HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

Monday 1 December, 2014

at 9.30 a.m.

in Committee Room 'B',
at the 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**

   3.1 To receive the minutes of the meeting held on 20 October 2014.

4. **ITEMS FOR DECISION**

4.1 Health Performance Framework Proposal (*Director of Child and Adult Services and Director of Public Health)*
4.2 Presentation and Report - Joint Health and Social Care Learning Disability Annual Self Assessment Framework (2012/13) (*Director of Child & Adult Services)*

5. **ITEMS FOR INFORMATION**

5.1 Presentation and Report - Due North – Report of the Inquiry on Health Equity for the North (*Director of Public Health)*
5.2 Better Care Fund Update (*Director of Child and Adult Services and Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group)*
5.3 HealthWatch Work Programme 2014/15 (*Healthwatch Hartlepool)*
5.4 The NHS Five Year Forward View *(Director of Public Health, Director of Child and Adult Services, Chief Officer Hartlepool and Stockton Clinical Commissioning Group and Director of Operations and Delivery, NHS England)*

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

Date of next meeting – 12 January 2015 at 9.30 am in the Civic Centre, Hartlepool.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

20 October 2014

The meeting commenced at 9.30 am in the Civic Centre, Hartlepool

Present:

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

Prescribed Members:
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Schock and Alison Wilson
Director of Public Health, Hartlepool Borough Council - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council – Gill Alexander
Representatives of Healthwatch – Ruby Marshall and Margaret Wrenn

Other Members:
Chief Executive, Hartlepool Borough Council – Dave Stubbs
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall
Shaun Jones as substitute for Caroline Thurlbeck, Representative of NHS England

Also in attendance:-
Dr Louisa Ells, Specialist Advisor to Public Health England (obesity, knowledge and intelligence)
Councillor Ainslie, Member of Audit and Governance Committee
S Johnson, G Johnson, L Allison, J Gray, HealthWatch

Hartlepool Borough Council Officers:
Steven Carter, Workplace Health Improvement Specialist
Deborah Gibbon, Health Improvement Practitioner
Joan Stevens, Scrutiny Manager
Amanda Whitaker, Democratic Services Team
Ed Carter, A Rae, Public Relations Team

21. Apologies for Absence

Elected Members, Hartlepool Borough Council - Councillors Carl Richardson and Chris Simmons
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council – Denise Ogden

Representative of the NHS England – Caroline Thurlbeck
Representative of Tees Esk and Wear Valley NHS Trust – Martin Barkley
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster

22. Declarations of interest by Members

Councillor Christopher Akers-Belcher reiterated the declaration he had made at a previous meeting of the Board (minute 3 refers) 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 had 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

23. Minutes

The minutes of the meeting held on 10 September 2014 were confirmed.

With reference to minute 16, the Chief Officer, Hartlepool and Stockton-on-Tees CCG, advised the Board that the Better Care Fund planning templates had been submitted in accordance with the deadlines previously reported to the Board. There had been no changes made to the planning templates subsequent to the Board meeting. It was noted that feedback would be reported to the Board when it had been received.

24. Childhood Obesity in Hartlepool (*Director of Public Health, Director of Child and Adult Services and Chief Officer, Hartlepool and Stockton-on-Tees CCG*)

The Health and Wellbeing Board, at its meeting on the 11 August 2014, had agreed to establish a defined work programme. The report set out the background to the identification of the topic area of work upon which to focus the Board's activities during 2014/15. The Board had recognised the scale and impact of the obesity epidemic and that it was imperative to tackle the obesity issue at a co-ordinated local level and understand the overall obesity issue in Hartlepool. It was acknowledged that childhood obesity in particular was one of the most serious global public health challenges for the 21st century and on this basis, it was agreed that the Board's work for 2014/15 should focus on childhood obesity.

Detailed background information including statistics and current initiatives

were set out in the report. The terms of reference for the Board's piece of work were included in the report together with potential areas to explore to gain evidence to inform the themed work programme. It was suggested that the Board could also wish to refer to a variety of documentary / internet sources as highlighted in the report. Board members reiterated the complexity of the issue and recognised that it was essential to understand the needs of the population together with educational and wider environmental implications.

It was recommended that Members of the Board consider receiving evidence and comparative information and invite a variety of individuals / bodies to participate in a stakeholder conference. The conference was considered to be a critical component of the work to be undertaken by the Board. Suggested invitees were outlined in the report and Board members suggested extending invitations to other partners/organisations including those involved in fast food outlets and supermarkets. It was noted that a report on the conference would be submitted to the Commissioning Executive and an update report would be submitted also to the next meeting of the Board.

It was recognised that a key stakeholder, and part of the Council's infrastructure, was the Children's Strategic Partnership. In recognition of this, specific consideration was given to how the Partnership could participate and it was agreed that the issue should be referred to the Partnership in order to commence their deliberations.

It was recognised also that community engagement would play a crucial role in the process and diversity issues had been considered in the background research for work under the Equality Standards for Local Government. Based upon the research undertaken, the report included suggestions as to potential groups which the Board could involve. Based on information set out in the report, a suggested timetable for the work to be undertaken was presented although it was recognised that this could be changed at any stage in the process.

The Board received a detailed presentation by Dr Louisa Ells, Specialist Advisor to Public Health England (obesity, knowledge and intelligence) and Reader in Public Health and Obesity at Teesside University. The presentation covered issues associated with obesity including causes and significant health and financial implications. The Director of Public Health continued the presentation and addressed obesity issues including changes in trends over a period of time with salient features highlighted by the Director and the Council's Workplace Health Improvement Specialist and Health Improvement Practitioner. The Council's Public Relations Manager concluded the presentation by addressing how obesity is reported, suggested phasing of communication and the continued use of the Change4Life initiative. The Board agreed that the Change4Life initiative was widely recognised and could be targeted locally.

Board Members discussed extensive research which had been undertaken and highlighted the requirement for outcomes to be evidence based and to be

mindful of best practice examples. Dr Ells updated the Board on current research and advised that she would be content to share the findings of that research with the Board. During the discussion the benefits of 'whole life' interventions were highlighted including pre conception, maternity and family centred issues.

The appropriateness of utilisation of the BMI formula/national child measurement programme was discussed. It was noted that concerns had been expressed regarding the terms of the 'standard letters' sent to parents regarding the outcome for their child of the national child measurement programme. The letter had been subsequently revised and the Chair of the Board requested that a copy of the revised letter be circulated to all Board Members.

Concerns were expressed in relation to the location of fast food outlets in close proximity to schools. The limitations of the powers of the Council's Planning Committee's consideration of planning applications relating to fast food outlets were highlighted. It was proposed that a letter should be written to the Rt Hon Eric Pickles, MP, Secretary of State for Communities and Local Government as it was considered that in order for progress to be made, it would be necessary for the issue of material planning considerations to be reviewed.

Issues relating to perception and stigma were discussed together with the benefits derived from use of 'Champions'/role models and the involvement of partner organisations. A suggestion was made that consideration should be given as to whether pupil premiums could be utilised in addressing obesity issues.

Decision

(i) The Board endorsed the use of the Change4Life initiative and agreed that an action plan be produced by the Council's Public Relations Manager.
(ii) It was agreed that the Children's Strategic Partnership be requested to consider their participation in the Board's chosen topic area.

25. Any Other Items which the Chairman Considers are Urgent

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

26. Nursing Care

A representative of HealthWatch referred to concerns regarding the

availability of nursing care beds in the community. In response, the Chair of the Board agreed that feedback should be made to the Board at its next meeting.

Meeting concluded at 11.15 a.m.

CHAIR

HEALTH AND WELLBEING BOARD

1st December 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: Director of Child and Adult Services / Director of Public Health

Subject: HEALTH PERFORMANCE FRAMEWORK PROPOSAL

1. PURPOSE OF REPORT

1.1 The purpose of this report is to seek the endorsement of the Health and Wellbeing Board to the proposed health performance framework.

2. BACKGROUND

2.1 As part of the overall governance and performance management arrangements of the Council and following on from the development session held in March 2014 which looked at measuring the performance of Health Services the following proposal for the reporting of health performance has been developed.

3. PROPOSAL

3.1 The key principles of the health performance framework are:

- To demonstrate change;
- To understand the trajectory of travel;
- To compare ourselves with others;
- To provide information to support decision making;
- To provide information in a way that is simple and easy to understand;
- To use information that is already readily and easily available.

3.2 The key to developing a performance framework that does not require much additional effort is to utilise performance indicators (PIs) that are already produced and reported.

3.3 The aim of this proposal is to develop a representative number of PIs into a framework that is understood and agreed by all partners i.e. the Health &

Wellbeing Strategy. Therefore it will be based on the outcomes of the Health & Wellbeing Strategy:

- Outcome 1: Give every child the best start in life
- Outcome 2: Enable all children and young people to maximise their capabilities and have control over their lives
- Outcome 3: Enable all adults to maximise their capabilities and have control over their lives
- Outcome 4: Create fair employment and good work for all
- Outcome 5: Ensure healthy standard of living for all
- Outcome 6: Create and develop healthy and sustainable places and communities
- Outcome 7: Strengthen the role and impact of ill health prevention

3.4 This proposal also seeks to ensure that the PIs included provide a relevant and recent picture of the Borough and enable the Board to react in a timely manner to areas of concern. Therefore we are proposing to have 2 levels of performance reporting.

3.5 **In Year Performance Reporting Framework:**
The first level of performance reporting will focus on the three health specific strategic priorities of the Health & Wellbeing Strategy:

Outcome 1: Give every child the best start in life
Outcome 3: Enable all adults to maximise their capabilities and have control over their lives
Outcome 7: Strengthen the role and impact of ill health prevention

3.6 Reporting will take place 6 monthly and will not include PIs that are reported following a lengthy time-lag (e.g. 3 year rolling averages where data is reported 2 years after) or where they are reported at lengthy intervals e.g. annually. In both cases it would be difficult for the Board to be able react in a timely manner to areas of concern within the year.

3.7 **Annual Performance Reporting Framework:**
Annual Performance Reporting will take place once a year as part of the Health & Wellbeing Board Annual Review Meeting. The framework will be widened to include the other, more cross-cutting strategic priorities and also Performance Indicators that are only reported once a year.

3.8 The proposed PIs for inclusion in the reporting framework are set out by outcome in appendix 1. For each PI it has been identified whether they are for in year or annual reporting.

3.9 **Presentation of Information to Board Members:**
In order for Board Members to understand what the latest performance information means for Hartlepool it is important to provide context and comparison. It is also important that the information is presented to Board Members in a way which is easy to understand. Therefore it is proposed that:

- Trend and benchmarking information is provided annually where available for:
    - Hartlepool over time;
    - Hartlepool compared to the other NE authority areas;
    - Hartlepool compared to its CIPFA near neighbours; and
    - Ward comparison within Hartlepool.
- The presentation of this information builds upon the variety of ways that health information is currently presented including that demonstrated in the Ward Health Profiles and north east health & wellbeing heat maps (appendix 2).

3.8 There will also be an annual performance meeting where time will be dedicated to considering the performance information and discussing potential future priorities. The meeting will also be an opportunity for the Board to consider other performance such as the Public Health Outcome Framework, Adult Social Care Outcome Framework, Better Care Fund etc.

4. FINANCIAL CONSIDERATIONS

4.1 There are no financial implications to the proposal.

5. RECOMMENDATIONS

5.1 The Health and Wellbeing Board is asked to endorse the proposed health performance framework.

5.2 That the Performance Indicators be reported to all Councillors on an annual basis by way of a Members' Seminar.

6. REASONS FOR RECOMMENDATIONS

6.1 The proposed health performance framework will assist the Health & Wellbeing Board to fulfil its role and to monitor the achievement of the Health & Wellbeing Strategy.

7. BACKGROUND PAPERS

7.1 There are no background papers.

8. CONTACT OFFICER

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Louise Wallace
Director of Public Health
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Appendix 1 - Performance Reporting Framework

The proposed PIs for inclusion in the reporting framework are as follows:

Outcome 1: Give every child the best start in life

Indicator	Frequency	Organisation
Prevalence of breast-feeding at 6-8 weeks from birth - % of infants being breastfed at 6-8 weeks	In year	PHD - HBC
Conceptions in women aged under 18 (i.e. 15-17) years per 1,000	In year	PHD - HBC
% of women who currently smoke at time of delivery	In year	PHD - HBC
% of children in reception who are classified as very overweight	Annual	PHD - HBC
% of children in Y6 who are classified as very overweight	Annual	PHD - HBC
Rate of Child Protection plans per 10,000 population	In year	CAD - HBC
Rate of Looked After Children per 10,000 population	In year	CAD - HBC
Proportion of children in poverty	Annual	CAD - HBC
% of children making a "good level of development" at end of foundation stage	Annual	CAD - HBC

Outcome 2: Enable all children and young people to maximise their capabilities and have control over their lives (annual only)

Indicator	Frequency	Organisation
Number of first time entrants to the Youth Justice System aged 10-17 per 100,000 population (aged 10-17)	Annual	CAD - HBC
Percentage of 16-18 year olds who are Not in Education, Employment or Training (NEET)	Annual	CAD - HBC
KS 4 % attaining at least 5+ GCSEs A*-C incl. English and Maths	Annual	CAD - HBC
Rate of Children In Need cases per 10,000 population	Annual	CAD – HBC
Children in Need attaining 5 GCSEs A*-C at KS4 incl. English and Maths	Annual	CAD – HBC

Outcome 3: Enable all adults to maximise their capabilities and have control over their lives

Indicator	Frequency	Organisation
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	In year	HBC
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	In year	HBC
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)	In year	HBC

'Patient/user experience' metric TBC	Annual	HBC
Estimated diagnosis rate for people with dementia*	Annual	CCG

* CCG investigating if data can be provided at a Hartlepool level not just at the CCG level.

Outcome 4: Create fair employment and good work for all (annual only)

Indicator	Frequency	Organisation
Number of jobs created	Annual	HBC
Overall employment rate (proportion of people of working age population who are in employment)	Annual	HBC
New business registration rate – the proportion of new business registration per 10,000 resident population (aged 16+)	Annual	HBC

Outcome 5: Ensure healthy standard of living for all (annual only)

Indicator	Frequency	Organisation
Fuel poverty for high fuel cost households^	Annual	DECC (HBC to provide)

^ Department for Energy & Climate Change indicator used in Marmot.

Outcome 6: Create and develop healthy and sustainable places and communities (annual only)

Indicator	Frequency	Organisation
Number of affordable homes delivered (gross)	Annual	HBC
Number of long term (over 6 months) empty homes brought back into use	Annual	HBC
Number of ASB incidents reported to the police	Annual	HBC
Number of deliberate fires in Hartlepool	Annual	HBC
% per capita reduction in CO2 emissions in the Local Authority area	Annual	HBC
The % change in the number of people killed or seriously injured in road traffic accidents during the calendar year compared to the average of the previous 3 years	Annual	HBC
The % change in the number of children killed or seriously injured in road traffic accidents during the calendar year compared to the average of the previous 3 years	Annual	HBC

Outcome 7: Strengthen the role and impact of ill health prevention

Indicator	Frequency	Organisation
Numbers of substance misusers going into effective treatment – opiate	In year	HBC

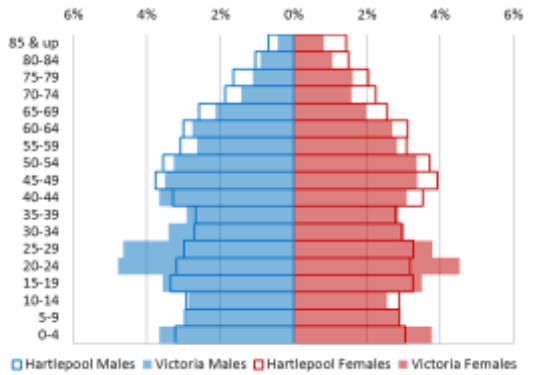
Proportion of substance misusers that successfully complete treatment – opiate	In year	HBC
Proportion of substance misuse who successfully completed treatment and represented back into treatment within 6 months	In year	HBC
Stopping smoking – rate of self-reported 4-week smoking quitters per 100,000 population aged 16 & over	In year	HBC
Admitted patients to start treatment within a maximum of 18 weeks from referral*	In year	CCG
Non-admitted patients to start treatment within a maximum of 18 weeks from referral*	In year	CCG
% of patients waiting 6 weeks for the 15 diagnostic tests (including audiology)*	In year	CCG
% of patients seen within 2 weeks of an urgent GP referral for suspected cancer*	In year	CCG
% of patients treated within 31 days of a cancer diagnosis*	In year	CCG
% of patients treated within 62 days of an urgent GP referral for suspected cancer*	In year	CCG
Total reduction in non-elective admissions into hospital (all age per 100,000 population)*	In year	CCG
% of people who left A&E without being seen	In year	NT&H NHS Trust
Number of unplanned follow-up attendances within 7 days of discharge from A&E for the original attendance	In year	NT&H NHS Trust
Alcohol-related admissions to hospital (rate per 100,000)	Annual	HBC

* CCG investigating if data can be provided at a Hartlepool level not just at the CCG level.

