HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

Monday 9 December 2013

at 10.00am

in Committee Room B
Civic Centre, 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) – Gill Alexander
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 28th October 2013 *(attached)*

4. ITEMS REQUIRING DECISION

4.1 Better Health Outcomes for Children and Young People/Child Poverty and Public Health *(Director of Public Health, Director of Child and Adult Services and Director of Regeneration and Neighbourhoods)*

5. ITEMS FOR INFORMATION

5.1 Strategic Planning in the NHS (*Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group)*
5.2 Integrated Transformation Fund (Director Child and Adult Services, Hartlepool Borough Council and *Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group)*
5.3 Local Healthwatch Work Plan *(Representatives of Healthwatch)*
5.4 End of Life Care (*Director of Public Health)*
5.5 Special Educational Needs Reform – The Children and Families Bill ((*Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group)*
5.6 Health Education North East – Presentation by Elaine Redhead (*Managing Director at Health Education North East)*

9. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT

10. ITEMS FOR INFORMATION

Date of next meeting – Monday 27th January 2014 at 10.00am in Committee Room B

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

28 OCTOBER 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 – Councillor Geoff Lilley and Councillor Chris Simmons.
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Pagni and Alison Wilson
Director of Public Health, Hartlepool Borough Council - Louise Wallace
Representatives of Healthwatch - Margaret Wrenn and Stephen Thomas.

Other Members:
Chief Executive, Hartlepool Borough Council – Dave Stubbs
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall
Representative of Tees Esk and Wear Valley NHS Trust – Martin Barkley
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster
Representative of North East Ambulance NHS Trust – Nicola Fairless
Representative of Cleveland Fire Brigade – Ian McHugh

Also in attendance:-

Andy Summerbell, NHS England
Lucia Saiger Burns, Director of Offender Management, Durham Tees Valley Probation Trust

Officers: Sally Robinson, Assistant Director, Children's Services
Zoe Westley, Head of Social and Education Inclusion
Richard Starrs, Strategy and Performance Officer
Joan Stevens, Scrutiny Manager
Andy Graham, Public Health Registrar
David Cosgrove, Democratic Services Team

37. Apologies for Absence

Councillors Ged Hall, Gill Alexander, Director of Child and Adult Services, Denise Ogden, Director of Regeneration and Neighbourhoods, Caroline Thurlbeck, NHS England, and Councillor Keith Fisher Representative of the

Audit and Governance Committee.

38. Declarations of interest by Members

None.

39. Minutes of the meeting held on 16 September 2013

Confirmed.

40. Maintaining and Developing the Joint Strategic Needs Assessment (JSNA) Proposal for 2013 Onwards (*Director of Public Health*)

The Director of Public Health gave an overview of the JSNA website including reference to the grouped topics in the website. The Director highlighted that following the recent changes within the NHS and the local authority, officers had been working with the CCG primarily in updating the various sections of the JSNA and the website.

The Director stressed the need for all partners to keep the JSNA updated, particularly with contact details for example, as changes to services became embedded and to improve existing topic content in breadth and depth where required and to demonstrate how policy and practice is influenced by JSNA processes.

The Director indicated that a summary of the current JSNA commissioning intentions and unmet needs had been published and a further report would be submitted to a future meeting.

Decision

That the content of the report and the process for maintaining and developing JSNA be noted.

41. Reviewing the Sustainable Community Strategy for Hartlepool (*Director of Public Health*)

The Strategy and Performance Officer reported that the Council had a statutory duty to prepare a Sustainable Community Strategy (SCS) for the Borough. The previous SCS was adopted 5 years ago in 2008 and therefore needed to be reviewed to ensure that it remains relevant, reflects local circumstances and responds to national changes.

Three options for reviewing the SCS were presented to Finance and Policy Committee on the 31st May 2013 and the Committee agreed to 'a change in approach with a downsized Community Strategy focussing on other key strategies to provide the detail.'

Therefore the new SCS would be greatly downsized and would compliment other key strategies and plans for the Borough for example the Health and Wellbeing Strategy, Housing Strategy, Economic Regeneration Strategy and the Community Safety Plan.

The first draft of the new strategy had been produced and had been subject to consultation through the summer. A copy of the draft was appended to the report for the Board's information. The Strategy and Performance Officer reported that there had been feedback from over 800 people to the draft strategy which were currently being analysed.

The second draft of the Strategy would be presented to Finance and Policy Committee in November. A further two week consultation would then be undertaken before the final draft of the SCS was produced for consideration by Finance and Policy Committee before submission to Council for adoption in February 2014.

Decision

That the first draft of the Strategy be noted and any feedback from partner organisations be provided to the Performance and Partnerships team at the Borough Council.

42. Making the Difference: the Role of Social Care Services in Supporting Vulnerable Offenders (*Director of Offender Management, Durham Tees Valley Probation Trust*)

The Director of Offender Management at Durham Tees Valley Probation Trust reported on the role of Social Care Services in supporting vulnerable offenders who live in Hartlepool in the light of the report 'Making the Difference'; the role of Adult Social Care Services in supporting Vulnerable Offenders'.

The Director highlighted that the Safer Hartlepool Partnership was ahead of many through its reducing re-offending focus and the role adult social care could play in assisting this. The 'Making the Difference report put the Health and Wellbeing Board in a key position in coordinating the provision of services to those offenders with multiple needs.

The Director also outlined for the Board the transition that probation trusts would be undergoing in the next twelve months as the government privatised offender rehabilitation services with an emphasis on payment by results. There was concern among many current probation trusts and probation officers that the most difficult offenders and those with complex needs could be almost excluded from the system as new contractors focussed their efforts on those offenders most likely to provide outcomes consistent with their contract.

Some Board members expressed their concern at the government's move to contracts with payment by results and the consequences that could have for

offenders with complex needs. The need to work with offenders to break the cycle of reoffending and help them attain things like stable tenancies and employment could not be underestimated. The Director commented that mental illness was prevalent among offenders and there was a great need to ensure there was appropriate early intervention combined with long term support as this had been shown to have the best results. This was one of the concerns with contracts that involved payment by results as this long term assistance may not be in the financial interests of contractors.

The Director indicated that with many offenders, by the time they came into the probation service at 18, much of the damage had already been done. The earlier intervention was made through social care services the better. Elected members agreed with the comments made by the Director but considered that the government's recent cut to Early Intervention Grant monies made this extremely difficult. The Chief Executive commented that it did appear that long term intervention strategies were not in favour with the government and the Board and all its partners needed to decide how they were going to invest in the provision of long term interventions. This view was supported by the representatives at the meeting and it was commented that greater communication between agencies was needed to ensure that maximum benefit was obtained from the services that were available across all providers.

The Director agreed that that level of communication at the front line was key as there had been reports of one family having as many as 29 different workers involved with them at one time. In such a situation, family members simply played one worker off against another. There were families where it had to be acknowledged that their life chances were extremely limited but breaking the cycle of offending could just be the key to improving their situation considerably. The concern was that with new contractors providing services from November 2014, there might be a level of reluctance from some to share information.

Decision

That the Health and Wellbeing Board considers the prioritising at both strategic and operational level within adult social care is key to ensuring that vulnerable offenders with multiple needs have those needs met in Hartlepool.

43. Summer and Winter Preparedness Plan (*Director of Public Health*)

Director of Public Health and Co-chair of the Local Health Resilience Partnership LHRP) and the Head of Emergency Panning, Risk and Resilience, NHS England's Durham Darlington and Tees Area Team (DDTAT) reported that a new Summer and Winter Preparedness Plan had been approved by the LHRP in August. The plan was informed through reference to the NHS England Heatwave Plan for 2013 and Cold Weather Plan for England 2011. The plan had been produced to provide a coordinated multi-agency response to the varying levels and, therefore, did not remove individual agency responsibilities to maintain their own plans in accordance

with the National documents.

Elected Members commented that the report and the plan were timely in light of the recent background of fuel price increases. There was some concern expressed at the apparent lack of consistency across local GP surgeries in ensuring take up of flu vaccinations. The government target of 70% take up across target groups seemed somewhat low in light of the potential benefits and risks. It was suggested that a more proactive approach involving health visitors and district nurses could assist in vaccinating some of the harder to reach patients. The key message was that you would not get the flu from the flu jab.

The Chief Officer of Hartlepool and Stockton-on-Tees Clinical Commissioning Group commented that the local target was 75% though some did fall short of that. The CCG had recently put in place a scheme to ensure that 85% of the target groups were vaccinated in Stockton and Hartlepool through provision of some additional funding available to GPs who were a little more innovative in reaching those hard to reach groups and those who were simply reluctant to have the vaccination. It was unfortunate that there were still a sizeable minority that refused to have the vaccination and it was commented that this applied to some front line staff as well. It was also highlighted that considerable effort was being applied to the vaccination of infant school aged children.

Decision

That the Summer and Winter Preparedness Plan be noted and endorsed.

44. Referral to the Audit and Governance Committee – Autism (*Audit and Governance Committee*)

In the absence of the Chair of the Audit and Governance Committee, the Scrutiny Manager reported that the Health and Wellbeing Board, at its meeting on the 5 August 2013, approved the Tees Autism Strategy and during the course of the meeting discussed a variety of issues in relation to the diagnosis and treatment of autism. The Board, as part of its discussions, was of the view that the issue would be appropriate for further consideration through the Scrutiny process and made a formal referral to the Audit and Governance Committee, for inclusion in its work programme.

The Audit and Governance Committee at its meeting on the 20 September 2013, considered the content of the referral and in doing so, noted that the Tees Valley Autism Strategy had been developed in conjunction with those diagnosed as being on the autistic spectrum, their families, service providers (both in the health and voluntary sectors) on a “you said, we did” basis. This had resulted in the development of a strategy that is fully responsive to service users’ needs.

In light of the information provided, and the only recent implementation of the Strategy, concern was expressed concern that the referral lacked significant detail to enable an effective scrutiny investigation to be undertaken, and as

such an investigation would add little, at this time, to the excellent piece of work already undertaken in the formulation of the strategy. In addition, the following points were raised;

(i) Given the complexity of the issue, other bodies would be much better placed to explore and define gaps in services, and address them.

(ii) Time and effort would be more appropriately applied to the implementation, and monitoring, of the recently approved Strategy.

The Committee discussed the referral in detail, including the constitutional requirement for consideration of such referrals, and after careful consideration, concluded that there was insufficient scope for an investigation at this time. On this basis, the Health and Wellbeing Board is asked to note that its referral has not been accepted for scrutiny by the Audit and Governance Committee.

