HEALTH AND WELLBEING BOARD AGENDA

Monday 16 September 2013

at 10.00 a.m.

in Committee Room 'B'
Civic Centre, Victoria Road, Hartlepool.

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillor C Akers-Belcher (substitute Councillor Richardson), Councillor Hall, Councillor G Lilley and Councillor Simmons
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Pagni and Alison Wilson
Director of Public Health, Hartlepool Borough Council (1); - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council (1) – Jill Harrison/Sally Robinson
Representatives of Healthwatch (2). Margaret Wrenn and Stephen Thomas
Other Members:
Chief Executive, Hartlepool Borough Council (1) – Dave Stubbs
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council (1) – Denise Ogden
Representative of the NHS England (1) – Caroline Thurlbeck
Representative of Hartlepool Voluntary & Community Sector (1) – Tracy Woodhall
Representative of Tees Esk and Wear Valley NHS Trust (1) – Martin Barkley
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster
Representative of North East Ambulance NHS Trust (1) – Nicola Fairless
Representative of Cleveland Fire Brigade (1) – Ian McHugh

Observer – Representative of the Audit & Governance Committee, Hartlepool Borough Council (1) – Councillor Fisher

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

3.1 To confirm the minutes of the meeting held on 5 August 2013

4. ITEMS REQUIRING DECISION

4.1 Funding Transfer from NHS England to Social Care – 2013/14 – *Assistant Director, Adult Services, Hartlepool Borough Council and Chief Operating Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group*

5. ITEMS FOR INFORMATION

5.1 Improving A&E Performance and Winter Planning – *Chief Officer – NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group*
5.2 Feedback from Health and Well Being Board Sub Groups – *Director of Public Health*
5.3 Pharmaceutical Needs Assessment – *Dr Phillipa Walters, Tees Valley Public Health Shared Service*
5.4 Feedback from Regional Meeting of Health and Wellbeing Board Chairs Network (to follow)
5.5 Presentation - NHS Structures
5.6 Presentation – A Call to Action – Working in Partnership with Health and Wellbeing Boards

6. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT

Date of next meeting – 28 October 2013 at 10 a.m. in Committee Room B, Civic Centre, Hartlepool

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

5 August 2013

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

Present:

Councillor Richardson (substitute for Councillor C Akers-Belcher, Leader of Council) (In the Chair)

Prescribed Members:
Elected Members, Hartlepool Borough Council, Councillors G Lilley and Simmons
Representing Hartlepool and Stockton-on-Tees Clinical Commissioning Group; Dr Pagni
Representing Director of Child and Adult Services, Jill Harrison, Assistant Director (Adult Services)
Director of Public Health, Hartlepool Borough Council, Louise Wallace
Representatives of Healthwatch, Margaret Wrenn and Steve Thomas

Other Members:
Chief Executive, Hartlepool Borough Council; Dave Stubbs
Representative of the NHS England; Caroline Thurlbeck
Representative of Hartlepool Voluntary & Community Sector, Tracy Woodall
Representative of North Tees and Hartlepool NHS Foundation Trust; Alan Foster
Representative of Tees Esk and Wear Valley NHS Trust, David Brown (substitute for Martin Barkley)

Councillor Fisher, Chair, Audit and Governance Committee (Observer)

Rosemary Granger, Project Director, Security Quality in Health Services

Officers: Neil Harrison, Hartlepool Borough Council, Head of Service
Joan Stevens, Hartlepool Borough Council, Scrutiny Manager
Amanda Whitaker, Democratic Services Team

Also in attendance were the following members of public:

Mr Hobbs and Health Watch representative

13. Apologies for Absence

Councillor C Akers-Belcher, Leader, Hartlepool Borough Council
Councillor Hall, Hartlepool Borough Council
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council, Denise Ogden
Representative Hartlepool and Stockton-on-Tees Clinical Commissioning Group; Alison Wilson

14. Declarations of interest by Members

None

15. Minutes

The minutes of the meeting of the Health and Wellbeing Board held on 24 June 2013 were received.

The following matters arising from the minutes were discussed:-

Minute 12 – Development of a New Hospital – an elected member sought clarification from the Chair regarding when he became aware of the item which sought the approval of the Board to send letters to the Secretary of State. Concerns were expressed that Board Members had not received advance notice of the item. Reference was made also to media coverage of the item and it was highlighted that not all Members of the Council supported the letters which had been sent to the Secretary of State.

Minute 4 – Health and Wellbeing Board Terms of Reference – The Director of Public Health highlighted that it had been agreed that the Children's Strategic Partnership (CSP), Health Inequalities Delivery Group & the Healthy and Independent Adults Delivery Group would be the regular sub groups of the Health and Wellbeing Board. Following suggestions made by the Director, the Board agreed that the Delivery Groups would be Chaired as follows:-

- Children's Strategic Partnership (CSP) – Chair of Hartlepool Borough Council's Children's Services Committee
- Health Inequalities Delivery Group – representative of Public Health Department
- Health Inequalities Delivery Group & the Healthy and Independent Adults Delivery Group – to be identified by Hartlepool Borough Council's Assistant Director, Adults Services and the Chief Officer, Hartlepool and Stockton on Tees Clinical Commissioning Group

Minute 7 – Potential Topics for inclusion in the Audit and Governance Statutory Scrutiny Health Work Programme – the Scrutiny Manager advised the Board that Hartlepool Borough Council's Audit and Governance Committee had agreed that the Health Scrutiny investigation for 2013/14 would be Chronic Obstructive Pulmonary Disease (COPD) rates and services

in Hartlepool.

16. Declaration on Tobacco Control (*Director of Public Health*)

The Board was presented with a proposed declaration on tobacco control. A charter on tobacco control had been adopted by Newcastle Council in May 2013 and had been circulated to the Board to consider whether the Board would also wish to make this declaration for Hartlepool.

The Board was reminded that smoking was still the single preventable killer across the North East and caused a significant burden of ill health including cancer and respiratory disease in communities. Around 23% of the adult population of Hartlepool smoke cigarettes and in some of the more socio-economically deprived wards over 50% of adults smoked. Therefore, there was still an ongoing public health challenge to tackle smoking rates and ensure sustained effort in an attempt to eradicate smoking.

Decision

Members of the Board supported the declaration on tobacco control for Hartlepool

17. Constitutional and Structural Arrangements for the Children's Strategic Partnership as a Subgroup of the Health and Wellbeing Board (*Assistant Director (Children's Services*)

The report informed members of the Board of the changes to the Children's Strategic Partnership, arising from the implementation of amendments to Hartlepool Borough Council's Constitution and the establishment of the statutory Health and Wellbeing Board from 1st April 2013.

The report set out the background to the establishment of Children's Trusts by the Children Act 2004. Whilst a number of sections of the Act had been repealed by the current government, the requirement to have a forum that brought together all services for children and young people remained with guidance being issued by the Department for Education as set out in the report.

Board Members were advised that Hartlepool Borough Council had agreed a new Constitution. Under the new arrangements there were 5 Policy Committees, which included a Children's Services Committee and the Chair of that Committee was the Lead Member for Children's Services. The Committee was responsible for all aspects of children's services, including children's social care, early intervention and prevention services, exercising the Council's functions as the Local Education Authority, commissioning and

the oversight of the Children's Strategic Partnership for the purposes of the Children Act 2004.

The function of the Children's Strategic Partnership was set out in the report together with a table which demonstrated the governance arrangements for the Partnership. The terms of reference for the Partnership was appended to the report. Board Members were requested to ratify the terms of reference.

The proposed membership of the Children's Strategic Partnership included Chair, NHS Hartlepool and Stockton on Tees Clinical Commissioning Group. Dr Pagni highlighted that due to his position on this Board it had been agreed that he would also represent the Clinical Commissioning Group on the Children's Strategic Partnership for continuity.

Decision

Board members agreed the governance arrangements for the Children's Strategic Partnership.

18. Tees Autism Strategy (*Assistant Director, Adult Services*)

The report set out the background to proposals outlined in the Tees Autism Strategy 2013-2018, a copy of which was appended to the report. The Tees Valley Autism Strategy Delivery Group (ASDG) had been formed in 2005 following a Strategic Health Authority review of mental health and learning disability services that highlighted shortfalls in the provision of services for people with autism. Following the introduction of requirements included in the Autism Act 2009, the Government had published statutory guidance for local councils and local NHS bodies setting out what they had to do to ensure they met the needs of adults with autism in England, details of which were highlighted in the report.

The Tees Autism Strategy had been developed over a period of two years using detailed information from statutory agencies, providers, adults with autism and families / carers. The strategy pulled together information gathered from three key sources, World Autism Day, a co-produced 'working together for change' report and feedback from key members of the Tees Valley ASDG. The strategy outcomes and key target areas would be monitored through the existing Tees Valley ASDG and reported to the North East Autism Consortium (NEAC) through an action plan published on their website. It was noted that the Tees Autism Strategy supported the Autism Act, the Department of Health's Guidance 'Rewarding and Fulfilling Lives' and provided the information required to support the development of Hartlepool's Joint Strategic Needs assessment.

It was highlighted that there was an ongoing commitment to train the existing workforce in Autism Awareness; not just within Child & Adult Services but all key contact points and public facing services. This work was underway but

funding needed to be identified to ensure that the wider workforce were able to access appropriate training. From April 2013 Tees Esk & Wear Valley NHS Foundation Trust's Adult Diagnostic and Assessment Service would be required to refer all newly diagnosed people to adult social care departments in order to meet their obligation under existing contractual arrangements. Additional resource implications were not known at this point.

Following a request prior to commencement of the meeting, the Chair permitted Mr Hobbs to address the Board. Mr Hobbs advised the Board of research which he had undertaken and referred to his grandson's experience of autism. He expressed the view that the only hope for recovery was for doctors to treat autism. Mr Hobbs highlighted that he had written a book entitled 'My Version of Autism Awareness' and that a copy of his comments on the Tees Autism Strategy had been circulated to all Board Members.

Board Members discussed the contents of the report and issues highlighted by Mr Hobbs as follows:-

- The Tees Autism Strategy appeared to focus on adults. Mr Harrison advised that although the Autism Act focused on adults, it was expected that where relevant it would be considered for Children also and that the Act mentioned People in transitions which was regarded as people aged 14 – 25.

- Social implications of autism in terms of impact on families and financial implications.

- Issues associated with autism should be addressed in childhood.

- It was appropriate to raise awareness of autism and for training to be available to the wider community. The Chair agreed with a suggestion made by Mr Hobbs that it was important that specialist autism training was essential.

- The complex nature of autism which included a wide range of conditions was highlighted together with the very skilled nature of the management of the condition. The Board noted that there were doctors employed by Tees Esk & Wear Valley NHS Foundation Trust who specialised in autism.

The Chair proposed that it was appropriate for Hartlepool Borough Council's Audit and Governance Committee to consider issues which had been highlighted at the meeting.

Decision

The Board approved the Autism Strategy and the associated action plan and agreed that the issues which had been highlighted at the meeting be referred

to the Audit and Governance Committee.

19. The Challenging Behaviour Charter (*Assistant Director, Adult Services)*

The report sought approval to sign up to the principles of the Challenging Behaviour Foundation (CBF) Charter. The Charter had been developed by the Challenging Behaviour National Strategy Group and had endorsement from the Association of Directors of Adult Social Services and several NHS organisations. The Charter requested Child and Adult Services and the NHS to collaborate and develop plans across education, social care and health to meet the individual needs of children, young people and adults with a behaviour described as challenging to ensure people have a good quality of life.

Board Members were advised that Hartlepool would continue to develop and review its Joint Strategic Needs Assessment (JSNA) in collaboration with NHS partners and could show good joint working which complements the CBF Charter. In March 2011, the Government had published its consultation Green Paper on special educational needs and disability (SEND). Hartlepool had been chosen as an early implementer (pathfinder) and had been supported to design new arrangements to pilot and improve life outcomes for children and young people; to give parents confidence by giving them more control; and to transfer power to professionals on the front line and to local communities. The (SEND) 0-25 pathway provided further evidence of joint working with the development of the single plan and the ability to deploy a personal budget for Health, Education and Care.

The Charter appended to the report would further support the development of the JSNA for Children and Adults and the rights and values expressed within the Charter would act as a checklist for commissioners. Also appended to the report was information on a range of key organisations already signed up to the CBF Charter.

Decision

The Health & Wellbeing Board endorsed the principles of the CBF Charter and reflected these principles in the JSNA and in any future commissioning decisions and that organisations that are members of the Health & Wellbeing Board sign up to the principles of the CBF Charter and promote best practice for people with challenging behaviour

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20. Scrutiny Investigation into Selected Joint Strategic Needs Assessment (JSNA) Topics – Final Report and

Agreed Actions(Scrutiny Manager)

The report set out the findings of the scrutiny investigation into the selected Joint Strategic Needs Assessment (JSNA) Topics. As part of the Overview and Scrutiny Work Programme for 2012/13, it was agreed that the Scrutiny Co-ordinating Committee, and each of the individual Scrutiny Forums, would consider selected JSNA topics and formulate views and comments for consideration where appropriate. Selected JSNA topics were looked at in detail during the course of 2012/13, culminating in the production of a report which had been circulated to the Board. Also appended to the report were the detailed outcomes of investigations into the selected JSNA topic areas.

The report and its appendices had been considered and accepted by the Finance and Policy Committee on the 28 June 2013 alongside detailed action plans, copies of which were appended to the report. In addition to the recommendations made by each Forum, the Board's attention was drawn to a number of overarching comments in relation to the overall JSNA process and content. These were detailed in the report and actions against them were detailed in the Appendix.

The Board was asked to note the content of the reports and the Action Plans. Progress against the actions identified would be monitored by the appropriate Policy Committees as part of the six monthly monitoring of outstanding scrutiny actions. The exception to this would be recommendations / actions in relation to the Sexual Health JSNA Topic, which would be monitored by the Audit and Governance Committee as part of the statutory scrutiny process.

Following reference made at the meeting to progress in addressing health inequality issues in the Borough, the Director of Public Health responded to an issue raised regarding availability of up to date information. The Director referred to the availability of both qualitative and quantitative data. The Director also referred to a presentation which had been made to Hartlepool Borough Council's Finance and Policy Committee which was based on the Longer Lives data, released on a national basis through Public Health England, on health inequalities. With regard to the JSNA topic of 'poverty', an Elected Member referred to the implications of Government Policy.

Decision

That Board noted the content of the report(s) at Appendix 1 and the Action Plans at Appendix 2

21. Securing Quality in Health Services (*Chief Officer, Hartlepool and Stockton on Tees Clinical Commissioning Group and Project Director, Security Quality in Health Services)*

The report informed the Board of a piece of work which was being carried out across County Durham and Tees Valley that was focused on improving the quality of acute hospital services. The project had been initiated in April 2012. The overall objective of the project was to enhance the commissioning of acute hospital services by reaching consensus on the key clinical quality standards in acute hospital care that should be commissioned by Clinical Commissioning Groups (CCG). The project aimed to produce a report that would describe the agreed clinical quality standards in the context of the financial and workforce resources that were expected to be available to support implementation of the standards. The project report from the first phase of the work was received at the final meetings of the Primary Care Trust in March 2013. A copy of the final summary report and quality standards had been circulated. The report set out a summary of key messages and recommendations for the four clinically led groups which considered acute paediatric, maternity and neonatal services, Acute Care, End of Life Care, Long Term Conditions and Planned Care

Following completion of phase one of this project and the project report described in the report, the five CCGs across County Durham and Tees Valley had agreed to build on this legacy work and would take this work forward in line with the duty placed upon them to commission high quality sustainable services. It had been agreed that this work would continue to be a commissioning led process and as such, Darlington CCG would lead the work on behalf of the five CCGs. Hambleton, Richmondshire and Whitby CCG was working closely with the project due to the scale of their patient flows into the Tees Valley area. The project would also feed into and is supported by the work of the Area Team of NHS England. The objectives for the next phase of work which was expected to be complete by the end of the summer 2013 were to assess the feasibility of, and options for, implementing the standards and progressing implementation.

The Project Director highlighted that a number of the quality standards were based on 24/7 availability of senior clinicians and presented some challenges in terms of workforce resources. Issues arising from the report were discussed including addressing the availability of midwives to meet the key quality standard of 1:1 Midwife care for women in established labour together with general capacity and training issues. The link to obesity of the expected increase in diabetes prevalence, referred to in the report, was also highlighted.

In response to clarification sought from the Director of Public Health with regard to further engagement with the Board, the Project Director agreed that an agenda item be included on the agenda for the meeting of the Board on 28 October 2013.

Decision

The Board accepted the report for information and agreed that a further report

be submitted to the October meeting of the Health and Wellbeing Board as the project progresses.

22. Feedback from Chairs of Health and Wellbeing Boards Regional Meeting (*Chair)*

The report provided feedback to the Board from the regional meeting of the Chairs of Health and Well Being Boards. The meeting of the Chairs of Health and Well Being Board was an opportunity for the chairs across the North East to discuss common issues affecting health and well being boards. The report set out the items which were discussed at the meeting on 17 June 2013 together with those items which had been deferred due to time constraints. It was noted that the meeting had been supported by the Association of North East Councils (ANEC).

In response to a request from a member of the Board the Chair agreed to include key issues, arising from meetings, in future reports to the Board and to circulate papers relating to those meetings to Board Members.

Decision

The report was noted.

23. Any Other Items which the Chairman Considers are Urgent

The Chairman ruled that the following items of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B) (4)(b) of the Local Government Act 1972 in order that the matters could be dealt with without delay.

24. NHS Structures and Budgets

As a general observation, it was highlighted to the Board that there was some confusion in relation to the NHS Structures and budgets. In response the Chairman suggested that a presentation be made to the next meeting of the Board.

25. Victoria Road Community Support Bed Facility

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Reference was made to consultation which was being undertaken in relation to the closure of the community support bed facility, located within 25 Victoria Road. The Tees Esk and Wear Valley NHS Trust representative referred to the need to provide better services and advised that a report was to be submitted to Hartlepool Borough

Council's Audit and Governance Committee, on 22 August, in relation to this issue.

CHAIR

HEALTH AND WELLBEING BOARD

16 September 2013

Report of: Assistant Director, Adult Services, HBC & Chief Operating Officer, NHS Hartlepool and Stockton-on-Tees CCG

Subject: **FUNDING TRANSFER FROM NHS ENGLAND TO SOCIAL CARE – 2013/14**

1. PURPOSE OF REPORT

1.1 To seek the Health & Wellbeing Board's approval for the use of the Funding Transfer from NHS England to Social Care – 2013/14.

2. BACKGROUND

2.1 In 2011/12, the NHS Operating Framework identified NHS funding for social care. Over £600m was allocated to PCTs, who were required to transfer the funding to their Local Authorities via an agreement under section 256 of the 2006 NHS Act (a s256 agreement) to invest in social care services which also had a health benefit. This funding was initially identified for 2011/12 and 2012/13.

2.2 The funding allocated for Hartlepool for 2011/12 and 2012/13 was £1,219,000.

2.3 In line with the guidance issued by the Department of Health, the Local Authority and PCT worked together to develop a plan for how this funding would be used. This was monitored through a North of Tees Reablement Steering Group which met regularly to monitor progress and evaluate performance information. The plan is attached as **Appendix 1**.

2.4 A letter from the Department for Communities and Local Government and the Department of Health to Chairs of Health and Wellbeing Boards and Directors of Adult Social Services on 26 June 2013 confirmed that this funding will remain in place until March 2016, with a significant increase in funding anticipated in 2015/16 as the letter announces a £3.8 billion pool of funding to promote the integration of health and social care services that support some of our most vulnerable population groups.

2.5 The letter explains what this means for adult social care and states that 'for local government, the new pool will ensure that service levels in the care and support system can be protected' and also advises Chairs of Health and Wellbeing Boards and Directors of Adult Social Services that it will enable 'investment in prevention and early intervention'.

2.6 The funding allocated for Hartlepool for 2013/14 is £1,793,604 – an increase of £574,604 on funding received in previous years.

3. PROPOSALS

3.1 Representatives from the Local Authority, CCG and Area Team have worked together to review the plan covering 2011/12 and 2012/13 and to identify priorities for the use of the additional funding for 2013/14.

3.2 The proposals for use of the funding meet the requirement for investment in adult social care with health benefits and will make a positive difference to social care services and outcomes for people using services.

3.2 The guidance is clear that the funding can be used to support existing services (that are of benefit to the social care system and provide good outcomes for service users) which 'would be reduced due to budget pressures in local authorities without this investment'.

3.3 On this basis, it is proposed that the additional funding for 2013/14 is used to maintain services that support people to remain independent in the community (including extra care, respite, domiciliary care and personal budgets) where the Local Authority currently has budget pressures and would be required to cut services without this investment.

3.4 The plan for use of the funding for 2013/14 is attached at Appendix 2.

3.5 A draft s256 agreement has been prepared by NHS England's Durham, Darlington & Tees Area Team and will be finalised and signed by the Area Team and the Local Authority following approval of the plan. The draft agreement is attached at **Appendix 3**.

4. RISK IMPLICATIONS

4.1 There are no risks identified in relation to the funding transfer - local authorities and local health bodies have a legal obligation to follow statutory guidance regarding this funding.

4.2 Any risks associated with individual schemes that are supported by this funding will be monitored on an ongoing basis through monitoring meetings and use of the Council's risk register where appropriate.

5. FINANCIAL CONSIDERATIONS

5.1 The funding allocated for Hartlepool is £1,793,604 – this represents continuation of funding from 2011/12 and 2012/13 of £1,219,00 plus an additional £574,604 identified for 2013/14.

6. EQUALITY AND DIVERSITY CONSIDERATIONS

6.1 There are no equality and diversity considerations regarding this funding – all of the services that will be supported by this funding are open to all residents of Hartlepool and appropriate adjustments are made to accommodate people who require additional support.

7. RECOMMENDATIONS

7.1 It is recommended that the Health & Wellbeing Board approves the plan for use of the Funding Transfer from NHS England to Social Care – 2013/14.

8. REASONS FOR RECOMMENDATIONS

8.1 It is a requirement of the funding transfer that plans are jointly agreed between Local Authorities and Clinical Commissioning Groups and approved by Health & Wellbeing Boards.

8.2 The planned use of the funding for Hartlepool meets the requirement for investment in adult social care services which demonstrates health benefits. The draft s256 agreement sets out the legal basis for the transfer and the monitoring arrangements that will be established.

9. CONTACT OFFICERS

Jill Harrison
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Social Care Funding Plan 2011/12 & 2012/13

Ref	Lead organisation	Purpose	What will funding be used for?	How do we know there is a need?	Performance Indicators	Financial assessment	Investment required	Agencies consulted and agree with proposals
1	HBC	To deliver a co-ordinated response to hospital discharge.	Increased capacity within MultiLink, Reablement Service & Intensive Social Support Team to provide ongoing assessment alongside the care manager with an output of improving the persons ability to undertake activities of daily living within a maximum of six weeks.	Anecdotal evidence highlights issues for the ability of current home care providers to always respond quickly enough meet client needs and to have workers skilled in terms of reablement approaches. Cost base information is evidenced through regional figures within RIEP project.	**NI125** - achieving independence for older people through rehabilitation / intermediate care **NI133** - timeliness of social care packages following assessment **NI136** - people supported to live independently through social services (all adults). **PO08** – older people helped to live at home. **PO66** - admissions of supported residents aged 65+ to residential / nursing care. **TCS20** - bed days lost due to delayed discharge. **TCS21** - percentage of patients whose discharge is delayed. **TCS25** – supporting independence with community services. **TCS31** – readmissions within 28 days.	Investment will be in recruitment of additional staff – reablement officers, OTs and OTAs, social care officers, contact officers and team clerk capacity as well as training and development for all staff working within the service. Delivery is reliant on additional £200K investment from social care funding - total cost of expansion is £650K. £70K of £450K replaces Supporting People funding withdrawn from April 2011, £380K is new investment delivering additionality.	£450,000	
2	HBC	To provide low level early intervention and prevention via a third sector organisation that supports the wider reablement model. To include welfare notices, luncheon clubs, a home visiting service addressing slips, trips and falls, fire safety, healthy eating etc, fuel poverty advice, debt management and expert patient programmes. The service will also link with the trusted assessor and Handyperson Scheme.	**Supported Access to independent Living Service (SAILS)** To commission a third sector organisation (Who Cares NE) to provide low level prevention and reablement services across Hartlepool.	The Connected Care pilot in Owton, incorporating SAILS, has been evaluated by the University of Durham and demonstrated some excellent outcomes in terms of supporting people to maintain their independence and reduce reliance on more costly services. Who Cares (NE) is currently working with the London School of Economics to identify the potential cost benefits of this model. It is anticipated that the successes in Owton can be replicated in other wards within Hartlepool.	**NI136** - people supported to live independently through social services (all adults). **PO71** – adults with physical disabilities helped to live at home. **PO68** – adults with learning disabilities helped to live at home. **PO69** - adults with mental health problems helped to live at home. **PO08** – older people helped to live at home. **TCS25** – supporting independence with community services. **TCS32** – rate of non-elective admissions.	Existing funding of £100Kp.a. (£50K from HBC and £50K from HPCT) funds the service in one ward. Costs for roll out across Hartlepool with focal points in the central and north areas as well as the south will cost an additional £240Kp.a. Delivery is reliant on £120Kp.a. investment from social care funding and £120K from reablement funding - total cost is £240K all of which is delivering additionality. Mirrors existing funding split and reflects delivery of health and social care outcomes. Investment will fund additional care navigator and development worker capacity as well as the dedicated SAILS team.	£120,000	

Ref	Lead organisation	Purpose	What will funding be used for?	How do we know there is a need?	Performance Indicators	Financial assessment	Investment required	Agencies consulted and agree with proposals
3	HBC	To reduce dependency on more intensive services by providing low level support, prevention and early intervention.	**Expansion of Telecare Service** To expand the existing telecare service to enable support to be offered to all people aged 75 and over as well as people with learning disabilities, physical disabilities or mental health needs.	Existing service has grown annually since being developed and feedback from people using the service is very positive. There is a body of evidence nationally that investment in assistive technology / telecare prevents or delays access to more intensive services.	**NI136** - people supported to live independently through social services (all adults). **PO51** - access to equipment & telecare: users with telecare **PO71** – adults with physical disabilities helped to live at home. **PO68** – adults with learning disabilities helped to live at home. **PO69** - adults with mental health problems helped to live at home. **PO08** – older people helped to live at home. **PO66** - admissions of supported residents aged 65+ to residential / nursing care. **PO70** - admissions of supported residents aged 18-64 to residential / nursing care	Current contract with Housing Hartlepool supports 700 users of telecare. Investment will enable an increase in capacity to 1,000 users.	£200,000	
4	HBC	To facilitate hospital discharge and support people to return home independently where possible, reducing readmissions and admissions to care homes.	**Transitional Care Provision** To maintain timely supported hospital discharge, and deliver reduction in readmissions and an increase in the number of people supported to return home independently.	Existing service at West View Lodge is well used and produces good outcomes. 33% of people receiving transitional care in West View Lodge return home compared to 14% in other homes.	**NI125** - achieving independence for older people through rehabilitation / intermediate care. **NI136** - people supported to live independently through social services (all adults). **PO66** - admissions of supported residents aged 65+ to residential / nursing care. **PO70** - admissions of supported residents aged 18-64 to residential / nursing care.	Investment will enable the current service to be maintained with potential to develop further through increased staff training, therapy input and links to other services.	£300,000	
5	HBC	To enable carers to continue in their caring role with appropriate assessment, support and services available.	**Carers Support** To support carers and reduce admissions to care homes and / or hospital as a result of carer breakdown.	The number of informal carers continues to grow, and an increasing number of people are accessing carers assessments and requesting services, either through the voluntary sector or via Direct Payments. A number of carers services were supported through the Working Neighbourhood Fund (which ceased in March 2011) and the Carers Grant which has been cut for 2011/12.	**NI135** - carers receiving assessment/review & a specific carer's service or advice & info.	Investment will enable current carers support services to be maintained including the Carers Emergency Respite Scheme and is expected to enable a greater proportion of carers to receive an assessment, a carers service (including Direct Payments) or advice and information by 2012/13.	£150,000	

Social Care Funding Plan 2013/14

Ref	Purpose	What will funding be used for?	How do we know there is a need?	Performance Indicators	Financial assessment	Investment required
1	To deliver a co-ordinated response to hospital discharge.	Increased capacity within MultiLink, Reablement Service & Intensive Social Support Team to provide ongoing assessment alongside the care manager with an output of improving the persons ability to undertake activities of daily living within a maximum of six weeks.	Anecdotal evidence highlights issues for the ability of current home care providers to always respond quickly enough meet client needs and to have workers skilled in terms of reablement approaches. Cost base information is evidenced through regional figures within RIEP project.	**Adult Social Care Outcomes Framework** • NI125 - achieving independence for older people through rehabilitation / intermediate care • NI136 - people supported to live independently through social services (all adults). • PO08 – older people helped to live at home. • ASCOF 1A Social care related quality of life • ASCOF 2A (part 2) Admissions of over 65's to residential • ASCOF 2C (part 2) Delayed transfers of care from hospital – those attributable to social care services. **NHS Outcomes Framework** • 2- Health related quality of life for people with long-term conditions. • 2.3 i) Unplanned hospitalisation for chromic ambulatory care sensitive conditions. • 2.6ii) A measure of the effectiveness of post discharge care in sustaining independence and improving quality of life. • 3.6 i) Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service • 3.6 ii) Proportion offered rehabilitation following discharge from acute or community hospital. **Public Health Outcomes Framework** • 4.11 Emergency readmissions within 30 days of discharge from hospital. • 4.13 Health related quality of life for older people (Placeholder) • 4.15 Excess winter deaths	Continuation of 2011/12 & 2012/13 investment to maintain these services.	£450,000

Ref	Purpose	What will funding be used for?	How do we know there is a need?	Performance Indicators	Financial assessment	Investment required
2	To provide low level early intervention and prevention via a third sector organisation that supports the wider reablement model. To include welfare notices, luncheon clubs, a home visiting service addressing slips, trips and falls, fire safety, healthy eating etc, fuel poverty advice, debt management and expert patient programmes. The service will also link with the trusted assessor and Handyperson Scheme.	**Low Level Support Service** To commission a third sector organisation to provide low level prevention and reablement services across Hartlepool.	The Low Level Support Service has been in place for over two years and reviews have demonstrated that services are well used (approx 2,400 referrals received per year) and highly rated by those who access them. The current contract ends in March 2014 and a review is underway to inform future commissioning intentions.	**Adult Social Care Outcomes Framework** • NI136 - people supported to live independently through social services (all adults). • PO71 – adults with physical disabilities helped to live at home. • PO68 – adults with learning disabilities helped to live at home. • PO69 - adults with mental health problems helped to live at home. • PO08 – older people helped to live at home. **NHS Outcomes Framework** • 3.6 i) Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service • 3.6 ii) Proportion offered rehabilitation following discharge from acute or community hospital. **Public Health Outcomes Framework** • 1.17 Fuel Poverty (Placeholder) • 4.13 Health related quality of life for older people (Placeholder) • 4..15 Excess winter deaths	Continuation of 2011/12 & 2012/13 investment to maintain this commissioned services.	£120,000

Ref	Purpose	What will funding be used for?	How do we know there is a need?	Performance Indicators	Financial assessment	Investment required
3	To reduce dependency on more intensive services by providing low level support, prevention and early intervention.	**Expansion of Telecare Service** To expand the existing telecare service to enable support to be offered to all people aged 75 and over as well as people with learning disabilities, physical disabilities or mental health needs.	Existing service has grown annually since being developed and feedback from people using the service is very positive. There is a body of evidence nationally that investment in assistive technology / telecare prevents or delays access to more intensive services.	**Adult Social Care Outcomes Framework** • NI136 - people supported to live independently through social services (all adults). • PO51 - access to equipment & telecare: users with telecare • PO71 – adults with physical disabilities helped to live at hom • PO68 – adults with learning disabilities helped to live at home. • PO69 - adults with mental health problems helped to live at home. • PO08 – older people helped to live at home. • ASCOF 2A (part 2) Admissions of over 65's to residential • ASCOF 2A (part 1) Admissions of 18-64's to residential • ASCOF 3A Overall satisfaction of people who use services with their care & support **NHS Outcomes Framework** • 2.3 i) Unplanned hospitalisation for chromic ambulatory care sensitive conditions. **Public Health Outcomes Framework** • 4.13 Health related quality of life for older people (Placeholder)	Continuation of 2011/12 & 2012/13 investment to maintain 1,000 service users.	£200,000

Ref	Purpose	What will funding be used for?	How do we know there is a need?	Performance Indicators	Financial assessment	Investment required
4	To facilitate hospital discharge and support people to return home independently where possible, reducing readmissions and admissions to care homes.	**Transitional Care Provision** To maintain timely supported hospital discharge, and deliver reduction in readmissions and an increase in the number of people supported to return home independently	Existing service at West View Lodge is well used and produces good outcomes. 33% of people receiving transitional care in West View Lodge return home compared to 14% in other homes.	**Adult Social Care Outcomes Framework** • NI125 - achieving independence for older people through rehabilitation / intermediate care. • NI136 - people supported to live independently through social services (all adults). • ASCOF 2A (part 2) Admissions of over 65's to residential • ASCOF 2A (part 1) Admissions of 18-64's to residential **NHS Outcomes Framework** • 3b Emergency readmissions within 30 days of discharge from hospital. • 3.6 i) Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service • 3.6 ii) Proportion offered rehabilitation following discharge from acute or community hospital. **Public Health Outcomes Framework** • PHOF 4.11 Emergency readmissions within 30 days of discharge from hospital. • 4.13 Health related quality of life for older people (Placeholder)	Continuation of 2011/12 & 2012/13 investment to maintain this commissioned services.	£300,000

Ref	Purpose	What will funding be used for?	How do we know there is a need?	Performance Indicators	Financial assessment	Investment required
5	To enable carers to continue in their caring role with appropriate assessment, support and services available.	**Carers Support** To support carers and reduce admissions to care homes and / or hospital as a result of carer breakdown.	The number of informal carers continues to grow, and an increasing number of people are accessing carers assessments and requesting services, either through the voluntary sector or via Direct Payments. A number of carers services were supported through the Working Neighbourhood Fund (which ceased in March 2011) and the Carers Grant which has been cut for 2011/12.	**Adult Social Care Outcomes Framework** • NI135 - carers receiving assessment/review & a specific carer's service or advice & info. • ASCOF 3B Overall satisfaction of carers with social services • ASCOF 1D Carer related quality of life **NHS Outcomes Framework** • 2.4 Health related quality of life for carers.	Continuation of 2011/12 & 2012/13 investment to maintain this commissioned services. Additional £40,000 required to fund additional Direct Payments for carers, which support access to short breaks.	£190,000
6	To support existing services that are of benefit to the social care system and provide good outcomes for service users which would be reduced due to budget pressures without this investment.	A range of services that support people to live independently in the community including extra care, respite, domiciliary care and personal budgets.	Increased activity and spend in all of these areas due to demographic pressures including an ageing population and increased prevalence of dementia.	**Adult Social Care Outcomes Framework** • NI125 - achieving independence for older people through rehabilitation / intermediate care. • NI136 - people supported to live independently through social services (all adults). • ASCOF 2A (part 2) Admissions of over 65's to residential • ASCOF 2A (part 1) Admissions of 18-64's to residential • ASCOF 3A Overall satisfaction of people who use services with their care & support **NHS Outcomes Framework** • 2.6ii) A measure of the effectiveness of post discharge care in sustaining independence and improving quality of life. • 3.6 i) Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service **Public Health Outcomes Framework** • 4.13 Health related quality of life for older people (Placeholder)	Investment of £100,000 in supported for adults with mental health needs who are supported in the community. Investment of £435,000 in non-residential support for older people. This includes £65,000 for residential / nursing respite, £75,000 for domiciliary care, £145,000 for extra care, £105,000 for respite via sitting service and £45,000 for Housing Related Support.	£535,000

NHS ENGLAND
(DURHAM, DARLINGTON AND TEES)

AND

HARTLEPOOL BOROUGH COUNCIL

PARTNERSHIP AGREEMENT
Section 256 of the NHS Act 2006

DATED XXX 2013

Revenue grant agreement relating to
Social Care funding 2013/14

Transfer of funding from NHS England
to
Hartlepool Borough Council

2013/2014

This Agreement is made as a DEED on the XXXth day of XXX 2013

BETWEEN

1. **Hartlepool Borough Council**, whose principle office address is at the Civic Centre, Hartlepool

and

2. **NHS ENGLAND (DURHAM, DARLINGTON AND TEES)**, whose principal office address is at The Old Exchange, Barnard Street, Darlington DL3 7DR ("NHS England"), which term shall include its statutory or legal successor to its functions and its permitted assignees.

