HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 13 February 2014

at 10.00 am

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 and 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 and 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 9 December 2013.

4. **KEY DECISIONS**

None

5. **ITEMS FOR DECISION**

5.1 Better Care Fund (BCF) Programme for Hartlepool – *Director of Child and Adults and Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group (to follow)*
5.2 Safer Hartlepool Partnership's Draft Community Safety Plan 2014 - 17 – *Director of Regeneration and Neighbourhoods*
5.3 Pharmaceutical Needs Assessment - *Director of Public Health*
5.4 Sub Group Structure of Health and Wellbeing Board – *Director of Child and Adult Services, Chief Officer Clinical Commissioning Group and Director of Public Health*

6. **ITEMS FOR INFORMATION**

6.1 Everyone Counts: Planning for Patients 2014/15 to 2018/19 (Planning Guidance) - *Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group*
6.2 Community Pharmacy Call to Action – Presentation, NHS England

7. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

Date of next meeting – 10 March 2014 at 10.00 am at the Civic Centre, Hartlepool.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

9 December 2013

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

Present:

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

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors Ged Hall, Geoff Lilley and Chris Simmons
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Dr Paul Pagni
Director of Public Health, Hartlepool Borough Council - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council – Gill Alexander
Representative of Healthwatch - Stephen Thomas

Other Members:
Representative of the NHS England – Caroline Thurlbeck
Representative of Cleveland Fire Brigade – Ian McHugh

In accordance with Council Procedure Rule 5.2 (ii), Karen Hawkins was in attendance as substitute for Ali Wilson, Mark Cotton was in attendance as substitute for Nichola Fairless and David Brown was in attendance as a substitute for Martin Barkley.

Also in attendance:-
Emma Thomas, North of England Commissioning Support

Officers: Jill Harrison, Assistant Director, Adult Services
Joan Stevens, Scrutiny Manager
Richard Starrs, Strategy and Performance Officer
Angela Armstrong, Principal Democratic Services Officer

48. Apologies for Absence

Apologies for absence were received from Ali Wilson (Hartlepool and Stockton-on-Tees Clinical Commissioning Group), Nichola Fairless (North East Ambulance NHS Trust), Martin Barkley (Tees Esk and Wear Valley NHS Trust), Dave Stubbs (Chief Executive, Hartlepool Borough Council), Denise Ogden (Director of Regeneration and Neighbourhoods, Hartlepool Borough Council, Margaret Wrenn (Healthwatch), Tracy Woodall (Hartlepool Voluntary

and Community Sector) and Alan Foster (North Tees and Hartlepool NHS Foundation Trust).

49. Declarations of interest by Members

None.

50. Minutes of the meeting held on 28 October 2013

Confirmed

51. 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*)

The Director of Public Health presented the report which provided the background to the ongoing work to the "better health outcomes for children and young people pledge". A joint letter from the Department of Health, Local Government Association, Royal College of Paediatrics and Child Health and Public Health England which was sent to the Lead Member for Children's Services and Chairs of Health and Wellbeing Boards was attached at Appendix 1. Also attached at Appendix 2 was a paper which challenged Health and Wellbeing Boards to consider taking action to tackle child poverty and make a long term contribution to health outcomes.

The Chair of the Children's Services Committee, Councillor Simmons confirmed that the Children's Committee was supportive that the pledge was signed as it was considered very worthwhile and supported the direction of travel of Children's Services. The Chair echoed these comments indicating the importance of implementing the pledge with the aim of eradicating child poverty.

During the discussions that followed, a Member highlighted that it was shocking to note that there had been an increase in child poverty in the 21st century and that taking a wider approach including examining the affects of mental health and the impact of the criminal justice system should also be explored.

The Director of Public Health commented that this pledge linked to the child poverty strategy which was regularly monitored and that a report would be submitted to a future meeting of the Board exploring ways of publicising the pledge and the efforts being made to eradicate child poverty and raising awareness with the public and appropriate organisations.

The representative from HealthWatch informed the Board that a health event would be held in the new year which was being designed and run by children and young people. It was noted that HealthWatch was working with local groups which involve children and young people to build an agenda for the

event and develop what they would like to see around the health and wellbeing of children and young people in the future. A Member highlighted the importance of involving Head Teachers from local schools who were ideally placed to be able to identify the affects of child poverty within families.

Decision

(i) The Board supported the work being undertaken with partners and young people to adapt the pledge to reflect local needs.
(ii) That further reports would be submitted to the Board on the progress of a local pledge with a view to adopting the pledge once complete.
(iii) That all partners be encouraged to contribute to the reduction of child poverty.

52. Strategic Planning in the NHS (*Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group)*

The representative from the NHS and Stockton on Tees Clinical Commissioning Group presented the report which informed the Board of the key activities and outputs required to complete the Annual Planning Round for the CCG for 2014/15. The report outlined the planning process which focussed on the best health outcomes which would 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 tasks
- Learning from patient feedback, including the outputs from Call to Action work
- Any national requirements and expectations, ie 7 day services
- Outcomes Frameworks

The timescale to support the delivery of the integration was outlined in the report and culminated in the submission of the final two year plan to be submitted by 4 April 2014 and the final five year plan by 20 June 2014.

Decision

The timescales and required approach to the 2014/15 NHS planning round was noted.

53. Integration Transformation Fund (*Director of Child and Adult Services, Hartlepool Borough Council and Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group*)

The Director of Child and Adult Services presented the report which provided the background to the Integration Transformation Fund which had been

created to promote the integration of health and social care services that support some of the most vulnerable population groups. The current guidance which set out the context of the Fund and how the £3.8bn funding pool will be created, how local plans should be developed for its use and the conditions for accessing the pooled fund was outlined in the report. The Board were informed that the Fund had recently been renamed the 'Better Care Fund'.

It was noted that the completed planning template had to be submitted by 15 February 2014 and a draft template was attached at Appendix 2. The Director of Child and Adult Services highlighted that the CCG were required to submit draft five years plans through their Health and Wellbeing Boards by 4 April 2014 with a final five year plan to be submitted by 20 June 2014. The Board was informed that CCG allocations of funding were expected to be issued later in December.

The Assistant Director, Adult Services confirmed that an additional meeting of the Health and Wellbeing Board had been arranged for 13 February 2014 to finalise the plan. However, in view of concerns expressed by the Chair in relation to the tight timescale involved, it was noted that a draft plan would be submitted to the meeting of the Board on 27 January to enable further consideration of the plan prior to it being finalised at the meeting of the Board in February.

Decision

(i) The current position in relation to the Integration Transformation Fund (now the Better Care Fund) was noted.
(ii) That a further report along with the draft plan be submitted to the Board in January to enable comments and views to be considered.
(iii) That the plan be submitted to the Board in February to seek approval for submission by 15 February 2013.

54. Local Healthwatch Work Plan 2013/14 (*HealthWatch Hartlepool*)

A representative from HealthWatch presented the report which informed the Board of HealthWatch Hartlepool's agreed work plan together with their Communication and Engagement proposal. The work plan would be delivered in conjunction with the Governance Framework, meetings of the associated task and finish groups, public meetings and service specification and the legislative requirements of the work plan were outlined in the report. The detailed work plan for 2013/14 was appended to the report.

During the discussions that followed it was noted that one of the key strengths of HealthWatch were the volunteers who dedicated a lot of valuable time and effort to implementing the work plan. A Member highlighted that a lot of concerns expressed by members of the public were around the discharge from hospital arrangements. The representative from HealthWatch confirmed

that this was one of the main areas highlighted, especially in relation to people who were discharged with complex care packages. It was noted that HealthWatch Hartlepool's work plan would involve examining hospital discharges across the hospital, the community and social services involvement. This will enable a full picture to be compiled to identify any pressure points on the process and how this can be managed more effectively in the future. Whilst it was recognised that this was a huge undertaking for the volunteers, all partner organisations had indicated they were fully supportive of this piece of work. One of the representatives from Hartlepool and Stockton-on-Tees CCG confirmed that they were already working with representatives from the Child and Adult Services Department to look at the hospital discharge process and were developing an Elderly Strategy with local care homes.

Decision

The HealthWatch Hartlepool work plan 2013/14 was noted.

55. Health Education North East – Presentation by Elaine Readhead (*Managing Director at Health Education North East*)

The Managing Director of Health Education North East was in attendance to provide the Board with an update on the work undertaken by the organisation. The Board were informed that the organisation was launched on 1 April 2013 to improve the quality of health and healthcare for the people and patients of England and was part of Health Education England. The Managing Director indicated that the organisation had a budget of £270, from a national budget of £5bn. It was highlighted that a significant investment was currently being made into dementia awareness and training. A brochure was circulated to Board members which provided a brief overview of the organisation, how decisions were made and how people can be involved.

The Director of Public Health commented that as the local authority had taken over responsibility for public health, it was reassuring to know that Health Education North East were co-ordinating the training for the local health sector workforce.

A Member questioned what was in place to ensure the continuation of consistent service provision through progression and recruitment. The Managing Director confirmed that one of the biggest areas of risk for the health sector was recruitment and retention and this was an area where a lot of work was ongoing and Health Education England has recently taken over responsibility for NHS Careers.

The representative from HealthWatch referred to the current economic climate and the financial difficulties being faced by organisations and questioned whether there had been a noticeable reduction in funding for training and education within the health service. The Managing Director indicated that the

funding of training and education within the health service was largely not affected in the north east, however, due to the additional winter pressures being placed on staff, the releasing of staff to attend training could be an issue.

In response to a question from the representative from HealthWatch, the Managing Director confirmed that all NHS employees were trained in dementia awareness, however this was an ongoing programme of training to ensure people understand and develop those skills further.

Decision

The Managing Director of Health Education North East was thanked for her attendance and informative presentation to the Board.

56. End of Life Care (*Director of Public Health*)

The Director of Public Health presented a letter to the Board from the Secretary of State for Health, the Rt Hon Jeremy Hunt MP. The letter outlined the work being done nationally to improve end of life care services and highlighted the importance of ensuring that people throughout the country had access to high quality services at the end of life. It was noted that this had been highlighted in the Mandate to NHS England who had undertaken to develop a fairer, per-patient funding system for palliative care. The Director of Public Health suggested that a report be submitted to a future meeting of the Board to provide an update on the actions taken locally to develop an end of life strategy. In response to a question, the Director of Public Health confirmed that the end of life strategy would be a comprehensive document that would include any provision available for children also.

A Member suggested that further examination of the wider context of end of life care be undertaken to look at how patients and their close relatives were affected. The representative from HealthWatch indicated that a number of cases regarding end of life issues were dealt with by HealthWatch and they were very distressing and traumatic for all involved and the whole grieving process should also be included.

Decision

(i) The letter from the Secretary of State for Health, the Rt Hon Jeremy Hunt MP was noted.
(ii) That a further report be submitted to a future meeting of the Board examining the development and implementation of the End of Life Strategy and the wider implications of this Strategy.

57. Special Educational Needs Reform – The Children and Families Bill (*Chief Officer, NHS Hartlepool and Stockton-on Tees Clinical Commissioning Group)*

One of the representatives from the NHS Hartlepool and Stockton on Tees Clinical Commissioning Group (CCG) presented the report which highlighted the implications of the new legislation relating to Special Educational Needs and health contributions to new processes to be introduced from 2014. The report provided details on how the CCG were considering and implementing the changes to their duties including the partnership working with the local authority. Further details of the proposals were included in the report and outlined the following:

- Joint Commissioning
- Joint Assessment, Planning and Individual Commissioning
- Personal Budgets
- Designated Health Officer
- Accountability

A Member questioned the reference in paragraphs 3.1.1 and 3.1.2 to the use of the term 'reasonable' and why the need to qualify the level of need was required. The representative from the CCG confirmed that the term 'reasonable' was about providing a service to meet the individual's needs without destabilising another part of their support package. Reference to 'reasonable' was key to ensuring that the overall picture was examined rather than dealing with specific issues in isolation.

Decision

(i) The content of the report and the receipt of future updates was noted.
(ii) The inclusion of a detailed examination of local SEN needs within the JSNA was supported.
(iii) Joint working arrangements were encouraged to ensure joint commissioning was achieved.

58. Any Other Items which the Chairman Considers are Urgent

None.

Meeting concluded at 11.00 am

CHAIR

HEALTH AND WELLBEING BOARD

13 February 2014

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

Subject: **BETTER CARE FUND**

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with further information regarding the Better Care Fund (formerly the Integration Transformation Fund) including the latest guidance, financial allocations and timescales. The report includes the draft plan that will be submitted for Hartlepool, for approval by the Health & Wellbeing Board, and outlines next steps regarding submission of the final plan by 4 April 2014.

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.

2.2 Subsequent guidance issued by the Local Government Association and NHS England sets out the context of the Better Care Fund (BCF), how the funding pool has been created and how local plans should be developed for its use.

2.3 The guidance reiterates that the BCF 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 BCF and respond to the outcomes of local Call to Action public engagement.

2.4 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.

2.5 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.

2.6 There are five nationally determined performance measures associated with the BCF:

- Permanent admissions of older people (aged 65 and over) to residential and nursing homes.
- Proportion of older people (aged 65 and over) who are still at home 91 days after discharge from hospital to reablement / rehabilitation services.
- Delayed transfers of care from hospital.
- Avoidable emergency admissions to hospital.
- A measure of patient / service user experience (which is still under development).

2.7 BCF plans are also required to include one locally determined performance measure. The agreed local measure for Hartlepool is:

- Estimated diagnosis rate for people with dementia.

2.8 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.

2.9 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. The North of Tees Partnership Board, as the 'unit of planning' 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.

3. DEVELOPMENT OF THE BCF PLAN FOR HARTLEPOOL

3.1 In December 2013, the North of Tees Partnership Board (an existing forum that brings together key strategic partners across health and social care, which has also acted as the oversight group for the BCF) agreed the local

principles for the BCF, which are consistent with the principles and aims set out in the planning guidance published on 20 December 2013.

3.2 The North of Tees Partnership Board also agreed that whilst plans would be developed at a local level, the Board would ensure that, where appropriate, similar services would be commissioned across the CCG footprint to ensure equity for local populations, avoid potential destabilisation of services and to ensure that providers are able to respond to required redesign of care pathways in a consistent and timely way.

3.3 The draft principles agreed were that BCF plans need to:

- support the priorities in the Joint Health and Wellbeing Strategy as well as align with the CCG Plan, NHS England operational plan and others;
- be based on clear evidence, including cost / benefit analysis of funding early-intervention and prevention services to achieve greater long-term sustainability and reduce pressure on acute services; and
- support existing or new services or transformation programmes where such programmes are of benefit to the wider health and social care system, have positive outcomes for service users and reduce demand on acute care.

3.4 Hartlepool's draft BCF plan has been developed in partnership with stakeholders from the Council, CCG, primary care and community services and acute and mental health service providers. Mechanisms to develop the plan have included:

- Fortnightly meetings of the North of Tees Partnership Board to ensure that the project was on schedule and meeting the aims and objectives of all partners as well as providing a forum for discussion regarding any issues or concerns
- Fortnightly meetings between key officers of the CCG and HBC
- Joint workshops and meetings with stakeholders from HBC, community service, acute services, primary care and mental health service providers to align the schemes and projects to the existing Momentum: Pathways to Healthcare programme, and to ensure that the schemes and projects support both health and local authorities to meet their objectives.

3.5 The draft BCF plan templates are attached as **Appendix 1** and **Appendix 2**. The planning templates include the detailed information relating to the Hartlepool BCF schemes, including a financial summary, the investment required to deliver the proposed developments and the outcomes and metrics against which the BCF plan will be measured. Part 2 of the planning template (**Appendix 2**), which relates to finance and metrics, will be further developed prior to the plan being finalised, as data and guidance is not yet available for all of the metrics.

4. NEXT STEPS AND IMPLEMENTATION

4.1 Key timescales and milestones for BCF are outlined below:

Key Milestones	Timescales
Draft BCF Plans submitted to NHS England and NHS Local Area Team	14 February 2014
Interim submission of the CCG Operational Plan (including BCF plan) to NHS England	14 March 2014
Final BCF Plans approved by Health & Wellbeing Board	March 2014
Final BCF Plans to be submitted to NHS England and NHS Local Area Team as part of the CCG Strategic and Operational Plans	4 April 2014
Report to Health & Wellbeing Board detailing governance, project management and risk sharing arrangements for the BCF	28 April 2014
Detailed implementation plan to be developed and agreed with clear project plans, milestones and performance metrics for each of the schemes.	June 2014

4.2 Although the majority of the impact of the BCF plans is expected in 2015/16 it should be noted that there is a drive to deliver as much as possible during 2014/15.

4.3 The North of Tees Partnership Board will continue to provide ongoing oversight of the Hartlepool and Stockton BCF plans, ensuring that there is strategic alignment of plans across North of Tees (as the agreed 'unit of planning') and encouraging the sharing of best practice.

4.4 A project team and programme structure will be required to manage the BCF implementation. Funding is available from the CCG to help support this and detail of how this will be structured and the associated resource implications will be developed and submitted to Health and Wellbeing Board for approval in April 2014.

4.5 More detailed work is also underway to confirm the risk sharing and contingency arrangements. A paper outlining these arrangements will also be submitted to the Health and Wellbeing Board for approval in April 2014.

5. FINANCIAL CONSIDERATIONS

5.1 The BCF allocation for Hartlepool is £7.19m which is made up as follows:

Funding Stream	Funding
Existing NHS Transfer to Social Care (2013/14)	£1.8m
Existing Reablement Funding	£0.61m
Existing Carers Funding	£0.2m
Additional NHS Transfer to Social Care (2014/15)	£0.5m
Capital Grants (including Disabled Facilities Grant)	£0.83m
Funding from CCG baseline budget	£3.25m

5.2 All existing resources and capital grants are fully committed and a piece of work will 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.

5.3 A high level summary of how the available funding will be allocated across the key themes within the BCF plan is included in **Appendix 2**. Further work will be undertaken as plans are developed to identify the funding required to deliver the BCF proposals and potential financial benefits resulting primarily from reduced admissions to hospital and residential or nursing care.

6. RISK IMPLICATIONS

6.1 The BCF requires partners to develop a shared risk register and have an agreed approach to risk sharing.

6.2 An initial risk assessment has been undertaken as part of the draft BCF plan and is included in **Appendix 1**. This is a high-level risk assessment and more detailed risk assessments will be developed for each of the planned developments identified in the plan.

6.3 In addition, contingency plans must be agreed to identify the implications of planned reductions in hospital and care home admissions not being achieved. Work is underway to develop these contingency plans which will be included in the final version of the BCF plan.

7. COMMUNICATION & ENGAGEMENT

7.1 The draft BCF plan has been jointly developed and agreed with key stakeholders from the Council, CCG, primary care and community services and acute and mental health service providers. The plan has also been informed by a range of existing engagement activities involving service users, carers, families and the public, focusing on a range of local health and social care services

7.2 There has not yet been any formal consultation relating specifically to the draft BCF plans but it is recognised that further engagement and consultation activities will be required throughout the implementation of the plan and a communication and engagement plan will be developed to support implementation.

8. RECOMMENDATIONS

8.1 It is recommended that the Health and Wellbeing Board review and approve the draft BCF plan for Hartlepool.

8.2 Final plans are required to be approved by the Health & Wellbeing Board in March 2014 for submission by 4 April 2014.

9. REASONS FOR RECOMMENDATIONS

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

10. CONTACT OFFICERS

Gill Alexander
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Ali Wilson
Chief Officer
NHS Hartlepool and Stockton-on-Tees CCG
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Better Care Fund Planning Template – Part 1

Please note there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Hartlepool Borough Council
Clinical Commissioning Groups	NHS Hartlepool & Stockton-on-Tees Clinical Commissioning Group
Boundary Differences	Hartlepool Borough Council and Hartlepool Health & Wellbeing Board share the same boundary. NHS Hartlepool & Stockton-on-Tees Clinical Commissioning Group also covers Stockton Borough Council area and a separate plan has been developed for the Stockton area.
Date agreed at Health and Well-Being Board:	13/02/2014
Date submitted:	14/02/2014
Minimum required value of BCF pooled budget: 2014/15	£418,000
2015/16	£7,192,000
Total agreed value of pooled budget: 2014/15	£503,000
2015/16	£7,192,000

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Hartlepool & Stockton-On-Tees Clinical Commissioning Group
By	Ali Wilson
Position	Chief Officer
Date	

Signed on behalf of the Council	Hartlepool Borough Council
By	Dave Stubbs
Position	Chief Executive
Date	

Signed on behalf of the Health and Wellbeing Board	Hartlepool Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Carl Richardson
Date	

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Our vision and plans reflect a number of existing programmes which have included health and social care providers as active participants; together with our voluntary and community sector.