The Scrutiny Manager indicated that in taking this decision, the Audit and Governance Committee emphasised their full support and appreciation of the extreme complexity of the issue and wished to make clear that this decision does not seek to undermine or devalue the importance of providing effective diagnosis and treatment services for those with autism.

A Member of the public present at the meeting questioned why autism was not treated by doctors and why there was no database of sufferers. It was indicated that should a GP consider that there may be a possibility of a child being diagnosed anywhere of the autistic spectrum, they were referred for a specialist assessment. The member of the public commented that for many autistic children their lack communication was one of their most debilitating symptoms which made diagnosis extremely difficult. This was agreed but it was highlighted that any diagnosis, while difficult, would involve a number of specialists on a multi-agency approach.

Decision

That the Health and Wellbeing Board note the Audit and Governance Committee's decision in respect of this particular referral.

45. Referral from Children's Services Committee regarding Speech and Language Therapy (*Children's Services Committee*)

The Chair of the Children's Services Committee reported that the committee wished to refer for consideration to the Health and Well Being Board the implications of the Early Intervention Grant Funding no longer being available for speech and language therapy services. The Chair indicated that at the meeting Members had received a report proposing cuts of over £1.5m following the government's Early Intervention Grant (EIG) reduction. Speech and language services were one of the cuts that the committee, reluctantly, had to accept.

The Chief Officer of Hartlepool and Stockton-on-Tees Clinical Commissioning Group questioned what issues had been raised through the impact assessment as there was concern that the removal of the commissioning of speech therapy services from EIG funds may increase referrals through to medical services. The Assistant Director, Children's Services commented that an Equality Impact Assessment had been completed but related to the impacts of the withdrawal of the service on service users. The CCG Chief Officer indicated that it was important that such issues were raised with partner organisation through the Board as all were in the same situation with budget cuts driving service reduction. It was important that where possible there was a coordinated approach to ensure that cuts in one organisation didn't simply lead to pressure in another.

The Chair questioned if a further report on the potential pressures should come to the next meeting. The CCG Chief Officer considered that there would need to be some time lapse following the removal of dedicated speech therapy from the early intervention services to judge the impact on other organisations. It was agreed that a report be submitted to the Board six months after the changes had taken place.

Decision

That a report be submitted to the Health and Wellbeing Board outlining the impacts of the removal of the commissioning of speech therapy services through the Early Intervention Grant six months after the implementation of the cuts enforced through the reduction in the grant.

46. Presentation - SEND Reforms and the Pathfinder Status (*Head of Social and Education Inclusion*)

The Head of Social and Education Inclusion gave a presentation to the Board updating the Board on the Council's Pathfinder Status for the implementation of the government's SEND Reforms. The previous updated presented to the Shadow Board in January had highlighted that the pathfinder status had been extended for a further 18 months. The Council was now essentially operating the reforms a year ahead of the legislative timetable.

The pathfinder status and the implementation of the new education, health and care plans had thrown up some interesting feedback from those involved. For example, parents had expressed a desire to see information accessible through mobile phones which would require some IT changes. There had been some trialling of personal budgets in relation to the provision of services to children with the new plans. The authorities experience with personal budgets in other service areas had informed the implementation though take-up was low at the moment.

One of the reforms that was going to be difficult to deliver was the single point of redress for families and young people. With a number of separate agencies involved in the delivery of services to children and young people with a plan providing a single point of redress was going to be difficult to coordinate and deliver.

Hartlepool was working with Darlington as a Pathfinder authority in terms of the implementation of the new legislation. Hartlepool was also acting as a 'champion' authority for north east authorities. A significant amount of work had been delivered during the pathfinder stage.

New plans need to be prepared for the children with current SEN Statements and Section 139a Assessments. This meant that around 700 new plans needed to be prepared. In response to questions, the Head of Social and Education Inclusion commented that there would be little form based work for GPs to do but those assessing children for their plans would meet parents to explain the details of the plan. There may be some time commitment but it was not expected to be particularly high for GPs.

Members questioned the impact on schools particularly with personal budgets. The Head of Social and Education Inclusion commented that there would be an element of funding that could not be accessed through personal budgets and that would be that allocated to the school.

The impact of the plans on young offenders was questioned and would providing them with assistance to desist from criminal activity be included in their new plan. The Head of Social and Education Inclusion commented that there would be one single plan for the young person so any plans in relation to offending would be included. Board members welcomed the new plans as an example of how agencies working together could make a significant difference on the lives of children and young people. The next time the progress was reported to the Board, members requested some real-life examples of the plans and how they were being implemented.

The Head of Social and Education Inclusion indicated that the Department of Health had published only two plans from the pathfinders as examples of good practice and one was a Hartlepool plan.

A series of consultation events were being held over the forthcoming weeks at the Historic Quay. Details of the events would be circulated to the Board.

Decision

That the presentation and discussions be noted.

47. Any Other Items which the Chairman Considers are Urgent

None.

The meeting closed at 11.50 am.

CHAIR

HEALTH AND WELLBEING BOARD

9th December 2013

HARTLEPOOL BOROUGH COUNCIL

Report of: Director of Public Health, Director of Child and Adult Services and Director of Regeneration and Neighbourhoods.

Subject: BETTER HEALTH OUTCOMES FOR CHILDREN & YOUNG PEOPLE/CHILD POVERTY AND PUBLIC HEALTH

1. PURPOSE OF REPORT

1.1 To gain support from Health and wellbeing Board members to sign up to the better health outcomes for children and young people pledge.

1.2 To highlight the new working paper: Child Poverty and Public Health from the North East Child Poverty Commission.

1.3 It is estimated that 33% of children in Hartlepool live in child poverty, this is an increase from 28% in the last two years.

2. BACKGROUND

2.1 In July 2013, a joint letter from: Department of Health, Local Government Association, Royal College of Paediatrics and Child Health and Public Health England was sent to the Lead Member for Children's Services and Chairs of Health and Wellbeing Boards (attached as Appendix 1)

2.2 The letter called for local authorities to do everything they can to improve children's health by signing up to the 'better health outcomes for children and young people pledge. The pledge is part of the February 2013 system wide response to the Children and Young People's Health Outcomes Forum Report (2012).

2.3 Signing up to the pledge will build on the commitment already made within the Local Health & Wellbeing Strategy to '*give every child the best start in life'*. The shared ambitions of the pledge are:

- Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority

- Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce

- Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell

- Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life

- There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people

3. CHILD POVERTY AND PUBLIC HEALTH

3.1 "Child Poverty and Public Health" (attached as Appendix 2) sets out research that shows the significant link between poverty and health outcomes. It states that *"Poverty is the greatest preventable threat to health, and tackling it is fundamental to addressing heath inequalities and boosting life chances."*
(Hirsch and Spencer)

3.2 The paper challenges Health and Wellbeing Boards to consider taking action to tackle child poverty which would make a long term contribution to health outcomes. It states that Health and Wellbeing Boards have a new opportunity to shape how services are delivered with actions focused on reducing child poverty.

4. PROPOSALS

4.1 No options submitted other than recommendations

5. RECOMMENDATIONS

5.1 It is recommended that the Health and Wellbeing Board acknowledges the content of the report and the appendices and:

- Considers working with partners and young people to adapt the pledge to reflect local needs
- Receive further reports on progress of a local pledge with a view to adopting the pledge once complete
- Considers how all partners can contribute to the reduction of child poverty

6. BACKGROUND PAPERS

Better health outcomes for children and young people ~ Our Pledge (Department of Health, Local Government Association, Royal College of Paediatrics and Child Health and Public Health England)

Child Poverty and Public Health (North East Child Poverty Commission)

7. CONTACT OFFICERS

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Department of Health | Local Government Association | RCPCH Royal College of Paediatrics and Child Health | Public Health England

20 July 2013

Dear Lead Member for Children's Services and Chair of the Health and Wellbeing Board,

Improving health outcomes for children and young people: Delivering and commissioning children and young people's public health services and invitation to sign the pledge

You will be as shocked as we are that childhood mortality in this country is among the worst in Europe. You will also want to know how poor many outcomes are for children and young people with long-term physical and mental conditions as well as those who are acutely sick. April 2013 marked the transfer of public health from the NHS to local authorities. Local authorities are now responsible for delivering and commissioning a range of children and young people's public health services for five to 19-year-olds, with responsibility for children under five following from 2015. This puts local authorities and health and wellbeing boards in a prime position to tackle the poor health outcomes experienced by children and young people.

We are writing jointly to you to share the resources available to assist councils with this increased responsibility and to invite you to sign up to the "Better health outcomes for children and young people pledge". The pledge is a part of the February 2013 system wide response to the Children and Young People's Health Outcomes Forum Report (2012).

Health and wellbeing boards are a crucial part of the new health landscape. Each board will want to ensure there is a proper focus on children within its priorities, that it has a thorough assessment of their needs through the Joint Strategic Needs Assessment, as well as from engagement with children and young people themselves. With a well-informed Joint Health and Wellbeing Strategy, services can be commissioned that will give children the best start in life. The resources outlined in Appendix A will help you to make this a reality.

We hope that signing up to the pledge will demonstrate a commitment to giving children the best start in life. We also hope it will start local conversations about how health and wellbeing boards, local authorities, health and wider partners can work together to improve health outcomes for children and young people, and tackle the unacceptable variation in the quality of care for children and young people across the country and reduce health inequalities. The Local Government Association (LGA), the Royal Colleges, the Department of Health and Public Health England are proud signatories of the pledge. We encourage you to work with partners and to engage with local children and young people to adapt the pledge to reflect local needs. A copy of the pledge is available at Appendix B.

Lead Members for Children's Services play a key role in these conversations and in ensuring that the health needs and wellbeing of all children and young people, including the most disadvantaged and vulnerable, and their families

and carers, are addressed. Lead Members will want to ensure they are working closely with their health and wellbeing boards in doing this.

We recognise that many local authorities are already doing important work to prioritise children's health outcomes through integration and partnership working. If all local areas were as good as the best, together we could improve children and young people's quality of life now, and their ability to live fulfilling lives as they move through childhood. We are inviting local authorities, health and wellbeing boards, health, schools and wider partners to share examples of good practice so that learning can be promoted nationally. If you would like to share what your local authority is doing or planning to do to improve health outcomes for children and young people email a short description to Samantha.Ramanah@local.gov.uk. All examples will be published on the LGA's website and Knowledge Hub for the National Learning Network for Health and Wellbeing Boards to share learning.

Not all change is an improvement, but there is no improvement without change. We ask you to make a commitment to using the information and resources attached to challenge the status quo and to signing the pledge. Bold and brave decisions will be needed if we are to give children, young people and families the services they deserve.