(individually known as a "Party" and together known as the "Parties")

LEGISLATIVE PROVISIONS AND BACKGROUND

A. Under section 256 of the 2006 Act and the Directions (as defined below) NHS England may make payments to a Local Authority in connection with expenditure on social services functions and/or health related functions of a Local Authority.

B. NHS England agrees to make grant payments to the Local Authority pursuant to section 256 of the 2006 Act in respect of revenue expenditure for costs associated with expenditure on social care functions and health related functions of the Local Authority.

C. This Agreement sets out the terms and conditions of the grant payments.

D. This Agreement seeks to fulfil the objectives set out in the Joint Commissioning Strategies of local NHS Commissioners (including Hartlepool and Stockton-on-Tees Clinical Commissioning Group, and the NHS England Durham, Darlington and Tees Area Team) and Hartlepool Borough Council.

E. Approval for this Agreement was agreed on behalf of the Local Authority and by NHS England by the Health and Wellbeing Board on the XXX day of XXX 2013.

F. NHS England is satisfied that the grant payments are likely to secure a more effective use of public funds than the deployment of an equivalent amount on the provision of services under section 3(1) of the 2006 Act.

G. The Parties have agreed to nominate officers to act on behalf of the Parties, who will monitor this Agreement, the performance of the Services, and report to the Health and Wellbeing Board (as defined below).

IT IS HEREBY AGREED BETWEEN NHS ENGLAND AND THE LOCAL AUTHORITY AS FOLLOWS:

1 DEFINITIONS AND INTERPRETATION

1.1 In this Agreement these words and expressions have these meanings where the context allows:

"2006 Act"	the National Health Service Act 2006;
"Agreed Costs"	the costs incurred by the Local Authority in connection with the Services in respect of which NHS England agrees to make payments in accordance with the terms of this Agreement as set out in Annex 5;
"Agreement"	means this agreement including all annexes;
"Health and Wellbeing Board"	means the Board that has responsibility for over sight of the working arrangements between NHS England and the Local Authority with particular reference to this Agreement;
"Commencement Date"	means the date agreed by each individual service through the reablement group;
"Directions"	means the Directions by the Secretary of State as to the conditions governing payments by health authorities to local authorities and other bodies under Section 28A of the National Health Service Act 1977 issued on 28 March 2000, which now apply to payments made under section 256 of the 2006 Act;
"FSA"	means the Financial Services Authority or such other body that has responsibility for the regulation of banks;
"Force Majeure"	means an act of God, fire, act of Government or state, war, civil commotion, insurrection, embargo, prevention from hindrance in obtaining raw materials, energy or other supplies and/or any other reason beyond the Parties' control;
"Good Industry Practice"	means the exercise of that degree of skill, diligence, prudence and foresight and operating practice that would reasonably and ordinarily be expected from a skilled and experienced person engaged as the case may be in the same type of undertaking as that of the Party in question under the same or similar circumstances;
"Interest Rate"	means one (1) per cent per annum above the base lending rate from time to time of the Bank of England or such other clearing bank as may be agreed between the Parties;
"Laws"	means all Legislation and any applicable judgement of the relevant court of law which sets a binding precedent;
"Legislation"	any Act of Parliament or subordinate legislation within the meaning of section 21(i) of the Interpretation Act 1978, any exercise of the Royal Prerogative and any enforceable community right within the meaning of section 2 of the European Communities Act 1972, in each case in the United Kingdom;
"Month"	means a calendar month;
"Nominated Officers"	means the group of officers appointed by the Parties which will act jointly to oversee the Agreement with powers being delegated by the Parties to whom the said officers will be accountable;

"Performance Indicators"	means the quality performance indicators agreed between the Parties and set out in Annex 3;
"Qualifying Persons"	means the persons receiving the Services under this Agreement as listed in Annex 4;
"Revenue Grant Payments"	the payments made under Clause 3 and detailed in Annex 5, which represents the funds designated by the NHS to support adult social care services that have a health benefit in 2013-14 (NHS England Gateway Reference 00186);
"Services"	means the post discharge services and reablement and social care services to be provided or procured by the Local Authority for the Qualifying Persons by expenditure of the Agreed Costs, and set out in more detail in Annex 3;
"Service Levels"	means the level of Services as set out in Annex 3;
"Service Specification"	means the specification for the Services as set out in Annex 3;
"Working Day"	means Monday to Friday inclusive in any week but excluding statutory holidays applicable in England.

1.2 In this Agreement:

1.2.1 References to any Legislation, statute, statutory provision, statutory instrument or direction shall be construed as a reference to that Legislation statute, statutory provision, statutory instrument or direction as replaced amended extended or re-enacted from time to time and shall include any subordinate legislation made under any Legislation, statute or statutory provision.

1.2.2 The headings are inserted for convenience only and shall be ignored in construing the terms and provisions of this Agreement.

1.2.3 References in this Agreement to any clause or sub-clause Schedule or paragraph of a Schedule without further designation shall be construed as a reference to the clause sub-cause schedule or paragraph of the schedule to this Agreement so numbered.

1.2.4 Words importing the singular include the plural and vice versa.

1.2.5 Words importing any gender include any other gender.

1.2.6 When NHS England is succeeded by a successor entity (the "Successor Entity") then on and from the date of such succession NHS England shall be deemed to be replaced by the Successor Entity

2 COMMENCEMENT, REVIEW AND OPERATION

Commencement

2.1 This Agreement shall come in to force on the date it has been validly and properly executed by the Parties (the "Agreement Execution Date"), save where the Commencement Date is before the Agreement Execution Date in which instance, the Parties shall have begun to carry out any of its duties, obligations and/or responsibilities referred to or set out in this Agreement earlier than the Agreement Execution Date. In such an instance, this Agreement shall be deemed to have commenced from the Commencement Date.

2.2 This Agreement shall continue until the 31 March 2014 unless terminated in accordance with Clause 10 and/or Clause 17.3.

Review of this Agreement

2.3 This Agreement shall be reviewed by the Parties in a form and by such representatives of the Parties as may be agreed, initially 3 Months after the Commencement Date and thereafter at any time in accordance with the terms of this Agreement, save that all such reviews must be held within 6 Months of each other.

Operation of the Nominated Officers

2.4 The Parties agree that responsibility for the managing, planning and monitoring of this Agreement (including any performance of the Services) shall be discharged by the Nominated Officers.

2.5 The Nominated Officers shall meet in the timescales set out in Annex 6, and shall act in accordance with the terms of reference as set out in Annex 7, and will receive or deliver reports as provided for in Annex 8.

3 REVENUE GRANT PAYMENTS

3.1 The Parties agree that NHS England will exercise its powers under Section 256 of the Act to execute this agreement and following release of funding by NHS England to the Area Team, the Area Team will within 30 working days make payments to the Local Authority for revenue expenditure in respect of the agreed costs.

3.2 The Revenue Grant Payments in respect of the Agreed Costs will be calculated, reviewed and paid in accordance with the arrangements described in Annex 5.

3.3 The Revenue Grant Payments are made on condition that the Local Authority:

3.3.1 Ensures, so far as is practicable, the most efficient and effective use of the Revenue Grant Payments;

3.3.2 Does not use the Revenue Grant Payments for any purposes other than expenditure on the Agreed Costs;

3.3.3 Provides or procures the Services in accordance with any Service Specifications and Service Levels as set out in Annex 3;

3.3.4 Maintains the Revenue Grant Payments in a UK based account of an FSA-authorised bank and notifies the details of such account to NHS England;

3.3.5 Signs the Memorandum of Agreement annexed in the form set out at Annex 1;

3.3.6 Completes and submits a monthly return of expenditure to the Area Team in accordance with Clause 6.

3.3.7 Completes and submits an annual voucher in the form set out at Annex 2 in accordance with Clause 3.6.

3.4 In the event that the Local Authority fails to comply with any of the conditions contained in this Clause 3 the provisions of Clause 10.1.1 shall apply.

3.5 Save where expressly stated in this Agreement no interest is payable by the Local Authority upon the sums paid to the Local Authority under this Agreement.

3.6 The Local Authority shall complete an annual voucher in the form set out at Annex 2 and this shall be authenticated on behalf of the Local Authority by its Chief Financial Officer. The Local Authority shall pass the completed voucher to its external auditor by no later than 30 September following the end of the financial year in which the Local Authority receives the Revenue Grant under this Agreement. The Local Authority shall arrange for the voucher to be certified by an auditor appointed under section 3 of the Audit Commission Act 1998 and submitted to NHS England by no later than 31 December of that year.

3.7 Where the Local Authority reduces the Services to be provided or procured under this Agreement, this shall be subject to the consent of NHS England. The Local Authority agrees to notify NHS England immediately of any circumstances which mandate the reduction of the Services under this Agreement and any variation to the terms of this Agreement shall take place in accordance with Clause 13.

4 FINANCIAL COMMITMENT BY THE LOCAL AUTHORITY

4.1 The Local Authority warrants to NHS England that it has available, and shall commit adequate funding and resources of its own, for the Services to the extent not funded by the Revenue Grant Payments for the duration of the Agreement.

4.2 The Local Authority shall ensure that any interest that accrues on the Revenue Grant Payments prior to the Revenue Grant Payments being fully expended on the Services is added to the amount of the Revenue Grant Payments remaining and used solely to contribute to the cost of the Services.

Overspending

4.3 The Local Authority warrants that any over spending in relation to the provision of the Services above and beyond the Revenue Grant Payments shall be the responsibility of the Local Authority.

Underspending

4.4 The Local Authority warrants that any under spending shall be used to fund services in accordance with this Agreement and as agreed with the Area Team and ratified through the Health and Wellbeing Board.

5 RECORDS

5.1 The Local Authority shall keep full and accurate minutes of its expenditure of the Revenue Grant Payments and of every meeting held in relation to the Revenue Grant Payments.

6 PROVISION OF INFORMATION AND INSPECTION

6.1 The Local Authority shall, within four weeks of the end of each calendar month, provide NHS England with monthly financial and performance reports, setting out how the funding is being used against the agreed programme of expenditure and outcomes against individual projects within the plan in relation to the Revenue Grant payments. The Local Authority shall promptly provide NHS England and the Health and Wellbeing Board with such reports and information as it may reasonably request from time to time relating to the activities (including the performance management of the services) and finances of the Local Authority in relation to the Revenue Grant Payments, including but not be limited to, all internal and external audit reports relating to the Local Authority.

6.2 The Local Authority shall on reasonable request provide NHS England with access to a copy of the Local Authority's audited accounts promptly.

6.3 The Local Authority shall notify NHS England as soon as practicable and in any event within 7 (seven) days of it being unable, for whatever reason, to continue to provide or procure the Services.

6.4 The Local Authority shall allow NHS England on reasonable notice in writing to inspect all accounts, books, records, documents and other information as NHS England may reasonably require for the purpose of verifying:

6.4.1 the ability of the Local Authority to provide or procure the Services; and/or

6.4.2 the observance and performance of the conditions of the Revenue Grant Payments as set out in Clause 3.

6.5 The Parties agree to hold meetings to discuss matters arising in connection with the Revenue Grant Payments. The meeting schedule will as a minimum be set in accordance with the dates set out in Annex 6. Additional meetings will be convened at the reasonable written request of either Party at a time and place to be agreed.

7 PERFORMANCE MONITORING

7.1 NHS England, the Clinical Commissioning Groups and the Local Authority will meet bi-monthly during the period of the Agreement and beyond, or more often or less often, if necessary or agreed, to review whether the Local Authority is providing or procuring the Services in accordance with the

agreed Service Levels, including the Performance Indicators and to monitor final outcomes as set out in Annex 3.

7.2 Where NHS England has a concern relating to the Local Authority's performance under the terms of this Agreement, NHS England will notify the Local Authority in writing of such concern and request that the concern be remedied. The Parties will meet within one (1) Month of the date the concern was raised to agree corrective actions to ensure performance of the Services improves to meet the appropriate standards, including the Performance Indicators, set out in this Agreement and to agree a reasonable timeframe for such improvement.

7.3 If the corrective actions agreed pursuant to Clause 7.2 do not result in any improvement in the performance of the Services within the agreed timeframe, NHS England may issue a performance notice to the Local Authority ("Performance Notice") setting out the matters giving rise to that Performance Notice and a reasonable timeframe within which the matters must be rectified.

7.4 The Local Authority will remedy the matters set out in the Performance Notice within the timeframe set out in the Performance Notice.

7.5 If the Local Authority disputes the matters set out in the Performance Notice, the Local Authority will notify NHS England of the reasons for the dispute and the Parties shall attempt to resolve the dispute in accordance with disputes resolution procedure set out in Clause 16.

7.6 Without prejudice to the rights of the Parties, if the Local Authority does not fulfil the requirements of the Performance Notice within the timeframe set out in the Performance Notice, then NHS England may serve (at its discretion) between 3 to 6 Month's written notice to the Local Authority to terminate this Agreement.

7.7 Notwithstanding any clause to the contrary in this Agreement, NHS England shall report to the Nominated Officers quarterly and annually in relation to NHS England's performance of the Services pursuant to the terms of this Agreement, and by reference to such other criteria as the Nominated Officers may require.

8 REPAYMENT OF REVENUE GRANT PAYMENTS

8.1 The Local Authority shall immediately repay to NHS England:

8.1.1 a sum equal to the amount of any part of the Revenue Grant Payments applied for any purpose other than the Agreed Costs together with, at the discretion of NHS England, interest at the Interest Rate to be charged on such sum calculated from the date such sum was applied for purposes other than the Agreed Costs until repayment;

8.1.2 any overpayment or erroneous payment received by it from NHS England;

8.1.3 where the Local Authority is served with notice of termination in accordance with clause 10.1, the total of the Revenue Grant Payments, less expenditure already spent on the Services at the time of service of the notice of termination;

8.1.4 where a notice of termination is served pursuant to clause 17.3, the total of the Revenue Grant Payments, less expenditure already spent on the Services at the time of service of the notice of termination.

8.2 For the avoidance of doubt, repayment under clause 8.1 shall not prejudice NHS England's rights under clauses 3.7 and 10.

9 LOCAL AUTHORITY'S REPRESENTATIONS AND WARRANTIES

9.1 The Local Authority warrants and represents that:

9.1.1 it has the power to enter into and perform its obligations under this Agreement and has taken all the necessary actions to authorise the execution and delivery and performance of the Agreement; and

9.1.2 it has the power to provide or procure the Services; and

9.1.3 it is not aware of any act, matter or thing which will or is likely to affect adversely its ability to comply with its obligations under this Agreement; and

9.1.4 all information supplied to NHS England by it, its servants or agents prior to the date of this Agreement was true and accurate in all material respects.

10 TERMINATION

10.1 Without prejudice to any right or remedy it may possess NHS England shall be entitled to terminate the Agreement upon (at the discretion of NHS England) between 3 to 6 Months written notice to the Local Authority upon the happening of any of the following events:

10.1.1 the Local Authority fails to comply with the conditions of the Revenue Grant Payments as set out in Clause 3;

10.1.2 the Local Authority commits a material breach of this Agreement and either such breach is in the reasonable opinion of NHS England not capable of remedy or such breach is in the reasonable opinion of NHS England capable of remedy and is not remedied to NHS England's reasonable satisfaction within such time period as NHS England, acting reasonably, shall impose, such time period being not less than 30 days of receipt by the Local Authority of notice by NHS England requiring such remedy;

10.1.3 the Local Authority is served with notice of termination under Clause 7.6 (Performance Monitoring);

10.1.4 the Local Authority is served with notice of termination under Clause 12.1.3 (Amendment and Severance);

10.1.5 the Local Authority is served with notice of termination under Clause 14.1 (Prevention of Bribery);

10.1.6 where clause 17.3 applies; or

10.1.7 where the payment of the Revenue Grant Payment pursuant to the terms of this Agreement is deemed by NHS England (acting reasonably) to be ultra vires, void, voidable, illegal or otherwise unenforceable.

10.2 In the event of a termination or expiry of this Agreement, the Parties shall cooperate to ensure an orderly wind down of any joint activities arising out of or pursuant to the terms of this Agreement.

10.3 Without prejudice to the generality of the aforementioned, the Local Authority shall be responsible for winding down its own financial affairs arising out of the operation of this Agreement.

11 PAYMENT OF LEGAL COSTS

11.1 The Parties agree that each shall bear their respective legal costs incurred in connection with the preparation, negotiation and execution of this Agreement.

12 AMENDMENT AND SEVERANCE

12.1 If any condition of this Agreement is declared by any judicial authority or considered by the Parties to be void, voidable, illegal or otherwise unenforceable:

12.1.1 the Parties shall amend that provision in such reasonable manner as mutually agreed in accordance with Clause 13; or

12.1.2 at the discretion of the Parties that provision may be severed from the Agreement and the remaining conditions of this Agreement shall except where otherwise provided remain in full force and effect unless otherwise terminable; or

12.1.3 NHS England may at its absolute discretion terminate this Agreement by giving notice of termination to the Local Authority.

13 VARIATION

13.1 There shall be no variation to this Agreement without the prior written consent of the Parties.

14 PREVENTION OF BRIBERY AND COUNTER FRAUD AND SECURITY MANAGEMENT ARRANGEMENTS

Prevention of Bribery

14.1 If the Local Authority, any of its employees or officers or anyone acting on behalf of the Local Authority

14.1.1 makes a gift or some other consideration to any person with the intent of obtaining some benefit in relation to this Agreement; and/or

14.1.2 puts pressure on any person with the intent of obtaining some benefit in relation to this Agreement; and/or

14.1.3 commits any offence under the Bribery Act 2010; and/or

14.1.4 commits any other similar offence under any subsequent legislation

then NHS England shall have the right to terminate this Agreement by giving notice of termination to the Local Authority except where (in the reasonable opinion of NHS England):

14.1.5 the action or offence described in Clause 14.1.1 to 14.1.4 above is an isolated infrequent or uncommon incident; and

14.1.6 the Local Authority has taken reasonable steps to avoid the commission by any of its officers, employees or anyone acting on its behalf of any such action or offence and the Local Authority has taken reasonable steps (including where appropriate the dismissal of any employee or officer) to prevent the future commission by any of its officers or employees or anyone acting on its behalf of any such action or offence; and

14.1.7 such action or offence has not been authorised endorsed or condoned by the Local Authority.

Counter fraud and security management arrangements

14.2 The Parties shall ensure that appropriate counter fraud and security management arrangements are in place.

14.3 A Party shall upon request permit a duly authorised person nominated by the other Party to review the counter fraud and security management arrangements put in place and shall implement such modifications to those arrangements within such time periods as such a duly authorised person may reasonably require.

14.4 The Parties shall, promptly upon becoming aware of any suspected fraud or corruptions involving a service user, staff or public funds, report such matter to the local counter fraud specialist.

15 THIRD PARTY RIGHTS

15.1 No person other than a party to this Agreement shall have any right under the Contracts (Rights of Third Parties) Act 1999 to enforce any of the terms of this Agreement.

16 DISPUTES

16.1 In the event of any dispute arising under the terms of this Agreement, the Parties shall attempt in good faith to resolve such disputes.

16.2 If such dispute cannot be solved under the provisions of Clause 16.1 within 30 days, it shall be referred for review and negotiation between the Chief Executive of the Local Authority and the Area Director, NHS England, Durham, Darlington and Tees who shall attempt to resolve the dispute within 10 days of it being referred to them.

16.3 If the matter is not resolved under the provisions of Clauses 16.1 and 16.2 the dispute shall be referred to a mediator as the Parties shall jointly nominate. If the Parties shall fail to agree on the selection of a mediator within 14 days after the date of expiry of the 30 days period specified in Clause 16.2 the mediator shall be nominated at the request of either Party by the President for the time being of the CEDR (Centre for Dispute Resolution).

16.4 The result of such mediation shall, except in the case of manifest error, be final and binding upon Parties.

16.5 The Local Authority and NHS England shall use their best endeavours to ensure that the mediation starts within 20 Working Days of nomination of the mediator under Clause 16.3. The mediator's fee shall be paid in proportions as advised by the mediator.

16.6 The provisions of this Clause 16 are without prejudice to the rights of the Parties expressed elsewhere in this Agreement and the use of the dispute resolution procedures set out in this Clause 16 shall not delay or take precedence over the provisions for termination.

16.7 Notwithstanding any provision in this Agreement to the contrary, a Party may, as a course of action, at any time seek remedies of injunction, or specific performance in relation to any matter arising out of or pursuant to this Agreement.

17 FORCE MAJEURE

17.1 Each Party shall give written notice to the other Party as soon as it becomes aware of any Force Majeure event, setting out details of the Force Majeure event, its likely duration and the steps being taken and to be taken by the Parties to minimise the effect of the Force Majeure on the Parties' obligations under the Agreement.

17.2 The Parties shall use all reasonable endeavours to mitigate the effects of the Force Majeure event and take appropriate remedial action in order to meet their obligations under the Agreement.

17.3 Where an event of Force Majeure continues for a period exceeding 90 calendar days either Party may terminate this Agreement in accordance with Clause 10.1.6.

18 FREEDOM OF INFORMATION AND DATA PROTECTION

18.1 The Parties shall be entitled to publish and/or release any and all terms or conditions of this Agreement and/or the contents of any documents and/or information relating to the formation of this Agreement under the provisions of the Freedom of Information Act 2000 (FOIA) and/or the Data Protection Act 1998 (DPA).

18.2 Each party shall:

18.2.1 Co-operate and supply to the other all necessary information and documentation required in connection with any request received by the other Party under FOIA and the DPA;

18.2.2 Supply all such information and documentation to the other Party within 7 Working Days of receipt of any request at any pre-arranged or agreed costs.

18.3 Should either Party receive a request for information, they shall not publish or otherwise disclose any information contained in this Agreement or in any negotiations leading to it without the other Party's previous written consent unless the Party wishing to disclose information is bound to publish and/or disclose such information under FOIA and/or the DPA.

18.4 The Parties shall comply with the Codes of Practice on the Discharge of Public Authorities' Functions and on the Management of Records (issued under sections 45 and 46 of the FOIA respectively), and the Environmental Information Regulations 2004 as may be amended, updated or replaced from time to time and any other applicable codes of practice and guidance applicable from time to time to the extent that they apply to the functions of the Parties under the Agreement.

19 CONFIDENTIALITY

19.1 Each Party shall subject to Clause 19.2 treat any information given to it by the other Party marked or referred to as "Commercial – in confidence" (or using such other similar words signifying that they should not be disclosed) confidential and shall not disclose such information to any third party.

19.2 Clause 19.1 shall not apply in the case of disclosures:

19.2.1 pursuant to the order of any court or where requested by any police or regulatory organisation in the United Kingdom; and

19.2.2 where disclosure is pursuant to FOIA, DPA, the Audit Commission Act 1998 or the Environmental Information Regulations 2004.

20 GENERAL

20.1 This Agreement is personal to the Local Authority and it shall not, without the previous written consent of NHS England, assign, transfer or vest, except by the operation of any statutory provision, the benefit of the Agreement to any other person.

20.2 The benefit and/or burden of this Agreement may be assigned or transferred by NHS England to any successor of all or part of their functions, property, rights and liabilities.

20.3 Any notice required to be given by each Party to the other shall be in writing and shall be served by sending the same by registered post or facsimile transmission or by delivering the same by hand (in the case of NHS England addressed to Mr Cameron Ward, Area Director, NHS England, Durham, Darlington and Tees and in the case of the Local Authority, addressed to Director of Child & Adult Services, Hartlepool Borough Council) to the relevant party's principal address and any notice shall be deemed to have been served:

20.3.1 48 hours after posting if sent by registered post; and

20.3.2 two hours after transmission if a notice is sent by facsimile transmission save that where such deemed time of service is not during normal business hours the notice shall be deemed to have been served at the opening of business on the next Working Day; and

20.3.3 immediately on delivery if served by hand.

20.4 In proving service it will be sufficient to prove:

20.4.1 in the case of a delivery by hand that the notice was delivered to or left at the correct address; or

20.4.2 in the case of a notice sent by registered post that the letter was properly addressed stamped and posted; or

20.4.3 in the case of a facsimile that it was properly addressed and dispatched to the correct number.

20.5 Any complaints relating to the performance of the Services by a Qualifying Person or anyone else shall be dealt with in accordance with the Local Authority's complaints procedure, as updated from time to time. Copies of such complaints and responses shall be provided to NHS England on demand.

20.6 No failure or delay on the part of NHS England to exercise any right or remedy under this Agreement shall be construed or operate as a waiver thereof nor shall any single or partial exercise of any right or remedy as the case may be and no waiver by NHS England of any breach of this Agreement shall be effective unless agreed by NHS England and the Local Authority in writing.

20.7 The Parties agree that this Agreement shall not be interpreted as constituting a partnership between the Parties nor constitute any agency between the Parties and the Local Authority agrees that it shall not do cause or permit anything to be done which might lead any person to believe otherwise.

20.8 This Agreement shall not be construed as an endorsement by NHS England of the Local Authority, its employees, agents or sub-contractors or the Local Authority's activities and the Local Authority agrees that it shall not do cause or permit anything to be done which might lead any person to believe otherwise.

20.9 Any termination of this Agreement shall be without prejudice to any rights or remedies of either Party in respect of any antecedent breach of this Agreement.

20.10 The termination of this Agreement shall not affect the coming into force or the continuation in force of any provision of this Agreement which is expressly or by implication intended to

come into or continue in force on or after such termination or expiry. For the avoidance of doubt, Clauses 8, 16, 18 and 19 shall survive expiry or termination of this Agreement.

20.11 Unless otherwise stated all sums stated in this Agreement (including but not limited to the Revenue Grant Payments) are inclusive of all applicable Value Added Tax (if any) or of any successor tax.

20.12 The Local Authority shall at all times observe and perform all Laws, court orders and bye-laws and all rules, regulations, provisions or conditions thereunder, and the Local Authority shall do and execute or cause to be done and executed all acts required to be done in respect of the project under or by virtue of such Laws, orders, bye-laws, rules, permissions or conditions.

20.13 The Local Authority shall, and shall ensure that its employees, agents and sub-contractors shall, at all times act in a way which is compatible with the convention rights within the meaning of Section 1 of the Human Rights Act 1998.

20.14 Prior to the issue of any press release about matters relating to this Agreement or making any contact with the press on any issue relating to this Agreement attracting media attention the Area Director, NHS England, Durham, Darlington and Tees and the Director of Child & Adult Services, Hartlepool Borough Council (or such persons as they shall each designate) will consult with each other to agree a joint strategy for the release or handling of the issue. The provisions of this clause are subject to any alternative arrangements that the Parties may agree for press relations in particular situations.

20.15 The construction, validity and performance of this Agreement shall be governed by the laws of England.

20.16 This Agreement may be entered into in any number of counterparts and by the parties to it on separate counterparts, each of which, when so executed and delivered shall be an original.

IN WITNESS WHEREOF the Parties have executed this Agreement as a Deed the day and year first above written:

THE COMMON SEAL of **NHS ENGLAND** was hereunto affixed in the presence of:

.....

Authorised Officer

THE COMMON SEAL of HARTLEPOOL BOROUGH COUNCIL was hereunto affixed in the presence of:

……

Authorised Officer

ANNEX 1

Memorandum of Agreement
Section 256 transfer

Reference number: NHS England Gateway Reference 00186

Title of scheme: Funding Transfer from NHS England to support Adult Social Care Services that also have a Health Benefit (the "**Scheme**")

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

2. How will this funding make a positive difference to social care services and outcomes for service users?

3. Description of scheme and relationship to Local Delivery Plan (In the case of revenue transfers, please specify the services for which money is being transferred).

4. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Revenue amount	Capital amount
2013/14	£1,793,604	£0

In the case of the capital payments, should a change of use as outlined in directions at paragraph 4(1)(b) occur, both parties agree that the original sum shall be recoverable by way of a legal charge on the Land Register as outlined in directions at paragraph 4(4).

5. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

Signed ..... for NHS England

..... Position

..... Date

..... for Local Authority

..... Position

..... Date

ANNEX 2

SECTION 256 ANNUAL VOUCHER

……..
HARTLEPOOL BOROUGH COUNCIL

PART 1 STATEMENT OF EXPENDITURE FOR THE FINANCIAL YEAR ENDED 31 MARCH 2014
(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	Revenue Expenditure £	Capital Expenditure £	Total Expenditure £

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by NHS England in accordance with Directions made by the Secretary of State under section 256 of the National Health Service Act 2006.

Signed…….
Date……

(Local Authority Chief Financial Officer (Section 151 Appointment), other relevant chief financial officer, or Chairman of voluntary sector organisation, as appropriate (see paragraph 6(2) of Directions).

Certificate of auditor appointed by the Audit Commission

The Statement of Responsibilities of grant-paying bodies, authorities, the Audit Commission and appointed auditors in relation to grant claims and returns, issued by the Audit Commission, sets out the respective responsibilities of these parties, and the limitations of our responsibilities as appointed auditors. I/We have:

- examined the entries in this form **[which replaces or amends the original submitted to me/us by the authority dated [ ]** and the related accounts and records of the authority in accordance with Certification Instruction A1 prepared by the Audit Commission for its appointed auditors; and

- carried out the tests specified in Certification Instruction HLG03 prepared by the Audit Commission for its appointed auditors, and I/we have obtained such evidence and explanations as I/we consider necessary.

[Except for the matters raised in the attached qualification letter dated [ ]

I/we have concluded that the entries are

- fairly stated; and

    - in accordance with the relevant terms and conditions.

Signature_____ Name (block capitals) _____

Date _____

ANNEX 3

DESCRIPTION OF THE SERVICES

SERVICE SPECIFICATION

Scheme	Specification

SERVICE LEVELS

Performance Indicators – Quality & Performance

Hartlepool Borough Council will be responsible for monitoring quality and performance of individual contracts with providers.

Performance against delivery of the strategy will be monitored via the nominated Officers Group meetings and a bi-annual report produced and presented to the Health and Well Being Board. This report should include progress against plan, the reasons for non-achievement – potential risks to delivery, outcomes achieved and any future recommendations.

The Services shall be carried out by the Local Authority in accordance with:-

1) Good Industry Practice;

2) the Laws;

3) where applicable with the registration and regulatory compliance guidance of the Care Quality Commission (or its successor), and any other appropriate/relevant regulatory body;

ANNEX 4

QUALIFYING PERSONS

Persons residing within the boundaries of Hartlepool Borough Council.

ANNEX 5

REVENUE GRANT PAYMENTS

The Agreed Costs are:

Total Transfer	**£XXX**

ANNEX 6

NOMINATED OFFICERS AND PERFORMANCE MEETING SCHEDULE

Nominated Officers including representatives from each of the organisations below:
NHS England Durham Darlington and Tees Area Team
Hartlepool Borough Council
Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Meeting Schedule (Dates to be confirmed)
September 2013
November 2013
January 2014
March 2014
May 2014
July 2014

ANNEX 7

TERMS OF REFERENCE OF THE NOMINATED OFFICERS

To be developed

ANNEX 8

REPORTING AND INFORMATION REQUIREMENT OF THE NOMINATED OFFICERS

- NHS England make it a condition of the transfer that Local Authority demonstrates how the funding transfer makes a positive difference to social care service, and outcomes for service users, compared to service plans in the absence of the funding transfer.
- NHS England require that expenditure plans and monitoring reports are categorised into the following service areas:

Analysis of the adult social care funding in 2013-14 for transfer to local authorities

Service Areas- 'Purchase of social care'	***Subjective code***
Community equipment and adaptations	52131015
Telecare	52131016
Integrated crisis and rapid response services	52131017
Maintaining eligibility criteria	52131018
Re-ablement services	52131019
Bed-based intermediate care services	52131020
Early supported hospital discharge schemes	52131021
Mental health services	52131022
Other preventative services	52131023
Other social care (please specify)	52131024
Total	

- NHS England make it a condition of the transfer that it has access to timely information (routine monthly performance reports within four weeks of month end plus access to ad-hoc information as requested) on how the funding is being used against the agreed programme of expenditure and the outcomes against the plan, in order to assure itself that the conditions for each funding transfer are being met.

HEALTH AND WELLBEING BOARD

16 September 2013

Report of: ALI WILSON, CHIEF OFFICER – NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG

Subject: IMPROVING A&E PERFORMANCE AND WINTER PLANNING

1. PURPOSE OF REPORT

1.1 To Provide the Health & Wellbeing Board an update in relation to National expectations and requirements for delivery of the 95% operational standard for A&E performance and the approach to winter planning 2013/14 as set out in the key paper – *Improving A&E Performance* (Gateway 00062 – Appendix A) issued by NHS England.

2. BACKGROUND

2.1 Gateway 00062 sets out the national approach to restoring the 95% operational standard for A&E patients being seen and admitted or discharged within 4 hours. NHS England have required each CCG to provide an A & E improvement plan by 31st May 2013 in response to national concerns about the performance of A & E departments against the 4 hour wait standard.

2.2 Gateway 00062 demonstrates how NHS England understands the current national (and local) problem, setting out requirements for its own Area teams to support CCGs (with providers) through Urgent Care Boards to develop Recovery and Improvement Plans by the end of May 2013.

2.3 Locally providers are achieving the 4 hour wait standard however they have been requested to submit a sustainability plan (Appendix B). It was agreed with the NHS England Area Team that the Urgent Care Sustainability Plan would capture the key pieces of work needed to relieve pressure on the urgent care system in the short and medium term (including taking action now to alleviate anticipated winter pressures in 2013/14).

2.4 As identified within the Gateway ref the requirement to establish an urgent care board has been undertaken with the dissolution of the Tees Integrated Urgent Care Network (TIUCN) and building on the existing HAST In Hospital Care workstream (Urgent Care Project Group) and the South Tees CCG

Urgent Care workstream to oversee the requirements of the board. The assessment of the longer term direction will need to be done in the context of the recent Kings Fund report on urgent care and will be determined by the board and workstream groups in terms of developing and delivering an urgent care strategy. Terms of Reference and membership for the Urgent Care Board are set out at Appendix C.

2.5 Consistent delivery of high quality emergency care in a timely manner remains an elusive goal for Emergency Departments nationally. There are numerous key components of emergency care, as referenced in 'The drive for quality', these are imperative to ensure Emergency Departments can deliver both quality and timely assessment for those entering the A&E remit. However, recognition must be given that a holistic approach, encompassing all elements of the health economy is paramount to success.

