HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

22 June 2015

10.00 am

Committee Room B, Civic Centre, Hartlepool

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors C Akers-Belcher, Richardson, Simmons and Thompson.
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) – Sally Robinson
Representatives of Healthwatch (2). Margaret Wrenn and Ruby Marshall

Other Members:
Chief Executive, Hartlepool Borough Council (1**)** – Gill Alexander
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council (1) – Denise Ogden
Representative of the NHS England (1) – Vacancy
Representative of Hartlepool Voluntary and Community Sector (1) – Tracy Woodhall
Representative of Tees, Esk and Wear Valley NHS Trust (1) – Martin Barkley
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster
Representative of Cleveland Police, ACC Simon Nickless.

Observer – Statutory Scrutiny Representative, Hartlepool Borough Council (1)

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

3.1 To confirm the minutes of the meeting held on 2 March 2015

4. **ITEMS FOR DECISION**

4.1 Joint Mental Health Implementation Plan and Mental Health Update (*Director of Child and Adult Services)*

4.2 Quality Premium 2015/16 *(Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group)*

4.3 Tees Wide Suicide Prevention Implementation Plan 2014-16 (Director of Public Health)

4.4 Scrutiny Investigation into Dementia: Early Diagnosis – Final Report and Action Plan *(Director of Public Health and Director of Child and Adult Services)*

4.5 Better Care Fund Performance Reporting (*Director of Child and Adult Services, HBC and Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group)*

5. **ITEMS FOR INFORMATION**

5.1 Community Based Urgent Care Update – June 2015 (*Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group)*

5.2 Annual Review Health Status Presentation (*Director of Public Health)*

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

Date of next meeting – Monday 3 August 2015 at 2.00 p.m. at the Civic Centre, Hartlepool.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

2 March 2015

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:
Elected Members, Hartlepool Borough Council – Councillors Carl Richardson and Paul Beck as substitute for Chris Simmons
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
Representatives of Healthwatch – Margaret Wrenn and Lynn Allison as substitute for Ruby Marshall

Other Members:
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council – Denise Ogden
Representative of the NHS England – Ben Clark
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster

Observer – Statutory Scrutiny Representative, Hartlepool Borough Council (1) – Councillor George Springer.

Also in attendance:-

Director of Balance, North East Alcohol Office - Colin Shevills,
Pharmaceutical Adviser, Tees Valley Public Health Shared Service - Philippa Walters
Elected Member, Hartlepool Borough Council - Councillor Jim Ainslie,
Health Improvement Practitioner (drugs and alcohol), Hartlepool Borough Council - Sharon Robson,
Representatives of Healthwatch – J Gray, S and G Johnson.

Officers: Joan Stevens, Scrutiny Manager
Amanda Whitaker, Democratic Services Team

46. Apologies for Absence

Elected Member, Hartlepool Borough Council – Councillor Chris Simmons
Representative of Healthwatch – Ruby Marshall
Chief Executive, Hartlepool Borough Council – Dave Stubbs
Director of Child and Adult Services, Hartlepool Borough Council – Gill Alexander
Representative from Tees, Esk and Wear Valley NHS Trust – Martin Barkley

47. Declarations of interest by Members

None.

48. Minutes

The minutes of the meeting held 12 January 2015 were confirmed.

In relation to Minute 39 – HealthWatch Hartlepool Hospital Discharge Investigation - it was agreed that the HealthWatch report be referred to the Council's Adult Services Committee. The Chairman advised that a meeting was to be held between HealthWatch and the North Tees and Hartlepool Foundation Trust.

49. Pharmaceutical Needs Assessment 2015 (*Director of Public Health*)

The Board's approval was sought of the final draft version of the Hartlepool Pharmaceutical Needs Assessment (PNA) 2015. The report set out the background to the Health and Wellbeing Board's statutory responsibility to publish and keep up to date a statement of needs for pharmaceutical services for the population in its area, referred to as a 'Pharmaceutical Needs Assessment' (PNA). Engagement and consultation (including statutory consultation) had been undertaken on the draft PNA, details of which were outlined in the report. A copy of the Board's response to the formal consultation had been included in the final draft of the PNA and had been appended to the report submitted to the Board. The consultation process had identified key areas of change and additional recommendations. Without prejudice to the full content of the PNA, the summary conclusions were presented in the report.

A representative of Hartlepool and Stockton-on-Tees Clinical Commissioning Group referred to the 'minor ailments' service and requested that the current wording that the service "is a necessary pharmaceutical service for at least some conditions and/ or some locations in Hartlepool where the needs of the population are greatest" be changed to reflect the service being desirable.

The Board was advised that in accordance with the Regulations, the Hartlepool PNA would be updated as a minimum every three years, however

notifications and Supplementary Statements had to be approved and published as required in the intervening time.

The representative from the Tees Valley Public Health Shared Service provided an assurance that the process undertaken to produce the PNA had been completed in line with the Board's statutory duty and the PNA had to be published before 1 April 2015. The representative also responded to a query from an Elected Member regarding the feedback from the consultation process.

The Chief Executive of North Tees and Hartlepool NHS Foundation Trust undertook to discuss issues relating to the provision of palliative care drugs to the Hartlepool and District Hospice with colleagues at the Foundation Trust.

Decision

The final version of the Pharmaceutical Needs Assessment was approved for publication on the Tees Valley Public Health Shared Service website before 1st April 2015 subject to changing the categorisation relating to minor ailments to desirable.

It was agreed to delegate authority to the Director of Public Health (in conjunction with the Chair of the Board, to approve as required.

- publication of minor errata/ service updates as on-going notifications that fall short of formal Supplementary Statements to the PNA (for example changes of ownership, minor relocations of pharmacies, minor adjustments to opening hours and service contracts that do not impact on need).
- any response on behalf of the Hartlepool HWB to NHS England (42 day) consultation on applications to provide new or amended pharmaceutical services, based on the PNA.

The Board acknowledged its responsibility for maintenance of the PNA including the need to assess on-going changes which might impact on pharmaceutical need and the assessment thereof and respond by initiating early review or publishing a Supplementary Statement to the 2015 PNA as required.
It was agreed to delegate authority to the Director of Public Health and Chair of the Board to make initial assessment with respect to potential Supplementary Statement or need for full review.

50. Minimum Unit Price for Alcohol – Referral from Council (*HBC Director of Public Health*)

The report provided the background to the Council's aspiration to establish a Minimum Unit Price (MUP). A representative from Balance was in attendance and provided a detailed and comprehensive presentation outlining the national position in on 'MUP – an exquisitely targeted policy'. The presentation outlined the problems associated with the consumption of alcohol along with the UK mortality trends and the affordability that drives the problem. Figures were provided on the consumption of alcohol by income group and highlighted that the heaviest drinkers buy the cheapest alcohol.

The presentation provided an outline of the benefits of MUP at 50p along with the percentage of English population to benefit as well as the effects on the total mortality reduction. The presentation concluded that an Exquisitely Targeted Policy would need to be aimed at the right products, the right market and the right people. The representative indicated his intention to submit a future paper to the Board in relation to the legal advice provided and the other options that may be available for consideration. The Chair advised the Board that at a recent meeting of Council it had been agreed that he would request the consideration of the Board in relation to whether an invitation would be extended to Members and Legal Officers from Manchester City Council with reference to their Minimum Unit Price considerations.

Board Members were advised that a group had been established in the north-west to consider MUP issues including cross boundary effects and to consider if the introduction of byelaws is appropriate/effective. With the approval of the Board, the Chair agreed to write to the group to advise that this Board was content to send a representative to be involved in that group. The Chair suggested also that it could be appropriate to refer the issue to the Association of North East Councils.

Decision

(i) It was agreed that the Chair write to the Chief Executive of Sefton Council as Chair of the North-West Councils Group on MUP to advise that this Board wishes to engage with the Group with the aim of establishing links to share and learn from each other in terms of how best to progress MUP in the absence of a national policy on this and to advise that the Board would be willing to be represented on that Group by the Chair of this Board.

(ii) It was agreed that the issue of MUP be referred to the Association of North East Councils to seek a view on each of the Councils on this issue.

(iii) It was agreed that a copy of the presentation be circulated to all Members of the Health and Wellbeing Board.

51. Implementation of the Special Educational Needs and Disability (SEND) Reforms (*HBC Assistant Director, Children's Services*)

The report provided the background to the implementation of the SEND reforms. It was noted that the Local Authority reported on the progress in implementing the reforms to the Department for Education through an Implementation Survey and regular contact with a DfE Adviser. The most recent visit from the DfE had been undertaken on 13 January 2015 to meet with stakeholders and details of the progress made were detailed within the report. It was noted that a multi agency steering group was in place to oversee the implementation of the reforms and reported to the Joint Commissioning Executive sub-group of this Board.

Decision

The Board recognised the significant progress made in implementing the SEND Reforms and agreed that all agencies should use the current momentum for change to further develop the cultural shift towards personalisation and the improved outcomes for children and young people with SEND.

52. Clinical Commissioning Group – Operational Plan (*Chief Officer, NHS Hartlepool and Stockton on Tees CCG*)

The report provided an overview of the NHS planning guidance issued in December 2014 for NHS commissioners, entitled 'The Forward View into Action: Planning for 2015/16 which built upon the vision set out in the 'NHS Five Year Forward View'. The report also provided the Health and Wellbeing Board with an overview of progress to date and constraints to determining local ambition indicator(s) noting that the CCGs operation plans were required to be submitted to NHS England by 10 April 2015. Further detail was included on the challenge for the NHS to deliver high quality care within available resources..

The Chief Officer, NHS Hartlepool and Stockton on Tees Clinical Commissioning Group advised the Board that outcome measures had not yet been received to enable discussion with the Board. It was confirmed that draft plans were being developed and that the CCG was committed to continuing developing dementia care as set out in the report. If there was an opportunity for further development that would be submitted to the Board. However if timescales precluded a further report being submitted to the Board, the authority of the Board was sought to allow discussions to be held with the Chair in order to determine how issues should be addressed.

The Chair highlighted reference in the report to creating new models of care

and suggested that following the Dalton Review, it would be appropriate to submit a report to the Board. The Chief Officer undertook to submit reports to the Board periodically.

Decision

The Board noted the timescales, approach and the requirements of the planning guidance.

53. Primary Care Co-Commissioning (*Chief Officer, NHS Hartlepool and Stockton on Tees CCG*)

Further to minute 45 of the meeting held on 12 January 2015, the report provided an overview of the current primary care co-commissioning guidance, outlined the CCG Council of Members decision in progressing this and shared the CCG's application to NHS England for Joint Commissioning arrangements from 1 April 2015 together with draft Terms of Reference for the Joint Committee. Also provided was the background to the submission of expressions of interest for the co-commissioning of primary care with the overall aim to harness the energy of CCGs to create a joined up, clinically led commissioning system to deliver seamless, integrated out-of-hospital services based around the needs of local populations. The following three models of co-commissioning were outlined in the report:

Model 1 – Greater Involvement;
Model 2 – Joint Commissioning; and
Model 3 – Delegated Arrangements.

The Board was advised that guidance and standardised models, including opportunities and risks, had been discussed in detail with the Council of Members at their meeting on 6 January 2015. An impact and risk assessment had been fully considered and it had been agreed that Model 2, Joint Commissioning, was the preferred option for 2015/16, as it would enable the CCG to further consider their plan and implementation strategy and better understand the potential finance and resource risks of moving to the fully delegated model. The CCG had submitted an application to NHS on 30 January 2015 [submitted as Appendix C] together with draft Terms of Reference for the Joint Committee [submitted as Appendix D].

It was noted that the CCGs in the north east were currently discussing roles and responsibilities for the Joint Committees with NHS England, with a view to the Terms of Reference being agreed by the end of March 2015, in preparation for implementation on 1 April 2015.

It was highlighted that a local Healthwatch representative and a local authority representative from the local Health and Wellbeing Board would have the right

to join the delegated committee as non-voting attendees. The Chair advised that, subject to the approval of the Board, he would be content to be the Board's local authority representative on the Joint Committee.

Decision

The Board noted the report and agreed that a local authority representative should attend the Joint Committee.
It was agreed that the Chair of the Board be appointed the local authority representative on the Joint Committee.

54. COPD Screenings (*HBC Scrutiny Support Officer*)

The report referred to the Audit and Governance Committee's investigation into Chronic Obstructive Pulmonary Disease and the associated action plan. Further detail was included on the impact/progress of the Action Plan along with a Public Health report in relation to COPD screenings. Further background was provided on the uptake, impact and variation of the COPD screening service provided by GP surgeries.

Decision

The progress of the COPD recommendations and action plan was noted.

55. 38 Degrees – Petition for Re-opening Hartlepool A & E (*HBC Scrutiny Manager*)

The report informed the Board that a copy of a petition sent to the Secretary of State calling for the re-opening of Hartlepool A&E had been received by the Leader of the Council; details of the content of the petition was included in the report.

The Chair indicated that he would write to the petitioner on behalf of the Board advising that the petition had been noted and that the issue had been referred to the Secretary of State.

The Board was advised by the Chair that he would feedback to the next meeting of the Board on the outcomes of the future meeting with the Secretary of State for Health.

Decision

(1) The petition was received and it was noted that this had been sent to the Secretary of State.

(2) The Chair to write to the petitioner advising that the petition had been noted by the Board.
(3) Feedback on the future meeting with the Secretary of State for Health would be submitted to the Board in due course.

56. Membership Request (*Chief Executive*)

The report sought consideration of a membership request received from Cleveland Police seeking a position on the Health and Wellbeing Board for a senior officer from Cleveland Police to 'enable stronger strategic joint working and the enhancement of preventative activity to support our communities'.

The Director of Regeneration and Neighbourhoods supported this request as a representative from the Safer Hartlepool Partnership.

Decision

That the membership of the Health and Wellbeing Board be amended to included a Senior Officer representative from Cleveland Police as a non-prescribed member and the Chair write to Cleveland Police advising of the Board's decision and to seek a nomination in respect of the Police representative.

57. Obesity Conference Feedback (*Director of Public Health*)

The report provided detailed feedback on the obesity conference 'Healthy Weight, Healthy Life – Tackling Obesity in Hartlepool' which was held on 3 February 2015. After the event, 26 evaluation forms had been completed and the results were outlined in the report. Details of specific comments received as part of the evaluation were attached at Appendix A which highlighted that the input from Hartlepool young people of a video and dedicated workshop being well received. It was noted that a significant amount of information and evidence had been obtained from the 'cafe' session and workshops held.

A small Officer group had been created to work with the Joint Commissioning Executive on the development of the Hartlepool Childhood Obesity Strategy which would be presented to the Health and Wellbeing Board for comment and approval at its first meeting in the new municipal year. Following this, a full action plan would be produced to monitor progress against the identified aims and assigned actions.

The Director of Public Health added that the conference would contribute positively to the development of a Childhood Obesity Strategy including the consideration of pathways and the individual roles of GPs and primary care.

Decision

The feedback on the Obesity Conference was noted along with the timescale for the preparation of the Strategy.

58. 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.

59. Any Other Business – Land at Hospital Site, Holdforth Road (*Chief Executive, North Tees and Hartlepool NHS Foundation Trust*)

The Chief Executive, North Tees and Hartlepool NHS Foundation Trust, referred to discussion at a recent Council meeting in relation to the Hartlepool Local Plan in the context of safeguarding the existing University Hospital of Hartlepool site for hospital and health related use. The Chief Executive took the opportunity to request some flexibility in the context of the land at the hospital site in Holdforth Road which he stressed continued to be in the ownership of the Trust. The 5 year forward view outlined the different models of care to be provided. He added that the position of the Trust continued to be a new hospital but also need work with Local Authority. It was highlighted that Hartlepool Hospice would need to consider how best to utilise their site. The Chief Executive added that even if health services were to be relocated back to this site, there was more land than would be required and a plea was made for flexibility to secure private investment for any unused part of the site in the form of private investment to enable the further development and investment in health services elsewhere.

The Chair clarified the motion submitted to Council indicating that Officers would liaise with all health partners to ensure the best outcome was achieved adding that the information provided at this meeting would be forwarded to the Planning Team.

Decision

The Chair agreed to feedback the issues, which had been highlighted at the Board meeting, to the Council's Planning Team.

Meeting concluded at 10.50 am

CHAIR

HEALTH & WELLBEING BOARD

22 June 2015

Report of: Director of Child & Adult Services

Subject: JOINT MENTAL HEALTH IMPLEMENTATION PLAN & MENTAL HEALTH UPDATE

1. TYPE OF DECISION / APPLICABLE CATEGORY

1.1 Non key decision.

2. PURPOSE OF REPORT

2.1 To seek approval from the Health & Wellbeing Board for the Joint Mental Health Implementation Plan 2015 -2108

2.2 To provide an update on a number of key reviews of mental health services.

3. BACKGROUND

3.1 A number of key framework documents have been produced in recent years that relate to mental health services. These documents aim to support improvements in mental health across all sectors and are heavily influenced by social inclusion perspectives.

3.2 Key documents include (but are not limited to) the following:-

- **NHS Outcomes Framework** - Improving experience of healthcare for people with mental illness
- **Adult Social Care Outcomes Framework** – people who use services are satisfied with their care
- **Public Health Outcomes Framework 2013/16** – Suicide rates
- **No Health without Mental Health 2011** – most people will have good mental health
- **Closing the Gap** – improved access to psychological therapies
- **Crisis Care Concordat 2014** – Access to support before crisis point

4. SCOPE

4.1 The Hartlepool Mental Health Forum, chaired by Hartlepool Healthwatch, aims to promote collaborative working across statutory, private and voluntary sector organisations in partnership with people who use mental health services, their carers and families

4.2 The Forum set up a task and finish group led by representatives from Hartlepool Borough Council and the Hartlepool & Stockton on Tees Clinical Commissioning Group (CCG) to support the development of a local Mental Health implementation plan.

4.3 During the summer of 2014 a Working Together for Change public engagement event was held which sought views from key organisations, people who use services, carers and commissioners.

4.4 The attached Joint Mental Health Implementation Plan for 2015-18 (see **Appendix 1**) was co-produced with the CCG. The plan incorporates the key national and local mental health outcomes and the action plan will be refreshed annually to demonstrate progress and reflect any changing national and local priorities.

5. METHODOLOGY

5.1

July 2014	Formulation of a Task & Finish Group
Sep 2014	Engagement and co-production of local plan
Oct 2014	Draft plan produced for consideration
Feb 2014	Agreement by Clinical Commissioning Group (CCG)
Mar 2015	Approval by Adult Services Committee
	Referral to Health & Wellbeing Board for approval and monitoring

6. PUBLIC ENGAGEMENT

6.1 As previously reported the plan was co-produced using feedback from the Working Together for Change Event in September 2014 and core members of the Hartlepool Mental Health Forum.

6.2 The Plan describes the national drivers, key deliverables and demographic pressures on the local community and uses the outcomes of the public engagement event as the basis to formulate an action plan.

7. SECTOR LED IMPROVEMENT

7.1 As part of Sector Led Improvement within the North East ADASS Region all Councils agreed to the Local Government Association (LGA) undertaking a Peer Challenge within adult social care over a three year period.

7.2 Hartlepool Borough Council's Peer Challenge took place in November 2014 and was focused on mental health services.

7.3 The Peer Challenge took place over a three day period and considered the following:

- the delivery of mental health social care services by the Council within the current partnership arrangement, to ensure that people utilising mental health services are in receipt of high quality, timely, and accessible social care.
- current achievements and any opportunities to improve the design and / or delivery of these services.
- helping the Council ensure that, wherever Social Workers are managed, the optimum infra-structure is in place to ensure that their role achieves the best possible social care outcomes for people with mental health problems.

7.4 Hartlepool Borough Council operate their adult mental health social care services under a s75 partnership agreement with Tees Esk and Wear Valleys NHS Foundation Trust (TEWV). TEWV is a large provider of acute, community and specialist mental health and learning disability services, operating over several local authority areas. In Hartlepool, social care staff have worked for 10 years in Integrated Community Mental Health Teams, managed and located within the Trust.

7.5 As part of the Peer Challenge, a team of experts from other areas of the country (including an Elected Member Peer, a Health Peer and a number of Senior Officer Peers from other local authorities) met with a range of stakeholders to discuss their experiences of services. Those interviewed included managers, frontline staff, people who user services and carers, service providers, commissioners and representatives from HealthWatch and the voluntary and community sector.

7.5 Recommendations from the review team were based on a triangulation of what they had read, seen and heard. Using existing materials, interviewing staff and using feedback from focus groups, they were able to scrutinise the delivery of mental health services focusing on the current partnership arrangements with Tees Esk & Wear Valley NHS Foundation Trust.

7.6 The review focused on 3 key themes; service delivery, working together and vision, strategy and leadership and for each area the team identified key strengths and areas for consideration as summarised below:

	Service Delivery	**Working Together**	**Vision, Strategy and Leadership**
Key Strengths	Benefits of integration recognised and supported at all levels.	The importance of the HWB was recognised as a lever for change.	The Mental Health Champion is passionate about improving services.
	Strong performance in number of people using Direct Payments.	The MH Forum and MH plan were good examples of interagency working.	The Council's committee structure allows all members to be involved in a proactive manner.
	Evidence of different disciplines sharing tasks.	Good multi agency development of a Mental Health Crisis Concordat Plan.	There is a willingness to ensure a clear strategic direction of travel for mental health.
Areas for consideration	Capacity within the teams with pressures on AMHP rotas.	Ensure data is pooled to better inform joint planning.	Ensure mental health is woven into wider corporate and financial planning and given higher priority by HWB.
	Availability of professional leadership and supervision needs to be consistent across teams.	Council to consider closer working relationships across Tees to effect strategic commissioning.	Recent changes in personnel represents an opportunity to clarify and streamline roles and responsibilities.
	Informal communication across teams could be improved.	Further work to reduce high levels of placements in long-term care.	Clarify the implications of the Care Act in relation to mental health.

7.6 Key recommendations include:-

- Supporting the development of the Health & Wellbeing Board and Joint Commissioning Executive as key routes for strategic and operational decision making.
- A review of existing governance and quality assurance frameworks with Tees Esk & Wear Valley NHS Foundation Trust.
- An early audit of cases and a review of compliance with the Care Act requirements.
- Reviewing the demand and capacity with the mental health teams, in particular the Approved Mental Health Practitioner (AMHP) role.

7.7 An action plan is being developed with TEWV to address the recommendations. Progress has already been made in the following areas:

- Development of the Joint Mental Health Implementation Plan to provide clear strategic direction and raise the profile of mental health issues through the Health & Wellbeing Board.
- Review of capacity within the mental health teams resulting in two additional posts being funded (one by TEWV and one by Hartlepool Borough Council using additional resources identified through the Care Act allocation to undertake additional assessments).
- An assessment of workforce development needs in relation to the Care Act being undertaken across all teams (including mental health teams).

8. CQC MENTAL HEALTH ACT MONITORIING VISIT

8.1 In December 2014 the Care Quality Commission undertook an announced visit to Tees Esk & Wear Valley NHS FT. By law, the Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. Mental Health Act Reviewers do this on behalf of CQC by interviewing detained patients or those who have their rights restricted under the Act and discussing their experience. They also talk to relatives, carers, staff, advocates and managers and review records and documents.

8.2 This visit looked at how Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) worked with other agencies, including local authorities, police and ambulance services to ensure that the right people were involved in the process; showed evidence of assessment outcome and why detention under the MHA was necessary; demonstrated adherence to the guiding principles of the MHA Code of Practice and complied with the requirements of law.

8.3 The key developments that were reviewed included:

- The closure of the section 136 suite at Sandwell Park Hospital, Hartlepool and centralisation of section 136 provision at Roseberry Park Hospital, Middleborough, where the police could take people who appeared to have mental health problems.
- The street triage team (STT) pilot in the Middlesbrough area in conjunction with Cleveland Police
- The improved working arrangements between AMHPs of all four local authorities (Hartlepool, Middlesbrough, Stockton and Redcar and Cleveland) and improved effectiveness of the emergency duty team that covers all four boroughs outside of core working times

8.4 CQC fed back that ‘the patients and carers we spoke with said that the staff had treated them with respect and courtesy. When one nearest relative recounted the circumstances of her daughter's MHA assessment to us she said that the people attending in her home “were all respectful". She also said that "the community psychiatric nurse was outstanding" in the way she had responded to her request for help by visiting them four times in the week of her daughter's admission and by visiting within an hour of her call on the day of the assessment’.

8.5 In each report CQC reviewed they saw that the AMHP had made a full record of the patient's own views and those of their nearest relative. Evidence was present of interpreters being provided when needed. While some AMHPs reported that they were concerned by the closure of some community resources, it was confirmed to CQC that a review had been undertaken which showed that none of the patients who had formerly used the services had since been admitted to hospital and no evidence was found that the hospital was being used because there were insufficient community alternatives.

8.6 Key areas for improvement for the Tees area were identified as follows:

- AMHPs were spending long periods of time attempting to locate section 12 approved doctors
- AMHPs and trust staff reported that at times they experienced long delays in accessing transportation via the ambulance service to convey the assessed service user to hospital.
- An increase in the number of service users self-presenting at the reception of Roseberry Park Hospital at night was identified as a risk.

8.7 In response to the recommendations:

- actions are already being put in place to rectify the issue regarding availability of Section 12 doctors
- additional funding has been allocated by the CCG to reduce conveyance times with the ambulance service; and
- funding has been agreed to develop additional resources to support people self-presenting at Roseberry Park.

9. CRISIS CARE CONCORDAT

9.1 The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

9.2 In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat. It focuses on four main areas:

- **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

9.3 The Mental Health Forum and key strategic partners (including the Tees Local Authorities, Cleveland Police, Cleveland Fire Brigade, North East Ambulance Service, TEWV NHS FT and the two acute Foundation Trusts) have signed up to the principles of the Crisis Care Concordat. An action plan is being monitored through the Tees Crisis Concordat Working Group.

10. MENTAL HEALTH ACT – REVISED CODE OF PRACTICE

10.1 A national consultation exercise has taken place on a revised Code of Practice for Mental Health.The main changes include:

- 5 new guiding principles
- new chapters on care planning, human rights, equality and health inequalities
- consideration of when to use the Mental Health Act and when to use to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and information to support victims
- new sections on physical healthcare, blanket restrictions, duties to support patients with dementia and immigration detainees
- significantly updated chapters on the appropriate use of restrictive interventions, particularly seclusion and long-term segregation, police powers and places of safety
- further guidance on how to support children and young people, those with a learning disability or autism

10.2 Work will be required to ensure professionals working under the revised Code of Practice for Mental Health are aware of the changes and remain confident practitioners. Senior managers will ensure that workforce plans are updated to reflect changes to key legislation and will monitor uptake through Continuous Professional Development.

11. RECOMMENDATIONS

11.1 It is recommended that the Health & Wellbeing Board:

- approve the Joint Mental Health Implementation Plan and receive further reports to monitor progress against the action plan.

- note the outcomes of recent reviews and the actions being taken to address the recommendations.

- note the revised Code of Practice for Mental Health.

12. REASONS FOR RECOMMENDATIONS

12.1 The Joint Mental Health Implementation Plan demonstrates joint working with strategic partners and provides evidence of local involvement, engagement and consultation in developing and shaping future service provision.

12.2 The Joint Mental Health Implementation Plan sets out shared commitment to mental health services over the next three years with clear milestones that allow progress to be monitored.

12.3 Recent reviews have identified some areas where further work is required in relation to mental health services. These recommendations will be addressed through the Joint Mental Health Implementation Plan and individual action plans linked to those reviews.

13. BACKGROUND PAPERS

https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

https://www.gov.uk/.../281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014

http://www.phoutcomes.info/

https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014

https://www.gov.uk/government/news/better-care-for-mental-health-crisis

https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

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2015 - 2018

Hartlepool

Implementation Plan of the 'No Health without Mental Health' National Strategy

Developed on behalf of the Hartlepool Mental Health Forum

Contents

Welcome

Acknowledgements

This plan was produced by the Mental Health Task & Finish Group which was made up of members from the Hartlepool Mental Health Forum.

The Task & Finish Group would like to first of all express thanks to the individuals who use or have used services, and indeed their carers for contributing to the plan by completing surveys or attending the stakeholder events.

Also thanks to the many organisations that have provided valuable support and input to the production of this plan:

Mariner Care
North Tees & Hartlepool NHS FT
Tees, Esk & Wear Valley NHS FT
CIC
DISC
Incontrol-able
Creative Support
Connected Communities
Healthy Communities & Independent Living for Life
Hartlepool & Stockton CCG
Community Integrated Care
Hartlepool Voluntary Development Agency
MAIN
CAMHS
Hartlepool Carers
Hartlepool MIND
Lloyds Pharmacy
Hartlepool Shopmobility
Healthwatch
Services Users
North of England Commissioning Support
Hartlepool Borough Council
Space for Thinking

Foreword

'We all have a part to play to meet the social and economic challenge posed by mental ill health, and to improve the wellbeing of the population. Their needs to be a shift, whereby citizens take more control over their lives and build more capable communities.

This Joint mental health plan aims to put people who use services at the heart of decision making and will be our governing principle. Care should be personalised to reflect people's needs, People should have access to the information and support they need to exercise informed choice.

This plan is aimed at empowering local organisations and practitioners to have the freedom to innovate and to drive improvements in services that deliver support of the highest quality for people of all ages, and all backgrounds and cultures.

This plan builds on the commitment of all stakeholders knowledge, sets out the ambitions the Government shares with its partners and against which it will be judged, and invites others to join us in making better mental health for all a reality'

Chair of the Hartlepool Health & Wellbeing Board - Cllr Christopher J Akers-Belcher

Summary of the Implementation Plan

The focus of this plan is to ensure Hartlepool & Stockton-on-Tees Clinical Commissioning Group and Hartlepool Borough Council work together as commissioners to effectively deploy their resources to support people with Mental Health needs

Whilst 'No Health without Mental Health' is the key driver and identifies several key ambitions, it is envisaged this report will take a holistic approach to mental wellbeing, adopting the recommendations from several national & local reports. This will ensure Hartlepool Citizens are at the centre of a co-produced action plan.

In addition to the 'working together for change' recommendations the report addresses the findings of the Local Government Agency, Sector Led Improvement Peer review, a Care Quality Commission Mental Health Act review and a strategic review of the Integrated Mental Health Service.

The recommendations form the basis of a robust action plan; the plan will be monitored by the Hartlepool Mental Health Forum, Hartlepool & Stockton-on-Tees CCG, with sign off by the Hartlepool Health & Wellbeing Board.

Introduction

A Collaborative Approach

A Task & Finish Group was established to lead on the development of this plan. This had representation from the following organisations:

The Task & Finish Group will become the Strategy Implementation Group and be responsible for overseeing the priorities set out in this plan (Table 1). The membership of the group will include key agencies, service user and carer representatives as well as a wide range of stakeholders. The group will produce and be responsible for the delivery of the detailed action plan and will report directly to the Hartlepool Mental Health Forum.