Dan Poulter MP,
Parliamentary Under Secretary of State for Health,
Department of Health

Cllr David Simmonds,
Chair of the Children and Young People Board,
Local Government Association

Christine Lenehan, Director, Council for Disabled Children and Co-Chair of the Children and Young People's Health Outcomes Forum

Professor Ian Lewis, Medical Director, Alder Hey Children's NHS Foundation Trust and Co-Chair of the Children and Young People's Health Outcomes Forum

Dr Hilary Cass,
President,
Royal College of Paediatrics and Child Health

Duncan Selbie
Chief Executive
Public Health England

Appendix A – Further resources

The Pledge can be accessed at:
www.gov.uk/government/publications/national-pledge-to-improve-children-s-health-and-reduce-child-deaths

Knowledge Hub for the National Learning Network for Health and Wellbeing Boards (HWBs)
The Knowledge Hub for HWBs is a free online platform, it shares information, resources, ideas and learning on Health and Wellbeing Boards. Members can ask for help from other members and participate in live question and answer sessions.
Join here:
https://knowledgehub.local.gov.uk/group/nationallearningnetworkforhealthandwellbeingboards
Email Samantha.Ramanah@local.gov.uk for help or further information

LGA dedicated children's health webpage
The LGA works with local authorities, including lead members for children's services to deliver better health and wellbeing outcomes for children and young people. Access the full range of support tools and latest information on children's health issues including safeguarding in the reformed NHS system, Health and Wellbeing Boards, local Healthwatch and public health issues.
www.local.gov.uk/childrens-health

The LGA has a dedicated webpage on health with tools and resources on public health, Healthwatch and health and wellbeing boards.
www.local.gov.uk/health

Child Protection Information Sharing project
The Children and Young People's Health Outcomes Forum welcomed the Department of Health's child protection – information sharing project, which Dan Poulter MP announced in December 2012. This will enhance national IT systems in emergency departments and other unscheduled health care settings to include information, fed securely from local authority systems, on the child protection status of individual children.

Local authorities are encouraged to express interest in the project now and to be ready to come on stream when it starts to roll out next year. More information can be found at:
www.gov.uk/government/news/child-protection-information-sharing-project

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 enable comparison locally, regionally and nationally. By using the profiles local organisations can work in partnership to plan and commission evidence-based services based on local need. The profiles allow local authorities to

compare the outcomes in their local population with others in order to identify and share best practice. Find your local profile at: www.chimat.org.uk/profiles

Atlas of Variation in Healthcare for Children and Young People
The Atlas of Variation provides information to allow clinicians, commissioners and service users to identify priority areas for improving outcome, quality and productivity.

Variations in healthcare exist for many legitimate reasons. Populations and individuals have distinct needs, and some of the variation observed is a reflection of the responsiveness of the service to meeting particular needs. However, the degree of variation demonstrated in the Child Health Atlas cannot be explained solely on that basis. Identifying and tackling variations in healthcare will improve both the quality and efficiency of the care provided, and deliver the best possible health outcomes for all children and young people.
www.rightcare.nhs.uk/index.php/atlas/children-and-young-adults

Establishing Local Healthwatch: Engaging with Children and Young People
Local Healthwatch's duties extend to involving children and young people in their work. It includes the need to develop strategies for effectively involving children and young people, and particularly those who are most disadvantaged. This is covered in one of a series of briefings produced by the Local Government Association to assist local authorities and their partners in local communities and the NHS to support the commissioning, setting up and early development of local Healthwatch. http://tinyurl.com/kxartmk

Factsheets for School Governors and Health and Wellbeing Boards and Children, Young People and Families
The Children and Young People's Health Outcomes Forum has published a range of factsheets. Local authorities may find the factsheets for school governors and health and wellbeing boards and children, young people and families of particular interest.
www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results

Factsheet on School Nursing
In addition the Department of Health has published a school nurse factsheet for head teachers and governors. The factsheet sets out details of the model and vision for school nursing which will positively impact on standards in all schools and improve health and wellbeing of school aged children and young people. http://tinyurl.com/kwpqvo2

Briefing on School Health Service

The Department of Health and Local Government Association have produced a briefing for Lead Members for Children's Services (LCMS) providing an overview of the School Health Service and sharing top tips to help LCMS think about how they can use the School Health services to deliver better health outcomes for 5-19 year olds.
www.gov.uk/government/publications/school-health-service-briefing-for-local-council-members

From transition to transformation in public health

The LGA and Department of Health has produced a set of online resource sheets. The purpose of this resource is to assist local authorities and public health to develop a local public health system that is designed to have the greatest potential for improving health, not just in councils but with all local partners. The focus is on transformation, showing how councils and public health are going beyond the practical steps of transition to develop a local vision public health, supported by new models for implementation.
http://tinyurl.com/kdk5w9t

National Child Measurement Programme: Briefing for elected members

These frequently asked questions for elected members have been jointly produced by the Local Government Association and Public Health England. They address a number of transitional issues relating to the transfer of responsibility for delivering the National Child Measurement Programme, which moved from PCTs to local government in April 2013.
http://tinyurl.com/n5etuj8

'Must Knows' for lead members for children's services

The 'Must knows' are a long-standing source of information and support for lead members for children's services (LMCS). The suite of information has been comprehensively revised for 2013 and focuses on the key issues facing lead members for children's services and the current and planned reforms impacting on children's services.
http://tinyurl.com/n3pdwt3

Teenage pregnancy resources for elected members and officers

The LGA has launched a number of resources on teenage pregnancy to help local authorities understand and address the key issues. The resources include: Relationships and sex education: a briefing for councillors and a briefing on local government's role in tackling teenage pregnancy.
http://tinyurl.com/l5ekp56

The council's role in tackling public health issues – resources for local authorities

The LGA has launched a number of resources on key public health issues including obesity, mental health, drugs and alcohol.
http://tinyurl.com/cod86q6

The 2012 report of the Children and Young People's Health Outcomes Forum
www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results

The system wide response to the Forum's Report
http://tinyurl.com/msaupsh

Statutory guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

Safeguarding children in the reformed NHS system
The Department for Education has published revised statutory guidance 'Working together to safeguard children' (2013)
http://tinyurl.com/brwtm77

NHS England has published an updated accountability and assurance framework for safeguarding vulnerable children and young people which sets out the responsibilities of each of the key players for safeguarding in the new NHS system. http://tinyurl.com/c57dca4

A guide for new councillors 2013/14
This Councillors' Guide, produced by the Local Government Association is designed to provide new councillors with all the information they need to know. It explores some of the key issues and challenges facing local government today and includes useful hints and tips from experienced councillors.
http://tinyurl.com/l95trlg

National Health Visitor Plan: progress to date and implementation 2013 onwards
The 'National Health Visitor Plan' is a joint DH, NHS England, Public Health England and Health Education England document. It sets out how these partner organisations will work with the health profession, families, local authorities and communities to achieve the government's health visiting commitment to increase the workforce by 4,200, transform the service by April 2015 and support its sustainability beyond 2015.

In 2011 the 'Health Visitor Implementation Plan 2011-15' set out action to revitalise the health visiting service, to help an expanded workforce to provide a new health visitor service model. We are now at the half-way point of a 4 year programme of recruitment and retention, professional development and improved commissioning linked to public health improvement.

'The National Health Visitor Plan: progress to date and implementation 2013' celebrates the successes of the programme so far and sets out how partner organisations within the new health landscape will work with the profession, families and communities in delivering the national commitment up to and beyond 2015. www.gov.uk/government/publications/health-visitor-vision

Better health outcomes for children and young people

Our pledge

ACADEMY OF MEDICAL ROYAL COLLEGES

ADCS
Leading Children's Services

Care Quality Commission

Department of Health

NHS CONFEDERATION

FACULTY OF PUBLIC HEALTH

MHRA
Regulating Medicines and Medical Devices

Birmingham Children's Hospital NHS
NHS Foundation Trust

NHS

NHS

Local Government Association

National Institute for Clinical Excellence

The Informati
for health and social care

NHS England

NHS Warrington Clinical Commissioning Group

NHS Health Education England

healthwatch

The British Society of Paediatric Dentistry

Publi lth England

RC GP Royal College of General Practitioners

ROYAL PHARMACEUTICAL SOCIETY

Royal College of Nursing

RCPCH
Royal College of Paediatrics and Child Health

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

solace

tda Trust Development Authority
Quality. Delivery. Sustainability.

> "The foundations for virtually every aspect of human development – physical, intellectual, and emotional – are laid in early childhood."
>
> (Marmot)

Children and young people growing up in England today are healthier than they ever have been before. Health care and social changes have had dramatic impacts. Previously common killer diseases are now rare. More children with serious illnesses and disabilities are surviving into adulthood and the infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.

But international comparisons and worrying long-term trends demonstrate there is room for improvement, with poor health outcomes for too many children and young people compared with other countries. A smaller group of more vulnerable children – such as looked after children – suffer much worse outcomes. The variation in outcomes and quality of healthcare for children and young people is unacceptable. The clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence-based early interventions can have significant positive impacts does not always inform how services are commissioned.

The need for improvement is not new; numerous reports have highlighted the issues. Individual initiatives have led to improvements in specific areas, but have not resulted in the system wide changes required to improve outcomes. What is new is the opportunity to ensure the focus on outcomes in the new health and care system includes children and young people clearly and explicitly, from conception through to adulthood.

We are committed to improving the health outcomes of our children and young people so that they become amongst the best in the world.

System-wide change is required to achieve this and each part of the system, at each level, has a vital contribution to make. To this end we pledge to work in partnership, both locally and nationally, with children, young people and their families.

Our shared ambitions are that:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.
5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

We all have a part to play in promoting the importance of the health of our children and young people.

Through our joint commitment and efforts we are determined to:

- **reduce child deaths** through evidence based public health measures and by providing the right care at the right time;
- **prevent ill health for children and young people and improve their opportunities for better long-term health** by supporting families to look after their children, when they need it, and helping children and young people and their families to prioritise healthy behaviour;
- **improve the mental health of our children and young people** by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it;
- **support and protect the most vulnerable** by focusing on the social determinants of health and providing better support to the groups that have the worst health **outcomes**;
- **provide better care for children and young people with long term conditions and disability** and increase life expectancy of those with life limiting conditions.

Because

- **the all-cause mortality rate for children aged 0 – 14 years has moved from the average to amongst the worst in Europe**[1]
- **26% of children's deaths showed 'identifiable failure in the child's direct care'**[2]
- **more than 8 out of 10 adults who have ever smoked regularly started before 19**[3]
- **more than 30% of 2 to 15 year olds are overweight or obese**[4]
- **half of life time mental illness starts by the age of 14**[5]
- **nearly half of looked after children have a mental health disorder and two thirds have at least one physical health complaint**[6]
- **about 75% of hospital admissions of children with asthma could have been prevented in primary care**[7]

Building momentum

At national level a new **Children and Young People's Health Outcomes Board**, led by the Chief Medical Officer, will bring together key system leaders in child health to provide a sustained focus and scrutiny on improving outcomes across the whole child health system.