The proposals in relation to the Better Care Fund were developed following confirmation of the North of tees Partnership Board as the 'unit of planning'. Each statutory body is represented on this group; membership includes the Clinical Commissioning Group (CCG), both local authorities (Stockton Borough Council and Hartlepool Borough Council) and both Foundation Trusts (North Tees and Hartlepool NHS Foundation Trust and Tees Esk and Wear Valley NHS Foundation Trust).

The North of Tees partnership Board;
- Agreed areas of focus for the BCF;
- Agreed principles for approval of plans;
- Provided oversight across the CCG boundaries in development of the plans;
- Agreed outcomes required and key performance indicators; and
- Ensured alignment of plans in order to achieve equitable services.

BCF proposals were further developed through:
- Fortnightly meetings of the North of Tees Partnership Board – to ensure the project was on schedule, meeting the agreed aims and objectives and dealing with issues raised by partners.
- Fortnightly meetings between the CCG and LA
- Workshops within the LA to develop ideas and gather data and supporting evidence from a social care perspective
- Joint workshops and meetings with stakeholders from the LA, community services, acute services, primary care and mental health service providers to align proposals to the existing Momentum programme and to ensure that proposals support both health and social care objectives.

As the North of Tees Partnership Board includes representatives of both local authorities that are within the CCG boundary there has been multi agency work undertaken to ensure that plans are aligned where appropriate.

In addition to the work specifically related to the BCF, the Council regularly engages with social care providers (including the care home market and providers of housing related support) through provider forums or consultation on specific issues. The Council's

direction of travel in terms of personalisation, reablement and promoting independence has been consistently communicated in recent years and a number of providers have shaped their services to meet changing demand and strategic direction as a result. A recent market engagement event relating to low level services attracted interest from a range of providers, some already established in the area and some not currently providing services locally, providing a further opportunity to encourage providers and potential providers to deliver joined up services that are focused on prevention and early intervention.

The CCG actively engages with providers across health and social care and the voluntary sector. Stakeholders are active participants and members of the CCG clinical work streams and project groups, which are responsible for developing and shaping future services and delivering the transformation agenda, and have been instrumental in shaping a number of the schemes.

The CCG has worked with providers in relation to joint engagement events (both internal and external facing) where system or service change is required and continues to work with providers in delivering the Momentum programme, which is the blueprint used to develop the BCF plans.

The voluntary sector is represented on the Health & Wellbeing Board, with the Chief Executive of Hartlepool & District Hospice being the nominated attendee. The Vulnerable Adults Forum, reporting to the Health & Wellbeing Board brings together commissioners and providers to develop a shared understanding of needs of the vulnerable adult population in Hartlepool, contribute to the evaluation of services and influence strategic planning and commissioning priorities

The LA and CCG see the Better Care Fund as a vehicle to build on the partnership working and integrated approach to services which has been in place in Hartlepool for a number of years, and to further improve outcomes for local people.

The Health and Wellbeing Board will consider the latest version of the draft plan in February 2014 before approving a final version of the plan in advance of the April deadline, by which time the CCG must submit the plan to NHSE (National Health Service England) as part of its Strategic and Operational plans. A wider range of providers will also have the opportunity to consider the plan and be able to comment on it.

In addition, formal contract meetings with all acute, community and mental health providers held by the CCG will be utilised to raise the profile of the plan and seek feedback on it. It will be included in commissioning intentions and contracting principles for 2014/15 and beyond to ensure that providers are engaged in and understand the planned impact.

d) Patient, service user and public engagement

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

Active consultation with people who use services and the public has contributed to the development of plans for local services and our vision is based on what people have told us is most important to them, including local community based services that provide care close to home.

By focusing on our vision for integrated care we have been able to engage with all partners and believe this will help us to achieve true co-design of the future sustainable model for health and social care delivery.

Our vision is based on what people have told us is most important to them. Over the past year, with the establishment of the CCG and the Health and Wellbeing Board, both the Council and the CCG have engaged with people who use services, carers, residents and the workforce across the public, private and voluntary sectors about the vision and priorities for health and social care.

The CCG remains committed to this level of engagement. A recent stakeholder engagement exercise focussed on local priorities with two 'Call to Action' engagement events held using a 'Market Stall' approach exercise which was clinically led and supported by CCG staff and wider team members from our Commissioning Support Unit.

To extend this conversation beyond the events, the CCG engaged with the voluntary sector and Healthwatch in both localities to undertake further conversations with those community groups that are often deemed as hard to hear/reach groups. This work with community groups was not completed until January, therefore analysis of all reports and themes is yet to be completed, but an early review indicates a number of areas the CCG will need to consider in developing plans. Existing communication and engagement plans will need to be refreshed to reflect findings in relation to how better to engage and ensure that people using services and carers are included when developing future services/pathways.

The CCG has a robust programme of engagement and communication to ensure that this momentum is built upon and is committed to undertake a number of engagement events focused on specific projects, including integrated care.

The Council engages with people who use services through regular forums such as the Carers Strategy Group, Learning Disability Partnership Board, Mental Health Forum and Champions of Older Lifestyles group and a Service User Focus Group that provides a user perspective on a range of issues and consultation topics. People who use services have been actively involved in the development of the Carers Strategy and Housing Care & Support Strategy, which clearly support the direction of travel for joined up services that intervene early and have a focus on prevention and maintaining people's independence for as long as possible.

Healthwatch Hartlepool is represented on the Health & Wellbeing Board and has been involved in recent consultation with service users and the public on a number of health and social care issues including domiciliary care and hospital discharge arrangements. Healthwatch Hartlepool also works closely with the Council to assess quality standards in care homes, providing a valuable independent perspective.

e) 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.

Document or information title	**Synopsis and links**
JSNA	Joint local authority and CCG assessment of the needs of the local population in order to improve the physical and mental health and well-being of individuals and communities.
Joint Health & Wellbeing Strategy	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out to address the needs identified in the JSNA.
Carers Strategy	Multi agency strategy that identifies the needs of carers locally and priorities to deliver improvements over a three to five year period.
Moving Forward Together	Hartlepool's vision for adult social care from 2011 – 2014.
2012/13 Local Account	Summary of the priorities, progress and future direction of adult social care in Hartlepool.
Clear and Credible Plan	Description of the main health issues and how the CCG will tackle these http://www.hartlepoolandstocktonccg.nhs.uk/publications/
CCG Prospectus	http://www.hartlepoolandstocktonccg.nhs.uk/publications/

2) VISION AND SCHEMES

a) 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?

The system vision is: *'To develop outstanding, innovative and equitable health and social care services, ensuring excellence and value in delivery of person centred care working across both health and social care'.*

We will do this by:

- Commissioning for quality outcomes and services that deliver the required standards;
- Putting people at the heart of what we do and creating a system that is flexible and responsive enough to recognise the different needs of individuals;
- Actively seeking out unmet need as well as responding to expressed need;
- Establishing systems and processes that are sustainable and affordable to deliver continuity of care, ensuring that people are involved in decision making and planning of their own care and support, including referrals, and being helped to navigate services and systems;
- Striving to improve on what we do through change and innovation;
- Learning from successes and setbacks; and
- Ensuring we include 'Care, Compassion, Competence, Communication, Courage, Commitment' in all we do.

Residents of Hartlepool deserve the best possible 'joined up' health and social care and should get the right care, in the right place, at the right time, supporting them to have longer, healthier lives and ensuring they can say *"I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me" (Integrated Care and Support: Our Shared Commitment).* This is why all partners in the public, independent and voluntary sector are working together to improve the local health and social care system.

There is already a strong focus on partnership working within Hartlepool. The Momentum: Pathways to Healthcare programme has been the blueprint for the last 5 years and is the means by which the Trust and local health community partners will reconfigure services to deliver safe, high quality, efficient and effective health services for the local population, reflecting both the expectations of the patients, and local and national initiatives which define the expectations on NHS provider organisations. This continues to provide the philosophy for the health and social care economy as closer integration is brought about.

Working in close partnership within the Momentum programme has helped us to achieve many changes in clinical services which deliver improved quality, safety and patient experience in the services that are commissioned. We now need to ensure that we continue this and ensure a joined up approach across health and social care partners. The Better Care Fund is seen as a significant step forward in developing integrated health and social care services, providing a framework for change and ensuring that

partners work together to provide better support at home and earlier treatment in the community. Through this joint planning we will be able to reduce pressures on urgent care and prevent people needing emergency care in hospital or a permanent care home admission.

Our vision of service delivery as we move forward is to have a sustained focus on integration, meaning '*organisations working together to create services that maximise health and wellbeing and address individual needs, improving outcomes and experiences for individuals and communities (Integrated Care and Support: Our Shared Commitment)'.*

Our vision is that by 2018/19 everyone is able to live at home longer, be healthier and get the right support services where required, whether this be provided by health and / or social care. We will have healthcare system where we have integrated health and social care, a focus on primary prevention, early diagnosis and intervention, and supported self-management. Where a person requires hospital treatment, if this cannot be provided in a community setting, we expect this will be carried out as a day case treatment or in an outpatient setting.

Care will be provided to the highest standards of quality and safety, with the person remaining at the centre of all decisions. Our focus will be to ensure that people can remain in their own homes or when this is not possible and they have to be treated in hospital we will ensure that their discharge is appropriately planned to ensure that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the 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?

The aims and objectives of our integrated system are:

- To ensure that the population of Hartlepool has access to a wide range of primary prevention interventions including, but not limited to, smoking cessation services, exercise, weight management, IAPT, problem drinking support, cancer screening programmes, immunisation, social prescribing, carer's support and good nutrition.
- To identify the 'missing thousands' of people who have undiagnosed and unmanaged long term conditions such as cardiovascular disease (including atrial fibrillation and hypertension), diabetes, COPD, liver disease dementia and early cancer.
- To maximise independence and quality of life and help people to stay healthy and well through the development of integrated community health and social care services with a focus on long term conditions, frail elderly (including end of life) and dementia, delivered through the roll out of an integrated care model building on existing care planning, care co-ordination, risk stratification and multi-disciplinary working.
- To streamline care and reduce activities that are carried out by multiple organisations

ensuring the right services are available in the right place, at the right time through an integrated community approach providing rapid response to support individuals to remain at home and avoid admission

- To improve people's experience of services through the introduction of a single point of access across health and social care, utilising the NHS number. We want to work towards improving systems and connectivity across the whole health and social care system that will share people's information to enhance the quality of care and ensuring continuity of delivery.
- To improve outcomes for service users and carers through clearer and simpler care pathways and proactive management of people with long term conditions. We will do this through co-designing models of care that will meet need. These pathways will be simple to understand, simple to follow and will be available for all staff, service users and carers to see.
- To have a skilled workforce that understands both the health and social care system and works across organisational boundaries, making every contact count.
- To ensure that each person has a package of care that improves their physical, social and emotional wellbeing, acknowledging that all three elements are necessary to enjoy good health.
- To support personalisation and choice by developing a range of co-ordinated alternatives to hospital and residential care. This will be delivered through investment in personalised health and care budgets ensuring individuals are able to make informed decisions.
- To ensure that digital technology is utilised innovatively to deliver the greatest possible benefit to people using services and carers across health and social care.
- To improve access to community health and social care services 7 days a week to improve user experience and provide responsive services in and out of hours, reduce delayed discharges and improve support to empower people to live independently.

Our vision for integration is ambitious, it is about establishing a landscape in which different public bodies are able to work together, and with their partners in the third and independent sectors, removing unhelpful boundaries and using their combined resources, to achieve maximum benefit for service users, carers and families.

The expected outcomes are both qualitative and quantative. We are determined that any changes we implement will have the person at the heart of them and specifically will increase the quality and timeliness of service provision.

The specific quantative aims of our the schemes are:

- To maintain or reduce the number of people aged 65 and over who are permanently admitted to residential care;
- To maintain current excellent performance in relation to delayed discharges attributable to social care;
- To maintain or reduce the number of delayed discharges and lost bed days from acute settings for people aged 65 and over who are medically fit for discharge;
- A decrease in avoidable emergency admissions of people aged 65 and over; and
- An increase in the estimated diagnosis rate of dementia.
- An increase in the number of people supported by assistive technology.

- An increase in the number of people accessing reablement services.

To support these aims, we will also expect to see significant qualitative improvements through a more integrated and person centred model of delivery including.

- Faster response times and more integrated support for individuals and their carers/families.
- Improved quality of care in care home settings; and
- Positive feedback and customer satisfaction reports.

A programme team will be established to oversee the planning, and mobilisation of the BCF proposals and the development of a performance framework to ensure that there is a detailed understanding of the impact of the services on local NHS providers and the local authority with a particular emphasis on how activity has moved throughout the health and social care system and most importantly, how the proposals have impacted on the outcomes and experiences of people using services.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- 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

The changes planned for Hartlepool mean significant change across the whole of the current health and care provider landscape and are focused in three key areas:

- Low Level Support and Management of Long Term Conditions
- Intermediate Care
- Improved Dementia Pathways

All services share a focus on provision of services as close to people's homes as possible, recognising that receiving care and support within Hartlepool whenever possible is important to our population and provides increased opportunities to maintain links with families, carers and the local community.

<u>Low Level Support and Management of Long Term Conditions</u>

People must be supported more systematically to maximise their own financial, human and community resources to achieve self-determination. We will support people to access resources in their own communities and to manage their own conditions and will work with the voluntary and community sector to ensure that those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well. We will invest in empowering local people through effective facilitation and signposting, carers support, self-management and low level preventative services to maximise their independence and wellbeing and we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

We will use the BCF to:

- Commission low level services that:
  - Link people to community activities and facilities
  - Signpost and support people, providing good information
  - Use facilitators to encourage people into the service and to support them to try

new experiences and activities, motivate and reassure them and co-ordinate a range of activities across community based sites
  - Include a community hub with meeting rooms for sessional work and services similar to those provided at the current day centres
  - Provide one to one support for people who have been assessed as eligible for this service (who are likely to have high level health needs and / or dementia) either within the community hub, in the community or in a person's own home.
  - Provide low level support services such as luncheon clubs and a handyperson service.

- Invest in good quality, accessible, person-centred advice, information and advocacy services that support people to manage their own conditions and maximise their own resources, as well as signposting to services where appropriate.

- Commission support and navigation services from the voluntary sector and user led organisations for people with long term conditions, such as stroke, and for people with sensory loss to help reduce social isolation and promote independence.

- Provide additional support to carers through direct payments allowing them to maintain a caring role while playing an active role in their own families / communities.

- Develop an expert carer programme that trains carers to manage the long term condition(s) of those that they care for.

- Develop an Occupational Therapy Trusted Assessor role providing advice and guidance on low level equipment and supporting daily living skills for those with lower level needs.

- Commission housing related support for vulnerable people in sheltered housing or extra care, enabling them to remain in their own homes for as long as possible.

<u>Intermediate Care</u>
We will support people in their own homes and in the community to prevent avoidable admissions to hospital and to prevent or postpone permanent admissions to residential care through providing a range of community based alternatives. Services will focus on supporting people in their own homes wherever possible through enhanced community nurse and social care intervention building upon and enhancing the model of community services already in place – the Community Integrated Assessment Team (CIAT) and Teams Around Practices (TAPS). This approach will be further enhanced through the availability of community based step up provision, which will focus on lower level health needs which currently account for high numbers of avoidable emergency admissions. When a hospital admission is necessary and can't be prevented, we will work together to ensure that hospital discharge is timely and seamless and that people are supported through reablement services to regain their confidence, maximise their abilities and develop the skills and capacity to retain their independence for as long as possible.

We will use the BCF to:

- Invest in a co-located Early Intervention model that supports hospital discharges through additional social work and occupational therapy capacity and procurement of additional capacity within the independent sector to deliver reablement packages

following a period of assessment. This will facilitate smooth hospital discharges and enable CIAT (and specifically the Rapid Response Nursing service) to discharge people efficiently following a period of intensive involvement and will be supported by a review of the current model of service for Rapid Response Nursing.

- Commission new pathways of care including a clinically led 'step up' service in the community for people requiring intensive, short term, complex nursing interventions that would normally necessitate a hospital admission. This locally focused service will ensure that Hartlepool residents are treated close to home with individual support that ensures continuity of care and is designed to meet the needs of the older population, inclusive of those with dementia. This service will primarily address the management of conditions which currently are admitted to hospital such as UTIs (the primary diagnosis for almost 400 admissions of over 65s per year in Hartlepool) and respiratory issues (the reason for almost 850 admissions of over 65s per year, at a cost of over £2m) as part of a new COPD pathway. The service will be clinically led by the most appropriate health professional and will complement existing services and those outlined in the plan. The service will ensure that any individual known to health and / or social care has a single care plan developed where appropriate.

- Expand the use of assistive technology and bring together existing community health and social care services that operate out of hours in a shared base within Hartlepool to meet planned and unplanned need for known service users overnight and during weekends. This will be achieved through:
  - a single personalised health and social care plan for all individuals with agreed contingency arrangements, risk assessment and RAG rating, linked to existing plans to roll out Emergency Health Care Plans;
  - better utilisation of personal budgets and personal health budgets which include contingency plans and can include planned access to respite care in a location of choice;
  - access to the Carers Emergency Respite Scheme;
  - proactive calls and visits;
  - reactive calls and visits that offer an integrated response and utilise skill mix to provide the most appropriate response for each individual; and
  - access to step up provision as an alternative to a hospital admission or a temporary place of safety if needed.

- Invest in additional professional support for care homes through an integrated care home liaison and support model that offers care home providers professional advice and support on a range of issues that are common factors in hospital admissions and / or safeguarding referrals. This will include pharmacist support in relation to medication issues, falls advice and support, support in relation to pressure ulcer and continence management, respiratory nurse input, dietetics and advice on management of dementia. This model will also support the community based 'step up' provision and builds on an existing pilot that has been supported with non recurrent CCG funding.

- Invest in a 7 day community equipment service to support hospital discharges at weekends, if there is evidence that this would be beneficial.

We will also deliver on the new provisions of GMS, including a named GP for patients

aged 75 and flexible provision over 7 days as well as providing additional GP input to care homes through Emergency Health Care Planning. A core focus for GPs will be on providing joined up support for those individuals with long-term conditions and complex health needs, particularly the frail elderly.

The volume of emergency activity in hospitals will be reduced and we will eliminate delays in transfers of care, reduce pressures in A&E and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

Improved Dementia Pathways

It is our aim that people with dementia can access the same range and quality of services as the general population and we will ensure that new service developments are dementia friendly and easily accessible by people with dementia and their carers. We will use the learning from the North of Tees Dementia Collaborative to inform the future direction of travel, and to ensure that improvements are made and sustained.

We will use the BCF to:

- Create Dementia Advisor roles that support individuals and their families from the earliest possible point in their journey, filling the gap between health and social care and offering proactive 'stigma-free' support to individuals who need information, advice and peer support at the pace they can absorb. The advisors will work closely with the memory screening service, community mental health and social care teams to offer seamless support for people with dementia and their carers and will facilitate peer to peer dementia support so that people with dementia can meet and discuss how dementia affects them and share coping strategies.

- Provide a sitting service that supports people with dementia, providing short breaks for carers and enabling them to continue in their caring role for as long as they are willing and able to.

- Commission a service that supports people with dementia to access the community, as well as providing a building based service for those requiring this level of support.

- Develop group living services for people with dementia as a further alternative to residential care, which reduces hospital admissions and enables people to stay in their own home and end their lives there if that is their choice.

- Fund additional social work capacity to support people with dementia, including those with young onset dementia. How this resource is best provided in an integrated model will be informed by a review of the Community Dementia Liaison Service.

An overview of the timeline for key elements of the proposals are provided below:

April – June 2014

- Development of an accommodation strategy to support co-location and integration.

- Engagement with clinicians to inform the service specification for step up provision.

- Evaluation of tenders for low level services (Social Inclusion & Lifestyle Pathways).

- Additional Social Work capacity in Early Intervention in place.

July – September 2014

- Review of current model for Rapid Response Nursing and 24hr District Nursing.
- Commence tender for step up provision should service model determine this is required.
- Dementia Advisors appointed for 1 October 2014 start date.
- Commissioned low level services (Social Inclusion & Lifestyle Pathways) commence.