FACT

People with mental illness are at increased risk of the top five health killers, including heart disease, stroke, liver and respiratory diseases.

If you have a mental health problem you are four times more likely to die of a respiratory disease

Smoking Cessation is a real problem for our patients as the programmes only seem to have an impact on people without mental health problems

Gastrointestinal disease is raised at least four times and most of that are liver issues to do with alcohol

Co-Production

The term “co-production” is increasingly being applied to new types of public service delivery in the UK. It refers to active input by the people who use all services, as well as, or instead of, those who have traditionally provided them. It emphasises that the people who use services have assets which can help to improve those services, rather than simply needs which must be met. These assets are not usually financial, but rather are the skills, expertise and mutual support that service users can contribute to effective public services.[1]

The Hartlepool Mental Health Forum agreed to use a method of co-production to gather the evidence from Hartlepool citizens. The Working Together for Change methodology is a process that uses person centred information and themes it to inform strategic change. The person centred information may come from person centred reviews, person centred plans, questionnaires or support plans.

This collaborative approach has allowed the Task & Finish Group to be well informed and equipped with the knowledge and understanding of what is working well, what needs to be improved and where the gaps are. This has enabled us to develop our key priorities.

The Implementation Plan covers ‘all ages’, is far reaching and aims to cover services for individuals with mild to moderate mental wellbeing needs as well as those with severe and enduring mental health conditions.

[1] Co-production: an emerging evidence base for adult social care transformation (2012) Social Care Institute for Excellence

There are a number of facts and figures[2] along with the priorities that feature throughout the document and are linked to relevant areas; these are also listed in full in Table 1.

Thanks go to all those individuals and organisations who contributed.

National Directives

There are a number of national directives and strategies that are relevant to the development of this implementation plan.

No Health without Mental Health[3]

The publication of No Health without Mental Health: A cross government mental health strategy for people of all ages published in February 2011 drew together the wider principles that the government has laid down for its health reforms, including patient-centred care and locally determined priorities and delivery. At a national level, the strategy sets out the 'high level' objectives to improve the mental health and wellbeing of the population. These are:

FACT

No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact.

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

Resulting from this an implementation framework has been developed and sets out how progress will be monitored through the outcomes frameworks and made a series of recommendations for local and regional organisations to take forward.

These included providers and commissioners of mental health services, primary, acute and community health providers, the new health and wellbeing boards, social services, children`s services, public health services, housing organisations, schools and colleges.

The position statement of the Royal College of Psychiatrists states:

- No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact
- Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour

[2] No Health without Public Mental Health, (2010) Royal College of Psychiatrists
[3] No Health without Mental Health(2011) HM Government

- Mental illness has not only a human and social cost, but also an economic one, with wider costs in England amounting to £105 billion a year

Mental health practice should aim to put the person's needs at the centre of care planning and service delivery. No Health without Mental Health encourages recovery based approaches; this is further reinforced in the NHS Outcomes Framework as well as the Social Care Outcomes Framework.

No Health without Mental Health states that a good start in life and positive parenting promotes good mental health, wellbeing, self-esteem and resilience to adversity throughout life. Parental mental health is an important factor in determining the child's mental health and secure attachments with parent or care-givers are associated with better outcomes for the child, including improved learning and academic achievement. As adults, those who are securely attached tend to have trusting, long-term relationships, higher self-esteem and supportive social networks.

A mental health dashboard[4] was then developed which brings together relevant measures from a wide range of sources to show us the progress being made against these objectives and to give a clear, concise picture of mental health outcomes as a whole. The dashboard draws only on existing, publicly available sources of information and is not intended to hold individual organisations to account.

The dashboard covers the full, wide scope of the strategy and aims to provide a balanced picture across all six of the strategy's objectives. It therefore focuses not only on mental health services, but also on the mental wellbeing of the whole population, the physical health of people with mental health problems, people's experience of care and experience of stigma and discrimination.

FACT

Circulatory, respiratory & digestive diseases are all raised in our population.

Then we've got diseases of the nervous system then mental & behavioural disorders

We have potentially got a minimum of 700 un-necessary deaths per year, that's 700 more deaths than to be expected on top of the poor lifestyle mortality

One in six of all deaths is attributed to smoking

On average mental health patients have twice the rate of smoking and this is not changing

The measures which make up the dashboard have been chosen for their relevance to these objectives and include those measures which are most relevant or important for mental health outcomes as a whole, not necessarily those which will be easiest, or even possible, for specific organisations (public services or other organisations) to affect. It focuses primarily on the outcomes we want to achieve, rather than how they will be achieved, or by whom.

The main purpose of the dashboard is to bring the best information we have about mental health outcomes together in one place, as a resource for everyone with an interest in improving these outcomes.

[4] No Health without Mental Health, mental health dashboard, (2013) HM Government

NHS England- Five Year Forward View[5]

The National Forward View acknowledges that physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people. The NHS ambition over the next five years is to drive towards an equal response to mental and physical health, and towards the two being treated together. Next year, for the first time, there will be waiting standards for mental health.

The Care Act 2014[6]

The new Care Act consolidates much of existing social care law along with best practise and creates a new obligation on local authorities to deliver the personalised agenda.

Many duties and requirements will be introduced particularly around assessments for carers and self-funders which will require a full care and support plan with Independent Personal Budgets for all adults who have eligible social care needs irrespective of whether they choose to have these met by the local authority.

The Act will also for the first time set out a clear legal framework for how local authorities and other parts of the health and care system should protect adults at risk of abuse or neglect.

Priority

Ensure that local people get the best possible start in life, including mental health support for expectant and new mothers

Children & Families Act 2014[7]

The Children & Families Act will mean changes in law to give greater protection to vulnerable children and young people, a new system for under 25s who have special education needs and disabilities to provide great choice and control and help for parents to balance work and family life. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background.

Closing the Gap: Priorities for essential change in mental health[8]

Closing the Gap supports the measures in the national mental health strategy No Health without Mental Health, the Mental Health Implementation Framework and the Suicide Prevention Strategy. It is intended to bridge the gap between long term strategic ambitions and short term actions through the 25 priorities for action –

[5] NHS England Five Year Forward View
[6] The Care Act (2014) HM Government
[7] Children & Families Act (2014) HM Government
[8] Closing the Gap: Priorities for essential change in mental health (2014) HM Government

issues that current programmes are starting to address and where 'strategy is coming to life'. The government will report on progress on these priorities next year.

The document is a useful update on significant developments such as the Crisis Care Concordat[9], which is a commitment from organisations to prevent crises through prevention and early intervention, and is a mechanism to promote partnership working. It emphasises the government's intention for parity between mental and physical healthcare as set out in the NHS Mandate.

Achieving parity of esteem between mental and physical health

In our society mental health does not receive the same attention as physical health. People with mental health problems frequently experience stigma and discrimination, not only in the wider community but also from services. This is exemplified in part by lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems.

FACTS

Annual homicides in England and Wales: 550.

Annual fatal road traffic accidents: 1850.

Total military casualties that have occurred in Afghanistan from the very beginning of the conflict to the present day: 446. (www.bbc.co.uk/news/uk-10629358)

How many people with a mental health condition die early every year of preventable conditions? 18,000 - and that is only ages 19–74.

There is an ambition for the NHS to put mental health on a par with physical health. However, the concept of parity in this context is not always well understood. In this report[10] an expert working group defines 'parity of esteem' in detail and examines why parity between mental and physical health does not currently exist and how it might be achieved in practice.

A Call to Action: Achieving Parity of Esteem

In July 2013, NHS England launched A Call to Action, which began a programme of engagement and evidence collection that encourages everyone to contribute to the debate about the future of health and care provision in England. It also signalled the beginning of a process to develop a new strategy for the health service.

A discussion paper was developed[11] which focuses on valuing mental and physical health equally. This resource focuses on one of the outcome ambitions set out in the strategic planning framework: to achieve 'parity of esteem' and is intended to

[9] Mental Health Crisis Care Concordat: Improving Outcomes for people experiencing mental health crisis (2014) HM Government
[10] Whole person care: from rhetoric to reality (Achieving parity of esteem between mental and physical health) (2013) RCP
[11] A Call to Action: Achieving parity of Esteem; Transformative ideas for commissioners (2013) NHS England

stimulate debate between Clinical Commissioning Groups and local partners to think about changes that can be made.

What do we mean by parity of esteem? It's about equality in how we think about mental health and physical health care – it's about how they're valued. We need to 'close the gap' between mental and physical health services – whether that's a gap in access, in quality, in research, or even in the aspirations we have for people. As the report makes clear so powerfully, the current state of disparity is obvious.

It is astonishing that in the 21st Century NHS, 3 in 4 people with common mental health problems receive no treatment, and even for psychotic disorders this figure is nearly 1 in 3. It is equally astonishing that people with severe mental illness are, in some cases 3 or 4 times more likely to die prematurely from the 'big killer' diseases, when compared to the population as a whole. This says something, of course, not only about mental health services, but also how we treat people with mental illness, something which must change (Norman Lamb MP, 2013).

Priority
To ensure physical health needs are met

The following 10 Facts are taken directly from A Call to Action: Achieving Parity of Esteem and are reasons why we should strive to achieve parity between physical and mental health.

1. Mental health problems develop at a young age. 1 in 5 children have a mental health problem in any given year. First experience of mental health in those suffering lifetime mental health problems: 50% by 14 years old and 75% by 25 years old

2. Mental health is widespread and common. Every year 1 in 4 adults experience at least one mental disorder

3. Mental health is a significant burden. Mental illness is the single largest cause of disability in the UK

4. Mental health impacts on life expectancy. Average life expectancy in England and Wales for people with mental health problems is behind the national average. 68 years for males and 73 years for females for people with mental health problems. 79 years for males and 83 years for females for everyone else.

5. People with mental health problems have worse physical outcomes. People with mental illness are at increased risk of the top five health killers, including heart disease, stroke, liver and respiratory diseases and some cancers. People with Schizophrenia are twice more likely to die from cardiovascular disease and three times more likely to die from respiratory disease.

6. When people with long term conditions also have mental health issues the cost of treatment can rise significantly. 1/3 of people with long term conditions also experience mental health problems increasing treatment costs by around £8–13 billion a year.

7. The mental health of people with serious physical health problems is often overlooked. ½ of terminally ill or advanced cancer patients suffer from depression, anxiety and/or an adjustment disorder, yet less than half receive treatment for their mental health

8. Mental health problems affect the likelihood that people will be compliant with their treatment. Depression co-morbid patients are three times more likely to be non-compliant with treatment recommendations than non-depressed patients.

9. There are often long walls for mental health services. 1 in 10 people wait over a year for access to talking therapies.

10. There is a wider economic impact of mental health. The full costs of mental illness in England have been estimated to be £105.2 billion a year

Crisis Care Concordat: Improving Outcomes for people experiencing mental health crisis

The Concordat is a shared agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental health crisis need help – in policy making and spending decisions, in anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur. The Concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

The Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat.

Priority

Support the recommendations and actions from the Tees Multi Agency Crisis Care Concordat. Reporting improvements through the Mental Health Crisis Concordat Steering Group

Transforming Rehabilitation

The Ministry of Justice 'Transforming Rehabilitation' programme of Probation reforms sets out proposals for reforming the delivery of offender services. On the 1st of June 2014 the Government split probation services into two new organisations: A new public sector National Probation Service (NPS) dealing with all those who pose

the highest risk of serious harm to the public and twenty one regional Community Rehabilitation Companies (CRCs) managing all other offenders.

Recognised, valued & supported: next steps for the Carers Strategy[12]

It is important that the role of unpaid carers of those with mental health problems is recognised. We know that caring for someone with a mental health problem can be emotionally and often financially draining. In 2014, National Institute for Health and Care Excellence (NICE) issued clinical guidelines for 'Psychosis and Schizophrenia in adults: treatment and management'.

These introduced new requirements in respect of identifying and supporting carers, including the following:

- Mental health services to offer and provide carers with an assessment of their own needs; develop a care plan to address any needs identified; review this annually and advise carers of their statutory right to a formal carer's assessment by social care services
- Give carers written and verbal information about diagnosis and management of psychosis and schizophrenia; positive outcomes and recovery; types of support for carers; role of teams and services; getting help in a crisis
- Negotiate with service users and carers about how information will be shared and review regularly
- Involve carers in decision making if the service user agrees
- Offer a carer focused education and support programme

There are a number of services commissioned to provide a free high quality service to support unpaid carers; this includes Young Carers, Adult Carers and Parent Carers who care for someone living in Hartlepool. These services provide confidential, non-judgmental and impartial one to one support, advice and information.

Better Care Fund

In June 2013, the government announced that it would be allocating £3.8 billion to a pooled budget called the Better Care Fund.

In Hartlepool, joint plans have been developed between the Local Authority and Clinical Commissioning Groups locally on health and social care initiatives

The aim of the Better Care Fund is to improve the health and wellbeing of the people of Hartlepool by innovating and transforming services, with a focus on reducing reliance on long term health and social care, providing more preventative services, helping people to stay independent in their own homes, and improving care in community settings.

[12] Recognised, valued & supported: next steps for the Carers Strategy (2010) HM Government

Priority
To improve access to psychological therapies

Transforming Care: A national response to Winterbourne View Hospital Department of Health Review*:* Final Report[13]

Following the BBC Panorama Programme on the abuse at Winterbourne View Hospital, The Department of Health set out a transformation programme that looks to ensure people with complex support needs due to a learning disability, mental health problem and/or autism are supported closer to home and where possible within their local communities. Each area is required to develop a local plan that sets out how people with complex needs will be supported in the future.

Welfare Reform

The Welfare Reform Act[14] legislates for a range of changes to the welfare system some of which will have a direct effect on people with mental health problems. It introduces a wide range of reforms including the introduction of Universal Credit and changes to housing benefit. There has been concern amongst a range of mental health stakeholders nationally about the impact of welfare reform on people with mental health problems.

Employment

Many people who experience mental health problems face difficulties in gaining and maintaining employment. They often face stigma and discrimination that sometimes results in losing their job or cause challenges in getting a job. People who experience severe and enduring mental health problems have one of the lowest employment rates. Only one user in five of specialist mental health services either has paid work or is in full-time education[15]

A specialist Employment Link team is based within the Economic and Regeneration team within Hartlepool Borough Council. The staff team are equipped with the skills competence and knowledge to support people of working age with additional needs. The National Indicator (NI 150) percentage of adults receiving secondary mental health services in Hartlepool known to be in employment as of July 2014 was 11.4%.

FACT

Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour.

[13] Transforming care: A national response to Winterbourne View Hospital (2012) HM Government
[14] Welfare Reform Act 2012
[15] Removing barriers: the facts about mental health and employment Centre for Mental Health (2009)

Lesbian, Gay, Bisexual & Transgender

Lesbian, Gay, Bisexual and Transgender (LGBT) people are a minority community who often suffer from widespread harassment, discrimination and at times violence. The high levels of stigmatisation often lead to higher rates of mental health issues within the community with much higher instances of self-harm and attempted suicide.

The problems of discrimination are especially prevalent in the case of transgender individuals who have very little in the way of support and are often isolated within their communities.

53% of transgender individuals have carried out some form of self-harm in their lives, while 48% have attempted suicide at some point in their lives, with 33% more than once.[16] These statistics seem alarming, however when put into context of a small isolated community with little or no support and a lack of community understanding they begin to make more sense.

Homelessness

Homelessness easily descends into a destructive cycle of hopelessness and mental distress. It has been described as “a dire condition and if protracted highly damaging to an individual’s identity, self-worth, morale and physical and mental health”[17].

There is a strong body of evidence[18] that points to markedly higher rates of mental health problems in populations of homeless adults than among the securely domiciled.

Most studies support the finding that unusually high rates of psychosis and substance misuse are a common feature of homeless populations. The difficulties of addressing combined substance misuse and mental illness (dual diagnosis), which exists in this group, has long been acknowledged. Nationally, the prevalence of substance misuse dependency among the homeless mentally ill can be as high as 50-60 percent and is up to five times higher than that for the general population.

Homeless people experience twice the rate of neurotic disorder than that of the general population, including anxiety, depression and mental distress. They are also more likely to become hospital in-patients than to be treated on an out-patient basis for their mental health problems.

[16] Trans Mental Health Study (2012)
[17] Building Homelessness Prevention Practice: Combining Research Evidence and Professional Knowledge, University of Sheffield
[18] Melvin P (2004) A Nursing Service for homeless people with Mental Health Problems. Mental Health Practice, vol 7 no 8

Transition[19]

The ages 16–18 are a particularly vulnerable time when there is increased susceptibility to mental illness, as well as major physiological, emotional, educational and social change. It is also the age at which the young person already in contact with mental health services will move from child and adolescent services (CAMHS) to adult services (AMHS).

Transitions can be problematic if there are gaps in service provision and different structures and systems to navigate.

Local Context

It is well recognised that social and health inequalities can both result in and be caused by mental ill health. Many of the acknowledged risk factors for mental illness are linked to deprivation. Measures of deprivation can help to identify geographical areas where the need for mental health services is likely to be the greatest. Hartlepool has some of the most deprived areas in the country.

- Mental health needs in Hartlepool are higher than the national average.
- Hartlepool has 40% greater need in relation to mental illness compared to England and 14% higher need in relation to common mental health problems.
- Employment opportunities for people with mental health problems in Hartlepool are very limited and of those long-term unemployed people claiming incapacity benefit, two-thirds have a mental health problem.
- Incapacity benefit levels for mental health in Hartlepool are more than 70% higher than the English average and above the North East Average
- Hartlepool is an area of high deprivation.

In order to be able to plan effective mental health services it is important that we understand the mental and emotional wellbeing needs of the population.

The collation of current information in relation to mental wellbeing needs to be co-ordinated better. Assessing need in relation to mental health and wellbeing is complex and there are a number of ways in which this challenging problem may be tackled.

It is essential to consider sources of information which tell us who and where in our communities are receiving support for mental health issues alongside the range of wider determinants which impact on mental health and wellbeing and cause individuals to be more vulnerable to poor mental health.

There are many factors that may increase the likelihood of becoming unwell, such as:

- poor housing
- homelessness

FACT

Women are more likely to have been treated for a mental health problem than men.

[19] Guidance for commissioners of mental health services for young people making t adolescent to adult services (2012)

- financial poverty
- unemployment
- drug and/or alcohol dependency
- being a carer
- poor physical health
- having a learning disability
- lesbian, gay, bisexual and transgendered people
- people that have committed criminal offences
- black, minority & ethnic people
- gypsies, roma & travellers

The North East Public Health Observatory published a Community Mental Health Profile for Hartlepool[20] which is designed to give an overview of mental health risks, prevalence and services at a local level.

Hartlepool Joint Health and Wellbeing Strategy

The Hartlepool Joint Health and Wellbeing Strategy[21] is a strategic document outlining how Hartlepool Borough Council, Hartlepool and Stockton on Tees Clinical Commissioning Group and other key organisations, through the Health and Wellbeing Board, will address the health and wellbeing needs of Hartlepool and help reduce health inequalities.

The Health and Social Care Act (2012) establishes Health and Wellbeing Boards as statutory bodies responsible for encouraging integrated working and developing a Joint Strategic Needs Assessment and Health and Wellbeing Strategy for their area. The Strategy is underpinned by the Joint Strategic Needs Assessment (JSNA) and together they will provide a foundation for strategic, evidence-based, outcomes-focused commissioning and planning for Hartlepool.

Strategic Outcome 7 of this strategy is to strengthen the role and impact of ill health prevention and improve the mental and physical wellbeing of the population by:

- Reducing the numbers of people living with preventable ill health and people dying prematurely
- Narrowing the gap of health inequalities between communities in Hartlepool

Delivery on the objectives will be ensured through an annual action plan which supports the Health & Wellbeing Strategy and specifies the detailed initiatives to deliver on the objectives.

Hartlepool Public Mental Health

The health of Hartlepool residents is improving; on average they are living healthier and longer lives. However, they still suffer more ill health and disability, higher death

[20] Hartlepool & Stockton on Tees Community Mental Health Programme 2014
[21] Hartlepool Health & Wellbeing Strategy (2013-2018)

rates from diseases such as cancer, heart disease and respiratory disease and live shorter lives than in most other parts of the country.

There is evidence to indicate that this 'health gap' is widening. There are also inequalities in the 'health experience' of communities within Hartlepool; the most deprived communities suffering significantly poorer health than the more affluent areas.

Department of Health sets out a programme of action to support people in making healthy choices. It identifies the following priorities:

- Reducing the numbers of people who smoke
- Reducing obesity and improving diet and nutrition
- Increasing exercise
- Encouraging and supporting sensible alcohol consumption
- Improving sexual health
- Improving mental health

Supporting People with Hearing Loss[22]

Hearing loss can have a significant impact on an individual's health and wellbeing. For children who are born with a hearing impairment, their language development, educational attainment and life chances can be affected. For adults with sudden or age acquired hearing loss, there is the risk of loss of employment, social isolation, depression and mental health problems.

Just over 16% of the population suffer a hearing loss. This amounts to 1 in 6 people or around 14,700 of the Hartlepool population.

In 2011 the Strategic Health Authority and Hartlepool Borough Council commissioned a review of services for deaf people in Hartlepool, and as a result, identified a number of recommendations on how services could be improved. The recommendations were grouped into 4 main categories:

1. Greater engagement of deaf people with the council
2. Improving the support that is offered to people (from children to adults)
3. Improving communication support
4. Prevention – early identification of issues

These recommendations were considered by Hartlepool Borough Council's Cabinet in November 2011 who wholeheartedly supported each one. In addition, the Cabinet made a commitment to develop the hearing loss strategy which looks at how we

[22] Supporting People with Hearing Loss, Hartlepool Borough Council (March 2013)

could offer longer term support to the 1 in 6 people, or 14,700 people who were thought to have a hearing loss in Hartlepool.

The strategy has been developed around the four key recommendations outlined above and the priorities for actions identified in the consultation. The strategy is structured to outline the policy objectives and what actions will be taken to support each main recommendation.

Whilst the development of this strategy has been led by Hartlepool Borough Council, its aim is to work with partners including the Clinical Commissioning Group and the Voluntary and Community Sector to build on the services that are currently provided. It will not be achieved in isolation and will work alongside other strategies and policies such as:

- The Joint Strategic Needs Assessment
- Moving Forward Together – the vision for adult social care in Hartlepool

The strategy is linked to and will be monitored by the Health and Wellbeing Board and will help support the board's key aim:

"To work in partnership with the people of Hartlepool to promote and ensure the best possible health and wellbeing."

Hartlepool Parent Led Forum

Hartlepool Parent Carer Forum: a parent carer forum of parents and carers of disabled children who work with the local authority, education, health and other providers to make sure the services they plan and deliver meet the needs of disabled children and families.

A steering group of parents lead this work and listen to the views of other parents in the local area to make sure they know what is important to them. The forum is keen to hear from as many parent carers as possible, and supports the ambition to develop a radically different system that:

Supports better life outcomes for young people

- a new approach to identifying Special Educational Needs (SEN)
- a joint assessment process and a single Education, Health and Care Plan (EHCP)

Gives parents more confidence by giving them control

- a local offer of all services available
- parents to have the option of a personal budget by 2014

Transfers power to front-line professionals and to local communities

- giving parents a real choice of school

- greater independence to the assessment of children's needs

Children, Young People and Families Plan 2012– 2015

The Children, Young People and Families Plan outlines:

"In Hartlepool we will work together through the Hartlepool Childrens partnership to keep children and young people and their families at the centre of services that we provide."

The plan details a number of priority areas, including:

- safeguarding children
- youth offending
- early intervention
- child poverty
- education
- young carers
- transitions
- health
- children with additional needs / disabled children
- looked after children

Priority *Ensure high quality of care through the implementation of the newly developed evidence based service specification for CAMHS and associated pathways*
Priority *Ensure that children with complex needs including mental health issues are given full and equal access whilst being assessed under the new Children's and families Act: Part 3 SEND reform responsibilities and where appropriate are able to take advantages of opportunities offered by personal health budgets including those children in special schools*
Priority *To develop a multi-agency pathway for children with sensory process disorder*
Priority *Continue to improve the local pathway of care for children and young people with Autism Spectrum Disorder*
Priority *Providing equality of access to equipment for children with mental health needs*

Tees Interim Children and Adolescent Mental Health Strategy 2015 – 17

The Joint Strategy for Tees is currently being developed by the Clinical Commissioning Groups and the local Borough Council in order to provide strategic direction across the locality.

This strategy has been developed to:

- Provide a cohesive approach across partner agencies, in regard to improving the mental health and wellbeing of children and young people in Hartlepool
- Ensure any work taken forward is centred on the child and family and is outcome focused

The strategic work plan within the document captures priority areas of focus related to children and young people's mental health and emotional wellbeing and is further developed in to the individual Hartlepool locality plan.

Priority *Improve transition arrangements between CAMHS and adult mental health services to ensure that there is no risk of untreated illness at this critical time*
Priority *To undertake a review of the mental health gateway service model*

Hartlepool Strategy for Assistive Technology 2010-15

Assistive technology' is a collective term used to describe a variety of services that use information and communication technology (ICT) and are linked to response services to support people to live in their own homes.

In Hartlepool, our vision of personal support is to enable the majority of people needing support to live as independently as possible in their own homes, for as long as they are able and wish to do so. This includes older people, people with disabilities or mental health problems and other vulnerable people.

Hartlepool Carers

The carer's service exists to improve the quality of lives of carers throughout Hartlepool and the surrounding villages, by providing bespoke advice, information and support services, as well as also raising awareness of carer's issues locally, regionally and nationally. Carers can be of any age and come from any social, ethnic or cultural background and will be treated with respect and dignity at all times.

A Mental Health project involves carers in local service development initiatives to promote carer awareness and improvements in local services. The project promotes the leadership training through the local NHS Foundation Trust Patient and Public Involvement, in order to help carers develop their confidence and skills in participating in service development.

Carers are involved through the Mental Health project with:

- Dementia Collaborative via the Dementia Advisory group
- Dementia Friendly Hartlepool
- Mental Health Forum

- Awareness raising through partnership working and promoting the directory of services and wellbeing

The Triangle of Care is led nationally by The Carers Trust. Tees Esk & Wear Valley NHS Foundation Trust has signed up to the group and are working with Carers and the Patient and Public Involvement Team to implement carer awareness training with the Trust staff.

The carers service support carers into work through Job club's and one to one support with Employment Support Officer's. The service provides access to courses through partnership working with Adult Education to provide Personal Development courses bespoke to Carers. Carer's can access services to meet their needs, advocating them when necessary. Tailored services help the individual and those they care for by providing a Carers assessment of needs. Benefit support is also available for carers through links with Citizens Advice Bureau to maximise carer's income.

The Mental Health project offers training and emotional support for carers through one to one support, in house counselling, or referral to other counselling services. The service seeks to reduce isolation through peer and social support groups and access to other local groups.

Young people undertake inappropriate levels of care due to a variety of reasons and complex circumstances. The young carer provider supports to up to 90 young carers living in Hartlepool and promotes identification, recognition and early help.

Veterans[23]

A Veteran is defined as anyone who has been a member of the serving Armed Forces for a day or more. There are approximately 4.8 million veterans in the UK (just under 4 million in England). All should be registered with a NHS GP Practice.

FACT

Self-harm statistics for the UK show one of the highest rates in Europe: 400 per 100,000 population.

The Department of Health (DoH) and the Ministry of Defence (MOD) have launched the first of a number of pilots designed to ensure that NHS health professionals have appropriate support and available expertise they may need to treat veterans with mental health problems. The four UK health departments, the Ministry of Defence, and the charity Combat Stress, have been working together closely to develop and pilot a new model of community based mental health care.

Centred on the client and GP, these arrangements will make it easier for veterans with concerns about their mental health to seek and access help. The pilot will provide veterans with a service, led by a Community Veterans' Mental Health Therapist that will offer understanding of the particular issues for those who have served in the Armed Forces.

[23] Veterans UK, Ministry of Defence Announcement

Learning Disabilities

It is estimated that there are approximately 1.2 million people in England who have some form of learning disability. It is well documented that for many people with a learning disability this means significantly poorer health and the risk of dying younger. Access to healthcare through the use of reasonable adjustments and the delivery of annual health checks can identify early indications of illness, many of which risk going undetected, often due to the lack of understanding of many of the issues faced by people with a learning disability.

In Hartlepool people are working together to improve access to healthcare, this includes; accessing the annual health check, hospitals, and other community services such as opticians, dentists and pharmacies.

Tees Esk & Wear Valley NHS Foundation Trust (TEWV) provide community and inpatient specialist assessment and treatment services to people with learning disabilities and mental health problems, autism, epilepsy and challenging behaviour. Tees Esk & Wear Valley NHS Foundation Trust, in partnership with Hartlepool Borough Council provides integrated social care and health teams. These teams offer care co-ordination for people with Mental Health and/or Learning Disability needs.

People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence found in those without learning disabilities. The percentage of adults aged 18 years and over with learning disabilities (2011/12) within Hartlepool is 0.57% which is higher than the England average of 0.45%.

The incidence of children with mild to severe learning disabilities is expected to rise by 1% year on year for the next 15 years due to a number of factors and 40% of these children have a diagnosable mental health problem. Across Hartlepool there are approximately 1000 children and young people with a learning disability and of these 390 will have mental ill-health, rising to 450 over the next 5 years.

A growth in the size of the population aged 65 years and over is expected which will increase the numbers of adults with a learning disability. As adults with a learning disability grow older, their carers will also grow older and will therefore be more likely to need services themselves. There is evidence that adults with a learning disability are more likely to be affected by dementia than people without a learning disability.

The current range of Service Provision

This section explains the range of services commissioned and provided by NHS England, Clinical Commissioning Groups and Hartlepool Borough Council.

Although the NHS has traditionally been the predominant provider of local mental health services, a number of independent and voluntary sector organisations have played a key part in delivering specific services to complement those in the statutory sector. This was highlighted in the scoping exercise the Task & Finish Group

undertook and demonstrated that there is a range of services currently available from numerous service providers.

Local Authority

Hartlepool Borough Council has developed a number of Mental Health services in the community. Others are provided by a number of Voluntary Community Sector services and Independent Sector Organisations across Hartlepool, who may be funded by both the Local Authority and the NHS.

The types of service provided include the following;

- Integrated mental health Social Work/Care Co-ordination teams covering each locality area
- Specialist residential care
- Supported living
- Outreach and Community-based floating support
- Domiciliary Care
- Post Diagnosis support for people with autism
- Services for Older People with mental health/Dementia issues
- Service-user led groups including Cree or Men's Sheds/Dementia Cafes & My Space
- Day care & drop in/Social access groups
- Volunteering and peer support
- Education/Employment/Training Support
- Specialist Advocacy
- Community Wellbeing Support Service
- Social Prescribing
- Looked after children service including Full Circle

In addition the council is promoting the development of an increasing number of personalised, individual service options which are funded thought direct payments.