A new **Children and Young People's Health Outcomes Forum** will provide both ongoing expertise in child health and offer constructive challenge to the next phase of this work. The Forum will hold an annual summit involving the CMO to monitor progress on child health outcomes and make recommendations for their improvement.

The Children and Young People's Health Outcomes Forum report and system response can be found at **http://www.dh.gov.uk/health/2012/07/cyp-report/**

For the very first time, everyone across the health and care system is determined to play their part in improving health outcomes for children and young people.

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1 Wolfe I, Cass H,Thompson MJ et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms. BMJ 2011; 342:d1277

2 CEMACH report 2008

3 Healthy Lives, Healthy People – our strategy for public health in England. Department of Health (2010)

4 Health Survey for England 2010

5 Kessler R, Angermeyer M, Anthony J et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry 2007 Oct; 6(3):168-76

6 DfE Outcomes for children looked after as at 31 March 2012

7 Asthma UK. Wish you were here – England (2008).

Working Paper 3

Child Poverty and Public Health

"Poverty and social inequalities in childhood have profound effects on the health of children, and their impact on health continues to reverberate throughout the life course into late adulthood"

Professor Nick Spencer (p2, 2008a)

Introduction

On the 1st April 2013, local authorities assumed responsibility for public health in England and Wales. As Richard Humphries has pointed out, councils are no strangers to health and public health has actually spent more of its history under council control than it has under the management of an NHS (p4, 2013). Each local authority has had to establish a Health & Wellbeing board and a local HealthWatch to engage patients and their families in the delivery of services. Local authorities also have 'local duties' under the Child Poverty Act (2010) and the impact of child poverty on health is well evidenced and understood. There is much that local authorities can do to improve children's health and mitigate the damage that poverty can do. Policies relating to education, employment, housing and welfare support can – and should - all have a positive impact on children's health. However, when the Local Government Association published a number of public health briefings for councillors, officers and health and wellbeing boards in the lead up to April 2013, poverty was noticeable by its absence. (LGA 2013)

The North East context

In a report exploring the 'prevalence, characteristics and distribution' of child poverty in the North East, Professor Jonathan Bradshaw noted that *"Most local authorities in the NE have worse child health than you would expect given their child poverty"* (p2, 2009) and *"on health, it is striking how many areas in the NE are doing much worse than would be expected given their material well-being rankings"* (p29). Local authorities in the North East occupied the bottom three places (out of 354 authorities in England at the time) for the health domain in an index of child wellbeing and the highest ranking authority for health was placed 244 out of 354 authorities. In short, the region's children are, on average, a lot less healthy than children in other regions, even allowing for the levels of poverty and deprivation in the North East.

A number of local authorities in the North East identified health related priorities in their Child Poverty Strategies, which they have to prepare as part of their local duties under the Child Poverty Act (Crossley 2012). Some of these priorities identified improving health related 'choices' and

'lifestyles' amongst people living in poverty but it has been argued that tackling health inequalities 'needs to move beyond bad behaviours' (Katikreddi *et al* 2013) and policies need to take into account the financial restraints that often make healthy lifestyles difficult to achieve. Recently published research has also highlighted how decision making ability can be affected by the constant effort of coping with the effects of low income and poverty (Mani *et al* 2013). The Marmot Review identified that *"having insufficient money to lead a healthy lifestyle is a highly significant cause of health inequalities"* (Marmot, p28 2010) and, as one young person involved in a photography project on poverty remarked, *"It's more expensive to buy strawberries than it is to buy a whole pizza"* (Children NE 2012).

Child Poverty and Public Health

In a paper for the End Child Poverty campaign Donald Hirsch and Professor Nick Spencer have written that: *"Poverty is the greatest preventable threat to health, and tackling it is fundamental to addressing health Inequalities and boosting life chances"* (p8, 2008) and the evidence has profound implications for public policy. The paper suggests that effective action to tackle child poverty would make an important long-term contribution to many health-related policy objectives, including reducing obesity, reducing heart disease, increasing breast feeding and improving mental health.

Not only does child poverty affect health during childhood, but it also affects adult health as well. In a separate paper drawing on over 70 different studies, Spencer argues that:

> *it is now clear that poverty and low socio-economic status in early life adversely affect health in ways that transmit across time and contribute to poor adult health. In other words, poor social circumstances in childhood are associated with poor health both in childhood itself and in adult life* (p2, 2008b)

The links between poverty and health are wide ranging. For example, poor quality housing can impact on children's health, as can maternal deprivation and poor health. In a report examining Children's Well-being in 2012, the Office for National Statistics noted that

> *reported life satisfaction was lower for those children who lived in households where adults experience material deprivation and the association was more marked if the children themselves were deprived of things other children enjoy* (Joloza p12, 2012)

In the conclusion to a short report called 'Health Consequences of Poverty for Children, Spencer provides a detailed account of how poverty affects those on low incomes:

> *Infants of poor women are at a disadvantage before they are born and are more likely to be stillborn or born too early or too small. They are more likely to die within the first week of life and in infancy. If they survive the first year of life they are at increased risk of dying throughout childhood and adolescence. Poor children are more likely to suffer disability and chronic illness and more likely to be admitted to hospital during childhood. They are also more susceptible to acute illnesses. Poor children are more likely to experience mental health problems and to suffer the consequence of parenting failure associated with chronic stress, debt and depression induced by economic disadvantage."*(p15, 2008a)

Role of local services

The positioning of public health within local authorities offers an opportunity to co-ordinate work across a number of social policy areas to improve the health of the population. Issues such as employment, housing, education, environment and income all affect health (Collins 2013) and it has been argued that 'many of the most promising interventions for reducing health inequalities operate outside of the health sector' (Katikreddi *et al* 2013).

With the new responsibilities for public health, local authorities have a new opportunity to shape how some services are delivered and how they can impact on child poverty. For example, Health visitors and midwives in Glasgow have helped to tackle child poverty through the *Healthier Wealthier Children* (HWC) project. Between October 2010 and January 2012, the project achieved an overall financial gain of £2,256,722 for pregnant women and families accessing HWC advice services through staff such as health visitors and midwives referring pregnant women and mothers with young children to welfare advice services. Around 1 in 2 people referred were eligible for extra financial support and the average gain was £3,404. The evaluation of the report states that

> *Follow-up interviews with clients accessing advice revealed that a number reported reduced stress, improved mood and increased sense of self-worth and security. Some also saw an improvement in relationships with families and friends. Other gains from accessing advice included help with childcare and housing, support with charitable applications, advocacy, switching to cheaper utility options and an increased uptake of Healthy Start vouchers.* (Naven *et al,* p3 2012)

It is estimated that between 16 and 23% of income related benefits nationally remain unclaimed. In 2009-10 this equated to between £7.52billion and £12.31billion. In 2010-11, it was estimated that between £50 and £140 million of tax credits alone remained unclaimed by families with children in the North East. Evidence suggests that when low-income families see an increase in their income, much of the increase is spent on protecting children from the effects of poverty (Warburton-Brown 2011)

Other opportunities for improving the health of children and young people lie outside of formal health structures. Some local authorities have developed area wide free school meal policies for all primary school children and Blackpool is now offering free breakfasts to 12,000 primary school pupils. These policies help to reduce the stigma attached to free school meals which is still in evidence and which impacts on children's participation in and experience of school.

The role of frontline workers across a range of services can also impact on health and wellbeing. The way people are talked about (and talked to) has an impact on them and their sense of self and people living in poverty are often acutely aware of how they are portrayed by the media, by politicians and by 'professionals'. However, research by Professor Mel Bartley of UCL showed

> *that those welfare professionals who listened, who were not judgemental, gave their clients time, who were prepared to advocate for their clients and seek solutions which were appropriate to their needs, were highly valued and made a positive difference to their lives* (Bartley 2006)

A number of recent research reports have highlighted the impact of 'austerity' and public sector cuts on some of the most vulnerable individuals and families in our society. Research by the Poverty & Social Exclusion Team suggests that '*the absolute and proportional scale of cuts in local government expenditure in England is greatest in the most deprived localities'* and that poorer families are therefore likely to suffer more than families with higher incomes (Besemer & Bramley, p40 2012).

Local services are, however, essential in efforts to mitigate the effects of poverty. Bramley & Besemer, in exploring access to local services in the UK, note that:

> *Free or heavily subsidized local services provide a form of 'social wage' or income in kind to households who may have little or no earnings from the labour market. Public services, particularly where universalistic in character, also provide an opportunity to participate in a wide range of activities alongside and on a common basis with the generality of the population, regardless of economic circumstances. This social participation … contributes directly to the fundamental concept of poverty developed by Townsend (1962, 1979), namely the ability to participate in the normal life of the community.* (p2, 2012)

Support for public services generally remains very high and this is especially the case for health related services. However, poorer people shouldn't be viewed as being disproportionately reliant and a possible 'burden' on healthcare services. Professor Danny Dorling, has noted a 'positive care law' in relation to care, and he argues that a 'revaluing of care' is needed as there is a correlation between *'the locations of the population with health needs and those providing many hours of unpaid care a week'* (2011, p144). This approach fits well with 'asset based' approaches to tackling poverty (see, for example, Haddad 2011)

Tackling poverty and deprivation should be central to local authority efforts to improve public health. The examples above highlight how local policy development and the daily interactions between workers delivering public services and members of the public can help to do this. Local authorities and their partners should ensure that services for poor people do not become poor services.

The **North East Child Poverty Commission** is a multi-agency stakeholder group that believes that every child should have an equal chance in life. It is made up of representatives from the public, voluntary and private sectors in the North East and works to promote public and political support for policies that will help to end child poverty.

The **Institute for Local Governance** (ILG) is a pioneering research and knowledge exchange venture designed to maximise the benefits of collaboration between all five universities in North East England and the wider public realm. It is a unique research partnership between North East local authorities, universities, police forces, fire and rescue services and other public sector partners. The ILG is hosted by Durham University Business School.

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HEALTH AND WELLBEING BOARD

9 December 2013

Report of: Chief Officer, NHS Hartlepool and Stockton-on-Tees CCG

Subject: STRATEGIC PLANNING IN THE NHS

1. PURPOSE OF REPORT

The purpose of this report is to inform the members of the Hartlepool Health and Wellbeing Board of the key activities and outputs required to complete the Annual Planning Round for the CCG for 14/15.

