HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

10 September 2014
at 2.00 p.m.
in Committee Room 'B'
Civic Centre, Hartlepool.

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors C Akers-Belcher, Brash, Richardson and Simmons.
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Schock 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 Ruby Marshall

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

Observer – Representative of the Audit and Governance Committee, Hartlepool Borough Council (1) – Councillor Springer.

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

To confirm the minutes of the meeting held on 11 August 2014

4. **ITEM FOR CONSIDERATION**

4.1 Introduction to Independent Chair of Hartlepool Safeguarding Children Board
4.2 Scoping Report – Obesity *(Director of Public Health) (to follow)*

5. **ITEMS FOR DECISION**

5.1 Scrutiny Investigation into COPD/Action Plan (*Director of Public Health*)
5.2 Making Smoking History 5% by 2025 Regional Vision (*Director of Public Health)*
5.3 Better Care Fund *(Director of Child and Adult Services) (to follow)*

6. **ITEMS FOR INFORMATION**

6.1` Transformation Challenge Award – Better Childhood Programme (*Director Child and Adult Services)*
6.2 Audit and Governance Committee Work Programme 2014/15 – Cardiovascular Disease (CVD) (*Scrutiny Manager*)
6.3 Safer Hartlepool Partnership Draft Reducing Reoffending Strategy 2014-2017 (*Director of Regeneration & Neighbourhoods*)
6.4 Clear and Credible Plan Refresh (*Chief Officer, NHS Hartlepool and Stockton on Tees CCG)*

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

Date of next meeting – Monday 20 October at 9.30 am in the Civic Centre, Hartlepool.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

11 August 2014

The meeting commenced at 2.00 p.m. in the Civic Centre, Hartlepool

Present:

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

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors Jonathan Brash, Carl Richardson and Chris Simmons
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group –Alison Wilson
Director of Public Health, Hartlepool Borough Council - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council – Gill Alexander
Representative of Healthwatch –Margaret Wrenn

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

Also in attendance – Dr Paul Pagni, Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Officers: Alastair Rae, Public Relations Manager, Hartlepool Borough Council
Joan Stevens, Scrutiny Manager, Hartlepool Borough Council
Amanda Whitaker, Democratic Services Team, Hartlepool Borough Council

1. Appointment of Vice Chair

It was agreed unanimously that Dr Schock be appointed Vice Chair of the Board for the ensuing Municipal Year.
Tribute was paid to Dr Pagni who had been Vice Chair of the Health and Wellbeing Board the previous year. Dr Pagni responded by thanking the Board for its support and wishing the Board continuing success.

2. Apologies for Absence

Apologies for absence had been submitted on behalf of the following Board Members:-
Dr Schock, Hartlepool and Stockton-on-Tees Clinical Commissioning Group
Ruby Marshall, Healthwatch
Denise Ogden, Director of Regeneration and Neighbourhoods, Hartlepool Borough Council
Martin Barkley, Tees Esk and Wear Valley NHS Trust
Alan Foster, North Tees and Hartlepool NHS Foundation Trust

3. Declarations of interest by Members

Councillor Brash declared a non prejudicial interest as a trustee of Hartlepool Families First.

The Chair, Councillor Christopher Akers-Belcher, advised that in accordance with the Council's Code of Conduct, he declared a personal interest as Manager for the Local HealthWatch, as a body exercising functions of a public nature, including responsibility for engaging in consultation exercises that could come before the Health and Wellbeing Board. He advised that where such consultation takes place (or where there is any connection with his employer), as a matter of good corporate governance, he would ensure that he left the meeting for the consideration of such an item to ensure there was no assertion of any conflict of interest.

4. Minutes

The minutes of the meeting held on 29 April 2014 were confirmed.

5. Strategic Context Presentation

The Board received a joint presentation by the Director of Public Health, Director of Child and Adult Services and Chief Officer, NHS Hartlepool and Stockton on Tees Clinical Commissioning Group. The presentation highlighted the following issues in relation to consideration of the strategic context of the Board:-

- Summary of statistical evidence for Tees Valley
- Health and Wellbeing Priorities
- The Way Forward
- Challenges to be addressed
- Partnership Issues
- Better Care Fund
- Better Childhood Programme

- Developing the role of the Health and Wellbeing Board.

Followed the presentation, Board Members discussed issues associated with delayed hospital discharges together with measures to prevent admission to hospital.. Child poverty was highlighted as an issue which required the focus of the Board and the issue was discussed in the context of the Better Care Fund and Partnership working.

Decision

The presentation was received by the Board.

6. Health and Wellbeing Board – Annual Review 2013/14 and Work Programming 2014/15

In order to assist the Board in completing its 2013/14 Annual Review, a presentation was given by the Director of Public Health to inform and promote discussion in relation to progress during 2013/14 against each of the Boards key duties and priority outcomes and the challenges facing the Health and Wellbeing Board in the provision of effective health services for Hartlepool residents. In developing the operation of the Board, in addition to undertaking statutorily required activities, the Board was asked to also consider the establishment of a defined work programme for 2014/15, with the identification of a single item upon which it could focus its activities for the year. To assist the Board in its discussions, details were presented to the Board of the outcome of the Face the Public Event, held on the 23 June 2014, with views and comments compiled in response to specific questions relating to health priorities. In order to facilitate discussions, the Board agreed to 'break out' into three groups to discuss and agree the wider determinants of health in Hartlepool and to identify one determinant to be focused on in 2014/15.

Following the 'break out' sessions, the Board received feedback. Although there had been a range of topics discussed, it was agreed that one of the topics suggested, childhood obesity, was a determinant that the Board should focus upon. The Board discussed the selected determinant and identified linkages across all partner activities and how the piece of work was to be undertaken. The Board accepted the range of issues to be considered in the context of addressing childhood obesity including obesity in general to convey the message that children and adults needed to 'Eat well. Live well'. Members wanted to focus on a positive campaign to reduce obesity and recognised the role of the Children's Strategic Partnership in supporting the Board.

In order that all Board Members could be involved in undertaking the work of the Board, a Board Member suggested that consideration should be given to the time of commencement of Board meetings.

Decision

(i) The outcomes of the Boards 'Annual Review' of activities during 2013/14 were noted.

(ii) The Board approved the establishment of a defined work programme for 2014/15; and identified a topic area of work, namely childhood obesity, upon which to focus its activities during 2014/15.

7. Communications and Engagement Strategy Presentation

The Board received a presentation by Hartlepool Borough Council's Public Relations Manager. Board Members were advised on strategic priorities, key components of the Communications and Engagement Strategy, identification of key areas, public engagement and moving forward with particular reference to 2014/15.

Concerns were expressed regarding elements of existing communication between Partner Organisations. It was recognised that it was important to ensure that communication was through a central function. It was recognised also that there was a requirement for Board Members to assist in terms of communication. In relation to discussions earlier in the meeting which had identified childhood obesity as the Board's topic area of work for 2014/15, the Public Relations Manager agreed to submit a campaign proposal to the Board which would include brand proposals and key objectives. The Public Relations Manager agreed also to liaise with key partners to discuss the alignment of communication plans of partner organisations.

Decision

(i) The Board received the presentation and the Public Relations Manager agreed to submit a campaign proposal to the Board.
(ii) It was agreed that the composition of the Board should be reviewed to determine whether there is a requirement to co-opt onto the Board to progress the Board's topic area of work, childhood obesity.

8. Meeting Dates

The Chairman advised the Board that the date of the next meeting had been changed from 8th September to 10 September. Recognising a request made

earlier in the meeting by an elected Member, the Democratic Services Team Manager was requested to contact the elected member to determine suitable times for Board meetings and to submit a schedule of meeting times and dates to all Board Members. It was noted that Board Members required advance notice of meetings.

Meeting concluded at 4.15 p.m.

CHAIR

HEALTH AND WELLBEING BOARD

10 September 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: **Chair of the Health and Wellbeing Board**

Subject: **SCOPING REPORT – OBESITY**

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1. PURPOSE OF REPORT

1.1 To outline the next stage of the process for the scoping of the piece of work in relation to obesity to be undertaken by the Committee during 2014/15.

2. BACKGROUND

2.1 The Health and Wellbeing Board, at its meeting on the 11 August 2014, identified obesity as a priority issue for consideration in 2014/15. In taking the issue forward, a scoping exercise is to be undertaken and a report presented to the Committee.

2.2 In preparing for the scoping of the issue by the Committee, it is felt that it would be beneficial to involve the Commissioning Executive (CE). On this basis, the issue has been added to the agenda for the next meeting of the CE, on the 25 September 2014. The views of the CE will then be incorporated in to the scoping report, which is to be considered by the Health and Wellbeing Board on the 20 October 2014.

5. RECOMMENDATIONS

5.1 The Health and Wellbeing Board process for the scoping of the piece of work in relation to obesity to be undertaken by the Committee during 2014/15.

6. REASONS FOR RECOMMENDATIONS

6.1 To update the Committee on progress in relation to the scoping of the obesity piece of work to be undertaken by the Committee.

7. BACKGROUND PAPERS

The following background paper was used in the preparation of this report:

- Minutes of the Health and Wellbeing Board held on the 11 August 2014.

8. CONTACT OFFICER

Joan Stevens – Scrutiny Manager
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HEALTH AND WELLBEING BOARD

10 September 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: **Director of Public Health**

Subject: **SCRUTINY INVESTIGATION INTO CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)– ACTION PLAN**

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1. PURPOSE OF REPORT

1.1 To agree the Action Plan (see **Appendix A**) in response to the findings and subsequent recommendations of the Audit and Governance Committee's investigation into Chronic Obstructive Pulmonary Disease (COPD).

2. BACKGROUND

2.1 As a result of the Audit and Governance Committee's investigation into COPD, a series of recommendations have been made. To assist the Health and Wellbeing Board in its determination of either approving or rejecting the proposed recommendations an action plan has been produced and is detailed along with the recommendations of the Audit and Governance Committee in **Appendix B.**

3. PROPOSALS

3.1 No options submitted for consideration other than the recommendation(s).

4. IMPLICATIONS OF RECOMMENDATIONS

4.1 Details of any financial or other considerations / implications are included in the action plans.

5. RECOMMENDATIONS

5.1 The Health and Wellbeing Board is requested to approve the action plan, as detailed in **Appendix A**, in response to the recommendations of the Audit and Governance Committee's investigation into COPD.

6. REASONS FOR RECOMMENDATIONS

6.1 The aim of Audit and Governance Committee's investigation was to examine the effectiveness of the services and pathways available to people diagnosed with COPD and explore how awareness of COPD can be increased to aid early diagnosis and prevention.

7. BACKGROUND PAPERS

The following background paper was used in the preparation of this report:-

Final Report of the Audit and Governance Committee into Chronic Obstructive Pulmonary Disease

8. CONTACT OFFICER

Laura Stones – Scrutiny Support Officer
Chief Executive's Department – Legal Services
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Appendix A

AUDIT AND GOVERNANCE SCRUTINY ENQUIRY ACTION PLAN

NAME OF COMMITTEE: Audit and Governance Committee

NAME OF SCRUTINY ENQUIRY: Chronic Obstructive Pulmonary Disease (COPD)

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION+	FINANCIAL / OTHER IMPLICATIONS	LEAD OFFICER	COMPLETION DATE*
(a) That the Health and Wellbeing Board develop a strategic approach to COPD to ensure that inequality is not worsened by:- (i) monitoring the review of the single point of access to establish whether the changes have had a positive impact on COPD patients and their families (ii) ensuring that any changes to service provision are appropriately evaluated to provide assurance that these changes are effective from an evidence and cost perspective	This action has been forwarded onto North Tees and Hartlepool NHS Foundation Trust and Hartlepool and Stockton on Tees Clinical Commissioning Group to provide a response			

(b) That the Health and Wellbeing Board explores ways to promote COPD support programmes, such as the pulmonary rehabilitation programme, to encourage people to attend	This action has been forwarded onto North Tees and Hartlepool NHS Foundation Trust and Hartlepool and Stockton on Tees Clinical Commissioning Group to provide a response			
(c) That the Health and Wellbeing Board, through an integrated and co-ordinated approach, work in partnership with relevant organisations and groups to promote a consistent message on COPD through the use of a single questionnaire	This action has been forwarded onto North Tees and Hartlepool NHS Foundation Trust and Hartlepool and Stockton on Tees Clinical Commissioning Group to provide a response			
(d) That the Health and Wellbeing Board raises community awareness of COPD by placing the COPD questionnaire in community and health venues across Hartlepool to find those people with undiagnosed COPD	Public Health has already taken the lead on behalf of the Board over the past year to promote the questionnaire. Public Health will build on this previous activity during 2014/15 to ensure the questionnaire is circulated across a range of settings to find those people with undiagnosed COPD.	N/A	Louise Wallace	Mach 2015

(e)	That the Health and Wellbeing Board explores the development of a targeted COPD awareness campaign for young people to raise awareness of the long term implications of smoking;	Public Health has led this activity on behalf of the Board and will continue to do so through activities such as theatre in education and schools. This approach has proven successful in raising awareness amongst young people of the short and long term healthy implications of smoking.	N/A	Louise Wallace	March 2015
(f)	That the Health and Wellbeing Board explores whether the number of COPD screenings taking place at various GP surgeries across Hartlepool can be publicised, as it would be valuable for the community to be aware of the variations in practices in order to aid patient choice and help to alleviate variations across GP surgeries.	Public health are responsible for commissioning the COPD screening programme in primary care. This requires practices to ensure that patients most at risk of developing COPD i.e those that smoke, are made aware of this service. Public Health will provide a report on uptake, impact and variation of this service provided by GP's to the Health and Wellbeing Board by March 2015.	N/A	Louise Wallace	March 2015

[+] please detail any risk implications, financial / legal / equality & diversity / staff / asset management considerations

* please note that for monitoring purposes a date is required rather than using phrases such as 'on-going'

HARTLEPOOL
BOROUGH COUNCIL

AUDIT AND GOVERNANCE COMMITTEE

FINAL REPORT

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

May 2014

AUDIT AND GOVERNANCE COMMITTEE

Report of: AUDIT AND GOVERNANCE COMMITTEE

Subject: FINAL REPORT – INVESTIGATION INTO CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

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1. PURPOSE OF REPORT

1.1 To present the findings of the Audit and Governance Committee following its investigation into Chronic Obstructive Pulmonary Disease (COPD).

2. BACKGROUND

2.1 The Audit and Governance Committee met on the 27 June 2013 to consider their Work Programme and agreed that the Committee would in 2013/14 focus on COPD as the health topic for investigation.

2.2 COPD is a chronic disabling disease which causes a gradual decline in lung function, with increasing episodes of chest infections and exacerbations as the condition progresses. It is a general term which includes chronic bronchitis and emphysema. It mainly affects people over the age of 40 and risk increases with age. Smoking is the main cause in the vast majority of cases.

2.3 COPD is incurable but treatments help to slow down the decline in the lung function therefore early diagnosis and support for effective self-management and self-care can help patients live an active life. About 835,000 people in the UK are currently diagnosed with COPD and an estimated 2.2 million people have the condition but do not know it. COPD is the fourth biggest killer in the UK, the second most common cause of emergency admissions to hospital and one of the most costly in-patient conditions treated by the NHS. In Hartlepool, there is a decreasing trend in the number of deaths from COPD but the number of people with COPD is increasing, placing additional demand on services[1].

2.4 The key issues, as identified in Hartlepool's Joint Strategic Needs Assessment (JSNA), relating to COPD are as follows:-

[1] Hartlepool Joint Strategic Needs Assessment – www.teesjsna.org.uk

(a) The estimated prevalence of COPD in Hartlepool is 4.3% but only 2.7% of the population has been diagnosed. This suggests that about 1,250 people with COPD remain undiagnosed.
(b) There is a lack of community awareness of COPD and its risk factors.
(c) There are high numbers with undiagnosed COPD that may lead to increased complications, ill health and health inequalities and inefficiency.
(d) The number of people with COPD is increasing, placing additional demand on services.
(e) There are variations in the quality of diagnosis and management of COPD among general practices.
(f) The COPD emergency admission rate in Hartlepool is higher than the England average.
(g) The capacity and capability of current services to cope with the projected increase in the number of people with COPD, from a recorded prevalence of 2.7% in 2010 to 4.4% in 2020.
(h) There is low awareness of lung health and COPD in communities that are at high risk, for example, current and ex-smokers and women.

(i) There is inequitable access to high quality spirometry in primary care and Community settings.

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION

3.1 The overall aim of the Scrutiny investigation was to examine the effectiveness of the services and pathways available to people diagnosed with COPD and explore how awareness of COPD can be increased to aid early diagnosis and prevention.

4. TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION

4.1 The Terms of Reference for the Scrutiny investigation were as outlined below:-

(a) To gain an understanding of COPD and the pathways available to people diagnosed with COPD (including the causes; signs and symptoms; prevention; and treatment);

(b) To consider the numbers of people with COPD in Hartlepool and examine the impact of unplanned emergency admissions on service provision;

(c) To identify the services available in Hartlepool for those diagnosed with COPD and ensure effective partnership working to encourage / increase early diagnosis and positive treatment outcomes;

(d) To examine the quality of diagnosis and management / treatment of COPD across GP practices and NHS services in Hartlepool;

(e) To explore how community awareness of COPD can be increased, in particular to those people / communities who are 'seldom heard, seldom seen' and to people / communities that are at high risk, for example, current and ex smokers and women;

(f) To seek the views of COPD patients and their families and carers; and groups / bodies who provide services for people diagnosed with COPD

5. MEMBERSHIP OF THE AUDIT AND GOVERNANCE COMMITTEE

5.1 The membership of the Scrutiny Forum was as detailed below:-

Councillors Ainslie, S Akers-Belcher, Brash, Fisher, Loynes, Robinson and Shields

6. METHODS OF INVESTIGATION

6.1 Members of the Audit and Governance Committee met formally from 22 August 2013 to 2 May 2014 to discuss and receive evidence relating to this investigation. A detailed record of the issues raised during these meetings is available from the Council's Democratic Services.

6.2 A brief summary of the methods of investigation are outlined below:-

(a) Setting the Scene presentation from the Public Health Team

(b) Presentation and verbal evidence received from North Tees and Hartlepool NHS Foundation Trust

(c) Presentation and verbal evidence received from the Hartlepool and Stockton-on-Tees Clinical Commissioning Group

(d) Presentation and verbal evidence received from the British Lung Foundation

(e) Presentation and verbal evidence received from Stockton and Hartlepool Stop Smoking Service

(f) Presentation, written and verbal evidence received from Tees Valley Public Health Shared Service

(g) Focus Group held on 10 December 2013

(h) Written evidence received from the COPD Exercise Group

(i) Presentation from Hartlepool Families First

(j) Report of HealthWatch Hartlepool entitled 'Listening to the Seldom Heard'

7. FINDINGS

WHAT IS COPD AND WHAT ARE THE PATHWAYS AVAILABLE TO PEOPLE DIAGNOSED WITH COPD (INCLUDING THE CAUSES; SIGNS AND SYMPTOMS; PREVENTION; AND TREATMENT)

7.1 Members at their meeting of 3 October 2013 received a setting the scene presentation from the Council's Specialty Registrar in Public Health to gain an understanding of COPD and the pathways available to people diagnosed with COPD (including the causes; signs and symptoms; prevention; and treatment).

Signs, Symptoms and Causes of COPD

7.2 Members were informed that COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema.

7.3 The principal cause of COPD is smoking. At least four out of five people who develop the disease are, or have been, smokers. Exposure to certain types of dust and chemicals at work, including grains, isocyanates, cadium and coal, have been linked to the development of COPD, even in people who do not smoke. The lining of the airways becomes inflamed and permanently damaged by smoking. This damage cannot be reversed. There is a rare genetic tendency to develop COPD called alpha-1-antitrypsin deficiency which causes COPD in about 1% of cases.

7.4 Members were interested to know about the numbers of people suffering with COPD who had not smoked but had been diagnosed with the disease and the potential causes other than smoking. The Public Health Registrar confirmed that not all people diagnosed with COPD were smokers or ex-smokers, and that people could have contracted the disease through environmental factors. Although looking at the population as a whole, the vast majority of COPD is smoking related.

7.5 The symptoms of COPD usually develop over a number of years and many people are unaware that they have the condition. COPD does not usually become noticeable until after the age of 35. Some of the signs include:-

- increasing breathlessness when exercising or moving around
- a persistent cough with phlegm that never seems to go away
- frequent chest infections, particularly in winter
- wheezing
- weight loss
- tiredness and fatigue
- swollen ankles

Prevention, Diagnosis and Treatment of COPD

7.6 Being diagnosed early allows for appropriate treatment and advice and help to stop or slow the progression of COPD. In order to assess how well the lungs work a spirometry breathing test is carried out, which measures the volume of air a person can breathe out in one second. A comparison is then carried out with normally expected readings to indicate whether airways are obstructed.

7.7 The Committee was informed that early identification of COPD and reducing the numbers that presented to Accident and Emergency departments was a major target. Members acknowledged that identifying sufferers before they presented to Accident and Emergency would be extremely difficult. Twenty percent of all Accident and Emergency attendances related to COPD. Members questioned whether other venues such as the One Life Centre would be able to treat people during an exacerbation, which is a flare up of symptoms, but it was pointed out that during an exacerbation treatment by specialist respiratory team was the most appropriate response.

7.8 COPD causes about 25,000 deaths a year in the UK, progression to severe COPD can be prevented by making lifestyle changes. Stopping smoking is the single most effective way to reduce the risk of getting the condition. Early detection leads to improved outcomes and health and wellbeing.

7.9 There is no cure for COPD, but treatment can help slow the progression of the condition and reduce the symptoms. Treatments help to slow down the decline in the lung function, so early diagnosis and support for effective self management and self care can help patients live an active life. If a person smokes, the best way to prevent COPD from getting worse is for the person to seek help to stop smoking.

7.10 The main aims of therapy are to improve symptoms such as breathlessness and help prevent an exacerbation. Inhaled bronchodilators are generally the first therapies that should be offered to people with COPD. Inhaled bronchodilators and inhaled steroids are used to reduce breathlessness and the chance of an exacerbation.

Numbers of people living with COPD in Hartlepool

7.11 The following diagram illustrates those people diagnosed with COPD compared to those that are undiagnosed across the Tees Valley.

Locality	**Reported Diagnosed COPD - GP disease register aged 16+, 2010/11)**	**Estimated Undiagnosed - 'missing numbers' - with COPD (based on GP registered population aged 16+, 2010/11)**
Hartlepool	2,578	1,602

Middlesbrough	3,828	5,208
Redcar & Cleveland	3,643	2,246
Stockton	4,032	5,544
Tees Total	14,081	14,600

8. SERVICES AVAILABLE IN HARTLEPOOL FOR THOSE DIAGNOSED WITH COPD AND EFFECTIVE PARTNERSHIP WORKING TO ENCOURAGE / INCREASE EARLY DIAGNOSIS AND POSITIVE TREATMENT OUTCOMES

8.1 The Committee at their meeting of 2 May 2014 welcomed evidence from Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) and North Tees and Hartlepool NHS Foundation Trust (NTHFT) in relation to service provision. The Chair of the CCG informed Members that:-

- Acute services are provided via NTHFT
- There is a pulmonary rehabilitation service for stage 1-2 patients and stage 3 and 4 patients
- Community services are provided via NTHFT, which includes a Community Respiratory Assessment and Management Service (CRAMS)
- Oxygen assessment is provided

8.2 The Consultant Respiratory Physician from NTHFT explained the service pathways for patients with COPD. Members were informed that patients can use self referral via the Single Point of Access at the One Life Centre to the CRAMS team. In addition to this there is a nurse led clinic at Hartlepool and Peterlee once a month, and daily at the One Life Centre. Patients can also be referred by their GP to the weekly delivered service at the One Life Centre and the CRAMS Team.

8.3 There is also a pulmonary rehabilitation service available to COPD patients. This programme includes a physical exercise programme and advice on lung health and coping with breathlessness. It is a gold standard programme which has proven benefits for up to 18 months afterwards. It can be accessed via GPs or via the CRAMS service. The programme is based in hospital or in the community and locations are Seaham, Peterlee and Hartlepool. It is a rolling programme with no waiting list. A member of the public who attended the Committee reported that the programme does work and is very beneficial. Members recognised that pulmonary rehabilitation is

a service that is effective and very helpful to COPD patients. Members questioned whether there was anything that the Committee could do to help its success and suggested widely promoting the service.

8.4 Members were informed that a new pilot programme had recently been developed and was running from Hartlepool Hospice. The programme is a breathlessness support group and is being funded by the CCG. It is to help patients and carers with anxiety when patients become breathless. A member of the public who was present at the meeting when this programme was discussed, reported that the programme was very beneficial, as the biggest problem for COPD sufferers was managing breathlessness. It was questioned whether more could be done through GPs on how to manage breathlessness. Representatives from the CCG said that there are educational projects for GPs and nurses to roll out the lessons from such pilots. There is also a patient education programme delivered via the CRAMS service.

Partnership Work

8.5 The Committee heard that many partnerships are in place to aid early diagnosis and these include ongoing work with the Local Authority / the Public Health Team and the Area Team. There is a COPD screening programme carried out in GP practices, where all patients aged 35 or over who smoke are invited to attend for screening and practices have signed up to provide Healthy Lung checks. The CCG will also continue its partnership working with the voluntary and community sector.

8.6 The Council, through the GP Referral Co-ordinator run a weekly exercise programme for COPD patients. The group completed a questionnaire and the results highlighted that six out of ten people had reduced their need for hospital visits since they had been involved in the exercise programme. Examples of some of the comments from the group are as follows:-

"It gives you the motivation to continue to do the exercises and also helps to keep you mobile"

"Feel a lot better in my mobility; feel relaxed and more energetic after class. My balance has improved. Enjoy the class very much".

Access to Services

8.7 Members were informed that the CCG are looking at the ideal pathway between GP practices and community/hospital services, as everyone wants the best possible experience of health services. The Better Care Fund plans to try and move care from hospital into the community. The respiratory pathway and associated services are under review and further work is being undertaken to improve direct access to services.

8.8 HealthWatch Hartlepool and COPD patients reported that the CRAMS service had developed a very good reputation with patients. However, throughout this investigation, it become apparent to the Committee that access to the CRAMS service, since the introduction of the single point of access is extremely difficult. COPD patients and family / carers reported that access to respiratory nurses used to be direct, for example patients could contact a respiratory nurse by calling him/her direct, but now access is via the single point of access number. A message is then passed onto the respiratory nurses. Both NTHFT and the CCG were aware of these problems and the Lead Respiratory Nurse at NTHFT reported that a Task and Finish Group had been set up to investigate the problems. The Group are due to meet in June to evaluate the practices and procedures. Further work is being undertaken to improve access and response times, for example, appointment times when visiting respiratory nurses have been extended and a late clinic is due to be piloted one day a week to see if this helps improve access.

8.9 The Committee was pleased to hear that there is more support for patients attending the One Life Centre as volunteers now work within the One Life Centre to escort patients to the COPD Clinic. It was acknowledged that patients have lost a little faith with the CRAMS services, and this faith needs to be restored. That is why direct access to nurses/consultants is being reviewed and a new pathway of care being developed. The Lead Respiratory Nurse commented that the satisfaction surveys that she sent out to COPD patients highlighted that patients were not happy with access to the service. A leaflet is also being collated with key contacts and patients will be asked to evaluate it to see if it will help improve access and the information provided to patients.

8.10 Members raised concerns about access to GPs and how there are problems with people not being able to get appointments. The Chair of the CCG commented that there are new changes to GP contracts, from 1 April 2014, which means that COPD patients, over 75, have a named responsible GP, in addition to their 'family' GP. Members were informed that this is an additional service that will provide speedier access to GP services. There is also a telephone line for patients to call. The CCG want to make sure that this service enhances links with patients. In order to further help links between patients and GPs, the CCG are looking to advertise using media methods such as Sky TV and Smart TVs.

8.11 The CCG sought views on health services through a 'Call to Action' questionnaire. HealthWatch Hartlepool gathered views, using the questionnaire from under-represented groups. One of the sections in the questionnaire related to long term conditions and the top three answers in relation to what is most important to you were, services are easy to access, services are available at weekends and there are good public transport links. In relation to how services could be improved, a sample of the comments are listed below:-

- ‘people with long term conditions together with their carers need to be made aware of local support groups’
- Planned follow-up with continuity of care i.e contact with the same doctor
- A better phone service – bring back direct contact with respiratory unit
-

8.12 Members received information from Hartlepool’s Families First in relation to the Health Bus. The Health Bus offers a range of health advice and health checks. The Bus used to offer spirometry tests, however, the Committee was informed that the spirometry equipment was removed for use by the NTHFT community teams and was not returned. Members were informed by the Lead Respiratory Nurse that national best practice is saying that spirometry testing should be carried out by GPs and respiratory nurses. Therefore, it was suggested that the use of the COPD questionnaire was appropriate to use in locations, such as the Health Bus, to direct people to the GP if they were showing signs of COPD.

Challenges for Commissioners and Service Providers

8.13 Members were interested to hear about the challenges that both Commissioners and Service Providers face. The CCG, as Commissioner, highlighted that their challenges are as follows:

(a) Managing the increasing demand for services, with patients with multiple conditions which means increased reliance on care and costs;

(b) Improving the commissioned provision to allow patients to avoid admission;

(c) Ensure that the service review is robust enough to meet the future demands and does not need to be repeated in the near future; and

(d) Integration across health and social care

8.14 The challenges facing the service provider NTHFT, include the volume of patients, although the statistics were high it was better to have identified those patients than not. Another challenge was the low uptake of extremely effective interventions, for example, the pulmonary rehabilitation programme.

8.15 In order to improve service provision further, Members were informed that improvements to the enhanced care team and the single point of access would contribute to an improved service. Along with improving patient self referral into the CRAMs service.

8.16 The Chair of the CCG outlined further changes which will help improve services including closer links in health and social care to ensure that patients can be supported to avoid hospital admission and quickly discharged, when appropriate. Also, effective reduction in the numbers who

smoke, and early diagnosis will mean fewer patients to be treated and managed in the longer term.

8.17 The Chair of the CCG highlighted to the Committee that COPD hardly happens if you do not smoke and it is about encouraging people not to smoke or stop as soon as possible or if people cannot stop then to reduce the amount they smoke.

9. QUALITY OF DIAGNOSIS AND MANAGEMENT / TREATMENT OF COPD ACROSS GP PRACTICES AND NHS SERVICES IN HARTLPEOOL

9.1 Members received a presentation from NTHFT and the CCG at their meeting on 2 May 2014 which explained how quality of diagnosis and management of COPD is measured. Hartlepool has a higher proportion of people diagnosed with COPD but Hartlepool GP practices perform better than others in the CCG area, which is better than the National average. However, work still needs to continue to diagnose people with COPD. The Committee was informed that there was a new programme, which involves a team visiting GP practices to do comprehensive assessments of diagnosis and management of COPD, to see what is happening at a 'grass roots level'. Contracts with providers include quality measures and clinical quality review meetings.

9.2 In primary care there is a standardised criteria for diagnosis of COPD and there is ongoing clinical training, for example lunch and learn sessions.

9.3 Members were informed that NTHFT provide a rolling education programme for primary care staff, which includes COPD courses for practice nurses (there is a demand for this type of training) and COPD study days. There are new guidelines on providing COPD care and NTHFT are looking towards a gold standard management of COPD.

9.4 The review of COPD pathways currently being conducted is expected to result in, improved access; reduction in emergency admissions; and services closer to home with patients being seen in either an acute or community setting.

10. IMPACT OF UNPLANNED EMERGENCY ADMISSIONS ON SERVICE PROVISION

10.1 Members received evidence in relation to the impact of unplanned admissions on service provision. Every exacerbation that a COPD patient has reduces lung function. Representatives from NTHFT informed Members that unplanned admissions have a significant impact on COPD patients and also on NHS services. The rate of admission is 144.9 per 1000 COPD patients. Approximately six patients per week have a length of stay of one day of less, which is a cost of £160,000. The total number of beds days in 2012/2013 was 6517 with the cost of hospital interventions being £298,164 per 1000 COPD patients.

10.2 NTHFT informed Members that NTHFT was improving the enhanced care team. This service aims to reduce hospital admissions and shorten the length of stay. The service will be consultant led and will include a nurse delivered 'hospital at home' for patients with COPD. It will be a fully comprehensive service, including respiratory consultant input for every patient. Rather than a patient coming into hospital, the patient would be visited by a specialist nurse, which would be able to provide packs, antibiotics, nebuliser etc and a follow up would be provided for five days. This will be backed up by rapid access to a GP, if needed.

10.3 Members discussed the use of rescue packs, which are packs that are kept at home with the patient that can help control an exacerbation and help prevent deterioration, which in turn avoids hospital admission. Members queried whether these packs were still available and it was confirmed by the Chair of the CCG that rescue packs were still available, however, the process for distributing them to people seems to have changed. The Committee recognised that these packs really help people with COPD and should be made readily available.

11. RAISING AWARENESS OF COPD AND BENEFITS OF EARLY DETECTION

11.1 The Committee focussed on the benefits of early detection of COPD and also how awareness can be raised of COPD at their meeting on 20 February 2014. Members received evidence from the British Lung Foundation, the Smoking Cessation Service and the Tees Valley Public Health Shared Service.

Evidence from the British Lung Foundation

11.2 The Committee welcomed evidence from Bev Wears, the Service Development Manager at the British Lung Foundation, who provided a very informative presentation outlining awareness of COPD and early detection of COPD.

11.3 Members were informed that respiratory disease is the third commonest cause of death but was not prioritised for treatment services. Members were astounded that mortality rates in the UK were twice the European average and lung cancer survival rates were also significantly lower than those in the USA.

11.4 The British Lung Foundation is the only UK charity for all lung conditions and the charity support people affected by lung disease, so that no one has to face it alone. The charity also promotes greater understanding of lung disease and the charity campaign for change in the nations' lung health. In addition to this the charity also funds vital research so that new treatments and cures can help save lives.

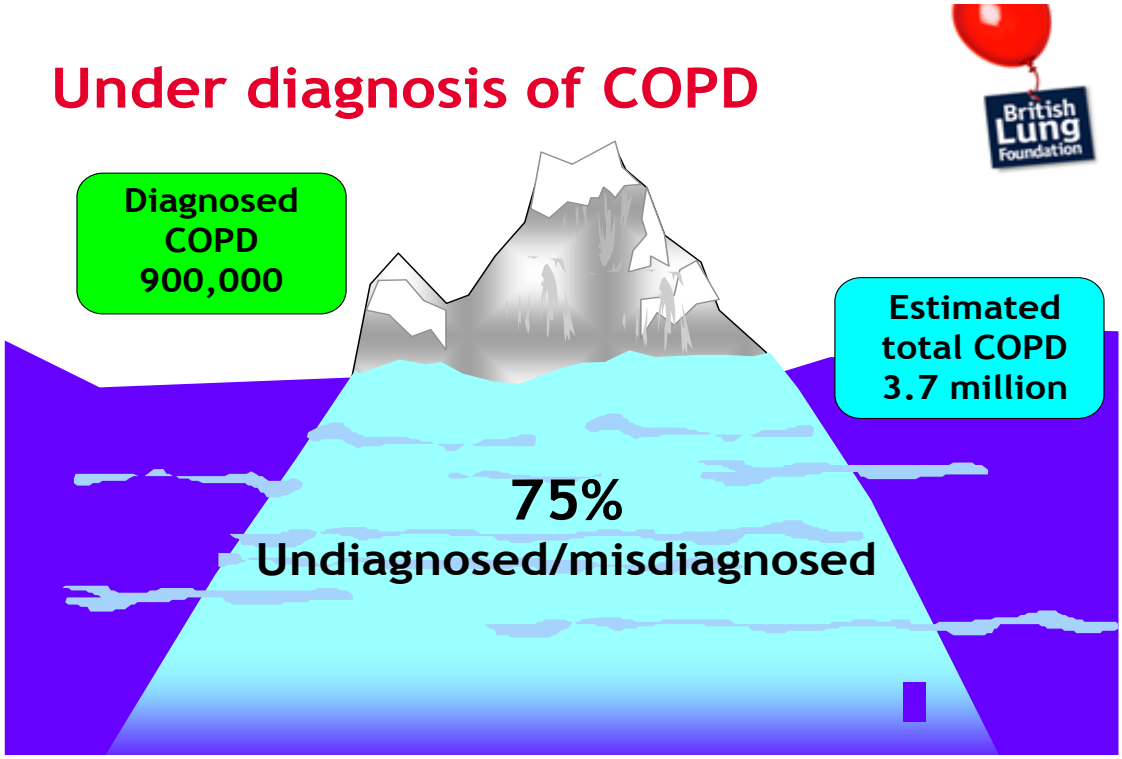
11.5 The Foundation in their Invisible Lives report mapped areas most at risk of future COPD hospital admission and found COPD hotspot areas across UK and the Foundation predict these communities are most likely to contain the 'missing millions'. The following identifies the top ten areas within the North East who have the highest proportion of people at risk of COPD:-

NORTH EAST - Top ten PCTs with highest proportion of people at risk of COPD

• South Tyneside	62% higher than UK average
• Gateshead	54%
• Sunderland Teaching	51%
• **Hartlepool**	**42%**
• County Durham	37%
• Middlesbrough	35%
• Newcastle	34%
• Redcar and Cleveland	28%
• North Tyneside	28%
• Darlington	11%

www.blf.org.uk

11.6 It was reiterated to the Committee that the number of people under diagnosed with COPD was extremely high and an area for concern. The diagram below illustrates the 'missing millions'.



11.7 In Hartlepool the estimated prevalence of COPD is 3.41 (% attributed populated) and the England average is 2.93%. The recorded prevalence in Hartlepool is 2.42 (% GP practice lists) against an England average of 1.69. The prevalence of undiagnosed COPD is 28.5 (% estimated with COPD).

11.8 The Committee was informed of a recent targeted awareness campaign at North Tyneside. The British Lung Foundation, CCG and North Tyneside Council worked together to deliver the awareness campaign. The campaign involved outbound calling to 5,000 'at risk' households, 6 public awareness events were held and promotion was carried out.

11.9 The Committee questioned if a targeted campaign had been undertaken in Hartlepool and they were informed that one had not happened in Hartlepool. However, the British Lung Foundation indicated they would be happy to run such a campaign subject to funding. It was highlighted that there was a systemic approach to screening for people over 35 who were or had been smokers. However, Members did raise concerns at the levels of screening undertaken by different GP surgeries as not all appeared to be proactive on COPD.

11.10 On 13 February 2014, results of a 20 year study led by researchers at Plymouth University Peninsula Schools of Medicine and Dentistry were published and found that:-

- doctors are missing chances to diagnose COPD earlier in up to 85% of cases

- 5 years before diagnosis, 85% of patients had visited their GP or hospital at least once with lower respiratory symptoms
- Opportunities were missed in 58% in 6-10 years before diagnosis and 42% in 11-15 years before diagnosis

11.11 The Committee questioned whether there is any good practice around the region that could be utilised in Hartlepool to try and help diagnose people with COPD. Overall, there is a large amount of good work being promoted around the region and within the community. However, there was variation in the work, with some excellent examples and some requiring improvement.

11.12 In relation to the resourcing services, the British Lung Foundation representative indicated that there was no uniform service delivery, therefore some areas were better resourced than others. Members thought that working with GP surgeries did limit the target group to those who visited the GP, however, wider campaigns had been carried out in the community, for example at supermarkets.

11.13 One of the key messages is around earlier diagnosis and lifestyle changes in order to increase early diagnosis of COPD. These lifestyle changes include stopping smoking and regular exercise. Other factors that need to be considered post diagnosis include good quality information at the time of diagnosis, self management options, which include written plans; educational programmes to reduce hospital admissions, improve quality of life, improve exercise endurance and reduce depression. Also, post rehabilitation long term exercise with a trained instructor prolongs functional and emotional benefits. Of benefit are also integrated patient support groups, for example Breathe Easy Groups.

11.14 The Committee was informed about how to help manage COPD and the British Lung Foundation has developed pathways of good practice based on Nice Quality Standards. There is also a range of information produced which includes British Lung Foundation free publications, helpline and online web community, penpals and Breathe Easy Groups, living well with COPD DVD, exercise handbook and information packs available at diagnosis.

11.15 Self management plans are available which include a range of information to help manage the condition and help and contacts. A patient record book is available which contains information that will be very useful to those who treat patients.

Evidence from the Smoking Cessation Service

11.16 Representatives from the Stockton and Hartlepool Stop Smoking Service attended the meeting of the Audit and Governance Committee on 20 February 2014 to provide information on active case finding of lung ill health.

11.17 The Committee was informed that the Stop Smoking Service aimed to help people stop smoking and not only did they identify people through the GP

practices but also did so within the wider community, who may not realise they were showing symptoms of COPD.

11.18 The service informed Members that they had developed a Lung Health Questionnaire with five basic questions that could lead to an individual being referred to their GP for a spirometry test. The roll out of this questionnaire to local pharmacies was also being explored. Members thought that the use of the questionnaire was very beneficial as it was a means of directing people with potential symptoms of COPD into their GP practice for screening. The Committee agreed that this questionnaire should be promoted and distributed in as many places as possible. It was noted by Members that the British Lung Foundation used a similar set of questions in its publicity and it was suggested that a consistent approach may help spread the message.

11.19 Members were supportive of advertising campaigns but were concerned that the messages are being delivered but are not having an effect, as some people with COPD are still smoking. It was suggested that educational campaigns in schools may help distribute the message.

11.20 Members highlighted that one of the areas that needed to be addressed was young people who smoked. Advertising campaigns, such as 'every breath you take' and 'stobtober' have played a major role in highlighting the dangers of smoking and helping people understand how early diagnosis of COPD can make a significant difference. One of strong messages that featured in the 'stoptober' campaign was the amount of money people could save if they quit smoking, for some people this could equate to £250 per month. The Committee was of the view that as well as highlighting the chronic debilitating effects of smoking, maybe by highlighting the financial saving this would have the most effect.

