SHADOW HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

11th March 2013

10.00 am

Committee Room B, Civic Centre
Victoria Road, 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, Cleveland Fire Authority.

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 28th January 2013 (attached)

4. **MATTERS ARISING FROM MINUTES**

   4.1 Breast Feeding – Media Coverage – Verbal Update – *Director of Public Health*

5. **ITEM FOR INFORMATION**

5.1 CCG Commissioning Intentions and Annual Planning Requirements – *Chief Officer, CCG* (attached)

5.2 NHS Reform – Public Health/Clinical Commissioning Group/NHS Commissioning Board – Verbal Update – *Director of Public Health*, *Chief Officer, CCG and Director of Operations & Delivery, NHS Commissioning Board*

5.3 Savings Programme 2013/14 – Adult Social Care- *Assistant Director – Adult Social Care* (attached)

5.4 Making a difference - Providing Quality Public Information About Health and Social Care – *Assistant Director – Adult Social Care* (attached)

5.5 Tele Health Paper from Tees Valley Chief Execs – *Chief Executive/Assistant Director – Adult Social Care* (attached)

6. **ITEMS REQUIRING DECISION**

6.1 Final Draft of the Joint Health and Wellbeing Strategy – *Director of Public Health* (attached)

7. **ITEM FOR DISCUSSION**

7.1 Dementia - attached a letter from the co-chairs of the Health and Care sub-Group, Sir Ian Carruthers OBE (NHS South of England) and Sarah Pickup (ADASS), sent with the endorsement of the Local Government Association.

7.2 Regional Health and Wellbeing Board Challenge Event (verbal update) – *Director of Regeneration and Neighbourhoods and Chief Clinical Commissioning Group*

8. **FUTURE AGENDA ITEMS**

9. **ANY OTHER BUSINESS**

SHADOW HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

28 JANUARY 2013

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

The Mayor, Stuart Drummond - In the Chair

Statutory Members: -

Councillors: Cath Hill (Deputy Mayor) (Children's and Community Services Portfolio Holder)
John Lauderdale (Adult and Public Health Services Portfolio Holder).
Paul Thompson (Finance and Corporate Services Portfolio Holder)

Dave Stubbs, Chief Executive
Louise Wallace, Director of Public Health
Denise Ogden, Director of Regeneration and Neighbourhoods
Jill Harrison, Assistant Director, Adult Social Care

Dr Paul Pagni, Clinical Commissioning Group
Margaret Wrenn, Hartlepool LINK Chair

Non Statutory Members: -

Alan Foster, Chief Executive, North Tees and Hartlepool NHS Foundation Trust
David Brown, Tees, Wear and Esk Valley NHS Trust
Petrina Smith, Contracting Manager, North East Ambulance Service

Also Present: Tracy Woodall, VCS Representative

Officers: Danielle Swainston, Head of Access and Strategic Planning
Zoe Westley, Head of Social and Education Inclusion
Catherine Grimwood, Performance and Partnerships Manager
Julian Heward, Public Relations Officer
David Cosgrove, Democratic Services Team

122. Apologies for Absence

Christopher Akers-Belcher, Hartlepool LINK Co-ordinator, Chris Willis, Chief Exec, NHS Hartlepool, Martin Barkley, Tees, Wear and Esk Valley NHS Trust.

123. Declarations of interest by Members

Councillor Paul Thompson declared a personal interest in Minute

124. Minutes of the meeting held on 10 December 2012

Confirmed.

125. Clinical Commissioning Group - Commissioning Intentions (*Chief Officer, Clinical Commissioning Group*)

It was reported that the CCG were working towards identifying its commissioning intentions based on the currently commissioned services that would transfer to it from April. Five workstreams had been identified – Keeping People out of Hospital, People in Hospital, Mental Health, Health and Wellbeing and Medicines Management.

Decision

That the report be noted.

126. Update on Public Health Ring Fenced Grant (*Director of Public Health*)

The Director of Public Health reported that the government had announced a two year grant settlement for Hartlepool. The Public Health grant would be £8.2m in 2013/14, rising to £8.4m in 2014/15. The grant would need to commission those mandated services transferred to the local authority as well as the eighteen discretionary services operated with partners such as the drug and alcohol services. Officers were still working through the detail of the grant allocation and further reports would be submitted to the Board and Cabinet.

Board Members welcomed the two year grant allocation. The grant awards for future years were raised and it was questioned if the work would continue to influence the funding formula which had been of great concern in the period leading up to this grant announcement. The Director indicated that the funding formula was still an issue high on the agenda in the North East. The Chief Executive commented that all the authorities in the North East were united on this issue and this was the first time they had had some level of success in persuading central government of the needs of the region, though it was highlighted that there was no new money within the grant, simply a maintenance of the overall spending power. The grant was only ring-fenced for two years and the concern was that after that time the ring-fencing would be removed, the grant 'transferred' into the annual grant settlement to local authorities and therefore subject to the overall grant reduction programme.

It was commented that through discussions between the partners it should

be of great importance to ensure that the resources were invested effectively.

Decision

That the report be noted.

127. Update on NHS Reform (*Director of Public Health and Chief Officer Clinical Commissioning Group*)

The Director of Public Health reported that the Area Teams were now in place with the majority of staff in position or due to transfer over the forthcoming weeks. The Primary Care Trust had moved towards a closing down phase and ensuring that al the appropriate roles and duties were in place in the successor organisations to ensure a smooth transfer of responsibilities.

The County Durham and Tees Area Team representative to the Board would be Caroline Thurlbeck. Public Health England was also beginning to take shape as staff transferred from other government departments.

The CCG now also had a nurse appointment in place on the group. A further round of appointments was due to commence shortly.

Decision

That the report be noted.

128. Hartlepool Borough Council (*Chief Executive, Hartlepool Borough Council*)

The Chief Executive reported that the local authority would be looking at its representation on the Board from April in line with the changes to the Council's governance arrangements. It was not intended to review the structure relating to the Director of Public Health at this time, though the authority would be seeking to appoint a new Director Child and Adult Services in the near future.

The Council was continuing work with Redcar and Cleveland and Darlington Borough Councils on collaboration possibilities and a further report on these was due to be submitted to Cabinet next month.

Decision

That the report be noted.

129. Special Educational Needs and/or Disability (SEND) Pathfinder - Six Monthly Update (*Head of Social and Education Inclusion*)

The Head of Social and Education Inclusion indicated that the authority had had its Pathfinder status extended for a further 18 months and had also

been given the opportunity to apply for national champion status. If this was achieved the authority would be a national leader providing support for other authorities in the country in relation to children with Special Educational Needs and/or Disability (SEND).

It was reported that the current assessment process for SEND children could take up to 26 weeks. This was seen as being too long not only by professionals but also the families of the children. Through the Pathfinder status the coordinated assessment process had been reduced to 15 weeks mainly through simply giving professionals tighter deadlines in which to complete their part of the assessment process. While this had been of great benefit, it was not known whether this could be maintained or was simply an effect of the pathfinder status. The government in its new guidance was proposing a timescale of no more than 20 weeks for all coordinated assessments. The Head of Social and Education Inclusion reported that while delivering Pathfinder status the department had also been required to meet the current legislation which had caused some difficulties.

The final few weeks of the coordinated assessment process were actually spent writing the plans. In the past the plans had been very bland, technical documents that were seldom used. The changes introduced through the pathfinder status made the plans much more focussed on the child and the family with all the support arrangements in one place. The aim was to provide any reader with a real life view of the child and its family before they encountered them in a service situation.

Anonimised versions of a couple of child plans were circulated of the Board to show how the new plans looked and how they set out the support to be delivered.

The Head of Social and Education Inclusion outlined the issues that arose with personal budgets. Families could request a personal budget should they so wish. There were some occasions where families utilising personal budgets had been able to provide cheaper care for their children than that the authority could provide. Home schooling was one area where this had occurred, though proper monitoring needed to be in place to ensure that children were achieving their appropriate education milestones.

The continuation of Pathfinder status would accelerate the introduction of the new coordinated assessment plans. This would mean the preparation of around 50-60 plans each year in Hartlepool. The government had changed the way that it would fund the services to SEND children and it was now expected that the single plan would identify the funding required for each individual child. This new coordinated assessment and the new plans would therefore need to be integrated into schools and partner organisations. Details of the assessment process had been uploaded to the FISH (Family Information and Support Hub) website.

There was concern at the ability of the SEN Team to meet the demands of

the new assessment process for all children and therefore partners in the process would need to become involved. Schools that had tried the process were generally impressed and had commented that having the assessments would save time in getting all the appropriate support in place in the later stages of the children's education.

The Head of Social and Education Inclusion responded to questions by indicating that the plans would remain in place through to age 25 years so there should only be one transition point into adult social care, if required. The plans would be quite significant in size but would put all the needs in one place simplifying things for families.

It was highlighted that the coordinated assessment forms did take quite some time to complete which could impact on GP's for example. The process was also causing schools to look at their offer over and above the universal offer to children.

It was highlighted that while the Health and Wellbeing Board was the managing board for the service, there was a Steering Group in place managing the Pathfinder process and the Chair requested that details of the steering group be circulated to the Board.

Decision

That the report be noted.

130. Improving Health and Care - The Role of the Outcomes Framework (*Assistant Director, Adult Social Care and Director of Public Health*)

The Assistant Director, Adult Social Care had circulated with the agenda papers the Department of Health document 'Improving Health and Care: The Role of the Outcomes Frameworks'. There were three Outcomes Frameworks one each for Public Health, Adult Social Care and the NHS. Through the outcomes the DoH was looking to encourage closer working between service providers. This would be an issue for the future of the Health and Wellbeing Board and all the partner organisations in being able to deliver the level of coordination now being promoted by the DoH.

Some representatives considered that there needed to be some targets set within the frameworks as these gave greater focus particularly when aiming to achieve such a substantial level of coordination. The Assistant Director commented that her were some targets in place in certain aspects f the frameworks. The targets in the Adult Social Care framework were very significant and would require monitoring by the Board.

It was commented that in relation to the NHS framework there were a number of technical documents with a lot of targets behind the principle issues.

Decision

That the report be noted.

131. Second Draft of Health and Wellbeing Strategy

(*Director of Public Health*)

The Director of Public Health submitted the second draft of the Health and Wellbeing Strategy for the Board's attention. There had been significant work in terms of the targets set within the second draft linked to national targets set by the government. The Strategy had now been circulated to all partner organisations for their input. Prior to the final version of the strategy being produced there would be some cross-referencing work together with the finalisation of the targets.

The Joint Strategic Needs Assessment (JSNA) had been incorporated in terms of targets and work plans. Over the next twelve months the Board would need to assess its impact and leadership in delivering the strategy and how it had affected the service delivery pathways across all commissioners. Any further comments on the strategy could be fed through to the Director.

Decision

That the report be noted and that any further comments on the strategy from commissioning partners be fed through to the Director of Public Health for incorporation in the final strategy document.

132. Supporting People with Hearing Loss (*Director of Child and Adult Services*)

The Assistant Director, Adult Social Care reported that a new strategy document for supporting people with hearing loss had been developed and a copy had been circulated to the Board. There were still some issues to resolve around service delivery between the Deaf Centre and Hartlepool Families First. However, the development of the strategy did place the authority ahead of many others in terms of coordinating and delivering services to people with hearing loss. The document also linked in to the JSNA.

It was indicated that ear, nose and throat services (including services to people with hearing loss) were not delivered by the North Tees and Hartlepool NHS Trust but by the South Tees Trust through James Cook Hospital in Middlesbrough. Those services were undergoing a review supported by the NTH Trust.

The level of services available in the area, particularly through schools was questioned as was if there was a register of the services and facilities available. The Chair commented that the council had some good facilities available and had used signers at large public meetings for example. Officers indicated that there were some very good services available in Hartlepool particularly with signers and support groups. One issue that had been identified in schools was that when a particular child had need of

specific equipment for example, this didn't follow the child through the education system but was retained within the school.

It had also been noted that there were two particular groups; those born deaf and those who became deaf and it was becoming clear that what would work for one group may not work for another. For example those born deaf had their own very close community and did not see themselves as having a disability. This group also had BSL (British Sign Language) as there first language. This could mean that they could often need letters and documents interpreting into BSL. Also having the equipment in place in buildings was only part of the solution; the people working there also needed to be trained in using the equipment and sympathetic to the needs of those with hearing loss.

The Assistant Director, Adult Social Care indicated that there would be a further report to the Board when a launch programme and promotion for the strategy had been developed.

Decision

That the report be noted.

133. Breastfeeding – Giving Every Child the Best Start in Life (*Director of Public Health*)

The Director of Public Health gave a brief presentation on the benefits of breast feeding and the statistics on the rates of breastfeeding in Hartlepool and other areas. While some areas had been able to show significant improvement in the rates of breastfeeding, Hartlepool's statistics showed little improvement and overall were significantly behind other areas in the Tees Valley, the North East and other comparable areas. This was a major issue for the JSNA target of giving every child the best start in life.

The Head of Access and Strategic Planning reported that significant work is being carried out by health and children's centre staff to encourage breast-feeding but it was still the case that many mothers were stopping within three days of giving birth. Some insight work had been carried out with new mothers and issues of feeling uncomfortable breastfeeding in public were highlighted as being a major issue. There were some breastfeeding friendly places within the town but more needed to be done in this respect.

It had been noted that Gateshead had achieved notable results from peer support and fifteen peer supporters had been trained in Hartlepool with a further group to be trained in the near future. It was hoped that direct peer support would help young mothers in particular persist with breastfeeding beyond the first three days. With all the work that was being done, officers were frustrated at the statistics being so low and did feel there was some cultural issues in Hartlepool that needed to be tackled. Some members of the board felt that young mothers had got the message that the first three days of breast feeding were important for a child's immune system but then seemed to think it was okay to stop after then. Members of the board also

felt that grandmothers needed to be a target of some of the work as in many families second and even third generations were not breast fed.

Some members of the Board considered that Hartlepool was struggling at every level when it came to breastfeeding. Some young mothers just seemed to think it wasn't the normal thing to do or believed that it would be bad for their breasts. It was clear that some cultural barriers needed to be broken and some positive role models would be helpful.

The Board discussed the issues in detail including the involvement of fathers in championing the message, the comparators with other areas, places that were breastfeeding friendly, levels of sustained breastfeeding beyond the first three days and the economic benefits of not having to purchase formula milk.

In concluding the debate the Director of Public Health commented that all the partner organisations needed to work together on their marketing and communications to put across a unified positive message about breastfeeding. Some qualitative work with young mothers was needed to identify what they think and believe about breastfeeding. It may be the case that more radical approaches may be needed to get the message across and make a difference to the statistics to ensure that in relation to breastfeeding the best start in life was been given to the town's children.

Decision

That the debate be noted.

134. Future Agenda Items

The Director of Public Health indicated that there would be a report to the next meeting of the Board on the new Board structure and membership prior to the transition of powers and duties to the new organisations on 1 April.

Hartlepool Link sought future discussion on the Mental Health services cuts. The Assistant Director, Adult Social Care indicated that she would bring a report to the Board.

The Assistant Director, Adult Social Care indicated that there would also be a report on services to those with dementia at the next meeting.

The Chief Executive, North Tees and Hartlepool NHS Foundation Trust commented that Tele-Health and Tele-care were two issues that he would wish the Board to discuss. The Trust also had major plans in place for c-difficile within the organisation but there was little in place in the wider community. A coordinated approach was needed to tackle this problem and the Chief Executive indicated that a discussion among partners at the next Board meeting may be helpful.

Decision

That the issues raised for discussion at the next board meeting be noted.

The meeting concluded at 11.55 a.m.

CHAIR

NHS Hartlepool and Stockton-On-Tees CCG

Title	Annual Operating Plan
Date	11th March 2013
Presenter	Ali Wilson
Purpose of Paper & Response required from DT	Update Health and Wellbeing Board of CCG Annual Planning requirements
Summary	The purpose of this paper is provide the Board an overview in relation to the Operating Framework requirements and the Planning and Assurance requirements for 13/14 and the local priorities agreed with Directors of Public Health
Financial Implications	
Legal/Regulatory Implications	All statutory responsibilities will be delivered.
Assurance Framework/Risk Register Implications	Key risks will be identified and added to the risk register
Details of Patient and Public Involvement and/or Implications	This report provides the operational plan for the first year of the Clear and Credible Plan which has been shared widely with the public and stakeholders. As new schemes and projects are progressed appropriate public engagement/consultation will be planned and initiated.
Details of Clinical Engagement and/or Implications	Developed through the CCG leadership team and locality groups.
Equality & Diversity	All schemes and new projects will be assessed as required.
Attachments	Local Priorities and Plan on a Page
Action	Board are requested to acknowledge and agree the local priorities outlined in the plan

1. Background

NHS Outcomes Framework

1.1 There are a number of outcomes frameworks in use throughout the public sector. The "NHS Outcomes Framework" (OF) addresses specific areas of service improvement and will be used by the NHS Commissioning Board Area Team (NHS CB AT) and Clinical Commissioning Group (CCG) to track progress.

1.2 There is the ability for the CCG to attract a reward for improvements in the quality of services that they commission and for associated improvements in health outcomes through the 'Quality Premium' this will be based on four national measures and three local measures, however it will be a pre-qualifying criteria that the CCG also manages within total resources and does not exceed agreed level of surplus drawdown and has no failure in meeting the constitutional rights or pledges. The Quality Premium is on top of the running costs allowance and the financial envelope is to be developed.

1.3 The OF is made up of two parts:

1.3.1 Annex A - OF measures across the 5 Domains. These 5 domains have 23 indicators of which 4 indicators (7 in actual as emergency admissions is a composite measure built up of 4 of the indicators) will be measured and where there is an improvement or achievement of high standards of quality this will secure a quality premium that is available to the CCG.

Annex A

NHS Outcomes Framework measures which the NHS Commissioning Board and Clinical Commissioning Groups will use to track progress (ie data can be generated at Clinical Commissioning Group level and a baseline can be determined against which progress can be considered).

1.	**Preventing people from dying prematurely**
Potential years of life lost (PYLL) from causes considered amendable to healthcare	
Under 75 mortality rate from cardiovascular disease	
Under 75 mortality rate from respiratory disease	
Under 75 mortality rate from liver disease	
Under 75 mortality rate from cancer	
2.	**Enhancing quality of life for people with long term conditions**
Health-related quality of life for people with long-term conditions	
Proportion of people feeling supported to manage their condition	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)[1]	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s[1]	
Estimated diagnosis rate for people with dementia	
3.	**Helping people to recover from episodes of ill health or following injury**
Emergency admissions for acute conditions that should not usually require hospital admission[1]	
Emergency readmissions within 30 days of discharge from hospital	
Total health gain assessed by patients i) Hip replacement ii) Knee replacement iii) Groin hernia iv) Varicose veins	
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)[1]	
4.	**Ensuring that people have a positive experience of care**
Patient experience of primary care i) GP Services ii) GP Out of Hours services	
Patient experience of hospital care	
Friends and family test	
5.	**Treating and caring for people in a safe environment and protecting them from avoidable harm**
Incidence of healthcare associated infection (HCAI) i) MRSA ii) *C.difficile*	

Quality Premium indicators

1.3.2 **Annex B** - OF measures are those that are included within the quality requirements of the NHS Standard contracts, by incorporation within Provider contracts this will ensure delivery through robust performance management ensuring delivery and the ability to measure the rights and pledges of the NHS constitution.

Annex B

Expected rights and pledges from the NHS Constitution 2013/14 (subject to current consultation) including the thresholds the NHS Commissioning Board will take when assessing organisational delivery.

Referral To Treatment waiting times for non-urgent consultant-led treatment
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%
Diagnostic test waiting times
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%
A&E waits
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%
Cancer waits – 2 week wait
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%
Cancer waits – 31 days
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%
Cancer waits – 62 days
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set
Category A ambulance calls
Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%
Mixed Sex Accommodation Breaches
Minimise breaches
Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.
Mental health
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%.

2. Requirements

Local Identified Measures

2.1 in addition to the OF measures A&B there is a requirement for CCGs to identify three local priorities which will be measured in order to secure the quality premium for achieving improvement and high standards of quality. The local measures have to be agreed with the NHS Commissioning Board after consideration with Health and Wellbeing boards. Each measure needs to be based on robust data and the improvement needed. Where the CCG has a concern with regards data robustness the CCG is expected to use the CCG Outcome Indicator Set as a default.