2. BACKGROUND

2.1 CCGs are required to have clear and credible strategic commissioning plans that best meet the needs of their local population within the resources available to them. We are required to actively manage and implement these plans to ensure the delivery of safe and high quality care for patients and the public. The CCG is required to develop a commissioning strategy and plans that align with the planning round of NHS England.

2.1 An established annual planning cycle operates within the NHS and this report reflects this planning at a local level. The report informs the Health and Wellbeing Board of the key activities and outputs required to complete the annual planning round for 14/15. This planning round is an intensive period of activity and involves a range of activities and outputs including issuing of commissioning intentions, production of an integrated plan, development of a financial plan and negotiations and agreement of contracts with Providers.

2.3 The CCG will need to align strategic plans in response to the Outcomes Framework when this is published, however it is recognised that during 14/15 and the national comprehensive spending review which delivers lower levels of funding growth for the NHS, that we will require greater levels of efficiency and integrated working across health and social care sectors.

2.4 The CCG aspiration set out in our Clear and Credible Plan (CCP) remain and the CCG is committed to deliver our obligations set out in the NHS Constitution. We will continue to work in partnership with the local authority in delivery of the Health & Wellbeing Delivery plans, including development of plans to meet the requirement of the Integrated Transformation Plans as set out in the gateway letter 00314.

2.5 The CCG aspiration is to utilise a corporate approach to the planning round with a decision cycle that is clinically led and with member practices providing input at every stage including alignment of our priorities to the Joint Strategic Needs Assessment (JSNA).

3 PLANNING PROCESS

3.1 The planning process will be based on the fundamentals that there will be a steady state of output, adjusted for demographic and known trends based on disease prevalence, demand for services and waiting times. Financially there will be no more additional monies to fund intentions without a compensating reduction being identified elsewhere. This will clearly require redesign of pathways to identify efficiencies in order to prevent the loss of services.

3.2 Fundamental to the process will be the timetable and alignment of plans to ensure that we are able to take advantage of opportunities for joint commissioning wherever possible.

3.3 Sustainability and financial resilience are paramount to enable us to focus on the best health outcomes for our population therefore investments and intentions should be driven from;

- Objectives set out in the Clear and Credible plan
- To address performance failure and ensure achievement of the NHS Constitution
- Any identified risks
- Learning from patient feedback, including the outputs from Call to Action work
- Any national requirements and expectations i.e. 7 day services
- Outcomes Frameworks

3.4 The other challenge that will have to be factored into the development of the plans is the government's publication of The Integration Transformation Fund (ITF) referenced at Agenda Item 5.2 of this meeting. The fund will be a combination of current health transfer monies for social care, re-ablement and carers, and an estimated additional amount from 2014/15 CCG Baseline.

3.5 To support the delivery of integration, local two year plans and five year strategic plans have to be developed by February 2014, first submission is expected by 14 February 2014 with final two year and draft five year plan to be submitted 4 April 2014 and final five year plans 20 June 2014. Plans are to be submitted to NHS England, Monitor, NHS TDA and LGA. The NHS and local authorities, with the Health and Wellbeing Board (HWB) having an oversight role with HWB expected to submit the completed template by 14th February.

3.6 A requirement set out in Gateway 00658 was the development of a 'unit of planning' in relation to development of the plans. The proposed unit for NHS

Hartlepool and Stockton-on-Tees CCG is 'North of Tees'. This includes Stockton-on-Tees Borough Council, Hartlepool Borough Council, North Tees and Hartlepool NHS Foundation Trust and Tees Esk and Wear Valley Mental Health NHS Foundation Trust. The proposal for this unit of planning was submitted to the NHS England Area Team as required on the 12th November 2013.

3.7 The Health and Wellbeing Board will be kept informed of commissioning intentions as the process develops.

4 RECOMMENDATION

The Health and Wellbeing Board are asked to NOTE the timescales and required approach to the 14/15 NHS planning round.

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HEALTH AND WELLBEING BOARD

9 December 2013

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

Subject: **INTEGRATION TRANSFORMATION FUND**

1. PURPOSE OF REPORT

1.1 To provide the Health & Wellbeing Board with information regarding the Integration Transformation Fund (ITF); including background and current guidance, timescales and indicative allocations.

2. BACKGROUND

2.1 As reported to the Health & Wellbeing Board previously, 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 announced a £3.8bn pool of funding to promote the integration of health and social care services that support some of our most vulnerable population groups.

3. CURRENT GUIDANCE

3.1 Further information has since been issued by the Local Government Association and NHS England (attached as **Appendix 1**) which sets out the context of the ITF, how the £3.8bn funding pool will be created and how local plans should be developed for its use.

3.2 The guidance reiterates that the ITF is a genuine catalyst to improve services and value for money and a real opportunity to create shared plans that integrate services to provide improvements for local communities and strengthen current arrangements for sharing information, staff, funding and risk across the health and social care economy. It forms part of the NHS planning framework that requires CCGs to agree five year strategies including two year operational plans that include the ITF and respond to the outcomes of local Call to Action public engagement.

3.3 There is a recognition that changing services will take time and that planning for 2015/16 when the fund becomes fully functional needs to commence so that implementation can begin during 2014. Providers must be engaged in the planning process from the outset given the impact of the changes and in order to achieve the best outcomes for local people.

3.4 There are six National Conditions that must be met in order for the pooled money to be accessed. These are:

- Plans to be jointly agreed (by Councils and CCGs, with engagement of providers and sign off by the Health & Wellbeing Board.
- Protection for social care services (not social care spending)
- Provision of seven day services in health and social care to support hospital discharges and prevent unnecessary admissions at weekends.
- Better data sharing between health and social care using the NHS number.
- A joint approach to assessments and care planning with an accountable professional for integrated packages of care.
- Agreement on the impact of changes in the acute sector.

3.5 The fund will be allocated to local areas where it will form a pooled budget jointly governed by the CCG and local authority. In order to access this fund, CCGs and local authorities must jointly agree plans for how the money will be spent, and the plans must meet certain requirements.

3.6 Strategic and operational planning by the CCG must take place within the context of a 'unit of planning' that will be the North of Tees. Whilst an oversight / partnership group across the North of Tees will ensure that there is strategic alignment of plans across that footprint and will encourage the sharing of best practice, the Adult Services & Maximising Capabilities Group that reports into the Health and Wellbeing Board will be responsible for the development of local plans for approval by the Health and Wellbeing Board.

4. TIMELINE FOR DEVELOPMENT OF PLANS

4.1 Health & Wellbeing Boards are required to submit a completed planning template for their area by 15 February 2014. In order to complete the template, Health & Wellbeing Boards need to provide information on:

- How service providers and patients / users have been engaged.
- Vision for Health and Care Services
- Integration Aims and Objectives
- Planned Changes
- Implications for the Acute Sector; and
- Governance Arrangements.

4.2 The plan must also identify:

- how the six National Conditions will be met;
- the expected outcomes and performance measures for the planned changes;

- how the pooled budget will be spent;
- contingency plans if planned improvements are not achieved; and
- key risks and plans to mitigate those risks.

4.3 The draft template is attached as **Appendix 2**.

4.4 The CCG are required to submit draft five year plans through their Health & Wellbeing Boards (including a two year operational plan that covers the ITF) by 4 April 2014, with final five year plans to be submitted by 20 June 2014.

5. FINANCIAL CONSIDERATIONS

5.1 Funding allocations have not yet been confirmed and CCG allocations are expected to be issued later in December.

5.2 Based on the announcements regarding the funding available nationally, the CCG have identified an indicative allocation for Hartlepool for 2015/16 of £7.7m.

5.3 The indicative allocation of £7.7m is made up as follows:

Funding Stream	Funding
Existing NHS Transfer to Social Care (2013/14)	£1.8m
Existing Reablement Funding	£0.6m
Existing Carers Funding	£0.2m
Additional NHS Transfer to Social Care (2014/15)	£0.4m
Capital Grants (including Disabled Facilities Grant)	£0.73m
Funding from CCG baseline budget	£3.97m

5.4 All existing resources are fully committed and a piece of work will need to be undertaken to review how these resources are being deployed, to ensure that the funding is being used to improve health and social care outcomes and support the integration agenda.

5.5 As outlined in Appendix 1, a significant element of the new funding (£1bn of the £3.8bn available nationally) will be linked to the achievement of outcomes, with an element of the funding paid based on performance. The measures are not yet agreed but are likely to focus on delayed discharges from hospital, emergency admissions, effectiveness of reablement services, admissions to residential and nursing care and patient / user experience.

6. RISK IMPLICATIONS

6.1 Whilst there are no specific risks identified in relation to the ITF at this stage, there will be implications for current services as work to develop local plans progress and risks associated with delivery of the national conditions and achievement of the national measures.

6.2 There is a requirement for partners to develop an agreed shared risk register in relation to the ITF with risk sharing and mitigation arrangements identified. This will include steps that will be taken if activity volumes do not change as planned e.g. an increase in emergency admissions or an increase in nursing home admissions.

7. RECOMMENDATIONS

7.1 It is recommended that the Health & Wellbeing Board notes the current position in relation to the Integration Transformation Fund and receives a further report in January 2014, when the completed planning template will need to be approved for submission by 15 February 2014.

8. REASONS FOR RECOMMENDATIONS

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

9. CONTACT OFFICERS

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NHS Hartlepool and Stockton-on-Tees CCG
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17 October 2013

To: CCG Clinical Leads
Health and Wellbeing Board Chairs
Chief Executives of upper tier Local Authorities
Directors of Adult Social Services

cc: CCG Accountable Officers
NHS England Regional and Area Directors

Dear Colleagues

Next Steps on implementing the Integration Transformation Fund

We wrote to you on 8 August 2013 setting out the opportunities presented by the integration transformation fund (ITF) announced in the spending review at the end of June. While a number of policy decisions are still being finalised with ministers, we know that you want early advice on the next steps. This letter therefore gives the best information available at this stage as you plan for the next two years.

Why the fund really matters

Residents and patients need Councils and Clinical Commissioning Groups (CCGs) to deliver on the aims and requirements of the ITF. It is a genuine catalyst to improve services and value for money .The alternative would be indefensible reductions in service volume and quality.

There is a real opportunity to create a shared plan for the totality of health and social care activity and expenditure that will have benefits way beyond the effective use of the mandated pooled fund. We encourage Health and Wellbeing Boards to extend the scope of the plan and pooled budgets.

Changing services and spending patterns will take time. The plan for 2015/16 needs to start in 2014 and form part of a five year strategy for health and care. Accordingly the NHS planning framework will invite CCGs to agree five year strategies, including a two year operational plan that covers the ITF through their Health and Wellbeing Board.