11.21 The Stop Smoking Service concluded that it is about balancing prevention and treatment approaches, detecting COPD early, using the stop smoking service as a gateway and reducing NHS costs and improving quality of life.

<u>Evidence from the Tees Valley Public Health Shared Service</u>

11.22 Dr Ononeze, Public Health Registrar attended the Audit and Governance Committee on 20 February 2014 to provide details on the Tees COPD Screening programme. There is a Tees COPD Screening Programme called 'the missing thousands', which is about systematic early identification of patients with undiagnosed long term conditions, which is key to improving health and reducing health inequalities. It is important to reduce variations in the management of patients with long term conditions and also important in reducing emergency hospital admissions. All Hartlepool GP practices have signed up to the campaign, which started in January 2013. The funding for this programme is non-re-occuring. It is important to find people who have COPD because it is key to improving health, reducing health inequalities and reducing hospital admissions

11.23 The Committee was interested to know the numbers of people screened and diagnosed, the diagram below illustrates.

Number screened and subsequently diagnosed with COPD: Jan - Dec 2013

TEES VALLEY PUBLIC HEALTH SHARED SERVICE

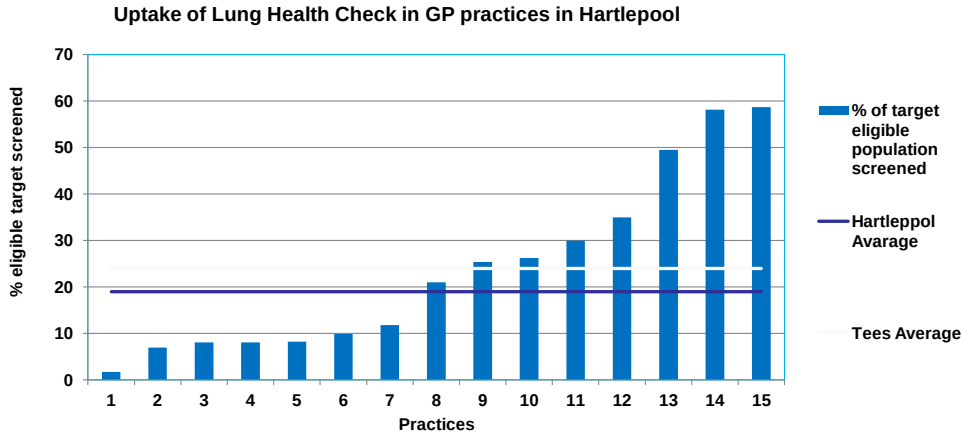
	Annual target of eligible population	Eligible number screened	Eligible number screened from Quintile 1 area (most deprived)	Number diagnosed following screening	Number diagnosed following screening from Quintile 1 (most deprived)
Hartlepool	2,140	410 (19%)	296 (72%)	89 (22%)	65 (21%)
Middlesbrough	3,336	774 (23%)	602 (78%)	147 (19%)	73 (12%)
Redcar & Cleveland	2,768	526 (19%)	385 (73%)	61 (12%)	37 (10%)
Stockton-on-Tees	3,710	1189 (32%)	731 (61%)	96 (8%)	80 (14%)
Tees Total	11,954	2,899 (24%)	2,014 (70%)	393 (14%)	255 (13%)

Darlington Borough Council · Stockton-on-Tees Borough Council · Middlesbrough moving forward · Hartlepool Borough Council · Redcar & Cleveland Borough Council

11.24 Members raised concerns about the variations of people diagnosed with COPD across the GP practices in Hartlepool and questioned why screening should differ significantly from one surgery to the next. Although, some areas will have higher levels of COPD, (as around 13% of those diagnosed from the current screening programme were from deprived communities) some GP practices may be more proactive in determining the illness than others. Members were of the opinion that it would be valuable for the community to know the number of screenings taking place at the various GP surgeries in Hartlepool. This would then assist people in comparing their surgery to others to determine whether to move to another surgery that was more proactive in determining illness. Dr Ononeze commented that those figures may be published in the future. The below diagram illustrates the uptake of Lung Health Checks in GP practices in Hartlepool

TEES VALLEY PUBLIC HEALTH SHARED SERVICE

Percentage of eligible target population screened by GP practices: Jan - Dec 2013



DARLINGTON BOROUGH COUNCIL · Stockton-on-Tees BOROUGH COUNCIL · Middlesbrough moving forward · HARTLEPOOL BOROUGH COUNCIL · REDCAR & CLEVELAND BOROUGH COUNCIL

11.25 The Committee considered the cost of emergency admissions for those people with no previous COPD diagnosis and were provided with the below information:

Case for screening (2): emergency COPD admissions* in those with no previous COPD diagnosis

	2010/11		2011/12	
Activity	**Hartlepool**	**Stockton**	**Hartlepool**	**Stockton**
Total number of patients admitted as emergency for COPD	467	717	443	689
No. of patients with no previous COPD	158	243	114	212
% of patients with no previous COPD	33.8%	33.9%	25.7%	30.8%
Cost of patient's admissions with no previous COPD	£ 309,144	£ 464,984	£ 239,976	£ 386,355

•Data relate to all Finished Consultant Episodes where the primary or secondary diagnosis was coded with a COPD ICD10 code (J40-J449). Excludes TEWV patients (provider = RX3) and MRCCS patients, NHS Tees Information Services, 2012

11.26 Dr Ononeze concluded her presentation by informing the Committee of the future plans, which are to embed the programme in general practices, undertake public health campaigns to raise awareness of lung health checks and explore how to implement lung health checks in appropriate community venues in order to improve availability and increase access.

12. VIEWS OF COPD PATIENTS AND THEIR FAMILIES AND CARERS AND GROUPS / BODIES WHO PROVIDE SERVICES FOR PEOPLE DIAGNOSED WITH COPD

12.1 The Committee recognises that COPD can affect daily life in many ways and by keeping healthy, being as active as possible, learning breathing techniques, and taking medication as prescribed can help to reduce the symptoms of COPD. The Committee held a focus group for COPD patients and their families and carers on 10 December 2013 to explore patient pathways and experiences.

12.2 The following summarises the key issues that were raised during the focus group session:-

1) The majority of people who attended the focus group were aware of COPD as they had the condition or they were aware of someone who had the condition. One woman had symptoms and had attended to find out more about the condition;

2) Change in access to services has resulted in patients / families finding it difficult to contact respiratory nurses. Access to respiratory nurses

used to be direct, for example patients could contact a respiratory nurse by calling him/her direct, and now access is via the 'single point of contact' number, who then passes on the message to the nurses. However, with COPD, it is more often than not, that an immediate response is required;

3) The system appears to be broken, the system has been changed and now it appears not to work and there was frustration and anger expressed;

4) It appears that the change in the system has resulted in a loss of expertise as people have been grouped together and now people cannot access the experts;

5) Patients are advised by the GP how best to manage their condition and if part of that management is direct access to a respiratory nurse then this should be available;

6) People who attended the focus group were finding it difficult to get appointments with their GP and often appointments were only available late afternoon or patients were having to wait for the GP to call them, which is hours later. Also, people would like appointments with their family doctor. Often people see locums who do not know them or their condition which means time is wasted on explanations, which affects the continuity of care.

7) Seems to be a great variation of how health professionals diagnose people who have COPD. People have been diagnosed with a different condition at first and then years later diagnosed with COPD. There needs to be a consistent approach to diagnosis. COPD needs clinical evaluation as there are a spectrum of conditions that fall within the term COPD;

8) People were of the view that there is a lack of information on COPD and said those people that are newly diagnosed would struggle to find information as information is not available;

9) The cost of emergency admissions needs to be compared with the cost of providing additional respiratory nurses. The changes to the services may have been as a result of cost saving, however, saving money in one place will more than likely result in additional cost in another, for example, an increase in emergency admissions;

10) People have produced their own exercises to manage their conditions, which includes cardboard breathing tubes;

11) GP practices should do two things:- 1) provide timely and appropriate access to care and 2) provide continuity of care. People with COPD are flagged on GP systems and care is tailored to the patient; and

12) GPs refer to the Community Respiratory Assessment and Management Service (CRAMS). All people at the focus group thought that the CRAMS service was an excellent service, which needs to be increased as it is under resourced.

12.3 A person who could not attend the Focus Group spoke to the Scrutiny Support Officer and said that she received a good service from her own GP and did not have trouble accessing nurses.

13. CONCLUSIONS

13.1 The Audit and Governance Committee concluded that:-

(a) Early diagnosis leads to improved outcomes and improved health and wellbeing:

(b) That stopping smoking is the most effective way to reduce the risk of COPD and targeting young people could help to reduce the numbers of young people smoking;

(c) Exercise programmes, such as pulmonary rehabilitation are an extremely effective intervention and need to be widely prompted to encourage people to attend;

(d) Work needs to continue to try and diagnosis the 'missing thousands'. The Committee was supportive of the 'missing thousands campaign';

(e) The service provision that is provided to COPD patients and their families is very good, however, patients are finding it difficult to access services and it is hoped that the review of the COPD pathways, including a review of the single point of access, will result in better direct access to services and to GP appointments;

(f) That COPD rescue packs are very beneficial to COPD patients and should be widely available to people with COPD;

(g) Overall, there is a large amount of good work being promoted around COPD, however, there is variation in the work, with some excellent examples and some requiring improvement;

(h) The level of screening undertaken by different GP surgeries varies and it appears that not all surgeries are proactive on COPD screening;

(i) There are a variety of questionnaires used to direct people who may have COPD to their GP for screening. The Committee agreed that the questionnaires were very beneficial but would be helpful if a consistent approach across organisations could be developed, with the use of a single questionnaire.

14. RECOMMENDATIONS

14.1 The Audit and Governance Committee has taken evidence from a wide variety of sources to assist in the formulation of a balanced range of recommendations. The Forum's key recommendations to the Health and Wellbeing Board are as outlined below:-

(a) That the Health and Wellbeing Board develop a strategic approach to COPD to ensure that inequality is not worsened by:-

(j) monitoring the review of the single point of access to establish whether the changes have had a positive impact on COPD patients and their families

(ii) ensuring that any changes to service provision are appropriately evaluated to provide assurance that these changes are effective from an evidence and cost perspective

(b) That the Health and Wellbeing Board explores ways to promote COPD support programmes, such as the pulmonary rehabilitation programme, to encourage people to attend;

(c) That the Health and Wellbeing Board, through an integrated and co-ordinated approach, work in partnership with relevant organisations and groups to promote a consistent message on COPD through the use of a single questionnaire;

(d) That the Health and Wellbeing Board raises community awareness of COPD by placing the COPD questionnaire in community and health venues across Hartlepool to find those people with undiagnosed COPD;

(e) That the Health and Wellbeing Board explores the development of a targeted COPD awareness campaign for young people to raise awareness of the long term implications of smoking;

(f) That the Health and Wellbeing Board explores whether the number of COPD screenings taking place at various GP surgeries across Hartlepool can be publicised, as it would be valuable for the community to be aware of the variations in practices in order to aid patient choice and help to alleviate variations across GP surgeries.

COUNCILLOR KEITH FISHER
CHAIR OF THE AUDIT AND GOVERNANCE COMMITTEE

ACKNOWLEDGEMENTS

The Forum is grateful to all those who have presented evidence during the course of our investigation. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:-

Hartlepool Borough Council:

Councillor Carl Richardson – Chair of the Health and Wellbeing Board

Louise Wallace – Director of Public Health

Andy Graham – Public Health Registrar

Lorraine Harrison – GP Referral Co-ordinator

External Representatives:

Hartlepool residents

Healthwatch Hartlepool

Hartlepool's Breathe Easy Group

Bev Wears – Service Development Manager, British Lung Foundation

Pat Marshall – Stop Smoking Service Manager, Stockton and Hartlepool Stop Smoking Service

Dr Victoria Ononeze – Public Health Specialist, Tees Valley Public Health Shared Service

Dr Monaghan - Consultant, NTHFT

Dr Elmer - NTHFT

Sandra Stych – Nurse Co-ordinator Lung Health, NTHFT

Dorothy Wood – Lead Respiratory Nurse, NTHFT

Sally Thompson, Assistant Director for Anaesthetics and Emergency Care, NTHFT

Dr Posmyk – Chair, Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Deborah Ward - Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Paul Thompson – Hartlepool Families First

Evidence provided to the Committee

The following evidence was presented to the Audit and Governance Committee throughout the course of the investigation into COPD:-

Date of Meeting	**Evidence Received**
22 August 2013	Scoping Report – *Scrutiny Support Officer*
3 October 2013	Setting the Scene Presentation – *Speciality Registrar in Public Health.*
10 December 2013	Focus Group with COPD patients
20 February 2014	Presentation and verbal evidence from:- - Smoking Cessation Service - Tees Valley Public Health Shared Service - British Lung Foundation
2 May 2014	Presentation and verbal evidence from:- - North Tees and Hartlepool NHS Foundation Trust - Hartlepool and Stockton on Tees Clinical Commissioning Group - Hartlepool Families First Feedback from the COPD Exercise Group

HEALTH AND WELLBEING BOARD

Wednesday 10th September 2014

Report of: Director of Public Health

Subject: MAKING SMOKING HISTORY 5% BY 2025 REGIONAL VISION

1. PURPOSE OF REPORT

1.1 The purpose of the presentation is to seek support for the "Making Smoking History in the North East Partnership" vision to reduce tobacco related harm and ultimately to reduce tobacco smoking to a suggested regional level of below 5% prevalence by 2025.

2. BACKGROUND

2.1 The Making Smoking History in the North East Partnership exists to work collectively towards the long term aim of making tobacco smoking a thing of the past. This will be achieved through shifting the social norms of tobacco use to make it less accessible, less affordable and less attractive and centre action around:

- Motivating and supporting smokers to stop
- Reducing uptake of smoking
- Protecting individuals and communities from tobacco related harm

2.2 The membership of this Partnership is wide ranging with representation from local authorities (Chief Executive, Leader (chairperson), elected member Health Portfolio holders, Director of Public Health), NHS England, Public Health England, CCGs, Association of North East Councils, FUSE, Fresh, Mental Health Trust, Smokefree North East Network, North East Trading Standards Association, North East Environmental Health Officers Group, Action on Smoking or Health, MPs.

2.3 The Partnership acknowledges that whilst the North East has made significant progress in recent years to reduce adult smoking prevalence from 29% in 2005 to 21% in 2011, that smoking remains the key contributor to premature death and disease causing over 5000 deaths annually in the North East.

2.4 The current National Tobacco Plan for England ends in 2015 and the Partnership is advocating for a new long term national cross government plan

to be developed for implementation after the 2015 general election. The Partnership is also involved in discussions with Action on Smoking or Health (ASH) around their development of a new ten year tobacco strategy for publication in June 2015 and is keen that the North East supports this development and feeds in ideas from across all partners. An event on this will be taking place in Leeds on 20th October to which Hartlepool representatives will be invited.

2.5 The Partnership vision has been presented during June and July 2014 to the regional Elected Mayors and Leaders Group, Health and Wellbeing Chairs Group and also the Association of Directors of Adult and Social Care Services and Association of Directors of Children's Services and been positively received. At the Elected Mayors/Leaders meeting on 11th July, members were supportive of seeking local sign up via the local Health and Wellbeing Boards to the regional vision. FRESH was asked to encourage Boards sign up as soon as possible so that a collective regional position could be taken and used in influencing political manifesto discussions and future planning.

3. PRESENTATION

3.1 The presentation will cover the rationale behind the vision, some key international and national developments around this topic, and feedback from the Partnership's workshop on 5th September 2014 around 'lean thinking' for 5% by 2025.

4. RECOMMENDATIONS

4.1 Members are asked to support the "Making Smoking History in the North East Partnership" vision to reduce tobacco related harm and ultimately to reduce tobacco smoking to a suggested regional level of below 5% prevalence by 2025.

5. REASONS FOR RECOMMENDATION5

5.1 Smoking is a significant public health issue and a key priority as identified in the Director of Public Health Annual Report 2013/14.

6. BACKGROUND PAPERS

6.1 None

7. CONTACT OFFICER

7.1 Louise Wallace
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(01429 266522)

HEALTH AND WELLBEING BOARD

10 September 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 This report provides the Health and Wellbeing Board with an overview of the new information requirements for the Better Care Fund (BCF) and changes to the assurance process and timeline. The paper also includes the updated Hartlepool BCF plan for approval.

2. BACKGROUND

2.1 Following the Health & Wellbeing Board approving the original Hartlepool Plan in March 2014, a number of changes have been made nationally to the Better Care Fund.

2.2 The Department of Health and Department for Communities and Local Government sent two letters to all Health and Wellbeing Board Chairs on 11 July 2014 outlining proposed changes to the BCF assurance and planning processes, including changes in relation to the performance and finance metrics.

2.3 The key points relating to pay for performance and risk sharing are as follows:

- Up to £1 billion of the Better Care Fund allocated to local areas is to be spent on out-of-hospital services according to the level of reduction in emergency admissions they achieve.
- Health and Wellbeing Boards will propose their own performance pot based on their level of ambition for reducing emergency admissions (with a guideline reduction in emergency admissions of at least 3.5%) and will be allocated a portion of the £1 billion performance money in the fund in accordance with the level of performance against this ambition.
- Where local areas do not achieve their target reduction in emergency admissions the money not released will be available to CCGs, principally to pay for the unbudgeted acute activity

- The remaining money from the performance pot not earned through reducing emergency admissions will be available upfront to be invested in out of hospital NHS commissioned services.
- Reduction in unplanned admissions will now be the sole indicator underpinning the pay for performance element of the BCF. The other existing performance metrics will not be linked to payments but must still be included within plans.

2.4 The Department of Health and Local Government Association issued a further letter to Health and Wellbeing Board Chairs on 25 July 2014, which set out the assurance requirements and timeline for redrafting local BCF plans by 19 September and included the revised planning and technical guidance and planning templates.

3. IMPACT OF THE CHANGES

3.1 Revised Assurance Process and Timeline

NHS England Local Area Teams (ATs) and Local Government regional leads are working with local areas to strengthen their BCF plans prior to submission on 19 September 2014 and providing regular progress updates to the national BCF Task Force (based on the following assurance checkpoints):

- NHS England (AT) BCF Checkpoint 1 – 7 August
- NHS England (AT) BCF Checkpoint 2 – 26 August
- Hartlepool Health & Wellbeing Board – 10 September
- NHS England (AT) BCF Checkpoint 3 – 11 September
- NHS England (AT) BCF Submission – 19 September

Once the BCF plans have been submitted, there will be an intensive two week desktop review of plans, focused on:

1. Overall review of narrative of plan
2. Analytical review of data, trends and targets
3. Financial review of calculations and financial projections

The feedback from Area Team and Local Government regional peers, and the outcome of the desktop review, will form the basis of the assurance process before plans are recommended for approval by Ministers.

3.2 Revised Planning and Technical Guidance

The revised BCF planning guidance and technical guidance documents set out what has changed in more detail. In summary, the previous £1bn Payment for Performance framework has been revised so that the proportion of the £1bn that is now linked to performance is dependent solely on level of ambition, and achievement of that ambition, in relation to reducing emergency hospital admissions. The national planning assumption is that this will be in the region of a 3.5% reduction against the baseline detailed in the technical guidance. If this is achieved, it would equate to a national payment for performance pool of £300m with the remaining £700m available in 2015/16 to be invested in NHS commissioned out-of-hospital services.

Health and Wellbeing Boards are required to propose and sign off their own performance pot based on their level of ambition for reducing emergency admissions.

The BCF project team has reviewed the revised planning and technical guidance and have benchmarked the BCF plan that was signed off by the Health and Wellbeing Board in April 2014 against what a 'good' plan should look like. The table in **Appendix 1** summarises the key changes in the BCF Part 1 and Part 2 planning templates.

3.3 Revised BCF Planning Templates

The planning templates have been revised to provide added emphasis on:

- A clearer articulation of the analysis and evidence that underpins the BCF plans.
- A clearer articulation of the delivery chain that will underpin the shift of activity away from acute activity.
- A tighter description of the schemes underpinning the plan schemes and the underlying success factors.
- A much clearer focus on the risks, the risk sharing arrangements and the contingency plan in case the target reduction in admissions are not met.
- A clearer articulation of the alignment between the BCF and other plans and initiatives within a locality across NHS and social care.
- Ensuring that the potential impact of proposed schemes on providers are understood, and providers are fully engaged.

Further detail is also required regarding the protection of social care services, with the following information required:

- The total amount from the BCF that has been allocated for the protection of social care services.
- The total level of resource that will be dedicated to carer-specific support, and the nature of that support.
- Confirmation that at least the local proportion of the £135m has been identified from the NHS £1.9bn funding for implementation of new Care Act duties on councils (including new entitlements for carers, national minimum eligibility threshold, advocacy, safeguarding and other measures in the Care Act).
- The financial impact on local authority's budgets resulting from changes to the BCF policy since April 2014.

3.9 The final BCF plan templates are attached as **Appendix 2** and **Appendix 3**.

4. FINANCIAL CONSIDERATIONS

4.1 The revised guidance sets out that a proportion of the BCF funding is to be held back by the CCG and linked to a reduction in total emergency admissions. The expected minimum target reduction in total emergency admissions is 3.5% for all Health and Wellbeing Board areas. If the locally set target is achieved then all of the funding linked to performance will be

released to spend on BCF plans. If the target is not achieved, then the CCG will retain the proportion of the money relating to non achievement of the agreed target, with any such funding to be spent by the CCG, in consultation with the Health and Wellbeing Board.

4.2 Based on the activity trajectories included in the CCG's 2 year operational plan which have been included in Part 2 of the BCF plan, this creates a performance pot of £505,745 which is calculated from the projected reduction in activity of 339 emergency admissions (3.5% reduction). The money will be released from the CCG into the pooled budget on a quarterly basis, depending on performance.

4.3 To manage the process of the funds being held back, the implementation of the BCF plan will have to be phased to ensure that the funds will be available. Hartlepool Borough Council and NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group have agreed that the proposed BCF developments will be evaluated throughout the year to identify added value and contribution to the delivery of the performance metrics, which may inform disinvestment and reinvestment decisions if appropriate. The CCG already has set contingencies within their financial plans which may be required should schemes not achieve agreed outcomes.

5. RISK IMPLICATIONS

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

5.2 An initial risk assessment has been undertaken as part of the BCF plan which is included in **Appendix 2**. 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.

5.3 The agreed BCF governance arrangements describe how risks will be managed throughout implementation. The BCF Plan also identifies proposed contingency arrangements in the event that the expected reductions in emergency admissions are not achieved.

6. COMMUNICATION & ENGAGEMENT

6.1 The 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 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.

7. RECOMMENDATIONS

7.1 It is recommended that the Health and Wellbeing Board:

- Notes the changes resulting from the revised BCF guidance, including the revised assurance process and timeline;
- Reviews and approves the updated BCF planning templates, in order for them to be submitted to the NHS Local Area Team and National BCF Task Force by 19 September 2014;
- Agrees the performance pot based on the Board's level of ambition for reducing emergency admissions;
- Agrees a process for ensuring that, if required, the BCF plans can be updated following this meeting to ensure that a final version can be submitted on 19 September. It is recommended that the Health & Wellbeing Board gives delegated authority to the Director of Child and Adult Services and Chief Officer, NHS Hartlepool & Stockton-on-Tees CCG (in consultation with the Health and Wellbeing Board Chair) to make any necessary changes, to the attached BCF planning templates, that are required prior to submission.

8. REASONS FOR RECOMMENDATIONS

8.1 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.

8.2 Final plans are required to be approved by the Health & Wellbeing Board for submission by 19 September 2014.

9. CONTACT OFFICERS

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gill.alexander@hartlepool.gov.uk

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Chief Officer
NHS Hartlepool and Stockton-on-Tees CCG
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Summary of the key changes in the revised planning templates resulting from the revised planning and technical guidance

Revised BCF Template Part 1

Section	Changes required
1. Summary of Plan	No significant changes
2. Vision for health and social care services	Additional information required in relation to scheme detail
3. Case for change	i. More detail of plan data using risk stratification to identify population to benefit from BCF plans. ii. Bespoke narrative to the local area required.
4. Plan of action	Further detail required on key milestones and interdependencies
4d. Planned BCF Schemes (Annex 1 within technical guidance)	New detailed template for each scheme required
5a. Risk log	New risks to be highlighted in view of funding of BCF and performance pay.
5b. Financial risk sharing and contingency	Financial Leads to review previous risk sharing and contingency arrangements in light of BCF funding changes
6. Alignment a. with other initiatives related to care and support underway in local area b. with existing 2 year and 5 year strategic plans, as well and local government planning documents c. plans for co-commissioning	Plan update on CCG plans for co-commissioning to be included in plans.
7a. Protecting social care services	Review of existing narrative required. i. Needs additional narrative to confirm that local proportion of the £135m for the implementation of the new Care Act is identified from the additional £1.9bn funding from the NHS. ii. Further information required on new duties resulting from care and support reform set out in the Care Act are met. iii. Further narrative required as to the extent the LA's budget affected against what was originally forecast with the

	original BCF plan.
7b. 7 day services to support discharge	Review – likely to be no change
7c. Data sharing	To be revised in light of Integrated Digital Care Fund application.
7d. Joint Assessment	i. Review against guidance ii. Additional narrative required to describe the joint process in place to assess risk, plan care and allocate a lead. iii. Additional narrative required in relation to individuals at high risk who already have a joint care plan in place
8. Engagement a. Patient, service user and public engagement b. Service provider engagement	Additional narrative required of future plans for engagement Need additional narrative to evidence provider engagement including; FT (Annex 2 of the guidance) Primary Care VCS

Revised BCF Template Part 2

Key Changes required
• Further detail of project plans including a detailed breakdown of the proposed budget showing where in the system the funding will be spent (e.g. social care, acute, community care, mental health)
• Updated risk log including impact of pay for performance where local areas do not achieve their target reduction in emergency Alignment with CCG plans for primary co-commissioning
• Identification of the expected financial benefits broken down by proposed Better Care Fund initiative, including details of the change in performance metrics which drives the benefit, which organisation the benefit will fall to, how the benefit has been calculated and how it will be tracked
• More detailed trajectories for the performance indicators – including an annual trajectory of planned changes in permanent admissions to residential care and effectiveness of reablement
• No national patient/service user metric agreed to be developed locally or use of existing
• Requirement for Health and Well Being Boards to propose and sign off their own performance pot based on their level of ambition for reducing emergency admissions which will be allocated a portion of the £1 billion performance money in the fund in accordance with the level of performance against this ambition.
• Future projections for the ongoing impact and investment required to maintain or implement BCF changes beyond 2015/16

Updated July 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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:	**10/09/14**
Date submitted:	**19/09/14**
Minimum required value of BCF pooled budget: 2014/15	**£418,000**
2015/16	**£7,476,000**
Total agreed value of pooled budget: 2014/15	**£503,000**
2015/16	**£7,476,000**

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 Christopher Akers-Belcher
Date	

c) 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 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	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 and priorities to deliver improvements over 3-5 years.
Moving Forward Together	Hartlepool's vision for adult social care 2011 – 2014.
2012/13 Local Account	Summary of the priorities, progress and future direction of adult social care in Hartlepool.
CCG Clear and Credible Plan	Description of the main health issues and how the CCG will tackle these http://www.hartlepoolandstocktonccg.nhs.uk/publications/
CCG 5 Year Strategic Plan	http://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2013/11/HAST-5-Yr-Plan-on-a-Page-FINAL.pptx
CCG 2 Year Operational Plan	http://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2013/11/HAST-2-Yr-Plan-on-a-Page.pptx

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

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 are working together to improve the local health and social care system.

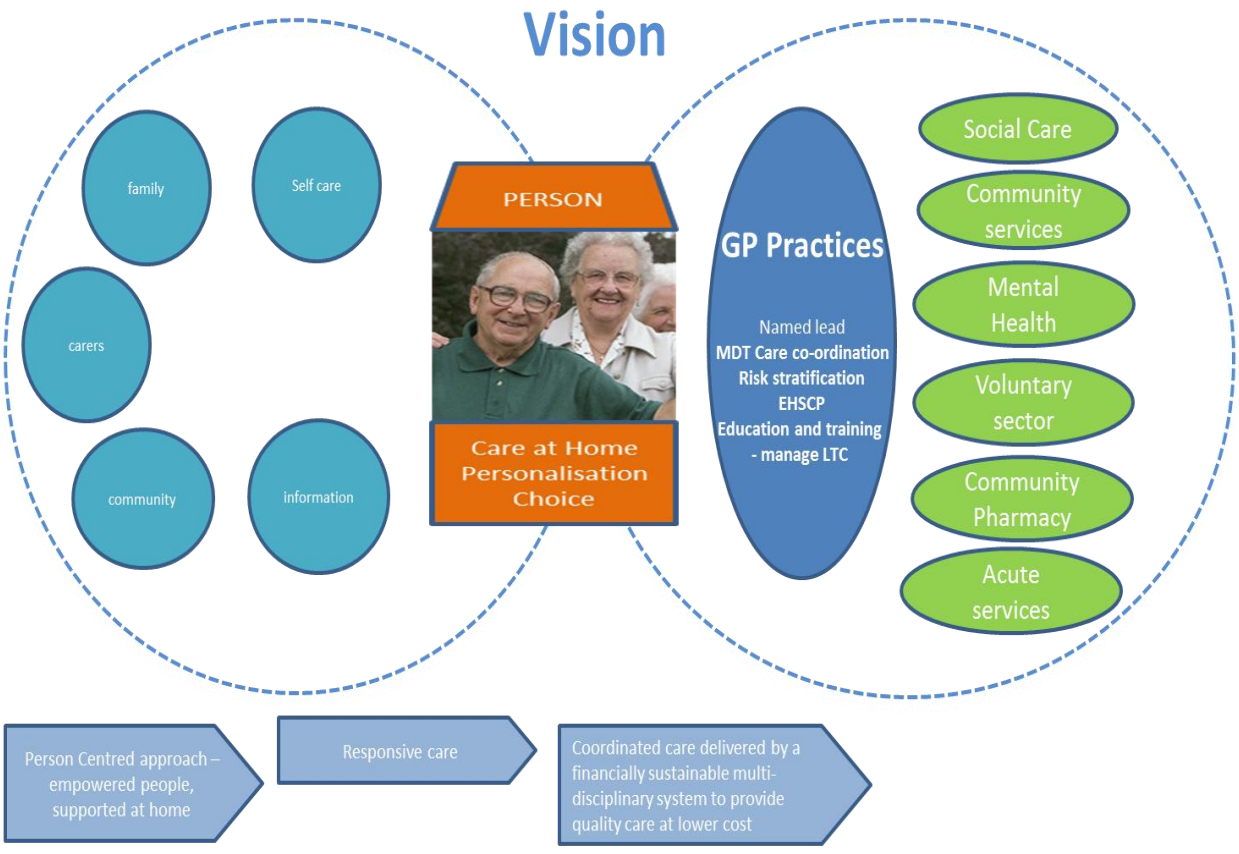
There is already a strong focus on partnership working within Hartlepool. The Momentum: Pathways to Healthcare programme has been the blueprint for the last 5 years and is the means by which the Trust and local health community partners will reconfigure services to deliver safe, high quality, efficient 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) What difference will this make to patient and service user outcomes?

The aims and objectives of our integrated system are:

- To ensure that the population of Hartlepool 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, 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. 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 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.

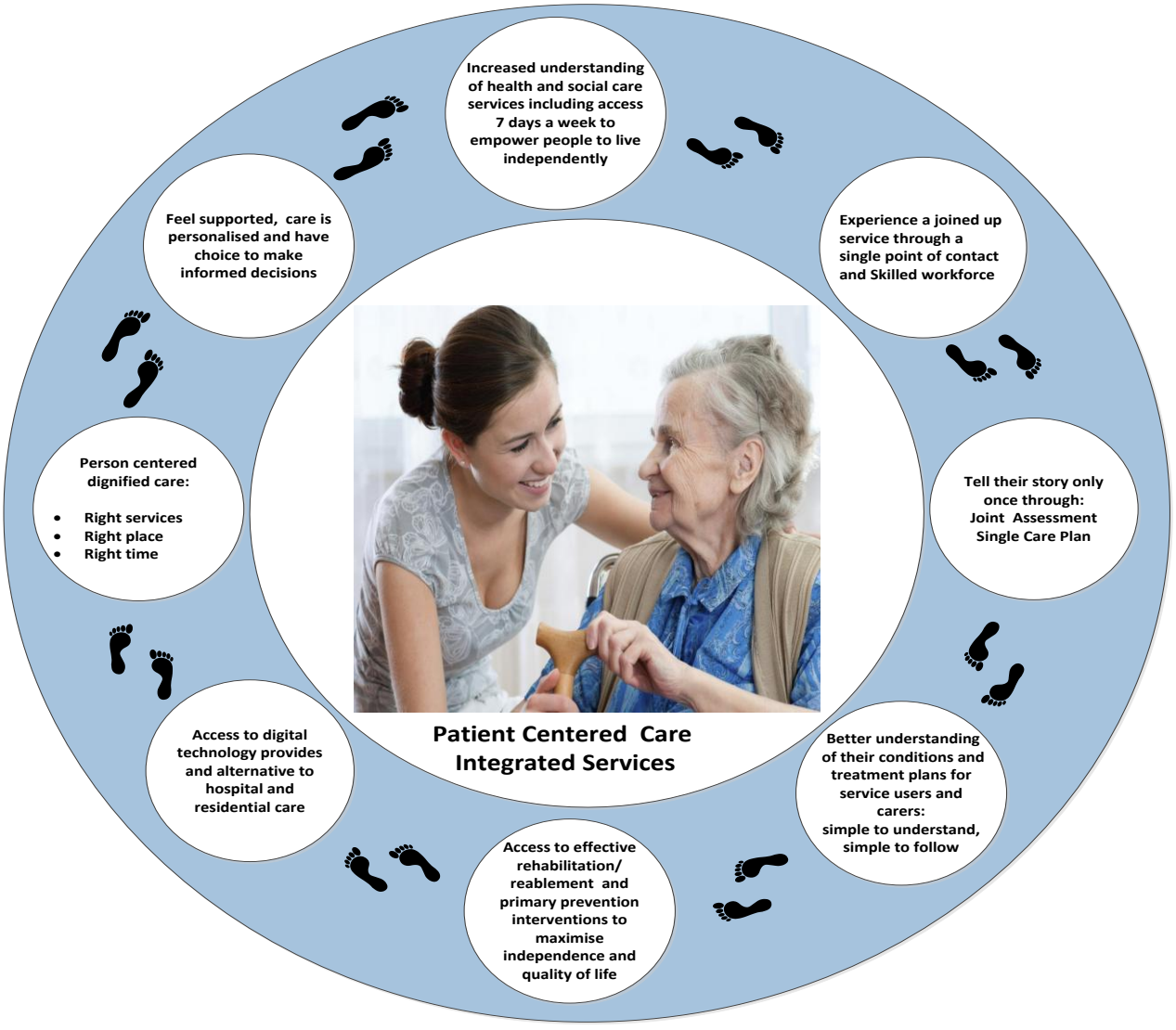
- To support personalisation and choice by being able to develop a range of coordinated alternatives to hospital and residential care, this will be delivered through investment in personalised health and care budgets ensuring individuals are able to make informed decisions.

- To ensure that digital technology is utilised innovatively to deliver the greatest possible benefit to people using services and carers across health and social care

services.

- 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.

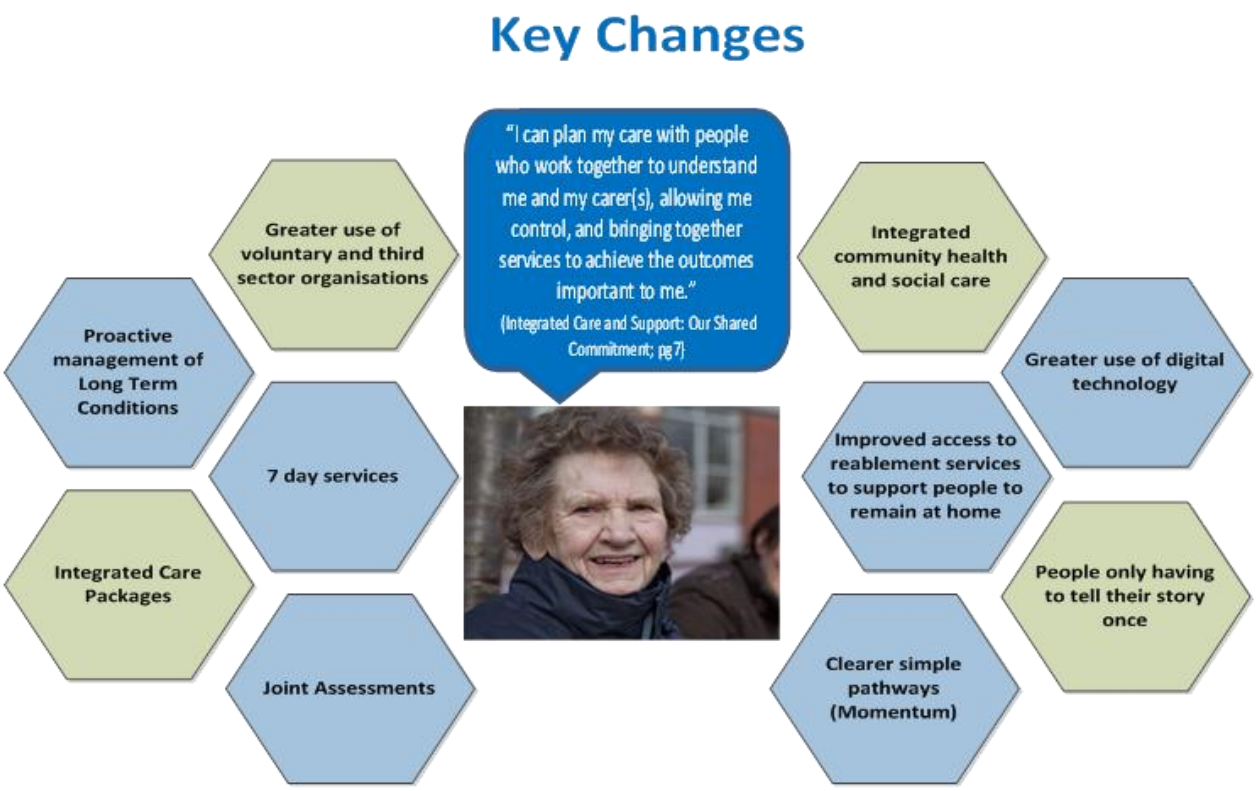
People will experience an integrated service that is flexible and responsive enough to recognise the different needs of individuals shifting from reactive unplanned care to prevention and proactive care. Success will mean that people travelling through our integrated services will report;



c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

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.

Key changes integration will bring:



The specific quantitative aims of our the schemes are:

- A reduction in the number of residents being admitted to nursing and residential care homes, from both acute and community settings.
- The effectiveness of the Reablement service in keeping people in their own homes after discharge from hospital.
- A decrease in the number of delayed discharges and lost bed days from acute settings for those patients medically fit for discharge.
- A decrease in emergency avoidable admissions.
- Increase in the estimated diagnosis rate of dementia.

People will experience an integrated service which is flexible and responsive enough to recognise the different needs of individuals shifting from reactive (unplanned) care to prevention and proactive care with:

- 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.

A programme team will be responsible for the planning and mobilisation of the schemes and will develop a performance framework to ensure analysis of the impact of the schemes at all levels including:

- impact on acute hospital services.
- impact on the local authority.
- How activity has moved through the system in order to help future proof the schemes and identify new opportunities.
- The level of satisfaction service users experience from the change.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Hartlepool faces demographic challenges in terms of deprivation, an ageing population and an increasing number of people with disabilities.

Detailed information regarding demographic challenges can be found in the Joint Strategic Needs Assessment. Key facts that outline the challenge for adult services include:

- Hartlepool is one of the most deprived areas in Britain, ranked 24th most deprived out of 354 Local Authority areas and with 7 of the 17 wards in Hartlepool amongst the 10% most deprived in the country.
- Life expectancy for both men and women is lower than the national average.
- Higher than average levels of unemployment.
- Higher than average rates of limiting long term illness and health problems.
- A high proportion of working age adults receiving benefits.
- A decreasing working age population and increasing population of over 65s and over 85s.
- Increasing numbers of people with learning disabilities and physical disabilities.
- Increasing prevalence of dementia and depression in older people.

<u>Wider Determinants of Health</u>
As the Marmot Review made clear, a person's health and wellbeing in later life is affected by a wide range of determinants such as poverty, housing, employment and education, as well as healthy lifestyles and health care. The Hartlepool Better Care Fund Plan recognises these wider determinants of health and aims to adopt an earlier intervention approach which includes a more holistic approach to care planning, which will incorporate housing issues, social isolation, healthy lifestyle issues, as well as the promotion of screening and vaccination programmes.

<u>An Ageing Population</u>
People are living longer and, whilst the increase in life expectancy is to be welcomed, this presents challenges for adult services as people living longer often have complex health conditions and require significant levels of support to remain independent.

Research shows that older age is associated with an increased incidence of multiple long term conditions and a growing number of functional and cognitive impairments and the number of older people who are living alone is increasing, with potential for social isolation.

These trends have resulted in a growing demand for health services to treat multiple long term conditions as well as care services to help individuals cope with everyday activities such as dressing, bathing, shopping, or preparing food.

In Hartlepool, there are approximately 2,900 emergency admissions to hospital each year for people aged over 65. Given the ageing population and associated levels of need for health services, this is expected to increase significantly over the next 5-10 years if services continue to support people in the current way. The demand on social care services and particularly long term care is also predicted to increase significantly over this time period.

In 2012/13, 4,987 people were supported to live independently through adult services provided by Hartlepool Borough Council and support was provided to almost 2,000 carers.