October – December 2014

- Conclude commissioning of step up service model
- NHS number identified for all current social care cases.

January – March 2014

- Expert carer programme commissioned.
- Appointment of additional Social Workers to support people with dementia.
- Contracts awarded for support and navigation services for LTCs and sensory loss.
- Appointment to posts providing professional support for care homes.

The outcomes of the BCF plan will be:

- Less dependency on intensive acute services due to earlier and targeted intervention.
- Fewer avoidable acute episodes through better management of conditions in the community, reducing unnecessary hospital and residential / nursing care admissions.
- A reduction in emergency bed days associated with repeat acute admissions by more timely and co-ordinated intervention.
- Reduced duplication, inefficiency and waste at the interface of care.
- Reorganisation of pathways and removal of professional boundaries.
- Health and social care delivered in a more co-ordinated, efficient and cohesive way.
- Patients and family carers knowing their individual pathway and having greater confidence in service delivery.

d) 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.

The implications for the acute sector are significant given that the funding to support BCF is already committed and the necessary shift of funding is most likely to come from spend with acute providers. The impact on acute providers has not been underestimated and plans have been shaped accordingly with input from NHS providers.

The main purpose of the proposed developments is to ensure that those individuals at high risk of health and social care interventions are proactively managed and supported to avoid the requirement for hospital based interventions.

We recognise to deliver the BCF plan and to achieve longer term sustainability, the overall spend in the acute sector must reduce significantly in order to properly resource the integrated out of hospital model. Through our joint workshop with the main acute provider locally, it has been agreed the proposed BCF model along with the Momentum Pathways to Healthcare programme will help us achieve this. Momentum: Pathways to Healthcare is based on delivery of a reduced hospital footprint, deliverable through scalable change in the way services are provided outside of hospital. The planned BCF developments will support this change and be a driver for transformation across health and social care.

The key to success will be in turning this high level plan into real action that allows all partners to reshape their models of service provision accordingly.

We will aim to target our efficiency savings specifically around a reduction in avoidable emergency admissions and A&E attendances, using the available data to target conditions and causes of admission which are deemed to be potentially avoidable.

e) Governance

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

The governance mechanism that oversees the progress and the outcomes for the work in relation to the BCF is the North of Tees Partnership Board This group brings together key partners and will provide strategic direction and performance management of the BCF plan as proposals are further developed and move to the implementation phase.

The Partnership Board will provide regular progress and outcome reports to ensure all partners are able to meet their respective reporting requirements in line with their own governance arrangements. This includes but is not limited to; ensuring that the Health and Wellbeing Board remains central to the development and oversight of the proposed schemes making up the Better Care Fund and provision of regular updates via the Vulnerable Adults Forum and Joint Commissioning Executive that support the Board.

There will be regular briefings with the Local Authority lead member and updates provided to the Council's Adult Services Committee ensuring that plans are aligned with the priorities of local communities and the wider strategic direction of the Council. The Adult Services Committee is the constitutional forum for key decision making and a core

part of the process for implementation of these changes and will also provide a forum for challenge and monitoring success.

The CCG Delivery Team and Governing Body will be kept appraised of the developments and kept informed of the progress of all plans; this will be achieved through development sessions and/or Governing Body meetings. Member Practices of the CCG will also be kept appraised through Clinical Time Out events, Clinical Reference Groups and Council of Member meetings.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

Protecting social care services means ensuring that people in Hartlepool with eligible social care need continue to be supported in a time of increasing demand and reducing local government resources.

This will be achieved through further integration of services that proactively intervene to support people at the earliest opportunity, ensuring that they remain well, are engaged in the management of their own wellbeing and wherever possible, are able to stay in their own homes and retain their independence while contributing to their local communities for as long as they are able to.

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

Funding currently allocated through the NHS Transfer to Social Care has been used to enable the local authority to sustain the current level of eligibility criteria and to support timely hospital discharge, delivery of reablement and telecare services, commissioning of low level support services and support for carers. This will need to be sustained to maintain this as the social care offer for Hartlepool, and increased in order to deliver 7 day services and to address the implications of the Care Bill which will requires additional assessments to be undertaken for people who did not previously access social care and provision of further support for carers.

It is proposed that additional resources will be invested in social care to deliver enhanced reablement services, which will reduce hospital readmissions and admissions to residential and nursing home care.

b) 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.

The integrated health and social care out of hours service will prevent unnecessary admissions during evenings, overnight periods and weekends through the provision of personalised health and social care plans and clearly identified contingency arrangements for all people known to services, and through the provision of an integrated and appropriate response to unplanned needs. In hours, co-location of the current Single Point of Access for community services with the Council's Early Intervention Service will provide an integrated response at the first point of contact, reducing duplication and ensuring that a seamless service is provided to the individual.

Step up provision will be provided across seven days and will enable patients to be maintained in a safe environment and reduce the necessity to be admitted to hospital This service will enhance and complement the existing services commissioned.

We will develop a social work function within the integrated health and social care out of

hours service, enabling social work assessments to be provided seven days a week. This will facilitate hospital discharge at weekends and enable professional social work support to be provided to the out of hours service so that decisions are made which are person centred and in the best interest of the individual. We will explore the delivery of the AMHP function through this service and the potential to review the current Emergency Duty Team arrangements (covering five neighbouring local authorities) and provide a more responsive, cost effective service based within Hartlepool and integrated with community health provision.

We will also determine if there is a requirement to invest in a 7 day community equipment service to support hospital discharges at weekends.

c) Data sharing

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

All health services use the NHS number as the primary identifier in correspondence.

All health providers are commissioned using the NHS Standard Contract. This contract requires completion of a valid NHS Number field and in mental health and acute commissioning data sets this is submitted via SUS. This is a national quality requirement of the contract with a financial penalty applied to breaches in threshold tolerance.

Adult social care services are committed to adopting the NHS number as the primary identifier for correspondence.

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

From an NHS perspective, where individual organisations are non compliant with the NHS Standard Contract terms, a Data Quality Improvement Plan (DQIP) would be agreed to ensure that this requirement is delivered.

From a social care perspective, there is a commitment to use the NHS number as the primary identifier for correspondence by April 2015.

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

We are committed to adopting systems based upon Open APIs and Open Standards.

Adult Services are committed to ensuring that all systems are established, maintained and developed in a open style with appropriate links to partner systems and, where required, with direct interfaces between systems. This requires further development between local health and social care IT systems to enable more automatic information sharing between health and social care.

Main systems currently in use within adult social care services are ‘CareFirst’ (master system for assessment and care management), ‘Controcc’ (services, direct payments & personal budgets, along with provider and client payments), ‘Call Confirm’ (domiciliary

scheduling & monitoring) & 'ICLipse' (document management system).
A project will commence in 2014 to look at N3 connection for Adult Social Care.

Hartlepool Borough Council has Public Services Network Compliance Certification and robustly uses secure email, e.g. through GCSX to NHS.net emailing etc.
From a CCG perspective a high percentage of member GP practices are actively updating the Summary Care Record, and there is a commitment to adopting Open API functionality as it becomes available in the clinical systems deployed through the GPSoC2 framework (SystmOne, EMIS and InPS). The CCG will also look to include appropriate weighting in future tenders and system replacements which favour those with Accessible/Open API functionality.

The Electronic Prescription Service is currently being implemented in all member practices, which will allow prescriptions issued by clinicians to meet the ISB0052 dm+d interoperability standards for transmission to other care partners.

The CCG is currently in the early stages of a CCG wide deployment of SharePoint which utilises OpenXML document standards and will facilitate greater information availability and sharing.

All clinicians and CCG staff are using NHSMail which complies with Government 'RESRICTED' standards and can be used to communicate Personal Identifiable Information securely with other clinicians and LA colleagues using GSX Mailboxes.

Please confirm that you are committed 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 Caldicott 2.

From an NHS perspective, all providers are required to comply with the terms and conditions of the NHS Standard Contract which requires confirmation from providers that they are compliant with the IG Toolkit Level 2. All providers are required to provide the relevant IG policies relating to confidentiality, data protection and information disclosure (GC21.10.1); handling and disclosing personal data (GC21.10.2 and 21.10.4); and obligations under NHS Care Records Guarantee (GC 21.10.3).

The Council's adult social care service is committed to maintaining and further developing a comprehensive range of Information Governance controls. A full range of IG policies are in place, which are overseen and reviewed by a corporate IG group and an extensive training and awareness programme is currently in place and will be reviewed during 2014. All new and revised contracts with provider agencies include a detailed Information Sharing Protocol that outlines full and comprehensive data sharing procedures. We are currently working on the Adult Social Care IG toolkit in order to gain compliance in 2014/15.

d) Joint assessment 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.

The proposed integrated model provides a single access point for every person with whom we engage with and a single personalised plan in order to facilitate the most appropriate health and social care response, in hours and out of hours.

The model will focus on all people known to community nursing and social care services initially, and will use a range of tools to identify those at higher risk of requiring intervention. These include:

- Social Care Eligibility Criteria (FACS)
- GP Practice Quality and Outcome Framework (QOF) Registers
- Risk Stratification Assessment and Identification, which is built in to provider contracts, both in primary care and community services

The predictive risk stratification model that is currently commissioned from a health perspective is delivered in partnership across GPs and community matrons and the current predictive risk tool identifies individuals most likely to be at risk of an emergency admission in the next twelve months. This tool is to be further developed to incorporate both social and health risk to enable a targeted multi disciplinary approach to support people to better self-manage their long term condition, having an appropriate identified accountable lead.

Whilst we acknowledge that each of the above has a part to play in risk identification, we do require a more structured and joint approach to risk stratification and this will form a key work stream of our overall plan for 2014/15.

We believe focusing on high intensive current users of health and social care within our area will provide us with the maximum impact and benefit in our joint work creating and maintaining a positive environment within which we can transform and integrate local health and social care services.

4) 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
Shifting resources to fund new integrated services destabilises current providers, particularly in the acute sector.	High	
A lack of detailed baseline data and the need to rely on current assumptions means that financial and performance targets for 2015/16 onwards are unachievable.	High	
Operational / demographic pressures restrict the ability of the workforce to deliver the required investment and associated projects to make the vision reality.	High	• 2014/15 schemes include non-recurrent investment in infrastructure and capacity to support overall organisational development.
Improvements in quality of care and preventative services fail to translate into required reductions in acute and care home activity by 2015/16, impacting on the overall funding available to support core services and future schemes.	High	• Assumptions have been modelled using a range of available data, • 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications.
The introduction of the Care Bill results in significant financial pressures for social care services that are not fully quantifiable and impacts on the sustainability of current social care funding and plans.	High	• We have undertaken an initial impact assessment of the effects of the Care Bill and will continue to refine our assumptions around this as we develop our final BCF response, and begin to deliver upon the associated schemes.
The non-coterminous boundaries for health and social care result in differing priorities and levels of investment that need to be managed by a single CCG and acute provider, which disadvantages Hartlepool.	High	• BCF Oversight Group covering the North of Tees Unit of Planning enables plans to be shared and implications understood. • Opportunities for joint working across the two LAs have been explored.

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Hartlepool Borough Council	Y	418,000	0	0
NHS Hartlepool and Stockton on Tees CCG	N	85,000	7,192,000	7,192,000
BCF Total		**503,000**	**7,192,000**	**7,192,000**

Approximately 25% of the BCF 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.

If the anticipated improvements are not achieved, it will not be possible to continue new services created through the BCF funding to deliver those improvements.

Contingency plan:		2015/16	Ongoing
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Planned savings (if targets fully achieved)	-	-
	Maximum support needed for other services (if targets not achieved)	-	-
Avoidable emergency admissions (composite measure)	Planned savings (if targets fully achieved)	1,437,057	1,437,057
	Maximum support needed for other services (if targets not achieved)	TBC	TBC

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Low Level Services	TBC	100,000		-	-	1,085,000	-	-	-
Intermediate Care	TBC	226,000		-	-	4,507,000	-	1,437,057	1,437,057
Dementia	TBC	115,000		-	-	430,000	-	-	-
Carers	TBC			-	-	345,000	-	-	-
DFG / Capital	TBC			-	-	825,000	-	-	-
Transitional	TBC		62,000	-	-		-	-	-
Total		441,000	62,000	-	-	7,192,000	-	1,437,057	1,437,057

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Permanent admissions of older people to residential and nursing homes: the expected outcome of the proposed BCF developments is a reduction in the number of admissions per 100,000 patients. The aim of the proposed developments is to maximise the ability of older people to remain independent in their own homes for as long as possible, reducing the need for permanent admissions to residential and nursing home settings, despite the increasing over 65 population and the increased prevalence of dementia.
Proportion of older people at home 91 days after discharge into reablement / rehabilitation services: Reablement services are well established in Hartlepool and over 83% of people discharged into reablement / rehabilitation services are currently maintained in their own homes 91 days after discharge. The BCF proposals include additional investment in reablement services and support for hospital discharges and it is expected that there will be an improvement on current performance as a result of this investment. **Delayed**
Transfers of Care: Hartlepool's current performance in relation to delayed transfers of care is very good due to existing joint working arrangements between health and social care, with no delayed discharge attributable to social care ever having been reported. It is anticipated that the planned BCF developments will enable this level of performance to be maintained despite the increasing over 65 population and the increased prevalence of dementia. **Avoidable Emergency**
Admissions: Data indicates that the level of avoidable emergency admissions is due to increase in 2014/15. It is anticipated that planned BCF developments will have a significant impact on this indicator in 2015/16 as more people are supported in their own homes without the need for a hospital admission. If any developments can be brought forward to 2014/15 the positive impact may be seen sooner. **Estimated Diagnosis Rate for Dementia:**
details to be added when metric information is available.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

National metric under development.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Performance plans have been agreed based on baseline data and analysis of trends and demographic projections. A performance framework will be developed for the BCF proposals which will provide assurance to the North of Tees Partnership Board (Unit of Planning Oversight Group) regarding delivery of projected performance. Performance will also be reported through internal processes within the Council (Corporate Management Team) and CCG (Delivery Team / Governing Body) and to the Health & Wellbeing Board on a regular basis.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not applicable - plan refers to Hartlepool Health & Wellbeing Board only.

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	857.8	N/A	847.9
	Numerator	140		145
	Denominator	16,205		17,100
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	83.6	N/A	86.6
	Numerator	56		58
	Denominator	67		67
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	5.99	5.95	5.91
	Numerator	4.3	4.3	4.3
	Denominator	71,730	72,200	72,800
		(April 2012 - March 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	3048.3	1612.8	1612.8
	Numerator	2826	1501	1471
	Denominator	92707	93064	93439
		(October 2012 - September	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience	**National measure being developed**			
Estimated diagnosis rate for people with dementia (NHS Outcomes Framework indicator 2.6.i)	*Metric Value*	**Data to be provided by CCG**		
	Numerator			
	Denominator			

HEALTH AND WELLBEING BOARD

13th February 2014

Report of: Director of Regeneration and Neighbourhoods

Subject: SAFER HARTLEPOOL PARTNERSHIP'S DRAFT COMMUNITY SAFETY PLAN 2014-17

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 Non -Key Decision.

2. PURPOSE OF REPORT

2.1 To present and seek comments from the Health and Wellbeing Board on the first draft of the Community Safety Plan 2014-17 (formerly known as the Community Safety Strategy).

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3. BACKGROUND

3.1 The Crime and Disorder Act 1998 established a statutory duty for the Local Authorities, Police, Fire Brigades, Clinical Commissioning Groups and Probation Trusts to work together to address local crime and disorder, substance misuse and re-offending issues. Collectively these five bodies are known as Responsible Authorities and make up the Safer Hartlepool Partnership.

3.2 In accordance with the Crime and Disorder Act 1998 and the Crime and Disorder Regulations 2007, the Safer Hartlepool Partnership is required to produce a three year Community Safety Plan to set out how it intends to tackle crime and disorder, substance misuse and re-offending in Hartlepool.

3.3 The current Hartlepool Community Safety Plan which was developed during 2010/11 will come to an end in March 2014.

4. DRAFT COMMUNITY SAFETY PLAN 2014-17

4.1 To inform the development and subsequent annual refresh of the Community Safety Plan, the Safer Hartlepool Partnership has a statutory

responsibility to undertake an annual strategic assessment to understand the community safety issues that are affecting the local community and identify the key priorities for the forthcoming year.

4.2 Undertaken in October 2013, the Safer Hartlepool Partnership strategic assessment, executive summary attached **Appendix 1**, includes the analysis of a wide range of local crime, anti-social behaviour, substance misuse and offending data combined with the results of community consultation, including the Councils Household Survey and Safer Hartlepool Partnership "Face the Public" event.

4.3 The first draft of the proposed Community Safety Plan 2014-17 is attached as **Appendix 2**.

4.4 Based on the findings from the strategic assessment and public consultation the plan sets out the Partnership's four strategic objectives 2014-17.

Strategic Objectives 2014 -17	
Reduce crime and repeat victimisation	Create confident, cohesive and safe communities
Reduce the harm caused by drug and alcohol misuse	Reduce offending and re-offending

4.5 During 2014-15 the Partnership will focus on Creating Confident, cohesive, and safe communities and the following six priorities.

Annual Priorities 2014-15	
Domestic violence & abuse	Anti-social behaviour
Acquisitive crime	Hate crime
Substance misuse	Re-offending

4.6 Responsibility for delivery against the annual priorities has been allocated to themed 'Task Groups' of the Safer Hartlepool Partnership, where performance will be monitored on a quarterly basis.

5. NEXT STEPS

5.1 The draft plan is being consulted upon in accordance with the Voluntary and Community Sector Strategy undertakings (this contains the former consultation codes of the Hartlepool Compact). The results of the consultation on the first draft of the Community Safety Plan 2014 -17 will be considered and used to inform the production of the second draft which will be presented to the Safer Hartlepool Partnership in March 2014, before being considered by full Council for adoption in April 2014.

6. LEGAL CONSIDERATIONS

6.1 In accordance with the Crime and Disorder Act 1998 and the Crime and Disorder Regulations 2007, the Safer Hartlepool Partnership is required to produce a three year Community Safety Plan to set out how it intends to tackle crime and disorder, substance misuse and re-offending in Hartlepool.

7. EQUALITY AND DIVERSITY CONSIDERATIONS

7.1 The strategic assessment and consultation process, with an annual refresh, will ensure that the needs of all sections of the community area considered when formulating and implementing the Community Safety Plan 2014-17.

8. SECTION 17

8.1 Failure to develop a Community Safety Plan would prevent the Local Authority from fulfilling its statutory responsibilities around reducing crime and disorder, substance misuse, and re-offending.

9. RECOMMENDATIONS

9.1 Health and Wellbeing Board is requested to note and comment on the draft Community Safety Plan 2014-17.

10. REASONS FOR RECOMMENDATIONS

10.1 As a Responsible Authority, the Local Authority has a statutory duty to develop a three year strategy aimed at reducing crime and disorder, substance misuse, and re-offending behaviour.

11. BACKGROUND PAPERS

11.1 Safer Hartlepool Partnership Plan 2011
http://www.saferhartlepool.co.uk/downloads/file/65/safer_hartlepool_partnership_plan-year_3-2011-2014

Report to Safer Hartlepool Partnership 5th July 2013 – Community Safety Strategy 2014-17 http://www.hartlepool.gov.uk/egov_downloads/05.07.13_-_Safer_Hartlepool_Partnership_Agenda.pdf

Report to Safer Hartlepool Partnership 13th December 2013 - Safer Hartlepool Partnership Strategic Assessment
http://www.hartlepool.gov.uk/egov_downloads/13.12.13_-_Safer_Hartlepool_Partnership_Agenda.pdf

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Safer Hartlepool Partnership
Strategic Assessment 2013

Executive Summary

November 2013

Acknowledgements

Safer Hartlepool Partnership Strategic Assessment prepared by the Community Safety Research Team, Hartlepool Borough Council.