2.6 The ability of A&E departments to provide a high quality patient experience, supported by the three strands of safety, clinical effectiveness and consistent system performance is dependent upon efforts locally to improve emergency medicine. Tees wide, there is a determination and commitment to improve Urgent Care as a whole. Collaborative working between Clinical Commissioning Groups (CCG), local Foundation Trusts and other partner agencies is allowing this direction of travel to progress rapidly.

2.7 Hartlepool and Stockton on Tees CCG has undertaken an immense amount of work with key stakeholders within Urgent Care to develop robust winter/surge plans. These plans are currently being formulated with all service providers and therefore cannot be tabled at this board meeting. However, this briefing paper aims to offer assurance of the work being completed which will be ratified by the 30th September 2013.

3. Urgent Care Work-stream

3.1 A dedicated project group aligned to Urgent Care is well established and refined terms of reference have been ratified. Dr Carl Parker is the clinical lead for the group supported by North of England Commissioning support service colleagues (NECS). Key stakeholders from both health and social care feature within the working group and there is close partnership working with the acute provider. Collaboration with all key stakeholders is imperative to allow the Urgent Care agenda to develop.

3.2 Clinical and managerial leads oversee the associated projects which will encompass primary and secondary care and progress updates are offered within each project group meeting to assure the group of progression. The Urgent Care Strategy is being modified and will be available to the wider group members within August 2013 and to share with the Health & Wellbeing Board at a future date.

3.3 The focus upon winter/surge planning, allows the CCG to be reassured from all key stakeholders that robust plans which will offer optimal urgent care are apparent within all services. The CCG are working in partnership with all

stakeholders to ensure that plans are realistic, achievable and are able to effectively manage the demand put upon urgent care services within winter months.

3.4 These plans are well developed and the target completion date for all providers is the 31st August 2013. This allows analysis of plans to be undertaken and a gap analysis of each individual plan be formulated. These plans will be discussed in depth at the Urgent Care project group meeting on the 2nd September, prior to discussion at Delivery Team and Urgent Care Board.

4. Urgent Care Boards

4.1 The publication of gateway ref document: 00062, sets out the requirement to develop an Urgent Care Board (UCB) for the local health community. Although Hartlepool and Stockton CCG have a specific Urgent Care project group, this did not constitute the requirements to fulfil an UCB. Urgent Care Boards are responsible for the co-ordination and production of winter capacity and escalation plans for their local health economy. To ensure the effective functioning and sustainability of urgent care systems, together with the delivery of NHS Constitution pledges and standards, local UCB's will seek assurance regarding the robustness of the collective integrated plans in order to prepare and manage through the winter period.

4.2 A Tees-wide UCB has been formulated in conjunction with South Tees CCG with the first meeting occurring on the 23rd July 2013. Both CCG's are in agreement that the chairing of this meeting will be undertaken by the clinical urgent care leads for both CCG's on a rotational basis. Terms of reference and membership are currently being refined, ensuring they meet the defined UCB requirements as set out in the guidance.

4.3 The next UCB meeting is due to be held on the 17th September and the winter plans will be integral to discussion. This will allow the Urgent Care Board to review, discuss, make suggestions for improvement or ultimately ratify the plans accordingly.

5. Winter Planning – Delivery and Implementation

5.1 NHS Hartlepool and Stockton on Tees CCG will ensure winter plans encompass and recognise the following:-

- Primary Care – Access, Out of Hours medical provision, Impact of 111, Developments within community services to offer alternative pathways of care
- Secondary Care – Operational bed management, Acute capacity, Critical Care, Diagnostic services, Ambulance handover times, Staffing of all disciplines
- Discharge Services – Utilisation of discharge lounges, Reduced delays of transfer, Discharge profiling across specialities, Community and Social Care support, Reablement

5.2 NHS Hartlepool and Stockton on Tees CCG will continue their engagement and collaborative working with their urgent care stakeholders to ensure service readiness. Testing of proposed plans will be undertaken within October 2013.

6. Conclusion

6.1 This paper summarises the work being undertaken to ensure delivery of effective optimal Urgent Care entering into the challenging winter period. We will continue to robustly assess and review all Urgent Care Services to ensure that demand can be met efficiently and will continue to collaborate with all key stakeholders involved within the Urgent Care agenda.

7. CONTACT OFFICER

Nicola Jones

NHS England

NHS England: Improving A&E Performance
Gateway ref: 00062

A. The Issue

1. Long waiting times in A&E departments (often experienced by those awaiting admission and hence ill patients) not only deliver poor quality in terms of patient experience, they also compromise patient safety and reduce clinical effectiveness.

2. We have an operational standard of 95% for patients being seen and discharged within 4 hours and we use this to be sure patients are being treated quickly. This operational standard is designed to deliver patients' rights under the NHS Constitution. A&E performance has deteriorated significantly over the last six months. In the last quarter of 2011/12, 47 out of 152 providers failed to meet the 95% standard for patients being seen and discharged within 4 hours. For the last quarter of 2012/13 this figure had increased to 94 out of 148 providers, double the previous number.

3. Despite much analysis there is no single trend or factor to explain the deterioration and there remains a wide variation in performance both across the country and within the same areas where similar factors apply. This has also been borne out in the perceptions from Clinical Commissioning Group (CCG) commissioners, gathered through the NHS Commissioning Assembly Rapid Reference Group.

4. A number of factors are assumed to have played a part in this deterioration, and not all of them pertain to every situation:

   - Increased numbers of patients arriving at A&E. There is a general rising tide with 5.9% more attendances in 2012/13, than in 2009/10. However, the total numbers attending in Q4 of 2012-13 (which is when the significant deterioration began) was 1.7% lower than the previous Q4.
   - Increased number of acute admissions putting pressure on beds. There were 10.6% more emergency admissions in 2012/13 than in 2009/10. There is general consensus (though it is hard to identify the evidence) that patients presenting are more ill and hence more likely to need admission and have longer stays.
   - Hospitals being less proactive in process management which plays a very significant part in their ability to admit patients. Patients who require admission are the ones who are most likely to wait over 4 hours.

- A lower threshold in hospitals for admitting or discharging patients to ensure safety standards. In some cases, this is perceived to be linked to the seniority of the workforce in A&E.
- A lack of specific services available to acute trusts in a timely fashion for certain specific patient groups, such as those with mental health, alcohol or drug abuse problems.
- More delayed discharges because primary, community or social care services are not place.

5. There are also many assumptions as to why these factors have played a greater part than in previous years:

- Perceived lack of availability of primary care and community services, especially out of hours.
- Reduction in bed numbers and staff as hospitals try to deliver cost improvement plans.
- The Francis report and its impact on clinical decision making thresholds.
- Lack of focus during transition for commissioners and uncertainty about changing roles in the new system.
- Pressure on social care budgets.
- Introduction of NHS 111.

B. Response

6. NHS England's role is to oversee the whole commissioning system and to ensure that, working in partnership with CCGs, patients receive the right standards and quality of care. Resolving the current situation will require the commissioning system to work with all key partners in hospitals, primary care, and local authorities to create a single national framework to ensure that we see rapid and sustainable improvement. The work needs to be considered in 3 phases:

i. An urgent recovery programme with significant attention given by local and national commissioners and providers to all factors which can help recover the standards, (including clear performance management).
ii. A medium term approach to ensure delivery over the next winter period. This will include care system planning as well as a review of the levers and incentives in the system.
iii. In the longer term, the implementation of the urgent care strategy in order to deliver safe and sustainable services.

7. Although all the above elements are inter-related and aspects of the work can be undertaken in parallel, this paper focuses specifically on the

immediate plan to improve A&E performance thus ensuring patients are seen swiftly and treated safely.

8. The plan builds on existing planning and contracting arrangements and discussions taking place to deliver Everyone Counts: Planning for Patients 2013-14. This includes the triangulation of plans and assessment of confidence in delivery, particularly where a reduced number of A&E attendances and emergency admissions is planned. We will need to be very clear about the level of tolerances in these assumptions, the potential impact on providers and the mitigating actions if assumptions prove to be incorrect.

9. In its planning guidance to CCGs published in December 2012, NHS England highlighted the importance it puts on commissioners and providers ensuring that waiting times for patients in A&E departments are kept to a minimum. It has set out that the NHS Constitution minimum of 95% of patients to be admitted, transferred or discharged within 4 hours of their arrival must be met. To follow through on this requirement, it was made part of the standard contract between commissioners and providers and will be part of CCG Assurance – i.e. CCGs will be subject to intervention if their providers are not maintaining a sufficient level of performance.

10. In addition, Everyone Counts has set out that no patients should wait more than 12 hours on a trolley in an A&E department – a requirement that did not exist under the previous system – and CCGs are empowered to take action (i.e. fines) against providers that breach this condition.

11. This document has been prepared in conjunction with NHS Trust Development Authority (TDA) and Monitor, as they themselves work closely with providers to support the changes they need to make internally. However, NHS TDA, Monitor and NHS England all recognise the need for there to be a joint approach and one which is also agreed, at both national and local level, with our partners in local authorities, particularly social services.

12. A range of national actions have been agreed between us, including a joint oversight function which is detailed here.

13. Much of the document focuses on the actions expected of NHS England's Area Teams. However, local commissioners have the key role in supporting and ensuring the delivery of high quality emergency services, including that they are delivered in line with the NHS Constitution rights and that the 95% operational target is met.

14. This document focusses specifically on that commissioning role and the need for commissioners to ensure that:

- They bring the system together and ensure good relationships and prevent fragmentation.
- They provide strategic oversight for the system.
- They have a clear focus on outcomes.
- They tackle the obstacles.
- They ensure that all the appropriate services are in place and they hold each provider to account for playing their part.
- They promote integration and close working between all partners but especially health and social care.

15. They should ensure that providers, including primary care providers, are given a strong leadership role in determining the best way to deliver high standards.

16. We are asking all Area Directors to facilitate a local partnership approach. This will include providing assurance that an Urgent Care Board is set up for each local health community, ensuring coverage for every A&E department. In some parts of the country, Urgent Care Boards (or a similar arrangement) are already in place and these should be utilised as appropriate.

17. In addition, we will undertake a review of the financial levers and incentives that will contribute to improved performance.

18. NHS England would like to acknowledge the excellent work undertaken by the King's Fund in a review of urgent care in the South of England. This describes a range of actions which are needed to improve urgent care, and particularly A&E services. We have drawn on this work significantly in the production of our plan. The work also includes a comprehensive checklist of actions which is appended to our plan. We commend this to local health economies as an excellent source of good practice.

C. National Oversight and Actions

19. Implementation of local and national actions will be overseen by a tripartite group from NHS England, NHS TDA and Monitor. This group will also work closely with Local Government Association and Association of Directors of Social Services and with CCGs through the NHS Commissioning Assembly. The group will include:

- Chief of Staff and a regional director, Monitor;

- Director of NHS Operations and Delivery (Corporate), NHS England; and,
- Director of Delivery and Development, NHS TDA.

20. This group will:

    a. Set the timescales for the delivery of recovery and improvement plans which set out when performance will be achieved and maintained;
    b. Have oversight of the delivery of recovery and improvement plans, with each organisation operating in line with its regulatory framework to hold individual commissioners and providers to account for delivery where required.
    c. Sponsor the requirement for regular information which gives insight into the system;
    d. Working with the NHS Commissioning Assembly, and the full range of provider representatives, to determine the specifications for any national support programme.

21. The detailed Terms of Reference for the group and the partnership agreement which underpins these are currently being developed and will be shared during May.

22. The group will commission research in a number of A&E systems to understand why there has been this change in performance. In essence, we need to understand what has happened between October 2012 and April 2013 that was different to previous years and have the evidence base to underpin this.

23. The group would be given delegated authority to act on behalf of the three organisations with access to organisational plans, to monitor and manage the reversal of the current situation in line with the regulatory framework for each sector. In response to current performance we will implement the winter management model which includes regular system wide conversations, deep-dives into organisations with difficult problems, trajectories for improvement and monitoring of progress and in parallel we will ask all communities to undertake an urgent review of winter and bring forward arrangements for next winter (we note that many commissioners are doing this).

24. We have already agreed that NHS IMAS will run a series of workshops across the country to support local health systems identifying best practice and the methods to implement this.

25. This tripartite arrangement will be mirrored at regional level. The regional arms of the NHS TDA, Monitor and NHS England, in line with the regulatory framework for each sector, will set up tripartite panels which will review and monitor the delivery of the plans. This will include intervention where plans are not delivered as agreed.

26. NHS England, Monitor and NHS TDA will be part of a programme oversight group which will include CCGs and will ensure the work is co-produced and learns from best practice.

D. Local Actions

27. NHS England Area Teams should facilitate the production of a recovery and improvement plan for each health community by working in partnership with CCGs, providers and local authorities. Recovery and improvement plans will need to look at each step of the patient's journey through the emergency system in three phases: firstly, prior to arrival at A&E; secondly, the patients journey through the hospital system; and thirdly, the discharge and out of hospital care.

28. Area Teams will ensure that Urgent Care Boards have been convened for all communities, which will feed into individual A&E departments. The Urgent Care Board will need to include all key stakeholders from health and social care as well as patient representatives and the appropriate clinical expertise.

29. We expect those Urgent Care Boards to ensure that:

- They review the full range of appropriate data.
- Best practice is adopted by all concerned.
- The effectiveness of primary care services is reviewed, including out of hours and admission avoidance schemes.
- The effectiveness of community services is reviewed, including any walk in centres, minor injury units and how they integrate with secondary care.
- The effectiveness of ambulance services is reviewed.
- The effectiveness of NHS 111 is reviewed.
- There are local plans in place to support the care of the key categories of patient who attend or are admitted frequently:
- Patients with multiple comorbidities especially those with poorly controlled chronic disease:
    - Frail elderly, especially those with mental health problems;
    - Sick children; and,

  - High dependency individuals, especially vulnerable adults (homeless, drug and alcohol related problems, mental health problems).
- A full range of services is available to acute trusts for those patients in A&E who need services not provided by acute hospitals are in place.
- Working with local authorities, a review to ensure early discharge is feasible is undertaken.

30. Where areas have not already agreed plans and committed funds, we expect the Urgent Care Board to oversee the use of the 70% funding retained from excess care urgent tariff. In particular, the use of this money must be clearly identified to support any aspect which will support the urgent care system and acute providers' ability to deliver the operational standard.

31. We would expect the use of this money to be signed-off jointly by CCG leaders, NHS England Area Directors, provider Chief Executives, and local authority Chief Executives by the end of June, so that schemes can be implemented ready for next winter. The use of the money must be clearly linked to specific delivery of outcomes and improvements in standards.

32. Urgent Care Boards will be expected to sign-off all aspects of the local recovery and improvement plan.

33. Recovery and improvement plans will need to include:

- An agreed local plan to bring the performance back on track by the end of Q1, including a sustainability plan, produced by the Area Team, including sign-off from Health and Social Care Partners.
- Preparation for working on a winter plan 2013/14 to sign-off by Area Team by November 2013.
- Evidence the best practice from Emergency Care Intensive Support Team (ECIST).

34. Recovery and improvement plans should consider the following aspects of care although this list of actions is not exhaustive and we must acknowledge there may be different issues at a local level:

A. Prior to A&E:

- Strengthening primary and community care for frail and elderly patients.
- Use of community diversion schemes.

- Strengthening GP out-of-hours services.
- Use of virtual wards in the community.
- Support to care homes to avoid emergency referrals.
- Peer review of GP emergency referrals.
- Reducing ambulance conveyance rates.
- Patient education on appropriate use of emergency services.
- Roll-out arrangements for NHS 111.

B. Flow within the hospital:

- Prompt booking of patients to reduce ambulance turnaround delays.
- Full see-and-treat in place for minors.
- Prompt initial senior clinical assessment within A&E and rapid referral if admission is needed
- Prompt initiation of blood and radiological tests with rapid delivery of test result.
- Prompt access to specialist medical opinion.
- Full use of computer-aided patient tracking and system for progress-chasing.
- Regular seven-day analysis should be in place for rapid identification and release of bottlenecks.
- Bed base management
- Daily consultant ward rounds.
- Provision of specific services for patients groups such as those with mental health problems.

C. Discharge and out of hospital care:

- Designation of expected date of discharge (EDD) on admission.
- Maximisation of morning and weekend discharges.
- Full use of discharge lounges.
- Minimisation of outliers.
- Delayed transfers of care reduced.
- Flexing of community service capacity to accept discharges.
- Review of continuing care processes.
- Assessment of use of reablement funding by local authorities.

35. In developing recovery and improvement plans, communities are encouraged to think about innovation and not simply commission traditional approaches. To facilitate this we would advocate the use of the NHS IQ improvement function, in particular ECIST, to ensure that best and good practice is adopted.

36. The recovery and improvement plans should draw on existing ECIST reports on local services and ensure these reports recommendations are implemented.

37. The recovery and improvement plans should also describe how the 70% funding retained from excess care urgent tariff will be used in the health community to reduce pressure on A&E (either within the hospital setting or in the community) or make improvements within A&E itself. It should demonstrate how all parties have been involved in the use of this funding and the responsibilities associated with the receipt of any of this funding, particularly in describing the expected outcomes and improvements in standards.

38. NHS England will ask its Area Teams to collate recovery and improvement plans and carry out initial quality assurance. These plans need to be completed and submitted to Regional Directors by 31 May 2013 to enable tripartite discussions with the NHS TDA and Monitor to commence.

E. Conclusion

39. Working closely with other key stakeholders, and building on the views already shared from CCGs and providers, NHS England will put in place an approach that will support the emergency and urgent care system, reduce pressure and ensure that patients do not have to wait longer than the agreed standards as identified in the NHS constitution and thus meet the national operating target of 95%.

40. This document outlines the overall approach and identifies the actions which Area Directors should now put in place to ensure that the commissioning system responds appropriately to support providers of A&E and urgent care services.

9 May 2013

Appendix: Emergency Care Checklist – Urgent and Emergency Care: A review for NHS South of England (The King's Fund, March 2013)

It is vital that health communities intelligently adapt what is known to work effectively and then ensure that this is actively managed and kept under review. The following approaches are based on current guidance from the Emergency Care Intensive Support Team and findings from our research.

Note that the evidence to support the ideas that follow is variable and many depend on the local context.

Urgent Care Boards

Establish a local Urgent Care Network (UCN) which incorporates strategic and operational leads across the emergency care system including consultants, GPs and ideally patient representatives. Develop robust terms of reference for the local UCN using the good practice set out in the DoH Emergency Care Network guidance.[1]

- Map out the range of existing groups/boards to ensure there is clarity with regard to both process and communications between the UCN and the local Trust Boards.
- Align commissioner and provider priorities and incorporate within a local strategy.
- Ensure all urgent care work streams report back to the UCN to support improved communication.
- Ensure all work streams are supported by programme management and leadership to enable whole system implementation.
- Develop a dashboard to monitor the overall impact of the programme and manage system resilience. The following example of a suite of whole system metrics may be helpful:
  - A primary care access metric at general practice level.
  - Ambulance turnaround times (30 minute arrival to clear) and category A and B response time delivery.
  - The four hour standard (underpinned by disposal profiles, showing the % of patients leaving the department after three hours forty five minutes has elapsed (for admitted patients, and two hours for non-admits)
  - Adult non-elective bed occupancy rate using an agreed non-expanded bed number consistently as the denominator.
  - Percentage of discharges from hospital before and after midday.

[1] Emergency care networks checklist (2004) Department of Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086939 (accessed 6th Jan 2012) This checklist shows how networks can improve patients' care by connecting all the members of a health community. It offers suggestions for membership and an example terms of reference, as well as early steps and specific actions for building effective local networks. It also contains links to support and resources.

- Community service based performance metrics (e.g. rate of delivery of a 4 hour standard for admission avoidance and a 12 hour standard for early supported discharge).
- Average time from referral to assessment for mental health patients with no physical illness.
- Social care response and performance metrics.
- Outcome and patient experience metrics (mortality, effectiveness of pain control, patient reported outcome measures etc).

Communication and information

- There should be a clear vision aligned to an emergency care system strategy aimed at improving capacity, demand, patient experience and quality across system. There should be a narrative that focuses on the safety and quality benefits for patients, and the development of a culture that views the system flow as everyone's responsibility across the health and social care community.
- A broad campaign to implement and embed practices known to work (particularly in the hospital) should be considered, this should engage all members of staff in understanding their roles and actions required to improve emergency care performance, and patient flow. There are mobilising and organising techniques which are useful to win hearts and minds and gain commitment - further information on large scale sustainable change is available from the NHS Institute.[2]
- Identify champions to optimise delivery of the emergency care strategy and engage other staff in making a high performing emergency care system "everyone's business". Clinical Directors should view good patient flow and capacity and demand management as part of their responsibility for quality and safety.
- A real time directory of services with capacity information seems to be an important aspect of management.
- The idea of notification systems, GP dashboards and other methods to inform GPs and case managers that their patients are in hospital should be explored.

Root cause analysis of emergency care system failures

Root cause analysis of system failures (such as ambulance handover delays, closure of multiple wards from Norovirus etc.) should be owned and undertaken by individual organisations, but findings shared across the system. There should be a robust assessment of the root causes, with a genuine effort made to get to the real root causes, rather than trying to demonstrate system failure was unavoidable.

The system must ensure findings result in action and improvement – a process of senior review would demonstrate the importance that organisations place on root cause analysis and learning from it.

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[2] NHS Institute information on large scale change:
http://www.institute.nhs.uk/general/general/leading_large_scale_change.html (accessed June 2012)

Commissioning

Unscheduled care commissioning intentions need to be clear, shared and communicated. The strategy and commissioning intentions need to be owned by local stakeholders and therefor developed with meaningful input from providers.

Commissioning decisions should be made around the approaches that are known to be effective in managing emergency care, these are outlined below. Commissioners should also ensure that the financial flows and contracts for services support patients moving through the system, and do not create dis-incentives and gaming.

Encouraging CCGs to federate and have a single dialogue with providers would go some way to enabling positive relationships to be established.

Commissioning around outcomes and allowing the provider to determine the detail of how services should be provided seems to be a key factor in successful approaches. The model of commissioning emergency care needs to be rethought, with providers given a stronger leadership and responsibility role in determining delivery. Commissioning emergency care needs to shift from a sometimes adversarial approach of micro-managing to one where CCGs take an oversight and scrutiny role, supported by a system dashboard that highlights the system capacity and demand.

Internal professional standards

- Response standards should be agreed for the whole system, including community, ambulance and hospital services, and cover time to:
    - Assessment (including diagnostics, investigations and therapy services). Within this implement single assessment processes to reduce duplication.
    - Treatment.
    - Review.
    - Referral. Within this simplify referral processes, rather than using them as mechanisms to "hold back" work.
    - Discharge (refer to the section below on discharges).
- Use metrics to measure performance and consistency of delivering IPS.

Staff training

Ensure relevant staff are trained in practices known to be effective (RAT, See and Treat etc.) Primarily focus effort on training key staff and consider using a "train the trainer" approach to roll out new practices quickly.

GP practices

- Ensure there are appointments available for urgent cases and follow published guidance.[3,4]
- Consider the use of GP telephone triage and GP call-back to manage demand, although studies around this approach are small scale the evidence is encouraging. Note that it also requires significant redesign of workflows – it is not a simple intervention
- Stagger home visits to reduce 'batching'. Using the ambulance service, nurses or a physician of the day may be one solution.
- Raise patient awareness of alternative services available (other than the emergency department, note that there is limited evidence of the effectiveness of patient education around emergency department avoidance.
- Undertake training and education around end of life.
- Ensure advanced planning is implemented consistently.
- Ensure all patients who need advanced care plans and end of life plans have them in place and that all health professionals they are in contact with are aware of these plans.
- Extending primary care hours is an approach that has yet to be proven and should be monitored.
- Implement productive general practice and other approaches to increase the availability of same day appointments.
- Consider methods for improving continuity of care for complex patients.
- Ensure high quality input into nursing and residential homes, this may require some reallocation of responsibilities.

GP out of hours

- Out of hours service contracts should be outcome based to promote joint working and integration with other services.
- Ensure GP out-of-hour services have access to patient records and care plans.
- Promote a greater emphasis on using alternative systems and patients being able to access the appropriate service based on their need.
- Look to co-locate GP out of hours within the hospital.

Walk-in centres and minor injury centres

- There are growing concerns around the effectiveness of walk in centres and these centres should be evaluated rigorously.
- Ensure opening times are aligned to other parts of the emergency care system to reduce duplication.

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[3] Urgent care: a practical guide to transforming same-day care in general practice. Primary Care Foundation (2009) http://www.primarycarefoundation.co.uk/report.html (accessed 26th November 2012)

[4] Introduction and User Guide - Urgent Care in General Practice Toolkit - A practical Toolkit to help GP Practices and GP Consortia improve patient experience and surgery workload. ECIST

- Where possible co-located and integrate with emergency departments.[5]
- Consistently use the See and Treat model.[6]
- Ensure clinical governance and management is integrated with the emergency care system.
- Ensure access to diagnostics.
- Ensure consultant advice is accessible.
- Work with the ambulance service to promote the centre as an alternative when appropriate.

Community services

As noted above the number of evidence based models and actions for community services are less well understood but appear to include the following:

- Critically examine pilots, projects and approaches. Ensure that initiatives are thoroughly evaluated and only roll out the most cost effective and promising.
- Remove some of the complexity, overlaps and individual schemes to create services on a large enough scale to be able to make significant differences in terms of supporting patients with long term conditions
- Ensure community services and can anticipate demand and are able to flex capacity to meet needs.
- Ensure there are simple referral criteria and streamlined assessments and documentation that enable patients to be transferred quickly.
- Consider basing community services around key hospital providers to enable strong relationships and integrated teams to be established.
- Use case management and risk stratification when appropriate.[7]
- Provide integrated health and social care crisis support teams.[8]
- Provide IV support to patients in the community.

Nursing and care homes

There is evidence that nursing and care home residents receive low levels of clinical care and that making good these shortfalls significantly reduces the number of emergency

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[5] Chalder. M., *et al* (8 March 2003) Impact of NHS walk-in centres on the workload of other local healthcare providers: time series analysis. BMJ: Primary Care. Vol 326 http://www.bmj.com/content/326/7388/532.reprint?maxtoshow=&HITS=80&hits=80&RESULTFORMAT=&fulltext=%22walk%20in%20centres%22&searchid=1&FIRSTINDEX=10&sortspec=date&resourcetype=HWCIT (accessed 26th November 2012)

[6] Keep things moving – see and treat patients in order (2008) Quality Service and Improvement Tools. NHS Institute http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/keep_things_moving_-_see_and_treat_patients_in_order.html (accessed 1st Nov 2012)

[7] Purdy, S. *et al.* (2012) Interventions to reduce unplanned hospital admission: A series of systematic reviews. Final Report June 2012. University of Bristol, University of Cardiff, National Institute for Health Research

[8] Thistlethwaite. P. (2011) Integrating health and social care in Torbay: improving care for Mrs Smith. London: King's Fund

attendances and admissions.[9] It is estimated that between 8% and 40% of patients seen in the emergency department that come from care homes could have been cared for outside of the department.[10] This patients are also at risk of rapidly decompensating once in the hospital, and where possible should be treated within nursing and care homes.

- Provide and end of life education, training and support to nursing and care homes.
- Implement advanced care plans.[11]
- Ensure regular case review and medicines management reviews.
- Increase the level of medical care and access to specialist advice (geriatricians and GPs) in nursing and care homes.[12,13,14]
- Provide IV support.

Frail elderly

Although these represent a relatively small number of overall admissions this patient group has a very high propensity to be admitted and once in hospital often decompensate, have a long length of stay and are problematical to discharge, therefore generating a large number of bed days.

The successful discharge of frail older people following an emergency admission to hospital relies on effective joint working between NHS, social care partners and the independent sector. In organising discharge systems, a whole systems approach is important. This should aim to anticipate and promptly respond to potential bottlenecks or obstacles, smooth patient flow, and recognise the interdependency between partners.

It is important to commission and embed practice and processes with a proven record of enhancing patient flow within acute hospitals – a summary of these effective

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[9] Steves. C.J., Schiff. R., Martin. F.C. (2009) Geriatricians and care homes: Perspectives from geriatric medicine departments and primary care trusts, Clinical Medicine 9:6 528-533

[10] Carter., Skinner., Robinson. (1998) Patients from care homes who attend the emergency department: could they be managed differently Emerg Med J doi:10.1136/emermed-2012-201630)

[11] Caplan. G.A., *et al* (2006) Advance care planning and hospital in the nursing home. Age and Ageing 2006; 35: 581–585 http://ageing.oxfordjournals.org/content/35/6/581.full.pdf+html (accessed 26 November 2012)

[12] Steves. C.J., Schiff. R., Martin. F.C. (2009) Geriatricians and care homes: Perspectives from geriatric medicine departments and primary care trusts, Clinical Medicine 9:6 528-533

[13] Crilly. J., Chaboyer. W., Wallis. M. (2011) A structure and process evaluation of an Australian hospital admission avoidance programme for aged care facility residents, Journal of Advanced Nursing 68:2, 322-334.

[14] Evans. G. (2011) Factors influencing emergency hospital admissions from nursing and residential homes: positive results from a practice-based audit. Journal of Evaluation in Clinical Practice. 17:6. 1045-49.

approaches is available from the Intensive Support Team.[15] These approaches should also ensure there is an active 'pull' from the community to ensure frail elderly patients who are medically fit to be discharged can return to the community.

Addictions and mental health

There is evidence from local studies that a small number of users of emergency services are 'frequent attenders' that often result in admission. Many of these frequent attenders suffer from drug and alcohol addictions or mental illness, or have social problems such as homelessness or unemployment.

- Develop and implement an alcohol strategy. Alcohol abuse has been found to account for 12% of emergency department attendances and 6.2% of hospital admissions.[16]
- Establish rapid response services for people with mental illness.[17] This should include approached for both known and unknown users.
- Implement psychiatrist input out of hours; case management; assertive outreach services; and within hospital liaison services especially for mental illness and alcohol abuse to reduce attendances, admissions and costs.[18,19]

Paediatrics

- Evaluate GP access, particularly between 3pm-8pm.
- Look at the GP skill mix and ensure paediatric primary care is available at a high standard.
- Review the appropriateness and availability f of paediatric cover in hospital.

Ambulatory emergency care directory

The Ambulatory Emergency Care Directory was published in 2007 by the NHS Institute, identifying 49 emergency conditions and clinical scenarios that have the potential to be managed on an ambulatory basis.[20] Actively managing patients with ambulatory care sensitive conditions (through vaccination; better self-management; disease-

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[15] Effective Approaches in Urgent and Emergency Care. Paper 3. Whole system priorities for the discharge of frail older people from hospital care. (2012) ECIST

[16] Pirmohamed. M., *et al* (2000) The burden of alcohol misuse on an inner-city general hospital. QJM (2000) 93 (5): 291-295.doi: 10.1093/qjmed/93.5.291. http://qjmed.oxfordjournals.org/content/93/5/291.short (accessed 2 Nov 2012)

[17] Glover. G., Arts. G., Babu. K.S. (2005) Crisis Resolution teams and inpatient mental health. Centre for Public Mental Health, University of Durham.

[18] Althaus. F., Parox. S., Hugli. O., Ghali. W.A., Daeppen. J-B. *et al* (2011) Effectiveness of interventions targeting frequent users of emergency departments: a systematic review, Annals of Emergency Medicine, 58:1, 41-52.

[19] Tadros. G., Salama. R., Mustafa. N., Pannell. R., Balloo. S. (2011) The Rapid Assessment Interface and Discharge Liaison Team, City Hospital Birmingham: Evaluation Report December 2009 – September 2010.

[20] Ambulatory Emergency Care Directory (2007) www.institute.nhs.uk/option,com...194/.../products_id,181.html (accessed 5th December 2012)

management or case-management; or lifestyle interventions) prevents acute exacerbations and reduces the need for emergency hospital admission.

- Ambulatory care services should be provided as an unscheduled service with closer working between the emergency department consultants and acute physicians. Have a clear plan to roll out at least two emergency conditions to the service each year and mainstream them.
- Ensure senior clinical decision makers are available to decide on the need for admission.
- Ensure ambulatory emergency care is available for all patients who meet the criteria.
- Ensure access to timely investigations to support clinical decision making.
- Community clinics for diabetes, heart failure and respiratory patients can be very expensive and the approaches to these inconsistent. Linking these outreach clinics to ambulatory care models may be a good use of scarce resources.

Ambulance services

Analysis of ambulance demand is key to understanding where to focus attention in the emergency care system.

Although there are some known approaches to improving performance (outlined below), the ambulance services still remains a largely untapped resource of skills and experience, both clinical and managerial, that should be explored further.

- Access to care plans and advanced care plans was flagged as an important area.
- Establish emergency care practitioners.[21,22,23]
- Ambulance handover should follow guidance available.[24]
- Review contracts to ensure that transport is available in a timely manner for patients who are medically fit and require ambulance transport back into the community.
- Analyse ambulance call outs to identify causes and areas of increase. Target frequent callers – including GPs

The emergency department[25]

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[21] Mason. S., O'Keeffe. C., Coleman. P., Edlin. E., Nicholl. J.(2007) Effectiveness of emergency care practitioners working within existing emergency service models of care, EMJ. 24:239-43

[22] O'Hara. R., O'Keeffe. C., Mason. S.. Coster. J.E., Hutchinson. A. (2012) Quality and Safety of care provided by emergency care practitioners, EMJ. 29:327-32

[23] *Ibid* O'Hara *et al* (2012)

[24] NHS South West - Ensuring timely handover of patient care - ambulance to hospital (2008) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089072 (accessed 30th Nov 2012)

- Implement Rapid Assessment and Treatment (RAT) for "majors" patients.[26] Early senior review is likely to increase the number of people able to be managed at home and to prevent adverse outcomes.[27]
- Implement See and Treat for patients with minor injuries and illnesses.[28]
- Reduce or eliminate triage.
- Emergency department crowding – Adopt the College of Emergency Medicine guidance around full capacity protocols.[29]
- Use appropriately trained nurses to admit patients in liaison with specialities.
- Review layout and physical capacity of the emergency department.
- Review services provided in the emergency department to ensure that inappropriate services (such as review services and follow up services) are removed to free up clinical time.
- Trusts need have a clinical staffing strategy to ensure the provision of the required competencies on an hour by hour basis. An appropriate mix of consultants, middle grades, advanced nurse practitioners, majors nurse practitioners, physician assistants and extended role HCAs need to be developed. This needs to be underpinned by robust job planning.

Patient streaming

- Create separate streams for minors and majors, with dedicated staff, processes and coordination. Create processes to ensure that the major's stream is not halted by a full resuscitation room.
- The ED should avoid acting as the default arrival point for referrals that do not require resuscitation or stabilisation (e.g. most GP or clinic referred patients) – these patients should by-pass the emergency department and go directly to acute medical units or specialist beds.