It is anticipated that further integration of health and social care services will help to address these issues through:

- Risk stratification and targeting of resources at those people who are most at risk of poor health outcomes and most likely to require intensive health and social care services in the future
- Improved care planning, care co-ordination and care delivery
- Better use of limited resources through multidisciplinary assessment and responses.
- A shift from reactive services to a more planned approach focusing on early intervention and prevention

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

September – December 2014

- Award of tenders for low level services (Social Inclusion & Lifestyle Pathways).
- Additional Social Work capacity in Early Intervention in place.
- Review of current model for Rapid Response Nursing and 24hr District Nursing.
- Develop and agree an enhanced care model for step up and step down services.
- NHS number identified for all current social care cases.

January – March 2015

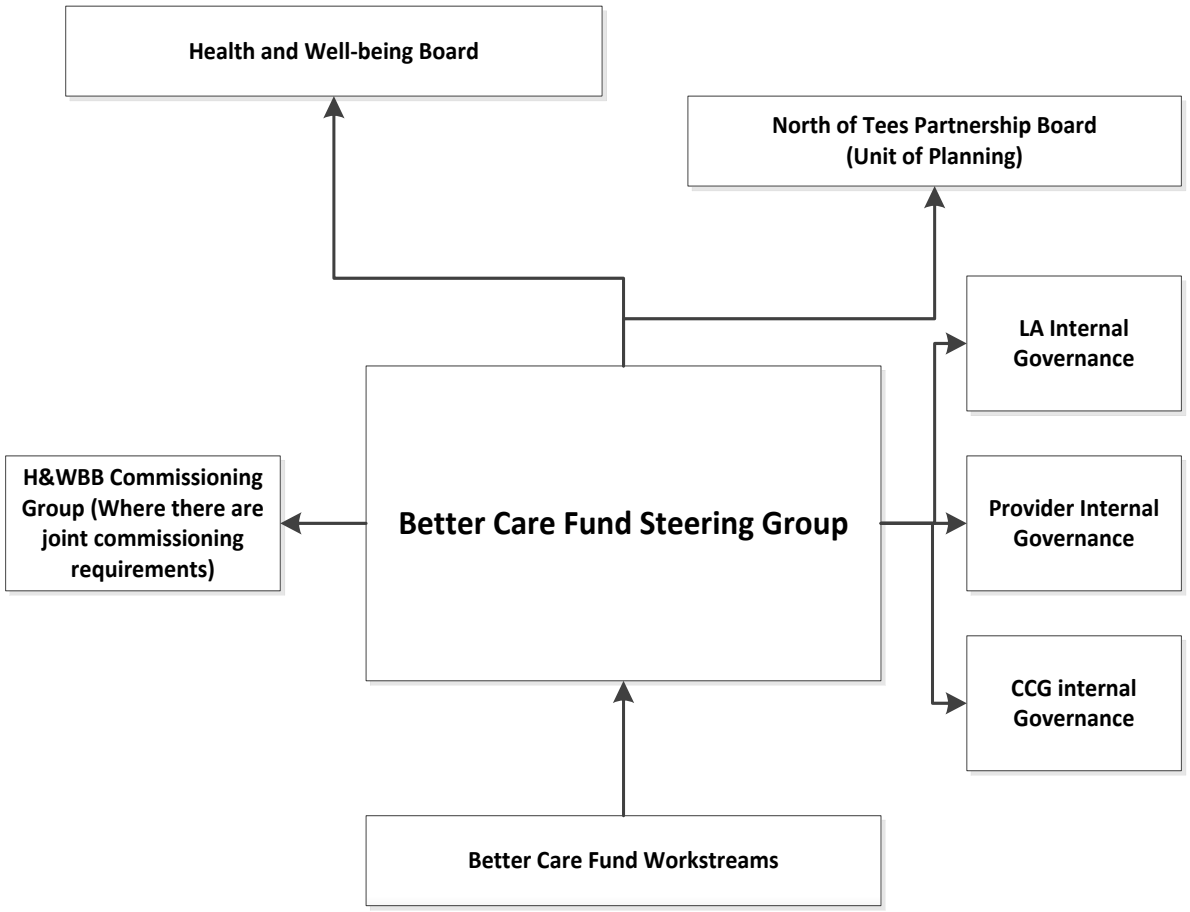
- Expert carer programme commissioned.
- Dementia Advisors appointed.
- Appointment of additional Social Workers to support people with dementia.
- Contracts awarded for support and navigation services for LTCs and sensory loss.
- Commissioned low level services (Social Inclusion & Lifestyle Pathways) commence.
- Appointment to posts providing professional support for care homes.
- Intermediate care model finalised

b) Please articulate the overarching governance arrangements for integrated care locally

Robust governance arrangements for the Hartlepool Better Care Fund Plan were agreed by the Health and Wellbeing Board in April 2014. These governance arrangements reflect the partnership approach that is required to effectively deliver the integrated approach described in our Better Care Fund Plan but also acknowledges the needs of individual partner organisations to ensure that decisions are taken through their own internal governance arrangements. The agreed governance arrangements ensure that a system wide perspective and approach is taken through the North of Tees Partnership Board which covers the Hartlepool & Stockton-on-Tees CCG Unit of Planning.

The diagram below sets out the governance arrangements for the Hartlepool Better Care Fund (BCF) programme:

Programme Management/Governance Arrangements



The **North of Tees Partnership Board** brings together key partners across the Unit of Planning to provide strategic leadership and oversight to the development and delivery of the Hartlepool and Stockton-on-Tees Better Care Fund Plans. Ensuring alignment with wider strategic plans across health and social care; co-ordinating and aligning all cross-organisational activities across the health and social care economy aimed at delivering service change; addressing risks and issues that might impact on the delivery of the

Better Care Fund; agreeing contingency and risk management arrangements in the event that planned schemes do not deliver to projections; coordinating and sharing how decisions will be taken within partner organisations; and supporting assurance processes.

The **Hartlepool Health & Wellbeing Board** is responsible for; signing off and ensuring delivery on the Hartlepool Better Care Fund Plan; ensuring that the BCF plan responds to local needs, is aligned with the Health & Wellbeing Strategy and supports system integration across health and social care; agreeing the use of funding under the Better Care Fund pooled budget arrangements; addressing any risks and issues arising that relate to the wider Hartlepool health and social care system; and progressing (through the Joint Commissioning Executive) any joint commissioning implications and requirements arising from the Better Care Fund.

The **Better Care Fund Steering Group** is responsible for; ensuring delivery on the Hartlepool & Stockton-on-Tees BCF plans; developing new pathways and models of care; ensuring that partner organisations have taken decisions through their internal governance processes in order for decisions to be made; ensuring each organisation provides sufficient resources to the work streams to ensure successful implementation of the programme; developing a joint communications strategy; resolving and appropriately escalating issues and risks associated with the Better Care Fund; ensuring other groups are updated and assured of progress.

The **Hartlepool BCF Work Streams** are responsible for developing the pathways and models of care under each of the BCF schemes; resolving issues and risks which are within the remit of the project; developing the detailed implementation plans and taking day-to-day responsibility for implementation once the new pathways and models of care have been agreed.

Each of the partner organisations will ensure that decisions and information is taken through their own internal governance structures. For example the CCG Delivery Team and Governing Body will be kept appraised of the developments and kept informed of the progress of all plans; this is intended to be 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.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The arrangements for management and oversight of the delivery of the Better Care Fund Plan is described in 4b above. A clear process for managing risks and issues and monitoring and managing performance has been agreed as part of the BCF governance arrangements.

In addition, dedicated project management resources have been identified within the partner organisations to support delivery on the Better Care Fund Plan.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Low Level Services & Self Management of Long Term Conditions
2	Intermediate Care
3	Improved Dementia Pathways

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?**	**Potential impact**	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
There is insufficient information and data at the correct level and quality to effectively monitor outcomes (financial and performance) of all the interlinking projects and schemes and ensure overall delivery of the BCF plan.				• Health and social care information teams will work together to ensure that information is collected and presented meaningfully to inform planning and service development. • Gaining assurance through the work streams that the planned BCF developments will deliver the required outcomes. Regular reviews will be undertaken to refine plans and potentially disinvest in schemes that fail to deliver the best outcomes • National performance measures will be used where appropriate and where these are not available a locally agreed indicator set will be developed.
The schemes are not in line with existing NHS or LA delivery plans undoing existing good practice.				• Partners are, and will continue to be, involved in the development of the BCF plans to ensure that organisational plans are aligned. • The agreed governance arrangements ensure that the impact of decisions relating to the implementation of the BCF is considered by all partners on the North of Tees Partnership Board. • Plans build on the good practice already in place.

There is insufficient time to implement the schemes to have the impact in the short term on performance and savings.				• Plans build on existing good practice. • Existing services will contribute to delivery of the BCF plan. • Any available funding during 14/15 will be utilised to progress the schemes faster, where appropriate. • Contractual mechanisms will be used where appropriate to ensure that partners are contractually bound to deliver changes within agreed timescales.
The schemes identified in the BCF fail to deliver the required reduction in acute and care home activity by 2015/16, impacting on the funding available to support core services and future schemes.				• Assumptions have been modelled using a range of available data. • 2014/15 will be used to review, test, and refine the assumptions.
The focus is on performance and savings rather than being person-centred and designed to ensure that the individual receives the best possible care.				• All the proposals will be implemented in a within a person centred approach. • Ongoing consultation and engagement throughout the implementation of the BCF plan to ensure service users are involved in the design of new care pathways.
Partners can't agree the best model of service delivery and / or the implementation of the model.				• Partners will continue to be involved in the development of evidence based services that meet local need. • The agreed governance arrangements ensure that there are mechanisms in place to reach agreement on decisions and resolve any issues via the North of Tees Partnership Board.
The non-coterminous boundaries for health and social care result in				• The North of Tees Partnership Board enables plans to be shared and implications understood with the clear service specifications in

differing priorities and levels of investment that need to be managed by a single CCG and acute provider, which disadvantages Hartlepool.				place to assure equity across both localities for people accessing services • Opportunities for joint working across the two LAs have been explored.
As current funding to social care is reduced there will be a detrimental impact on the delivery of savings and BCF outcomes.				• Funding has been agreed and secured for 14/15 and 15/16 subject to the implementation of the schemes. • North of Tees Partnership Board will continue to monitor the impact of changes to social care funding and risks posed to the BCF.
Introduction of the Care Bill results in significant pressures for social care services with resulting impacts on the delivery of the BCF plan as well as the wider Health and Social Care system.				• Work is being undertaken to understand the possible impact of the Care Bill; this will be refined as the detail is confirmed.
Organisational pressures and wider health and social care reform restrict the capacity of all partners to deliver the BCF plan.				• Dedicated project management resources are being identified to support delivery of the BCF and capacity will be regularly reviewed.
Workforce skill mix and availability to deliver the new pathways of care is not adequate.				• Workforce planning and development with Health Education North East and NHS England Local Area Team.
Shifting resources to fund new integrated services destabilises current providers, particularly in the acute sector.				• Further work will be undertaken to understand the wider impact of the proposed developments.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

To manage the process of the funds being held back to create the Pay for Performance Pool, the implementation of the BCF plan will have to be phased to ensure that the funds will be available. Hartlepool Borough Council and NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group have agreed that the proposed BCF developments will be evaluated throughout the year to identify added value and contribution to the delivery of the performance metrics, which may inform disinvestment and reinvestment decisions if appropriate. The CCG already has set contingencies within their financial plans which may be required should schemes not achieve agreed outcomes.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

These plans have been designed to benefit from, align to and enhance work already underway within the CCG and wider health environment. The CCG is committed to reducing health inequalities and improving the quality of services and therefore the experience of patients. This responsibility is met through the CCG workstream process which involves partners from the wider health environment to ensure that work is not undertaken in isolation and we can mutually maximise on our efforts.

The CCG works with and has commissioned a number of local services and initiatives within the local voluntary and community sector. These services and projects are intended to support various patients to engage with health, social care and other community services. These include:

1. Commissioning self-management and support programmes for patients with long-term respiratory disease from the local hospice
2. Providing additional support programmes for patients with early-disease respiratory disease
3. Commissioning of voluntary and community services to help reduce health inequalities and support the local health priorities.

The Better Care Fund plans are aligned to and are informing developments within social care, which are intended to maximise the benefits of the additional investment from 2015/16. These developments include restructuring within operational services to create an Early Intervention Team, which brings together social care first point of contact, hospital discharge and reablement and exploring options for this team to be co-located with the Single Point of Access for NHS community services. Work is also underway to review the current assistive technology service and intermediate care service to identify how capacity can be increased and additional resources used most effectively, and there is a review underway of how intermediate care beds are utilised to better understand where there are gaps in service or opportunities to use existing resources differently to improve outcomes.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

In order to develop our plan we worked collaboratively with partners from the Health and Well Being Boards to ensure that we established a set of aims that while specific to our organisation also reflected the delivery of broader system wide goals and ambitions.

In further developing our strategic plan, in line with our vision, we have revisited these aims to ensure they are fully inclusive of the integration process as part of the Better Care Fund (BCF) the Clear and Credible Plan, and in light of national guidance (i.e. Everyone Counts 2014/15-2018/19 strategic and operational plans.

The vision for adult social care services in Hartlepool - Moving Forward Together, is closely aligned with the Better Care Fund plans and reflects the shared vision and Better Care Fund success measures. The outcome measures for Moving Forward Together are

as follows:

- Good quality, up-to-date and accessible information available in a range of formats and utilising a comprehensive and accessible web site available to everyone, including people who fund their own care and support, so that they can get the information and advice they need.
- A dynamic and varied market in personalised social care is in place offering people a choice in the way they receive support.
- Strong partnerships are evident with a joined-up approach between social care, health, housing, employment and other sector partners to deliver better outcomes for people.
- People are supported to stay safe and risks are managed to maximise people's choice, control and ability to develop their potential.
- More people living in the community, supported to lead independent lives and in receipt of a personal budget which helps them to achieve their personal outcomes.
- More people empowered to be active and socially engaged regardless of their age, disability or caring responsibilities.
- People who use services and carers continue to say that they feel supported, valued and involved.
- New ways of working with health are in place to support people stay well, manage needs before they escalate and increasingly evidence a growth in social capital, volunteering and inclusive networks of support.
- More people with disabilities or mental health needs have settled accommodation and are in employment.
- People increasingly feel able to manage their long term conditions for themselves using new technologies and less people are admitted to hospital or residential care.
- More people are supported to remain in their own homes and regain their independence after a crisis or period of ill-health by utilising robust re-ablement services in a timely and accessible way;
- Good quality residential care services are available to those who need them with people's personal dignity upheld at all times;
- Systems and processes for service delivery are as lean as possible, simple to use and fit for purpose with more people accessing self-directed services and managing their own support.
- Different organisations are working in partnership together to provide transformative, cost-effective, efficient services with joined-up pathways and shared services where appropriate.
- People's views of services are captured through a variety of mechanisms i.e. forums, surveys, compliments/ complaints and consultation events. Improvements to the way we deliver our services are made where "lessons have been learned" in a truly customer-centric service response.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCG submitted an expression of interest for co-commissioning in June and are currently waiting to hear the outcome of the application from NHS England.

The CCG intends to work with member practices, stakeholders, voluntary organisations, public health and social care partners and local communities to identify and shape key

health improvements. This approach will target parts of the local community where the greatest impact can be achieved, following the principles of proportionate universalism, to attempt to reduce inequality of outcomes. The CCG believes that working with partners to shape improvement will enable the creation of a culture across organisational boundaries of peer-based challenge and support, which in turn will develop a system with a focus on continuous learning and improvement of patient and person-centred care with birth to death delivery.

A key aim will be to develop a way of working that motivates the primary care workforce, providing a better work/life balance and thus sustainable primary care provision for the longer term. This will involve promoting professional autonomy and responsibility and ensuring that staff are engaged in developing their ability to drive decisions and make improvements within services to help improve patient care with a focus on improving quality outcomes.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

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 due to the ageing population, 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.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

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 maintain existing integrated services that support timely hospital discharge, delivery of reablement and telecare services, commissioning of low level support services and support for carers. Investment in these services will need to be sustained to maintain this as the social care offer for Hartlepool and to maintain current eligibility criteria and increased in order to deliver 7 day services and to address the implications of the Care Bill, which will require 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 are invested in social care to deliver enhanced reablement and step up services, which will reduce hospital admissions and readmissions as well as permanent admissions to residential and nursing home care.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The amount from the BCF that has been allocated for protection of adult social care services is £2.989m. This includes the existing NHS Transfer to Social Care which is being used, as outlined above, to sustain the current level of eligibility criteria and to maintain existing integrated services that support timely hospital discharge, delivery of reablement and telecare services, commissioning of low level support services and support for carers. This funding (£2.3m) will continue to protect adult social care services in 2015/16 and beyond. In addition, the plan identifies further funding of approximately £700k which will be invested in protecting adult social care services which would otherwise be at risk. These services include low level services to support people with

long term conditions and sensory loss and assistive technology services that support people to remain independent in their own homes.

As identified within the original BCF plan, the local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties. For Hartlepool this equates to £266k.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Work is currently underway to assess the financial implications of the Care Act. It is not possible, until this work is completed, to estimate whether the allocation identified is sufficient to meet the additional costs that are anticipated, which include additional social care and financial assessments and meeting additional responsibilities in relation to advise and information, self-funders and carers.

v) Please specify the level of resource that will be dedicated to carer-specific support

The level of resource dedicated to carer specific support within the plan is £345k. It should be noted that a number of other services will benefit carers but have been reported as services for dementia or intermediate care, as this better reflects the key focus of the service.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The impact on the local authority's budget is expected to be minimal as the original plan included an element of contingency and included a significant level of investment in NHS community services. The requirement to hold back further funding to create the Performance Fund at the required level will result in 2 key schemes being phased to commence later in the year than originally planned in order to create slippage for the Performance Fund. This is not expected to have a major impact on the local authority's budget but will impact on the ability of the local health and social care economy to deliver in full the anticipated benefits of these schemes.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to 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

i) Please set out the plans you have in place for 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.

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.

ii) Please explain your approach for 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.

To enable cross-boundary working across agenices, a system will be procured that will extract data from core systems and present the service user / patient data in real time. This will provide one view over the whole systems of health and social care, and allow queries and analyses to take place across multiple, separate systems while maintaining base data in individual systems and improving data quality by identifying gaps or inconsistent records. See diagram on page 27 (an extract from the Integrated Care Fund application which has been co-ordinated by Stockton Borough Council on behalf of partners).

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice 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 for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

The integrated approach within this BCF plan will ensure that people who are at high risk of poor outcomes, including those most at risk of hospital admission and admission to long term care will be jointly assessed, will have in place a care plan and will have assigned an appropriate lead professional to coordinate their care.

The predictive risk stratification model (RAIDr) 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 hospital admission in the next twelve months. This has been used to identify those patients at highest risk of hospital admission.

Work is underway to develop an approach that can build upon the existing RAIDr system to incorporate social care information and explore the possibility of also incorporating an evidence based frailty score. This will enable a targeted multi-disciplinary approach to support people to better self-manage their long term condition, having an appropriate identified accountable lead. This information will also be used in conjunction with other sources of public health intelligence to ensure that resources are targeted at reducing health inequalities.

Focusing on high intensity current users of health and social care will provide maximum impact and benefit in our joint work, creating and maintaining a positive environment within which local health and social care services can be transformed and integrated. However, over time it is hoped that this targeting approach will begin to be more focused on prevention and earlier intervention with those individuals who are in the medium risk categories.

The new pathways of care will ensure that every individual is assigned an accountable lead professional to coordinate their care. This will be the most appropriate professional dependent upon the individual's primary need. The approach will be aligned with the new primary care requirements for all over 75s to have a named GP.

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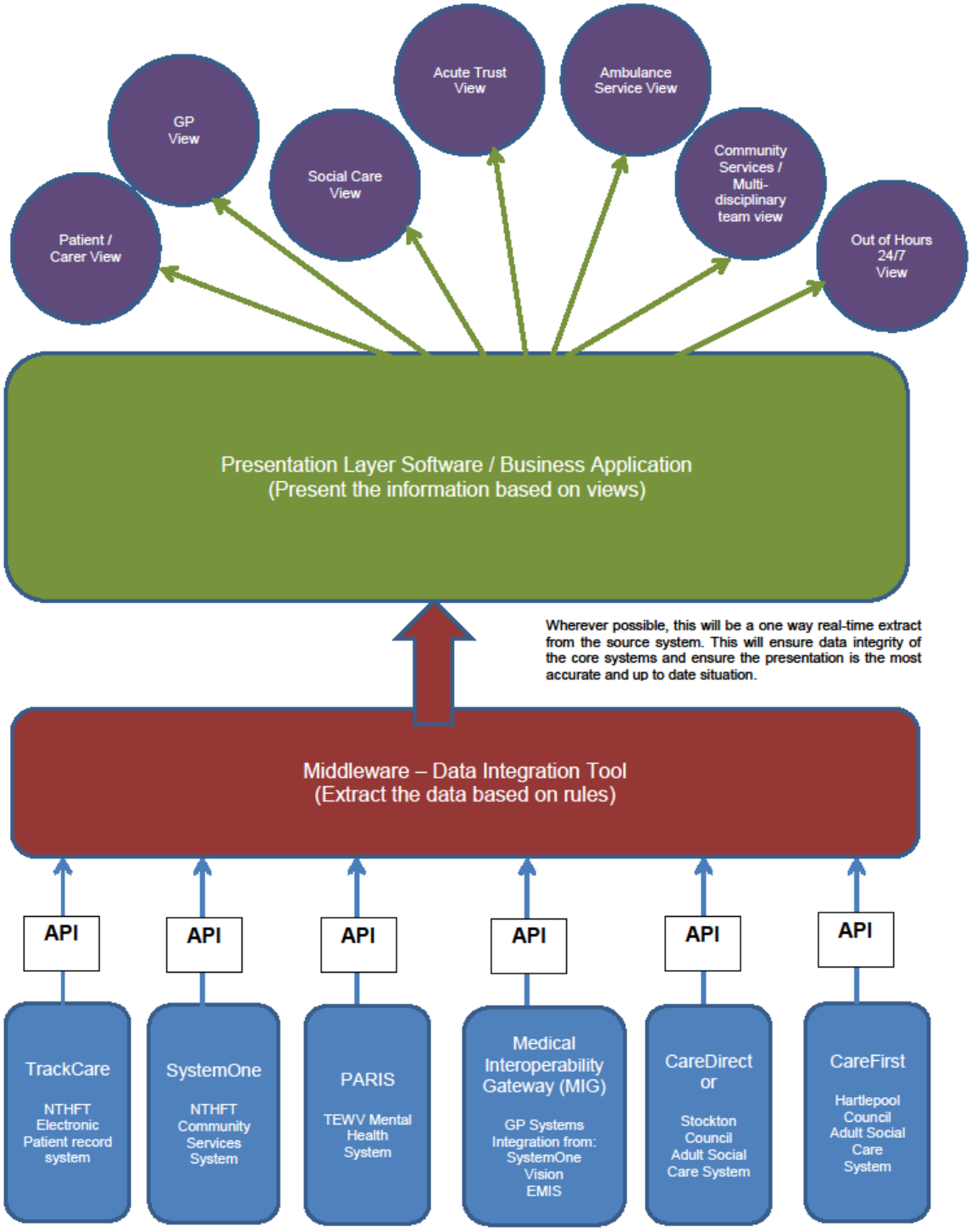
Access will be web based and the view will be determined by the requirements of the system user and the security / information protocols which will be developed as part of the project. Ideally there will be a single-sign on process to prevent multiple log on & passwords.



There are major upgrades taking place over the next couple of years because of legislative changes such as the Care Act, therefore the versions of the systems will change before the procurement is completed. The intention is to ensure that the procurement of the APIs puts the responsibility for maintaining the API with the main system provider – thus ensuring forward compatibility.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

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 acknowledging 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.

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.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

A number of individuals at high risk, including people who receive an element of Continuing Health Care funding as part of a joint package of care and people receiving a personal health budget, will have joint care plans in place but this data is not currently collected.

Every individual with both health and social care needs who receives support from the proposed integrated services will have a joint care plan in place.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

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 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 to undertake further conversations with those community groups that are often deemed as hard to hear / reach.

Key themes and comments from people were

- Services close to home
- Improved communication
- Self-management for Long Term Conditions
- Improved access
- Improved Urgent Care
- Education and support for carers

The work undertaken to engage with the public and the themes identified have provided assurance that service user views are driving the development of integrated services that will meet local needs.

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.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

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 that 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. Issues identified in relation to the development of the plans are discussed and worked through by operational leads and

then brought back to the North of Tees Partnership Board for agreement if required.

To ensure parity of esteem between physical and mental health across the health and social care economy whilst creating new models of care, our main mental health provider has been actively engaged in appropriate clinical work streams within the CCG and has been a key member of the North of Tees Partnership Board.

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 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 considered the draft plan in February 2014 before approving the final version of the plan for submission by the 4 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.

ii) primary care providers

The CCG when developing their 2 & 5 years plans with Better Care Fund plans being an intrinsic component of those plans have undertaken appropriate clinical engagement /consultation with the CCG Council of Members who represent the CCG and Governing Body. Clinical Time Out events have been held with member practices, which have been instrumental in the development of the Better Care Fund plans and commissioning intentions. The CCG Hartlepool locality lead is also a member of the North of Tees Partnership Board.

iii) social care and providers from the voluntary and community sector

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.

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 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

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

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.

Our efficiency savings will specifically target 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.

The net impact on acute providers is not as significant as BCF plans suggest. The CCG 2 and 5 year plans reflect the BCF implications for delivery of services and have been included in contract negotiations with acute providers which also include recurring growth investment aligned to demographic uplift.

The CCG will work with providers, through the continual assessment of cost improvement plans using the Star Chamber approach, to support and sustain services within the financial envelope, including BCF schemes.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description (1)

Scheme ref no.
Ref 1
Scheme name
Low Level Services & Self Management of Long Term Conditions
What is the strategic objective of this scheme?
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 work with our public health colleagues to review opportunities to further support and target people with a range of long term conditions in the community and / or their own homes, building upon the success of existing programmes commissioned by public health (such as Health Trainers and the Falls Service) whilst developing a more preventative, proactive and targeted approach.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
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.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Low level services have been jointly funded by health and social care for a number of years and are commissioned by the Local Authority from a range of voluntary and independent providers. It is anticipated that this approach will continue for new developments within this scheme, such as the expert carer programme.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evaluation of low level services provided in Hartlepool demonstrates that services make a valuable contribution to improving people's lives, promoting their independence, safety and wellbeing, preventing social isolation and exclusion, supporting people to live as independently as possible within their own homes and supporting timely, safe hospital discharges.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Increasing numbers of people supported to live independently in their own homes for longer with low level services, preventing or delaying the need for most costly and intensive health and social care interventions.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of Low Level Services & Self Management of Long Term Conditions will be measured through a range of indicators including the national BCF measures and an agreed basket of local indicators which will be developed into a local performance framework. Each individual scheme will be evaluated on an ongoing basis to determine the added value being provided, and to inform decisions regarding further investment or disinvestment as appropriate.

What are the key success factors for implementation of this scheme?
• Development of robust service specifications with clear performance measures that are monitored regularly. • Award of contracts and implementation of services. • Promotion of low level services as alternatives to health and social care support, where appropriate.

ANNEX 1 – Detailed Scheme Description (2)

Scheme ref no.
Ref 2
Scheme name
Intermediate Care
What is the strategic objective of this scheme?
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 be provided seven days a week across health and social care with a 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, integrated health and social care services 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.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
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. To determine the most appropriate model of care and

associated pathways for the 'step up' service an independent review has been commissioned and agreed by the Unit of Planning. The review will include consideration of integrated community based services that provide enhanced support in people's own homes and step up beds within the community to deliver an alternative to hospital admission. The review will commence in April and will consist of both desk top appraisal and a clinical evaluation of the different models. This evaluation will ensure that all factors are considered in determining the most suitable, clinically safe, evidence based model which will also take into account local demographics, choice for people and their carers and provision of care close to home. This approach will ensure delivery of a sustainable future model that meets the needs of the local population.

- 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.

The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
This is yet to be determined, although it is anticipated that elements of the scheme will be provided by existing social care and community health services.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
This scheme has and will continue to be informed by the emerging evidence. Peopletoo completed a regional review of Reablement and Intermediate Care services in 2012 which found that although there was good practice in place, there were opportunities to maximise utilisation, improve benefits tracking and performance monitoring and to utilise the private and independent sectors as part of the solution. Peopletoo undertook a further piece of work in 2014 to map existing provision of intermediate care services across Hartlepool and Stockton, which identified some areas for consideration: **Supported 7 day discharge** – whilst anecdotally this takes place, formally the Hospital Discharge Liaison Team only operates 8.30 a.m. to 5p.m. Monday to Friday which can result in people remaining in an acute setting over the weekend. We would recommend that existing service levels are reviewed. **24/7 Credible Alternatives to Admission** – CIAT teams which incorporate Rapid Response currently only operate 8a.m. to 10p.m. in Hartlepool. This means that out of hours there are limited alternatives available to admission. GPs state that one of the reasons for admission is the lack of credible alternatives available of hours. Introduction of a 24/7 Single Point of Access which can coordinate access to step up and step down services along with out of hours alternatives such as sitting services and step-up beds with a multi-disciplinary assessment taking place the following day, could help to address this. **Capacity available within current Rehabilitation and Reablement Teams –** from analysing data provided and meetings with key personnel, it is apparent that there are issues with referral rates and capacity. The service in Hartlepoool receives on average 23 referrals per month but emergency hospital admissions for over 65's average 88 per week and this does not include elective admission discharges (some of which may be appropriate for rehabilitation / reablement). Other Sources of Evidence include; Kings Fund National Audit of Intermediate Care 2013
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Supports 7 day discharge from hospital • Reduced emergency admissions at weekends • Improve the capacity within the teams to support 7 day working
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The impact of proposed changes to intermediate care pathway will be measured through a range of indicators. Including the national BCF measures and a basket of local indicators which will be developed into a local performance framework. The different elements of the service will be evaluated on an ongoing basis to determine the added value being provided, and to inform decisions regarding further investment or disinvestment as appropriate.
What are the key success factors for implementation of this scheme?
• Design - getting the design of the service right is critical to the success of the programme and significant time and resource is being invested during 2013/14 to involve all partners in this process, including the establishment of a task and finish group to take forward the step up service design. • Workforce development and supporting cultural change to support new ways of working. • Strong and sustained system leadership through the agreed governance structures and local task and finish groups. • Ownership and involvement of frontline professionals – Front line professionals will be leading and supporting the development of the new pathways.

ANNEX 1 – Detailed Scheme Description (3)

Scheme ref no.
Ref 3
Scheme name
Improved Dementia Pathways
What is the strategic objective of this scheme?
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.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
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.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
It is anticipated that services to support people with dementia in their own home and

within the local community will continue to be commissioned by the Local Authority from voluntary and independent sector providers.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Evaluation of services for people with dementia in Hartlepool demonstrates that services make a valuable contribution to improving people's lives, promoting their independence, safety and wellbeing, preventing social isolation and exclusion and supporting people to live as independently as possible within their own homes.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
More people with dementia supported to live independently in their own homes for longer with low level services, preventing or delaying the need for most costly and intensive health and social care interventions. More carers of people with dementia supported to maintain their caring role.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The impact of proposed changes to Dementia Pathway will be measured through a range of indicators. Including the national BCF measures and a basket of local indicators which will be developed into a local performance framework. Each individual scheme will be evaluated on an ongoing basis to determine the added value being provided, and to inform decisions regarding further investment or disinvestment as appropriate.
What are the key success factors for implementation of this scheme?
• Development of a Dementia Friendly Community. • Continuation of the North of Tees Dementia Collaborative, with an increased focus on embedding and sustaining improvements • Improved advice and information of people with dementia and their carers. • Promotion of low level services as alternatives to health and social care support, where appropriate. • Improved diagnosis rates enabling people to access appropriate treatment and support at the earliest opportunity.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Hartlepool Health & Wellbeing Board
Name of Provider organisation	North Tees & Hartlepool NHS Foundation Trust
Name of Provider CEO	Alan Foster
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

Health and Wellbeing Board Details

ROCR approval applied for
Version 3

Please select Health and Wellbeing Board:

Hartlepool

Please provide:

<Contact Name>
<Contact Email>

Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

Hartlepool

1. Reduction in non elective activity

Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	9,656
Change in Non Elective Activity	-339
% Change in Non Elective Activity	-3.5%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds

Figures in £

Financial Value of Non Elective Saving/ Performance Fund	505,745
Combined total of Performance and Ringfenced Funds	1,922,254
Ringfenced Fund	1,416,510
Value of NHS Commissioned Services	1,557,500
Shortfall of Contribution to NHS Commissioned Services	0

2015/16 Quarterly Breakdown of P4P

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	2,370	4,794	7,188	9,656
Cumulative Change in Non Elective Activity	60	-72	-204	-339
Cumulative % Change in Non Elective Activity	0.6%	-0.7%	-2.1%	-3.5%
Financial Value of Non Elective Saving/ Performance Fund (£)	0	107,430	196,680	201,634

Health and Wellbeing Funding Sources

Hartlepool

Please complete white cells

	Gross Contribution (£000)	
	2014/15	**2015/16**
Local Authority Social Services		
Hartlepool	503	825
<Please select Local Authority>		
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<Please select Local Authority>		
<Please select Local Authority>		
Total Local Authority Contribution	**503**	**825**
CCG Minimum Contribution		
NHS Hartlepool and Stockton-On-Tees CCG		6,651
-		-
-		-
-		-
-		-
-		-
-		-
-		-
Total Minimum CCG Contribution	**-**	**6,651**
Additional CCG Contribution		
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Total Additional CCG Contribution	**-**	**-**
Total Contribution	**503**	**7,476**

Summary of Health and Wellbeing Board Schemes

Hartlepool

Please complete white cells

Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	-	-			
Mental Health	115	430			
Community Health	-	1,090			
Continuing Care	-	-			
Primary Care	-	-			
Social Care	388	5,156	100	2,989	2,989
Other	-	800			
Total	**503**	**7,476**		**2,989**	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure
	2015/16
Mental Health	215
Community Health	718
Continuing Care	-
Primary Care	-
Social Care	225
Other	400
Total	**1,558**

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	-	-	
Increased effectiveness of reablement	-	-	
Reduction in delayed transfers of care	-	-	
Reduction in non-elective (general + acute only)	-	(1,137)	506
Other	-	-	
Total	**-**	**(1,137)**	**506**

he period January 15 to December 15. The benefits in D44 are for the period April 15

Health and Wellbeing Board Expenditure Plan

Hartlepool

Please complete white cells (for as many rows as required):

	Expenditure								
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**if Joint % NHS**	**if Joint % LA**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
Intermediate Care	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		1,216
Intermediate Care	Other	developed. The service will be made	Joint	50%	50%		CCG Minimum Contribution		800
Intermediate Care	Social Care		Local Authority			Local Authority	Local Authority Social Services	226	
Intermediate Care	Community Health		CCG				CCG Minimum Contribution		120
Intermediate Care	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		120
Intermediate Care	Community Health		Joint	50%	50%	NHS Community Provider	CCG Minimum Contribution		168
Intermediate Care	Social Care		Joint	50%	50%	Private Sector	CCG Minimum Contribution		400
Intermediate Care	Social Care		Joint	50%	50%	Local Authority	CCG Minimum Contribution		50
Intermediate Care	Social Care		Local Authority			Private Sector	CCG Minimum Contribution		1,235
Intermediate Care	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		225
Intermediate Care	Community Health		Joint	50%	50%	NHS Community Provider			200
Intermediate Care	Community Health		Joint	50%	50%	Private Sector	CCG Minimum Contribution		177
Low Level Services	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		240
Low Level Services	Social Care		Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution		100
Low Level Services	Social Care		Local Authority				Local Authority Social Services	100	
Low Level Services	Community Health		CCG				CCG Minimum Contribution		80
Low Level Services	Social Care		Local Authority			Private Sector	CCG Minimum Contribution		745
Dementia	Mental Health		Joint	50%	50%	Local Authority	CCG Minimum Contribution		162
Dementia	Mental Health		Joint	50%	50%	NHS Mental Health Provider	CCG Minimum Contribution		123
Dementia	Mental Health		Local Authority			Local Authority	Local Authority Social Services	115	
Dementia	Mental Health		Joint	50%	50%	Charity/Voluntary Sector	CCG Minimum Contribution		145
Carers	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		40
Carers	Social Care		Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution		200
Carers	Social Care		Local Authority			Private Sector	CCG Minimum Contribution		75
Carers	Social Care		Local Authority				CCG Minimum Contribution		30
DFG/Capital	Social Care		Local Authority			Local Authority	Local Authority Social Services		825
Transition	Social Care		Local Authority			Local Authority	Local Authority Social Services	62	
Total								**503**	**7,476**

Health and Wellbeing Board Financial Benefits Plan

Hartlepool

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled “Aggregated benefit of schemes for X”, completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the “aggregated benefit” line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

			2014/15					
Benefit achieved from	If other please specifiy	Scheme Name	Organisation to Benefit	Change in activity measure	Unit Price (£)	Total (Saving) (£)	How was the saving value calculated?	How will the savings against plan be monitored?
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Total						**-**		

2015/16

			2015/16					
Benefit achieved from		**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		Intermediate care	NHS Commissioner	(763)	1,490	(1,136,870)	Within the financial plans for the CCG a forecast was built in for growth in 15/16 and then savings were calculated to get down to the reduced activity included in the Unify return. This makes the actual savings to be made higher than just the reduction on the previous year's activity.	This template will be updated with actual data as it becomes available (monthly) and will be compared to the plan to show how the schemes are performing.
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Total						**(1,136,870)**		

Hartlepool

Red triangles indicate comments

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**2,558**	**2,617**	**2,584**	**2,664**	**2,616**	**2,467**	**2,435**	**2,511**	**2,483**
	Numerator	2,370	2,424	2,394	2,468	2,430	2,292	2,262	2,333	2,313
	Denominator	92,639	92,639	92,639	92,639	92,901	92,901	92,901	92,901	93,172

Rationale for red/amber ratings

P4P annual change in admissions -339
P4P annual change in admissions (%) -3.5%
P4P annual saving *£505,745*

Please enter the average cost of a non elective admission[1] **£1,490**

Rationale for change from £1,490

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in Hartlepool	% Hartlepool resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Durham Dales, Easington and Sedgefield CCG	8,470	8,630	8,570	8,727	0.1%	0.4%	10	10	10	10
NHS Hartlepool and Stockton-On-Tees CCG	7,400	7,567	7,474	7,706	31.9%	99.6%	2,361	2,414	2,384	2,458
Total						**100%**	**2,370**	**2,424**	**2,394**	**2,468**

References

[1] The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

Hartlepool

Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)

Planned improvement on baseline

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**907.2**	**823.9**	**807.8**
	Numerator	145	140	140
	Denominator	16,205	16,992	17,331
	Annual change in admissions		*-5*	*0*
	Annual change in admissions %		*-3.4%*	*0.0%*

Rationale for red rating

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**87.5**	**87.7**	**89.2**
	Numerator	55	57	58
	Denominator	65	65	65
	Annual change in proportion		*0.2*	*1.5*
	Annual change in proportion %		*0.2%*	*1.8%*

Rationale for red rating

Delayed transfers of care

Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**438.8**	**578.1**	**695.4**	**754.1**	**956.8**	**956.8**	**956.8**	**823.8**	**755.1**	**686.5**	**617.8**	**547.8**
	Numerator	318	419	504	547	694	694	694	600	550	500	450	400
	Denominator	72,478	72,478	72,478	72,534	72,534	72,534	72,534	72,833	72,833	72,833	72,833	73,024
						Annual change in admissions			*894*			*Annual change in admissions*	*-782*
						Annual change in admissions %			*50.0%*			*Annual change in admissions %*	*-29.2%*

Rationale for red ratings There is currently a lack of nursing beds in Hartlepool which is impacting on patient cho

Patient / Service User Experience Metric

Metric		Baseline [enter time period]	Planned 14/15 (if available)	Planned 15/16
To be locally determined and baselines to be calculated Spring 15/16 - Possible regional approach	*Metric Value*			
	Numerator			
	Denominator			
Improvement indicated by:	<Please select>			

Local Metric

Metric		Baseline Apr 13 - Sep 13	Planned 14/15 (if available)	Planned 15/16
Estimated diagnosis rate for people with Dementia (NHS Outcomes Framework 2.6.i)	*Metric Value*	60.4	68.0	
	Numerator	632	773	
	Denominator	1,047	1,137	
Improvement indicated by:	Increase			

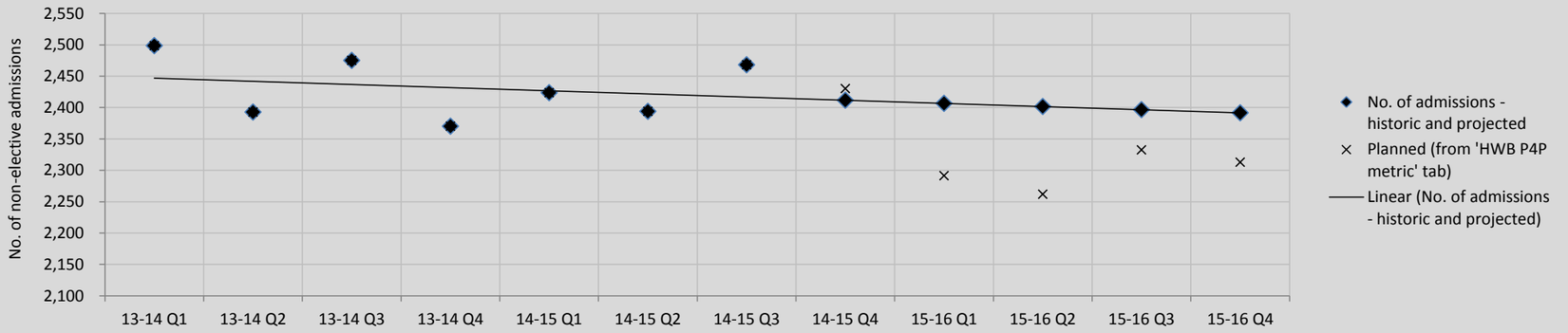
Hartlepool

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

Metric		Historic			Baseline				Projection				
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	2,499	2,393	2,475	2,370	2,424	2,394	2,468	2,412	2,407	2,402	2,397	2,392

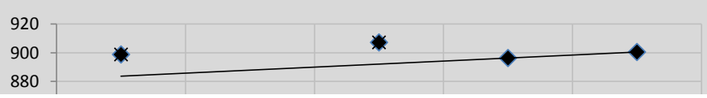


Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*2,603.4*	*2,590.7*	*2,585.3*	*2,579.9*	*2,567.0*
	Numerator	*2,412*	*2,407*	*2,402*	*2,397*	*2,392*
	Denominator	*92,639*	*92,901*	*92,901*	*92,901*	*93,172*

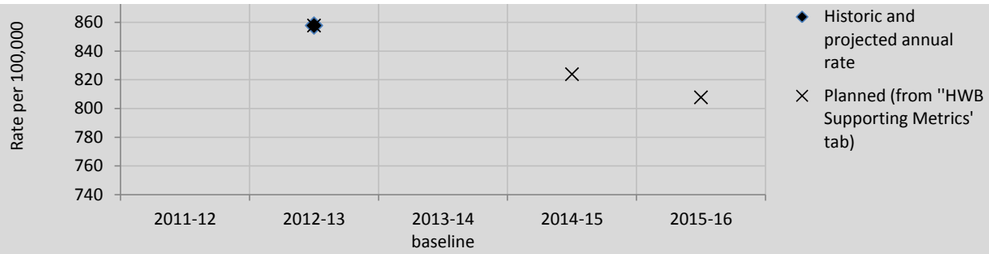
* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	899	858	907	*896*	*901*
	Numerator	140	140	145	*152*	*156*
	Denominator	15,690	16,205	16,205	*16,992*	*17,331*

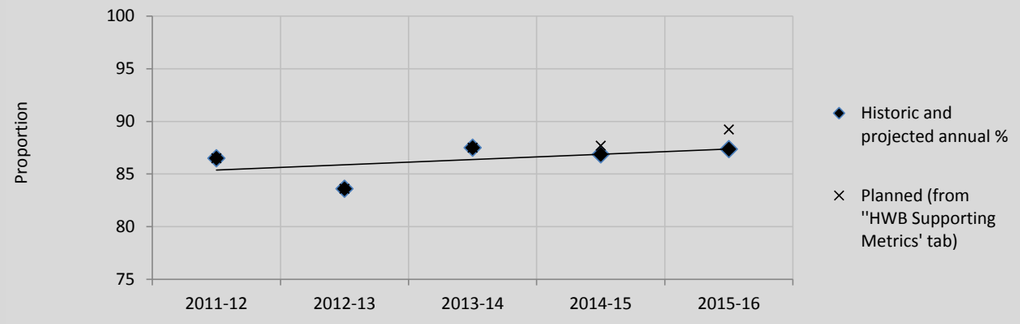


This is based on a simple projection of the metric proportion.