A fully integrated service calls for a step change in our current arrangements to share information, share staff, share money and share risk. There is excellent practice in some areas that needs to be replicated everywhere. The ingredients are the same across England; the recipe for success differs locality by locality.

Integrated Care Pioneers, to be announced shortly, will be valuable in accelerating development of successful approaches. We are collaborating with all the national partners to support accelerated adoption of integrated approaches, and will be launching support programmes and tools later in 2013.

Where does the money come from?

The fund does not in itself address the financial pressures faced by local authorities and CCGs in 2015/16, which remain very challenging. The £3.8bn pool brings together NHS and Local Government resources that are already committed to existing core activity. (The requirements of the fund are likely to significantly exceed existing pooled budget arrangements). Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals. This calls for a new shared approach to delivering services and setting priorities, and presents Councils and CCGs, working together through their Health and Wellbeing Board, with an unprecedented opportunity to shape sustainable health and care for the foreseeable future.

Working with providers

It will be essential for CCGs and Local Authorities to engage from the outset with all providers, both NHS and social care, likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the fund includes agreement to the service change consequences.

Supporting localities to deliver

We are acutely aware that time is pressing, and that Councils and CCGs need as much certainty as possible about how the detail of the fund will be implemented. Some elements of the ITF are matters of Government policy on which Ministers will make decisions. These will be communicated by Government in the normal way. The Local Government Association and NHS England are working closely together, and collaborating with government officials, to arrive at arrangements that support all localities to make the best possible use of the fund, for the benefit of their residents and patients. In that spirit we have set out in the attached annex our best advice on how the Fund will work and how Councils and CCGs should prepare for it.

The Government has made clear that part of the fund will be linked to performance. We know that there is a lot of interest amongst CCGs and Local Authorities in how this “pay-for-performance” element will work. Ministers have yet to make decisions on this. The types of performance metrics we can use (at least initially) are likely to be largely determined by data that is already available. However, it is important that local discussions are not constrained by what we can measure. The emphasis should be on using the fund as a catalyst for agreeing a joint vision of how integrated

care will improve outcomes for local people and using it to build commitment among local partners for accelerated change.

Joint local decision making and planning will be crucial to the delivery of integrated care for people and a more joined up use of resources locally. The ITF is intended to support and encourage delivery of integrated care at scale and pace whilst respecting the autonomy of locally accountable organisations.

This annex to this letter sets out further information on:

- How the pooled fund will be distributed;
- How councils and CCGs will set goals and be rewarded for achieving them;
- Possible changes in the statutory framework to underpin the fund;
- The format of the plans for integrated care and a template to assist localities with drawing up plans that meet the criteria agreed for the fund;
- Definitions of the national conditions that have to be met in order to draw on the polled fund in any locality; and
- Further information on how local authorities, CCGs, NHS England and government departments will be assured on the effective delivery of integrated care using the pooled fund.

Leads from the NHS and Local Government will be identified to assist us to work with Councils and CCGs to support implementation. More details on this can be found in the annex. We will issue a monthly bulletin to Councils and CCGs with updates on the Integration Transformation Fund.

Yours faithfully

Carolyn Downs
Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

NHS England Publications Gateway Ref. No.00535

Annex

Advice on the Integration Transformation Fund

What is included in the ITF and what does it cover?

Details of the ITF Fund

The June 2013 SR 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	£3.8bn pooled budget to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the ITF will be created from the following:
£1.9bn NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. Composed of:
• £130m Carers' Breaks funding
• £300m CCG reablement funding
• £354m capital funding (including c.£220m of Disabled Facilities Grant)
• £1.1bn existing transfer from health to social care

1. The Integration Transformation Fund will be £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users. In 2014/15 an additional £200m transfer from the NHS to social care in addition to the £900m transfer already planned will enable localities to prepare for the full ITF in 2015/16.

2. In 2014/15 use of pooled budgets remains consistent with the guidance[1] from the Department of Health to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

3. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

4. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

discussions between the Board, clinical commissioning groups and local authorities on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.

5. *In line with our responsibilities under the Health and Social Care Act, NHS England is also making it a condition of the transfer that local authorities and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

6. *NHS England is also making it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

7. In 2015/16 The fund will be allocated to local areas, where it will be put into pooled budgets under joint governance between CCGs and local authorities. A condition on accessing the money in the fund is that CCGs and local authorities must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

How will the ITF be distributed?

8. Councils will receive their detailed funding allocation following the Autumn Statement in the normal way. When allocations are made and announced later this year, they will be two-year allocations for 2014/15 and 2015/16 to enable planning.

9. In 2014/15 the existing £900m s.256 transfer to Local Authorities for social care to benefit health, and the additional £200m will be distributed using the same formula as at present.

10. The formula for distribution of the full £3.8bn fund in 2015/16 will be subject to ministerial decisions in the coming weeks.

11. In total each Health and Wellbeing Board area will receive a notification of its share of the pooled fund for 2014/15 and 2015/6 based on the aggregate of these allocation mechanisms to be determined by ministers. The allocation letter will also specify the amount that is included in the pay-for-performance element, and is therefore contingent in part on planning and performance in 2014/5 and in part on achieving specified goals in 2015/6.

How will Councils and CCGs be rewarded for meeting goals?

12. The Spending Review agreed that £1bn of the £3.8bn would be linked to achieving outcomes.

13. In summary 50% of the pay-for-performance element will be paid at the beginning of 2015/16, contingent on the Health and Wellbeing Board adopting a plan that

meets the national conditions by April 2014, and on the basis of 2014/15 performance. The remaining 50% will be paid in the second half of the year and could be based on in-year performance. We are still agreeing the detail of how this will work, including for any locally agreed measures.

14. In practice there is a very limited choice of national measures that can be used in 2015/6 because it must be possible to baseline them in 2014/5 and therefore they need to be collected now with sufficient regularity and rigour. For simplicity we want to keep the number of measures small and, while the exact measures are still to be determined, the areas under consideration include:

    - Delayed transfers of care;
    - Emergency admissions;
    - Effectiveness of re-ablement;
    - Admissions to residential and nursing care;
    - Patient and service user experience.

15. In future we would hope to have better indicators that focus on outcomes for individuals and we are working with Government to develop such measures. These can be introduced after 2016/7 as the approach develops and subject to the usual consultation and testing.

16. When levels of ambition are set it will be clear how much money localities will receive for different levels of performance. In the event that the agreed levels of performance are not achieved, there will be a process of peer review, facilitated by NHS England and the LGA, to avoid large financial penalties which could impact on the quality of service provided to local people. The funding will remain allocated for the benefit of local patients and residents and the arrangements for commissioning services will be reconsidered.

Does the fund require a change in statutory framework?

17. The Department of Health is considering what legislation may be necessary to establish the Integrated Transformation Fund, including arrangements to create the pooled budgets and the payment for performance framework. Government officials are exploring options for laying any required legislation in the Care Bill. Further details will be made available in due course. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the fund?

18. Each upper tier Health and Wellbeing Board will sign off the plan for its constituent local authorities and CCGs. The specific priorities and performance goals are clearly a matter for each locality but it will be valuable to be able to:

    - Aggregate the ambitions set for the fund across all Health and Wellbeing Boards;

- Assure that the national conditions have been achieved; and

- Understand the performance goals and payment regimes have been agreed in each area.

19. To assist Health and Wellbeing Boards we have developed a draft template which we expect everyone to use in developing, agreeing and publishing their integration plan. This is attached as a separate Excel spread sheet.

20. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the ITF. We strongly encourage Councils and CCGs to make immediate use of this template while awaiting further guidance on NHS planning and financial allocations.

21. Local areas will be asked to provide an agreed shared risk register, with agreed risk sharing and mitigation covering, as a minimum, steps that will be taken if activity volumes do not change as planned. For example if emergency admissions increase or nursing home admissions increase.

What are the National Conditions?

22. The Spending Review established six national conditions:

National Condition	Definition
Plans to be jointly agreed	The Integration Plan covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and Local Authorities should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 2 to 6,

National Condition	Definition
	above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The forthcoming national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England will provide guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas will be asked to: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas, and will make this available alongside the planning template. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas will be asked to identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning.
Agreement on the consequential impact of changes in the acute sector	Local areas will be asked to identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient engagement in this planning, as well as plans for political buy-in.

How will preparation and plans be assured?

23. Ministers will wish to be assured that the ITF is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

24. To maximise our collective capacity to achieve these outcomes and deliver sustainable services we will have a shared approach to supporting local areas and assuring plans. This process will be aligned as closely as possible to the existing NHS planning rounds, and CCGs can work with their Area Teams to develop their ITF plans alongside their other planning requirements.

25. We will establish in each region a lead local authority Chief Executive who will work with the Area and Regional Teams, Councils, ADASS branches, DPHs and other interested parties to identify how Health and Wellbeing Boards can support one another and work collaboratively to develop good local plans and delivery arrangements.

26. Where issues are identified, these will be shared locally for resolution and also nationally through the Health Transformation Task Group hosted by LGA, so that the national partners can broker advice, guidance and support to local Health and Well Being Boards, and link the ITF planning to other national programmes including the Health and Care Integration Pioneers and the Health and Well Being Board Peer Challenge programme. We will have a first review of readiness in early November 2013.

27. We will ask Health and Well Being Boards to return the completed planning template (draft attached) by 15 February 2014, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the ITF.

Integration Transformation Fund

Draft Plan Submission Template

Local Authority	**<Name of Local Authority>**
Clinical Commissioning Groups	**<CCG Name/s>**
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

Authorisation and Sign Off

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
date	<date>

Signed on behalf of the Clinical Commissioning Group	
By	<Name of Signatory>
Position	<Job Title>
date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Local Authority	
By	<Name of Signatory>
Position	<Job Title>
date	<date>

Signed on behalf of the Health & Wellbeing Board	
By Chair of the HWB:	<Name of Signatory>
Position	<Job Title>
date	<date>

Service provider engagement

Please describe how health and social care providers have been involved in the development of this pla, and the extent to which they are party to it

Patient, service user and public engagement

Please describe how patients, services users and the public have been involved in the development of this plan, and the extent to which they are party to it

Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition

Vision for Health and Care Services

Please describe the vision for health and social care services for this community for 2018/19.
- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Integration Aims & Objectives

Please describe your overall aims and objectives for integrated care and provide information on how the integration transformation fund will secure improved outcomes in health and care in your area. Suggested points to cover:
• What are the aims and objectives of your integrated system?
• How will you measure these aims and objectives?
• What measures of health gain will you apply to your population?