Appendix 2 – Presentation of Health Information

Ward Health Profiles:

Population Pyramid (2012)

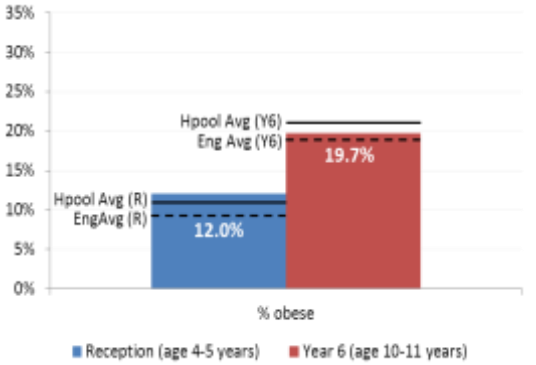


The estimated population of Victoria is 8,920 (4,522 Males & 4,398 Females). There is a much higher proportion of 20 to 29-year-olds than the Hartlepool average. *Source: Office of National Statistics (2012)*

Maternal Smoking (2010/11 to 2012/13)

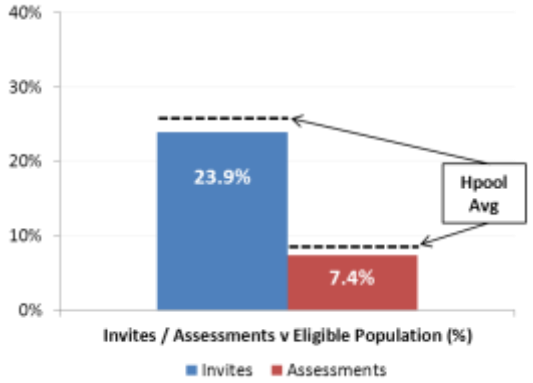
In Victoria, more than 29% of pregnant women are smoking at delivery. This is higher than the Hartlepool (22%) and England (13%) averages.
Source: North Tees Hospital Foundation Trust

% Obese 5-year-olds and 11-year-olds (2012/13)



In reception, 12% of children are obese. In year 6, this rises to almost 20%. Both age groups are higher than the England average.
Source: National child measurement programme 2012/13

% NHS Health Checks (invites and assessments) v eligible population (2013/14)



In Victoria, there were less invites for NHS health checks (compared to the Hartlepool average), this resulted in a lower proportion of assessments were carried out. *Source: NECSU*

Appendix 2 - North East Health & Wellbeing Heat Map: North East Regional Analysis Baseline - September 2014

Worse than England Average → England Average → Better than England Average

Section	Indicator													
	1. Early Intervention -Number of CAFs underatken per 10,000 population 13/14	Northumberland 66.5	Gateshead 92.8	Durham 94.5	North Tyneside 128.2	Middlesbrough 137.2	Darlington 150.1	Newcastle 167.2	South Tyneside 190.6	VCSN Average 195.6	Hartlepool 215.3	Redcar & Cleveland 282.3	Sunderland 287.6	Stockton 616.4
Safeguarding	2. Rate of Child Protection plans per 10,000 population -13/14 provisional	Redcar & Cleveland 78.8	Middlesbrough 75.2	Stockton 70.0	Newcastle 69.0	Gateshead 68.3	Hartlepool 63.1	Darlington 58.3	Northumberland 58.1	South Tyneside 57.9	Sunderland 55.8	Durham 45.4	North Tyneside 38.9	England 2013 37.9
Safeguarding	3. Rate of Children's Services Referrals per 10,000 population -13/14 provisional	Northumberland 916.5	Middlesbrough 756.4	Durham 714.6	Stockton 702.0	South Tyneside 625.6	Sunderland 617.7	Hartlepool 613.8	Darlington 611.2	Redcar & Cleveland 607.9	Gateshead 602.5	North Tyneside 546.2	England 2013 520.7	Newcastle 518.1
Safeguarding	4. Rate of Child In Need cases per 10,000 population -13/14 provisional	Middlesbrough 694.4	Northumberland 598.6	Stockton 490.3	Sunderland 486.9	South Tyneside 469.0	Newcastle 451.3	Hartlepool 438.9	Redcar & Cleveland 425.1	Gateshead 396.5	North Tyneside 388.0	Darlington 371	England 2012-13 332.2	Durham 304.6
Safeguarding	5. Rate of Children's Social care initial (or single) assessments per 10,000 population -13/14 provisional	Middlesbrough 619.8	Northumberland 598.4	Sunderland 576.3	Gateshead 573.8	Stockton 551.8	Hartlepool 545.3	North Tyneside 533.3	South Tyneside 523.6	Redcar & Cleveland 521.0	Durham 510.7	Newcastle 503.7	England 2013 387.4	Darlington 375.1
Safeguarding	6. Percentage of Children subject to 2nd or subsequent Child Protection plan -13/14 provisional	Newcastle 22.1	Stockton 15.0	England 2013 14.9	Durham 14.7	Sunderland 13.7	Northumberland 12.0	Gateshead 11.0	Redcar & Cleveland 9.1	Middlesbrough 8.9	Darlington 8.4	South Tyneside 7.9	North Tyneside 5.6	Hartlepool 3.7
Looked After Children	7. Rate of Looked After Children per 10,000 population -13/14 -provisional	Middlesbrough 113	South Tyneside 107	Newcastle 103	Hartlepool 102	Stockton 90	Sunderland 90	Gateshead 89	Darlington 77	North Tyneside 76	Redcar & Cleveland 63	England 2013 60	Durham 60	Northumberland 53
Looked After Children	8. Percentage of Looked After Children in own LA provision -12/13	Middlesbrough 44.4	Redcar & Cleveland 45.7	Stockton 51.4	South Tyneside 54.0	England 2013 58.2	Gateshead 67.9	Darlington 69.0	Newcastle 70.9	Durham 74.4	Northumberland 76.2	Sunderland 78.2	Hartlepool 81.6	North Tyneside 83.1
Looked After Children	9. Placement stability- 3 moves or more -13/14 provisional	Redcar & Cleveland 16	South Tyneside 12.4	Sunderland 11.9	Darlington 11.6	Northumberland 11.4	England 2013 11	Durham 10	North Tyneside 8.52	Middlesbrough 8.4	Stockton 7.9	Newcastle 6.6	Gateshead 6.39	Hartlepool 3.4
Looked After Children	10. Placement stability - in care for 2.5 years and in same placement for 2 years -13/14 provisional	Stockton 51.8	Redcar & Cleveland 56.7	Durham 58.3	Newcastle 62.4	South Tyneside 62.8	North Tyneside 64.4	England 2013 67	Middlesbrough 67.97	Northumberland 68	Sunderland 68	Darlington 68.4	Gateshead 75.6	Hartlepool 85
Looked After Children	11. Percenatge of those leaving care due to Adoption -13/14 provisional	Middlesbrough 9	England 2013 14	Northumberland 14.7	Stockton 16.1	Hartlepool 16.5	Sunderland 17.1	Gateshead 17.9	North Tyneside 19.4	Darlington 20	South Tyneside 24.7	Durham 25.3	Newcastle 25.9	Redcar & Cleveland 28
Looked After Children	12. Adoption -Average time between care and placement for adoption 2014 single year provisional	South Tyneside 807	North Tyneside 743	Gateshead 723	England 2010-13 647	Darlington 626	Sunderland 599	Northumberland 589	Redcar & Cleveland 582.9	Middlesbrough 559	Durham 540	Hartlepool 525	Newcastle 522	Stockton 503
Looked After Children	13. Adoption -Average time between court order and match 2014 single year provisional	Redcar & Cleveland 315.9	North Tyneside 290	Hartlepool 268	Stockton 237	Durham 235	Middlesbrough 230	Sunderland 215	England 2010-13 210	Gateshead 200	Northumberland 188	South Tyneside 151	Newcastle 122	Darlington 112
Looked After Children	14. Percentage of care leavers Not in Education, Employment or Training 2014 provisional	Durham 65.5	Stockton 60	Sunderland 58	Hartlepool 53.8	Darlington 50	Gateshead 41	England 2011-13 34	North Tyneside 33	Middlesbrough 29.4	Redcar & Cleveland 25	Northumberland 19	South Tyneside 19	
Youth Justice	15. Rate of First Time Entrants to the Youth Justice System -Jan 13-Dec 13	Stockton 856	South Tees 831	Hartlepool 654	Newcastle 649	Gateshead 591	South Tyneside 512	Northumberland 506	Durham 487	Darlington 486	England 460	Sunderland 447	North Tyneside 409	
Youth Justice	16. Re-offending rates Jul 11-Jun 12	Newcastle 46.5	North Tyneside 45.7	Durham 37.5	South Tyneside 37.5	Gateshead 37.3	Northumberland 37.2	Hartlepool 37.1	Darlington 36.7	Sunderland 35.4	England 35.3	South Tees 34.9	Stockton 27.3	
Youth Justice	17. Custody Rate per 1,000 10-17 population (2013/14)	South Tees 1.43	South Tyneside 0.82	Stockton 0.77	Durham 0.63	Darlington 0.61	Newcastle 0.47	Sunderland 0.45	England 0.44	North Tyneside 0.40	Hartlepool 0.11	Northumberland 0.07		
Education	18. Percentage making a 'good level of development' within Foundation Stage Profile -2013	Gateshead 34	Middlesbrough 38	Stockton 41	Durham 42	Newcastle 44	Hartlepool 48	North Tyneside 48	Darlington 49	Northumberland 49	South Tyneside 50	Redcar & Cleveland 51	England 52	Sunderland 53
Education	19. KS2 Percentage attaining at least Level 4+ Reading Writing and Maths -2014 -PROVISIONAL	South Tyneside 75	Middlesbrough 77	North Tyneside 77	Newcastle 78	England 79	Durham 79	Hartlepool 79	Northumberland 79	Sunderland 79	Gateshead 80	Stockton 80	Darlington 81	Redcar & Cleveland 83
Education	20. Percentage of pupils deemed Secondary Ready -2014 PROVISIONAL	South Tyneside 65	Middlesbrough 66	Newcastle 66	England 67	Durham 67	North Tyneside 67	Northumberland 67	Gateshead 68	Hartlepool 68	Sunderland 68	Stockton 69	Darlington 70	Redcar & Cleveland 72
Education	21. KS4 Percentage attaining at least 5+GCSEs inc Eng and Maths -2013	Middlesbrough 50.3	Redcar & Cleveland 55.1	Northumberland 55.2	Newcastle 57.3	Stockton 57.4	Hartlepool 59.0	South Tyneside 59.2	Sunderland 60.1	England 60.8	Gateshead 61.7	Durham 63.1	Darlington 64.8	North Tyneside 64.8
Education	22. Percentage of pupils who are persistantly absent in Secondary schools AY12-13 HT1-6	Middlesbrough 9.2	Newcastle 9.2	Darlington 8.6	Sunderland 8.4	Redcar & Cleveland 8.2	Gateshead 7.3	South Tyneside 7.2	Durham 6.7	Stockton 6.7	England 6.5	North Tyneside 6.3	Hartlepool 6	Northumberland 5.9
Education	23. Ofsted Percentage of primary pupils in good/outstanding schools - June 2014[1]	Middlesbrough 78.3	England 80.2	Redcar & Cleveland 80.6	Northumberland 86.2	Sunderland 86.3	Durham 88.7	Hartlepool 89.4	South Tyneside 89.4	Gateshead 90.8	Stockton 91.1	Darlington 91.4	Newcastle 96.1	North Tyneside 97.8
Education	24. Ofsted Percentage of secondary pupils in good/outstanding schools - June 2014[1]	Hartlepool 34.7	Stockton 45.8	Middlesbrough 48.4	Redcar & Cleveland 52.2	Darlington 53.6	Northumberland 65.9	Sunderland 71.7	England 74.1	Gateshead 74.2	Newcastle 83.7	Durham 87.6	North Tyneside 88.1	South Tyneside 90.8

Appendix 2 - North East Health & Wellbeing Heat Map

North East Regional Analysis Baseline - September 2014

Worse than England Average

England Average

Better than England Average

Vulnerable Learners

25. Disadvantaged pupils gap at KS2 - 2013						Northumberland 22%	Durham 21%	Stockton 21%	Hartlepool 20%	Middlesbrough 20%	Sunderland 20%	**England 18%**	Gateshead 18%	Newcastle 17%	Darlington 15%	Redcar & Cleveland 15%	South Tyneside 15%	North Tyneside 15%
26. Disadvantaged pupils gap at KS4 - 2013	Northumberland 36.1	Newcastle 34	Sunderland 33.7	Darlington 33.2	Stockton 33.1	Redcar & Cleveland 30.8	South Tyneside 30.7	Durham 30.6	Hartlepool 30.4	Gateshead 29.9	Middlesbrough 29.6	**England 26.9**	North Tyneside 24.7					
27. Children in Need attaining at least a level 4 at KS2 inc Reading writing and maths -2013								Sunderland 32.0	Gateshead 34.4	Darlington 38.7	Stockton 40.0	**England 42.3**	Northumberland 42.9	Redcar & Cleveland 44.4	South Tyneside 44.9	Middlesbrough 47.4	Newcastle 48.5	North Tyneside 50.9	Hartlepool 51.2
28. Children in Need attaining 5 GCSEs A*-C at KS4 inc E+M -2013							Middlesbrough 6.6	Sunderland 11.1	Northumberland 12.3	Hartlepool 13.0	Stockton 15.6	**England 16.1**	Gateshead 16.7	North Tyneside 23.3	South Tyneside 24.0			
29. Looked After Children KS2 Level 4+ in Reading, writing and maths 2013						Redcar & Cleveland 20	Middlesbrough 23.1	Northumberland 33	Sunderland 39	North Tyneside 43	Stockton 46	**VCSN average 47.2**	Durham 50	South Tyneside 55	Hartlepool 66.7	Darlington 71.4	Gateshead 72.7	
30. Looked After Children KS4 5+ GCSEs A*-C inc E+M 2013						Newcastle 9.8	Darlington 10.5	Redcar & Cleveland 11.1	Northumberland 12	Sunderland 12	Middlesbrough 12.5	**England 15.3**	Durham 20	South Tyneside 24	North Tyneside 25	Hartlepool 27.8	Gateshead 34.8	