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[25] Effective Approaches in Urgent and Emergency Care. Paper One. Priorities within Acute Hospitals (2011) ECIST (http://www.nhsimas.nhs.uk/fileadmin/Files/ECIST_Conference_October_2012/ECIST_papers/FINAL_ECIST_Paper_1_-_Priorities_within_Acute_Hospitals.pdf (accessed 5th December 2012)

[26] Effective Approaches in Urgent and Emergency Care. Paper Two - Rapid Assessment and Treatment Models in Emergency Departments. (June 2012) ECIST http://www.nhsimas.nhs.uk/fileadmin/Files/ECIST_Conference_October_2012/ECIST_papers/FINAL_ECIST_Paper_2_-_Rapid_Assessment_and_Treatment_in_EDs_June_2012.pdf (accessed 30th Nov 2012)

[27] Caring to the End? A review of the care of patients who died in hospital within four days of admission A report of the National Confidential Enquiry into Patient Outcome and Death (2009) http://www.ncepod.org.uk/2009report2/Downloads/DAH_report.pdf (accessed 7th Jan 2013) Emergency Admissions: A journey in the right direction? A report of the National Confidential Enquiry into Patient Outcome and Death (2007) http://www.ncepod.org.uk/2007ea.htm (accessed 7th Jan 2013)

[28] Keep things moving – see and treat patients in order. Quality Service and Improvement Tools. (2008) NHS Institute http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/keep_things_moving_-_see_and_treat_patients_in_order.html (accessed 1st Nov 2012)

[29] The College of Emergency Medicine - Crowding in Emergency Departments (August 2012) secure.collemergencymed.ac.uk/code/document.asp?ID=6296 (accessed 1st Nov 2012)

- Ensure senior decision makers in high volume specialties are available to attend the emergency department within thirty minutes of referral.
- Ensure the emergency department has direct admission rights using agreed protocols.
- Provide short stay capacity for patients with an anticipated length of stay of up to two midnights (assessment and short stay capacity is usually co-located in acute medical units). A review of what is achievable through short stays in unscheduled care has been published by the NHS institute.[30]
- Further streams should be to specialist beds (for complex speciality patients requiring greater than seventy two hour stays), beds for patients with complex discharge needs (e.g. the frail elderly) and catastrophic illness (e.g. critical care and stroke patients).
- Ambulatory emergency care should be provided where appropriate.

Acute Assessment Unit (AMU)

There is an issue with a lack of standard terminology across the country (they can also be known as Clinical Decision Units / Observation Units /Acute Medical Units / or Surgical Assessment Unit), which can lead to confusion as to what is being described and what the core function of these units is. The ownership, role and responsibility of all such units should be clearly defined and agreed by the clinical leadership of the trust. The Royal College of Physicians has set out a clear set of standards for medical assessment units; these have been supplemented recently with guidance on workforce and job planning.[31]

- When undertaking clinical duties on the AMU, the consultant should be free from any other specialty, ward or management commitments.
- Individual consultants' duties on the AMU should be for two or more consecutive days; any variation must be specifically designed to optimise continuity of care on the AMU.
- Appropriate diagnostic and support services should be provided seven days per week, to ensure that the full benefits of consultant delivered-care to patients are realised.
- During the period of consultant presence on AMU, all newly admitted patients should be seen within six to eight hours, with the provision for immediate review as required according to illness severity.
- A newly admitted patient must be seen by a consultant within 14 hours after arrival on AMU.

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[30] Focus on Short Stay: NHS Institute (2007) http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,192.html (accessed Jan 7th 2013)

[31] http://www.rcplondon.ac.uk/sites/default/files/documents/acute-care-toolkit-4.pdf (accessed 7th Jan 2013)

- All patients in the AMU should be reviewed twice each day by the AMU consultant or appropriate specialty team.
- Consultant presence on the AMU should start no later than 8am.
- Duration of an individual consultant's presence on the AMU should usually be between eight and 12 hours.
- Extended evening working until 10pm should be considered, depending on local patterns of patient referral and arrival.

The units should also ensure:

- It stays below 85-90% utilisation at all times so that it has capacity to care for the anticipated number of arrivals hour by hour.[32]
- Consultant-led rolling ward rounds to avoid batching patients to be seen on "set piece" ward rounds.
- Clear systems for patients requiring specialist care, so they can be cared for in the most appropriate setting as quickly as possible.
- A targeted discharge standard of all patients to be discharged by 1pm, to be reviewed at an 8am board round (anything beyond that would be regarded as a breach and attract the same root cause analysis as an emergency department breach).
- Standardised clerking documentation.
- "Home for Lunch" schemes, whereby the hospital gives patients written commitment to get them home for lunch on their day of discharge, and therefore to plan to move the patient from their bed to the discharge lounge early in the day; family members and carers are also alerted.
- Regular patient experience monitoring supported by performance information as the patient experience of these busy, noisy units is often very poor and patients often stay there for inappropriately long periods.

> The Surgical Assessment Unit at one trust had a clear patient cohort and it takes referrals from the emergency department and direct from GPs. The Unit is well supported, with a co-ordinator undertaking a nursing assessment and a junior doctor reviewing within 30 minutes. More senior support at middle grade or consultant level is easily accessible, with an operating list close by providing ready access if required. Access to diagnostics was good, with ring-fenced ultrasounds and reserved CT slots, duplex scanning and a set weekend consultant radiologist schedule. There are twice-daily board and safety rounds of each patient with a multi-disciplinary team present around the white board (scripted morning meeting at 9am focussing on actions required to discharge home, then a briefer handover meeting at 12pm). The estimated discharge dates are consultant-led and a discharge lounge available for "fit for discharge" patients.

[32] Planning for predictable flows of patients into unscheduled care systems beyond the Emergency Department: Meeting Demand and Delivering Quality. (February 2010) ECIST

Escalation beds

- Adding the capability to flex capacity has the risk of changing admission thresholds and the story of winter wards that prove impossible to close is well known. Solutions that allow capacity flex, without creating supplier-induced demand are required. The effective use of AMUs (that maintain approximately 15% free capacity) can mean specialities wards can operate at close to 100%.

Specialty Wards

- Ensure that a consultant sees all patients, and their care plans are confirmed, within two to three hours of admission to the ward (or a maximum of twelve hours if admitted out of hours), and sooner if the patient's clinical need requires it.
- Twice daily one-stop board-ward rounds should be the standard. Develop 'one stop ward rounds', where tasks such as completing a 'To Take Out' form and filling request forms are completed before the round moves onto the next patient (avoid batching work to the end of the round).
- Ward managers need to be supernumerary to coordinate and drive care.
- Schedule main ward rounds for the mornings, and see potential discharges first, so that beds are freed as early as possible.

Step down facilities

Look into establishing step down beds for patients awaiting complex care packages, and private funded nursing home patients deciding on placements. This would improve the flow of the hospital. Using community services or contract home care nursing providers for rapidly creating home care support also seems to be effective

Readmissions

Discharge planning, risk stratification of patients being discharged, support with medications and community and social care support are all well understood interventions in this area.

There have been some successful approaches to hospital led discharge teams, who provide continuity of care to patients in the first few weeks after discharge and have prevent readmissions. Another approach is to have a dedicated number for possible readmissions and access to a clinic for patients to come to and be reviewed by a consultant.

Discharge planning

- Every patient having a consultant-led expected date of discharge (EDD) completed within 12 hours of admission (a number of trusts have found specifying a morning discharge helps improve bed availability earlier).

- Care plans must include an EDD and criteria for discharge. Empower the multi-disciplinary team to discharge when criteria are met (particularly at weekends), rather than waiting for senior medical confirmation.
- There should be daily, early morning board rounds by a senior clinical decision maker (normally a consultant) to ensure that the care plan is on track.
- Schedule short board rounds for the mornings, and see potential discharges first, so that beds are freed as early as possible and those patients who are deteriorating are picked up early by a senior doctor.
- Clinical criteria for discharge recorded in each patient's notes.
- Any non-clinical change to the EDD should be captured separately and reviewed.
- Identify patients at risk of prolonged stay at an early stage using simple tools like the Blaylock assessment.[33]
- Manage planning for frail elderly people assertively to avoid in-hospital decompensation with associated prolonged stays. [34]
- Ensure services required for discharge are accessible at weekends.
- Co-locate social services staff with the discharge planning team in the hospital. Another option which has been effective is twice weekly conference calls with a strong chair and with decision makers present.
- Simplify the documentation and forms surrounding patient transfers.

System capacity and demand management

- Develop system wide predictive modelling based on demand and capacity utilising the national bed management tools.[35,36,37] Often the bed bureau / bed management office within trusts is operated by staff retaining knowledge in their heads and being reactive, rather than operating easy to understand systems that are aimed at increasing capacity up-stream.

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[33] Mistiaen. P., Duijnhouwer. E., Prins-Hoekstra. A., Ros. W., Blaylock. A. (1999) Predictive validity of the BRASS index in screening patients with post-discharge problems. Blaylock Risk Assessment Screening Score.
J Adv Nurs 1999, 30(5):1050-1056

[34] Effective Approaches in Urgent and Emergency Care. Paper 3. Whole system priorities for the discharge of frail older people from hospital care. (2012) ECIST

[35] Faster access: Bed management demand and discharge predictors (2004) Department of Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4091598 (accessed 26 November 2012)

[36] Planning for predictable flows of patients into unscheduled care systems beyond the Emergency Department: Meeting Demand and Delivering Quality. (February 2010) ECIST

[37] Demand and Capacity – Basic Concepts (2008) Institute for Innovation and Improvement http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/demand_and_capacity_-_basic_concepts.html (accessed 5th December 2012)

- Develop an agreed system wide escalation protocol that has input from all relevant stakeholders.
- Use a tool to predict the expected number of admissions – if anticipated admissions exceed expected bed availability, escalate early.
- Where there has been a spike in admissions systems to anticipate the following spike in demand for community and social care is requried
- Undertake demand and capacity management within primary care.
- Within the acute trust each specialty and supporting department should plan to match capacity to demand. Staffing rotas should be designed to match demand profiles. In general, focus on early assessment by senior and experienced staff to plan care is likely to be the most important step to reduce the unnecessarily long acute hospital stays which some patients endure. Experience of hospitals which have worked hard to follow the principles of best practice is that length of stay does fall substantially. More importantly perhaps, patient satisfaction increases and complaints fall. Critical incidents become less frequent and the safety of the patients in hospital is improved.[38]

[38] Planning for predictable flows of patients into unscheduled care pathways beyond the Emergency Department: Meeting Demand and Delivering Quality. (February 2010) ECIST

Tees Recovery and Sustainability Plans

July 2013

Introduction

Consistent delivery of high quality emergency care in a timely manner remains an elusive goal for Emergency Departments nationally. There are numerous key components of emergency care, as referenced in 'The drive for quality', these are imperative to ensure Emergency Departments can deliver both quality and timely assessment for those entering the A&E remit. However, recognition must be given that a holistic approach, encompassing all elements of the health economy is paramount to success.

The ability of A&E departments to provide a high quality patient experience, supported by the three strands of safety, clinical effectiveness and consistent system performance is dependent upon efforts locally to improve emergency medicine. Tees wide, there is a determination and commitment to improve Urgent Care as a whole. Collaborative working between Clinical Commissioning Groups (CCG), local Foundation Trusts and other partner agencies is allowing this direction of travel to progress at pace.

A recent report from the Kings Fund 'Urgent and Emergency Care: A review for NHS South of England' (2013) identifies learning from successful organisations and systems, and suggests how this can be used to improve and sustain performance in the future. The report contains a helpful emergency care system checklist that includes an outline of current approaches and processes that are known to improve emergency care performance and where possible supported by research evidence.

NHS England organised an event on 13th June 2013 to review emergency care which built on the Kings Fund Report report and considered potential approaches and improvements. At the event CCGs across the Area Team agreed to consider a collaborative approach to improve the Directory of Services, to share good practice around primary care support in residential and nursing care homes and to ensure that escalation processes are robust, consistent and understood in relation to NEEP plans. CCGs have agreed to work with Emergency Care Intensive Support Team (ECIST) in

September 2013 to share knowledge, learning and best practice across the local health economy.

Risk and Recommendations from the Francis Report

Risk and issues, including surges in demand such as winter will be managed initially by the Urgent Care Board to ensure mutual support is co-ordinated between health economies

The sustainability plans have been formulated giving due consideration of responses to the Francis report. All members of the Urgent Care Workstreams are responsible for providing assurance that all risks are mitigated and all safeguarding measures are in place which comply with the Francis recommendations.

Workload

The workload of the modern day A&E departments is high with 22% (33 out of 152) departments in the UK now reviewing in excess of 100,000 patients per year. Attendance rates are continually rising and this is evidenced across the Tees locality. Despite many initiatives to reduce demand on departments over the last few years, little sustainable progress has been made in impacting on the choices patients make and therefore attendances continue to rise.

Issues

The operational standard of 95% for patients being seen and admitted or discharged within 4 hours, in alignment with the NHS Constitution is designed to promote safe and timely assessment of those patients requiring medical attention. Historic delivery of the standard has been robust across the system as a whole in recent years, although there remains a recurring trend of weaker performance in Q3 and Q4 each year, driven mainly by winter pressures.

Despite significant analysis being undertaken to explore the cause, there is no single trend or factor to explain this. The main themes providers are citing are as follows; volume of activity and emergency admissions, acuity of patients (increase in co-morbidities, frail/elderly), patient flow (delayed discharges) and workforce capacity.

Local Context

Locally, both North Tees and Hartlepool NHS Foundation Trust and South Tees NHS Foundation Trust did meet the 95% target at year end for 2012/13 and therefore do not, in line with NHS England guidance (Gateway reference 00062), require recovery plans to be formulated. However locally we have been working in collaboration with both FTs to compile sustainability plans to offer assurance that should they experience any surge in activity they have appropriate measures to effectively deal with this. At quarter 1 of 2013/14 both Trusts met the 95% target as anticipated.

NHS 111 has been rolled out across the Tees CCG areas via a five year contract with NEAS. The service has four lead CCGs for the region and the contract management is provided via NECS.

The Urgent Care Board covers NHS James Cook University Hospital Accident and Emergency Department and NHS North Tees Hospital A and E. The Urgent Care Strategy for both CCGs highlights other urgent care provision within the localities.

Urgent Care – Hartlepool and Stockton CCG (HAST)

Historically urgent care projects have been managed within existing work streams, the approach undertaken by HAST in relation to urgent care for this year is to extract all

relevant urgent care projects from the existing workstreams and manage these projects in a focussed urgent care project group.

Both clinical and managerial leads will oversee the associated projects which will encompass both primary and secondary care. The Urgent Care strategy is currently being developed by the workstream leads. The terms of reference (appendix 1) for the project group have been devised and will be ratified imminently. The attached urgent care action plans (appendix 2) will supplement this section and clearly articulate the proposals for sustainability and further planning required for winter/surge.

Urgent Care – South Tees CCG

A dedicated work stream aligned to urgent care is well established, terms of reference (appendix 3) are in place and work has recently been undertaken to review these. Key stakeholders from both health and social care feature within the working group and there is close partnership working with the acute provider.

Both clinical and managerial leads will oversee the associated projects which will encompass primary and secondary care. The Urgent Care Strategy is being finalised and will be ratified imminently. The attached urgent care action plans (appendix 4) will supplement this section and clearly articulate the proposals for sustainability and further planning required for winter/surge.

Urgent Care Boards

Following publication of gateway ref: 00062, that sets out the requirement to develop an Urgent Care Board (UCB) for the local health community. Both CCGs have undertaken a review of existing locality based urgent care groups to assess compliance with this guidance.

This review has identified that within Tees existing arrangements do not comply with the guidance, however, there is a local Teeswide Integrated Urgent Care Network (TIUCN) which although is fit for current purpose will not suffice as an UCB. It has been agreed between HAST and South Tees CCG's that the TIUCN will be discontinued and replaced as an UCB. Both CCG's are in agreement that the chairing of this meeting will be undertaken by the clinical urgent care leads on a rotational basis.

Winter Planning – Delivery and Implementation

Urgent Care Boards are responsible for the co-ordination and production of winter capacity and escalation plans for their local health economy. To ensure the effective functioning and sustainability of urgent care systems, together with the delivery of NHS Constitution pledges and standards, local UCB's will seek assurance regarding the robustness of the collective integrated plans in order to prepare and manage through the winter period.

The Tees locality will develop winter plans encompassing and recognising the following:-

- Primary Care – Access, Out of Hours medical provision, Impact of 111, Developments within community services to offer alternative pathways of care
- Secondary Care – Operational bed management, Acute capacity, Critical Care, Diagnostic services, Ambulance handover times, Staffing of all disciplines
- Discharge Services – Utilisation of discharge lounges, Reduced delays of transfer, Discharge profiling across specialities, Community and Social Care support, Reablement

Both HAST and South Tees CCG's will continue their engagement and collaborative working with their respective acute providers to ensure service readiness. Testing of proposed plans will be undertaken within September and October 2013.

Conclusion

This paper, and the attached documentation, summarises the work being undertaken to ensure sustainable delivery of the 95% standard into the future. We will continue to robustly manage delivery and ensure appropriate arrangements are in place to support sustainable achievement of this standard alongside working to reform the urgent care system as a whole.

There is significant dedication and motivation to refine and enhance urgent care services within Tees and the promotion of the UCB will align to this. Although it is recognised that GPs are the navigators of the patient journey and therefore primary care is a key area of focus, collaborative working with all key stakeholders is essential to success. However if

underperformance occurs or contractual issues are raised, providers will be accountable to the CCGs.

There is willingness from both primary and secondary care to develop working relationships and ensure that appropriate reform to the urgent care system as a whole is possible.

Based on historical performance of our local trusts coupled with the action plans provided to date, both HAST and South Tees CCG has a high degree of confidence that the A&E standard will continue to be delivered over the coming months as we progress the development of the winter plans and associated performance framework.

Good Health - Everybody's business

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Urgent Care Project Group Terms of Reference

1. Purpose

1.1 The purpose of the Urgent Care Project Group is to support and drive the delivery of the Hartlepool and Stockton- on-Tees Clinical Commissioning Group (CCG) Clear and Credible Plan (CCP) and annual plan and to ensure delivery of QIPP.

1.2 Clinical leadership and locality input to plans and their delivery is fundamental and whilst some of the projects have been encompassed in wider programmes of work the overall drive for improvement in all areas is very definitely owned by the CCG's member practices through locality group members and outputs from the projects will be provided to member practices on a regular basis.

1.3 To develop and deliver a joint Urgent Care Strategy and oversee the portfolio of projects within this strategy that will;

- Ensure that urgent care services deliver high quality care, which are safe effective and meet local needs
- Ensure that urgent care services that are coherent and make sense to patients
- Ensure that urgent care services are responsive
- Ensure that urgent care services are integrated
- Ensure that urgent care services are cost effective

2. Roles

2.1 Ensure knowledge and understanding of urgent care commissioning requirements

2.2 Ensure clinical engagement in Commissioning of urgent Care

2.3 To strengthen System Wide relationships to ensure delivery of the urgent care strategy and improve patient outcomes and processes.

2.4 Ensure issues of quality and safety are considered and inform all urgent care work stream activity

2.5 Ensure co-ordination with other projects and work streams e.g. Out of Hospital Care relating to the GP practice variation in spend

2.6 To operate as a collaborative to co-ordinate and deliver agreed objectives by agreed timescales

2.7 Look at variation in use of Urgent Care; understand underlying cause e.g. patient flows and support improvement / development

2.8 Ensure consultation with localities and other stakeholders i.e. LA; health & Wellbeing Board

2.9 Ensure quality impact assessments are completed in respect of all business cases.

2.10 Make recommendations and support the development of business cases in response to the CCG Urgent Care Strategy

2.11 Group to seek assurance from local Health and Social Care organisations that they have prepared for the pressures that are placed on them during winter months. The assurance sought will cover all actions to identify organisational and system risks in all aspects of 'surge' i.e. critical care, pandemic flu, winter planning and immunisation and provide clear and auditable evidence.

2.12 To report and monitor progress of the Urgent Care projects

2.13 Group to provide support/solutions/facilitation to issues raised across the projects to ensure delivery and continued progress

3 Membership

3.1 The group will comprise of the following members:

- CCG GP In Hospital Care work stream lead (Chair)
- NECS In Hospital Care work stream manager lead
- NECS urgent care project leads and officers
- 111 GP Lead
- Service Providers:
    - NT&HFT (A&E, Emergency Assessment Unit, Operational Management)
    - GP representative for each of the Walk-in Centres
    - Minor Injury Unit
    - Community Services
    - North East Ambulance Service
    - NDUC Out of Hours
- Local Medical Committee representative
- Health & Wellbeing – LA/Public Health reprehensive?
- Hartlepool and Stockton Social Care Departments (as required only)
- Dental Committee (as required only)

Deputies will be identified to attend in the absence of a member

Other stakeholders will be asked to attend meetings as and when required

4. Administration and Agenda

4.1 Administration support will be provided by the CCG administration team for the collation of action points and agenda setting only for the monthly work stream meetings any other administrative support in relation to work stream projects would be provided by NECs.

4.2 The clinical lead will agree the agenda with the managerial work stream lead and provide the administrator these details to circulate to the project team

4.3 Agenda to be circulated to all work stream members one week prior to the meeting

4.4 Standing agenda items as a minimum for each work stream to include update on:

- Conflicts of Interest
- Progress reports for each work stream area against plan (template set out in Appendix B)
- Exception reporting
- Items for escalation (escalation and reporting set out in Appendix C)

5. Quorum

5.1 No business shall be transacted at a work stream meeting unless at least the work stream clinical lead or senior CCG manager (in the absence of the clinical lead) and work stream managerial lead or senior NECS manager (in the absence of the managerial Lead) are present

6. Frequency and Review

6.2 Project Group meetings will be held every four weeks unless otherwise agreed with the clinical and managerial leads

6.3 Terms of Reference to be reviewed annually

7. Remit and Responsibilities of the Group

7.1 To ensure coordination between work streams to rationalise and prioritise existing projects and actions, ensuring actions are measurable and manageable (SMART) and to avoid duplication of effort

7.2 To work with other clinicians, member practices, stakeholders and the public to review plans and determine implications for any service changes identified within projects and escalate changes to the relevant committee

7.3 To rigorously track progress of each project and produce progress and exception reports in relation to project actions and report to the In Hospital Care work stream group (see appendix c)

7.4 To identify gaps and develop intentions to progress for future commissioning plans and identify areas in year that may require non recurrent support (n/r), such areas

identified will require a business case to be developed to support release of the n/r support held by NHS England. And ensure any business cases are quality impact assessed

7.5 To identify any additional resource required to deliver projects

7.6 To ensure that the projects deliver high quality care which is safe, effective and meet local needs

7.7 To ensure issues of quality and safety are considered and inform all project activities

The Project Group will be clinically led and the clinician will be retaining overall responsibility in relation to delivery of the actions outlined within each project plan. The clinicians will be supported by the managerial lead and both parties will agree how they will manage business and delivery on a day to day basis outside of the monthly Project Group meeting**.**

8. Managing Conflicts of Interest

8.1 As required by section 14O of the National Health Service Act 2006, as inserted by section 25 of the Health and Social Care Act 2012 and set out in the Group's Constitution, the CCG will make arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made will be taken and seen to be taken without any possibility of the influence of external or private interest.

8.2 Where a member of the Group has an interest, or becomes aware of an interest which could lead to a conflict of interest in the event of the Group considering an action or decision in relation to that interest, that must be considered as a potential conflict and is subject to the provisions of the CCG processes for Standards of Business Conduct and Managing Conflicts of Interest.

8.3 A conflict of interest will include:

- A direct pecuniary interest: where an individual may financially benefit from the consequences of a decision;
- An in direct pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a decision;
- A non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commission decision;
- A non-pecuniary person benefit: where an individual may enjoy a qualitative benefit from the consequence of a decision which cannot be given monetary value;
- Where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.

8.4 If in doubt, the individual concerned should assume that a potential conflict of interests exists and consults the CCG's Standards of Business Conduct and Managing Conflicts of Interest.

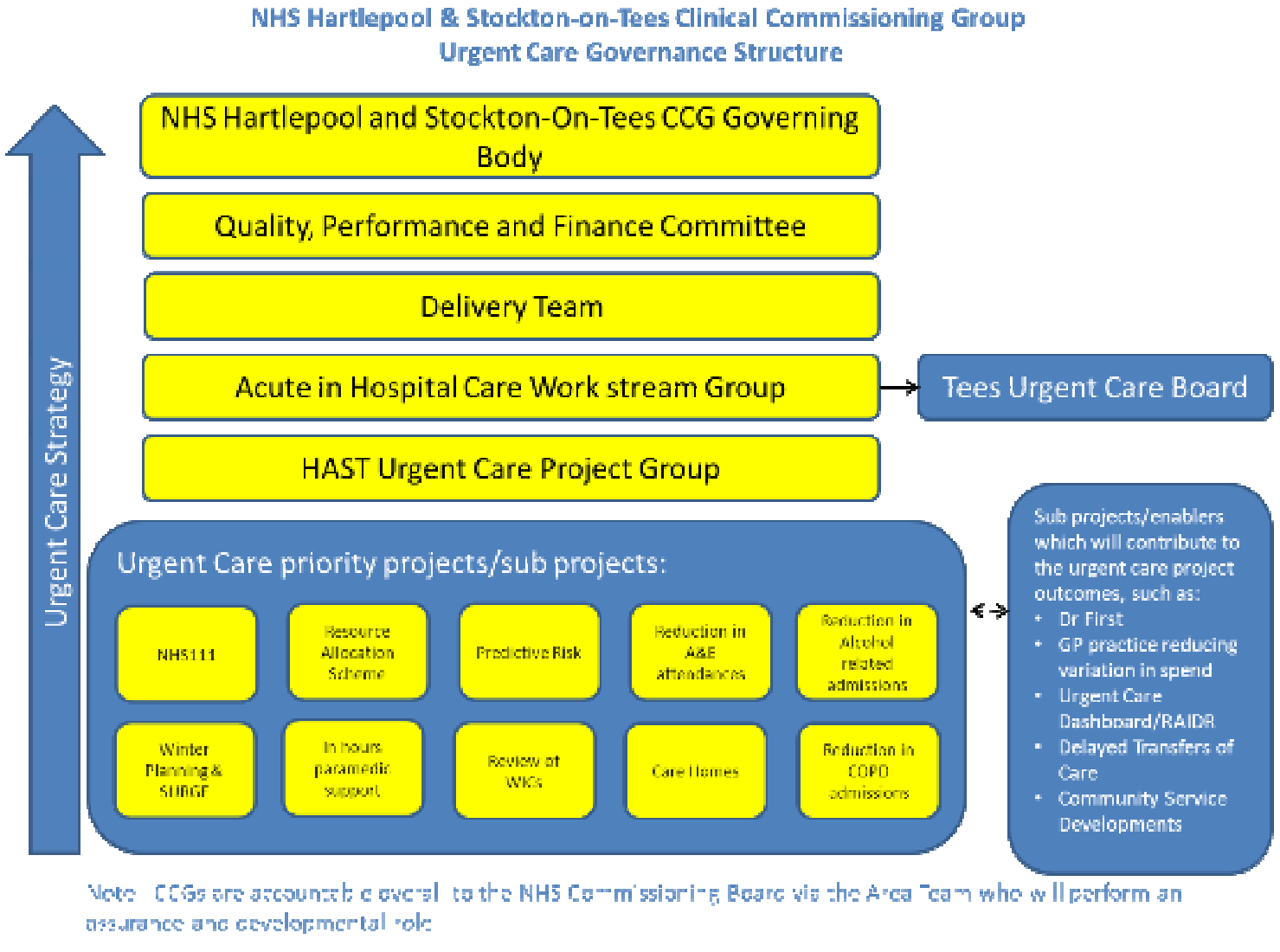
Appendix A

Project overview

Project	Clinical Lead	Managerial Lead	Support Officers
NHS111	Dr Peter Haywood	Nicola Jones/Sue Prout	n/a
Resource Allocation Scheme (RAS)	Dr Helen Murray	Jayne Robson	TBC
Predictive Risk: FT tool Risk profiling DES	Dr Helen Murray	 Julie Stevens TBC	 Yvonne Watson TBC
Reduction in A&E Attendances	Dr Helen Murray	Paul Whittingham	Iain Marley
Reduction in Alcohol related admissions	Dr Paul Pagni Dr Jonathan Berry	Deborah Ward	Sue Kirkham
Reduction in COPD admissions	Dr Paul Pagni Dr Jonathan Berry	Deborah Ward	Sue Kirkham
Care Homes	Dr Helen Murray	Paul Whittingham	Melissa Graham
Review of Walk-in-Centres	Dr Helen Murray	Deborah Bowden	Helen Metcalfe
In hours paramedic support	Dr Carl Parker	Nicola Jones	n/a
Winter Planning and SURGE	Dr Carl Parker	TBC	n/a

Appendix B – Progress Report Template – *TBC*

Appendix C – Urgent Care Governance



Note: CCGs are accountable overall to the NHS Commissioning Board via the Area Team who will perform an assurance and developmental role

Version Control

Version	Date	Name	Comments
1.0	15/5/13	Deborah Bowden	1st Draft circulated for comment

North Tees and Hartlepool NHS
NHS Foundation Trust

Appendix 2a

A/E Sustainability Plan

May 2013

The organisation has continuously been proactive in identifying issues affecting capacity and management of emergency admissions ensuring timely intervention to maintain performance and deliver a quality and safe service at all times. The Trust consistently achieves the four hour emergency care standard and the additional metrics including achievement of ambulance handover and turnaround times.

Work is continuously on going through a number of work streams and project groups to ensure the Trust maintains a proactive Trust wide approach in managing emergency and urgent admissions. The table below demonstrates measures and processes in place to facilitate this as well as further planned work. It is anticipated that a majority of the additional measures being explored would be ready for implementation by October 2013.

Flow within the hospital		
Factor	**Measures and Processes in Existence**	**Additional Measures Being Explored**
Ambulance Handover/Turnaround	• Clear process in place agreed with NEAS • Ambulance crew free to leave post handover once patient on hospital trolley/chair • Ambulance crews not expected to book patients in, this is done by A/E	• The Trust consistently achieves the 15min handover metric and does not have any issues or concern with delays in handovers or turnaround times. The measures in place are proving to be effective, the weekly monitoring would give early warning

	staff • Ambulance handover screen placed in central location • Weekly handover validation meetings between NEAS and Trust staff have been taking place for over 3 years to analyse and monitor any handover delays over 15mins. • Monthly NEAS and Trust Operational meeting held to explore any issues concerning ambulance related transfers and admissions. • Trust representation at regional "zero tolerance" meetings	signs of any adverse performance trends. • Currently NEAS are reviewing their reporting mechanisms to improve accuracy. The revised methodology used to produce the NEAS handover times has put the Trust's percentage compliance with this standard at risk. A meeting is being arranged between the Trust's A&E managers and NEAS to discuss the current data collection, validation and reporting procedures. An action plan will be developed to address any key issues identified from this meeting. • Meeting planned on 29th May with NEAS to discuss their reporting mechanisms
Majors Stream	• Consultant presence in A/E 7 days a week from 8am to 10pm aiding prompt initial senior clinical assessment • Direct admissions right to acute medicine • Established pathways for some conditions such as Neck of Femur fractures • Access to ambulatory care or Emergency assessment unit • Direct access to specialist opinion/referral via oncall teams • Mental health teams based in A/E at	• Exploring direct admission rights to all specialties • Majors nurse practitioners • Rapid extended triage for majors (nurse initiated cannulation, phlebotomy etc) • Rapid assessment stream • Explore additional pathways for ambulance admissions to have direct access to EAU • Readmissions reductions being explored • Working with HFMA and CCG to complete Heath opportunities

	specific times (RAID) • Twice daily board rounds increasing based on need. • Work in progress with nursing homes to reduce admissions to A/E	Assessment (HOA) this will be used to help inform work around integrating care.
Minors Stream	• Established ENP led separate minors stream with dedicated staffing • Established See and Treat model • Additional medical support 12:00 to 19:00 Saturday and Sunday	• Additional staff being trained to support both ENP succession planning and planned increase in numbers. • Paediatric Day Unit extended opening hours to accommodate winter surge, looking at potential future extension of peripatetic team.
Bed Management/Patient Flow	• 24/7 Patient flow/management team • Electronic patient tracking systems include Bed Management system and A/E patient tracking system • Daily use of recently updated bed predictor tool • Twice daily multi specialty bed meetings which include the presence of Manager on Call, staffing resource and delayed discharge teams. These meetings are increased based on need identifed through escalation process • Emergency assessment unit twice daily ward rounds • Meetings for different streams of work led through the internal	• Meetings to establish further support to A/E, improved escalation and leadership

	emergency collaborative to facilitate improved working and pathways	
Escalation	• Escalation Plans and measures in place • Organisation rehearsed in escalation management • Sessions delivered to staff to raise awareness of escalation procedures and responses required trust wide • Escalation plans reviewed each year post winter debrief and as part of winter planning • Internal emergency collaborative meetings to explore interdepartmental issues affecting escalation and flow	• Exploring sensitivity between levels of escalation • Planned simulated exercise for surge/capacity management which will reflect leadership from board to ward
Discharge	• EDD on admission • Daily consultant ward rounds or senior decision maker rounds • Emergency assessment unit 7/7 ward rounds to facilitate discharge and flow • Discharge planning steering group established to facilitate timely discharge of patients • Mapping event – multi stakeholder including social care and patient representative to identify blocks in the discharge process • Monthly discharge lounge utilisation	• 7/7 Nurse led discharge • Explore use of nurse practitioner and ward based pharmacist to aid improvements in timely production of discharge summary and prescription • Improved use of discharge lounges • Step down facility –increase in community beds • Review of processes between social care and trust • Explore discharge planning at preassessment for all elective patients to prevent unnecessary delays when medically fit

	reports to monitor use • Reablement plans in place • Continuing care procesess being reviewed	• Explore replicating therapy model used in A/E and EAU for wards to facilitate speedier discharge • Explore effectiveness of directory of services to aid admission prevention • The Trust currently has a number of long term condition pathways which are being reviewed to improve both efficiency and patient quality such as: Stroke, Diabetes, Respiratory, Elderly, Neurology and Parkinson's.
Analysis	• Daily sitreps produced showing ED breaches or capacity issues to aid early intervention • Weekly ED performance reports produced • Fortnightly Emergency Care Target meeting held to explore issues impacting on capacity and flow • Breach root cause analysis instigated if identified as necessary • Daily analysis of delayed discharges	
Staffing	• Staffing establishment has been reviewed in A/E • Vacancies are advertised and recruited to promptly • Staffing numbers are reviewed and increased to facilitate surge management	

NHS Hartlepool & Stockton-on-Tees CCG - A&E Sustainability Plan **Appendix 2b**

2013/14 Projects that will contribute to a reduction in A&E attendances and emergency admissions

Project	Clinical Lead	Workstream Lead	Project Lead	Action	Timescales
Winter Planning & Surge	Dr Carl Parker	Sharon Tolputt	Helen Metcalfe	1. Learn lessons from 2012/13 2. Ensure winter planning is within Urgent Care Strategy (strategy to include Vision, current services and future preferred model) 3. Ensure winter plans are completed for all organisations 4. Daily & Weekly calls. Multi agency management	30th September 2013 4. 31st March 2014
OOHs paramedic support	Dr Carl Parker	Nicola Jones		1. Review pilot 2. Present outcomes and propose options	1. 30th June 2013
111	Dr Carl Parker	Nicola Jones/Sue Prout		1. continually review implementation 2. ensure that primary care and secondary care individuals complete the Health Care Professional Feedback Form should an issue arise that they would like investigating	1. Ongoing 2. 31st March 2014
Care Homes	Dr Helen Murray	Paul Whittingham	Melissa Graham	1. Develop pilot and offer to practices across Tees 2. Pilot completion of EHCPs within nursing homes 3. Review feedback and develop report with recommendations 4. Present Report to CCG via Delivery Team 5. Develop plan for roll-out or alternative approach	1. Complete 2. 31st March 2013 3. 31st May 2013 4. 12th June 2013 5. 30th June - 31st March 2013