2.2 Following discussion with the DPH Hartlepool and the DPH and representatives in Stockton it was agreed that the three local priorities should be in the following areas:

- Emergency Readmissions within 30 days of discharge from hospital
- ***Estimated diagnosis rate for people with dementia***
- Smoking in Pregnancy - Increase in the number of women achieving quitting smoking at time of delivery

2.3 Since discussion has been held national guidance has been released and the indicator in relation to Dementia cannot be selected as a local priority to attract the Quality Premium. This is due to a trajectory for this area having already been provided as part of the annual planning template which the CCG will already be measured against; therefore this has been regarded as a duplication of priorities.

The CCG has since discussed this with both DPHs and a new indicator has been selected as outlined below;

- Increase in uptake of bowel screening

Ambition in relation to the local priorities and data sources can be found at Appendix A (bowel screening ambition to be determined). Rationale for selection of the indicators can also be found at Appendix B.

2.4 CCG Outcomes Indicator Set

The CCG Outcomes Indicator Set measures the health outcomes and quality of care including PROMS and patient experience. These measures include indicators from the NHS OF/Adult Social Care Outcomes/NICE quality standards/Public Health Outcome Framework. This framework will enable CCGs to benchmark their performance and identify priorities for improvement in partnership with local area teams, public health and social care agencies. These indicators will be measured through an assurance framework which is currently being progressed by the NHSCB. These outcomes should be used as a default to select local priorities where there is concern about the validity of data.

3. Commissioning Intentions

3.1 The commissioning intentions for 13/14 contracting round have been developed; Intentions have been identified from;

- A stocktake and intelligence from the 12/13 contracting intentions
- The CCG Clear and Credible Plan and Delivery Plan
- The Everyone Counts Planning Framework
- Local stakeholder engagement
- JSNA/Health & Wellbeing Strategy

Intentions were prioritised and further developed and subsequently shared with member practices and partners through the CCG locality group meetings. These intentions will now be taken forward through contract negotiations. Intentions have been updated to reflect the requirements set out in the Everyone Counts Planning for Patients 13/14 document and it is likely that intentions will during negotiations continue to be further developed as has been carried out in previous years.
Negotiations teams have been established with a CCG clinical lead and initial negotiations have commenced.
The timeline for delivery of the intentions and incorporation into Provider contracts for 13/14 is the end of February 2013. The Plan on a Page at Appendix C sets out the CCG Plans for 13/14.

4. Planning responsibilities

4.1 In line with our establishment as a commissioner of health services, the development of an Operating Plan for 2013-14 is a responsibility of the CCG as it was for the PCT. Requirements were set out in the Everyone Counts Planning for patients 2013/14 document and as set out below.

Date	Activity	
	CCG Plans	Direct Commissioning Plans
w/c 17 Dec 12	Allocations published Planning guidance published	
	Draft supporting information published Draft NHS Standard Contract published	
25 Jan 13	CCGs to share first draft of plans with Area Team Directors to include: • "Plan on a Page" including (i) key elements of transformational change; (ii) key risks; and (iii) confirmation that national requirements will be met; • trajectories on relevant measures in Section 2 plus three local priorities; • activity plans – summary at commissioner level; • financial information	Area Team Directors to share first draft of plans with Regional Directors to include: • "Plan on a Page" for each element of their direct commissioning; including confirmation that national requirements will be met; • key risks; • activity plans; • trajectories on relevant measures; • financial information
By 8 Feb 13	Area Directors to provide feedback to CCGs	Regional Directors to provide feedback to Area Team Directors
11 Feb to 29 Mar 13	Discussions to support Area Team Director assurance of plans	Regional and Area Team Director discussions to support assurance of plans
31 Mar 13	CCG and NHS Commissioning Board contracts signed off	
5 Apr 13	Final CCG plans shared with Area Team Director	Final direct commissioning plans shared with Regional Director
8 Apr to 19 Apr 13	Board analyses CCG plans and plans for direct commissioning with a view to identifying risks to delivery	
22 Apr to 10 May 13	Board confirms that plans add up to a position that delivers the mandate and improves patient outcomes within allocated resources	
By 31 May 2013	Each clinical commissioning group publishes its prospectus for its local population	

5. Progress to date

5.1 Draft CCG Planning Guidance was issued regarding the structure in the form of a toolkit pro forma in which CCGs are expected to provide Self certification/Plan on page/Trajectories. A planning group has been established, including HAST CCG, South Tees CCG and NECS representatives who are meeting regularly to support the development of local annual plans.

5.2 First draft plans (plan on a page) have been produced Appendix C**,** which was shared with the NHS CB AT on the 25th January, with a further iteration and assurance plans shared on

the 22nd February setting out how the CCG intends to deliver the operating framework requirements. The plans have been informed by the agreed 13/14 commissioning intentions and the CCG Clear and Credible Plan.

6. Next Steps

The CCG will be meeting the NHS CB AT on the 19th March to provide assurance in relation to the plans submitted in advance of final submission on the 5th April.

8. Action Required

8.1 Board is requested to:-

8.1.1 Note the content of this paper

8.1.2 Agree the three local priorities

Hartlepool & Stockton CCG Local Priorities

	Smoking Status at Time of Delivery*				Emergency Readmissions		Bowel Screening	
Indicator Description	Percentage of women known to have been smoking at time of delivery.				Emergency readmissions within 30 days of discharge from hospital - standardised percentage.		Indicator : Bowel screening test kits received back within reporting period as a percentage of the number of invitations within reporting period (ages 60-74 inclusive for CCG GP Registered Population).	
Numerator Description	Number of women known to have been smokers at time of delivery.				The number of finished and unfinished continuous inpatient (CIP) spells that are emergency admissions within 0-29 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main specialty upon readmission coded under obstetric; and those where the readmitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell.		Indicators : Number of test kits received back within reporting period from persons aged 60-74 inclusive from CCG GP Registered Population. (Please note: the number of test kits received back in an individual reporting period are not necessarily from the same subjects who were invited in that reporting period. For example, test kits received in January could belong to subjects who were invited at any time in that month or the previous 6 calendar months.)	
Denominator Description	The number of women in the relevant CCG population who give birth to one or more live or still born babies of at least 24 weeks gestation where the baby is delivered by either midwife or a doctor and the place of delivery is either at home or in an NHS hospital (including GP units). Exclude all maternities that occur in either psychiatric or private beds / hospitals. Do not count the number of babies, but count the number of mothers instead. Note: 'Maternity' is used instead of 'delivery' for consistency with the ONS definition.				The number of finished CIP spells within selected medical and surgical specialties, with a discharge date up to 31 March within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days prior to admission are excluded.		Indicator : Number of invitations within reporting period (ages 60-74 inclusive for CCG GP Registered Population).	
Monitoring Source	Omnibus				Hospital Episode Statistics		North East Bowel Cancer Screening Hub	
Baseline Data	HP&ST CCG	National Position	HP&ST CCG	National Position	HP&ST CCG	National Position	HP&ST CCG	North East SHA Position
Baseline Data - Period	2011/12	2011/12	Q3 2012/13 YTD	Q2 2012/13 YTD	2010/11	2010/11	Indicator 1: Q2 YTD 2012/13	Indicator 1: Q2 YTD 2012/13
Baseline Data - Indicator	19.3%	13.2%	17.9%	12.7%	12.29% (Indirectly Standardised)	11.76%	61.19%	62.96%
Baseline Data - Numerator	685	-	469	-	4932	-	7546	70751
Baseline Data - Denominator	3557	-	2614	-	38313	-	12333	112368
Baseline Data - Source	The Health and Social Care Information Centre	The Health and Social Care Information Centre	PCT Omnibus Return	The Health and Social Care Information Centre	The Health and Social Care Information Centre	The Health and Social Care Information Centre (published Jun12)	North East Bowel Cancer Screening Hub	
Comments							This information will be reported by individual quarter from the information reported by the North East Bowel Cancer Screening Hub.	
Trajectory - Period	2013/14 (Annual)				2013/14 (Annual)		2013/14 (Annual) - Indicator 1	
Trajectory - Indicator	16.4%				12.3%		#DIV/0!	
Trajectory - Numerator	573				4709			
Trajectory - Denominator	3485				38313			
Trajectory Rationale	Mark Reilly 18.02.13 - "My advice is to use the 'target' levels that were provided before by Lisa Jones. I understand that these were proposed in line with the content of the DH Tobacco Strategy. If these targets are already part of CCG plans (and MIDAS) then there seems to be no point in producing others." Denominator Q3 maternities: 2614/3*4 = 3485. Lisa Jones' suggested trajectories calculated to CCG level (%s applied to 2012/13 FOT maternities).				Mark Reilly 18.02.13 - "The proportion of readmissions within 30 days is rising locally and nationally. My advice is either to aim to 'halt the increase' or to aim to achieve a local increase that is no higher than the same % increase for England." The 2010/11 STANDARDISED percentage has been applied to the 2010/11 UNSTANDARDISED denominator to calculate the numerator.			

*Please also see file 'SSATOD 1213 Q2 NE Benchmarking'

Mothers Smoking Status at Delivery

Historic Data

Smokers as % of all maternities	2004/05 OT	2005/06 OT	2006/07 OT	2007/08 OT	2008/09 OT	2009/10 OT	2010/11 OT	2011/12 OT	2012/13 Q2
England	-	-	15.12%	14.44%	14.38%	13.99%	13.52%	13.19%	12.75%
North East (Q30)	25.59%	24.15%	23.49%	22.18%	22.65%	22.20%	21.06%	20.66%	18.95%
Middlesbrough PCT (5KM)	28.21%	30.80%	33.07%	29.56%	30.97%	28.88%	27.16%	26.27%	23.03%
Redcar And Cleveland PCT (5QR)	25.53%	26.46%	30.79%	31.17%	25.51%	27.05%	25.07%	27.63%	25.50%
North Tees PCT (5E1)	21.23%	18.03%	21.64%	19.82%	20.25%	19.89%	18.38%	17.71%	16.37%
Hartlepool PCT (5D9)	32.27%	27.76%	31.03%	27.75%	23.95%	26.62%	22.58%	22.48%	20.33%

Source - Information Centre

2012/13

2013/14 targets based on Lisa Jones PCT suggestions

Middlesbrough PCT — *2012/13*

	Q1	Q2	Q3	Q3 2012/13 YTD
Number of maternities	491	547	573	1,611
Number of women known to have been smokers at time of delivery	131	126	163	420
Percentage of mothers smoking at delivery	26.7%	23.0%	28.4%	26.1%

Middlesbrough PCT	
12/13 Forecast Maternities	2148
Numerator	488
Target 13/14	22.7%

Redcar & Cleveland PCT — *2012/13*

	Q1	Q2	Q3	Q3 2012/13 YTD
Number of maternities	353	404	379	1,136
Number of women known to have been smokers at time of delivery	80	103	94	277
Percentage of mothers smoking at delivery	22.7%	25.5%	24.8%	24.4%

Redcar & Cleveland PCT	
12/13 Forecast Maternities	1515
Numerator	317
Target 13/14	20.9%

South Tees CCG — *2012/13*

	Q1	*Q2*	*Q3*	Q3 2012/13 YTD
Number of maternities	*844*	*951*	*952*	*2,747*
Number of women known to have been smokers at time of delivery	*211*	*229*	*257*	*697*
Percentage of mothers smoking at delivery	*25.0%*	*24.1%*	*27.0%*	*25.4%*

South Tees CCG	
12/13 Forecast Maternities	3663
Numerator	804
Target 13/14	22.0%

Hartlepool PCT — *2012/13*

	Q1	Q2	Q3	Q3 2012/13 YTD
Number of maternities	271	305	276	852
Number of women known to have been smokers at time of delivery	55	62	61	178
Percentage of mothers smoking at delivery	20.3%	20.3%	22.1%	20.9%

Hartlepool PCT	
12/13 Forecast Maternities	1136
Numerator	214
Target 13/14	18.8%

Stockton PCT — *2012/13*

	Q1	Q2	Q3	Q3 2012/13 YTD
Number of maternities	575	623	564	1,762
Number of women known to have been smokers at time of delivery	88	102	101	291
Percentage of mothers smoking at delivery	15.3%	16.4%	17.9%	16.5%

Stockton PCT	
12/13 Forecast Maternities	2349
Numerator	359
Target 13/14	15.3%

HP & ST CCG — *2012/13*

	Q1	*Q2*	*Q3*	Q3 2012/13 YTD
Number of maternities	*846*	*928*	*840*	*2,614*
Number of women known to have been smokers at time of delivery	*143*	*164*	*162*	*469*
Percentage of mothers smoking at delivery	*16.9%*	*17.7%*	*19.3%*	*17.9%*

HP & ST CCG	
12/13 Forecast Maternities	3485
Numerator	573
Target 13/14	16.4%

Source - PCT submissions

Suggested Targets from Lisa Jones (PHE) 09.02.12 - "These targets are aligned to the national ambition for maternal smoking as set out in the DH Tobacco Control Strategy."

Rationale: The following target trajectories are based on aligning local ambition with national action to halve the national smoking in pregnancy rate by 2020.

Year/PCT	HP	ST	MB	RC
2010/11 (baseline)	*22.6*	*18.4*	*27.2*	*25.1*
2011/12	21.3	17.4	25.7	23.7
2012/13	20.1	16.4	24.2	22.3
2013/14	18.8	15.3	22.7	20.9
2014/15	17.5	14.3	21.2	19.5
2015/16	16.3	13.3	19.7	18.2
2016/17	15	12.3	18.2	16.8
2017/18	13.7	11.3	16.7	15.4
2018/19	12.5	10.2	15.2	14.0
2019/20	11.3	9.2	13.6	12.6

Percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission (NOF 3b)

PCT of Residence	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
England	*10.65*	*10.8*	*10.98*	*11.3*	*11.55*	*11.76*
North East SHA	*11.53*	*11.41*	*11.53*	*12.01*	*12.24*	*12.59*
Middlesbrough	11.92	12.41	12.06	12.33	12.86	13.3
Redcar & Cleveland	10.95	11.43	11.35	11.84	11.77	12.5
Hartlepool	11.01	10.99	11.16	12.02	12.67	12.24
Stockton	11.22	11.2	11.59	12.19	12.03	12.23

Source - NHS IC Indicator Portal

Percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission (CCG OIS 3.2)

By Registered CCG	2010/11
South Tees CCG	13
HP&ST CCG	12.29

Source - NHS IC Indicator Portal

Bowel Screening

Indicator 1 - Bowel screening test kits received back within reporting period as a percentage of the number of invitations within reporting period (ages 60-74 inclusive for CCG GP Registered Population).

HP&ST CCG

Period	2011/12					2012/13		
	Q1	Q2	Q3	Q4	YTD	Q1	Q2	YTD (Q2)
Indicator	62.54%	58.92%	60.16%	65.77%	61.79%	59.48%	62.86%	61.19%
Numerator	2835	3321	3053	3484	12693	3628	3918	7546
Denominator	4533	5636	5075	5297	20541	6100	6233	12333

North East SHA

Period	*2011/12*					*2012/13*		
	Q1	*Q2*	*Q3*	*Q4*	*YTD*	*Q1*	*Q2*	*YTD (Q2)*
Indicator	*62.71%*	*57.33%*	*61.72%*	*72.74%*	*63.33%*	*61.32%*	*64.33%*	*62.96%*
Numerator	*29069*	*33101*	*32189*	*35481*	*129840*	*31284*	*39467*	*70751*
Denominator	*46357*	*57735*	*52157*	*48775*	*205024*	*51015*	*61353*	*112368*

*Population 60-74 as at the end of each quarter

Rationale for Local Priorities

Smoking in Pregnancy - Increase in the number of women achieving quitting smoking at time of delivery

The CCG has specific populations consisting of two localities; Stockton-On-Tees and Hartlepool. The burden of risks to population health is high across both localities including higher than national (England) average levels of behavioural risks to health which includes smoking.

Health Inequalities are spread across the CCG and within localities smoking prevalence varies from 16% to 48%. 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 smoking was an area selected as being a priority.. There are high rates of smoking during pregnancy therefore it was determined in line with all of strategies this area should be selected as a local priority.

This indicator will attribute towards the delivery of the NHS Outcomes Framework – Preventing People from Dying Prematurely and the CCG Outcomes Indicator Set – Reducing Deaths in babies and Young Children. Both Health and Wellbeing Strategies have identified 'Giving every child the best start in life' as a key priority.

Smoking in Pregnancy Baseline 10/11: Hartlepool 22.6% Stockton 18.4%

13/14 Expected Outcome: CCG 16.4%

Emergency Readmissions within 30 days of discharge from hospital

The CCG will agree plans with health and social care providers for post discharge services to prevent avoidable readmissions. The CCG is working with neighbouring commissioning groups to identify best practice in care home management. The CCG have included within the commissioning intentions for 13/14 an intention to develop an approach that reduces inappropriate unplanned admissions and use of A&E. This indicator will attribute towards the delivery of the NHS Outcomes Framework – Helping people to recover from episodes of ill health or following injury. The indicator links clearly to the Health and Wellbeing Strategy priorities, in reducing long-term conditions; and reducing readmissions e.g. attributable to alcohol, where increasing screening and brief interventions and referral on to appropriate treatment services would help reduce readmissions.

13/14 Expected Outcome: Halt annual increase or increase in line with national % growth Target of 12.3% using standardised %.

Increase in Bowel screening uptake

The CCG set out within our CCP that we intended to significantly improve the uptake of bowel screening to identify those who have undiagnosed conditions as it has been identified nationally that 25% of bowel cancers are picked up by emergency A&E presentation. The impact on earlier diagnosis is significant with a 5 year survival rate Duke A of 90% compared with the 5 year survival rate of Duke C of 40%, it has also been identified that screening reduces risk of death by 25% in those screened (Cochrane 2011).

The CCG has worked collaboratively with the Directors of Public Health (DPHs) and their colleagues across Hartlepool and Stockton to agree this priority to ensure a joined up approach for bowel screening services targeting people who do not take up screening from socio economic groups as it is recognised that uptake is

lower in women and SE groups and ethnic minorities.

Although the CCG will not be the responsible commissioner to commission bowel screening services this was selected as a priority area due to current performance and the CCG and DPHs felt that a joint commissioning approach would better improve performance. Working collaboratively as partners outlines our commitment in the new architecture of commissioning to deliver a shared approach to meet the needs of the local population.

This indicator will attribute towards the delivery of the NHS Outcomes Framework Preventing People from Dying Prematurely and the CCG Outcomes Indicator Set: One and five year survival from breast, lung & colorectal cancers.

CCG Baseline 11/12: Q2 61.19%

13/14 Expected Outcome:

(This indicator is to be further developed following the UNIFY clarification published 21/02/13 outlining we are unable to progress with the initial local indicator selected of Dementia – we would anticipate achieving a target in line with the England average or North East average, further analysis to determine the statistically appropriate level of ambition)

DRAFT NHS Hartlepool and Stockton-On-Tees CCG – Plan on a Page 2013/14

Vision (CCP page 7)

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.