Employment and Skills

31. Percentage of 16-18 year olds NOT in education, employment or training - 2014	Newcastle 9.80%	Middlesbrough 9.70%	Stockton 8.6%	South Tyneside 8.3%	Sunderland 8.0%	Hartlepool 7.8%	Redcar & Cleveland 7.7%	Gateshead 7.2%	Durham 7.1%	Darlington 6.7%	North Tyneside 6.2%	Northumberland 5.3%	**England 5.20%**					
32. Percentage of 18-24 year olds claiming Job Seekers Allowance - July 2014		Hartlepool 9	South Tyneside 8.8	Redcar & Cleveland 8.9	Stockton 7.4	Middlesbrough 7.3	Darlington 6.7	Northumberland 6.5	Sunderland 7	Gateshead 6.8	North Tyneside 6.4	Durham 5.1	**Great Britain 3.9**	Newcastle 3				
33. Percentage of pupils participatiing in STEM[2] subjects at KS5 -2013			Sunderland 24.5	Darlington 25.1	Hartlepool 26.4	Newcastle 28.7	Middlesbrough 29.3	Gateshead 29.9	Durham 30.2	South Tyneside 30.7	North Tyneside 32.3	Redcar & Cleveland 32.7	**England 33.3**	Stockton 34.5	Northumberland 38.2			
34. Percentage of High Grade Achievements in STEM[2] subjects at KS5 -2013	Redcar & Cleveland 21.5	Newcastle 22.2	Middlesbrough 23.1	South Tyneside 23.6	Hartlepool 24.3	Stockton 26.4	Sunderland 26.4	Northumberland 27.4	North Tyneside 29.1	Darlington 29.8	Gateshead 31	Durham 32.5	**England 34.9**					
35. Percentage of young people at age 19 qualified to at least level 3 -2013	Middlesbrough 48	Sunderland 48	Newcastle 50	Durham 51	Gateshead 51	South Tyneside 51	Hartlepool 52	Darlington 53	Northumberland 54	North Tyneside 55	Redcar & Cleveland 55	Stockton 55	**England 56**					
36. Percentage of YP from low income families progressing to Higher Education 2011-12	Darlington 11	Northumberland 11	Durham 12	South Tyneside 12	Gateshead 15	Sunderland 15	Newcastle 16	Redcar & Cleveland 16	Stockton 16	North Tyneside 17	Hartlepool 18	Middlesbrough 20	**England 21**					
37. Key Stage 5 destination - Apprenticeship 2011/12											Hartlepool 3	Redcar & Cleveland 3	**England 4**	Gateshead 4	Middlesbrough 5	Newcastle 5	Stockton 5	Darlington 6	Sunderland 6	Durham 7	North Tyneside 7	South Tyneside 7	Northumberland 8

NOTES
1. All Ofsted data is taken from the Ofsted download provided in June 2014. Pupil numbers relate to January Census 2014.
2. STEM is defined for these purposes to include Biological Science, Chemistry, Physics, Other Science, Maths, Further Maths, Design and Technology, Computer

Appendix 2 - North East Health & Wellbeing Heat Maps

North East Regional Analysis Baseline - September 2014

Worse than England Average

England Average

Better than England Average

Health and Wellbeing

38. Child Poverty 2011	Middlesbrough 34.5	Hartlepool 30.2	Newcastle 29.9	South Tyneside 28.1	Redcar & Cleveland 26.2	Sunderland 26.2	Gateshead 24.8	Durham 23.0	Stockton 22.8	Darlington 21.3	**England 20.6**	North Tyneside 20.4	Northumberland 18.4								
39. Obese Children (aged 4-5) 2013				Redcar & Cleveland 14.8	Newcastle 12.3	Middlesbrough 11.9	North Tyneside 11.5	Hartlepool 11.1	South Tyneside 10.7	Sunderland 10.5	**England 9.3**	Northumberland 9.2	Durham 9.1	Gateshead 8.7	Darlington 8.5	Stockton 8.5					
40. Obese Children (aged 10-11) 2013		Redcar & Cleveland 23.6	South Tyneside 23.0	Middlesbrough 22.9	Newcastle 22.3	Gateshead 21.9	Sunderland 21.4	Hartlepool 21.1	Stockton 21.1	Durham 21.0	North Tyneside 19.3	**England 18.9**	Darlington 18.8	Northumberland 17.2							
41. Under 18 Conceptions 2012	Middlesbrough 52	Sunderland 43.1	Stockton 40	Darlington 38.2	Hartlepool 36.6	Redcar & Cleveland 35.4	Durham 33.7	North Tyneside 33.7	Newcastle 33.1	South Tyneside 31.1	Gateshead 30.2	Northumberland 28.4	**England 27.7**								
42. Breastfeeding Prevalence at 6-8 weeks after birth 2012/13	Hartlepool 19.7	Redcar & Cleveland 22.6	South Tyneside 22.7	Middlesbrough 24.1	Sunderland 24.7	Durham 27.7	Stockton 27.8	Gateshead 33.4	Darlington 35.0	Northumberland 36.5	North Tyneside 39.2	Newcastle 40.1	**England 47.2**								
43. Obesity in Adults 2012		Hartlepool 30.6	Darlington 29.3	Redcar & Cleveland 27.5	Durham 27.4	North Tyneside 26.6	Sunderland 26.6	Stockton 26.1	South Tyneside 26.0	Northumberland 25.7	Middlesbrough 24.0	Gateshead 23.2	**England 23**	Newcastle 21.6							
44. Hospital admission substance miuse under 15-24 year olds 2010/11-2012/13		Darlington 200.8	Redcar & Cleveland 187	Middlesbrough 171	North Tyneside 143	Sunderland 142	Stockton 130	Hartlepool 121	Gateshead 115	South Tyneside 109	Northumberland 95	Durham 95	**England 75.2**	Newcastle 74							
45. Hospital admission alcohol under 18s 2010/11-2012/13	South Tyneside 98.7	Darlington 86.2	Redcar & Cleveland 85.2	Sunderland 84.8	Durham 80.5	Middlesbrough 78.8	Hartlepool 76.9	North Tyneside 76.9	Gateshead 70.5	Stockton 53.7	Newcastle 45.0	Northumberland 44.1	**England 42.7**								
46. Hospital Stays for self harm (adults) 2012/13	Middlesbrough 504	Sunderland 388.6	Redcar & Cleveland 382.3	Hartlepool 357.6	Stockton 345.2	Darlington 314.1	Durham 269.5	Gateshead 266.6	North Tyneside 251.6	Northumberland 234.8	Newcastle 221.3	South Tyneside 202.9	**England 188**								
47. Hospital Stays for alcohol related harm (adults) 2012/13	Sunderland 1071	Middlesbrough 993	South Tyneside 982	North Tyneside 974	Gateshead 841	Newcastle 828	Durham 794	Northumberland 788	Hartlepool 783	Darlington 778	Redcar & Cleveland 775	Stockton 754	**England 637**								
48. Adults Smoking 2012		Hartlepool 28.2	Middlesbrough 24.4	Sunderland 23.4	North Tyneside 23	Gateshead 22.9	Newcastle 22.9	Durham 22.2	Redcar & Cleveland 21.8	Stockton 21.6	Darlington 21.3	South Tyneside 20.7	**England 19.5**	Northumberland 17.6							
49. Smoking related deaths 2010-12	Middlesbrough 439.9	South Tyneside 427.6	Gateshead 418.6	Sunderland 404.7	Hartlepool 402.9	Newcastle 392	Durham 372.4	North Tyneside 354.9	Redcar & Cleveland 345.4	Stockton 333.9	Darlington 333.1	Northumberland 312.4	**England 291.9**								

Appendix 2 - North East Health & Wellbeing Heat Map: # North East Regional Analysis - September 2014

Worse than England Average

England Average

Better than England Average

1. Enhancing the quality of life for people with care and support needs

ASCOF 1A: Social Care-Related Quality of Life

Redcar & Cleveland	**England**	Gateshead	Darlington	Stockton	Northumberland	South Tyneside	Hartlepool	Newcastle	North Tyneside	Durham	Middlesbrough	Sunderland
18.7	**19**	19	19	19.1	19.2	19.2	19.2	19.3	19.5	19.5	19.6	19.6

ASCOF 1B: The proportion of people who use services who have control over their daily life

Darlington	Redcar & Cleveland	Sunderland	Hartlepool	**England**	Newcastle	North Tyneside	South Tyneside	Gateshead	Northumberland	Stockton	Durham	Middlesbrough
74.8	75.2	76.3	76.3	**76.70**	76.70	77.7	77.7	78	79	80.2	81.2	81.7

ASCOF 1C Part 1: Self Directed Support (National)

Stockton	Middlesbrough	Darlington	Redcar & Cleveland	Gateshead	Durham	**England**	Hartlepool	Newcastle	Sunderland	Northumberland	North Tyneside	South Tyneside
29.6	40.2	47	49.1	54.7	60.1	**62.1**	70.8	72	73.3	77.8	92.1	93.7

ASCOF 1C Part 1: Self Directed Support (Local) *

Gateshead	Newcastle	Middlesbrough	Stockton	Redcar & Cleveland	**North East Av.**	Northumberland	South Tyneside	Durham	Darlington	Sunderland	North Tyneside	Hartlepool
74.21	79.76	81.34	82.43	87.53	**89.04**	92.36	93.63	94.39	95.14	96.8	97.41	98.9

ASCOF 1C Part 2: Proportion of people using social care who receive Direct Payments (National)

Stockton	Durham	Middlesbrough	Gateshead	Darlington	Northumberland	North Tyneside	Sunderland	Redcar & Cleveland	**England**	South Tyneside	Hartlepool	Newcastle
7.8	8.6	8.6	9.1	13.9	14	16.3	16.3	18.6	**19.1**	23.8	27.9	36.6

ASCOF 1C Part 2: Proportion of people using social care who receive Direct Payments (Local)*

Gateshead	Northumberland	North Tyneside	Stockton	Durham	Middlesbrough	Sunderland	South Tyneside	**North East Av.**	Darlington	Redcar & Cleveland	Hartlepool	Newcastle
12.39	17.94	18.21	19.24	19.5	21.31	21.56	23.73	**24.25**	28.13	30.06	39.00	40.52

ASCOF 1E: Proportion of adults with learning disabilities in paid employment

South Tyneside	Durham	Northumberland	Middlesbrough	Gateshead	Redcar & Cleveland	**England**	Sunderland	Newcastle	Darlington	North Tyneside	Stockton	Hartlepool
0.6	2.7	3.1	4.9	6.2	6.3	**6.8**	6.8	6.9	7.5	7.9	7.9	15.6

ASCOF 1G: Proportion of adults with learning disabilities who live in their own home or with their family

Gateshead	Hartlepool	Redcar & Cleveland	**England**	Middlesbrough	Stockton	South Tyneside	Sunderland	Northumberland	Durham	Newcastle	North Tyneside	Darlington
70.5	72.7	73.7	**74.8**	75	76.7	78.4	79	80.2	86.1	87.2	88.4	89.8

ASCOF 1I: Proportion of people who use services who reported that they had as much social contact as they would like

Redcar & Cleveland	Gateshead	Stockton	Darlington	**England**	Northumberland	South Tyneside	Hartlepool	Newcastle	Durham	North Tyneside	Middlesbrough	Sunderland
41.1	41.9	43	44	**44.2**	46.3	47.8	49.4	50.8	51	51.62	52.4	53.1

Proportion of carers receiving services or advice and information

Darlington	South Tyneside	Redcar & Cleveland	Middlesbrough	Stockton	**England**	Durham	Northumberland	Sunderland	Gateshead	Newcastle	North Tyneside	Hartlepool
13.98	20.16	25.40	28.29	28.79	**33.44**	33.99	37.11	38.90	41.01	42.48	50.16	65.13

2. Delaying and reducing the need for care and support

ASCOF 2A1: Permanent admissions to residential and nursing care homes, per 100,000 population, 18-64 (Part 1)

Middlesbrough	Redcar & Cleveland	Hartlepool	Darlington	Newcastle	Stockton	Northumberland	Durham	Sunderland	**England**	South Tyneside	North Tyneside	Gateshead
33.8	26.2	23.3	19	18.1	17.7	15.4	15.1	15.1	**14.4**	14.3	8.9	8.1

ASCOF 2A2: Permanent admissions to residential and nursing care homes, per 100,000 population, 65+ (Part 2)

Middlesbrough	Darlington	Sunderland	Gateshead	Stockton	Hartlepool	South Tyneside	Newcastle	Redcar & Cleveland	North Tyneside	Durham	**England**	Northumberland
1277.4	1076.8	982.4	944	907.8	907.2	848.1	844.2	784.8	758.7	736.2	**668.4**	517.3

ASCOF 2B1: Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service)

Redcar & Cleveland	Darlington	South Tyneside	**England**	Newcastle	Stockton	Sunderland	Middlesbrough	Gateshead	Hartlepool	Durham	North Tyneside	Northumberland
80.8	81.2	81.3	**81.9**	84.6	85.3	85.5	85.9	86	87.5	89.4	91.3	92.2

ASCOF 2B2: The proportion of older people aged 65 and over offered reablement services following discharge from hospital

Stockton	Redcar & Cleveland	Durham	Middlesbrough	Hartlepool	South Tyneside	**England**	Newcastle	Sunderland	Northumberland	North Tyneside	Gateshead	Darlington
1.2	1.8	2	2.1	2.3	3.2	**3.3**	3.3	3.5	4.4	4.6	4.6	4.9

ASCOF 2C1: Delayed transfers of care from hospital - all delays (Part 1)

Darlington	Redcar & Cleveland	Middlesbrough	Durham	**England**	Sunderland	Newcastle	Hartlepool	North Tyneside	Gateshead	Northumberland	Stockton	South Tyneside
16	15.3	13.8	10.5	**9.7**	8.7	8.4	6	5.7	5.5	4.5	3.3	2.5

ASCOF 2C2: Delayed transfers of care from hospital - Delays attributable to Adult Social Care or both (Part 2)

Sunderland	Gateshead	**England**	Redcar & Cleveland	Middlesbrough	Northumberland	Newcastle	North Tyneside	South Tyneside	Durham	Darlington	Stockton	Hartlepool
4.8	3.3	**3.1**	2.7	2.5	2.4	1.9	1.8	1.2	1	0.8	0.4	0

Percentage of people with no ongoing care needs following completion of a reablement package (Peopletoo)*

South Tyneside	Newcastle	Sunderland	Durham	Stockton	**North East Av.**	North Tyneside	Northumberland	Middlesbrough	Darlington	Gateshead	Redcar & Cleveland	Hartlepool
42.40	53.01	60.45	62.32	64.08	**64.91**	65.64	74.78	74.83	76.32	81.36	77.92	89.8

% reablement clients coming back into adult social care (within 6 months of package ending) *

Newcastle	Gateshead	Darlington	South Tyneside	**North East Av.**	Stockton	Northumberland	North Tyneside	Sunderland	Durham
33.7	27.17	21.67	15.46	**15.18**	10.12	10.04	8.9	8.36	3.43

Appendix 2 - North East Health & Wellbeing Heat Map: **North East Regional Analysis - September 2014**

Worse than England Average | England Average | Better than England Average

3. Positive experience of care and support	ASCOF 3A: Overall satisfaction of people who use services with their care and support					Darlington 62.4	Newcastle 64.3	Gateshead 64.8	**England 64.9**	North Tyneside 65	Redcar & Cleveland 66.3	Sunderland 67.1	Durham 67.1	Northumberland 68.2	South Tyneside 69	Middlesbrough 70.4	Stockton 71	Hartlepool 73.1		
	ASCOF 3D: The proportion of people who use services and carers who find it easy to find information about services							Darlington 73.7	**England 74.7**	Gateshead 74.8	South Tyneside 75	Sunderland 76.9	North Tyneside 78.4	Middlesbrough 79.6	Newcastle 80.2	Redcar & Cleveland 80.9	Stockton 81.2	Durham 81.4	Hartlepool 81.7	Northumberland 83.3
4. Safeguarding adults	ASCOF 4A: The proportion of people who use services who feel safe				Stockton 61.6	Gateshead 64.3	Redcar & Cleveland 64.7	Hartlepool 65.8	**England 66**	Durham 67.4	Newcastle 69.4	Darlington 69.5	South Tyneside 69.7	Northumberland 69.8	Middlesbrough 73.1	North Tyneside 74.3	Sunderland 76.1			
	ASCOF 4B: The proportion of people who use services who say that those services have made them feel safe and secure		Hartlepool 54.8	Darlington 72.5	Durham 72.6	Gateshead 74.5	Newcastle 77.5	Stockton 77.9	**England 79.2**	South Tyneside 79.7	North Tyneside 84.8	Redcar & Cleveland 86.2	Northumberland 87.2	Sunderland 91	Middlesbrough 92.8					
	Rate of safeguarding referrals per 1,000 population aged 18+ **	Sunderland 0.53	Durham 1.20	Northumberland 1.73	Stockton 2.01	South Tyneside 2.02	Hartlepool 2.04	Darlington 2.17	**England 2.47**	North Tyneside 2.62	Middlesbrough 3.14	Redcar &Cleveland 3.95	Gateshead 4.41	Newcastle 5.29						
	Proportion of safeguarding referrals fully or partially substantiated **							North Tyneside 38.97	**England 42.54**	Northumberland 43.82	Hartlepool 46.50	Redcar & Cleveland 48.27	Newcastle 49.23	Durham 49.23	Gateshead 51.16	Middlesbrough 54.28	South Tyneside 54.59	Sunderland 55.56	Darlington 58.49	Stockton 59.46

NOTES
* These outurns are locally collected and are excluded from any analysis against the national position as there is no national average.
** These outurns are based on national returns but there is no nationally determined guidance on whether lower is better or higher, authorities need to consider their own local conditions and operating models.
Local authorities bordered green rank in the top quartile in England and those bordered red rank in the bottom quartile

HEALTH AND WELLBEING BOARD

1 DECEMBER 2014

Report of: Director of Child & Adult Services

Subject: JOINT HEALTH AND SOCIAL CARE LEARNING DISABILITY ANNUAL SELF ASSESSMENT FRAMEWORK (2012/13)

1. PURPOSE OF REPORT

1.1 To update the Health and Wellbeing Board on the results of the eighth annual learning disability performance and self assessment framework (SAF).