Project	Clinical Lead	Workstream Lead	Project Lead	Action	Timescales
Adult Community Services Model - review and evaluation	Dr Mike Smith	Paul Whittingham	Julie Stevens	During 2012/13 the CCG worked closely with North Tees and Hartlepool NHS Foundation Trust to develop a model of care to improve outcomes for patients. Particular emphasis has been placed on avoiding unnecessary admissions to hospital, providing more care closer to home and improving communications between practices and community services. Teams Around Practices (TAPS), community nursing teams formed around and covering more than one practice went live in October 2012. The Community Integrated Assessment Team (CIAT) comprising of therapy and nursing staff who work within community but also provide an in-reach service supporting a safe and timely discharge also went live in October 2012. Finally, the Single Point of Access (SPA) a dedicated team responsible for dealing with all new referrals and patient queries went live on the 1st of December 2012. A review of the new community services model (TAPS/CIAT/SPA) to determine effectiveness of this and to inform future commissioning arrangements will take place as follows: 1. Trust issued with KPIs for community services model 2. Evaluation to be presented to the CCG via a final Community Services Meeting	1. 30th April 2013 2. 18th June 2013 3. 18th June 2013 4. 19th July 2013 5. 31st July 2013 6. 30th September 2013
Trust - Predictive Risk Tool (re-admissions)	Dr Helen Murray	Paul Whittingham	Yvonne Watson	1. Receive a report from the Trust on the tool they recommend 2. Agree with the Trust the most appropriate predicative tool via CCG Delivery Team 3. Trust to develop an implementation plan for roll-out of the tool on wards and nursing visits 4. Evaluation report against KPIs to be submitted to CCG via Delivery Team	
GP Practice - Risk Profiling Enhanced Service	Dr Helen Murray	Paul Whittingham		1. CCGs will seek to invite and agree arrangements with GP Practices under the enhanced service by 30th June 2013 2. Where CCGs do not have an existing agreement in place with GP Practices for 2013/14 they will offer on behalf of the NHS CB, an enhanced service agreement that is consistent with the minimum requirements and funding detailed in the NHS CB specification 3. Where CCGs do have an existing local agreement in place with GP Practices for 2013/14 they will offer on behalf of the NHS CB either: a) an enhanced service agreement that supplements the existing local agreement with the aim of providing additional activity/ benefits that are proportionate to the available funding; or, b) (if GP practice agree) they can replace the existing local agreement with this enhanced service and use the local funding they would otherwise have invested in a manner that is agreed locally 4. Notify the NHS CB of participating GP Practices by 31st August 2013 so that the NHS CB can make payments under this enhanced service	1. 30th June 2013 4. 31st August 2013

Project	Clinical Lead	Workstream Lead	Project Lead	Action	Timescales
QOF	Dr Helen Murray	Paul Whittingham	Melissa Graham	1. Identify 6 pathways for the Quality and Productivity (QP) indicators, 3 of which to relate to non-elective care 2. Practices to work in clusters to identify actions in relation pathway changes and share best practice 3. Practices to complete an A&E plan with a focus on improving primary care access	1. 30th September 2013 2. 31st March 2014 3. September 2014
Resource Allocation Scheme (RAS)	Dr Helen Murray	Paul Whittingham			
Practice Support/GVIS/ GP Variation	Dr Helen Murray	Paul Whittingham	Katie Davis	1. Continued production/ circulation of practice reports - GVIS, Performance Reports, individual practice one-page reports 2. Continued practice benchmarking against evidence based practice e.g. GVIS reports, Map of Medicine, NICE etc. 3. Continuation of practice support and associated practice visits	
Doctor First	Dr Helen Murray	Paul Whittingham	Helen Metcalfe	1. All 12 current Doctor First practices to have 'gone live' 2. Evaluate and present recommendations to the CCG via Delivery Team 3. Implementation any recommendations	1. 31st August 2013 2. 31st October 2013 3. 31st March 2014
Urgent Care Clinical Dashboard	Dr Helen Murray	Paul Whittingham		1. Continue to encourage usage of the dashboard, capture best practice and monitor usage	1. May 2013 7. May 2013 9. June 2013 10. July 2013
Review of urgent care walk-in capacity	Dr Helen Murray	Paul Whittingham	Deborah Bowden/Helen Metcalf	1. Define scope of service review and specific objectives 2. Organise contract review team meetings 3. Identify information requirements, sources and responsibility for gathering information 4. Commence and conduct data collection 5. Finalise agreed TOR, scope, objectives responsibilities 6. Share and discuss findings with review team 7. Review all collected data and information 8. Commence service review report 9. Finalise service review report, presenting options for future commissioning 10. Final Report presented to CCG DT for discussion	1. 31st May 2013 2. 31st May 2013 3. 30th November 2013 4. 31st December 2013 5. 31st March 2014

Project	Clinical Lead	Workstream Lead	Project Lead	Action	Timescales
Reduction in A&E attendances (inc. A&E Triage)	Dr Helen Murray	Paul Whittingham	Paul Whittingham	1. Agree format of baseline assessment and undertake this to identify patient behaviour in the use of A&E (L4/5 category) 2. Implement increase signposting in A&E to alternative urgent services where appropriate 3. Develop local pathway for triage including proposed working arrangements with other Providers (NDUC/WIC) and potential tariff based payment for this assessment and triage 4. Share pathway with CCG for approval 5. Agree roll out plan for new pathway	1. 31st May 2013 2. 31st May 2013 3. 30th November 2013 4. 31st December 2013 5. 31st March 2014
Increase in brief interventions and reduction in alcohol related A&E attendances and admissions	Dr Paul Pagni & Dr Jonathan Berry	Deborah Ward	Hartlepool LA/ PH Lead - Louise Wallace Stockton LA/ PH Lead - Sarah Bowman NECS - Sue Kirkham	1. Complete evaluation of Public Health Transformational Alcohol Worker 2. Complete baseline of alcohol related admissions 3. Outcome measures for (KPI's for current providers). Revised measures to be negotiated into current contracts 4. Alcohol DES and LESs to be reviewed 5. Data to be shared on the use of the alcohol tool at practice level 6. Work with Public Health in relation to delivery of the alcohol strategy and determine future requirements for commissioned services	1. 30th June 2013 2. 31st May 2013 3. 31st July 2013 4. 31st July 2013 5. 31st May 2013 6. 31st March 2014
COPD Admissions	Dr Paul Pagni & Dr Jonathan Berry	Deborah Ward	Sue Kirkham	1. Need to determine best method of delivering training for staff 2. Standardise primary care response to the management of COPD patients, focusing on variation against best practice 3. Commission a bespoke education package intended for patients living with COPD. 4. Provide supportive for general practice to utilise to improve the management of patients with COPD (i.e.. use of Telehealth) 5.Utilise CQUIN to promote smoking cessation to patients via an acute setting and/or offer NRT therapy upon admission 6. Increase the number of patients provided with self-management packs. 7.Increase Flu Vacs for COPD patients 8. Increase number of smokers who are given NRT treatment when admitted	1. 31st September 2013 2. 31st September 2013 3. 31st September 2013 4. 31st August 2013

5.1 Appendix B
Appendix 3

NHS
South Tees
Clinical Commissioning Group

Urgent Care Work Stream

Terms of reference

1. **Purpose**

To develop and deliver a joint Urgent Care Strategy and oversee the portfolio of projects within this strategy that will;

- Ensure that Urgent Care services deliver high quality care, which are safe effective and meet local needs
- Ensure that Urgent Care services that are coherent and make sense to patients
- Ensure that Urgent Care services are responsive
- Ensure that Urgent Care services are integrated
- Ensure that Urgent Care services are cost effective

2. **Remit**

- Ensure knowledge and understanding of Urgent Care Commissioning requirements
- Ensure clinical engagement in Commissioning of Urgent Care
- To strengthen system wide relationships to ensure delivery of the Urgent Care Strategy and improve patient outcomes and processes.
- Ensure issues of quality and safety are considered and inform all Urgent Care Workstream activity
- Ensure co-ordination with other projects and work streams e.g. alignment to the IMProVE Strategic Outline Case and Delivery Programme.
- To operate as a collaborative to co-ordinate and deliver agreed objectives by agreed timescales
- Look at variation in use of Urgent Care; understand underlying cause e.g. patient flows and support improvement / development
- Ensure consultation with localities and other stakeholders i.e. LA; Health & Wellbeing Board
- Ensure quality impact assessments are completed in respect of all business cases.
- Make recommendations and support the development of business cases in response to the CCG Urgent Care Strategy
- Group to seek assurance from local Health and Social Care organisations that they have prepared for the pressures that are placed on them during winter months. The assurance sought will cover all actions to identify organisational and system risks in all aspects of 'surge' i.e. critical care, pandemic flu, winter planning and immunisation and provide clear and auditable evidence.
- To allow reporting and monitoring of progress across the Urgent Care Workstream projects
- Group to provide support/solutions/facilitation to issues raised across the work stream projects to ensure delivery and continued progress
- 111
  - To raise any locality issues to the regional 111 Clinical Governance Group
  - Ensure multi agency / provider clinical discussion
  - Agreement of Pathway Reform
  - Propose variations to 111 contract
  - Review of Urgent Care SUIs

3. **Membership**
Membership will consist of the following or nominated deputies
   - CCG Urgent Care Workstream Lead – Dr Mike Milner
   - CCG Urgent Care Workstream Projects Leads – Sharon Tolputt / Helen Metcalfe
   - 111 GP Lead for STEES CCG – Dr Peter Heywood
   - Service Provider
     - STHFT (A&E, Emergency Assessment Unit, Operational Management)
     - 1 GP representative for all South Tees CCG GP led Health Centres
     - Minor Injury Units
     - Urgent Care Centres
     - Community Services
     - North East Ambulance Service
     - NDUC Out of Hours
   - Commissioning and project support via NECS
   - Middlesbrough and Redcar & Cleveland Council Social Care Departments
   - Local Medical Committee representative
   - Health & Wellbeing
   - Dental Committee (as required only)

4. **In attendance**
Other attendees will be invited as required, depending upon the agenda.

5. **Quoracy**
A quorum of the Committee shall be four members consisting of;
   - CCG
   - NECS
   - Service Provider(s)

6. **Frequency of meetings**
Meetings will be held monthly and the Terms of Reference will be reviewed every 6 months.

7. **Reporting Arrangements**
   - The CCG Work Stream lead is responsible for reporting to the South Tees CCG Operational Group
   - Recommendations and areas for consideration will be included in reports presented to the South Tees Operational Group.
   - All Reports will be produced by North of England Commissioning Support.
   - Appendix 1 shows the Urgent Care Governance Structure.
   - The workstream will be represented at the Tees Urgent Care Board.

8. **Standard Agenda Items (To be finalised)**
   - Conflicts of Interest
   - 111
   - Progress report on work stream projects using the attached template

Project Update
Template - June 201

9. **Probity**
Each member of the group is required to declare any personal or pecuniary interest (direct or indirect) in any agenda items for discussion and shall take no part in the discussion or

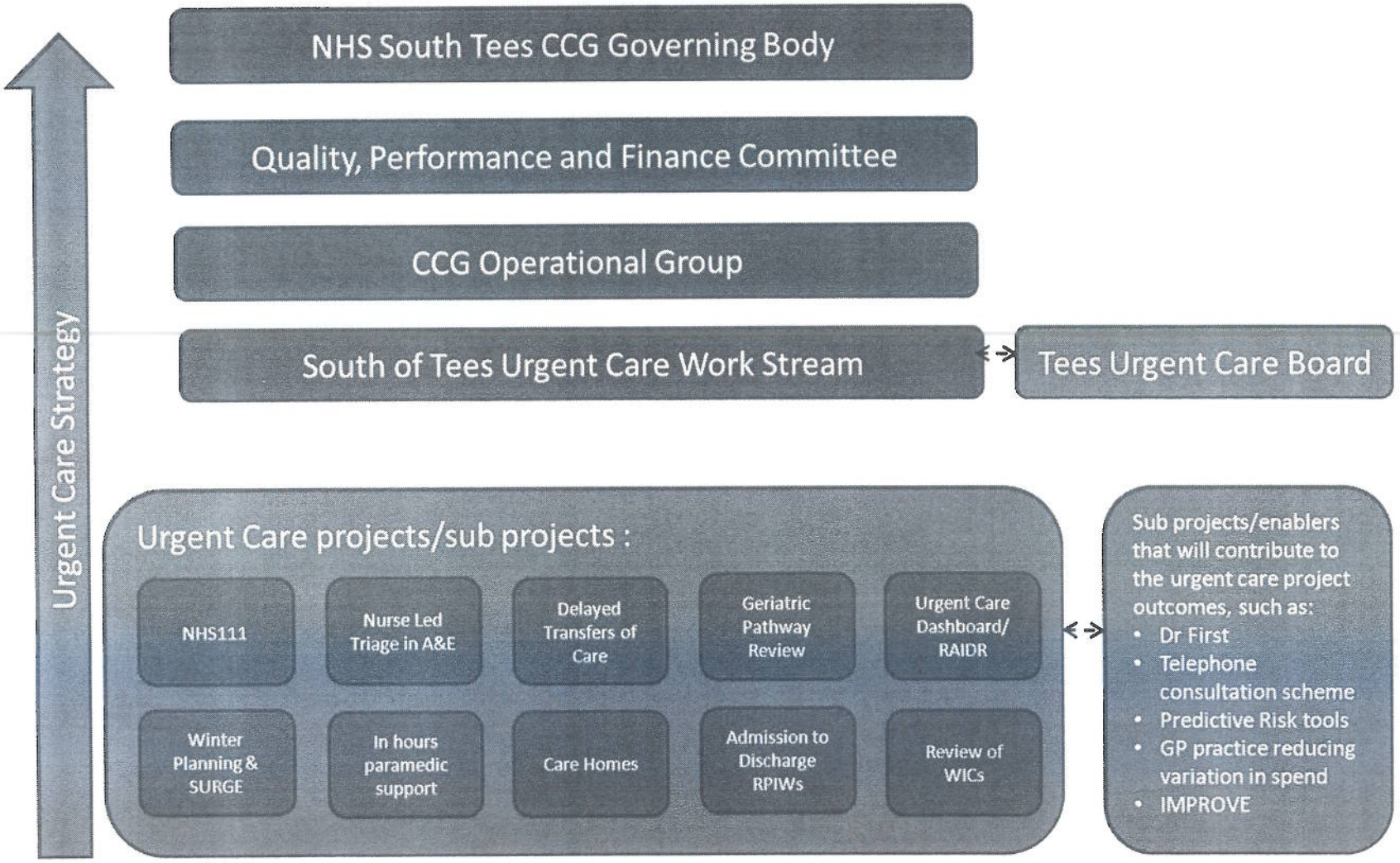
decision-making on that item. Ultimately, the responsibility for decision making regarding Urgent Care Services is the South Tees Clinical Commissioning Group.

1. Version control

Version	Date	Name	Comments
1.0	30.1.13	Richard Harrety	First draft circulated for comment
2.0	31.1.13	Julie Stevens	Amendment for alignment to SOC
3.0	03.5.13	Helen Metcalfe	Amendment as per 27/3/13 Urgent Care Workstream meeting
4.0	28.7.13	Helen Metcalfe	Amendment for alignment to new NECS processes.

Appendix 1

South Tees CCG Urgent Care Governance Structure



Note - CCGs are accountable overall to the NHS Commissioning Board via the Area Team who will perform an assurance and developmental role

South Tees Hospitals NHS Foundation Trust A & E Action Plan – Updated May 2013

Issue	Action	Responsible Key Leads	Comments/Completed – Yes/No
Escalation between A & E team and Corporate Bed Management Team (CBMT)	Improve methods of communicating when patients requiring admission are within their last 60 minutes of breaching Ensure all parties are compliant with the escalation process.	A & E Directorate Manager Lead Nurse, CBMT	The CBMT are revisiting the escalation process on 6/2/13 to ensure all staff are consistent and compliant with the escalation policy. All patients who are in the last 60 minutes of breaching are escalated to the CBMT or in working hours to the relevant specialty teams. All communication is recorded in the A&E patient flow record. Action completed in the current work time of 9am to 9pm. Trust to explore 24 hour cover action date July 2013
CBMT to facilitate the increase in available bed capacity earlier in the day	Earlier during the morning, review the potential outlying patients to create acute medical beds	Lead Nurse, CBMT	Action completed The working practice of the CBMT has been reviewed. The site sisters will visit all medical wards to acquire patients for discharge and expedite the discharge. The patient flow co-ordinator will visit the remaining wards to highlight beds available to outlie patients into. This process will be completed between 9am and 12noon.
Identify suitable patients to outlie in order to support the increase in available bed capacity	Directorate Manager to attend wards early morning to check for suitable patients to outlie. This information to be communicated to the CBMT before 10.30 a.m.	Directorate Managers, Acute Medicine	Action completed The directorate managers in medicine have stopped completing this process and it has reverted back to the old process of the wards faxing the information. Further discussion with the Divisional Manager for Acute Medicine is being arranged to discuss the best way forward.
Centralise surgical bed management to improve flexibility of CBMT and infrastructure	Business case to be developed to seek approval for any additional costs associated with the centralisation of surgical bed management	Divisional Manager for Surgery Head of Performance Management	Meeting has already taken place and options proposed, business case written. Implementation date :1/09/2013

		Lead Nurse, CBMT	
Transfer of patients direct from A & E to an acute medical ward bypassing AAU	CBMT to work with the A & E medics for clinically suitable patients	A & E Clinical Director Lead Nurse, CBMT	This action is completed for daytime (Mon – Fri between the hours of 09.00 and 16.00.) This still only occurs on rare occasions. Although this was agreed previously, further work on the process with clinical/medical teams is required in order to accept direct admissions ensuring patient care is not compromised. Final completion date 1/10/2013
Review the processes for recording information electronically to ensure an accurate record of outlying patient information is available as current practice is not robust	Explore whether E-Camis could be used to produce electronic list of identified outliers	Lead Nurse, CBMT IT and Systems Development Team	Ongoing process Final Action date: 1/09 2013
Review the efficiency and effectiveness of the CBMT to identify a suitable bed within the 4 hour target	Undertake an audit of all December breaches attributed to 'bed wait' as the reason and provide analysis	Lead Nurse, CBMT Head of Performance Management	Action completed
Representation and interaction by CBMT at the weekly A & E breach meetings	CBMT to ensure there is always representation at the weekly breach meetings held in the A & E department and to ensure any ongoing issues relating to CBMT processes and systems are resolved. Feedback mechanisms from the A & E weekly breach meetings to be formalised within the CBMT team to ensure opportunity for appropriate discussion and awareness of issues across the full team.	Lead Nurse, CBMT Head of Performance Management	Action completed Weekly breach meeting is in both the Lead Nurse and Head of Performance Mgt diaries. Monthly team meetings for CBMT are in place and the A & E breach meetings will be a regular agenda item.

Increase CBMT resources throughout the Q4 period.	An additional Band 7 Site Sister will be on duty on Sundays and Mondays throughout January, February and March to support the current infrastructure in the CBMT at busier times.	Lead Nurse, CBMT Head of Performance Management	Action completed This was in place for the Q4 period. CBMT are reviewing the need for this arrangement for 8 hour shifts during the week/weekend for the next coming year. A proposal has been submitted.
The purpose of bed management should be confirmed as supporting flow models - the aim is to get the right patient into the right bed without delay.	Revise bed management policy and standard operating procedures.	Lead Nurse, CBMT Head of Performance Management	Implementation date 1/7/2013 The bed mgt policy has been revised and approved. Standard Operating Procedures (SOPs) incorporate the flow models from an operational perspective and are more detailed than the policy. To be approved at Formal Management Group in June 2013.
Bed managers should all be trained to use Camis effectively to support bed management processes.	Ensure appropriate processes and systems are in place for training and refresher training on the PAS system.	Lead Nurse, CBMT	Action completed All staff currently employed within the corporate bed mgt team have received training on CAMIS and there is a training procedure in place for new starters and those returning from having a period of time away from work. The corporate bed mgt team work in collaboration with IT & Health Care Records Directorate for this. Applying the theory and using test patients is quite different to putting this into 'live' practice and we recognise this can be challenging at times for staff when they are under constant pressure. Therefore, to ensure the process is robust, this element will be discussed with existing staff as part of their yearly SDR. Refresher training will be recommended if this is highlighted as a performance issue. This does not necessarily need to wait until an SDR if such performance issues are highlighted earlier (before the SDR is due).
Ambulances queues CQI	Need to ensure that flow within the department is sustained and escalation policy followed. Patients triaged who can be moved to the waiting area for S&T	Shop floor consultant. Nurse co-coordinator All senior staff	Review date as part of funding plan by 1/09/2013 All ambulance patients triaged and observations recorded as appropriate, escalation to NEAS and YAS when delays are

	or clinical assessment area. See and treat majors model Sat, Sun Mondays Nurse Practitioner support		occurring. Consultant on call review patients in the queue. See and treat majors model improves patients flow when there is capacity in the department of the process to take place. Senior decision making and fast access to diagnostics allows for early intervention and discharge decisions. However this is currently only over 3 days of the week. The model allows the shop floor consultant to manage the resus area without impacting directly on the majors area in the short term. (This ends March 31 2013) Nurse practitioner roles support the medical team and clerking of patients whilst improving the patient pathway, and expediting discharges. (This model was supported by non-recurrent funding)
Supported discharge	A&E therapies team	Case management team A&E staff	Action completed-pilot in operation Improved discharge from A&E for patients who require therapy support. Effective for supported discharge according to the activity figures.
Total time in department	Weekly breaches meetings	Directorate manager Senior sister A&E	Action completed Improvements in communication for breach reasons and sharing information and analysis. Feedback for specialties for recurrent breaches who are then taking the information back to discuss with teams to improve pathways and response times. Improvements in communication mean that specialty breaches are investigated thoroughly and are actioned appropriately as necessary.
Specialty patients referred directly to department	Feedback to relevant specialty when inappropriate referrals made	Clinical and nursing teams	Action completed, monitoring of performance at weekly breach meetings A&E Clinical team to ensure that specialty teams follow correct pathways and give feedback to them when there are deviations.
Improvements in communication within the nursing team	Twice daily huddles with the nursing team	Nursing team	Action completed Discuss workload, performance and challenges. Issues that impact upon the daily working practices. Any new processes etc. Ongoing and very informative.

Medical cover in the department	Review and revision of the medical rota to ensure that there is more senior cover at critical times in the department	Clinical Director CoS Divisional manager	1/9/2013 Improved consultant cover at busy periods to ensure that patients who require resus are managed appropriately without the majors area being depleted of medical staffing to maintain flow and processing.
RPIW	A front of house RPIW is being scoped in partnership with the CCG.	Deputy Director of Transformation	1/10/2013 Scoping workshop scheduled for June 3 2013. Full RPIW to take place 15th July.
Internal diverts	A proposal has been put forward by the A&E team to change the flow process with the trust.	Medical Director	1/9/2013 This will be discussed by the Chiefs of Service May 29 2013.
Improving delayed discharges	Several day-out workshops (RPIW style) have been organized for staff to improve and escalate the work on delayed discharges. This includes information provided by case managers on reasons for delayed discharges	Gill Collinson Julie Poultney	Expected completion: 1/10/2013 Action in progress. 3 wards have finished these days with positive feedback. A further 20 wards have been scheduled

NHS South Tees CCG - A&E Sustainability Plan **Appendix 4b**

2013/14 Projects that will contribute to a reduction in A&E attendances and emergency admissions

Project	Clinical Lead	Workstream Lead	Project Lead	Action	Timescales
Winter Planning & Surge	Dr Ruth Johnson	Sharon Tolputt	Helen Metcalfe	1. Learn lessons from 2012/13 2. Ensure winter planning is within Urgent Care Strategy (strategy to include Vision, current services and future preferred model) 3. Ensure winter plans are completed for all organisations 4. Daily & Weekly calls. Multi agency management	30th September 2013 4. 31st March 2014
OOH paramedic support	Dr Ruth Johnson	Nicola Jones		1. Review pilot 2. Present outcomes and propose options	1. 30th June 2013
111	Dr Ruth Johnson	Nicola Jones/Sue Prout		1. continually review implementation 2. ensure that primary care and secondary care individuals complete the Health Care Professional Feedback Form should an issue arise that they would like investigating	1. Ongoing 2. 31st March 2014
Care Homes	Dr Vaishali Nanda	Paul Whittingham	Melissa Graham	1. Develop pilot and offer to practices across Tees 2. Pilot completion of EHCPs within nursing homes 3. Review feedback and develop report with recommendations 4. Present Report to CCG via Delivery Team 5. Develop plan for roll-out or alternative approach	1. Complete 2. 31st March 2013 3. 31st May 2013 4. 12th June 2013 5. 30th June - 31st March 2013
Trust - Predictive Risk Tool (re-admissions)	Dr Ruth Johnson	Julie Stevens	Yvonne Watson	1. Receive a report from the Trust on the tool they recommend 2. Agree with the Trust the most appropriate predicative tool via CCG Delivery Team 3. Trust to develop an implementation plan for roll-out of the tool on wards and nursing visits 4. Evaluation report against KPIs to be submitted to CCG via Delivery Team	

Project	Clinical Lead	Workstream Lead	Project Lead	Action	Timescales
GP Practice - Risk Profiling Enhanced Service	Dr Ruth Johnson	Julie Stevens	Yvonne Watson	1. CCGs will seek to invite and agree arrangements with GP Practices under the enhanced service by 30th June 2013 2. Where CCGs do not have an existing agreement in place with GP Practices for 2013/14 they will offer on behalf of the NHS CB, an enhanced service agreement that is consistent with the minimum requirements and funding detailed in the NHS CB specification 3. Where CCGs do have an existing local agreement in place with GP Practices for 2013/14 they will offer on behalf of the NHS CB either: a) an enhanced service agreement that supplements the existing local agreement with the aim of providing additional activity/ benefits that are proportionate to the available funding; or, b) (if GP practice agree) they can replace the existing local agreement with this enhanced service and use the local funding they would otherwise have invested in a manner that is agreed locally 4. Notify the NHS CB of participating GP Practices by 31st August 2013 so that the NHS CB can make payments under this enhanced service	1. 30th June 2013 4. 31st August 2013
QOF	Dr Vaishali Nanda	Dee Ward	Melissa Graham	1. Identify 6 pathways for the Quality and Productivity (QP) indicators, 3 of which to relate to non-elective care 2. Practices to work in clusters to identify actions in relation pathway changes and share best practice 3. Practices to complete an A&E plan with a focus on improving primary care access	1. 30th September 2013 2. 31st March 2014 3. September 2014
Practice Support/GVIS/ GP Variation	Dr Vaishali Nanda	Dee Ward	Melissa Graham	1. Continued production/ circulation of practice reports - GVIS, Performance Reports, individual practice one-page reports 2. Continued practice benchmarking against evidence based practice e.g. GVIS reports, Map of Medicine, NICE etc. 3. Continuation of practice support and associated practice visits	
Doctor First	Dr Vaishali Nanda	Paul Whittingham	Helen Metcalfe	1. All 12 current Doctor First practices to have 'gone live' 2. Evaluate and present recommendations to the CCG via Delivery Team 3. Implementation any recommendations	1. 31st August 2013 2. 31st October 2013 3. 31st March 2014
Urgent Care Clinical Dashboard	Dr Mike Milner	Nicola Jones	Paul Whittingham	1. Continue to encourage usage of the dashboard, capture best practice and monitor usage	1. May 2013 7. May 2013 9. June 2013 10. July 2013

Project	Clinical Lead	Workstream Lead	Project Lead	Action	Timescales
Review of urgent care walk-in capacity	Dr Mike Milner	Nicola Jones	Deborah Bowden/Helen Metcalfe	1. Define scope of service review and specific objectives 2. Organise contract review team meetings 3. Identify information requirements, sources and responsibility for gathering information 4. Commence and conduct data collection 5. Finalise agreed TOR, scope, objectives responsibilities 6. Share and discuss findings with review team 7. Review all collected data and information 8. Commence service review report 9. Finalise service review report, presenting options for future commissioning 10. Final Report presented to CCG DT for discussion	1. 31st May 2013 2. 31st May 2013 3. 30th November 2013 4. 31st December 2013 5. 31st March 2014
Reduction in A&E attendances (inc. A&E Triage)	Dr Mike Milner	Nicola Jones	Iain Marley/Helen Metcalfe	1. Agree format of baseline assessment and undertake this to identify patient behaviour in the use of A&E (L4/5 category) 2. Implement increase signposting in A&E to alternative urgent services where appropriate 3. Develop local pathway for triage including proposed working arrangements with other Providers (NDUC/WIC) and potential tariff based payment for this assessment and triage 4. Share pathway with CCG for approval 5. Agree roll out plan for new pathway	1. 31st May 2013 2. 31st May 2013 3. 30th November 2013 4. 31st December 2013 5. 31st March 2014
Front of House RPIW	Dr Mike Milner	Nicola Jones	Deborah Bowden	1. Scope the RPIW for Front of House (FT, CCG/NECS and NETS) 2. Conduct RPIW 3. Implement actions from RPIW	1. June 2013 2. July 2013 3. October 2013 (30/60/90 days following RPIW)
Increase in brief interventions and reduction in alcohol related A&E attendances and admissions	Dr Steve McIlhinney	Deborah Ward	Middlesbrough LA/ PH Lead - David Jackson Redcar and Cleveland LA/ PH Lead - Vicky Whelan NECS - Sue Kirkham	1. Complete evaluation of Public Health Transformational Alcohol Worker 2. Complete baseline of alcohol related admissions 3. Outcome measures for (KPI's for current providers). Revised measures to be negotiated into current contracts 4. Alcohol DES and LESs to be reviewed 5. Data to be shared on the use of the alcohol tool at practice level 6. Work with Public Health in relation to delivery of the alcohol strategy and determine future requirements for commissioned services	1. 30th June 2013 2. 31st May 2013 3. 31st July 2013 4. 31st July 2013 5. 31st May 2013 6. 31st March 2014

Project	Clinical Lead	Workstream Lead	Project Lead	Action	Timescales
COPD Admissions	Dr Steve McIlhinney	Deborah Ward	Sue Kirkham	1. Need to determine best method of delivering training for staff 2. Standardise primary care response to the management of COPD patients, focusing on variation against best practice 3. Commission a bespoke education package intended for patients living with COPD. 4. Provide supportive for general practice to utilise to improve the management of patients with COPD (i.e.. use of Telehealth) 5.Utilise CQUIN to promote smoking cessation to patients via an acute setting and/or offer NRT therapy upon admission 6. Increase the number of patients provided with self-management packs. 7.Increase Flu Vacs for COPD patients 8. Increase number of smokers who are given NRT treatment when admitted	1. 31st September 2013 2. 31st September 2013 3. 31st September 2013 4. 31st August 2013
Community Services/ IMProVE (Integrated Management and Proactive Care for the Elderly)	Dr Ruth Johnson	Julie Stevens		The CCG has been working closely with South Tees Foundation Trust and Local Authority colleagues to improve Community Services. There are a number of key changes which support this aim: - A Predictive Risk Tool which practice use to identify patients at risk of re-admission to be managed by Community Matrons - Changes to the way Community Matrons manage patients on their caseload known as the Integrated Community Care Team (ICCT) - A rapid response service to enable patients to remain in their own homes, aimed at reducing the number of avoidable admissions - An IMProVE (Integrated Management and Proactive Care for the Elderly) Workstream which includes a number of projects including: Review of existing community nursing outcome measures, review of Pulmonary Rehabilitation Services, Stroke Pathway, Respiratory Pathway, Heart Failure Pathway, Palliative Care Pathway, Intermediate Care Review and a Single Point of Contact.	
Delayed Discharges	Dr Mike Milner	Nicola Jones	Deborah Bowden	1. Develop Delayed Discharge action plan 2. Develop standard processes and role out workshops to wards at STFT 3. Prepare for and conduct an RPIW for Community Hospitals	1. 31st May 2013 2. 31st October 2013 3. 31st August 2013

Terms of Reference

Urgent Care Board - Tees

Document control

Audience	Urgent Care Board - Tees
Document Title	Urgent Care Board - Tees
Document Status	Draftfor sign off.
Document Version	3.0
Issue Date	August 2013
Prepared By	Nicola Jones, Senior Commissioning Manager NECS on behalf of Dr Milner and Dr Parker – Chair(s) of the Urgent Care Board

Version	Date	Name	Comment
1.0	19/6/13	Nicola Jones	First draft for comments
2.0	9/8/13	Nicola Jones	Second draft for comments
3.0	21/8/13	Deborah Bowden	Third draft for comments

Contents

Document control **2**

Contents **3**

1 Introduction **4**

Purpose 4

Status 4

Related documents 4

2 Purpose **5**

Context 5

Functions 5

Performance Metrics 6

Accountability 6

Responsibilities 6

Supportive Relationships 7

3 Meeting Details **8**

Membership 8

Agenda 8

Frequency & location 8

Introduction

Purpose

The Teeswide Clinical Commissioning Group (CCG) led Urgent Care Board (UCB) has been established in response to NHS England: Improving A&E Performance Gateway ref 00062 (attached as appendix 1 to this document).

The UCB will be strategically and operationally accountable for the performance delivery of the A&E 95% 4 hour operational target. In addition to this, the UCB will be accountable for ensuring that robust winter/surge plans are evident and agreed by key stakeholders.

Status

This version of the document is a draft for consultation and initial approval with members of the board.

Related documents

This document should be read in conjunction with

- NHS England: Improving A&E Performance Gateway ref: 00062. http://www.england.nhs.uk/wp-content/uploads/2013/05/ae-imp-plan.pdf

Purpose

Context

The Teeswide (CCG) led UCB has a mandate to develop recovery (where necessary) and improvement plans targeted at the delivery and sustainability of the A&E 95% 4 hour operational target. The UCB will also develop and ratify winter/surge plans for local providers, ensuring that they meet the needs of the local population. Urgent Care issues which require multidisciplinary direction will also be included within this board and conclusions deduced for the development of models of delivery.

For the purpose of this group the scope of urgent care is from immediate presentation of the patient within all settings encompassing primary, secondary and social care to point of arriving home.

Objectives

The Board will seek assurance Tees-wide that there is adequate capacity to deliver urgent care services at all times to meet demand, particularly during surges in demand and during the winter period. Gaps in sustainability and winter plans will be discussed to ensure there is whole system planning and resilience.

The Board will make recommendations for consideration by the CCGs and respective organisations.

The Board will receive exception reports from the CCG work streams and project groups that will highlight any projects that need additional action to be taken. Providers will be asked to report by exception on any issues that are impacting on service delivery.

The Board will review and make recommendations on non-recurring funding and commissioning intention proposals. The impact of the proposals on the whole system will be considered and any gaps for future proposals identified.