Strategic Aims (CCP page 12)

- Bringing care closer to home
- Tackling Health Inequalities
- Caring for an aging population
- Addressing our priority health conditions
- Improving quality in primary care
- Ensuring quality and patient safety
- Improving patient experience
- Seeking best value for money within budget

Transformational Work Streams & Cross cutting themes (CCP page 12)

- Personalisation
- Carers
- PPI
- Prevention
- Innovation

Prioritised Initiatives (Commissioning Intentions) [link to outcome framework domains]

Health and Wellbeing

Priority

*Maternal smoking at Delivery
*Uptake in Bowel Screening

- Commission sufficient capacity to meet the demand of the screening programmes
- Work with Primary Care Providers to increase uptake of bowel screening
- Reduce Hospital Admissions in relation to alcohol;
  - Signposting to support services offered to patients identified
  - Collaborate with Public Health in relation to delivery of the alcohol strategy and determine future requirements for commissioned services
- Reduce smoking prevalence;
  - Collaborate with Public Health to develop a joint strategy in relation to smoking cessation services to improve access and attendance and focus on improving the quit rate of women smoking at time of delivery
  - Ensure the smoking cessation services are linked to the Community Renaissance Teams
- Reduce COPD Admissions
  - Carry out a review of acute and community respiratory services
  - Commission a range of preventative initiatives such self care packs and patient education

Out of Hospital Care

Priority

Emergency Readmissions within 30 days of discharge From hospital

- Improve the Quality of Care within Residential and Nursing Homes
  - All residential/ nursing home patients will have a regularly reviewed Health Care Plan (HCP)
- Triage and signpost patients who are not appropriate to be seen in A&E to the relevant care provider in order to support the re-education programme
- Implement management plans for all patients identified by the LACE tool as being at high risk of readmission
- Review and audit of the new community services model
- Developing integrated health care facilities in Stockton, Billingham, Hartlepool and Yarm
- To improve the quality and capacity in Primary Care
  - Better understand capacity and demand within Primary Care to determine future commissioning intent
  - Continue to support Primary Care in reducing variation in General Practice, both in terms of quality and financial spend
- Reduction in readmissions

Acute In-Hospital Care

- Continued Reduction in C2C Referrals
- Reduction in N:R ratio and review of Nurse delivered clinics
- Extend the Hartlepool plastics service to include access for Stockton patients
- Choose & Book
  - Ensure letters are reviewed prior to clinics to ensure patients are attending correct clinics
  - Ensure patients are redirected to most appropriate clinics where wrong referral has been made
  - Ensure advice and guidance is available via Choose and Book
- Implement revised MSK pathway
  - Pathway to include direct access to core Physiotherapy and direct access to MSK
  - The CCG expects where referral is sent to incorrect, referral will automatically refer on to appropriate service without sending back to GP or requesting a re-referral
- Work with providers to reduce the number of delayed discharges
- Review of Commissioner Requested Services (CRS) to establish any additional services the CCG required
- Work with Provider to ensure that routine services are offered 7 days a week

Mental Health, Learning Disabilities and Dementia

Priority

- Robust and accurate registers of patients with Dementia
- Development of a pilot memory clinic within a primary care setting
- Perinatal Mental Health – to ensure compliance with NICE guidance including potential for specialist community service
- Continued development of Mental Health Payment by Results
- Ensure CAMHS services meet NICE requirements and improves assessment to diagnosis waiting times
- Review of 'Stepping Forward' model for vulnerable, high activity MH patients
- Out of Area specialist placements/rehab services - to identify potential opportunities for developing services for low volume/high cost cases closer to home
- TEWV Primary Care Therapy Services - align both the funding and contract management to the existing Any Qualified Provider
- Development of alternative rehabilitation and recovery services to support complex individual residents
- Review current commissioning arrangements for specialist sensory assessments and develop local pathway
- E-Communications
  - Implementation of e-discharge solution which transfers information directly into clinical system (inpatient and outpatients)
  - Implementation of Choose and Book, including advice and guidance
- Provide independent assessments of individuals with Learning Disabilities to establish to most appropriate packages of care that fulfils their needs
- Movement of patients from autism inpatient and assessment of treatment beds into community based settings
- Work collaboratively with Social Care Commissioners to deliver improved, joined up services to people whose needs are complex and whose behaviour is challenging to services
- Identify all young people that require a Health Action Plan
- Support Health funded individuals through bridging packages
- Support the us of quality checkers to advise on and highlight areas that may require reasonable adjustment

Medicines Optimisation

- Improve Costs in relation HCD spend
  - Commissioned services will continue to use defined and standard list of drugs and indications that will be accepted for pass-through payment
  - Existing contracts held by providers will be reviewed, and the CCG will be consulted on these prior to entering or re-negotiating a contract, for the provision of specialist drugs via a third party provider
- To improve the quality of discharge information and medication supply
  - Patients will be provided with at least 28 days supply of long-term medicines, appliances and nutritional supplements on discharge
  - Patients will be supplied a "monitored dosage system" where this was in use prior to admission, or has been deemed necessary by valid assessment during the in-patient stay
  - Patients will be supplied full treatment course for all drugs where a defined treatment course is indicated e.g. antibiotics, steroids
- Self administration of medication in secondary care

Outcome framework

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions.
- Helping people recover from episodes of ill health or following injury
- Ensuring that people have positive experience of care
- Treating and caring for people in a safe Environment and protecting them from harm:
- Social Care / Public Health Outcomes

Report of: Assistant Director – Adult Social Care

Subject: SAVINGS PROGRAMME 2013/14 – ADULT SOCIAL CARE

1.0 PURPOSE OF REPORT

1.1 The purpose of the report is to identify the proposals for delivering savings in respect of adult social care as part of the budget for 2013/14.

2.0 BACKGROUND

2.1 The report details one of the reviews which forms part of the 2013/14 Savings Programme

2.2 The proposals in the report identify the savings to be made, the risks associated with these and the considerations which have been taken into account in developing them including consideration of key elements which together comprise SROI.

2.3 Scope

The areas of expenditure that are under consideration within this review are as follows:

Assessment & Care Management
- Social Work Teams
- Adult Safeguarding
- Occupational Therapy Team

Residential Placements

Personal Budgets
- Home Care
- Equipment
- Day Services
- Supported Accommodation
- Direct Payments (allocations to people to use as they wish to meet their care and support needs)

2.4 Aims

The focus of adult social care is to support people to remain independent and to exercise choice and control regarding how their support needs are met. Some services are provided by the department (including assessment and care management and disability day services) and others are commissioned for people (such as residential placements and day services for older people).

2.5 Service Users

People who use adult social care services in Hartlepool are over 18 and assessed against the Fair Access to Care Services (FACS) criteria as having a substantial or critical level of need. Services support older people, people with learning disabilities or a physical disability, people with mental health needs, people who have alcohol dependency and carers.

2.6 Engagement

The department engages with people who use services through a range of methods including:

- Carers Strategy Group
- Learning Disability Partnership Board
- Mental Health Forum
- Champions of Older Lifestyles Group
- Service User Focus Groups; and
- Family Leadership Courses

Feedback is also obtained through the annual Adult Social Care User Survey, Service User Experience Sampling and through complaints and compliments.

The first Local Account for adult social care was published in December 2012 and tells residents about:

- how well adult social care in Hartlepool has performed
- the challenges faced; and
- plans for future improvements

It is a requirement that a Local Account is produced annually and feedback on the first published document in 2012 will inform future versions.

2.7 Inputs / Expenditure

The total expenditure on adult social care is £41.1m, with £8.2m income from people's personal contributions and a further £3.7m from other income (primarily NHS funding).

The breakdown of how the £41.1m is spent is as follows:

Area of Expenditure	**Spend**
Assessment & Care Management	£6.2m
Residential Placements	£17.5m
Personal Budgets	£17.4m

The breakdown of spend on personal budgets is as follows:

Area of Expenditure	**Spend**
Home Care	£6.85m
Direct Payments	£4.5m
Supported Accommodation	£1.87m
Day Services	£1.8m
Equipment	£1m

Other	£1.38m

2.8 Outputs / Outcomes

The Care Quality Commission no longer assess or rate adult social care service provision but the last two assessments rated Hartlepool's services as excellent – the best rating that could be achieved. Since the last assessment, services have continued to perform well and the majority of the performance indicators for adult social care have been achieved or exceeded.

Some of the outputs achieved are as follows:

- Over 5,700 people receive support from adult social care services.
- Over 2,000 carers had an assessment during the last year and received support to maintain their caring role.
- The number of people using telecare continues to grow with almost 900 people currently being supported.
- People received over 5,200 pieces of equipment to help them stay at home.
- Over 95% of people receive their equipment and adaptations within 7 working days.

Some areas where particularly positive outcomes have been achieved include:

- Just over 90% of people who have ongoing social care needs and are eligible to receive a personal budget have their support provided through a personal budget and exercise choice and control over how their support needs are met.
- Over 18% of people with a learning disability and approximately 12% of people receiving mental health services are in paid employment.
- Hartlepool has not had a delayed transfer of care from hospital which is attributable to social care.
- A wide range of services have been developed to support older people to retain their independence. These include reablement services, extra care housing options and telecare.

2.9 Savings Target

The savings target for the Child & Adult Services Department for 2013/14 is £2,580,000 and £860,000 of this target relates to Adult Social Care.

3.0 PROPOSALS

3.1 Commissioned Services

There are a range of services that are commissioned by the department to support people who are eligible for adult social care services. These include:

- Carers Assessment and Information Services
- Direct Payment Support Service

- Housing Related Support (extra care housing, floating support and supported accommodation schemes)
- Respite Service for People with Learning Disabilities
- Day Opportunities for People with Mental Health Needs; and
- Day Opportunities for Older People

A significant level of savings was achieved from commissioned services in 2012/13 and all services have been reviewed again to identify areas where further savings can be made in 2013/14.

There are two commissioned services which provide building based day opportunities for older people – a day centre at Hartfields and a service specifically for people with dementia at Gretton Court (which is jointly funded by the PCT). Ongoing work with the day centre for older people at Hartfields has identified a saving of £120,000 due to lower uptake of places than was anticipated when the service was originally commissioned. This is largely due to people using direct payments to access support and social activities in different ways. There will be no reduction in service as a result of this saving being achieved, so no impact on people using the service.

A review of funding for support for carers has identified that a saving of £80,000 can be made through changing how some services are delivered and also through additional funding being secured from the PCT. For example, the support required when carers access the Carers Emergency Respite Service is now provided through the in-house Direct Care & Support Service and a new three year contract for Carers Assessment and Support will be jointly funded rather than being fully funded by the Council. There will be no reduction in service as a result of this saving being achieved; there will be additional investment from the PCT in carers services which will support carers to meet their own health needs. There will be no adverse impact on carers who are currently being supported.

A review of high cost placements for people with learning disabilities has identified a saving of £40,000. This saving has been achieved through negotiation with providers to ensure that people are receiving appropriate levels of care and hours of support based on their individual assessed needs. Again, there will be no reduction in service as a result of this saving being achieved, so no impact on people receiving this support.

The total saving from commissioned services is £240,000.

3.2 <u>Equipment Budget</u>

Approximately £1m is spent each year on equipment and adaptations that enable people to retain their independence and stay in their own homes for as long as they are able to. The type of equipment supplied includes;

- Mobility aids such as walking sticks and walking frames
- Grab rails
- Bathing aids; and
- Daily living aids that help with dressing, cooking and cleaning.

The budget has been under spent for the last three years and the balance has been used to support Disabled Facilities Grants (which fund larger adaptations such as level access shower rooms and downstairs bath or bedrooms) or to offset pressures elsewhere within the adult social care budget. This under spend of £100,000 has now been identified to contribute to the adult social care savings for 2013/14.

3.3 Provider Services

There are a small range of services which are provided in-house by adult social care. These are:

- Direct Care & Support Service – Reablement and Home Care
- Disability Day Services - Warren Road and the Centre for Independent Living (previously the Havelock Day Centre)
- Employment Link and Floating Support Service for People with Learning Disabilities or Mental Health Needs

All of these services have been reviewed and a number of areas where savings can be made have been identified. The restructure involves bringing all of the services together under a single Provider Services Manager, which will reduce management costs and enable more flexible working across services, making best use of the skills and experience of the current staff.

Within the Direct Care & Support Service there are a number of unworked hours / vacant posts which have been held, partly as a contingency to manage peaks in demand and partly to create redeployment opportunities for staff identified as being at risk in other areas of the service. The saving that can be identified in this area, while still retaining some posts for redeployment, is £200,000.

The proposed restructure within Disability Day Services involves reducing tiers of management, making the service more streamlined without having a direct impact on the people who are supported at Warren Road and the Centre for Independent Living. This will involve deleting seven posts (including two vacancies) and creating three new posts.

The Employment Link and Floating Support Service supports people with mental health needs and / or learning disabilities to access employment and services within their communities. The team is made up of:

- 1 Band 12 Team Manager
- 1 Band 10 Supervisor
- 3 Band 8 Employment Link Workers
- 7 Band 8 Floating Support Workers
- 4 Band 6 Community Workers
- 1 Band 6 Team Clerk

The Employment Link element of the service supports a total of 116 people with 12 new referrals in 2011 and 35 referrals in 2012 (linked to the introduction of a new apprenticeship scheme). It is proposed that the team

of three Employment Link Workers moves to be managed within the Employment Development Team in Economic Regeneration. This is a more effective use of resources and will mean that people with additional support needs due to their learning disability or mental health issues will be able to access the generic employment support service while still having access to staff with the particular knowledge and expertise required to meet those needs. This model provides greater resilience within the Employment Development Team and promotes the integration of people with additional needs within mainstream services.

The floating support element of the service provides a service to approximately 80 people at any one time, supporting people to access community services, build their confidence and become more independent. A review of the service has identified that the work undertaken and the focus on increasing independence is very similar to the approach taken within the reablement service although with smaller caseloads and slower throughput. As a result, it is proposed that this service is disbanded and all posts are deleted, with four new posts created within the reablement service to pick up this element of work. A total of fourteen posts would be deleted with four new posts created within the reablement team to absorb some of this work and to provide redeployment opportunities. The loss of this number of posts will inevitably result in a change or reduction in service for some people. Individuals who are affected will be offered support to use their personal budget differently to access services through a Personal Assistant or other alternative.

The proposed restructures within disability day services, employment link and floating support service will achieve a saving of £320,000. Together with the removal of vacant posts / unworked hours within the home care service, the total saving from provider services is £520,000

4.0 OPTIONS ANALYSIS

4.1 Various options have been explored across Adult Social Care to achieve the savings which have been discounted, primarily due to the level of risk involved. These include:

- Reduce capacity in social work teams – considered too high risk due to impact on waiting times, performance indicators and caseloads.
- Reduce spend on residential placements – not possible in light of the fair cost of care exercise and increased pressures on residential provision.
- Reduce spend on personal budgets – this is not possible without a fundamental review of the Council's approach to personalisation and the Resource Allocation System. People who already have services could not have their resource reduced without evidence of a change in their assessed level of need.
- Increase income from personal contributions – this would require a full review of the current Contributions Policy involving a formal consultation

exercise and the level of savings that would be generated has not been quantified. This may be revisited for 2014/15.

- Increase income from the NHS – this is a very volatile area and funding secured is often allocated on a short term basis, which does not address the requirement for ongoing cuts from the general fund budget.

5.0 RISK IMPLICATIONS

5.1 There are a number of risks implicit in the delivery of any package of savings and it is important to recognise these as part of any decision making. A summary of the risks considered as part of the proposals has been identified below:

- Reduced flexibility within provider serviced to manage peaks in demand, which are usually associated with severe winters or pressures within NHS services. This may result in delayed transfers of care from hospital which are attributable to adult social care as well as tensions with the Foundation Trust if cases cannot be picked up as quickly as they have been previously.
- Reduced flexibility to manage changing demand for equipment services, which may result in increased waiting times and / or financial pressures in future years.
- Increased spend on personal budgets due to the disbanding of the floating support service for people with learning disabilities or mental health needs.

6.0 FINANCIAL CONSIDERATIONS

6.1 The Savings Programme 2013/14 is planned to deliver total savings of £3.8m towards the budget deficit for 2013/14. It has been highlighted in previous reports to Cabinet that failure to take savings identified as part of the Savings Programme will only mean the need to make alternative unplanned cuts and redundancies elsewhere in the Authority to balance next year's budget.

6.2 The proposals outlined will deliver the following savings:-

Service	**Proposed Savings**
Commissioned Services	£240,000
OT Equipment Budget	£100,000
Provider Services	£520,000
Total Proposed Savings	**£860,000**

6.3 The proposals in relation to Provider Services involve a number of posts being deleted, which will result in redundancy costs. The exact costs can't be determined until redeployment opportunities are fully explored and the relevant redundancy selection processes are undertaken.

7.0 EQUALITY AND DIVERSITY CONSIDERATIONS

7.1 An Equality Impact Assessment has been undertaken and is attached as Appendix A.

7.2 By definition, all of the savings proposals in adult social care will affect the people who access adult social care services – people who are over eighteen and assessed against the Fair Access to Care Services (FACS) criteria as having a substantial or critical level of need (older people, people with learning disabilities or a physical disability, people with mental health needs, people who have alcohol dependency and carers).

8.0 STAFF CONSIDERATIONS

8.1 Informal consultation with Trade Unions regarding the recommendations has been undertaken. Staff affected by the proposals have been informally and formal consultation will be undertaken (in line with agreed HR policies and procedures) if the proposals are accepted.

8.2 It is anticipated that a total of 21 posts will be deleted resulting in 13 potential redundancies and 8 people being redeployed into posts that are being held / created to reduce the impact on staff. Of the 13 people at risk of redundancy there have been 5 expressions of interest in voluntary redundancy leaving 8 people at risk of compulsory redundancy if the voluntary redundancy applications are approved and they are not successfully redeployed.

9.0 COMMENTS FROM SCRUTINY REVIEW

The Adult & Community Services Scrutiny Forum considered the savings proposals for adult social care at their meetings on 17 September, 23 October and 5 November 2012.

In relation to the savings proposals put forward 'Members of the Adult and Community Services Scrutiny Forum were mindful of the very difficult financial position and the required savings required in Adult and Community Services. Although Members reluctantly recognised the need to support a number of the saving proposals they wished to draw Cabinet's attention towards the desire to protect vulnerable people wherever possible from cuts, particularly when related to mental health needs'.

In relation to reductions in front line service provision 'Members were particularly concerned about the proposed staffing implications through the deletion of 15-20 posts. Although the Forum acknowledged that savings had to be found, they emphasised that if there was a way to protect staff from compulsory redundancies, then those avenues should be explored'.

10.0 RECOMMENDATIONS

It is recommended that Cabinet support the proposals outlined, which will achieve savings of £860,000 in adult social care in 2013/14.

11.0 REASONS FOR RECOMMENDATIONS

11.1 The review forms part of the 2013/14 Savings Programme, as set out in the Medium Term Financial Strategy 2013/14 to 2016/17 report to Cabinet on 11 June 2012.

12. CONTACT OFFICER

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Department	Division	Section	Owner/Officer
Child & Adult Services	Adult Social Care		Jill Harrison, Assistant Director – Adult Social Care

Function/ Service	**Adult Social Care Services** <u>Commissioned Services</u> • Day opportunities services for older people • Services that support carers • Residential placements for people with disabilities <u>Provider Services</u> • Disability Day Services • Employment Link Service • Floating Support Services
Information Available	Savings proposals have been identified following careful consideration of commissioning budgets, spend in service areas over the past three years and existing staffing structures. The proposed savings from commissioned services will be achieved without any reduction in service or direct impact on those people currently accessing services. The proposed savings from provider services will be achieved without any reduction in service or direct impact on those people currently accessing services. There will be less flexibility for services to respond to increased demand and less potential for one off investment in provision of Disabled Facilities Grants. People who are eligible to receive Disabled Facilities Grants will still receive the same service although there may be longer waiting times. People who currently access floating support services will continue to receive a service, although this will be provided by reablement workers with a specific focus on working age adults. The support will continue to focus on supporting people to access community services, build their confidence and become more independent but may be more time-limited than the current service with people encouraged to use their personal budget to access support if they have ongoing support needs and are eligible for services. In such cases, care managers will work with individuals to identify their support needs and how they can most appropriately be met. The Direct Payment Support Service is also available for people to access if they need help with managing their finances, employing staff etc. The service currently supports adults with learning disabilities and / or mental health needs who will be informed of the change in how services are provided and any negative impact will be monitored. The proposed savings from provider services will involve the deletion of approximately 21 posts. From the information available from workforce statistics, there is no inequity in terms of impact on staff due to their age, gender or any other protected characteristic.

Relevance *Identify which strands are relevant to the area you are reviewing or changing*	**Age**	**X**
	Disability	**X**
	Gender Re-assignment	
	Race	
	Religion	
	Gender	
	Sexual Orientation	
	Marriage & Civil Partnership	
	Pregnancy & Maternity	
Information Gaps	Staff affected by the proposed restructure in Provider Services will be formally consulted in (line with agreed HR policies and procedures) if the proposals are accepted. With regards to the floating support service, whilst we know that currently the service supports 80 people at any one time to access community services, build their confidence and become more independent, we are not sure how many of these individuals can make more use of their personal budget to arrange their own support or will need support from the reablement team. We will monitor the service to ensure that the impact of the proposed changes for those who access the service is minimised.	
What is the Impact	**Eliminate Unlawful discrimination**, harassment, victimisation, and any other conduct prohibited by the act *N/A* **Advance Equality of Opportunity**, between people who share protected characteristics and those who don't *N/A* **Foster Good Relations**, between people who share a protected characteristic and people who do not share it. *N/A*	
Addressing the impact	1. No Impact- No Major Change	
	2. Adjust/Change Policy	
	3. Adverse Impact but Continue **The proposed changes to the floating support service will potentially have an impact on people who access those services who are more likely to be people with a mental health problem and / or learning disability. However, we will monitor the proposal to ensure that individuals maximise the use of their personal budget to identify more personalised support. In addition, support will still be available via the reablement service and we will monitor take up of that service.**	
	4. Stop/Remove Policy/Proposal	

Action identified	Responsible Officer	By When	How will this be evaluated?
Consultation with Provider Services staff.	Neil Harrison, Head of Service	31 January 2013	Staff will have been offered the opportunity to consider / comment on proposals and put forward alternative suggestions, in line with agreed HR policies and procedures.
Communication with people using floating support services.	Neil Harrison, Head of Service	31 March 2013	People who use the services will have been offered the opportunity to consider / comment on proposals and put forward alternative suggestions.
Monitor uptake of reablement services and use of personal budgets by people currently accessing floating support services.	Neil Harrison, Head of Service	31 January 2014	Services will be reviewed to ensure that they are meeting the identified needs of individuals who are eligible for services and require ongoing support.