We would like to thank the following agencies, partners and organisations who have provided data, material and / or comment on this assessment's content:

- Hartlepool Borough Council Hartlepool Borough Council
  - Community Safety Team
  - Youth Offending Service
  - Public Health
  - Child & Adult Services

- Cleveland Fire Brigade
- Cleveland Police
- Durham Tees Valley Probation Trust
- North Tees and Hartlepool NHS Foundation Trust
- Office of the Cleveland Police and Crime Commissioner
- Housing Hartlepool
- Balance
- Victim Support
- Harbour
- Hart Gables

Introduction

The Safer Hartlepool Partnership has a statutory requirement to undertake an annual strategic assessment to identify and address the community safety issues that impact upon and really matter to the local community. It is important to understand not only what is happening where, but what may be causing the problems and the best way to tackle them. All the work of the Safer Hartlepool Partnership is intelligence led provided by analysis contained within the Strategic Assessment and other detailed analytical reports.

The strategic assessment contains information to aid understanding of the priority community safety issues identified for the communities of Hartlepool, including what has changed over the last year, what work we are doing, how we are measuring effectiveness and future challenges. The executive summary provides a description of the current local and national delivery landscape and a reminder of the objectives and priorities that we set last year.

As the Partnership nears the end of its three year plan 2011-2014, the Strategic Assessment 2013 will assist the Partnership in setting strategic objectives to inform the new Safer Hartlepool Partnership Plan 2014 – 2017.

The Strategic Assessment for 2013 also informs the Hartlepool Joint Strategic Needs Assessment (JSNA), the Alcohol and Drugs Needs Assessments, Community Strategy and the Police and Crime Plan produced by the Office of the Cleveland Police and Crime Commissioner.

Strategic Objectives & Priorities

As agreed by the Safer Hartlepool Partnership in February 2013 and detailed in the Community Safety Plan 2013/14, the Partnerships current strategic objectives and priorities are:

Strategic Objectives 2011-14	Annual Priorities 2013-14
Reduce crime and repeat victimisation	Acquisitive crime – domestic burglary and theft Domestic violence and abuse Support victims and reduce the risk of repeat victimisation
Reduce the harm caused by drug and alcohol misuse	Address substance misuse through a combination of prevention, control and treatment services
Create confident, cohesive and safe communities	Protect and support vulnerable victims and communities including victims of hate crime. Improve public reassurance and fear of crime by actively communicating, engaging and working with local communities. Continue to address anti-social behaviour at a neighbourhood level through effective multi agency working.
Reduce offending and re-offending	Tackle offending and re-offending behaviour through a combination of prevention, diversion and enforcement activity underpinned by a strong multi agency approach.

The Delivery Landscape

There are many factors that will impact on the Safer Hartlepool Partnership in the coming years:

- A challenging economic climate, including the impact of welfare reform.
- Changes to commissioning arrangements following the transition of Public Health into Hartlepool Borough Council and the election of a Police and Crime Commissioner.
- Significant changes to and development of Government policy in key areas, including re-offending, anti-social behaviour, alcohol and serious organised crime.
- Widespread restructuring and change across local public sector agencies due to the significant loss of funding.
- More integrated working across agencies, placing increased reliance on strong effective partnerships, effectiveness and value for money.

The Safer Hartlepool Partnership is well placed to meet these challenges. We have a long established evidence-led service planning and delivery process, ensuring that resources are targeted where they are most needed.

We recognise that community safety priorities impact upon each other, and those of partner organisations, and with limited resources and budgets, there is opportunity to maximise collaborative working and joint commissioning at a local level.

Community engagement and increasing public confidence at a neighbourhood level underpins all partnership work, and involving communities in developing local solutions will become increasingly important. This extends to understanding how we can work more effectively with the community and voluntary sector, and local businesses – not just in terms of delivering against our priorities but also involving these wider partners in identifying the issues for Hartlepool, and their involvement in the prioritisation and planning process.

As a partnership we need to develop new ways to engage with our communities including the increased use of technology and in particular social media, whilst continuing to build good quality relationships with communities to increase social connectedness, confidence, and safety across the neighbourhoods of Hartlepool.

Local Context

Hartlepool is the smallest unitary authority in the North East region and the third smallest in the country comprising of some of the most disadvantaged areas in England. Issues around community safety can be understood by a number of contextual factors:

Population

- Hartlepool has a stable population rate, maintained by low levels of migration.
- Hartlepool has become more diverse in recent years, although a very small proportion of the population are from the Black Minority Ethnic (BME) community.
- 46% of the population in Hartlepool live in five of the most deprived wards in the country, where crime and anti-social behaviour rates are high.

Housing

- Strong links exists between the occurrence of anti-social behaviour and the location of private rented housing.
- The percentage of long term empty properties in Hartlepool is higher than the regional average.

Deprivation

- Hartlepool has pockets of high deprivation where communities experience multiple issues: higher unemployment, lower incomes, child poverty, ill health, low qualification, poorer housing conditions and higher crime rates.
- Residents living in more deprived, and densely populated areas have high perceptions of crime and anti-social behaviour and feel less safe.

Unemployment

- Unemployment rates in Hartlepool are above the regional average and more than double the national average.
- 14.5% of young people aged 18-24 years are unemployed.
- Hartlepool has high rates of people incapable of work due to disability and ill health.

Health & Wellbeing

- The health of people in Hartlepool is generally worse than the England average.
- There is a higher prevalence of long term health problems, including mental health.
- The number of alcohol related hospital admissions and hospital stays for self-harm in Hartlepool are significantly worse than the England average.
- The number of Class A drug users in Hartlepool is more than double the national average.

Geography

- Community safety problems are not evenly spread and tend to be concentrated in geographic hotspots, particularly in the most deprived wards in Hartlepool.

Performance – October 2012 to September 2013

Crime & Incidents	Incidence 2012/13	Actual change since 2011/12	% change since 2011/12
All Crime	**6,426**	**- 185**	**- 2.8%**
Victim Based Crime[1]	**5,679**	**- 43**	**- 0.8%**
Non-Victim Based Crime[2]	**747**	**- 142**	**- 16.0%**
Victim Based Crime Summary			
Violence against the Person	**1,167**	**- 185**	**- 13.7%**
Violence with Injury	659	- 159	-19.4%
Violence without Injury	508	- 26	- 4.9%
Sexual Offences	**84**	**-4**	**- 4.5%**
Rape	34	-7	- 17.1%
Other Sexual Offences	50	3	6.4%
Acquisitive Crime	**3,102**	**285**	**10.1%**
Domestic Burglary	302	- 19	- 5.9%
Other Burglary	395	90	29.5%
Robbery – Personal	22	4	22.2%
Robbery – Business	10	3	42.9%
Vehicle Crime	421	31	7.9%
Shoplifting	873	169	24.0%
Other Acquisitive	1079	7	0.7%
Criminal Damage & Arson	**1,326**	**-139**	**-9.5**
Non-Victim Based Crime Summary			
Public Disorder	**184**	**- 52**	**- 22.0%**
Drug Offences	**418**	**- 29**	**- 6.5%**
Trafficking of drugs	78	- 18	- 18.8%
Possession/Use of drugs	340	- 11	- 3.1%
Crime Prevented/Disrupted	**89**	**- 30**	**- 25.2%**
Other State based/Non Victim	**31**	**7**	**29.2%**
Fraud & Forgery	**25**	**- 38**	**-60.3%**
Anti-social Behaviour			
Police – Anti-social Behaviour Incidents	7460	21	0.3%
HBC – Anti-social Behaviour Cases	330	-69	- 17.3%
Housing Hartlepool – TRET Cases	729	-14	- 1.9%
HBC – Noise Nuisance Complaints	589	91	18.3%
Deliberate Fire Setting			
Deliberate Primary Fires	37	- 13	- 26.0%
Deliberate Secondary Fires	223	29	14.9%

[1] In accordance with HMIC guidance – victim based crime includes all police-recorded crimes where there is a direct victim.
[2] In accordance with HMIC guidance – non-victim based crime includes a police-recorded crime where there is no direct individual victim. The rates for some crime types within this category are indicative of proactive police activity, for example searching suspects and finding them in possession of weapons or drugs.

Community Perceptions	2008	2013
% of people who feel unsafe during the day	5%	5%
% of people who feel unsafe after dark	32%	28%
% of people who think rubbish or litter lying around is a problem in their local area	44%	38%
% of people who think speeding and volume of traffic is a problem in their local area	-	34%
% of people who think people using drug or dealing drugs is a problem in their local area	30%	29%
% of people who think groups hanging around the streets is a problem in their local area	43%	25%
% of people who think people being drunk or rowdy in a public place is a problem in their local area	28%	19%
% of people who think run down boarded up properties is a problem in their local area	-	18%
% of people who think vandalism, graffiti and damage is a problem in their local area	27%	17%
% of people who think house burglary is a problem in their local area	-	14%
% of people who think vehicle crime is a problem in their local area	-	13%
% of people who think noisy neighbours or loud parties are a problem in their local area	14%	12%
% of people who think people being harassed or attacked in their local area is a problem	-	9%
% of people who think property being set on fire is a problem in their local area	-	5%
% of people who think racial harassment is a problem in their local area	-	3%
% of people who think abandoned or burnt out cars are a problem in their local area	5%	2%
% of people who think people from different ethnic backgrounds get on well together	72%	42%
% of people who feel they belong to their local area	60%	71%
% of people who feel part of their local community	52%	47%
% of people who feel that they can influence decisions that affect their local area	33%	12%
% of people who are satisfied with the quality of service provided by the Police	62%	59%

Strategic Summary

Performance

Overall Hartlepool is a high crime area when compared to similar areas elsewhere in the country.

Despite significant challenges over the last few years Hartlepool continues to experience year on year reductions in overall crime rates, albeit that reductions are smaller than those experienced previously.

It is notable that non-victim based crimes, which are indicative of proactive policing and enforcement activity, have reduced at a greater level (-16%) than victim-based crime offences which have reduced by 0.8%.

Some crimes, particularly those falling within the acquisitive crime category are on the increase with projections indicating an increasing trend for the following twelve months. Whilst current socio-economic factors can affect this crime type, locally it is recognised that substance misuse and re-offending are key drivers in the prevalence of acquisitive offences.

Whilst performance is strong in regard to violence against the person offences, it continues to account for 18.1% of total recorded crime in Hartlepool, with recorded levels being higher than the most similar group average.

Unlike the previous reporting year anti-social behaviour incidents reported to the Police have increased by 0.3%, with year end[3] projections indicating an increase of more than 20%.

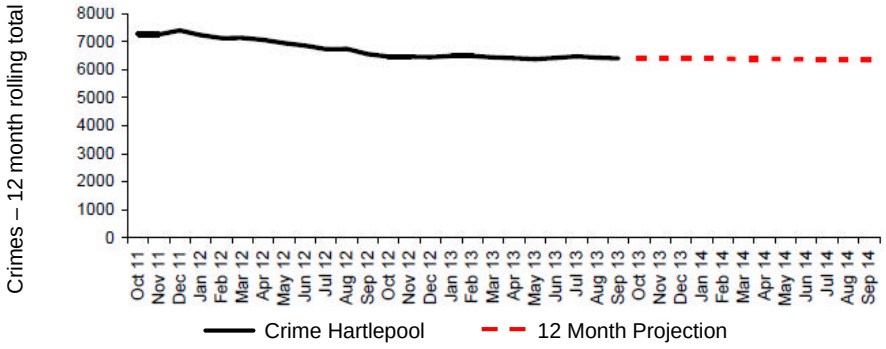
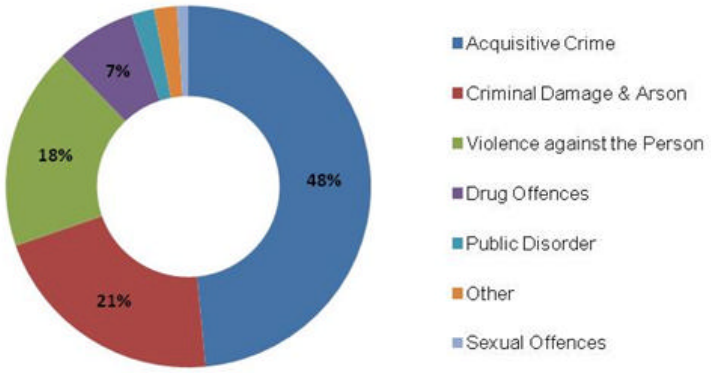
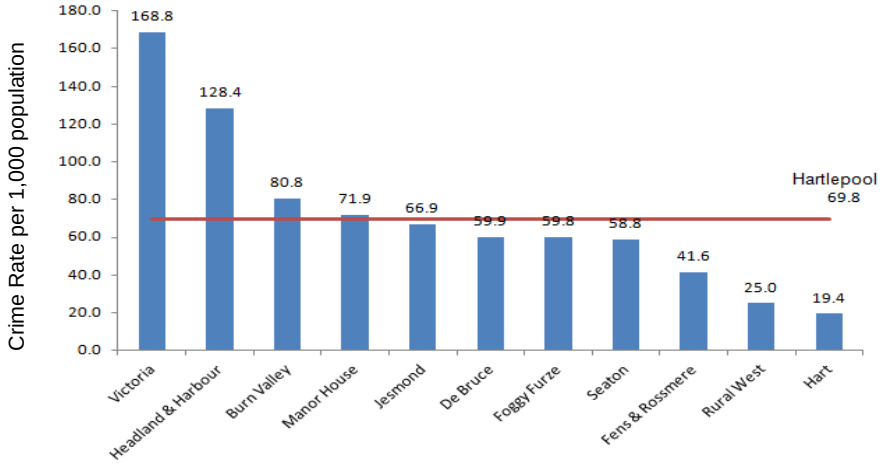
Anti-social behaviour continues to follow a strong seasonal trend with police incidents, Anti-social Behaviour Unit cases, Tenancy Relations & Enforcement Team (TRET) cases and Noise Nuisance complaints reaching their peak during the summer months.

Hartlepool continues to have the second highest anti-social behaviour rate in Cleveland.

Community perception results from the recent Household Survey indicate that from a town wide perspective the fear of crime and anti-social behaviour related issues have generally improved, however it is noted that these results do vary across wards with perceptions in our most disadvantaged communities remaining high.

Anti-social behaviour and drug dealing related activity continues to be a primary concern to the community, with all 11 wards in Hartlepool citing this as a Neighbourhood Policing ward priority. However despite this prioritisation, it is notable that proactive policing crimes related to these issues, specifically public order and drug offences, have decreased in comparison to the previous assessment period.

[3] March 2014

QUICK FACTS - RECORDED CRIME IN HARTLEPOOL	
Figures refer to the 12 month period ending 30th September 2013	
Level of Crime	6,426 recorded crimes
Annual change	Reduced by 2.8% (185 crimes) compared with 2012/13
Crime rate per 1,000 population	69.8 crimes per 1,000 population
Local Comparison	Hartlepool has the second highest crime rate in the Cleveland area • Middlesbrough – 101.3 per 1,000 population • Stockton – 61.8 per 1,000 population • Redcar & Cleveland – 59.9 per 1,000 population • Cleveland – 72.5 per 1,000 population
National Comparison	The crime rate in Hartlepool is above the national average of 66.0[4] crimes per 1,000 population and the Most Similar Group[5] average of 65.6 per 1,000 population
General trend	
Breakdown of crime types	
Crime rates by ward	

[4] Crime in England & Wales 2012/13

[5] Most Similar Group (MSG) Community Safety Partnerships – I-Quanta: Gateshead, South Tyneside, Neath & Port Talbot, Sunderland, Walsall, Stockton-on-Tees, Merthyr Tydfil, Barnsley, Corby, Rochdale, Doncaster, Halton, North East Lincolnshire, Middlesbrough.

Crime

It is estimated that the total cost of crime in Hartlepool during the last 12 months exceeds £60 million[6].

Crime continues to be concentrated in our most disadvantaged and vulnerable communities, co-existing with high levels of anti-social behaviour, health inequalities, unemployment and poor housing all of which place a significant demand on partner resources. People living in deprived areas experience significantly higher levels of crime and disorder, therefore they are at greater risk of victimisation and for this reason remain vulnerable.

Crime rates in the Victoria, Headland & Harbour, Burn Valley and Manor House wards continue to be much higher than the rest of the town, with the crime rate in the Victoria being twice the national average.

It is anticipated that acquisitive crime rates will increase over the forthcoming twelve months placing residents and businesses at risk in Hartlepool. It is therefore imperative that the partnership works with at risk groups to reduce the risk of victimisation and opportunities for offenders, whilst also ensuring that effective offender management arrangements reduce the risk of re-offending.

Whilst violence against the person offences have reduced by 13.7%, crime rates still remain above the local[7] and national average. Most notably the rate of emergency hospital admissions for violence in Hartlepool, 133.8 per 100,000 population, is almost double the national average of 67.7.

Domestic violence continues to be a key factor in the occurrence of violence offences, with more than half of offences being domestic related. Domestic violence has a devastating impact on individuals, families and communities. Tackling this issue requires a significant amount of resources from all public sector agencies.

Whilst trends in reported crime show a slight decrease, it is anticipated that there is a risk that levels will increase as victims and their families struggle to cope with added financial and emotional pressures brought about by the current economic situation i.e. higher unemployment and welfare reform.

Females continue to be at the greatest risk of domestic violence, where repeat victimisation is apparent. Often indirect victims, children experiencing domestic abuse are at an increased risk of behavioural, emotional trauma and mental health issues that may continue into adulthood.

Under reporting continues to be factor in domestic related violence, especially in regards to Black & Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Transgender (LGBT) communities.

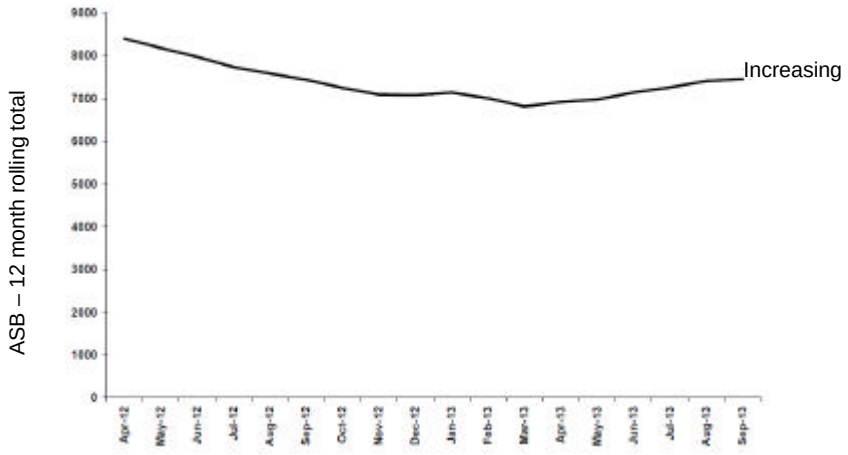
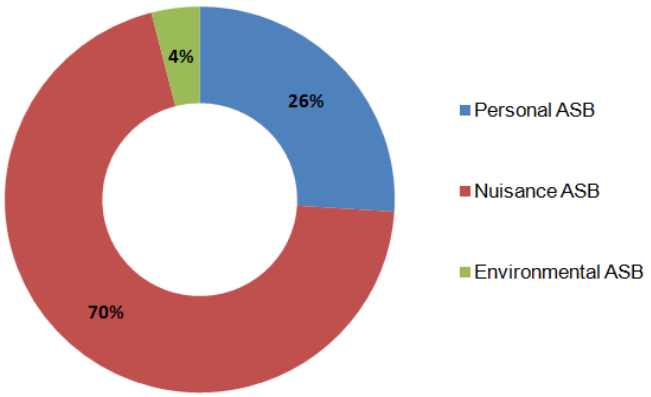
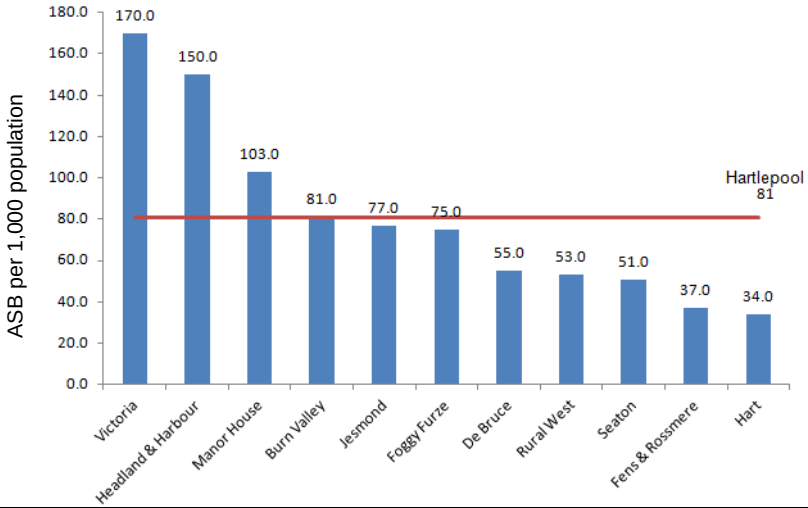
The relatively low level of referrals from Health professionals into domestic violence support services and the Multi-Agency Risk Assessment Conference (MARAC), particularly from the primary care setting continues to be an area of concern.