Description of Planned Changes

Please provide an overview of the scemes and changes covered by your joint work programme, including:
1. The key success factors including an outline of processes, end points and time frames for delivery
2. How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Implications for the Acute Sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

National Conditions

1 Protecting social care services

Please outline your agreed local definition of protecting social care services.

Please explain how local social care services will be protected within your plans.

2 7-day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)
Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

3 Data-sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are commited to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please confirm that you are commited to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements , professional clinical practise and in particular requirements set out in Caldicott2.

4 Joint-assessments and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Outcomes and metrics

Please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Outcome measures- Examples only	Current Baseline (as at....)	14/15 Projected delivery (full year?)	15/16 Projected delivery (full year?)
Delayed transfers of care			
Emergency admissions			
Effectiveness of reablement			
Admissions to residential and nursing care			
Patient and service-user experience			
<Local measure>			
<Local measure>			
<Local measure>			

Finance

Please summarize the total health and care spend for each commissioner in your area. Please

Organisation	2013/14 spend	2013/14 benefits	2014/15 spend	2014/15 benefits	2015/16 spend	
Local Authority Social Services						
CCG						
Primary Care						
Specialised commissioning						
Local Authority Public Health						
Total						

Please summarize where your pooled budget will be spent. NB the total must be equal to or more than your total ITF allocation

ITF Investment	2014/15 spend	2014/15 benefits	2015/16 spend	2015/16 benefits
Scheme 1				
Scheme 2				
Scheme 3				
Scheme 4				
Scheme 5				
Total				

Approximately 25% of the ITF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully		
	Maximum support needed for other		
Outcome 2	Planned savings (if targets fully		
	Maximum support needed for other		

Key Risks

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk Rating	Mitigating Actions
Risk 1		
Risk 2		
Risk 3		
Risk4		

HEALTH AND WELLBEING BOARD

9th December 2013

Report of: HealthWatch Hartlepool

Subject: LOCAL HEALTHWATCH WORK PLAN 2013/14

1. PURPOSE OF REPORT

1.1 To inform the Health & Wellbeing Board of HealthWatch Hartlepool's agreed work plan together with their Communication & Engagement proposal. The board is also asked to note the work plan and comment on the intended priorities.

2. BACKGROUND

2.1 HealthWatch Hartlepool is the independent consumer champion for patients and users of health & social care services in Hartlepool. To support our work we have appointed an Executive committee, which enables us to feed information collated through our communication & engagement plan to form the strategic vision. This ultimately should lead to influence of all services within the borough. Further information relating to the work of Healthwatch can be viewed via www.healthwatchhartlepool.co.uk

2.2 The purpose of this work programme is to set out the activities, priorities and outcomes expected from Healthwatch Hartlepool in 2013/14. This will be delivered in conjunction with the Governance Framework, meetings of associated task & finish groups, public meetings and service specification.

3. PROPOSALS

3.1 Established under the Health and Social Care Act 2012, the requirements set out in the legislation mean HealthWatch Hartlepool will be expected to:

- Obtain the views of the wider community about their needs for and experience of local health and social care services and make those views known to those involved in the commissioning, provision and scrutiny of health and social care services.
- Promote and support the involvement of a diverse range of people in the monitoring, commissioning and provision of local health and social care services through membership of local residents and service users.

- Make reports and recommendations about how those services could or should be improved.
- Provide information to the public about accessing health and social care services together with choice in relation to aspects of those services.
- Represent the views of the whole community, patients and service users on the Health & Wellbeing Board and the Hartlepool Clinical Commissioning Group (locality) Board.
- Make the views and experiences of the broad range of people and communities known to Healthwatch England helping it to carry out its role as national champion.
- Make recommendations to Healthwatch England to advise the Care Quality Commission (CQC) to carry out special reviews or investigations into areas of concern (or, if the circumstances justify it, go direct to the CQC with recommendations, if for example urgent action were required by the CQC).

4. EQUALITY & DIVERSITY CONSIDERATIONS

4.1 HealthWatch Hartlepool is for adults, children and young people who live in or access health and/or social care services in the Borough of Hartlepool. HealthWatch Hartlepool aims to be accessible to all sections of the community. The Executive committee will review performance against the work programme on a quarterly basis and report progress to our membership through the 'Update' newsletter and an Annual Report. The full Healthwatch Hartlepool work programme will be available from www.healthwatchhartlepool.co.uk

5. RECOMMENDATIONS

5.1 That the Board note the HealthWatch Hartlepool work plan 2013/14 and provide feedback where necessary.

6. REASONS FOR RECOMMENDATIONS

6.1 Coordinated communication and engagement between any local healthwatch organisation and their partner Health & Wellbeing board are integral to the success of both service areas. The proposals laid out here within the HealthWatch Hartlepool work plan intend to ensure that the vision and expectations of joint working can be achieved.

7. BACKGROUND PAPERS

7.1 Governance Framework and Communication & Engagement proposal

8. CONTACT OFFICER

Christopher Akers-Belcher - HealthWatch Manager
Hartlepool Voluntary Development Agency
'Rockhaven'
36 Victoria Road
HARTLEPOOL. TS24 8DD

Work Programme 2013/14

HealthWatch Hartlepool is the independent consumer champion for patients and users of health & social care services in Hartlepool. To support our work we have appointed an Executive committee, which enables us to feed information collated through our communication & engagement plan to form the strategic vision. This ultimately should lead to influence of all services within the borough. Further information relating to the work of Healthwatch can be viewed via www.healthwatchhartlepool.co.uk

The purpose of this work programme is to set out the activities, priorities and outcomes expected from Healthwatch Hartlepool in 2013/14. This will be delivered in conjunction with the Governance Framework, meetings of associated task & finish groups, public meetings and service specification.

Established under the Health and Social Care Act 2012, the requirements set out in the legislation mean HealthWatch Hartlepool will be expected to:

- Obtain the views of the wider community about their needs for and experience of local health and social care services and make those views known to those involved in the commissioning, provision and scrutiny of health and social care services.
- Promote and support the involvement of a diverse range of people in the monitoring, commissioning and provision of local health and social care services through membership of local residents and service users.
- Make reports and recommendations about how those services could or should be improved.

- Provide information to the public about accessing health and social care services together with choice in relation to aspects of those services.
- Represent the views of the whole community, patients and service users on the Health & Wellbeing Board and the Hartlepool Clinical Commissioning Group (locality) Board.
- Make the views and experiences of the broad range of people and communities known to Healthwatch England helping it to carry out its role as national champion.
- Make recommendations to Healthwatch England to advise the Care Quality Commission (CQC) to carry out special reviews or investigations into areas of concern (or, if the circumstances justify it, go direct to the CQC with recommendations, if for example urgent action were required by the CQC).

HealthWatch Hartlepool is for adults, children and young people whom live in or access health and/or social care services in the Borough of Hartlepool. HealthWatch Hartlepool aims to be accessible to all sections of the community. The Executive committee will review performance against the work programme on a quarterly basis and report progress to our membership through the 'Update' newsletter and an Annual Report. The full Healthwatch Hartlepool work programme will be available from www.healthwatchhartlepool.co.uk

Please note Appendix (A) details the key principles we shall follow when delivering the HealthWatch Hartlepool work programme

Theme	Objective	Time frame
Acute Care	Sensory Loss – Examine the provision of services for those patients/residents with any form of sensory loss in the access of acute services	May to December 2013
Acute Care	Transport – Examine equality of access in relation to arrangements for patients travelling from Hartlepool to North Tees hospital	Completed

Acute Care	To ensure discharge procedures are followed and patients feel supported with a timely discharge from hospital. Review equality of access and design of service.	November 2013 to March 2014
Acute	Review implementation of Hartlepool LINk recommendations in relation to Dementia Awareness with North Tees & Hartlepool NHS Hospital Trust	January to March 2014
Primary Health	Review prescribing and distribution arrangements of Methadone within Hartlepool Pharmacies	October 2013 to February 2014
Primary Health	Consult with GP's regarding the purpose and adherence of Palliative Care registers and the wider community in respect of Cancer Care. Objective to influence and design the future of cancer care services.	Ongoing – Referred to NHS England due to failure to respond from practices. May require FOI re Palliative Care questionnaires
Primary Health	Participate in NHS Call to Action – Discrete piece of work to compliment the work of the CCG by consulting groups, which are seldom heard.	November 2013 to January 2014
Social Care	Review the quality of domiciliary care services within Hartlepool. Engage on the development of the new specification based on review.	June 2013 to date

Life Long conditions	Organise and host 3 seminars focusing on member led priorities. Arthritis, Respiratory & Heart conditions	September complete January 2014 March 2014
Strategic	Review policies and procedures in line with service specification e.g. Governance Framework	Complete
Strategic	Agree monitoring framework in line with service specification – Focus on quality	Complete Review January 2014
Strategic	Represent and contribute to strategic decision making across the borough. Examples of such: • Health & Wellbeing Board • Audit & Governance • Clinical Commissioning Group • Vulnerable Adults Board • Quality Standards Steering Group • North East Ambulance Service	Complete
Strategic	Managing expectations, relationships and responsibilities through HealthWatch development review	Completed and to be reviewed six monthly in line with Governance Framework

Enter & View	Review training & development in respect of legal responsibilities, Dignity in care, role of the volunteer, interviewing skills, report writing	1st phase completed November 2014
Training & development	Undertake member training needs analysis Complete member development programme to include all aspects of training required including: Dementia training & Safeguarding	Ongoing
Communication & Engagement	Adhere to communication and engagement proposal: • Engaging with local communities • Understanding stakeholders in the community • Mapping outreach • Collating patient stories • Effective outreach • Analysis and reporting • Annual General Meeting	Ongoing
Communication & Engagement	Promote the work of Healthwatch with the wider community: • Website • Monthly newsletters • Press releases • Annual report	Ongoing

Communication & Engagement	Develop and publish a guide to Health & Social Care services in Hartlepool to fulfil our signposting and choice duty	July 2013 to January 2014

Workplan:-

Appendix A:

Clear-We will be clear about what activities we are carrying out. For example, we will be honest about whether we are informing, consulting, involving or co-producing.

Identify the need-We will be clear about the need to engage the community by:

a. Being clear about the identified need or knowledge gap
b. Involving the community at the earliest stage in the process
c. Identify and justify the target audience
d. Produce a clear project plan with deadlines including details of when results and actions will be available.

Consider other options/information

a. Where possible, look to coordinate consultation
b. Identify if there has been recent research –sharing results
c. Sharing common intelligence
d. Forward planning-where possible linking consultation to the business planning cycle

Consistent-We are committed to involving citizens in all aspects of our work. These principles apply to the way we involve and consult across the board, including the way that we involve our own staff in decisions that affect their working lives.