Reablement

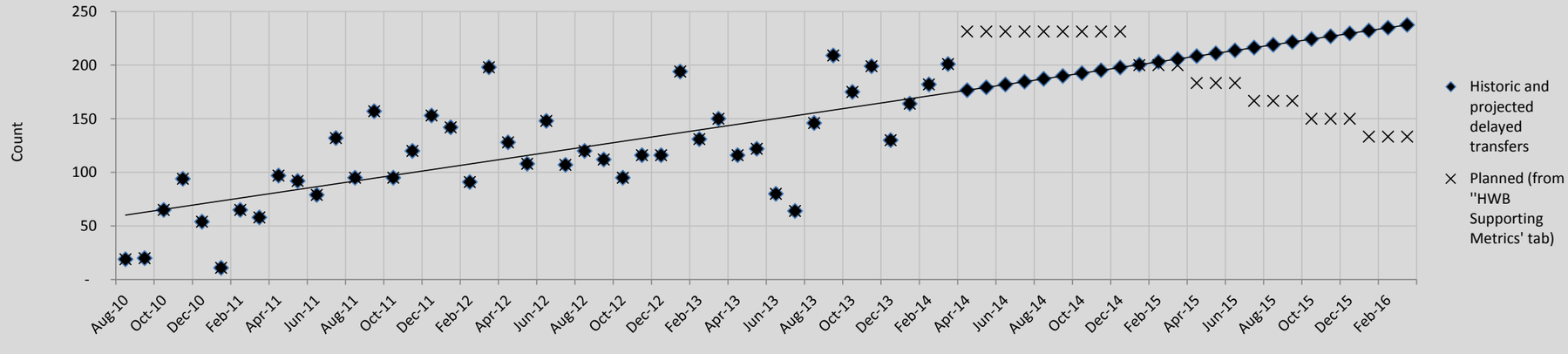
Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	86.5	83.6	87.5	*86.9*	*87.4*
	Numerator	30	55	55	*56*	*57*
	Denominator	35	65	65	*65*	*65*



This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11
Delayed transfers of care (delayed days) from hospital	*Historic and projected delayed transfers*	19	20	65	94	54	11	65	58	97	92	79	132



Metric		Projected rates*							
		2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*741.4*	*774.3*	*807.1*	*836.5*	*869.2*	*901.9*	*934.6*	*964.8*
	Numerator	*538*	*562*	*585*	*609*	*633*	*657*	*681*	*705*
	Denominator	*72,534*	*72,534*	*72,534*	*72,833*	*72,833*	*72,833*	*72,833*	*73,024*

* The projected rates are based on annual population projections and therefore will not change linearly

HWB Financial Plan

Date	Sheet	Cells	Description
28/07/2014	Payment for Performance	B23	formula modified to *=IF(B21-B19<0,0,B21-B19)*
28/07/2014	1. HWB Funding Sources	C27	formula modified to *=SUM(C20:C26)*
28/07/2014	HWB ID	J2	Changed to Version 2
28/07/2014	a	Various	Data mapped correctly for Bournemouth & Poole
29/07/2014	a	AP1:AP348	Allocation updated for changes
28/07/2014	All sheets	Columns	Allowed to modify column width if required
30/07/2014	8. Non elective admissions - CCG		Updated CCG plans for Wolverhampton, Ashford and Canterbury CCGs
30/07/2014	6. HWB supporting metrics	D18	Updated conditional formatting to not show green if baseline is 0
30/07/2014	6. HWB supporting metrics	D19	Comment added
30/07/2014	7. Metric trends	K11:O11, G43:H43,G66:H66	Updated forecast formulas
30/07/2014	Data	Various	Changed a couple of 'dashes' to zeros
30/07/2014	5. HWB P4P metric	H14	Removed rounding
31/07/2014	1. HWB Funding Sources	A48:C54	Unprotect cells and allow entry
01/08/2014	5. HWB P4P metric	G10:K10	Updated conditional formatting
01/08/2014	5. HWB P4P metric	H13	formula modified to *=IF(OR(G10<0,H10<0,I10<0,J10<0),"",IF(OR(ISTEXT(G10),ISTEXT(H10),ISTEXT(I10),ISTEXT(J10)),"",IF(SUM(G10:J10)=0,"",(SUM(G10:J10)/SUM(C10:F10))-1)))*
01/08/2014	5. HWB P4P metric	H13	Apply conditional formatting
01/08/2014	5. HWB P4P metric	H14	formula modified to *=if(H13="","",-H12*J14)*
01/08/2014	4. HWB Benefits Plan	J69:J118	Remove formula
01/08/2014	4. HWB Benefits Plan	B11:B60, B69:B118	Texted modified
Version 2			
13/08/2014	4. HWB Benefits Plan	I61, I119, J61, J119	Delete formula
13/08/2014	4. HWB Benefits Plan	rows 119:168	Additional 50 rows added to 14-15 table for orgaanisations that need it. Please unhide to use
13/08/2014	4. HWB Benefits Plan	rows 59:108	Additional 50 rows added to 15-16 table for orgaanisations that need it. Please unhide to use
13/08/2014	3. HWB Expenditure Plan	rows 59:108	Additional 50 rows added to table for orgaanisations that need it. Please unhide to use
13/08/2014	a	M8	Add Primary Care to drop down list in column I on sheet '*3. HWB Expenditure Plan*'
13/08/2014	HWB ID	J2	Changed to Version 3
13/08/2014	6. HWB supporting metrics	C11, I32, M32	Change text to *'Annual change in admissions'*
13/08/2014	6. HWB supporting metrics	C12, I33, M33	Change text to *'Annual change in admissions %'*
13/08/2014	6. HWB supporting metrics	C21	Change text to *'Annual change in proportion'*
13/08/2014	6. HWB supporting metrics	C22	Change text to *'Annual change in proportion %'*
13/08/2014	6. HWB supporting metrics	D21	Change formula to *=if(D19=0,0,D 18 -C 18)*
13/08/2014	6. HWB supporting metrics	D21	Change format to 1.dec. place
13/08/2014	6. HWB supporting metrics	E21	Change formula to *= if(E19=0,0,E 18 -D 18)*
13/08/2014	6. HWB supporting metrics	E21	Change format to 1.dec. place
13/08/2014	6. HWB supporting metrics	D22	Change formula to *=if(D19=0,0,D 18 /C 18 -1)*
13/08/2014	6. HWB supporting metrics	E22	Change formula to *=if(E19=0,0,E 18 /D 18 -1)*
13/08/2014	5. HWB P4P metric	J14	Cell can now be modified - £1,490 in as a placeholder
13/08/2014	5. HWB P4P metric	N9:AL9	Test box for an explanation of why different to £1,490 if it is.
13/08/2014	4. HWB Benefits Plan	H11:H110, H119:H218	Change formula to eg. *=H11*G11*
13/08/2014	2. Summary	G44:M44	Test box for an explanation for the difference between the calculated NEL saving on the metrics tab and the benefits tab

HEALTH AND WELLBEING BOARD

10 September 2014

Report of: Director of Child and Adult Services

Subject: TRANSFORMATION CHALLENGE AWARD : BETTER CHILDHOOD PROGRAMME

1. PURPOSE OF REPORT

1.1 The purpose of this report is to seek the endorsement of the Health and Wellbeing Board to the submission of a bid for the Department for Communities and Local Government Transformation Challenge Award 2015-16.

2. BACKGROUND

2.1 In April 2014, the Department for Communities and Local Government (DCLG) published its 'Transformation Challenge Award and Capital Receipt Flexibility 2014 – 2016 Prospectus.' This document invites local authorities and their partners to develop ambitious plans to transform services through greater sharing and efficiency.

2.2 The Government has set aside £320m over the next two years to support this programme. The funding is available to all local authorities in England to submit bids to re-engineer their business processes, redesign the way that services are delivered and work with the wider public sector to improve the lives of local people.

2.3 The Transformation Challenge Award 2015-16 has set aside £305m funding comprising of £105m revenue grant and £200m flexible use of capital receipts. The funding has two elements:

A) Encouraging local authorities which already share a senior management team and any chief executive to go further with their plans to redesign their services; and
B) Encouraging places that have ambitious plans to work in partnership across the public sector and with the voluntary and community sector or the private sector to re-design services.

The Corporate Management Team has considered these options and proposes that Child and Adults Services should bid for funding under criteria B above to re-design and integrate health, education, safeguarding, early help and employability processes and services around the needs of vulnerable families.

3. PROPOSALS

3.1 Hartlepool Borough Council, Children's Services, Public Health and Economic Development and its partners, North Tees and Hartlepool Clinical Commissioning Group, Cleveland Police and North Tees and Hartlepool Foundation Trust intends to submit a bid to deliver The Hartlepool Better Childhood Programme. The programme will focus on the following business process re-engineering and re-design:

- Establishing an integrated single point of access which will provide a multi professional triage and assessment hub to improve intelligence and information sharing, risk assessment and decision making in the identification of vulnerable families and ensuring they get access to the right early or specialist support;
- Redesigning the approach to early help to establish a multi professional team of family partners utilising capacity within health, local authority and voluntary and community sector;
- Achieving efficiencies within the NHS Trust in relation to avoidable presentation and admissions to Accident and Emergency of children by strengthening early help and clinical capacity to meet health needs of children at a locality level.

3.2 A copy of the Expression of Interest is attached at **Appendix 1**. The bid to the DCLG is for £750,000 and it is proposed that, if successful, this funding be used to fund the following:

- Programme management capacity;
- Programme delivery capacity;
- Development of software to capture qualitative and quantative outcomes data;
- Transforming leadership and workforce development; and
- Programme evaluation.

3.3 Following the submission of an Expression of Interest the Local Authority been invited, on behalf of partners, to submit a formal bid. The DCLG will provide support to the authority to develop the formal bid and the bid should be submitted by 1st October 2014.

4. FINANCIAL CONSIDERATIONS

4.1 There are no financial implications to the submission of the formal bid for the Transformation Challenge Award. There is a requirement, however, that the bid must be approved and signed by the Section 151 officer of the local authority and partner agencies.

4.2 If the formal bid is successful, this will bring additional funding into Hartlepool to support service redesign and re-engineering with the intention of integrating services to produce future efficiencies and better services for children, young people and families in Hartlepool.

5. RECOMMENDATIONS

5.1 The Health and Wellbeing Board is asked to endorse the submission of a formal bid for the DCLG Transformation Challenge Award to invest in the integration and transport of early help services and processes.

6. REASONS FOR RECOMMENDATIONS

6.1 The Hartlepool Better Childhood Programme will be a major initiative of the Council in 2015/16, seeking additional funding to support this development will enable the Programme to be effectively managed and delivered within timescales agreed by the partnership. Children's Services Committee has responsibility to agree bids for additional funding for the Council.

7. BACKGROUND PAPERS

DCLG April 2014 'Transformation Challenge Award and Capital Receipt Flexibility 2014 – 2016 Prospectus.'

8. CONTACT OFFICER

Gill Alexander
Director of Child and Adult Services
01429 523732
Gill.alexander@hartlepool.gov.uk

Sally Robinson
Assistant Director, Children's Services
01429 523732
Sally.robinson@hartlepool.gov.uk

Transformation Challenge Award

2015-16 Expression of Interest Form B

B. Encouraging places that have ambitious plans to work in partnership across the public sector and with the voluntary and community sector or private sector to re-design services.

Disclaimer
There shall be no expectation of grant until authorities have been formally notified in writing by the department. All the applicant's costs and charges incurred as a result of making this expression on interest/application shall be for the applicant's account and cannot be claimed as part of the project.

The Data Protection Act: Freedom of Information Act 2000
The Department for Communities and Local Government undertakes to use its best endeavours to hold confidential any information provided in any application form submitted, subject to our contracting obligations under law, including the Freedom of Information Act 2000. If you consider that any of the information submitted in the application form should not be disclosed because of its sensitivity then this should be stated with the reason for considering it sensitive. The department will then consult with you in considering any request received under the Freedom of Information Act 2000 before replying to such a request.

Applicants should be aware that the following conditions will also apply to all bid applications:

- We may use your information for the purposes of research and statistical analysis and may share anonymised information with other government departments, agencies or third parties for research and statistical analysis and reporting purposes.
- Our policies and procedures in relation to the application and evaluation of grants are subject to audit and review by both internal and external auditors. Your information may be subject to such audit and review.
- We propose to include light touch monitoring by the department utilising publicly available information. We would encourage applicants to regularly publicise progress on their websites and disseminate good practice.
- The department will publish summaries of all successful bids.

2015-16 Transformation Challenge Award –
Expression of Interest form B and financial business case

Completed Expression of Interest forms should be approved and signed by the Section 151 officer of each local authority partner to the bid and authorised person for other partners. The form should be returned in electronic format to transformation@communities.gsi.gov.uk by no later than 5pm on 1 July 2014. Please also complete and send the short financial business case spread sheet with your application.

Section A: Applicant contact information

Note: This bid is for the Transformation Challenge Award 2015-16 B.

Local Authority Name/Name of bidding organisation:	HARTLEPOOL BOROUGH COUNCIL
Name of Contact(s):	GILL ALEXANDER
Position in authority:	DIRECTOR OF CHILD AND ADULTS SERVICES
Telephone number(s) of the contact(s):	01429 523910
Email address of the contact(s):	Gill.alexander@hartlepool.gov.uk

Section B: Eligibility criteria

Note: This bid is for the Transformation Challenge Award 2015-16 B.
Please tick to confirm that the bid meets all the following eligibility criteria:

1. Savings must exceed the amount of grant / capital receipt flexibility sought. X☐
2. The bid must have a positive impact on service users. X☐
3. As a minimum bids must be in partnership with at least one other partner. This could be another local authority, public authority, the Voluntary and Community Sector or a private sector partner. X☐
4. ***For capital flexibility only***. That the value of the asset sale is genuinely additional to those disposals that would have happened anyway – tick or specify not applicable. ☐
5. The proposal has been signed off by your Section 151 officer. X☐

Section C: Project description

Note: This bid is for the Transformation Challenge Award 2015-16 B.

Short Project Title: Please give the bid a short name, unique to any other bids from your organisation.

The Better Childhood Programme

Project Summary (500 words maximum): Please provide a brief description outlining the rationale for the project and the key elements of proposed service transformation.

The challenges Hartlepool faces are recognised nationally. The Government's recently published Child Poverty Strategy 2014-17 identifies Hartlepool as highest nationally for working-age unemployment rates and 4th highest for working-age adults with a limiting, long-term health condition. It has the tenth highest rate of child poverty rate at 33% compared with a national average of 21%.

The Ofsted inspection of children's services judged the local authority to be good but identified a key issue in relation to intergenerational neglect which is significantly limiting the health and wellbeing of children and young people leading to poor outcomes. We need to get better traction on tackling the extent and impact of child poverty, neglect and health inequalities. The Better Childhood Programme will transform processes, systems and service models to create new multi professional solutions. The challenges faced by Hartlepool are mirrored in neighbouring authorities and our model will act as a prototype to be delivered initially on a north Tees basis and for wider roll out across the sub region.

The programme brings together the services of:

- Hartlepool Council Children's Services, Economic Development and Public Health;
- NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group;
- North Tees and Hartlepool NHS Foundation Trust;
- Tees, Esk and Wear Valley NHS Foundation Trust;
- Cleveland Police;
- Local voluntary and community sector services.

The programme has three elements:

1. Establishing an integrated single point of access across north Tees (including Stockton Borough Council) through a multi professional triage and assessment hub to improve intelligence sharing, risk assessment and

decision making for vulnerable families and ensuring they get access to the right early or specialist support. This will involve a re-engineering of business processes and the development of software linked to Munro's recommendations in relation to monitoring the qualitative and quantitative impact of interventions with families.

2. Redesigning our approach to early help and social care to establish multi professional teams of family partners utilising capacity within health, local authority and the voluntary sector. These teams will deliver intervention based practice to improve outcomes in relation to education, family health, economic well being and support for children with disabilities and special educational needs. Organisational arrangements and service delivery models will be redesigned to create a new multi skilled workforce model underpinned by a leadership and workforce development programme. It will also develop and provide mobile tools for front line workers supporting effective monitoring and planning to ensure interventions do not drift.

3. Achieving efficiencies within the NHS Trust in relation to avoidable presentation and admissions of children to hospital through Accident and Emergency by strengthening early help and clinical capacity to meet the health needs of children at a locality level.

Delivery of the programme will take account of recent research into the impact of neglect and the best models for bringing about change in intergenerational cycles. An integral part of the programme will involve getting research evidence into practice and we will seek a University partner to assist us in this.

Expected Grant Requirement: Please state the total amount you expect to be bidding for from the Transformation Challenge Award.

£750,000

Joint Application: Is the bid being submitted jointly with other local authorities, and/or other partner organisations? (Please tick appropriate box)

Yes X No ☐

If yes, please provide the names of all partners

Name of delivery partner 1	Hartlepool Borough Council
Name of delivery partner 2	NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group
Name of delivery partner 3	Cleveland Police

Other bids: Please provide the details of any other bids submitted by partners in this proposal that have been submitted to the Transformation Challenge Award. Please specify name of bid, lead bidding organisation, and the partnership arrangements of the bid.

None

Assets: Does the project involve a land or property transaction or asset transfer to a joint vehicle? If so, please provide details of what is involved or say not applicable.

No

Asset additionality: Please explain how any asset sale is additional to what would have happened anyway and how it impacts on the overall proposal.

N/A

Section D: Project outputs and beneficiaries

Note: This bid is for the Transformation Challenge Award 2015-16 B.

Your bid should include a clear and concise narrative description using and extending the box below (no longer than four pages, including any supporting evidence) setting out the rationale, the key stages/milestones, consequent benefits and timelines. This should cover:

- All costs associated with the project have been identified
- An explanation of why you believe the costs to be reasonable
- The level of organisational and financial commitment where funding is contributed from other sources, including any dependencies
- The nature and agreement on governance arrangements and project management arrangements, necessary to take forward this project.
- That financial risks have been identified and mitigation plans are in place (A risk register should be included)
- The sustainability of savings in future years (the benefits calculator asks applicants to provide a profile of savings over the next ten years)

Programme Costs

The costs associated with the Better Childhood Programme relate to five areas of expenditure:

1. Establishing Programme Management capacity. In order to ensure the effective delivery of this transformational programme within timescales we need to ensure there is sufficient capacity for programme management. This can be achieved through the setting up of a small and light programme management arrangement consisting of one manager and one administrative officer over the length of the programme from design to implementation. This is estimated to cost £100,000.

2. Accelerating service and system redesign and integration will require technical capacity to assist in business process re-engineering, workflow analysis and developing the workforce and organisational model required to deliver the level of change necessary. This will entail undertaking an audit of existing processes across health, police and the local authority to identify where intelligence is held, how information is managed and recorded, where risk assessment takes place, how services are configured and delivered and developing options for eradicating duplication and improving efficiency. It will also involve working across partners to develop a blueprint for the future service delivery model. We will need to commission expertise and capacity to assist us in this work over a 12 month period and we estimate the costs of this technical ability to be in the region of £160,000. This is calculated on the basis of 2 people for 200 days each at an estimate rate of £400 per day.

3. Developing the enabling ICT and software to capture qualitative and quantitative outcomes data to support effective risk assessment, planning and record keeping. Effective use of ICT and software will be fundamental to our ability to prevent drift in our interventions with families by measuring impact in a consistent way and identifying delay. To progress this aspect of the programme we would propose a partnership approach with the Council's ICT provider to develop an ICT and software model fit for purpose that would capture qualitative outcomes for children and families and measure impact. Following development, this model could be made more widely available for implementation nationally. The current estimate we are working with for this development is £400,000 in order to develop software and purchase hardware to support the workforce in new models of working.

4. Transforming leadership and workforce practice. This is the cornerstone of our Programme and is essential to its success. The delivery of the Programme will require a radical shift in the way organisations and professionals deliver services moving away from silo working and professional boundaries. The success of the programme will require transformational leadership at senior and middle leader levels and new and innovative practice models across the children's workforce in health, social care, the police and education. We are therefore proposing to commission:
    a. A Transformational Leadership Programme for health, social care, education and police;
    b. A Research into Practice Programme in partnership with a leading University to ensure current evidence of what works is fed rapidly into practice.

The estimated cost for leadership and workforce development is £200,000.

5. Programme Evaluation. We recognise that the level of innovation in the Better Childhood Programme and its status as a prototype for the Teesside authorities will require rigorous independent evaluation. We will therefore seek a nationally recognised expert to undertake an evaluation of the programme from its inception through to service implementation. The estimated cost of this is £50,000

Organisational and Financial Commitment

The Better Childhood Programme has been developed through the Hartlepool Health and Well Being Board Joint Commissioning Executive and the Joint Strategic Partners Group. It has also been agreed by the Tees Strategic Management Board that Hartlepool will bid for this Transformation Challenge Award to develop a prototype for new service delivery across the sub region. The programme will be led by an Assistant Director for Children's Services with support from a core team of senior leaders from the Clinical Commissioning Group, North Tees and Hartlepool Foundation Trust, Tees Esk and Wear Valley NHS Trust, Public Health and the Police. The partners will make a non recurring contribution of £160,000 to deliver the Better Childhood Programme. The Health and Wellbeing Board Joint Commissioning Executive has earmarked reserves to drive system change in this area and this will be utilised in support of this programme.

Outputs

It is expected that the remodelling of services for children and families to reduce the impact of neglect, poverty and health inequalities will reduce demand for and consequent costs associated with specialist interventions such as child protection and looked after services resulting in a saving of £1m over 3 years. This will be achieved through efficiencies arising from business process and workforce re-engineering leading to improved assessment and intervention to respond to emerging need, earlier identification of and response to risk and intervention based practice which facilitates sustainable change for families.

By strengthening our early help and clinical capacity to give families confidence to respond to health needs of children it is anticipated that we will reduce costs in relation to unnecessary presentation of children to Accident and Emergency. Additional benefits realised through the programme will be achieved in:

- Reduction in offending and anti social behaviour by young people;
- Improved educational attendance and outcomes;
- Reduction in youth unemployment;
- Efficiencies in relation to welfare benefit costs associated with unemployment;
- Reduction in childhood obesity rates;
- Reduction in teenage pregnancy rates;

- Increased take up of childhood immunisations;
- Reduction in admissions to accident &emergency for drug and alcohol misuse by young people; and
- The development of a prototype for achieving system and service change for roll out across the Tees Valley in relation to early help and reduction of high end demand.

There will be financial savings arising from the above outputs however, these are not yet quantified. A cost benefit analysis will be undertaken to quantify these savings and included with the formal bid if successful.

Milestones

Stage 1 April – July 2015
System and service audit, needs analysis, mapping and stakeholder engagement.
Commission research, development and evaluation partner.
Stage 2 July – September 2015
System and service design and consultation with key stakeholders.
Information management and system development.
Design and development of workforce development programme.
Stage 3 October – December 2015
Approval of proposed model and formal consultation.
Commence delivery of workforce development programme.
Stage 4 January – April 2016
Implementation and piloting of systems and service model.
April 2016 – July 16
Launch
Full evaluation report available and disseminated through national conference.

Governance

The programme will be governed by the Joint Commissioning Executive reporting to the Hartlepool Health and Wellbeing Board, Hartlepool Strategic Partners Group and the Tees Strategic Management Board. We will establish a Project Implementation Group involving senior leaders from partner agencies to oversee the delivery plan and a programme office to support the work of this Group.

Risks
There are a number of risks implicit in the delivery of any change programme and it is important to recognise and manage these as part of the project plan.

The risks relate to
- Partners unable to fully engage in the process and agree the best ways of working together to achieve the necessary level of change;

- Pace of change is not sufficient to deliver service and system change within agreed timescales;
- Workforce skill mix and availability to deliver the programme is not adequate;
- Loss of individual professional expertise;
- There is insufficient information and data at the correct level and quality to effectively monitor outcomes.

Financial Risks

- Unable to bring about sufficient change to reduce high end demand and projected savings not achieved;
- Cost to deliver programme is greater than grant and agency contribution.

Risk can be mitigated through

- Effective project management and governance;
- Commencing the redesign process as early as possible;
- Providing effective workforce development to support the change;
- Risk register maintained and managed by Project Implementation Group;
- Planned use of reserves to support the shift from acute spend to prevention

Sustainability

The level of need within Hartlepool is a significant driver of increasing expenditure in demand led budgets. The level of pressure being experienced by partner agencies as a result of this is, in itself, not sustainable. The Better Childhood Programme will therefore be key to sustaining a viable and modernised public sector in Hartlepool. The level of efficiencies that will be achieved will enable ongoing investment in the system and service model that underpins the reform programme.

Section E: Project funding

Note: This bid is for the Transformation Challenge Award 2015-16 B.

Please complete the financial business case spread sheet and enclose the completed table as a separate attachment. Summary data presented in the following sections should be consistent with data shown in the spread sheet table.

Funding sources: Please specify the proposed funding sources for the project, including the breakdown by:

a) Transformation Challenge Award Grant sought
b) Capital Receipt Flexibility allocated to project (funding, if applicable, resulting from capital assets receipts as described in the Prospectus)

c) Other funding being made available and the source of that funding (including funding from other governmental departments). If this relates to a specific element of the project, then this should be outlined in the text.

Funding source	Amount being sought
Transformation Challenge Award Grant	£750,000
Capital Receipt Flexibility (if applicable)	N/A
Other funding (please specify all additional sources separately)	£160,000

Other sources of funding: Please comment briefly on all other sources of funding identified above, setting out the extent to which these are confirmed, whether they are dependent on Transformation Challenge Award, and how they will be used

Funding stream	Details including: are these confirmed, are they dependent on the Transformation Challenge Award and how will they be used.
Hartlepool Borough Council	£60,000 confirmed and committed to delivery of project to remodel workforce. Will be added to total budget to ensure successful delivery of programme
NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group	The CCG have agreed in principle to provide £60,000 non-recurrent support for the project delivery and remodelling of the workforce. Will be added to total budget to ensure successful delivery of programme
Cleveland Police	Cleveland police have indicated a commitment to this project which will either be by way of £40,000 through secondment of officer to programme or other financial contribution.

If you are in receipt of other funding or bidding for other funding, (including from other departments) please explain how a Transformation Challenge Award will enable you to achieve different or further benefits.

N/A

Section F: Financial business case – savings

Note: This bid is for the Transformation Challenge Award 2015-16 B.

Estimated Savings Net Present Value arising from new shared arrangements	**£** £5,273,415

Section G: Benefits to local people

Note: This bid is for the Transformation Challenge Award 2015-16 B.

Please provide details of the anticipated improvements / benefits to local people including protection of front line services.

Children, young people and their families across the continuum of need from early help to statutory and specialist intervention and support will benefit from better education, health and support to secure their protection. Based on current figures this equates to around 5,000 children in Hartlepool. The harm associated with neglect, poverty and health inequalities will be mitigated as families will benefit from wraparound integrated services and a Family Partner who will respond to emerging need to prevent this from becoming complex, acute and harmful. To prevent harm from occurring is better than responding once it has occurred. Where children require specialist services, these will be assertive and intervention based helping families to achieve sustainable change. Outcomes achieved will be tangible and measurable through qualitative and quantitative information.

Parents and carers will benefit from strengthened and more confident parenting leading to a reduced reliance on statutory services. They will have increased access to employment and training opportunities enabling them to break the cycle of intergenerational poverty.

The strategy of the local authority and partner agencies in managing reducing budgets has been to protect front line services from cuts and making efficiencies in other areas. This approach is not sustainable and a new way of managing local public sector services is required, one which works to a single assessment and plan with families, in a coordinated way. This approach reduces duplication and consequently maximises the effectiveness of what is available across the children's workforce to respond to families and meet their needs.

HEALTH AND WELLBEING BOARD

10 September 2014

Report of: Scrutiny Manager

Subject: AUDIT AND GOVERNANCE COMMITTEE WORK PROGRAMME 2014/15 – CARDIOVASCULAR DISEASE (CVD)

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1. PURPOSE OF REPORT

1.1 To advise the Health and Wellbeing Board of the selection of Cardiovascular Disease as the topic for investigation by the Audit and Governance Committee as part of its statutory scrutiny responsibilities.

2. BACKGROUND

2.1 In fulfilling the requirements of the Health and Social Care Act 2012, the Council has a statutory responsibility to review and scrutinise matters relating to the planning, provision and operation of health services at both local and regional levels. In doing this, local authorities not only look at themselves (i.e. in relation to public health), but also at all health service providers and any other factors that affect people's health.

2.2 This function is fulfilled through the Audit and Governance Committee, which reviews / scrutinises and makes reports with recommendations to the Council, a 'responsible person' (that being relevant NHS body or health service provider) and other relevant agencies about possible service improvements in the following areas:-

(i) health issues identified by, or of concern to, the local population;

(ii) proposed substantial development or variation in the provision of health services in the local authority area (except where a decision has been taken as a result of a risk to safety or welfare of patients or staff);

(iii) the impact of interventions on the health of local inhabitants;

(iv) an overview of delivery against key national and local targets, particularly those which improve the public's health;

(v) the development of integrated strategies for health improvement; and

(vi) The accessibility of services that impact on the health of local people to all parts of the local community.

2.3 The Audit and Governance Committee establishes an annual work programme, as a means of fulfilling the Councils responsibilities, and met on the 7 August 2014 to select topics for investigation in 2014/15. At this meeting, the Committee welcomed the Health and Wellbeing Boards support for an investigation in relation to cardiovascular disease and went on to select the issue as its primary topic for 2014/15.

2.4 In progressing the investigation, the Audit and Governance Committee will co-ordinate its activities alongside that of partner organisations to prevent duplication and ensure that the most effective / worthwhile outcome is achieved. The first stage in this process is the 'scoping' of the investigation and the Audit and Governance Committee will at its meeting on the 21 August 2014 establish the overall aim of the investigation, its terms of reference, potential sources of evidence and timetable. Work will then be undertaken during the course of 2014/15, resulting in the formulation of a final report that will make recommendations to the Health and Wellbeing Board and partner organisations where appropriate.

3. EQUALITY AND DIVERSITY CONSIDERATIONS

3.1 There are no equality of diversity implications.

4. RECOMMENDATIONS

4.1 That that selection of 'cardiovascular disease' as the health topic for investigation by the Audit and Governance Committee be noted.

5. REASONS FOR RECOMMENDATIONS

5.1 To ensure that the Health and Wellbeing Board is kept fully informed and updated.

6. BACKGROUND PAPERS

Audit and Governance Committee (7 August 2014):

- Report of the Scrutiny Manager entitled 'Selection of Potential Topics for Inclusion in the 2014/15 Statutory Scrutiny Work Programme'
- Minutes

7. CONTACT OFFICER

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HEALTH AND WELLBEING BOARD

10th September 2014

Report of: Director of Regeneration and Neighbourhoods

SUBJECT: SAFER HARTLEPOOL PARTNERSHIP DRAFT REDUCING RE-OFFENDING STRATEGY 2014-2017

1. PURPOSE OF REPORT

1.1 To present and seek comments from the Health and Wellbeing Board on the second draft of the Safer Hartlepool Partnership Reducing Re-offending Strategy 2014-2017.

2. BACKGROUND

2.1 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 the Responsible Authorities and make up the Safer Hartlepool Partnership.

2.2 Following the Safer Hartlepool Partnership Development Day held in April 2013, the Safer Hartlepool Partnership agreed that there was a need to develop a local Reducing Re-offending Strategy to tackle high rates of re-offending whilst at the same time managing changes brought about by the Government 'Transforming Rehabilitation' agenda.

3. STRATEGY DEVELOPMENT

3.1 In September 2013 the first draft of the Reducing Re-offending Strategy was presented to and approved by the Safer Hartlepool Partnership; however it was acknowledged that finalisation and consultation on the strategy should be delayed pending findings from the Audit and Governance investigation into the level, complexities and impact of re-offending in Hartlepool.

3.2 Following the conclusion of the Audit and Governance investigation in May 2014, the strategy was revised, second draft as attached at **Appendix 1**,

and approved for consultation by the Safer Hartlepool Partnership on 18th July 2014.

3.3 The overall aim of the strategy is – 'To ensure that local services are co-ordinated in a manner that meets the needs of offenders, whilst at the same time ensuring local communities remain safe'. It is proposed that this will be achieved through the focus on three key objectives:

- Improving pathways out of re-offending.
- All partners working together with the needs of offenders and public safety at the heart of service planning.
- Delivering a local response to local problems through a better understanding of offending behaviour and impact of interventions.

3.4 In addition an action plan, attached at **Appendix 2**, underpinning delivery of the strategy has been developed by the Safer Hartlepool Partnership Reducing Re-offending Task Group, taking into account key findings from the Offender Housing Needs Event held in December 2013 and ongoing work to develop a Tees-wide single Integrated Offender Management (IOM) scheme, to address the behaviour of our most chaotic and priority offenders.

3.5 Responsibility for delivery against the strategic objectives and action plan has been allocated to the Safer Hartlepool Partnership Reducing Re-offending Task Group, where performance will be monitored by the Safer Hartlepool Partnership.

4. NEXT STEPS

4.1 The draft strategy is being consulted upon in accordance with the Voluntary and Community Sector Strategy undertaking (this contains the former consultation codes of the Hartlepool Compact). The results of the consultation on the second draft of the Reducing Re-offending Strategy 2014-2017 will be considered and used to inform the production of the final draft which will be presented to the Safer Hartlepool Partnership in October 2014 for adoption.

5. LEGAL CONSIDERATIONS

5.1 Under the Crime and Disorder Act 1998 the Safer Hartlepool Partnership has a duty to provide a co-ordinated response to reducing crime and disorder, tackling substance misuse, and reducing re-offending in Hartlepool.

6. EQUALITY AND DIVERSITY CONSIDERATIONS

6.1 Effective implementation of the strategy will ensure that offenders are not placed at a disadvantage in relation to the provision of local services, as well

as protecting our most disadvantaged and vulnerable communities who are at the greatest risk of crime and anti-social behaviour.

7. SECTION 17 OF THE CRIME AND DISORDER ACT 1998 CONSIDERATIONS

7.1 Failure to implement a reducing re-offending strategy will undermine the Safer Hartlepool Partnerships ability to fulfil its statutory obligations under Section 17 of the Crime and Disorder Act 1998 to reduce re-offending.

8. RECOMMENDATION

8.1 The Health and Wellbeing Board is requested to note and comment on the draft Safer Hartlepool Partnership Reducing Re-offending Strategy 2014-2017.

9. REASON FOR RECOMMENDATION

9.1 As a Responsible Authority, the Local Authority has a statutory obligation under the Crime and Disorder Act 1998 to reduce re-offending in Hartlepool.

10. BACKGROUND PAPERS

Report to Safer Hartlepool Partnership 5th July 2013 - Safer Hartlepool Partnership Development Day Feedback
http://www.hartlepool.gov.uk/egov_downloads/05.07.13_-_Safer_Hartlepool_Partnership_Agenda.pdf

Report to Safer Hartlepool Partnership 27th September 2013 – Reducing Re-offending in Hartlepool
http://www.hartlepool.gov.uk/egov_downloads/27.09.13_-__Safer_Hartlepool_Partnership_Agenda.pdf

Report to Audit and Governance Committee 15th May 2014 – Draft Final Report – Re-offending Investigation
http://www.hartlepool.gov.uk/egov_downloads/15.05.14_-_Audit_and_Governance_Committee_Agenda.pdf

Report to Safer Hartlepool Partnership 18th July 2014 – Reducing Re-offending Strategy 2014-2017 -
http://www.hartlepool.gov.uk/egov_downloads/Safer_Hartlepool_Partnership.pdf

11. CONTACT OFFICERS

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Hartlepool Reducing Re-offending Strategy

2014-2017

'Ensuring that local services are coordinated in a manner that meets the needs of offenders, whilst at the same time ensuring local communities remain safe.'

Contents

Foreword

I am very pleased to be able to introduce the Hartlepool Reducing Re-offending Strategy 2014-2017 which has been developed by the Safer Hartlepool Partnership.

The strategy builds in the excellent work that has been going on in Hartlepool for a number of years now.

Despite this, re-offending continues to be of great concern in Hartlepool, with a small number of offenders causing a disproportionate amount of crime and disorder in our local community.

As a partnership we need improve pathways out of re-offending and ensure services meet the needs of offenders, whilst at the same time keeping the Hartlepool community safe.

Cllr Christopher Akers-Belcher
Chair of the Safer Hartlepool Partnership

National Context

Nationally, significant changes are currently underway in relation to the transformation of rehabilitation services with the aim of bringing about greater reductions in re-offending and addressing the wider harm caused to the community by re-offending behaviour.

Re-offending has a personal cost for victims. In many cases this may be an immediate financial loss, but it is the impact of crime on the mental and physical well being of victims that can often have long lasting devastating consequences on individuals, and their families.

Re-offending also has a broader economic impact on society in general (estimated to be over £4bn annually)**.** Investment in prisons and probation has not realised reduced reoffending rates with those sentenced to under 12 months receiving no form of statutory support in the community. This has led to a review in the way rehabilitation services could be delivered in the future. As such the recently published report 'Transforming Rehabilitation: A Strategy for Reform' (May 2013) sets out governments plans to transform the way rehabilitation services will be delivered in the future underpinned by the following principles:

- Offenders need to be **supported through the prison gate,** providing consistency between custody and community.
- Those released from **short-term sentences**, who currently do no get support, need rehabilitation if we are to bring their offending under control.
- **Public protection** is paramount, and the public sector must take the role in keeping people safe.
- **The voluntary sector** has an important contribution to make in **mentoring** and turning offenders lives around.
- Nothing will work unless it is rooted in **local partnerships** and brings together the full range of support, be it housing, employment advice, drug treatment or mental health service.

The reforms thus make provision for: new 'through the gate' services and designated resettlement prisons where prisoners will be returned for at least 3 months prior to release; the extension of rehabilitation to the most prolific offenders (those receiving less than a 12 month custodial sentence); the opening up of competition for the delivery of rehabilitation services to a wider range of providers; and the introduction of a payment by results system.

The new system which will go live in autumn 2014 also introduces a new national public sector probation service which will retain the management of offenders who pose a high risk of serious harm to the public. For those offenders falling outside of the 'high risk' category new providers of services

will be expected to integrate with existing local partnerships to make the new system work. In this respect 21 contract package areas have been identified nationally with the current Durham Tees Valley Probation Trust area being identified as one contract package area.

As such intelligence on local needs and priorities will be fundamental in informing the future commissioning process, as will the commissioning priorities of local partners, including the Police and Crime Commissioner (PCC), and health providers.

The new providers are also expected to have regard to PCC Plans, and once contracts are let, new providers are expected to work collaboratively with PCCs who are in turn expected to engage with providers through local forums such as Community Safety Partnerships, thus ensuring that providers are working together to deliver local priorities and reduce crime in local areas.

The key role for local Community Safety Partnerships in this new landscape will therefore be to ensure that the full range of local support services are co-ordinated in manner that meets the needs of offenders whilst at the same time keeping the Hartlepool community safe.