Clinical Commissioning Groups & NHS Foundation Trust

The Clinical Commissioning Group's commission the majority of mental health services from Tees, Esk & Wear Valleys NHS Foundation Trust.

The Trust provide community and inpatient mental health services for adults of working age in partnership with social care and a wide range of voluntary and independent service providers. The Trust treats patients with psychotic illnesses and also those with affective illnesses, such as depression, anxiety and compulsive disorders.

Primary and secondary care is often referred to within mental health services. Below is a brief explanation of what is meant by each term:

- Primary mental health services mainly provide support for people with mild to moderate mental health conditions, such as depression and anxiety. However, these services can also support people with some of the more severe mental health conditions if they are not at risk of harming themselves or others. GPs are usually the first point of contact for people with mild to moderate mental health conditions.

- Secondary (or specialist) mental health services provide support for people with severe and complex mental health conditions, such as schizophrenia and bi-polar. They also support people with other mental health conditions if they are at risk of harming themselves or others.

Common mental health problems such as depression and anxiety related conditions are generally treated in a primary care setting. NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group commission a range of services in the area. For people aged 16 and over there is a primary care psychological therapy service which provides all National Institute of Care and Excellence (NICE) accredited psychological therapies for people with common mental health problems.

Additionally for adults who have a long term mental health problem which is currently stable there is a commissioned primary care mental health service to support General Practice with the management of these patients.
More complex mental health conditions are managed in secondary care by specialist mental health providers.

The services we currently commission, as of January 2015, include:

Community

- Specialist Community Mental Health Teams for Affective disorders (multi-disciplinary service for people with severe and complex mood related mental health problems)
- Specialist Community Mental Health Teams for Psychosis (multi-disciplinary service for people with severe and complex psychotic mental health problems)

- Mental Health Access service (first point of contact for referrers)
- Mental Health Crisis Team (multi-disciplinary service for people with complex mental health conditions who are in crisis requiring an urgent response)
- Mental Health Home Treatment service (multi-disciplinary service to support people in their own home as an alternative to hospital admission)
- Intensive Home Support Service (psychologically led service for Older People in mental health crisis who exhibit complex and high risk behaviours)
- Older peoples Community Mental Health Team (for assessment and treatment of older adults with complex mental health conditions)
- Assertive Outreach service (to offer more intensive ongoing support for people with severe and enduring mental health problems who are vulnerable or prone to rapid relapse)
- Early Intervention in Psychosis service (multi-disciplinary service aimed at people aged between 14 and 35 years who experience a first episode of psychosis, specialising in focussed family work and psycho-education alongside judicial use of antipsychotic medication)
- Acute Hospital Liaison Service (specialist multi-disciplinary mental health service operating 24/7 within the acute trust to assess, treat, and help manage people with mental health conditions who present at the acute hospital, offering signposting to specialist mental health services or other provision where appropriate)
- Stepping forwards – an assertive community based service which aims to target those vulnerable individuals who have frequent contact with services through A&E, Police, MH Crisis teams but who struggle to engage with appointments and follow up.
- Hartlepool Carers – a service which offers support, advice and guidance to carers of people with mental health problems
- Baby bereavement – emotional support for bereaved parents
- Recovery College[24] - A local recovery college has been commissioned to support the recovery approach.
- Community eating disorders service, specialist community team providing treatment and support for people with eating disorders (primarily anorexia nervosa and bulimia nervosa

Inpatient Services

- Adult acute mental health wards for assessment and treatment of complex mental health problems.
- Psychiatric Intensive Care ward for people in an acute phase of mental illness with very high risk behaviours
- Male Locked Rehabilitation for men who exhibit high risk behaviours relating to their mental health problems and require inpatient care for a longer period of time

[24] Recovery College

- Female locked rehabilitation for women who exhibit high risk behaviours relating to their mental health problems and require inpatient care for a longer period of time
- Specialist mental health rehabilitation for people who require longer periods of mental health treatment, up to 18 months.
- Specialist mental health rehabilitation for people who require longer term in-patient treatment, 18 months plus

It should be noted that in-patient services for adult eating disorders and all secure services are now commissioned by NHS England rather than through local Clinical Commissioning Groups.

There are contracts in place for people whose needs require specialist input which isn't effectively provided through the other commissioned services.

Priority   *Reduce the rate of admissions of children and young people for self-harm*
Priority   *Work to encourage General Practices to appoint a Mental Health Champion to drive forward implementation*
Priority   *To consider the findings of the CQC – Mental Health Act Inspection*

Voluntary and Community Sector

There are many voluntary and community organisations within Hartlepool providing treatment and support for people with mental health issues. Some people prefer to seek help from an organisation separate from the NHS and the voluntary sector provides many alternative options. Most, but not all, voluntary sector services work on a self-referral basis, so that individuals can approach the organisation themselves without the need for a referral from a GP or other worker.

Voluntary and Community Sector organisations operate in diverse and wide-ranging fields including many that work in health and social care, community leisure and recreation activities, environmental work, arts, sport, education, campaigning and advocacy and many are faith based organisations.

Many voluntary sector organisations are more specialised in what they provide, such as advocacy and supported accommodation, as well as help for carers, minority ethnic communities and women. Others are focused around a particular activity, such as gardening or employment.

Some community led organisations have a good understanding of local need and as a result they are better placed or more able than the larger statutory agencies to engage with communities. Many organisations have developed innovative ways of working to help people, such as through peer support or providing wellbeing activities within the community.

Recovery

FACT

1 in 4 people will experience some kind of mental health problem in the course of a year.

Recovery in this instance equates to personal recovery and is a different concept to clinical recovery, which is focused on the absence of symptoms and 'returning to normal'. Personal recovery is considered to be individually defined and is about living a satisfying and meaningful life, with or without symptoms.

A recent review of the recovery literature identified five components that have a significant role in most people's recovery, namely:

- Connectedness (relationships)
- Hope
- Identity (beyond a diagnosis or service user)
- Meaning and purpose to life
- Empowerment

These five factors are known collectively as the CHIME framework.

Services that are recovery orientated focus on the individual goals of individuals, recognising and building on their personal strengths, foster self-management and offer a range of opportunities for individuals to find meaning in their lives. Co-production, learning from and working with people with lived experience of mental health to develop and deliver services should be at the heart of genuine recovery focused approach.

Priority   *To evaluate the Recovery College*
Priority   *To maintain a focus on a recovery approach*
Priority   *Implement the recommendations of the Local Government Association (LGA) and Directors of Adult Social Services (ADASS) Mental health peer challenge*

Recovery has been described as:

"...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond catastrophic effects of mental illness". [25]

FACT

About 10% of children have a mental health problem at any one time.

Recovery challenges conventional approaches to treating mental ill health. It is consistent with the government's vision

[25] Anthony WA (1993). *Recovery from mental illness: the guiding vision of the mental health service system in the 1990s*. Psychosocial Rehabilitation Journal 16(4): 11-23.

and takes a more holistic approach to mental wellbeing and health improvement, rather than addressing mental illness in isolation from other important factors in people's lives.

We know that current and former service users can help to support people who experience problems with their mental health. Peer Support is one way of helping people recover from mental distress and its impact on their lives. It enables people to provide knowledge, experience, and emotional, social or practical help to each other.

Peer support relies on the assets, skills and knowledge in the community, and the recognition that local people can offer help in ways that are sometimes more effective than professional help.

Child & Adolescent Mental Health Service (CAMHS)

The term CAMHS is used as a broad concept embracing all services that contribute to the mental health and emotional wellbeing and care of children and young people, whether provided by health, education, social services or other agencies. The structure of CAMHS is often explained in terms of how a child or young person accesses the service, with four 'tiers' of service provision.

Tier 1 Universal Services

Universal services are accessible by all children and young people; and include general practitioners, primary care services, health visitors, schools and early year's provision. The mental health role of universal services is to promote positive mental health and wellbeing and to help identify, refer on and support those children who may require input from targeted or specialist services.

Tier 2 Targeted Services

Targeted services are for children and young people who may be considered to have specific identified mental health needs and/or to be vulnerable, where some low intensity monitoring/interventions may be required. Service settings include universal settings, but the provision is aimed at identified groups, not the whole population.

Tier 3 - Specialist Services

Specialist CAMHS services are for children and young people with identified complex and/or high levels of need or mental health problems. These services are provided by multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions.

Tier 4 – Highly Specialist Services

Tier 4 services are the most specialised elements of CAMHS provision and are commissioned by NHS England. Services are part of a highly specialist pathway and provide for a level of complexity that cannot be provided for by comprehensive secondary, Tier 3 community services. It is generally the complexity and severity rather than the nature of the disorder that determines the need for specialist care.

Tier 4 services include inpatient services for children and adolescents and specialist services that are provided at a regional rather than local level. Inpatient assessment and treatment and low secure services being provided at West Lane Hospital in Middlesbrough. West Lane Hospital is also the base for the specialist regional North East and North Cumbria eating disorder inpatient service for children and young people.

Although the four tier model provides a useful framework for understanding comprehensive CAMHS it is important to recognise that children and services rarely fall neatly into one tier. Children and young people may enter the system at any point and do not necessarily move up the tiers. Therefore, two services may span multiple tiers.

Health & Justice, North East & Cumbria

Forensic services are specialist services which treat patients referred by the criminal justice system because of mental health or learning disabilities conditions which have been a factor driving their offending. Tees, Esk & Wear Valley NHS Foundation Trust provide community, inpatient and rehabilitation forensic services for people with mental health problems and/or learning disabilities.

Inpatient services, including medium and low secure environments are based at Roseberry Park. Community forensic services including criminal justice liaison services that work across the whole offending behaviour pathway, for example street triage in Middlesbrough and the mental health service within all seven North East prisons are also provided.

The Clinical Commissioning Group's also have contracts with independent hospitals both in and out of the area. These provisions are utilised to support the most complex cases and offer a range of interventions.

Offenders are more likely to smoke, misuse drugs and/or alcohol, and/or suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population. Nearly half of all prisoners have anxiety or depression and nearly a third of all 13 to 18 year olds who offend have a mental health issue. For many offenders who have a mental health issue or vulnerability, prison can make their situation worse.

A high proportion of both boys and girls in secure settings have mental health needs and substance misuse issues. Approximately half of all deaths in or following police custody involve detainees with some form of mental health problem. 72% of male and 70% of female sentenced prisoners suffer from two or more mental health disorders.

Section 15 of the Health and Social Care Act 2012 gives the Secretary of State the power to require NHS England to commission certain services instead of Clinical Commissioning Groups. These include "services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description".

It is NHS England's responsibility to directly commission health services or facilities for persons who are detained in prison or in other secure accommodation and for victims of sexual assault. NHS England carries out this function through 10 Health and Justice host area teams on behalf of the 27 area teams across England.

NHS England is responsible for planning, securing and monitoring an agreed set of services for:

- Prisons
- Young Offender Institutions (YOIs)
- Immigration Removal Centres
- Secure Training Centres
- Secure Children's Homes
- Police Custody Suites
- Court Liaison and Diversion Services
- Sexual Assault Services

FACT

Only 1 in 10 prisoners has no mental disorder.

NHS England is also responsible for specialised commissioning, for people who require a secure setting within a hospital. This is hosted by Cumbria, Northumberland and Tyne & Wear area team.

Research

There is an underpinning principle to the implementation plan of using evidence based practice to information interventions and programmes.

Mental health research is becoming increasingly enshrined in care delivery of Tees, Esk and Wear Valleys NHS Foundation Trust. The growth of research within the Trust is underpinned by collaborative partnership with Durham University, where strategic research priorities of primary care, youth mental health and drug safety are supported.

Mental health research has added complexity to that of other disease areas due to associated consenting and retention issues. This makes robust links between primary and secondary care all the more necessary in order to deliver quality research as integral to the best patient experience. Working across care sectors through robust research partnerships is the aim of the new Clinical Research Network structures of the National Institute of Healthcare Research.

The outcome of the review is to ensure that social workers and social care staff are enabled to add maximum value and provide optimum professional expertise within the mental health system in respect of the social determinants of mental ill-health.

Local Government Association (Sector Led Improvement) Mental Health Peer Review

A Mental Health Peer Review took place in November 2014; this challenged Hartlepool Integrated Mental Health Services in a constructive and supportive process and identified achievements, opportunities to improve the design and delivery of these services.

The overall aim of the Peer Review will be to contribute to ensuring that wherever social workers are managed, the infra-structure has to be in place to ensure that their role is maintained to achieve the best possible social care services for people with mental health problems in Hartlepool.

Summary of findings November 2014

LGA – Peer Challenge	Service Delivery	Working together	Vision, strategy and Leadership
Key Strengths	Benefits of integration recognised and supported at all levels	The importance of the HWBB was recognised as a lever for change	The MH Champion is passionate about improving services
	Strong performance in number of people using Direct Payments	The MH Forum and MH plan was a good example of interagency working.	The councils committee structure allows all members to be involved in a proactive manner
	Evidence of different disciplines sharing tasks	Good multi agency development of a Mental Health Crisis Concordat	There is a willingness to ensure a clear strategic direction of travel for mental health
Areas for consideration	Capacity within the teams with pressures on AMHP Rota's	Ensure date is pooled to assist with planning, using data to better inform planning	Ensure MH is woven into the wider councils corporate and financial planning and given higher priority by HWBB
	Availability of professional leadership and supervision needs to be consistent across teams	Council to consider closer working relationships across Tees to effect strategic commissioning	Recent changes in personnel represents an opportunity to clarify and streamline roles and responsibilities
	Informal communication	Further work to reduce high levels of	Implications and consideration in relation to

	across teams could be improved	placements in long-term care	the care act and mental health

Funding

No other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact[26]. The annual cost of mental ill-health in England is estimated at £105 billion[27]. By comparison, the total costs of obesity to the UK economy is £16 billion a year[28] and cardiovascular disease £31 billion[29].

NHS Hartlepool and Stockton on Tees Clinical Commissioning Group are actively involved in the development of a Clinical Quality and Innovation Scheme (CQUIN) which operates across the wider Tees Esk and Wear Valley area. Nationally mandated schemes are supplemented by local incentives which are jointly developed by Providers and Commissioners. CQUIN is used to continuously improve and drive the quality or services though financial incentives which, in total amount to 2.5% of the contractual value.

FACT

There is a wider economic impact of mental health; full costs in England have been estimated to be £105.2 billion a year.

During 2014/15 the scheme has ten indicators, three of which are nationally defined and seven that have been developed locally. These cover a diverse range of services and in most cases are closely linked to the No Health without Mental Health strategy. The schemes are developed on an annual basis with indicators from the previous year moving into the generic requirements of the contract and others being further developed in the following year's scheme.
The Implementation Plan sets out to ensure that we are using existing funding efficiently and effectively to commission quality mental health services which meet the needs of our communities. Ensuring we achieve value for money is vital because of the constraints on available funding in future years.

Implementation & Governance

The Implementation Plan will be led by the Mental Health Forum which is a sub group of the Health and Wellbeing Board and is a mechanism for engagement, consultation and involvement with service users and carers to support the work of the Health and Wellbeing Board.

The Task & Finish Group will become the Strategy Implementation Group and be responsible for overseeing the priorities set out in this plan (Table 1). The

[26] Promoting mental health & preventing mental illness, Freidli, L & Parsonage, M (2009)
[27] The Economic and Social Costs of Mental Health Problems in 2009/10 (2010) Centre for Mental Health
[28] Tackling obesities: future choices (2007) Project report Government Office for Science Foresight
[29] Prevention of cardiovascular disease at population level (2010) NICE

membership of the group will include key agencies, service user and carer representatives as well as a wide range of stakeholders.

The group will produce and be responsible for the delivery of the detailed action plan and will report directly to the Hartlepool Mental Health Forum.

The final document will be agreed by the Health & Wellbeing Board. There will be a number of actions underpinning each priority which will be developed by the Implementation Plan Steering Group as soon as this plan is agreed. The Implementation Plan will then be reviewed and revised on an annual basis.

Table 1 – Local Priorities

NHWMH Objective	Local Priorities	Lead Organisation(s)
1. More people will have good mental health *More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well*	Ensure that local people get the best possible start in life, including mental health support for expectant and new mothers	CCG
	Improve the uptake and awareness of good mental health resilience – mental health first aid	HBC
2. More people with mental health problems will recover *More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live*	To evaluate the Recovery College	CCG
	To maintain a focus on a recovery approach	CCG
	Support a multi-agency Skills Funding Agency community learning pathway bid	HBC
	Implement the recommendations of the Local Government Association (LGA) and Directors of Adult Social Services (ADASS) Mental health peer challenge: • Refresh the Joint Strategic needs Assessment (JSNA) for Mental health ensuring data is aligned to better inform planning • Explore the potential to use the existing Tees Integrated Commissioning Group forum to extend its remit to include Mental	HBC / CCG

	Health • Appoint to a new Locality Manager for the Integrated Mental Health Service • Refresh the existing service directory and develop Information, Advice and Guidance that is Care Act compliant. • Create a review function in the affective disorders team to support additional capacity and reduce pressures on AMHP's	
3. More people with mental health problems will have good physical health *Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health*	To ensure Physical health needs are met	CCG
	Support a positive approach to mental health through the community activities network	HBC
4. More people will have a positive experience of care and support *Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected*	Ensure high quality of care through the implementation of the newly developed evidence based service specification for the CAMHS service and associated pathways	CCG
	Ensure that children with complex needs including mental health issues are given full and equal access whilst being assessed under the new Children and Families Act: Part 3 SEND reform responsibilities and where appropriate are able to take advantages of opportunities offered by personal health budgets including those children in special schools	CCG
	Improve transition arrangements between CAMHS and adult mental health services to ensure that there is no risk of untreated illness at this critical time	CCG

	To develop a multi-agency pathway for children with sensory process disorder	CCG
	Continuing to improve the local pathway of care for children and young people with Autism Spectrum Disorder	CCG
	Providing equality of access to equipment for children with mental health needs	CCG
	To improve Access to Psychological Therapies	CCG
	To undertake a review of the mental health gateway service model	CCG
	To consider the findings of the CQC – Mental Health Act Inspection: • Approved Mental Health Practitioners (AMHP's)are spending long periods of time locating section 12 approved doctors - Support AMHP's trough the regional forum to ensure timeliness of assessments are improved • Approved Mental Health Practitioners (AMHP's)and trust staff reported delays in accessing transportation to convey a person to Hospital - Evaluate the additional resources deployed to support a Mental Health Patient Transport Service (NEAS) • *An increased number of people were self-presenting at the reception of Roseberry Park Hospital at night* - Evaluate the impact of the new 136 assessment suite at Roseberry Park	HBC / CCG / TEWV
	Ensure that staff are aware of changes in the revised Code of Practice, including the 5 new guiding principles, the appropriate use of particular interventions and further guidance to support vulnerable groups. Equip staff with the Skills, Competence and Knowledge to ensure they are best supported to improve the lives of people with a mental health need.	HBC / TEWV

5. Fewer people will suffer avoidable harm *People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service*	Reduce the rate of admissions of children and young people for self-harm	CCG
	Implement the recommendations within the Care Act in respect to adult safeguarding and protecting people from harm	HBC
	Support the recommendations and actions from the Tees Multi Agency Crisis Care Concordat. Reporting improvements through the Mental Health Crisis Concordat Steering Group: • *Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.* • *Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.* • *Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.* • *Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.*	CCG / HBC
6. Fewer people will experience stigma and discrimination *Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease*	Work to encourage General Practices to appoint a Mental Health Champion to drive forward implementation	CCG
	Work with the mental health forum to ensure a coordinated approach to tackle discrimination - promoting an event for worls mental health day	HBC

Glossary

Our glossary lists some website links which may be useful to explain some of the terminology used within the document and to seek further information about the documents we have referred to.

Useful Websites

Mental Health A to Z
http://www.mind.org.uk/information-support/mental-health-a-z/

Types of Mental Health Problems
http://www.mind.org.uk/information-support/types-of-mental-health-problems/?gclid=CPmEn8yN6rwCFfLHtAod130Atg

A guide to Mental Health terminology
http://www.health.vic.gov.au/mentalhealth/termnlgy.htm

Mental Health: The Facts
http://www.health.vic.gov.au/mentalhealth/termnlgy.htm

NHS Hartlepool and Stockton on Tees Clinical Commissioning Group
http://www.hartlepoolandstocktonccg.nhs.uk/

North of England Commissioning Support (NECS)
http://www.necsu.nhs.uk/

Hartlepool Borough Council
http://www.hartlepool.gov.uk/

NHS England
http://www.england.nhs.uk/

Footnotes

1. Co-production: an emerging evidence base for adult social care transformation (2012) Social Care Institute for Excellence
www.scie.org.uk/publications

2. No Health without Public Mental Health, (2010) Royal College of Psychiatrists
http://www.rcpsych.ac.uk/PDF/Position%20Statement%204%20website.pdf

3. No Health without Mental Health (2011) HM Government
https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

4. No Health without Mental Health, mental health dashboard, (2013) HM Government
https://www.gov.uk/government/publications/mental-health-dashboard

5. NHS England Fiver Year Forward View
http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

6. The Care Act 2014
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

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HEALTH AND WELLBEING BOARD

22 June 2015

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

Subject: QUALITY PREMIUM 2015/16

1. PURPOSE OF REPORT

1.1 The purpose of this paper is to provide the Health and Wellbeing Board (HWBB) members with an update in relation to the Clinical Commissioning Group (CCG) Quality Premium Guidance for 15/16. This is a follow up to the paper presented to members on the 2nd March 2015 regarding the CCG operational plans and as outlined within the paper the CCG at the time of the report were not in receipt of the Quality Premium guidance and requirements for 15/16. This paper is therefore to provide members an overview of the guidance and to advise of the approach taken to select local indicators to enable final plans to be submitted to NHS England on the 14th May.

2. BACKGROUND

2.1 The Quality Premium for 2015/16 has been published, and is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvement in health outcomes. This premium will be paid to CCGs in 2016/17, and covers a number of national and local priorities.

2.2 Based on population size, the Quality Premium provides an opportunity to earn £1,428,885 should all measures be achieved. Monies will be awarded for the achievement of the following:

Nationally mandated measures;

- Reducing potential years of life lost (10%)
- Avoidable emergency admissions (30%)
- Mental health (30%)
- Improving antibiotic prescribing (10%)

2.3 For the ***avoidable emergency admissions*** there are 3 measures to choose from and CCGs were able to choose 1, 2 or 3 of these with the 30% weighting subsequently distributed evenly across the number of indicators chosen.

The CCG delivery team opted for 2 of the 3 indicators, each of which will now carry a 15% weighting - the avoidable emergency admissions composite indicator as per the 14/15 measure, plus one of the new measures around increasing weekend or bank holiday discharges. We did not select the delayed transfers of care measure as we understand from reviewing the historical data and the indicator measure (NHS delays) that the trusts do not have a consistent way of recording and the range in year is from 600 – 200 delays attributable to the NHS therefore selecting an ambition for this measure proved difficult and would be unlikely to be achieved.

2.4 For the ***mental health*** measures, there are 4 measures to choose from and CCGs were able to choose 1, 2, 3 or 4 of these with the 30% weighting subsequently distributed evenly across the number of indicators chosen.
The CCG delivery team opted for all 4 of the mental health indicators, these are all new measures to the 15/16 quality premium each of which will now carry a 7.5% weighting. As these are new measures a baseline will be determined this year with the view to identify how we can stretch performance in future years in relation to these indicators.

The measures are;

- Achieving 95% or greater of patients with MH needs being seen in under 4 hours in A&E;
- Reduction in percentage of people with severe mental illness who smoke;
- Increase in proportion of adults in contact with mental health services who are in paid employment;
- Improvement in health related quality of life with people with a long-term mental health condition.

2.5 There are also a number of **NHS Constitution** indicators that will impact on the Quality Premium. Failure of these indicators mean that monies will be deducted for non-achievement, therefore even when a CCG has achieved the national and local indicators, should a constitutional measure be failed the % penalty will be applied.
These are:

- RTT; 90% completed admitted; 95% completed non-admitted and 92% incomplete standard (10%)
- Maximum four hour waits for A&E departments – 95% standard (30%)
- Maximum 14 day wait from an urgent GP referral for suspected cancer – 93% standard (20%)
- Maximum 8 minutes responses for Category A (Red 1) ambulance calls – 75% standard (20%)

3. LOCAL INDICATORS

3.1 There were choices and decisions that required formal agreement of Health and Wellbeing Boards set out in the guidance, however due to the late publication of the guidance and the requirement for CCG planning

documents to be submitted to NHS England by 14 May 2015, coupled with National and local elections and purdah there was no opportunity to present the information to the Health and Wellbeing Boards due to meetings not taking place during the election period.

3.2 The CCG in the absence of a HWBB has therefore worked with both Local Authority Public Health teams to sight them on the requirement of the quality premium guidance and submission and agreed relevant indicators to be selected as local measures from the CCG Outcome Indicator set and those that linked with the JSNA.

3.3 The **two local measures** discussed and selected for submission for the plans are:

- Improving estimated diagnosis rate for people with dementia stretching our planning target from 69% to 72%
- A reduction in maternal smoking at delivery from 14/15 to 15/16

3.4 It was agreed as both indicators were selected by the HWBB and CCG in previous years that these should continue to be an area of focus. Members will be minded that the dementia indicator is a performance measure of BCF plans therefore stretching this target will help achieve not only BCF but the quality premium measure.

4. RECOMMENDATIONS

4.1 Health and Wellbeing Board members are requested to note the update and ratify the local indicators as selected by the CCG and Public Health colleagues.

5. REASONS FOR RECOMMENDATIONS

5.1 To ensure that Health and Wellbeing Board members are updated and kept appraised of progress and actions undertaken in order to deliver our agreed joint vision.

6. BACKGROUND PAPERS

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7. CONTACT OFFICER

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HEALTH AND WELLBEING BOARD

22 June 2015

Report of: Director of Public Health

Subject: TEES WIDE SUICIDE PREVENTION IMPLEMENTATION PLAN 2014-16

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 Non-key Decision

2. PURPOSE OF REPORT

2.1 To:-

i) Present to the Board the Tees Wide Suicide Prevention Implementation Plan (attached at **Appendix A**);
ii) Bring to the Board's attention recommendations made by Middlesbrough Borough Council's Health Scrutiny Panel in relation to the Tees Wide Suicide Prevention Implementation Plan (attached at **Appendix B**); and
iii) Consider the referral of the Tees Wide Suicide Prevention Implementation Plan to the Council's Planning Committee.

3. BACKGROUND

3.1 Suicide is a major issue for the Teesside population and a leading cause of years of life lost in Teesside. Suicide is often the end point of a complex pattern of risk factors and distressing events, and the prevention of suicide has to address this complexity. Suicides are not inevitable and most are preventable. There are many things that services, communities, individuals and society as a whole can do to help prevent suicide.

3.2 In addressing the issue of suicide prevention, the Tees Suicide Prevention Implementation Plan 2014-2016 has been developed. The Plan mirrors the national Suicide Prevention Strategy and is monitored through each of the Health and Wellbeing Boards across the Tees Valley, with the aim of:-

Action 1: Reducing the risk of suicide in key high-risk groups.
Action 2: Tailoring approaches to improve mental health in specific groups.
Action 3: Reducing access to the means of suicide.

Action 4: Providing better information and support to those bereaved or affected by suicide.
Action 5: Supporting the media in delivering sensitive approaches to suicide suicidal behaviour.
Action 6: Supporting research, data collection and monitoring.

3.3 In July 2014, Middlesbrough Borough Council's Health Scrutiny Panel explored the link between deprivation across Middlesbrough and levels of suicide and in doing so requested further information regarding the Tees Suicide Prevention Implementation Plan. This information was considered on the 21 October 2014, and the Panel agreed that:

- A recommendation be made to the Planning Authority in relation to the Tees Suicide Prevention Implementation Plan, asking that the Planning Authority should receive the details of the action developers will take in terms of suicide prevention e.g. safety fencing; and

- Other scrutiny panels across the Tees area be asked to explore the same issues with a view to making a similar recommendation.

3.4 Middlesbrough Borough Council's Health Scrutiny Panel report went on to be considered by the Tees Valley Joint Health Scrutiny Committee on the 22nd January 2015. The Committee supported the views and recommendations of the Middlesbrough Health Scrutiny Panel and in doing so recommended that each Local Authority be asked to explore the issues affecting their local authority area and if appropriate make recommendations in line with the recommendations of Middlesbrough Borough Council.

4. ACTION REQUESTED AGAINST OVERVIEW AND SCRUTINY RECOMMENDATIONS MADE BY OVERVIEW AND SCRUTINY

4.1 In taking forward the recommendations put forward by Middlesbrough Borough Council's Health Scrutiny Panel, to assist the Board in gaining an understanding of the issues affecting Hartlepool details of local suicide data, gathered over a 17 year period (1997-2013), is provided below.

4.2 <u>Overall Data</u>

- 152 suicides in a 17 year period.
- The annual total of suicides in Hartlepool has fluctuated over the period – between15 in 2011 less than 5 in 2010 – every year within the 17 year period falling within this range.
- Males account for 76.1% (102) of all suicides.
- Average age for males and females who committed suicide was 43 years for males and 51 years for females.
- 99% (99) were white British.
- Most frequent marital status was single 49% (66) followed by divorced / separated 22% (29), Married 19% (26), and widowed 7% (10).

- Living status 48% (70) were living alone. Higher for males 50% (56) – females 42% (14). A further 26% were living with a spouse/partner.
- Employment status – 46% (67) were unemployed or not in paid work; 25% (37) were either employed or waiting to start work and 16% (23) were retired. Higher number of males not in paid work compared to females, however 42% (14) females were classified as housewives and so also not in paid work.
- Those with housing status recorded (45), 36% (16) owned their own property, with a further 42% (19) renting.
- Most frequent days of death – Sunday, Monday and Tuesday with 16.5% each.

4.3 Information on Death

- Hanging/strangulation the most frequent method of suicide with 52% (79) of suicides followed by self-poisoning with 30% (45) Clear difference in gender in Hartlepool for these suicide methods. 56% (99) of males used hanging/strangulation compared to 38% (13) for females, whilst 53% (18) females used self-poisoning compared with 23% (27) for males.
- Most common location is still the home.
- From 2005 the main contributing theme of the suicide was multiple diagnoses and relationship problems with 11% (7) each, followed by ill health and mental health problems.

4.4 Substance used for self-poisoning

- 44 used the method of self-poisoning. (12) analgesic, (9) multiple substances and the rest a variety of substances including antidepressants, paracetamol, opiates, etc.
- 35% of all clients had alcohol in their system at the time of death

4.5 Location

4.5.1 Levels of suicide in Hartlepool mirror those of deprivation with significantly higher numbers in north east of the town compared to more rural Hartlepool.