1.2 To highlight the issues raised by the Hartlepool Learning Disability Partnership Board in completion of the SAF.

1.3 To present the NHS England publication 'A practical guide for Health and Wellbeing Boards – leading local response to Winterbourne View'.

2. BACKGROUND

2.1 An independent inquiry into access to healthcare for people with learning disabilities was established under Sir Jonathan Michael's leadership in May 2007. The inquiry found convincing evidence that people with learning disabilities have higher levels of unmet need and receive less effective treatment.

2.2 Valuing People Now, a three year strategy for people with learning disabilities, identified that a key priority for delivery was to secure access to, and improvements in healthcare.

2.3 A North East regional programme of work was launched in April 2008 with the aim of ensuring people with a learning disability are as healthy as possible and have equality of access to health care.

2.4 The North East regional programme is chaired by Dr Dominic Slowie, the National Clinical Director for Learning Disability, NHS England.

2.5 The report provides an update on the outcome of the joint health and social care learning disability annual self assessment.

2.6 A change to the report has requested Clinical Commissioning Groups and Local Authorities undertake a joint health and social care assessment relating to their respective Learning Disability Partnership Board (LDPB) area.

2.7 Hartlepool Borough Council and Hartlepool and Stockton on Tees Clinical Commissioning Group, through the North of England Commissioning Support Unit (NECS) has completed the joint self assessment and following validation by NHS England presents the outcomes of the findings.

3. BRIEF OVERVIEW

3.1 The SAF and its findings are presented locally to the Hartlepool Learning Disability Partnership Board and agreement is reached prior to submission.

3.2 The focus of the 2012/13 SAF is applied alongside the following policies and guidance documents;

- Winterbourne View concordat report
- Adult Social Care Outcomes Framework (ASCOF)
- Public Health Outcomes Framework (PHOF)
- The Health Equalities Framework (HEF)
- National Health Service Outcomes Framework (NHSOF)
- The 6 Lives Report 2009 - an investigation into the deaths of six people with learning disabilities who were in the care of the NHS

3.3 The SAF is measured against three distinct areas, using a traffic light rating system (Red, Amber and Green)

1. Section A - Staying Healthy
2. Section B – Being Safe
3. Section C – Living Well

3.4 All documents relating to the 2012/13 SAF can be found at:- https://www.improvinghealthandlives.org.uk/projects/hscldsaf.

3.5 Section A (Staying Healthy) assesses how primary care enablers, such as the Direct Enhanced Service, Quality and Outcomes Framework and registers for people with learning disabilities are implemented in primary care. Health commissioners have an essential role in completing this section

3.6 Section B (Being Safe) assesses how robust commissioning and safeguarding arrangements are against well established best practice, for example the areas exposed in the Winterbourne View concordat report.

3.7 Section C (Living Well) is about inclusion, being a respected and valued part of society and leading fulfilling and rewarding lives.

3.8 The SAF examines the data returns including statutory returns to give a broad set of information to help assess the environment for people with a learning disability locally.

3.9 Unfortunately due to the changes in the SAF for 2012/13 it is not possible to make comparisons against assessments in previous years. It is possible however to extrapolate data and identify key strengths and areas for improvement.

4. SUMMARY OF FINDINGS

41 A link to the full report and findings from the National Learning Disability SAF is included in Section 11: background papers. The Quality Assurance report for Hartlepool is attached as **Appendix 1**.

4.2 A brief overview of the Hartlepool SAF is as follows:-

Section	Overall Summary
A: Staying Healthy	• 100% sign up of GP practices to the DES is a real achievement. • The Open Doors event held at the University Hospitals of North Tees and Hartlepool provides a good opportunity for people with learning disabilities and carers to familiarise themselves with the building and the staff before they need to use them and allow professionals to mix with individuals and carers. • The level of engagement in Hartlepool in respect of Healthwatch; who really do appear to be championing the cause of people with a learning disability, is impressive. • Joint work to increase in the number of annual health checks. • Joint work across health, social care and public health in relation to health promotion • The use of a regionally developed model of good practice for medication has reduced the number of medication errors occurring with people who are likely to access multiple venues throughout the day. • Research has taken place with Teesside University to review dental services • "Shining a Light on learning disability" training and awareness raising events and a survey of people with LD admitted to hospital.
B: Being Safe	• 15 people with a learning disability live out of area and all have been reviewed. There is a well-established and robust quality assurance process for all provision with annual checks on standards.

	• Transitions protocols and processes established. Special Educational Needs and Disability (SEND) Pathfinder work well underway and making significant progress to improve integrated response. • Good evidence of work on meshing the needs of people with a learning disability with the wider community safety agenda. • The 'Safe Transport' initiative is positive. • Hate crime has been identified as a priority; Tees 'Place of Safety Initiative' is an example of good practise. • The All Together Better course demonstrates a commitment to supporting people with a learning disability to gain skills and confidence to participate in decision making and personal planning. • Healthwatch have used experts by experience to support them to review services. • Several joint commissioned frameworks have been developed including ones for Autism and forensic services. • Mental Capacity Act is well embedded within the Safeguarding Vulnerable Adults structure and there is a dedicated service.
C: Living Well	• The Local Authority has very solid working relationships with other corporate departments and wider community engagement was also evident. • Evidence of excellent leadership at all levels with senior strategic influence in relation to learning disability. • Evidence of working with leisure services through a community activity network where grants and bids are identified to enhance offer. • A lot of detailed work has taken place around housing. There are a range of supported housing options for people and these have been reviewed. This has provided a mechanism to enable people to move on. • There is a high percentage, against the national average, of people with a learning disability in employment. Clearly Hartlepool is having some success and has used innovative approaches such as a joint apprenticeship scheme. • Hartlepool is a Special Educational Needs and Disabilities (SEND) pathfinder and has made good progress with a target to transfer all SEND statements to "One Plan" before September 2014.

5. KEY CHALLENGES & PRIORITIES

5.1 The Quality Assurance report makes reference to several key challenges, recognising the current financial climate and organisational changes.

5.2 Key Challenges to Staying Healthy

- Quantitative data collection is more robust but remains a challenge. This is a regional challenge and a regional approach may be of benefit.
- Linking the Health Action Plan and the Health Check; including the assessment by the Community Learning Disability Team practitioners.
- An Area Team/CCG wide system is needed for ensuring that learning disability status and the need for reasonable adjustments are included in referrals from primary care to other health care providers.
- Ensuring the extent and quality of the work in prisons. Involvement of the CCG Lead in the SAF would be valuable

5.3 Key challenges to Being Safe

- Ensure all contracts to have a scheduled review every year.
- Work with Trusts to request evidence about learning disability in Monitor and Equality Delivery System returns as a specific assurance item.

5.4 Key Challenges to Living Well

- Although teams are co-located there are no formal agreements around partnership working and no pooled budget.
- The Health and Wellbeing Board engaged with the Learning Disability Partnership Board in its early iteration however this is not now as obvious.
- The Health and Wellbeing Strategy, whilst recognising learning disability, did not have a specific priority or objective relating to it.
- A review of the physical health needs of people living in either residential or supported housing would be good practice to see if any trends are arising in relation to the quality of care

6. LOCAL PRIORITIES

6.1 At a meeting of the Hartlepool Learning Disability Partnership Board on 30 May 2014 the report was discussed and the Board agreed to set the following key priorities:

- Linking Health Action Plans and Annual Health Checks
- Continued work with the CCG and NECS to improve health outcomes
- Reviewing current arrangements to support more joined up and better partnership working across health and social care.

7. RISK IMPLICATIONS

7.1 There is a risk that the Learning Disability Partnership Board may not be able to continue to co-ordinate the responses to the SAF, and the level of data and evidence being examined and ratified by the Board is often difficult to present in a meaningful format.

7.2 Representatives from the LDPB met on 10 July and have forwarded a letter to key stakeholders in respect of their growing concerns in relation to capacity and the Board's remit in respect of the completion of the SAF.

7.3 There is no funding to support the LDPB, and co-ordination of the SAF and additional self assessments, for autism for example, is leaving little time to allow the board to tackle and consult on local issues.

7.4 Despite the LDPB's best efforts there has been little progress to improve targets. Targets are often seen as unachievable or impossible to validate.

7.5 NHS England is presently considering suggestions for changes to the SAF in 2014 with potential to implement the next iteration in November 2014.

8. RECOMMENDATIONS

8.1 It is recommended that the Health and Wellbeing Board

- notes the content of the report and the progress made;
- agrees the key priorities for improvement for 2014/15; and
- considers the challenges and constraints in respect of completion of the SAF for 2014/15 and considers how the process could be better supported.

9. REASONS FOR RECOMMENDATIONS

9.1 The Department of Health requires local Learning Disability Partnership Boards to report progress of the joint health and social care learning disability annual self assessment to local Health and Wellbeing Boards

10. BACKGROUND PAPERS

10.1 http://www.improvinghealthandlives.org.uk/projects/hscldsaf

11. CONTACT OFFICER

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NHS England

Learning Disability

Quality Assurance of the Joint Health and Social Care Self Assessment Framework

2012 – 2013

Hartlepool

Contents

Hartlepool Joint Health and Social Care Learning Disability Self –Assessment Framework

Quality Assurance Report

March 2014

People with a learning disability and carers in Hartlepool have discussed the Health and Social Care Self-Assessment Framework (HSCSAF) measures at the Learning Disability Partnership Board and the health sub-group. Health Watch are involved and manystories from different individuals and groups have been recorded and presented to the panel as a DVD.

Things that people with a learning disability and carers told the panel have been taken into account within the post quality assurance rating of the HSCSAF and can be found in appendix 2.

Listening to the people with a learning disability, carers and staff at the panel it was clear that there is a lot of work to be proud of in Hartlepool. It demonstrates that the vision that for the North East to be the best place to live for people with a learning disability can become a reality. There are also challenges and further work that needs to be undertaken. This is summarised in the pages below. Detailed comments are included in appendix 1

In the current financial climate and organisational change, limitations in the work that can be undertaken were acknowledged but the locality is working in partnership and creatively to maintain and improve services.

Staying Healthy

Examples of Good Practice

- 100% sign up of GP practices to the DES is a real achievement.
- The Open Doors event held at the University Hospitals of North Tees and Hartlepool provides a good opportunity for people with LD and carers to familiarise themselves with the building and the staff before they need to use them and allow professionals to mix with individuals and carers.
- The level of engagement in Hartlepool in respect of Healthwatch; who really do appear to be championing the cause of people with a learning disability, is impressive.
- Joint work to increase in the number of annual health checks.
- Joint work across health, social care and public health in relation to health promotion
- The use of a regionally developed model of good practice for medication has reduced the number of medication errors occurring with people who are likely to access multiple venues throughout the day.
- Research has taken place with Teesside University to review Dental services
- "Shining a Light on learning disability" training and awareness raising events and a survey of people with LD admitted to hospital.
- Foundation Trust are opening their doors to people with learning disabilities, their families and carers. This is an opportunity to visit hospital departments and wards while they are well providing opportunities to ask questions and meet the Doctors, Nurses and Allied Healthcare Professionals.

Challenges

- Quantitative data collection is more robust but remains a challenge. *This is a regional challenge and a regional approach may be of benefit*
- Linking the Health Action Plan and the Health Check; including the assessment by the CLDT practitioners. *This is a regional challenge and a regional approach may be of benefit*
- An Area Team/CCG wide system is needed for ensuring that learning disability status and the need for reasonable adjustments are included in referrals from primary care to other health care providers.
- Ensuring the extent and quality of the work in prisons. *This is a regional challenge and a regional approach may be of benefit*
- Involvement of the GP CCG Lead in the HSCSAF panel would be valuable

Being Safe

Examples of good practise

- 15 people with a learning disability live out of area and all have been reviewed.There is a well-established and robust quality assurance process for all provision with annual checks on standards.
- Transitions protocols and processes established. SEND Pathfinder work well underway and making significant progress to improve integrated response.
- Good evidence of work on meshing the needs of people with a learning disability with the wider community safety agenda.
- The 'Safe Transport' initiative is positive.
- Hate crime has been identified as a priority;Tees 'Place of Safety Initiative'is an example of good practise.
- The All Together Better course demonstrates a commitment to supporting people with a learning disability to gain skills and confidence to participate in decision making and personal planning.
- Healthwatch have used experts by experience to support them to review services.
- Several joint commissioned frameworks have been developed including ones for Autism and forensic services.
- Mental Capacity Act is well embedded within the Safeguarding Vulnerable Adults structure and there is a dedicated service.

Challenges

- Ensure all contracts to have a scheduled review every year.
- Work with Trusts to request evidence about Learning Disability in Monitor and Equality Delivery System returns as a specific assurance item

Living Well

Examples of good practise

- The Local Authority hasvery solid working relationships with other corporate departments and wider community engagement was also evident.
- Evidence of excellent leadership at all levels with senior strategic influence in relation to learning disability.
- Evidence of working with leisure services through a community activity network where grants and bids are identified to enhance offer.

- A lot of detailed work has taken place around housing. There are a range of supported housing options for people and these have been reviewed. This has provided a mechanism to enable people to move on.
- There is a high percentage, against national average, of people with a learning disability in employment. Clearly Hartlepool is having some success and has used innovative approaches such as a joint apprenticeship scheme.
- Hartlepool is a SEND pathfinder and has made good progress with a target to transfer all SEND statements to “One Plan” before September 2014.

Challenges

- Although teams are co-located there are no formal agreements around partnership working and no pooled budget. There is a Tees wide commissioning group and a Tees wide approach to responding to the JSNA.
- The Health and Well Being Board engaged with the Learning Disability Partnership Board in its early iteration however this is not now as obvious. The HWB strategy whilst recognising learning disability did not have a specific priority or objective relating to it.
- A review of the physical health needs of people living in either residential or supported housing would be good practice to see if any trends are arising in relation to the quality of care

Suggested Regional Priorities

Quantitative data collection.

Linking the Health Action Plan and the Health Check; including the assessment by the CLDT practitioners.

Ensuring the extent and quality of the work in prisons.

Pooled budgets

Monitoring

Appendix 1

Joint Health and Social Care Learning Disability Self -Assessment Framework 2013

Locality–Hartlepool

Date of validation meeting: 4th March 2014

Measures	Measure Description	2013 Pre-Quality Assurance (RAG)	2013 post Quality Assurance (RAG)	Rationale: evidence provided, good practice, gaps in evidence.	Information requested on key points	Panel notes
A	**Stay Healthy**					
A1	**LD QOF register in primary care**			A statement has been made that Learning Disability and Down Syndrome Registers are captured and identify local prevalence this can also be stratified in the required data set (e.g. age / complexity)	1. Check that this reflects prevalence data and that it covers all of the data set age, complexity, BME and autism. For green it needs to be complete and cover all practices.	