Local Context

Over the last seven years crime and disorder rates in Hartlepool have been reducing year on year with the most recent statistics for 2012/13 showing a reductions of 9.7% in relation to crime and a reduction of 22.4% in relation to anti-social behaviour. However, compared to our local peers Hartlepool continues to have the second highest crime and anti-social behaviour rate across the Cleveland force area, and in terms of re-offending, according to the Ministry of Justice single proven re-offending measure Hartlepool has the second highest re-offending rate nationally (October 2011-2012).

Within this context the national reforms underway in relation to rehabilitation services will inevitably present some key challenges for the Safer Hartlepool Partnership.

Engaging with new providers of rehabilitation services will require an investment in developing good quality relationships if we are to make the system work. Equally local partners will also need to consider how they will deal with the increased demand for their services following the statutory expansion of rehabilitation services to those offenders receiving a custodial sentence of less than twelve months.

Having a clear picture of who the re-offenders are in Hartlepool, why they reoffend and the likely demand on services is therefore crucial to successfully delivering rehabilitation services in the future to reduce re-offending and the broader harm caused to communities.

The Extent of Re-offending in Hartlepool

According to the Ministry of Justices single 'proven reoffending' measure Hartlepool has he second highest reoffending rate nationally.

The single 'proven re-offending' measure was introduced by the Ministry of Justice in 2011 with the aim of providing a consistent measure enabling communities to hold local service providers to account. This data is published on a quarterly basis in relation to adults and juveniles, who, within a rolling period of 12 months have:

- Received a caution, reprimand or warning; or
- Received a court conviction other than immediate custody; or
- Were discharged from custody; or
- Tested positive for class A drugs on arrest

In an effort to provide some further insight into re-offending in Hartlepool, additional analytical was undertaken by the Safer Hartlepool Partnership examining a cohort of Hartlepool reoffenders for the period April 2012 - March 2013. This work looked at who the offenders are, who is currently working with them, and the types of offence committed. The top 10 offenders were also identified along with the breadth of their offending behaviour and where they were likely to commit offences.

Who are the re-offenders in Hartlepool?

The analysis reveals that during the 12 month period a total cohort of 1,704 offenders were identified with 531 of these offenders having committed a reoffence within the 12 month period.

The majority of re-offenders were adults (93%), with 84.4 % (420) being male. Within the male reoffending cohort the 21-24 years age group and 29-31 years age group were dominant but this was also accompanied by a spike in the number of male adult re-offenders aged 18 years, the majority of which were previously known to the Youth Offending Service. The age range in relation to female re-offenders in the group was also slightly different with the 23-25 years and 31-34 years age groups being predominant.

Which services are the re-offenders engaged with?

42% of the adult re-offending cohort were known to probation and many of these (16%) were receiving intensive intervention via the Integrated Offender Management Team (IOM), known locally as the Criminal Justice Interventions Team (CJIT), or the Team around the Household Initiative (TAH). All juvenile re-offenders (33) within the re-offending cohort were known to the Youth Offending Service and were therefore receiving intensive intervention to address their re-offending behaviour

Significantly, just over one third of the re-offenders tested positive for opiates or cocaine and a similar percentage (35%) were known to local drug and alcohol treatment services.

What are the predominant types of re-offences committed?

Crimes of an acquisitive nature represented over a third of the re-offences committed by re-offending cohort with a further 14% of re-offences being linked to violence against the person with 35% of violence re-offences being domestic related. Of interest, the offending profile of those re-offenders not known to probation showed a slight difference in terms of the types of reoffences committed with those re-offenders not known to Probation committing more anti-social behaviour related crimes such as drunk and disorderly and criminal damage offences.

The differences in offending behaviour across gender was also apparent with more than one third (39%) of female re-offenders committing shoplifting offences, compared to 22% of males. Within the re-offending cohort males were also more likely to commit serious acquisitive crime offences such as burglary and violence offences, with 8% of male re-offenders also being Prolific and Priority Offenders (PPOs).

Substance misuse, particularly opiates, was found to be a motivating factor in re-offending across both genders within the cohort, but females are more likely to seek support from treatment service than males.

What is the profile of the top ten re-offenders in Hartlepool 2012/13?

The profile of the top ten adult re-offenders displays the breadth of their offending in Hartlepool but most noticeably, only seven of the offenders were known to probation with only one being a PPO, and six of the offenders being High Crime Causers (HCCs). Further geographical analysis also demonstrated that the top ten adult re-offenders tend to reside in and offend in the most vulnerable and disadvantaged communities in Hartlepool.

The needs of offenders and pathways out of re-offending

Both national and local research indicates that adults and young people who offend are often the most socially excluded in society with the majority often having complex and deep rooted problems, such as substance misuse, mental health, homelessness and financial problems.

Improving pathways out of re-offending through the provision of local services that meet the needs of offenders, and tackling their issues in a holistic, and coordinated way is therefore fundamental to achieving the reduction in reoffending that is anticipated by government through their reforms.

An 'offender centric' approach is already evident in local initiatives in Hartlepool, including the Integrated Offender Management Team, and Team around the Household Initiative where it has been used to great success with offenders being at the centre of service design supported by a multi-agency team underpinned by a restorative approach to reducing offending.

However, addressing the underlying causes of re-offending in order to prevent re-offending is recognised as an inherently complex task and in many cases may require services to be reshaped to meet the need of offenders and growing demand for services.

The main criminogenic needs of offenders and therefore pathways out of reoffending are generally identified as follows:

- Accommodation
- Employment, Training, and Education
- Health – physical and mental
- Drugs and Alcohol
- Financial management
- Attitudes, thinking and behaviour, and relationships

A further insight into the criminogenic needs of those re-offenders known to Durham Tees Valley Probation Trust has also been provided as a result of analytical work undertaken by the Trust during 2012/13. This piece of work informs that those offenders who go onto re-offend within the Durham Tees Valley area have a different criminogenic needs profile to those who don't go on to re-offend, with accommodation, employability, drugs and alcohol, and financial management being the key factors to addressing their offending behaviour.

The importance of the drug and alcohol treatment pathway is also evident in the data collated by the Safer Hartlepool Partnership, and following the need for greater collaboration in the commissioning of health services being

identified at the Safer Hartlepool Partnership development day held in April 2013.

Regard is also given to recent regional research into pathways to rehabilitation undertaken by ANEC/NOMs (Reducing Reoffending in the North East: improving joint working between prisons and local authorities June 2013) which sets out how 'through the gate' services could be improved to reduce reoffending through improved joint working between local authorities and prisons. Of particular note in this respect is the growing evidence base highlighted in the report suggesting that by far the most important criminogenic need / pathway to rehabilitation is accommodation.

This is also supported through the evaluation of the local Team around the Household Initiative which involved some of the most difficult families/households to engage with in Hartlepool. These were households where offending behaviour had been passed from one generation to the next, sometimes across as many as five generations, and all of the households were known to all local agencies for the wrong reasons.

During 2011 the Safer Hartlepool Partnership identified these households for intensive intervention due to the negative impact their offending behaviour was having on the local community. Offender engagement with the TAH process was consensual, and without exception all offenders involved in the initiative had accommodation needs with the offer of appropriate accommodation often being the hook to get offenders engaged in the TAH process. The evaluation also demonstrated that having the right housing for the households involved was key to stabilising household members and reducing/stopping their offending behaviour.

For agencies involved in the TAH process the management of the households involved was also easier. Similar to Multi Agency Public Protection Assessment (MAPPA) arrangements, by sharing the risk, both potential victims, and the broader community were given maximum protection whilst giving offenders the best chance to rehabilitate. This subsequently resulted in improved financial management and increased employability prospects for those offenders involved.

The local 'Offender Housing Needs Group', chaired by the Safer Hartlepool Partnership Housing Sector representative, has also identified that whilst appropriate accommodation is, and can be made available to offenders through increased flexibility in allocation policies, and greater collaboration with 'through the gate' services', there is both a clear need for an improved understanding of existing locally commissioned services across all pathways, together with the need to provide day to day support for offenders to ensure

that offenders remain on the right track in order to break the cycle of their reoffending.

From an operational perspective moves are also underway to explore the criminogenic needs profile of the top ten offenders as identified by the Partnership and merging the best practice of the IOM approach and the TAH approach. This will result in an individual action plan for each offender with sanctions developed on the basis of an offender profile that enables all needs and interventions to be assessed and outcomes measured.

However, it is the view of the Offender Housing Needs Group, that on the basis of existing evidence, the Safer Hartlepool Partnership, should give consideration to pooling resources to commission the service of a specialist housing advisor dedicated to working with re-offenders in Hartlepool. The Group also recommends that the need for day to day support for offenders in order to keep offenders on the right track and break the cycle of reoffending should remain paramount. The type and level of support required for the total cohort of re-offenders is therefore something that requires further investigation.

Strategic Priorities

The Safer Hartlepool Partnership has a statutory duty to develop a strategy to reducing reoffending in Hartlepool. High reoffending rates in Hartlepool and changes in national policy, together with national, regional and local research indicates that the main thrust of a local reducing reoffending strategy for Hartlepool should be to:

'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.'

It is proposed that this will be achieved locally by focusing on:

- Improving pathways out of re-offending
- All partners working together with the needs of offenders and public safety at the heart of service planning.
- Delivering a local response to local problems through a better understanding of offending behaviour and impact of interventions.

The strategy will be backed by an action plan based on the above objectives, and the collation of ongoing evidence with appropriate outcomes will be adopted to measure the success of the strategy and direction of travel in relation to the cohort of re-offenders identified.

In relation to criminogenic needs and pathways to services, the

accommodation pathway will be a priority in the first year of the strategy with consideration being given as to how this pathway can be improved, and ensuring that the support of a specialist housing advisor is in place.

Monitoring Delivery of the Reducing Re-offending Strategy

An action plan has been produced that details how the aim and objectives of the Strategy will be achieved.

It is imperative that progress made against the Strategy is managed and monitored. This will be overseen by the Safer Hartlepool Partnership Reducing Re-offending Task Group. The action plan will be monitored on a quarterly basis and reviewed annually by the Safer Hartlepool Partnership to ensure that delivery is being achieved as well as to ensure that it is kept up to date with any changes in national or local policy.

Safer Hartlepool Partnership Reducing Re-offending

DRAFT ACTION PLAN

This action plan accompanies the Safer Hartlepool Partnership Reducing Re-offending Strategy and underpins its implementation. This plan details how we will achieve and monitor the objectives set out in the strategy. The actions contained within this plan contribute to the overarching aim of the strategy which, is to 'Ensure that local services are co-ordinated in a manner that meets the needs of offenders, whilst at the same time ensuring local communities safe'.

Objective 1: Improving pathways out of re-offending						
Priority	**Key Action**	**Progress Measure**	**Responsibility Resource**	**Timescale**	**Progress**	**Outcome**
1.1 Improve housing pathways for offenders within the custody setting.	Create a Housing Liaison post to work between the custody setting and local housing teams/landlords to help offenders to find tenancies in advance of release date. Develop supported housing provision in Hartlepool for the most problematic offenders from the Hartlepool area.	Increase in the number of referrals into housing support services. Increase in the number of offenders leaving the custody setting into suitable accommodation. Increase in the number of PPOs into supported accommodation on release from custody into the local area				Offenders have improved access to appropriate accommodation on leaving the custody setting. Offenders leaving custody have access to supported accommodation in Hartlepool
1.2 The development of improved partnership working with checks in place to ensure flexibility	Housing advice to begin in adequate time prior to release from custody	Increase in the number of offenders receiving Housing advice no less than				Offenders in custody have improved access to housing advice

in local approaches to the housing of offenders, and that there is no stigma applied to offenders in the allocation of housing.	Review and streamline the Compass application process, including housing history Agencies to have a shared understanding of the need and risk of offenders. Explore the feasibility of introducing the use of one risk assessment form, accompanied by a workable risk management plan.	3 months prior to release from custody Increase in the number of offenders being placed in appropriate accommodation Risk assessment agreed and in place				Offenders receive an improved service through the housing options centre that is non-discriminatory and flexible to their address needs resulting in increased access to appropriate housing. The risks to the community in relation to re-offending are shared and there is improved management of risk between agencies
1.3 Improve the employment pathway for those leaving custody.	Explore local involvement with schemes similar to the 'Change for Change' scheme operated at Deerbolt Prison encouraging the provision of employment /apprentice opportunities for ex-offenders with	Increase in the number of offenders leaving custody going into training and employment within the local authority area				Offenders leaving custody have increased employment and training

	businesses and within the local authority context					
1.4 Address unemployment and poor educational attainment in disadvantaged areas, to raise aspirations and challenge the cycle of offender behaviour across generations.	Pilot the Our Place programme in the Dyke House Area of Hartlepool by developing a partnership of employment and training providers linking employment and training opportunities to the Hartlepool vision	Pilot Programme commenced in the Dyke House area				A network of employment and training providers is in place to raise aspirations of the Local residents in the Dyke House area
1.5 Improve offender mental health pathways through the early identification of problems and the early intervention of mental health /drug alcohol services.	Criminal Justice Liaison and Diversion Service be developed in Hartlepool.	An increase in offenders/those at risk of offending receiving a mental health assessment and referrals to appropriate mental health/drug and alcohol services Plans are in place for the joint commissioning of the criminal justice liaison and diversion service considered by the CCG/public health and PCC				Offenders with mental health /substance misuse problems have improved access to health and social services at the earliest opportunity
1.6 Work to improve the finance and benefits pathway by developing better co-ordination of services to offenders on the day of release from	Explore the introduction of a 'one-stop shop' to bring services and benefits directly together for offenders upon their	Increase in the number of offenders receiving co-ordinated services on release from custody				Offenders are provided with the services they need on release from custody to prevent them from reoffending and re-entering the

custody particularly around benefits	release.					prison system
1.7 Support families to maintain relationships where a family member receives a custodial sentence	Ensure as far as possible prison placements to be within the local area Process for Team Around Meetings to be established across the custody setting, linking with Troubled Families agenda.					Offenders and their families are able to maintain their relationships beyond the prison gate and have the opportunity to joint plan for release to reduce the risk of reoffending

Objective 2: All partners working together with the needs of offenders and public safety at the heart of service planning.						
Priority	**Action**	**Progress Measure**	**Responsibility Resource**	**Timescale**	**Progress**	**Outcome**
2.1 Implement a co-oridnated approach to address the needs of offenders, using a Team around the Offender' model and IOM principles as a template for the provision of holistic offender/centric services	Ensure continuation of IOM model through the new Community Rehabilitation Company The continued development and delivery of holistic/offender centric plans incorporating risk, criminogenic needs, and the inclusion of a range of sanctions falling outside those attached to sentencing	Number of PPOs/HCCs/DRR offenders supported through the IOM approach Increased offender engagement with services and an increase in the breadth of sanctions used to ensure compliance with offender management plans				IOM cohort identified and receiving co-ordinated and intensive interventions to reduce their offending behaviour. Multi-agency holistic offender management plans are used by all agencies working with offenders incorporating criminogenic needs.

2.2 Embed a restorative approach to reducing re-offending and improving victim satisfaction with the punishment of offenders	Ensure restorative interventions are offered to all victims of crime. Explore with Cleveland Police the further development of the extension of the triage service to adults Those working with offenders to receive training in restorative interventions The Community Payback scheme to be supported, and in taking it forward additional training be provided for staff to equip them to effectively interact with ex-offenders in a work environment	Increase in the number of victims of crime receiving restorative interventions Triage scheme developed with an increase in adult offenders receiving punishments outside of the court processes Increase in the number of those working with offenders receiving training in restorative interventions New agreement established for the continuance of Community Payback in Hartlepool in conjunction with the CRC, and HBCs Community Safety and Environmental Services Toolbox Talk developed – increase in the number of HBC staff trained on how to interact with				Offenders have a Increased awareness of the impact of their offending behaviour resulting in subsequent reductions in offending Victims feel that justice has been done and have an improved satisfaction with the criminal justice process Increased visibility in justice being done within the community setting and an increase in the number of offenders putting something back into the community

		offenders in the workplace				
2.3 Improve the transition of young re-offenders into adult services.	Review the needs of 16/17 year re-offenders current to YOS.	Assessments are in place for all young offenders moving from child to adult offender management services				Services have a better understanding of the needs of this group of offenders and are able to improve the support provided resulting in a reduction of the reoffending rate of this particular group
2.4 Ensure adequate substance misuse support services are in place for offenders that adopt a Team Around Approach to support delivery of integrated offender management plans Plans for the joint commissioning of the criminal justice liaison and diversion service considered by the CCG/public health and PCC	Review and Re-commission drug support services through Criminal Justice Interventions Team	Drug services are reviewed and successfully commissioned to ensure integration and support for the delivery of offender management plans		March 2015		Offenders with substance misuse issues are provided with a holistic wrap around service that address their criminogenic needs to improve outcomes across health, employment, housing, and reduced reoffending behaviour

Objective 3: Delivering a local response to local problems through a better understanding of offending behaviour and impact of interventions.						
Priority	**Action**	**Progress measure**	**Responsibility Resource**	**Timescale**	**Progress**	**Outcome**
3.1 Improve the identification of the most problematic offenders.	Review the current Integrated Offender Management (IOM) selection and de-selection process.	Standardised matrix and selection/de-selection process in place that addresses local priorities and the criminogenic				Improved knowledge and effective management of offenders resulting in a reduction in the reoffending rate of the

		needs of offenders				IOM cohort and improved public safety
3.2 Avoid duplication and loss of effectiveness in service delivery following the reform of offender management services	New NPS and CRC to be represented on the SHP as statutory partners with accountability for the management of offenders within the community and the protection of the public Reducing Re-offending Task Group to take responsibility for management of the reducing reoffending strategy action plan SHP /HBC to be represented on Teeswide Single IOM Steering Group	Members are invited and are attending partnership meetings SHP are provided with regular progress and performance updates from NPS and CRC including PBR claims etc Reducing Re-offending group established supported by HBC Community Safety Team and Director of CRC (Chair) Safer Hartlepool to agree Single IOM terms of reference and Partnership involvement in the Teeswide single IOM group				The new NPS and CRC are integrated into local partnership arrangements resulting in improved pathways and management of offenders and reduced risk of harm to the public
3.4 Improve understanding of the impact of interventions and benefits	Adopt a suite of indicators that adequately demonstrate the impact and progress in relation to multi-agency approaches to reducing reoffending					Improved understanding of the impact of interventions and benefits within the new landscape

HEALTH AND WELLBEING BOARD

10 September 2014

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

Subject: Clear and Credible Plan Refresh

1. PURPOSE OF REPORT

1.1 The purpose of the report is to provide the members of the Health and Wellbeing Board a copy of the Clinical Commissioning Group Clear and Credible Plan (refresh) for 2014/15 -2018/19.

2. BACKGROUND

2.1 Following the issue of the planning guidance 'Everyone Counts: Planning for Patients 2014/15 to 2018/19, which set out the ambition for the NHS over the years ahead, including a focus on outcomes for patients and which described a series of changes to the way health services are delivered to improve outcomes the CCG had to provide a response to this document by way of developing a 5 year strategic plan and 2 year operational plan (incorporating BCF plans).

2.2 Plans and an overview of requirements from NHS England have been provided to Health and Wellbeing Board members over recent months, each of the plans reviewed to date were provided in the documentation required by NHS England and it was noted that these were not easy to navigate and content was in technical and NHS terms therefore would not be appropriate to share with members of the public.

2.3 Since submission of the plans the CCG has built upon and refreshed the original Clear and Credible Plan 2012-2017. The refreshed plan now incorporates the planning requirements as described above and sets out our strategy for 2014/15 – 2018/19. The Plan describes who we are, our joint vision, the case for change and how we are going to achieve our vision.

3. RECOMMENDATIONS

3.1 Health and Wellbeing Board members are asked to note the refreshed Clear and Credible Plan.

4. REASONS FOR RECOMMENDATIONS

4.1 To continue to ensure partners are informed and engaged in the CCG planning process and requirements.
The CCG understands that ccoordinated communication and engagement between commissioners, providers and patient organisations and their partner Health & Wellbeing board are integral to the success of delivering our joint vision and will continually keep members informed.

5. BACKGROUND PAPERS

5.1 Everyone Counts: Planning for Patients 2014/15 to 2018/19
CCG Clear and Credible Plan 2012-2017

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Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Clear and Credible Plan Refresh 2014/15 – 2018/19

(Our 5 year strategy)

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Foreword

We are committed to involving local people in decisions about the provision of healthcare for our local communities and we have worked with local people to develop the vision, priorities and future plans as set out in this document.

We want to see a health service that provides high quality and safe care to all local people that meet our 21st century requirements and help us reduce the inequality that exists across our communities and looks to keep improving.

We want to see everyone get healthier, but we want the health of the most vulnerable around us to be as good as that of the most fortunate.

Clinical commissioning is about serving our local communities and patients better by allowing GP Practices to make the important decisions as to how money is used and how NHS services can be improved. We have a real opportunity over the next five years 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.

Based on feedback from patients, the community and GP Practices three aspects stand out where we will need to show improvement:

- Quality of care and of the patient experience
- More timely access to care and care closer to home
- Equality of access and fairness in treatment.

These important points are at the heart of our strategic outcomes. These are difficult to achieve. A finite budget and increasing demand will need us to make choices about the services we commission. Initially this will be focused on reducing unnecessary demand and reducing waste and inefficiency. These are the challenges we must face up to. "We" being the GP practices, the patients, the community, the providers of services and other partner organisations we work with. "Good health is everyone's business".

We must have the confidence to take the difficult decisions. We must do the right things, in the right way, to meet the needs of the people.

We will do this by basing our decisions on clinical evidence and financial reality, by listening to patients and by co-ordinating what we do with other services.

As health professionals with the responsibility to make these decisions we are in a privileged position of trust. We must balance the decisions we make between improving the health of the community and addressing individual needs. We must work well as a team with NHS managers and other partner organisations.

We are building strong and lasting relationships with our local partners and stakeholders and working together to address shared challenges and priorities. Key partners include Stockton-on-Tees and Hartlepool Borough Councils, our local Healthwatch organisations, North Tees and Hartlepool NHS Foundation Trust, South Tees NHS Foundation Trust, Tees, Esk and Wear Valley NHS Foundation Trust and the North East Ambulance NHS Foundation Trust, as well as other key providers in the NHS and independent sector. We have in addition developed strong links with a range of community and voluntary organisations that are able to help us to reach out to those who are often overlooked or seldom heard.

Having been honest about the challenges we face, as clinicians, we are also optimistic about the future.

There are real opportunities we can take. For example:

- Making services more responsive to patient needs and expectations whilst improving quality and maximising efficiency
- Reducing the level of management cost and ensuring maximum investment in frontline care
- Working much more closely with partners such as the local council and health providers to streamline pathways of care and achieve better value.

This document sets out our strategy to achieve these over the next five years. We hope you find this inspiring and would welcome your comments, ideas and support. You can contact us on: 01642 745000 or www.hartlepoolandstocktonccg.nhs.uk

Finally, thank you to everyone who has worked hard through considerable challenges in our first year as a CCG to get us to where we are today. We are still at the start of a long journey, but one that we are confident will prove rewarding and successful. Please continue to give us your time, commitment and feedback on how we are doing – it is greatly appreciated.

Dr Boleslaw Posmyk
Chair, NHS Hartlepool and Stockton-on-Tees CCG

Executive Summary

"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."

NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) mission is to build 21st century health services for and with the Hartlepool and Stockton-on-Tees communities so that health inequalities reduce and wellbeing continuously improves.

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.

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

Developing and maintaining relationships with all of our stakeholders and exploring opportunities for collaborative working, will therefore underpin the effectiveness of this strategy.

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 local people.

We are committed to ensuring that our citizens are fully included in all aspects of service design and change, and that patients are fully empowered in their own care.

We will build upon existing mechanisms to maximise opportunities to engage with and seek the views of patients, carers and the local population.

This strategy sets out a description of our vision in relation to what healthcare services will be commissioned over the next five years to achieve our strategic aims:

- Bringing care closer to home
- Tackling health inequalities
- Caring for an aging population
- Priority health conditions
- Improving quality in primary care
- Quality and safety
- Improving the patient experience
- Seeking best value for money in budget.

This strategy builds upon our local priorities as set out in our Clear and Credible Plan (CCP) 2012/17, as these objectives remain extant, the excellent progress made during 2013/14 and reflects the CCG's current direction of travel. We are committed to deliver our obligations as well as those that are set out in the NHS Constitution.

The CCG through this plan will 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 people through an integrated and evidence based approach.

Section 1: Who We Are

NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group

A Clinical Commissioning Group (CCG) is an NHS organisation which brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

NHS Hartlepool and Stockton-on-Tees CCG is the organisation responsible for planning and paying for the services that the public and patients of Hartlepool and Stockton-on-Tees need and is led by GPs who look after the resident population.

The services we are responsible for planning and commissioning are:

- Mothers and newborns
- People with need for support with mental health
- People with learning disabilities
- People who need emergency and urgent care
- People who need routine operations
- People with long-term conditions
- People at the end of life
- People with continuing healthcare needs.

Importantly we are not currently responsible for commissioning primary care, (which includes GP practices, dentists and opticians), specialised health services, offender health and some services for armed forces – as these areas are commissioned by local area teams of NHS England, of which our region is covered by the Durham, Darlington and Tees Area Team.

However, plans are being developed nationally to allow CCGs to co-commission primary care and NHS Hartlepool and Stockton-on-Tees CCG has commenced discussions with the Area Team about how we can be instrumental in progressing a holistic approach to enhancing quality for patient care. These proposals are currently being progressed and will further support our current commissioning arrangements to focus on reducing inequality and targeting areas of significant deprivation.

Our mission is to build 21st century health services for and with the Hartlepool and Stockton-on-Tees communities so that health inequalities reduce and wellbeing continuously improves

The CCG is a clinically-led membership organisation made up of all the GP practices in the Hartlepool and Stockton-on-Tees area. Details of the member practices which comprise the membership can be found in Appendix 1 and more detailed governance arrangements are described in section 4.

The running of the CCG is overseen by the Governing Body, which is collectively appointed by member practices and acts on behalf of its membership through delegated arrangements.

Key responsibilities include (but are not limited to):

- Ensuring the delivery of delegated statutory duties within resource allocation
- Upholding the principles of the NHS Constitution
- Support and develop its members to contribute to commissioning
- Commission services to improve the quality, safety and health outcomes.

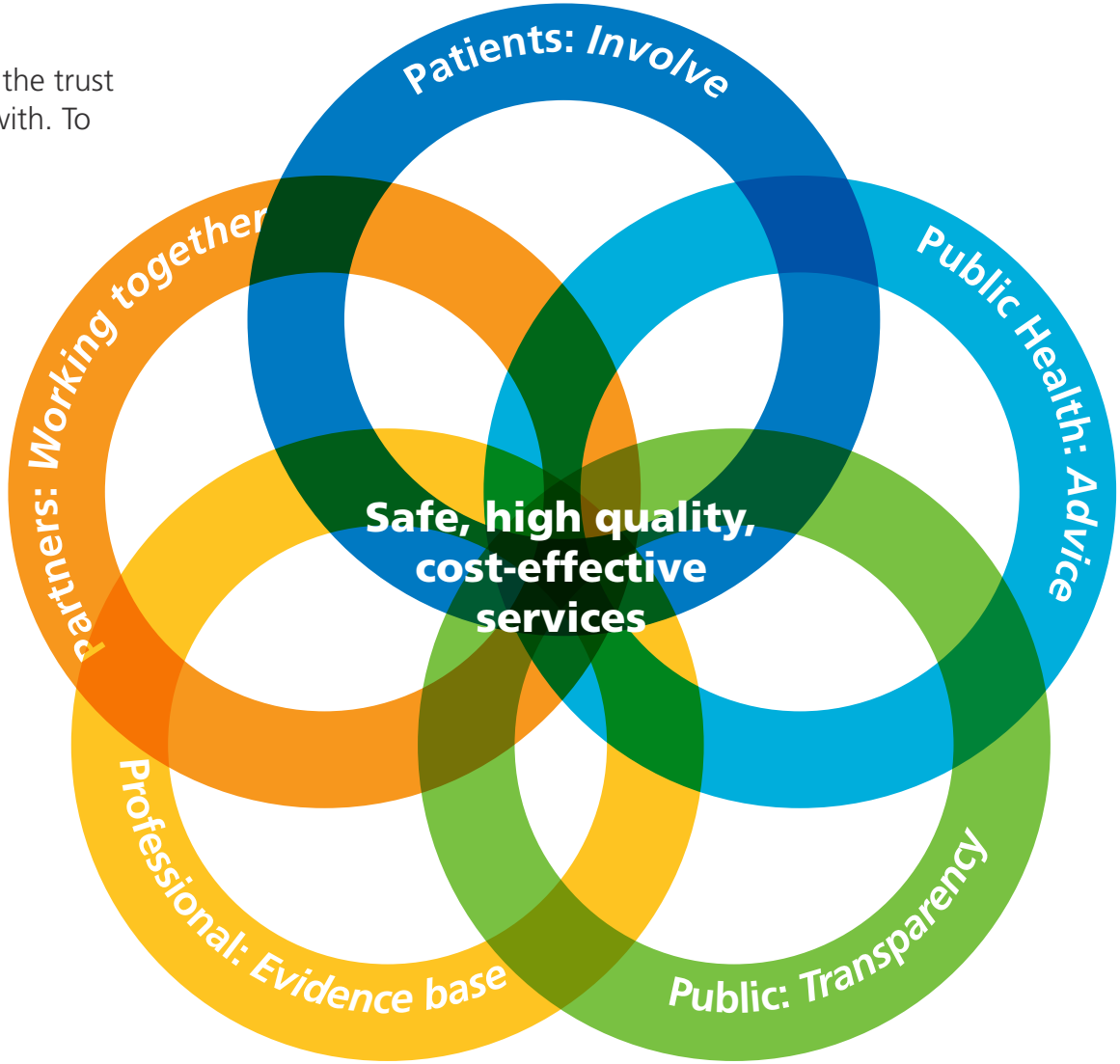
Our aims

- Work with our patients to promote and support healthy living and self-care
- Involve service users, carers, staff, providers, partners and the public to develop services and reduce health inequalities
- Work in partnership to transform services and ensure transparency through inclusion of all stakeholders to meet patient needs
- Make use of and contribute to the evidence base that drives service transformation, embracing opportunities to innovate
- Commission sustainable services as close to the patient's home as possible
- Ensure services are safe, high quality and cost effective
- Plan and respond to the identified needs at a locality level for the residents of Hartlepool and Stockton-on-Tees.

Our principles

To be successful, the CCG needs to win and maintain the trust of the public, its staff and the organisations it works with. To do this the CCG signs up to these principles:

- Being open about its plans and consulting on them before making key decisions
- Acting with integrity and honesty. We will work in the public interest and not to gain financial or other material benefits for ourselves, family, or friends
- Acting objectively making decisions on clinical and economic evidence
- Having courage to lead by taking difficult decisions when necessary and avoiding unnecessary delay
- We will be accountable for our decisions and actions to the public.



Our values

- Focus on quality and continually improve service outcomes
- Build and ensure sustained clinical and provider engagement and collaboration to redesign and implement pathway / service redesign
- Partnership working with key providers, recognising that by joint working and collaboration with key partners, all stakeholders will benefit from the alignment of aims and objectives that will benefit the entire local health economy
- Ensuring effective use of resources and achievement of Value For Money in the services we commission
- Share the rationale underpinning commissioning decisions with our members, communities and partners to ensure transparency
- Use of evidenced based practice to effect change
- Using service user/patient engagement and involvement in review development and implementation of commissioning functions
- Consistent use of the National Institute for Clinical Excellence (NICE) Commissioning Outcomes Framework to ensure principles of quality based commissioning approach
- A Quality, Innovation, Productivity and Prevention (QIPP) approach to commissioning services with a continuous focus on quality for the improvement of patient safety
- Ensure that we uphold the requirements of the NHS constitution and CCG constitution.

We also champion the seven principles enshrined in the NHS Constitution:

- The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief
- Access to NHS services is based on clinical need, not an individual's ability to pay
- The NHS aspires to the highest standards of excellence and professionalism
- NHS services must reflect the needs and preferences of patients, their families and their carers
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
- The NHS is accountable to the public, communities and patients it serves.

Achievements to date

Delivering high quality, accessible healthcare services is central to our improvement plan for Hartlepool and Stockton-on-Tees and we take an integrated, community-centred approach, building our services around the needs of our patients. Our Annual Report[1] documents full details of our progress, a few highlights of which are:

Improving access to services in local communities - we successfully transferred services into our local communities, for example physiotherapy and occupational services for patients with long-term neurological conditions are now relocated from University Hospital of North Tees (UHNT) to Billingham Health Centre, and we worked with North Tees and Hartlepool Foundation Trust on transfer of emergency medical and critical care services from the University Hospital of Hartlepool to the UHNT.

Improving quality in acute care - over the past year, working with neighbouring clinical commissioning groups and acute trusts, the Securing Quality in Health Services (SeQHiS) project has focused on establishing the key clinical quality standards that should be commissioned in acute hospitals in the areas of paediatrics and maternity services, acute care and end of life care.

Current delivery of these standards has been assessed and the planning stage of delivering the unmet standards has commenced.

Improving the quality of care within residential and nursing homes - we have introduced Emergency Health Care Plans (EHCPs) so that care home patients can be reassured that if they fall ill, the emergency care they receive will have been discussed with them in advance, based on their needs and wishes. EHCPs are designed to ensure that patients receive the correct healthcare promptly, in the most appropriate setting, without the need to repeat their wishes to different healthcare providers.

Improving the quality and capacity within primary care - a number of schemes were launched to improve the quality and capacity in Primary Care - one provided valuable information on patient demand, another "Dr First" gave practices the opportunity to innovatively change the way they offer their appointments. We undertook a full review of all Primary Care "Enhanced" Services to ensure the best quality services were being provided in line with best practice, national and local standards and we enhanced capacity over the winter period to help mitigate winter pressures on acute trusts.

Reducing demand to urgent care - responding to increased demand over the winter months, the CCG provided significant additional investment for emergency care practitioners and senior doctors at weekends, paediatric nurse practitioners to support the assessment and treatment of children, additional care home beds and seven day opening of the hospital pharmacy.

We also piloted increased access to GP practices as noted above and piloted a service to improve access and advice to paramedics, out of hours, in order to prevent unnecessary hospital admissions.

Improving access to elective care - we reviewed each specialty against agreed quality measures, such as outpatient 'new to review' ratios, 'consultant to consultant' referrals and NICE guidance to ensure that each contact with the service 'adds' value to the patient; waste is eliminated; and appropriate evidence based standards are met.

To improve access and reduce waiting times, a revised Musculo-Skeletal (MSK) pathway was implemented allowing direct referral to Core Physiotherapy and MSK, plus automatic re-routing of referrals where necessary to avoid delay in treatment.

Advice and guidance was made available for primary care clinicians through the Choose and Book system. This plus the continued updating of our local Map of Medicines pages continues to support clinical decision making and streamlined care for patients.

Promoting good health and wellbeing (medicines) - we supported a range of high profile promotional health campaigns over the year designed to signpost local people to the right NHS service to meet their needs. The campaign was launched to coincide with the busy winter period and included a number of key messages:

- **Keep calm and ask a pharmacist reminded** people that their local chemist could help with many of the common ailments that people suffer from during the winter
- **Keep calm and call 111** as an alternative form of advice when GP practices is closed, 111 will signpost patients to the most appropriate service to meet their needs
- **Keep calm and antibiotics aren't always the answe**r reinforced the message that many winter-related ailments often get better without antibiotics.

The 'My Medicines, My Health' promotion was also launched and was designed to improve medicines management in older people with long-term medical conditions by using a 'green bag' to store medications and take them to any key medical appointments.

Improving Dementia care - one of our priority areas has been to improve care for people with dementia by ensuring that diagnosis is made early and care is more effectively co-ordinated. Robust and accurate local registers for dementia has been key to this work.

Improving Health and Wellbeing - the CCG has worked collaboratively with commissioners across NHS England and Local Authorities to develop approaches to achieve better uptake of screening programmes and earlier diagnosis and treatment. Examples include:

- **Bowel screening** – supported the launch of the National bowel cancer awareness campaign
- **Alcohol** – improved GP practice awareness of local commissioned services for earlier access to alcohol support services and co-developed a local alcohol strategy
- **Chronic Obstructive Pulmonary Disease (COPD)** – improved uptake of screening in 'at risk' patients; undertook review of community respiratory services to inform future model of care, and commissioned a COPD 'rescue pack' to enable patients to self-manage and avoid the need for hospital admission
- **Influenza Vaccination Programme** – in addition to the national plan to provide influenza vaccinations to at risk groups, the CCG recognised the contribution of carers and included them as a priority group in these plans.

COPD Pathway – a pilot project was developed in partnership with the two local hospices (Butterwick Hospice and Hartlepool and District Hospice), to deliver a series of 'Breathlessness' programmes for patients with respiratory conditions. The programme includes working with the patient's carer in order to support them to recognise and manage the impact on their own health too.

A Fairer Start – working with a local Voluntary Sector partner (Catalyst) and Stockton Public Health partners the Fairer Start project will work with young families from the Stockton central ward for the next two years to support them in parenting and social skills to improve the immediate and longer-term health outcomes for children.

Looking Local – the CCG has become one of the first in country to have its own television information channel and smartphone App. These services allow patients to access information on local health services such as GPs, hospitals and dentists any time of the day or night.

Reflections

Key highlights of our performance in 2013/14 included:

- Formal assurance from NHS England (via the national CCG Assurance process) confirming that NHS Hartlepool and Stockton-on-Tees CCG is demonstrating ongoing good performance and improvement against local and national measures including delivery of the NHS Constitution Rights and Pledges
- Successful working with providers to ensure 95% of patients presenting at A&E are seen and treated within 4 hours and receive high quality care despite the continued challenge of high levels of demand across all A&E and urgent care services nationally
- Ensuring patients were seen within the target and timeframe of 18 weeks for consultant led treatment
- Working with providers ensuring the successful delivery of the handover of patients from ambulance to hospital
- Improvement in the diagnosis rate of patients with dementia.

Although we made significant improvements in year and received assurance from NHS England, we recognise that there were areas where we failed to deliver the expected outcomes.

We believe our key performance challenges during 2013/14 were:

- Cancer 62 day referral to first definitive treatment
- Incidence of healthcare associated infections - zero tolerance to MRSA
- Emergency readmissions within 30 days
- Smoking in pregnancy performance.

We have put in place a number of actions and associated measures working with key stakeholders and partners to further improve our performance during 2014/15:

- We will continue to work collaboratively with NHS England, Cancer screening network and providers to better understand cancer pathways and ascertain required changes to improve future performance
- We will continue to work with providers undertaking root cause analysis of each incidence of MRSA to put in place measures to prevent future failure
- Work will be undertaken with providers to address the readmissions performance, including but not limited to clinical audits

- Whilst a scheme was developed to improve smoking in pregnancy, work commissioned by our partners prevented implementation of this as there was a potential for the results of their expected outcomes to become undermined. Implementation of the scheme will be re-assessed when the commissioned work is completed.

We are committed to deliver the requirements of the NHS outcomes framework and have ambition to stretch further in these areas during 2014/15.

What do we want now?

We believe that residents of Hartlepool and Stockton-on-Tees deserve the best possible, 'joined up' health and social care, which is why NHS Hartlepool and Stockton-on-Tees 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 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."[2]

This 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. Our plan builds upon the excellent progress made during 2013/14 and reflects the CCG's current direction of travel and local priorities as set out in our Clear and Credible Plan (CCP) 2012/17, 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.

This plan describes how the CCG will work with all partners across the local health and social care system to ensure we are able to sustain and deliver effective patient centred services whilst we work within financial and resource constraints. The CCG through this plan will 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 people through an integrated and evidence based approach.

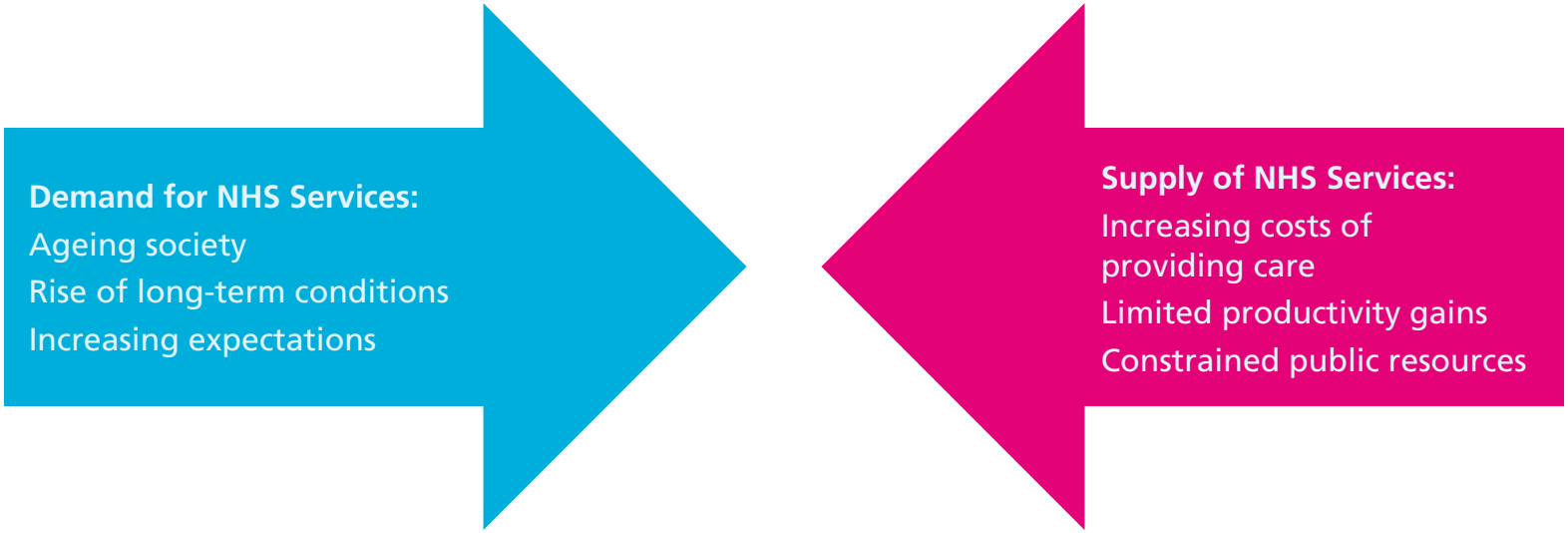
Section 2: The Case for Change

National context

A Call to Action

NHS England's A Call to Action[3] set out the current and future challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of the quality of care.