Functions

The Urgent Care Board for Tees will:-

- Ensure that both the Urgent Care Work stream and Urgent Care Project Groups focus upon primary care and its effectiveness and admission avoidance schemes
- Ensure best practice is adopted in relation to Urgent Care Services

- Consider, following reviews completed locally the effectiveness of community services, including Walk in Centres/Minor Injury Units and how they integrate with secondary care
- Oversee the recovery (where necessary) and implementation/sustainability plans ensuring strategic alignment to national guidance (e.g. Everyone Counts: Planning for Patients 2013/14, Improving A&E performance).
- Evidence alignment and consistency with national best practice from Emergency Care Intensive Support Team (ECIST).
- Seek assurance that recovery/sustainability plans consider all aspects of the patient journey – Prior to A&E through to discharge from an Acute environment
- Deliver an agreed local plan to ensure performance delivery of the 95% 4 hour operational target in Q1 2013/14, including a sustainability plan to ensure delivery in Q2, Q3 and Q4 2013/14 for both Hartlepool and Stockton on Tees and South Tees CCG's.
- Review the winter plans and gap analysis in preparation for the 2013/14 Teeswide CCG led Winter Plan sign off by the area team in November 2013.
- Align the UCB's work plan with the strategic and operational objectives of all partner organisations and in particular those of local Foundation Trusts and the Local Authorities.
- Empower the public to be in control and understand their choices in relation to unplanned/urgent care.
- Optimise capacity and capability across the whole system of unplanned care and align resources with strategic/operational priorities.
- Receive exceptions reports and identify any additional remedial action needed to deliver the CCG projects being managed by the local work stream/project group.
- Review the effectiveness of ambulance services/conveyance rates
- Continuously review the effectiveness of NHS 111.
- Seek assurance that work in collaboration with local authorities is effectively facilitating timely discharge from hospital
- Oversee the use of the 70% funding retained from excess urgent care tariff. The use of this resource must be clearly linked to the delivery of outcomes and improvements specific to standards of unplanned/urgent care. The use of this resource is to be signed-off jointly by CCG leaders, NHS England Area Directors, provider Chief Executives, and local authority Chief Executives by end of June 2013. Although it should be recognised that CCG's are ultimately accountable for the resource available.

Performance Metrics

Reported metrics to be determined by the Local Area Team/Urgent Care Board and will be underpinned by measures which demonstrate effectiveness, efficiency, safety and patient experience.

Accountability

The Urgent Care Board is accountable to both the Hartlepool and Stockton-on-Tees and South Tees CCG's Governing Bodies.

Responsibilities

- To provide and receive exception reports as appropriate against the recovery and implementation milestones
- To review and realise the benefits delivered by the recovery and implementation plan
- To monitor progress to date including setting and reviewing milestones in the implementation plan
- To monitor and ensure sustainable performance improvement against the implementation plan milestones
- Make recommendations to urgent care project group and work stream
- To ensure effective and full involvement of all partners in decisions which relate to the implementation plan
- To provide support in managing and identifying implementation plan risks and issues
- To identify and manage interdependencies at strategic and operational level between the board and providers

Supportive Relationships

- A high level of trust between partners based on agreed and shared principles of co-operation and confidentiality
- A willingness to work together and consult with the widest possible network of communities and service users
- A commitment to share information to aid discussion
- A flexible approach and an openness to innovative ways of working

Meeting Details

Membership

Membership of the Urgent Care Board for Tees is outlined below

Further members may be co-opted as required by the Chair

Organisation	Represented by:
South Tees CCG	Chair of UCB on a rotational basis
Hartlepool and Stockton-on-Tees CCG	Chair of UCB on a rotational basis
North of England Commissioning Support	Process Owner/Senior Commissioning Manager
North of England Commissioning Support	Commissioning Manager
Local Area Team	Director Lead
Local Authority X 4	Assistant Director
North Tees & Hartlepool NHS Foundation Trust	Chief Operating Officer/Deputy Chief Executive
South Tees NHS Foundation Trust	Operational Services Director
NEAS	Director of Finance
TEWV	Consultant Psychiatrist
NDUC	Operations Manager
Healthwatch	X 2 Lead for Tees

Agenda and Minutes

The meeting will be formatted around the key functions of the group but the standing agenda items will include A&E performance data, recovery/sustainability and improvement action plan, winter plan 2013/14 and excess urgent care tariff.

Meeting support will be provided by the Admin team at Tees' CCG's with minutes and action notes being issued no later than one week after the meeting

Frequency & location

The Board will meet bi-monthly and be held at Teesdale House, Thornaby, Stockton on Tees.

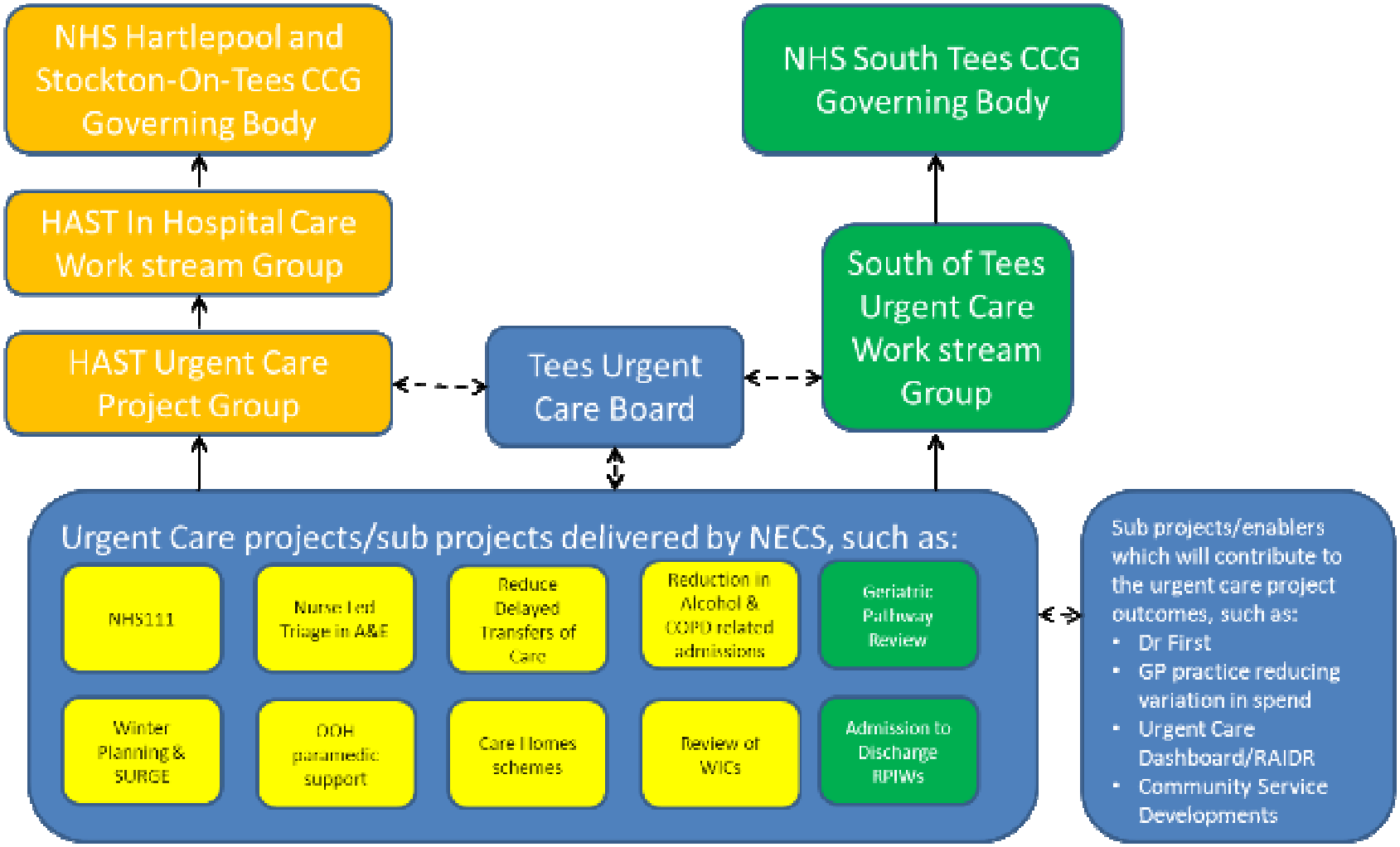
Quoracy

The meeting will be deemed quorate if there is:-

- 1 CCG GP representative

- 1 NECS representative
- 1 Healthw atch representative
- 1 LA representative
- 1 Acute Trust

Tees Urgent Care Board Governance Structure



Key - HAST, **STEES**, Both CCGs

Note - CCGs are accountable overall to the NHS Commissioning Board via the Area Team who will perform an assurance and developmental role

HEALTH AND WELLBEING BOARD

16th September 2013

Report of: Director of Public Health

Subject: Feedback from Health and Well Being Board Sub Groups

1. PURPOSE OF REPORT

1.1 The purpose of this report is to inform the Health and Well Being Board of the progress of establishing the three sub groups supporting the work of the Board in the light of the terms of reference for the Board.

2. BACKGROUND

2.1 The terms of reference for the Health and Well Being Board describe three sub groups reporting to the Board with responsibility for overseeing the implementation of the Health and Well Being Strategy and associated action plan.

2.2 At the Health and Well Being Board meeting on 5th August 2013, the following were identified as chairs of the sub groups and asked to establish initial meetings of these groups by September 2013:

- Children's Partnership – Councillor Chris Simmons
- Health Inequalities – Public Health, Andy Graham – Registrar in Public Health
- Adults and Maximising Capabilities – Jill Harrison and Ali Wilson

3. Health and Well Being Strategy Action Plan

3.1 The Health and Well Being Strategy Action Plan has been reviewed and appendix 1 suggests which sub groups take responsibility for overseeing specific elements of the action plan.

4. RECOMMENDATIONS

4.1 The Health and Well Being Board notes the progress that has been made in establishing the sub groups and the allocation of actions from the Health and Well Being Strategy Action Plan across the three groups.

5. REASONS FOR RECOMMENDATIONS

5.1 To ensure implementation of the Health and Well Being Strategy.

6. BACKGROUND PAPERS

6.1 Hartlepool Health and Well Being Strategy 2013-2017.

7. CONTACT OFFICER

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Hartlepool

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Health and Wellbeing Strategy Outcome		Health and Wellbeing Sub Group	Chair / Lead Officer
1. Give Every Child the best start in life	A. Reduce child poverty	**Children's Partnership**	Cllr Simmons Sally Robinson
	B. Deliver Early Intervention Strategy		
2. Enable all children and young people to maximise their capabilities and have control over their lives	A. Children and young people are empowered to make positive choices about their lives	**Children's Partnership**	Cllr Simmons Sally Robinson
	B. Develop and deliver new approaches to children and young people with special educational needs and disabilities		
3. Enable all adults to maximise their capabilities and have control over their lives	A. Adults with health and social care needs are supported to maintain maximum independence.	**Healthy and Independent Adults Delivery Group**	Jill Harrison / Ali Wilson
	B. Vulnerable adults are safeguarded and supported while having choice and control about how their outcomes are achieved		
	C. Meet Specific Housing Needs		
4. Create fair employment and good work for all	A. To improve business growth and business infrastructure and enhance a culture of entrepreneurship	The key actions and PI's are reported through the Economic Regeneration Strategy and Council Plan. These are updated quarterly and can be fed back H and WB Board.	
	B. To increase employment and skills levels and develop a competitive workforce that meets the demands of employers and the economy		
5. Ensure a healthy standard of living for all	A. Address the implications of Welfare Reform	A Welfare Reform Strategy group has been established, an agreed line of communication with the H and WB Board will be developed.	
	B. Mitigate against the impact of poverty and unemployment in the town		

6. create and develop healthy and sustainable places and communities	A. Deliver new homes and improve existing homes, contributing to Sustainable Communities	The key actions and PI's are identified within the Community Safety Plan, Community Cohesion Plan, and Council Plan. These are updated quarterly and can fed back to the H and WB Board.	
	B. Create confident, cohesive and safe communities		
	C. Local people have a greater influence over local decision making and delivery of services		
	D. Prepare for the impacts of climate change and takes action to mitigate the effects		
	E. Ensure safer and healthier travel		
7. Strengthen the role of ill health prevention	A. Reduce the numbers of people living with preventable ill health and people dying prematurely	**Inequalities Sub Group**	Andrew Graham.
	B. Narrow the gap of health inequalities between communities in Hartlepool		

HEALTH AND WELLBEING BOARD

16 September 2013

Report of: Dr Philippa Walters,
Tees Valley Public Health Shared Service

Subject: PHARMACEUTICAL NEEDS ASSESSMENT

1. PURPOSE OF REPORT

1.1 To update the Board on responsibilities related to the Pharmaceutical Needs Assessment for Hartlepool.

2. BACKGROUND

2.1 The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations[1] 2013 SI 2013/349 which came into force on 1st April 2013 are the current legislative regime which governs the arrangements for the provision of these services in England.

2.2 Each Health and Wellbeing Board (HWB) has some key duties and risks in relation to these Regulations. The headline duty is easy to identify; i.e. *the HWB must publish its first PNA by 1 April 2015;* which may seem a comfortably long time away.

2.3 The 2013 Regulations set out the minimum requirements for the first HWB PNA produced under this duty, and these include such things as data on the health needs of the population, current provision of pharmaceutical services, and gaps in current provision. The PNA will also consider the future provision of pharmaceutical services. HWBs will be required to undertake a consultation on their first PNA for a minimum of 60 days and the Regulations list those persons and organisations that must be consulted e.g., NHS England, the relevant local pharmaceutical committee and local medical committee, the local Healthwatch and other patient and public groups. Experience suggests that full new publication of the PNA will take a minimum of 12 to 15 months.

2.4 However it is equally important that this distant date does not allow HWBs to lose sight of the other duties / risks which may require action more imminently, and in an on-going way. In accordance with the 2013 Regulations, the Hartlepool HWB is now responsible for the latest PNA published by the former PCT (NHS Hartlepool). This inherited PNA is now in

[1] Hereafter referred to as the 2013 Regulations

use by NHS England (Durham, Darlington Tees Area Team), directing decision-making on the commissioning of pharmaceutical services in our HWB area (such as applications to open new pharmacies).

2.5 It is therefore important that each PNA is robust and up date. Consequently, the HWB also have a (statutory) duty to publish a revised PNA if there are significant changes to pharmaceutical services in their area. The only exception to this is where the HWB is satisfied that making a revised assessment would be a disproportionate response. A process for assessing change in need and proportionality of response is therefore essential to avoid a potential failure to act.

2.6 HWBs need to ensure that they have good relationships with NHS England to allow the flow of information with regards the provision of pharmaceutical services by pharmacies, dispensing appliance contractors and dispensing doctors. HWBs also need to ensure they are aware of any changes to the commissioning of public health services by the local authority and the commissioning of services by clinical commissioning groups as these may affect the need for pharmaceutical services.

2.7 It is also important that all council members and officers understand their new 'relationship' to the current and future PNAs as a consequence of the transfer of responsibility to the HWB. In the past, members were often approached by potential applicants of new pharmacies to seek endorsement of the 'need' for a new pharmacy in a given area. Now this document is owned by the HWB, members and officers should be aware of the implications of supporting views which may conflict with those contained within the PNA.

2.8 The Tees Valley Public Health Shared Service (TVPHSS) provides the expertise of a team which includes highly specialist Pharmacist Advisers and Public Health Intelligence Specialists offering Hartlepool HWB assurance of their capacity to deliver on these statutory duties.

3. PROPOSALS

3.3 To be certain of meeting the statutory timescale regarding publication of their first PNA, the HWB would be advised to fully understand the actions and associated timescales involved in developing its first PNA. Tees Valley Public Health Shared Service will co-ordinate the development of a suitable action plan towards development of the first PNA.

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3.4 As the inherited PNA is already being used by NHS England, and the duty is placed upon the HWB to ensure that the PNA is robust and up date, it is advised that the HWB, via TVPHSS, put systems in place that allow them to:

- undertake, as soon as reasonably practicable, an assessment of the PNA that they have inherited from the PCT to ensure that it meets the requirements of the 2013 Regulations and is suitably up-to-date
- make the PNA (and any supplementary statements) publically available
- be properly informed about any and all changes to pharmaceutical services in their area by (a) establishing and maintaining formal communication pathways

with both the DDT AT [2] and the local CCGs[3] and (b) keeping good records of any changes notified

- identify changes to the need for pharmaceutical services within their area and additionally
    - o assess whether the changes are significant and
    - o decide whether producing a new PNA is a disproportionate response
    - o decide whether to publish a supplementary statement explaining changes to the availability of pharmaceutical services since the publication of its or a Primary Care Trust's pharmaceutical needs assessment.

3.5 Additionally, in the course of their administration of applications to provide or amend pharmaceutical services, Schedule 2 to the Regulations requires NHS England to give notice to the "relevant HWB and any other HWB any part of whose area is within 2 kilometres of the premises or location to which the application relates." This notice gives the HWB the right to make representations in relation to the application (within 42 days). This is an important element of the HWB involvement which may be easily overlooked; these notices are already being issued. It is therefore also advised that the HWB acknowledge the need for systems to be maintained via the TVPHSS that allow them to receive such notifications and, in response, to

- determine whether or not to make representations in response to a particular application and as required
- prepare and deliver a response to the DDT AT within the required time-frame
- maintain records of these representations with the outcome of any decision subsequently reported to the HWB.

4. RISK IMPLICATIONS / LEGAL CONSIDERATIONS

4.1 The PNA is already being used by NHS England. Such decisions are appealable and decisions made on appeal can be challenged through the courts. The use of PNAs for the purpose of determining applications for new premises is relatively new. It is therefore expected that many decisions made will be appealed and that eventually there will be judicial reviews of decisions made by the NHS Litigation Authority's Family Health Services Appeal Unit. It is therefore vitally important that PNAs comply with the requirements of the regulations, due process is followed in their development and that they are kept up-to-date.

4.2 Failure to comply with the regulatory duties may lead to a legal challenge, for example where a party believes that they have been disadvantaged following the refusal by NHS England of their application to open new premises. Although HWBs have until 1 April 2015 to produce their first PNA it may be possible that this needs to be brought forward in order to reduce the risk of challenge. Due to the high level of risk associated with these duties, it may

[2] E.g., requesting DDT AT report the outcome of any decisions or changes to pharmaceutical services to the TVPHSS on behalf of the HWB
[3] Reminding CCGs that decisions related to commissioning/ de-commissioning of enhanced services or other pharmaceutical services take PNA into account and inform or consult with HWB via the TVPHSS

be recommended that the development of the PNA is added to a suitable risk register.

4.3 In addition to the Regulatory requirement for NHS England to use the PNA in their decision-making regarding commissioned pharmaceutical services, the PNA should also be referenced when others in the local commissioning economy (e.g., the Stockton and Hartlepool CCG, perhaps via NECs, and even the Borough Council themselves) consider commissioning (or decommissioning) services from pharmacies. The HWB may wish to be assured that all potential commissioners are fully aware of the existence and content of the PNA.

5. RECOMMENDATIONS

5.1 It is recommended that the HWB acknowledge the content of the Report and

- consideration is given to the option to add the development of the PNA to any suitable risk register
- TVPHSS continue to advise on all issues related to the PNA on behalf of the HWB as noted above
- an update regarding action plans and processes for review, maintenance (including Supplementary Statements) and future publication of the Hartlepool PNA be brought back to a future Board meeting.

6. REASONS FOR RECOMMENDATIONS

Included in the body of the report

7. BACKGROUND PAPERS

The NHS Hartlepool Pharmaceutical Needs Assessment published 1st February 2011 and the Annual Refresh 2012 and 2013 are relevant background papers to this report but it is not necessary to include these documents in order to understand the content of this Report. The documents are in the process of being made available via the Tees Public Health website as the NHS Tees website was archived on 1st April 2013. Links or pdf versions may be provided on request to the TVPHSS.

8. CONTACT OFFICER

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HEALTH AND WELL BEING BOARD

16th September 2013

Report of: Chair – Cllr Carl Richardson

Subject: Feedback from Chairs of Health and Well Being Boards Regional Meeting

1. TYPE OF DECISION/APPLICABLE CATEGORY

NON KEY

2. PURPOSE OF REPORT

2.1 The purpose of this report is to provide feedback to the Board from the regional meeting of the Chairs of Health and Well Being Boards held on Monday 9th September 2013 (papers attached).

3. BACKGROUND

3.1 The meeting of the chairs of Health and Well Being Board is an opportunity for the chairs across the North East to discuss common issues affecting health and well being boards.

3.2 This meeting is supported by the Association of North East Councils (ANEC).

4. ITEMS DISCUSSED AT MEETING ON 9th SEPTEMBER 2013

4.1 The following items were discussed and actions agreed:

1. Investment in tobacco by Local Authority Pension Funds

Actions agreed:

- Further develop paper in pack of papers discussed at meeting and present it to leaders and mayors across the North East with a view to collective action to withdraw from such investments.
- Explore how other areas have approached this issue who have withdrawn from such investments.

- Alert our own councilors who are representatives on the Teesside pension Fund of this issue.

2. Minimum unit price for alcohol

Actions agreed:

- Referred to leaders and mayors across the North East as this is a key public health issue.

3. Health Update – paper attached

Actions agreed:

- Content of report noted and the issue of health and social care integration very high on agenda nationally.

4. Public Health Knowledge Resources

Actions agreed:

- Content of report noted

5. Work Programme

Actions agreed:

- Future issues to focus on winter pressures and health and social care integration.

5. RECOMMENDATIONS

5.1 Members of the Board are note the content of the report.

6. REASONS FOR RECOMMENDATIONS

6.1 To ensure the Board receives feedback from the regional meeting that the chairman of the board attends on behalf of the Hartlepool Health and Well Being Board.

7. CONTACT OFFICER

7.1 Louise Wallace
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HEALTH & WELLBEING BOARD CHAIRS NETWORK

2–4pm Monday 9 September 2013

Committee Room 1B, County Hall, Durham

ASSOCIATION OF NORTH EAST COUNCILS

AGENDA

1. **APOLOGIES FOR ABSENCE**.

2. **NOTES** of the meeting held on 17 June 2013 (*No.2 attached*).

3. **TOBACCO INVESTMENTS IN LOCAL AUTHORITY PENSION FUNDS** Ailsa Rutter, Director, Fresh in attendance (*No.3 attached*).

4. **MINIMUM UNIT PRICING UPDATE** (*No.4 attached*).

5. **HEALTH UPDATE** (*No.5 attached*).

6. **PUBLIC HEALTH KNOWLEDGE RESOURCES** (*No.6 attached*).

7. **WORK PROGRAMME** (*No.7 attached*).

8. **DATE OF NEXT MEETING** 2-4pm on Thursday 14 November 2013 in Committee Room 3, Civic Centre, Sunderland.

HEALTH & WELLBEING BOARD CHAIRS NETWORK
Monday 17 June 2013
County Hall, Durham

2

NOTES

PRESENT:

Newcastle City Council	Councillor Nick Forbes *(Chair)*
Durham County Council	Councillor Lucy Hovvels
□ateshead Council	Councillor Martin □annon
Hartlepool Borough Council	Councillor Carl Richardson
North Tyneside Council	Mayor Norma Redfearn
Northumberland County Council	Cynthia Atkin
Redcar □ Cleveland Borough Council	Councillor □eorge Dunning
Stockton on Tees Borough Council	Councillor □im Beall
Sunderland City Council	Councillor Mel Speding

IN ATTENDANCE:

ANEC	Melanie Laws
	□onathan Rew
NHS England	Cameron Ward *(for items 35-36)*
	Wendy Balmain *(for item 38)*
Public Health England	Roberta Marshall *(for items 35-37)*

APOLOGIES:

Darlington Borough Council	Councillor Bill Dixon
□ateshead Council	Councillor Mick Henry
Hartlepool Borough Council	Councillor Chris Akers□Belcher
Middlesbrough Borough Council	Councillor David Budd
Northumberland County Council	Councillor Scott Dickinson
South Tyneside Council	Councillor Iain Malcolm
Sunderland City Council	Councillor Paul Watson

The Chair welcomed Mayor Norma Redfearn and Councillor Carl Richardson, who were attending their first meeting of the Network.

33. NOTES
The notes of the meeting held on 25 April 2013 were A□REED as a correct record.

34. APPOINTMENT OF VICE-CHAIR
It was A□REED that Councillor □im Beall be appointed Vice□Chair of the Network.

35. UPDATE AND WORK PROGRAMME
The Chief Executive introduced a report on recent developments. Members discussed the following:

- the outcome of the recent meeting with Anna Soubry MP, Public Health Minister, was noted. It appeared that she had some sympathy for the Network's concerns, e.g. around plain packaging and minimum unit pricing. She was also favourable towards local initiatives in health improvement, and it would be worth considering how this sort of approach might be developed;

- the Winterbourne View stocktake document – HWBs had been asked to take a lead in developing and signing off responses. Members felt that this re□uest raised some important issues about the role of HWBs, which they understood was about □oining up health and social care and improving health outcomes, rather than detailed performance management of aspects of commissioning (and in any event there was no funding for this role). They were also concerned that this could be the first in a series of similar re□uests. It was A□REED that ANEC should (a) find out what each HWB was doing about the stocktake and (b) draft a collective response to the Department of Health about these concerns;
- the launch by Public Health England (PHE) of the Longer Lives' website, which illustrated variations in premature mortality – from all causes and from specific causes such as cancer and heart disease □between local authorities, and ranked areas according to their performance in reducing premature mortality. Members expressed the view that the information was a simple snapshot at a point in time and did not reflect trends or the work that had been done (and was ongoing) to bring about improvements. It was also unhelpful in terms of promoting the North East. It did however graphically illustrate where resources needed to be allocated and should be used to support our case on public health funding allocations; and
- the re□uest by Fuse, the Centre for Translational Research in Public Health, to make a presentation on their research and evaluation service. Members noted the re□uest and asked that, as a first step, a short paper should be prepared for the Network on the knowledge resources that were available – including, for example relevant parts of PHE as well as Fuse and similar bodies.

It was A□REED that the report be noted and action taken as set out above.

36. NHS ENGLAND/AREA TEAMS UPDATE

Cameron Ward gave an update on a number of issues including:

- accident and emergency services – a review was being carried out in response to current issues, led by Sir Bruce □eogh. Urgent Care Boards were being set up in local areas, with some flexibility around membership;
- CC□s had been asked to prepare prospectus documents, which should mesh with HWB strategies;
- Sir David Nicholson had announced plans for a ma□or review of NHS strategy, which could include reconsideration of the commissioner□provider split; and
- the announcement of a further review of paediatric heart surgery.

There was a discussion about clinically led service reviews and it was noted that tension could exist between clinical grounds for moving services and local people's preferences.

37. ROLE OF PUBLIC HEALTH ENGLAND

Dr Roberta Marshall (North East Centre Director, Public Health England) outlined the role of PHE, which had assumed its full responsibilities on 1 April 2013. It was an executive agency of the Department of Public Health, providing expertise and specialist commissioning in the three domains of health protection, healthcare public health and health improvement, and operating at national, regional and local level. □ey issues for PHE included the recent measles outbreak, where there had been good cooperation and local authority public health teams had met the demands placed on them; health checks; new vaccination pro□ects; and preparing for the transfer of health visitors to local authorities in 2015.

Members asked for clarification on responsibility for MRSA and infection control generally. It was pointed out that while this was a clinical matter in the first instance, local authorities had responsibility for health protection as part of their public health remit and would need assurance that infection control was being applied robustly; PHE could provide support on this. More broadly, Dr Marshall said she would be happy to have a dialogue on the support that PHE was able to give in feeding the Network's concerns into the system.

Members suggested that it would be helpful to have a statement of the PHE's offer', both nationally and regionally; Dr Marshall said that this was in preparation.

38. INTEGRATION OF HEALTH AND SOCIAL CARE

Wendy Balmain outlined the Department of Health's re uest for expressions of interest from local areas seeking to become pioneers on the overnment's health and social care integration programme. Health economies awarded pioneer status would be offered support and advice by a central team to help overcome barriers to integration. The closing date for the first wave of applications was 2 une. Ms Balmain commented that the North East had a strong health economy and track record, and urged local areas to apply. Essentially, integration was about doing things differently – putting the individual at the centre and organising services around their needs.

While supporting the principle of integration, members commented that other organisations might not share this commitment because they were driven by different financial models which incentivised them to increase uptake of their services. Ms Balmain noted the point but commented that there could be scope to look again at tariffs. Members also made the point that reviews in other contexts had tended to make assumptions about how far savings could be replicated across the system.

39. BETTER HEALTH AT WORK AWARD

Following previous discussion by the Network and the Regional Chief Executives roup, a revised proposition for the future coordination and delivery of the North East Better Health at Work Award was put forward.

It was A REED that the proposition be supported and referred to the Regional Chief Executives roup and Leaders Elected Mayors roup.

40. INVESTMENT IN TOBACCO BY PENSION FUNDS

It was A REED that the report be deferred to the next meeting to enable full discussion of the issues.

41. MINIMUM UNIT PRICE FOR ALCOHOL

A policy update had been prepared by Balance reflecting the fact that minimum unit pricing appeared unlikely to remain in the National Alcohol Strategy.

It was A REED that the report be referred to the Regional Chief Executives roup and Leaders Elected Mayors roup.

42. HEALTH AND WELLBEING STRATEGIES AND SYNERGIES: EMERGING THEMES AND FUTURE ACTION

A report was submitted taking forward previous discussions on common themes and priorities from emerging Health and Wellbeing Strategies. It was suggested that given the changes in the health landscape, and particularly in lead responsibilities for the various public health functions, it would now be appropriate to take an approach which focused on key priorities for local government, particularly those where there was added value to be

gained from □oint working. Tobacco and alcohol control, and workplace health, had already been recognised in this context. Local authorities' responsibilities for health protection, and for developing local strategies to deal with obesity, could also be considered at some point.

It was also proposed to draw up a programme of events where local authorities and the NHS could consider operational issues and forward planning, as follows:

- an event later in 2013 focusing on winter pressures and □oint working, including input from the ADASS and Directors of Children's Services Networks;
- another event later on 2013 on the lessons of the Francis report and Winterbourne View, leading up to;
- a Health Summit early in 2014, which would take stock of progress since the transition to the new health system in April 2013 and could involve all the key organisations engaged in the health agenda.

It was A□REED that the report be noted and that a programme of events be developed as outlined above.

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Briefing paper- Tobacco investments in local authority pension funds

Recommended to be read alongside ASH/Fair Pensions Paper http://www.ash.org.uk/pensions)

1) Background

Fresh has been asked to provide a briefing for the Health and Wellbeing Board Chairs Network on the issue of local authority pension fund investments in tobacco shares and to provide information in relation to some of the potential areas for discussion that Health and Wellbeing Boards may wish to consider. The area is currently attracting some scrutiny both within public health and externally though the media (e.g. The Independent). This paper will highlight some of the key issues from a health perspective and the Chairs Network may also wish to consider evidence from other sectors including financial representation.

Fresh is a tobacco control programme which aims to reduce the impact of tobacco smoking (the single greatest contributor to premature and death disease in the region and 11 people dying prematurely each day on our region from preventable smoking related diseases) on the health and wellbeing of the North East and related health ine□ualities.

The work is focussed on the delivery across eight key strands of activity which are designed to motivate and support smokers to stop, reduce uptake of new smokers and protect from secondhand smoke and other tobacco related harm.

Adult smoking rates have declined at double the decline of the England average in recent years reducing from 29□ in 2005 to 21□ in 2011.

2) Current position

Some local authority pension funds hold investments in tobacco shares. In the North East it was estimated that around □1□□ million was invested in tobacco shares (March 2012: http://tobaccofreepensions.wordpress.com).

The 12 North East local authorities are currently involved in four separate pension schemes: Durham, Northumberland, Teesside and Tyne and Wear. The level of tobacco shares is shown overleaf and is taken from the website listed above.

The annual deaths figure is from www.tobaccoprofiles.info/tobaccocontrol

Local Authority Scheme	Annual deaths from smoking	Tobacco investment shares and bonds	Size of pension fund	Proportion of pension fund as %	Tobacco investment income for last full year (2011-12)
Durham	□2□	□50,799,5□1	□1,□□□,□30,000	2.□9□	□710,599
Northumberland	43□	Pension Fund has no direct holdings in any of the listed tobacco shares.			
Teesside	102□	□70,407,340	□2,444,314,7□0	2.□□□	□2,077,475
Tyne and Wear	17□□	□4□,427,992	□4,□22,000,000	0.9□□	□1,522,491
Total	**4076**	**£167,634,893**			**£4,310,565.**

3) Key issues

Issues have been raised about local authority pension funds in the U□ and concerns around them holding investments in the tobacco industry, particularly in recent months with the transition around public health responsibilities to local government from primary care organisations. These issues largely centre on the role of tobacco in health ine□ualities, the international nature of tobacco control and the conduct of the tobacco industry.

- **Health inequalities:** Tobacco products are uni□ue in that when the product is used directly as the manufacturer intends, it currently results in the premature death of half of its long term users with 11 deaths a day on a daily basis in the North East from smoking related diseases. Smoking is responsible for around half of the difference in life expectancy between the most and least affluent groups. Smoking is responsible for up to half the difference in life expectancy between the most and least affluent people in the U□. Internationally, around □ million deaths annually are caused by smoking with the WHO estimating that 1 billion people will die this century from tobacco unless effective action is taken.

  It is estimated that every year more than 200,000 children in the U□ start smoking, nearly 9000 in the North East. Among adult smokers, about two□thirds report that they took up smoking before the age of 1□ and over □0□ before the age of 20. In the North East the average for starting to smoke is 15 years of age.

- **International nature of tobacco control policy**: The regulatory environment for tobacco is changing following the on□going implementation of the WHO Framework Convention on Tobacco Control (FCTC): http://www.who.int/fctc/en/ – the world's first health treaty ratified by 17□ countries including the U□.

  The FCTC aims to reverse the global tobacco epidemic by re□uiring parties to implement legislation and tougher regulatory controls including: smokefree laws; tobacco tax increases; comprehensive bans on all forms of tobacco advertising; mass media campaigns on dangers of tobacco; and protecting health policies from tobacco industry interference (specifically in article 5.3). The momentum for

tobacco control laws and reforms is being accelerated by the Bloomberg Initiative and the □ates Foundation who have invested US□□00m to reverse the tobacco epidemic.

Tobacco markets in developed countries are noted to be shrinking due to tighter legislation and implementation of key FCTC recommendations. For example Imperial Tobacco has underperformed the FTSE 100 by 25□ over the last year. Business reports from Euromonitor and Citigroup have raised doubts about the future based on 50 years of data showing falling smoking rates. Citigroup has suggested that many important tobacco markets including Britain could "virtually disappear" by 2050 in Britain: http://www.telegraph.co.uk/finance/newsbysector/retailandconsumer/□24□9□7/Smoking□could□disappear□by□2050□says□Citigroup.html

Standardised tobacco packaging has been introduced in Australia and other countries are actively considering following. The global ratings agency Fitch has described standardised packaging as the biggest regulatory risk facing the tobacco industry: www.cfoworld.co.uk/news/risk/3427□21/plain□packaging□should□worry□big□tobacco□says□fitch/

- There is existing guidance about □overnment institutions not investing in tobacco control in the Framework Convention on Tobacco Control: http://www.who.int/fctc/guidelines/article_5_3.pdf

  Article 5.3 of the FCTC states□*"There is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests. The tobacco industry produces and promotes a product that has been proven scientifically to be addictive, to cause disease and death and to give rise to a variety of social ills, including increased poverty. Therefore, Parties should protect the formulation and implementation of public health policies for tobacco control from the tobacco industry to the greatest extent possible."*

  The guidelines to Article 5.3 apply to setting and implementing Parties' public health policies with respect to tobacco control. They also apply to persons, bodies or entities that contribute to, or could contribute to, the formulation, implementation, administration or enforcement of those policies. The purpose of these guidelines is to ensure that efforts to protect tobacco control from commercial and other vested interests of the tobacco industry are comprehensive and effective. Parties it is recommended should implement measures in all branches of government that may have an interest in, or the capacity to, affect public health policies with respect to tobacco control.