Overall acquisitive crime and domestic related violence & abuse pose a significant risk to the community, businesses, vulnerable people and families.

[6] Home Office - Integrated Offender Management Value for Money Toolkit 2011 – Multipliers & Unit Costs of Crime
[7] Cleveland

QUICK FACTS - ANTI-SOCIAL BEHAVIOUR (ASB) IN HARTLEPOOL

Figures refer to the 12 month period ending 30th September 2013

Level of ASB	7,460 incidents
Annual change	Increase by 0.3% (+21 incidents) compared with 2012/13
ASB rate per 1,000 pop	81 incidents per 1,000 population
Local Comparison	Hartlepool has the second highest ASB rate in the Cleveland area • Middlesbrough – 86.5 per 1,000 population • Stockton – 67.8 per 1,000 population • Redcar & Cleveland – 70.2 per 1,000 population • Cleveland – 75.2 per 1,000 population
National Comparison	The ASB rate in Hartlepool is twice the national average of 40[8] incidents per 1,000 population
General trend	
Breakdown of ASB incident categories	
ASB rates by Ward	

[8] Crime in England & Wales 2012/13

Anti-social Behaviour

Anti-social behaviour continues to be the number one priority for the community.

Anti-social behaviour in all its forms, nuisance or rowdy behaviour, misuse of vehicles, littering, dog fouling, is a very visible sign of disorder in our communities and is closely linked to perceptions of safety, satisfaction with the local area as a place to live and confidence in local services. As identified from the Partnership's Vulnerable Victims Group, in its most persistent and serious forms it can have a significant impact on health and wellbeing.

Anti-social behaviour continues to be linked to a wide range of other issues including hate crime, the night-time economy, drug dealing, alcohol misuse and housing tenure.

Reported incidence of anti-social behaviour shows considerable variance, with over half of all anti-social behaviour incidents reported in Victoria, Headland & Harbour, Manor House and Burn Valley wards. The rate of incidents per 1,000 population in these neighbourhoods is double the national average.

Public perceptions of anti-social behaviour commonly highlight young people as "being a problem", however despite this only one third of anti-social behaviour incidents are linked to young people. The type of anti-social behaviour linked to young people predominantly relates to groups of young people congregating in public spaces, underage drinking, being noisy and verbally abusive. Therefore the continued provision of targeted outreach services for young people is an essential diversion tool.

Hate Crime

Hate crime remains high on the Partnership agenda, with the number of reported hate crimes and incidents increasing by 27%.

Hate crime is different to other forms of crime as it targets people because of their identity. Research has shown that hate crime causes greater psychological harm than similar crimes without a motivation or prejudice. Hate crime creates fear in victims, groups and communities and can act as a catalyst to communities to turn against each other.

Local data suggests that victims of racially motivated incidents and crimes are more likely to report such matters, unlike victims of sexual orientation, disabilist and transphobic discrimination where incident levels remain low.

The reasons for not reporting include anticipation that it will not be taken seriously, a fear of negative response and a belief that there is little that anyone can do. In relation to the LBGT community, national research[9] indicates that two thirds of those who experienced a hate crime or incident did not report it.

Therefore building confidence in local communities to report hate and discrimination should be a primary focus over the next twelve months, ensuring that victims of hate crime can access third party reporting centres and rapidly receive the support that they need.

The Partnership's Community Intelligence process continues to assist in the identification of individuals who may be vulnerable to hate crime as either a victim or perpetrator, and extends to the disruption of right-wing activity that is a threat to community cohesion.

[9] Stonewall – British Gay Crime Survey 2013

Victims

Whilst crime rates in Hartlepool have fallen, the likelihood of being a victim of crime still remains a reality, especially in our most vulnerable and disadvantaged communities.

The risk of being a victim of crime or anti-social behaviour in Hartlepool is higher than in some of our neighbouring local authorities[10] in the Cleveland area.

It is acknowledged that the likelihood of someone reporting a crime can depend on the nature of the crime they have experienced, this is particularly relevant to domestic related abuse and hate crime.

A variation in repeat victimisation is evident, with those experiencing domestic violence & abuse, particularly females, being more likely to suffer from repeat victimisation than any other type of victim.

Locally there continues to be established pathways into support services for victims of crime and domestic abuse, but pathways for victims of anti-social behaviour need to be improved.

The impact of becoming a victim of crime or anti-social behaviour varies from person to person. A relatively minor offence can have a serious outcome for a vulnerable victim. Therefore it is essential that the Partnership adopts a victim-centred approach; responding to the needs of the individual, rather than the crime type or incident suffered.

[10] Redcar & Cleveland and Stockton

Community Perceptions

Community Perceptions 2013	Hartlepool	Most Deprived → Least Deprived										
		Headland & Harbour	Manor House	Victoria	De Bruce	Jesmond	Burn Valley	Foggy Furze	Fens & Rossmere	Seaton	Hart	Rural West
% of people who think that they do not belong to their local area	29%	27%	**31%**	**40%**	27%	**35%**	**33%**	**31%**	24%	22%	**32%**	24%
% of people you feel that they cannot influence decisions that affect their local area?	56%	51%	52%	**57%**	56%	53%	**59%**	55%	**57%**	**57%**	56%	56%
% of people who do not feel part of the local community	53%	48%	**56%**	**59%**	**54%**	**60%**	**58%**	**57%**	52%	48%	**57%**	42%
% of people who believe people from different ethnic backgrounds do not get on well together in their local area	16%	**19%**	**19%**	**19%**	**19%**	**20%**	**19%**	**17%**	13%	12%	15%	9%
% of people who do not think that people in the area pull together to improve the local area	28%	**28%**	**32%**	**42%**	**37%**	**32%**	**34%**	**29%**	18%	20%	**30%**	13%
% of people who feel unsafe when outside in your local area after dark	28%	27%	**37%**	**45%**	**29%**	**37%**	**35%**	37%	20%	15%	18%	16%
% of people who feel unsafe when outside in your local area during the day	5%	**7%**	**6%**	**12%**	**6%**	**6%**	**7%**	**7%**	3%	1%	3%	2%
% of people who think noisy neighbours or loud parties are a problem	12%	**16%**	**19%**	**23%**	**16%**	**18%**	**17%**	**14%**	6%	5%	6%	4%
% of people who think rubbish or litter lying around is a problem	38%	**51%**	**45%**	**56%**	**44%**	**44%**	**47%**	**43%**	21%	29%	27%	21%
% of people who think vandalism, graffiti and other deliberate damage to property or vehicles is a problem	17%	**26%**	**22%**	**31%**	**23%**	**23%**	**22%**	17%	7%	9%	10%	9%
% of people who think drug use or dealing is a problem	29%	**42%**	**40%**	**54%**	**39%**	**29%**	**46%**	37%	12%	12%	7%	11%
% of people who think drunk or rowdy in public places is a problem	19%	**27%**	**24%**	**40%**	18%	**20%**	**34%**	**23%**	9%	9%	7%	7%
% of people who think groups hanging around the streets is a problem	25%	**27%**	**32%**	**37%**	**31%**	**34%**	**29%**	**28%**	20%	18%	18%	12%
% of people who think abandoned or burnt out cars are a problem	2%	**3%**	1%	2%	2%	**5%**	2%	1%	1%	1%	1%	1%
% of people who think run down or boarded up properties are a problem	18%	**23%**	9%	**42%**	12%	**23%**	**42%**	**23%**	4%	**19%**	3%	8%
% of people who think speed and volume of road traffic is a problem	34%	29%	**38%**	**40%**	**37%**	33%	**48%**	**38%**	30%	28%	25%	30%
% of people who think racial harassment is a problem	3%	**5%**	3%	**7%**	**4%**	**5%**	**4%**	3%	1%	1%	2%	1%
% of people who think being attacked or harassed is a problem	9%	**15%**	**12%**	**20%**	**10%**	**14%**	**13%**	**10%**	4%	4%	5%	3%
% of people who think household burglary is a problem	14%	**16%**	**15%**	**24%**	**17%**	**17%**	**22%**	**15%**	7%	6%	11%	8%
% of people who think car crime is a problem	13%	**21%**	**21%**	**23%**	**16%**	**18%**	**19%**	10%	6%	7%	5%	5%
% of people who think property being set on fire is a problem	5%	**6%**	**6%**	**10%**	**6%**	**7%**	4%	3%	2%	2%	1%	5%
% of people disatisfied with the quality of the service provided by the police	13%	**17%**	**15%**	13%	13%	13%	13%	**15%**	11%	11%	10%	11%

Community Perceptions and Neighbourhoods

Results from the Household Survey indicate that there has been a general town-wide improvement in perceptions of crime and anti-social behaviour when compared to results from 2008.

However perceptions regarding crime and anti-social behaviour remain much higher in our most disadvantaged neighbourhoods, where residents continue to identify anti-social behaviour related issues specifically; litter, speeding traffic and drug use/supply as community priorities.

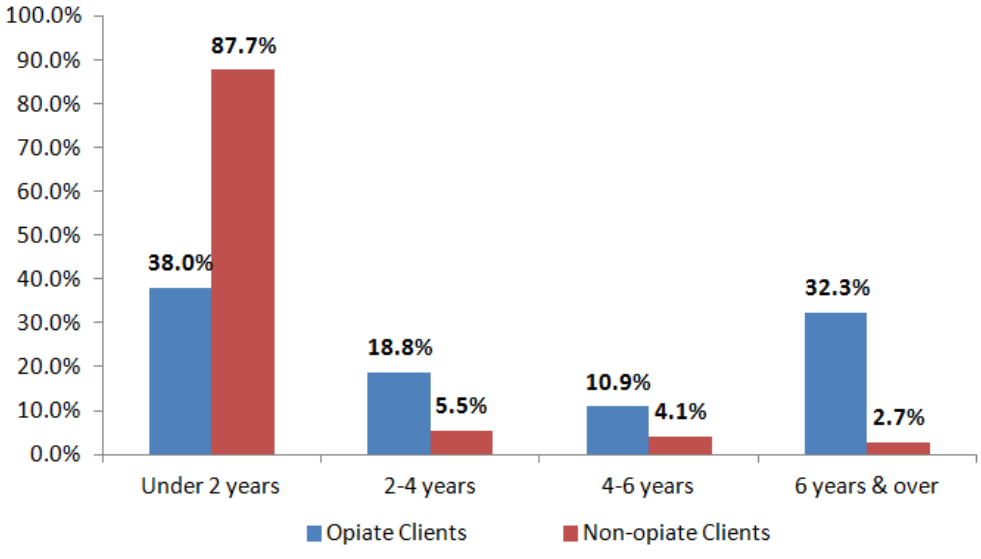
These findings generally correlate to local Neighbourhoood Policing ward priorities, where anti-social behaviour and drug dealing related activity feature as priorities for all 11 wards in Hartlepool.

The continuation of Neighbourhood Policing in Hartlepool is also a community priority, with residents raising their concerns about policing levels with the Police & Crime Commissioner at Your Force Your Voice meetings. Neighbourhood Policing has also been raised as a priority through the Partnerships Face the Public Event, and through consultation undertaken on the Community Strategy.

From a community cohesion perspective only four out of ten people participating in the Household Survey agreed that their local area is a place where people from different backgrounds get on well together. This is a marked reduction from responses received in 2008, when 72% of people agreed with this statement. Similarly, percentage rates remain low in relation to community engagement, where only one in ten residents feel that they can influence decisions in their local area.

Our most disadvantaged and vulnerable neighbourhoods; Victoria, Headland & Harbour, Burn Valley and Manor House wards continue to suffer from disproportionate levels of crime and anti-social behaviour issues.

Partnership working is essential to successfully tackle these community safety issues at a neighbourhood level. Proactive neighbourhood management that considers all aspects of the local environment and aims to increase social connectedness both between those living and sharing the same space, and those providing services in neighbourhoods, is a key element in promoting cohesive confident communities, reducing crime and anti-social behaviour, and making the local area safer, more attractive and economically productive.

Alcohol consumption	In Hartlepool approximately 4,800 people aged over 16 years are drinking at higher risk levels, more than double than double the recommended safe levels or above.
Alcohol Related Hospital Admissions per 100,000 population	Alcohol related hospital admissions have reduced by 2.3% in Hartlepool. 
Number of arrests	33% of arrests in Hartlepool were alcohol related
Number of people dependent on opiates and/or crack	Hartlepool rate: 18.6 per 1,000 population National rate: 8.7 per 1,000 population
Proportion of dependent drug users in treatment	Hartlepool rate: 63.7% National rate: 53.4%
Number of people in drug treatment	861 people are in treatment, comprising of 706 opiate users and 155 non-opiate users.
Proportion of clients still in treatment in years	

It is estimated that costs associated with alcohol misuse in Hartlepool are in excess of £40 million[11]. This figure equates to an overall cost per head of population of £459, the second highest of the 12 local authorities in the North East region.

Alcohol cuts across all aspects of partnership service delivery and represents a significant cross cutting theme for other priority areas of criminality. Alcohol is associated with a range of crime and anti-social behaviour but plays a particular factor in violent crime, with more than half of assault related Accident & Emergency (A&E) presentations being linked to alcohol.

Alcohol related violent crime remains at its highest in the Victoria and Headland & Harbour wards and is predominantly linked to the night-time economy, where offences have increased by 13%

Linked to price, availability and social attitudes, alcohol consumption levels in Hartlepool remain above the national and regional average. Despite a reduction the number of alcohol related hospital admissions for adults and young people remain high.

Drugs

Although the number of drug related offences have reduced by 6.5% in Hartlepool, drug use and drug dealing continues to be a community concern particularly in our most deprived neighbourhoods.

Nationally the number of individuals accessing drug treatment has fallen by 1.1%, however in Hartlepool numbers have increased by 5.5%

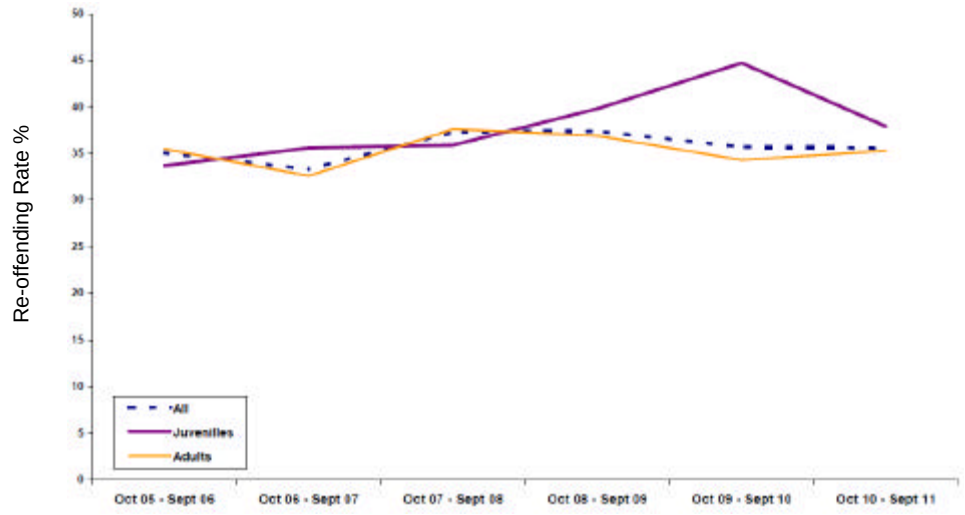
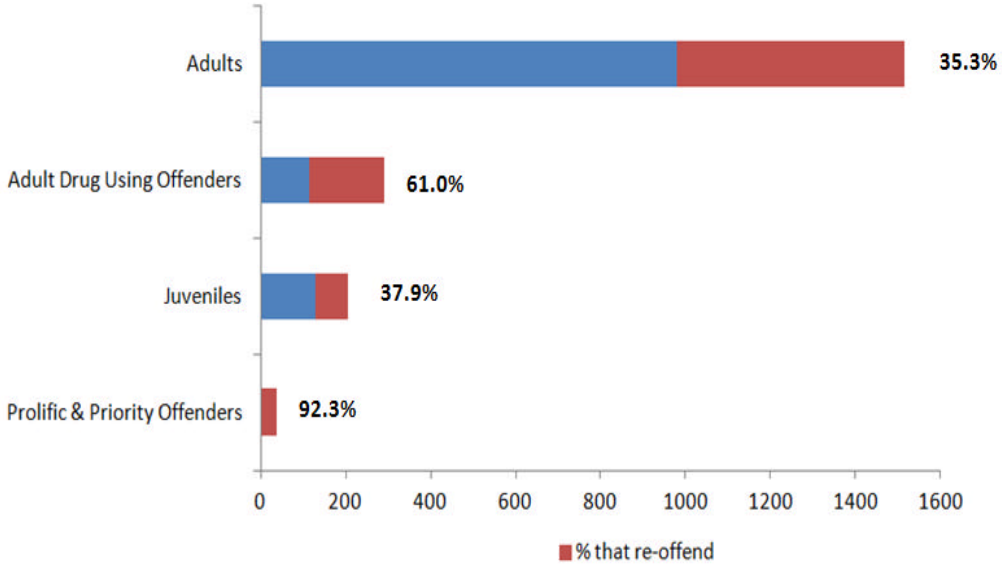
In Hartlepool the number of people who are dependent on drugs is twice the national average, standing at 18.6 per 1,000 population, with more than half of these users accessing treatment services. More than 80% of the treatment population are opiate users, where successful treatment completions remain below the national average, with almost one third of clients retained in treatment for 6 or more years.

Drug misuse continues to be a contributory factor in adult offending behaviour, specifically in regard to acquisitive crime and high rates of re-offending.

Cannabis misuse continues to be the most prevalent drug used by young people in Hartlepool, where adjunctive use with alcohol is high.

QUICK FACTS – RE-OFFENDING
All offenders cautioned, convicted or released from custody in the 12 month period ending

[11] Balance – The Cost of Alcohol 2013

	September 2011, measured over the following 12 months
Re-offending Rate	? Total cohort of offenders 1,720 ? 35.6% of offenders re-offended within 12 months ? 612 re-offenders committed 2,029 re-offences (3.32 offences per offender)
Annual Change	Reduced from 35.7%, minus 0.1 percentage point
Local Comparison	Hartlepool has the highest re-offending rate in Cleveland • Middlesbrough – 32.8% • Stockton – 30.2% • Redcar & Cleveland – 29.1%
National Comparison	The national re-offending rate stands at 26.9%, Hartlepool has the second highest re-offending rate in the country.
General trend	
Re-offending rate of offender cohorts	

Repeat offending in Hartlepool accounts for more than two thirds of crime[12], with re-offending rates remaining higher than the national average for both adults and young people.

Acquisitive crime continues to account for the highest proportion of re-offences in Hartlepool, with shoplifting accounting for more than half of these.

Drug and alcohol misuse has a significant impact upon re-offending activity, with opiate misuse being a key driver in the occurrence of acquisitive crime.

Adult repeat offending continues to be a significant factor, with 92% of repeat offenders being aged 18 years and over.

Offenders are often the most socially excluded in society and often have complex and deep rooted health and social problems, such as substance misuse, mental health, housing issues and debt, family and financial problems. Understanding and addressing these underlying issues in a holistic and co-ordinated way is important to provide “pathways out of offending”, reduce crime and break the cycle of offending behaviour across generations.

Both local and national data suggests that offenders who receive short prison sentences are at the greatest risk of re-offending, therefore it is essential that partners work together to identify the offenders that present the most risk to their communities, intervening early to prevent an escalation of offending and providing community-based support to address their needs.

A single Reducing Re-offending Strategy will assist in identifying gaps, learning more about non-statutory offenders and offender health and wellbeing needs (including mental health).

Overall re-offending continues to present a high risk to communities of Hartlepool, with adult repeat offending presenting the highest risk.

Proposed Strategic Objectives and Priorities

[12] Detected crime

The Safer Hartlepool Partnership is required to publish its Community Safety Plan 2014 – 2017 by 1st April 2014.