A2	**Health screening and promotion (obesity, diabetes, cardio vascular and epilepsy)**			A statement made that "comparative data in all of the health areas listed in the descriptor is available and being collected. There is evidence that people are accessing these programmes and further analysis is required to demonstrate whether there are any specific areas highlighting a lower than average take up (at practice level)"	1. Need to provide comparative data in all of the areas listed 2. What are the gaps if any in data collection? **3.** What evidence do you have that people are accessing disease prevention and health promotion in any of these areas?	Data should be available, the primary care data sharing agreement was signed up but there are still problems with the robustness of the data available and there were gaps in the IHAL submission. The practice data was not back in time for the SAF and IHAL told NECS not to submit it again. CCG leads and Public Health data links are now strong at LD partnership board. No further data was submitted following panel, agree red rating.
A3	**Annual Health Checks and registers**			There has been an improved uptake of annual health checks from previous years, all 15 GP surgeries have signed up to LD DES contract. Registers are said to be validated on a practice level basis. Training, promotion and awareness in relation to Annual Health Checks continue to take place. Training has been	1. Have all registers been validated against the LA register within the last 12 months? **2.** What % of people with LD had an annual health check? To achieve amber this has to be 50%. **3.** 100% sign up of practices to deliver the LD	59.1% of people had an annual health check, this confirms the amber rating. This represents a considerable increase in uptake for annual health checks. There are only 15 GP practice in Hartlepool and this meant that they could focus intensely and drive the strategy. Support at CCG level has also pushed the agenda. The LA has also instructed social workers to include questions about annual health checks during individual reviews. Throughout the panel the strong partnership approach with people with LD and families

				provided for GP surgeries, Independent Providers, Carers and Service Users. Quality Checkers have completed training and are ready to undertake practice visits to help inform reasonable adjustments (None of the web links to In Control-able will open)	DES is a real achievement.	was noted. In this measure excellent practice in the use of quality checkers.
A4	**Health Action Plans**			Limited evidence that the Annual Health Check and Health Action Plans are integrated in Hartlepool. Further quality checking is required to fully understand this.	Have you identified any action to take to improve integration of AHC's and HAP's?	
A5	**Screening :Cervical Breast Bowel**			Comparative data is stated to be available for all screening areas identified and that further scrutiny is required to establish equity for people with learning disabilities and the general population. The CHERISH Project	What action/reasonable adjustments have been agreed with the Screening and Immunisation Manager?	

				works to promote positive changes and better experiences of health care for people with LD There is some ongoing work to raise the profile of LD within screening services. Contact has been made with the Regional Screening and Immunisation Manager to discuss the barriers faced by people with LD. The CHERISH Project facilitated two events with the TEWV Health facilitator specifically focussing on the issue of cancer screening		
A6	**Primary care communication of LD status at referral**			There is said to be some evidence of the use of LD status and suggested reasonable adjustments on referrals; however it is acknowledged that this needs to be fully embedded into the referral process.	To rate Amber there needs to be some evidence of an Area Team/CCG wide system for ensuring that LD status and the need for reasonable adjustments are included in referrals from primary care to other health care	No further evidence has been provided of an Area Team/CCG wide system for ensuring LD status is communicated from primary care to other health care providers and that it contains information about reasonable adjustments and the individual's capacity and consent. To set this in context most areas across the NE and the NW have either self-rated red or been unable to provide evidence for amber and green.

				Some work has been ongoing to raise the profile of LD within screening services. This has included joint working with the local screening programme leads and a self-advocacy group (commissioned by the CCG) to look at reasonable adjustments, awareness raising for staff carrying out the checks and also how people can be supported to attend the screening appointments. No evidence has been provided that there is an Area Team/CCG wide system for ensuring that LD status and the need for reasonable adjustments are included in referrals to other health care providers .	providers. Other health care providers include acute services and community services such as those highlighted in A8. This needs to include any issues about capacity and consent. Do you have such a system in place? The work that you have commissioned from the self- advocacy group sounds very interesting and innovative; this is obviously something that you have done in collaboration with other areas. Will you provide further information about this?	

A7	**LD Liaison function. Info collated in Trusts.**			The submission states that LD leadership is in place within the acute Trust and that this is well embedded into the organisation with senior leadership. Hospital passports are completed and are forwarded to the specialist nurses. Notes are then electronically flagged and the Hospital Passport is placed in medical notes. Other initiatives taking place in the Trust include "Shining a Light on LD" training and awareness raising events and a survey of people with LD admitted to hospital. The University Hospitals of North Tees and Hartlepool NHS Foundation Trust are opening their doors to People with Learning Disabilities, their families and carers. This is an opportunity to visit	Is there a LD Liaison function across all acute settings? How do you use activity data to employ the LD nurse against demand? For example do admission figures (HES data) demonstrate a good fit between the number of people admitted and the number of contacts/people known to the LD nurse? This is one way of demonstrating that the flagging system is working. Are the figures manageable for one post and how is this monitored? Can you provide more detailed information about how broader assurance about progress on the LD agenda is delivered in the Trust/s? How is leadership embedded and what are the formal reporting and monitoring	North Tees hospitals website demonstrate a variety of QA reports taken to the Board, including Safeguarding, CQUIN's (there is an LD CQUIN re flagging)

				hospital departments and wards while they are well providing opportunities to ask questions and meet the Doctors, Nurses and Allied Healthcare Professionals. This sounds like a very positive initiative taken by the Trust. Some gaps in evidence for green, mainly around data, demand and wider assurance.	routes?	
A8	**Universal services flag and identify and make reasonable adjustments**			A statement made that some universal services provide excellent services; these include podiatry, optometry and pharmacies. However no evidence of the type and extent of reasonable adjustments have been provided. It is not clear whether these services have flagging systems in place. No evidence provided of plans for service	Which universal services have flagging systems in place identifying people with LD? Do these record the need for reasonable adjustments? Need to provide some evidence of the type and extent of the reasonable adjustments provided by some of these universal services. Are there any examples of improvement plans in place for any of these services to enable them	At the panel meeting it was confirmed that there is no flagging system in place in these services. The acute Trusts have made good progress as a result of the LD CQUIN but in order to roll this out to community services there is some consideration of extending the CQUIN LD awareness raising training is provided to all of the community services provided by the Acute FT No additional evidence provided following panel Confirm the red rating

				improvement based on knowledge of need The Cherish project works with professionals to raise awareness of the issues people face and what reasonable adjustments might help.	to provide a more effective service to people with LD?	
A9	**Offender health and the Criminal Justice System**			There are significant gaps for the amber rating There is no systematic collection of data about the numbers of people with LD in the criminal justice system and there is a problem establishing information relating to people diagnosed with protected characteristics. The links with Prison healthcare and the Criminal justice system are not fully in place. Some autism awareness raising	1. There are significant gaps in an amber rating. 2. What improvement plans are in place for this measure?	No additional evidence has been provided There is insufficient evidence for amber. Confirm red rating

				training has been delivered to 50 CJS staff The Waverley Allotment Group in partnership with the prison supported 15 people with joint funding from the LSIS project, however this has now ceased. There are some links through the Tees Safeguarding Boards and through the Tees Safe Places Scheme work. No evidence that an assessment process has been agreed for people with LD in all offender health services, for example LDSQ. Not clear what type of offender health teams/services are in place. No evidence of any easy read information provided within the CJS .		

B						
B1	**Regular care reviews**			There appear to be tight monitoring and tracking of people with complex LD and ASC via the Tees Integrated Commissioning group which was established in 2005 Within health over 90% of CHC and joint funded packages have been reviewed. For those people with Direct Payments or Personal Budgets a Care Coordinator reviews support plans against the quality of life outcomes. No evidence provide about the number/% of individual reviews carried out by Social Care.	Need confirmation of the actual % of care packages reviewed within the last 12 months. To obtain green this figure must be 100%and must include all funded health and social care commissioned packages including PB's. Evidence of schedule and compliance with review timetable or other compliance evidence would be useful.	The care management review process is overseen by Neil Harrison. The social work care managers and health team are co-located and work closely together. There are 384 active cases under social work team and number of joint cases which are worked with TEWV. Confident that all will have had a review. 93% of people known to the council have a personal budget and the team is also able to offer health and education budgets. Out of area reviews – 15 people placed out of the area funded by the LA, all have been reviewed and assurance provided that placements are safe. 1 person lives in Cornwall and care managed from a distance. Current discussion around Hartlepool and Cornwall co-managing the individual. However the average distance for placements for the 15 is 48 miles.
B2	**Contract compliance assurance**			All residential and nursing homes within Hartlepool are audited against a Quality Assurance Framework which was developed	To secure amber, need assurance that 90% of all health and social care contracts have had contract /service review in the last 12 months.	At panel There is a quality assurance process for all provision with checks at 18 month intervals on standards. There was an acknowledgement that this process is not as

				with providers. This does include a range of indicators and outcomes supporting quality assurance. There are section 75 agreements between the CCG and Local Authority in place that monitor care homes within the area Hartlepool has developed a range of framework agreements to support people with a Learning Disability, Autism, or complex and behaviours described as challenging. These were not provided. NHS contracts are in place and there are systems to review and monitor these. A Clinical Quality Assurance tools is in place with continuous development led by commissioners. Examples of the contract visit reports for residential and nursing homes have been	This measure is about all health and social care commissioned services not just residential and care homes and hospitals; it should include reviews of services such as supported living, short breaks, day care, and domiciliary care. Will you please provide a copy of the Clinical Quality Assurance Tool Do you have service specifications outlining quality indicators and outcomes for the frameworks that you have developed? How do you review and monitor providers delivering services within the frameworks? For amber, need to evidence how you report information about quality and performance of commissioned services to exec boards in health and social care.	frequent or robust as it used to be. The criteria for amber require all contracts to have a scheduled review every year.

				provided. These are available on the Council's website and are available to the public.		
B3	**Assurance of Monitor compliance**			Assurance is available through standard contract reporting method and the CCG has sight of the NHS Foundation Trust equality objectives and action plans via the Regional Equality Diversity and Human Rights (EDHR) Leads Group. Commissioners will be working with Trusts to request this area specifically as an identified assurance item	1. Do you actually review the Monitor and EDS returns or the objectives and action plans to ensure that they include relevant information about people with LD? 2. Evidence how you do this.	EDS is developing as well as expected and commissioners are working with Trusts to monitor progress Risks are shared at the Quality surveillance Group. Commissioners will work with the Trusts to request evidence about LD in Monitor and EDS returns as a specific assurance item in future.
B4	**Assurance of Safeguarding in *all* provided services and support**			Evidence has been provided to demonstrate that there is a SAB which has a robust business action plan covering a range of issues relevant for people with LD. SAB policies procedures and	1. When you monitor the quality of the services you commission is assurance about quality (performance intelligence, themes etc.) provided to the Safeguarding Board or to exec boards in health	Discussed at panel. Is LD a priority? – Yes, a unique set up around Teesside looking at improving quality, safety and the measures will be for everybody and not just people with a learning disability. The focus has been on ensuring that the

				protocols were not provided but were referenced clearly in the SAB business plan. Evidence provided that the Adult Services committee receives reports about LD in particular Winterbourne View. Effective coordination of the re-provision of services following prolonged safeguarding investigations in one provided service.	and social care, can you provide evidence of this? 2. Do you have evidence to show that the LDPB has been involved in reviewing progress on Safeguarding? 3. Have all providers assured their boards that safeguarding is a clinical and strategic priority? Do you have any evidence to demonstrate this? 4. Does the acute FT demonstrate the delivery of safeguarding using the Safeguarding Adults Assurance Framework or equivalent system or process?	key policy areas are communicated across the board. Looked at Winterbourne concordat and looked at the implications for similar areas and any action is implemented and included in policy communication. Acute Trust website includes documents and other evidence that demonstrate a robust safeguarding process. An adult safeguarding lead in in post. Of positive note is that the A&E department had two weeks intensive and practical safeguarding training which included MCA, DoLS and LD.
B5	**Involvement in training and recruitment**			Partners in Policy Making have delivered an "All together Better" course and graduates are being supported to assist organisations locally to recruit and where appropriate train	To obtain amber you need to be able to demonstrate that 90% of LD specific services can provide you with evidence that people with LD and families are involved in	Panel were informed that LD awareness training is offered to all universal health services provided by the Acute Trust. Self- advocates who attended panel provided information about the ways that they have been involved in monitoring services. Of note is the fact that the local Healthwatch was

				staff. There is a commitment to self-directed support and this means that people are involved in recruiting their own staff. People with LD have been involved in reviewing services and evaluating tenders. Hartlepool Healthwatch has been working with experts by experience to support their review work. (Unable to open the In control link)	recruitment, training and monitoring of staff (for example appraisal and review or induction). Can you confirm that this is the case and how do you audit this? Do you have any additional evidence to demonstrate that LD awareness raising and the use of reasonable adjustments is embedded in universal services?	represented at the Panel and the LD agenda and involvement of experts by experience is integrated within the health watch plan. No additional evidence has been provided in response to the gaps but the evidence provided in the submission and at panel is sufficient for amber
B6	**Recruitment and the management of staff is based on value based culture**			There are specialist frameworks in place for a range of levels of intensity of service for people with complex needs and or Autism. Providers are expected to employ staff and align their skills with the Skills for Care qualifications. To rate green Commissioners should require providers to demonstrate compassionate care and	Do contracts and service specifications clearly require providers to deliver and demonstrate compassionate care and values based recruitment? Can you provide some examples of the ways that providers have used value based recruitment and management and how you check out that the	No additional evidence has been provided for this measure to address the gaps for green. Insufficient evidence for green

				value based recruitment and management of the workforce. This would in the first instance be demonstrated by contracts and service specifications, no evidence of this currently provided. Commissioners need to demonstrate that they check out the quality of services and that they look for evidence of compassionate care and value based recruitment and management. Currently no evidence of this has been provided. No evidence provided to show that universal services demonstrate compassionate care and value based recruitment	culture of the organisation is based on compassion, dignity, respect etc.? To obtain green you need to provide evidence that universal services demonstrate compassionate care and value based recruitment. Since the Francis inquiry it is likely that every acute service will have refocused/reviewed their approach to values and culture and should be able to provide you with evidence.	
B7	**LA strategies are subject to Equality Impact Assessments**			There is an up to date generic Housing Care and Support Strategy in place that makes specific reference to people with Learning Disabilities and Autism.	1. The Housing, Care and Support strategy for people with LD ended in 2012, has this been reviewed or are there any other examples of up to date	

				One target is to increase the number of people with LD in settled accommodation from 65% to 70% in the next three years. This has been based on a more detailed assessment of housing and support need contained in the Housing Care and Support strategy for people with LD. Following an impact assessment for the Choice Based Letting process, Housing Hartlepool introduced some reasonable adjustments that would be suitable for people with LD. In collaboration with a self-advocacy group a number of easy read fact sheets have been produced including one for housing options. Several impact assessments have been made available on the Council's website and	commissioning strategies that you can evidence? 2.How have you presented key strategies and impact assessments to people with LD	

				cover a range of services including community (arts and culture) and adults social care funded services.		
B8	**Commissioner can demonstrate that all providers change practice as a result of feedback, complaints and whistle blowing**			The Council received 1 complaint relating to an adult with a Learning Disability in 2012/13. This led to a review of the Regional Model of good practice for medication which has now reduced the number of medication errors occurring with people who are likely to access multiple venues throughout the day. No evidence of complaints made to health services and it is not clear if the one complaint raised to the Council was about a Council service or a commissioned service. No evidence of feedback influencing service development.	1. Can you evidence that 50% of health and social care provider contracts require them to collect patient experience data and information about complaints and other feedback? 2. How do you monitor the way in which providers comply with this aspect of the contract? 3. Do your contracts require providers to have a whistle blowing policy? 4. Do you monitor complaints made to or about providers and have systems in place to deal with them in a strategic way, for example intelligence shared with	No additional evidence has been provided. An examination of the web sites for the LA and the Acute FT provides some reassurance that patient experience data is collected, that whistle blowing is included in the multi-agency safeguarding policy. The response to panel questions for B4 provided reassurance that the quality and safety of services is a high priority and that systems are in place to monitor this. The Local Account shows that the quality Standards Framework is used to check and audit how well providers deal with and learn from complaints about the service. On balance there is sufficient evidence for amber.