It is clearly stated that the NHS must change to meet these demands, make the most of new medicines and technology and will not contemplate reducing or charging for core services.



(Image adapted from 'A Call to Action')

Highlights of the future pressures identified by A Call to Action that "threaten to overwhelm the NHS" are:

- **An ageing population:**
  - Life expectancy in England between 1990-2010 increased by 4.2 years
  - Roughly ⅔ of people admitted to hospital are over 65 years old
  - Over 2 million unplanned admissions per year are for people over 65, which is nearly 70% of all hospital emergency bed days.
- **Growing co-morbidities:**
  - Over 15 million people in England have a long-term condition
  - It is estimated that 46% of men and 40% of women will be obese by 2035, resulting in 550,000 additional cases of diabetes, and 400,000 additional cases of stroke and heart disease
  - Lifestyle risk factors (alcohol, smoking, poor diet and lack of physical activity) are attributable to approximately 80% of deaths from major diseases, such as cancer.
- **Increasing pressure on NHS financial resources:**
  - Over the last 10 years, demand on NHS hospital resources has increased: 35% increase in emergency hospital admissions and 65% in secondary care episodes for those over 75
  - People with long-term conditions use a large amount of NHS resources: 50% of all GP appointments, 70% of all hospital bed days and 70% of the total health and care spend in England
  - By 2021 dementia is estimated to cost the NHS, local authorities and families £23 billion a year.
- **Persistent inequalities in access & quality of care:**
  - Disadvantaged groups (e.g. frail elderly, black and minority ethnic groups, younger people and vulnerable children) generally access poorer quality services and have a poorer experience of care
  - On average, people living in the poorest areas will die seven years earlier than people living in the richest areas.

NHS Outcomes and Ambitions

The *NHS Outcome Framework 2011/12*[4] set out the first framework of accountability that focused directly on how well services were improving outcomes for people. The framework, which has been built upon each year up to the current 2014/15 version[5], sets out the high-level national outcomes that the NHS should be aiming to improve, grouped around 5 domains.

The *CCG Outcomes Indicator Set*[6] contains measures that can be monitored at a CCG level together to help focus the health system on measuring outcomes under each of the 5 domains. These indicators provide clear, comparative information about the quality of health services commissioned locally and are useful for CCGs in identifying local priorities for quality improvement and the associated health outcome improvements.

The *Everyone Counts* guidance goes one step further to translate the high-level outcomes into specific and measurable ambitions:

NHS Outcome Framework 5 Domains	7 Outcome Ambitions
Domain 1: Preventing people from dying prematurely	1. Securing additional years of life for the people of England with treatable mental and physical health conditions.
	2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
Domain 2: Enhancing quality of life for people with long-term conditions	3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
Domain 3: Helping people to recover from episodes of ill health or following injury	4. Increasing the proportion of older people living independently at home following discharge from hospital.
Domain 4: Ensuring that people have a positive experience of care	5. Increasing the number of people having a positive experience of hospital care.
	6. 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.
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

NHS Quality Premium and Constitution Measures

CCGs are responsible for the quality of the care and treatment that they commission on behalf of their population. The 'quality premium' rewards clinical CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities:

1. Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people
2. Improving access to psychological therapies (IAPT)
3. Avoidable emergency admissions (composite measure)
4. Addressing any issues and supporting roll out of Friends and Family Test and showing improvement in a selected indicator from Domain 4 of the CCG Outcomes Indicator Set
5. Improved reporting of medication-related safety incidents
6. Further local measure agreed by each CCG with their local Health and Wellbeing Board and with NHS England.

As part of the quality premium incentive, CCG's are responsible for ensuring that the providers from whom it commissions services meet the NHS Constitution requirements for the following patient rights or pledges:

- Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral
- Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department
- Maximum two week (14-day) wait from urgent GP referral to first outpatient appointment for suspected cancer
- Red 1 ambulance calls resulting in an emergency response arriving within 8 minutes.

NHS 6 characteristics

NHS England has identified that any high quality, sustainable health and care system in England will have the following six characteristics in five years:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence.

NHS England wants local communities and partners to determine the best way to deliver services for patients to meet these characteristics which best suits local geographies and capabilities.

Our challenge is to reflect the national NHS objectives, ambitions and outcomes in our strategy and stretch them further to deliver better services and improve the health of our local population.

Local Context

Joint Strategic Needs Assessment

Improving peoples' health goes beyond the NHS. Factors such as employment prospects and housing are equally as important. The 2010 report produced from the Marmot review 'Fair Society, Healthy Lives' emphasises the link between an individual's socioeconomic position and good health. Analysis of the wider health challenges that face the people of Stockton-on-Tees and Hartlepool shows we must work with our partner organisations to address our major health inequalities and help people live healthier lives.

Hartlepool

- Deprivation higher than average (England)
- Approximately 5,400 children live in poverty
- Life expectancy 12.3 years lower for men and 8.2 years lower for women in the most deprived areas than the least deprived areas
- Early death rates from cancer, heart disease and stroke have fallen but remain worse than average
- 24.3% of children in Year 6 classified as obese
- Rates of smoking related deaths and hospital stays for alcohol related harm worse than average.

Stockton-on-Tees

- Deprivation higher than average (England)
- Approximately 8,300 children live in poverty
- Life expectancy 15.3 years lower for men and 11.3 years lower for women in the most deprived areas than the least deprived areas
- Early death rates from cancer, heart disease and stroke have fallen but remain worse than average
- 22.1% of children in Year 6 classified as obese
- Rates of smoking related deaths and hospital stays for alcohol related harm worse than average.

The Joint Strategic Needs Assessments (JSNAs) highlight the main health and wellbeing priorities for our residents taking account of data and information on inequalities within and between communities.

The JSNAs identify those health conditions that most affect people in Stockton-on-Tees and Hartlepool as:

- Cardiovascular disease – including heart disease and strokes
- Cancer
- Smoking-related illness
- Alcohol related illness
- Mental health including dementia.

The burden of risks to population health is high across both localities including higher than national (England) average levels of behavioural risks to health such as smoking, excess alcohol consumption and lack of exercise.

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

Prevalence predictions have been produced for some of the long-term conditions that our residents suffer. We have produced predictions for chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), diabetes mellitus, hypertension and stroke.

We have ambitions to set clear targets to tackle the effects of these priority health conditions. Tackling these big killers, the behaviours that contribute to them and the resulting health inequalities are key to our plans.

We also have an ageing population. We expect our over 65 year population to increase from 17% (44,400) to 22% (59,500) over the next 16 years. As larger numbers of older people live longer, more people are likely to develop diabetes, ischemic heart disease (IHD) and chronic airways disease while some people have more than one long-term condition. This ageing population will see an increasing degree of dementia and therefore the associated demand for increased health and social care provision.

The health priorities for both Hartlepool and Stockton according to the JSNAs are:

Short-term actions

- Ensure that people with existing disease are managed effectively: Reduce variation in clinical management of long-term conditions, cancer, mental health and dementia to ensure equitable access, across all social groups, to effective care, which minimises progression, enhances recovery and promotes independence.

- Ensure that people at high risk are identified and managed at the earliest opportunity: Increase uptake of preventative and early intervention programmes with more targeted approaches for deprived and vulnerable groups (such as people with learning disability, mental health).
- Increase early identification of long-term conditions, cancer, mental health and dementia by raising community awareness and promoting health seeking behaviours (targeted at high risk groups and those 'seldom seen, seldom heard' and socially isolated or excluded).
- Give all children the best start in life by tackling smoking and obesity in pregnancy, breast feeding and uptake of healthy start vitamins.

Medium-term actions

- Make all care 'planned care': reduce reliance on urgent care, emergency admissions and delayed/late stage presentations for cancer, circulatory diseases, diabetes and other long-term conditions, including mental health and dementia.
- Prevent illness by addressing lifestyle risk factors: design community based interventions that tackle obesity, smoking and alcohol misuse with a clear focus on improve mental wellbeing.
- Strengthen the role of primary care, social care and VCS organisations in delivering lifestyle and behaviour modification programmes.

Long-term actions

- Address the social causes of poor health and premature deaths: continue to address the 'causes of the causes' of illness and premature deaths such as unemployment, poor quality housing, fuel poverty, raising literacy and educational attainment.
- Improve maternal and child health by addressing the social causes of poor health including; teenage pregnancy, educational attainment, unemployment, food poverty and maternal mental health.

Commissioning for value insight packs

The Commissioning for Value packs highlight the following areas as being commissioning for value opportunities:

- Cancer & Tumours
- Circulation Problems (CVD)
- Respiratory System Problems
- Mental Health Problems
- Endocrine
- Nutritional and Metabolic Problems
- Gastrointestinal Musculoskeletal System.

The top two areas of cancer and CVD correlate with the priorities identified by the JSNA as does the respiratory system problems which can be linked to the smoking related deaths.

Member practices and clinicians

The CCG will operate with the strong clinical leadership of local practices to commission and improve local services. Just as our clinicians' experience gives us a deep insight into local health and care services, we recognise that as users of these services, 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 individual and not that people are defined around the structures in place.

GPs are central to organising and coordinating patient care; their 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 local people. Our local GP CCG members and clinical leaders are also attuned to their patients' views and the choices they make in practice consultations.

The CCG is organised into two 'localities' to reflect the needs of the two communities of Stockton-on-Tees and Hartlepool. Representatives from each of our member practices come together in Hartlepool and Stockton-on-Tees Locality Clinical Councils, every six weeks, chaired by Dr Mike Smith (Hartlepool) and Dr Paul Williams (Stockton).

The practice representatives from each locality have a responsibility to represent their patients' needs, to ensure that local intelligence supports improvements within quality and service provision, and to ensure that they take leadership of their aligned workstreams and drive member practices to achieve the outcomes and ambitions.

We have communicated with all locally representatives when setting our ambitions and have shared the outcome ambitions with locality groups, GP practice member groups and practice manager groups.

Local engagement key themes

The CCG lead the local Call to Action consultation for the Boroughs of Stockton and Hartlepool and as part of the engagement plan commissioned Catalyst Stockton (Catalyst) and HealthWatch Hartlepool to hold 20 conversations with various groups across the Boroughs, due to their local links and experience in engagement.

Catalyst is the leading infrastructure organisation for the voluntary and community sector (VCS) in Stockton, providing practical guidance and support to the VCS, bringing together organisations to tackle common issues and act as a conduit between public and community services. The VCS in Stockton-On-Tees has historically always worked with very diverse groups, often those who do not engage with mainstream services.

Recommendations from Catalyst's review included:

- The CCG should think about continuing to communicate with the communities who have taken part in a Call to Action whilst they are still keen to engage in this process
- There should be serious consideration into working closer with community services and developing a mechanism to engage the 'hard to reach' through these groups, utilising the findings outlined within this report
- Consider developing an effective education programme in conjunction with VCS groups to support the 'hard to reach' to help remove barriers to services.

HealthWatch Hartlepool is the independent voice on health and social care for people in Hartlepool with the increased powers and responsibilities for the 'public voice'.

A common theme from HealthWatch Hartlepool's report was around communication and access to services. It came of no surprise that respondents focused on the migration of services from Hartlepool to North Tees yet there was an overwhelming desire for more services to be provided locally complimented by a greater number of home visits.

The CCG also held two 'Call to Action' engagement events which focused on the priority areas identified in relation to commissioning intention themes, including:

- Children and Young People
- Long-term Conditions
- Mental Health
- Maternity
- Urgent and Emergency Care
- Frail and Elderly/End of Life.

Members of the public who attended the event were requested to prioritise their top four core health care values, these being:

- Close to Home
- Safe service and well trained staff
- Continuity of care
- Health services via mobile phone and internet
- Appointments on an evening or a weekend
- Supporting you to look after yourself
- Friendliness and person centred care.

The top three priorities identified through this exercise were:

- Safe service and well trained staff
- Appointments on an evening or a weekend
- Friendliness and person centred care.

Sustainability Challenge

A *Call to Action* forecasts a financial gap of £30 billion by 2020/21 therefore the affordability challenges in 2014/15 and 2015/16 are real and urgent. In 2014/15, specialised commissioning remains the area with the most challenging efficiency requirement, however in 2015/16, with the introduction of the Better Care Fund, CCGs face a more significant efficiency challenge.

The prospect of resources being outstripped by demand, driven largely by an ageing population and an increasing prevalence of chronic diseases presents a significant sustainability challenge to the way we commission care from providers, both currently and in the future.

As well as the likely future financial environment, the workforce context must also be taken into account when understanding the constraints on delivering higher quality levels of service.

An assessment of the workforce issues and challenges has been undertaken as part of the Securing Quality in Health Services (SeQiHS) work to understand the specific current and future gaps against the recommendations made within this report about workforce quality standards, such as the supply and demand of particular grades and skills within the acute sector in County Durham, Darlington and Tees.

We welcome the prospect of reviewing current systems and processes to take advantage of new opportunities and approaches to healthcare; however we cannot meet future challenges alone and thus recognises the importance of working with our stakeholders and partners to deliver effective change, whilst ensuring we continuously seek patient's views and opinions from users of our services.

Our challenge is to ensure that our vision and strategy reflect the needs of our local population and deliver outcomes to improve the health of our local population and reduce the inequalities that currently exist.

Driving the Change

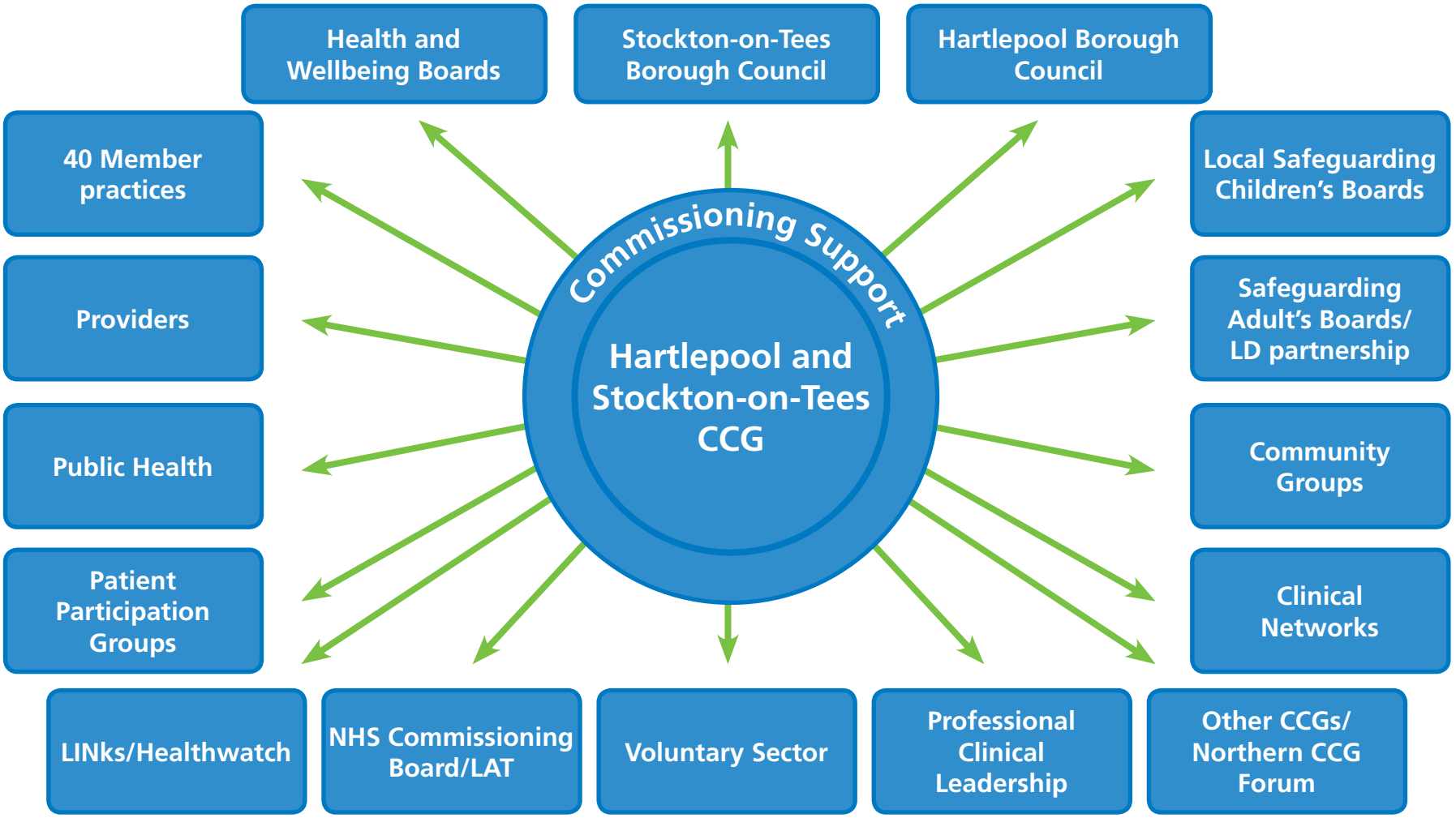
Whole system approach to transformational change

To enable wider and more strategic health economy planning, CCGs are being tasked with coming together in close collaboration with relevant Area Teams, providers and Local Authorities to draw up their critical long term service change strategies across larger patches approved by NHS England. Where appropriate CCGs may also choose to join with neighbouring CCGs in a larger 'Unit of Planning' to aggregate plans, ensure that strategies align in a holistic way and maximise the value for money from the planning resources and support at their disposal.

Hartlepool and Stockton-on-Tees CCG already has relationships with a large number of stakeholders. Developing and maintaining relationships with all of our stakeholders and exploring opportunities for collaborative working, will underpin the effectiveness of this strategy. 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.

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 people who use our services 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 person centred services and simpler patient focussed care pathways that reduce duplication and inappropriate use of resources through integration in the next five years.

All partners have signed up to the strategic vision and agreed that 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[8].


Health and Wellbeing Boards
Stockton-on-Tees Borough Council
Hartlepool Borough Council
40 Member practices
Providers
Public Health
Patient Participation Groups
Local Safeguarding Children's Boards
Safeguarding Adult's Boards/ LD partnership
Community Groups
Clinical Networks
Commissioning Support
Hartlepool and Stockton-on-Tees CCG
LINks/Healthwatch
NHS Commissioning Board/LAT
Voluntary Sector
Professional Clinical Leadership
Other CCGs/ Northern CCG Forum

Unit of planning

Hartlepool and Stockton-on-Tees CCG agreed one 'Unit of Planning' aligned to both Stockton Council and Hartlepool Council and includes representatives from the CCG, Local Authority and the two main local health providers – North Tees & Hartlepool NHS Foundation Trust and Tees Esk & Wear Valley NHS Foundation Trust.

The purpose of the Unit of Planning (North of Tees Partnership Board) was to:

- Agree principles for approval of plans
- Develop a shared vision for integrated services
- Provide oversight across the CCG area on progress in developing plans for Better care Fund (BCF)
- Ensure alignment between plans in order to deliver services that provide equitable outcomes for local people
- Ensure two way communications with and where appropriate make recommendations to the Health & Wellbeing Board commissioning groups
- Consider requirements for procurement ensuring that a range of providers are developed to ensure appropriate delivery of services
- Agree outcomes required and the key performance indicators
- Ensure plans are based on best available evidence to meet local need and deliver the required outcomes.

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. This plan is therefore intrinsic to delivering the 5 year strategic vision.

Strategy Alignment

The CCG is committed to ensuring that our plans align to the key issues and priorities identified within our partner organisations strategies and plans.

Health and wellbeing strategies

The CCG works as part of the Health and Wellbeing Board for each locality, which is responsible for understanding the health and wellbeing needs of local populations and co-ordinating the NHS, public health and social care in collaboration with other local agencies.

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.

Clinical leads from the CCG's health and wellbeing workstream sit on the Health and Wellbeing Boards, in each locality, with Public Health colleagues and wider partnership groups to ensure that there is clinical and strategic awareness of the locality priorities which can be reflected back in the workstream and CCG plans.

We have an agreed Joint Health and Wellbeing Strategy for each locality which clearly sets out our shared health and wellbeing goals and we will look to build upon this strategy over the next five years.

Stockton Joint Health and Wellbeing Strategy

The key shared priorities are:

- Address smoking in pregnancy and breastfeeding rates
- Improve rates of childhood obesity
- Reduce rates of teenage pregnancy
- Improve sexual health of young people
- Improve mental health and wellbeing of children and young people by expanding range of mental health services
- Increase uptake of childhood immunisations
- Increase primary and community services to support care closer to home and enable independent living

- Develop programmes to find and treat people at risk of cardiovascular disease, cancer, diabetes and respiratory illness
- Improve pathways and choice for end of life
- Reduce smoking prevalence and harmful impact of alcohol.

Hartlepool Joint Health and Wellbeing Strategy[9]

The key shared priorities are:

- Give every child the best start in life
  - Reduce child poverty
- Enable all children and young people to maximise their capabilities and have control over their lives
  - Children and young people are empowered to make positive choices about their lives
  - Develop and deliver new approaches to children and young people with special educational needs and disabilities.
- Enable all adults to maximise their capabilities and have control over their lives
  - Adults with health and social care needs are supported to maintain maximum independence.
  - Vulnerable adults are safeguarded and supported while having choice and control about how their outcomes are achieved.
- Strengthen the role and impact of ill health prevention
  - Reduce the numbers of people living with preventable ill health and people dying prematurely
  - Narrow the gap of health inequalities between communities in Hartlepool.

NHS Durham, Darlington and Tees NHS Area Team

Key priorities identified in the primary care operational plan that can be aligned with our vision and plans are:

- Implement the named accountable GP for over 75's
- Implement Friends and Family Test in primary care
- Work with CCG and LMC to develop an effective measure of GP primary care access
- Maintain focus on access and patient satisfaction of dental services
- Work with the dental LPN to review urgent dental care access
- Increase hospital initiated referral to community pharmacy
- Work with the pharmacy LPN and CCG to develop joint aspirations for primary care pharmacy
- Work with the optometry LPN to support development of eye health in primary, secondary and social care to support service integration
- Improve access for sight tests for hard to reach groups.

Key priorities identified in the health and justice commissioning plan that can be aligned with our vision and plans are:

- Liaise with CCGs to improve access to hospice care for offenders
- Roll out Friends and Family Test in offender health services
- Support provider service improvement in care planning for offenders with Long-Term Conditions
- Determine and secure pathways into community learning disability services.

Key priorities identified in the public health commissioning operational plan that can be aligned with our vision and plans are:

- Work with CCG to agree joint approaches to understand and reduce variation in the level of screening and immunisation across practices
- Work with CCG to give consistent health promoting messages on prevention and early diagnosis
- Work with partners in locality led work linked to Health and Well Being Strategies to deliver a more joined up approach to support breast feeding, healthy eating and exercise and oral health.

The CCG will work with our member practices to assist with the Area Team plans and will also align this to our work with the Better Care Fund (BCF) to ensure better integration of primary, community and social care services to move care closer to home.

NHS Cumbria, Northumberland, Tyne and Wear Area Team

Everyone Counts signalled the intent to move to fewer centres of provision for specialised services (characteristic 6) and work is currently ongoing in NHS England to develop a national strategy which will set out the case for maximising quality, effectiveness and efficiency in the delivery of these services. The draft consultation is due July 2014 and the CCG will work with the Area Team to assist them in their plans following the outcome of this consultation.

Provider plans

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. When acute hospital care is provided this will be in a state of the art facility that will meet the emergency and urgent care needs of the population.

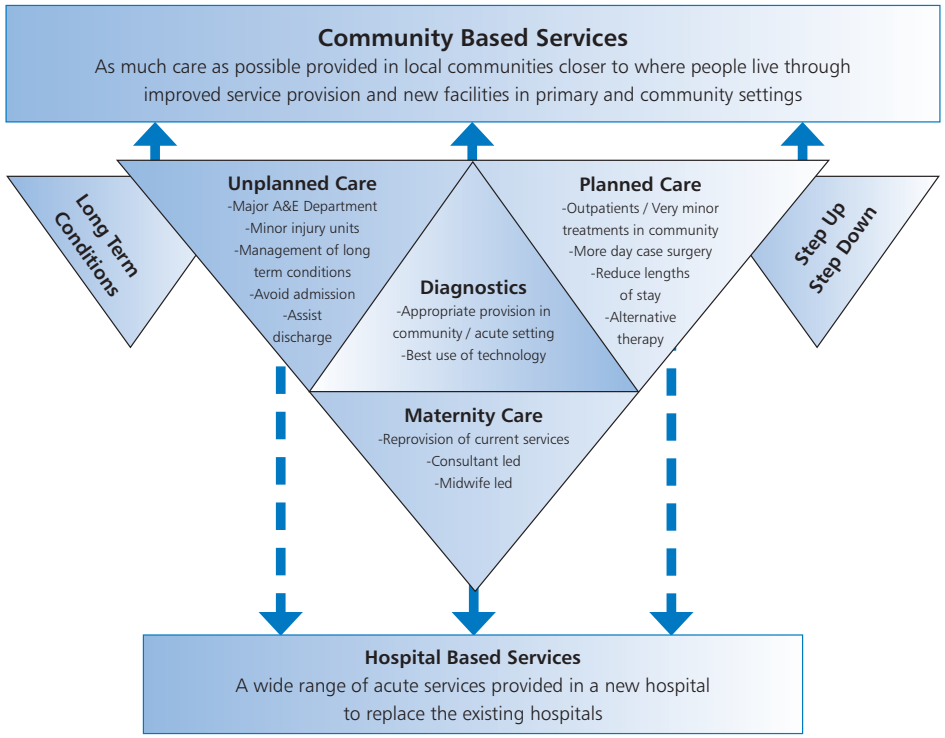
We work very closely with our major hospital provider Trusts – North Tees and Hartlepool NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust and Tees, Esk and Wear Valley NHS Foundation Trust. (South Tees provides some of our general acute services but also a number of our specialist services).

North Tees and Hartlepool NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust provides acute and community services to our population and the basis for their FT application was the vision to transform secondary care services as part of a whole system change. We share this vision.

The Momentum: Pathways to Healthcare has been the blueprint for the last five 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 has improved quality, safety and patient experience in the services we commission. We now need to ensure that we continue this and the reconfiguration of services will be a major plank of our future strategy. The diagram below illustrates how we want our services to integrate.



Section 3: What we want to achieve and how we will achieve it

Our 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 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 individuals are involved in decisions and planning their own care and support, 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
- Ensuring we include 'Care, Compassion, Competence, Communication, Courage, Commitment' in all we do.

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 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 clear clinical accountability. 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.

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.

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.

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:

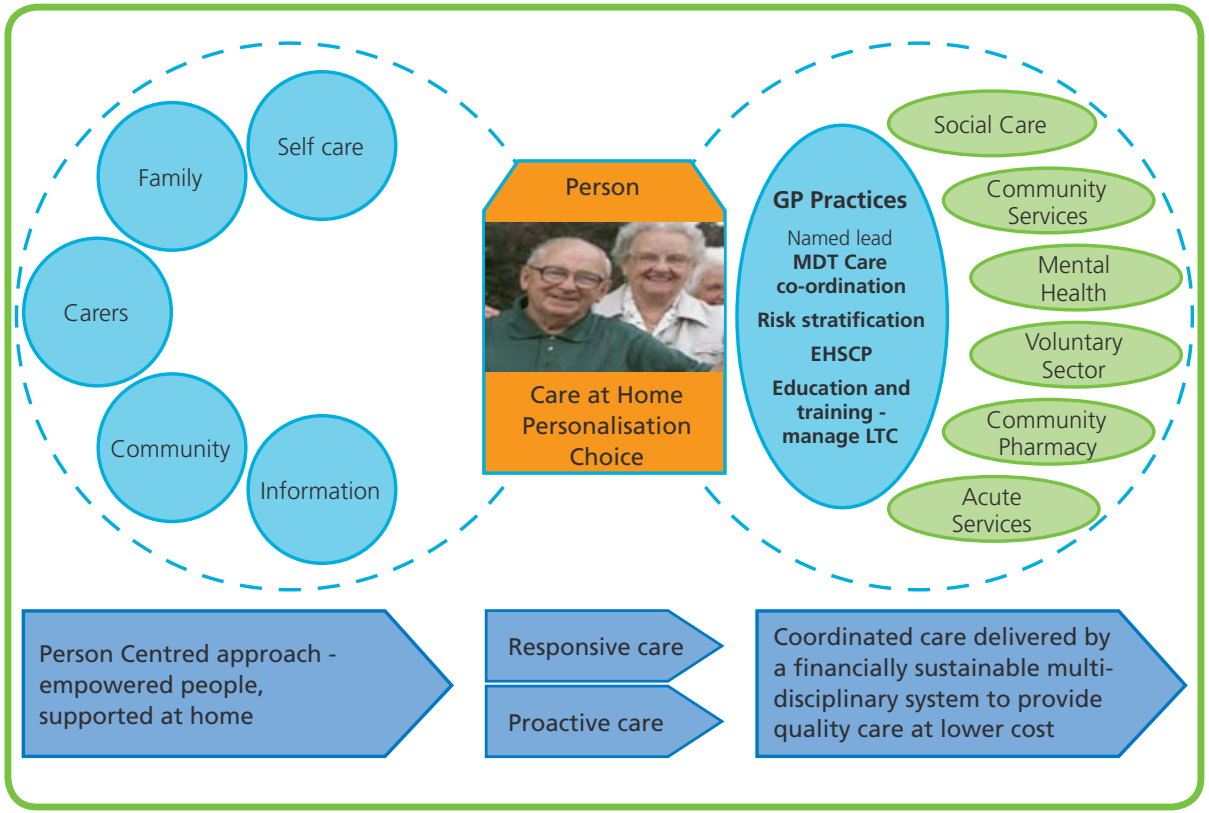
- To ensure people have **access to a wide range of primary prevention interventions** including but not limited to smoking cessation services, exercise, weight management, IAPT, problem drinking support, cancer screening programs, immunisation, social prescribing, carer's support and good nutrition
- 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, liver disease dementia and early cancer
- 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 **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. 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 working
- 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 proactively manage 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 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 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 that **digital technology** is utilised innovatively to deliver the greatest possible benefit to people using services and carers across health and social care services
- To improve **access to community health and social care services seven 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.

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), social care services and the independent and voluntary sector play a central role in helping people live healthy, independent lives with dignity and respect.

Our Vision for Integration



It is these services that will ensure delivery of quality and improvement in user experience and deliver support and education packages to individuals 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 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 with social care services, 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.

We will therefore ensure investment in the enhancement to the provisions in relation to extending GP services to 7 days per week with a focus on better supporting people with complex health needs, those with long-term conditions, those most at risk of admission to hospital and those most in need of social and emotional support.

In every case, an appropriately skilled professional will oversee the care pathways and packages of care, within a model which will often deviate from convention and emanate from a very different health and social care model.

Better planned, person centred 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. Prevention of duplication of effort and inputs will ensure a much more streamlined approach to the organisation and delivery of patient care, with accessibility for patients a priority which will translate into local services and care closer to home whenever this is safe to do.

We will also ensure that these developments are delivered within a strong and clear governance framework which will be essential to deliver the required service transformation.

Our values

- Focus on quality and continually improve service outcomes
- Use of evidence-based practice to effect change
- Build and ensure sustained clinical and provider engagement and collaboration to redesign and implement pathway/service redesign
- Using service user/patient engagement and involvement in review development and implementation of commissioning function
- Partnership working with key providers, recognising that by joint working and collaboration with key partners, all stakeholders will benefit from the alignment of aims and objectives that will benefit the entire health economy
- Consistent use of the National Institute for Clinical Excellence (NICE) Commissioning Outcomes Framework to ensure principles of quality-based commissioning approach
- Ensuring effective use of resources and achievement of Value for Money in the services we commission
- A Quality Innovation, Productivity and Prevention (QIPP) approach to commissioning services with a continuous focus on quality for the improvement of patient safety
- Share the rationale underpinning commissioning decisions with our members, communities and partners to ensure transparency
- Ensure that we uphold the requirements of the NHS constitution and CCG constitution

Strategic aims

We have looked at the most up to date information available from a range of sources from patient views to national clinical publications to local health and wellbeing data as you can see in our case for change above. Based on this we have set out what we see as our strategic outcomes. We describe the outcomes and where we want to get to for each of these.

Strategic Aim 1: Bringing care closer to home

Being in hospital should only happen when it is clinically indicated and when it is the right medical decision. When a person needs planned or unplanned care in a hospital setting we need to ensure that this happens in a timely manner.

However - too many people are admitted as a result of complications in their long-term conditions which could be avoided, too many people stay too long in hospital because of a lack of support on discharge and too many people have no choice at the end of their lives.

We aim to:

- Reduce the number of people being admitted to hospital when an alternative arrangement would be in their best interests
- Ensure that when people need care it is in the right place – either at home or in a community setting
- Simplify the navigation of urgent care services – improving the understanding about accessing care out of hours or in an emergency, providing care at locations which provide necessary education to support people to look after themselves
- Redesign services to be more integrated, streamlined and efficient e.g. commission day case and outpatient procedures rather than inpatient stays where appropriate, and reduce secondary care review appointments in favour of more primary care management
- Make our primary care services the hub for patient management.

Strategic Aim 2: Tackling health inequalities

The ability to understand, embrace and operate in diverse communities is critical to the ability to promote social inclusion and reduce health inequalities.

Health inequalities will be addressed by the CCG at a population, personal and community level. Inequalities relating to deprivation have to be tackled through concerted action across public sector services; therefore we will work closely with other public sector service providers through the Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies.

The CCG working closely with Public Health aims to address areas of particular concern, such as:

- Making healthy lifestyle choices easier, including stopping smoking, promoting safe, sensible drinking and increasing physical activity
- Improve access to community based preventative services in particular vulnerable/hard to reach groups (e.g. BME/ Mental Health/ Routine and Manual Workers and Young People) supported by more effective information and advice, signposting of services, transport arrangements etc.
- Improve the uptake of screening programmes to help people identify sooner if they are at risk of cardiovascular disease, cancer, and other illnesses so they can get the right care and treatment quickly to prevent them getting ill
- Improving access to, and quality of, care and treatment for people if they do get ill
- Supporting people in old age and with long-term health conditions to live independent, good quality lives
- Ensure that services are commissioned which focus on prevention, early intervention and reablement, such as the healthy heart check and cancer early intervention and prevention programmes
- Ensuring patients, carers, the public and our staff are not discriminated against on the grounds of age, disability, gender, race, religious beliefs or sexual orientation.

We plan to be working in an integrated manner with our key partners to ensure that the actions we take as commissioners contribute to the wider determinants of health and that the advice we can contribute to the health impact of actions of our partners will result in us making an impact together on the health of our residents.

Strategic Aim 3: Caring for an aging population

Not only does an ageing population present increasing demands on health care but also on housing and social care needs and the need to provide services in a different way to support people in their own homes, living as independently as possible for as long as they and their carers would like.

Too many deaths occur in hospital which is not always necessary - when people reach the end of their lives we need to ensure they are able to be in the location of their choice.

To tackle this we will:

- Move services closer to home into the community where care is more accessible and can provide a better patient experience
- Identify the healthcare issues associated with the elderly and manage these more effectively to minimise urgent care use

- Directly tackle, through a dedicated project group, the challenges faced by individuals, families and carers with dementia
- Reduce avoidable hospital admissions
- Work effectively with adult social care services through the Health and Wellbeing Board to align reablement and social care support
- Commission services that are flexible and responsive to changing locations to care for people in their own place of residence
- Support carers to continue their invaluable work to help people live independent lives
- Promote end of life care to be in a location of choice rather than unavoidably in hospital.

Strategic Aim 4: Priority health conditions

Episodes of ill-health relating to these and other long-term conditions such as diabetes are often avoidable. We aim to reduce deaths and morbidity as a result of these conditions by improving the quality of advice and treatment to help self-management.

The 'disease prevalence models' developed by the Public Health England[7] considers data trends, risk factors for specific diseases and predicted changes in population structure to then project at a population level the estimated levels of disease in the future.

Prevalence predictions have been produced for chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), diabetes mellitus, hypertension and stroke.

We have used these predictions to set ambitious targets to tackle the priority health risks. In particular, we want to:

- Increase the number of people surviving cancer at 5 and 10 years after diagnosis
- Reduce the number of people who develop a chronic respiratory disease
- Increase the number of people who are screened for cancers and cardio vascular diseases through targeted campaigns and expansion of existing programmes.

Early detection and treatment will be crucial to achieving these targets. We will support our partners by ensuring the promotion of the offer to all adults aged 40-74 of the NHS Health Check programme. We will ensure the appropriate diagnostic and treatment services are commissioned to meet the identified need. Helping people to stop smoking, reducing the impact of alcohol consumption and improving access to advice and treatment with keeping mentally well will be continuous activities across our services.

We shall also work with other public services to support people with chronic respiratory diseases and other long-term conditions to live healthier lives, manage their condition and retain their independence.

We will continue to improve access to and the quality of GP and primary care services including providing more services closer to people's homes and help in self-care of chronic and long-term conditions utilising, where possible, new technologies available to us.

Strategic Aim 5: Improving quality in primary care

For many patients the beginning of their care starts with a visit to the doctor or nurse in general practice and the decisions taken at this point directly affect the type and quality of service that is received.

Ensuring that the right referral is made at the right time is key to reducing unnecessary admissions, providing excellent diagnostics and ensuring efficient management of patient care.

Providing more coordinated arrangements that are simpler to navigate in order to help people access more local services 24 hours a day affects primary care as much as secondary care.

Practices therefore are experiencing greater demand on their time and resources and will require support to reduce waste and develop increasing efficiencies whilst balancing the need to increase primary care in a sustainable and manageable manner.

We will support primary care improvements by:

- Involving as many GPs and health professionals as we can from primary care in looking at pathways and helping to design them
- Ensuring member practices involve patients in pathway designs
- Seeking feedback through a smooth and clear process to helps us monitor our success and publish data about our performance
- Identifying and managing variation in referral practices through practice level data to tells us more about the specific needs of patients at this local level to inform our vision of continuous improvement
- Promoting the primary care system as the hub for patients care so that they can access the right advice and care 24 hours a day, supported by NHS 111
- Enabling GP practices to continuously improve the efficiency of their services.

Strategic Aim 6: Quality and safety

We all expect, and should get, a high quality and safe health service. Improving the quality and safety of all our services is a theme that will run throughout our detailed plans.

The CCG will ensure that contracts with health providers will be centred on improving outcomes for patients and we will use Clinical Quality Review Groups to ensure that robust clinical challenge occurs between providers and commissioners as we strive to commission safe, effective quality services.

The CCG will use the Commissioning for Quality and Innovation (CQUIN) scheme to drive forward quality improvements in providers. CQUIN rewards excellence, by linking a proportion of healthcare providers' income to achieving quality improvement targets set by the CCG.

The CCG will develop a quality dashboard. We will work collaboratively with all of our provider organisations in driving forward national, regional and local initiatives to improve patient safety.

We shall use the summary care record (SCR) so that all health care providers can access good electronic patient records. Many avoidable hospital adverse events are medication related. Use of SCR should make patient care safer by improving communication.

Two thirds of practices use the system and we are working hard to assist the remainder to develop the systems. We are prioritising use of the SCR in secondary care, especially for urgent care, end of life and diabetes.

The CCG is acutely sighted on the importance of patient safety. We are passionate in working proactively and collaboratively with our providers in ensuring that all requirements are met under the umbrella of the national initiative Energising for Excellence (ref). We will ensure that our providers implement the requirements of the NHS Safety Thermometer data collection and in addition to this, drive forward required improvements in the 4 targeted harms:

- Venous thromboembolism
- Catheter associated urinary tract infections
- Falls
- Pressure sores.

We will learn from the times when things go wrong, robustly investigating serious incidents and monitoring the implementation of recommendations.

The CCG recognises the importance of continuing to reduce healthcare associated infections (HCAI) in acute and community settings. Whilst significant progress has been made, the CCG will continue to focus on reducing cases of MRSA and Clostridium difficile.

We recognise the important of collaborative working in this area and we will ensure this continues with root cause analysis and lessons learned and shared for each case. Our determination to move care closer to home will also make it less likely that patients are exposed to these infections.

Safeguarding

Safeguarding our vulnerable children and adults to keep them safe, well and away from harm is an important aspect of our duties and our joint working efforts.

Systems and processes will be continually reviewed and refined to support quality improvement and to evidence outcomes. We will ensure that we discharge our statutory functions accordingly and build upon improvements to date in this area for both adults and children. We will be working closely with the Local Safeguarding Children's Boards, Safeguarding Adults Boards and with our partners across the area including local authorities, schools and police services.

Strategic Aim 7: Improving the patient experience

Our endeavours for improvement are driven by patient experience. We believe that we have a high quality NHS service; however we know that our patients' experience is the ultimate measure of the quality of our care and whether our services are operating efficiently.

Improving the overall experience – be that clinical outcome or the way people have accessed services – is our challenge.

In November and December 2013, views were sought from local people, patents, carers and stakeholders across Teesside as part of 'A Call to Action'. Some of the key priorities returned via the questionnaire[11] included:

- Better information/education
- Better access to services
- Better home care/more time with patients
- To be involved in discussions/asked for opinions
- Quicker consultations/shorter waiting times
- Quality and safety of the care provided
- Services to be available at weekends and in the evenings.

GP Practice Patient Participation Groups will be in place in every practice and be able to provide a smooth process for seeking views, getting involved in service design and specific activities, such as medicines management. We will be able to ensure that there are ways in which comments and experiences raised in personal consultations can be drawn upon to improve services – whilst also respecting the patient's wishes and confidences.

