU for very specialist expertise to be explored.	Build upon exiting clinical groups to define purpose, outcomes and objectives, supported by programme and project management. CSU development and options. Federated approach to shared expertise.			
The CCG recognises that at		There is not yet handover plan from the	Identify timing and process for handover of functions	Agree federated functions and			

a time of change relationships can be lost without an excellent understanding of existing relationships and a robust handover mechanism.		PCT cluster to CCG.	from PCT to CCG.	make, share, buy. Attend stocktaking event with Tees in September and SHA event in Sept 2011. Agreed handover plan with PCT cluster.			
There are effective relationships with all the Local Authorities/district /borough councils and partnerships in the community.		CCG objectives have not always been identified in each relationship.	Consistent stakeholder management process and clarification of objective and priorities. An effective partnership to be developed to oversee joint commissioning across the federation.	As part of federation development			