				One of the issues about people with LD using services is that they find it difficult to make a complaint or to comment on the service that they receive, sometimes services do not empower them to do this and they may find it difficult to understand the complaints/compliments process. The fact that only one complaint has been made in a 12 month period may indicate a high level of satisfaction or it may point to the need to review ease of access to the various complaints procedures for people with LD.	Safeguarding Board? 5. Do providers have easy read information about complaints and feedback?	
B9	**Mental Capacity Act and Deprivation of Liberty**			It is a contractual requirement of Health and Social Care that all providers have in place robust policies and procedures in relation to the Mental Capacity Act. These are routinely	1. Can you provide some evidence to illustrate your statement that providers are routinely monitored and some examples where providers have taken action to improve or	Green

				monitored and providers are required to provide evidence as part of routine quality reporting and reporting by exception where issues arise. Evidence has been provided to demonstrate that MCA is well embedded within the Safeguarding Vulnerable Adults structure with dedicated services for safeguarding/MCA and Best interest. There is a Deprivation of Liberty Safeguards/Best interest assessor's sub group of the SAVB.	embed practice? 2. Have you ever audited the use of restraint or physical intervention in the services that you commission?	
C						
C1	**Effective joint working**			A range of informal joint working arrangements and joint frameworks for services across Tees have been developed. The Tees Integrated Commissioning structure has secured effective joint	1. Is there a formal joint commissioning strategy in place? 2. Evidence of shared commissioning intentions, monitoring and reporting arrangements. For example where does the	At panel there was confirmation that there are no formal arrangements in place such as pooled budget arrangements or integrated governance structures and an acknowledgement that a systemic approach to joint working was lacking. Agreement for sharing some resource across Tees's area which is sensible.

				arrangements in commissioning some services including a Tees Autism framework and a Tees Forensic services agreement Access to care management is provided by co-located staff teams (Health and Social Care). There are section 75 agreements in place which cover care home contract monitoring for people with Learning Disabilities. Good use of person centred reviews to inform the development of the Autism commissioning strategy.	Integrated Commissioning Group report to, how is it held accountable for commissioning decisions and use of resources? 3. There are a number of informal meetings and arrangements, how is all of this pulled together into a coherent strategic approach to deliver improvements. 4. Who is monitoring and providing oversight and scrutiny of any LD improvement plan?	The Health and Wellbeing Board recognises the LDPB as a consultative group but there is felt to be limited influence over the agenda. Teesside has had an informal integrated commissioning group since 2005, health and social care and commissioner meet regularly. . Developing a joint approach and commissioning ratings for winterbourne by the new financial year. Green light tool kit creates synergy between mental health and LD.
C2	**Local amenities and transport**			A Tees Place of Safety scheme has been developed with the support of the Police and Crime Commissioner. In Hartlepool over 40 businesses had signed up to the 'Safe on the	1. The Safe on the Move in Hartlepool project appears to be an innovative scheme, will you please provide some more details about it and how it works?	

				move in Hartlepool' scheme. Plans will be made to combine the two during 2014. Hartlepool's passenger transport unit supported the development of a 'safe on the move in Hartlepool' scheme which includes the provision of detailed personalised transport plans. Some evidence provided for C3 demonstrates that some venues in the town centre are now fully accessible with Changing Places installed.		
C3	**Arts and culture**			Evidence that one of the local cinemas has regular Autism friendly screenings. Hartlepool has 4 Changing Places including some in arts and culture venues. People with LD are supported to display their work in art galleries	1. What does the LA do to promote arts and culture for this group of people, any evidence of reasonably adjusted facilities? 2. How do libraries, museums and art galleries for example ensure that their cultural offer is accessible for	No additional evidence provided. This measure and C4 are new measures and it is harder to judge the ratings and greater scope for subjectivity. For example what is the difference between some, and numerous or extensive? The aim of the measure is to assess how mainstream local authority services meet the needs of people with LD. There is some evidence of arts and cultural activities and also evidence provided at panel that people with LD have been involved in the

				and museums. Two groups champion the rights of people with a LD through film and theatre production.	people with LD? 3. Is there evidence of some inclusive activities and any examples of good reasonable adjustments made to those activities to enable people with LD to participate?	discussion about the SAF and ratings. Although no evidence has been provided to address the gaps, the LDPB has approved the amber rating.
C4	**Sport and leisure**			A number of people with LD have been referred to the Hartlepool Exercise for Life Programme (H.E.L.P) Some people work on an allotment (WAG) Currently there is insufficient evidence to fully demonstrate the amber rating.	1. Is there a good range of sports and leisure buildings that are physically accessible, including for people with PMLD, for example are there some suitable Changing Places and full access to swimming pools? 3. Are there inclusion or enablement facilitators in post to help people to tackle barriers to participation in some areas of sport and leisure? If not how do you help people to do this? 4. Can you provide some evidence of reasonable adjustments made to facilities or to	This measure was discussed at panel. Is there anything strategic in engagement with adult services? – Work closely with the community activities network. This meets quarterly and opportunities for grants and bids are discussed. The issue about how services can meet the needs of people with LD has been raised by LD champions and this is now included in council tenders. In previous years there were opportunities to use LDDF to develop joint bids but this is no longer available.

					some sports and leisure activities to ensure that they are inclusive?	
C5	**Supporting people with LD into employment**			High percentages (compared to national average) of people with LD are in employment. (15%) Effective joint work and service level agreements between employment services and economic regeneration services. Involvement with NDTi and the Preparing for Adulthood SEND pathfinder work	1. What was your ASCOF target for LD employment and did you achieve it? 2. Can you provide evidence to demonstrate that there is a link between commissioning intentions and activity and employment? Noted that there are some commissioning intentions about employment in the JSNA which was provided as evidence for C7 3. You are clearly having success supporting people into employment and you have a range of exciting	Some further information about approaches to employment has been provided.

					initiatives such as the Roots to employment scheme. A joint apprenticeship scheme, job carving and job sharing approaches. Any information that you can provide about these initiatives that we can share in a good practice directory would be very welcome.	
C6	**Effective transition Single education health and care plan (not this year)**			Hartlepool is a SEND pathfinder and has plans to transfer all existing SEND statements onto a single EHC plan before September 2014. The CCG has been involved with the SEND reforms and there is CCG representation at the SEND panel to sign off plans No evidence provided of a well-established and monitored transition strategy, service pathways/transition protocols and multi-agency involvement.	To secure green You should focus on providing evidence of a multi-agency transition strategy and shared protocols and service pathways across health and social care. Can you provide evidence that you have transition services or functions and the way in which they are monitored or governed? For example you may have a transition team or transition social workers or an employment service working specifically with	Formal project established to develop SEN reform requirements with 7 work streams which is positive. Previously had separate Children's and Adult Teams but plans to co-locate. Commissioning post now working across both children and adults services. Website checked Transition pathway, protocol and procedures recently revised, Transition Operation Group is tracking young people within the system. TOG data updated quarterly to reflect new People coming into the system. Newly formed 0-25 disability team in place There is an action plan for children and young

				No evidence provided of specific transition services or functions. No evidence of joint health and social care scrutiny and ownership of transition. This may have been provided on the web link to the Hartlepool website; however the transition to adulthood page was empty.	young people in transition. How is transition "owned" and scrutinised across health and social care?	people with LD and learning difficulties and there is evidence on the website that progress on actions is recorded.
C7	**Community Inclusion and citizenship**			The JSNA recognises the importance of hate crime and there are a number of issues identified as improvement actions. The JSNA includes evidence derived from consultation with people with LD and family members No evidence provided of commissioning intentions or action plans that address the social inclusion and citizenship needs of people with LD including the support of friendship	Although social inclusion, citizenship, relationships and friendships have not been identified as priorities by the LDPB there may be evidence That you can provide to show that commissioning intentions or action plans do address them.	Panel discussed this measure. Good evidence of work on hate crime. PCC has knowledge of LD given past role in Council however there needs to be more evidence of the community safety needs of people with learning disabilities being reflected in mainstream improvement plans e.g. community safety and health and wellbeing strategies Safe transport project is also taking place Sub groups across the four tees localities and work together around the disability hate crime and successful prosecutions have been undertaken. The communication sub group has published accessible information.

				development and maintenance.		Accessible information available on the LA website about bullying. No additional evidence has been provided to demonstrate that there are commissioning plans or commissioning intentions in place, this is a requirement for amber. However, there are a number of services and initiatives that are in place that clearly address this agenda. For example a campaign to increase the number of people with LD who vote has been held, this addresses the citizenship agenda. New advocacy services are being commissioned There is a strong focus on employment and awareness that this is the main way that people will be able to move out of poverty and this has paid off with considerably higher than average figures of people with LD in employment. When developing commissioning plans this measure should be addressed.
C8	**Involvement in service planning and**			Hartlepool has used the methodology of Working Together for Change	Some really strong evidence of co-production used in a	Experts by experience, Voice for you have visited acute FT and provided feedback about A&T that will be used to improve services.

	decision making. Co – production			(WTFC) to review a number of services and develop some strategic plans. WTFC supports people who use services to co- produce strategic commissioning intentions including in Hartlepool the JSNA. Staff members have been trained to facilitate further reviews. Approximately 90% of adults with LD in receipt of adult social care have a personal budget. (In the JSNA it states that half of the people known to the LA live with families and that the majority of the other half live in residential or nursing homes, this does not appear to fit the statement that 90% receive a PB) No evidence provided that universal services use co production, this is a requirement for the green rating.	strategic way to influence commissioning intentions. Will you please clarify the statement that you made about the use of PB's? For green you need to be able to demonstrate evidence of co-production in universal services that the commissioner uses to inform commissioning practice.	There is a commitment to work with the pharmacy service in the same way.
C9	**Family Carers**			There is an up to date	Can you provide some	No additional evidence has been provided.

				Carers strategy “A multi-agency strategy for carers in Hartlepool 2011-2016, this was developed following consultation with carers. There is a carer led carer’s strategy group. The ASCOF ranked Hartlepool as one of the best performing Councils for support to Carers.	additional information to show how LD providers involve carers in service development and identify some improvements that have been made as a result?	Need to focus on this to provide evidence for the SAF 2014.

Appendix 2

What people with a learning disability told us at the quality assurance panel

- A person with a learning disability is a co-chair on the Learning Disability Partnership Board for Hartlepool. Health is one of the topics that are discussed at the board.
- There have been several pilot schemes within GP practices to review the practises from a learning disability perspective. Health Watch and 'Voice for You' trained 6 quality health checkers. They looked at the experience of people with a learning disability, access, information on display and easy read information. Changes such as wheel chair access have been made as a result of the reviews and a report of this work will be fed back to the CCG work streams.
- Quality checks of pharmacies are also planned.
- Research has taken place with Teesside University to review Dental services
- 'Voice for You' has carried out some tours of the Emergency Department to assist members who may have anyanxiety about hospital process.
- Jobs – A person with a learning disability has worked in the garden centre for 16 years. He has also been a volunteer worker for 27 years. He says that his friends are also in employment. Hartlepool promotes employment across the patch; they are in the process of working with the National Development Team for Inclusion (NDTi) to submit evidence about how they are reaching their target of 18% employment. They are currently at 15% (double the national average)
- Housing – choice around housing is promoted through social care support and assistive technology. Good support within the individual's network area. Hartlepool has a mapping system which mapsindividual's needs around the community.
- Leisure centres are wheel chair accessible and have changing places.

Report compiled by Lucy Hall and Janice Wycherley with administrative support from Kirsty Bell

Health and wellbeing boards: leading local response to Winterbourne View

A practical guide for health and wellbeing boards

July 2014

Key points

- Leading local response to Winterbourne View is an important role for all health and wellbeing boards, irrespective of whether the local area has inpatient care placements.
- Boards will want assurance appropriate person-centred, community-based services are in place to meet the needs of any local people in this vulnerable group; to limit problems arising, manage any problems that do arise, and prevent future institutional admissions.
- Assimilating the joint plan into the JSNA and JHWS process can have significant benefits.
- Approaches used for integrated working and joint commissioning, for example the Better Care Fund, may be relevant for other complex, multi-agency issues.

Health and wellbeing boards can play a significant role in leading local response to Winterbourne View – making a real difference by helping reshape local services to improve health outcomes for children and adults with learning disabilities and/or autism who have mental health conditions or behaviour that challenges.

The abuse scandal at Winterbourne View brought into focus the need to permanently transform care and support for people in this vulnerable group. Local partners need to be working together with a sense of urgency to find solutions that are right for each individual. Local leaders – working through their health and wellbeing boards – can play a crucial role as champions for progress.

At a glance

- **Audience:** This guide is aimed at all health and wellbeing board members, and in particular councillors and commissioners.
- **Purpose:** To provide practical information and guidance on the significant role health and wellbeing boards can play in leading local response to Winterbourne View.
- **Development:** This resource was developed by a working group including NHS Confederation, the Local Government Association, NHS England, Regional Voices and the Winterbourne View Joint Improvement Programme.

Supported by

Local Government Association

NHS CONFEDERATION

regional voices for better health

NHS England

There is an opportunity for health and wellbeing boards to not only help achieve a sizeable and permanent reduction in the numbers of local people who are inpatients in secure hospitals or assessment and treatment settings, but to create a lasting legacy of local, personalised, community-based support for individuals and their families.

Commitments in the Winterbourne View Concordat and Department of Health's Transforming Care report include:

- health and care commissioners to review all current placements and support those people inappropriately placed in inpatient / hospital settings to move into community-based support
- every area to develop a locally agreed joint plan for high-quality care and support, focused on prevention and sustainability, to reduce reliance on inpatient care for this group.

Background

Transforming care and support services for people with learning disabilities or autism, who have mental health conditions or behaviour that challenges, necessitates a significant shift in the planning and practice of local commissioners. The presumption should be that services are local and integrated around the needs of the individual, and that people remain in their local communities. This approach requires more focus on community-based services, prevention and early intervention. Health and wellbeing boards (HWBs) can play a significant role in leading local change.

Recent learning disability census data identified 3,250 people with a learning disability and/or autism with a mental health condition or behaviour that challenges, who are in secure hospitals or assessment and treatment settings. Many people in this vulnerable group have been inpatients for a long time: 60 per cent for a year or more, and 18 per cent for five years or longer.

Furthermore, around one in five inpatients are in units over 100km from home. For more information see: **www.hscic.gov.uk/catalogue/PUB13149/ld-census-initial-eng-sep13-rep.pdf**

Case study: Gavin's story

Gavin spent many years in assessment and treatment units between the ages of 20 and 35 years. With appropriate support he is now able to live independently in his own community. He has a community learning disability nurse who visits him once a month and uses a direct payment for nine hours of support each week, including help with housework, washing and cooking. Since 2011, Gavin has been a councillor for Selby Town Council. To read more about Gavin's story see: **www.local.gov.uk/web/guest/place-i-call-home/-/journal_content/56/10180/5969117/ARTICLE**

The Winterbourne View Joint Improvement Programme (WVJIP), led by the Local Government Association and NHS England, is working with and supporting local areas to transform services, building on and sharing current good practice. For more information on improvement activity and support options, see: **www.local.gov.uk/place-i-call-home** and **www.england.nhs.uk/ourwork/qual-clin-lead/wint-view-impr-prog/**

At the request of local areas, the WVJP has clarified and defined key individuals included within the remit of the programme, see: **www.local.gov.uk/place-i-call-home** and published status reports for each HWB area identifying progress across a number of key issues, including funding and commissioning. See: **www.local.gov.uk/place-i-call-home/-/journal_content/56/10180/5765518/ARTICLE**

Key questions health and wellbeing board members might ask

1. Does the board know how many local people in the vulnerable group are currently in hospital, within the local area and outside it; and does this number equate with the latest data available from NHS England?
2. Is the board aware of the planned discharge date for all vulnerable individuals, so as to ensure the required support is in place for their return to the local area?
3. Is the board working in a proactive, co-productive and collaborative way with individuals and their families, carers and advocates to identify and understand their assets, needs and priorities?
4. Will there be effective commissioning procedures and processes in place by June 2014 that will lead to a permanent reduction in the number of local vulnerable people in secure hospitals or assessment and treatment settings?
5. Will any individual on discharge from inpatient care be appropriately supported in a local, personalised, community-based setting?
6. Is the board exploring all possible integration and joint commissioning options to best deliver expanded and improved person-centred community provision?
7. Is there effective partnership working across the whole local system, including with providers, to provide appropriate local services to meet the identified needs and future anticipated needs of any local people in the vulnerable group?
8. Are appropriate services in place for prevention and early intervention for children, young people and families, including well targeted support for individuals at early risk?
9. Has the joint strategic plan been assimilated into the JSNA and JHWS process to enable a more strategic approach to commissioning services for children and adults in this vulnerable group?
10. Are there well developed, suitable and effective safeguarding procedures and processes in place locally, used appropriately?
11. Is the board clearly communicating what is being done to change how health and wellbeing services are designed and delivered?