  While persuasive rather than binding in nature, the guidelines specify that Parties should not invest in the tobacco industry. Article 5.3 uidelines state overnment institutions and their bodies should not have any financial interest in the tobacco industry, unless they are responsible for managing a Party's ownership interest in a State□owned tobacco industry .

- **Tobacco industry conduct and reputation:** Concerns have been expressed in relation to the behaviour of the tobacco industry□these are explored more fully in this website run by Bath University: http://tobaccotactics.org/index.php/Main_Page□

4) ASH/Fair Pensions Position

Local authority pension funds in the U□ have attracted public criticism for holding investments in the tobacco industry as set out by the issues above. There are three common responses to this criticism:

- Local authority pension funds have a legal duty to maximise financial return and cannot give consideration to ethical issues
- Pension fund trustees do not interfere with the day to day decisions of external investment funds managers
- Tobacco is a low risk, high return investment.

An informative paper has been produced by ASH and Fair Pensions and it is recommended that it is read alongside this briefing, and is available at http://www.ash.org.uk/pensions

The briefing explores the claim that local authorities are in effect duty bound' to invest in tobacco and:

- Clarifies the law regarding the legal duties of pension fund trustees and explains the options for trustees wishing to properly consider ethical concerns around investments in the tobacco industry
- Counters common misconceptions about the fiduciary duties around investments; and
- Provides information on the financial risks facing the tobacco industry which raises doubts about its long term investment viability

5) International screening out of tobacco investments

In addition, seeking alternative investments within public sector pension schemes is gaining international momentum. overnment funds in Norway, N, five US states and several Australian superannuation and other funds have screened out tobacco investment citing concerns about treaty commitments and tobacco s litigation risks and uncertain regulatory future. This is discussed more fully in a paper from ASH Australia http://www.ashaust.org.au/lv4/Lv4action_investment.htm

Summary:

The Health and Wellbeing Board Chairs Network are asked to consider this briefing and the issues it raises.

Ailsa Rutter Director of Fresh (ailsa.rutter freshne.com /01913337141).

January 2012

Local authority pension funds and investments in the tobacco industry

Purpose of this briefing

This briefing is a position statement by Action on Smoking and Health and FairPensions which aims to inform stakeholders in local authority pensions, including councillors, pension fund members, local taxpayers and pension fund trustees.

Local authority pension funds in the UK have attracted public criticism for holding investments in the tobacco industry. There are three common responses to this criticism, each of which will be examined in this briefing:

1. Local authority pension funds have a legal duty to maximise financial return and cannot give consideration to ethical issues.
2. Pension fund trustees do not interfere with the day to day decisions of external investment fund managers.
3. Tobacco is a low risk, high return investment.

This briefing challenges the claim that local authorities are in effect 'duty bound' to invest in tobacco and:

1. clarifies the law regarding the legal duties of pension fund trustees and explains the options for trustees wishing to properly consider ethical concerns around investments in the tobacco industry;
2. counters common misconceptions about the fiduciary duties around investments; and
3. provides information on the financial risks facing the tobacco industry which raises doubts about its long-term investment viability.

Argument #1: 'We have a fiduciary duty to maximise return'

Trustees' legal obligations to pension fund members are known as fiduciary duties. Pension funds often justify tobacco investments by claiming that their fiduciary duty requires them to maximise returns and ignore ethical considerations. However, this conventional interpretation of the law is somewhat simplistic.

Response

Although local authority pension funds are governed by different laws to other types of pensions (see Box C), members of their pensions committees have similar fiduciary duties to pension fund trustees. The phrase 'duty to maximise return' does not appear in any UK statute or case law. Pension fund trustees have a fiduciary duty to invest "in the best interests of members and beneficiaries."[1] This is based on the common law duty of loyalty, which exists to ensure that trustees avoid conflicts of interest and do not abuse their position to further their own ends.[2] Trustees also have a duty to invest prudently.[3]

In the 1984 case of Cowan v Scargill (see Box A), the judge ruled that, in a pensions context, *"the best interests of the beneficiaries are normally their best financial interests."*[4] This is often quoted as evidence that pension fund trustees are prohibited from considering ethical issues. However, the judgement explicitly denies this interpretation, going on to say: "*I am not asserting that the benefit of the beneficiaries which a trustee must make his paramount concern inevitably and solely means their financial benefit.*"[5]

Box A: Cowan v Scargill 1984

This case concerned the mineworkers' pension scheme. The five trustees appointed by the National Union of Mineworkers (NUM), led by Arthur Scargill, refused to approve an investment plan for the trust unless it excluded *all* overseas investments and all investments in industries directly competing with coal (e.g. oil and gas). The court upheld the employer-nominated trustees' contention that this was a breach of fiduciary duty, as:

- The trustees were motivated by their personal views and by a desire to pursue union policy, and were not putting the beneficiaries first (a breach of the duty of loyalty)
- Many of the beneficiaries, such as widows and dependants, would not be directly affected by the health of the mining industry, but would suffer any negative impacts from the likely sacrifice of return (a breach of the duty of impartiality)
- In any case, the social benefits of the policy were too speculative and remote: the pension fund's assets were not large enough to have any material impact on the prosperity of the mining industry or the national economy.

It is worth bearing in mind that, contrary to popular belief, the policy was not rejected on the grounds that it is unlawful for trustees to consider non-financial issues (see above). Rather, it was rejected on grounds specific to the facts of the case, including the trustees' decision-making process.

Indeed, it has been noted that the policy at issue bore little resemblance to a modern responsible or ethical investment policy. A landmark 2005 report by law firm Freshfields Bruckhaus Derringer concluded that "*No court today would treat Cowan v Scargill as good authority for a binding rule that trustees must seek the maximum rate of return possible with every individual investment and ignore other considerations*."[1]

1 UNEP-FI, 2005, 'A legal framework for the integration of environmental, social and governance issues into institutional investment'

Similarly, in the case of Martin v City of Edinburgh District Council (see Box B), the judge said, "*I cannot conceive that trustees have an unqualified duty... simply to invest trust funds in the most profitable investment available.*"[6]

Indeed, local authority pension schemes (in line with other occupational pension schemes) are required to say in their Statement of Investment Principles "*the extent (if at all) to which social, environmental or ethical considerations are taken into account in the selection, retention and realisation of investments*".[7] This provision was intended as a 'light-touch' intervention to clarify that it is indeed legitimate for pension funds to take ethical issues into account.[8]

Case law does indicate that it would be difficult for trustees to justify an ethical restriction which significantly damaged financial returns, largely because of their duty to act impartially: it would not be fair if the ethical preferences of one group of beneficiaries hurt the retirement

prospects of another group who did not share their views.[9] However, this is not the same as a bar on considering ethical issues. In particular, it leaves open two scenarios in which trustees might be able to exclude certain investments: firstly, if it would make no material difference to investment returns (the '**ethical tie-break**'), and secondly, if they have reason to believe it would actually enhance performance over the long run (the '**responsible investment approach**').

Box B: Martin v City of Edinburgh 1995

In the case of Martin v City of Edinburgh District Council, a Conservative councillor sued his Labour colleagues for implementing a policy of disinvestment from apartheid-era South Africa. The judge ruled that the councillors had failed in their fiduciary duty because they had not undergone due process and taken proper advice. But he stressed that had they done so, the policy could have been legitimate: indeed, the fund's performance actually improved after the policy was implemented.

Moreover, the judge explicitly rejected the plaintiff's claim that Cowan v Scargill required trustees "*merely to rubber-stamp the professional advice of financial advisors*." On the contrary, he said:

"*I cannot conceive that trustees have an unqualified duty... simply to invest trust funds in the most profitable investment available. To accept that without qualification would, in my view, involve substituting the discretion of financial advisers for the discretion of trustees.*"

The ethical tie-break

In Cowan v Scargill, the union trustees were insisting on a blanket exclusion of all overseas investments, and of any industries in competition with coal. In a subsequent paper the judge speculated that a more nuanced policy – for example, of excluding certain investments 'all other things being equal' – might have been permissible.[10] More broadly, he suggested that an investment policy which accommodated the ethical concerns of some members without compromising the financial interests of others would be in the best interests of the beneficiaries as a whole. In other words, ethical criteria could be used to choose between two investment options that are equally attractive financially. This 'tie-break' principle has been restated several times in UK and US law and guidance.[11]

Of course, trustees cannot be expected to predict actual investment performance. For this reason, the test of whether two options were 'equivalent' is not outcome but process: did the trustees take appropriate advice, and, based on the information available at the time, was their decision reasonable? It is very possible to imagine that a decision to exclude tobacco could pass this test. Indeed, many funds with much broader ethical exclusions (for example, the Norwegian State Pension Fund which excludes investments in tobacco producers among other things[12]) have consistently matched or outperformed the market.

The responsible investment approach

Trustees may also decide that excluding a particular investment would have a positive impact on the fund's long-term performance. It is now widely accepted that environmental, social and governance (ESG) issues can affect company performance. In a landmark 2005 report, the law firm Freshfields Bruckhaus Derringer concluded that considering these factors is well within the scope of investors' fiduciary duties: indeed, "***it may be a breach of fiduciary duties to fail to take account of ESG considerations that are relevant and to give them appropriate weight.***"[13]

On this basis, there are various reasons why trustees might conclude that tobacco is a risky long-term investment and these reasons are explored below (see Argument #3). Indeed, the London Borough of Newham currently excludes tobacco on this basis, saying in its Statement of Investment Principles:
"*Fund managers are instructed not to invest segregated elements of their portfolio in companies that generate over half of their income from tobacco products, due to the risk that tobacco companies may face large liabilities from outstanding court actions.*"[14]

Where does this leave fiduciary duty?

All of this suggests that the law does not oblige pension funds to dismiss the ethical concerns of their members out of hand. Rather, the appropriate response is to analyse whether those concerns could be accommodated without compromising the performance of the fund. Moreover, non-financial issues which could affect the performance of the fund should be considered by funds as part of their normal investment analysis.

Argument #2: "It is not our policy to interfere with our fund managers' discretion"

Response:

It is common practice for pension funds to delegate day-to-day investment decision-making to external fund managers. However, this does not prevent them from instructing their fund managers in particular matters (as in the Newham example above). Indeed, the law is quite clear that, although trustees may delegate their investment functions, they cannot delegate their fiduciary responsibilities.

Final responsibility for investment decision-making rests with the trustees themselves. The judge in Martin v City of Edinburgh (see Box B above) stressed that trustees must "*appl*[y] *their minds separately and specifically to the question whether [the decision at hand] would be in the best interests of the beneficiaries.*"[15] Moreover, in order to fulfil their fiduciary duties, the law requires trustees to monitor their fund managers on an ongoing basis.[16] In other words, as FairPensions' recent report concluded, "*It is a vital principle of fiduciary obligation that fiduciaries cannot outsource their obligation to think*."[17]

Box C: Local authority pensions – a special case?

Local authority pension funds are governed by different *statutory* rules to other occupational pension schemes.[1] There is no statutory requirement for assets to be invested in the best interests of beneficiaries, and schemes must take account of the interests of local taxpayers.[2] In our view this does not amount to a significant difference in the underlying legal principles governing scheme investment. Common law fiduciary duties – to which the above analysis refers – still apply. However, given their duty to taxpayers, it is arguably also relevant for local authority pension schemes to consider the cost to the taxpayer both of measures to prevent smoking and of dealing with the public health impacts of smoking when evaluating their tobacco investments.

1 The Local Government Pension Scheme (Management and Investment of Funds) Regulations 2009 (SI 2009/3093)

2 The Myners Principles, http://www.thepensionsregulator.gov.uk/docs/igg-myners-principles-update.pdf

Argument #3: The tobacco industry is a low risk, high profit investment

Response:
Tobacco shares have traditionally been a low-risk, high profit investment. However, there are a number of factors indicating that investments may be a risk in the medium and long term and there is a strong business case for reviewing investments in the short term.

There is a risk that some tobacco investments may currently be overvalued. In November 2011 Goldman Sachs downgraded Imperial Tobacco to "sell" from "neutral", having previously downgraded the stock from "buy" to "neutral" in September 2011[18,19] and an article by 'Smart Investor' on City Wire in August 2011 suggested that British American Tobacco shares may be overvalued.[20]

Is the tobacco industry in terminal decline?
Analyst Adam Spielman has argued that tobacco could virtually disappear in 30 to 50 years. In the Financial Times, Spielman argues that "*The percentage of smokers is declining across the developed world … If these trends continue, then by 2050 many important tobacco markets will have gone to zero smoking.*"[21]

The UK, European and American markets
Sales in the UK and Europe have been in long-term decline and are predicted to decline further. In the UK adult smoking rates have fallen from 27% in 2000 to 21% in 2009[22] and since 1990 there has been a decline in smoking rates in almost all EU states.[23]

The European Commission is currently revising the Tobacco Products Directive, which is likely to include proposals to make pictorial warnings mandatory and larger (80% of the pack) and to introduce plain packaging of tobacco products.[24] The UK government has set out its ambition to reduce adult smoking prevalence in England from 21% to 18% by 2015,[25] resulting in 210,000 fewer smokers every year. The Welsh Government plans to reduce adult smoking rates from 23% to 16% by 2020.[26]

The American market is also in long term decline, with cigarette sales falling steadily from 640 billion in 1981 to 380 billion in 2006.[27]

Imperial Tobacco is still highly dependent on its EU and American markets with 55% of net revenue coming from the declining EU market,[28] having sought to diminish dependence on the UK and expand sales through acquisitions in America and Europe, acquiring brands including Fortuna, Gauloises and Gitanes in 2008. However, the risk of this dependency on the European and American markets was demonstrated in 2010 when net revenue in the Americas decreased by 9 per cent to £780 million and adjusted operating profit declined by 15 per cent to £244 million following substantial increases in federal excise tax.[29]

Developing world markets
Tobacco companies have sought to manage the risk posed by declining EU volumes through investing in new, profitable markets, such as investments in Africa and China. However, excluding China where the transnational tobacco companies have little market share, global tobacco consumption is already declining[30,31,32] and with increased regulation these markets can no longer be relied on to provide the growth tobacco companies need to balance declining EU sales.

Regulatory Risk

Framework Convention on Tobacco Control

The World Health Organization's Framework Convention on Tobacco Control (FCTC)[33] aims to restrict smoking prevalence in the very countries where the industry has achieved its growth in recent years. More than 170 countries are now party to the FCTC. The FCTC covers price and tax measures to reduce the demand for tobacco products (Article 6), non-price measures to reduce demand (Article 7) product regulation (Article 9) packaging and labelling (Article 11), reducing advertising promotion and sponsorship (Article 13) and measures to reduce supply (Articles 15-17).

Countries across the globe are introducing measures to meet their FCTC requirements, including widespread legislation for smokefree workplaces and advertising bans. For example China, which accounts for over 40% of the total global tobacco market, introduced a range of measures to tackle tobacco in May 2011, including a ban on smoking in all public places.[34]

In Russia, the world's fifth biggest market, health warnings were introduced in 2010 and the national parliament is mandated to pass legislation to bring Russia into full alignment with the FCTC, which will mean smokefree indoor public places and public transport and a complete ban on all advertising, promotion and sponsorship by 2015.[35]

Uruguay has introduced a range of measures, including an increase in tobacco tax, graphic health warnings taking up 80% of the packet and a ban on all tobacco advertising.[36]

Tax increases

Several countries have introduced substantial increases in tobacco taxation. During 2010 Spain introduced a 28% increase in tobacco duty as part of a package to tackle the budget deficit,[37] Japan introduced a 33% increase[38] and in Australia tax was increased by 25%.[39] The Indonesian government announced a 15% increase in tobacco excise from January 2012.[40]

These abrupt, high level tax increases are likely to have a greater impact on tobacco industry profits. There is a significant risk that similar tobacco tax increases will become increasingly attractive to governments seeking to tackle budget deficits.

Plain packaging

Australia is set to become the first country in the world to require tobacco products to be sold in plain, standardised packaging with promotional features removed, from 1 December 2012.[41]

In the UK, the Government has committed to consult on options to reduce the promotional impact of tobacco packaging, including the introduction of plain packaging.[42] In addition to Australia and the UK, other countries are also examining the option of introducing plain packaging, including Turkey, New Zealand and Canada. According to the Financial Times: "*If the Australian proposals are implemented, similar laws will emerge elsewhere, with damaging effects on profits.*"[43]

Front cover of the tobacco industry journal warning of the business risk from plain packaging (2008)

In 2008 the industry journal Tobacco Journal International reported on proposals to require plain packaging for tobacco products, stating: "*standardisation of cigarette packaging* [would] *drive down pricing and put an end to the appeal of premium cigarettes which carry higher profit margins*". Although the article concluded the 2008 proposal had little chance of success at that time, the author observed "*how much industry regulation has come to pass, namely once it has been put on the table it never really goes away until one country becomes bold enough to implement it and then others soon follow suit.*"[44]

A report produced for Philip Morris by Jorge Padilla[45] argues that plain packaging will lead to substantial price reductions, by removing the brand loyalty that enables tobacco companies to charge premium prices. The report also argues that plain packaging will make market entry by new suppliers of super-low price "no-name" products easier. Although Padilla's claims have been challenged by a leading economist,[46] shareholders should be aware of the risk implied by the industry's own analysis.

Analyst Adam Spielman has also highlighted the risk to the industry's profitability posed by reduced brand equity likely to result from plain packaging. "*The industry is so profitable only because consumers are willing to pay a premium of £1.50 for certain brands.*"[47] "*If the proposal is carried out, it would reduce the brand equity of cigarettes massively… Anything that weakens this will dramatically reduce profitability.*"[48]

Litigation – from Nunavut to Nigeria

In 1998, 46 US states settled their Medicaid lawsuits against the tobacco industry for recovery of tobacco-related health care costs and were awarded $206 billion in compensation. The deal, known as the Master Settlement Agreement, was in addition to $36.8 billion awarded to the states of Mississippi, Florida, Texas, and Minnesota.[49]

The industry now faces a new threat from other governments around the world that are suing tobacco companies for the cost of providing healthcare. In recent years Argentina, Israel, Italy, Turkey, France, Poland India, Nigeria, Canadian provinces and Sri Lanka have all brought suits against tobacco companies relating to the healthcare costs arising from smoking. The EU took action in the US courts against tobacco manufacturers for colluding in tobacco smuggling under the Racketeering Influenced Corrupt Organisations Act.[50] In 2011, the Australian government announced that it was considering legal action to seek compensation from tobacco companies for the health care costs of smoking.[51]

Tobacco industry profits have suffered from over £250 billion paid out in litigation costs and if recent law suits are successful this is likely to open the door to encourage similar cases elsewhere.

The damage to the tobacco industry from litigation is not limited to the cost of settlements alone. "*There is also a risk that, regardless of the outcome of the litigation, negative publicity from the litigation and other factors might make smoking less acceptable to the public, enhance public restrictions on smoking, induce many similar lawsuits against JT and its subsidiaries, forcing them to deal with and bear the costs of such lawsuits, and so on.*" Japan Tobacco Inc., 2007[52]

Box D: Tobacco – an industry with a disappearing future

- 170 countries are parties to the Framework Convention on Tobacco Control, and committed to introduce price and tax measures to reduce the demand for tobacco products
- UK government plans to cut the number of smokers by 210,000 every year
- Plain packaging "*will dramatically reduce profitability*."

The questions that stakeholders should be asking

- Has the pension fund asked its fund managers for their view on the long-term financial viability of tobacco, in light of declining markets and regulatory or litigation risks?

- Has the pension fund asked its fund managers to undertake an analysis of the long-term impact of excluding tobacco from their portfolio, taking into account any measures that could be taken to compensate for the exclusion (for example, increasing weightings of other defensive stocks)?

- If not, will pension fund trustees:
  - commission these analyses;
  - make the results available to members; and
  - review their tobacco holdings, taking into account these findings as well as the ethical concerns of members?

- Will the pension fund develop and publish a statement of policy in relation to investments in tobacco companies?

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MINIMUM UNIT PRICING UPDATE

Purpose of the Report

1. To present a communications strategy developed by Balance designed to demonstrate the region's on□going commitment to the introduction of a minimum unit price for alcohol.

Minimum Unit Pricing – the Government's response to the alcohol strategy consultation

2. On 17 □uly the Minister of State for Crime Prevention (□eremy Browne MP) announced that plans in relation to minimum unit pricing would not be proceeded with at the present time, though the policy would remain under consideration. The □overnment has also decided not to introduce a ban on multi□buy promotions. Instead the □overnment has said they will ban below costs sales of alcohol.

3. After a presentation by Colin Shevills at the Leaders' and Elected Mayors' meeting held on 12 □uly 2013, members re□uested that Balance develop a communications strategy designed to demonstrate the region's on□going commitment to the introduction of a minimum unit price for alcohol. This is appended in Annex A.

Recommendations

4. It is recommended that:

   a) the information be noted; and
   b) the strategy be presented for approval by Leaders and Elected Mayors.

Contact: ***Andy Robinson, Head of Local Government Policy***

Annex A

What next for Minimum Unit Price?

ANEC Communications Approach to Keeping MUP in the News

Introduction

Following a recent meeting of the Association of North East Council's Leaders' and Elected Mayors' Group, Balance was tasked with outlining a communications strategy designed to demonstrate the region's ongoing commitment to the introduction of a minimum unit price (MUP) for alcohol. This paper contains a number of suggested initiatives for consideration by the group, all of which are designed to secure media attention and demonstrate that ongoing commitment.

Background

This paper was requested prior to the Government's response to the National Alcohol Strategy consultation. However, as expected, the Government failed to commit to introduce MUP in the foreseeable future. Instead they have said they will ban below costs sales of alcohol, a measure which independent experts estimate to be between 40 and 50 times less effective than a MUP set at 45p per unit. The Government have also decided not to introduce a ban on multi-buy promotions. As a result of the Government's decisions, it will still be possible to buy two litres of strong, white cider for £1.43. (see attached table for relative impacts of below cost ban, MUP at 45p and MUP at 50p).

Tackling the affordability of alcohol remains critical if we are to reduce alcohol harm and, despite ministerial statements to the contrary, MUP is an evidence-based intervention which targets young and heavy drinkers while not penalising moderate drinkers, no matter what their level of income. As a result, groups with the public's health and welfare at heart will continue to champion its introduction. This includes a number of local authorities in the North West of England who had been exploring the introduction of a MUP bye-law before the Government included the measure in the draft National Alcohol Strategy in March 2012.

Purpose/aims/objectives

The initiatives outlined in this document are designed to:

- Demonstrate the North East's commitment to tackling the problems caused by alcohol sold at pocket money prices

- Demonstrate that the local authorities are acting as one
- Help keep the problems of cheap alcohol and the opportunities offered by MUP in the minds of public and key decision-makers
- Keep up the pressure on the UK Government
- Help build a community of local authorities working together in supporting the introduction of MUP, to include identifying new local authority supporters outside the North of England heartland

Potential initiatives

The list of initiatives below is not exhaustive and all of them do not have to be implemented. Rather, they should be treated as a menu of possible activities. In order to demonstrate support for MUP and build pressure on the UK Government, the aim would be to secure media coverage of the range of activities proposed.

MUP Task and Finish Group

Councils may wish to consider the benefits of setting up a task and finish group to look at potential ways to tackle the problems caused by cheap alcohol. This would include consideration of the introduction of a local MUP, but would also consider other initiatives such as voluntary conditions in alcohol licenses and the introduction of initiatives similar to the one seen in Ipswich where retailers agreed to stop selling strong alcohol products in designated areas. This group could report to the Health and Wellbeing Board Chairs meeting and act as a vehicle for some of the initiatives outlined below.

Link to North West Local Authorities

ANEC's Leaders' and Mayors' Group has already endorsed the attendance of Balance at planning meetings of those North West authorities looking to instigate bye-laws for MUP in their communities. This process is likely to lead for calls from those authorities for the North East councils to join them in bringing in bye-laws and in setting up fighting funds to do so. Council leaders may wish to consider whether this is a course of action they wish to follow. They may also wish to consider whether they would be willing to support a lead North East local authority pursuing the introduction of a bye-law alongside partners in the North West.

Engage/Challenge the LGA

The LGA's response to the initial alcohol strategy consultation and reaction to the Government's recent decisions was weak, despite many councils and other professional and public bodies coming out in support of MUP. While much of the local authority support for MUP seems to reside in the North of England, there are councils elsewhere who face similar problems and have an appetite to get rid of cheap alcohol.

Engage Political Parties

The Government's recent consultation response implied that MUP would not entirely be abandoned as a policy; rather it would be "delayed until there is enough evidence that its introduction would be effective in reducing harms associated with problem drinking". MUP is official Labour Party policy and Balance will be working with partners nationally to highlight the importance of including MUP in the election manifestos of each of the main political parties. ANEC could also invite Members of Parliament to see for themselves the problems caused by cheap alcohol by asking them to visit treatment services; call in on an Emergency Department at a busy time; and take a trip out with the police on a Friday or Saturday evening. At the same time the North East councils could urge politicians to include MUP in their respective election manifestos.

Parliamentary Scrutiny

It is important that the problem of cheap alcohol remains on the parliamentary agenda. One way to do so would be for council leaders, through ANEC, to call for enquiries into the Government's National Alcohol Strategy to be carried out by the Health Select Committee (of which the Easington MP, Graham Morris, is a member) and the Home Affairs Select Committee (of which the Houghton & Sunderland South MP, Bridget Phillipson is a member). In particular, those committees could be urged to consider the Government statement that there is a lack of evidence to support MUP, whilst choosing to introduce a below cost ban, for which there is no evidence of effectiveness. The committees could also be asked to look at the role of the alcohol industry; the effectiveness of self -regulation and the Responsibility Deal; and to scrutinise their influence on Government decisions in relation to MUP.

Balance/ANEC Alcohol Conference

Working with ANEC, Balance is organising an alcohol conference to take place at Hardwick Hall on 21 and 22 November. The key speaker will be Prof Tim Stockwell, from the University of Victoria, British Columbia and leader of the team analysing the impact of minimum price in Canada. The conference presents an opportunity to bring together local leaders, perhaps via a breakfast meeting or speakers' dinner, to hear how effectively the policy is working in practice. It also provides an opportunity to demonstrate the level of support from a range of organisations across the North East, perhaps by issuing some kind of public declaration.

HEALTH UPDATE

PURPOSE OF THE REPORT

1. This report summarises recent developments for the Network's information.

Integration of Health and Social Care

2. In May the overnment announced that local areas must develop integrated health and social care services over the next five years. The Care Bill, currently before Parliament, gives local authorities a duty to carry out their care and support functions with the aim of integrating services with those provided by the NHS and with other health related services. (This parallels the duty on the NHS under the Health and Social Care Act 2012).

3. In collaboration with a range of partners in local government, health and social care, the overnment published Integrated Care and Support: Our Shared Commitment , which sets out a vision of the action that will be needed, across organisations, to make integrated care and support happen. It adopts the following definition of integrated care:

> *"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me".*

4. The Department of Health has sought expressions of interest from local areas seeking to become pioneers' on the health and social care integration programme. The closing date for the first wave of applications was 2 une.

5. As part of the 2015/1 Spending Round, the overnment has created a 3. billion pool of health and social care funding for integration. According to a oint DCL /DH letter, this investment will strengthen incentives for local authorities and the NHS to work together and deliver integrated services more efficiently , through measures such as:

- better sharing of information so people only need to explain their problems once;
- avoiding unnecessary hospital admissions and reducing A E visits;
- social care and NHS staff working together, with families and carers, to ensure people can leave hospital as soon as they are ready; and
- provision of integrated support to carers.

. For 2014/15, an additional 200m will be transferred to local government from the NHS to support transformation.

7. The L□A and NHS England have issued a □oint statement (Annex A) on the pooled budget, which is referred to as the health and social care Integration Transformation Fund (ITF). The ITF will be created from □1.9bn existing funding continued from 2014/15 (which will already have been allocated across the NHS and social care to support integration), plus □1.9bn additional NHS money from a range of sources. □1bn of the total will be performance□related, with half paid on 1 April 2015 (based on performance in the previous year) and half in the second half of 2015/1□ (which could be based on in□year performance).

□. To access the ITF, each locality will be asked to develop a local plan by March 2014 setting out how the pooled funding will be used and how the national and local targets attached to the performance□related element will be met. The plan will also set out how the □200m transfer to local authorities in 2014/15 will be used to make progress and build momentum. Plans will need to be developed □ointly by CC□s and local authorities and signed off by each party and the local Health and Wellbeing Board. They will also need to be signed off by Ministers. The Secretary of State has been □uoted as saying that to access the funding CC□s and HWBs must bring forward extremely ambitious plans.

9. □iven the timescale, it is suggested that local discussions about the use of the ITF start now in preparation for more detailed planning in autumn/winter.

10. The plans will need to address the following conditions:

- they must be □ointly agreed;
- protection for social care services (not spending);
- 7□day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that this will re□uire the resolution of some information governance issues by the Department of Health);
- □oint approach to assessments and care planning;
- where funding is used for integrated packages of care, there must be an accountable professional;
- risk□sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached; and
- agreement on the conse□uential impact of changes in the acute sector.

11. The conditions for payment of the performance□related □1bn are still under discussion. It is envisaged that they will consist of a mix of national and locally chosen measures.

12. Whilst the ITF will be created from □1.9bn existing funding, plus □1.9bn additional NHS money from a range of sources, it should be noted that DCL□ technical consultations published on 25 □uly suggest much higher cuts than expected from the Spending Review, with a □3.1billion cash cut in core funding in 2015/1□ rather than the □2.1billion cut announced in the Review. Research suggests additional funding for new items, including social care new burdens (as recommended by Dilnott), now being funded by an □□00 million cut from core funding. Directors of Resources are preparing responses to the technical consultations.

Caring for our Future – consultation

13. In 2012 the □overnment published a White Paper Caring for our Future: Reforming Care and Support', alongside a draft Care and Support Bill. These documents set out the overnment's acceptance of the Dilnot principles' as the basis for a new model of funding for social care: namely financial protection for individuals through a cap on total lifetime costs, and the extension of the means□tested threshold.

14. In its response to the draft Care and Support Bill (October 2012), the Association welcomed the overnment's support for the Dilnot principles, while noting that more work needed to be done to assess the costs of the proposals and how they were to be funded – especially given the strain on adult social care budgets, and the significant cost reductions and cost pressures being experienced.

15. The □overnment has now issued a consultation paper on its proposals for transforming the way social care is paid for and the amounts that people have to pay. □ey points include:

- from April 201□, a lifetime cap on eligible care costs will be set at □72,000 for people of state pension age. People who develop eligible needs before state pension age will benefit from a lower cap (to be determined), and people who reach the age of 1□ with eligible needs will receive free care and support;
- the total cost of meeting the person's eligible needs will count towards the cap, rather than their financial contribution (so if they are receiving some local authority support, that will count towards the cap as well);
- people receiving residential care will remain responsible for a contribution to daily living costs, which will be set at around □12,000 per annum;
- also from April 201□, the financial limit used in the financial assessment for people in residential care will increase from the current □23,250 to □11□,000, when the value of the person's home is considered as part of their capital; and
- from April 2015, every local authority will be re□uired to offer the option of a deferred payment to anyone who needs to sell their home to pay for residential care – they will be able to defer their care fees for their lifetime and pay from their estate.

1□. The consultation paper notes that the □overnment has provided □335m for 2015/1□ to cover the costs of implementation of the cap and the re□uirement to offer deferred payments for residential care.

17. The consultation paper also sets out proposed arrangements for assessing people's care and support needs and providing advice (including financial advice) on the types of care and support available to them. This is the first stage in a process that establishes whether a person's needs are eligible and allows their local authority to track the care costs that count towards the cap – as well as ensuring that the local authority picks up the costs once the cap is reached. It is estimated that an additional 500,000 people could contact their local authority in 201□ for an assessment and advice.

1□. The closing date for responses is 25 October. It is proposed that the Association should prepare a response in consultation with member authorities and ADASS and this will be considered in the forthcoming round of meetings.

NHS Mandate – consultation

19. The Government is required to publish, and update annually, a Mandate to NHS England setting out the key objectives that it is expected to achieve.

20. In July the Government published a consultation paper on refreshing the Mandate for 2014/15. Key aims of the refresh include:

- to reflect the recommendations of the Francis report and the Winterbourne View Inquiry to transform patient care and safety;
- to ensure that NHS England leads the way in making best use of resources at a time of pressure on public finances; and
- in response to unprecedented pressures on Accident & Emergency Services, to work with NHS England to develop a vulnerable older people's plan, which will explore how the NHS can improve out of hospital care.

21. The closing date for responses is 27 September. The Mandate is essentially directed at NHS England rather than local government and at this stage it does not appear that there are any issues for the Association to take up.

Minimum Unit Pricing – the Government's response to the alcohol strategy consultation

22. On 17 July the Minister of State for Crime Prevention (Jeremy Browne MP) announced that plans in relation to minimum unit pricing would not be proceeded with at the present time, though the policy would remain under consideration. The Government considered that there was not yet enough concrete evidence that its introduction would be effective in reducing harms associated with problem drinking without penalising people who drink responsibly.

23. At their meeting on 12 July, Leaders and Elected Mayors asked for an action plan to be drawn up. This is the subject of a separate report on this agenda and will be referred to the Leaders and Elected Mayors' Group at their next meeting.

Tobacco – standardised packaging

24. The Government has published a response to the consultation on the standardised packaging of tobacco products. In a written statement, the Secretary of State for Health notes that many thousands of responses to the consultation were received, and the views expressed were highly polarised. Of those who provided detailed feedback, some 53% were in favour of standardised packaging while 43% thought the Government should do nothing. Having considered these views, the Government has decided to wait until the emerging impact of the decision in Australia to introduce standardised packaging can be measured.

25. The issue of investment in tobacco companies by pension funds is the subject of a separate item on today's agenda.

Programme of events

26. It has previously been agreed to draw up a programme of events where local authorities and the NHS can consider operational issues and forward planning, including:

- events in 2013 on winter pressures and □oint working, and the lessons of the Francis report and Winterbourne View; leading up to
- a Health Summit in Spring 2014 which would take stock of progress since the transition to the new health system in April 2013 and could involve all the key organisations involved in the health agenda.

27. Work is in hand to scope these events in consultation with partner organisations including Public Health England and NHS England.

Role of Health and Wellbeing Boards

2□. Following the discussion at the last Network meeting about the Winterbourne View stocktake, a letter was sent to the Department of Health and the Chair of the Winterbourne View Improvement □oint Committee about the implications for HWBs and their responsibility for local performance management. A meeting with the lead DH civil servant for local government policy has also been re□uested.

Recommendations

29. Network members are asked to note this information and consider if there is any advice it wishes to give and/or any issues it wishes to pursue.

Contact: ***Jonathan Rew, Specialist Support Officer***

Annex A

Statement on the health and social care Integration Transformation Fund

Summary

1. The □une 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand pressures on services. In this context the announcement of □3.□ billion worth of funding to ensure closer integration between health and social care was a real positive. The money is an opportunity to improve the lives of some of the most vulnerable people in our society. We must give them control, placing them at the centre of their own care and support, make their dignity paramount and, in doing so, provide them with a better service and better □uality of life. Unless we sei□e this opportunity to do something radically different, then services will get worse, costs to taxpayers will rise, and those who suffer the most will be people who could otherwise lead more independent lives.