4.6 What we are doing to prevent suicide in Hartlepool

4.6.1 In Hartlepool we:

- Joint commission across Tees a mental health training hub providing awareness and training for a wide range of key workers from a variety of organisations and businesses in the town – both statutory and voluntary.
- Provide bereavement counselling including counselling specific to those who have been bereaved by suicide.
- Promote and support World Mental Health day to raise awareness and reduce stigma.
- Encourage workplace policies that support mental health through the Health at Work Award.

- As a local authority provide mental health awareness training for managers to better support staff.
- Provide details of local services to support good mental health through the Hartlepool Now website.
- Promote the newly-developed GP/Primary Care e-learning package

4.7 Following consideration of the Plan **(Appendix A),** the recommendations of the Health Scrutiny (**Appendix B),** and the position in Hartlepool as outlined in Sections 4.2 to 4.6, the Board is asked to consider the appropriateness of recommending that the Tees Wide Suicide Prevention Implementation Plan be considered in the development of Council's Local Plan and any policy relating to the built environment.

5. RECOMMENDATIONS

5.1 That the Health and Wellbeing Board:

i) Notes the recommendations of Middlesbrough Borough Council's Health Scrutiny Panel;
ii) Explore the issue of suicide in Hartlepool, with the assistance of the information provided in Sections 4.2 to 4.6;
iii) Recommend that the Tees Wide Suicide Prevention Implementation Plan be considered in the development of Council's Local Plan and any policy relating to the built environment.

6. REASONS FOR RECOMMENDATIONS

6.1 To provide information on suicide issues in Hartlepool and ascertain from the Board its wishes in relation to a potential recommendation to the Planning Committee or that the Plan be considered in the development of Council's Local Plan and any policy relating to the built environment.

7. BACKGROUND PAPERS

The following background papers were used in preparation of this report:-

(a) Tees Suicide Prevention Implementation Plan 2014-16
(b) Middlesbrough Council's Overview and Scrutiny Board – Tees Suicide Prevention Implementation Plan – 21 October 2014
(c) Minutes of the Tees Valley Joint Health Scrutiny Committee held on 22 January 2015

8. CONTACT OFFICER

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(01429 266522)

Tees Suicide Prevention Implementation Plan 2014 – 2016

Hartlepool

Middlesbrough

Redcar & Cleveland

Stockton

Foreword from the chair of the Tees Suicide Prevention Taskforce

Suicides are not inevitable , in most cases they can be prevented. Suicide and non-fatal self-harm account for more than 4000 deaths and 200,000 hospital presentations every year in England. Local audit across Tees shows that between January 2008 and December 2010, 128 people took their own lives. Of these:

- 20 were from Hartlepool
- 36 were from Stockton-on-Tees
- 35 were from Middlesbrough
- 37 were from Redcar & Cleveland

Further details on the epidemiology of for suicide and self harm across Tees is available through the joint strategic needs assessment (www.teesjsna.org.uk).

Factors that lead to suicide are complex but nonetheless preventable. Preventing suicides requires multi-agency action as well as efforts at an individual, family, community and local authority level. The current economic climate and the welfare reforms present significant challenges for health and well-being in general and more specifically emotional well-being and mental health. The success of suicide prevention depends upon several inter-connected factors; leadership, local champions, identification of suicide prevention as a priority, availability of resources and the long-term survival of suicide prevention groups. This implementation is the local response to the national suicide prevention - *Preventing suicide in England, A cross-government outcomes strategy to save lives* launched in September 2012. This implementation plan brings together, through the Tees suicide prevention taskforce, key partners, local knowledge about groups at higher risk of suicide, applying the evidence of most effective interventions and most importantly highlighting resources needed to implement these plans. The plan will be supported by a work programme which goes into more detail on the key activities and the milestones for the taskforce. The taskforce has already made progress in the following programmes:

- The introduction of an early alert system to ensure the timely identification of trends.
- Middlesbrough Safer Care ensuring all substance misuse staff have ASIST training.
- Development of a Primary Care Suicide Prevention Awareness E-learning platform that will be available across the region.

Suicide and self harm prevention needs to be everyone's business. I look forward to working with you to prevent suicides and self harm across Teesside.

Edward Kunonga
Director of Public Health, Middlesbrough Council
Chair – Tees Suicide Prevention Taskforce

Introduction

Suicide is a major issue for our local population and a leading cause of years of life lost in Teesside. Nationally the number of people who take their own lives has been reducing in recent years. However, the UK rate increased significantly between 2010 and 2011 and in England the rate increased by 6% between 2010 and 2011 from 9.8 to 10.4 deaths per 100,000 population. By 2012 the rate remained at 10.4. In 2011 the suicide rate was highest in the North East at 12.9 deaths per 100,000 population rising from 11.2 deaths per 100,000 population in 2010. (ONS 2013). By 2012 there was a slight drop recorded at 11.9 deaths per 100,000 population with the North West now being the area with the highest rate. The North East however remains the second highest.

The average cost of suicide for those of working age in England is estimated to be around £1.67m per case (at 2009 prices). If this estimate is applied to the North East of England the projected cost to the local economy is £410.8 million for the 246 cases of suicide and undetermined injury recorded in 2012.

Suicide is often the end point of a complex pattern of risk factors and distressing events, and the prevention of suicide has to address this complexity. Suicides are not inevitable; indeed most are preventable (WHO 2004).

There are many things that services, communities, individuals and society as a whole can do to help prevent suicide.

Preventing suicide in England is a cross government outcomes based strategy produced in 2012 to help save lives and build on the work achieved by the last suicide prevention strategy. The local suicide prevention taskforce therefore seeks to drive local implementation of this new strategy and coordinate partnership working in Teesside and ensure that prevention is everyone's business.

From April 2013, local authorities became responsible for leading on local public health and improvement, which includes coordinating and implementing work on suicide prevention. The local suicide prevention taskforce is working on strengthening local partnerships and developing its own action plans focusing on how the national strategy action points are implemented in a way that reflects local population needs.

In Feb 2013, the taskforce held a seminar for service providers across Teesside. The purpose of the seminar was to seek local input into how the national suicide prevention strategy may be implemented. The findings from that event will inform the local strategy and subsequent action plans.

Preventing suicide in England; a *cross government outcomes strategy to save lives*

Preventing suicide in England; a *cross government outcomes strategy to save lives* is a national all age prevention strategy which aims to build on the successes of the earlier strategy published in 2002.

The overall objectives of the National Strategy are:

A reduction in the suicide rate in the general population in England; and
Better support for those bereaved or affected by suicide.

The Strategy identifies six key areas for action to support delivery of these objectives:

1. Reduce the risk of suicide in key high-risk groups
2. T ailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

Key Area for Action 1: Reduce the risk of suicide in key high-risk groups

Some groups of people are known to be at higher risk of suicide than the general population. The high risk groups that have been identified nationally are:

- Young middle aged men
- People in the care of mental health services including inpatients
- People with a history of self-harm
- People in contact with the criminal justice system
- Specific occupational groups such as doctors, nurses, veterinary workers and farmers

What's the current picture on Teesside?

Across Teesside the highest number of suicides are among young men (aged 20- 59). Compared to the national average of 1 female death for every 3 male deaths Teesside there is a ratio of 2.8 male deaths for each female death. There are variations by local area which are described in more detail in the JSNA. The other high risk groups across Tees are:

- *People with mental health problems – the local audit identified people who had contact with mental health services within 3 months of dying by suicide*
- *People with previous history of self harm*
- *People in contact with the police and the criminal justice system*
- *People in certain occupations such as the* care sector for women and labouring, engineering, construction and drivers for men.

The local audit of suicides in Tees also identified a higher percentage of suicides involved people who were not in employment and living alone.

There is a disproportionate distribution of suicides across Teesside with more suicides occurring in people living in deprived compared to affluent wards. Further details are available on the JSNA website www.teesjsna.org.uk

What are we going to do in Teesside?

1. Use local suicide audit data and the early alert system to identify local high risk groups and develop intervention strategies.
2. Ensure pathways of care are communicated across all partner agencies.
3. Support the provision of a GP and Primary Care suicide prevention awareness e-learning platform which includes the risk assessment and management of the suicidal patient.
4. Support national, regional and local campaigns to challenge mental health stigma and discrimination.
5. Encourage workplace policies that support mental health.
6. Support self-harm and suicide prevention programmes/activities.

Key Area for action 2: Tailor approaches to improve mental health in specific groups

As well as targeting high-risk groups, another way to reduce suicide is to improve the mental health of the whole population. The approach to improve public mental health needs to be applies across the life course, starting from pre-birth all the way to the older age groups. It should include a blended approach that combines universal with targeted approaches especially for high risk and vulnerable groups. Across Teesside these groups include:

- Children and young people known to mental health services
- Vulnerable children such as: Looked after children, children in need, carers and those in the known to the Youth Justice Services
- Survivors of domestic and sexual abuse or violence
- Veterans and ex-service personnel
- People living with long term conditions
- People with untreated depression and other mental health conditions
- People who are especially vulnerable due to social and economic circumstances – unemployed, homeless
- People who misuse drugs or alcohol
- Lesbian, gay, bisexual and transgender (LGBT)
- Black and Minority Ethnic (BME) groups
- Asylum seekers and refugees
- Older people with social isolation
- People who have recently lost their jobs or businesses
- People recently bereaved – especially those bereaved by loosing a family member, friend, relative to suicide.

What are we going to do in Teesside ?

1. GP Practices to complete the GP audit tool to capture data regarding any potential suicide.
2. Monitor the potential impact of the current economic climate and welfare reforms on mental health, self harm and suicide and work with other agencies to ensure appropriate support is available.
3. Ensure all primary, secondary and third sector organisations are aware of local data and regional service developments that support the needs of specific groups.
4. Promote the use of the on line e-learning resource on transgender available free at http://www.gires.org.uk/localauthorities.php#elearning

Key Area for action 3: Reduce access to the means of suicide.

One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. This is because people sometimes attempt suicide on impulse, and if the means are not easily available, or if they attempt suicide and survive, the suicidal impulse may pass. Suicide methods most amenable to intervention include:

- Hanging and strangulation in psychiatric inpatient and CJS settings
- Self-poisoning
- Those at high risk locations
- Those on the rail and underground networks

The media also has an important role in avoiding reporting and portraying new high lethality methods of suicide that may increase the number of fatal attempts

Local Suicide and Undetermined Injury Audit 2009-2012

Local audit shows that the majority of all deaths are by hanging with this method being used in 71% of all male deaths and 39% of all female deaths. Self poisoning was the method of death in 13% of all male deaths and 36% of all female deaths.
Locally only in Middlesbrough between 2009-2012 was there overall more self poisoning than hanging

Local high risk locations:

- Along River Tees including Bridges
- Saltburn Cliffs (including Huntscliff)
- Skinningrove Cliffs
- Redcar Sea Front
- Prison

What are we going to do locally?

1. Use the suicide prevention audit, early alert system and information from partner agencies such as the criminal justice services to identify any local hotspots.
2. Identify responsibilities for the design, development and maintenance of suicide prevention signage.
3. Ensure multiagency awareness of any local hotspots identified including safeguarding leads.
4. Support the ongoing work between the Samaritans, British Transport Police and Network Rail to reduce suicides on the railways.
5. Work with local Heads of Pharmacy to support safe prescribing and encourage the return of unused prescribed medication.
6. Encourage local authority planning departments and developers to include suicide in health and safety considerations when designing structures.

Suicide Prevention - Key Contacts

SAMARITANS:Phone: 08457 90 90 90 (24 hour helpline)
Email: jo@samaritans.org
Write to: Chris, PO Box 9090, Stirling, FK8 2SA
www.samaritans.org.uk

HOPELineUK [PAPYRUS] Young suicide prevention society (under the age of 35)
Phone: 0800 068 4141 (free from landlines Monday-Friday 10am – 5pm and 7pm -10pm, and 2pm – 5 pm on weekends)
www.papyrus-uk.org

Survivors of Bereavement by Suicide (SOBS)
helpline: 0844 561 6855 web: www.uk-sobs.org.uk

Cruse Bereavement Care
tel. 0844 477 4900 web: www.crusebereavementcare.org.uk

Depression Alliance
tel. 0845 123 2320 web: www.depressionalliance.org

Campaign Against Living Miserably [CALM]). A campaign and charity set up to reduce the high suicide rate among young men (under 35).
Helpline: 0800 585858 (free from landlines 5pm – midnight every Sat, Sun, Mon and Tues
www.thecalmzone.net info@the CALMzone.net

Key Area for action 4: Providing better information and support to those bereaved or affected by suicide

Family and friends bereaved by a suicide are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves. Studies show that in addition to immediate family and friends, many others will be affected in some way. They include neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, faith leaders and witnesses to the incident.

There may be a risk of suicide clusters or 'copycat suicides' in a community, particularly among young people, if another young person or a high-profile celebrity dies by suicide.

In order to prevent suicide clusters or copycat suicides it is important that real time data is available to monitor local trends and ensure early intervention to prevent further cases. In Tees an early alert system is in place which allows the suicide prevention taskforce to monitor patterns of suicide and instigate prevention and early intervention at the earliest opportunity.
This system which was adopted from the County Durham and Darlington Suicide Prevention Taskforce has proved to be a very useful for surveillance tool and for informing local action.

Local Suicide and Undetermined Injury Audit 2009-2012

Across Tees, bereavement featured as a contributing factor in 11.7 % of suicide cases. Most of these cases had lost family members i.e. partner or parents, siblings or other relative. Half of these cases had been bereaved a year or more prior to death with less than five having been bereaved within the year leading to their death.

There a gaps in the current provision of information and support for individuals bereaved or affected by suicide across Tees. There is need for a full review of the current service provision and ensure there is specialist provision for those individuals, families and communities affected by suicide.

What are we going to do in Teesside ?

1. Evaluate current service provision for those bereaved or affected by suicide.
2. Identify if there is a need for the development of specialist services for those bereaved or affected by suicide.
3. Provide information about local, regional and national services available for those bereaved or affected by suicide including how to access.
4. Consideration of the establishment the increasing trend/cluster management protocol.

Key Area for action 5: Support the media in delivering sensitive approaches to suicide suicidal behaviour

The media have a significant influence on behaviour and attitudes. There is already compelling evidence that media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk. With the increasing popularity of social media more work needs to be done to make these safer especially for young people who can easily be influenced or affected by information communicated through these channels.

The media can be supported to deliver sensitive approaches to suicide and suicidal behaviour by:

- Promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media
- Continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services

The national suicide prevention strategy encourages local services and agencies to work with their respective local and regional newspapers and other media outlets,, to encourage responsible reporting of self harm, suicidal behaviour and suicide cases. This can be achieved by providing information on local sources of support and helplines for mental health, suicide and self harm when reporting incidents.

What are we going to do locally?

1. Promote the use of the Samaritans media guidelines for reporting suicides and self-harm.

2. Develop a communications strategy which;
   - reflects the guidelines,
   - identifies strategies to report unhelpful media stories and
   - promote the use of details of sources of information and advice being given at the end of any relevant media story.

3. Provide positive promotional materials that
   - encourage help seeking behaviour,
   - support understanding and recognition of those at risk, what to do to support someone and where to go to for help.

Key Area for action 6: Support research, data collection and monitoring

Intelligence and surveillance of suicides, self harm and mental health are the foundations of suicide prevention efforts. Further national and local research is required to address gaps in knowledge on self harm, suicidal behaviour and suicides. The national strategy outlines the following areas to support research, data collection and monitoring:

- Build on the existing research evidence and other relevant sources of data on suicide and suicide prevention
- Expand and improve the systematic collection of and access to data on suicides
- Monitor progress against the objectives of the national suicide prevention strategy
- Reliable, timely and accurate suicide statistics are the cornerstone of any suicide prevention strategy and of tremendous public importance

What is the situation on Teesside?

The suicide prevention task force produces an annual report on local suicide and undetermined injury deaths across Teesside. These reports are used to inform local suicide prevention strategies and to monitor their effectiveness. In addition there is an early alert system in place which allows the coroners officer to inform the local suicide prevention team of any potential death by suicide and undetermined injury in order that any increasing trends or potential clusters are identified and acted upon in a timely fashion.

More work is required to understand the epidemiology of self harm across Teesside. Whilst there are a number of agencies that collect self harm data, further analysis is required to help inform targeted preventative action.

Self harm related admissions in Tees are among some of the highest in England and more work is required to understand the local picture in more detail and interventions put in place to address these issues.

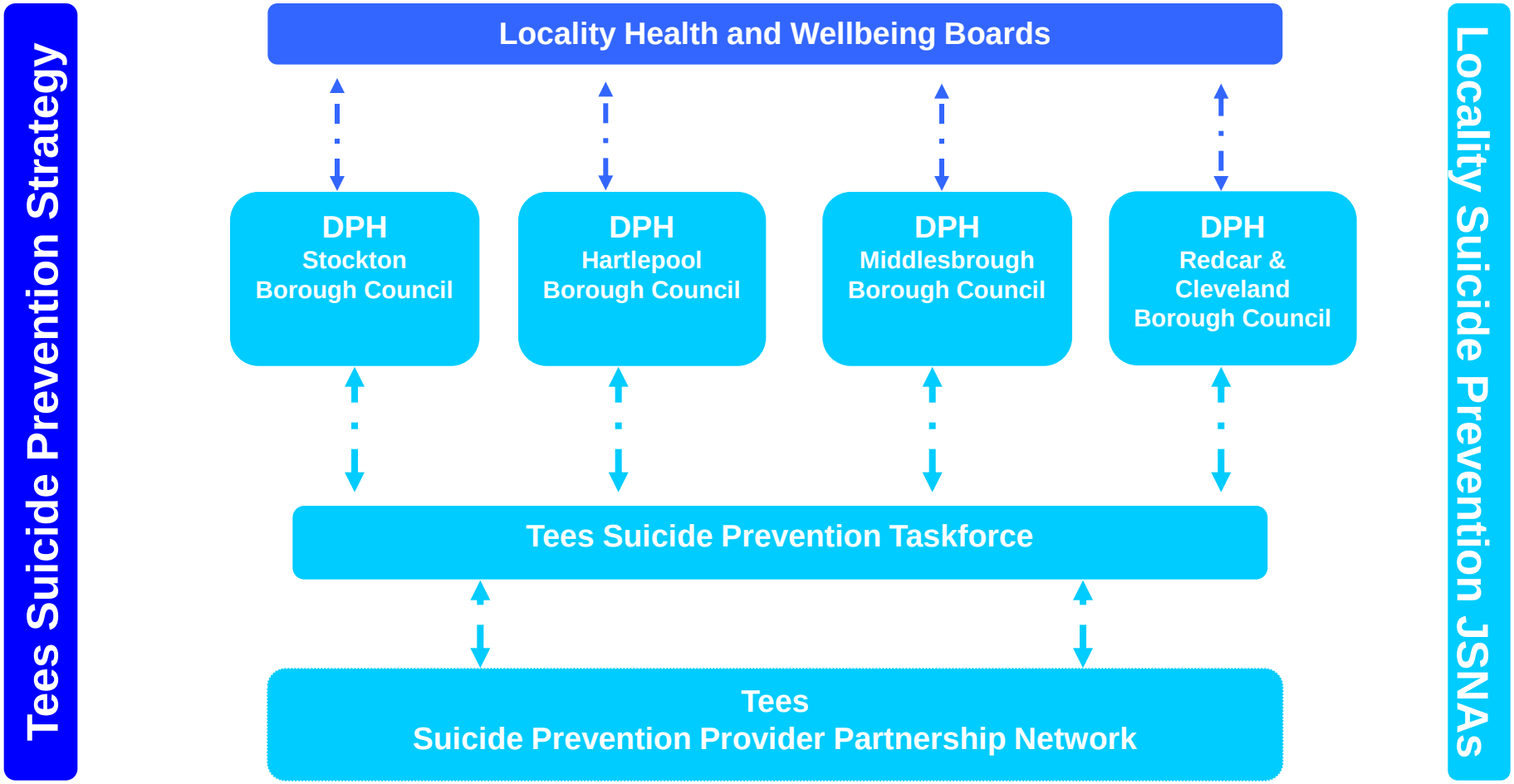
What are we going to do locally?

1. Pilot a 'near miss' review process within a high risk group.

2. Explore opportunities for partner agencies to collect and share data regarding suicide and self harm and link to the public health suicide audit.

3. Provide regular updates to the CCGs and Mental Health and Wellbeing Boards regarding the local audit data and early alert system.

Suicide Prevention governance arrangements across Middlesbrough, Hartlepool, Stockton and Redcar & Cleveland



Suicide Prevention – Local Contacts

- Ring NHS 111 for urgent access to services - 24 hours a day, 365 days a year.

- Contact your general practitioner (GP). If you do not have a GP or do not know your GP's telephone number contact 111 or visit
  www.nhs.uk

- **Redcar & Cleveland People's Information Network (PIN)**
  www.peoplesinfonet.org.uk

- **South Tees CCG IAPT Information**
  http://www.southteesccg.nhs.uk/about-us/mental-health-services/

4.3 Appendix B

MIDDLESBROUGH COUNCIL

OVERVIEW AND SCRUTINY BOARD

21 OCTOBER 2014

TEES SUICIDE PREVENTION IMPLEMENTATION PLAN – Response from the Health Scrutiny Panel

PURPOSE OF THE REPORT

1. To provide members of the Overview & Scrutiny Board with an update on the findings of the Health Scrutiny Panel, following their meeting regarding the Tees Suicide Prevention Implementation Plan.

BACKGROUND INFORMATION

2. At a panel meeting in July, Members received a presentation from the Director of Public Health. In discussing the levels of deprivation across Middlesbrough, Members were particularly interested in whether or not there was a link between the pattern of deprivation across the town and levels of suicide.

3. Members heard that there was a Tees Suicide Prevention Implementation Plan which had been developed to address these issues and Members were keen to receive further information.

THE PANEL'S FINDINGS

4. The panel met on 15 September to receive information about the plan and discuss its content. During that meeting the panel heard that suicides are not inevitable and in most cases they can be prevented. Preventing suicides does however require a multi-agency approach as well as efforts at an individual, family, community and local authority level. It was also noted that the current economic climate and the welfare reforms are presenting significant challenges for people's health and well-being in general and more specifically people's emotional well-being and mental health.

Suicide Audit

5. The panel were advised that the Trust had undertaken a suicide audit in the four areas of Teesside and Darlington and the information had been fed in to the Tees Suicide Prevention Taskforce. Between 1997 and 2013, 289 suicides had taken place in Middlesbrough, which was the second highest number in the Tees area (behind Stockton with 293). Whilst the number of suicides had fluctuated over a 17 year period there had been a decreasing trend in numbers.

6. In terms of age range and gender, it was reported that males accounted for 76% of suicides, which was in line with the national picture. The key trend was predominantly males aged 35-49 (43%) and 25-34 (23%) with the highest number in females aged 35-45 (over 50%).

7. The panel heard that data was not captured or analysed in relation to attempted suicides, despite the fact that it was believed that around half of those who committed suicide would have made previous attempts.

8. Statistically, the most frequent month for suicides was January, followed by May and October. Research had indicated that a trend had developed for suicides occurring in Spring time, this coincided with changes in daylight and it was assumed that people were more motivated to act.

9. Other factors that impacted on deaths by suicide were

> **Marital and living status.** 47% of suicides were carried out by single people, followed by 22% that were divorced/separated and 21% were married. From the data, it was noted that 56% (9 people) were widowed and aged 75 or over at the time of death, 62% (29 people) of those that were married at the time of death were aged 35-49 and 58% (51 people) of those that were single were aged 20-34. 45% (122 people) were living alone at the time of suicide with 79% of those being male.
>
> **Employment and housing.** 52% of those that had committed suicide were either unemployed or not in paid work and 13% were retired. In relation to housing, it was highlighted that data was often missed around property ownership, but figures showed that around 43% owned their own property with a further 30% in rented accommodation.

Types of Suicide

10. The Panel was advised that the most frequent method was hanging/strangulation at 45%, followed by self-poisoning at 32%. This presented a clear difference in gender with 52% of males using hanging/strangulation compared to 24% for females, whilst 57% of females used self-poisoning compared to 23% for males.

11. Jumping from a height was the third most frequent method of suicide in Teesside and it was noted that there were many high points in this area. No information was available about the numbers of people who had been talked down from such structures. However it was thought that, in order to help people in those circumstances, it would be helpful if better signage was available which could provide details of useful support services such as the Samaritans.

12. Looking at the themes in the reasons why people commit suicide, the panel found that a diagnosis with health issues, particularly multiple diagnoses, was the most common with 23%, followed by relationship problems with 13% and mental health diagnoses with 10%. Depression and anxiety or relationship and family problems contributed to multiple factors and this was the picture both nationally and locally.

Location

13. A Map of Middlesbrough was shown to the Panel which provided a breakdown of deaths by suicide by Ward. Middlehaven and Gresham Wards had the highest numbers of suicide and this mirrored the highest levels of deprivation in north/central Middlesbrough.

14. Members queried whether historical information was available in relation to suicide numbers and whether there had been any change. Members were informed that it was difficult to map the information prior to 1997 but there had been a target to reduce suicide by 20% and that the recorded reduction for that period was 18%, however, it was noted that since the recession the rate had begun to increase.

Preventing the means to suicide

15. Research showed that if access to the means of suicide was reduced, then naturally suicides committed by that method also reduced as people did not seek to find an alternative method. It was highlighted that research had showed that a substitute affect tended not to occur, for example, the introduction of North Sea gas and catalytic converters in cars had resulted in a significant reduction in the overall numbers of suicides. In some cases, individuals who would have planned to commit death by suicide and would go to a certain point to do so, however, if that was interrupted, for whatever reason, they would not then go and find an alternative means. Therefore part of the strategy involved the consideration of how to prevent the means of suicide and in particular access to bridges and other high points. Adaptations such as building netting around bridges could be considered but it was noted that this could be a costly option.

16. The Panel considered that reducing means was a key part of the strategy and suggested that physical suicide prevention measures, such as safety fencing/netting and signage, should be incorporated into new developments at the planning application stage. The Panel agreed to make a recommendation to the Planning Authority in relation to this.

17. It was highlighted that the Council's highways department had advised of incidents that had occurred at the Zetland Multi Storey Car Park and it was proposed that the top floors of the car park would be netted and there were plans to provide signage there for people who felt suicidal which would give details of where to access help and support.

The Tees Suicide Prevention Implementation Plan

18. Joe Chidanyika, Health Improvement Specialist and Public Mental Health Lead with Middlesbrough Council was also in attendance at the meeting to guide Members through the Tees Suicide Prevention Implementation Plan 2014-2016, which mirrored the national Suicide Prevention Strategy.

19. Preventing suicide in England: a cross Government outcomes strategy to save lives, was a national prevention strategy aiming to build on the successes of the earlier strategy published in 2002. The overall objectives of the National

Strategy were to reduce suicide rates in the general population in England and to better support those bereaved or affected by suicide.

20. The Strategy identified six key areas for action to support the delivery of the following objectives -

- Reduce the risk of suicide in key high risk groups.
- Tailor approaches to improve mental health in specific groups.
- Reduce access to the means of suicide.
- Provide better information and support to those bereaved or affected by suicide.
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
- Support research, data collection and monitoring.

21. The Tees Suicide Prevention Implementation Plan represented the four boroughs in the Tees area and the document was currently out for consultation. It was acknowledged the factors leading to suicide were very complex and suicide prevention required multi-agency action. The Tees Suicide Prevention Taskforce fed into the Plan along with other key partners and highlighted the resources need to implement the Plan. The taskforce had already made progress in the following areas:-

- Introduction of an early alert system to ensure the timely identification of trends.
- Middlesbrough Safer Care ensuring all substance misuse staff have ASIST training.
- Development of a Primary Care Suicide Prevention Awareness E-learning platform that would be available across the region.

22. The Panel was informed that, nationally, the current rate of deaths by suicide was 8.5 deaths per 100,000 of the population. This figure was slightly higher in the North East. The current figure for Middlesbrough was 10.8 per 100,000. There was an estimated that the cost of suicide to the local economy in the North East was approximately £410.8 million for the 246 recorded cases (in 2012) of suicide and undetermined injury.

23. The panel enquired as to whether information was available in relation to those admitted to hospital for attempted suicide or self-harming. The Panel was advised that information was available but a detailed analysis had not yet been carried out in terms of self-harm data. There were also cases where an individual might have self-harmed but was not severe enough to present to the health services.

24. Members were concerned that substance misuse was not identified within the Key Area for Action 1. Members were informed that substance misuse formed part of the key high risk groups, and in response to concerns regarding the apparent disjointed work in Middlesbrough in relation to substance misuse, it was reported that the Middlesbrough Partnership would commence a pilot project in the near future around women's substance misuse.

25. Members were interested as to whether suicide rates within the BME community were comparable, Members were advised that the Coroner did not record ethnicity, however, research indicated that this was a high risk group, together with refugees/asylum seekers.

26. One of the key areas for action was about identifying high risk groups, one of which was people with mental health problems. The local audit had identified people who had contact with mental health services within three months of dying by suicide. It was queried how well GPs were identifying people with mental health issues who might be at risk. The Senior Practitioner stated that it appeared to depend on where the individual lived and that many GPs did not have a focus on mental health. It was noted that mental health was currently not a compulsory element of a GP's training but this was to be changed.

27. Reference was made to the region having the highest prescription rates of anti-depressants in the country and it was queried whether Clinical Commissioning Groups were commissioning an alternative such as social prescribing, which considers more creative solutions to get to the root of problems. Members were advised that the CCG was working towards that, in conjunction with Public Health but that there was still a long way to go. The MVDA had now been commissioned to lead on social prescribing.

28. A Communication Strategy would be developed as part of the action plan that would, amongst other things, promote the use of detailed sources of information and advice given at the end of any relevant media stories and it would also identify strategies to report unhelpful media stories. It was noted that the media would be encouraged to promote the use of the Samaritans and there would be media guidelines for reporting suicides and self-harm. In addition, the Panel was advised of the 'Stay Alive' app which had been signed up to by Public Health England that provided details in relation to sources of help available.

29. It was considered that ensuring emotional well-being was a key factor in suicide prevention and that everyone needed to be made aware of the signs people, who may have emotional wellbeing problems, might display. Councillors deal with a wide variety of people on a regular basis and it was thought that the training that had been commissioned in Teesside would be beneficial to them in their role.

30. Mental health first aid training and ASIST training (Applied Suicide Intervention Skills Training) were being offered by MIND. The training gave a practical outline of the types of questions to ask and how to help develop a safe plan for the individual concerned. The panel agreed that it would be useful to share this information with all Middlesbrough's Councillors.

CONCLUSIONS

31. The panel made a number of conclusions which are as follows
    a) That a major factor in preventing suicide was the removal of the means or factors that deterred or made it difficult
    b) The panel were supportive of the work of the public health team in their preparation and delivery of the plan.

c) The panel were keen to assist the team in publicising the plan and strengthen the team's work in preventing the means of suicide by making a recommendation to the planning authority.
d) The panel wanted to be kept up to date with the developments in this area and the general implementation of the strategy.