Enablers for leading local response

This resource sets out five key enablers to guide HWBs in leading a robust and effective local response to Winterbourne View. Linked local case studies can be viewed in the appendix.

- Engaging with individuals, their families, carers and advocates
- Building a comprehensive understanding of assets, needs and priorities
- Encouraging change in commissioning behaviour
- Driving integration and coordination
- Delivering the joint strategic plan.

1. Engaging with individuals, their families, carers and advocates

Effective engagement with individuals, their families, carers and advocates, working in co-productive partnership in the planning, design, inspection and review of local community services is important. HWBs will want to ensure decisions are always made with an individual and their family's best

interests as the guiding principle. With a seat on the board, local Healthwatch has an integral role, but their efforts could be supplemented to achieve engagement more widely and deeply. Some local voluntary and community organisations are likely to have expertise in proactive and meaningful engagement. Local Learning Disability Partnership Boards (LDPBs), Autism Partnership Boards (APBs), and local mental health networks will have valuable knowledge that can be accessed. Community-based providers offer another helpful route to engagement. It will be beneficial to actively involve these local partners as local plans are developed.

> 'HWBs will want to ensure decisions are always made with an individual and their family's best interests as the guiding principle.'

To raise public confidence in the quality of health and care provision for people in this vulnerable group, the HWB will want to communicate what is being done to change how health and wellbeing services are designed and delivered and be transparent about progress. HWB can publish and share their stocktake, status reports, and local area plan for example, and provide updates on how services are developing and numbers of inpatients in this vulnerable group decreasing.

For more guidance, see appendix: *Case study 1: Facilitating the involvement of individuals, their families, carers and advocates, in Salford.*

2. Building a comprehensive understanding of assets, needs and priorities

To support development of the joint strategic plan, the board could be asking whether there is a comprehensive picture of the assets, needs and priorities of local people in this vulnerable group.

The views and stories of individuals, their families, carers and advocates are particularly valuable as they provide first-hand accounts of their needs and experiences. They can help reveal local assets and innovative ideas for how to provide more local, personalised, community-based support. Some local areas may have already undertaken a needs assessment specifically for people in this group, which is a useful resource. Joint Health and Social Care Learning Disability Self-Assessments were completed in every local authority area in 2013 and the development of local registers for all people with challenging behaviour in NHS-funded care was a key action of the Concordat. Local LDPBs, APBs and mental health networks can have considerable expertise that is helpful to access, as do specialist learning disability community teams, specialist autism teams and community mental health teams.

Future need

Anticipating future need can help achieve better person-centred strategic planning, particularly important at transition points. People with learning disabilities or autism are living longer, and more young people are anticipated to transfer from children's services with complex needs and behaviour that challenges. At the other end of the age spectrum, more people with a learning disability or autism are affected by dementia, potentially resulting in an increase in challenging behaviour with age. The health inequalities and high prevalence of co-morbidities experienced by people with learning disabilities should also be recognised in the planning and development of services.

Priorities

For the joint plan to be effective, boards might consider identifying a small number of key strategic priorities which will have the most impact. This might take into account the different type and complexity of individuals' needs, the needs of carers, evidence of what works, budget constraints, and what is possible to achieve and influence in terms of service delivery.

For more guidance, see appendix: *Case study 4: Using a dementia care pathway for people with learning disabilities in Northamptonshire.*

3. Encouraging change in commissioning behaviour

HWBs can improve outcomes for the group concerned by encouraging a significant change in local commissioning behaviour – to focus consistently on high-quality care, as well as placing increased emphasis on prevention and sustainable local care and support solutions across all age groups.

A strategic whole-system approach

HWBs can support a strategic whole-system approach to local commissioning. The development of the joint strategic plans could be assimilated into the JSNA and JHWS process, since these are based on continuous strategic assessment and planning.

Strengthening local capacity

To reduce dependency on hospital-based services, it is important that HWBs ensure local commissioners strengthen local capacity through provision of local, personalised care and support in the community. This might include infrastructure that enables independent living such as personalised day support, supported accommodation, and specialist clinical support including clinical psychology and psychiatry, and skilled community care staff. To expand capacity and choice, commissioners might also consider innovations in clinical care and treatment, including assistive technology, telecare and telehealth. Boards can support a whole local system approach, looking beyond the boundaries of conventional health and care services to meet the wider wellbeing needs and aspirations of the vulnerable people concerned – encompassing the opportunities, activities, resources and relationships available in their local communities. Care reviews for people in out-of-area placements also can provide valuable insight, particularly as to why the placements happened.

Some people may need access to assessment and treatment settings as part of their care pathway. To significantly reduce average 'inpatient' time, boards will want to ensure that where such services are commissioned they are time limited, as close to home as possible, focused from the point of admission on planning for discharge into the local community, and involve regular care reviews.

Prevention and early intervention across the life course

Commissioning services across the life course, which anticipate and prevent as well as manage care, can help achieve better health outcomes. How support is managed for children and young people has implications for the individual and their families later in life. Early identification of risk factors and proactive intervention can prevent challenging behaviour developing and limit or avoid crises. The development of local crisis intervention services can help ensure that when crises do occur, people are supported to remain in their community. Effective transition planning will help ensure continuity of support and stop people slipping through the net, especially when they move from child to adult services.

Safeguarding

Boards will inevitably be concerned that there are suitable, well developed safeguarding processes and procedures in place locally, and used appropriately. They will also want to ensure close partnership working with local safeguarding children and adult boards.

Working closely with providers

HWBs will want to have considerable influence on the delivery as well as commissioning of services to achieve the level of integration required for transforming care of people in the vulnerable group. This necessitates a more inter-cooperative relationship with providers whereby they are more actively involved in design and development, and work more closely

with commissioners to get the outcomes needed. New provider entrants and existing provider reform can help expand local capacity, and increase pace of change. For more information, see: *Stronger together: how health and wellbeing boards can work more effectively with providers* **www.nhsconfed.org/hwb**

For more guidance, see appendix: *Case study 2: Supporting vulnerable individuals to stay in their own homes in Dudley* and *Case study 3: Making use of personal budgets to support independent living in Trafford*.

4. Driving integration and coordination

Integrated working and funding across the whole local health and care system will be necessary to ensure rapid, effective expansion and improvement in person-centred, community provision.

> 'Pooling resources and aligning these with strategic priorities in the joint plan can release significant additional funding capacity.'

Links to wider work

Proposals in the joint strategic plan for addressing needs and priorities can set the foundation for joined-up commissioning and be used to support stronger service integration. Boards may see opportunities in joint financing arrangements that could better meet these needs and priorities.

Integrating personal budgets (social care) with new personal health budgets (NHS) for vulnerable service users could promote greater service integration at the level of the individual. Boards may also want to consider utilising new funding mechanisms for integrated work, including the Better Care Fund.

For more information, see: **www.local.gov.uk/integration-better-care-fund**

Pooling resources and aligning these with strategic priorities in the joint plan can release significant additional funding capacity. It may also need the transfer of resources from some existing services and the decommissioning of others, and perhaps development of shared services with neighbouring local areas. Such arrangements will need careful management. More formalised accountability mechanisms may be required. Boards could make use of new forms of governance to secure more effective resource use, such as linking joint commissioning plans to an overarching Section 75 agreement. The WVJIP can provide work to support more flexible financial arrangements; for more information see: **www.local.gov.uk/web/guest/adult-social-care/-/journal_content/56/10180/5615915/ARTICLE**

At different levels

HWBs will consider integration at several different levels: across funding organisations, including local authorities and the NHS (local health and specialised commissioning); across funding streams, such as criminal justice services; through coordinated care pathways across physical and mental health and wellbeing services; and on improving the transition between children's and adults' services. HWB may also wish to use existing work making links across regions where a cross or sub-regional response is required.

Build on existing work

There may be existing local integrated plans and care pathways based around particular work areas with this vulnerable group, e.g. pathways developed by the local LDPB or APB, or child and mental health services (CAHMS). In some local areas, liaison and diversion teams are being introduced to ensure people in this vulnerable group who are in prison or police custody have joined-up health care and support. These pathways can be used as a building block for closer integration

across wider services or to support maximisation of improved life outcomes from different parts of the system.

Working across HWB boundaries

Given likely low numbers of local people in this vulnerable group, and the highly specialised nature of some necessary care and support services, consideration might be given to working across HWB boundaries, e.g. undertaking a needs assessment jointly, sharing data, designing care pathways covering combined HWB areas to best meet needs, pooling resources to invest in shared specialist services to prevent inpatient admissions. For more information on HWBs working across boundaries, see: **www.nhsconfed.org/hwb**

5. Delivering the joint strategic plan

Alignment

Joined-up plans with consistent priorities and outcomes for this vulnerable group can strengthen coordination, prevent cross-purpose working, and avoid gaps or duplication across the whole local system. Alignment is important between the joint plan and other local assessments and plans.

A toolkit has been published by the Association of Directors of Adult Social Services (ADASS), designed to help local partners develop a local joint strategic plan, and to check that the right supports, services and reviews are in place. It also sets out key questions board members might ask to be assured appropriate local actions are being taken in response to Winterbourne View. See: *Getting Things Right: a response to Winterbourne View* **www.westmidlandsiep.gov.uk/index.php?page=863**

Oversight and accountability

Board members can use both 'soft' governance mechanisms, such as shared culture, common purpose and trust, and 'hard' mechanisms, to hold each other to account. The JHWS is the most important 'hard' mechanism and incorporating the joint plan within this process can have significant benefits. Overview and Scrutiny committees can be used to ensure understanding of the health and care needs of the vulnerable group concerned, that health inequalities experienced by them are being reduced, and health and care services are integrated around their needs. For further information, see: *A guide to governance for health and wellbeing boards* at **www.nhsconfed.org/hwb** and *Health and wellbeing boards: a practical guide to governance and constitutional issues* at **www.local.gov.uk/publications/-/journal_content/56/10180/3896494/PUBLICATION**

Again it will be important that HWBs communicate what is being done to change how services are being designed and delivered for this vulnerable group, and are transparent about progress.

Monitoring and reporting on outcomes

Boards will want to be assured that there are robust systems for monitoring performance as well as evaluating whether and how outcomes have changed as a result of what they are doing. Regular monitoring can enable early intervention when performance suggests quality standards or outcomes may suffer. Any monitoring like this may also involve the local authority's Overview and Scrutiny function.

To assess how the local area is doing, it will be important for HWBs to examine relevant data. NHS England publish a quarterly data collection for all NHS commissioners in order to help local areas monitor progress against the commitments outlined in *Transforming Care* and the *Concordat*. The data includes information about transfer arrangements for patients currently in inpatient care. See: **www.england.nhs.uk/2014/03/18/wvc-data/**

Additional resources for health and wellbeing boards

- The WVJIP has published a Core Principles document to support the commissioning of high quality and safe services which meet the needs of this group. See: **www.local.gov.uk/place-i-call-home/-/journal_content/56/10180/5971490/ARTICLE**
- The Government's Transforming Care report and Concordat outline the commitments by partners to improving care and support for people with learning disabilities and/or autism and behaviour that challenges following Winterbourne View, see: **www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response**
- The Winterbourne View Concordat outlines four key milestone dates for local areas, see: **www.local.gov.uk/place-i-call-home/-/journal_content/56/10180/6015966/ARTICLE**
- As part of the WVJIP, a stocktake of progress against the Transforming Care and Concordat commitments was completed by all local authorities with local partners, with an analysis of findings and good practice examples published in October 2013. For more information, see: **www.local.gov.uk/web/guest/adult-social-care/-/journal_content/56/10180/5615959/ARTICLE**
- Letter from Norman Lamb, Minister of State for Care and Support, to chairs of health and wellbeing boards, May 2013. See: **www.england.nhs.uk/wp-content/uploads/2013/05/130517-Letter-to-HWBs.pdf**
- Inclusion North has published a short guide on the various Winterbourne View reports. These resources may be helpful for local engagement work. Also included is a set of questions from the Yorkshire and Humber Family Carers Network that families and people with learning disabilities might want to ask local board members and commissioners. See: **www.inclusionnorth.org/resources/information-packs/winterbourne-view**

Further information

Email: hwb@nhsconfed.org
www.nhsconfed.org/HWB

NHS England Publications Gateway Reference: 01747
INF37801

HEALTH AND WELL BEING BOARD

Monday 1st December 2014

Report of: Director of Public Health

Subject: DUE NORTH –REPORT OF THE INQUIRY ON HEALTH EQUITY FOR THE NORTH

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 NON KEY

2. PURPOSE OF REPORT

2.1 This paper introduces a presentation regarding *Due North: the Report of the Independent Inquiry on Health Equity for the North* published on 15th September 2014.

3. BACKGROUND

3.1 *Due North* is the report of an independent inquiry, commissioned by Public Health England. Its aim was to provide further evidence on the socio-economic determinants of health and additional insights into health inequalities for the North of England (covering the North East, North West and Yorkshire and the Humber regions). Whilst *Due North* is from and about the North of England, the issues presented and the recommendations made will be of interest to every part of the country and indeed to the country as a whole.

The report builds on the *Marmot Review* focusing on the following three themes:

- a fair start for children
- the economy and welfare
- democratic and community empowerment

The report provides additional evidence on what actions are needed to tackle the underlying determinants of health on the scale needed to make a difference. It also sets out challenges to local areas, communities, businesses, councils, the health sector and national political leaders about potential actions they could deliver which could disrupt these persistent health inequalities.

4. Current state

4.1 That health inequalities exist and persist across the North of England is not news; but that does not mean that health inequalities are inevitable. In general, the causes of health inequalities are the same across the country; it is the severity of these causes that is greater in the North of England, and which contributes to the observed regional pattern in health.

5. Report Recommendations

5.1 *Due North* sets out four high level recommendations, as follows:

- tackle poverty and economic inequality within the North and between the North of England and the rest of England
- promote healthy development in early childhood
- share power over resources across the North and increase the influence that the public has on how resources are used to improve the determinants of health
- strengthen the role of the health sector in promoting health equity

Recommendations and underpinning supporting actions are aimed at two distinct groups: first, to policy makers and practitioners working within agencies in the North of England and secondly, to central government.

6. RECOMMENDATIONS

6.1 The Health and well Being Board note the content of the presentation and consider how to work with organizations such as Public Health England to implement the recommendations.

7. REASONS FOR RECOMMENDATIONS

7.1 Improving the health and well being of the population and reducing health inequalities is a key focus of the Health and Well Being Board.

8. CONTACT OFFICERS

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HEALTH AND WELLBEING BOARD

1 December 2014

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

Subject: **BETTER CARE FUND UPDATE**

1. PURPOSE OF REPORT

1.1 This report provides the Health and Wellbeing Board with an update regarding the assurance process for the Better Care Fund (BCF) and the outcome for Hartlepool, as well as an update on progress in relation to implementation.

2. BACKGROUND

2.1 NHS England Local Area Teams (ATs) and Local Government regional leads have worked with local areas to strengthen their BCF plans prior to resubmission on 19 September 2014.

Following resubmission of the BCF plans there was an intensive two week desktop review of plans, focused on:

- Overall review of narrative of plan
- Analytical review of data, trends and targets
- Financial review of calculations and financial projections

The feedback from Area Team and Local Government regional peers, and the outcome of the desktop review, has formed the basis of the assurance process prior to plans being recommended for approval by Ministers.

2.2 The Nationally Consistent Assurance Review (NCAR) process assessed plans as being in one of the following four categories:

Approved - the aim is for all plans to have reached this standard by April. Areas whose plans are 'Approved' following the NCAR process at the end of October will receive a letter to notify them of the result of the assurance of their plan and will effectively handover ongoing support and monitoring responsibilities from the Taskforce to NHS England.

Approved with support - Areas whose plans are in this category following the NCAR process at the end of October will receive a letter to notify them of

the result of the assurance of their plan and explain that there are some items of evidence or information that will need to be submitted to provide full assurance in order to move to the fully approved category. The letter will need to detail handover arrangements from the Taskforce to NHS England, and a relationship manager / point of contact from NHS England will be assigned to manage that process of receiving additional evidence and recommending they move to fully approved. This should be a straightforward and light-touch process and we would aim for all HWBs in this category to be fully approved before December.