The CCG will seek assurance from providers as to the steps they are taking to record and improve the patient experience. This will include monitoring collection of data and actions taken to address areas for improvement. We recognise that sometimes things go wrong and complaints are one way of learning how to improve the services we commission. We have a clear complaints handling process which aims to deal with complaints quickly and promptly.

GPs have fed back that patients are consistently highlighting the issues on the complexity of what services to access and when to access them, particularly Urgent Care. Our work will focus on improving the efficiency of the patient pathway. We strongly believe that by better coordination of services and treating patients closer to home we can significantly reduce costs whilst improving patients' experience.

Strategic Aim 8: Seeking best value for money in budget

The NHS faces an unprecedented financial challenge as a result of continuously rising demand, expensive new treatments and continuing the ambitious national reform programme.

At the same time funding is becoming much tighter. There is only a 2.14% (£7.6m) increase in 2014/15 across Hartlepool and Stockton-on-Tees, reducing to 1.7% increase in 2018/19. In 2014/15 the CCG will need to make £14.8m savings which represents 4.0% of its total budget for the year. Similar levels of savings will be required in each of the following years.

The CCG will become increasingly reliant on efficiency savings as a means of generating resource to fund future growth and investment. Current planned commitments include inflation increase in CQUIN payments, as well as demand and demographic growth will commit £24m for 2014/15.

The CCG recognises the challenge and will need to take decisive action to address the finances in order to ensure the contracts which it can influence are in recurrent affordable balance by 31st March 2015. We will need to make plans that are realistic and affordable and that we discriminate between "needs" and "wants".

The CCG implemented initiatives with our major providers, in the 2013/14 financial year, which helped us achieve our budget targets. The Better Care Fund and Prescribing efficiencies will be the key drivers to deliver the required efficiencies. The key future focus will be to reduce emergency activity by c8% in 15/16 and then maintain these levels for the future years, the investment in community, primary care and social care services will be the key transformation to delivery.

The key themes around delivering the QIPP challenge for the next five years are set out in the finance and QIPP workstream section below. The financial impact of all the CCG's initiatives is built into each of the workstream programmes. The CCG governing body ensures that both the clinical and financial business cases make sense for all initiatives.

Impact of Investment (QIPP)

	2014-15	2015-16	2016-17	2017-18	2018-19
	Rec £000	Rec £000	Rec £000	Rec £000	Rec £000
Acute	2,669	4,428	3,607	3,116	2,584
Prescribing	710	734	759	785	812
MH/LD	255	26			
Primary	11				
Community	148				
Joint Commissioning	144	344			
Running Costs	374	368	13	11	11
Other Commissioning	86	58			
Technical	10,533	11,603	10,395	10,419	10,452
Annual savings achieved/ planned	**14,930**	**17,561**	**14,774**	**14,331**	**13,859**

Ambitions for Improving Outcomes

What is our ambition for securing additional years of life from conditions considered amenable to healthcare?

	Potential Years of Life Lost (Rate per 100,000 population)	Planned reduction
Baseline	2,384	
2014/15	2,232	-6.4%
2015/16	2,175	-2.6%
2016/17	2,118	-2.6%
2017/18	2,060	-2.7%
2018/19	2,003	-2.8%

Hartlepool and Stockton-on-Tees CCG is the 5th best amongst our peer CCGs (baseline 2,384) however the NHS England average is 2001 (rate per 100,000 population). Every CCG nationally is tasked with a 6.4% reduction for 14/15 and 15/16. The total reduction we are aiming for is 16% in 5 years which would close the gap against the England average, whilst maintain current position against peers.

What is our ambition for improving the health-related quality of life for people with long-term conditions?

	Average health status (EQ-5D) score for people reporting having one or more long-term condition	Planned improvement
Baseline	69.20	
2014/15	70.7	1%
2015/16	71.4	1%
2016/17	72.1	1%
2017/18	72.8	1%
2018/19	73.6	1%

Again, we are 5th best amongst our peer CCGs, however short of the national average of 73.1. This 5% improvement over 5 years will start to bridge this gap.

What is our ambition for reducing emergency admissions?

	Potential Years of Life Lost (Rate per 100,000 population)	Planned reduction
Baseline	2,712	
2014/15	2,631	-3%
2015/16	2,578	-2%
2016/17	2,527	-2%
2017/18	2,476	-2%
2018/19	2,427	-2%

This is a composite measure of:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency admissions for children with lower respiratory tract infections (LRTI)

We are planning on a total reduction of 11% over the next 5 years. This will help us move towards, but not achieve, the national average which is currently 2,053 whilst maintaining our position of 6th best amongst comparative CCGs.

What is our ambition for increasing the proportion of people having a positive experience of hospital care?

	The proportion of people reporting poor patient experience of inpatient care	Planned improvement
Baseline	126.6	
2014/15	124.0	-2.25%
2015/16	121.2	-2.25%
2016/17	118.5	-2.25%
2017/18	115.8	-2.25%
2018/19	113.2	-2.25%

Measured as a rate of responses of 'poor' experience of inpatient care per 100 patients based on a national in-patient survey, we require an 11.25% reduction over the next 5 years to bring us in line with the national average.

Please refer to the website **www.hartlepoolandstocktonccg.nhs.uk/publications** to see Plan on a page – 2 Year Operational Plan and Plan on a page – 5 Year Strategic Plan.

What is our ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community?

	The proportion of people reporting poor patient experience of inpatient care	Planned improvement
Baseline	5.2	
2014/15	5.06	-2.6%
2015/16	4.93	-2.7%
2016/17	4.79	-2.7%
2017/18	4.66	-2.8%
2018/19	4.5	-2.9%

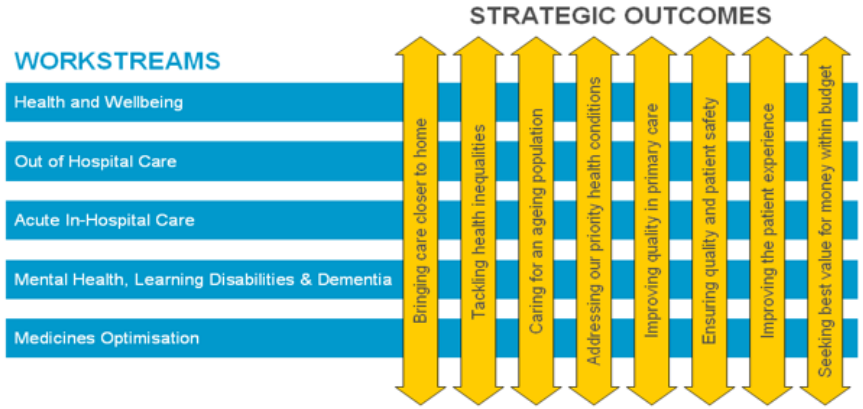
This measures the total number (per hundred responses) of responses of either 'fairly poor' or 'very poor' experience across two questions:

- Overall, how would you describe your experience of your GP Surgery
- Overall, how would you describe your experience of Out of Hours GP services

We plan on further improving our position against the national average of 6.1 with an additional reduction of 13% over 5 years.

How we are going to achieve it

In order to practically implement actions to address our strategic outcomes and meet our ambitions, we have 5 transformational workstreams (our clinical workstreams). The diagram below shows the relationship between the strategic outcomes and the workstreams.



The following sections break down each clinical 'workstreams' to explain some of our plans in more detail. Each workstream is led by a clinical lead and supported by a senior manager, and project team drawn from the CCG, member practices, partners and the North East Commissioning Support Service.

WORKSTREAMS

HEALTH & WELLBEING	OUT HOSPITAL CARE	ACUTE IN-HOSPITAL CARE	MENTAL HEALTH & LD	MEDICINES OPTIMISATION

PROJECT GROUPS

FRAIL ELDERLY/ CARE HOMES (EHCP)	QUALITY IN PRIMARY CARE	URGENT CARE	DEMENTIA	BETTER CARE FUND	GP IT

These are long-term workstreams within which projects and activities will vary from year to year as we work through our plans to achieve our strategic outcomes. So the way we will engage clinicians and the amount of commissioning support we will need will vary. Our aims to include patients, our partners and clinical professionals run through all our workstreams. At different times we will engage different people, based on the skills we need and the capacity required to implement changes. We consider that these workstreams will have sufficient longevity so as to ensure a stable environment for our planning, partnerships and development.

Health and Wellbeing

Improving peoples' health goes beyond the NHS. Factors such as employment prospects and housing are as equally important. The 2010 report from the Marmot review 'Fair Society, Healthy Lives' emphasises the link between an individual's socioeconomic position and good health. Over the next 5 years we aim to tackle, with our partner organisations, the wider health challenges that face the people of Stockton-on-Tees and Hartlepool.

We intend to significantly improve screening to identify those who have undiagnosed conditions, namely for:

- Chronic obstructive pulmonary disease – "missing thousands" via the provision of Healthy Lung Checks
- CVD – Promotion of "healthy heart" checks within primary care
- Bowel, cervical and breast cancer screening.

The CCG has recognised the contribution that carers make to the local health economy. We now jointly commission carers support services with each local authority and continue to develop a joint carer's strategy.

We were able to commission a new Adult Carers Support Service in Stockton-on-Tees which will deliver:

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

We are now in the process of commencing the process to commission a Young Carers Service and expect to have selection process and implementation completed within the next few months.

Over the past year we have worked in partnership with the Health and Wellbeing Boards in each locality. We have agreed approaches in relation to the sharing of information and joint decision making. We have recognised that we require a longer-term approach to addressing local health inequalities which have existed for many years and now generations. We are working with our partners to jointly develop and implement plans and projects. We have also taken steps to jointly commission and fund services within the local voluntary and community sectors that have links to hard to reach groups.

We are also in the process of developing a 5 year cancer strategy in order to ensure that we address the immediate and long-term need around cancer screening, diagnosis, treatment and survivorship.

Success measures and outcomes

- Reduction in the % of patients with COPD diagnosis on emergency admission
- Reduction in unnecessary A&E/GP attendances and admissions
- Reduction of illness during pregnancy and improved health of baby
- Reduction in childhood illnesses requiring an emergency admission
- Increased patient awareness of their condition and the longer term management options
- Improved rates of earlier cancer diagnosis (stage 1 and 2)
- Increased number of patients accessing stop smoking services
- Increased number of patients screened for Atrial Fibrillation
- Reduction in stroke related admissions.

Out of Hospital Care

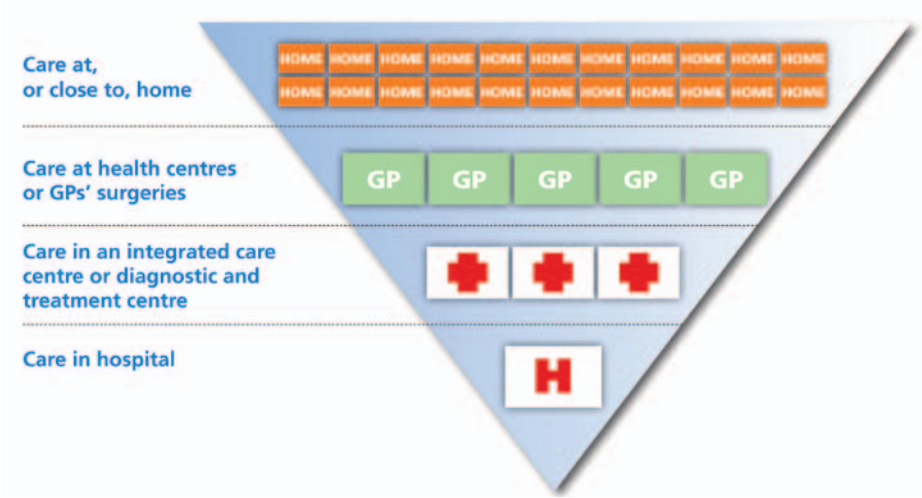
There a wide variation in how primary care operates - ranging from how services are accessed and referral routes, to treatment decisions, such as prescribing choices. Some variation is required to reflect individual patient needs, however eliminating unexplained variation is critical to improving value for money as well as improving clinical outcome.

The CCG recognises the importance of an effective community service to deliver patient outcomes. Outcomes have been developed in relation to service delivery with our community services provider. This will shape services to better enable General Practices to co-ordinate patient care particularly those with long-term conditions.

It is critical that care is moved from acute to community settings to improve the patient experience and maximise efficiency. Resources can then be used to fund new initiatives and areas of increasing demand. Progress is already under way to achieve these goals, but this will need to accelerate in order to deliver the required efficiency savings in the financial plan. We need to improve the way people access services, ensuring equality of access for all – regardless of age or other factors.

The CCG will continue to work with and lead the Momentum: Pathways to Healthcare Programme, involving a whole system re-design of care pathways supported by a number of community facilities and the development of a single site hospital.

Momentum: where healthcare could be provided



To improve efficiency and productivity, community services and primary care will be organised around pathways rather than professional domains whilst improving the team work between practice and community staff through the 'Teams around the Practices' (TaPs) initiative.

By taking a systematic approach to reviewing care pathways, the CCG will manage the demand for hospital treatment by using effective services and facilitating a more timely discharge back to services provided in the community.

Quality in Primary Care

The CCG is committed to transforming primary care by driving up quality. This is facilitated through our Quality in Primary Care project group of which the group remit includes the monitoring of General Practice Variation in Spend (GVIS).

We also have a Quality in Primary Care clinical reference group whose focus includes:

- Improving patient experience
- Continuity of care
- Improving Primary Care access
- Improving patient outcomes
- Reducing hospital admissions/attendances.

Supporting this work will be the delivery of the over 75's agenda.

The 2014/15 General Medical Services (GMS) contract supports a more proactive, integrated and personalised care for patients through:

- Ensuring that all people aged 75 and over have a named, accountable GP who is responsible for overseeing their care
- Introducing more systematic arrangements for risk profiling and proactive care management, under the supervision of a named GP, for patients with the most complex health and care needs
- Giving GP practices more specific responsibilities for helping monitor the quality of out-of-hours services for their patients and supporting more integrated working with out-of-hours services.

The CCG will support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding of around £5 per head of population for each practice. This broadly equates to £50 for patients aged 75 and over. This funding is to commission additional services which practices, either individually or collectively, have identified will further support the 'accountable GP' agenda in improving quality of care for older people and practice plans must be complementary to initiatives already in development as part of the Better Care Fund.

Frail Elderly Strategy

Improving the care of the Frail Elderly population is a priority for the CCG, and in 2014/15 we will complete the Frail Elderly Strategy and begin a transformation in integrated health and social care. Feeding into this will be the outcomes from the multi-agency Frail Elderly Summit which was held in April 2014.

Workstream success measures and outcomes

- Reduction in health inequalities
- Reduction in inappropriate out-patient referrals
- Increased number of care/nursing home patients with a quality assured Emergency Health Care Plan (EHCP) in place
- Reduction in emergency admissions/re-admissions from care/nursing homes
- Increased number of care/nursing home patients dying in preferred place of death
- Reduction in A&E attendances
- Improved patient experience
- Patient satisfaction surveys for GP access
- Reduced GP Variation and Spend (GVIS)
- Increased capacity within primary care through improved productivity.

Acute in-hospital care

Hospital admissions and attendances at Accident and Emergency are growing. The demand for urgent care needs to be minimised where possible by identifying health conditions earlier and handling them in a more measured way. When patients do need urgent care, access must be as simple as possible.

We will use examples of best practice to improve Urgent Care services that are coherent and make sense to patients. As part of effective demand-management, it is essential that patients have access to information about accessing local services to enable them to choose the appropriate service for their need.

We are taking several initiatives to improve services and productivity. For example, monitoring the number of outpatient review appointments that are generated by each new referral ("New to Review Activity") and providing the acute trusts with targets to reduce this activity. We will also taking measures to reduce the length of stay for patients as appropriate and shift day case activity to outpatient activity in line with best practice.

Clinicians from primary and secondary care will continue to collaborate across specialties to identify initiatives that could improve the patient pathway. We are also engaging with the clinical networks for Urgent Care, CHD, stroke, diabetes and neurology.

We will provide more treatment for patients closer to home where possible. In particular the following initiatives are being taken forward:

- Developing closer working between Out Of Hours and Minor injury service providers and hospital services
- Using the 'Urgent Care Clinical Dashboard' to monitor unscheduled care activity including A&E attendances, emergency admissions and GP Out of Hours attendances
- Developing the approach that enables ambulance paramedics to contact a GP within 5 minutes for advice if they think a patient could be managed more effectively at home or another care setting as an alternative to taking them to A&E
- Making greater use of local pharmacists to provide more advice and treatment of minor ailments
- Identifying services that can and should be implemented across 7 days
- Supporting patients to make informed choices about which NHS service is most suitable for their illness or injury, and also promote self-care where this is most appropriate. Increasing the awareness of 111 is a key element of this
- Refining ambulatory care to minimise admissions
- Planning for the delivery of the quality standards identified in the SeQiSH project.

Elective Care

For people who need episodic, elective care, access to services must be designed and managed from start to finish to remove error, maximise quality, and achieve a major step – change in productivity.

We expect to see centres that deliver high quality treatment, treating adequate numbers to be expert, and with the most modern equipment available. To concentrate specialised services in fewer sites and transform out-of-hospital care, we need to review how we deliver routine planned admissions for patients for less complex treatments. International comparisons suggest that, as well as quality improvements, there are significant productivity gains to be made if we can change our model of delivering elective care – giving us the opportunity to treat even more patients at the same or lower cost.

CCGs are tasked with a step-change in the productivity of elective care in order to realise a 20% productivity improvement within 5 years, so that existing activity levels are delivered but with better outcomes and 20% less resource. Our elective care activity trajectories are provided in the section below and will be achieved through our commissioning intentions, of which schemes such as the outpatient review programme, new to review ratios and consultant to consultant benchmarking will contribute.

Urgent Care Strategy

The CCG has developed a 5 year urgent care strategy and a detailed 2 year urgent care plan.

The strategic aim and objective is to provide a 24/7 seamless urgent care pathway that will meet the needs of the local population and will deliver the quality and financial requirements of QIPP.

It will focus on revised pathways of care and will navigate patients and the public to the most appropriate service. The commissioning intentions for 2014/15 form part of the detailed 2 year plan and will provide the infrastructure to progress the overall strategy with a strong emphasis on communication and education.

NHS urgent and emergency care services provide life-saving and life-changing care for patients who need medical help quickly and unexpectedly. We know our accident and emergency departments are under increasing pressure and we want to improve the urgent and emergency care system so patients get safe and effective care whenever they need it.

During 2014/15 pilots designed to extend access to general practice services and stimulate innovative ways of providing primary care services will be run, supported by the Prime Minister's £50 million challenge fund. There will be at least nine pilots covering around half a million patients and testing new ways of providing evening and weekend access, making greater use of email and phone consultations, joining up urgent care and out-of-hours care, and providing a range of other flexibilities in how citizens access services.

Workstream success measures and outcomes

- Achievement of targeted New to Review ratios
- Reduce the number of patients who are admitted to hospital only to be discharged very soon afterwards
- Reduction in emergency admissions
- Reduction in face-to-face follow-ups
- Increase in telephone follow-ups
- Reduction in unnecessary A&E/Walk-in Centre/GP attendances for minor ailments
- Increased capacity in primary care (increased choice and access for patients).

Activity trajectories

The following table and supporting narrative highlights our activity trajectories planned over the next 5 years. Although this activity is acute based the commissioning intentions and associated projects being delivered across all workstreams and project groups will contribute to delivery of the associate targets.

Activity Trajectories

	E.C.1	E.C.2	E.C.3	E.C.9	E.C.10	E.C.11	E.C.4	E.C.5	E.C.12	E.C.6
CCG Activity	Elective Admissions - Ordinary Admissions	Total Elective Admissions - Day Cases (FFCEs)	Total Elective (FFCEs)	GP Written Referrals (G&A)	Other Referrals (G&A)	Total Referrals	Non-elective FFCEs	All First Outpatient Attendance	First Outpatient Attendance - following GP Referral	All Subsequent Outpatient Attendance (All specialties)
2013/14 Forecast out-turn	7,961	40,014	47,975	61,014	29,000	90,014	30,890	68,581	47,191	137,223
Forecast growth in 2014/15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-1.7%	0.0%	0.0%	0.0%
2014/15 Total	7,963	40,024	47,987	61,013	29,002	90,015	30,375	68,579	47,191	137,222
Forecast growth in 2015/16	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-4.9%	0.0%	0.0%	0.0%
2015/16 Total	7,966	40,033	47,999	61,013	29,002	90,015	28,874	68,579	47,191	137,222
Forecast growth in 2016/17	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-1.0%	0.0%	0.0%	0.0%
2016/17 Total	7,964	40,031	47,995	61,014	29,000	90,014	28,596	68,581	47,191	137,223
Forecast growth in 2017/18	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.1%	0.0%	0.0%	0.0%
2017/18 Total	7,964	40,031	47,995	61,014	29,000	90,014	28,581	68,581	47,191	137,223
Forecast growth in 2018/19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.1%	0.0%	0.0%	0.0%
2018/19 Total	7,964	40,031	47,995	61,014	29,000	90,014	28,566	68,581	47,191	137,223

Non- Electives

We are planning to reduce non-elective activity levels over the next 5 years based on our 13/14 forecast out-turn. This equates to over a 16% efficiency requirement, when you consider the annual growth rate. To deliver this efficiency it is absolutely imperative that the initiatives identified in the BCF work programme are effective and deliver a care landscape where emergency admission requirement is significantly reduced. The developments as outlined in the urgent care strategy will also contribute to a reduction in non-elective admissions.

Electives

Over the next 5 years we plan to maintain current (2013/14 forecast out-turn) elective activity levels (e.g. 0% growth). This equates to a 10% efficiency requirement when you consider the annual growth rate. To deliver this efficiency, innovative interventions are needed which increase the potential to improve a patient's health outcome without the requirement for an elective procedure. Reducing GP practice Variation in Spend (using the GVIS tool) and the expansion of primary care will contribute to sourcing and providing alternative services to the traditional hospital based model. There may also be scope to identify opportunities where procedures can be modernised to allow them to be performed as a day case rather than require an overnight stay. This will help reduce cost per case and help to deliver efficiency.

Outpatients

We are also planning to maintain current (2013/14 forecast out-turn) of Outpatient activity levels over the next 5 years, which considering the annual growth rate, equates to a 14% efficiency for new appointments and 15.5% efficiency for follow-up appointments. This is a significant ambition and projects such as reducing GP practice variation will contribute by sharing best practice and providing an alternative to the hospital model, while the New-to-Review outpatient appointment re-appraisal process will transfer appropriate patient reviews from an outpatient setting into primary care.

Referrals

This is in line with the reduction in First Outpatient appointments. This will be supported by reducing GP practice variation.

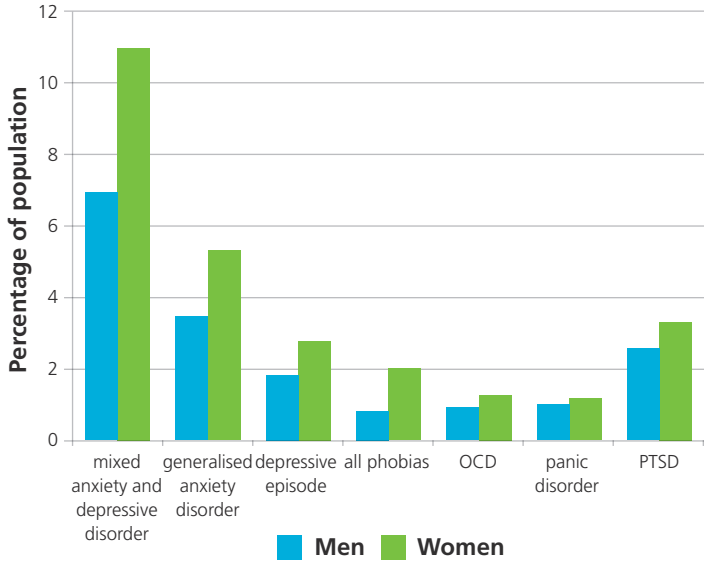
A&E

A&E activity levels are also being planned with a reduction over the next 5 years (-1% growth year on year). When you consider the annual growth rate, this equates to 9% efficiency over the five year period. The combination of increased access to primary care, implementing seven day services and the projects underpinning delivery of the urgent care strategy will support the delivery of the necessary shift in this activity, while measures to increase public awareness and use of 111 will encourage appropriate public use of urgent services when A&E attendance is not actually needed.

Mental health and learning disabilities

It is estimated that around 17.7% of adults aged 18 and older meet the diagnostic criteria for at least one common mental health disorder, including depression, anxiety, alcohol misuse and post-traumatic stress disorder. Reducing the prevalence of common mental health disorders such as anxiety and depressive disorders is a major health concern.

Common mental health disorder



The CCG is committed to implementing "Parity of Esteem" (equally valuing mental health with physical health and vice versa) and this forms a core part of the working principles of our unit of commissioning.

The CCG will target:

- Improved access to Psychological Therapies
- Ensure all those with learning disabilities have annual health check and a health action plan if they wish
- Map and benchmark existing services against best practice
- Developing services and effective pathways for access to diagnosis and support for people with autism.

We will improve access to mainstream health services for people with learning disabilities. We will work to minimise living away from the local area to access services to meet their needs. We will continue to review all high cost and risk share placements.

Our plans will meet the requirements of the Autism Act and the National Autism Strategy and promote equity of health outcomes for people with a learning disability. We will improve access to diagnosis and appropriate support for adults with autistic spectrum conditions. A Tees Children's Autism Strategy group has been formed to ensure compliance with NICE guidance and develop a local Autism Strategy.

We will support local SEN reforms and the development of notional Personal Health Budgets.

We will work with mental health providers to develop mental health care models that prioritise early detection and intervention to maximise recovery.

We will continue to focus on improving access and choice to psychological therapies and the following local indicator will be used to measure improved access to psychological services (IAPT) for people with depression and/or anxiety disorders:

	The number of people who receive psychological therapies	The number of people who have depression and/or anxiety disorders (local estimate based on National Adult Psychiatric Morbidity Survey 2000)	Planned proportion entering treatment
Q1 2014/15	1,225	36,356	3.37%
Q2 2015/16	1,270	36,356	3.49%
Q3 2016/17	1,320	36,356	3.63%
Q4 2017/18	1,360	36,356	3.74%
2015/16	5,440	36,356	14.96%

Although guidance advises that we should be reaching 15% of people with a need for IAPT to enter treatment, the CCG is not achieving this currently and it is unlikely that we can achieve it by the end of 2014/15.

We will strive to achieve this for 2015/16 however we recognise that this is a big challenge. We are also aiming for a 50% recovery rate for people who have completed treatment in 2014/15 and 2015/16.

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

Dementia

We have an ageing population. We expect our over 65 year population to increase over the next 15 years. As larger numbers of older people live longer, more people are likely to develop or have more than one long-term condition. This ageing population will see an increasing degree of dementia and therefore the associated demand for increased health and social care provision. It is recognised people with dementia experience worse outcomes in acute settings and remains in hospital a third longer than average.

Building on the work of the Dementia Collaborative we will continue to work with our partners as we face a major challenge to getting our services fit for the increase in demand and able to provide the range of services required for our dementia population. We are also working with Primary Care and our Secondary Care providers to cross check practice registers to ensure that all new diagnosis are recorded accurately.

The following local indicator for dementia has been agreed with the Health and Well Being Boards as this is the local indicator agreed in relation to the Better Care Fund:

	Number of people diagnosed	Prevalence of dementia	% diagnosis rate
2014/15	2,357	3,517	67.02%
2015/16	2,472.96	3,584	69.00%

An increase in the dementia diagnosis rate to 67% should be achieved by March 2015 and we aim to increase this further to 69% by 2016.

Winterbourne review

We will continue to work with our partners to ensure delivery of the national Winterbourne View Concordat and provide effective transition from inpatient settings to the community. We are also committed to ensuring the community infrastructure is sufficiently resourced and equipped to deliver the robust health care needed to successfully resettle those identified through the Winterbourne View work.

Patients stepping down from secure services are being identified through close working with NHS England. To ensure that providers are aware of the new ways of working and to reiterate the need to be informed and involved at a much earlier stage in this process, the CCG will work with NHS England and Joint Commissioners to review and re-launch the necessary protocols for this to be undertaken more effectively.

MH strategy

The CCG working with both local authorities respectively will be developing a local Mental Health Implementation Plan incorporating the priorities as set out in the 'Closing the gap: priorities for essential change in mental health'. A collaborative approach will be taken and Task & Finish Groups will be established which will report to Stockton Mental Health Partnership Board and Hartlepool Mental Health Forum. These groups will have a wide membership with representation from service users and carers.

CAMHS strategy

The development of a CAMHS strategy is underway to ensure that primary mental health services can meet the needs of children and young people with early stage mental health difficulties; through early intervention and quality longer term services for those children with more complex mental illness.

Special Education Needs

As part of our responsibilities set out in The Children and Families Bill in relation to children and young people with Special Education Needs (SEN), we are engaging with our local authorities to create joint commissioning arrangements for the health and social care provision required by children and young people identified as having SEN.

Hartlepool is an SEN pathfinder and is currently testing the new process with families directly. There are established processes for decision making in relation to Emergency Health Care Plan (EHCP) assessment, planning and sign off and the CCG have made available a small amount of funding to test the personal health budget (PHB) element of this plan for healthcare services other than children's continuing care. This work will support the pathfinder evaluation but also the wider CCG implementation of PHB's.

The CCG is committed to improving outcomes for disabled children and this has been translated in to our Foundation Trust provider contract requirements.

Workstream success measures and outcomes

- Reduction in out-of-area learning disability placements
- Reduced waiting times for assessment of ASD
- Improved equality of access to healthcare for those with learning disabilities
- Increased percentage of patients with learning disabilities to be offered an annual health check and health action plan
- Reduction in behaviourally related admissions for people with dementia
- Reduction in unplanned hospital admission, readmission rates and acute/MH bed days for people with dementia
- More people accessing screening for dementia
- Increased dementia diagnosis
- Increased identification of patients requiring support
- Increased accuracy of coding in primary care re diagnosis and outcomes
- Increased safeguarding of children and vulnerable adults
- Increased earlier detection and interventions
- Reduction in hospital admissions due to self-harm

- Reduction in hospital admissions for mental health disorders
- Reduction in length of stay
- Reduction in demand for crisis support
- Improved patient experience/positive experience of care
- Reduced excess under 60 mortality in adults with learning disabilities.

Medicines Optimisation

Medicines account for 12% of NHS spend and 70% of this is spent in primary care. Nationally it is estimated that £300m of medicine is wasted annually and £90m of medication is unused in peoples' homes.

The quality of prescribing is generally high in our CCG although there remains variation in the use of medicines across different practices and there are still benefits to be realised from the elimination of waste such as unnecessary prescriptions.

The CCG has arrangements in place to ensure the optimal use of medicines, including:

- Medicines optimisation plan
- Medication review and reconciliation of medicines
- Systems for ensuring cost effective, clinically effective and safe use of medicines
- Arrangements in place for local decision making on new medicines
- Support and advice to ensure statutory responsibilities are met in relation to medicines
- Governance and assurance processes including local intelligence network and preparation of assurance reports
- Close performance management of provider contracts to meet our QIPP targets
- Direct support to member practices on medicines optimisation matters.

We will maintain an up to date medicines management commissioning toolkit to support safe, effective use of medicines within contracts.

We will provide a range of prescribing analysis reports in order to plan for, monitor, audit and manage medicines usage and expenditure.

Workstream success measures and outcomes

- Increase in repeat dispensing rates
- Increase in number of prescriptions transferred electronically
- Reduction in cost for oral nutrition prescribing
- Increased referrals for respiratory focussed MURs
- Increased referrals to pulmonary rehabilitation
- Annual review of care home patients
- Improve access to medicines
- Maximise opportunity to save GP practice administration time
- Reduction of fraud and waste of medicines.

Cross cutting projects

Integrated care and Better Care Fund

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, independence and quality of life will be maximised to help people to stay healthy and well. 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 working.

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

The Better Care Fund (BCF) is therefore seen as a significant step forwards in developing integrated health and social care services, providing a framework for change. 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 a permanent care home admission.

The BCF is a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities.

Within the BCF the 'multi-disciplinary team' scheme will build upon the existing Momentum: Pathways to Healthcare programme. The first year will entail a multi-agency design of the proposal, underpinned with some key principles and required outcomes, to ensure buy-in from all stakeholders and ensure deliverability.

This scheme would be at the heart of the transformation needed to meet the aspiration and ambition which the Better Care Fund has been established to achieve.

The multi-disciplinary team will have two key aims:

1. Delivering targeted early intervention and preventative approaches to reduce the individuals need for health and social care services
2. Effective crisis management to ensure the individual can maintain their levels of independence and maximise their health and well-being.

One initiative within the scheme would look at assessments and interventions being multi-disciplinary, with a lead professional who would have the ability to assess and co-ordinate support/care. The clinical lead would be an appropriate health care professional and this scheme would link to the new requirement for all over 75s to have a named GP.

Other areas of focus within the BCF plans are:

- Frail and elderly (including dementia)
- 24/7 integrated community teams (including rapid response)
- Intermediate care – step up, step down
- Single Point of Access
- 7 Day services to support discharges.

The BCF supports the stated intentions of both the Local Authority and the CCG to deliver services which are value for money and improve outcomes through closer integration of the two organisations.

7 day working

Patients need the NHS every day. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality.

The NHS Services, Seven Days a Week Forum, chaired by the National Medical Director, reported to NHS England on how NHS services can be improved to provide a more responsive and patient centred service across the seven day week.

The Forum's review which focused on urgent and emergency care services and their supporting diagnostic services, pointed to significant variation in outcomes for patients admitted to hospital at the weekend across the NHS. This variation is seen in mortality rates, patient experience, length of stay and re-admission rates.

The subsequent seven day national clinical standards were developed through extensive engagement with stakeholders and include a comprehensive supporting evidence base.

The CCG will be working with our local acute trusts to deliver these clinical standards and has used the contract mechanisms available to us to ensure an action plan is developed to co-ordinate this delivery. Meeting the seven day standards will be challenging, however we welcome the opportunity to work with our providers to explore new ways of working to consider the distribution of different services between trusts.

Securing Quality in Health Services

We are fully committed to seeking and sustaining quality care and services across health and social care. The Securing Quality in Health Services (SeQiHS) work (which builds upon the Acute Services Quality Legacy Project) will continue to drive this in relation to understand the opportunities and challenges in achieving best-in-class levels of acute hospital services, within the likely financial environment over the coming years.

The SeQiHS report provides analysis and clinical recommendations, supported by wider workforce and economic modelling, with a focus on sustainable, high-quality care. It defines the highest standards of service quality we expect and identifies what factors are most important when considering the sustainability of services to meet these standards in the future.

The implications of this work range from potential changes to be made to provider contracts through incorporating the agreed clinical quality standards, to potential service reconfiguration needed across County Durham and Tees valley.

It is clear from SeQiHS and the national seven day standards work that this will require CCGs and Area Teams to commission care and services differently and for providers to develop new ways of working that will inevitably lead to a realignment of services. Commissioners and providers will clearly need to work together closely to take this work forward in a coherent way.

Darlington CCG is leading the work on behalf of the six CCGs across County Durham, Darlington, Tees and Hambleton, Richmondshire and Whitby and the project will also collaborate with the Durham, Darlington and Tees Area Team with regards to specialised commissioning.

Section 4: Enablers

Finance and QIPP Context

This section gives an overview of the CCG's financial plan, summarising its planning assumptions around income and expenditure over the next 5 years, and outlining arrangements for ensuring the CCG achieves financial balance and its other statutory duties.

Source of Funding (CCG Resource Allocations 2014/15 – 2018/19)

The 2014/15 and 2015/16 allocations to CCGs and for NHS England direct commissioning were published on 20th December 2013, using a new allocation formula. Planning guidance has indicated that for 2016/17 to 2018/19 commissioners should assume continuity of the current allocations policy, although no decisions on allocations beyond 2015/16 have yet been taken. The table opposite summarises the CCG's planning assumptions around its resource allocations for the next 5 years.

	2014/15	2015/16	2016/17	2017/18	2018/19
Programme Baseline Allocation	365,657	371,874	378,568	385,004	391,550
Better Care Fund (BCF) allocation	-	6,171	6,171	6,171	6,171
Total Programme Allocation	365,657	378,045	384,739	391,175	397,721
Running Cost Allocation	7,123	6,398	6,385	6,374	6,363
Total CCG Allocation	372,780	384,443	391,124	397,549	404,084
Programme allocation change %	2.14%	1.70%	1.80%	1.70%	1.70%
Running Cost Allocation change %	0%	-10%	0%	0%	0%
Total Notified Allocation change %	2.09%	3.13%	1.74%	1.64%	1.64%

HAST CCG Resource Allocations 2014/15 – 2018/19

The following key points should be noted:

- Under the revised formula the CCG is marginally above its target allocation (0.67% / £2.3m over in 2014/15 and 0.47% / £1.7m over in 2015/16).
- All CCGs will receive a minimum programme allocation uplift of 2.14% in 2014/15 (average increase of 2.54%), and 1.7% in 2015/16 (average 2.09%). As HAST CCG is above its target allocation it receives the minimum uplifts.
- Planning guidance indicates that for 2016/17-2018/19 commissioners should assume that allocations increase in line with the GDP deflator (1.8% in 2016/17 and 1.7% thereafter).
- From 2015/16 CCGs will be required to create the Better Care Fund (BCF). This resource will be required to be pooled with Local Authorities to fund health and social care to benefit health. The additional resource required form the CCG baseline is c£11m with an expectation of impacting on a reduction in acute care in relation to reduced Emergency Admissions.
- Income is allocated separately for Programme and administrative costs (Running Costs). Expenditure against these allocations is monitored separately. Underspends on Running Costs may be spent on Programme costs, but the Running Cost allocation must not be overspent.
- The 10% reduction in the Running Costs allocation in 2015/16 reflects the national assumption that overall health sector administration costs will be reduced by 10% in 2015/16. The small reductions thereafter relate to redistribution of the Running Cost allocation based on populations.
- Surpluses and deficits accumulated as at 31 March 2014 and in subsequent years will be carried forward into the following financial years. The CCG generated an additional surplus of £3.6 million in 2013/14 over and above the required 1%, and is planning on utilising this in 2015/16 to offset the risks arising from the creation of the Better Care Fund (see Use of Funding section below).

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

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

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

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

Use of Funding (CCG Expenditure Plans 2014/15 – 2018/19)

The diagram below shows the CCG's planned spend for the next 5 years, 2014/15 split by the main categories of spend. It can be seen that over half of all expenditure is with the acute sector.

Use of Funding (CCG Expenditure Plans 2014/15 - 2018/19)	2014-15		2015-16		2016-17		2017-18		2018-19	
	Rec £000	N'Rec £000	Rec £000	N'Rec £000	Rec £000	N'Rec £000	Rec £000	N'Rec £000	Rec £000	N'Rec £000
Uplift & CQUIN										
Uplift	9,405		9,989		13,889		11,414		11,366	
Tariff coding pressures	604		0		0		0		0	
Total Uplift	**10,009**	**0**	**9,989**	**0**	**13,889**	**0**	**11,414**	**0**	**11,366**	**0**
Cost Pressures										
13/14 out-turn pressures above reserves	1,641									
Specialist Commissioning	1,344									
Sub total	**2,985**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Demographics & demand changes										
Acute	2,663		2,589		2,534		2,510		2,494	
Prescribing	943		976		1,010		1,046		1,082	
MH/LD Packages/SS/Strategy	199		0		0		0		0	
Joint Commissioning - CHC	996		1,071		1,151		1,247		1,330	
Sub total	**4,801**	**0**	**4,616**	**0**	**4,695**	**0**	**4,803**	**0**	**4,906**	**0**
Other commitments										
Winterbourne/CAMHS/MH/LD	666									
Acute risk Share changes	494									
Sub total	**1,160**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
DH Policy Initiatives										
Integrated transformation Fund			10,928							
Social care transfer from AT			6,171							
0.5% Call to action reserve	1,862		-5,502							
GP £5 investment	1,413									
Sub total	**3,275**	**0**	**11,597**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Local Developments										
Community Investment	352		701		0		1,500		1,500	
MH/LD Investment	1,341		1,133		600		971		991	
Acute transformation Town Centre Dev					1,000		500			
Primary Care Investment	12				500		500		500	
Local Investment			1,912		784		1,079		1,141	
Non Recurrent Investment	1,705	9,129		7,024		3,687		3,965		3,653
			3,746	7,024	2,884	3,687	4,550	3,965	4,132	3,653
Total Applications	**23,935**	**9,129**	**29,948**	**7,024**	**21,468**	**3,687**	**20,767**	**3,965**	**20,404**	**3,653**

Over the 5 year planning period the CCG plans to invest in community, primary care and mental health services to fit with the implementation of its strategic objectives and longer term commissioning plans.

The CCG's expenditure plans for 2014/15 – 2018/19 is based on a number of planning assumptions and business rules as detailed below:

Business rules

2014/15:

- CCG must maintain a minimum 0.5% contingency reserve
- CCG must generate a 1% cumulative surplus to carry forward
- CCG must commit 2.5% of its allocation to be spent on a non-recurrent basis (including 1% for transformation).

2015/16-2018/19:

- CCG must maintain a minimum 0.5% contingency reserve
- CCG must generate a 1% cumulative surplus to carry forward
- CCG must commit 1% of its allocation to non-recurrent spend
- Better Care Fund spend as notified separately.

2013/14 pressures

During 2013/14 the CCG reported pressures in a number of areas:

- Prescribing £2,500k
- Acute £3,400k
- Continuing Care £650k
- Adult Hearing AQP £300k
- Total £6,850k.

The 2014/15 baseline budgets have been adjusted to reflect these overspends, resulting in a corresponding reduction in reserves. This means the CCG has no other reserves besides those listed above to offset risks arising in 2014/15, highlighting the importance of QIPP delivery.