Discussion Paper to the Health and Wellbeing Board
February 2013

Making a difference … providing quality public information about health and social care.

1. Background

1.1. The quantity, quality and availability of public information about health and adult social care has been a constant area of complaint raised at consultations and from local groups including the Learning Disability Partnership Board, the Champions of Older Lifestyles group, Carers Strategy Steering group, family leadership courses and service user focus groups.

1.2. In May 2012 the Department of Health published 'The power of information: Putting us all in control of the health and care information we need'. The document set out a strategy aimed at transforming information for health and social care. It covers public health, healthcare and social care in adult and children's services in England.

1.3. The report argues that information can bring enormous benefits by allowing people to understand how to improve their own and their family's health, to know what care and treatment choices are and to assess for themselves the quality of services and support available.

1.4. We all have a responsibility to provide information and signpost people to services. The government will be encouraging a wide range of organisations to take a broad role in making information accessible and usable for all people.

1.5. Organisations will be encouraged to provide more information about care at clinical or professional team level and information that enables people to 'benchmark' services.

1.6. Similarly, more information is to be made available to help people see and compare the quality of care provided by local services, to help people choose the service which best meets their needs.

1.7. The NHS and local government are to do more to offer support for those who need it to access, understand and use information.

2. Local Activity

2.1. Because of the criticism of the amount and quality of public information available the local authority using the Working Together for Change methodology, ran two sessions to try and establish what was working

around public information, what was not working and what actions we can take to improve the quality of the information provided by agencies.

2.2. The importance of this work has been reinforced by the publication of the Department of Health's information strategy.

2.3. The purpose of Working Together for Change is to take information from contributors to inform strategic change. It allows a structured approach to engage with people to review their experiences and determine their priorities for change. The systematic approach provides an insight into what is working and not working as well as people's aspirations for the future.

2.3. Two Working Together for Change sessions (December 2011 and February 2012) were held. The sessions were facilitated by staff from the Child and Adult Services Department in the local authority.

2.4. Attendees at the events were:

- Members of the Local Involvement Network (LINk)
- Members of the public
- Members of the voluntary and community groups

3. Findings from the events

3.1. We collected a considerable amount of data from the events but for the purposes of this report we will summarise the information provided.

3.2. **What's working?**

3.3. There was quite a positive response in terms of what was working with public information particularly related to information provided by the voluntary and community sector. Some examples include:

- Word of mouth
- Libraries
- 50+ Forum
- HVDA
- Hartlepool MIND
- Belle Vue Centre / Skillshare
- Some G.P surgeries
- Hartlepool Access Group
- LINK
- Hartlepool Carers
- Hartlepool Now
- Fire Brigade
- West View & Resource Centre
- C.A.B
- Connected Care

3.3. **What's not working?**

3.4. There was a considerable amount of data collected in relation to what's not working. This information was themed and included:

- Provision of timely information e.g. websites are not updated regularly.
- Accurate information e.g. quality of information can be poor
- Health information e.g. lack of information about specific illnesses or conditions, lack of information about hospitals, and lack of clarity about the services that are available.
- Accessible information e.g. information can be confusing, there is too much reliance on the internet and there is not enough information provided in different formats such as easy read.
- Leisure/activities e.g. information on activities in the town is not adequate
- Links and networking to share information e.g. there seems to be a lack of communication between departments and organisations and links between the statutory and voluntary sectors do not seem strong in relation to information.
- Benefits advice e.g. benefit information is not distributed pro-actively
- Lack of information for carers e.g. Information & advice on entitlement to carers' services is not enough and accessible information on services that are available to carers in Hartlepool is insufficient
- Employment advice e.g. quality and timely availability of information and advice for Carers on employment issues is not adequate
- Information on social care e.g. information on assessment is not adequate.

3.5. Important for the future

3.6. There was much discussion in the groups about how things could be moved forward. There was a general agreement however that without a commitment from all of the statutory organisations who provide and/or commission health and social care services to participate and help with developments, no real improvements can be made.

3.7. One key area identified was the idea of creating a number of information hubs across the statutory, voluntary and community sector. The role of the hubs was not to be a place where all knowledge is kept, rather a place from where people can be signposted to information and/or to organisations who might be better placed to provide information and support.

3.8. It was identified by the group for the hub idea to work, commitment was needed from organisations to act as hubs but also for information providers to ensure that any changes or updates to information is communicated to the hubs.

3.9. A further meeting was agreed the aim of which was to try and get the commitment from organisations to pursue the idea of the development of and promotion of information hubs.

3.10. Invitations were sent to a number of statutory and voluntary organisations. Unfortunately the meeting had to be cancelled due to the number of apologies received from the statutory organisations. A second meeting was organised and also had to be cancelled due to the majority of invitees from statutory organisations sending their apologies.

3.11. The representatives from LINks and the voluntary sector could see no benefit in meeting to discuss this further without the attendance and commitment of statutory organisations.

4. Conclusions

4.1. The Department of Work and Pensions (2008) argue that people do not want to be bombarded with information before they perceive a need for it. They would prefer to have the confidence to know that they will be able to find out what they need to know when they need to know it.

4.2. Accessible, clear and well-produced information is what users of services should expect. They cannot make choices about services unless they have access to information on the full range of services available within their communities. We need to ensure that service users, carers and the general public can access the information they need.

4.3. As commissioners of health and social care, we have a responsibility to provide people with information. If we don't have the information ourselves, we need to know where to get it or are able to direct people to where it might be.

4.4. The Department of Health power of information report and strategy reinforces the important role that statutory organisations have in providing information.

4.5. From April 2012, the Healthwatch will have a crucial role in signposting people to public information and work in the statutory sector needs to support the Healthwatch in achieving this.

5. Recommendations

5.1. That the Health and Wellbeing board commit to ensuring that the work on progressing information hubs is supported by each organisation and that nominating individuals from those organisations to participate in a 'task and finish' group to develop and implement the information hub process which links the available information. The end goal will be to have relevant information available wherever a person makes contact

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Agenda Item

Report of:	Stephen Catchpole, Managing Director
Report to:	Tees Valley Local Authority Chief Executives
Date:	20th February 2013
Subject:	Telehealth: A Potential Tees Valley Approach

1.1. DEFINITIONS

To ensure clarity on the subject matter, the following definitions are used:

- **Telecare** is the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes. Telecare provides support and reassurance from outside the home, generally using assistive technology such as alarms and sensors.
- **Telehealth** technology assists the patient and health professionals to monitor the patient's vital signs through the use of electronic information and telecoms technologies. These include the monitoring of vital signs such as blood pressure.
- **Telemedicine/teleconsultation** is the use of video conferencing or other technology that enables a medical professional to consult with patients or fellow professionals virtually.
- **Mobile health**/Mhealth is the practice of healthcare using mobile health technology, such as mobile phones and PDAs. This is principally used to collect clinical data, deliver healthcare information and monitor patients in real-time.

2. BACKGROUND

A large amount of work has been carried out in relation to telecare and telehealth, exploring the possibilities and opportunities open to Tees Valley in this fast developing area of healthcare. Tees Valley appears to have all the attributes needed to lead this agenda, including 5 nationally-recognised Foundation Trusts, two leading universities specialising in health and social care, the headquarters of a number of leading social care businesses, an innovative digital sector and a population with a high prevalence of long-term conditions.

Such activity includes; Teesside University holding an Integrated Care Conference in July 2012 centred on learning from best practice on telecare and telehealth across the globe; and the Tees Valley Healthcare Sector Action

Plan, produced in Summer 2012 following engagement with industry, which highlighted that the 5 local authorities, in partnership with the NHS Trusts, Clinical Commissioning Groups, Teesside University and TVU, should work together to "develop the Tees Valley as a centre of excellence in telecare/telehealth," bringing resulting business and investment opportunities. Other work completed includes mapping out and engaging with leading private sector providers on their feel for the market opportunities in the UK.

3. OPPORTUNITIES FROM GOVERNMENT AND NHS POLICY

Telecare and telehealth is beginning to form a key part of government and NHS strategy, reflecting current Department of Health (DH) policy and the structural changes taking place within the NHS. A key way of generating the efficiency savings required by the NHS – of £20bn by 2015 and a reported further £50bn by 2020 – shifting the service closer to the community through Clinical Commissioning Groups (CCG) and meeting the demands of the ageing population, is the use of telecare and telehealth.

Although there are over 1.5 million telecare patients in the UK, there has been very limited take-up of telehealth provision, with fewer than 10,000 deployments in England. Some of the barriers to take-up include: cultural resistance within the NHS; lack of funding; poor patient awareness; limited clinical evidence; and complex procurement. Yet large scale implementation of telehealth has the potential, according to the DH, to "save the NHS up to £1.2bn over five years." It also has clinical benefits with the large DH 'Whole Systems Demonstrator' project finding; a 15% reduction in emergency admissions; a 14% reduction in bed days; and a 45% reduction in mortality rates.

The Government is championing further telecare and telehealth expansion through its '3million lives' campaign, aimed at rolling out technology to benefit patients, alongside the Technology Strategy Board's Delivering Assisted Living Lifestyles at Scale ('DALLAS') programme. The latter aims to facilitate the establishment of a number of telehealth deployments involving over 10,000 patients, showing how assistive living technologies can promote well-being. Most recently, in Nov 2012, the DH announced seven locations as telehealth pathfinder projects to increase roll-out. The NHS Commissioning Board are pushing telehealth as recent guidance states that NHS Trusts must monitor a baseline for telehealth in 2012/2013 and prove upward trajectory in 2013/14 in order to get certain payments.

4. ENGAGEMENT WITH NHS TRUSTS IN TEES VALLEY

To build on the work already underway and maximise the opportunities stemming from government policy and NHS structural changes, TVU met with the five NHS Foundation Trusts in Aug/Sept 2012 covering the Tees Valley (CDDFT, North Tees, South Tees, Mental Health Trust, Ambulance Trust) to ask about previous and current work on telecare and telehealth, future plans and fit with trust strategy. The possibility of collaboration across the Tees Valley was raised to gauge reaction. All agreed the overall aim was worth

exploring; that of turning Tees Valley and Durham into a centre of excellence for telecare, telehealth, teleconsultation and telemedicine. To do so would, crucially, require clinical engagement (through liaison with the CCGs) and the buy-in of the Trusts, along with short term actions to create a sense of momentum. The report recommended:

- The creation of a Tees Valley and Durham best practice telecare/telehealth centre to share knowledge on technologies and other issues, encouraging joint working;
- The need for a Tees Valley and Durham Telehealth Programme Board to develop a collaborative approach to telehealth (Trusts, CCGs, Universities, TVU, LAs)

5. VISION AND BENEFITS

5.1. Ambition

To turn Tees Valley and Durham into the leading area in the UK for telecare, telehealth, teleconsultation and telemedicine to benefit patients, clinicians and businesses, generating employment opportunities and significant economic impact.

5.2. What this will look like

NHS Trusts and local authorities working together to provide a well-patronised joined up telecare and telehealth offer across Tees Valley and Durham, providing patients with an integrated, personalised service catering for their needs. Trusts save money through fewer elective and emergency admissions, patient satisfaction rises as patients, particularly those with long-term conditions, are given independence and treated in their own homes and CCGs are confident in commissioning services from a proven telehealth model that works.

Over the long-term private sector providers of telecare and telehealth equipment could look to locate in Tees Valley to both service these large key contracts and to benefit from new innovations and research stemming from the universities, particularly around digital applications and the local customisation of telehealth provision. Employment opportunities in the sector increase through the growth of digital start-ups and spin-outs, as well as the expansion of healthcare-related indigenous business and inward investment. Other parts of the healthcare supply chain locate to Tees Valley as the telehealth and telecare cluster develops. Tees Valley is increasingly recognised as the UK's leading area for telecare and telehealth.

5.3. Market opportunity

Very few areas in the UK have maximised this opportunity by delivering the large scale roll out of telehealth required to attract substantial private sector investment in technology or services. Both Phillips and Tunstall, the world's leading telecare and telehealth providers, believe there is a big market

opportunity in telehealth in the UK (seen as the biggest market in Europe), but only limited numbers of units have been deployed so far. This is due to a lack of scale and partnership working. Therefore, there is a need to collaborate across trusts to generate sufficient critical mass and join up health and social care through engagement between local authorities, trusts and CCGs. There is also an opportunity for digital firms to tap into the growing move towards personalised healthcare and assistive technologies. The NHS Commissioning Board, for example, announced in Jan 2013 that it wanted to find out about IT innovations, particularly the cutting edge developments from micro-enterprises and gifted developers.

5.4. Key ingredients to get there

There needs to be buy-in from Clinical Commissioning Groups to look to commission services on telecare and telehealth when they come into force in April 2013. Senior buy-in from NHS Trusts to pool resources and collaborate (if the will is not there, the project will not go ahead) is important, along with engagement from local authorities to help create a whole system project between health and social care.

As outlined above, sufficient scale is required as private suppliers spoken to by TVU say they need a critical mass of over 10,000 people; something that the Trusts covering Tees Valley and Durham could provide. In terms of funding sources, there could be the opportunity to tap into DH and other funding sources (for example, DH recently announced £50m to promote independent living technologies for dementia) to spur development. A Telehealth Action Plan has been drafted, which begins to set out the steps needed to put Tees Valley at the forefront of this agenda. It is proposed that this draft action plan is worked up by local authority officers, with particular input from Directors of Adult Services and Directors of Public Health.

6. RELATED WORK

Smart Specialisation Strategy
Sustainable innovation and smart specialisation are key themes of the Europe 2020 Strategy and will inform EU priorities for the use of structural and cohesion funding over the period 2014 – 2020. TVU has commissioned research looking at the potential for innovation and new technology development in Tees Valley, which includes telehealth.

DH funding for innovation
Announced in Jan 2013, the DH is funding joint NHS Trust-university research into innovative approaches to healthcare The Fund is looking for research of ways to improve NHS services. £2m per year per collaborative partnership over 5 years starting in Jan 2014 (applications need to be in by May 2013).

South Tees NHS Trust – Teleinnovations project
South Tees NHS Trust, Middlesbrough Council and Redcar and Cleveland Council are currently looking at a joint teleinnovations project looking at the potential for collaboration.

7. LEADERS AND MAYORS AND LEADERSHIP BOARD

This paper went to TVU Leadership Board in Dec 2012 and Leaders and Mayors in Jan 2013, with the direction of travel agreed.

8. SUMMARY

Telecare is part of the social care responsibility of local authorities, and is relatively well established (with potential for further expansion and possible collaboration in certain areas) whereas telehealth is the responsibility of the NHS (CCGs and Trusts) and real life applications have been extremely limited. Trusts are keen on the activity, as are a number of local authorities and there is funding available which could interest the private sector and start to generate a sense of momentum for telehealth in Tees Valley.

9. PROPOSED NEXT STEPS

i) Tees Valley Directors of Public Health to examine the evidence base of the health population in Tees Valley to start to assess the willingness of commissioners (the CCGs) to invest in telehealth.
ii) TVU to work with local authority officers, with particular input from Directors of Adult Services and Directors of Public Health, on a draft action plan
iii) TVU to work with Durham and Teesside Universities to explore potential research funding opportunities (from the DH and other sources)
iv) TVU to work with Teesside University to highlight the opportunities for digital firms in telehealth and the NHS as a whole
v) TVU to support and work with NHS Trusts on telehealth projects (e.g. South Tees NHS Trust and Teleinnovations)
vi) Work to be undertaken to consider establishing a focus group of Tees Valley businesses interested in accessing this market

10. RECOMMENDATIONS

It is recommended that Chief Executives agree to the proposed next steps detailed above.

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SHADOW HEALTH & WELL BEING BOARD

Report of: Director of Public Health

Subject: FINAL DRAFT OF THE JOINT HEALTH AND WELLBEING STRATEGY

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present to Shadow Health and Well Being Board the final draft of the joint Hartlepool Health and Wellbeing Strategy (JHWS) for agreement.

2. BACKGROUND

2.1 NHS reforms require the Local Authority with partner agencies including the NHS to develop a joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment (JSNA). The final strategy must be adopted by April 2013. The strategy should focus on not only protecting the health of the population but improving it through a range of evidence based interventions.

2.2 The strategy is based on the Marmot Report (2010) focusing on the following policy areas:

- Give every child best start in life
- Enable all children and young people to maximise capabilities
- Enable all adults to maximise capabilities
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places
- Strengthen the role and impact of ill health prevention

3. CONSIDERATIONS FOR SHADOW HEALTH AND WELL BEING BOARD

3.1 The following amendments have been made to the draft Health and Well Being Strategy since the second draft was presented to the Forum in January 2013:

- Foreword added

- Section 3. The Case for improving Health and Wellbeing in Hartlepool.

  The map showing life expectancy within our old wards has been replaced with two new maps. The first (figure 1) shows levels of deprivation within our new wards and the second (figure 2) shows the Standard Mortality Ratio within the new Wards and the correlation between poor health and deprivation.

- Section 7. Strategic Priorities

  The Key Outcomes and Objectives of the strategy have been added to this section.

- Section 8. Strategy Ownership and Review.

  This section has been added to explain the strategy ownership and how the Annual Action Plan will be managed and reviewed.

- Appendix 3 - The NHS Hartlepool Stockton on Tees CCG Plan on a page has been updated.

3.2 The annual action plan for the strategy is still being revised and the final version of this plan will be presented with the strategy to full Council and CCG Governing Body in April 2013.

4. RECOMMENDATIONS

4.1 Shadow Health and Well Being Board is asked to agree the final version of the Hartlepool Health and Wellbeing Strategy.

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HARTLEPOOL HEALTH AND WELLBEING STRATEGY 2013-18

Foreword

Healthy people living longer, healthier lives is the aspiration of the Hartlepool Health and Wellbeing Board.

This newly created Board brings together a range of agencies, including the Council and the Clinical Commissioning Group for the NHS, with a joint ambition to support people to make healthier choices, maximise opportunities for wellbeing and ensure a healthy standard of living for all.

This Strategy sets out how the Health & Wellbeing Board for Hartlepool intends to achieve this ambition.

The Strategy is not all about treating illness, although high quality accessible services are vital when needed; it is also about helping people to make healthier choices. Detecting illness early and ensuring people get effective and timely treatment is essential. Equally important for health is the need for people to live in good quality, affordable housing, with education and employment opportunities to maximise control and capabilities, as well as achieving a good standard of living for all.

This Strategy intends to address the challenges of ill health and premature death in Hartlepool. In Hartlepool there is a 9 year gap between affluent and deprived communities in how long a man might expect to live. This life expectancy gap is 7 years for women. This is a great social injustice, which is unfair and needs tackling through all of the interventions and actions proposed through this Strategy.

This Strategy is based on what you, the people of Hartlepool, have told the Health & Wellbeing Board matters. The public consultation that was undertaken when developing this Strategy showed that the people of Hartlepool wanted their children to have the “best start in life”.

Through the energy, effort and drive of all involved in this Strategy, that is what we aim to do. Not only give the “best start in life”, but the best health and wellbeing throughout life and make Hartlepool a healthier, happy and vibrant town.

Partnership organisations
To be added: Sign-up page with organisations’ logos.

1. Vision

The vision of the Hartlepool Health & Wellbeing Strategy is to:

Improve health and wellbeing and reduce health inequalities among the population of Hartlepool.

This will be achieved through integrated working, focusing on outcomes and improving efficiency.

2. Purpose

The Joint Health and Wellbeing Strategy (JHWS) is a strategic document outlining how Hartlepool Borough Council, Hartlepool and Stockton Clinical Commissioning Group and other key organisations, through the Health and Wellbeing Board, will address the health and wellbeing needs of Hartlepool and help reduce health inequalities.

The Health and Social Care Act (2012) establishes Health and Wellbeing Boards as statutory bodies responsible for encouraging integrated working and developing a Joint Strategic Needs Assessment and Health and Wellbeing Strategy for their area[1]. The Strategy is underpinned by the Joint Strategic Needs Assessment (JSNA) and together they will provide a foundation for strategic, evidence-based, outcomes-focused commissioning and planning for Hartlepool[2].