RECOMMENDATIONS

32. The panel make the following recommendations

a) That a recommendation be made to the Planning Authority in relation to the Tees Suicide Prevention Implementation Plan, asking that the Planning Authority should receive the details of the action developers will take in terms of suicide prevention e.g. safety fencing
b) That other scrutiny panels across the Tees area be asked to explore the same issues with a view to making a similar recommendation.
c) That a copy of the Tees Suicide Prevention Implementation Plan be circulated to all Members of the Council.
d) Those Councillors are made aware of the mental health first aid training, ASIST Training and on-line training.
e) That the Public Health Team be invited back to the panel in 6 months' time, along with representatives of MVDA in order for the panel to consider the progress with social prescribing.

ACKNOWLEDGEMENTS

33. The panel would like to thank the following people for their attendance at the meeting

- Joe Chidanyika, Health Improvement Specialist – Public Health, Middlesbrough Council
- D Colmer , Senior Practitioner, Suicide Prevention – Tees, Esk and Wear Valley NHS Foundation Trust

BACKGROUND PAPERS

34. Minutes of the Health Scrutiny Panel 15 September 2014.

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HEALTH AND WELLBEING BOARD

22 June 2015

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

Subject: SCRUTINY INVESTIGATION INTO DEMENTIA: EARLY DIAGNOSIS – FINAL REPORT AND ACTION PLAN

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1. PURPOSE OF REPORT

1.1 To agree the Action Plan in response to the findings and subsequent recommendations of the Dementia Working Group's investigation into Dementia: Early Diagnosis.

2. BACKGROUND

2.1 As a result of the Scrutiny investigation into Dementia, a series of recommendations have been made. To assist the Health and Wellbeing Board in its determination of either approving or rejecting the proposed recommendations an action plan has been produced, (attached as Appendix A) and is detailed along with the Final Report and recommendations of the Working Group attached as **Appendix B.**

3. PROPOSALS

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

4. IMPLICATIONS OF RECOMMENDATIONS

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

5. RECOMMENDATIONS

5.1 The Health and Wellbeing Board is requested to approve the proposed recommendations and to approve the action plan in response to the recommendations of the Dementia Working Group's investigation into Dementia: Early Diagnosis.

6. REASONS FOR RECOMMENDATIONS

6.1 The aim of the investigation was to gain an understanding of the work that is currently ongoing in Hartlepool in relation to dementia and to examine how services assist with early diagnosis.

7. BACKGROUND PAPERS

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

Final Report of the Dementia Working Group into Dementia: Early Diagnosis

8. CONTACT OFFICER

Laura Stones – Scrutiny Support Officer
Chief Executive's Department – Legal Services
Hartlepool Borough Council
Tel: 01429 523087
e-mail: laura.stones@hartlepool.gov.uk

COUNCIL SCRUTINY ENQUIRY ACTION PLAN

NAME OF COMMITTEE: Dementia Working Group

NAME OF SCRUTINY ENQUIRY: Dementia: Early Diagnosis

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION+	FINANCIAL / OTHER IMPLICATIONS	LEAD OFFICER	COMPLETION DATE*
That Council:- (a) Pledge their support towards Hartlepool becoming a Dementia Friendly Town	Pledges received from key Council Members, pledges being gathered from key council officers. Dementia Friendly Community accreditation obtained, secretary of the DFC steering group to arrange for a launch event – to be raised at next steering group meeting	None	Co-ordination Jeanette Willis	Complete
That the Health and Wellbeing Board:- (b) Raise awareness of dementia in order to promote a greater understanding of the condition across:- (i) Council departments by encouraging Council staff to become dementia	Dementia Friends sessions already been rolled out across the council 70 trained so far with	None financial, some time resources	Jeanette Willis/DFC Steering	Complete - In place ongoing awareness

	friends to raise awareness of the signs/symptoms and also the services available;	a further 50 in partner agencies. Further training to be offered through the Dementia Friendly Communities project & internally via Commissioning team HBC	required	Group	raising programme
(ii)	Organisations/businesses in Hartlepool, with the aim of each organisation/business pledging their support towards a Dementia Friendly Hartlepool; and	Already many local organisations signed up to DFC – official launch will be conduit for promotion to wider community and organisations	Printing & Advertising – to be shared across steering group partners	DFC Steering Group (HBC contact Jeanette Willis)	Early Summer
(iii)	Communities and the general public.	Hartlepool Now – revised information and advice system to be accessed by all professionals and can be accessed by community if internet access available. All providers will link to this site contractually to ensure information is up to date and relevant. The Bridge – community central hub for dementia – established by Hospital of God to complement all dementia services.	In place – wider promotion through other council departments outside of Adult Services & local communities None	Leigh Keeble	Complete -In place ongoing promotion across the council, partner agencies and communities Complete - Opened May 2015
(c)	Explore how support to people with dementia and their families	Identified dementia social workers in each of the locality	Established currently	John Lovatt	Complete - In place

/ carers can be maximised and co-ordinated across all services, including the establishment of identified individuals responsible for maintaining contact and co-ordination	teams in Adult Services. Dementia Advisory service currently out for tender to ensure information and advice available from diagnosis through to end of life. Dementia contract let October 2014 incorporating, day opportunities and personalised support in the community. Additional services provided by the successful organisation (Hospital of God) include home to hospital support and carer support services. ICLES (Intensive Community Liaison Services) working into Care Homes and Community Dementia Liaison Service both provided by TEWV contracted by CCG. Review to be undertaken in coming months to ensure sustainability and effectiveness. Proactive approaches to be taken following review to ensure actions are not retrospective.	Subject to successful tendering process Established contract None	Jeanette Willis Jeanette Willis Jeanette Willis/John Lovatt	July 2015 Complete - In place Review by CCG Summer 2015

[+] please detail any risk implications, financial / legal / equality & diversity / staff / asset management considerations
* please note that for monitoring purposes a date is required rather than using phrases such as ‘on-going’

HARTLEPOOL
BOROUGH COUNCIL

DEMENTIA WORKING GROUP

FINAL REPORT

DEMENTIA: EARLY DIAGNOSIS

MARCH 2015

HARTLEPOOL
BOROUGH COUNCIL

COUNCIL

16 March 2015

Report of: DEMENTIA WORKING GROUP

Subject: FINAL REPORT – INVESTIGATION INTO DEMENTIA: EARLY DIAGNOSIS

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1. PURPOSE OF REPORT

1.1 To present the findings of the Dementia Working Group following its investigation into Dementia: Early Diagnosis.

2. BACKGROUND

2.1 The Audit and Governance Committee met on the 7 August 2014 to consider their Work Programme and agreed that the Committee would set up a working group to look at dementia. With effect from 24 November 2014, Health Scrutiny responsibilities were transferred from the Audit and Governance Committee to Full Council and from this date all members of Council were invited to attend the dementia working group meetings.

2.2 Dementia is one of the most pressing issues relating to older people. It has a range of symptoms including memory loss, mood change, and problems with communication and reasoning that are brought about by diseases that damage the brain, such as Alzheimer's disease. It is progressive and at present there are no cures.

2.3 It is predicted that the number of people in Hartlepool who have dementia will increase significantly in the next 16 years from 1,171 in 2014 to 1,811 in 2030[1]. This is an increase of approximately 40% and is a key pressure at a time of shrinking resources. The Joint Strategic Needs Assessment for Hartlepool identifies this increase as a key priority that requires action and this is also reflected in Hartlepool and Stockton on Tees Clinical Commissioning Group's commissioning intentions.

2.4 Lack of early identification of people with dementia and formal diagnosis remain an issue that impact on early intervention. Reasons for this include:

[1] Projecting Older People Population Information - Institute for Public Care at Oxford Brookes University

- lack of information;
- lack of awareness and confidence in dealing with people with dementia by both the general public and medical and support staff; and
- The taboo - dementia remains a subject that many people find hard to talk about, much like cancer was 15 – 20 years ago. We all know someone who has it or is affected by it but we don't talk about it.

2.5 Adult Services support people with dementia and / or their carers through a range of services that are provided in the community or in people's own homes, including day services and residential care. There is also a significant amount of work ongoing at the present time involving Adult Services and a range of partner organisations to explore the possibility of Hartlepool becoming accredited as a 'Dementia Friendly Community'.

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION

3.1 To gain an understanding of the work that is currently ongoing in Hartlepool in relation to dementia and to examine how services assist with early diagnosis

4. TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION

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

(a) To examine the incidence and prevalence of dementia from a population health perspective;

(b) To gain an understanding of dementia and the diseases that are associated with dementia including diagnosis and current treatments;

(c) To gain an understanding of the work that is currently ongoing in Hartlepool, including how awareness is raised and the progress towards a dementia friendly community; and

(d) To explore and examine how services contribute to the early identification of people with dementia and identify whether there is anything further that can be done to aid early diagnosis

5. MEMBERSHIP OF THE DEMENTIA WORKING GROUP

5.1 The membership of the working group is as detailed below:-

Councillors J Ainslie, S Akers-Belcher, K Sirs, G Springer, P Thompson and C Wilson (Independent Person)

The membership of Full Council is as detailed below:-

Councillors Ainslie, C Akers-Belcher, S Akers-Belcher, Atkinson, Barclay, Beck, Brash, Clark, Cook, Cranney, Dawkins, Fleet, Gibbon, Griffin, Hall, Hargreaves, Hind, Jackson, James, Lauderdale, Lilley, Loynes, Martin-Wells, Morris, Payne, Richardson, Riddle, Robinson, Simmons, Sirs, Springer, Thomas and Thompson.

6. METHODS OF INVESTIGATION

6.1 Members of the working group met formally from 7 November 2014 to 6 February 2015 to discuss and receive evidence relating to this investigation. A detailed record of the issues raised during these meetings is available on request.

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

(a) Setting the Scene presentation from the Director of Public Health;

(b) Presentation and verbal evidence received from Tees, Esk and Wear Valleys NHS Foundation Trust;

(c) Presentation and verbal evidence received from Adult Social Care;

(d) Verbal evidence received from the Hospital of God;

(e) Visit to Minerva House held on 8 January 2015; and

(f) Focus Group held on 6 February 2015

7. FINDINGS

INCIDENCE AND PREVALENCE OF DEMENTIA FROM A POPULATION HEALTH PERSPECTIVE

7.1 Members welcomed evidence from the Director of Public Health who presented information to the group regarding the prevalence of dementia and highlighted that dementia was a relevant public health concern. In 2010/11, there were approximately 440 people with dementia recorded on general practice registers in Hartlepool and in 2011/12, this rose to 0.54%, similar to the England average (0.53%).

7.2 Members were informed that the number of people aged over 65 with dementia is expected to increase by 15% in the next 5 years, and by 30% within ten years. By 2022, there is likely to be 1,300 people with dementia in Hartlepool, compared with 1,030 in 2012. In the UK there are approximately 800,000 people with dementia; the prevalence of dementia almost doubles every five years after the age of 60. Globally, it is estimated the number of people with dementia will rise from around 35.6million in 2010 to 115.4 million in 2050 unless prevention efforts succeed.

7.3 There are a range of lifestyle behaviours that could potentially increase a person's risk of developing dementia including smoking, obesity and physical activity, however, that said, more longitudinal research is needed over many decades to test the causal relationships between modifiable lifestyle determinants and dementia. There needs to be greater public awareness, such as Public Health England supporting the Dementia Friends Campaign and the training of the wider workforce. It was questioned whether it could be said categorically that smoking, obesity etc could be linked. The Director of Public Health stated that further research needed to be undertaken to be 100 percent sure of the causes.

8. DEMENTIA AND THE DISEASES THAT ARE ASSOCIATED WITH DEMENTIA INCLUDING DIAGNOSIS AND CURRENT TREATMENTS

8.1 The Working Group received evidence from representatives from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). The group were informed that dementia is a term for a range of acquired disorders which worsen over time. It affects a range of different cognitive functions including:- memory, language, visuo-spatial ability, executive functioning (ability to plan/organise). This can result in changes in mood and behaviour, such as being withdrawn, anxious, sad, restless, agitated). There are over 50 causes of dementia, the most common being Alzheimer's disease, vascular dementia, fronto-temporal dementia, korsakoff (from heavy alcohol use) and dementia with lewy bodies. Dementia affects people at different stages of life, affects different parts of the brain and at different speeds.

How is Dementia diagnosed?

8.2 The group were informed that a clinical interview is carried out, which includes an assessment of physical wellbeing (including any head injuries, infections), and family history, education etc. Cognitive screening is used and there are different profiles for each type of dementia. Different forms of cognitive screening include mood assessments, CT, MRI or SPECT scans. Further tests may be carried out, such as neuropsychology tests. Members questioned whether dementia could be self diagnosed. It was highlighted to Members that a professional was required to diagnose dementia. Dementia can only be conclusively diagnosed post mortem. If people have one type of dementia this can increase the risk of having another and many people have mixed types of dementia. The person's personality, environment, opportunities for life to remain meaningful and supporting relationships all affect how the dementia presents.

Dementia Care Pathway

8.3 The group explored TEWV's dementia care pathway. The pathway begins pre-diagnosis for people with cognitive deterioration where dementia is suspected. The pathway includes all individuals except people with a

diagnosed learning disability. There are key points throughout the pre-diagnosis assessment, which include providing information; gaining consent (or not); assessing depression; conducting a carers assessment, communicating with the GP and conducting a diagnostic discussion with psychiatry, psychology and specialist nurses. Members questioned the variations in diagnosis across GP surgeries. NHS England does look at variations across practices to reduce inequality.

8.4 The dementia care pathway post diagnosis for medication consists of physical checks, information gathering and seeking consent. A titration clinic appointment is arranged for 4 weeks later and a letter is sent to the GP regarding initiation of medication, ideally within 24 hours but it must be within 5 days. Within 30 days of the diagnostic appointment, there is a post diagnostic face to face discussion with the patient and carer. Items that are discussed are deciding rights, lasting power of attorney, reconsideration of referrals to other professionals and a discussion on research / the Jooin Dementia Research system, which is a new national system from the National Institute for Health Research (NIHR) and TEWV are the first organisation from outside of London to join the system. Members questioned whether many patients look after themselves. Representatives confirmed that an assessment would be made and it may be that the person can be independent or maybe home care could help, for example, to ensure that medication is taken. Non pharmacological interventions may be used post diagnosis, for example, psycho-education, psychological therapy and cognitive stimulation.

8.5 In Hartlepool, care delivery is through the Mental Health Services for Older People Team, which is based at Sovereign House, Hartlepool. The Team has a multi-disciplinary approach to the delivery of care and operates 5 days a week from 9am to 5pm. It has out of hours support 8am – 8pm from the Teesside Intensive Community Liaison Service. After 8pm, people should contact their GP or the emergency duty team. A representative from TEWV praised the commitment of two social workers from Hartlepool Council for their outstanding commitment in dealing with a recent case. Members commented that they do not often hear of the good work carried out and would welcome more examples of outstanding work carried out. The team delivers patient centred care in partnership with the individual, their carers and other linked professionals, guided by the Care Programme Approach.

8.6 Members were informed of the referral process into the Community Mental Health Team. It is an open referral process, with GPs able to refer to the team. The referral rate is increasing, as per below:-

2012: 501 patients referred
2013: 558 (11% increase in referral rate)
2014: 548 to November (18% increase forecast)
31% increase in referrals over 3 years.

The referrals are pre-diagnosis, and not all are relating to dementia. At present the team has a caseload of around 700 people.

8.7 The Community Mental Health Team has links with other agencies, for example, social care, primary care, dementia reablement practitioner, the Community Liaison Service, the dementia collaborative, the TEWV Acute Hospital Liaison Service, Hartlepool Carers and Hospital of God. Members were informed that the key to good integration is health and social care working together.

9. DEMENTIA SERVICES IN HARTLEPOOL AND HOW PEOPLE WHO HAVE DEMENTIA ARE SUPPORTED BY ADULT SERVICES AND LOCAL PROVIDERS

9.1 The Head of Strategic Commissioning presented information to the group demonstrating that the broad challenges for Local Authorities were around awareness, good quality information and early diagnosis; high quality residential services; services in the community; good housing and related support; intermediate care and End of Life Care.

9.2 Members were informed that the dementia services in Hartlepool are as follows:-

- 483 residential placement beds
- 62 nursing residential placements
- 121 beds dual registered for residential or nursing
- The hospital of God provides a social inclusion and support service incorporating day opportunities, community pastimes, memory/carer cafes
- Intensive Community Liaison Service, offering support for care homes
- Extra care is provided in Hartfields and Laurel Gardens
- Direct Payments
- Domiciliary Care Services

9.3 The group was informed about the North of Tees Dementia Collaborative which involves five statutory organisations working together to improve services for people with dementia and their families / carers. Sustained improvements have been made to current working practices. The Dementia Collaborative uses a systematic approach to looking at areas to be analysed, specific task and finish groups have been established to drive projects forward, for example, medical checks in care homes. The Collaborative has also become a means of sharing innovative activity and in April 2014, a 5 day workshop was held with the overarching aim to make sure a care home resident had a peaceful and dignified death, with care delivered by a caring and respectful workforce. The pilot period took place in four care homes, all registered with the Gold Standard Framework. There is also a current training programme underway with care homes.

Progress towards a Dementia Friendly Community in Hartlepool

9.4 A dementia friendly community is a community where people are aware of and understand more about dementia and people with dementia will feel included in their community. The interest from Hartlepool in dementia friendly communities came from a discussion at the Hartlepool Dementia Forum with the initial discussions of interest gaining overwhelming support. In Spring 2014 a project was established to identify other interested parties. The group was informed that, to date, 18 organisations have expressed an interest in being involved including representatives of every department of Hartlepool Borough Council. An action plan has been established with 4 specific work streams, with a core working group to drive the project forward. Progress towards a dementia friendly community in Hartlepool is underway, the activities so far include, identifying local priorities for building a dementia friendly community identified through consultation with people with dementia and their carers. Approximately, 80 Dementia Friends have been recruited for all departments of the Council and five new dementia friends Champions have been trained. An application has been made to Hartlepool and Stockton-on-Tees Clinical Commissioning Group's "Innovation /Ideas Cave" to fund a part time development worker (by Hartlepool Voluntary and Development Agency on behalf of the project). Advice from regional national sources indicates that dedicated work time is crucial to a projects success. A draft directory of services for people with dementia identifying key organisations that can offer support has been produced and information distributed by each core organisation has been mapped. The group was informed of the dementia friendly organisations in Hartlepool.

9.5 The next step to progress the dementia friendly community is to agree arrangements for formal sign up and pledging and then gain accreditation. Members questioned how accreditation would be gained. In order to gain accreditation, each organisation has to pledge to say how they are going to become dementia friendly and then this pledge is presented to Dementia Friends at a national level. For example, the pledge could be that employees are aware of what to do if a person with dementia needs help. Argos has set up an area where customers can go to if they need help or look as though they might need help. The pledges all need to be 'future proof' and embedded into the organisation so that they continue when existing staff and management leave the organisation. There is an option to go for accreditation for the whole of Hartlepool or in smaller pockets of communities in Hartlepool. It was the view of the Modernisation Lead that Hartlepool should do it all in one go.

9.6 The group questioned how Elected Members could help. Officers responded by saying that it is about integrating dementia across all Council services. A steering group has been established, which consists of representatives from all organisations that have expressed an interest in the project together with representatives from all Council departments. It was highlighted that the Headland Parish Council is including dementia in their Neighbourhood Plan to make it an integral part of the community.

The Hospital of God

9.7 The Hospital of God is a charitable organisation and provides a range of services / activities for people with Dementia, as listed below:-

- Hartlepool Day Centre provides day care for older people with dementia and support for their carers. Once a month a Memory Lane Café is held. These have been set up to provide people with dementia and their carers with opportunities to enjoy social activities together in a friendly and informal environment with the presence of supportive staff.

- Home from Hospital provides people with dementia with emotional and practical support on admission into hospital, for the duration of stay and upon discharge. This specialised service will support the person with dementia and their family in order to minimise their stay in hospital and prevent readmission by providing practical support before, during and after their stay in hospital. Support is provided for up to six weeks after discharge and the service is free to the patient.

- Stichell House is a residential care home

- Gretton Court is a nursing home for people with dementia.

- Community Pastimes is for people who want to have one to one support to carry out activities in the community or at home. These activities could be going shopping, attending leisure facilities, the cinema or museums.

- Carer Support Service.

- Community Service – the information and advice hub for people in Hartlepool to call in if they need some advice on memory loss and dementia.

- Minerva House – Members visited Minerva House which is located in Horden. It is a new and innovative resource for people with dementia and their carers and is available to people living in the East Durham Area. Members were very impressed with the building and how it had been designed to be dementia friendly. Members would welcome a facility similar to Minerva House in Hartlepool and the Hospital of God was refurbishing Gretton Court to the same standard.

9.8 The work and ethos of the Hospital of God and the dedication of their staff and how they supported people from the very early stages of dementia was praised. The Hospital of God is a smart organisation and their values shone through. Members asked what the average age of people with dementia was at Gretton Court and representatives confirmed that it was on average from 70 years upwards (although referrals were accepted for people who were younger than this). It was highlighted that Gretton Court provided the right ethos for care and should be used as a benchmark. Representatives

from the Hospital of God informed Members that Gretton Court was due to be refurbished in the New Year.

9.9 HealthWatch commented that when they carry out inspections of care homes, they always look at levels of staffing/training, and have always found that Gretton Court is good and it should be used as a blueprint of how things should be across the care sector.

9.10 The group asked about the financial position and how this would affect the future of services. The Assistant Director commented that it is a challenge and the Council are currently planning how to make the best use of the Better Care Fund, which aims to stop people going into hospital and support people at home / in the community. Within the Better Care Fund (BCF) there is an area that focuses on dementia. The group was informed that the Better Care Fund is aimed at refocusing spend from acute services into community based activity so consequently this is a reshaping of how resources are spent and it is intended to integrate health and social care.

9.11 The representative from HealthWatch informed the group that the consistent message that comes across to HealthWatch is that people are to be supported in the community longer before going into a care setting. It was highlighted to Members that the cost of supporting people in the community properly and safely can be significantly more expensive than providing care in a care home setting. People / families wishes need to be taken into account as well as the management of risk.

9.12 The Council's Head of Strategic Commissioning highlighted to Members that the Council are really successful with working with providers and has acknowledged that the providers are the experts in the field and the Council are the conduit to share learning. This allows providers to be innovative, flexible and gets the best out of people. The group questioned whether the system that the Council were implementing was the correct one. Officers responded and said yes because in the past there seemed to be a tendency to consider people with dementia as the exception, but this has to change and people with dementia should be considered as the rule.

9.13 In conclusion, Members were informed that the next 5 years will be very difficult with the driver to keep people at home / in the community longer. However, in the past 6 years, progress has been made and services for people with dementia and their families / carers have improved. This progress now needs to be built upon with all sectors and organisations. One of the key messages that the group was informed about was that it is possible to live well with dementia.

10. HOW SERVICES CONTRIBUTE TO THE EARLY IDENTIFICATION OF PEOPLE WITH DEMENTIA AND IDENTIFY WHETHER THERE IS ANYTHING FURTHER THAT CAN BE DONE TO AID EARLY DIAGNOSIS

10.1 A Dementia Focus Group was held on 6th February 2015 and an analysis of the comments from the Focus Group is provided below.

Introduction

10.2 The event was attended by approximately 25 to 30 people from a range of backgrounds: people with dementia and carers, people providing support services to people with dementia and their carers, commissioners of services and elected members. The purpose of the meeting was to gauge people's views, understanding and feelings about what dementia meant to them.

10.3 Discussions took place in 3 mixed groups and which looked at:

- What does Dementia mean to you?
- What do you do if you think someone has dementia?
- What services do you think there are to support people with dementia?
- Do you think there is more you can do to diagnose dementia?
- How do you think we could work to better improve services for people with dementia and their families?

10.4 As well as participating in the group discussion, participants were also given the opportunity to write their own comments on "post-it notes." These are also included in the write up of the group.

What does Dementia mean to you?

10.5 All three groups initially identified the negative impact of dementia in terms of what it meant to them. The word dementia still brings a sense of fear, there was also frustration and a lack of knowledge about where to go for help and then a lack of understanding about what was happening.

10.6 However there were also positive comments with people suggesting that we can help people to live well. Whilst it has a large impact on life it's not the end of life "I am still me." There is also humour in it, from stories that help deal with it.

What do you do if you think someone has dementia?

10.7 Most people suggested that GPs were the people to contact if you suspected someone has dementia but there was concern about the variability of the response not just to the person with dementia but the carer or family member too. This included GPs who were not prepared to work with family members until lack of capacity had been established, a reluctance to diagnose dementia and also a large variation about knowledge diagnosis and treatment.

10.8 Other suggested points of contact for people who may have dementia were:

- Social services,
- Memory Lane [cafes],

- Talking and support,
- Memory Clinic,
- Friends and family
- Getting power of attorney set up as soon as possible

10.9 Using accessible language was also seen as important as was the importance of 5 or 6 clear messages of guidance about what to expect.

10.10 There was strong support for improved pathway that supports the person with dementia and the carer /family at all points, including after initial contact but before a confirmed diagnosis is given. The support should also be flexible enough to change as circumstances change or where other illnesses of conditions impact.

What services do you think there are to support people with dementia?

10.11 Knowledge of what services to support people with dementia and their carers and families were available was mixed. This ranged from a complete lack of knowledge e.g. " I don't know," and "Who do you ask?" it included comments about not knowing who to ask or not knowing what support is available and that isolated vulnerable people could, potentially, be missed.

10.12 Alternatively many specific services and resources were mentioned such as Memory cafes and Memory clinic, Gretton Court [Hospital of God at Greatham], Intensive Community Liaison Support (ICLES), Life Story Network, Dementia Friends [although this may not be enough on its own,] Admiral nurses [although none locally] and Talking Therapies.

Do you think there is more you can do to diagnose dementia?

10.13 Regarding identification of people with dementia it was suggested that "lay people" could look for trends and lead to early identification and diagnosis and that knowledge of symptoms can help people and have a ripple effect so awareness raising was very important. It was also seen as important for carers to be "empowered so that they are able to "challenge" GPs and other professionals where they feel things are being overlooked. Education, positive marketing, self help groups, talking to other people early diagnosis and treatment and a compassionate approach were all valued too.

How do you think we could work to better improve services for people with dementia and their families

10.14 In identifying what could work better to improve services for people with dementia and their families there was a clear imperative to maximise support to carers and families who are the ones who are usually giving the greatest support to the person with dementia. Another key point was the need for coordinated approaches preferable with single identified individuals who are responsible for maintaining contact and doing the coordination.

10.15 If people with dementia are living on their own, there is a need for appropriate prompts to ensure that they keep appointments and for appropriate support so that they can take part in activities. To facilitate this there is a need for information about more accessible services such as shops and supermarkets that have greater understanding of dementia.

10.16 A full copy of all the comments noted at the Focus group meeting is included in **Appendix 1.**

10.17 An analysis of the Working to Build a Dementia Friendly Hartlepool project consultation is also included as **Appendix 2.**

11. CONCLUSIONS

11.1 The Dementia Working Group concluded that:-

(a) One of the key messages regarding dementia is that 'people can live well with Dementia' and it is important that people understand this. There is also a need for appropriate support to be provided to people with dementia to help them live at home for as long as possible;

(b) Often the word dementia brings a sense of fear and the word dementia often has a stigma attached to it, which needs to be dispelled;

(c) Services for dementia have improved over the years and this progress now needs to be built upon with all sectors and organisations;

(d) There is a need for greater awareness and understanding of dementia in the community and workplace;

(e) Hartlepool as a dementia friendly community was supported by the group;

(f) Support to people with dementia and their carers / families should be maximised at all points in the pathway, including after initial contact but before a confirmed diagnosis.

(g) A co-ordinated approach across services should be established with identified individuals responsible for maintaining contact and co-ordination. The support should also be flexible enough to change as circumstances change or where other illnesses of conditions impact;

(h) Regarding early diagnosis, it is essential that people have knowledge of the signs / symptoms of dementia and also the services available in order to help the individual person;

12. RECOMMENDATIONS

12.1 The Working Group has taken evidence from a wide variety of sources to assist in the formulation of a balanced range of recommendations. With due regard to the evidence considered, the Working Group's key recommendations to Council and the Health and Wellbeing Board are as outlined below:-

That Council:-

(a) Pledge their support towards Hartlepool becoming a Dementia Friendly Town

That the Health and Wellbeing Board:-

(b) Raise awareness of dementia in order to promote a greater understanding of the condition across:-

(i) Council departments by encouraging Council staff to become dementia friends to raise awareness of the signs/symptoms and also the services available;

(ii) Organisations/businesses in Hartlepool, with the aim of each organisation/business pledging their support towards a Dementia Friendly Hartlepool; and

(iii) Communities and the general public.

(c) Explore how support to people with dementia and their families / carers can be maximised and co-ordinated across all services, including the establishment of identified individuals responsible for maintaining contact and co-ordination

COUNCILLOR JIM AINSLIE
CHAIR OF THE WORKING GROUP

ACKNOWLEDGEMENTS

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

Hartlepool Borough Council:

Louise Wallace – Director of Public Health

Jill Harrison – Assistant Director (Adult Services)

Jeanette Willis - Head of Strategic Commissioning Adult Services

John Lovatt – Head of Service, Adult Services

Steve Thomas - Modernisation lead, Adult Services

External Representatives:

Hartlepool residents and carers

HealthWatch Hartlepool

Sarah Straughan, TEWV

Sarah Dexter-Smith, TEWV

Keith Hopper, TEWV

David Granath – Hospital of God

Gail Defty – Hospital of God

Hartlepool Carers

Joseph Rowntree

North Tees and Hartlepool NHS Foundation Trust

Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Evidence provided to the Group

The following evidence was presented to the Working Group throughout the course of the investigation:-

Date of Meeting	**Evidence Received**
7 November 2014	Presentation and verbal evidence from:- - The Director of Public Health - TEVW
5 December 2014	Presentation and verbal evidence from:- - Adult Social Care
8 January 2015	Visit to Minerva House
6 February 2015	Focus Group

Appendix 1

1. What does Dementia mean for you?

Table 1:

- Not always negative – we can help people to live well;
- Increasing panic at the numbers;
- Younger people being diagnosed;
- Different types of dementia – co-morbidity/long term conditions;
- Do carers struggle more than the person – sometimes person is in 'world of their own'.
- Challenging to understand;
- Will it happen to me!
- Humour is in it – stories about carers – helps to deal with it!

Table 2:

- End of normal life – marriage, family it's all lost;
- Loss, heartbreak, long bereavement, loss of control;
- Where do you go for support?
- Frustrating – who to turn to;
- Changes (how) actions.