2. The funding is described as: a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities . We are calling this money the health and social care Integration Transformation Fund (ITF) and this note sets out our □oint thinking on how the Fund could work and on the next steps localities might usefully take.

3. NHS England, the Local □overnment Association (L□A) and the Association of Directors of Adult Social Services (ADASS) are working closely with the Department of Health and Department for Communities and Local □overnment to shape the way the ITF will work in practice. We have also established a working group of CC□s, local authorities and NHS England Area Teams to help us in this process.

4. In *Integrated care and support: our shared commitment*' integration was helpfully defined by National Voices – from the perspective of the individual – as being able to plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me . The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

5. Whilst the ITF does not come into full effect until 2015/1□ we think it is essential that CC□s and local authorities build momentum in 2014/15, using the additional □200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two□year plans for 2014/15 and

2015/1□, which must be in place by March 2014. To this end we would encourage local discussions about the use of the fund to start now in preparation for more detailed planning in the Autumn and Winter.

Context: challenge and opportunity

□. The ITF provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The ITF is an important opportunity to take the integration agenda forward at scale and pace – a goal that both sectors have been discussing for several years. We see the ITF as a significant catalyst for change.

7. There is also an excellent opportunity to align the ITF with the strategy process set out by NHS England, and supported by the L□A and others, in *The NHS belongs to the people: a call to action*[1]. This process will support the development of the shared vision for services, with the ITF providing part of the investment to achieve it.

□. The ITF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work CC□s and local authorities are already doing, for example, as part of the integrated care pioneers initiative and Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

Background

9. The □une 2013 Spending Round set out the following:

2014/15	**2015/16**
An additional □200m transfer from the NHS to social care, in addition to the □900m transfer already planned	□3.□ billion pooled budget to be deployed locally on health and social care through pooled budget arrangements.

10. In 2015/1□ the ITF will be created from the following:

£1.9 billion existing funding continued from 14/15 - this money will already have been allocated across the NHS and social care to support integration
□130 million Carers' Breaks funding.
□300 million CC□ reablement funding.

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

c. £350 million capital grant funding (including £220m of Disabled Facilities Grant).
£1.1 billion existing transfer from health to social care.
£1.9 billion additional NHS money Includes funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill. Includes £1 billion that will be performance related, with half paid on 1 April 2015 (which we anticipate will be based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in year performance).

11. To access the ITF each locality will be asked to develop a local plan by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance related £1 billion will be met. This plan will also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

12. Plans for the use of the pooled monies will need to be developed jointly by CCGs and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.

Conditions of the full ITF

13. The ITF will be a pooled budget which will can be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7 day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health;
- ensure a joint approach to assessments and care planning;
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- risk sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached; and
- agreement on the consequential impact of changes in the acute sector.

14. Ministers have agreed that they will oversee and sign off the plans. As part of achieving the right balance between national and local inputs the L□A and NHS England will work together to develop proposals for how this could be done in an efficient and proportionate way.

Conditions of the performance-related £1 billion

15. □1 billion of the ITF in 2015/1□ will be dependent on performance and local areas will need to set and monitor achievement of these outcomes during 2014/15 as the first half of the □1 billion, paid on 1 April 2015, is likely to be based on performance in the previous year. We will be working with central □overnment on the details of this scheme, but we anticipate that it will consist of a combination of national and locally chosen measures.

Delivery through Partnership

1□. We are clear that success will re□uire a genuine commitment to partnership working between CC□s and local authorities. Both parties need to recognise the challenges they each face and work together to address them.

- Finding the extra NHS investment re□uired: □iven demographic pressures and efficiency re□uirements of around 4□, CC□s are likely to have to re□ deploy funds from existing NHS services. It is critical that CC□s and local authorities engage health care providers to assess the implications for existing services and how these should be managed;
- Protecting adult social care services: Although the emphasis of the ITF is rightly on a pooled budget, as with the current transfer from the NHS to social care, flexibility must be retained to allow for some of the fund to be used to offset the impact of the funding reductions overall. This will happen alongside the on□going work that councils and health are currently engaged in to deliver efficiencies across the health and care system.
- Targeting the pooled budget to best effect: The conditions the □overnment has set make it clear that the pooled funds must deliver improvements across social care and the NHS. Robust planning and analysis will be re□uired to (i) target resources on initiatives which will have the biggest benefit in terms outcomes for people and (ii) measure and monitor their impact;
- Managing the service change conse□uences: The scale of investment CC□s are re□uired to make into the pooled budget cannot be delivered without service transformation. The process for agreeing the use of the pooled budget must therefore include an assessment of the impact on acute services and agreement on the scale and nature of changes re□uired, e.g. impact of reduced emergency activity on bed capacity.

Assurance

17. Local Health and Wellbeing Boards will sign off the plans, which will have been agreed between the local authority and CC□s. The HWB is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector□led approach to the process. The plans will then go through an assurance process involving NHS England to assure Ministers.

Timetable and Alignment with Local Government and NHS Planning Process

1. Plans for use of the pooled budgets should not be seen in isolation. They will need to be developed in the context of:

- local joint strategic plans;
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term strategic plans as part of the NHS Call to Action)
- the announcement of integration pioneer sites in October, and the forthcoming integration roadshows.

19. The outline timetable for developing the pooled budget plans in 2013/14 is broadly as follows:

- August to October: Initial local planning discussions and further work nationally to define conditions etc
- November/December: NHS Planning Framework issued
- December to January: Completion of Plans
- March: Plans assured

Next Steps

20. NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of Funds
- Conditions, including definitions, metrics and application
- Risk sharing arrangements
- Assurance arrangements for plans
- Analytical support e.g. shared financial planning tools and benchmarking data packs.

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Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

8 August 2013

NHS England Publications Gateway Ref. No.00314

PUBLIC HEALTH KNOWLEDGE RESOURCES

Purpose of the report

1. This report provides Network members with information on existing knowledge resources in the field of public health. □nowledge and information can, of course, be found from many places and organisations but this report picks up some of the key sources.

Background

2. At their last meeting, members noted a re□uest from Fuse, the Centre for Translational Research in Public Health, to make a presentation on their research and evaluation service. Members noted the re□uest and asked that, as a first step, a short paper should be prepared for the Network on the knowledge resources that were available – including, for example, relevant parts of Public Health England (PHE) as well as Fuse and similar bodies.

3. The following information has been collated.

Public Health England

4. PHE supports councils' intelligence teams by undertaking a combination of national and locally tailored knowledge and intelligence work. A full description of PHE's work in this field is attached (Annex A); in brief, this includes:

- producing a range of national products including indicators, profiles, tools and reports;
- working with local partners to support the local use of these outputs;
- holding a range of raw data sets that are used to support local work – such as hospital episode statistics, births and deaths data, population figures and data held by the Regional Maternity Survey Office;
- facilitating regional intelligence networks such as PHINE (Public Health Intelligence Northern England); and
- providing training for local authority analysts in the use of this data.

5. In terms of structure, the North East is covered by the Northern and □orkshire □nowledge and Intelligence Team, headed by Professor Brian Ferguson; an Associate Director, Dr David Chappel, is based in Durham.

Fuse – Centre for Translational Research in Public Health

□. Fuse is a Public Health Centre of Excellence, drawing together a group of public health researchers from the five North East universities who work together on issues connected with improving health and reducing health ine□ualities. Fuse has

launched a service called AskFuse, a rapid response research and evaluation service which aims to respond to re□uests from anyone working in the broad field of health wellbeing or social care. A briefing outlining the services offered is attached (Annex B).

7. Fuse has previously asked to make a presentation to the Network on the services that it offers.

Local authorities

□. In addition to the above, local authorities also hold extensive data on public health within their own authority. As an example, attached (Annex C) is a list of public health data held by □ateshead Council. These data sets are accessed from a variety of sources (see second column of table) and are in addition to data provided by Public Health England. The data sets are compiled and managed for □ateshead, South Tyneside and Sunderland by the North of England Commissioning Support Unit (NECS) which was previously part of NHS South of Tyne □ Wear.

Recommendations

9. The Network is asked:

a) to note this information; and
b) if it wishes to receive a presentation from Fuse.

Contact: ***Jonathan Rew, Specialist Support Advisor***

Annex A

Knowledge and Intelligence Team

Northern and Yorkshire

Public Health England

Briefing on Public Health knowledge resources

Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health. In the North East, Public Health England is represented by the North East Centre and links to the Northern and Yorkshire Knowledge and Intelligence Team.

Intelligence teams within councils remain the first port of call for knowledge resources locally. However, PHE supports these teams by undertaking a combination of national and locally tailored knowledge and intelligence work.

PHE produces a range of national products and will develop new ones on a 'do once for all' basis; this includes indicators, profiles, tools and reports. These include the well established Health Profiles www.healthprofiles.info, specific profiles for in a range of areas www.apho.org.uk, and the Public Health Outcomes Framework www.phoutcomes.info (see Appendix 1 for a full list). PHE will also take an active lead in working with local intelligence partners to support the local use of these outputs through regular dissemination, helping with the local interpretation and application, and facilitating the feedback process.

PHE Knowledge and Intelligence Teams also hold a range of raw data sets which will be used to support local work. These include: Hospital Episode Statistics, births and deaths data, population figures and the wide range of data held by the Regional Maternity Survey Office. The delivery of locally tailored work will be determined by business plans developed by PHE in collaboration with local partners but ad hoc requests for pieces of work will be also considered if they correspond clearly with local public health priorities and business plans, particularly if they relate to a wide geographical area, such as that covered by a PHE Centre or a Strategic Clinical Network.

PHE will facilitate regional intelligence networks, for the purposes of sharing learning and supporting continuing professional development. For the North East, this means the continuation of the successful PHINE network, providing both quarterly network events open to all, and a web presence to support resource sharing and communities of practice (www.phine.org.uk). There is a group set up on PHINE for each local authority in the region, hosting many of the relevant public health resources for that area, and allowing council staff and members to load additional public health resources of interest e.g. http://www.phine.org.uk/stockton/resources.

Appendix 1: PHE Data and Knowledge Gateway resources

https://www.phe□datagateway.org.uk/phe□dataportal/

There is some repetition of resources in the following lists as some outputs support work on several different topics. There is also a predominance of data and information resources rather than knowledge from research evidence. This will change in time but other agencies such as NICE www.nice.org.uk produce much of this.

Cancer intelligence

1. Cancer commissioning toolkit
   The toolkit is the first point of contact for cancer commissioners to benchmark the services they commission at national, NHS trust, primary care trust, □P practice and clinical commissioning group levels.
2. Cancer e□atlas
   Provides information on incidence, mortality and survival for the main types of cancers in males and females.
3. Cancer mortality profiles
   Interactive spreadsheets to support the monitoring, commissioning and planning of local cancer services. Show trends in cancer mortality rates for under 75 year□olds by different levels of geography.
4. Cancer patient experience
   Department of Health survey providing insights into the care experienced by cancer patients across England who were treated as day cases or inpatients.
5. □P practice profiles
   □P Practice Profiles bring together a range of outcomes and process information relevant to cancer in primary care providing readily available and comparative information at □eneral Practice level
6. □ynaecological cancer hub
   The hub provides links to external resources, data and intelligence on all gynaecological cancers, comprising: e□atlas profiles; useful links for the general public; and resources for health professionals.
7. □ynaecological cancer profiles
   Incidence and mortality rates for the main gynaecological cancers, survival, associated risk factors and cervical screening indicators at primary care trust and cancer network level.
8. Head and neck cancer e□atlas (profiles)
   The United □ingdom Head and Neck e□Atlas covers the main subgroups of head and neck cancers for the whole of the United □ingdom. The aim of the e□ Atlas is to provide the public, health care professionals, commissioners and

health service managers with basic information on incidence and mortality for the main types of head and neck cancers in males and females.

9. Head and neck cancer e□atlas (resources)
   Provides the public, health care professionals, commissioners and health service managers with basic information on incidence and mortality for the main types of head and neck cancers in males and females.
10. Head and neck cancer hub
    Provides NHS providers, commissioners, cancer networks, charities and clinicians with data and intelligence on head and neck cancers in England. It also provides information for patients and the public.
11. National cancer intelligence network
12. PCT profiles
    Provide information about 2□ key indicators relating to cancer services for every primary care trust in England.
13. Prevalence e□atlas
    An interactive tool which uses maps, charts and data tables to display cancer prevalence data by cancer network for the U□.
14. Service profiles
    The Cancer Service Profiles for breast and colorectal bring together a range of outcomes and process information relevant to cancer in secondary care (accessed via the Cancer Commissioning Toolkit)
15. Skin cancer hub
    Information and intelligence to support professionals and educate the public about skin cancer prevention and early diagnosis. Includes profiles, factsheets, reports and points to other information sources.
1□. Skin cancer profiles
    Indicators to help identify and understand trends in skin cancer across England. Includes incidence and mortality rates for malignant melanoma and influencing factors such as deprivation.
17. Thirty□day postoperative mortality after colorectal cancer surgery in England
    e□Atlases containing information on the 30□day postoperative mortality rates of all English NHS trusts and cancer networks undertaking ma□or surgery for colorectal cancer.
1□. U□ cancer information service (U□CIS)
    National web□based reporting tool, running across the NHS national network, providing the user access to cancer information for their area. (Users must be registered and connected to the NHS network)
19. Urological cancer hub
    Contains factsheets, reports, profiles and analysis of data on the urological cancers.
20. Urological cancer profiles
    Incidence, mortality and survival data for the urological cancers. Presented at various geographies in an interactive web□based tool.

Child and Maternal Health

1. Breastfeeding profiles
   The breastfeeding profiles for primary care trusts (PCTs) show performance against a range of indicators describing demographic, breastfeeding behaviour and health outcome data for mothers and their children.
2. Child and maternal health intelligence network
   Provides information and intelligence to improve decision-making relating to children, families and maternal health.
3. Child health profiles
   Child Health Profiles provide a snapshot of child health and well-being for each local authority in England using key health indicators, which enables comparison locally, regionally and nationally.
4. Comprehensive CAMHS integrated workforce planning tool
   Helps you produce your Comprehensive CAMHS Integrated Workforce Plan.
5. Data atlas – children, young people and maternity
   Data atlas brings together all relevant national datasets relating to children, young people and maternity in a user friendly, accessible way.
6. Disease management information toolkit (DMIT) - children
   DMIT allows commissioners to compare the performance of organisations in their area for emergency admissions for children with diabetes, epilepsy and asthma against the national average and other organisations.
7. Healthy schools profiles
   See at a glance how your local area performs against key indicators and compare data with other local authorities and nationally.
8. Infant mortality profiles
   The Infant mortality profiles for primary care trusts (PCTs) show performance against a range of indicators to help support the Implementation plan for reducing health inequalities in infant mortality.
9. JSNA navigator – children and young people
   Direct access to the data which you need when conducting a joint strategic needs assessment (JSNA) locally for children and young people.
10. Knowledge hub - children's, young people's and maternal health
    The knowledge hub provides easy access to a range of information, evidence, knowledge and expertise relating to all aspects of children's, young people's and maternal health.
11. Needs assessment reports – CAMHS, disability, continence, demographic profile, maternity, speech and language
    Appropriate evidence-based information on prevalence, incidence and risk factors affecting children's health and the provision of healthcare services.
12. NHS atlas of variation in healthcare for children and young people
    The atlas identifies unwarranted variation in children's services, highlighting opportunities for commissioners and clinicians to improve health outcomes and minimise inequalities.

13. Outcomes versus expenditure tools – CAMHS, child health, maternity and newborn
    Compare expenditure and other aspects of service with a number of outcome measures at primary care trust (PCT) level.
14. PREview planning resources – early years
    A set of planning resources to help commissioners, managers and professionals to target preventive resources, in particular around the Healthy Child Programme.
15. IPP resource packs – child health, maternity
    Looking at a range of indicators and evidence, these reports will help you identify opportunities to improve the uality and value of local services for mothers, children and their families in your area.
1. Self assessment tools acute paediatric services, infant mortality, NICE neonatal standards, young peoples mental health transitions Tools designed to help commissioners and local health economies assess their progress in implementing key national policy.
17. Service snapshots CAMHS, disability, infant mortality, maternity, obesity, teenage pregnancy and vaccination and immunisation
    Provide a summary of demand, risk factors, provision and outcomes for services in a particular area.
1. Tools and data directory – child and maternal health
    This directory brings together a range of commissioning tools and data collections and statistics to support planning and decision making to improve children s, young peoples and maternity services.
19. Topical reports – accident prevention, healthy schools, youth ustice
20. outh ustice health and wellbeing needs assessment toolkit
    This toolkit helps with the planning, commissioning and writing of health and wellbeing needs assessments for use across the youth ustice system, in both community and secure settings.
21. outh ustice liaison and diversion toolkit
    This toolkit helps the commissioning and delivery of services for children and young people (and their families) whose behaviour puts them in contact or at risk of contact with the youth ustice system.

Comparison, practice and performance

1. National general practice profiles
    Helps Ps and clinical commissioning groups commission effective and appropriate healthcare services for their populations. Individual practice profiles can grouped together to produce a cluster' profile.
2. PCT CC spend and outcome factsheets and tool (SPOT)
    The PCT spend and outcome factsheets and tool (SPOT) helps commissioners to link health outcomes and expenditure using programme budgeting, a techni ue for assessing programmes of care rather than services.

3. Public health outcomes framework
   Sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected.
4. □uality profiles for NHS mental health trusts in England

Drugs, alcohol and tobacco

1. Alcohol learning centre data tools
   Tools and guidance from the Alcohol Learning Centre for commissioners and providers for needs assessment, treatment capacity, service impact and planning responses in local alcohol service delivery.
2. Drug and alcohol monitoring system (DAMS)
   The national drug and alcohol treatment monitoring system (NDTMS) is a secure platform for treatment providers and prisons to upload and validate their data each month.
3. Information on drug and alcohol treatment
   The NDTMS collects data from drug and alcohol treatment services in England in order to monitor progress of local systems and assure delivery of the treatment element of the overnment's drug strategy
4. Local alcohol profiles for England (LAPE)
   Comprising 25 updated indicators, including new data on hospital admissions for alcohol□related harm (formerly national indicator NI39).
5. Local tobacco control profiles for England
   Provides a snapshot of the extent of tobacco use, tobacco related harm, and measures being taken to reduce this harm at a local level.

End of life care

1. End of life care profiles
   Indicators by local authority and primary care trust to help commissioners and providers understand the end of life care needs of their populations.
2. End of life care □uality assessment tool (ELC□uA)
   Free online self□assessment tool for organisations caring for people at the end of life. Designed to support local service improvement.
3. National end of life care intelligence network
   Information and intelligence to drive improvements in the □uality and productivity of end of life care for adults in England. Includes profiles, reports and a compendium of data sources.

General health profiles

1. European Health Profile Tool
2. European regional health profiles (I2SARE)
   The European pro□ect I2SARE (Health Ine□ualities Indicators in the Regions of Europe) gives decision makers an overview about the health situation in each region in comparison with other European regions.

3. Health profiles
   The profiles give an overview of health for each local authority in England. They help local government and health services make decisions and plans to improve local people's health and reduce inequalities.
4. Health protection profiles
   The Health Protection Profiles cover health protection issues from environmental hazards to vaccine preventable infections. They inform health choices and improve awareness of local health protection risks.
5. Local health (neighbourhood) profiles
   Local health gives access to interactive maps and reports at ward, middle super output area (MSOA) and local authority level, and any user defined combination of these geographies.
6. Small area indicators for joint strategic needs assessment
   Indicators at middle super output area (MSOA) level for carrying out joint strategic needs assessment. It includes population estimates, mortality, hospitalisation, lifestyle and socioeconomic data.

Health Impact Assessment

1. Health impact assessment (HIA) gateway
   Resources and information on HIA and other impact assessments for those new to HIA, HIA practitioners and those wishing to commission HIAs.

Health inequalities

1. Health Inequalities Gap Measurement Tool
2. Health inequalities intervention toolkit
   For English local authorities, illustrates inequalities in life expectancy and infant deaths, especially for disadvantaged populations, and how such inequalities can be reduced by evidence-based interventions.
3. Health inequality indicators
   Health inequalities data for each local authority and primary care organisation in England. The statistic presented is the slope index of inequality in life expectancy for males and females.
4. Health poverty index (HPI)
5. Infant mortality tool (part of the health inequalities intervention toolkit)
   This tool includes data and charts showing trends in infant death rates and information on factors influencing infant mortality.
6. Life expectancy calculator: local authority and ward level
   Tool to calculate life expectancy figures. The template is for an abridged life table using 5-year age intervals with a final age interval of 85.
7. Longer lives
   Longer lives highlights premature mortality across every local authority in England, giving people important information to help them improve their community's health.

□. Marmot indicators for local authorities in England
□ey indicators for English local authorities of social determinants of health, health outcomes and social ine□uality, corresponding as closely as possible to indicators proposed in the 2010 Marmot Review.

Injuries and Violence

1. Hospital admissions due to in□ury in age 0□17 years
Hospital admissions due to in□ury in age 0□17 years: local authority level comparisons.
2. In□ury profiles for England
Provide a snapshot of in□uries occurring in each local authority in England. Interactive maps and charts enable regional and national comparisons for over 40 in□ury related indicators.
3. Violence indicator profiles for the English regions (VIPER)
Comprising eight different indicators, including hospital admissions for violence and unintentional and deliberate in□uries in under 1□s (formerly NI70), police recorded violent crime and mortality data.

Learning disabilities

1. Learning disabilities profiles
Set of 22 population, health and social care, and care co□ordination indicators for health care commissioners and local authorities, and for □oint strategic needs assessment.

Long term conditions

1. Adult obesity maps
This dynamic map of England shows the change in prevalence of adult obesity for sub□national geographies from 1993□2010. The data are from the Health Survey for England (HSE).
2. Electoral ward level prevalence data by BMI status
National Child Measurement Programme obesity and healthy weight prevalence data by 2011 electoral ward and 2001 middle super output area (MSOA) of residence with local authority and England comparative data.
3. Health impact of physical inactivity (HIPI) tool
Tool to support □oint strategic needs assessment. Estimates how many cases of certain diseases could be prevented in each local authority, if 40□79 year□ olds engaged in recommended amounts of physical activity.
4. Obesity data e□atlas
Interactive mapping tools for the analysis of data on the prevalence of obesity and its determinants at middle super output area (MSOA) and local authority level in England.
5. Obesity tool for local authorities
This information tool is designed to guide and support local authorities□ work to tackle obesity.

6. Children and young people diabetes community health profile
   The profiles aim to bring together a range of data on diabetes services and related health issues. They can be used to benchmark against other PCTs and provides a starting point for needs assessment work.
7. Diabetes community health profiles
   The profiles bring together a wide range of data on diabetes in adults in England. They provide an overview of the key areas of diabetes care and highlights further investigation.
8. Diabetes footcare activity profiles
   The profiles provide information on the inpatient care of people with diabetes who are admitted to hospital for a range of footcare conditions.
9. Diabetes outcomes versus expenditure tool (DOVE)
   Compare expenditure on diabetes care with clinical outcomes for a selected clinical commissioning group (CC□), other CC□s with similar populations and all other CC□s.
10. Diabetes prevalence model for local authorities in England
    Estimates diabetes prevalence (diagnosed and undiagnosed) by local authority. Calculations also show the potential impact of the increasing prevalence of overweight and obesity on diabetes prevalence.
11. Disease prevalence models
    Data and projections which give some background information to help understand local health needs and demands on health services now and in the future.
12. Interactive health atlas for lung conditions in England (inhale)
    Helps commissioners assess the impact of respiratory disease on local populations, assess variation and identify the services required to meet those needs.
13. □idney disease CC□ profiles
    A range of clinical commissioning group (CC□) level data on kidney disease, risk factors and services. For commissioners, □Ps, patients and kidney service staff for benchmarking and local needs assessment.
14. Mortality among inpatients with diabetes: profiles
    Analysis of mortality among hospital inpatients with diabetes. The profiles assess case□mix and risk factors for inpatient mortality and identify variation in the risk of an inpatient with diabetes dying.
15. National cardiovascular disease (CVD) profiles
16. National diabetes information service
    The National Diabetes Information Service (NDIS) has a comprehensive range of diabetes data, tools and information to aid decision making and improve services.
17. Variation in inpatient activity: diabetes
    The tool allows users to compare information on inpatient activity (day cases, bed days and emergency readmissions) for those with and without diabetes to provide evidence on differing care patterns.

Mental Health and Wellbeing

1. Community mental health profiles
   Present mental health information for local authorities in England, giving an overview of mental health risks, prevalence and services at a local, regional and national level using an interactive mapping tool.
2. Mental health hospital admissions by diagnosis
3. Mental health hospital admissions by ethnicity

Screening

1. NHS abdominal aortic aneurysm screening programme
   National key performance indicator (□PI), □uality standard and general activity reports for the NHS abdominal aortic aneurysm screening programme.
2. NHS newborn blood spot screening programme
   Annual data collection and performance analysis reports for the NHS newborn blood□spot programme.
3. NHS newborn hearing screening programme
   Hearing screening tests and follow up/referral assessment data. Used to enable monitoring of coverage, activity and data □uality to help mitigate risk in order to help improve programme delivery.
4. NHS sickle cell and thalassaemia screening programme
   Annual data reports for the NHS sickle cell and thalassaemia programme.

Sexual health

1. Health protection and sexual health profiles
2. HIV and STI web portal
3. Sexual health balanced scorecard
   Provides a snapshot of sexual health at local level. Compare regionally and nationally across a range of indicators, including teenage pregnancy, abortions, contraception and sexually transmitted infections.
4. Teenage pregnancy atlases, forecasts and other resources
   Interactive maps of under□1□ conception data at local authority and ward level and making comparisons with England.

Social care, adults and older people

1. Excess winter deaths (EWD) in England atlas
   Shows excess winter deaths data in England by local authority with the option to view trend data from 1990 to 2011. EWD data can also be viewed by disease condition or age group.
2. The older people□s health and wellbeing atlas
   Provides a snapshot profile of each local authority in England. Interactive maps and charts enable comparisons to be made nationally for over 100 indicators.

What is Askfuse?

Fuse (www.fuse.ac.uk) is a Public Health Centre of Excellence, drawing together a group of public health researchers from the five North East Universities who work together on questions connected with improving health and reducing health inequalities. This June, Fuse launched a service called Askfuse, which is a rapid response research and evaluation service. This short document explains what this service does and where to find out more details about it.

What can it do for you?

The aim of Askfuse is to respond to requests from anyone working in the broad field of health, well being or social care. For example, this could be about how the existing evidence base applies locally, making best use of current data, or evaluating services that are already in operation. Askfuse will draw on the expertise of colleagues most applicable to the issue at hand, and provide outputs that are useful, timely, independent, high quality and in plain English. The aim is to work collaboratively with partners at all stages of the process of addressing a specific issue, in a way that best meets the client's needs.

Here are some examples of the kinds of work that Askfuse could undertake – not an exhaustive list, but a flavour of what can be done:

- Research digests/scoping exercises – based on currently available evidence
- Rapid evaluations of current services and how they are working
- Reviews of documents produced within client organisations
- Analysis of routine data – to enable interpretation
- Undertaking new research from scratch, to address the client's question(s)
- Economic evaluation of costs and benefits of service
- Larger scale projects including full evaluations of effectiveness

How much will it cost?

This will depend on the scale and duration of the work undertaken. Initial conversations are free (see reverse of this sheet). Work on a project will only progress if the client is satisfied with what is proposed, and written agreement has been reached .

How can I find out more about Askfuse?

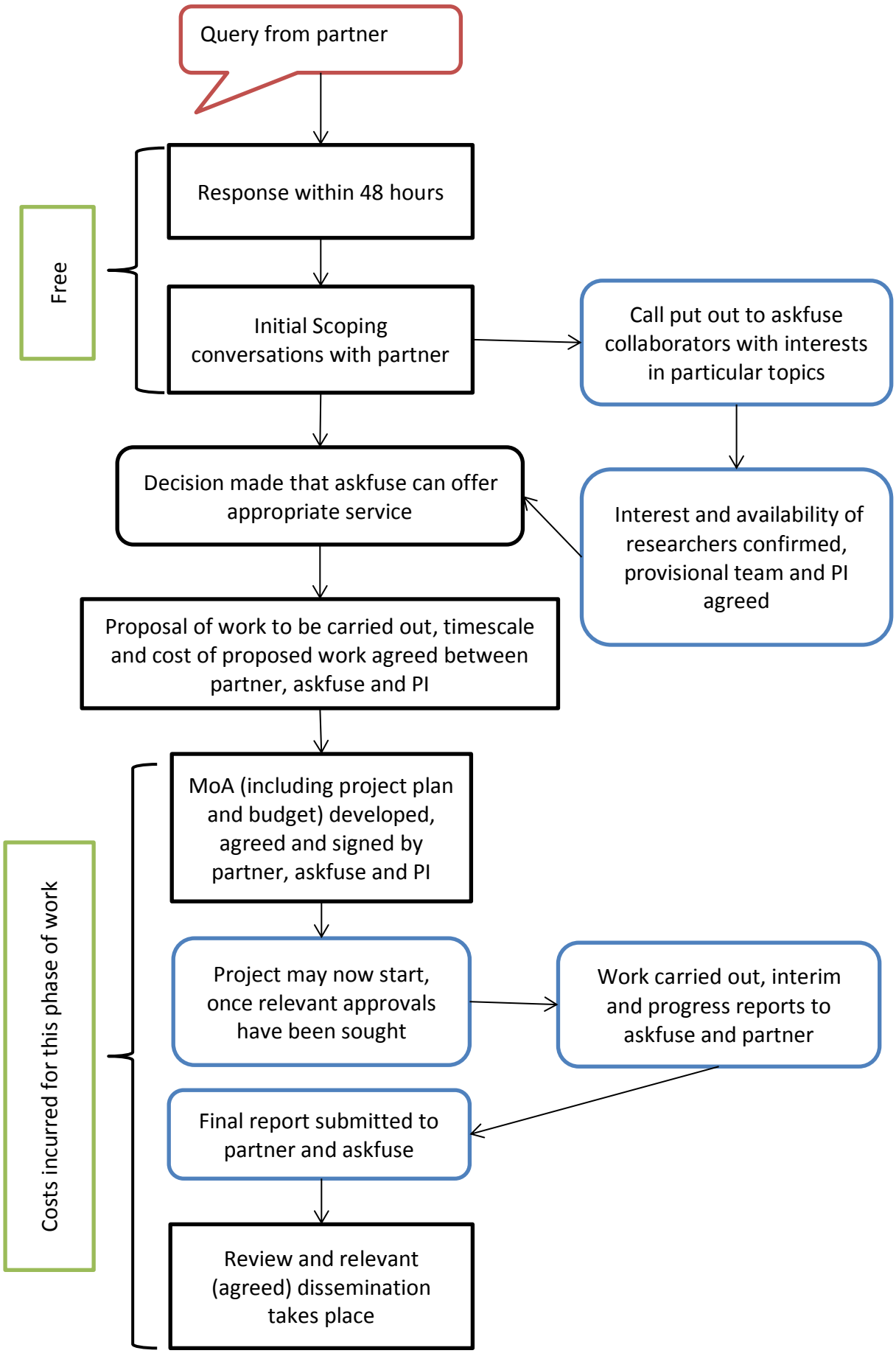
There is a dedicated part of the Fuse **website** on Askfuse www.fuse.ac.uk/askfuse In addition to introducing Askfuse, it has a section covering frequently asked questions about, for example, making an initial contact, the first response, costs, the timescales for work, ethical approval and data sharing. Examples of how we have worked with partners before may also be viewed on the website. Fuse is working on a **postcard** designed to sum up the Askfuse offer in a nutshell, and provide contact details for making an enquiry.

To make direct contact with Askfuse:
Tel: 01642 342757
Email: ask@fuse.ac.uk
Or complete our online enquiry form

How will Askfuse work?

The flow diagram on the reverse of this briefing note illustrates how Askfuse will work step by step.

How askfuse works



ANNEX C

Public Health Data held by LA

(Note: this is in addition to data held/provided by Public Health England)

Data Type	Data Source
Childhood Obesity (NCMP)	School Nursing / Child Health
Health Checks (IPMR)	GP Practices
Breast Feeding Continuation	Child Health
Smoking Cessation	Provider System (Call it Quits)
Breast Feeding Initiation	Foundation Trusts
Smoking at Time of Delivery	Foundation Trusts
Blood Spot Screening[1]	Child Health
Childhood Vaccinations (COVER)	Child Health
HPV	School Nursing / Child Health
Retinal Screening	Service Provider
School Leaver Vaccinations (KC50)[1]	School Nursing / Child Health
Flu Vaccinations	Immform
Health Checks	GP Practices
LVSD	GP Practices
Slimming on Referral	Hydra
Smoking Cessation	Service Providers
Alcohol Related Admissions	SUS
Breast Feeding Initiation	Foundation Trusts
Breast Feeding at Primary Booking	Child Health
Breast Feeding Continuation	Child Health
Childhood Obesity	School Nursing / Child Health
Childhood Vaccinations (13-18 year old)	Child Health
Childhood Vaccinations (Under 5s)	Child Health
Childrens Acute Metrics	SUS
Childrens A&E Analysis[2]	SUS
Childrens Admissions for Unintentional and Deliberate Injury	SUS
HPV Analysis	School Nursing
Life Expectancy Dashboard	Various
Life Expectancy / Healthy Life Expectancy	ONS
Low Birth Weights	ONS
MI Four Treatments	GP Practices
Mortality Rates (incl. all age - all cause, CVD etc.)	ONS
Suicide Audit Support	ONS
Teenage Births and Terminations	SUS

WORK PROGRAMME

Purpose of the report

1. This report updates members on the progress of items in the Network's work programme.

Issues

2. The following issues are on the agenda for today's meeting, either as stand alone reports or as part of the update report:

- Investment in tobacco by pension funds;
- Minimum Unit Pricing – action plan;
- Public Health – knowledge resources;
- Integration of Health and Social Care, and the Integration Transformation Fund; and
- Caring for our Future – consultation.

3. The following themes have previously been identified by the Network as potential issues for future consideration:

- reducing obesity and improving diet;
- low rates of breast feeding/smoking in pregnancy;
- how authorities are embedding public health, and integrating health into their other functions;
- exploring the causes of ill health in the North East – what are the drivers, and how can investment be directed into the right areas?
- safeguarding issues (staffing, systems, resources) for adults and children; and
- relationship between HWBs and Overview and Scrutiny.

Programme of events

4. It has previously been agreed to draw up a programme of events where local authorities and health partners can consider operational issues and forward planning. These include:

- Winter pressures – recognising that all parts of the health service, particularly hospitals, experience significant pressures during the winter period, the aim of the event will be to consider the actions that different parts of the health economy in the North East are taking to identify, mitigate and deal with these pressures, and how coordination between different organisations involved in this work can be improved. Discussions have been held with colleagues in Public Health England and NHS England Area Teams to scope the event, which is intended to take place in late October/early November;
- Learning the lessons of the Francis report and Winterbourne View; and

- A Health Summit in Spring 2014 which would take stock of progress since the transition to the new health system in April 2013 and could involve all the key organisations involved in the health agenda.

Recommendation

5. Members are asked to note the report and give any advice on how these issues should be taken forward and/or whether there are any other issues the Network should address.

Contact: ***Jonathan Rew, Specialist Support Officer***