Approved subject to conditions - Areas whose plans are in this category following the NCAR process at the end of October will receive a letter to notify them of the result of the assurance of their plan and explain that there are various conditions that have been imposed on them because of some substantial issues or risks in their plan without enough demonstration of how these will be mitigated. The letter will state that they will be restricted in implementation in terms of any intention to pool or commit resources now from next year's additional BCF pool through for example contracting for services. The letter will explain the ongoing responsibility of the Taskforce in terms of plan improvement support and final assurance of plans – and they will be assigned a single point of contact for this to help develop an action plan detailing how and by when they expect to meet the conditions, what support they might need, and agree the level of resubmission that will be require. The aim is to have these areas fully approved before January.

Not approved - Areas whose plans are in this category following the NCAR process at the end of October will receive a letter to notify them of the result of the assurance of their plan and explain that their plan is not approved and therefore they will not be able to progress to implementation until they address the risk areas highlighted through the NCAR and a revised plan is resubmitted. The letter will state that they will be restricted in implementation in terms of any intention to pool or commit resources now from next year's additional BCF pool through for example contracting for services.The aim is to have the results of the secondary NCAR assurance process in January, so they are approved in time to begin implementation.

3. OUTCOME OF THE ASSURANCE PROCESS

3.1 The outcome of the assurance process was announced on 30 October 2014.

3.2 The national picture was as follows:

- Approved 4%
- Approved with support 61%
- Approved with conditions 32%
- Not approved 3%

3.3 Hartlepool's plan was assessed as 'approved with support'.

4. NEXT STEPS

4.1 Work is underway to provide the additional evidence required in order to have the plan fully approved. This includes further detail in relation to risk sharing and contingency arrangements, agreement of a patient experience metric and some additional detail demonstrating how the various elements of the plan contribute to the delivery of the agreed outcomes. An action plan has been drafted and information is being gathered for submission to the Area Team by 28 November 2014.

4.2 Work has continued in parallel to the assurance process to ensure that the plan can be implemented from April 2015. A number of the developments in relation to low level support and improved dementia pathways have already been progressed. Further work has been undertaken in relation to the intermediate care element of the plan, including a range of clinical audits and a review of community nursing and the outcomes of this work will be considered in detail at a planned event on 27 November 2014 to further develop the model for an integrated intermediate care service.

4.3 There will be a further progress update provided to the Health & Wellbeing Board in January.

5. RECOMMENDATIONS

5.1 It is recommended that the Health and Wellbeing Board:

- Notes the outcome of the assurance process;
- Notes the further work being undertaken to progress implementation of the plan and receives further updates as detailed plans are developed.

6. REASONS FOR RECOMMENDATIONS

6.1 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.

7. CONTACT OFFICERS

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HEALTH AND WELLBEING BOARD

1st December 2014

Report of: HealthWatch Hartlepool

Subject: LOCAL HEALTHWATCH WORK PLAN 2014/15

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1. PURPOSE OF REPORT

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

2. BACKGROUND

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

2.2 The purpose of this work programme is to set out the activities, priorities and outcomes expected from Healthwatch Hartlepool in 2014/15. This will be delivered in conjunction with the Governance Framework, meetings of associated task & finish groups, public meetings and service specification.

3. PROPOSALS

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

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

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

4. EQUALITY & DIVERSITY CONSIDERATIONS

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

5. RECOMMENDATIONS

5.1 That the Board note the HealthWatch Hartlepool work plan 2014/15 and provide feedback where necessary.

6. REASONS FOR RECOMMENDATIONS

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

7. BACKGROUND PAPERS

7.1 Governance Framework and Communication & Engagement proposal

8. CONTACT OFFICER

Stephen Thomas - HealthWatch Development Officer
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36 Victoria Road
HARTLEPOOL. TS24 8DD

Work Programme 2014/15

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

The purpose of this work programme is to set out the activities, priorities and outcomes expected from Healthwatch Hartlepool in 2014/15. This will be delivered in conjunction with the Governance Framework, meetings of associated task & finish groups, public meetings and service specification and will build upon progress made during 2013/14.

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

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

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

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

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

Theme	**Objective**	**Time frame**
Acute Care	Conclude and disseminate the findings from our investigation into Hospital Discharge Procedures and associated patient experience.	November 2014
Acute Care	Investigate the quality and timeliness of service provision by the North East Ambulance Service to all categories from the perspective of patients and	November 2014 February 2015

	stakeholders	
Mental Health	Continue to work with the Hartlepool Mental Health Forum in closely monitoring the impact of ongoing reconfiguration of TEWV services areas such as Crisis and Community based services to ensure patient care and experience is maintained and improved.	Ongoing
Primary Health	Consult with GP's regarding to diagnostic and support procedures and practices relating to patients with signs of the onset of dementia.	January 2014 April 2015
Primary/Acute	Investigate the provision of Out of Hours Services in Hartlepool and in particular patient experience and pathways associated with out of hours care and treatment	December 2014 March 2015
Social Care	Look at the experiences of residents in care homes across Hartlepool who are experiencing the onset of dementia by means of a programme of enter and View visits.	September December 2014
Life Long conditions	Organise and host 4 seminars focusing on member led lifelong condition priorities.	November 2014 April 2015
Strategic	Continue to recruit, develop and support Board members with a view to having a fully functioning	Ongoing to April 2015

	shadow Shadow Board operational and in place.	
Strategic	Continue to apply and operate monitoring framework in line with service specification – Focus on quality	Ongoing
Strategic	Represent and contribute to strategic decision making across the borough. Examples of such: • Health & Wellbeing Board • Audit & Governance • Adult Services Policy Group • Clinical Commissioning Group • Vulnerable Adults Board • North Tees and Hartlepool Quality Standards Steering Group • North East Ambulance Service • Hartlepool Mental Health Forum	Ongoing
Strategic	Review Healthwatch Hartlepool Board, Executive and general work stream related meeting structures and patterns	Implementation by November 2014
Enter & View	Continue to review and develop member training &	Ongoing

	development requirements around their Enter and View role and activity.	
Training & Development	Develop, implement and deliver a robust and meaningful Induction Programme for Healthwatch Hartlepool Board members	September 2014 April 2015
Communication & Engagement	Continue to develop and deliver a comprehensive schedule of activity which will focus on developing engagement activity with seldom heard and hard to reach groups including - • Engaging with local communities • Understanding stakeholders in the community • Mapping outreach • Collating patient stories • Effective outreach • Analysis and reporting • Joint ICA/Healthwatch Surgery • Introduce Healthwatch Community Champions • Annual General Meeting	Ongoing
Communication & Engagement	Promote the work of Healthwatch with the wider	Ongoing

community: • Further develop the Healthwatch Hartlepool Website • Examine use of social media to enhance engagement with children and young people • Monthly newsletters • Press releases • Input into the HBC Social Care Local account • Annual report	

Workplan:-

Appendix A:

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

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

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

Consider other options/information

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

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

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

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

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

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

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

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

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

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

Inclusive-We will be inclusive by:

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

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

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

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

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

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

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

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

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

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

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

HEALTH AND WELLBEING BOARD

Monday 1st December 2014

Report of: Director of Public Health, Director of Child and Adult Services, Chief Officer Hartlepool and Stockton Clinical Commissioning Group and Director of Operations and Delivery, NHS England

Subject: The NHS Five Year Forward View (5YFV)

1. PURPOSE OF REPORT

1.1 The purpose of this report is to introduce a document summarizing the key issues in The NHS Five Year Forward View (5YFV) published on 23rd October 2014.

2. BACKGROUND

2.1 The NHS Five Year Forward View (5YFV) describes the collective view of NHS England, Public Health England, Monitor, the NHS Trust Development Authority, the Care Quality Commission and Health Education England on why change in the NHS is needed, what that change might look like and how it could be achieved. This paper summarises what is already a fairly succinct document (with an executive summary) and outlines the potential implications for the Durham, Darlington and Tees Area Team and the NHS organisations within that geographical footprint.

3. REPORT

3.1 The report attached covers the following areas:

- Public health and prevention
- Greater patient control
- New models of care
- Enabling work
- Financial perspective
- Local implications.

4. RECOMMENDATIONS

4.1 It is recommended the Board note the content of the report.

4.2 It is recommended the Board considers the local implications of this report with a view to undertaking work on various scenarios across all organisations.

5. REASONS FOR RECOMMENDATION5

5.1 This report will inform the future planning and commissioning of health services across all Health and Well Being Board partners.

6. BACKGROUND PAPERS

6.1 None

7. CONTACT OFFICER

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NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group

The NHS Five Year Forward View

1. Background

The NHS Five Year Forward View (5YFV) was published on 23 October 2014. It describes the collective view of NHS England, Public Health England, Monitor, the NHS Trust Development Authority, the Care Quality Commission and Health Education England on why change in the NHS is needed, what that change might look like and how it could be achieved. This paper summarises what is already a fairly succinct document (with an executive summary) and outlines the potential implications for the Durham, Darlington and Tees Area Team and the NHS organisations within that geographical footprint.

2. The key proposition

The key proposition in the 5YFV is that it is possible to maintain a financially sustainable NHS without contraction of the current scope of services. It describes how the predicted funding gap can be closed by addressing the current gaps in care, quality, health and wellbeing. To do so, the 5YFV argues that this can only be achieved by a combination of local action, in managing demand and introducing more efficient services thus reducing the amount of funding the service will require and national action by increasing the current forecast allocation (thus closing the remaining funding gap).

2.1 Local action

The 5YFV argues that the following approaches must be taken if local services are to close the care and quality and health and wellbeing gaps that will make the service more efficient:

- A "radical upgrade" in prevention and public health.
- Patients gaining far greater control of their own health care.
- The NHS breaking down the barriers in how care is provided.

These actions will be supported by much greater engagement of communities, recognition of carers and a range of enabling activities.

2.2 Public Health and prevention

The 5YFV describes a lost decade since the Wanless Report[1] which outlined the need for much greater emphasis on public health and prevention of unnecessary illness (which then requires more expensive treatments). By particularly focusing on reducing smoking, levels of obesity and inactivity, harmful drinking and poor child health, we can reduce the health and wellbeing gap and reduce the treatment burden on the NHS. This needs to be a shared agenda between the public health functions of local authorities and through secondary prevention in the NHS.

2.3 Greater patient control

Patients will be given much greater control of their care through a combination of having better information (see the enabling activities section), more support to manage their own care and more say over where and which care they receive (with financial mechanisms that support this such as Integrated Personal Care budgets).

As the population ages and develops more long term conditions, the already critical role of carers will become more and more vital. The NHS, working in partnership with local authorities and the voluntary sector, will need to do much more to identify and support them, particularly the most vulnerable i.e. young carers and the elderly who are carers themselves. The NHS will make it easier for voluntary and charitable organisations that support patients and carers to access funding through shorter, simpler alternatives to the NHS Standard Contract currently used.

By giving patients greater control and support, patients with conditions such as dementia will have services that work for them as individuals. The 5YFV also supports greater volunteering (as opposed to voluntary organisations) of individuals who are currently working across a range of services and the role of the NHS as a leader of change and a significant employer itself.

2.4 New models of care

Whilst there is a commitment to a list-based primary care service continuing as the foundation of the NHS (albeit with a “New Deal” of additional investment in primary care services, increased numbers of GP in training and widened control of the NHS budget for clinical commissioning groups), the 5YFV opens the door to the introduction of a range of new models of care.

[1] http://webarchive.nationalarchives.gov.uk/20130129110402/http://www.hm-treasury.gov.uk/consult_wanless04_final.htm

These models of care will work across (and breakdown) traditional barriers – either between health and social care, between primary and secondary care or between physical and mental health care providers.

These new models include:

- Multi-specialty Community Providers (MCPs). Building on the role of GP as "expert generalist", this model will allow extended group practices to come together, employing a wider range of health and social care professionals (including consultants, community and mental health staff and social workers). These MCPs could begin to provide alternative locations for outpatient and ambulatory care services outside of traditional hospital settings, even in some cases taking over community hospitals to take on more services (e.g. diagnostics and chemotherapy). Ultimately these groups could take on delegated responsibility for managing the budgets of their patients.

- Primary and Acute Care Systems (PACS). The PACS model sees the "vertical integration" of primary and acute services, allowing hospital providers to provide general practice services with their own registered lists. Ultimately this could see a PACS service become an accountable care organisation (ACO) working with a capitated budget for its population.

- Re-designed urgent and emergency care services. The Urgent and Emergency Care system will be simplified and strengthened by creating stronger, linked specialist emergency centres, urgent care centres, community and primary care alternatives (working with the wider primary care such as community pharmacy) underpinned by a coordinating clinical triage and advice service. These services with be fully integrated with mental health crisis services and be available seven days a week.

- New opportunities for smaller hospitals. The 5YFV offers a role for viable smaller hospitals in the future. It clearly states that these smaller hospitals should not be providing complex acute services where there is evidence that high volumes are associated with quality of care. It does however argue that smaller hospitals (with new financial mechanisms and new staffing models) can continue to provide services as part of a hospital chain, having some services provided on-site by a different specialised provider or vertically integrating with community and primary care services (as described in the PACS model above).

- Specialised care. There is evidence that concentrating care can lead to improvements in patients outcomes. The 5YFV describes a three year rolling programme of reviews that will look to develop networks of services across geographies supported by delegated budgets or prime contract arrangements.

- Maternity services. The 5YFV outlines a review of future models of maternity services (to be completed in summer 2015) that supports women to make the best choice of place of birth and allows midwives to make best use of their skills.

- Enhanced care in care homes. In partnership with local authorities, and building on the better care fund, locally-led work with the care home sector will develop new models of in-reach support services that will help improve the quality of life and reduce hospital utilisation.

The 5YFV is clear that a national "one-size-fits" all approach to the implementation of these models will not work, with each area needed to reflect its individual circumstances. Neither however does it support letting "a thousand flowers bloom".

The NHS will work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop:

- Detailed prototyping of each of the new care models described above, (together with any others that may be proposed that offer the potential to deliver the necessary transformation)

- A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models

- National and regional expertise and support to implement care model change rapidly and at scale.

- National flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models.

- Design of a model to help pump-prime and 'fast track' a cross-section of the new care models.

2.5 Enabling work

This work will be underpinned by a range of enabling activities:

- Alignment of reporting and interventions regimes across Monitor, the TDA and NHS England
- Workforce development led by Health Education England to development new roles and identifying education and training needs
- Improved health technology and information such as more transparent performance data, expanding accredited health "apps", developing fully interoperable electronic health records and bringing together audit data
- Accelerating innovation by cutting costs on randomised control trials, expansion of the Early Access to Medicines and Commissioning Through Evaluation programmes, developing "test-bed" sites for combinations of health innovations and exploring the development of health and care "new towns", amongst other things

3. The financial perspective

The 5YFV argues that:

- By maximising prevention and public health, demand for hospital services will be moderated (over a number of years)
- That through a combination of "catch up" (levelling up of providers to those that are most efficient) and "frontier shift" (implementing new care models and introducing technological advancements) then up to 3% efficiency may be released. This will not be realised in year one and would require pump-priming investment (potentially from FT surpluses and sale of excess land and estate) to support transformation.
- That additional funding would need to be found to close the remaining funding gap.

Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way as described by three funding scenarios.

These three scenarios are:

- Scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion.

- Scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion.

- Scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21.

4. In summary

In summary, the 5YFV offers a route-map to a financially sustainable, tax funded NHS which is free at the point of use achieved through the re-shaping of the current health service landscape.

5. Local Implications

Clearly the 5 year forward view offers opportunities to consider the preferred local scope and shape of services. The Health and Wellbeing Board has recently considered and agreed through the Better Care Fund (BCF) planning process, a system wide vision for local health and care services that is consistent with the local approaches described in section 2.1. Work has already commenced in relation to reshaping urgent care services, supporting enhanced care in residential and nursing homes and in enhancing the quality of primary care provision, as part of the BCF and the Clinical Commissioning Group's Clear and Credible (commissioning) Plan and supporting strategies that have been informed by public engagement processes during the last year.

Local NHS leaders with key partners such as Hartlepool Borough Council, voluntary and third sector organisations and the public, will need to consider the preferred model of service provision that will provide the best 'fit' to meet local health and care needs and deliver the best and most sustainable outcomes for local people.