Table 3:

- Lack of ability to communicate/loss of dignity;
- Affects everybody differently;
- As a service provider have to develop as a service, put changes in place;
- Ensure staff are trained;
- 'Dementia' – word brings fear;
- Support for carers/families;
- Legal point of view – see clients from early onset right through to end stage of dementia;
- People are frightened and afraid, stigma attached – 'advertising campaigns' deliver powerful message;
- Very powerful advocates for dementia – said has impacted on life but not ended life, 'I'm still me';
- Can learn to live with dementia.

Post-it notes:

- Acceptance – very difficult – don't know how to handle it;
- Increase knowledge – change culture – myth busting;
- Not just eccentricity – carers need tolerance – person can't see they have it;
- It's not just Alzheimer's – all impact on the brain;
- Awareness is raised.

2. What do you do if you think someone has dementia?

Table 1:

- Consult GP;
- Use assessable language;
- Don't bring stigma of the 'D' word;
- Memory Lane;
- Better information;
- Memory Clinic;
- Talk, support;
- Denial always the first step;
- Diagnosis is key?? Time for annual check up?
- Awareness raising across the general public – put the message across;
- Key message – 5-6 key things – clear things;
- Ask family and friends.

Table 2:

- Ring Social Services;
- Go to doctors;
- Doctors not communicating with family until lack of capacity confirmed;
- Power of attorney – issues with bank;
- Living circumstances change – assisted housing/care home/adaptations.

Table 3:

- Service provider – good relations with PCT/HBC – referral process, informal processes in place;
- Struggled to get GP to diagnose people;
- Can be difficult to get diagnosis;
- Person with dementia may not want to discuss with doctor;
- GP difficult position – safeguard confidentiality;
- No support in place for period while waiting for diagnosis – pathways to be clearer;
- GP didn't have enough knowledge to diagnose people;
- HW picked up, real differences how surgeries diagnose;
- Gaps in service provision (result of a fall);
- Still relate to person with dementia, not the dementia;
- GP said couldn't refer unless did it themselves.

3. <u>What services do you think there are to support people with dementia</u>?

Table 1:

- Memory cafes/clinics;
- GP services;
- Social Services;
- Don't know;
- Only know if you're in it??
- Lack of knowledge;
- Gretton Court;

- Services tailored for each gender;
- Telephone/remote control/lack of dexterity – technology gap;
- Isolation – own home;
- ICLES. [Intensive Community Liaison Support]

Table 2:

- People even lots of professionals don't know what to do;
- Very vulnerable if person on their own/no family has dementia – what happens to them;
- What is the support available?
- Who do you ask?
- Carers are the ones that need support;
- Costs high especially if no personal budget entitlement.

Table 3:

- Hartlepool Carers massive support (publicise what is a carer) – nice knowing someone there;
- Didn't know where to go, who to turn to;
- Life stories, excellent;
- Hospital of God bringing in One Stop Shop – offer extra support (near library);
- Not enough services to support people with dementia, is improving with Dementia Friends;
- What about people who are alone / vulnerable people, how do we identify those people?
- Dementia Friends can help, still a barrier of fear, 'is that person going to help';
- Other generic services can identify people with dementia;
- Very difficult to get people to get help;
- Can only GP refer? More sense to self-refer into Mental Health Team/into Services;
- Admiral/Dementia nurses (none in North East);
- Variety of practices to see same GP.

4. <u>Do you think there is more you can do to diagnose dementia</u>?

Table 1:

- Professor – Durham University – DR Durham Trust – can you do P17??
- Professional only;
- Misdiagnosis;
- Lay people can look for patterns – to lead to early diagnosis;
- Education – campaign;
- Marketing – positive – government led;
- Self help groups;
- Who do! Approach other people.

Table 2:

- GP's and other professionals not listening to family and delaying diagnosis and treatment;

- Carers having confidence and knowledge to challenge GP's;
- Talking therapies;
- More compassionate approach;
- Reduce delays in diagnosis;
- Start medication early;
- Don't generalise – everyone is different.

Table 3:

- Yes;
- Pick up changes in care homes;
- But people on own, raise awareness of signs and symptoms;
- Difficult to see signs/symptoms;
- Front line staff can raise concerns;
- Knowing symptoms helps other people, ripples out;
- Part of diagnosis, don't be frightened of it or embarrassed about it, find further info – need to know where to get info.

5. How do you think we could work better to improve services for people with dementia and their families?

Table 1:

- Support for carers;
- Peer support groups;
- Transport;
- Building regulations;
- Everyday conversation;
- Acknowledgement that the carer is sometimes the voice of the person;
- Patient confidentiality;
- Alzheimer's Society Forum; - website;
- Listening and sharing;
- GP – education;
- This is me! – Hartfields;
- Services – how do they know;
- AWARENESS – EDUCATION;
- Not new – how do you tweak the ones you've got.

Table 2:

- More flexible approach;
- Continuity of SW for carers;
- Don't make us fight for our rights for treatment and services;
- Support families better;
- Educate others, GPs, banks;
- Know what you need to know when you need to know it;
- Listen;

- Centralised points for people to access, memory cafes with professional advice;
- Continuity of carers;
- Better care agencies with more commitment to involving patient and family in decisions;
- Social inclusion.

Post-it notes:

- Carer isolation will lead to mental health issues for carer;
- One person alone should not be responsible for care of a dementia sufferer;
- Care and support should be free for dementia sufferers.

Table 3:

- Services built around individual person;
- Join services up;
- Services talk to each other;
- One person in health to co-ordinate all services (good idea);
- Talking about one GP for each Care Home;
- Basic things i.e. people with appointments, if living on own need someone to prompt them of appointment;
- If GPs ringing, often doesn't work;
- Power of attorney in place much sooner;
- As service provider, have to look at how services can be more dementia friendly;
- People with dementia can take part in activities, explain to carers (have to calculate risk);
- Information in all services has to be more accessible – shops, supermarkets have greater understanding of dementia;
- People who work with general public should have some dementia training on a regular basis;
- Why have to sell a property if have dementia? Is a terminal illness (same as cancer) – not fair.

Appendix 2

Consultation with people who have dementia and their carers about the key priorities for "Working to Build a Dementia Friendly Hartlepool" September and October 2014

This report is a combined analysis of a survey of people's views carried out via a questionnaire during September 2014 and a consultation event for people with memory problems and dementia and their carers held on 10th October 2014 at Hartfields Retirement Village.

Background

The "Working to Build a Dementia Friendly Hartlepool" project is looking to develop a more dementia friendly community in Hartlepool. Dementia Friendly Communities are a national campaign to improve the lives of people with dementia and their carers.

A project group was formed to test the support for working towards a dementia friendly community. As support became clearer this group evolved into a steering group to develop the project. An action plan has been developed. Four work streams are now in place:

- Awareness raising
- Hands on working group to drive the steps of the project plan
- Information group
- Resources and funding group

Advice was sought from existing dementia friendly communities and regional and national sources. This identified that the vital first step for the project was to gather the views of people with dementia and their carers. This will be an ongoing process but to date has involved the use the questionnaires and a consultation event mentioned above.

This document looks at the information gathered through the questionnaire and consultation event and gives an analysis of the key points. Both mechanisms looked at:

- things people with dementia and their carers routinely did,
- what helps and what hinders
- things that they used to do but had stopped and the reason why
- what might help them start to do these things again
- new things that they would like to do

There were 31 respondents to the questionnaire. This included 6 people with dementia who filled it in themselves, 12 where carers completed it for the person with dementia, 2 where a care worker completed it for the person with dementia, 7 carers who gave their own view and 4 that were unattributable or did not fall in to

these categories. The consultation event was attended by 25 people who were a mixture of people with dementia and carers, approximately 1/3rd / 2/3rd respectively.

Key themes

People with dementia

People with dementia were very clear that they want to participate in the community but the sorts of things they do when out in the community are very varied. Activities described included, shopping socialising, going to football matches, visiting people and places, having lunch, going to cafes, walking and dancing. Some also identified using Hartlepool Blind Welfare and Laurel Gdns Extra care scheme.

When asked what helped people with dementia said: transport and support from friends and family, care staff. When asked what makes it more difficult it was the need for this level of support and , reliance on family or others , the need for transport often from the same people who offer support but also memory and mobility issue.

People with dementia said that they had stopped going out alone to bingo, socially and football matches, gardening and domestic activities including cooking. When asked what stopped them, people with dementia said;

- lack of transport and not being able to access activities and facilities,
- can't remember,
- impact of illness [other than dementia]
- loss of confidence
- not being cook because they couldn't remember what to do

Carers

The biggest issue for carers appeared to be lack of 'time' which leads to pressure on them. One commented to the question "are there things that you used to do but have stopped doing?" said "everything is more difficult!"

The majority of comments from carers at the consultation event were about the increasing need to take over task for the cared-for person. This included having to increasingly orientate them and reorientate them to the extent of having to "do their thinking for them." Almost universally, the comments from carers indicated that this was a very difficult and frustrating thing to do, especially when it had to be done repeatedly over a short period of time. One example of this was where a carer needed to tell the person with dementia four or more times that it was their birthday, including the person writing it down only for the note to be 'lost.'

Another main area of comments was the impact of loss of ability to cope on not only the person themselves, their carers but also on the rest of the family.

Key areas of concern

Analysis of the comments identified a number of key categories of concerns and issues for people with dementia talking about themselves and their carers views of them as well as their own thoughts about their own situation, specifically :

- Shops, shopping and going out in the community
- Transport, mobility and getting out and about including getting to the point of pick-up, accessible timetables and better signage
- Health and Hospital issues
- Activities and access to them
- Food and feeding

Carers also identified several areas where they had concerns that were not raised by people with dementia, namely

- Information and advice
- Care Homes, extra care facilities and care in the community
- Diagnosis and treatment
- Feeling under pressure
- Safeguarding and planning for the future
- Household up-keep and DIY
- Direct support for carers
- Awareness raising , training and increased tolerance
- Making sure participation works

Ideas and suggestions from people with dementia and their carers that would make Hartlepool a more dementia friendly community

- Better information giving at the point of diagnosis for both the person with dementia and their carer, whose needs for information may be different- 1:1 discussion re information and advice post-diagnosis was suggested
- Training for carers about “what to expect” and “how to handle it”
- “All About Me” and “This is Me” documents were well thought of but families and professionals including doctors, hospital and care home staff need to be better informed about them and use them to share information.
- Better “systematic” recognition of the role of the carer especially by doctors and hospital staff [use them as an “expert by experience” about the person with dementia]
- Effective use of assistive technology such as:
    - Key finders
    - Smart phone diaries
    - “buddi”
    - Magi-plug anti overflow devices
    - Phone barring – to stop cold calling
    - Liaison canisters / ”message in a bottle’
- Education and training for the whole community to improve awareness of dementia and how it affects people but also to tackle prejudice and discrimination of both the person with dementia and carers
- Home safety/ fire safety checks as a default
- Access to “Blue Badges” and RADAR toilet keys – criteria currently dominated by physical need mental need not recognised as well
- Identified “Dementia Friendly” places

- Better information to identify appropriate care and nursing homes that can meet the needs of the person with dementia, especially if there are more conditions than just dementia, which is common.
- Improved access to/facilitated access to transport in general but also specifically linked to activities, for instance, arranged transport linked to facilitated shopping and return home that can be arranged in advanced but by just 1 call!
- Improved signage both indoors and out that reflect research that has been proven to help people with dementia e.g. black floors can look like holes; white shiny floors can look like water.
- Better designed environment both in buildings and outdoors, for instance avoid the use of protective glass panels in reception settings and banks that muffle voices and standardise road crossings so they all give the same sound, visual and tactile signals ad avoiding dropped kerbs on footpaths on the apex of corners as this can disorientate people with dementia as well as those who are visually impaired
- Physically separated footpaths and cycle paths

A fuller report of the 2 events can be seen in the individual reports

HEALTH AND WELLBEING BOARD

22 June 2015

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

Subject: BETTER CARE FUND PERFORMANCE REPORTING

1. PURPOSE OF REPORT

1.1 This report provides the Health and Wellbeing Board with an update regarding the performance reporting arrangements for the Better Care Fund (BCF) and the return submitted in relation to Q4 of 2014/15.

2. BACKGROUND

2.1 The Better Care Fund has six National Conditions that must be met in order for the pooled money to be accessed. These are:

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

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

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

2.3 BCF plans were also required to include one locally determined performance measure. The agreed local measure for Hartlepool is the estimated diagnosis rate for people with dementia.

2.4 BCF plans were required to demonstrate achievement of the national conditions, and to set targets to improve performance against the national and locally determined measures. Performance against these conditions and targets will be monitored nationally by NHS England.

3. PERFORMANCE REPORTING

3.1 NHS England issued 'Guidance for the Operationalisation of BCF in 2015/16' in March 2015 (attached as **Appendix 1**). The guidance includes a quarterly performance reporting template (attached as **Appendix 2)** and confirmed dates for submission of the templates as follows:

Submission Date	Reporting Period
29 May 2015	January – March 2015
28 August 2015	April – June 2015
27 November 2015	July – September 2015
26 February 2016	October – December 2015
27 May 2016	January – March 2016

3.2 The dates for quarterly submissions are set nationally and involve collation of performance information from a number of sources across health and social care. The dates will create some challenges in terms of Health & Wellbeing Board sign off prior to submission. This will need to be addressed through delegating responsibility for sign off, with reports submitted to the Health & Wellbeing Board at the earliest opportunity.

3.3 On 11 May 2015 a revised and simplified reporting template was issued specifically for the first submission on 29 May 2015.

4. HARTLEPOOL PERFORMANCE REPORT

4.1 The revised reporting template for 29 May 2015 was completed by officers of the Council and CCG and is attached as **Appendix 3**.

4.2 Although there was no requirement to report on the performance measures for this quarter, information has been collated and indicates that improvements have been seen in a number of areas:

Performance Measure	Q4 Plan	Q4 Actual	Q4 Performance
Reduce Care Home Admissions	140	187	+ 47 admissions
Increase Access to Reablement	57	79	+ 22 people supported
Reduce Delayed Transfers of Care	547	509	- 38 delays
Reduce Non Elective Admissions	2,593	2,496	- 97 admissions
Increase Dementia Diagnosis Rate	67.99%	78.80%	+ 10.8% diagnosis rate

4.3 The one indicator where performance is not shown to have improved is admissions to care homes of people aged 65 and over. Performance against this indicator has actually improved significantly in real terms in 2014/15 when compared to the previous year, with a reduction from 145 admissions to 125 admissions over the twelve month period. This is a 13.8% reduction, which is a significant achievement in the context of demographic pressures and increasing prevalence of dementia. However, the way that this indicator is measured has changed nationally and full cost paying residents are now included within the measure. This figure has not been included in the indicator in previous years, but the change to the national definition means that the total number of admissions for 2014/15 must now be reported as 187 for 2014/15.

4.4 Performance against all of the BCF indicators will continue to be monitored throughout the year through the BCF officers group and North of Tees Partnership Board and the monthly data collected for this purpose will inform the quarterly reports.

5. RECOMMENDATIONS

5.1 It is recommended that the Health and Wellbeing Board:

- Note the performance reporting process;
- Note the report submitted on 29 May 2015;
- Note the issues raised in relation to timing of performance reports and Health & Wellbeing Board meetings and delegate authority to the Director of Child and Adult Services for Hartlepool Borough Council and Chief Officer of NHS Hartlepool and Stockton-on-Tees CCG to sign off returns, in conjunction with the Chair of the Health & wellbeing Board, if timescales do not allow for formal Health & Wellbeing Board sign off prior to submission deadlines, with reports submitted to the Board at the earliest possible opportunity following submission.

6. REASONS FOR RECOMMENDATIONS

6.1 It is a requirement that Health & Wellbeing Boards approve plans and performance reports in relation to the BCF.

7. CONTACT OFFICERS

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NHS England Publications Gateway Reference 03001

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Better Care Fund Task Force

Better Care Fund:

Guidance for the Operationalisation of the BCF in 2015-16

The Better Care Fund

Contents

PURPOSE

1. This document provides local partners to Better Care Fund plans – Clinical Commissioning Groups (CCGs), Local Authorities (LAs), and Health and Wellbeing Boards (HWBs) – with guidance on the operationalisation of these plans in 2015-16.

2. In particular it sets out:
    - the Care Act legislation underpinning the BCF;
    - the accountability arrangements and flows of funding;
    - the reporting and monitoring requirements for 15-16;
    - arrangements for the operation of the payment for performance framework;
    - how progress against plans will be managed and what the escalation process will look like; and
    - the role of the BCF Task Force / Better Care Support Team going forward.

3. There are a number of annexes that this document should be read alongside, as well as the policy framework[1] for the fund, published by the Department of Health (DH) and Department of Communities and Local Government (DCLG).

4. This guidance has been co-developed across the national organisations on the BCF Task Force with input from Local Authorities and Clinical Commissioning Groups.

LEGAL POWERS FROM THE CARE ACT (2014)

5. Under s.223G of the NHS Act 2006 (as amended most recently by the Care Act 2014), NHS England has the power to set conditions around the payment of funds to CCGs. In relation to the BCF allocation, section 223GA states that this must include a condition that funds are paid into a section 75 pooled fund, and may include (but is not limited to) conditions relating to:

    - the preparation and agreement of a spending plan by the CCG(s) and local authority party to the pooled fund;
    - the approval of the plan by NHS England;
    - the inclusion of performance objectives in a spending plan – i.e. the non-elective admissions reduction target; and
    - the meeting of any performance objectives included in a spending plan or specified by NHS England – i.e. payment proportional to performance as per the BCF Technical Guidance.

6. Where a condition is not met, s.223GA of the NHS Act 2006 (as amended most recently by the Care Act 2014) enables NHS England to:
    - ***withhold the payment*** (insofar as it has not been made);
    - ***recover the payment*** (insofar as it has been made);

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/381848/BCF.pdf

- ***direct the CCG(s) as to the use*** of the designated amount for purposes relating to service integration or for making payments under s.256 of the 2006 Act.

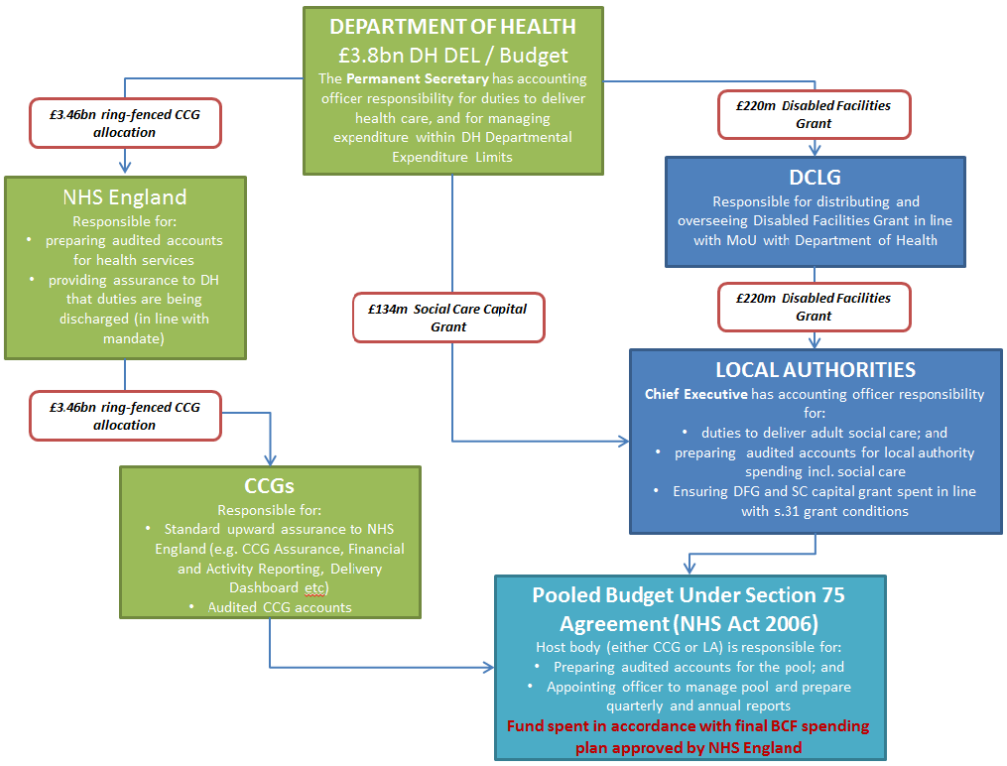
7. The three powers of intervention set out above where a condition is not met apply to the £3.46bn of the BCF that is being routed through CCGs. The powers do not apply to the remaining £354m (social care capital grant and disabled facilities grant) which will be paid by DH and DCLG directly to local authorities under s.31 of the Local Government Act 2003.

8. These powers are only triggered once the Secretary of State for Health uses his powers to include in the mandate a requirement for NHS England to ring-fence some of its funding to fund integration. The mandate for 15/16 was published on 11 December 2014 with the relevant requirements around the BCF.

9. The mandate requires that NHS England consult with the Department of Health and Department for Communities and Local Government before exercising its powers in relation to the failure to meet specified conditions.

ACCOUNTABILITY STRUCTURES AND FUNDING FLOWS IN 15-16

10. One of the recommendations of the 2014 NAO report[2] on the BCF was to develop clear accountability structures for the fund, including how accounting officers will gain assurance on how local areas spend the Fund. Below is a diagram setting out the accountability arrangements and flow of funding for the BCF.



[2] http://www.nao.org.uk/wp-content/uploads/2014/11/Planning-for-the-better-care-fund.pdf

11. In summary, at national level:
    - the full £3.8bn of funding will be part of DH's budget so overall accountability to Parliament will sit with the DH Permanent Secretary;
    - DCLG will retain policy responsibility for the Disabled Facilities Grant (DFG);
    - the NHS England Accounting Officer is accountable for the effective use of the £3.46bn of the fund which constitutes revenue grant;
    - the £3.46bn will pass from NHS England to CCGs through 15/16 allocations, and then from CCGs to pooled budgets (via section 75 agreements);
    - the capital grant monies will flow directly to LAs (from DH for the £134m Adult Social Care Capital Grant and from DH to DCLG and then to LAs for the £220m DFG), and then into the pooled budget via s.75; and
    - the monies will then be spent on services in line with their approved BCF plan.

12. At local level:
    - CCGs (Accountable Officers) will be the accountable body for their share of the £3.46bn of the BCF allocated to them by NHS England (and any additional monies they plan to voluntarily add to the pooled fund), and will be held to account by NHS England for the appropriate use of BCF resources locally; and
    - local authorities (s.151 officers) will be the accountable body, under the terms of their grant agreements, for the £354m of funding that is paid directly to them by DH and DCLG (and any additional monies they plan to voluntarily add to the pooled fund).

13. At a local level, as legal recipients of the funding, CCGs and LAs are the accountable bodies for the respective elements of the BCF allocated to them, and therefore responsible for ensuring the appropriate use of the funds. This means that they retain responsibility for spending decisions and monitoring the proper expenditure of the fund in accordance with the approved plan. At present these tasks cannot be delegated by them to the HWB. However, local authorities may be able to delegate such tasks to the HWB in the future as new regulations broadening the role of HWBs are being consulted upon[3]. LAs should check the DCLG website for progress.

14. HWBs are a valuable forum for stakeholders to come together to review performance of the BCF and consider future work. The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners. Given they are a committee of the LA, HWBs are accountable to the LA and ultimately to the LA's electorate. HWBs also have their own statutory duty to help commissioners provide integrated care that must be complied with[4]. Particularly where members of a HWB include providers delivering care that is or could be commissioned under BCF, care will need to be taken to ensure that any conflicts of interest are appropriately dealt with.

[3] https://www.gov.uk/government/consultations/proposed-local-authorities-functions-and-responsibilities-england-regulations-2015

[4] Section 195 of the Health and Social Care Act 2012

15. In terms of operational oversight of the BCF, the regulations[5] governing s.75 agreements require the agreement to set out (amongst other provisions):
    - the arrangements for monitoring the delivery of the services that it covers;
    - who the "host" organisation is that will be responsible for accounting and audit; and
    - who the "pool manager" is that will be responsible for submitting to the partners quarterly reports, and an annual return, about income and expenditure from the pooled fund, and other information by which partners can monitor the effectiveness of the pooled fund arrangements.

16. Therefore, arrangements for monitoring delivery, accounting and audit should be governed by the local s.75 agreement, in addition to the separate reporting and accountability arrangements each partner organisation will have for their share of the funding being pooled.

17. The BCF Task Force released guidance and support[6] for local areas in developing their local s.75 agreements in September which included a template s.75 agreement accompanied by an explanatory memorandum. The explanatory memorandum provides support for local areas considering their local governance and oversight arrangements. Traditionally, s.75 agreements are governed by a partnership board made up of the bodies that are signatories to the agreement. Each of those signatories should be authorised to act on behalf of their employing organisation, so the partnership board is able to make joint decisions.

18. In order for the HWB to review performance of the BCF and consider future work, it would need to have the appropriate information reported to it from a partnership board. HWBs can require CCGs that are represented on the HWB and the LA that established the HWB to provide it with relevant information, for example the quarterly reports and annual report. This can be done under section 199 of the Health & Social Care Act 2012. For the purposes of the BCF, there should be a partnership board with minimum representation across the relevant CCG(s) and LA(s) – many localities will already have a partnership board in place and where this is the case there is no need to set up one specifically for the BCF.

19. ***NHS England recommends to CCGs:***
    - ***that a partnership board is in place to govern the s.75 agreement;***
    - ***that a clause is included in the s.75 agreement that sets out what information should be included in the host partner's quarterly reports and annual reports to ensure the ability to monitor the effectiveness of the pooled fund arrangements and provide assurance to NHS England as to the appropriate use of the fund (this is explained in more detail in the next section with template reports); and***
    - ***that a clause is included to ensure the quarterly reports and annual returns are signed off by the HWB.***

[5] NHS Bodies and Local Authorities Partnership Agreements Regulations 2000

[6] http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/risk-sharing/

REPORTING AND MONITORING IN 15-16

20. The BCF will be embedded into business as usual processes in NHS England for planning, performance monitoring, assurance, and performance management[7] as far as possible. However, on the most part, this will be at CCG level rather than HWB level.

21. As previously agreed, and reflected in the assurance outcome letters, every CCG will have the following standard conditions on its BCF funding using powers under s.223G of the NHS Act 2006:
    - The fund being used in accordance with their final approved plan and through a section 75 pooled budget agreement; and
    - The full value of the element of the fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[8]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance.

22. As part of the enforcement of the first condition, NHS England can require CCGs to:
    - explain the governance arrangements they have in place; and
    - report on spending and provide evidence that it has been spent in a particular way (in accordance with their approved plan).

23. As part of the enforcement of the payment for performance condition, NHS England can require CCGs to report on their non-elective admissions, how much money has been released into the pooled fund, and if any element has been held back (in accordance with the technical guidance) what that has been spent on. Contained in annex 1 is a summary of the guidance, including information on the baseline, data source, and dates of performance and related payment. ***This information should be included in the quarterly reports and annual reports, and the s. 75 agreement should require it.***

24. The size of the final Payment for Performance pot linked to the non-elective admissions reduction ambition is likely to change from the figures reported in October in the NCAR meta-analysis[9] for the following reasons:
    - Updated baseline data to reflect actual performance for Q1-3 in 14/15, and any changes to Q4 2013/14 figures resulting from 12 month routine data revisions in MAR (Monthly Activity Return);

[7] Such as: NHS England Board Performance Report, Regional Operations and Delivery Directors report, Delivery Dashboard, Finance and Activity Report, CCG Assurance Framework

[8] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

[9] http://www.england.nhs.uk/wp-content/uploads/2014/11/bcf-ncar-results-analysis.pdf

- areas who were 'approved with support', 'approved subject to conditions' or 'not approved' may have had an action on the back of their NCAR review requiring them to resubmit a revised plan with an amended non-elective admissions ambition; and
- any changes to targets agreed and approved in line with the further guidance on alignment of BCF targets with operational plan targets set out in the Payment for Performance section below.

25. An analytical tool has been published on the Better Care Fund webpage, which aims to support areas understand the impact of the revised baseline on their non-elective admissions plan, the resulting impact on the size of the payment for performance pot, and therefore the balancing minimum required amount to be invested in NHS commissioned out of hospital services. The tool will also help areas considering reviewing their BCF non-elective admissions target as part of the NHS operational planning process.

26. If there are any disputes locally between CCG(s) and LA(s) regarding the non-elective admission ambition and payment for performance, this should be managed locally and you should refer to your risk sharing agreement agreed as part of your BCF plan. If the dispute cannot be resolved locally, please then refer to your relevant NHS England sub-region, and Local Government regional peers for assistance. If there are any disagreements on data issues, this should be handled through the usual MAR revisions process.

27. The Better Care Fund Task Force has produced standard reports that will fulfil both local reporting obligations and the minimum national reporting obligations against the key requirements and conditions of the Fund. The standard reports aim to fulfil both the quarterly reporting and annual reporting requirements referred to earlier in this guidance document under the s.75 regulations. Using the standardised reports ensures there is a mechanism in place to monitor the totality of the fund at HWB level, i.e. the planning footprint of the BCF.

28. ***The joint BCF Task Force ask CCGs and LAs to use the quarterly reporting template (example contained in annex 2), as well as an annual reporting template which is currently in development and will be released in due course. The template covers reporting on: income and expenditure, payment for performance, the supporting metrics, and the national conditions. It is suggested that these reports are discussed and signed-off by HWBs given their lead role in the BCF as part of discharging their duty under s.195 of the Health and Social Care Act (2012) to encourage commissioners to provide health and social care services in an integrated manner***[10]. ***Furthermore, NHS England recommends to CCGs that this approach is built into their local s.75 agreements, and require CCGs to report back on this which should also include confirmation that the HWB has signed it off.***

[10] Section 95 of the Health & Social Care Act 2012

29. The draft Year-End reporting guidance and an annual report template is in development across NHS England and LGA, and will build on the quarterly reporting. There are some outstanding queries around accounting and audit being worked through before these can be finalised and issued. Once finalised the template and guidance will be available on the Better Care Fund webpage.

PAYMENT FOR PERFORMANCE

30. As detailed in the quarterly reporting template and guidance in annex 1, the reports are due for submission at 5 points in the year:

    - 29 May 2015 – for the period January to March 2015
    - 28 August 2015 – for the period April to June 2015
    - 27 November 2015 – for the period July to September 2015
    - 26 February 2016 – for the period October – December 2015
    - 27 May 2016 – for the period January – March 2016

31. The reason the reporting commences from January 2015, is due to the baseline for the quarterly Payment for Performance schedule, linked to the non-elective admissions ambition. This is detailed in the BCF planning guidance and technical guidance published in the summer of 2014, and summarised in annex 1.

32. We understand that Health and Wellbeing Boards may wish to consider the alignment of BCF targets with the planning assumptions included in final CCG operational plans. In some cases, differences might arise when a broad range of planning factors are taken into account, including:

    - actual performance in the year to date, particularly through the winter;
    - the actual outturn for 2014/15; or
    - progress with contract negotiations with providers.