Accountable-We will make sure that we feed citizen's views into decisions, policies and service developments and we will demonstrate and communicate what has changed as a result of public involvement.

Purposeful-We will only carry out engagement when there is a clear purpose. For example:

a. Stakeholders themselves want to be involved
b. The policy or strategy will have a direct impact on stakeholders' lives
c. We have identified a gap in our knowledge
d. There is a statutory requirement

Honest-when involving and consulting we will be honest about:

a. What we are doing
b. Why we are doing it
c. What level of commitment we are asking from participants
d. Be clear about individual responsibilities (that is both those asking and those responding)
e. Only consult on what is achievable
f. How we will use our findings
g. How this feeds into our decision-making process
h. How we will feed back

Open-We will make sure that our full meetings are held in public and that stakeholders can easily access the records of our meetings. We will also increase the opportunities for stakeholders to be involved.

Accessible- We will make sure that engagement is accessible by:

a. Using plain English in any documents we publish
b. Using the right methods of engagement for the right audiences
c. Actively promoting materials in a range of formats, for example on tape, in Braille or in large print
d. Using venues that are easy to get to and held at times and place that are appropriate to the participants.

Inclusive-We will be inclusive by:

a. Making extra efforts to involve people whose views have been underrepresented in the past
b. Making sure that people are not excluded from engagement processes through circumstances. This might mean providing crèches or carer support, hearing loop systems, language signers and holding meetings at appropriate times and in appropriate venues
c. Making sure that no participants are out-of-pocket for taking part in involvement activities
d. Ensuring consultees have the necessary information to participate effectively
e. Enabling people to participate through building their capacity or by providing advocacy arrangements
f. Communicating using plain English, avoiding jargon and abbreviations
g. Making sure the consultation is widely communicated to the target audience
h. Making sure information is available on request in large print or other formats (e.g. audio tape) and in both paper and electronic formats

Flexible- We will endeavour to provide a flexible approach by:

a. Making sure that we allow enough time and space so that participants can contribute
b. Where we have time constraints, making this clear and explaining the reasons why
c. Making sure, where possible, to involve stakeholders at the earliest stages in the planning of services and projects rather than simply consulting then about pre-determined options
d. Giving people the chance to get involved in ways that suit them best by offering a range of ways they can respond
e. Making sure, with reason everyone who wants to take part can do so
f. Giving people enough time to take part
g. Working within the VCS Compact when involving voluntary and community groups
h. Undertake robust research that can stand up to scrutiny

Safe- We will make sure that participants are safe and their views respected by:

a. Making sure that we consider the needs of vulnerable participants
b. Respecting what participants tell us in confidence
c. Complying with the Data Protection Act 1998
d. Recognising our duties under the Freedom of Information Act 2000.

Efficient-We will co-ordinate and link our community engagement activities where appropriate to help avoid duplication of effort, time and resources. We will take an active

part in regional and countrywide activities and networks intended to achieve cost effectiveness.

Supported-We will make sure that elected members and staff undertaking public involvement activities are properly supported resourced and trained.

Evaluated- We will make sure that we build evaluation and monitoring into our consultation planning so that there is a way of measuring whether the outcomes have impacted on policy and strategy development.

Shared- We will make the results of engagement available to participants, partners and wherever possible, the general public and other key stakeholders.

Improved- We will learn lessons from our own activities and those conducted elsewhere so that we share, promote ad publicise good practice and innovation in engagement

Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

Dear Colleague,

- 4 NOV 2013

I would like to take the opportunity to inform you of work being done nationally to improve end of life care services and to highlight the importance of ensuring that people throughout the country have access to high quality services at the end of life.

As I am sure you are aware, the Government has specifically highlighted the importance of end of life care in the Mandate to NHS England. End of life care also features in the NHS Outcomes Framework and the updated NHS Constitution. However, whilst significant progress has been made in recent years to improve end of life care services, there is still much more work to do to ensure that people are receiving the highest standards of care at the end of life.

As part of this work, NHS England is currently undertaking a review and refocus of the End of Life Care Strategy, which is due to be completed in early 2014. Alongside this, the Leadership Alliance for the Care of Dying People, under the chairmanship of the National Clinical Director for End of Life Care, Dr Bee Wee, is working to set out the principles of good end of life care and to formulate a system-wide response to the Independent Review of the Liverpool Care Pathway, which was published in July.

NHS England is also undertaking work to develop a fairer, per-patient funding system for palliative care. The eight funding pilots we set up following the report of the independent Palliative Care Funding Review are due to complete in April 2014, with the aim of setting up a new funding system by 2015.

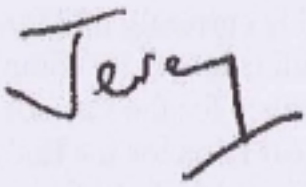
I am keen to ensure that the progress and momentum achieved in recent years in implementing the end of life care strategy is maintained. Health and Wellbeing Boards, as leaders in the local health and care system, are uniquely placed to contribute as part of a joined-up approach to improving care, informed by work being done nationally.

I am therefore keen to support Health and Wellbeing Boards in ensuring that locally-owned processes to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies fully consider end of life services; that the views and experiences of patients and families are fully and appropriately considered in the development process; and the commissioning and planning of local services is joined up with the work being done to improve these services at a national level.

As you will be aware, the Department has produced statutory guidance on JSNAs and JHWSs. We are also funding the Local Government Association and others to develop further resources to support the development of JSNAs, as well as support for local and national Healthwatch on patient and public engagement. https://knowledgehub.local.gov.uk

I know you will share my desire to see end of life care services continue to improve across the country. The work of Health and Wellbeing Boards is central to this goal and I believe that by ensuring local work on end of life care is joined up with, and informed by work being done nationally, we will make progress together towards improving the provision of end of life care and the experiences of patients and families.

Yours sincerely,



JEREMY HUNT

HEALTH AND WELLBEING BOARD

9 December 2013

Report of: Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Subject: SPECIAL EDUCATIONAL NEEDS REFORM – THE CHILDREN AND FAMILIES BILL

1. PURPOSE OF REPORT

The purpose of this report is to highlight to the Hartlepool Health and Wellbeing Board the implications of the new legislation relating to Special Educational Needs and health contributions to new processes to be introduced from 2014.

2. BACKGROUND

A single, simpler assessment process will be introduced for children with Special Educational Needs (SEN) backed up by the new single plan – part of the biggest reforms to SEN in 30 years. The Bill is expected to be introduced in spring 2014 and implemented during 2014. The main elements of the forthcoming Bill include:

- Replacing SEN statements and Learning Difficulty Assessments (for 16-25 year-olds) with a single 0-25 assessment process for Education, Health and Care and a resulting single plan from 2014.
- Providing statutory protections comparable to those currently associated with a statement of SEN to up to 25 years of age if they are in further education – instead of it being cut off at 16.
- Requiring local authorities to publish a local offer showing the support available to disabled children and young people and those with SEN, and their families
- Giving parents or young people with a single plan the right to a direct payment (including a health and education element) to meet their support needs.
- Introducing mediation for disputes and a trial giving children the right to appeal if they are unhappy with their support.

3. PROPOSALS

3.1 Implications for health

3.1.1 Joint commissioning

The Children and Families Bill places duties on the local Clinical Commissioning Group (NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG) in relation to children and young people with SEN. NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG must engage with the Local Authority to create joint commissioning arrangements for the health and social care provision required by children and young people identified as having SEN. These arrangements need to set out what health provision is to be secured and who is responsible for securing it. The arrangements must also establish a mechanism to resolve disputes between the different commissioning parties.

NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG will determine which services it will commission to meet the reasonable health needs of the children and young people with SEN for whom it is responsible. These services should be described in the local offer. NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG's must also work with the LA in the development and publishing of a local offer.

The mechanisms currently being utilised to prepare for the changes are the Hartlepool SEN Pathfinder Steering Group and supporting sub-structure of work streams. Also the Hartlepool Learning Disability and Disability Strategy Group action plan which contains key actions to ensure changes are considered and implemented.

3.1.2 Joint assessment, planning and individual commissioning

NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG must also cooperate with the Local Authority in the creation of an Education, Health and Care plan by advising on what kind of health provision is reasonably required by the learning difficulties and disabilities which result in the child or young person having SEN. This could include specialist support and therapies, occupational therapy, and physiotherapy, a range of nursing support, specialist equipment, wheelchairs and continence supplies. The Education, Health and Care plan will have to be approved by the relevant health commissioning body, and if it is approved, the health service must ensure that the support set out in the EHC plan is made available.

Where relevant local clinicians, such as community paediatricians, will participate in the development of the child's or young person's EHC plan. NHS HARTLEPOOL AND STOCKTON-ON-TEES CCGs must agree the health services in the plan, even though decisions may be made by a health professional. In most cases therefore, NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG may have minimal involvement in the process, as this will be led by clinicians. NHS HARTLEPOOL AND STOCKTON-ON-

TEES CCG's involvement may be limited to formally agreeing the commissioning of a service, especially to meet the complex needs of an individual, and where services aren't met by the local offer.

Currently the Hartlepool SEN Panel which meets monthly is the proposed structure for informing NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG of plans and signing them off.

3.1.3 Personal Budgets

Development of personal health budgets for children as proposed will have an impact on future commissioning arrangements. A personal health budget refers to the budget that will be made available should a young person or child have complex, long-term and/or a life-limiting condition/s. A personal health budget may also be made available to help with equipment costs or other health services. NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG has the flexibility to award a PHB where deemed appropriate for the individual. Children, who are supported through 'Continuing Care' funding, will have **the right** to request a personal health budget from April 2014. From August 2013, the NHS has had the legal power to give direct payments.

To prepare and learn more about the potential impact, NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG has made available £5,000 non-recurring funds to test other areas for personal health budgets outside of continuing care.

3.1.4 Designated Health Officer

As part of this process the health service needs to appoint a Designated Health Officer (DHO), an individual whose role is to ensure that NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG is meeting its statutory responsibilities for SEN. The DHO might be an employee of a NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG, or an employee of an NHS Trust or other provider commissioned by a NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG, NHS England or a local authority, but they should have a level of expertise that allows them to carry out this role effectively. There is already some recognition of this role within the current community peadiatrician delivery.

3.1.5 Accountability

The NHS Commissioning Board mandate commits to ensuring these changes are implemented. NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG's will be required to demonstrate compliance.

4. RECOMMENDATIONS

4.1 Considerations/Actions for the Health and Wellbeing Board:

- Note the content of briefing and agree to receive regular updates
- Support the inclusion of a detailed examination of local SEN needs within the JSNA
- Encourage joint working arrangements to ensure joint commissioning is achieved

5. CONTACT OFFICER

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