Based upon the findings from the Strategic Assessment, it is proposed that the Partnership focuses on one key strategic objective during 2014/15 which will be to:

"Create confident, cohesive and safe communities"

It is proposed that this objective is underpinned by the following proposed priorities for 2014 – 2015.

Create Confident Cohesive and Safe Communities
Re-offending - reduce re-offending through a combination of prevention, diversion and enforcement activity
Acquisitive Crime – reduce acquisitive crime through raising awareness and encouraging preventative activity
Domestic violence and abuse –reduce the risk of serious harm and provide the right response to safeguard individuals and their families from violence and abuse
Anti-social behaviour – ensure effective resolution of ASB, divert perpetrators and identify and support vulnerable individuals and communities
Substance misuse – reduce the harm caused to individuals, their family and the community, by illegal drug and alcohol misuse
Reduce hate crime - work together to better understand the true impact of hate crime in our communities, improve our understanding of issues for vulnerable groups and increase reporting

Safer Hartlepool Partnership

Safer Hartlepool Partnership Plan 2014 – 2017 Year 1

Safer Hartlepool

Contents

Foreword

I am pleased to introduce the Safer Hartlepool Partnership Plan for 2014 - 2017. This new three year plan, based on the findings from the Partnership's Annual Strategic Assessment and consultation with the public at the annual "Face the Public" event, outlines the Partnership's strategic objectives and priorities and will be refreshed annually to incorporate new objectives and priorities as they emerge.

Since becoming Chair of the Safer Hartlepool Partnership in May 2013, I have been impressed by the strength of partnership working and the dedication and continued support of those organisations that are responsible for the Partnership; the Council, Police, Fire Authority, Clinical Commissioning Group, Probation and the Cleveland Police and Crime Commissioner.

Despite the ongoing cuts to public services and significant reductions in funding, the Safer Hartlepool Partnership has continued to make Hartlepool a safer place to live, work and socialise. Since the beginning of the previous Partnership Plan in April 2011, recorded crime and anti social behaviour has reduced year on year.

The Safer Hartlepool Partnership has successfully supported and delivered numerous partnership initiatives and some of these successes are outlined in this plan.

During the lifetime of this plan, there are a number of factors which will impact on the Safer Hartlepool Partnership; a challenging economic climate, including the impact of Welfare Reform, changes to commissioning arrangements following the transition of Public Health into Hartlepool Borough Council and the election of a Police and Crime Commissioner and widespread restructuring and change across local public sector agencies.

I am confident that this Partnership Plan will help us to make Hartlepool a safer place to live, work, and socialise.

Councillor Christopher Akers-Belcher
Chair of the Safer Hartlepool Partnership

The Safer Hartlepool Partnership

The Safer Hartlepool Partnership is Hartlepool's statutory Community Safety Partnership and is one of the four[1] themed partnerships of the Hartlepool Strategic Partners Board. The aim of the Safer Hartlepool Partnership is to make Hartlepool a safer place to live, work and socialise by addressing crime and anti-social behaviour, substance misuse and to reduce re-offending.

The Partnership is responsible for delivering the following: *Community Safety Plan; annual Youth Justice Plan; Substance Misuse Plan (Drugs and Alcohol); CCTV Strategy; Domestic Violence Strategy; Social Behaviour Plan; Prevent Action Plan; Cohesion Strategy; Troubled Families Programme. The Partnership is also responsible for the delivery of the community safety outcomes within the Sustainable Communities Strategy and the Hartlepool Plan*. These local strategies and plans will have regard to the Cleveland Police and Crime Plan and appropriate national strategies and plans, to ensure that national policy is followed.

[1] The themed Partnerships are: The Safer Hartlepool Partnership, The Health and Well Being Board, the Housing Partnership and the Economic Regeneration Forum

Local Context

Hartlepool is the smallest unitary authority in the North East region and the third smallest in the country comprising of some of the most disadvantaged areas in England. Issues around community safety can be understood by a number of contextual factors:

Population

- Hartlepool has a stable population rate, maintained by low levels of migration.
- Hartlepool has become more diverse in recent years, although a very small proportion of the population are from the Black Minority Ethnic (BME) community.
- 46% of the population in Hartlepool live in five of the most deprived wards in the country, where crime and anti-social behaviour rates are high.

Housing

- Strong links exists between the occurrence of anti-social behaviour and the location of private rented housing.
- The percentage of long term empty properties in Hartlepool is higher than the regional average.

Health & Wellbeing

- The health of people in Hartlepool is generally worse than the England average.
- There is a higher prevalence of long term health problems, including mental health.
- The number of alcohol related hospital admissions and hospital stays for self-harm in Hartlepool are significantly worse than the England average.
- The number of Class A drug users in Hartlepool is more than double the national average.

Geography

- Community safety problems are not evenly spread and tend to be concentrated in geographic hotspots, particularly in the most deprived wards in Hartlepool.

Deprivation

- Hartlepool has pockets of high deprivation where communities experience multiple issues: higher unemployment, lower incomes, child poverty, ill health, low qualification, poorer housing conditions and higher crime rates.
- Residents living in more deprived and in densely populated areas have high perceptions of crime and anti-social behaviour and feel less safe.

Unemployment

- Unemployment rates in Hartlepool are above the regional average and more than double the national average.
- 14.5% of young people aged 18-24 years are unemployed.
- Hartlepool has high rates of people incapable of work due to disability and ill health.

Partnership Activity 2011 – 2014

Over the last the 3 years, the Partnership has delivered a number of projects and initiatives against the strategic objectives in the Partnership Plan 2011 - 2014, and developed new services which have been designed to reduce crime, disorder, anti-social behaviour, substance misuse and re-offending. Examples are listed below:

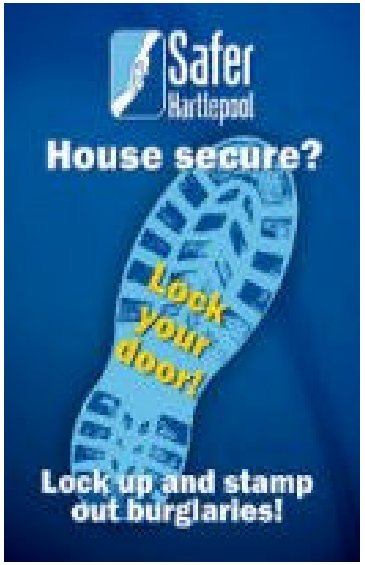
Strategic Objective: Reduce Crime & Repeat Victimisation

- **Crime Prevention & Target Hardening -** We have continued to offer crime prevention advice and promote safety measures throughout the year, with seasonal campaigns addressing specific crime types and issues. Since 2011 we have targeted hardened more than 1,700 properties in Hartlepool, providing reassurance to victims and reducing their risk of repeat victimisation.

- **Dedicated Victim Service –** We have enhanced our services for victims through the provision of a Victim Support Officer who has been trained to provide crime prevention advice, enabling them to provide a holistic response to victims needs. Over 85% of victims who have received this service report increased feelings of safety.

- **Specialist Domestic Violence Service –** In April 2012 we jointly commissioned Harbour to provide support to victims and families suffering domestic violence and abuse. Over the last 18 months Harbour has received more than 1,000 requests for support.

- **Joint Action Groups (JAG's) –** Using an intelligence led approach the JAG continues to tackle community safety issues at a neighbourhood level. Each multi-agency JAG has a localised action plan that has focused on areas of greatest vulnerability and need, but also keeping abreast of any emerging issues or trends. The JAG has supported the delivery of youth diversionary activities, domestic violence joint repeat visits initiative and neighbourhood CCTV provision.



harbour
working for safer communities

victim support
find the strength

Strategic Objective: Reduce the harm caused by drug & alcohol misuse

- **Drug and Alcohol Treatment and Support –** The Partnership has commissioned a range of community based specialist services to support those who misuse substances. Operating across four sites in Hartlepool, these services have helped more than 1,000 people on their journey to recovery.
- **Awareness Campaigns –** The Partnership is driving forward campaigns to promote responsible drinking and highlight the dangers of drug misuse - campaigns include Dry January and Substance Misuse Week.
- **Alcohol Arrest Referral** – Operating in Hartlepool custody suite, this scheme had delivered over 1,500 brief interventions to individuals arrested for an alcohol related crime in Hartlepool. Brief interventions include linking alcohol and the offence, with the aim of motivating a reduction in alcohol consumption and re-offending behaviour.
- **Community Alcohol Partnership** – The Community Alcochol Partnership has secured funding to deliver a range of preventative, educational and enforcement activity to address the issue of alcohol misuse amongst young people in our most disadvantaged communities.

Strategic Objective: Create confident, cohesive and safe communities

- **Community Cohesion Action Plan –** A range of activities and initiatives to promote cohesion and inclusion have been supported by the Partnership during 2013 including the roll out of the 'Safe Places Scheme', and a Diversity Event held in November to promote cultural awareness. The event was attended by 150 local community members who received presentations from the Partnership on hate crime and how to report it, and how the Partnership monitors and supports our most vulnerable and at risk victims to ensure that appropriate multi-agency interventions can be deployed to reduce the risk of further victimisation
- **Anti-social Behaviour Awareness Day (ASBAD) –** More than 1,500 secondary school pupils have taken part in the annual ASBAD event. Interactive sessions on topics such as alcohol awareness, making hoax calls, bullying and litter are led by a series of partner agencies, with successive event evaluations demonstrating that ASBAD continues to be successful in engaging young people in thinking about behaviour, its effects and consequences.
- **Restore Project –** Supported by the Police and Crime Commissioner, the Safer Hartlepool Partnership launched their Restore Project in Hartlepool in November 2013. The project has recruited and trained a group of facilitators in restorative conferencing and is now available to provide an alternative way of dealing with the harm caused to victims of minor crimes and anti-social behaviour. Restorative Justice is proven to improve victim satisfaction rates, and reduce offending behaviour by bringing the offender face to face with the harm their behaviour has caused.

Strategic Objective: Reduce offending and re-offending

Reducing offending and re-offending has been one of the main focuses of the Partnership during 2013/14. In response to high rates of reoffending in Hartlepool the Partnership is in the process of developing a new strategy which aims to break the cycle of re-offending behaviour and improve public safety. The strategy will strengthen the ability of the Partnership to work together to provide local solutions to reoffending set against the broader context of the national Transforming Rehabilitation Strategy. Current activities aimed at reducing offending and reoffending include:

- **Triage Programme -** This scheme diverts young offenders into positive activities and support, instead of charging them and taking them to court. The initiative has significantly reduced the numbers of young Hartlepool people entering the criminal justice system in Hartlepool and the success of the scheme is now being replicated across the Cleveland area.

- **Integrated Offender Management (IOM) –** This multi-agency team involving Council, Cleveland Police, Durham & Tees Valley Probation Trust, HMP Prison Service and Outreach Workers, is dedicated to working with the most prolific offenders responsible for committing a large number of crimes in Hartlepool, together with those offenders on substance misuse orders issued by the Courts. The team is currently working with over 100 offenders providing support to address the problems associated with their offending behaviour, and challenging and taking enforcement action where necessary.

- **Troubled Families Programme – Think Family / Think Community –** This government funded initiative is now in its second year. The programme aims to reduce youth offending, reduce anti-social behaviour, increase education attendance and get people into work. During the first year of the programme 56 pay-by-results claims have been made where 64% of young people had reduced their offending behaviour and 93% of families had reduced their anti-social behaviour.

Strategic Assessment 2012/13

The seventh Safer Hartlepool Strategic Assessment was completed in December 2013 and contains information to aid the Partnership's understanding of the priority community safety issues in Hartlepool. The Assessment forms part of an intelligence-led approach to community safety, which enables a more focused, resource-effective and partnership-orientated delivery of options to help:

- Better understand the patterns and trends relating to crime, disorder and substance misuse issues affecting the Borough;
- Set clear and robust strategic priorities for the Partnership;
- Develop interventions and activities that are driven by reliable intelligence-led evidence.

The Strategic Assessment covers the twelve month period October 2012 to September 2013 and contains analysis of data obtained from both statutory and non-statutory partner agencies including: the Hartlepool Borough Council, Cleveland Police, Durham Tees Valley Probation Service, Cleveland Fire Brigade, North Tees & Hartlepool NHS Foundation Trust, Housing Hartlepool, and Harbour Support Services. Additional information has also been obtained from community consultations and meetings.

Key findings from the Strategic Assessment period include:

Strategic Objective: Reduce Crime & Repeat Victimisation

- We continue to make great progress in reducing crime in Hartlepool with year on year reductions in crime for the seventh consecutive year.
- Successful reductions have been achieved in most major crime categories, however acquisitive crime and violence continues to account for more than two thirds of total crime.
- The theft of pedal cycles has been an emerging issue throughout the assessment period.
- Repeat victimisation is evident in most crime categories; however it is even higher in violence offences, particularly domestic related violence.
- In the current economic climate there is potential that the numbers of repeat and vulnerable victims will increases.

Strategic Objective: Reduce the harm caused by drug & alcohol misuse

- The cost of alcohol misuse equates to £459 per head of population.
- Alcohol plays a significant factor in the occurrence of violent crime, including domestic violence and abuse.
- Alcohol specific hospital admissions for adults and under 18's in Hartlepool are significantly higher than the national average.
- The number of people dependant on drugs in Hartlepool is twice the national average.
- There is a clear link between Class A drug misuse and the occurrence of acquisitive crime.
- The number of individuals accessing drug treatment has increased since the previous assessment period.

Strategic Objective: Create confident, cohesive and safe communities

- Anti social behaviour is following an increasing trend with certain communities and neighbourhoods suffering from disproportionate levels.
- Hotspot locations for anti social behaviour are located in areas that are densely populated by privately rented properties.
- Perceptions of anti social behaviour in Hartlepool are above the national average.

Strategic Objective: Reduce offending and re-offending

- Hartlepool has one of the highest proven re-offending rates in the country.
- Re-offenders have greater needs in respect of housing, education, training, employment and substance misuse.
- The number of young people entering the criminal justice system for the first time has reduced by almost 4% in comparison to the previous assessment period.

Public Consultation

To ensure that the Partnership is focusing on the issues that residents consider to be a priority, findings from local community consultations have been taken into consideration when setting the strategic objectives and priorities.

Face the Public

At the Safer Hartlepool Partnership 'Face the Public' event held in September 2013 we asked:

"What can the Safer Hartlepool Partnership do to make your neighbourhood a safer place to live?"

Public responses included:

- Maintain partnership working
- Improve Neighbourhood Policing
- Tackle anti-social behaviour & improve neighbourhood safety
- Reduce re-offending
- Break the cycle of domestic violence
- Address substance misuse

Sustainable Community Strategy Consultation

The Sustainable Community Strategy identifies 'Safer, Stronger Neighbourhoods' as one of its key priorities. During consultation on the strategy participants were asked:

"Which one of the Safer Stronger Neighbourhoods improvements is most important to you?"

From the four choices available, the majority of respondents identified creating confident, strong and safe communities as the area most in need of improvement, as below:

- Create confident, strong and safe communities (37%)
- Reduce crime and victimisation (24%)
- Reduce the harm caused by drug and alcohol misuse (23%)
- Reduce offending and re-offending (17%)

Hartlepool Household Survey

The Hartlepool Household Survey was undertaken during May – August 2013. Questionnaires were delivered to 18, 960 households with a 30.6% response rate and over 6,000 completed surveys being returned.

Results from the Household Survey indicate that there has been a general town-wide improvement in perceptions of crime and anti-social behaviour when compared to results from 2008. But when residents were presented with a list of anti-social behaviour issues, and asked to tell us which they felt were a very or fairly big problem in their local area the following three issues were identified:

Rubbish or litter lying around **Speed and volume of road traffic** **People using or dealing drugs**

Partnership Strategic Objectives 2014-2017

Based on the findings in the annual Strategic Assessment and consultation with the local community, the Partnership will retain the following four strategic objectives during the lifetime of the three year plan:

Strategic Objectives 2014 - 2017	
Reduce crime and repeat victimisation	Reduce the harm caused by drug and alcohol misuse
Create confident, cohesive and safe communities	Reduce offending and re-offending

Partnership Priorities 2014-2015

To reflect community priorities evidenced in the community consultation process, during the first year of this plan our key focus will be to: **"Create confident, cohesive and safe communities"** by concentrating on the following areas of concern:

Annual Priorities 2014 - 2015	
Re-offending - reduce re-offending through a combination of prevention, diversion and enforcement activity	**Acquisitive Crime –** reduce acquisitive crime through raising awareness and encouraging preventative activity
Domestic violence and abuse –reduce the risk of serious harm and provide the right response to safeguard individuals and their families from violence and abuse	**Anti-social behaviour –** ensure effective resolution of anti-social behaviour, divert perpetrators and identify and support vulnerable individuals and communities
Substance misuse – reduce the harm caused to individuals, their family and the community, by illegal drug and alcohol misuse	**Hate crime** - work together to better understand the true impact of hate crime in our communities, improve our understanding of issues for vulnerable groups and increase reporting

Key activities over the next 12 months include:

Restorative Justice - We will embed and promote a partnership approach to Restorative Justice as a tool to reduce crime and anti-social behaviour in Hartlepool.

Community Cohesion - We will embed public reassurance; community engagement and confidence work at a neighbourhood level. In response to the public priorities raised at the Safer Hartlepool Partnership Face the Public event, we will work with the Cleveland Police & Crime Commissioner to further develop Neighbourhood Policing, improving communication with youth people and the wider community.

Support for Victims - The Partnership will continue to support dedicated victim services in Hartlepool and improve pathways for victims of anti social behaviour.

Substance Misuse – In response to community concerns raised in relation to drug use and dealing, will we focus on providing education and awareness in relation to the danger of drugs to young people, work together to disrupt the availabliity of drugs, and promote recovery services.

Environmental Crime Campaign – As identified from the Hartlepool Household Survey, environmental issues continue to be a top priority for residents, as such the Partnership will drive forward an enforcement campaign to tackle environmental issues at the earliest opportunity.

Hate Crime – We will work with local communities to build confidence in reporting hate crime, ensuring victims can access third party reporting centres and rapidly receive the advice and support that they need.

Crime Prevention – The Partnership is committed to continue to offer crime prevention advice and promote safety measures throughout the year. This activity will be accompanied by a wide-scale improvement to Hartlepool street lighting and maximising the use of CCTV technologies.

Anti-social Behaviour – The Partnership will continue to effectively use anti-social behaviour tools and powers to curb the behaviour of serious and persistent offenders, this will also include the extension of Selective Licensing of private rented properties across the town.

Troubled Families Programme – We will continue to develop new ways of working with families to prevent them from offending, increase education attendance and get parents back into work.

Re-offending Strategy – We will develop a strategy to reduce reoffending in Hartlepool which will ensure that local services are coordinated in a manner that meets the needs of offenders, whilst at the same time ensuring local communities remain safe.

Face the Public Event – As part of our continuing commitment to consulting with communities we will hold a Face the Public event in September 2014.

Measuring Performance

Partnership performance monitoring will be undertaken on a quarterly basis to assess progress against key priorities drawn from the strategic assessment and identify any emerging issues. Performance management reports will be provided to the Safer Hartlepool Partnership.

The following performance indicators will be monitored over the next 12 months:

Strategic Objective	Performance Indicator
Reduce crime & repeat victimisation	Total recorded crime rate per 1,000 population
	Domestic burglary rate per 1,000 household
	Vehicle crime rate per 1,000 population
	Robbery rate per 1,000 population
	Shoplifting rate per 1,000 population
	Violent crime (including sexual violence) rate per 1,000 population*
	% of violent crime (including sexual violence) that is domestic related
	% of repeat cases of domestic violence (MARAC)
	Violent crime (including sexual violence) hospital admissions for violence per 100,000 population*
Reduce the harm caused by drug and alcohol misuse	Drug offences per 1,000 population
	% of people who think drug use or dealing is a problem
	% of opiate drug users that have successfully completed drug treatment*
	% of non-opiate drug users that have successfully completed drug treatment*
	% of alcohol users that have successfully completed alcohol treatment
	Alcohol related hospital admissions rate per 100,000 population*
	Number of young people known to substance misuse services

*Indicators link to the Public Health Outcome Framework

Strategic Objective	Performance Indicator
Create confident, cohesive & safe communities	Anti-social behaviour incidents per 1,000 population
	Public order offences per 1,000 population
	Criminal damage rate per 1,000 population
	Deliberate fires rate per 1,000 population
	Number of reported hate crimes & incidents
	% of the population affected by noise - number of complaints about noise
	% of people who feel safe during the day
	% of people who feel safe after dark
	% of people who think rubbish or litter lying around is a problem
	% of people who think groups hanging around the streets is a problem
	% of people who think people being drunk or rowdy in a public place is a problem
	% of people who think vandalism, graffiti and other deliberate damage to property is a problem
	% of people who think noisy neighbours or loud parties is a problem
	% of people who think abandoned or burnt out cars are a problem
	% of people who think that they belong to their local area
	% of people who feel that they can influence decisions that affect their local area
	% of people who believe that people from different back grounds get on well together
	% of people who think that people in the area pull together to improve the local area
Reduce offending & re-offending	Rate of first-time entrants to the Youth Justice System per 100,000 population*
	Re-offending levels - percentage of offenders who re-offend*
	Re-offending levels - average number of re-offences per offender*
	Re-offending rate of Prolific & Priority Offenders
	Re-offending rate of High Crime Causers
	% of Troubled Families who have reduced their offending behaviour

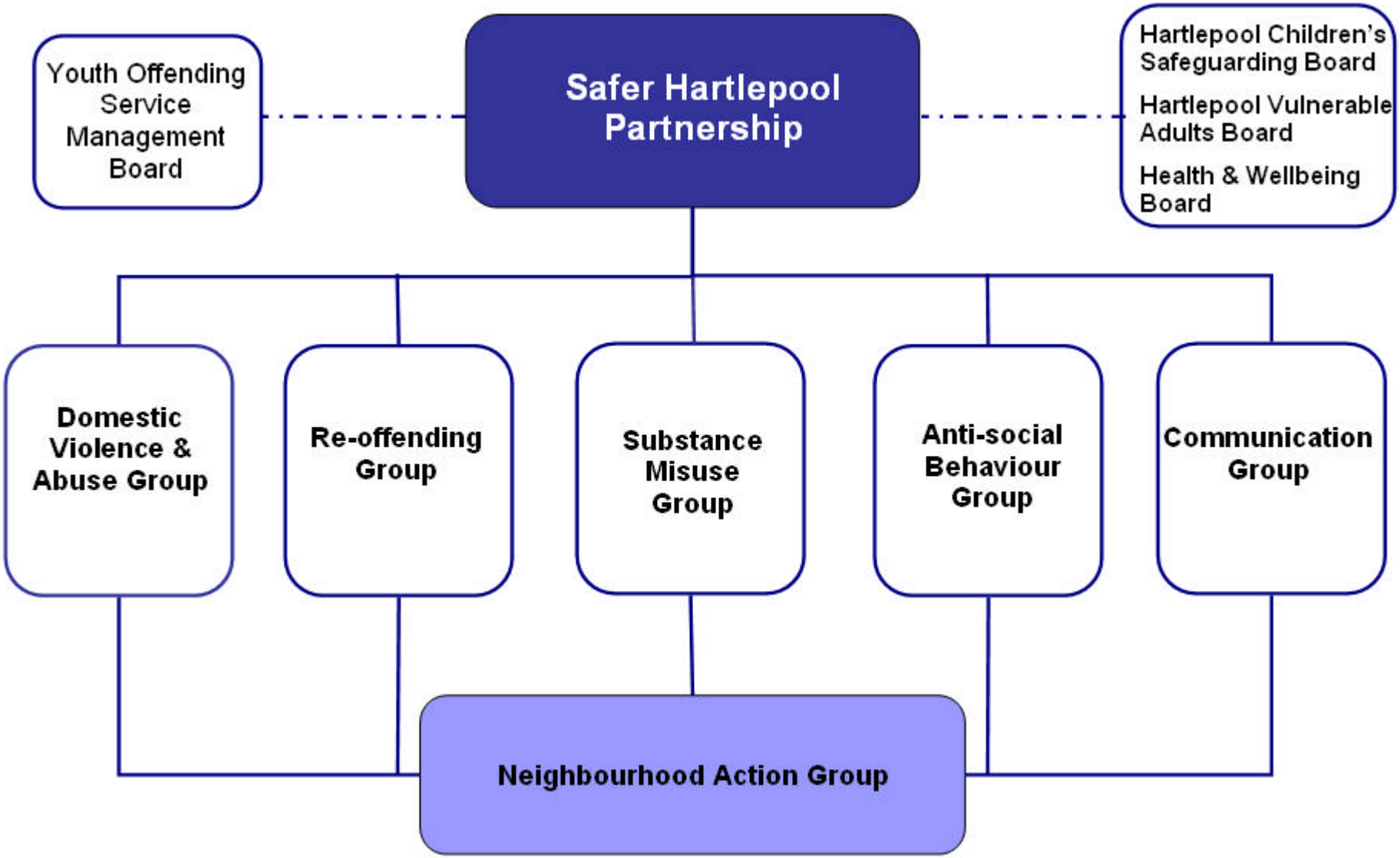
*Indicators link to the Public Health Outcome Framework

To be published in April 2014

Delivering the 2014/15 Priorities – Delivery Structure

Appendix 2

The responsibility for delivery of each of the priorities has been allocated to a dedicated theme group of the Safer Hartlepool Executive Group.




CLEVELAND
POLICE
Putting People First


HARTLEPOOL
BOROUGH COUNCIL


CLEVELAND
FIRE BRIGADE
Protecting local
communities


Durham Tees Valley
Probation Trust
Doing more to
keep you safe


NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group


Safe
in Tees Valley


POLICE AND CRIME
COMMISSIONER
FOR CLEVELAND


housingHartlepool
Part of the Vela Group

HEALTH AND WELLBEING BOARD

13th February 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: Director of Public Health

Subject: PHARMACEUTICAL NEEDS ASSESSMENT

1. PURPOSE OF REPORT

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

2. BACKGROUND

2.1 In a previous report (16 September 2013) the Health and Wellbeing Board (HWB) was updated on statutory duties and responsibilities regarding the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations[1] 2013 SI 2013/349 and Pharmaceutical Needs Assessments.

2.2 The Board understands its key duties and responsibilities and intends to publish its own first PNA within the required timeframe (by 1 April 2015).

2.3 The PNA inherited from Hartlepool PCT[2] is currently used by NHS England (Durham, Darlington Tees Area Team), directing decision-making on the commissioning of pharmaceutical services in our HWB area (such as applications to open new pharmacies). The duty is placed upon the HWB to ensure that the PNA is robust and up date

2.4 The TVPHSS has also advised that the process leading to publication of a new PNA for the Board will take approximately 12-15 months, including the full minimum 60-day consultation period required.

3. PROPOSALS

3.1 Assessing the PNA and associated Refresh documents inherited from the PCT against the 2013 Regulations, it must be acknowledged that this Assessment was, according to the Regulations in place at the time, intended to 'expire' in Feb 2014.

[1] Hereafter referred to as the 2013 Regulations

[2] Reference to the 'inherited PNA' means the NHS Hartlepool PNA dated 1.2.2011 and any associated Refresh documents incorporating Supplementary Statements

3.2 Consequently, notwithstanding any changes to pharmaceutical services and related NHS services that have taken place since first publication in 2011, and without prejudice to the assessment of need described in the existing PNA, the Board is advised to formally report that the Pharmaceutical Needs Assessment of NHS Hartlepool 2011 is under review. The Board is similarly advised to formally commence the process leading to publication of a revised assessment, its own first PNA; with a planned publication date in March 2015.

3.3 The new PNA 2015 must reflect the priorities and needs of the HWB. For economy of scale and efficient use of resources, TVPHSS will establish and lead a Joint PNA Project Steering Group that provides clear direction and project plans, specialist pharmaceutical and PH intelligence, and other clinical advice, resource and action towards development of the PNA. TVPHSS will facilitate suitable learning events as required throughout the development process.

3.4 The Director of Public Health will identify a PNA Champion from within the Public Health team, to work within the context of this shared resource to lead the PNA development process for Hartlepool to ensure suitable engagement with local teams, partners, processes and population from the start. This is vital to the successful production of a high quality and valuable PNA.

3.5 A draft PNA will be presented to the HWB for approval mid-late summer 2014 prior to formal 60-day consultation to include those stakeholders identified in Part 2, Regulation 8 (1) of the 2013 Regulations i.e.,

(a) any Local Pharmaceutical Committee for its area (including any Local Pharmaceutical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);

(b) any Local Medical Committee for its area (including any Local Medical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);

(c) any persons on the pharmaceutical lists and any dispensing doctors list for its area;

(d) any LPS chemist in its area with whom the NHSCB has made arrangements for the provision of any local pharmaceutical services;

(e) any Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB1 has an interest in the provision of pharmaceutical services in its area; and

(f) any NHS trust or NHS foundation trust in its area;

(g) the NHSCB (NHS England); and

(h) any neighbouring HWB.

3.6 This is a critical part of the development process that the Director of Public Health, and the HWB, acknowledge the commitment to resource.

3.7 Final draft of the PNA will then be presented to the HWB in late 2014/early 2015 to ensure approval and readiness for final formal publication in March.

3.8 In the intervening time, the HWB (facilitated by TVPHSS) is still required to

(a) respond to any consultation request from NHS England in respect of pharmacy applications

(b) undertake the decision-making required in relation to the publishing of any associated Supplementary Statement and

(c) maintain and publish an up to date map as required

(d) respond, when consulted by a neighbouring Health and Wellbeing Board on a draft of their PNA; the Health and Wellbeing Board must consult with the Local Pharmaceutical Committee (LPC) and Local Medical Committee (LMC) for its area (unless the areas are served by the same LPC and/or LMC) and have regard for the representations from these committee(s) before making its own response to the consultation.

4. RISK IMPLICATIONS / LEGAL CONSIDERATIONS

4.1 The use of PNAs by NHS England for the purpose of determining applications for new premises is relatively new. It is anticipated that many decisions made will continue to be appealed and that eventually there will be judicial reviews of decisions made by the NHS Litigation Authority's Family Health Services Appeal Unit. It is therefore important that PNAs comply with the requirements of the regulations, due process is followed in their development and that they are kept up-to-date.

5. RECOMMENDATIONS

5.1 It is recommended that the HWB acknowledge the content of the Report including the outline plan and timetable towards the first PNA of the Hartlepool HWB, commencing immediately.

5.2 It is further recommended that

- a Statement (or a link to a Statement) reporting this will thereafter be available on the HWB website as follows:

"Hartlepool Health and Wellbeing Board understands its statutory duties in relation to Pharmaceutical Needs Assessment and intends to publish its own first PNA within the required timeframe. The HWB acknowledges that the PNA inherited from their respective PCT was, according to the Regulations in place at the time, intended to 'expire' in Feb 2014. Notwithstanding any changes to pharmaceutical services and related NHS services that have taken place since first publication, and without prejudice to the assessment of need described in the existing PNA, the HWB for Hartlepool formally reports that the Pharmaceutical Needs Assessment of NHS Hartlepool (2011) is under review. Hartlepool HWB has commenced the process leading to publication of a revised assessment, its own first PNA; with a planned publication date in March 2015."

- TVPHSS continue to facilitate and advise on all issues related to the PNA on behalf of the HWB as noted above
- agenda items related to consultation, review, maintenance (including Supplementary Statements) and future publication of the Hartlepool PNA be received as required at future Board meetings.

6. REASONS FOR RECOMMENDATIONS

Included in the body of the report

7. BACKGROUND PAPERS

7.1 National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 SI 2013/349

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

8. CONTACT OFFICER

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HEALTH AND WELL BEING BOARD

Monday 13th February 2014

Report of: Director of Child and Adult Services, Chief Officer Clinical Commissioning Group and Director of Public Health

Subject: Sub Group Structure of Health and Wellbeing Board

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 NON KEY

2. PURPOSE OF REPORT

2.1 The purpose of this report is to propose that the Board agrees to establish two engagement forums and a joint commissioning executive to support the work of the Health and Well Being Board.

3. BACKGROUND

3.1 In May 2013 the Health and Well Being Board agreed a terms of reference that included establishing sub groups to support the work of the Board.

The Children's Strategic Partnership was included in the terms of reference as a formal subcommittee of the Board as its origins were as a Children's Trust under the Children Act 2004.

3.2 As members are aware, the Health and Well Being Board has three statutory responsibilities:

1. Responsibility for the preparation and implementation of a health and well being strategy for the Borough.

2. Responsibility for the development and use of a comprehensive evidence based joint strategic needs assessment (JSNA) for Hartlepool.

3. Responsibility for ensuring consistency between commissioning priorities of partners and the Health and Well Being Strategy and

the JSNA. Having strategic influence over commissioning and investment decisions across health, public health and social care services to ensure integration and joint commissioning particularly for those services being commissioned and provided to the most vulnerable people.

The Children's Partnership, proposed engagement forums and joint commissioning executive will support the delivery of the above duties.

4. ENGAGEMENT FORUMS

4.1 It is proposed that two engagement forums are established as illustrated in the diagram overleaf (**Appendix 1**). One will focus on issues affecting with vulnerable adults and the other with health inequalities. The purpose of both forums is to develop a shared understanding of needs; contribute to the evaluation of services and influence strategic planning and commissioning priorities.
It is proposed that the forums include both commissioners and providers of services from statutory and non statutory sectors to ensure a comprehensive understanding of need.

It is proposed that the vulnerable adults forum is chaired by the Director of Child and Adults and the Chief Officer of the Clinical Commissioning Group and the health inequalities forum is chaired by the Director of Public Health.

5. COMMISSIONING EXECUTIVE

5.1 It is proposed that a joint health and local authority commissioning executive is established to develop commissioning strategies for children and adult services. The executive will develop and monitor new integrated service delivery models. It is proposed that the commissioning executive will include representatives from the Clinical Commissioning Group, public health, adult social care, children's education and social care. The executive will drive forward development work through time limited workstreams. The workstreams will focus on pathways of care to deliver improved outcomes for people through integrated multi-agency working.

6. RECOMMENDATIONS

6.1 The Board is asked to support the creation of two engagement forums and a joint commissioning executive to support the work of the Health and Well Being Board.

7. REASONS FOR RECOMMENDATIONS

7.1 The Health and Social Care Act 2012 requires that areas develop a Health and Well Being Board to deliver the statutory requirements as outlined in section 3.2.

8. CONTACT OFFICERS

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Chief Officer
Hartlepool and Stockton Clinical Commissioning Group.
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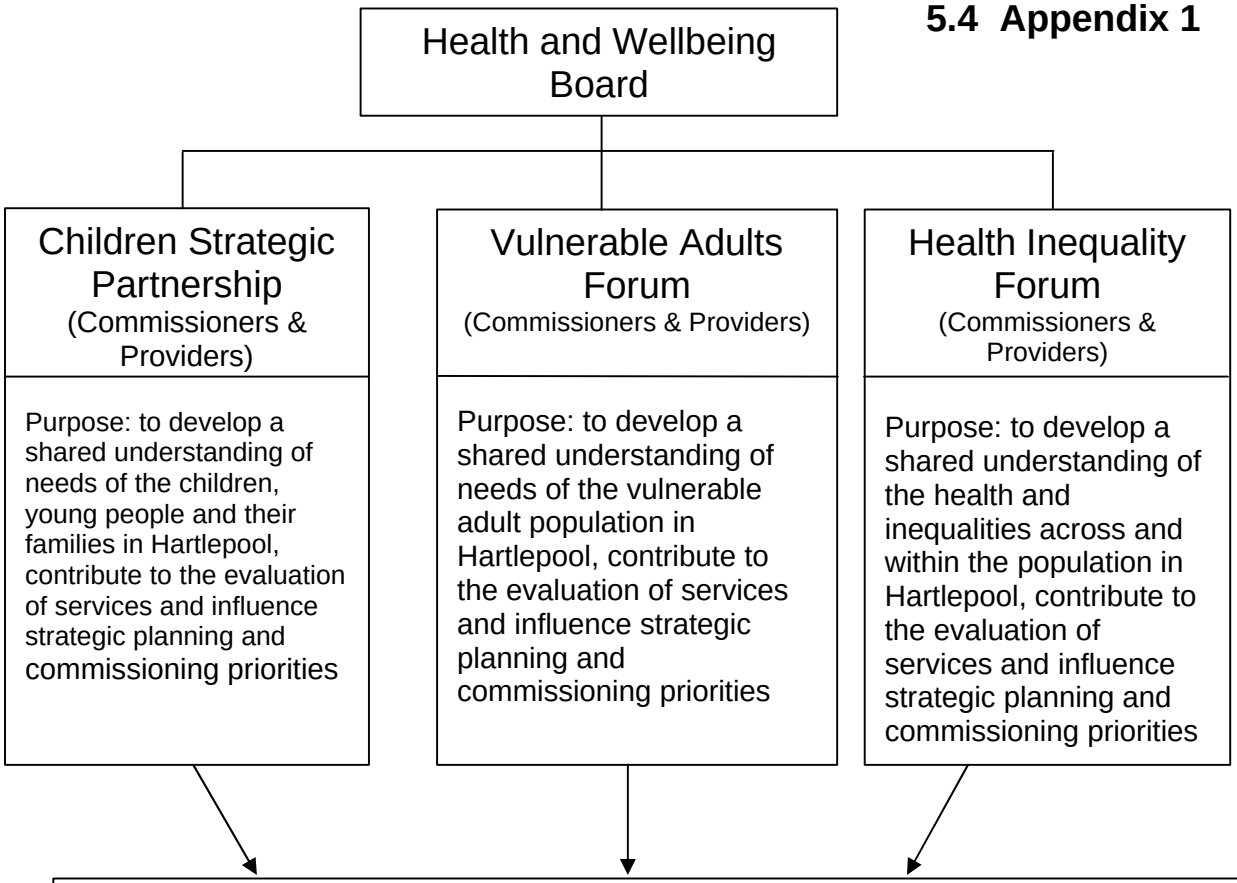
5.4 Appendix 1



Joint Commissioning Executive: CCG; Public Health; Adult Social Care; Children's Education and Social Care

Purpose: To agree joint health and local authority commissioning strategies for children and adults services and develop integrated service delivery models.

Proposed workstreams:

Adults:

- Intermediate Care & Reablement
- Urgent Care
- Early Intervention & Low Level Support
- CIL / Management of Long Term Conditions
- Dementia Pathways

Children:

- 0-25 SEND / LDD including autism and ADHD diagnosis and assessment and commissioning of education, health and care specialist provision
- Sick child pathways
- Multi professional assessment, intervention and early help model
- Therapeutic services including psychological support / CAMHS model

6.1

HEALTH AND WELLBEING BOARD

13 February 2014

HARTLEPOOL BOROUGH COUNCIL

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

Subject: EVERYONE COUNTS: PLANNING FOR PATIENTS 2014/15 TO 2018/19 (PLANNING GUIDANCE)

1. PURPOSE OF REPORT

1.1 This paper presents an overview of the planning guidance issued on the 20th December 2013 for commissioners. The guidance is entitled '**Everyone Counts: Planning for Patients 2014/15 to 2018/19**, and is built on the planning guidance published in 2012.

The guidance sets out the ambition for the NHS over the years ahead, including a focus on outcomes for patients. It describes a series of changes to the way health services are delivered that are considered required to deliver improved outcomes within the resources that are available to the NHS.

The guidance also sets out the steps expected of commissioners to take in order to achieve the ambitions identified. It explains the planning requirements to develop 5 year strategic plans (for 2014/15 to 2018/19) and 2 year operating plans (for 2014/15 to 2015/16).

The key elements are outlined expected to be included in strategic and operational plans.

The paper also provides an update of the local timetable in place to ensure delivery of the requirements of the Better Care Fund (Previously referred to Integration Transformation Fund) and the first DRAFT of the CCG vision statement required for both the Strategic and Better Care Fund Plan.

2. BACKGROUND

2.1 The planning guidance is bold in asking commissioners to work with providers and partners in local government to develop strong, robust and ambitious plans to secure the continuity of sustainable high quality care for all, now and for future generations.

2.2 The document builds on the work CCGs undertook last year in response to Everyone Counts: Planning for Patients 2013/14 and reiterates the five domains expected to be delivered. Part 1 of the document focuses on the outcomes NHS England expects for patients and describes bold ambitions to deliver them.

Five Domains

- Preventing people from dying prematurely
- Enhancing quality of life for people with Long Term Conditions
- Helping people recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from harm

2.3 It describes the emerging findings from the call to action strategy, which leads to six new models of care which are believed as necessary to deliver the transformational change needed if the NHS is to deliver improving outcomes at a time of increasing need, unprecedented new treatment options and economic restraint.

Six Models of Care characteristics

- Listening to patients views
- Wider primary care provided at scale
- A modern model of integrated care
- Access to high quality urgent and emergency care
- A step change in the productivity of elective care
- Specialised services concentrated in centers of excellence

2.4 It sets out the importance of translating outcomes into specific measurable ambitions and critical indicators of success, against which CCGs can track progress. Working with clinicians, our partners in the LA, patients and public and with other key stakeholders we have to deliver seven specific ambitions:

Seven ambitions

- Securing additional years of life for the people of England with treatable mental and physical health conditions.
- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people having a positive experience of hospital care.
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

2.5 There are a further three measures on which NHSE expect to see significant focus and rapid improvements in as set out below;
- Improving health
- Reducing health inequalities
- Parity of Esteem

2.6 CCGs will also be expected to evidence how we maintain focus with our plans on the four essential elements to drive outcomes;

Four Essential Elements
- Quality
- Access
- Innovation
- Value for money

2.7 Planning – Part 2, the guidance sets out in Part 2
- The Strategic and Operational Planning process
- Strategic Operational and Financial Planning
- Direct Commissioning
- Better Care Fund planning (Previously referred to Integration Transformation Fund)

2.8 Strategic and Operational planning has to set out the local ambitions for outcomes with our available funding. Each CCG is required to do a 5 year strategic plan and 2 year operational plan aligned to robust financial plans. CCGs are expected to take a lead in working with all key stakeholders especially local authorities to develop the plans and unlike in previous years the guidance is not prescriptive in how ambition should be achieved, however the guidance states plans should be:
- Ambitious
- Developed in partnership
- Locally led

2.9 Planning templates have been issued to complete in relation to:
- Strategic plans
- Operational plans
- Financial plans
- Direct Commissioning plan
- Better Care Fund plan and;
- Provider plan

2.10 Each strategic plan needs to have the ownership and buy-in of the whole local health economy and reflect a joint vision for the area, including the road map required to attain this. All organisations need to be satisfied that the plan will support the delivery of improvements for patients and service users. The plan should be short and focused, will require the creation of a System

narrative 'plan on a page'; and organisation specific key highlights (an overview of the content for the strategic plan is detailed below).

2.11 The operational plan will include the key operational metrics needed to support the assurance of, and measure performance against, strategic plans. The plan will be structured around the four headings; this will also include the Better Care Fund plan;

2.12 The Better Care Fund plan requires local areas to formulate a joint plan for integrated health and social care and to set out how their single pooled Better Care Fund budget will be implemented to facilitate closer working between health and social care services. Joint plans should be approved through the relevant local Health and Wellbeing Board. Progress and a local timetable in relation to developing the plan is set out in section 5 of this report.

2.13 The plan needs to clearly demonstrate how they will meet all of the requirements set out in the Better Care Fund conditions, which includes details of the expected outcomes and benefits of the schemes involved.

2.14 The measures that will be used to ensure delivery of the expected outcomes are set out below;

2.15 The financial plan will provide the detailed financial breakdown of each plan and include the key financial metrics to support the assurance of, and measure performance against, strategic plans. It will require information under the following headings:

2.16 NHS England has statutory direct commissioning responsibilities to commission services for patients across Primary, medical, dental, pharmacy and optical services and secondary care dental services; specialised services; public health section 7A services; services for members of the Armed Forces and their families; and services for people in the justice system. It will be the responsibility of NHS England's Area Teams to produce strategic and operational plans for the services they commission on the same basis as CCGs.

2.17 Assurance of plans

NHS Hartlepool and Stockton-on-Tees CCG unit of planning as agreed by NHSE 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. Assurance of the overall strategic plan will be at the unit of planning level.

- Assurance of the overall strategic plan will be at Unit of Planning level, including engagement with patients and public in the local community;
- Operational plans will be assured at CCG and at Health and Wellbeing Board level, and at Area Team level for NHS England's directly commissioned services;

- Area Teams to lead the assurance of CCG plans;
- Regional Teams manage the assurance of Direct Commissioning plans;
- Area Teams to assure the overall consolidated commissioning position and strength of local partnerships;
- Area Teams and CCGs to ensure mutual assurance of Direct Commissioning plans, with escalation by exception; and
- Boards and governing bodies should satisfy themselves that the outcomes or recommendations of the plan assurance process have been appropriately addressed prior to plan sign off.

2.18 The review and triangulation of plans will include;

- The finances to secure delivery of the output objectives and adherence to the requirements outlined in the planning guidance;
- Ensuring the finance and activity projections are supported by reasonable and deliverable planning assumptions including level of assumed QIPP delivery and underlying activity growth;
- Triangulation of finance and activity;
- Coherence with the other planning and output assumptions; and
- Testing the strength of local relationships, which are key to ensuring delivery

2.19 The timetable for submission of plans is as set out below;

First submission of plans	14 February 2014
Contracts signed	28 February 2014
Refresh of plan post contract sign off	5 March 2014
Reconciliation process with NHS TDA and Monitor	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year operational plans and draft 5 year strategic plan	04 April 2014
Submission of final 5 year strategic plans Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

3 PROPOSALS

3.1 As outlined in the previous paper submitted to Health and Wellbeing Board in December 'NHS Planning Cycle and outline of the Integration Transformation Fund (ITF)'. The CCG has already established a unit of planning (para. 4.1) that has an oversight group responsible for overseeing delivery of all of the planning requirements with working groups established to progress the plans.

3.2 At the Oversight Group in December 2013, which included members from the CCG, Council, and Providers, local principles for use of the Fund were agreed, in advance of the issue of the planning guidance. The principles agreed were consistent with the principles and aims now set out in the

planning guidance. The group also agreed that whilst plans will be developed at a locality level, the oversight group will ensure that where appropriate similar services will be commissioned across the CCG footprint to ensure equity for our local populations, to avoid potential destabilisation of services and/or to ensure providers are able to respond to required redesign of care pathways in a consistent and timely way.

3.3 Principles agreed in draft form for further discussion and progress by the working group in development of the plans were:

- Needs to support the priorities in the Joint Health and Wellbeing Strategy as well as align with the CCG Plan, NHS England operational plan and others
- Needs to be based on clear evidence including cost/benefit analysis of funding early-intervention and prevention services to achieve greater long-term sustainability and reduce pressure on acute services;
- The funding can be used to support existing or new services or transformation programmes where such programmes are of benefit to the wider health and social care system where positive outcomes for service users have been identified and will reduce demand on acute care.

3.4 The Oversight Group acknowledged that: i) the Fund does not represent "new" money flowing into the local health and social care system; ii) given the extent of services already in place associated to existing funding, local plans for use of the Fund will need to consider these services and ensure they deliver any national requirements; iii) the element of that will be subject to a "payment by results" test will require clarity on impact on Acute Providers.

3.5 Each organisation is currently working towards externally imposed deadlines for developing the plan which will be an iterative process throughout the following weeks as more information, support and guidance from the LGA/NHS England becomes available.

3.6 Work on the required template has started to reflect existing arrangements and a local timetable has been produced Appendix A highlighting key milestones working across both Local Authorities to ensure we meet the requirements of the planning guidance in relation to development of the BCF as Health and Wellbeing Boards should provide the first cut of their completed Better Care Plan template, as an integral part of the CCGs' Strategic and Operational Plans by 14 February 2014. The revised version of the Better Care Plan should be submitted to NHS England, as an integral part of the CCGs' Strategic and Operational Plans by 4 April 2014.

3.7 Both the CCG Strategic Plan and the Better Care Fund Plan require a strategic vision statement describing what the desired state would be for the health economy in 2018/19 – this is required to be a description across the health and care system rather than an individual organisation view. As there is a requirement for a vision statement for both plans the CCG working

with partners has produced the first DRAFT for Health and Wellbeing to review at Appendix B.

3.8 Throughout the planning process, Health and Wellbeing Board will be kept appraised of the developments and kept informed of the progress of all plans; this is intended to be through partnership meetings and/or Health and Wellbeing Board meetings.

4. RECOMMENDATIONS

4.1 **NOTE** the timescales and approach
NOTE the requirements of the Planning guidance
AGREE the vision statement describing what the desired state would be for the health economy in 2018/19 – this is required to be a description across the health and care system rather than an individual organisation view

5. BACKGROUND PAPERS

Appendix A – Local timetable
Appendix B – DRAFT Vision Statement

6. CONTACT OFFICER

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Better Care Fund (Integration) Timeline

6.1

Appendix A

Time Line	CCG	Stockton LA	Hartlepool LA
06/01/14	First draft plan shared with workstreams	First draft better Care Funding Plan	
08/01/14			CCG/LA meeting to discuss Better Care Fund development
09/01/14 3-4pm SBC		CCG/LA meeting to discuss Better Care Fund development	
13/01/14 2.30-4.30 HBC			CCG/LA meeting to discuss Better Care Fund development
14/01/14	Delivery Team Update		
17/01/14		LA meeting to further agree proposed projects/planned changes	
20/01/14 1.30-2.00PM HaST			CCG/LA meeting to discuss Better Care Fund development
22/01/14	SBC/CCG/Providers workshop to finalise draft	SBC/CCG/Providers workshop to finalise draft plan	
24/01/14 1-2PM SBC		CCG/LA meeting to discuss Better Care Fund continued development	
27/01/14			CCG/LA meeting to discuss Better Care Fund development
28/01/14	Draft Plan to be shared with Governing Body		
31/01/14		Meeting with SBC to discuss ongoing BCF	
03/02/14 1.30-3.30 HaST			CCG/LA meeting to discuss Better Care Fund development
04/02/14	Governing Body (Extraordinary meeting)	Meeting with SBC to discuss ongoing BCF	
05/02/14		Final draft of Better Care Fund	
12/02/14		H&WB Approval	
13/02/14			H&WB Approval
14/02/14	Completed return to be submitted	Completed return to be submitted	Completed return to be submitted
25/02/14		Adult HWB group to determine mobilisation and operational process	
27/02/14			H&WB

System Vision

'To develop outstanding, innovative and equitable health and social care services, ensuring excellence and value in delivery of person centred care working across both Health and Social Care'

We will do this by;

- Ensuring commissioning for quality outcomes and services deliver the required standards
- Putting patients at the heart of what we do and creating a system that is flexible and responsive enough to recognise the different needs of individuals
- Actively seeking out unmet need as well as responding to expressed need
- Establishing systems and processes that are sustainable and affordable to deliver continuity of care ensuring patients are involved in treatment decisions and planning their own care, including referrals, and being helped to navigate services and systems outside the GP practice
- Striving to improve on what we do through change and innovation
- Learning from successes and setbacks
- Remembering to always be caring and compassionate

Residents of Hartlepool and Stockton-on-Tees deserve the best possible, "joined up" health and social care. This is why NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG), alongside all our partners in the public, independent and voluntary sector are working to improve our local Health and Social Care system. We believe everyone should get the right care, in the right place, at the right time, which will help them have longer, healthier lives ensuring ***"I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me."*** *(Integrated Care and Support: Our Shared Commitment; pg7)* is how our communities.

Different organisations have responsibilities for different parts of commissioning services and changes are needed to ensure we work jointly to improve experience and outcomes for our communities.

The CCG Strategic Commissioning Plan sets out a description of our vision in relation to what healthcare services will be commissioned over the next five years. These plans will ensure local residents have access to the best possible health and health care services that deliver the best outcomes.

The plan describes the CCG's undertaking to ensure continual improvement in the quality of health services, reduce health inequalities, prevent illness and promote health, driving greater efficiency and productivity in services and to look for

innovative solutions to ensure the very best healthcare is available to patients through an integrated and evidence based approach.

Our Vision and Plans are being developed through working closely with all our stakeholders and partners in the NHS, Local Authority and voluntary and community sector (VCS), as well as through active consultation with our patients and the public. This partnership working is crucial to achieving our ambitions and to meeting the challenges of the years ahead. We need to ensure we are able to sustain services whilst we work within the financial and resource constraints across our organisations, ensuring we are able to deliver effective patient centred services and simpler care pathways that reduce duplication and inappropriate use of resources through integration in the next five years.

NHS England's Call to Action forecasts a financial gap of £30 billion by 2020/21 and the affordability challenges in 2014/15 and 2015/16 are real and urgent. The prospect of resources being outstripped by demand, driven largely by an ageing population and an increasing prevalence of chronic diseases presents a significant challenge to the way we currently commission care from providers. We cannot meet future challenges alone and we recognise the importance of prevention and co-ordinated pathways of care and it is clear that by working with stakeholders and partners to deliver effective change, whilst ensuring we continuously seek patient's views and opinions.

There is already a strong focus on Partnership working within Hartlepool and Stockton-on-Tees, Momentum: Pathways to Healthcare has been the blueprint for the last 5 years. Working in close partnership with our Providers this has helped us to achieve many changes in clinical services which improved quality, safety and patient experience in the services we commission. We now need to ensure that we continue this and ensure a joined up approach with our social care partners, the Better Care Fund is therefore seen as a significant step forwards in developing integrated health and social care services. Ensuring we work together to provide better support at home and earlier treatment in the community, through this joint planning we will be able to reduce the pressures on urgent care and prevent people needing emergency care in hospital or care homes.

Given the constructive partnership that has developed through the establishment of the Health and Wellbeing Boards within Hartlepool and Stockton, there is a strong desire and commitment to further develop the partnership working that has been achieved to date and to build on this utilising some of the additional opportunities that the changes in national policy bring.

Our vision of service delivery as we move forward is to have a sustained focus on integration, meaning **organisations working together to create services that maximise health and wellbeing and address individual needs, improving outcomes and experiences for individuals and communities.** (*Integrated Care and Support: Our Shared Commitment*; *pg13*).

This is seen as particularly important in our local economy given the financial constraints that individual organisations are already experiencing. This, coupled with a continuing increase in the needs of our aging population and increased prevalence of long term conditions and a recognition that we have patterns of care and services that will be unsustainable in their current form, means we will need to work differently if we are to achieve the transformation of care required and deliver more with less. The development of a sustainable care system in Hartlepool and Stockton will only be possible through an integrated approach and stronger alignment of priorities, resources, and incentives and rewards.

Partners consensus is that 'going it alone' is not an option and we will not be able to achieve the objectives of individual organisations or the shared priorities of the Health and Wellbeing Strategy unless we focus on shared priorities, coordinate our efforts and align our resources across the economy and all organisations.

Our vision is that by 2018/19 everyone is able to live at home longer, be healthier and get the right support services where required, whether this be provided by health and or a social care. We will have a healthcare system where we have integrated health and social care, a focus on primary prevention, early diagnosis and intervention, and supported self-management. Where a person requires hospital treatment if this cannot be provided in a community setting, we expect this will be carried out as a day case treatment or in an outpatient setting.

Care will be provided to the highest standards of quality and safety, with the person remaining at the centre of all decisions. Our focus will be to ensure that people can remain in their own homes or when this is not possible and they have to be treated in hospital we will ensure that their discharge is appropriately planned to ensure that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Each individual's care will need co-ordination, decision-making and leadership. Those with the greatest need will have a named professional health and social care coordinator who will have responsibility for leading their care and taking a proactive approach to meeting the individual's health and social care needs.

Our five year plan builds upon the excellent progress made during 2014/15 in partnership with member practices, stakeholders and the public. It reflects the CCG's current direction of travel and local priorities as set out in our Clear and Credible Plan 2012/17 (CCP) as these objectives remain extant and the CCG is committed to deliver our obligations as well as those that are set out in the NHS Constitution.

What does this mean for the people we serve?

We want the people of Hartlepool and Stockton-on-Tees to live as healthily as possible at home, supported by high quality primary care, community health and social care services, supported by new advances in technology.

We want

- To ensure that the population of Hartlepool and Stockton-on-Tees have access to a wide range of primary prevention interventions including but not limited to smoking cessation services, exercise, weight management, IAPT, problem drinking support, cancer screening programs, immunisation, social prescribing, carer's support and good nutrition.

- To identify the 'missing thousands' of people who have undiagnosed and unmanaged long term conditions such as cardiovascular disease (including atrial fibrillation and hypertension), diabetes, COPD, dementia and early cancer.

- To maximise independence and quality of life and helping people to stay healthy and well through the development of integrated community health and social care services with a focus on long term conditions, frail elderly (including end of life) and dementia. This will be delivered through the roll out of an integrated care model building on existing care planning, care co-ordination, risk stratification and multi-disciplinary teams in place

- To streamline care and reduce activities that are carried out by multiple organisations ensuring the right services are available at the right place, right time through an integrated community team providing rapid response to support individuals in order to remain at home and avoid admission

- To improve people's experience of services through the introduction of a single point of access across health and social care, utilising the NHS number. We want to work towards a digital information system across the whole health and social care system that will share people's information to enhance the quality of care and ensuring continuity of delivery.

- To improving outcomes for service users and carers through clearer and simpler care pathways; proactive management of people with long term conditions. We will do this through co-designing models of care that will meet need. These pathways will be simple to understand, simple to follow and will be available for all staff, patients and carers to see.

- To have a skilled workforce that understands both the health and social care system and works across organisational boundaries, making every contact count.

- For each person to have a package of care that improves their physical, social and emotional wellbeing, acknowledging that all three elements are necessary to enjoy good health.

- To support personalisation and choice by being able to develop a range of coordinated alternatives to hospital and residential care, this will be delivered through investment in personalised health and care budgets ensuring individuals are able to make informed decisions

- To ensure the innovative use of digital technology are utilised to deliver the greatest possible benefit to patients and carers across health and social care services

- To improve access to community health and social care services 7 days a week to improve patient experience and provide responsive services in and out of hours, reduce delayed discharges and improve support to empower people to live independently

Our vision for integration is ambitious, it is about establishing a landscape in which different public bodies are able to work together, and with their partners in the third and independent sectors, removing unhelpful boundaries and using their combined resources, to achieve maximum benefit for patients, service users, carers and families.

It is acknowledged that this means new ways of working and a change across the current landscape. Acute, Primary, community care services (including Mental Health services) and the independent and voluntary sector play a central role in helping people live healthy, independent lives with dignity and respect. It is these services that will ensure delivery of quality and improvement in patient experience and deliver support and education packages to patients and their carers to enable them to manage conditions to the best of their ability. This will change how health and care services are delivered so we can deliver care in a personal setting that ensures hospital admission is avoided where appropriate resulting in a consolidation of acute care to optimise efficiency and deliver the highest quality and safety standards required nationally.

Our vision is of primary and community care services working ever more closely together, along with voluntary organisations and other independent sector organisations agreeing common goals for improving the health and well-being of local people and communities. We will engage with partners and the community and work with service users to develop innovative approaches. Community engagement and community development will become increasingly important in our joined up approach to health and well-being.

Our Provider organisations are of critical importance in delivering our vision for the future of primary and community care requiring a commitment to drive service transformation, build on existing care planning care co-ordination and risk stratification across multi-disciplinary teams to ensure an integrated approach.

GPs are central to organising and coordinating patient care. Clinical leadership brings real added value to the commissioning of local services. As professionals working on the frontline with patients every day, Hartlepool and Stockton clinicians understand the local health economy and are well placed to work with colleagues across health and social care to improve the local quality of care and outcomes for our patients. CCG members and clinical leaders are also attuned to their patients' views and the choices they make in practice consultations. The CCG is structured to reflect these consultation room choices in its future commissioning plans within the existing workstreams haven already been configured. We will therefore ensure investment in the enhancement to the provisions in relation to extending GP services to 7 days per week and a focus on better supporting people with complex health needs and those with long term conditions and those most at risk of admission to hospital or those most in need of social and emotional support.

The CCG will operate with the strong clinical leadership of local practices to commission and improve local services. Just as our clinical experience gives us a deep insight into local health and care services, we recognise that as users of these services, patients and the public play an equally important role in establishing the priorities we set and the decisions we take and should be central to developments so services are developed around the patient and not that patients are defined around the structures in place.

Better planned, person centered services are expected to deliver a more responsive service across health and social care with a continued focus on those with greater need such as those such as those at the end of their lives or those with complex medical problems.

We will work with our partners to improve the way we commission services as we have a joint Health & Wellbeing Strategy which clearly sets out our shared health and wellbeing goals and we will determine which services could be jointly commissioned where appropriate.