33. BCF plans should continue to represent ambitious stretch targets that aim to accelerate progress on reducing non-elective admissions. It is therefore expected that the target included in the BCF plan may be higher than operational planning assumptions. A difference between these does not mean that the BCF target needs to be amended.

34. However, Health and Wellbeing Boards may feel that the emergence of large differences begins to affect the credibility of the BCF ambition. In these circumstances they may wish to amend the BCF target to more closely align with the CCG operational plan. If so we expect that:

    - there will be no change to the targets included in BCF plans where these are within 2 percentage points of assumptions in operational plans. For example, where the BCF target is for a 4% reduction in non-elective admissions, provided the operational plan target is for a 2% (or greater) reduction, the BCF target

should not change. In these HWB areas there will be no further central plan review and assurance; and

- where the target in BCF plans is greater than 2 percentage points away from assumptions in operational plans (for example a BCF target of 6% and an operational plan target of 1%), the HWB may, at its discretion, amend the BCF target where it believes this change is required to ensure it remains credible and realistic. Any changes will need to be agreed by the HWB and will be subject to approval by NHS England (in consultation with Ministers).

35. Any review or change to BCF targets around non-elective admissions should be undertaken within the partnership approach underpinning local BCF planning and agreed by the HWB.

36. If, through this process, the planned level of improvement is reduced the HWB must also approve a balancing increase in the amount to be invested in NHS commissioned out-of-hospital services, in line with the BCF planning guidance (unless that level of investment already exceeds the required minimum). Where any balancing increase is necessary, HWBs will need to ensure that this change does not impact on their ability to meet the national BCF conditions, in particular on the protection of social care. NHS England will be seeking assurance on this point as part of the approval process of any proposed changes to BCF targets.

37. The payment for performance element of the Fund will be linked to the performance of local areas in reducing non-elective admissions in line with the trajectory agreed in their BCF plan. This performance element of the Fund will be paid by CCGs into the pooled fund in four quarterly instalments, and payment will be proportionate to actual performance (as per annex 1). The first of these will be made in May 2015, based on performance in the fourth quarter of 2014/15. The first quarterly performance target will continue to be based on the trajectory for improvement set out in the BCF plan approved in October (or approved subsequently for plans initially not approved or approved subject to conditions). Any amendments which are approved to targets as a result of the process set out above will only affect the three remaining quarterly targets.

38. The nominal payment for performance sum will be equivalent to the number of reduced non-elective admissions in the BCF target paid at tariff, and an analytical tool has been published on the Better Care Fund website to help areas calculate the sum (and update the figure following final baseline data and any changes to targets agreed and approved by NHS England as set out above). The actual payment will be dependent on the actual level of reduction achieved.

39. Each CCG will be expected to have budgeted for a payment for performance sum consistent with the operating plan reduction in admissions. Where the BCF plan includes a greater level of reduction, and where this reduction is achieved, CCGs will need to ensure that their contracts are sufficiently sophisticated and granular to

ensure that where the stretch target is achieved, the money is available for payment for performance in line with the BCF plan.

40. Where contracts with acute providers are based on a marginal rate rather than full tariff the source of funding for the resulting payment will be as follows:

- a reduction in payment to acute provider at the agreed marginal rate; and
- the balance to full tariff which is currently withheld by the CCG and used for investment in services to relieve pressure on A&E services by the System Resilience Group (SRG). Any such money must not be committed beyond the date at which it would need to be released into the payment for performance pot unless there is express prior agreement of all parties through the Health and Wellbeing Board that this investment would be deemed a suitable use of the payment for performance pot and as such could continue to be invested in that scheme as part of the performance reward.

BETTER CARE SUPPORT TEAM IN 15-16

41. A joint Better Care Support Team with representation across NHS England, LGA, DH and DCLG will continue into 15-16 and will focus on the below, working through the NHS England and Local Government Regions:

- Supporting local areas with the implementation of their BCF plans;
- Monitoring progress with the delivery of plans through the quarterly and annual reporting processes set out in this document;
- supporting the performance management and escalation processes for the BCF, including the enactment of Care Act powers where relevant; and
- reporting progress to the national BCF Programme Board and Cross-Ministerial Board.

MANAGING PROGRESS AND WHAT THE ESCALATION PROCESS WILL LOOK LIKE

42. Performance management for the BCF will be led by NHS England and the local government regions, with the joint Better Care Support Team providing support and advice. Working with the Better Care Support Team, NHS England and the Local Government regions will monitor progress against plans from the quarterly monitoring process described above, and will determine whether areas are continuing to meet the standard conditions of the Fund as detailed in the BCF plan assurance letters:
    1. That the Fund is pooled under a s.75 agreement
    2. That the Fund is used in accordance with their final approved plan
    3. That they continue to meet the requirements around the payment for performance framework

43. In addition to the standard conditions of the Fund above, the NHS England and Local Government regions will work with the Better Care Support Team to monitor progress around the delivery of the national conditions. The national conditions were a key focus of the Nationally Consistent Assurance Review (NCAR) process. Areas will have been approved on the basis of having a satisfactory plan to achieve the national conditions – as access to the funds was conditional upon the plan satisfactorily meeting the national conditions.

44. If an area fails to meet any of the standard conditions of the Fund, including if the funds are not being spent in accordance with the plan with the result that delivery of the national conditions is jeopardised, the Better Care Support Team may make a recommendation to NHS England that they should initiate an escalation process. The key steps of the escalation process are detailed below – with the main principle being that intervention should be appropriate to the risk identified. The process ultimately leads to the ability for NHS England to use its powers of intervention provided by the Care Act legislation, in consultation with DH and DCLG as the last resort. Note that the quarterly reporting templates allow for any variation in spending from the plan to be explained.

45. The below table sets out the proposed escalation process which will normally be initiated if any of the conditions of the Fund are not met following the return of the quarterly reports. The Better Care Support Team will support this process, making recommendations to NHS England for decision where necessary. The process may be adapted to accommodate local circumstances. Local stakeholders will be notified if this is the case. It may also be updated to reflect learning from experience.

1 – Assurance meeting	The assurance meeting is the opportunity to use national and local insight to drive a discussion about areas of concern. It would be the first formal opportunity to raise concerns. It is expected that in line with the principle of 'no surprises', issues will have been raised through ongoing relationships via Regions, Area Teams and local government regional peers. The meeting would be an opportunity to discuss the concerns and agree actions and next steps, including whether support is required.
2 – Formal letter and clarification of agreed actions	The CCG(s) will be issued with a letter summarising the assurance meeting and clarifying the next steps agreed, timescales, and how this will be monitored and by whom. If support was requested by the CCG(s), an update on what support will be made available to them will be included. This may be support from regional or national teams.
3 – Regular monitoring of agreed actions	The agreed actions will be monitored by a named point of contact to track progress.
4 – Consideration of intervention options	If it is found that the concern is so deep set or serious (or the agreed actions do not take place satisfactorily) that intervention may be appropriate, then the

	implications of doing so will be considered carefully. The principle must be that the consequences of the intervention action for patients is at the very least no worse than the status quo of not intervening.
5 – Regional and national consistency	It will be important to ensure that peer review is sought through the assurance consistency process to ensure that the rationale for intervention is robust.
6 – Consultation with ministers	NHS England consults with DH and DCLG in accordance with the 2015/16 Mandate
7 – Summary report and directions drafted for committee approval	Finally, the relevant evidence and legal wording needs to be submitted to NHS England's Assurance and Development Committee for consideration. Once approved the documentation, including any directions, will be passed to the Chief Executive for signature.

ANNEXES

Annex 1 – Summary of Payment for Performance Guidance

Annex 2 – Example Quarterly Report Template and Guidance

ANNEX 1 – SUMMARY OF PAYMENT FOR PERFORMANCE GUIDANCE

1. The performance-related funding will be made on the basis of performance over the final quarter of 2014/15 and the first three quarters of 2015/16, against the trajectory as set out in the plans. HWBs are therefore required to set an annual target (from Q4 2014/15 until end of Q3 2015/16), with quarterly milestones, in the finance and activity plan template.

2. Assessments of how suitable the locally set targets are will be made by HWBs and through the NCAR assurance process. Payments will be made in arrears as set out below:
   - May 2015 (based on Q4 2014/15 performance)
   - August 2015 (based on Q1 2015/16 performance)
   - November 2015 (based on Q2 2015/16 performance)
   - February 2016 (based on Q3 2015/16 performance)

3. At each 'payment point', CCGs will release money into the BCF pooled fund on the basis of performance to date, against plan. Each quarterly payment will be proportionate to the level of improvement achieved so far (calculated as a proportion of the planned full-year reduction against the baseline). The relationship between payment and progress toward target will be directly linear (e.g. achieving 30% of the target will release 30% of the funding). There will be no additional payment for performing beyond the target.

4. The steps to calculating the quarterly payment are:

   a. take the cumulative activity reduction against the baseline at quarter end and divide it by the cumulative Q3 2015/16 target reduction;
   b. multiply that by the size of the performance pot available; and
   c. subtract any performance payments made for the year to date.

5. The minimum payment in a quarter is £0 (there will not be a negative payment or 'claw back' mechanism) and the maximum paid out by the end of each quarter cannot exceed the planned cumulative performance pot available for release each quarter.

6. Although we are asking areas to plan on the basis of the baseline being actual Q4 13/14 outturn, and planned Q1, Q2, Q3 14/15 outturn, for the purposes of assessing performance in 15/16, for quarters 1-3 in 14/15 areas will be assessed against their actual outturn. Through the technical guidance we asked areas to ensure any financial risk associated with this is managed appropriately and articulated in plans.

7. The data source for non-elective admissions data is Monthly Activity Returns (MAR) data. For the 15/16 planning round, both MAR and SUS (Secondary Uses Service) data will be collected with the aim that these data sources should begin to align.

ANNEX 2 – EXAMPLE HWB QUARTERLY REPORTING TEMPLATE

1. The example quarterly reporting template (attached as a spreadsheet) is to provide local areas with an early indication of what the report will cover.

2. The actual quarterly reporting templates will be accessible via the UNIFY system as soon as the MAR data has been released for each relevant quarter.

3. The template in UNIFY will pre-populate the baseline data and actual performance data at each quarter.

Notes for Completion

The template requires the HWB to track through the high level metrics from the HWB plan.
The template will require completion on a quarterly basis and submitted to **bettercarefund@dh.gsi.gov.uk**
The deadline for submitting the returns are as follows:
Q4 14/15 - 29/05/2015
Q1 15/16 - 28/08/2015
Q2 15/16 - 27/11/2015
Q3 15/16 - 26/02/2016
Q4 15/16 - 27/05/2016
The template return will require sign off by the HWB.
The template is based on the BCF plan template (part 2). Therefore the guidance for the part 2 template may help in completing this form.
To accompany the quarterly report we will require the HWB to submit a written narrative to explain any changes to plan and any material variances against the plan.
The template should be completed in line with relevant accounting standards. The guidance published by CIPFA and HFMA will give further details.

The template consists of four sheets:
1) Cover Sheet
2) I&E - this tracks through the funding and spend for the HWB and the expected level of benefits
3) P4P - this details the Payment for Performance calculation
4) Non Elective - tracks through the changes to non-elective activity
5) Support Metrics - details the other metrics included within the HWB plan.
6) National Conditions - checklist against the national conditions as set out in the Spending Review.

Yellow cells require input, blue cells do not.

1) Cover Sheet
On the cover sheet please enter the following information:
Health and Well Being Board
The Quarter to which this report relates to
Who has completed the report, email and contact number in case any queries arise
The cover sheet will also indicate whether the quality checks have been met and provide details of which areas need reviewing
Please detail who has signed off the report on behalf of the Health and Well Being Report.

2) I&E
The format of this sheet is combines sheets (1) and (2) from the BCF plan template.
The sheet is split into two main sections - summary of total BCF funding and summary of total BCF expenditure.
The summary of total BCF funding is split into:
Local Authority services;
CCG minimum contribution; and
additional CCG contribution.
Please select the relevant organisations from the drop down menu.
The sheet requires both the plan information and forecast information (year to date columns B and C and total columns F and G).
The total plan values should be the same as the figures submitted on the BCF template unless there has been a change agreed at the HWB.

The summary of total BCF expenditure requires details of plan and actual expenditure both year to date and forecast outturn.

Completion of both these sections will calculate the contribution less expenditure (row 52).

Four other boxes then need completing with plan and forecast information. These are:
CCG share of £1.1bn contribution to Social Care;
CCG share of £2.4m minimum contribution;
summary of NHS commissioned out of hospital services spend from minimum BCF pool
Summary of Benefits

At the end of the section the form requires 2 questions to be answered;
Has the Local Authority recived their share of the Disabled Facilites Grant (DFG)?
Have the funds been pooled via a s.76 pooled budget arrangement?

3) P4P

The majority of information feeds through from the non-elective sheet.
Input is required for the combined total of performance and ring-fenced funds. *(Note: we will see if we can pre-populate this)*
Input is required to show whether the P4P element has been paid over for the relevant quarters.
If there is a variance between the P4P element planned to be paid over and the value actually paid over please select from the drop down box. The options are:
Payment not due - for example Q2 payment would not be due if completing the Q1 report.
Non-elective admission - the P4P element will not be paid if non-elective admissions over-perform. Therefore the CCG will likely use the funding not paid over to fund the additional costs of non-elective admissions.
Other (please explain) - If for any reason the funding not paid over is not used for off-setting the additional cost of non-elective admissions please select other and explain what the funding is being spent on in the yellow box below.

4) Non Elective

The format for this sheet is the same as section 5 of the BCF template submission.
This section is split into four sections.
a) Plan - this should reflect the numbers as they appeared in your submitted plan.
b) Performance against revised plan - this should include actual and forecast performance relating to 2015/16.
c) Variance against revised plan

5) Support Metrics

This section requires information to be completed for the support metrics i.e.
Residential admissions
Regalement
Delayed transfers of Care
Patient / Service User Experience Metric
Local Metric

The data required for each section is the same as the format as the non elective sheet:
a) Plan - this should reflect the numbers as they appeared in your submitted plan.
b) Performance against revised plan - this should include actual and forecast performance relating to 2015/16.
c) Variance against revised plan

6) National Conditions

This section requires the HWB to confirm whether the six national conditions detailed in the BCF Planning Guidance is still on track for delivery.
It sets out the 6 conditions and requires the HWB to confirm 'yes' or 'no' that these are on track. If 'no' is selected please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
Full details of the conditions are detailed at the end of the page.

Anytown HWB	Q1 2015/15 Report

Completed by:

Email:

Contact Number:

Quality Checks Cleared?

Signed off on behalf of the HWB:

Submission Gudiance

The template will require completion on a quarterly basis and submitted to **bettercarefund@dh.gsi.gov.uk**

The deadline for submitting the returns are as follows:

Q4 14/15 - 29/05/2015
Q1 15/16 - 28/08/2015
Q2 15/16 - 27/11/2015
Q3 15/16 - 26/02/2016
Q4 15/16 - 27/05/2016

Anytown HWB	Q1 2015/15 Report

Income and Expenditure Summary
Figures in £000

Summary of Total BCF Funding	Year to Date			Forecast Outturn		
Local Authority Social Services -Minimum Contribution	2015/16 Plan	2015/16 Forecast	2015/16 Variance	2015/16 Plan	2015/16 Forecast	2015/16 Variance
AnyTown	500	500	-	2,000	2,000	-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
Total Local Authority Minimum Contribution	**500**	**500**	**-**	**2,000**	**2,000**	**-**
Additional Local Authority Contribution						
AnyTown	1,000	1,000	-	4,000	4,000	-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
Total Additional Local Authority Contribution	**1,000**	**1,000**	**-**	**4,000**	**4,000**	**-**
CCG Minimum Contribution						
NHS Anytown	2,000	2,000	-	8,000	8,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total Minimum CCG Contribution	**2,000**	**2,000**	**-**	**8,000**	**8,000**	**-**
Additional CCG Contribution						
NHS Anytown	1,000	1,000	-	4,000	4,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total Additional CCG Contribution	**1,000**	**1,000**	**-**	**4,000**	**4,000**	**-**
Total Contribution	**4,500**	**4,500**	**-**	**18,000**	**18,000**	**-**

Summary of Total BCF Expenditure

BCF Expenditure						
Acute			-			-
Mental Health	500	500	-	2,000	2,000	-
Community Health	500	500	-	2,000	2,000	-
Continuing Care	500	500	-	2,000	2,000	-
Primary Care	1,000	1,000	-	4,000	4,000	-
Social Care	2,000	2,000	-	8,000	8,000	-
Other			-			-
Total	**4,500**	**4,500**	**-**	**18,000**	**18,000**	**-**

Contribution less Expenditure	-	-	-	-	-	-

CCG Share of £1.1bn Contribution to Social Care						
NHS Anytown	500	500	-	2,000	2,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total Minimum CCG Share of £1.1bn Contribution to Social Care	**500**	**500**	**-**	**2,000**	**2,000**	**-**

CCG Share of £2.4m Minimum Contribution						
NHS Anytown	1,500	1,500	-	6,000	6,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total CCG Share of Minimum £2.4bn Contribution	**1,500**	**1,500**	**-**	**6,000**	**6,000**	**-**

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool						
Mental Health			-			-
Community Health	1,000	1,000	-	4,000	4,000	-
Continuing Care	500	500	-	2,000	2,000	-
Primary Care	500	500	-	2,000	2,000	-
Social Care			-			-
Other			-			-
Total	**2,000**	**2,000**	**-**	**8,000**	**8,000**	**-**

Summary of Benefits						
Reduction in permanent residential admissions			-			-
Increased effectiveness of reablement			-			-
Reduction in delayed transfers of care			-			-
Reduction in non-elective (general + acute only)	(112)	(112)	-	(447)	(447)	-
Other			-			-
Total	**(112)**	**(112)**	**-**	**(447)**	**(447)**	**-**

Has the housing authority received its DFG allocation?	
Have the funds been pooled via a s.75 pooled budget arrangement?	

Anytown HWB	

Payment for Performance

	Plan	Forecast	Variance against Revised Plan
1. Reduction in non elective activity			
Baseline of non elective activity	20,100	20,100	-
Change in non elective activity	(400)	(700)	(300)
% change in non elective activity	-2.0%	-3.5%	-1.5%
2. Calculation of performance and NHS commissioned ringfenced funds			
Financial value of non elective saving / performance fund	596,000	1,043,000	447,000
Combined total of performance and ringfenced funds	3,900,000	3,900,000	-
Ringfenced funds	3,304,000	2,857,000	(447,000)
Value of NHS commissioned services	6,000,000	6,000,000	-
Shortfall of contribution to NHS commissioned services	0		-

	Q4 14/15 Revised Plan	Q1 15/16 Revised Plan	Q2 15/16 Revised Plan	Q3 15/16 Revised Plan
Cumulative quarterly baseline of non elective activity	5,000	10,100	15,000	20,100
Cumulative change in non elective activity	(200)	(300)	(200)	(400)
Cumulative % change in non elective activity	-4.0%	-3.0%	-1.3%	-2.0%
Financial value of non elective saving / performance fund (£)	148,259	151,224	145,294	151,224
Value of payment made over to BCF	148,259	-	-	-
Variance	(0)	151,224	145,294	151,224
Commentary on Variance		Payment not due	Payment not due	Payment not due

Anytown HWB	Q1 2015/15 Report

Non - Elective admissions (general and acute)

Plan

Metric		Baseline				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	2,500	2,550	2,450	25,500	2,376	2,475	2,475	2,426	2,402
	Numerator	5,000	5,100	4,900	5,100	4,800	5,000	5,000	4,900	4,900
	Denominator	200,000	200,000	200,000	20,000	202,000	202,000	202,000	202,000	204,000

P4P annual change in admissions	*-400*		
P4P annual change in admissions (%)	*-2.0%*	Please enter the average cost of a non-elective admission	£1,490
P4P annual saving	*£596,000*		

Peformance against plan

Metric		Baseline				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	2,500	2,550	2,450	25,500	2,327	2,426	2,426	2,426	2,353
	Numerator	5,000	5,100	4,900	5,100	4,700	4,900	4,900	4,900	4,800
	Denominator	200,000	200,000	200,000	20,000	202,000	202,000	202,000	202,000	204,000

P4P annual change in admissions	*-700*		
P4P annual change in admissions (%)	*-3.5%*	Please enter the average cost of a non-elective admission	£1,490
P4P annual saving	*£1,043,000*		

Variance against plan

Metric		Baseline				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	-	-	-	-	50	50	50	-	49
	Numerator	-	-	-	-	100	100	100	-	100
	Denominator	-	-	-	-	-	-	-	-	-

Anytown HWB	Q1 2015/15 Report

Residential admissions

Plan

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	664	663.4	635.5
	Numerator	130	130	125
	Denominator	19,600	19,597	19,669
	Annual change in admissions		*0*	*-5*
	Annual change in admissions %		*0.0%*	*-3.8%*

Performance against plan

Metric		Baseline (2013/14)	Planned 14/15	15/16 Performance
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	664.0	663.4	635.5
	Numerator	130	130	125
	Denominator	19,600	19,597	19,669
	Annual change in admissions		*0*	*-5*
	Annual change in admissions %		*0.0%*	*-3.8%*

Variance against plan

Metric		Baseline (2013/14) Variance	14/15 Variance	15/16 Variance
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	-	-	-
	Numerator	-	-	-
	Denominator	-	-	-

Reablement

Plan

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	#REF!	**89.3**	**90.0**
	Numerator	#REF!	125	135
	Denominator	#REF!	140	150
	Annual change in admissions		*#REF!*	*10*
	Annual change in admissions %		*#REF!*	*8.0%*

Performance against plan

Metric		Baseline (2013/14)	Planned 14/15	15/16 Performance
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	#REF!	89.3	**90.0**
	Numerator	#REF!	125	135
	Denominator	#REF!	140	150
	Annual change in admissions		*#REF!*	*10*
	Annual change in admissions %		*#REF!*	*8.0%*

Variance against plan

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	#REF!	-	-
	Numerator	#REF!	-	-
	Denominator	#REF!	-	-

Delayed transfers of Care

Performance against revised plan

Metric		14/15 plans Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	15-16 plans Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**357.3**	**360.1**	**433.8**	**338.0**	**357.0**	**359.8**	**433.4**	**337.8**
	Numerator	500	504	607	482	509	513	618	491
	Denominator	139,942	139,942	139,942	142,593	142,593	142,593	142,593	145,357

Performance against revised plan

Metric		14/15 plans Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	15-16 performance Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**357.3**	**360.1**	**433.8**	**338.0**	**357.0**	**359.8**	**433.4**	**337.8**
	Numerator	500	504	607	482	509	513	618	491
	Denominator	139,942	139,942	139,942	142,593	142,593	142,593	142,593	145,357

Variance against revised plan

Metric		14/15 variance Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	15-16 variance Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	-	-	-	-	-	-	-	-
	Numerator	-	-	-	-	-	-	-	-
	Denominator	-	-	-	-	-	-	-	-

Patient / Service User Experience Metric

Plan

Metric		Baseline Apr'13-Mar'14	Planned 14/15 (if available)	Planned 15/16
Proportion of people with LTC who feel supported to manage their condition (as measured through national GP patient survey)	*Metric Value*	56.3%	58.0%	61.4%
	Numerator	680	724	793
	Denominator	1,207	1,249	1,292
Improvement indicated by:				

Performance against plan

Metric		Baseline Apr'13-Mar'14	Planned 14/15 (if available)	15/16 Performance
Proportion of people with LTC who feel supported to manage their condition (as measured through national GP patient survey)	*Metric Value*	56.3%	58.0%	61.4%
	Numerator	680	724	793
	Denominator	1,207	1,249	1,292
Improvement indicated by:				

Variance against plan

Metric		Baseline Apr'13-Mar'14	14/15 Variance	15/16 Variance
Proportion of people with LTC who feel supported to manage their condition (as measured through national GP patient survey)	*Metric Value*	-	-	-
	Numerator	-	-	-
	Denominator	-	-	-

Local Metric

Plan

Metric		Baseline Apr'12 to Mar'13	Planned 14/15 (if available)	Planned 15/16
Prevention of Falls (per 100,000)	*Metric Value*	1721.0		1471.0
	Numerator	447		377
	Denominator	19,855		19,855
Improvement indicated by:				

Performance against plan

Metric		Baseline Apr'12 to Mar'13	Planned 14/15 (if available)	15/16 Performance
Prevention of Falls (per 100,000)	*Metric Value*	1721.0		1471.0
	Numerator	447		377
	Denominator	19,855		19,855
Improvement indicated by:				

Variance against plan

Metric		Baseline Apr'12 to Mar'13	14/15 Variance	15/16 Variance
Prevention of Falls (per 100,000)	*Metric Value*	-	-	-
	Numerator	-	-	-
	Denominator	-	-	-

Anytown HWB	Q1 2015/15 Report

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'yes' or 'no' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If no is selected for any of the conditions please include a comment in the box below

Condition	Please Select (yes or no)	Comment
1) Have plans have been jointly agreed?		
2) Have Social Care Services (not spending) been protected?		
3) 7 day services to support patients being discharged and prevent unnecessary admission at weekends are in place and delivering?		
4) In respect of data sharing - confirm that:		
i) The NHS Number is being used as the primary identifier for health and care services		
ii) You are pursuing open APIs (i.e. systems that speak to each other);		
iii) Appropriate Information Governance controls are in place for information sharing in line with Caldicott 2		
5) A joint approach to assessments and care planning is in place and where funding is used for integrated packages of care, there will be an accountable professional?		
6) Agreement on the consequential impact of changes in the acute sector?		

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed
The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals.
The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

Agreement on the consequential impact of changes in the acute sector

Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in.
Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics from the Health & Wellbeing Board plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 29th May 2015

This initial Q4 Excel data collection template focuses on the allocation, budget arrangments and national conditions. Details on future data collection requirements and mechanisms (including possible use of Unify 2) will be announced ahead of the Q1 2015/16 data collection.

To accompany the quarterly data collection we will require the Health & Wellbeing Board to submit a written narrative that contains any additional information you feel is appropriate including explanation of any material variances against the plan and associated performance trajectory that was approved.

Content

The data collection template consists of 4 sheets:

1) Cover Sheet - this includes basic details and question completion
2) A&B - this tracks through the funding and spend for the Health & Wellbeing Board and the expected level of benefits
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Narrative - please provide a written narrative
To note - Yellow cells require input, blue cells do not.

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 4 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) A&B

This requires 4 questions to be answered. Please answer as at the time of completion.
Has the Local Authority recived their share of the Disabled Facilites Grant (DFG)?
If the answer to the above is 'No' please indicate when this will happen.
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track for delivery (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

Cover and Basic Details
Q4 2014/15

Health and Well Being Board	Hartlepool
completed by:	Jill Harrison (Assistant Director - Adult Services)
e-mail:	jill.harrison@hartlepool.gov.uk
contact number:	01429 523911
Who has signed off the report on behalf of the Health and Well Being Board:	Gill Alexander (Director of Child & Adult Services)

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB.xls' for example 'County Durham HWB.xls'

	No. of questions answered
1. Cover	5
2. A&B	4
3. National Conditions	16
4. Narrative	1

Selected Health and Well Being Board:

Hartlepool

Data Submission Period:

Q4 2014/15

Allocation and budget arrangements

Has the housing authority received its DFG allocation?	Yes
If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?	Yes
If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy

Selected Health and Well Being Board:

Hartlepool

Data Submission Period:

Q4 2014/15

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	Comment
1) Are the plans still jointly agreed?	Yes	
2) Are Social Care Services (not spending) being protected?	Yes	
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	The services that are currently working 7 days are Emergency Duty Team (Social Care), Rapid Response, Intermediate Care. Work continues to establish baselines and understand demand for existing services over the weekend period. Expansion of current services and additional services is expected to be in place be Autumn 2015.
4) In respect of data sharing - confirm that:		
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Workstream established and project lead appointed to take this forward.
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	No - In Progress	Appropriate IG controls are currently in place across Health and Social care systems. A Workstream has been established and project lead appointed to develop new IG controls to support integrated working.
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress	In place for some cases but not consistently for all integrated packages of care.
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Selected Health and Well Being Board:

Hartlepool

Data Submission Period:

Q4 2014/15

Narrative	remaining characters	32,741

Please provide any additional information you feel is appropriate to support the return including explanation of any material variances against the plan and associated performance trajectory that was approved by NHS England.
No additional information.

HEALTH AND WELLBEING BOARD

22 June 2015

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

Subject: COMMUNITY BASED URGENT CARE UPDATE – JUNE 2015

1. PURPOSE OF REPORT

1.1 The purpose of this paper is to provide the Health and Wellbeing Board members with an update following the paper presented in January 2015. The paper details the actions undertaken to date and associated timelines in relation to the integrated urgent care service.

2. BACKGROUND

2.1 Our aim is to simplify the navigation of urgent care services – improve the understanding about accessing care out of hours or in an emergency, and to provide care at locations which provide necessary education to support people to look after themselves. In order to meet our aims we have reviewed our existing points of access for urgent care. The community based urgent care health services in Hartlepool (and Stockton-on-Tees) is supported by a range of providers, from different locations and with separate contracts including; primary care, GP out of hours, healthy living pharmacies, Minor Injuries Unit, 111 telephone advice and GP led Alternative Provider of Medical Services (APMS) Walk in Centres.

2.2 The APMS Walk in Centre contracts were originally agreed to run for a period of 5 years and are due to expire by the end of March 2016. In line with the NHS England policy entitled 'Managing the end of time limited contracts for primary medical services', this has provided the CCG with the opportunity to review existing services, with a view better integrate urgent care services. This work will need to commence early in 2015 to enable services to be procured and operational by April 2016.

3. ENGAGEMENT

3.1 As the Health and Wellbeing Board are aware a number of engagement events have been undertaken across Hartlepool (and Stockton-on-Tees) where there was a clear message from the public, patients and partners stating that the current model for community based urgent care services is not easily navigated, there is a lack of understanding of the difference in providers and service provision across venues. It was clear from the engagement analysis and listening to concerns of the public, partners and our GP members that we need to ensure that future services must be easily understood, are accessible and are easily navigated. We are now in a position with current contracts that we are able to work with our communities and partners to develop a better model for community based urgent care services to make it easier for local people to get the right treatment at the right location at the right times.

3.2 The CCG is committed to engaging with partners and the residents of Hartlepool (and Stockton-on-Tees) to inform service redesign and development, which includes the commissioning of community urgent care services.

3.3 Following the previous update to the Health and Wellbeing Board the CCG have been working with the communications and engagement team within the commissioning support unit to develop a communications and engagement plan.

3.4 The communication and engagement activities undertaken to date have been shared with partners and stakeholders in advance of issue to ensure they were appraised of actions and able to review and contribute to the surveys being undertaken.