Growth assumptions

- Acute activity-based contracts have been uplifted based on projected population changes and prevalence of disease.
- Prescribing budgets have been increased to reflect national horizon scanning intelligence.
- Other budgets have been increased to reflect the best available information on demand growth, e.g. continuing health care (joint commissioning).

Price inflation – national tariffs

The CCG has used the national planning assumptions with regards to future tariff increases and efficiency requirements, as follows:

	2014/15	2015/16	2016/17	2017/18	2018/19
Inflation	2.5%	2.9%	4.4%	3.4%	3.3%
Efficiency	-4.0%	-4.5%	-4.0%	-4.0%	-4.0%
Net tariff uplift	-1.5%	-1.6%	0.4%	-0.6%	-0.7%

Delivery of these levels of efficiency will be challenging for providers given the efficiencies already delivered in previous years, and more radical approaches will be required to create efficiencies going forward.

Price inflation – prescribing

Local determination – expected to be in a range of 4% to 7% per annum increase. HAST CCG is assuming a 5% increase in each of the 5 year plans.

Price inflation – continuing health care

Local determination – expected to be in a range of 2% to 5% per annum increase. HAST is assuming a 3% increase in each of the 5 year plans.

Better Care Fund (BCF)

The BCF is created in 2015/16 with a total value of £19.533m and comprises:

- £6.171m via CCG allocations (see above)
- £2.433m existing reablement and carers funding
- £10.927m from existing CCG core funding.

The transfer from existing CCG core funding is a real risk as it will require reductions in spending in other areas, in particular a reduction in emergency acute activity.

In 2014/15 the CCG has also set aside £1.4m (£5 per head of population) per the planning guidance for GP practices to invest in appropriate community and primary care services, complementing the BCF.

CHC restitution payments

It has been proposed that a national risk share arrangement is to be set up, for which HAST CCG has had to set aside £1.4m in 2014/15.

The efficiency challenge

In common with all other commissioners, HAST CCG faces a significant financial challenge in the next five years, given an ambitious strategy and vastly reduced expected levels of allocation growth in future years. Monitoring and management of demand and care pathways through contracting arrangements will be crucial to a successful outcome and the need to engage both CCG and hospital clinicians in this agenda will be essential to delivery.

The CCG will need to achieve efficiency savings of circa 4% per annum over the next 5 years (£14m-£17m), with the greatest requirement in 2015/16 when the BCF is created. Circa £10m-£11m per annum will be delivered through national tariff efficiencies, with the remaining £4m-£5m requiring specific local efficiency schemes within the CCG's Quality, Innovation, Productivity & Prevention (QIPP) programme. The detailed programme is defined above in strategic aim 8 page 49.

Projected Efficiency Savings

Impact of Investment	2014-15		2015-16		2016-17		2017-18		2018-19	
	Rec £000	N'Rec £000	Rec £000	N'Rec £000	Rec £000	N'Rec £000	Rec £000	N'Rec £000	Rec £000	N'Rec £000
Acute	2,669		4,428		3,607		3,116		2,584	
Prescribing	710		734		759		785		812	
MH/LD	255		26							
Primary	11									
Community	148									
Joint Commissioning	144		344							
Running Costs	374		368		13		11		11	
Other Commissioning	86		58							
Technical	10,533		11,603		10,935		10,419		10,452	
Annual savings achieved/planned	**14,930**		**17,561**		**14,774**		**14,331**		**13,859**	

Risk assessment and mitigation

The CCG has assessed its risk across all areas of spend and those areas which are activity driven have been risk scored on a low, medium and a high risk basis giving a potential risk range of between scenarios.

The CCG has contingency plans in relation to utilising its 0.5% contingency reserve, has set aside reserves for joint commissioning growth, and plans to utilise some resources on a non-recurrent basis to offset other risks. This means that some investments, particularly the 2.5% non-recurrent spend, will require phasing towards the last two quarters of the year to ensure resources are available to manage these risks. Below is a schedule of scenarios and mitigation of risks.

Risk and Contingency Plan 2014/15				
Risk	**Low**	**Medium**	**High**	
	£'s	**£'s**	**£'s**	**%'s**
Acute	551,535	827,303	1,103,071	2/3/4
MH/LD	0	0	0	
Community	8,605	17,210	25,814	1/2/3
Joint	238,016	714,047	1,190,079	1/3/5
Primary Care	1,003,289	2,006,578	3,009,867	2/4/6
Other	21,750	43,501	65,251	1/2/3
	1,823,196	**3,608,639**	**5,394,082**	

Mitigation	Low	Medium	High
	£'s	**£'s**	**£'s**
acute risk - 2.5%	700,000	700,000	700,000
prescribing risk - 2.5%	700,000	700,000	700,000
chc risk - 2.5%	400,000	400,000	400,000
community risk - 2.5%	95,000	95,000	95,000
general reserve 0.5%		1,906,791	1,906,791
carer funding - slippage			737,451
slippage on winter pressures			1,500,000
	1,895,000	**3,801,791**	**6,039,241**

Risk and Contingency Plan 2015/16				
Risk	**Low**	**Medium**	**High**	
	£'s	**£'s**	**£'s**	**%'s**
Acute	534,104	801,156	1,068,209	2/3/4
MH/LD	0	0	0	
Community	15,451	30,903	46,354	1/2/3
Joint	255,867	767,601	1,279,335	1/3/5
Primary Care	1,038,056	2,076,112	3,114,167	2/4/6
Other	21,608	43,215	64,823	1/2/3
	1,865,086	**3,718,987**	**5,572,887**	

Mitigation	Low	Medium	High
	£'s	**£'s**	**£'s**
general reserve 0.5%	1,965,214	1,965,214	1,965,214
risk reserve		1,462,914	1,462,914
non recurrent c fwd		3,600,000	3,600,000
	1,965,214	**7,028,128**	**7,028,128**

Risk and Contingency Plan 2016/17				
Risk	**Low**	**Medium**	**High**	
	£'s	**£'s**	**£'s**	**%'s**
Acute	533,258	799,888	1,066,517	2/3/4
MH/LD	0	0	0	
Community	15,544	31,088	46,632	1/2/3
Joint	275,057	825,171	1,375,285	1/3/5
Primary Care	1,074,038	2,148,076	3,222,114	2/4/6
Other	21,778	43,556	65,334	1/2/3
	1,919,675	**3,847,778**	**5,775,882**	

Mitigation	Low	Medium	High
	£'s	**£'s**	**£'s**
general reserve 0.5%	1,981,991	1,981,991	1,981,991
risk reserve		2,000,000	2,000,000
non recurrent 1%			3,799,117
	0	**2,000,000**	**5,799,117**

Risk and Contingency Plan 2017/18				
Risk	Low	Medium	High	
	£'s	£'s	£'s	%'s
Acute	529,095	793,643	1,058,190	2/3/4
MH/LD	0	0	0	
Community	15,591	31,182	46,773	1/2/3
Joint	295,686	887,059	1,478,431	1/3/5
Primary Care	1,111,279	2,222,558	3,333,836	2/4/6
Other	21,745	43,490	65,235	1/2/3
	1,973,396	**3,977,931**	**5,982,465**	

Mitigation	Low	Medium	High
	£'s	£'s	£'s
general reserve 0.5%	2,014,283	2,014,283	2,014,283
risk reserve		2,000,000	2,000,000
non recurrent 1%			3,863,477
	2,014,283	**4,014,283**	**7,877,760**

Risk and Contingency Plan 2018/19				
Risk	Low	Medium	High	
	£'s	£'s	£'s	%'s
Acute	525,856	788,784	1,051,711	2/3/4
MH/LD	0	0	0	
Community	15,640	31,280	46,920	1/2/3
Joint	317,863	953,588	1,589,313	1/3/5
Primary Care	1,149,822	2,299,645	3,449,467	2/4/6
Other	21,715	43,431	65,146	1/2/3
	2,030,896	**4,116,728**	**6,202,559**	

Mitigation	Low	Medium	High
	£'s	£'s	£'s
general reserve 0.5%	2,047,278	2,047,278	2,047,278
risk reserve		2,100,000	2,100,000
non recurrent 1%			3,928,931
	2,047,278	**4,147,278**	**8,076,209**

The table below shows the key risk areas and mitigation plans alongside the responsible officer.

Risk	Probability	Impact	Management strategy	Responsible director
Further reductions in management capacity impacting on ability to deliver efficiency programme	Medium	High	Prioritise areas of greatest risk SLA / Performance Management	Chief Officer
Insufficient progress on QIPP schemes, impacting on investment plan assumptions	Medium	Medium	Monitoring arrangements in place through QIPP Boards. Re-work plans through year if necessary. - Independent scrutiny of plan	Chief Officer/Chief Finance Officer
Fail to manage prescribing costs	Medium	Medium	Prescribing advisors working with practices to deliver cost effective prescribing and required efficiencies.	Chief Officer/Chief Finance Officer
Fail to manage Continuing Care spend within affordable levels	Medium	Medium	CHC team work closely with LA staff to ensure respective responsibilities are clear. Continuous monitoring of demand. A contingency has been set within the CCG Budgets	Chief Officer/Chief Finance Officer
Fail to contain contract costs in year to an affordable level.	Low	High	Negotiation of risk share arrangements in relation to contracts with main providers. The main providers are NTHFT/STHFT/TEWV	Chief Officer/Chief Finance Officer
Contingency arrangements insufficient to cover in year pressures	Low	High	Release of investment funding will be subject to delivery of efficiencies. Risk management arrangements in place with key providers and continuous monitoring and review to highlight pressures immediately to CCG leads and Exec Team.	Chief Finance Officer

Quality and Patient Safety

We are currently refreshing our Quality Strategic Framework which underpins our approach to optimising the quality and safety of services that we commission. This includes how we link with national and local strategies and partners to ensure our population's health needs are addressed whilst keeping the provision of high quality safe care central to all the actions of the CCG. This is in accordance with *Equity and Excellence: Liberating the NHS* (DH July 2010) and *The Health Act* (March 2012).

By adopting the comprehensive definition of quality that encompasses Safety, Effectiveness and Patient experience, the nationally mandated contracts with our providers of health services have been substantially augmented by Local Quality Requirements to enhance and increase the performance expectations and associated rigour of monitoring. As the nature and focus of services evolve, particularly through the developments arising from this strategic plan, the focus on quality will continue to ensure it remains a central component of the outcomes received by our patients, carers and families.

This approach is mirrored in the undertaking of our safeguarding responsibilities for both children and adults, and will be further enhanced by developments in both statute and national guidance.

To provide independent assurance of our ability to deliver against our objectives, we will work closely with local and national partners to review, and revise where appropriate, our mechanisms and processes to ensure adherence to "best practice" and value for money. As a transparent organisation the results of this work will be available to our partners and public via our Governing Body papers.

Patient Engagement and Feedback

The CCG is committed to ensuring that our citizens are fully included in all aspects of service design and change, and that patients are fully empowered in their own care.

Our model for engagement with patients/carers and the public includes:

- Working with local GP patient groups
- Development and implementation of membership model (MY NHS) to encourage and facilitate involvement of the general public
- Working closely with local Healthwatch
- Identification of key stakeholders including community and voluntary groups and including those representing BME groups and others identified as 'protected' by the Equalities Act
- Ongoing development of relationships with these stakeholders
- Working to ensure barriers to effective involvement, particularly in relation of those who are 'seldom heard' are removed
- Promotion of the CCG's work and mechanisms available for engagement.

NHS Hartlepool and Stockton-on-Tees CCG will build upon existing mechanisms to maximise opportunities to engage with and seek the views of patients, carers and the local population.

We will:

- Communicate key messages
- Engage and consult with patients, carers and stakeholders on service and pathway design (e.g. promote involvement opportunities)
- Capture the views of patients, carers and stakeholders of NHS services (e.g. through surveys, public events and focus groups)
- Engage with "seldom heard" groups
- Feedback to patients, carers and stakeholders on the outcomes of activity and how it has impacted upon decision making. (e.g. via online platforms, direct mail, e-bulletins and public meetings)
- Establish a presence in the heart of the community to enable proactive engagement with the wider public
- Ensure that appropriate engagement and consultation techniques are applied throughout the commissioning cycle; in strategy and planning, service development and procurement and in monitoring and reviewing services
- Further develop and enhance the existing MY NHS programme, which currently has around 700 members signed up, to support a wider range of involvement opportunities.

Patient feedback is fundamental to the way we work. All our member practices have a representation through the Council of Members and through their Locality Lead. The localities are designed to ensure that the very local intelligence is gathered and used to monitor service quality and make improvements.

The CCG will also work with the local HealthWatch organisations which champion the views and experiences of patients, people using these services, carers and the wider public.

The CCG will also work with agencies such as local authorities, other NHS organisations, Local Healthwatch and Voluntary and Community Sector (VCS) Organisations to capitalise on network and engagement opportunities.

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

The CCG will continue to hold some of its governing body meetings in public and will include the public in the decisions as to how best to involve them in these meetings

The CCG will seek assurance from providers as to the steps they are taking to record and improve the patient experience. This will include monitoring collection of data and actions taken to address identified areas for improvement.

Health and wellbeing information is live! Simply go to Sky channel 539 or Virgin 233 and press the red button. If you have a smartphone just scan this QR code and download our app. You can also visit us as usual at www.hartlepoolandstocktonccg.nhs.uk

CCG Communication and Engagement Objective	This will be achieved by:
1. Ensure that the priorities of the public, patients and carers are reflected in commissioning, service development and provisioning decisions through continuous and meaningful communication and engagement activity.	Utilising the MY NHS engagement platform which will enable us to involve and establish an on-going dialogue with the local population, including those that are "hard to reach" or "seldom heard". It will provide a mechanism to solicit views, communicate key messages and feedback on outcomes and the impact that activity has had i.e. how it has influenced the decision making process. Developing and strengthening GP practice patient participation groups (PPG's) to contribute to intelligence gathering at both practice and CCG level. Maximising the use of new media platforms The development of robust communication and engagement plans to support workstream activity. Monitoring and measuring the experience of patients through a range of sources, triangulating information to identify trends and directly impacting upon commissioning decisions. Utilising intelligence from complaints and concerns relating to CCG business and commissioned services to understand patients' experiences and inform commissioning decisions. Proactively working with local authorities, Health and Wellbeing Boards, Local HealthWatch and Overview and Scrutiny functions over vision and plans.
2. Raise the profile of the CCG, its role and priorities, in line with its vision and values	Developing a positive, strong brand for the CCG Working with the local and regional media to promote the CCG and reinforce its vision and priorities Maximising the use of web and social media to reach a wider audience.

CCG Communication and Engagement Objective	This will be achieved by:
3. Manage the reputation of the CCG and increase confidence in the CCG as a responsive commissioning organisation	Communicating and engaging with stakeholders and partners to promote the CCG Vision and Clear and Credible Plan. Continuation of good relationships with local and regional media Providing timely reactive responses to the media and maximising the opportunities for proactive good news stories. Providing media training for CCG members as required. Building effective relationships with partners and stakeholders.
4. Deliver effective internal communications which ensures that the CCG Board, wider CCG members and GP community are best placed to deliver effective clinical commissioning	Establishing e- bulletins and newsletters. Providing key information in a concise format and in plain English. Delivering a programme of engagement events for staff.

Workforce development, research, estates and IT

Workforce

The CCG recognises the importance of ensuring that the providers of NHS services commissioned by them have a workforce that is of sufficient size with the appropriate skills and competencies. It understands that the CCG role is not to performance manage the detailed workforce planning of provider organisations but to promote understanding of key workforce capacity risks and opportunities, and set an environment for potential joint action that reflects a healthy balance between contestability and collaboration in workforce issues across the local health economy. Further the CCG accepts the duty to promote education and training.

Health Education England (HEE) is the new national leadership organisation responsible for ensuring that education, training, and workforce development drives the highest quality public health and patient outcomes. Health Education North East (HENE) aim to support HEE in delivering its objectives by ensuring local workforce requirements are met to ensure security of supply of a competent, compassionate and caring workforce to provide excellent quality health and patient care. HENE invests in education and training for the NHS workforce, including pre and post registration levels and across a range of staff groups and disciplines, across the North East and North Cumbria.

The CCG is working collaboratively with HENE, Providers, other CCGs across the North East and our Local Authority Partners to better understand the implications of proposed strategic intentions on workforce with a particular focus on primary and community care requirements. This includes the development of a workforce development, education and training strategy to ensure sustainability of the broader workforce requirements in order to deliver our commissioning plans.

Research

Our research and development (R&D) services are provided by our commissioning support service (NECS). The key function of this service includes undertaking the assurance (risk and feasibility) and delivery in GP practices of a range of research projects which are nationally funded and peer reviewed to provide assurance regarding the quality of the research. This funding also provides sessional support for GP/CCG to act as research lead.

The R&D support also includes:

- Working with secondary care providers to seek out and support developing research questions to increase the evidence base in areas of priority and encouraging GPs to be partners in this research e.g. as co-investigators/ collaborators in a research funding bid
- Assisting GPs to identify patients as potential research subjects as many research studies require patients at different points on the service pathway
- Supporting providers through their duty to ensure excess treatment costs associated with research in services they commission is funded.

Estates and IT

Estates Strategy

The CCG does not own any estate assets and has a lease with NHS Property Services for its HQ buildings in Billingham Health Centre. The CCG are working with our partners across Durham and Tees LiFT Company to update our strategic estate strategy.

Our plans for care closer to home and integration of health and social care services requires transformation of primary and community services including the transfer of outpatient and diagnostic services currently provided in a hospital setting. A priority will be to better utilise facilities in the existing primary and community estate for example Yarm Health Centre, Eaglescliffe HC, Billingham HC in Stockton and Hartlepool one life, the Headland HC and Wynyard Road facility in Hartlepool. The CCG are already working with NHS Property Services and the Foundation Trust to progress these plans to meet our strategic intentions.

The key estate development is in relation to the proposed new hospital at Wynyard and this is at outline business case stage with a planned opening 2018/19. If successful, there will be a need to develop a facility in central Stockton to provide minor injuries, walk in facilities and outpatient appointments. Initial scoping and capital requirements have been identified in the 5 year financial plan with an expectation that this would be built the later part of 2016/17. This is also consistent with the CCG urgent care strategy.

IT strategy

The CCG vision for IM and T is to have a safe and secure, integrated and easily accessible IT system with high quality data shared between primary care, secondary care and social services, patients and any providers who contribute to the patient record. This will enable transformation of patient services and an effective, efficient business IT solution.

CCG allocations in relation to GPIT are significantly less than the current funded requirements and transitional bids have been put forward. The CCG plans to implement all national projects

- GP to GP transfer of record
- Electronic Prescribing
- Web-based clinical systems
- NHS mail
- Patient access to health records.

The integration of services with social care and the unit of planning has identified 5 key areas:

- Digital Care Records
- Integrated Digital Care Records
- E-Prescribing
- Open Source Solutions
- Raising Digital Maturity.

And the use of NHS number strategy has identified 8 key areas

1. Review all existing systems
2. Ensure that all systems are using the NHS number
3. Put in place data sharing arrangements based on using the NHS number
4. Put in place the appropriate levels of technical security
5. Put in place data sharing protocols
6. Training of staff in information security
7. Identify the best way of ensuring GPs and other practitioners have access to single assessment data i.e. Health and Social Care records – this may be through a shared portal
8. Ensure that co-located teams are collecting the right data and updating the right systems.

The CCG are a key contributor to the development of a digital hub across the Tees Valley which has been sponsored by the Academic Health Science Network. Our aim is to maximise the benefits of digitalisation in relation to service transformation that will improve patient experience and clinical outcomes and develop efficient working practices.

The CCG recognise a barrier to deliver integrated services is the absence of a robust shared electronic patient record that is accessible to and used by all those involved in providing care to people with complex conditions. We will work with partners, providers and NHS England to overcome the information governance barriers in relation to data sharing and ensure these are being addressed at local, regional and national level to deliver our vision of integrated care.

Governance arrangements

The CCG has robust governance arrangements in place to enabling us to deliver our strategic objectives and remain a safe organisation.

Our governance structure seeks to ensure that member practices are fully engaged in driving a clinically led organisation. Roles are clearly defined to maximise added value from the clinical knowledge of health professionals where it is most needed. Clinical engagement will be secured best when clinicians consider that their skills are used and their voices are heard in making a difference to the way services are provided for their patients. Our model therefore seeks to use that skill in the most appropriate way.

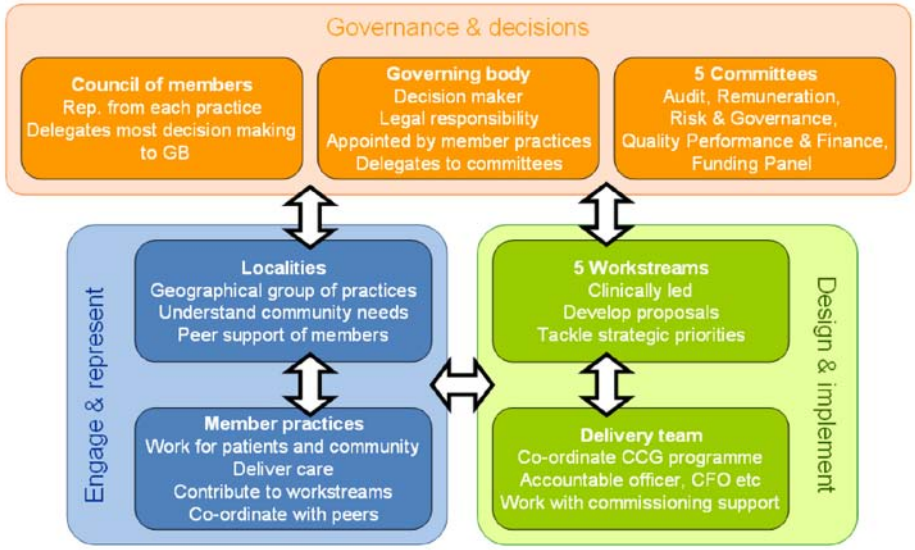
We have worked hard to understand any potential conflicts that may arise as a result of the commissioning infrastructure and will be keeping a clear separation between commissioning and providing activities. This will be apparent at both CCG and locality level and all of our role outlines make very clear the commissioning responsibilities of post holders from practice representatives through to the governing body so that no personal business interest can be seen to be driving commissioning decisions.

We have taken care to ensure that our Governing Body does not have a majority of GPs but has additional non-GP clinical members to form the majority of clinical members - thus in keeping with a "clinical commissioning group" whilst avoiding potential primary care dominated conflicts.

As described in section one, the CCG is a membership organisation run by a Governing Body. To support the Governing Body to undertake its statutory duties, the CCG has a constitution, standing orders and prime financial policies with a clear scheme of delegation clarifying the delegated responsibilities of the CCG Governing Body's sub-committees who will support the Governing Body in discharging its duties.

The structure of the organisation is set out below showing the relationship between the Governing Body, sub-committees, member practices, localities, workstreams and the delivery team.

Organisational Structure



The **Council of Members** is made up of representatives of all the registered patient list holding General Practices serving the populations of Hartlepool and Stockton-on-Tees and through this mechanism comes together for collective decision making, in accordance with our constitution, standing orders and scheme of reservation and delegation. The Council ensures that the elected clinicians and appointed Officers are held to account for the delivery of the duties, aims and priorities of the CCG. The Council also holds the CCG Governing Body to account for the decisions it makes and the action it takes to improve health for local people on behalf of the wider CCG.

The **Quality, Performance and Finance Committee**, which is clinically chaired, monitors our performance. We believe that an integrated committee linking quality, performance and finance together is the best way of ensuring that all elements of this strategy are monitored together.

Our **delivery team**, chaired by the CCG Chief Officer, has a day to day role in implementing this strategy, supporting clinical workstream leads and overseeing operational management.

The CCG is organised into two 'localities' to reflect the needs of the two communities of Stockton-on-Tees and Hartlepool. The practice representatives from each locality have a responsibility to represent their patients' needs. Two of the GP representatives from each locality are part of the governing body of the CCG which makes the CCG's decisions as well as a GP chair from the CCG area as a whole. An independent lay member of the governing body has specific responsibility for patient and public involvement across the CCG.

How will we manage our risks?

The Governing Body will be responsible for the management of key risks as defined within an Assurance Framework and corporate risk register. The governance infrastructure (Risk and Governance Committee) and scheme of delegation further embed risk management responsibilities throughout the organisation to ensure management of risk is appropriately delegated to CCG leads, clinicians, and chief officers. All staff and commissioning support will be aware they have a responsibility for the management of risk.

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

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

What Commissioning Support will we need?

We plan to be a lean, clinically-led organisation. We recognise that there are skills that we will need to secure, either through direct employment or by securing this from outside organisations.

North East Commissioning Support (NECS) is a commissioning support organisation providing a range of skills and expertise to support CCGs in effective commissioning. We intend to secure the necessary support primarily through NECS. This may change over the longer term as we recognise this is a developing relationship. NECS has been successful to date in securing the necessary permission to continue to develop and we consider that it is in the best interests of the CCG and its population to work with NECS to embed the new arrangements. We have signed a Memorandum of Understanding with NECS and are now developing more detailed arrangements for working together.

There are some guiding principles by which we will be securing the necessary support.

- Support that works with our local approach including our Clinical Workstreams Developing relationships with staff within NECS to secure a long-term knowledge of our needs
- Securing support in conjunction with other CCGs (primarily South Tees) where this makes sense
- Support to manage our role as lead commissioners alongside other North East CCGs
- Working within our allocated budget for running our organisation (currently £25/head).

We will be securing our IT needs through NECS, in particular, and will be building on the work undertaken across NHS Tees up to now. See Integrated Cluster Plan section 10 for the relevant information.

How will we secure public health advice and expertise?

Developing a detailed understanding of the needs of the patients in each member practice will be important to us to develop a targeted approach to commissioning the right services in the right places. Over time we will plan our services according to more granular understanding of smaller populations.

We will be working closely with the Directors of Public Health and organisations that can provide us with detailed information to support a practice population analysis of need that supports our commissioning intentions through a shared service approach.

How will we ensure we develop successfully?

We recognise this is still a relatively new organisation and the importance of setting up in a sustainable manner. We will include the right people at the right time with the right skills to help us. Where there are gaps in knowledge or a need to learn to work better together we have developed an Organisational Development plan to aid:

- Our transition,
- The pathway to authorisation and
- Our on-going succession planning and development.

Who will we collaborate with in our commissioning work?

We will be working very closely, when necessary with our neighbouring CCG, NHS South Tees CCG. We will work closely with other CCG's as appropriate, particularly around collaborative commissioning.

Good relationships are already established with regular meeting of all CCGs in the North East coming together to share common agendas. Working relationships are developing with Durham Dales, Easington and Sedgefield CCG around joint commissioning for acute services. (as part of the Momentum programme).

Stronger links are being established across Durham and Tees Valley where service strategy is being developed jointly. A Tees Valley strategic partnership forum has been developed to ensure joint working across health and social care partners and to develop the evidence base for longer term strategic plans.

The CCG has established particularly close links with NHS South Tees CCG. Due to its history of close working as a former Tees PCT Cluster, the relationship with the main providers in South Tees, Tees, Esk and Wear Valley and North Tees and Hartlepool and existing commissioning support staff are strong. Regular meetings take place between lead officers and clinicians and joint working arrangements and posts are in development, particularly aimed at ensuring continuity and robustness around safeguarding and patient safety.

The two CCG's plan to work closely together around medicines management, prescribing committees, funding panels and public health developing further joint working as appropriate to meet the needs of our respective populations.

The CCG needs to ensure that there is a strong and diverse range of local health providers to buy services from. The CCG currently has 42 major contracts across the Hartlepool and Stockton-on-Tees.

As the strategic direction of the CCG is to ensure patients are only treated in a hospital setting if clinically appropriate than we need to ensure through commissioning intentions and contract management that funding flows reflect these changes.

Our success in driving our strategic outcomes will be considerably improved by working closely with our local authority partners – Hartlepool and Stockton-on-Tees councils. As our plans for the implementation of the Better Care Fund develop, we will where appropriate, commission services in liaison with our local authority colleagues. Throughout this plan we have referenced a wide number of ways in which we will need to do this from planning through to delivery.

Appendices and References

Appendix 1: Member Practices

Practice	Address
The Birchtree Practice	The Health Centre, Lawson Street, Stockton on Tees, TS18 1HU
Park Lane Surgery	Redmarshall Street, Stillington, Stockton, TS21 1JS
Tennant Street Medical Practice	Tennant Street, Stockton, TS18 2AT
Melrose Medical Centre	38 Melrose Ave, Billingham, TS18 2EP
AB Practice endurance House	Clarence Street, Stockton on Tees, TS18 2EP
Woodbridge Practice	Thornaby Health Centre, Trenchard Avenue, Thornaby, Stockton, TS17 0EE
Woodlands Family Medical Centre	106 Yarm Lane, Stockton on Tees, TS18 1YE
Queenstree Practice	Queensway, Billingham, TS23 2LA
Kingsway Medical Practice	Kingsway, Billingham, TS23 2LS

Practice	Address
The Roseberry Practice	Abbey Health Centre, Finchale Avenue, Billingham, TS23 2DG
Eaglescliffe Medical Practice	Sunningdale Drive, Eaglescliffe, Stockton on Tees, TS16 9EA
Alma Medical Centre	Nolan Place, Stockton, TS18 2BP
Thornaby & Barwick Medical Group	Thornaby Medical Centre, Trenchard Avenue, Thornaby, TS17 0EE
The Dovecot Surgery	The Health Centre, Lawson Street, Stockton on Tees, TS18 1HU
Marsh House Medical Centre	Abbey Health Centre, Finchale Avenue, Billingham, TS23 2DG
Queens Park Medical Centre	Farrer Street, Stockton, TS18 2AW
Riverside Medical Practice	Alma Street, Stockton, TS18 2AP
Dr S Rasool	Abbey Health Centre, Finchale Avenue, Billingham, TS23 2DG

Practice	Address
Yarm Medical Practice	1 Worsall Road, Yarm, TS15 9DD
Dr Y Syed Surgery	Endurance House, Clarence Street, Stockton on Tees, TS18 2EP
Norton Medical Centre	Billingham Road, Norton, Stockton on Tees, TS20 2UZ
Elm Tree Surgery	Endurance House, Clarence Street, Stockton on Tees, TS18 2EP
The Arrival Medical Practice	Endurance House, Clarence Street, Stockton on Tees, TS18 2EP
Densham Surgery	Lawson Street Health Centre, Lawson Street Stockton, TS18 1HU
Stockton NHS Health Care Centre	High Newham Road, Hardwick, Stockton on Tees, TS19 8RH
West View Millennium Surgery	West View Road, Hartlepool, TS24 9LJ
Havelock Grange Practice	One Life Centre Hartlepool, Park Road, Hartlepool, TS24 7PW
McKenzie Group Practice	McKenzie House, 17 Kendal Road, Hartlepool, TS25 1QU
Chadwick Practice	One Life Centre Hartlepool, Park Road, Hartlepool, TS24 7PW
Hart Medical Practice	The General Medical Centre, Surgery Lane, Wells Avenue, Hartlepool, TS24 9DN

Practice	Address
Victoria Medical Practice	The Health Centre, Victoria Road, Hartlepool, TS26 8DB
The Health Centre (Koh)	Victoria Road, Hartlepool, TS26 8DB
Journee Medical Practice	Victoria Road, Hartlepool, TS26 8DB
The Headland Medical Centre	2 Grove Street, The Headland, Hartlepool, TS24 0NZ
Seaton Surgery	Station Lane, Seaton Carew, Hartlepool, TS25 1AX
Gladstone House Surgery	46 Victoria Rd, Hartlepool, TS26 8DD
Bank House Surgery	One Life Centre Hartlepool, Park Road, Hartlepool, TS24 7PW
Wynyard Road Primary Care Centre	Wynyard Road, Hartlepool, TS25 3DQ
Hartfields Medical Practice	Hartfields Manor, Hartlepool, TS26 0US
The Fens Medical Centre	434 Catcote Road, Fens Estate, Hartlepool, TS25 2LS

Appendix 2: Governing Body membership

Dr Boleslaw Posmyk – Chair

Dr Posmyk qualified as a GP in Leeds in 1981 and became a GP in Hartlepool from 1986 where he still practices. Dr Posmyk was elected to be the Locality GP Representative and Chair of the then Hartlepool Shadow Pathfinder Committee. Following the merger of the Hartlepool CCG and Stockton-on-Tees CCG he was elected as the Chair of the Governing Body for Hartlepool and Stockton-on-Tees Clinical commissioning Group.

Ali Wilson – Chief Officer

Ms Wilson has worked for 30 years in the public sector, the last 7 years of which has been on Teesside. Whilst she has many years' experience in health services commissioning working at Board level, Ali also has a background in health services research, service improvement, medical education and in hospital and general practice based clinical practice, having been one of the countries' first Masters nurse practitioner graduates. Ms Wilson was appointed as (accountable) chief officer in January 2013.

Graeme Niven – Chief Finance Officer

Mr Niven an experienced NHS Senior Manager with previous experience of working at Executive Director level. He qualified as a Chartered Institute of Management Accountant in 1994. He is currently working as Chief Finance Officer and prior to this, Graeme was Chief Finance Officer Designate for the CCG and prior to this, the Strategic Financial Officer for NHS Tees.

Dr Mike Smith – GP Locality Lead (Hartlepool)

Dr Smith qualified as a doctor at Edinburgh University in 1985 and has worked as a full-time GP independent practitioner at Bankhouse Surgery in Hartlepool since 1991. He is also a GP trainer, working at Durham and Tees Valley Vocational Training Scheme as a training programme director and is also a GP appraiser. Mike is the GP Lead for the Hartlepool Locality on the Governing Body.

Dr Paul Williams – Locality Lead GP (Stockton-on-Tees)

Dr Williams qualified as a doctor in Newcastle upon Tyne in 1996, where he also obtained a master's degree in public health. As a GP he has worked in Thornaby, Ingleby Barwick, Redcar, Middlesbrough and in several practices in Stockton, and is currently a GP at A&B Medical Practice, Stockton-on-Tees. Paul is the GP lead for the Stockton locality on the Governing Body.

Dr Bhadresh Contractor – GP Member

After graduating in India, Dr Contractor came to England in 1973 for further training. He qualified as a surgeon in December 1976 and following post -graduation qualification, pursued a career in general surgery until 1983. Subsequently, he decided to change career and entered into general practice and works at Woodbridge Practice in Stockton-on-Tees. Dr Contractor is a locality member for Stockton-on-Tees.

Dr Nick Timlin – GP Member

Dr Timlin qualified as a doctor at Manchester in 1984 and completed the Cleveland vocational training scheme and starting work as a GP principal in 1990. Nick is also a fully qualified Forensic Medical Examiner and Occupational physician and has worked for Cleveland police and local firms. He currently works at McKenzie Group Practice in Hartlepool. Nick is a member of the governing body and the workstream lead for medicines optimisation.

Jean Fruend – Executive Nurse

Ms Fruend has been a registered nurse since 1986. With previous experience of working in areas from across the healthcare landscape and abroad, more recently Ms Fruend was working in Acute hospitals prior to joining the Clinical Commissioning Group. Ms Fruend also works for South Tees Clinical commissioning Group as Executive Nurse.

Hilary Thompson – Lay Member (Patient and Public Involvement) – Deputy Chair

Mrs Thompson taught for many years in nursery and primary schools in both Stockton and Hartlepool. In 1993, she became a full-time lecturer in Early Years at New College, Durham and later on taught part-time at Middlesbrough College and New College. In 2009, Hilary was elected Hartlepool Borough Councillor for Elwick Ward and held Cabinet posts with responsibility for Culture, Leisure and Tourism, "Performance" and "Adult Services and Public Health", before stepping down in 2012. Hilary serves as Deputy Chair of the Governing Body.

Stephen Smith – Lay Member (Audit)

Mr Smith, upon leaving University, qualified as a Chartered Accountant with a ''Big Four" firm before moving into industry. In 1987 Steve joined Northgate plc, and over the next 23 years led a team that grew the business to become the largest van rental business in both the UK and Spain, with a turnover of over £600m and around 3500 employees. Steve retired as CEO in March 2010. Steve is the Chair of the Audit Committee, bringing his commercial experience and expertise to Hartlepool and Stockton-on Tees CCG.

Dr Charles Stanley – Secondary Care Consultant

Dr Stanley qualified as a doctor at the University of London in 1982. In 2001 he became a consultant child and adolescent psychiatrist and currently undertakes this role in Leeds and is an honorary senior lecturer in child and adolescent psychiatrist at the University of Leeds. He is also associate medical director at Leeds Community Health Care NHS Trust. Prior to training in psychiatry, he worked as a hospital-based paediatrician. Charles is the Secondary Care Consultant on the Governing Body.

Appendix 3: Commissioning Intentions 2014/15

Health and Wellbeing

- Identify and develop pathways and services for health improvement
- Work with LA to identify current provision and gaps for child health improvement
- Audit provision and variation of training/support provided by practices/acute for patients with LTCs and standardise education pathways
- Work with Public Health to develop the specification for midwifery services
- Work with Public Health and NTHFT to map pathway and services to improve breastfeeding rates
- Work with partners to develop plans to reduce the number of mothers using alcohol during pregnancy
- Enable NTHFT midwives to provide vaccinations to pregnant women including flu vacs
- Confirm pathways for perinatal MH anxiety and depression and access to appropriate IAPT
- Work with Public Health to align plans for health improvement initiatives for cancer
- Develop scheme to improve the screening of AF in practices
- Include cancer screening take-up rates in quality dashboard so that levels can be improved
- Review COPD screening/ healthy lung check service with Public Health
- Improve secondary care referrals to smoking cessation services and how to identify and engage with patients as part of pre-operative assessments, inpatient process and following discharge
- Implement MSD Excellence into Practice model in practice to identify patients with COPD
- Work with partners to develop a 3-5 year Cancer Strategy
- Work with practices to implement the Willie Hamilton cancer risk assessment tool
- Pilot COPD support programmes via Hartlepool and Butterwick Hospices
- Continue to use Looking Local television channel and app to engage with patients and the public
- Review respiratory service and pulmonary rehab provision
- Implementation of Fairer Start pilot to promote better health outcomes for children aged 0-3 years within the Stockton Central Ward

Out of Hospital Care

- Expand the Cataract Referral Service into the Stockton Locality
- Improve the health and wellbeing of the frail and elderly population living in Hartlepool and Stockton by providing a proactive, structured approach to care. The following will commence/ continue during 2014/15 which will support this objective:
  - Emergency Health Care Plans (EHCPs) for patients in Care Home evaluation
  - Continuation of the EHCP scheme/ implementation of other Care Home schemes to improve quality
  - Implementation of case managing patients identified by the risk stratification tool
  - £5 per patient monies
  - Better Care Fund
  - Frail Elderly event, report and strategy
- Development of an End of Life strategy
- An extended access scheme to improve capacity and demand within GP Practices
- Review the Stockton Emergency Eye Care Scheme
- Care home quality incentive scheme
- Community Development and Prevention Programme (Healthcare Toolkit)
- NTHFT community block review
- Monitor Community Renaissance Model (TAPS/CIAT/SPA) action plan following service evaluation

Acute In-Hospital Care

- Identify improvements in pathways through N2R and C2C clinical meetings
- Development of a prescribing pharmacist service
- Implementation of a GP support service in and out of hours for NEAS paramedics
- Community skin service
- Increase the use of 111 to encourage patients to 'talk before you walk'
- Implement the regional back pain pathway
- Mobile devices to enhance patient flow
- Improving care for patients with dementia through IT improvements in the acute and community facility
- Evaluation of Winter bids to inform future commissioning intentions
- Audit of NTHFT admissions, re-admissions and ambulatory care attendances
- Identify and transfer outpatient services that can be moved to a community based setting to support the development of integrated healthcare facilities
- Improved analysis of delayed discharges.
- Move towards services 7 days per week in line with National Guidance

Mental Health and Learning Disabilities

- Support the implementation of the National Dementia Strategy across Stockton & Hartlepool
- Implement Community Dementia Liaison Service (CDLS) across Stockton depending on evaluation of service in Hartlepool
- Roll out of EHCP for patients with dementia residing in care homes
- Review impact of perinatal maternal mental health pathways on primary care and specialist services
- Implement Stepping Forward pilot across Stockton and Hartlepool
- PHB SEN Hartlepool pathfinder
- Streamline children's disability and complex needs services
- Compliance with Children and Families Bill re SEN and EHCP
- Integrated children's equipment services
- Continuation of the Tees CAMHS transformation and pathway improvement
- Deliver an integrated Advocacy Hub to respond to the Winterbourne View concordat

Medicines Optimisation

- Prioritisation of Care Home medication review
- Improve the management of COPD in primary care through delivering Advanced Inhaler technique training to all relevant HCPs
- Develop referral pathways from GP practice and hospital to community pharmacy for targeted Medicine Use Review (MURs)
- Develop and implement an annual practice team workplan to identify variation in practice
- Review the use of insulin prescribing in type 2 diabetes in line with NICE CG87
- Develop, agree and implement an action plan to reduce levels and inequities in prescribing identified through recently completed 2013/14 audit
- Increase and modernise the uptake of repeat dispensing via an e-Learning tool
- Support the implementation of EPS
- Support a joint review of the model for dressings provision
- Promote good antimicrobial stewardship in line with national 5 year plan and ensure prescribing is in line with local and national clinical guidance
- Review transfer of prescribing arrangements for treatment and prophylaxis with Low Molecular Weight Heparin across all specialities
- Medicine reconciliation
- Improve management of costs in relation to high cost drug spend and continue to complete a relevant NICE audit tool e.g. cytokine modulators
- Implementation of drug approval model for new medicines or changes to formulary
- Support effective community non-medical prescribing
- Implementation of revised testing and reporting of B12 deficiency
- Explore options for "gain-sharing" initiatives

References

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10. http://www.apho.org.uk/DISEASEPREVALENCEMODELS
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