3. The case for improving health and wellbeing in Hartlepool

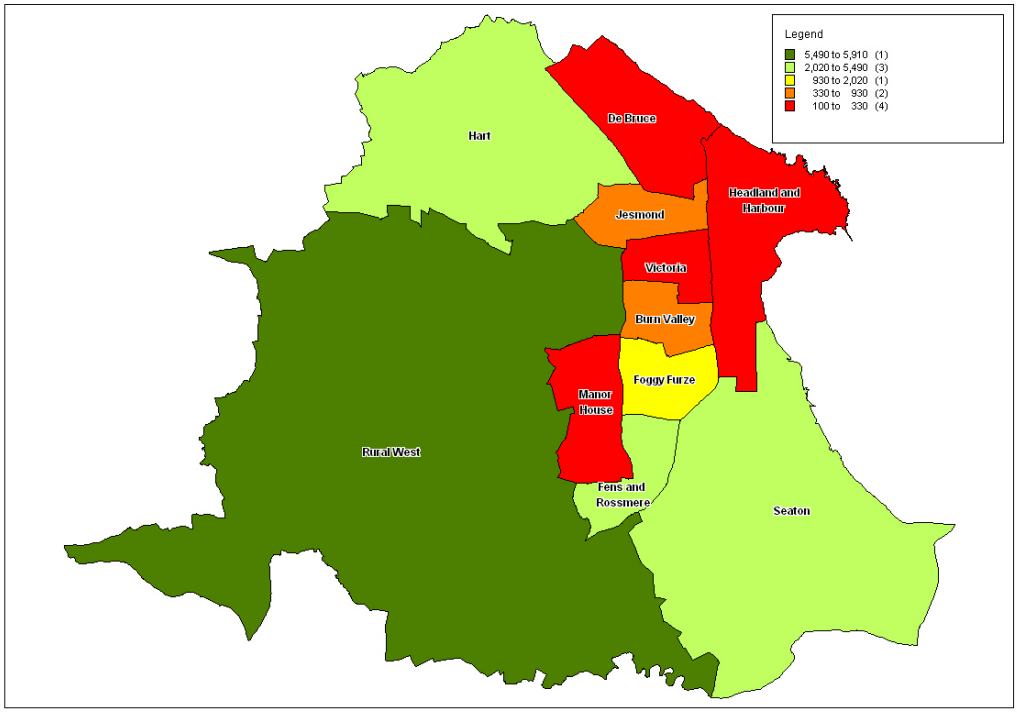
Health in Hartlepool is generally improving. There has been a fall in early deaths from heart disease and stroke; and the rate of road injuries and deaths is better than the England average[3].

However, there is still much to do (**Box 1**). Health in Hartlepool is still worse than the national average. Levels of deprivation are higher and life expectancy is lower than the national average. **Figure 1** shows the levels of deprivation in Hartlepool and **Figure 2** shows the difference in Standard Morality Ratio (SMR) between the deprived and more affluent areas of the Borough.

Box 1: At a glance: Health initiatives and challenges in Hartlepool[3]

- Levels of deprivation are higher and life expectancy is lower than the England average.
- Inequalities exist: life expectancy is 9 years lower for men living in the most deprived areas, compared to least deprived areas. The difference is 7 years for women.
- Over the last 10 years, the death rate from all causes has fallen for men but has fluctuated for women.
- The early death rate from cancer has changed little over the last 10 years.
- Both the death rate from smoking and the percentage of mothers smoking in pregnancy are worse than the England average.
- Alcohol-related hospital admissions are higher than the national average.
- Childhood immunisations rates are significantly lower than the national average.
- 25% of Year 6 pupils are classed as obese, this is the highest in the Tees Valley.

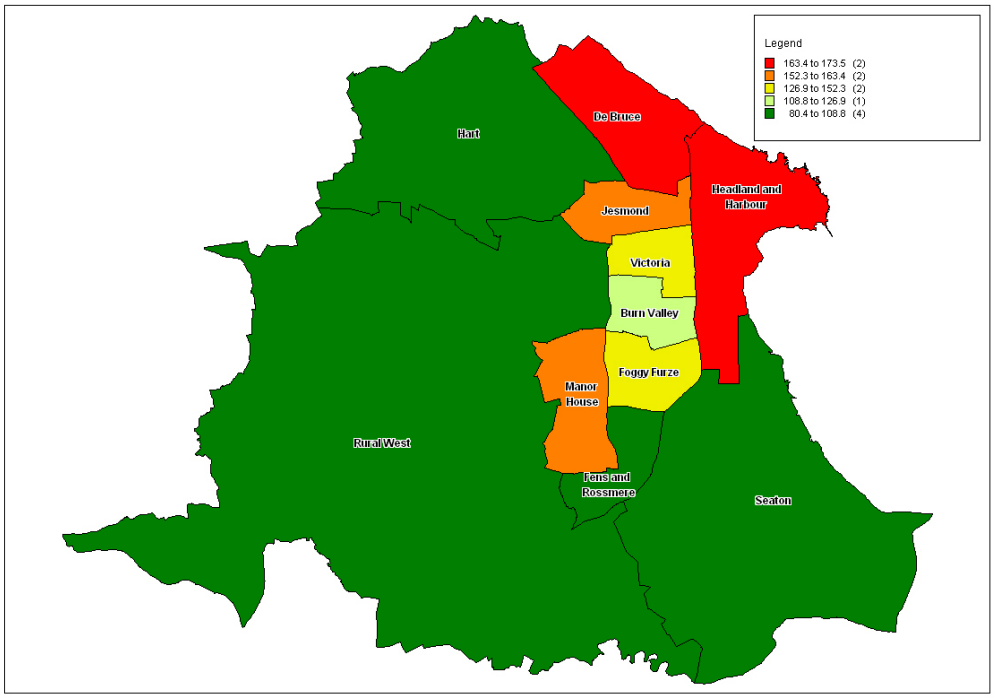
Figure 1: Index of Multiple Deprivation at Ward level in Hartlepool



The Index of Multiple Deprivation provides a relative measure of deprivation in small areas across England. They are based on the concept that deprivation consists of more than just poverty. Poverty is not having enough money to get by on whereas deprivation refers to general lack of resources and opportunities. The above map shows the levels of deprivation within Hartlepool by Ward. The IMD 2010, tells us that there are high levels of deprivation within six of Hartlepool's eleven wards; those being De Bruce, Headland and Harbour,

Victoria, Manor House, Jesmond and Burn Valley. There is a clear correlation between levels of deprivation and poor health. The lower a persons social position the more likely it is that his or her health will be worse.

Figure 2: Standard Mortality Ratio in Hartlepool (Ages 0 – 64)

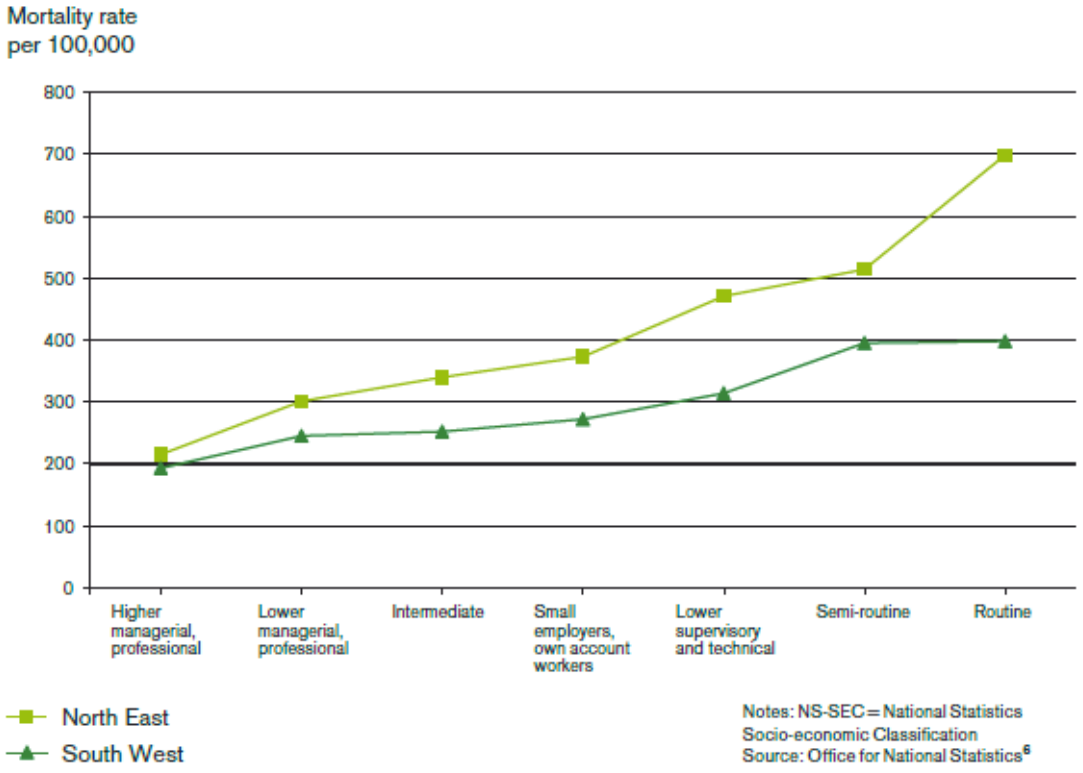


The Standard Mortality Ratio (SMR) compare local death rates with national ones. They are calculated by dividing the actual number of deaths in an area by the number that would be expected using National death rates by ages and sex of the population. The resulting number is multiplied by 100. If an area has an SMR of 100, this indicates that local death rates are similar to National rates. If they are greater than 100, this indicates higher death rates than the national average and vice versa. SMRs are often used as proxy indicators for illness and health within an area. Clearly there is a link between SMR and levels of deprivation with Hartlepool's most disadvantaged Wards having a significantly higher score than the national average.

There is a 9 year difference in male life expectancy between the most advantaged and the most disadvantaged wards in Hartlepool[3,14]. We know that socio-economic inequalities lead to inequalities in life expectancy and disability-free life expectancy. Furthermore, the relationship between these is finely graded – for every decrease in socio-economic conditions, both life expectancy and disability-free life expectancy drop. Social and economic inequalities are important causes of this relationship[4]. In his *Strategic Review of Health Inequalities in England* (2010)[4], Prof. Sir Michael Marmot argues that fair distribution of health, wellbeing and sustainability will impact positively on the country's economic growth. To improve health and wellbeing, action is needed

across all social determinants of health to reduce health inequalities; and to make a difference, action to improve health and wellbeing should be across all socio-economic groups but tailored to a greater scale and intensity as the level of disadvantage increases[4]. As demonstrated in **Figure 3**, the effect of socioeconomic disadvantage on life expectancy is greater in more disadvantaged areas. However, the effect is also more pronounced in the North East compared to the South West, for all socioeconomic groups.

Figure 3: Age-standardised mortality rates by socioeconomic classification (NS-SEC) in the North East and South West regions, men aged 25-64, 2001-2003[4]



We also know that focusing on early years interventions – giving children the best start in life – helps deliver the greatest benefits in health inequalities and economic terms. Health and wellbeing improvements delivered during childhood can reap benefits both in early life and throughout the individual's life-course[4].

4. What does this Strategy cover?

This Strategy outlines the strategic health and wellbeing priorities for Hartlepool. It builds on the good work already underway, whilst maximising the opportunity for better integration of services and closer partnership working presented by moving much of the NHS Public Health services, into Local Authorities. Working together with other areas in the North East will help achieve better outcomes and

value, for the 'big issues' in health and wellbeing[5]. The Strategy supports the ten themes of *Better Health, Fairer Health* (2008)[5,6] – the North East's vision and 25 year plan for improving Health and Wellbeing which is supported by other Local Authorities across the North East (**Box 2**).

Box 2: *Better Health, Fairer Health* (2008)[6]

- Economy, culture and environment
- Mental health, happiness and wellbeing
- Tobacco
- Obesity, diet and physical activity
- Alcohol
- Prevention, fair and early treatment
- Early life
- Mature and working life
- Later life
- A good death

'Health and Wellbeing' has a broad remit and it will be important for a range of partner organisations to work together, to deliver improvement. This Strategy focuses on areas of work impacting directly on health and wellbeing, or acting as clear 'wider determinants' of health and wellbeing.

The National Review of Health Inequalities, 'Fair Society, Healthy Lives', led by Prof. Sir Michael Marmot, drew on extensive global research into Health inequalities. Reflecting on inequalities in our society and health inequalities in particular, Prof. Sir Marmot stated: *'To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Greater intensity of action is likely to be needed for those with a greater social and economic disadvantage. But focussing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem'.*

The Marmot review identified six 'Areas for Action'. These are:

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities;
- Strengthen the role and impact of ill health prevention.

To focus activity in these areas, the key outcomes within this strategy reflect these wider determinants.

Other elements of health and wellbeing (initially summarised by Dahlgren and Whitehead in their social model of health[7] - **Appendix 1**) will be outside the direct remit and influence of the Health and Wellbeing Board and its partner organisations. They will be delivered through associated strategies and work programmes within Hartlepool Borough Council, the NHS and associated partners. Communication and governance processes will ensure links between departments and strategies to limit duplication, further build joint working and integration and enable economies of scale. The action plan underpinning the Strategy will define the activities needed to deliver the outcomes in the Strategy, and the partners responsible. The work will take place in the context of local service provision, including the Momentum project, which focusses on redesigning services and providing care closer to home.

5. Our Values

To work together successfully and achieve the vision set out in this Strategy, it is important that all organisations involved sign up to and work within, a set of shared values[8,9]. For Hartlepool, these values fit with the proposed operating principles for Boards[8] and the Board Terms of Reference. The values are:

- Partnership working and increased integration[2,8] across the NHS, social care and Public Health
- Focus on health and wellbeing outcomes
- Focus on prevention
- Focus on robust evidence of need and evidence of 'what works'
- Ensure the work encompasses and is embedded in the three 'domains' of Public Health practice: Health Protection, Health Services and Health Improvement[10]
- Shared decision-making and priority-setting, in consultation with CCGs and other key groups
- Maintain an oversight of and work within the budgets for health and wellbeing
- Support joint commissioning and pooled budget arrangements, where all parties agree this makes sense
- Maximise the process of democratic accountability and develop the Strategy and related plans in consultation with the public and service users

The Health and Wellbeing Board and the Health and Wellbeing Strategy provide the opportunity to maximise partnerships and evidence base, generating new ways of tackling health and wellbeing challenges. This includes recognising and mobilising the talents, skills and assets of local communities to maximise health and wellbeing[11].

6. Identifying our key outcomes

The Strategy's key outcomes and objectives have been developed in consultation with stakeholders and with the following in mind:

- Services Hartlepool Borough Council will be mandated to provide from April 2013[12]. The services are listed in **Appendix 2**.

- Clinical Commissioning Group draft plans

The Strategy has been developed in close liaison with the Clinical Commissioning Group for Hartlepool and Stockton-on-Tees, whose draft Clear and Credible plan[13] has highlighted key challenges: cardiovascular disease; cancer; smoking –related illness e.g. COPD; alcohol-related disease. These areas reflect the results of a 2010 public engagement campaign, which recorded the views of 1883 people regarding priorities for them and their families. See **Appendix 3** for an overview of the draft CCG commissioning plan.

- The Health and Wellbeing Strategy should be read in conjunction with the Joint Strategic Needs Assessment (JSNA). The JSNA is currently being refreshed through engaging partners and will outline the commissioning intentions for health and social care. The JSNA website address is http://www.teesjsna.org.uk/hartlepool/

- Hartlepool Public Health Transition Plan

The transition plan outlines the proposed activity to be funded through the Public Health budget (**Appendix 4**).

Stakeholder engagement and consultation

It is very important that this Strategy reflects both the evidence available about population health and wellbeing need; and the views and priorities of stakeholders. Stakeholders have been involved throughout the development of the Strategy, including the public, service users and partner organisations. The Shadow Health and Wellbeing Board membership which owned the Strategy included LINkS representation, democratically elected members, NHS organisations and Local Authority representation.

A full consultation process provided the opportunity to identify the public's priorities for health and wellbeing in Hartlepool; and the outcomes of the consultation have been reflected in the priorities for the Strategy. The consultation process and a summary of its outcomes is outlined in **Appendix 5**.

7. Strategic priorities and objectives

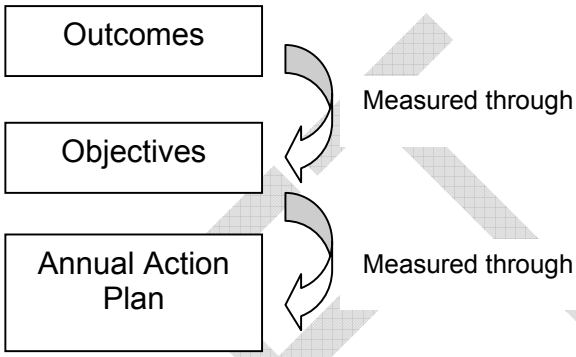
The outcomes outlined within the Strategy reflect the 'areas for action' identified by Marmot reflecting the wider determinants of health and wellbeing.

The key objectives that sit beneath each outcome are aligned with a number of key strategies being delivered across the Borough to ensure the effective coordination of delivery. The objectives show how the Health and Wellbeing Board for Hartlepool will deliver on the outcomes identified, and meet the challenge set out by Marmot's suggested 'areas for action'. The key objectives are:

Outcome 1: Give every child the best start in life	
Objective A	Reduce child poverty
Objective B	Deliver early intervention strategy
Outcome 2: Enable all children and young people to maximise their capabilities and have control over their lives	
Objective A	Children and young people are empowered to make positive choices about their lives
Outcome 3: Enable all adults to maximise their capabilities and have control over their lives	
Objective A	Adults with health and social care needs are supported to maintain maximum independence.
Objective B	Vulnerable adults are safeguarded and supported while having choice and control about how their outcomes are achieved.
Objective C	Meet Specific Housing Needs
Outcome 4: Create fair employment and good work for all	
Objective A	To improve business growth and business infrastructure and enhance a culture of entrepreneurship
Objective B	To increase employment and skills levels and develop a competitive workforce that meets the demands of employers and the economy
Outcome 5: Ensure healthy standard of living for all	
Objective A	Address the implications of Welfare Reform
Objective B	Mitigate against the impact of poverty and unemployment in the town
Outcome 6: Create and develop healthy and sustainable places and communities	
Objective A	Deliver new homes and improve existing homes, contributing to Sustainable Communities
Objective B	Create confident, cohesive and safe communities
Objective C	Local people have a greater influence over local decision making and delivery of services
Objective D	Prepare for the impacts of climate change and takes action to mitigate the effects
Objective E	Ensure safer and healthier travel
Outcome 7: Strengthen the role and impact of ill health prevention	
Objective A	Reduce the numbers of people living with preventable ill health and people dying prematurely
Objective B	Narrow the gap of health inequalities between communities in Hartlepool

Delivery on the objectives will be ensured through an annual action plan which supports this Strategy. The action plan specifies the detailed initiatives to deliver on the objectives and will also include, amongst others, the indicators identified in the Public Health Outcomes Framework[15]. **Figure 2** summarises the mechanism for ensuring delivery on the key outcomes.

Figure 2: Delivering on the key outcomes



Due to the broad nature of health and wellbeing, improvements will only be seen if the health and wellbeing agenda is also embedded in wider relevant Local Authority strategies and services. The action plan outlines how this is being done.

8. Strategy ownership and review

This Strategy is owned by the Health and Wellbeing Board. Although the Strategy is a 5 year document it will be reviewed by the Board every 3 years to ensure that it remains relevant and continues to reflect local priorities.

Each year the Board will agree an action plan setting out how the Strategy will be delivered. The action plan will set out agreed timescales for delivery and clear ownership for the actions. The action plan will also include a number of performance indicators which will be used to assess the progress being made. The key risks for implementing the Strategy will also be identified. The Board will monitor progress through quarterly performance reports and seek to maximise resources and secure new resources into the Borough.

The next review of the Health & Wellbeing Strategy will take place by April 2016.

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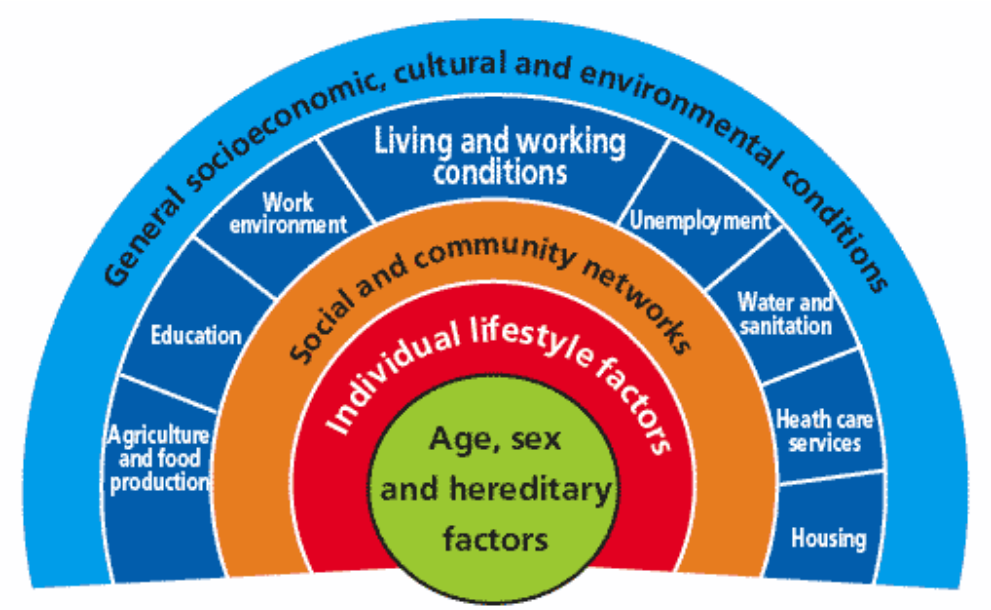
Appendices

Appendix 1: Social model of health (Dahlgren and Whitehead, 1998)[7]



Appendix 2:
Local Authority mandated services[12]
Under the coalition government's proposals for the new Public Health system, Local Authorities will be mandated to provide the following from April 2013:

- Appropriate access to sexual health services
- Steps to be taken to protect the health of the population, in particular, giving the Director of Public Health a duty to ensure there are plans in place to protect the health of the population
- Ensuring NHS commissioners receive the public health advice they need
- The National Child Measurement Programme
- NHS Health Check assessment

Consideration is also being given locally to the various additional services not covered by this list, which would be important to continue to provide e.g. stop smoking services.

Appendix 3: NHS Hartlepool and Stockton-On-Tees CCG – Plan on a Page 2013/14[13]

Vision (CCP page 7)

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.

Strategic Aims (CCP page 12)

- Bringing care closer to home
- Tackling Health Inequalities
- Caring for an aging population
- Addressing our priority health conditions
- Improving quality in primary care
- Ensuring quality and patient safety
- **Improving patient experience**
- Seeking best value for money within budget

Transformational Work Streams & Cross cutting themes (CCP page 12)

Personalisation; Carers; PPI; Prevention; Innovation

Prioritised Initiatives (Commissioning Intentions) [link to outcome framework domains]

Health and Wellbeing

Priority
Maternal smoking at delivery

- Commission sufficient capacity to meet the demand of the screening programmes
- Work with Primary Care Providers to increase uptake of bowel screening
- Reduce Hospital Admissions in relation to alcohol;
  - Signposting to support services offered to patients identified
  - Collaborate with Public Health in relation to delivery of the alcohol strategy and determine future requirements for commissioned services
- Reduce smoking prevalence;
  - Collaborate with Public Health to develop a joint strategy in relation to smoking cessation services to improve access and attendance and focus on improving the quit rate of women smoking at time of delivery
  - Ensure the smoking cessation services are linked to the Community Renaissance Teams
- Reduce COPD Admissions
  - Carry out a review of acute and community respiratory services
  - Commission a range of preventative initiatives such self care packs and patient education

Out of Hospital Care

Priority
Emergency Readmissions within 30 days of discharge From hospital

- Improve the Quality of Care within Residential and Nursing Homes
  - All residential/ nursing home patients will have a regularly reviewed Health Care Plan (HCP)
- Triage and signpost patients who are not appropriate to be seen in A&E to the relevant care provider in order to support the re-education programme
- Implement management plans for all patients identified by the LACE tool as being at high risk of readmission
- Review and audit of the new community services model
- Developing integrated health care facilities in Stockton, Billingham, Hartlepool and Yarm
- To improve the quality and capacity in Primary Care
  - Better understand capacity and demand within Primary Care to determine future commissioning intent
  - Continue to support Primary Care in reducing variation in General Practice, both in terms of quality and financial spend
- Reduction in readmissions

Acute In-Hospital Care

- Continued Reduction in C2C Referrals
- Reduction in N:R ratio and review of Nurse delivered clinics
- Extend the Hartlepool plastics service to include access for Stockton patients
- Choose & Book
  - Ensure letters are reviewed prior to clinics to ensure patients are attending correct clinics
  - Ensure patients are redirected to most appropriate clinics where wrong referral has been made
  - Ensure advice and guidance is available via Choose and Book
- Implement revised MSK pathway
  - Pathway to include direct access to core Physiotherapy and direct access to MSK
  - The CCG expects where referral is sent to incorrect, referral will automatically refer on to appropriate service without sending back to GP or requesting a re-referral
- Work with providers to reduce the number of delayed discharges
- Review of Commissioner Requested Services (CRS) to establish any additional services the CCG required
- Work with Provider to ensure that routine services are offered 7 days a week

Mental Health, Learning Disabilities and Dementia

Priority
Estimated diagnosis Rate for people with Dementia

- Robust and accurate registers of patients with Dementia
- Development of a pilot memory clinic within a primary care setting
- Perinatal Mental Health – to ensure compliance with NICE guidance including potential for specialist community service
- Continued development of Mental Health Payment by Results
- Ensure CAMHS services meet NICE requirements and improves assessment to diagnosis waiting times
- Review of 'Stepping Forward' model for vulnerable, high activity MH patients
- Out of Area specialist placements/rehab services - to identify potential opportunities for developing services for low volume/high cost cases closer to home
- TEWV Primary Care Therapy Services - align both the funding and contract management to the existing Any Qualified Provider
- Development of alternative rehabilitation and recovery services to support complex individual residents
- Review current commissioning arrangements for specialist sensory assessments and develop local pathway
- E-Communications
  - Implementation of e-discharge solution which transfers information directly into clinical system (inpatient and outpatients)
  - Implementation of Choose and Book, including advice and guidance
- Provide independent assessments of individuals with Learning Disabilities to establish to most appropriate packages of care that fulfils their needs
- Movement of patients from autism inpatient and assessment of treatment beds into community based settings
- Work collaboratively with Social Care Commissioners to deliver improved, joined up services to people whose needs are complex and whose behaviour is challenging to services
- Identify all young people that require a Health Action Plan
- Support Health funded individuals through bridging packages
- Support the us of quality checkers to advise on and highlight areas that may require reasonable adjustment

Medicines Optimisation

- Improve Costs in relation HCD spend
  - Commissioned services will continue to use defined and standard list of drugs and indications that will be accepted for pass-through payment
  - Existing contracts held by providers will be reviewed, and the CCG will be consulted on these prior to entering or re-negotiating a contract, for the provision of specialist drugs via a third party provider
- To improve the quality of discharge information and medication supply
  - Patients will be provided with at least 28 days supply of long-term medicines, appliances and nutritional supplements on discharge
  - Patients will be supplied a "monitored dosage system" where this was in use prior to admission, or has been deemed necessary by valid assessment during the in-patient stay
  - Patients will be supplied full treatment course for all drugs where a defined treatment course is indicated e.g. antibiotics, steroids
- Self administration of medication in acute care

Outcome framework

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions.
- Helping people recover from episodes of ill health or following injury
- Ensuring that people have positive experience of care
- Treating and caring for people in a safe Environment and protecting them from harm:

Risks

- Monitoring effective partnership and membership engagement
- Balancing capacity and demand to counter the financial pressures of an ageing and growing population and technological advances
- Contract Signature for 13/14
- Impact of transition of specialist commissioning to NHSCB
- Transition and pace of change
- Delay in implementing Momentum: Pathways to Healthcare

Appendix 4: Hartlepool Public Health Transition Plan: Proposed activity to be funded from the Public Health budget

NB: Subject to confirmation of the budgets available.

Public health topic	Proposed activity to be funded from Public Health budget
Sexual health	Testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, all outreach and preventative work
Immunisation against infectious disease	School immunisation programmes, such as HPV.
Seasonal mortality	Local initiatives to reduce hospital admissions and seasonal excess deaths
Accidental injury prevention	Local initiatives such as falls prevention and reducing childhood injuries
Public mental health	Mental health promotion, mental illness prevention and suicide prevention
Nutrition	Locally led initiatives
Physical activity	Local programmes to reduce inactivity; influencing town planning such as the design of built environment and physical activities role in the management / prevention of long tram conditions
Obesity programmes	Local programmes to prevent and treat obesity, e.g. delivering the National Child Measurement programme; commissioning of weight management services
Drug misuse	Drug misuse services, prevention and treatment
Alcohol misuse	Alcohol misuse services, prevention and treatment
Tobacco control	Tobacco control local activity, including stop smoking services, prevention activity, enforcement and awareness campaigns
NHS Health check	Assessment and lifestyle interventions
Health at work	Local initiatives on workplace health and responsibility deal
Prevention and early presentation	Behavioural/ lifestyle campaigns/ services to prevent cancer, long term conditions, campaigns to prompt early diagnosis
Children's public health 5-19	The Healthy Child Programme for school age children, school nurses, health promotion and prevention interventions by the multi professional team
Community safety and violence prevention and response	Specialist domestic violence services that provide counselling and support services for victims of violence including sexual violence
Social exclusion	Support for families with multiple problems, such as intensive family based interventions
Dental Public Health	Targeting oral health promotion strategies to those in greatest need.

Appendix 5: Consultation process for identifying objectives

The Strategy consultation ran from June – October 2012, in line with Local Authority consultation processes and statutory responsibilities. It consisted of:

A 'Face the Public' event
Approximately 70 people attended, representing a range of organisations from the community, voluntary and statutory sector and elected members.

A resource-allocation exercise
Set up in a range of venues including the shopping centre, the library, children's centres, GP surgeries and youth centres. The exercise asked members of the public to allocate £25 'virtual pounds' across the Marmot policy areas. 465 members of the public took part. 'Giving every child the best start in life' was the most popular priority amongst participants with almost 30% of the total budget allocated to this area.

When broken down by the type of venue, 'giving every child the best start in life' is the most popular priority across all venues, however this percentage is significantly less in the results obtained within libraries, where there was a more even spread across each priority area.

The next most popular was 'ensure a healthy standard of living for all' (16%).

An online survey
Open to the general public, the survey asked respondents to prioritise a range of suggested interventions listed under each Marmot policy area. Respondents were asked to choose the 3 most important issues under each Marmot area. They were:

- Give every child the best start in life – levels of child poverty (60%) and better parenting (62%). Next most popular: early years education (up to age 5) 25%
- Enable all children and young people to maximise their capabilities and have control over their lives – employment and training (60%), educational attainment (48%), aspirations of young people
- Enable all adults to maximise their capabilities and have control over their lives – employment and training opportunities (81%), aspiration levels (58%), educational attainment (57%)
- Create fair employment and good work for all – access to good jobs (78%), access to good quality training (52%), young people not in education or training (46%)
- Ensure a healthy standard of living for all – job opportunities (63%), having the level of income needed for leading a healthy life (55%), unemployment levels (43%)
- Create and develop healthy and sustainable places – levels of anti-social behaviour (53%), access to good quality housing for all (48%), good quality transport (37%)

- Strengthen the role and impact of ill health prevention – levels of obesity (62%), smoking levels (56%), alcohol intake (48%)

Free-text comments generally fitted with the areas of work that were presented as options for responders in the rest of the survey.

Consultation was also carried out with existing members of the LINkS. The draft Strategy was also shared with the CCG, through discussion at the CCG locality meeting, and through CCG membership on the Health and Wellbeing Board.

Outcome 1: Give every child the best start in life	
Objective A	Reduce child poverty
Objective B	Deliver early intervention strategy
Outcome 2: Enable all children and young people to maximise their capabilities and have control over their lives	
Objective A	Children and young people are empowered to make positive choices about their lives
Outcome 3: Enable all adults to maximise their capabilities and have control over their lives	
Objective A	Adults with health and social care needs are supported to maintain maximum independence.
Objective B	Vulnerable adults are safeguarded and supported while having choice and control about how their outcomes are achieved.
Objective C	Meet Specific Housing Needs
Outcome 4: Create fair employment and good work for all	
Objective A	To improve business growth and business infrastructure and enhance a culture of entrepreneurship
Objective B	To increase employment and skills levels and develop a competitive workforce that meets the demands of employers and the economy
Outcome 5: Ensure healthy standard of living for all	
Objective A	Address the implications of Welfare Reform
Objective B	Mitigate against the impact of poverty and unemployment in the town
Outcome 6: Create and develop healthy and sustainable places and communities	
Objective A	Deliver new homes and improve existing homes, contributing to Sustainable Communities
Objective B	Create confident, cohesive and safe communities
Objective C	Local people have a greater influence over local decision making and delivery of services

Objective D	Prepare for the impacts of climate change and takes action to mitigate the effects
Objective E	Ensure safer and healthier travel
Outcome 7: Strengthen the role and impact of ill health prevention	
Objective A	Reduce the numbers of people living with preventable ill health and people dying prematurely
Objective B	Narrow the gap of health inequalities between communities in Hartlepool

**** Identifies Public Health Outcome Framework Indicators**

OUTCOME 1: GIVE EVERY CHILD THE BEST START IN LIFE

LEAD OFFICER: SALLY ROBINSON, ASSISTANT DIRECTOR (PREVENTION, SAFEGUARDING AND SPECIALIST SERVICES), HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Immunisation Strategy
- Breastfeeding Strategy
- Stop Smoking Maternal Action Plan
- Healthy Schools
- Teenage Pregnancy Strategy & Action Plan
- Children & Young People's Plan
- Child Poverty Strategy
- Clinical Commissioning Group Commissioning Plan
- Public Health Transition Plan
- Early Intervention Strategy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- North Tees & Hartlepool NHS Foundation Trust
- Hartlepool & Stockton Clinical Commissioning Group
- Children's Strategic Partnership
- Teenage Pregnancy Strategy Group
- 'Be Healthy' Group
- Immunisation Strategy Group
- Child Poverty Strategy Group
- Cleveland Casualty Reduction Group
- Tees health Childhood Injury Prevention Group

- Living Streets – LSTF Hartlepool Walk to School Project.

OBJECTIVE A – REDUCE CHILD POVERY

	Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**NI 116	**NI 116 Proportion of Children living in poverty	HMRC	Annually	No current target as government reviewing measurement
	Proportion of children living in workless households	DWP	Annually	
	Rate of family homelessness	DCLG	Annually	

ACTION	ASSIGNED TO	DUE DATE
Ensure that children who live in poverty are safe	Sally Robinson	March 2015
Deliver Family-wise project	Anthony Steinberg	March 2015
Improve skill levels in parents and children	Danielle Swainston	March 2015
Increase benefit take up rate including in work and out of work benefits	Danielle Swainston	March 2015
Prevent those at risk falling into poverty	Danielle Swainston/John Robinson	March 2015
Where it is evident that a family is experiencing poverty, take action to mitigate its effects	Danielle Swainston/John Robinson	March 2015

RISK			
Code	**Risk**	**Assignee**	**Dept**
CAD R025	Failure to meet statutory duties and functions in relation to childcare sufficiency	Danielle Swainston	CAD
RND R088	Failure to achieve sufficient uptake of school meals	Karen Oliver	RND

OBJECTIVE B – DELIVER EARLY INTERVENTION STRATEGY

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
	**School Readiness	TBC (Placeholder)	TBC	TBC
	**low birth weight of term babies	ONS	TBC	TBC
NI53a	** Prevalence of breast-feeding at 6-8 wks from birth - Percentage of infants for whom breastfeeding status is recorded	TBC	Financial Year	Monitor
LAAHW P001	**Percentage of women smoking at time of delivery	HBC	Financial Year	19%
NI 55 (iv)	**The percentage of children in reception who are obese	HBC	Financial Year	Monitor
NI59 (ix)	**The percentage of children in year six who are obese	HBC	Financial Year	Monitor
New	Children achieving a good level of development at age 5	HBC	Academic Year	Monitor

NI 117	**Percentage of 16 – 18 year olds who are not in education, employment or training (NEET)	HBC	Financial Year	6.8%
NI 112	**The change in rate of under 18 conceptions per 1000 girls aged 15 – 17, as compared to 1998 rate.	DoH	Financial Year	Monitor
	**Infant Mortality	ONS	Annual	Annual
	**Tooth decay in children aged five years	TBC	4 Yearly	
NI 75	Percentage of pupils achieving 5 or more A* - C grades at GCSE or equivalent including English and Maths	HBC	Academic Year	60%
New	Number of children defined as defined as Child In Need, rate per 10,000 per population	HBC	Financial Year	Monitor
	**Child development at 2 – 2.5 Years	TBC (Placeholder)		

ACTION	ASSIGNED TO	DUE DATE
Implement Early Intervention Strategy	Danielle Swainston	March 2015
Embed common assessment as a means to identify and respond to need	Danielle Swainston	October 2013
Provide a multi agency single point of contact for information, advice, guidance and access to services for children and their families	Danielle Swainston	March 2013
Implement the Early Years Pathway delivering targeted support to children pre birth to five	John Robinson	September 2013
Deliver an integrated 0-19 multi agency family support service for children who require support additional to that provided by universal services.	John Robinson	March 2013
Provide integrated support for young people via the One Stop Shop	Mark Smith	March 2013
Promotion and delivery of the Hartlepool Independent Travel Training scheme.	Paul Watson/Jayne Brown	March 2014

RISKS			
Code	**Risk**	**Assignee**	**Dept**
CAD R026	Failure to deliver Early Intervention Strategy	Sally Robinson	CAD
CAD R017	Failure to recruit & retain suitable staff in children's services (Actively Managed)	Sally Robinson	CAD
CAD R019	Failure to plan for future need and ensure sufficient placement provision to meet demand (Actively Managed)	Sally Robinson	CAD
CAD R020	Insufficient capacity in the independent sector to meet placement demand (Actively Managed)	Ian Merritt	CAD
CAD R021	Increased demand on services due to socio-economic pressures (Actively Managed)	Sally Robinson	CAD
CAD R022	Failure to provide statutory services to safeguard children and protect their well-being (Actively Managed)	Sally Robinson	CAD
CAD R023	Impact of change to funding arrangements across Children's Services (Actively Managed)	Sally Robinson	CAD
CAD R024	Failure to meet statutory duties and functions in relation to the Youth Offending Service (Actively Managed)	Mark Smith	CAD
CAD R029	Failure to effectively manage risks exhibited by young people and families (Actively Managed)	Sally Robinson	CAD
CAD R030	Failure to deal with sensitive, personal or confidential information in a secure way, resulting in loss of data with associated fines, loss of public confidence and/or damage to reputation.	Kay Forgie, Trevor Smith	CAD
CAD R054	Failure to ensure awareness and training of staff regarding safeguarding (Actively Managed)	John Mennear	CAD

OUTCOME 2: ENABLE ALL CHILDREN AND YOUNG PEOPLE TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

LEAD OFFICER:

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Children's & Young people's Plan
- Child Poverty Strategy
- Public Health Transition Plan
- Stop Smoking Maternal Action Plan
- Teenage Pregnancy Strategy & Action Plan
- Carers Strategy
- Clinical Commissioning Group Community Plan
- Mental Health / CAM HS Strategy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Children's Strategic Partnership
- Teenage Pregnancy Strategy Group
- Child Poverty Strategy Group
- North Tees, Hartlepool NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Health Foundation Trust
- NHS Hartlepool & Stockton-on-Tees CCG

OBJECTIVE A: CHILDREN AND YOUNG PEOPLE ARE EMPOWERED TO MAKE POSITIVE CHOICES ABOUT THEIR LIVES

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
	**Pupil Absence	School Absence record	6 Monthly	TBC
NI 111	**Number of first time entrants to the Youth Justice System aged 10-17 per 100,000 population (aged 10-17)	PNC	Annual	TBC
NI 112	**The change in rate of under 18 conceptions per 1000 girls aged 15 – 17, as compared to 1998 rate.	ONS	Annual	TBC
	**Child development at 2-2.5 years	TBC (placeholder)	TBC	TBC
NI 117	**Percentage of 16 – 18 year olds who are not in education, employment or training (NEET)	HBC	Financial Year	6.8%
NI 70	**emergency hospital admissions caused by unintentional and deliberate injuries to children and young people	Hospital Episodes Stats	Annual	TBC
NI58	**Emotional and behavioural health of looked after children	HBC (placeholder)	Annual	TBC
	**Smoking prevalence – 15 year olds	TBC		
	**Hospital admissions as a result of self harm	Hospital Episode Stats	Annual	
NI 106	Percentage gap between those young people from low income backgrounds and those that are not progressing to higher education	HBC	Annual	20%
NI 79	Percentage of young people achieving a Level 2 qualification by the age of 19	HBC	Annual	78.5%
NI 80	Percentage of young people achieving a Level 3 qualification by the age of 19	HBC	Annual	49.5%

NI 81	Percentage gap in the achievement of a Level 3 qualification by the age of 19 between those claiming free schools meals at academic age 15 and those that were not	HBC	Annual	21%
NI 82	Percentage of young people who were in receipt of free school meals at academic age 15 who attained Level 2 Qualifications by the age of 19	HBC	Annual	21%
	Unplanned hospitalisation for asthma, diabetes & epilepsy in under 19's	CCG	Quarterly	TBC
	Emergency Admissions for Children with lower respiratory tract infections	CCG	Quarterly	TBC
	SEN children or those with disability with personal budgets and single assessment across health, social care & education	CCG, HBC, SCHOOLS	Quarterly	TBC
RPD 045	Employment rate (16-24) – proportion of 16-24 year olds who are in employment	NOMIS, HBC	Annual	2014 target 46.5%
NI 117	% of 16-18 year olds who are not in education, employment or training (NEET)	HBC	Annual	2014 target 6.5%
RPD 054	Youth unemployment rate – the proportion of economically active 18-24 year olds who are unemployed.	HBC	Annual	2014 target 14.1%

ACTION	ASSIGNED TO	DUE DATE
Reduce the level of young people who are Not in Employment, Education or Training (NEET) by implementing NEET Strategy.	Mark Smith	March 2014
Ensure access to high quality learning opportunities that increase the skills and qualifications of local residents via implementing the Adult Education Service Plan	Maggie Heaps	July 2014
Increase the take up of Apprenticeships by liaising with local employers to increase opportunities	Maggie Heaps	July 2014
Work collaboratively with LA & Schools to review and develop single assessment arrangements for children with SEN or disability	TBC	March 2014
Develop plans to increase the number of SEN and disabled children with personal budgets	TBC	March 2014

Develop plans to improve education and support to families and children/young people with chronic health conditions	TBC	March 2014

SECTION			
Code	**Risk**	**Assignee**	**Dept**
CAD R001	Service issue as a result of insufficient budget allocation or changes in national funding/grants (Actively Managed)	Jill Harrison	CAD
CAD R004	An increase in the number of schools falling below Performance Achievement Standard (Actively Managed)	Dean Jackson	CAD
CAD R005	Failure to meet the statutory duties and requirements vested within the Child and Adult Services department (Actively Managed)	Dean Jackson	CAD
CAD R012	Failure to plan school provision appropriately	Peter McIntosh	CAD
CAD R015	Failure to carry out specific duties and/or comply with regulatory codes of practice	Dean Jackson	CAD
CAD R031	Failure to recruit and retain staff in educational support services (Actively Managed)	Dean Jackson	CAD
CAD R032	Increase in the number of schools falling below national average for pupil attendance (Actively Managed)	Dean Jackson	CAD

OUTCOME 3: ENABLE ALL ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

LEAD OFFICER: JILL HARRISON, ASSISTANT DIRECTOR (ADULT SOCIAL CARE), HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Vision for Adult Social Care in Hartlepool
- Carers Strategy
- Mental Health Strategy
- Housing, Care & Support Strategy
- Reablement Strategy
- Telecare Strategy
- Clinical Commissioning Group Commissioning Plan

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- North Tees & Hartlepool NHS Foundation Trust
- Hartlepool & Stockton Clinical Commissioning Group
- Learning Disabilities Partnership Board
- Safeguarding Vulnerable Adults Board
- Mental Health Consultation Group
- Carers Strategy Group
- Champions of Older Lifestyles Group
- Teesside Vulnerable Adults Board
- 50+ Forum
- Housing Care & Support Group
- Long Term Conditions Planning Group

OBJECTIVE A: ADULTS WITH HEALTH AND SOCIAL CARE NEEDS ARE SUPPORTED TO MAINTAIN MAXIMUM INDEPENDENCE

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
NI 125	Achieving independence for older people through rehabilitation / intermediate care.	HBC	Financial Year	Monitor
NI 131	Delayed transfers of care attributable to social care	HBC	Financial Year	0%
NI 135	Carers receiving needs assessment or review and a specific carers service or advice and information.	HBC	Financial Year	25%
NI 136	People supported to live independently through social services.	HBC	Financial Year	Monitor
P0 50	Access to equipment: percentage delivered within 7 days	HBC	Financial Year	91%
P0 51	Access to equipment: users with telecare	HBC	Financial Year	1000
P0 66	Admissions to residential care age 65+	HBC	Financial Year	90%
	Patients with a LOS<24hrs with an overnight stay NEL admissions via A&E NEL admissions via GP/Bed bureau A&E attendances ALOS (excl O LOS) ALOS for patients discharged to a different location to admitting location Delays to transfer of care (Bed days) Acute admissions from care homes Emergency readmissions within 30 days of discharge from hospital Emergency readmission rate within 30 days of discharge from hospital	CCG		TBC

	No of ambulatory care patients			
	Carer-reported quality of life	ASC Outcome Framework		
	Health related quality of life for carers	NHS Outcome Framework		
	The proportion of people who use services who feel safe	ASC Outcome Framework		
	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	ASC Outcome Framework		
	Improving people's experience of integrated care	ASC & NHS Outcome Framework Placeholder		
	**Health related quality of life for people with long-term conditions	NHS Outcome Framework		
	Social care related quality of life	ASC Outcome Framework		

ACTION	ASSIGNED TO	DUE DATE
Continue to work in partnership with health partners to develop robust reablement services that promote maximum independence, facilitate people living in their own homes, avoid unnecessary admissions to hospital and enable timely and safe hospital discharges.	Geraldine Martin, HBC	March 2014
Increase the number of people using assistive technology as a means to remain independent.	Neil Harrison, HBC	March 2014
Develop services to provide information and support to carers	Geraldine Martin, HBC	March 2014

with a focus on short breaks and access to employment opportunities.		
Implement the recommendations from the Hearing Loss Strategy, as well as supporting people with a disability into employment.	Neil Harrison, HBC	March 2014
Work collaboratively with partners to implement the National Dementia Strategy in Hartlepool.	John Lovatt, HBC	March 2014
Improve the transitions process to ensure every child and young person in transition (aged 14-25) with a disability has a person centred outcome focused plan for adulthood.	Neil Harrison, HBC	March 2014
Continue to promote independence and facilitate recovery for people with mental health needs by increasing the numbers of personal budgets and direct payments, promoting independence and increasing volunteering and employment opportunities.	Geraldine Martin, HBC	
Development and implementation of Hartlepool Independent Travel Training Programme	Paul Watson/Jayne Brown, HBC	March 2014

OBJECTIVE B: VULNERABLE ADULTS ARE SAFEGAUREDED AND SUPPORTED WHILE HAVING CHOICE AND CONTROL ABOUT HOW THEIR OUTCOMES ARE ACHIEVED.

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
NI 130b	Social care clients receiving self directed support	HBC	Financial Year	TBC
NI 146	Adults with learning disabilities in employment.	HBC	Financial Year	Monitored
NI 150	Adults in contact with secondary mental health services in employment.	HBC / TE&WV FT	Financial Year	Monitored

	Estimated diagnosis rate for people with dementia	NHS Outcome Framework		
	Dementia: effectiveness of post diagnosis care in sustaining independence and improving quality of life	NHS Outcome Framework (Placeholder)		
	**People in prison who have a mental illness or significant mental illness	TBC	TBC	TBC
	**Employment for those with a long-term health condition including those with a learning difficulty / disability or mental illness	Labour Force Survey	TBC	TBC

ACTION	ASSIGNED TO	DUE DATE
Continue to increase the number of people accessing personal budgets through focused work in mental health services, developing personal budgets for carers and continued work with health partners.	Geraldine Martin, HBC	March 2014
Further develop local arrangements to safeguard vulnerable adults, ensuring the engagement of all strategic partners and an appropriate and timely response to any new legislation that is introduced.	John Lovatt, HBC	March 2014

RISKS			
Code	**Risk**	**Assignee**	**Dept**
CAD R011	Failure to work in effective partnerships with NHS, including risk of cost shunting. (Actively Managed)	Jill Harrison	CAD
CAD	Failure to deal with sensitive, personal or confidential information in a secure way, resulting in loss of	Kay Forgie,	CAD

R030	data with associated fines, loss of public confidence and/or damage to reputation.	Trevor Smith	
CAD R033	Failure to plan for future need and ensure sufficient placement provision to meet demand within adult social care. (Actively Managed)	Jill Harrison	CAD
CAD R034	Insufficient capacity in the independent sector to meet placement demand within adult social care. (Actively Managed)	Phil Hornsby	CAD
CAD R035	Increased demand on adult social care services due to demographic pressures. (Actively Managed)	Jill Harrison	CAD
CAD R037	Failure to achieve targets in relation to assessments within 28 days and annual reviews, due to increased pressures on services. (Actively Managed)	John Lovatt	CAD
CAD R038	Failure to provide statutory services to safeguard vulnerable adult. (Actively Managed)	Jill Harrison	CAD
CAD R039	Impact of change to funding arrangements across adult social care services. (Actively Managed)	Jill Harrison	CAD
CAD R040	Failure to deliver the Reablement Strategy. (Actively Managed)	Jill Harrison	CAD
CAD R041	Failure to recruit & retain suitable staff in adult social care. (Actively Managed)	Jill Harrison	CAD
CAD R043	Delayed transfers of care from hospital due to reduced capacity and changing working arrangements for hospital discharge. (Actively Managed)	John Lovatt	CAD
CAD R054	Failure to ensure awareness and training of staff regarding safeguarding (Actively Managed)	John Mennear	CAD

OBJECTIVE C: MEET SPECIFIC HOUSING NEEDS

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
NI 145 Adults with learning disabilities in settled accommodation.	HBC	Financial Year	73%
NI 149 Adults in contact with secondary mental	HBC	Financial Year	70%

health services in settled accommodation.			
**Statutory homelessness: Homelessness applications	HBC		
**Statutory homelessness: Households in temporary accommodation	HBC		
Average waiting time for a Disabled Facilities Grant to be completed	HBC	Financial Year	95 Days

ACTION		ASSIGNED TO	DUE DATE
HS3B2	Improve partnership working with health and social care in service planning and delivery for older people through the Housing Care and Support Strategy Steering Group	Housing Services Manager Nigel Johnson Head of Service (C&A) Phil Hornsby	March 2013
3B5	Monitor access to new and existing housing care and support schemes for people with disabilities	Head of Service (C&A) Neil Harrison	March 2015
3B9 (proposed replacement action)	Undertake a review of the current Housing Adaptations Policy and gather data to inform the new Policy and Implementation Plan.	Karen Kelly	December 2013
Proposed new action	Assist people to maintain independent living through the provision of minor adaptations.	Karen Kelly	March 2014
HS3B10	Increase the use of Assisted Technology by case finding as a preventative measure	All Registered Providers Head of Service (C&A) Phil Hornsby	March 2014

RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R070	Failure to provide correct housing advice to the public.	Lynda Igoe	RND

OUTCOME 4: CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL
LEAD OFFICER: DENISE OGDEN, DIRECTOR OF REGENERATION & NEIGHBOURHOODS, HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Economic Regeneration Strategy
- 14 - 19 Strategy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Economic Regeneration Forum

OBJECTIVE A: TO IMPROVE BUSINESS GROWTH AND BUSINESS INFRASTRUCTURE AND ENHANCE A CULTURE OF ENTREPRENEURSHIP

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
Business stock (business units in Hartlepool)	Annual Business Register / NOMIS, HBC	Annual	2014 target of 2,400
Percentage of newly born enterprises surviving two years	Annual Business Register / NOMIS, HBC	Annual	2014 target of 77.4%

New business registration rate – the proportion of new business registration per 10,000 resident population	Annual Business Register / NOMIS, HBC	Annual	2014 target of 30

ACTION	ASSIGNED TO	DUE DATE
Deliver Business Advice and Brokerage – Programme of targeted account management with key businesses. Develop and maintain relationships with individual businesses.	Mick Emerson	March 2014
Continued provision of Incubation support service including mentoring, pre-start support (Enterprise Coaching), financial assistance, brokerage and other initiatives.	Mick Emerson	March 2014
Undertake 'Get Serious' awareness raising activities including marketing campaigns and events.	Mick Emerson	March 2014
Engage with DWP Providers to offer unemployed individuals a wider package of support where appropriate to enter into self-employment.	Mick Emerson	March 2014
Provision of personalised journey/travel plans to increase employment options.	Paul Watson	On-going programme.

OBJECTIVE B: TO INCREASE EMPLOYMENT AND SKILL LEVELS AND DEVELOP A COMPETITIVE WORKFORCE THAT MEETS THE DEMANDS OF EMPLOYERS AND THE ECONOMY.

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
NI 151	Overall employment rate (proportion of people of working	Annual Population	Annual	2014 target of

	age population who are in employment)	Survey, NOMIS, HBC		63%
RND P090	Self-employment rate	NOMIS, HBC	Annual	2014 target of 9%
RPD 045	Employment rate (16-24) – proportion of 16-24 year olds who are in employment	NOMIS, HBC	Annual	2014 target of 46.5%
NI 117	Percentage of 16 to 18 year olds who are in not in education, employment or training (NEET)	Department for Education, HBC	Annual	2014 target of 6.5%
RPD 054	Youth unemployment rate (Hartlepool) – The proportion of economically active 18 to 24 year olds who are unemployed	NOMIS, HBC	Annual	2014 target of 14.1%

ACTION	ASSIGNED TO	DUE DATE
Full implementation of the Raising Participation Age (RPA) Strategy	Mark Smith/Tom Argument	March 2014
Develop the 14-19 curriculum pathways in conjunction with employers from new industries and identified growth sector areas	Tom Argument	March 2014
Fully implement the 11-19 Operational Plan to raise education standards at key stage 4 and 5	Tom Argument	March 2014
Development of new partnership arrangements between Hartlepool Borough Council and the National Apprenticeship Service (NAS) to promote apprenticeship programmes to employer	Patrick Wilson	April 2013
Implementation of the Hartlepool Youth Investment Project	Patrick Wilson/Tom Argument	September 2014

RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R071	Failure to deliver local economic objectives as a result of shifts in policies and priorities of external partners.	Antony Steinberg	RND

CAD R027	Failure to meet statutory duties and functions in relation to the post 16 cohort and raising of the participation age	Mark Smith	CAD

OUTCOME 5: ENSURE A HEALTHY STANDARD OF LIVING FOR ALL
LEAD OFFICER: LOUISE WALLACE – DIRECTOR OF PUBLIC HEALTH, HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Child Poverty Strategy
- Children's and Young People's Plan
- Public Health Transition Plan
- Clinical Commissioning Group Commissioning Plan

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Hartlepool and Stockton Clinical Commissioning Group

OBJECTIVE A: ADDRESS THE IMPLICATIONS OF WELFARE REFORM

ACTION	ASSIGNED TO	DUE DATE
Implement and review Discretionary Council Tax Support Framework	Julie Pullman	December 2013
Respond to Welfare Reform changes by engaging and supporting affected households	Julie Pullman	March 2014
Develop partnership outreach process to ensure that families understand and plan for Welfare Reform	Danielle Swainston	March 2014
Support workforce to identify risk factors re: child poverty/welfare reform and implement appropriate packages of support	Danielle Swainston	March 2014
Implement a programme of Benefits and Free School Meals take	Julie Pullman	March 2014

up initiatives		
Develop referral channels for adults to access financial advice services and financial products	John Morton	March 2014

OBJECTIVE B: MITIGATE AGAINST THE IMPACT OF POVERTY AND UNEMPLOYMENT ACROSS THE TOWN

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**Fuel Poverty	HBC	TBC	TBC
Proportion of children living in workless households	DWP	Annually	

ACTION	ASSIGNED TO	DUE DATE
Develop training package for family workforce to identify poverty issues and support parents in poverty	Danielle Swainston	March 2014
Deliver Familywise project	Anthony Steinberg	March 2015
Improve skill levels in parents and children	Danielle Swainston	March 2015

OUTCOME 6: CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

LEAD OFFICER: DENISE OGDEN; DIRECTOR OF REGENERATION AND NEIGHBOURHOODS, HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Housing Strategy
- Housing, Care & Support Strategy
- Fuel Poverty Strategy
- Public Health Transition Plan
- Crime & Disorder Strategy
- Local Transport Plan
- Community Cohesion Strategy
- Climate Change Strategy
- Neighbourhood Management and Empowerment Strategy
- Parks and open space
- Cleveland Casualty Reduction Group
- Tees Health Childhood Injury Prevention Group
- Cleveland Strategic Road Safety Partnership

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Housing Partnership
- Safer Hartlepool Partnership

OBJECTIVE A: DELIVERING NEW HOMES AND IMPROVE EXISTING HOMES, CONTRIBUTING TO SUSTAINABLE COMMUNITIES

Performance Indicator	Data Source &	Collection Period	Annual Target

	Responsible Organisation		
New homes constructed to lifetime homes standard	Housing Monitoring System HBC	Quarterly	50
Sustainable homes constructed	Housing Monitoring System HBC	Quarterly	50
Number of properties improved through the grants or loans schemes	Authority Public Protection (APP) System HBC	Quarterly	None – the numbers of properties improved will depend on funding – the overall aim to reduce waiting list
Number of long term (over 6 months) empty homes brought back into use	Authority Public Protection (APP) System and Council Tax data HBC	Quarterly	10% of long term (over 6 months) empty homes brought back into use annually
Number of social rented houses fitted with renewables such as Photo Voltaic panels and/or cells, solar hot water and air source heat pumps	RP Management Systems All Registered Providers	Annually	50
Number of excess cold HHSRS Category 1 hazards rectified	Authority Public Protection (APP) System HBC	Quarterly	None – the number of complaints received on an annual basis will vary

ACTION		ASSIGNED TO	DUE DATE
HS1A4 (proposed replacement	Monitor the schemes included in the 2011-15 NAHP programme and report any changes to the Housing Partnership.	Nigel Johnson	March 2015

action)			
1B1	Encourage developers to meet lifetime home standards and relevant Government energy efficiency levels through negotiation and planning conditions where appropriate	Planning Services Manager Chris Pipe	March 2014
HS1C3 (proposed replacement action)	Monitor the progress of acquisition on the Carr/Hopps Street regeneration scheme	Amy Waller; Nigel Johnson	March 2015
New proposed action from 2D4	Work with landlords to prevent homes from becoming long-term empty through early intervention.	Amy Waller	March 2015
HS2E2	Support landlords to carry out energy efficiency works to deal with excess cold hazards through education and promotion of the benefits	Housing Services Manager Nigel Johnson	March 2015
HS2E4	Explore opportunities and options for encouraging property owners to retrofit homes with renewables such as Photo Voltaic panels and/or cells solar hot water and air source heat pumps	Principal Policy Officer Valerie Hastie	March 2015

SECTION 4 RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R057	Reduction in funding for housing investment	Nigel Johnson	RND
RND R061	Inability to meet very high levels of local housing needs including affordable housing	Nigel Johnson	RND
RND R062	Effective delivery of housing market renewal affected by external decisions and funding	Nigel Johnson	RND

RND R015	Failure to secure funding for delivery of empty homes strategy	Nigel Johnson	RND
RND R061	Inability to meet very high levels of local housing needs including affordable housing	Nigel Johnson	RND
RND R062	Effective delivery of housing market renewal affected by external decisions and funding	Nigel Johnson	RND
RND R053	Failure to respond to and implement changes to selective licensing	Nigel Johnson	RND

OBJECTIVE B: CREATE CONFIDENT, COHESIVE & SAFE COMMUNTIES

	Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
	Reduce perceptions of anti-social behaviour	Viewpoint Hartlepool Borough Council	Biannual	Reduce in comparison to baseline year – 29%
	Maintain perception level of drunk/rowdy behaviour as a problem	Viewpoint Hartlepool Borough Council	Biannual	Maintain in comparison to baseline year – 25%

	Reduce anti-social behaviour (asb) incidents reported to the police	Police recorded (asb) incidents – Cleveland Police	Quarterly	Reduce in comparison to baseline year – 8,779
	Increase the number of recorded hate incidents	Recorded Crimes and Incidents – Cleveland Police, Housing Hartlepool and Hartlepool Borough Council	Quarterly	Increase in comparison to the baseline year – 98
NI 32	**Repeat incidents of Domestic violence	NI32		
	**Violent Crime (including sexual offence)	TBC		
NI 30	**Reoffending rate of prolific and other priority offenders	HBC		
	**Percentage of population affected by noise	TBC		
	** Utilisation of green space for exercise / health reasons	National Environment Survey		
	**Social connectedness	TBC (placeholder)		
	**Older Peoples perception of community safety	TBC (placeholder)		

ACTION	ASSIGNED TO	DUE DATE
Implement the PREVENT action plan as guided by the Silver group.	Sally Forth	March 2014
Develop new Anti-Social Behaviour Strategy and action plan in line with Government policy	Sally Forth	March 2014
Monitor the implementation of the community cohesion framework action plan	Adele Wilson	March 2014
In conjunction with partners improve reporting, recording, and responses/interventions to vulnerable victims and victims of hate crime.	Nicholas Stone	March 2014

Introduce restorative practice across Safer Hartlepool partners to give victims a greater voice in the criminal justice system.	Sally Forth	March 2014
Development of route/community based local safety schemes to incorporate 20mph zones.	Peter Frost	March 2014
Reduce the anti-social impact that speeding traffic has on communities.	Paul Watson/Peter Frost	March 2014
Deliver the domestic violence action plan	Sally Forth	March 2014
Embed the Think Families / Think communities approach to reducing crime and anti social behaviour, improving educational attendance and reducing worklessness, resulting in reduced costs to the public purse.	Lisa Oldroyd	March 2014

RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R032	Failure of officers to fully embrace their responsibilities under the terms of Section 17, Crime and Disorder Act 1998	Sally Forth	RND

OBJECTIVE C: LOCAL PEOPLE HAVE A GREATER INFLUENCE OVER LOCAL DECISION MAKING AND DELIVERY OF SERVICES

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
Percentage of residents feeling that they can influence decisions that affect their local area	HBC	Annual	Monitored

ACTION	ASSIGNED TO	DUE DATE
Support the delivery of Face the Public Events by the Strategic Partners Group and Theme Groups	Catherine Grimwood	March 2014
Facilitate involvement of residents on a neighbourhood level by supporting existing and newly emerging resident, 'friends of' and interest groups	Adele Wilson	
Address and monitor progress on priorities outlined in the eleven ward profiles developed across the town with a particular focus on areas falling in top 5% most disadvantaged	Adele Wilson	
Address and monitor progress on priorities outlined in the eleven ward profiles developed across the town with a particular focus on areas falling in top 5% most disadvantaged	Adele Wilson	
Support the development and implementation of the Voluntary and Community Sector Strategy and Action Plan	Fiona Stanforth	
Deliver the Community Pool Funding Programme	Fiona Stanforth	

4 RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R056	Failure of service providers to focus resources on Hartlepool deprived areas	Clare Clark	RND

OBJECTIVE D - PREPARE FOR THE IMPACTS OF CLIMATE CHANGE AND TAKE ACTION TO MITIGATE THE EFFECTS

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
NI 185	CO_2 reduction from local authority operations	NI185 outturn produced by Council	Financial Year	7% (currently under review, and will be smaller for 2013/14)
NI 186	Per capita CO_2 emissions from the local authority area	NI186 outturn produced by Department for Energy & Climate Change	Calendar Year	3.75%
NI 188	Planning to Adapt to Climate Change	NI188 outturn produced by Council	Financial Year	Level 4 by end 2013/14
	**Air Pollution	TBC		
	**Public Sector organisations with board approved sustainable development management plan	TBC		

ACTION	ASSIGNED TO	DUE DATE
Implement actions of the Joint Strategic Needs Assessment	Paul Hurwood	Mar 2014

(JSNA) Scrutiny review with regard to the environment.		
Consult and promote a community 'Collective Energy Switching' programme throughout the borough	Dave Hammond / Paul Hurwood	Mar 2014
Development of travel plans and promotion of walking and cycling as an alternative to the private motor car.	Paul Watson	Mar 2014

SECTION 4 RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R067	Failure to achieve recycling targets resulting in loss of income and additional costs.	Fiona Srogi	RND
RND R076	Consequences of climate change through the failure of the Council to tackle climate issues locally	Paul Hurwood	RND
RND R087	Income fluctuations in the market for recyclable materials resulting in difficulties in budget planning and forecasting.	Fiona Srogi	RND

OBJECTIVE E - ENSURE SAFER HEALTHIER TRAVEL

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
NI47- People killed or seriously injured in road traffic accidents	Cleveland Police & Hartlepool Borough Council	Annually	Yes
NI48- Children killed or seriously injured in road traffic accidents	Cleveland Police & Hartlepool Borough Council	Annually	Yes

ACTION	ASSIGNED TO	DUE DATE
Develop Safer Routes to Schools to incorporate 20 mph zones, safer walking and cycling routes and local safety schemes.	Paul Watson/Peter Frost	March 2014 (Annual programme)
Develop minor safety schemes to reduce road danger and casualties and encourage safer road user behaviour.	Peter Frost	March 2014 (Annual programme)
Identify schemes to implement signalised crossings	Peter Frost	March 2014 (Annual programme)
Identify roads and routes where speeding vehicles contribute to community Safety Camera Partnership	Paul Watson	March 2014 (Annual programme)
Identify schools to benefit from 20mph zones through the safer routes to school programme	Peter Frost/Paul Watson	March 2014 (Annual programme)
Delivery of a comprehensive education, training and publicity programme in schools and to neighbourhoods.	Paul Watson	March 2014 (Annual programme)
Contribution to the management and delivery of Ridewell Tees Valley Motorcycle Training Scheme	Paul Watson	March 2014 (Annual programme)
Delivery of National Standard Bikeability Cycle Training in schools to improve safety, reduce collisions and reduce reliance on the private motor vehicle.	Paul Watson	March 2014 (Annual programme)
Development and continuation of the Schools Practical Pedestrian Training Scheme	Paul Watson	March 2014 (Annual programme)
Development and support of the Living Streets – LSTF Hartlepool Walk to School Outreach Project to promote walking to school	Paul Watson	3 Year Programme commenced September 2012.

RISKS			
Code	**Risk**	**Assignee**	**Dept**

RND R054	Failure to maintain infrastructure to acceptable standard resulting in additional cost implications through insurance claims	Mike Blair	RND
RND R078	Failure to develop an integrated transport strategy	Paul Robson	RND

OUTCOME 7: STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

LEAD OFFICER: LOUISE WALLACE, DIRECTOR OF PUBLIC HEALTH, HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Immunisation Strategy
- Alcohol Harm Reduction Strategy
- Stop Smoking Action Plan
- Tobacco Alliance Plan
- Cardiovascular Disease Programme Plan
- National Early Detection & Awareness of Cancer Plan
- Flu Plan (Seasonal)
- Clinical Commissioning Group Commissioning Plan
- Public Health Transition Plan
- Breastfeeding Strategy
- Health Schools
- Healthy Weight, Healthy Lives Strategy
- Vision for Adult Social Care in Hartlepool
- Mental Health Strategy
- Drug Treatment Plan
- Health & Safety Service plan
- Food Law Enforcement Plan

- Alcohol Licensing Policy
- Trading Standards Service Plan
- Food Sampling Policy
- North East Outbreak Control Policy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- North Tees & Hartlepool NHS Foundation Trust
- Hartlepool & Stockton Clinical Commissioning Group
- Immunisation Strategy Group
- Coronary Heart Disease Local Implementation Team
- Diabetes Local Implementation Team
- British Heart Foundation Group
- 'Be Healthy' Groups
- Alcohol Strategy Group
- HPA / Public Health England
- FRESH
- BALANCE

OBJECTIVE A: REDUCE THE NUMBER OF PEOPLE LIVING WITH PREVENTABLE ILL HEALTH AND DYING PREMATURELY

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target

**Healthy life expectancy	ONS		
** Sickness absence rate: Percentage of employees who had at least one day off sick in the previous week / Number of working days lost due to sickness absence.	TBC		
** Sickness absence rate: Rate of fit notes issued per quarter	TBC		
**Differences in life expectancy and health expectancy between communities	TBC		
**Diet	TBC (placeholder)		
**Excess weight in adults	TBC		
**Successful completion of drug treatment	National drug treatment monitoring system		
**People entering prison with a substance dependence issue who are not previously known to community treatment	TBC		
2.18 Alcohol related admissions to hospital	Hospital Episode Stats		
2.17 recorded diabetes	Quality management analysis system		
2.18 Alcohol related admissions to hospital	Hospital Episode stats		
**Access to non cancer screening programmes : infectious disease testing in pregnancy – HIV, syphilis, hepatitis B, and susceptibility to rubella	TBC		
**Access to non cancer screening programmes : Antenatal sickle cell and thalassaemia screening	TBC		
**Access to non cancer screening programmes : Newborn blood spot screening	TBC		
**Access to non cancer screening programmes : Newborn hearing screening	TBC		

**Access to non cancer screening programmes : Newborn physical examinations	TBC		
**Access to non cancer screening programmes :Diabetic retinopathy	TBC		
**Take up of the NHS Health Check programme – by those eligible	TBC		
**Self reported wellbeing	TBC		
**Chlamydia diagnoses	TBC		
**Population vaccination coverage	TBC		
**People presenting with HIV at a late stage of infection	TBC		
**Treatment completion for tuberculosis	TBC		
**Comprehensive inter-agency plans for dealing with public health incidents	TBC (placeholder)		
**Mortality rate from causes considered preventable	ONS		
**Under 75 mortality rate from all cardiovascular diseases	ONS		
**Under 75 mortality from cancer	ONS		
**Under 75 mortality from liver disease	ONS		
**Under 75 mortality from respiratory disease	ONS		
**Mortality from infectious and parasitic diseases	ONS		
**Emergency readmissions within 30 days of discharge from hospital	ONS (placeholder)		
**Preventable sight loss	Certificate of Visual impairments		
**Health related quality of life for older people	TBC		

ACTION	ASSIGNED TO	DUE DATE
Commission a comprehensive healthy heart check	Director of Public Health	March 2014

programme for all eligible people across Hartlepool		
Commission a comprehensive range of accessible and equitable sexual health services	Director of Public Health	March 2014
Develop a comprehensive health protection plan for Hartlepool and provide assurance that the health of then population is comprehensively protected	Director of Public Health	March 2014
Commission a comprehensive range of services to reduce the individual and community impact of alcohol related harm	Substance Misuse Joint Strategy Group / Director of Public Health	March 2014
Commission services to ensure people maintain a healthy weight and a healthy life.	Healthy Weight Healthy Lives Strategy Group	March 2014
Deliver a comprehensive programme to improve workplace health	Director of Public Health	March 2014
Ensure effective integrated treatment of drug and alcohol services	Chris Hart	March 2014
Develop and implement a school, families and community based Safe and Active Travel programme with targeted walking and cycling promotion schemes.	Paul Watson	March 2014
Develop an active travel GP referral scheme to encourage and promote cycling as a weight management and cardiovascular disease prevention measure	Paul Watson	March 2014
Develop and implement a school, families and community based Safe and Active Travel programme with targeted walking and cycling promotion schemes.	Paul Watson	March 2014

OBJECTIVE B: REDUCE THE HEALTH INEQUALITY GAP BETWEEN COMMUNITIES ACROSS HARTLEPOOL

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**Fuel Poverty	English Housing Survey		
**Proportion of physically active and inactive adults	TBC		
**Smoking prevalence adults	Integrated Health Survey		
**Cancer diagnosed at stages 1 & 2	TBC (placeholder)		
**Cancer screening coverage	TBC		
**Injuries due to falls in people aged 65 and over	TBC		
**Under 75 mortality rate from al cardiovascular diseases	ONS		
**Under 75 mortality from liver disease	ONS		
**Under 75 mortality from respiratory disease	ONS		
**under 75 mortality rate from cancer	ONS		
**Excess under 75 mortality rate in adults with serious mental illness	TBC (placeholder)		
**Suicide rate	ONS		
**Hip fractures in people aged 65 and over	Hospital Episode Stats		
**Excess winter deaths	ONS		
**Dementia and its impacts	TBC		
** Mortality rate from communicable diseases	TBC (placeholder)		

ACTION	ASSIGNED TO	DUE DATE
Commission a comprehensive range of services to enable people to stop smoking	Director of Public Health	March 2014
Develop a comprehensive systematic approach for addressing excessive winter deaths	Director of Public Health	September 2014
Commission services to promote positive mental health and well being	Director of Public Health	March 2014
Promote the early detection and awareness of signs and symptoms of cancer across Hartlepool	Director of Public Health	March 2014
Develop a comprehensive programme of accident prevention	Director of Public Health	March 2014
Develop a programme of adult cycling promotion and training.	Paul Watson	

RISKS			
Code	**Risk**	**Assignee**	**Dept**
CAD R014	Failure to make significant inroads in Health Impact	Carole Johnson; Louise Wallace	CAD

To: Chairs of Health and Wellbeing Boards

Dear Colleagues

As you may know, the Prime Minister launched a 'Challenge on Dementia' in March 2012 to deliver major improvements in dementia care and research by 2015.

The National Dementia Strategy Programme Board, chaired by the Minister for Care Services Norman Lamb MP, has been tasked with going further and faster to deliver for people with dementia and their family carers. Three sub-groups have been formed to lead on: creating dementia-friendly communities, better research, and driving improvements in health and care.

We are the co-chairs of the Health and Care Sub-Group and we, with the support of the Local Government Association, are writing to ask for your commitment to the Dementia Challenge and your assistance in taking this important agenda forward.

A number of key commitments were made by the Prime Minister as part of the March 2012 launch. I'd therefore like to ask that your local health and wellbeing board considers:

- Reviewing your local Dementia Strategy with particular emphasis on enablement and intermediate care access for people with dementia, accommodation solutions, end of life support and health and social care workforce development
- Ensuring the needs of people with dementia and their carers are part of the Joint Strategic Needs Assessment process
- Whether you need to make dementia a priority in your Joint Health and Wellbeing Strategies.
- Signing up to the National Dementia Declaration and joining your Local Dementia Action Alliance to work with local partners to drive forward improvements for people with dementia in your area (link below).

We are also asking health and wellbeing boards nationally to sign up to the *Dementia Care and Support Compact* – found in Annex B of the challenge document. Please consider publicising this on your websites, stating how you will fulfil this commitment and asking your local Health Trusts to do the same.

We would also encourage you to ask your Acute Hospital Trusts to sign up to the call to action – the Right Care: creating dementia friendly hospitals (link below). This will allow hospitals in your area to gain access to support and advice on becoming more dementia friendly including supporting people with dementia to be discharged back home.

The Prime Minister has asked the National Dementia Strategy Board to provide a formal update on progress by March 2013. We would encourage

you to share your progress through the Dementia Challenge 'Get Involved' website. Some useful online resources are listed below.

For more information or to send in best practice, please use the Dementia Challenge email address: dementiachallenge@dh.gsi.gov.uk

Yours sincerely

Sarah Pickup, President, Association of Directors of Social Services

Sir Ian Carruthers OBE, Chief Executive, NHS South of England

and Councillor David Rogers OBE Chair, LGA Community Wellbeing Board

Online resources:

Number 10 Press Launch
http://www.number10.gov.uk/news/a-day-to-remember-dementia-campaign-launches/

Dementia Challenge Documents
http://www.dh.gov.uk/health/2012/03/pm-dementia-challenge/

Dementia Challenge – Get Involved
www.dementiachallenge.dh.gov.uk

Local Government Association – Adult Social Care resources
http://www.local.gov.uk/adult-social-care

National Dementia Declaration and Dementia Action Alliance
http://www.dementiaaction.org.uk/info/5/join_the_alliance

Right Care: creating dementia friendly hospitals
http://www.dementiaaction.org.uk/info/2/action_plans/165/the_right_care_creating_dementia_friendly_hospitals

Health and Wellbeing Board challenge event – 28 Feb 2013

Purpose of Report

To provide the Shadow Health and Wellbeing Board with feedback on the Health and Wellbeing Board challenge event, and to share the findings and proposals to the Board for further discussion.

Background

At the previous board meeting members agreed for representatives to attend the above event which was designed to provide developmental challenge for each Board across the region. The attendees from Hartlepool were;

- Ali Wilson Chief Officer, NHS Hartlepool and Stockton-on-Tees CCG
- Denise Ogden Director of Regeneration and Neighbourhoods, Hartlepool Borough Council
- Richard Starrs Strategy and Performance Officer, Hartlepool Borough Council.

The event was designed to provide developmental challenge for each Board through mirroring the real world of reform, change, and financial and organisational pressure and so help Boards consider how they might;

- Identify the role of the Board and how to work together effectively
- Work with complex issues that often conflict
- Assess the implications of decisions and actions of different agencies
- Consider partnership working and integration
- Achieve public and service user engagement.

The programme used a series of scenarios to challenge and understand the inherent complexities and conflicts of interest within roles and between agencies on the Board.

The scenarios considered by the Hartlepool delegation were;

1. Reconfiguring hospital services – this scenario set out the issues facing a notional NHS Foundation Trust in supporting the delivery of a 24/7 consultant delivered service, through the development of larger A&E departments with acute medical and surgical care, critical care, maternity and paediatric services on the same site (this was a compulsory scenario and not related to any local changes).

2. Housing and Children's Health – looked at recommendations made by a Housing Partnership Board following representations from a local head teacher to target funding for improving housing on a deprived housing estate. The Board were asked to consider what actions were needed to support the education and health of children on the estate.

Based on the discussions undertaken in addressing the scenarios the group were asked to consider the possible developmental needs of the Board and translate those needs into a series of actions.

Outcomes of the meeting
A subsequent action plan was developed and is attached as **Appendix A**. The action plan is broken down into timescales of 0-3 months, 3-6 months, 6-9 months and 9-12 months. Given membership of the H&WB is in the process of being reviewed and the short period of time to undertake the exercise the action plan is designed to stimulate further discussion at the Board with the aim of establishing a more detailed development plan with smart actions moving forward.

The common themes identified in discussions were;

1. Identifying the 'added value' of the Board and the need to define aligned priorities.
2. How Board the can best engage with the public, and ensure coordinated messages by improving communication, engagement and consultation.
3. How partner organisations can work more collectively to deliver key priorities
4. Identification of a work programme and forward plan for the coming year which doesn't just reflect each organisations contribution but will deliver greater added value
5. How to energise the HWB Board and the continued commitment from partners

The notes of the facilitator / observer are also attached as **Appendix B** for information.

Recommendations
The Board are asked to consider the findings from the event and agree the most appropriate route in taking these proposals forward.

Appendix A - Hartlepool development needs and action plans

Timescale	Development Needs/Issues raised	Key actions
0-3 Months	Developing and presenting a collective voice (may not be collective view) Silo organisations. Difficult conversations and decisions Identify key priorities-big things that we can impact on. Engagement and consultation. Board agendas How to identify added value of board. How to identify whether we are making a difference. Accountability and Authority of board and members.	Discuss with the whole board. ? Simulation event with board Identify board development programme with the whole board to address the issues raised. Including, roles, responsibilities, accountability. Impact measures etc. Links into existing partnerships Define added value of board. Clarity over who chairs
3-6 Months	Public perception of the role of the board Future public meetings Meaningful public engagement. Provider enagement.	Review constitution, clarify public and press access. Identify communication strategy. Identify patient and public engagement strategy
6-9 Months	Moving from what to how, particularly in relation to funding.	Clarity re input/contribution of different partners to achieving aligned priorities, and any resource requirements.
9-12 Months	How do we know if we are making a difference?	Process Measures of effectiveness (e.g. agendas, contribution, attendance) Output/outcome measures ? Impact of board.

Appendix B – Observer Feedback

North East Health and Wellbeing Board Simulation Event 28th February 2013

Notes from Hartlepool representatives

Observer –Carol Ward (cward@opm.co.uk) – Senior Fellow,OPM

Observer feedback:-

Although only three people were able to attend , this was a friendly , thoughtful and very productive group. The simulations raised a number of key issues, which included:-

- Identifying the 'added value' of the board. The need to define aligned priorities.
- Clarifying roles and responsibilities.
- Public consultation and engagement.
- Public perception of board.
- Future open meetings
- Relationship with HOSC
- Future chair
- The need to have future difficult conversations in order to make difficult decisions.
- Recognising where there may be conflicting priorities, and the need to have a collective public voice.
- Moving from strategy to operational.
- Measuring future impact.

Following the scenario discussion, a number of development needs and potential action plans were developed by the attendees. These are outlined in the table on the following page. As this was a small group, they agreed to take the issues raised to the next Board meeting, and also drew up an agenda item for the board to consider, whilst at the event.

As an observer I thoroughly enjoyed working with the participants, as they were very keen to ensure that the process was meaningful for them , and I'd like to thank them for their enthusiasm on the day.

Carol Ward
Senior Fellow OPM