3.5 Market research has been undertaken to gauge public feeling, to explore what is important to local people to ensure that the urgent care services commissioned are accessible and enhanced for the future and to understand the impact that the proposed changes might have for them. This has involved street interviews being undertaken in Hartlepool town centre. The surveys were completed on Friday 29th May and couriered to an independent company to enable analysis to be undertaken. The report of findings from the survey is expected to be completed by 9th June and shared with the CCG to inform the specification development.

3.6 A market engagement exercise with potential providers commenced on 8 May 2015. The purpose of the exercise was to gain information from the market that would identify any barriers and constraints to future service delivery and also to determine the capability and capacity of the market to respond to the procurement that will be undertaken.

3.7 The communications team are currently undertaking an exercise to recruit patient representatives to assist in the development of the service model and evaluation of potential providers.

4. ACTIONS/NEXT STEPS

4.1 The outputs from the market engagement and public engagement exercises will be reviewed from 5 June 2015. Intelligence gathered from these events will be used to develop the service specification.

4.2 It is envisaged that the tender for the integrated urgent care service will be published in Mid-July 2015. Evaluation will be undertaken during August and September and a contract subsequently awarded to ensure service commencement for 01 April 2016.

5. RECOMMENDATIONS

5.1 Health and Wellbeing Board members are requested to note the update.

6. REASONS FOR RECOMMENDATIONS

6.1 To ensure that Health and Wellbeing Board members are kept appraised of progress and actions undertaken in order to deliver our agreed joint vision. Future updates will be shared with members to ensure they are kept appraised and in advance of any planned engagement activities being undertaken to ensure a joint approach.

7. BACKGROUND PAPERS

Appendix 1 – Street Survey
Appendix 2 - Stakeholder correspondence

8. CONTACT OFFICER

Karen Hawkins
Head of Commissioning and Delivery
NHS Hartlepool and Stockton-on-Tees CCG
01642 745126

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

HARTLEPOOL AREA

NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) are looking at urgent care services throughout the Hartlepool and Stockton-on-Tees areas.

CCGs are groups led by doctors (GPs), nurses and other health professionals. They think about what health services are needed in local communities, and develop and buy (commission) health services to meet the needs of local people.

NHS Hartlepool and Stockton-on-Tees CCG recognises that it is important to talk to local people and involve them in its work to make sure that the health services it develops and buys really do meet the needs of the people that will use them.

The CCG would like to know your views on the management of urgent minor injuries and urgent illnesses in the Hartlepool area:

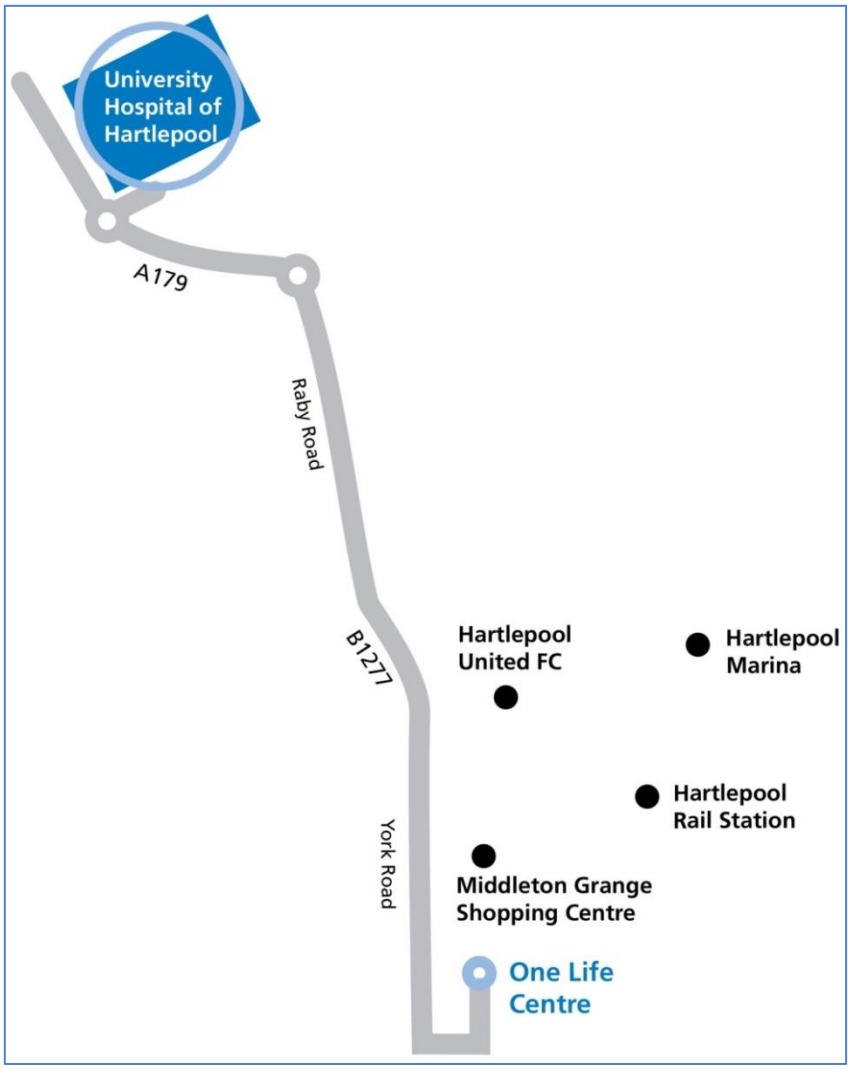
- Out-of-hours GP services accessed via NHS 111 for urgent GP services, which may include telephone advice, home visits or by appointment at One Life Hartlepool
- GP walk-in services in Hartlepool provided at One Life Hartlepool between 8am – 8pm, 7 days a week
- Minor Injury services provided at One Life Hartlepool 24 hours a day, 7 days a week

The contracts for the out-of-hours GP service and the GP walk-in service both end in March 2016. The CCG want to understand views on the best location for the future location of the services and whether these should be located at:

- Hartlepool One Life, Park Road, Hartlepool
- University Hospital of Hartlepool, Holdforth Road, Hartlepool

Your views will help the CCG develop a plan to enhance the current delivery of services in the same place making it seamless for patients to access.

Section A: Urgent Care Centre - One Life Hartlepool



1. Have you ever been ill and been to see a doctor or nurse at the centre within One Life Hartlepool?

☐ Yes, in the last week	☐ Yes, in the last month	☐ Yes, in the last six months	☐ Yes, longer than six months	☐ No
If yes, what did you think of the service you received there? *What was good, what could be improved?* Walk-in service? Minor Injuries service?				

GP Out of Hours service?

Have you ever been ill and been to see a doctor or nurse at another walk in centre? (Tithebarn/ Resolution (North Ormesby)/ Peterlee/ Easington)

☐ Yes	☐ No

If yes, which one(s)?

☐ Tithebarn (Stockton)	☐ Resolution (North Ormesby)	☐ Peterlee	☐ Easington	☐ Other

2. GP walk-in services at the Walk-in Centres are provided from 8am to 8pm every day. When the Walk-in centre is closed and you feel unwell, what would you do?

☐ Phone NHS 111	☐ Pharmacy	☐ Self care	☐ A&E	☐ OOH	☐ Wait to see own GP	☐ Other
Other, please say						
Please give reasons for your answer						

3. Do you have a preference for the MIU/WIC/GP OOH services to be in the same place at:

☐ One Life Hartlepool	☐ University Hospital Hartlepool	☐ No opinion

Advantages of preference? *Disadvantages of preference?*

4. We know from looking at what happens now at the walk-in centre that many people who attend could have been seen by a pharmacist or their own GP.

   Do you think it is clear which service you should attend if you feel unwell?

☐ Yes	☐ No	☐ Don't know
Please give reasons		

   What information would you need to make an informed decision to help you choose where to go?

Section B: Pharmacy

5. Pharmacists can give advice and treatment for minor ailments without the need for an appointment.

   Have you or a member of your family ever seen a pharmacist for advice?

☐ Yes, in the	☐ Yes, in the	☐ Yes, in the	☐ Yes, longer	☐ No

last week	last month	last six months	than six months	
If yes, what did you think of the service you received there? *What's good, what could be improved?* If no, what would be the barriers to you using this service?				

Section C: GP surgery

6. Have you ever visited the walk-in centre because you could not get an appointment with a GP or nurse?

☐ Yes	☐ No

Section D: NHS 111

7. Have you or a member of your family ever used the NHS 111 service?

☐ Yes	☐ No
What was good about the service? What could be improved?	

We want to know everyone's view of NHS 111 - even if you haven't used it – in your opinion what ONE thing do you think should be improved about the NHS 111 service?

Section E: Out-of-hours GP Service

8. Do you know how to contact the GP out-of-hours service?

☐ Yes	☐ No	☐ No but I'm confident I would be able to easily find out	☐ Don't know

9. A GP out-of-hours service in Hartlepool area is accessed via NHS 111 including telephone advice, home visiting and bookable appointments between 6.30pm-8.00am on weekdays and 24 hours a day at weekends and on Bank Holidays.

   Have you ever used any of these services?

☐ Yes, in the	☐ Yes, in the	☐ Yes, in the last six	☐ Yes, longer than six	☐ No

last week	last month	months	months	

If yes, what did you think of the service you received there?

Was it good?

What could be improved?

10. How do you feel about how quickly you received care from the out of hours GP service?

☐ It was about right	☐ It took too long	☐ Don't know / doesn't apply

11. If the out-of-hours GP service at One Life moves to Hartlepool Hospital, do you think that this would cause any problems to you and your family?

☐ Yes	☐ No	☐ Don't know

If yes, can you tell us what those problems might be?

Demographic Profile:

1. Which best describes you?

☐ I am a patient	☐ I work for the NHS

2. Gender

☐ Female	☐ Male	☐ Transgender	☐ Prefer not to say

3. Age?

☐ Under 16 years	☐ 16-25 years
☐ 26-35 years	☐ 36-45 years
☐ 46-55 years	☐ 56-65 years
☐ 66-75 years	☐ Over 75 years

4. Carer – do you provide care for someone who is elderly or living with a long-term condition?

☐ Yes	☐ No	☐ I do not wish to disclose

5. Ethnicity – please choose the category which best describes you:

☐ White	☐ Mixed
☐ Asian/Asian Black	☐ Black/Black British
☐ Chinese	☐ Other ethnic group
☐ I do not wish to disclose my ethnicity	

6. Disability – do you consider yourself to have a disability or a long-term health condition?

☐ Yes	☐ No	☐ I do not wish to disclose

7. What is your postcode

Good Health - Everybody's business

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

14th May 2015

1st Floor
Billingham Health Centre
Queensway
Billingham
TS23 2LA

Tel: 01642 745982

Dear Colleague,

Re: Hartlepool Health Services for Urgent Illnesses and Urgent Minor Injuries

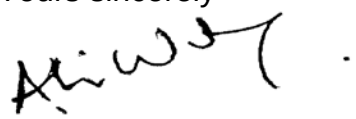
As part of our Urgent Care Strategy, the first phase is to scope an integrated urgent care service both in Hartlepool and Stockton-on-Tees. Contract end dates for current providers of health services for urgent illnesses and minor injuries in this area present the opportunity for us to achieve service improvements for local patients in line with this strategy in the next twelve months.

We are talking to local people for their experiences of these services, to understand their expectations and to get their views on options for service improvements we are considering and wish to make you aware of this.

Over the next few weeks we will be undertaking on-street surveys to gauge and explore what is important to local people to ensure that the urgent care services we commission are accessible and enhanced for the future. If you receive any enquiries from the public or local stakeholders, please don't hesitate to direct them to us where we will be able to provide a response.

I attach a briefing for your information and would welcome the chance to brief you in person if you would find that useful.

Yours sincerely



Ali Wilson
Chief Officer

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

Briefing paper

Hartlepool health services for urgent illnesses and urgent minor injuries

May 2015

"To commission and develop a simple, accessible, high quality service, managing patients at the point they present in a sensitive and person-centred approach, yet robust and resilient way. Reducing the need for urgent care with better management of long term conditions with primary and secondary prevention."

This is the vision for a local urgent care pathway that we at Hartlepool and Stockton-on-Tees Clinical Commissioning Group set out in our Urgent Care Strategy 2013-2018 and in our in *Clear and Credible Plan Refresh 2014/15-2018/19,* the five-year strategy we published in response to the annual planning requirements in '*Everyone Counts: Planning for Patients 2014/15 to 2018/19'.*

Health services in the area must be joined up and make sense if local residents are to have seamless 24/7 urgent care services that meet their needs at the point of first contact.

Building upon the joint vision developed between the Health and Wellbeing partners, the expectation is to commission and develop a simple, accessible, high quality service, managing patients at the point they present in a sensitive and person-centred approach, yet in a robust and resilient way. This is with a view to reducing the need for urgent care with the better management of long term conditions with primary and secondary prevention as a focus.

Contract end dates for current providers present the opportunity to achieve service improvements in the next twelve months. We are talking to local people for their experiences of these services, to understand their expectations, and to get their views on options for service improvement we are considering:

> That the 08.00-20.00 Walk in Centre service and nurse-led 24/7 Minor injury service contracts at One Life Centre in Hartlepool are combined with an Out of Hours GP service into one 24/7 urgent care service located in One Life, Hartlepool or at the Hartlepool Hospital site.

No services will be lost. The service improvements we are considering respond to the feedback patients have given us and will transform the service into a highly responsive, effective and personalised service that is easy to understand and access. This builds on the national direction for urgent care, taking learning from successful models elsewhere in the region and England; and (where appropriate depending upon the symptoms and condition), providing 24 hour access to urgent care, to the right practitioner, in the right place. We are using on-street surveys to

gauge and explore what is important to local people to ensure that urgent care services are accessible and enhanced for the future.

To make sure we secure the views of carers and those who are unable to leave their homes, we will work with local community and voluntary organisations to undertake additional interviews.

In line with population figures and service user demographics, local people in Hartlepool will be asked to participate.

We expect to report on the feedback we receive in mid-June.

ENDS

HEALTH AND WELL BEING BOARD

22nd June 2015

HARTLEPOOL BOROUGH COUNCIL

Report of: Director of Public Health

Subject: Annual Review Health Status Presentation

1. TYPE OF DECISION/APPLICABLE CATEGORY

NON KEY

2. PURPOSE OF REPORT

2.1 The purpose of this report is to present to the Health and Well Being Board key messages regarding the health status of the people of Hartlepool.

3. BACKGROUND

3.1 Understanding the health status of the population is a key public health activity. In order to improve and protect health, it is vital to understand what the health of a local population is like, in order to measure any positive or negative change.

3.2 Measuring health status is complex and relies on a range of data sources from routinely collected national and local quantitative statistics, as well as qualitative measures and adhoc and bespoke data collection.

3.3 Public Health England (PHE) has responsibility to support knowledge and intelligence across the health system. On an annual basis PHE produces local Health Profiles for each local authority area providing an overview of key measures relating to the Health and Well Being of a population. This is a useful resource for members of the Board.

3.4 The presentation provides an opportunity for discussion at the Health and Well Being Board regarding what is known about the current health status of the people of Hartlepool. It is anticipated the discussion may help to and reaffirm priorities for action and service development.

4. RECOMMENDATIONS

4.1 Members of the Board are asked to consider the content of the presentation and discuss the key messages regarding the health status of the people of Hartlepool.

5. CONTACT OFFICER

5.1 Louise Wallace
Director of Public Health
Hartlepool Borough Council
4th Floor Civic Centre
louise.wallace@hartlepool.gov.uk

Public Health England

Protecting and improving the nation's health

Hartlepool

Unitary Authority

This profile was produced on 2 June 2015

Health Profile 2015

Health in summary
The health of people in Hartlepool is generally worse than the England average. Deprivation is higher than average and about 29.8% (5,300) children live in poverty. Life expectancy for both men and women is lower than the England average.

Living longer
Life expectancy is 10.8 years lower for men and 8.6 years lower for women in the most deprived areas of Hartlepool than in the least deprived areas.

Child health
In Year 6, 24.4% (245) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 54.2*. This represents 12 stays per year. Levels of teenage pregnancy, breastfeeding and smoking at time of delivery are worse than the England average.

Adult health
In 2012, 30.6% of adults are classified as obese, worse than the average for England. The rate of alcohol related harm hospital stays was 831*, worse than the average for England. This represents 750 stays per year. The rate of self-harm hospital stays was 294.9*, worse than the average for England. This represents 273 stays per year. The rate of smoking related deaths was 391*, worse than the average for England. This represents 199 deaths per year. Estimated levels of adult excess weight, smoking and physical activity are worse than the England average. The rate of hip fractures is worse than average. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average.

Local priorities
Priorities in Hartlepool include reducing smoking prevalence, reducing drug and alcohol-related harm, and reducing levels of obesity across the population. For more information see www.teespublichealth.nhs.uk

* rate per 100,000 population

Population: 93,000
Mid-2013 population estimate. Source: Office for National Statistics.

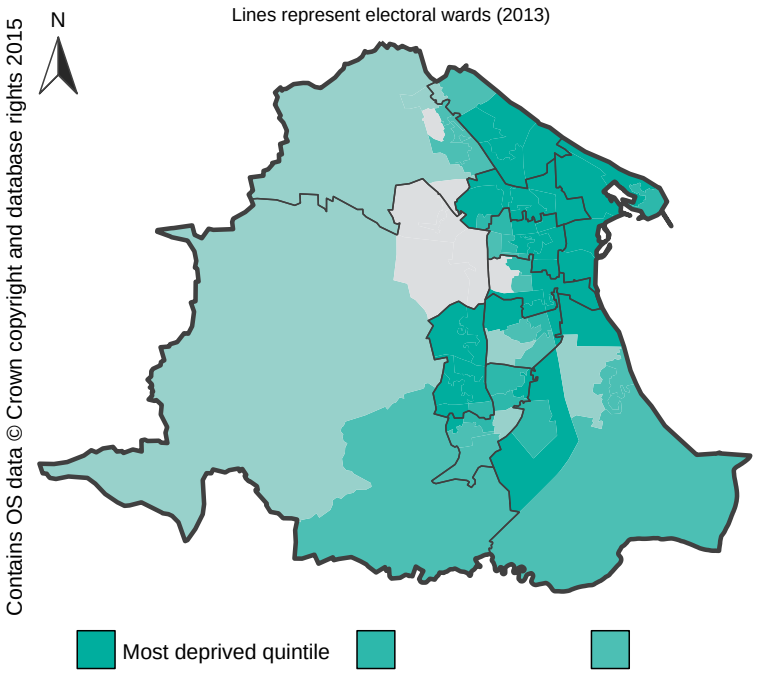
This profile gives a picture of people's health in Hartlepool. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

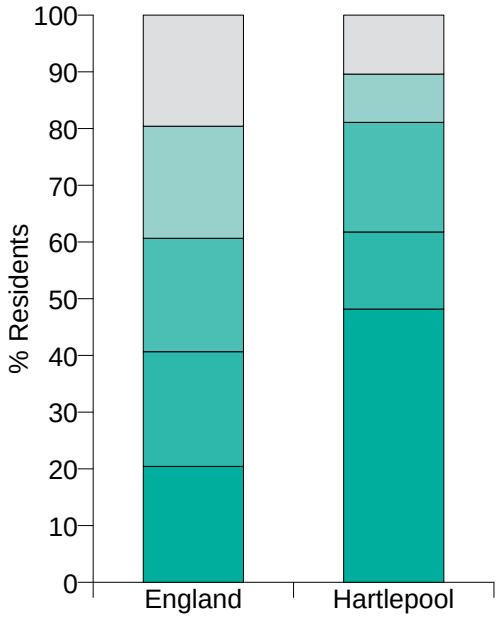
Follow @PHE_uk on Twitter

Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using quintiles (fifths) of the Index of Multiple Deprivation 2010, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



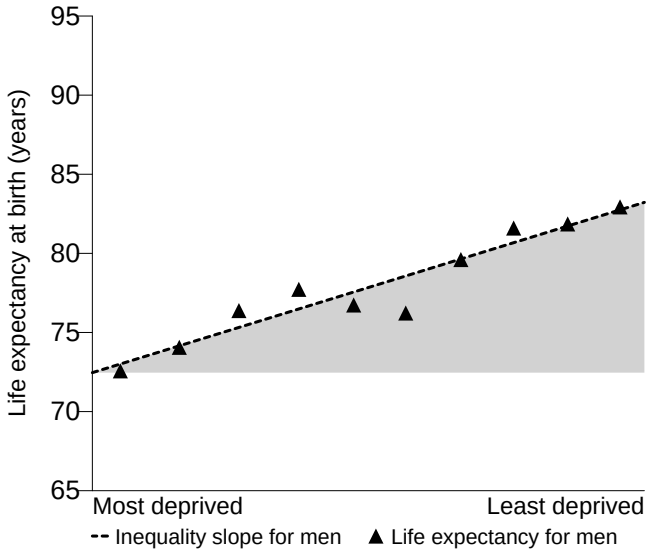
This chart shows the percentage of the population who live in areas at each level of deprivation.



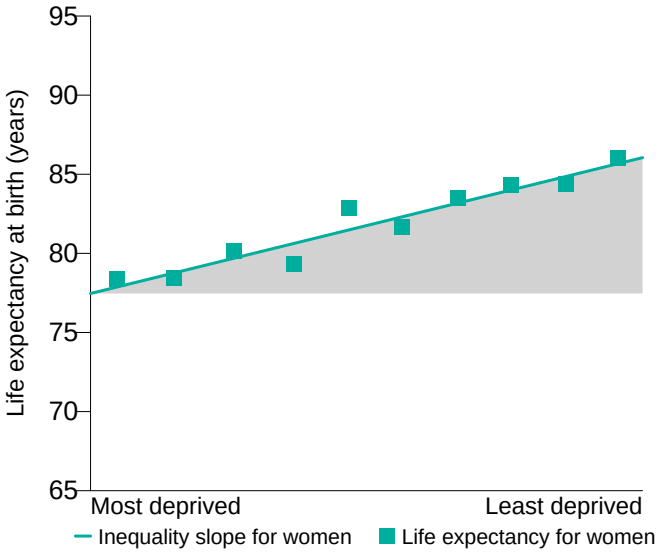
Life expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2011-2013. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life expectancy gap for men: 10.8 years



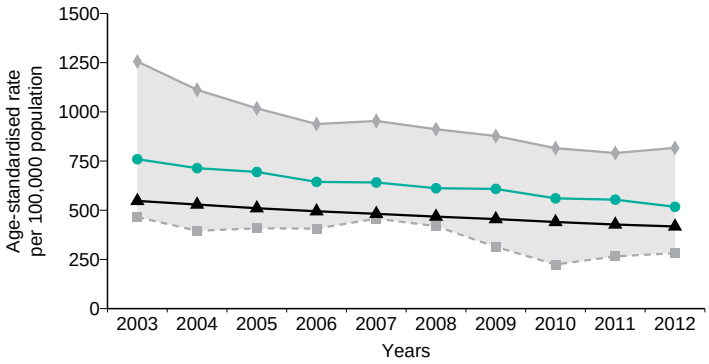
Life expectancy gap for women: 8.6 years



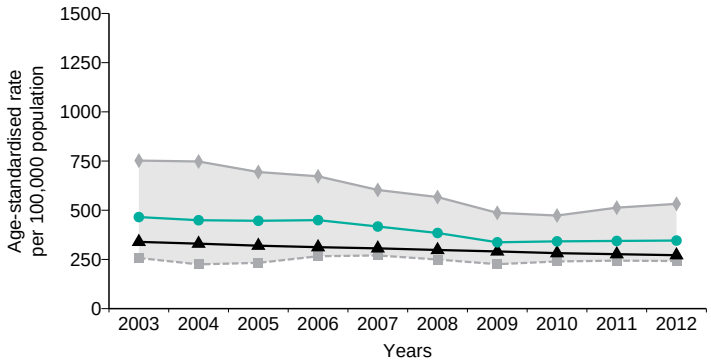
Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

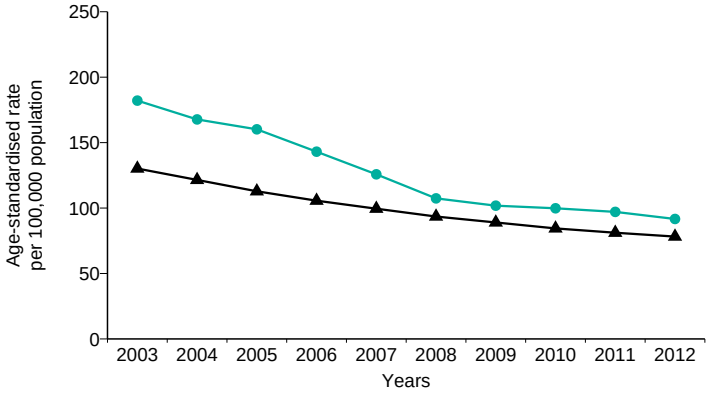
Early deaths from all causes: MEN



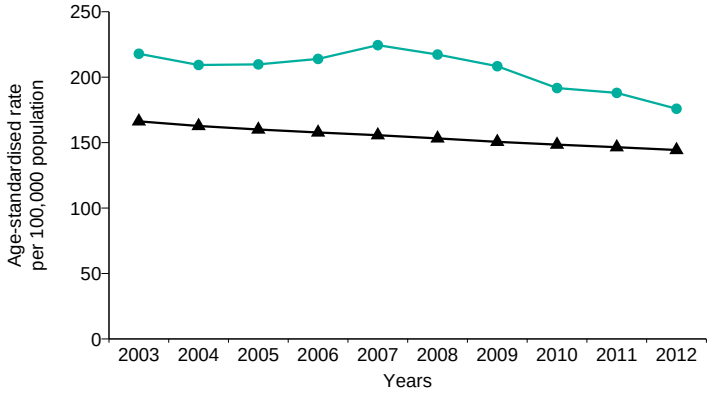
Early deaths from all causes: WOMEN

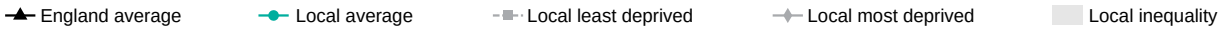


Early deaths from heart disease and stroke



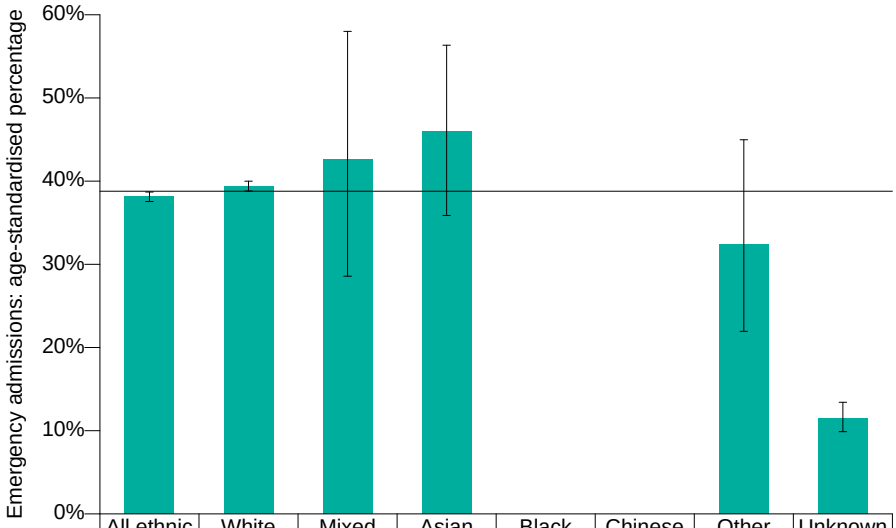
Early deaths from cancer





Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group, 2013



This chart shows the percentage of hospital admissions for each ethnic group that were emergencies, rather than planned. A higher percentage of emergency admissions may be caused by higher levels of urgent need for hospital services or lower use of services in the community. Comparing percentages for each ethnic group may help identify inequalities.

Hartlepool

England average (all ethnic groups)

95% confidence interval

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
10,434	10,198	18	41	-	-	19	144	Local number of emergency admissions
38.1	39.4	42.6	45.9	-	-	32.4	11.5	Local value %
38.8	39.2	38.3	43.0	42.5	35.2	44.9	30.1	England value %

Health summary for Hartlepool

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average^ England Average

England Worst | 25th Percentile | 75th Percentile | England Best

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation	44,642	48.2	20.4	83.8		0.0
	2	Children in poverty (under 16s)	5,315	29.8	19.2	37.9		5.8
	3	Statutory homelessness	33	0.8	2.3	12.5		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	618	55.1	56.8	35.4		79.9
	5	Violent crime (violence offences)	1,078	11.7	11.1	27.8		2.8
	6	Long term unemployment	1,233	21.2	7.1	23.5		0.9
Children's and young people's health	7	Smoking status at time of delivery	181	18.2	12.0	27.5		1.9
	8	Breastfeeding initiation	505	47.8	73.9			
	9	Obese children (Year 6)	245	24.4	19.1	27.1		9.4
	10	Alcohol-specific hospital stays (under 18)†	11.7	54.2	40.1	105.8		11.2
	11	Under 18 conceptions	58	33.0	24.3	44.0		7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	24.0	18.4	30.0		9.0
	13	Percentage of physically active adults	214	47.1	56.0	43.5		69.7
	14	Obese adults	n/a	30.6	23.0	35.2		11.2
	15	Excess weight in adults	164	68.5	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma†	10.7	13.2	18.4	38.0		4.8
	17	Hospital stays for self-harm	273	294.9	203.2	682.7		60.9
	18	Hospital stays for alcohol related harm†	750	831	645	1231		366
	19	Prevalence of opiate and/or crack use	1,018	17.0	8.4	25.0		1.4
	20	Recorded diabetes	4,730	6.2	6.2	9.0		3.4
	21	Incidence of TB†	5.7	6.1	14.8	113.7		0.0
	22	New STI (exc Chlamydia aged under 25)	423	711	832	3269		172
	23	Hip fractures in people aged 65 and over	129	757	580	838		354
Life expectancy and causes of death	24	Excess winter deaths (three year)	55.5	19.3	17.4	34.3		3.9
	25	Life expectancy at birth (Male)	n/a	77.8	79.4	74.3		83.0
	26	Life expectancy at birth (Female)	n/a	81.6	83.1	80.0		86.4
	27	Infant mortality	3	2.7	4.0	7.6		1.1
	28	Smoking related deaths	199	390.8	288.7	471.6		167.4
	29	Suicide rate	10	11.4	8.8			
	30	Under 75 mortality rate: cardiovascular	70	91.7	78.2	137.0		37.1
	31	Under 75 mortality rate: cancer	136	175.9	144.4	202.9		104.0
	32	Killed and seriously injured on roads	26	28.5	39.7	119.6		7.8

Indicator notes

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013 13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

† Indicator has had methodological changes so is not directly comparable with previously released values. ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk